

Public Document



UTILIZATION REVIEW GUIDELINES

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TABLE OF CONTENTS

PREFACE

Definition of Terms

Application of Time Limitations

BENEFIT GUIDELINES

Code on Dental Procedures

DIAGNOSTIC	D0100 - D0999
PREVENTIVE	D1000 - D1999
RESTORATIVE	D2000 - D2999
ENDODONTICS	D3000 - D3999
PERIODONTICS	D4000 - D4999
PROSTHODONTICS, REMOVABLE	D5000 - D5899
MAXILLOFACIAL PROSTHETICS	D5900 - D5999
IMPLANT SERVICES	D6000 - D6199
PROSTHODONTICS, FIXED	D6200 - D6999
ORAL AND MAXILLOFACIAL SURGERY	D7000 - D7999
ORTHODONTICS	D8000 - D8999
ADJUNCTIVE GENERAL SERVICES	D9000 - D9999
EVIDENCE BASED DENTISTRY	

PREFACE

The following dental treatment guidelines should be used in determining whether a service qualifies for coverage under the terms of a group contract. While services may be dentally appropriate and necessary, they may not be covered by contractual time limitations.

In administering the policies, the following definitions should be used consistently.

APPROVE- The procedure has been reviewed and qualifies for coverage in accordance with the guidelines set forth in this document. The procedure is subject to all deductibles, co-insurance and maximums under the group contract.

DENY- The procedure has been reviewed and does not qualify for benefits under the guidelines set forth in this document. A procedure may also be denied for contractual reasons. **Whenever a procedure is denied, the patient is held responsible up to the dentist's charge.**

DISALLOW- No payment is made by Altus and the patient is held harmless. A disallow can only be enforced on a participating dentist.

A procedure may be DISALLOWED for:

Unbundling; Example: Dentist submits for a pulpotomy (D3220) and root canal (D3310-D3330) on the same tooth within 60 days of each other. The pulpotomy is considered part of the root canal and it will not be paid separately. DISALLOW -par/DENY- non par.

ALTERNATE BENEFIT- A non covered procedure is performed, yet the group contract covers a least costly alternative procedure, an alternate benefit is applied. The patient is held responsible for the difference up to the dentist's charge.

Example: Composite restorations on posterior teeth. An alternate benefit of an amalgam restoration will be made and the patient is responsible for the difference up to the dentist's charge for the composite restoration.

SUBMITTED AMOUNT- The dentist's charge for the service.

APPROVED AMOUNT- For a par dentist: the fee profile. For non par dentist: the submitted charge.

ALLOWED AMOUNT- For a par dentist: the fee profile. For a non-par dentist, the allowance is equal to the fee set in the Ingenix (Usual & Customary) table.

POLICY REGARDING APPLICATION OF TIME LIMITATIONS

Time limitations apply when claims history reflects that a procedure has been paid by Altus or uploaded from another carrier.

BENEFIT GUIDELINES

The following sections list the appropriate CDT (Codes for Dental Terminology) codes, a description of the procedure, a short summary of the benefit guideline and the documentation requirements for that procedure code.

Although a procedure code may be listed in our benefit guidelines, a group may not cover all procedures. The group account chooses the benefit coverage. **Payment for a procedure code is based on Altus Dental's reimbursement policies, utilization review guidelines, and documentation requirements, which may include descriptions that are at variance with descriptions included in CDT codes (Code for Dental Terminology), which are owned and licensed by the American Dental Association.**

Procedures that require review by DCM/Consultant, are denoted in **Documentation Requirements**

DIAGNOSTIC 0100-0999

Code	Description of Service	Administrative Guidelines	Documentation Requirements
CLINICAL ORAL EVALUATIONS			
Evaluations/examinations include, but are not limited to, examination of all hard and soft tissues of the oral cavity, periodontal charting, and oral cancer screening.			
Evaluations/examinations must be performed by a licensed dentist to be considered for reimbursement.			
There is no distinction made between evaluations provided by general practitioners and Specialists.			
D0120	Periodic oral evaluation	<p>CDT: An evaluation performed on a patient of record to determine any changes in the patient's dental and medical health status since a previous comprehensive or periodic evaluation. This includes an oral cancer evaluation and periodontal screening where indicated, and may require interpretation of information acquired through additional diagnostic procedures. Report additional diagnostic procedures separately.</p> <p>Up to two periodic oral exams may be benefited based on the group contract, per member, per calendar year or policy year (beginning with the year following the initial exam).</p>	
D0140	Limited oral evaluation - problem focused	<p>CDT: An evaluation limited to a specific oral health problem or complaint. This may require interpretation of information acquired through additional diagnostic procedures. Report additional diagnostic procedures separately. Definitive procedures may be required on the same date as the evaluation.</p> <p>Typically, patients receiving this type of evaluation present with a specific problem and/or dental emergencies, trauma, acute infections, etc.</p> <p>Effective June 1, 2002, a Limited Oral Evaluation (Emergency Exam) is allowed with definitive treatment.</p> <p>The performance of an Emergency Exam does count toward the patient's benefit of two exams per calendar year.</p>	
D0145	Oral evaluation-patient under 3 years of age and counseling with primary caregiver	<p>CDT: Diagnostic services performed for a child under the age of three, preferably within the first six months of the eruption of the first primary tooth, including recording the oral and physical health history, evaluation of caries susceptibility, development of an appropriate preventive oral health regimen and communication with and counseling of the child's parent, legal guardian and/or primary caregiver.</p> <p>Note: Procedure code D1330 is disallowed when submitted with this code since the nomenclature includes this service. If patient is 3 years of age or older, deny procedure. If a D0150 is received after a D0145, allow. Allow payment for a general dentist or specialist.</p>	
D0150	Comprehensive oral evaluation - new or established patient	<p>CDT: Used by a general dentist and/or specialist when evaluating a patient comprehensively. This applies to new patients; established patients who have had a significant change in health conditions or other unusual circumstances, by report, or established patients who have been absent from active treatment for three or more years. It is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues. It may require interpretation of information acquired through additional diagnostic procedures. Additional diagnostic procedures should be reported separately.</p> <p>This includes an evaluation for oral cancer where indicated, the evaluation and recording of the patient's dental and medical history and a general health assessment. It may include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, existing prostheses, occlusal relationships, periodontal conditions (including periodontal screening and/or charting), hard and soft tissue anomalies, etc.</p>	

		<p>1.) Allow benefit as long as there is no history of a D0150, D0120 or other services by the same dentist/dental office within 36 months. 2.) If the patient has had services by the same dentist/dental office within 36 months, but has no history of an D0150 or an D0120, allow the D0150. 3.) If the patient has history of a D0120 within the last 36 months, pay the D0150 as an D0120 and disallow the balance.</p> <p>EXCEPTIONS: D0150 will NOT be converted to D0120 when the following procedure codes are found in history within the prior 36 months: D0140, D0220, & D7111-D9999 (including D9110). Updated 3/15/06.</p> <p><u>Limitation:</u></p> <p>Either one comprehensive oral evaluation (D0150), one detailed and extensive oral evaluation (D0160), or one Comprehensive Perio Eval (D0180) is allowed in a 36 month period when performed by the same dentist.</p> <p><u>Rationale:</u></p> <p>Accepted dental standards indicate that an initial visit should involve a comprehensive oral examination. Subsequent visits will be called periodic and are done on a routine basis.</p>	
D0160	Detailed and extensive oral evaluation - problem focused, by report	<p>CDT: A detailed and extensive problem focused evaluation entails extensive diagnostic and cognitive modalities based on the findings of a comprehensive oral evaluation. Integration of more extensive diagnostic modalities to develop a treatment plan for a specific problem is required. The condition requiring this type of evaluation should be described and documented.</p> <p>Examples of conditions requiring this type of evaluation may include dentofacial anomalies, complicated perio-prosthetic conditions, complex temporomandibular dysfunction, facial pain of unknown origin, conditions requiring multi-disciplinary consultation, etc.</p> <p><u>Limitation:</u></p> <p>Either one comprehensive oral evaluation (D0150), one detailed and extensive oral evaluation (D0160), or one Comprehensive Perio Eval (D0180) is allowed in a 36 month period when performed by the same dentist.</p>	
D0170	Re-evaluation -limited, problem focused (established patient; not post-op visit)	<p>CDT: Assessing the status of a previously existing condition. For example: 1) traumatic injury where no treatment was rendered but the patient needs follow-up monitoring, 2) evaluation for undiagnosed continuing pain and 3) soft tissue lesion requiring follow-up evaluation.</p> <p><u>Limitation:</u></p> <p>By definition, this procedure is not to be used for a post-operative visit. By the same logic, this procedure is not to be used for follow-up to “non-surgical” definitive care such as root canal treatment or the seating of a crown.</p> <p>If this procedure is submitted alone on a claim (no definitive treatment), benefit as submitted. If the D0170 is submitted with definitive treatment (same date of service), DISALLOW.</p>	
D0180	Comprehensive periodontal evaluation - new or established patient	<p>CDT: This procedure is indicated for patients showing signs or symptoms of periodontal disease and for patients with risk factors such as smoking or diabetes .It includes evaluation of periodontal conditions, probing and charting, evaluation and recording of the patient's dental and medical history and general health assessment. It may include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, occlusal relationships & oral cancer evaluation.</p> <p><u>Limitation:</u></p> <p>Allowed as long as patient has not had a D0150, D0120 by the submitting dentist/dental office within 36 months. If there is evidence of treatment other than a D4910 by the submitting dentist/dental office, convert the D0180 to an D0120 and allow the dentist to bill up to their allowance for the D0180.</p> <p><u>EXCEPTIONS:</u></p> <p>D0180 will NOT be converted to D0120 when the following procedure codes are found in history within the prior 36 months: D0140, D0220, & D7111-D9999 (including D9110). Updated 3-6-07</p>	
RADIOGRAPHS/DIAGNOSTIC IMAGING (Including interpretation)			
Fees for duplication (copying) of radiographs for insurance purposes are disallowed.			
Radiographs must be of diagnostic quality, and include patient name, the date the x-ray was taken and labeled left or right.			
D0210	Intraoral - complete series (including bitewings)	<p>CDT: A radiographic survey of the whole mouth, usually consisting of 14-22 periapical and posterior bitewing images intended to display the crowns and roots of all teeth, periapical areas and alveolar bone.</p>	

		A full-mouth series (or panoramic film) is covered once every 36 or 60 months in accordance with the group's benefits. A full mouth series includes bitewings and all necessary periapicals (minimum of 10). If bitewings and FMX are taken in the same calendar year, the fee will be adjusted accordingly.	
		A full series of x-rays taken on children under the age of 12 will be disallowed. A participating dentist may not charge the patient for this service.	
		<u>Limitation:</u>	
		For contracts with 1 series of bitewings per calendar year: If bitewings are taken on a different DOS from an FMX within the same calendar year, they will be denied (if taken after the FMX) or deducted from the FMX (if taken before the FMX) with the patient responsible for the bitewings as the fee for an FMX includes bitewings.	
		Patients with double Altus Dental coverage are allowed an additional full mouth series in the three or five year period if they meet at least one of the following criteria for dental necessity: 1) Current active perio therapy consisting of D4341 at a minimum 2) History of more than 3 root canals 3) Third molars still present and a history of treatment for pericoronitis 4) History of cysts of the jaw	
D0220	Intraoral periapical-first film	<u>Definition:</u> A diagnostic film taken prior to a procedure in a limited area of the mouth.	
D0230	Intraoral periapical - each additional film	Routine working and final treatment x-rays are part of the complete procedure and not a separate benefit. Individually listed intraoral radiographs by the same dentist/dental office are considered a complete series if the fee for individual radiographs equals or exceeds the fee for a complete series done on the <u>same date of service</u> . Any fee in excess of the fee for a full mouth series of radiographs is disallowed.	
		Proc. code D0220 performed on the same date of service as a crown insertion will be DISALLOWED. (Update 1/1/06)	
D0240	Intraoral - occlusal film	Two occlusal films are allowed in a 12-month period.	
D0250	Extraoral - first film		
D0260	Extraoral - each additional film		
D0270	Bitewing - single film	One set of bitewings (2, 3, 4 or vertical) is allowed per calendar year. A maximum of 7 films (periapical/occlusal/bitewings) are allowed in a calendar year for the same provider. <u>Example: 4 BWX (D0274) equate to one film.</u> (Additional films beyond seven (7) for the same par dentist will be disallowed; denied to same non-par dentist). If a different dentist does additional films, allow.	
D0272	Bitewings - two films	Bitewing radiographs are considered to be part of the FMX when taken in the same calendar year, by the same provider. Bitewing x-rays taken on the same date of service as a panoramic film by the same provider should be disallowed for participating dentists/ denied for non-participating dentists. If bitewings and a panoramic film are taken on the same date of service by the same dentist/dental office, an allowance of an FMX will be made. A single bitewing taken for emergency purposes (D9110) is allowed.	
D0273	Bitewings - three films	Bitewings taken on a different date of service within the same calendar year as a panoramic film are allowed separately so long as the frequency limitation for bitewings (usually one series per calendar year) has not been met.	
D0274	Bitewings - four films	Patients with double Altus Dental coverage are allowed an additional set in a calendar year if they meet at least one of the following criteria for dental necessity: 1) History of active caries. Previous series of x-rays resulted in treatment of at least 2 interproximal lesions. 2) Active periodontal therapy consisting of regular periodontal probings and receiving at least service D4910 (and all more aggressive perio therapy). 3) Radiation therapy to the head and neck during the previous six months. A narrative must be submitted for DCM to review. If no narrative, the claim will deny up front.	
		Bitewing, periapical and/or occlusal x-rays taken on the same date of service as a panoramic film by the same provider should be considered a complete series (D0210) for time limitations and any fee in excess of the fee for an FMX is DISALLOWED for participating providers or DENIED for non-participating providers.	
D0277	Vertical bitewings - 7 to 8 films	CDT: This does not constitute a full mouth radiographic series.	

D0290	Posterior/anterior or lateral skull and facial bone survey film	60 month time limitation.	
D0310	Sialography	60 month time limitation.	Narrative
D0320	Temporomandibular joint arthrogram, including injection	60 month time limitation.	
D0321	Other Temporomandibular joint films, by report	60 month time limitation.	
D0322	Tomographic survey	Not a covered benefit.	
D0330	Panoramic film	A panoramic film is covered once every 36 or 60 months in accordance with the group's benefits. If bitewings and a panoramic film are taken on the same date of service by the same dentist/dental office, an allowance of an FMX will be made. <u>Limitations:</u> Bitewing, periapical and/or occlusal x-rays taken on the same date of service as a panoramic film by the same provider should be considered a complete series (0210) for time limitations and any fee in excess of the fee for an FMX is DISALLOWED for participating providers or DENIED for non-participating providers. For all dentists, a panoramic film taken on the same date of service as an FMX is disallowed as part of the FMX for participating providers or DENIED for non-participating providers.	
D0340	Cephalometric film	Covered for orthodontic purposes only. The fee for this film is included in the overall orthodontic case fee and cannot be billed separately by participating dentists. Patient must have ortho coverage.	
D0350	Oral/facial photographic images	CDT: This includes photographic images, including those obtained by intraoral and extraoral cameras, excluding radiographic images. These photographic images should be a part of the patient's clinical record. Benefits are available for orthodontic diagnosis only. The fee for orthodontic photographs is included in the overall orthodontic case fee and cannot be billed separately (Includes intra and extraoral images). <u>Limitation:</u> Benefits are available for orthodontic records only when the patient elects not to start treatment. This must be documented in the treatment chart. <u>Rationale:</u> Diagnostic photographs / images are considered part of ortho records and are not separately billable to the patient or to Altus.	
D0360	Cone beam ct - craniofacial data capture	CDT: Includes axial, coronal and sagittal data. Not a covered benefit.	
D0362	Cone beam - two-dimensional image reconstruction using existing data, includes multiple images	Not a covered benefit.	
D0363	Cone beam - three-dimensional image reconstruction using existing data, includes multiple images	Not a covered benefit.	
TESTS AND EXAMINATIONS			
D0415	Collection of microorganisms for culture and sensitivity	Not a covered benefit unless specified under the group contract. For those groups with coverage, this procedure is limited to once per calendar year.	
D0416	Viral Culture	CDT: A diagnostic test to identify viral organisms, most often herpes virus. Not a covered benefit.	

D0417	Collection and preparation of saliva sample for laboratory diagnostic testing	Not a covered benefit unless specified under the group contract.	
D0418	Analysis of saliva sample	Not a covered benefit unless specified under the group contract.	
D0421	Genetic test for susceptibility to oral diseases	CDT: Sample collection for the purpose of certified laboratory analysis to detect specific genetic variations associated with increased susceptibility for oral diseases such as severe periodontal disease. Not a covered benefit.	
D0425	Caries susceptibility test	CDT: Not to be used for carious dentin staining. Not a covered benefit unless specified under the group contract. For those groups with coverage, this procedure is limited to once per lifetime.	
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	Not a covered benefit.	
D0460	Pulp vitality tests	CDT: Includes multiple teeth and contra lateral comparison(s), as indicated. Pulp Vitality tests are payable per visit, not per tooth, and only for the diagnosis of emergency conditions. Fees for pulp tests are disallowed when performed on the same date as any other definitive procedure, except emergency evaluation (D0140) or palliative treatment (D9110).	
D0470	Diagnostic casts	CDT: Also known as diagnostic models or study models. Benefits are available for diagnostic casts when taken as an initial diagnostic aid in determining a patient's total treatment plan. <u>Limitation:</u> Fees for working models, such as those utilized for preparation of crowns, bridges, periodontal surgical stents, occlusal guards, nightguards etc. are not considered diagnostic in nature and are included in the fees for those procedures. The patient cannot be billed separately for such working models. If definitive prosthetic treatment (crown, bridge, dentures) is completed within 12 months after date of service of diagnostic casts, the fee for diagnostic casts will be deducted from the definitive treatment fee. <u>Rationale:</u> Diagnostic models are considered part of the overall treatment rendered.	
ORAL PATHOLOGY LABORATORY (Use codes D0472-D0502)			
D0472	Accession of tissue, gross examination, preparation and transmission of written report	CDT: To be used in reporting architecturally intact tissue obtained by invasive means. Not a covered benefit.	
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	CDT: To be used in reporting architecturally intact tissue obtained by invasive means. Not a covered benefit.	

D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	CDT: To be used in reporting architecturally intact tissue obtained by invasive means. Not a covered benefit.	
D0475	Decalcification procedure	CDT: Procedure in which hard tissue is processed in order to allow sectioning and subsequent microscopic examination. Not a covered benefit.	
D0476	Special stains for microorganisms	CDT: Procedure in which additional stains are applied to a biopsy or surgical specimen in order to identify microorganisms. Not a covered benefit.	
D0477	Special stains, not for microorganisms	CDT: Procedure in which additional stains are applied to a biopsy or surgical specimen in order to identify such things as melanin, mucin, iron, glycogen, etc. Not a covered benefit.	
D0478	Immunohistochemical stains	CDT: A procedure in which specific antibody based reagents are applied to tissue samples in order to facilitate diagnosis. Not a covered benefit.	
D0479	Tissue in- situ hybridization, including interpretation	CDT: A procedure that allows for the identification of nucleic acids, DNA and RNA, in the tissue sample in order to aid in the diagnosis of microorganisms and tumors. Not a covered benefit.	
D0480	Accession of exfoliative cytologic smears, microscopic examination, preparation and transmission of written report	CDT: To be used in reporting disaggregated, non-transepithelial cell cytology sample via mild scraping of the oral mucosa. Not a covered benefit.	
D0481	Electron microscopy - diagnostic	CDT: An extreme high magnification diagnostic procedure that enables identification of cell components and microorganisms that are otherwise not identifiable under light microscopy. Not a covered benefit.	
D0482	Direct immunofluorescence	CDT: A technique used to identify immunoreactants that are localized to the patient's skin or mucous membranes. Not a covered benefit.	
D0483	Indirect immunofluorescence	CDT: A technique used to identify circulating immunoreactants. Not a covered benefit.	
D0484	Consultation on slides prepared elsewhere	A service provided in which microscopic slides of a biopsy specimen prepared at another laboratory are evaluated to aid in the diagnosis of a difficult case or to offer a consultative opinion at the patient's request. The findings are delivered by written report. Not a covered benefit.	
D0485	Consultation, including preparation of slides from biopsy material supplied by referring source	CDT: A service that requires the consulting pathologist to prepare the slides as well as render a written report. The slides are evaluated to aid in the diagnosis of a difficult case or to offer a consultative opinion at the patient's request. Not a covered benefit.	
D0486	Laboratory accession of	CDT: To be used in pathology laboratory reporting transepithelial, disaggregated cell samples by brush biopsy technique.	Pathology report

	brush biopsy sample, microscopic examination, preparation and transmission of written report	<u>Limitation:</u> Allow if D7288 in history. Not a medical prime code; group specific.	
D0502	Other oral pathology procedures, by report	Not a covered benefit.	
D0999	Unspecified diagnostic procedure, by report	<p>CDT: Used for procedure that is not adequately described by a code. Describe procedure. Individual Consideration by a Dental Consultant.</p> <p>When a claim is submitted under a "D_999" code:</p> <p>1.The information submitted, specifically the narrative, should be reviewed for its content and translated to a recognized code if possible. For example, if information is submitted under D4999 and it is determined that a gingivectomy was performed, the code should be changed to a D4211 and processed accordingly.</p> <p>2. If, however, an unusual procedure was performed for which there is no code, the narrative should be reviewed along with the submitted charge. The Dental Consultant will determine what a "reasonable" fee is for the procedure depending on both the degree of difficulty and the time involved.</p>	Narrative
PREVENTIVE D1000-D1999			
DENTAL PROPHYLAXIS			
D1110	Prophylaxis-adult, age 14 and over	<p>CDT: Removal of plaque, calculus and stains from the tooth structures in the permanent and transitional dentition. It is intended to control local irritational factors.</p> <p><u>Limitation:</u> Most contracts provide for two cleanings in a calendar year period; some contracts allow one every 6 months.</p> <p><u>Exception:</u> The average dental patient requires two prophylaxes per year. Any patient requiring more than this has a need that is outside the average. Additional prophylaxis can be done when the patient agrees to assume the additional cost.</p> <p>If scaling and root planing (D4341 or D4342) or osseous surgery (D4260 or D4261), is submitted in conjunction with any type of a full mouth prophylaxis (including D1110, D4910), the scaling and root planing or osseous surgery should be paid as submitted if it qualifies. The prophylaxis should be pro-rated excluding the quadrant(s) that were already benefited for other periodontal procedures.</p> <p><u>Example:</u> URQ of D4341 is submitted on same date of service as D1110, pay the D4341 (if it qualifies), and pro-rate the D1110, 75% of the allowance of a D1110.</p>	
D1120	Prophylaxis-child	<p>CDT: Removal of plaque, calculus and stains from the tooth structures in the primary and transitional dentition. It is intended to control local irritational factors.</p> <p><u>Limitation:</u> Considered a child prophylaxis up to, but not including their 14th birthday. (Update 1/1/06)</p>	
D1203	Topical application of fluoride - child	<p>CDT: Used when reporting prophylaxis and fluoride procedures separately.</p> <p><u>Limitation:</u> Most groups cover one (1) topical application of fluoride per 12 months for covered dependents up to, but not including their 19th birthday (prophylaxis not included). Fluoride must be applied separately from prophylaxis paste.</p>	
D1204	Topical application of fluoride - adult	<p>CDT: Used when reporting prophylaxis and fluoride procedures separately.</p> <p>Topical fluoride for an adult is not a covered benefit.</p>	
D1206	Topical fluoride, varnish; therapeutic application for moderate to high caries risk patients	<p>CDT: Application of topical fluoride varnish, delivered in a single visit and involving the entire oral cavity. Not to be used for desensitization.</p> <p>Not a covered benefit under most group contracts.</p>	
		Benefited once every 12 months for patients over age 16 following gingival flap or osseous surgery; D4240, D4260.	

OTHER PREVENTIVE SERVICES

D1310	Nutritional counseling for control of dental disease	<p>CDT: Counseling on food selection and dietary habits as a part of treatment and control of periodontal disease and caries.</p> <p>Not a covered benefit.</p>	
D1320	Tobacco counseling for the control and prevention of oral disease	<p>CDT: Tobacco prevention and cessation services reduce patient risks of developing tobacco-related oral diseases and conditions and improves prognosis for certain dental therapies.</p> <p>Not a covered benefit.</p>	
D1330	Oral hygiene instruction	<p>CDT: This may include instructions for home care. Examples include tooth brushing technique, flossing, use of special oral hygiene aids.</p> <p>Not a covered benefit.</p>	
D1351	Sealant-per tooth	<p>CDT: Mechanically and/or chemically prepared enamel surface sealed to prevent decay.</p> <p>Benefit is subject to a 36 month time limitation (per contract) per unrestored tooth and includes all necessary repair or replacement. If repair/replacement is submitted within 36 months from initial application, disallow to the same participating dentist/denied for non-par or different dentist. Special consideration for eruption can be given upon submission of a narrative.</p>	

SPACE MAINTENANCE (Passive Appliances)

Passive appliances are designed to prevent tooth movement.

Space maintainers are used to retain space for the eruption of permanent teeth when the primary teeth are lost prematurely. Most permanent teeth erupt by the age of 14 years.

D1510	Space maintainer-fixed unilateral	<u>Limitation:</u>	Indicate quadrant
D1515	Space maintainer-fixed bilateral	Space maintainers are a benefit for covered dependents up to, but not including their 14 th birthday and are payable upon placement.	Indicate arch
D1520	Space maintainer-removable unilateral	Space maintainers are not a benefit on anterior teeth (central and lateral incisors).	Indicate quadrant
D1525	Space maintainer-removable bilateral	<p>Benefits will be provided for one space maintainer in 60 months in the same area.</p> <p>There is no separate benefit for a stainless steel or resin crown when used as part of the space maintainer.</p> <p><u>Rationale:</u></p> <p>A space maintainer will normally perform its function during the time needed without replacement if fitted and cemented correctly. It is the rare case that requires replacement because of oral changes due to growth. Lost, broken or stolen appliances are not a benefit and are the patient's responsibility.</p>	Indicate arch
D1550	Re-cementation of space maintainer	<p><u>Limitation:</u></p> <p>One recementation per office is covered. Additional recements are denied thereafter as a patient responsibility.</p>	Indicate arch or quadrant
D1555	Removal of fixed space maintainer	<p>CDT: Procedure delivered by dentist who did not originally place the appliance, or by the practice where the appliance was originally delivered to the patient.</p> <p><u>Limitation:</u></p> <p>Allow only when performed by a different dentist/dental office than placed the appliance. Disallow to the same dentist/dental office. The fee for the removal of a fixed space maintainer is disallowed when submitted with recementation (D1550) by the same provider on the same date of service.</p>	

RESTORATIVE D2000-D2999

****If the procedure reported was the result of an accident, it should be submitted to the patient's medical and/or liability insurer first.****

AMALGAM RESTORATIONS (Including Polishing)

		<p>CDT: Tooth preparation, all adhesives (including amalgam bonding agents), liners and bases are included as part of the restoration. If pins are used, they should be reported separately (see D2951).</p> <p align="center">General Policy – All Restorations</p>	
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		Limit of One Restoration Per Surface: Payment is made for one restoration in each tooth surface irrespective of the number or combination of restorations placed. A separate charge may not be made to the patient by a participating dentist.	
		Ex: Dentist submits for tooth #3 O (pit) and again #3 O (pit) on the same claim form. Altus Dental will reimburse for one restoration, #3 O.	
		Multiple Surfaces Restored on a tooth on the same day: Multiple surfaces restored on the same tooth on the same day will be benefited as one multi-surface restoration.	
		Posterior restorations involving the proximal and the occlusal surfaces are considered one restoration for payment purposes.	
		Ex: Dentist submits for tooth #3 MO as well as #3 DO on the same claim form. Altus Dental will reimburse as #3 MOD.	
		Replacement of Restorations – 12 Month Rule: The replacement of amalgam or composite restorations within 12 months of the original placement is not allowed if the <u>exact</u> same surfaces are restored by the same dentist. A separate fee may not be charged to the patient by the same participating dentist DISALLOW - par dentist/DENY - non par (pay if different dentist).	
		Exception: If not an exact match on surfaces, allow entire restoration. Ex: #4 MOL in tooth history, claim submitted 6 months later for #4 MODL - ALLOW.	
		Exception: If endo treatment is performed within the 12 months, another restoration will be allowed regardless of surfaces involved.	
		Restorations for altering occlusion involving vertical dimension and the replacement of tooth structure lost due to attrition, erosion, abrasion, abfraction, corrosion and TMD are denied. Exception - Class V (facial or lingual surface) restorations are allowed when these conditions are present.	
		Gingivectomies done on the same day as a restoration are considered part of the procedure and a separate charge may not be made to the patient (except in the case of a Class V restoration; gingivectomy is allowed on the same day in this instance).	
		An amalgam or resin restoration placed the same day as a crown on the same tooth is disallowed as part of the procedure. If the dentist submits for a single surface filling after the crown is placed, pay for the filling. If the dentist submits for a multi-surface filling after the crown is placed, disallow.	
		Other Reviews: (Usually bundled on original processing)	
		In cases of multiple restorations involving the proximal and occlusal surfaces of the same tooth, benefits are limited to that of a multisurface restoration. A separate benefit may be allowed for a non-contiguous restoration on the buccal or lingual surface(s) of the same tooth. Examples:	
		· Office bills for an "M" (D2140), "O" (D2140) & "D" (D2140) on #3. Benefit is limited to a three-surface restoration, "MOD" (D2160).	
		· Office bills for an "M" (D2140), "O" (D2140), "D" (D2140) & "B" (D2140) on #3. Benefit is limited to a three-surface restoration, "MOD" (D2160) and a one-surface restoration, "B" (D2140).	
		· In the event an anterior proximal restoration involves a significant portion of the labial or lingual surface, it may be reported as D2331 or D2332, as appropriate.	
		· Any restoration involving two or more contiguous surfaces should be reported using the appropriate multiple surface restoration code.	
D2140	Amalgam - one surface, primary or permanent		
D2150	Amalgam - two surface, primary or permanent		
D2160	Amalgam -three surface, primary or permanent		
D2161	Amalgam - four or more surfaces, primary or permanent		
RESIN-BASED COMPOSITE RESTORATIONS - DIRECT			

		CDT: Resin-based composite refers to a broad category of materials including but not limited to composites. May include bonded composite, light-cured composite, etc. Tooth preparation, acid etching, adhesives (including resin bonding agents), liners and bases and curing are included as part of the restoration. Glass ionomers, when used as restorations, should be reported with these codes. If pins are used, they should be reported separately (see D2951).	
		The replacement of composite restorations within 12 months of the original placement is not allowed if the exact same surfaces are restored by the same dentist. A separate fee may not be charged to the patient by the same participating dentist DISALLOW - par dentist/DENY - non par (pay if different dentist).	
		Gingivectomies done on the same day as a restoration are considered part of the procedure and a separate charge may not be made to the patient by a par dentist; disallow.	
		** Benefits for composite resin restorations on permanent bicuspid or primary and permanent molars will be based on the corresponding benefit for an amalgam restoration. The patient is responsible for any difference up to the dentist's charge.	
		Posterior restorations involving the proximal and the occlusal surfaces are considered one restoration for payment purposes.	
D2330	Resin-based composite - one surface, anterior		
D2331	Resin-based composite - two surfaces, anterior		
D2332	Resin-based composite - three surfaces, anterior		
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	CDT: Incisal angle to be defined as one of the angles formed by the junction of the incisal and the mesial or distal surface of an anterior tooth.	
D2390	Resin-based composite crown, anterior	CDT: Full resin-based composite coverage of tooth. Code D2390-if performed on a <u>primary</u> anterior tooth, does not require Consultant review and is subject to a 24-month time limitation.	
		If code D2390 is performed on a <u>permanent</u> anterior tooth, it is considered a final crown restoration and is subject to the review criteria for restorative crowns. This procedure is subject to a 60-month time limitation.	
D2391	Resin-based composite - one surface, posterior	CDT: Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure. See ** above.	
D2392	Resin-based composite - two surface, posterior	See ** above.	
D2393	Resin-based composite - three surface, posterior	See ** above.	
D2394	Resin-based composite - four or more surfaces, posterior	See ** above.	
GOLD FOIL RESTORATIONS			
D2410	Gold-foil - one surface	Not a covered benefit.	
D2420	Gold-foil - two surfaces	Not a covered benefit.	
D2430	Gold-foil - three surfaces	Not a covered benefit.	
INLAY/ONLAY RESTORATIONS			

		This section includes cast inlays, onlays, restorative crowns and fixed bridges. Materials used can be cast in precious metals, semi-precious metals, non-precious metals, as well as porcelain. Cast restorations include all models, temporaries, final x-rays and other associated procedures.	
		NOTE: In some cases, an onlay is reported using both an inlay code and an onlay code. For example, a porcelain onlay on tooth #19 may be reported as tooth #19 code D2610 & tooth #19 code D2643. An onlay, by definition, includes the inlay. When the procedure is "split" into these two codes, combine the submitted fees for the inlay and onlay and process the claim using only the onlay code (D2643).	
		<u>Criteria for Inlays & Onlays:</u>	
		Inlays – Metallic will be benefited as an alternate benefit of an amalgam restoration. Porcelain/ceramic, composite/resin will be benefited as an alternate benefit of an amalgam restoration on posterior teeth and as a composite restoration on anterior teeth. Patients are responsible for the difference up to the dentist's charge. If covered under the group contract, it must meet the criteria for crown coverage.	
		Onlays (metallic and porcelain/ceramic) – see D2542-D2644 Tooth must meet the criteria for crown coverage for approval. If the tooth does not meet the criteria for crown coverage, process as an alternate benefit of an amalgam restoration on posterior teeth, or as a composite restoration on anterior teeth.	
		Composite/Resin Onlays – process as an alternate benefit of an amalgam restoration on posterior teeth and as a composite restoration on anterior teeth whether or not the tooth qualifies for full crown coverage. Patient is responsible for the difference up to the dentist's charge.	
		<u>Limitation:</u>	
		~~ Administration of 60-Month Time Limitation: The general rule is that benefits for either one onlay or one crown per tooth will be allowed in a 60-month period. If an onlay were to be replaced with a single tooth crown within the 60-month time limitation, Altus Dental will make a payment of the difference between the current allowance for a crown and the amount Altus originally paid for the onlay. The patient is responsible for the balance up to the maximum allowable charge for the crown. For a non-participating dentist, the patient is responsible up to the dentist's charge.	
		~~A Gingivectomy performed on the same day as an onlay placement is considered part of the procedure and a separate charge may not be made to the patient.	
		~~ If a buildup is submitted with an inlay, the buildup is wrapped up as part of the inlay procedure.	
		<u>Rationale:</u>	
		The application of an alternate benefit is in keeping with Altus's general policy to pay the least expensive professionally acceptable treatment. Inlays do not protect teeth from cuspal fractures, therefore are no better than amalgams in that respect. If cuspal protection is not needed, amalgams will adequately restore the teeth. Altus Dental routinely reimburses the least costly benefit when more than one treatment modality can be used.	
D2510	Inlay - metallic - one surface	An alternate benefit allowance of an amalgam restoration will be made towards the cost of all metallic inlays. The patient is responsible for the difference up to the dentist's charge.	
D2520	Inlay - metallic - two surfaces		
D2530	Inlay - metallic - three or more surfaces		
D2542	Onlay - metallic - two surfaces	An allowance for a metallic onlay will be made only if the tooth meets the criteria for crown placement. Otherwise, an alternate benefit allowance of an amalgam restoration will be made with the patient responsible for the difference up to the dentist's charge.	Tooth number, surfaces, and pre-operative periapical x-ray
D2543	Onlay - metallic - three surfaces		Tooth number, surfaces, and pre-operative periapical x-ray
D2544	Onlay - metallic - four or more surfaces		Tooth number, surfaces, and pre-operative periapical x-ray

D2610	Inlay - porcelain/ceramic - one surface	An alternate benefit allowance of an amalgam (posterior teeth)/composite (anterior teeth) restoration will be made towards the cost of all porcelain inlays. The patient is responsible for the difference up to the dentist's charge.	
D2620	Inlay - porcelain/ceramic - two surfaces		
D2630	Inlay - porcelain/ceramic - three or more surfaces		
D2642	Onlay - porcelain/ceramic - two surfaces	A porcelain onlay is a covered benefit if the tooth meets the requirements for crown placement. Only one onlay or one crown per tooth will be benefited in a five-year period. If the tooth does not qualify for a crown, an alternate benefit allowance of an amalgam (posterior teeth)/composite (anterior teeth) restoration will be made. The patient is responsible for the difference up to the dentist's charge when an alternate benefit is made.	Tooth number, surfaces, pre-op periapical x-ray and narrative
D2643	Onlay - porcelain/ceramic - three surfaces		Tooth number, surfaces, pre-op periapical x-ray and narrative
D2644	Onlay - porcelain/ceramic - four or more surfaces		Tooth number, surfaces, pre-op periapical x-ray and narrative
D2650	Inlay - resin based composite - one surface	An alternate benefit allowance of an amalgam restoration (posterior teeth)/composite restoration (anterior teeth) will be made toward the cost of all composite inlays. The patient is responsible for the difference up to the dentist's charge.	
D2651	Inlay - resin based composite - two surfaces		
D2652	Inlay - resin based composite - three or more surfaces		
D2662	Onlay - resin based composite - two surfaces	A composite/resin onlay is not a covered benefit. An alternate benefit allowance of an amalgam restoration (posterior teeth)/composite restoration (anterior teeth) will be made toward the cost of all composite onlays whether or not the tooth meets the criteria for crown coverage. The patient is responsible for the difference up to the dentist's charge.	
D2663	Onlay - resin based composite - three surfaces		
D2664	Onlay - resin based composite - four or more surfaces		
Criteria for Restorative Crowns			
		Cast restorations include all models, temporaries, final x-rays and other associated procedures. Gingivectomy, in conjunction with and for the purpose of placement of restorations/crowns, is included in the fee for the restoration; a separate charge may not be made to the patient. Exceptions: Allow a gingivectomy when performed on the same day as crown/onlay insertion if the tooth is broken below the gumline. A digital photograph is required. This policy pertains to crowns/onlays fabricated with Cerec.	
		Benefits are payable when the treatment is complete. For crowns, this is on the <u>insertion/cementation date</u> of the permanent crown, NOT the date of preparation.	
		If a root canal appears to be inadequately filled, incomplete or unsuccessful in a tooth that is being treated with major restorative procedures, DENY.	

		Attrition/Erosion/Abrasion/Abfraction/Corrosion and TMD Cases: Treatment to restore tooth structure lost due to attrition/erosion/abrasion/abfraction/corrosion and TMD is a contractual limitation and not a covered benefit. A Dental Consultant will review each case individually. Benefits for crowns will be made only for teeth that are in <u>imminent danger of pulpal exposure</u> . It will be solely the judgment of the Dental Consultant to determine "imminent pulpal exposure" from radiographs and any information provided by the treating dentist.	
		Replacement: Benefits are allowed for one crown per tooth in a 60-month period.	
		Criteria for Crown Coverage	
		~ Anterior teeth must exhibit <u>at least two</u> of the following:	
		At least 50% of the incisal angle must be filled or fractured; or	
		The existing restoration must be within 2mm or less of the pulp; or	
		There must be large existing restorations involving both mesial and distal surfaces, encompassing at least 50% of tooth structure	
		~ Posterior teeth must exhibit <u>at least two</u> of the following:	
		Large area of decay on additional surface: or	
		Extensive recurrent decay; or	
		Evidence of cuspal fracture	
		- Premolars must show evidence of at least one entire cuspal fracture	
		- Molars must show evidence of a large restoration with a single cuspal fracture	
		Must have at least a three surface restoration leaving very thin buccal/lingual walls; or	
		Depth of the existing restoration must be within 2mm of the pulp radiographically	
		Molars with minimal or no restoration present, with a single cuspal fracture do not qualify for crown coverage.	
		Exception: Maxillary molars with fracture of the mesial portion of the palatal cusp will qualify for coverage.	
		Cracked Tooth Syndrome: Crowns for teeth with Cracked Tooth Syndrome will be considered on an I.C. basis:	
		o Sensitivity to cold AND sensitivity to occlusal load that ceases when pressure is withdrawn.	
		o Reasonable length of time that tooth is symptomatic (3-12 months)	
		o Fracture line should be able to be probed with explorer tip.	
		o Evidence of light transmission into the dentin.	
		Documentation necessary for review:	
		· Treatment chart indicating history of cracked tooth syndrome, and the conservative treatment(s) that have been attempted to make the tooth asymptomatic.	
		· Narrative documenting clinical findings for the diagnosis of cracked tooth.	
		· X-ray (if apparent on film)	
		· Photograph	
		· Quadrant impression (if apparent)	
		Periodontally Involved Tooth: As a guideline, any tooth that has only 50% or less of remaining bone should be considered questionable in terms of long-term prognosis. A narrative explaining the patient's periodontal history or an evaluation by a periodontist should be considered. Factors that should be taken into consideration include: the age of the patient, clinical findings such as pocket depths, mobility, the condition of the soft tissues, bone density, vertical vs. horizontal bone loss, the length of the roots and furcation involvement. If the supporting documentation is not sufficient to benefit the procedure, the Dental Consultant will deny the case.	
		A filling placed the same day as a crown on the same tooth is disallowed as part of the procedure. If the dentist submits for a single surface filling after the crown is placed, pay for the filling. If the dentist submits for a multi-surface filling after the crown is placed, disallow.	
CROWNS - Single Restorations Only			

		Pretreatment estimates are recommended (not required) for all crowns. Failure to obtain a pretreatment estimate may result in disallowance. In order to qualify for benefits, the existing restoration must be of significant width and depth. When the radiograph does not clearly exhibit the need for crown placement, a narrative describing the reason for crown placement is necessary.	
		Classification Of Materials	
		Classification of Metals (Source: ADA Council on Scientific Affairs)	
		The noble metal classification system has been adopted as a more precise method of reporting various alloys used in dentistry. The alloys are defined on the basis of the percentage of metal content: high noble - Gold (Au), Palladium (Pd), and/or Platinum (Pt) ≥ 60% (with at least 40% Au); titanium and titanium alloys - Titanium (Ti) > 85%; noble - Gold (Au), Palladium (Pd), and/or Platinum (Pt) ≥ 25%; predominantly base - Gold (Au), Palladium (Pd), and/or Platinum (Pt) < 25%.	
		Porcelain/ceramic	
		Refers to those non-metal, non-resin inorganic refractory compounds processed at high temperatures (600°C/1112°F and above) and pressed, polished or milled - including porcelains, glasses and glass-ceramics.	
		Resin	
		Refers to any resin-based composite, including fiber or ceramic/reinforced polymer compounds.	
D2710	Crown – resin-based composite (indirect)	CDT: Utilized or non-reinforced resin crowns should be reported using D2999.	Tooth number and pre-operative periapical x-ray
D2712	Crown – 3/4 resin-based composite (indirect)	CDT: This code does not include facial veneers. (Facial veneer codes are D2960, D2961 and D2962).	Tooth number and pre-operative periapical x-ray
D2720	Crown - resin with high noble metal	Benefits are allowed for only one crown per tooth in a five-year period, and may not be disallowed if submitted by the same par dentist within that same period-replacement within 5 years is a contractual deny.	Tooth number and pre-operative periapical x-ray
D2721	Crown - resin with predominantly base metal		Tooth number and pre-operative periapical x-ray
D2722	Crown - resin with noble metal		Tooth number and pre-operative periapical x-ray
D2740	Crown - porcelain/ceramic substrate		Tooth number and pre-operative periapical x-ray
D2750	Crown - porcelain fused to high noble metal		Tooth number and pre-operative periapical x-ray
D2751	Crown - porcelain fused to predominately base metal		Tooth number and pre-operative periapical x-ray
D2752	Crown - -porcelain fused to noble metal		Tooth number and pre-operative periapical x-ray
D2780	Crown - 3/4 cast high noble metal		Tooth number and pre-operative periapical x-ray
D2781	Crown - 3/4 cast predominately base metal		Tooth number and pre-operative periapical x-ray

D2782	Crown - 3/4 cast noble metal		Tooth number and pre-operative periapical x-ray
D2783	Crown - 3/4 porcelain/ceramic	CDT: This code does not include facial veneers. (Facial veneer codes are D2960, D2961 and D2962).	Tooth number and pre-operative periapical x-ray
D2790	Crown - full cast high noble metal		Tooth number and pre-operative periapical x-ray
D2791	Crown - full cast predominately base metal		Tooth number and pre-operative periapical x-ray
D2792	Crown - full cast noble metal		Tooth number and pre-operative periapical x-ray
D2794	Crown - titanium		Tooth number and pre-operative periapical x-ray
D2799	Provisional crown	CDT: Crown utilized as an interim restoration of at least six months duration during restorative treatment to allow adequate time for healing or completion of other procedures. This includes, but is not limited to changing vertical dimension, completing periodontal therapy or cracked tooth syndrome. This is not to be used as a temporary crown (D2970) for a routine prosthetic restoration.	Tooth number, pre-operative periapical x-ray and narrative
Criteria for Provisional Crowns			
		If a temporary crown is placed for an extended period of time (e.g., 6 months or longer), this is considered a provisional crown. The dentist may submit a claim for Dental Consultant review to determine whether the dentist can bill the patient as opposed to including the provisional crown as part of the greater procedure, and therefore disallowed. Circumstances that would be considered include a patient in perio treatment or undergoing extensive prosthodontic work, orthodontic cases in conjunction with crown and bridge, and lab processed temporary crowns for long-span bridges.	
		If the Dental Consultant determines that the treatment plan is appropriate and provisional crowns are warranted, the claim should be denied as a patient responsibility.	
		When the permanent crown/bridge is finally placed, the permanent procedure should pay in full with no deduction for the provisional paid previously by the patient.	
OTHER RESTORATIVE SERVICES			
D2910	Recement inlay, onlay, or partial coverage restoration	A recementation performed after 6 months of delivery by the same or different dentist/dental office is benefited once per 60 months. Recementations are benefited for permanent prosthesis only. ~If recementation is paid in history, the crown is replaced and then recemented within 60 months of the 1st recementation - pay. ~If recementation is done within 6 months of delivery and is done by a different dentist - pay. ~If recementation is done within 6 months by the original dentist ~ DISALLOW - par/DENY - non par.	
D2915	Recement cast or prefabricated post and core	If a post recementation is done on the same date of service as a crown recementation, the recementation of the post will be disallowed/denied.	
D2920	Recement crown	See D2910 for Guidelines	
D2930	Prefabricated stainless steel crown - primary tooth	Allowed for children up to their 16 th birthday on primary teeth (A-T) only. Replacement of a stainless steel crown on a primary tooth by the same dentist within 24 months is DISALLOWED - par dentist/DENIED - non-par. Replacement within 24 months by a different dentist - deny.	

D2931	Prefabricated stainless steel crown - permanent tooth	Benefits are allowed once per tooth in a 24 month period on permanent first and second molars for children up to their 19 th birthday. If a D2931 is listed on the same claim as the permanent crown, treat as a temporary crown and disallow - par. If a claim is submitted for a permanent crown and a stainless steel crown is in history within 24 months, deduct the amount paid for the SS crown.	
D2932	Prefabricated resin crown	Allowed on primary anterior teeth once per tooth in a 24 month period. If submitted on a permanent tooth, the code should be converted to procedure code D2970 and processed as a temporary crown.	
D2933	Prefabricated stainless steel crown with resin window	CDT: Open-face stainless steel crown with aesthetic resin facing or veneer. Same guideline as D2932.	
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth	CDT: Stainless steel primary crown with exterior esthetic coating. Allowed on primary anterior teeth once per tooth in a 24 month period. If submitted for a posterior primary tooth, allow an alternate benefit of D2930 (prefabricated stainless steel crown-primary tooth). If submitted for a permanent tooth, deny.	
D2940	Sedative filling	CDT: Temporary restoration intended to relieve pain. Not to be used as a base or liner under a restoration. A sedative filling is a benefit as long as no other definitive treatment (i.e.: filling, RCT) is rendered to the tooth on the same date. Subject to 60 month time limitation; deny within that time period.	
		A sedative filling on a tooth that has had root canal therapy is not allowed. DISALLOW same par dentist, DENY different dentist.	
D2950	Core buildup, including any pins	CDT: Refers to building up of anatomical crown when restorative crown will be placed, whether or not pins are used. A material is placed in the tooth preparation for a crown when there is insufficient tooth strength and retention for the crown procedure. This should not be reported when the procedure only involves a filler to eliminate any undercut, box form or concave irregularity in the preparation.	Tooth number and pre-operative periapical x-ray
		A core buildup is a benefit once per tooth in 60 months. Pins are not separately reimbursed.	
		A core buildup only qualifies for benefits when it is necessary to retain a cast restoration due to extensive loss of tooth structure from caries or fracture.	
		A tooth does not automatically qualify for a core buildup although it qualifies for a crown; deny.	
		If the crown and buildup are submitted on the same claim/pretx and both do not qualify; deny.	
		Crown lengthening indicated: If the tooth exhibits insufficient clinical crown length to support a major restoration, Consultant deny. OR if the decay or fractures extends below the osseous crest, Consultant deny.	
		A tooth may have a core buildup, followed by endodontic therapy and then require another core buildup - the 60-month time limitation will be waived. A core buildup done within 12 months of a 4 or more surface restoration will be disallowed to the same par dentist or denied to a non-par dentist as long as root canal therapy was not performed in between.	
		Buildups performed in conjunction with inlays are disallowed to a par dentist/deny to non par.	
D2951	Pin retention - per tooth, in addition to restoration	Benefits for pin retention are allowed on a per tooth basis (regardless of the number of pins placed) only in conjunction with an amalgam or composite restoration.	
D2952	Post and core in addition to crown, indirectly fabricated	CDT: Post and core are custom fabricated as a single unit. Post and core is a benefit once in 60 months provided the tooth has been successfully treated endodontically and includes all pins and core necessary to complete the procedure. In order to qualify for coverage, anterior teeth must have radiographic evidence of 50% or more of tooth structure missing or evidence of fracture. All teeth submitted for post and core should have a favorable endodontic and periodontal prognosis.	Tooth number and post operative endo periapical x-ray
		A post & core on an endodontically treated anterior tooth will be reviewed to determine if an access prep only will be allowed. If the Dental Consultant finds the tooth does not qualify for the post & core, an alternate benefit of proc D2330 to repair the access opening should be benefited. Patient is responsible for the difference up to dentist's charge. (Tooth does not qualify for a crown in these cases.) If a crown is also submitted, in this case, it should be denied by the Consultant	
		<u>*Additional D2950 with D2952/D2954:</u>	

		Initially, if a D2950 is submitted in conjunction with a D2952/D2954, there will be no additional benefit; the D2950 is considered part of the more comprehensive procedure. If submitted on appeal, and it is stated that there is no crown to be placed in the immediate future, the Dental Consultant should review on an I.C. basis and allow an additional benefit if found to be dentally appropriate and necessary. The additional allowance should equal 50% of the Altus D2950 procedure allowance and a 24-month time limitation is applied to the additional benefit. If a crown is placed by the same dentist/dental office within 24 months of the additional D2950 benefit, payment for the D2950 will be deducted from the crown procedure.	
		*If a post & core is benefited and the tooth subsequently requires endo retreatment, a new post & core will be allowed (60-month time limitation is waived).	
		If a Consultant determines the endo prognosis remains unfavorable after endo treatment, the claim for the crown, post & core and/or buildup should be DISALLOWED - par dentist/DENY- non par.	
		*If a core buildup (D2950) has been done and the tooth subsequently requires a post & core within the 60-month time frame, allow the D2952/D2954 with a deduction for the fee paid on the D2950 in history.	
D2953	Each additional indirectly fabricated post - same tooth	CDT: To be used with D2952.	Tooth number, post-operative endo periapical x-ray and narrative
D2954	Prefabricated post and core in addition to crown	CDT: Core is built around a prefabricated post. This procedure includes the core material.	Tooth number and post operative endo periapical x-ray
		~If a prefabricated post and core is submitted with the same date of service as a crown, disallow both procedures and request the seat date.	
		See D2952 for Guidelines.	
D2955	Post removal (not in conjunction with endodontic therapy)	CDT: For removal of posts (e.g., fractured posts) not to be used in conjunction with endodontic retreatment (D3346, D3347, D3348).	
		Removal of posts is included in the fee for a retreatment if done by the same dentist performing the retreatment. A separate charge may not be made to the patient -DISALLOW - par dentist/DENY - non par. If no other procedure is performed with D2955, allow.	
D2957	Each additional prefabricated post - same tooth	CDT: To be used with D2954	Tooth number, post-operative endo periapical x-ray and narrative
D2960	Labial veneers (resin laminate) - chairside	CDT: Refers to labial/facial direct resin bonded veneers. Not a covered benefit under most contracts.	
D2961	Labial veneer (resin laminate - laboratory)	CDT: Refers to labial/facial indirect resin bonded veneers. Not a covered benefit under most contracts.	
D2962	Labial veneer (porcelain laminate) - laboratory	CDT: Refers also to facial veneers that extend interproximally and/or cover the incisal edge. Porcelain/ceramic veneers presently include all ceramic and porcelain veneers.	Tooth number and pre-operative periapical x-ray
		Benefits may be allowed if the tooth qualifies for full crown coverage. No additional restorative procedures (including crowns) will be allowed for 60 months. If the tooth does not qualify for crown coverage, benefits are denied.	
D2970	Temporary crown (fractured tooth)	CDT: Usually a preformed artificial crown, which is fitted over a damaged tooth as an immediate protective device. This is not to be used as temporization during crown fabrication.	Tooth number, pre-operative periapical x-ray and narrative
		Rationale:	
		Temporary crowns are used after a tooth is prepped and while awaiting the placement of the permanent crown. They are considered part of the procedure for the permanent crown and the charge is included in the fee for the permanent crown.	
		A separate charge for a temporary crown is not allowed for a participating provider. DISALLOW - par dentist/DENY - non par dentist	

Temporary Crown - 2 Different Dentists			
		If a patient does not return to the original dentist to have the permanent crown seated, an allowance for the temporary crown can be made. If the patient then goes to another dentist and the temporary has been paid in history, deduct the amount allowed for the temporary crown from the allowed amount of the permanent crown and the patient is responsible for the difference. If a permanent crown is placed within 5 years of the temporary, same deduction rule applies.	
D2971	Additional procedures to construct new crown under existing partial denture framework	CDT: To be reported in addition to a crown code. Not a covered benefit.	
D2975	Coping	CDT: A thin covering of the remaining portion of a tooth, usually fabricated of metal and devoid of anatomic contour. This is to be used as definitive restoration. Not a covered benefit.	
D2980	Crown repair, by report	CDT: Includes removal of crown, if necessary. Describe procedure. Repair of veneers on crowns are benefits once in a 60-month period. Replacement of crown or pontics due to fractured veneers are benefits only after a 60-month limitation. A narrative describing what was done should be submitted. If the repair is beyond the norm, e.g., an extensive crown repair, then send the claim to the Consultant for Individual Consideration. In determining an appropriate fee, the Consultant may want to request a lab bill or call the dentist directly.	Narrative
D2999	Unspecified restorative procedure, by report	CDT: Use for a procedure that is not adequately described by a code. Describe procedure. May require IC review by Dental Consultant. If a patient goes to a lab for shade enhancement, the lab charges the dentist for a custom shade. The dentist can submit the procedure "Custom shade" D2999 on the same claim with the crown. This is a non-covered benefit and will be denied. The dentist is allowed to charge the patient.	Narrative
MISCELLANEOUS RESTORATIVE			
		Multi stage procedures are reported when completed. The completion date for crowns, onlays, bridges is the cementation date, regardless of the type of cement utilized.	
		If a claim/pretreat for a crown is submitted with no x-rays , it will be considered only when accompanied by a narrative. (i.e.: patient is pregnant, x-rays lost in the mail). Photographs or diagnostic models are alternative documentation.	
		Porcelain Labial Margins – (Porcelain Butt Joints)	
		Porcelain Butt Joints are not a covered benefit.	
		A crown on a retained deciduous tooth is allowed as long as it has no successor and has sufficient periodontal support, i.e., no root resorption. The retained deciduous tooth must meet the criteria for a crown.	
		Crowns for peg laterals are a benefit only if they meet the criteria for a crown.	
		Restoring Occlusion: Procedures, appliances or restorations that are necessary to increase vertical dimension, restore occlusion or replace tooth structure lost by attrition, erosion, abrasion, abfraction, corrosion and TMD are contractually excluded. Other procedures for correcting congenital or developmental defects placed for esthetic purposes are contractually excluded and not reimbursable by Altus. If performed, the patient is responsible for the cost.	
		A crown on a supra-erupted tooth is not a benefit if being performed to bring an extruded tooth into the proper plane of occlusion. This is a contractual limitation, (i.e., altering, restoring or maintaining occlusion). It is only benefited if the tooth qualifies for a crown.	
		Crowns for Hemisectioned Teeth: Altus Dental allows only one crown per tooth. The fact that a tooth has been hemisected does not change the policy. The patient will be responsible for the additional crown.	
		Teeth Splinted with Crowns (Rather than extracting the teeth and placing a fixed bridge - periodontally involved teeth) is not a covered benefit.	
ENDODONTICS (D3000-D3999)			
		If the procedure reported was the result of an accident, it should be submitted to the patient's medical and/or liability insurer first.	

PULP CAPPING			
D3110	Pulp cap - direct (excluding final restoration)	CDT: Procedure in which the exposed pulp is covered with a dressing or cement that protects the pulp and promotes healing and repair.	
D3120	Pulp cap - indirect (excluding final restoration)	CDT: Procedure in which the nearly exposed pulp is covered with a protective dressing to protect the pulp from additional injury and to promote healing and repair via formation of secondary dentin. This code is not to be used for bases and liners when all caries have been removed.	
		The allowance for a final restoration includes pulp caps, cavity liners and cement bases. A separate fee may not be charged to the patient by a participating dentist and should be disallowed/denied.	
PULPOTOMY			
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	CDT: Pulpotomy is the surgical removal of a portion of the pulp with the aim of maintaining the vitality of the remaining portion by means of an adequate dressing. -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	
		Benefits are allowed on primary and permanent teeth. If a root canal is completed within 30 days by the same dentist, deduct the amount allowed for the pulpotomy from the root canal allowance. If the root canal is completed by a different dentist or is completed 30 days after the pulpotomy, no deduction will be made.	
D3221	Pulpal debridement, primary and permanent teeth	CDT: Pulpal debridement for the relief of acute pain prior to conventional root canal therapy. This procedure is not to be used when endodontic treatment is completed on the same day.	
		Allow as a separate benefit to a root canal if performed on a different date of service. If performed on the same day by the same dentist, disallow.	
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	CDT: Removal of a portion of the pulp and application of a medicament with the aim of maintaining the vitality of the remaining portion to encourage continued physiological development and formation of the root. This procedure is not to be construed as the first stage of root canal therapy.	
		1: Covered only on permanent teeth with incomplete root development. 2: Disallow the fee when performed on the same day or within 30 days on the same tooth by the same provider as root canal therapy (D3310 - D3330), retreatment of previous root canal (D3346 - D3348) or apexification/recalcification procedures (D3351 – D3353).	
ENDODONTIC THERAPY ON PRIMARY TEETH			
D3230	Pulpal therapy (resorbable filling) anterior, primary tooth (excluding final restoration)	CDT: Primary incisors and cuspids Root canal therapy on primary teeth is not a covered benefit unless there is no permanent successor.	
D3240	Pulpal therapy (resorbable filling) posterior, primary tooth (excluding final restoration)	CDT: Primary first and second molars Root canal therapy on primary teeth is not a covered benefit, unless there is no permanent successor.	
ENDODONTIC THERAPY (including Treatment Plan, Clinical Procedures and Follow-up Care)			
		Complete root canal therapy includes all appointments necessary to complete treatment and radiographs. Does not include diagnostic evaluation. Benefits are payable on the completion date/final fill.	
		Benefits for root canals on teeth supporting an overdenture are only allowed if there is evidence of pathology. Otherwise, it is the patient's responsibility.	

		A periodontally compromised tooth requiring endo will be benefited.	
		<u>Questionable cases (DISALLOWED to a par dentist) may include:</u>	
		- The fill is extremely short of the radiographic apex.	
		- There is visible patent canal space left unfilled or has significant voids in the obturation of the canal. This fill may appear very poorly condensed (as if one accessory point were placed in the canal).	
		- There is excessive over-extension of the filling material with obvious voids in the apical third of the canal.	
		- Silver points were used with a very short fill or an overfill through the apices of the root.	
		If a narrative is submitted with a reasonable explanation (i.e., calcified canal; unable to fill to apex, but tooth asymptomatic), the claim will be allowed. Each of these cases will require Individual Consideration.	
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	If a dentist cannot complete a RCT and submits for payment, process as D3999 and send to Consultant to assign fee. If the same dentist completes the RCT at a later date, deduct the amount allowed for the D3999 from the RCT allowance. If the RCT is completed by a different dentist, no deduction will be made.	
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	If a dentist does not complete the RCT because the patient does not return in a timely manner for completion (approximately 3 months), process as a D3310, D3320 or D3330 and pay <u>one half of</u> the allowance. If the patient returns to the same dentist for completion of the RCT, deduct the amount that was allowed for the D3310, D3320 or D3330 from the RCT allowance.	
D3330	Endodontic therapy, molar (excluding final restoration)	Root canals on deciduous teeth are not benefits. However, if there is no permanent successor, a root canal will be allowed and benefited as either an anterior or bicuspid root canal based on the position of the tooth. (I.C. review by a Dental Consultant). Need post-op endo PA for review	
D3331	Treatment of root canal obstruction; non-surgical access	CDT: In lieu of surgery, the formation of a pathway to achieve an apical seal without surgical intervention because of a non-negotiable root canal blocked by foreign bodies, including but not limited to separated instruments, broken posts or calcification of 50% or more of the length of the tooth root.	
		This procedure is considered a component of a root canal for a general dentist. DISALLOW - par dentist/DENY- non par. For endodontists, this procedure is payable.	
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	CDT: Considerable time is necessary to determine diagnosis and/or provide initial treatment before the fracture makes the tooth unretainable. Not to be confused with an incomplete RCT (D3999). This code is to be used for a tooth that is inoperable, unrestorable or fractured. Since the tooth is deemed unrestorable, no further treatment will be benefited (except for an extraction). Individual consideration may be given if an endodontist is able to successfully complete the root canal.	Pre-op and working periapicals x-rays & narrative
D3333	Internal root repair of perforation defects	CDT: Non-surgical seal of perforation caused by resorption and/or decay but not iatrogenic by provider filing claim.	
		The procedure is accomplished by recalcification of the defect. Benefits are administered with the same policies and system edits as code D3351 (apexification), not to exceed 3 visits. In the event surgical intervention is performed, the procedure is disallowed in addition to apicoectomy and/or retrograde filling.	
		Denied if reported on primary teeth.	
ENDODONTIC RETREATMENT			
		This procedure may include the removal of a post, pin(s), old root canal filling material, and the procedures necessary to prepare the canals and place the canal filling. This includes complete root canal therapy.	
D3346	Retreatment of previous root canal - anterior	An allowance for retreatment will be made when a root canal previously completed by another dentist has failed and retreatment is indicated. Retreatment within 24 months by the same dentist must be reviewed by the Dental Consultant. Benefits can be approved, however, if determined to be a quality of care issue, DISALLOW - par dentist/DENY - non par.	Pre-op x-rays and a narrative (for pre tx) and post op x-rays and a narrative (for claim)
D3347	Retreatment of previous root canal - bicuspid		

D3348	Retreatment of previous root canal - molar		
APEXIFICATION/RECALCIFICATION PROCEDURES			
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	CDT: Includes opening tooth, pulpectomy, preparation of canal spaces, first placement of medication and necessary radiographs. (This procedure includes first phase of complete root canal therapy). Apexification treatment is allowed when radiographs show incomplete closure of the tooth apex, or the tooth is being treated for traumatic injuries; not to exceed 3 visits prior to the root canal therapy.	
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)	CDT: For visits in which the intra-canal medication is replaced with new medication and necessary radiographs. There may be several of these visits. Apexification treatment is allowed when radiographs show incomplete closure of the tooth apex, or the tooth is being treated for traumatic injuries; D3352 is not to exceed 3 visits prior to the root canal therapy.	
D3353	Apexification/recalcification - final visit medication replacement (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	CDT: Includes removal of intra-canal medication and procedures necessary to place final root canal filling material including necessary radiographs. (This procedure includes last phase of complete root canal therapy).	
APICOECTOMY/PERIRADICULAR SERVICES			
D3410	Apicoectomy/peri radicular surgery – anterior	CDT: For surgery on root of anterior tooth. Does not include placement of retrograde filling material. Periradicular surgery is a term used to describe surgery to the root surface, i.e., apicoectomy, repair of a root perforation or resorptive defect, exploratory curettage to look for root fractures, removal of extruded filling material or instruments, removal of broken root fragments, sealing of accessory canals, etc. Procedures include the exam , all pre-operative, operative & post-operative x-rays, bacteriologic cultures, local anesthesia and routine follow-up care. Retreatment by the same dentist within 24 months is considered part of the original procedure DISALLOW - par dentist/DENY - non par. If an oral exam (any of codes D0120-D0180) is submitted in conjunction with an apicoectomy on the same date of service, the exam should disallow regardless of the specialty of the provider. <u>Reason:</u> the exam is considered part of the apicoectomy.	
D3421	Apicoectomy/peri radicular surgery – bicuspid (first root)	CDT: For surgery on one root of a bicuspid. Does not include placement of retrograde filling material. If more than one root is treated, see procedure code D3426.	
D3425	Apicoectomy/peri radicular surgery – molar (first root)	CDT: For surgery on one root of a molar. Does not include placement of retrograde filling material. If more than one root is treated, see procedure D3426.	
D3426	Apicoectomy/ periradicular surgery (each additional root)	CDT: Typically used for bicuspid and molar surgeries when more than one root is treated during the same procedure. This does not include retrograde filling material placement. [Note: Maximum benefit up to 3 roots – follows same logic as retrograde fillings.]	
D3430	Retrograde filling - per root	CDT: For placement of retrograde filling material during periradicular surgery procedures. If more than one filling is placed in one root - report as D3999 and describe. If more than one root is filled in a tooth, list each retrograde filling separately. ~ Allow 1 retro grade filling per anterior tooth. For each additional root, DISALLOW - par/DENY - non par. ~ Allow 2 retro grade fillings per bicuspid tooth. For each additional root, DISALLOW - par/DENY - non par. ~ Allow 3 retro grade fillings per molar tooth. For each additional root, DISALLOW - par/DENY - non par.	
D3450	Root amputation - per root	CDT: Root resection of a multi-rooted tooth while leaving the crown. If the crown is sectioned, see D3920.	

		Root amputation involves the removal of a root of a <u>multi-rooted</u> tooth without the removal of the corresponding portion of the crown.	
		If a claim is submitted for a root amp for a single rooted tooth, the procedure is considered and benefited as a D7210 surgical extraction. This may occur with any tooth, but is more likely to occur with a bicuspid or anterior tooth.	
		<u>Root amputation is indicated for:</u>	
		a) "Through and through" periodontal furcation defects	
		b) An untreatable infrabony defect of one root of a multi-rooted tooth	
		c) Fractures extending into furcation	
		d) Teeth where non-surgical endodontic treatment is not possible or unsuccessful for at least one root and periapical surgery is not possible into the furcation	
		e) Teeth where a vertical root fracture exists and is confined to the root, which is to be separated and extracted	
		f) Chronic periapical pathology	
		g) Cases of persistent sinus tract, periradicular inflammation, or periradicular pathosis where non-surgical root canal therapy or periradular surgery is not possible.	
		h) Inoperable or uncorrectable resorptive defects of the root.	
		Root amputation necessitates root canal treatment of all remaining roots.	
D3460	Endodontic endosseous implant	CDT: Placement of implant material, which extends from a pulpal space into the bone beyond the end of the root. Not a covered benefit.	
D3470	Intentional reimplantation (including necessary splinting)	CDT: For the intentional removal, inspection and treatment of the root and replacement of a tooth into its own socket. This does not include necessary retrograde filling material placement. Not a covered benefit.	
OTHER ENDODONTIC PROCEDURES			
D3910	Surgical procedure for isolation of tooth with rubber dam	The fee for isolation with a rubber dam is included in the fee for the entire endodontic procedure.	
D3920	Hemisection (including any root removal), not including root canal therapy	CDT: Includes separation of a multi-rooted tooth into separate sections containing the root and the overlying portion of the crown. It may also include the removal of one or more of those sections. An allowance for a crown or bridge pontic replacing the extracted portion of the hemisectioned tooth is denied; (use "X" for the tooth # of the pontic). Abutments can be approved.	
D3950	Canal preparation and fitting of preformed dowel or post	CDT: Should not be reported in conjunction with D2952, D2953, D2954, D2957 by the same practitioner. The preparation of a posthole for a preformed dowel or post is not a separate benefit and an additional fee is not chargeable to the patient by a participating dentist.	
D3999	Unspecified endodontic procedure, by report	CDT: Used for an endodontic procedure that is not adequately described by a code. Describe procedure. May require IC review by Dental Consultant.	Narrative
PERIODONTICS D4000-D4999			
		If the procedure reported was the result of an accident, it should be submitted to the patient's medical and/or liability insurer first.	
		Codes covered if group has Enhanced Perio and Implant Riders: D4263, D4264, D4266, D4267, D7953	
		<u>Required Perio Charting:</u>	
		· Must be dated and include the patient's name.	
		· Complete perio charting taken within the last 12 months including a minimum of 4-6 probe readings per tooth.	
		Laser disinfection is a technique, not a procedure. The fee for laser disinfection is disallowed.	
		<u>CDT Definition:</u>	

		Site: A term used to describe a single area, position or locus. The word "site" is frequently used to indicate an area of soft tissue recession on a single tooth or an osseous defect adjacent to a single tooth; also used to indicate soft tissue defects and/or osseous defects in edentulous tooth positions.	
		· If two contiguous teeth have areas of soft tissue recession, each area of recession is a single site.	
		· If two contiguous teeth have adjacent but separate osseous defects, each defect is a single site.	
		· If two contiguous teeth have a communicating interproximal osseous defect, it should be considered a single site.	
		· All non-communicating osseous defects are single sites.	
		· All edentulous non-contiguous tooth positions are single sites.	
		· Depending on the dimensions of the defect, up to two contiguous edentulous tooth positions may be considered a single site.	
		Tooth Bounded Space: A space created by one or more missing teeth that has a tooth on each side.	
SURGICAL PROCEDURES (including usual postoperative care)			
D4210	Gingivectomy or gingivoplasty-per quadrant (four or more contiguous teeth or tooth bounded spaces per quadrant)	CDT: Involves the excision of the soft tissue wall of the periodontal pocket by either an external or an internal bevel. It is performed to eliminate suprabony pockets after adequate initial preparation, to allow access for restorative dentistry in the presence of suprabony pockets, or to restore normal architecture when gingival enlargements or asymmetrical or unaesthetic topography is evident with normal bony configuration. Count tooth bounded spaces for pocket reduction surgery that includes a flap procedure (D4240, D4260). Do not count tooth bounded spaces for D4210, D4341; count only "diseased teeth/periodontium". A tooth bounded space is the edentulous area bounded by two qualifying teeth. A tooth bounded space counts as one space irrespective of the number of teeth that would normally exist in the space.	Quadrant or tooth numbers, current periodontal charting taken within 12 months w/4-6 probings per tooth or narrative describing condition of the tissue
		Benefit only two full quadrants of surgery on the same date of service. Additional documentation, including a treatment chart and explanation of treatment plan, are required when more than two quadrants are done on the same day. Disallow.	
D4211	Gingivectomy or gingivoplasty – 1 to 3 contiguous teeth or tooth bounded spaces per quadrant	CDT: Involves the excision of the soft tissue wall of the periodontal pocket by either an external or an internal bevel. It is performed to eliminate suprabony pockets after adequate initial preparation, to allow access for restorative dentistry in the presence of suprabony pockets, or to restore normal architecture when gingival enlargements or asymmetrical or unaesthetic topography is evident with normal bony configuration. Crown lengthening involving <u>soft tissue only</u> is appropriately coded as D4211. See D4210 descriptor.	Quadrant or tooth numbers, current periodontal charting taken within 12 months w/4-6 probings per tooth or narrative describing condition of the tissue
		Gingivectomy, in conjunction with and for the purpose of placement of restorations/crowns, is included in the fee for the restoration; a separate charge may not be made to the patient. Exceptions: Allow a gingivectomy whether performed with a scalpel, electrosurge or laser, on the same date of service as a Class V restoration if necessary to access all decay present at the site and restore the tooth adequately. Other gingivectomies should be allowed if performed at least 14 days prior to a restoration (crowns, core buildups, fillings other than Class V if meets existing criteria. For example, if a narrative refers to hyperplastic tissue, this will be considered, however there should be a 14-day healing period.	
		Gingivectomy, in conjunction with and for the purpose of placement of restorations/crowns, is included in the fee for the restoration; a separate charge may not be made to the patient. *Allow a gingivectomy when performed on the same day as a Cerec crown/onlay insertion if the tooth is broken below the gumline. A digital photograph is required. This policy was approved by the QMC on 5/10/06-and pertained to Cerec crowns/onlays only.	
		Any surgical re-entry in the same quadrant within 3 months is disallowed to a par dentist. From 4 to 24 months any re-entry is denied. Surgical re-entry includes gingivectomy (D4210 or D4211) and osseous surgery (D4260).	
		Gingivectomy, when submitted with the same date of service as osseous surgery (D4260), is considered part of the osseous surgery. DISALLOW - par dentist/DENY - non par.	
		*Gingivectomy performed around an implant may be approved if a narrative indicates hyperplastic tissue.	
		Removal of hyperplastic tissue with a laser for orthodontic reasons is a gingivectomy D4211 and may be billed separately. Claim must be accompanied by a narrative and photo for benefit determination. If the gingivectomy is performed to aid eruption of the tooth prior to bracket placement, disallow.	

D4230	Anatomical crown exposure - four or more contiguous teeth per quadrant	CDT: This procedure is utilized in an otherwise periodontally healthy area to remove enlarged gingival tissue and supporting bone (ostectomy) to provide an anatomically correct gingival relationship. Not a covered benefit. This procedure is considered primarily cosmetic in nature. If this procedure is being done because of decay or fracture, the proper code to use is D4249.	
D4231	Anatomical crown exposure - one to three teeth per quadrant	CDT: This procedure is utilized in an otherwise periodontally healthy area to remove enlarged gingival tissue and supporting bone (ostectomy) to provide an anatomically correct gingival relationship. Not a covered benefit. This procedure is considered primarily cosmetic in nature. If this procedure is being done because of decay or fracture, the proper code to use is D4249.	
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	CDT: A soft tissue flap is reflected or resected to allow debridement of the root surface and the removal of granulation tissue. Osseous recontouring is not accomplished in conjunction with this procedure. May include open flap curettage, reverse bevel flap surgery, modified Kirkland flap procedure, and modified Widman surgery. This procedure is performed in the presence of moderate to deep probing depths, loss of attachment, need to maintain esthetics, need for increased access to the root surface and alveolar bone, or to determine the presence of a cracked tooth, fractured root or external root resorption. Other procedures may be required concurrent to D4240 and should be reported separately using their own unique codes.	FMX; complete perio charting
		Benefit only two full quadrants of flap surgery on the same date of service. Additional documentation, including a treatment chart and explanation of treatment plan, are required when more than two quadrants are done on the same day. Disallow additional quads.	
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	CDT: A soft tissue flap is reflected or resected to allow debridement of the root surface and the removal of granulation tissue. Osseous recontouring is not accomplished in conjunction with this procedure. May include open flap curettage, reverse bevel flap surgery, modified Kirkland flap procedure, and modified Widman surgery. This procedure is performed in the presence of moderate to deep probing depths, loss of attachment, need to maintain esthetics, need for increased access to the root surface and alveolar bone, or to determine the presence of a cracked tooth, fractured root or external root resorption. Other procedures may be required concurrent to D4241 and should be reported separately using their own unique codes.	FMX; complete perio charting
		<u>When done on the same date of service as osseous surgery, and it is in the same surgical site, this procedure is considered part of the osseous surgery.</u> DISALLOW - par dentist/DENY - non par.	
		Any surgical re-entry in the same quadrant within 3 months is disallowed to a par provider. Re-entry from 4 months to 24 months is denied. Surgical re-entry includes gingivectomy (D4210 or D4211), gingival flap procedures (D4240 or D4245) and osseous surgery (D4260 or D4261).	
		<u>In order to qualify for benefits the following conditions must exist:</u>	
		1. Probing depths must be 5mm or greater.	
		2. Radiographs must show attachment loss with the appearance of reduction of the alveolar crest beyond the 1 -1 1/2mm proximity to the cemento-enamel junction (CEJ).	
		Count tooth bounded spaces for pocket reduction surgery that includes a flap procedure (D4240, D4260). Do not count tooth bounded teeth for D4210, D4341; count only "diseased teeth/periodontium." A tooth bounded space is the edentulous area bounded by two qualifying teeth. A tooth bounded space counts as one space irrespective of the number of teeth that would normally exist in the space.	
D4245	Apically positioned flap	CDT: Procedure is used to preserve keratinized gingival in conjunction with osseous resection and second stage implant procedure. Procedure may also be used to preserve keratinized/attached gingival during surgical exposure of labially impacted teeth, and may be used during treatment of peri-implantitis. *Same criteria and administration as procedure D4240.	FMX; complete perio charting
		Any surgical re-entry in the same quadrant within 3 months is disallowed to a par dentist. Reentry within 4 to 24 months is denied. Surgical re-entry includes gingivectomy (D4210 or D4211) and osseous surgery (D4260 or D4261).	
D4249	Clinical crown lengthening - hard tissue, by report	CDT: This procedure is employed to allow restorative procedure or crown with little or no tooth structure exposed to the oral cavity. Crown lengthening requires reflection of a flap and is performed in a healthy periodontal environment, as opposed to osseous surgery, which is performed in the presence of periodontal disease. Where there are adjacent teeth, the flap design may involve a larger surgical area.	Tooth number, current pre-operative periapical x-rays and a narrative
		This procedure is subject to a 60-month time limitation.	
		Crown lengthening will be considered only when a crown or deep subgingival restoration is indicated. This procedure must include alveolar bone recontouring in order to qualify for benefits. If not, deny.	

		Crown lengthening (D4249) performed on the same date of service in conjunction with free soft tissue graft procedures (D4271) or osseous surgery (D4260) in the same quadrant should not exceed the reimbursement for one quadrant of osseous surgery. If multiple D4249's are performed in the same quadrant on the same date of service, the allowance should not exceed that of a full quadrant of osseous surgery. update 3/14/07	
		Crown lengthening is covered when performed on the same date of service as a crown buildup, post & core or restorations.	
		Crown lengthening performed on the same date of service or within 14 days of a crown cementation is disallowed.	
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	CDT: This procedure modifies the bony support of the teeth by reshaping the alveolar process to achieve a more physiologic form. This may include the removal of supporting bone (ostectomy) and/or non-supporting bone (osteoplasty). Other procedures may be required concurrent to D4260 and should be reported using their own unique codes.	FMX; complete perio charting
		Osseous surgery is performed in the presence of periodontal disease. The procedure is designed to modify and reshape deformities in the alveolar bone surrounding the teeth and to reduce pocket depths.	
		Benefit only two full quadrants of osseous surgery on the same date of service. Additional documentation, including a treatment chart and explanation of treatment plan, are required when more than two quadrants are done on the same day. Disallow.	
D4261	Osseous surgery (including flap entry and closure) - one to three teeth or bounded teeth spaces per quadrant	The fee for osseous surgery includes: Osseous contouring, distal or proximal wedge surgery; frenectomy; curettage or scaling and root planing; soft tissue grafts; gingivectomy; flap procedures. These procedures are considered part of the osseous surgery. Disallow - par dentists/deny - non par. When crown lengthening is done in the same surgical site and on the same date of service as osseous, the total reimbursement for both procedures should not exceed the reimbursement for one full quadrant of osseous surgery.	FMX; complete perio charting
		A healing period of at least 14 days should be allowed after scaling and root planing (D4341) before osseous surgery can be performed.	
		If there is a combination of procedures in one quadrant (i.e., buccal flap procedure, gingivectomy on lingual surfaces, etc.), then the greater procedure (D4260) is benefited.	
		Any surgical re-entry in the same quadrant within 3 months is disallowed to a par dentist. Reentry within 4 to 24 months is denied. Surgical re-entry includes gingivectomy (D4210 or D4211) and osseous surgery (D4260 or D4261).	
		If a perio maintenance (D4910) or adult prophy (D1110) is performed on the same date of service as osseous surgery (D4260) or gingival flap procedures (D4240 or D4245), reduce the reimbursement on the preventive procedure in accordance with the number of quadrants having surgery. Example: the patient has scheduled their preventive procedure on the same date as a quadrant of osseous surgery. In this case, the allowance for the preventive procedure should be reduced by 1/4.	
		<u>In order to qualify for benefits the following conditions must exist:</u>	
		1. Probing depths must be 5mm or greater.	
		2. Radiographs must show attachment loss with the appearance of reduction of the alveolar crest beyond the 1 - 1 1/2 mm proximity to the cemento-enamel junction (CEJ).	
		A full quadrant code D4260 is used when 4 or more teeth are treated in a quadrant. If 1-3 teeth are treated, use partial quadrant code D4261.	
		Count tooth bounded spaces for pocket reduction surgery that includes a flap procedure (D4240, D4260). Do not count tooth bounded spaces for D4210, D4341; count only "diseased teeth/periodontium." A tooth bounded space is the edentulous area bounded by two qualifying teeth. A tooth bounded space counts as one space irrespective of the number of teeth that would normally exist in the space.	
		If no teeth in the quadrant qualify, Dental Consultant will deny.	
D4263	Bone replacement graft - first site in quadrant	CDT: This procedure involves the use of osseous autografts, osseous allografts or non-osseous grafts to stimulate periodontal regeneration when the disease process has led to a deformity of the bone. This procedure does not include flap entry and closure, wound debridement, osseous contouring or the placement of biologic materials to aid in osseous tissue regeneration or barrier membranes. Other separate procedures may be required concurrent to D4263 and should be reported using their own unique codes.	

D4264	Bone replacement graft- each additional site in quadrant	CDT: This procedure involves the use of osseous autografts, osseous allografts or non-osseous grafts to stimulate periodontal regeneration when the disease process has led to a deformity of the bone. This procedure does not include flap entry and closure, wound debridement, osseous contouring or the placement of biologic materials to aid in osseous tissue regeneration or barrier membranes. This code is used if performed concurrently with D4263 and allows reporting of the exact number of sites involved.	
		D4263 & D4264 are not covered benefits unless specified under the group contract.	
		Osseous grafts are limited to periodontal deformities due to the disease process and are considered regenerative techniques. The procedure is limited to a 24-month time limitation.	
D4265	Biologic materials to aid in soft and osseous tissue regeneration	CDT: Biologic materials may be used alone or with other regenerative substrates such as bone and barrier membranes, depending upon their formulation and the presentation of the periodontal defect. This procedure does not include surgical entry and closure, wound debridement, osseous contouring, or the placement of graft materials and/or barrier membranes. Other separate procedures may be required concurrent to D4265 and should be reported using their own unique codes.	
		Not a covered benefit.	
D4266	Guided tissue regeneration-resorbable barrier, per site	CDT: A membrane is placed over the root surfaces or defect area following surgical exposure and debridement. The mucoperiosteal flaps are then adapted over the membrane and sutured. The membrane is placed to exclude epithelium and gingival connective tissue from the healing wound. This procedure may require subsequent surgical procedures to correct the gingival contours. Guided tissue regeneration may also be carried out in conjunction with bone replacement grafts or to correct deformities resulting from inadequate faciolingual bone width in an edentulous area. When guided tissue regeneration is used in association with a tooth, each site on a specific tooth should be reported separately. Other separate procedures may be required concurrent to D4266 and should be reported using their own unique codes.	
		The tooth/teeth must qualify for osseous surgery and exhibit vertical wall defects.	
nm		The procedure is limited to a 24 month time limitation.	
D4267	Guided tissue regeneration - nonresorbable barrier, per site (includes membrane removal)	CDT: This procedure is used to regenerate lost or injured periodontal tissue by directing differential tissue responses. A membrane is placed over the root surfaces or defect area following surgical exposure and debridement. The mucoperiosteal flaps are then adapted over the membrane and sutured. This procedure does not include flap entry and closure, wound debridement, osseous contouring, bone replacement grafts, or the placement of biologic materials to aid in osseous tissue regeneration. The membrane is placed to exclude epithelium and gingival connective tissue from the healing wound. This procedure requires subsequent surgical procedures to remove the membranes and/or to correct the gingival contours. Guided tissue regeneration may be used in conjunction with bone replacement grafts or to correct deformities resulting from inadequate faciolingual bone width in an edentulous area. When guided tissue regeneration is used in association with a tooth, each site on a specific tooth should be reported separately with this code. When no tooth is present, each site should be reported separately. Other separate procedures may be required concurrent to D4267 and should be reported using their own unique codes.	
		Same guideline as D4266.	
D4268	Surgical revision procedure, per tooth	CDT: This procedure is to refine the results of a previously provided surgical procedure. This may require a surgical procedure to modify the irregular contours of hard or soft tissue. A mucoperiosteal flap may be elevated to allow access to reshape alveolar bone. The flaps are replaced or repositioned and sutured.	
		Periodontal surgical procedures include all necessary post-operative care, finishing procedures, evaluations for three months, as well as re-entry for 24 months. When this procedure is billed within three months of the initial surgical procedure, this procedure is DISALLOWED to the same par dentist/DENIED to the same non-par dentist. From 4 months to 24 months DISALLOW - par / DENY - nonpar.	
D4270	Pedicle soft tissue graft procedure	CDT: A pedicle flap of gingiva can be raised from an edentulous ridge, adjacent teeth or from the existing gingival on the tooth and moved laterally or coronally to replace alveolar mucosa as marginal tissue. The procedure can be used to cover an exposed root or to eliminate a gingival defect if the root is not too prominent in the arch.	Tooth numbers, current periodontal charting (no more than 12 months old)
		This procedure is subject to a 60-month time limitation at the same site. Deny.	showing measurements of

		Two (2) millimeters or less of attached gingiva normally indicates the need for this procedure and where there is adequate donor tissue adjacent to the defect. If one or two contiguous teeth are grafted, a benefit of one tooth segment (a tooth segment is defined as two contiguous teeth) will be allowed. If a third contiguous tooth is grafted, it will be benefited an additional 50% of the Altus allowance for a tooth segment. If a fourth contiguous tooth is grafted, it also will be benefited an additional 50% of the Altus Dental allowance for a tooth segment. No additional allowance is made after the fourth contiguous tooth (in one quadrant) and the patient may not be billed any difference.	recession, and amount of pre-surgical attached gingival
		Example #1:	
		1st tooth by itself ~ full allowance of graft	
		Example #2:	
		1st tooth, with 2nd contiguous tooth ~ 1/2 allowance for each tooth	
		3rd contiguous tooth ~ 1/2 allowance	
		4th contiguous tooth ~ 1/2 allowance	
		5th contiguous tooth ~ no add'l allowance - DISALLOW - par/DENY - non par.	
		A tissue graft performed exclusively to repair an extraction site is not a covered benefit – DENY.	
		Benefits for a soft tissue graft can be made available if there is an implant present, or if the graft is being done for preparation of implant due to lack of keratinized tissue. A narrative is required. Deny if done for aesthetic purposes. Update 3/19/07.	
		When reviewing procedures D4270 and D4271 count the tooth bounded spaces between contiguous teeth being treated as part of a site. Example: #18 & #20 are being treated; #19 is missing. Benefit as 1 1/2 sites. Depending on the dimensions of the defect, up to two contiguous tooth positions may be considered as part of the site.	
		If the edentulous tooth bounded space is greater than two teeth, consider the bounding teeth being grafted as two separate sites. For par dentists, the patient cannot be billed for the difference. For non-par dentists, the patient is responsible for any difference between the dentist's charge and Altus's allowance. Facial and lingual surfaces are considered two separate surgical sites.	
		** Edentulous tooth bounded spaces included in the graft procedure should be identified as tooth "X" in order to capture graft history. (using tooth # in an edentulous space is prohibited as extraction may be in history).	
		Crown lengthening, D4249, performed on the same date of service in conjunction with soft tissue graft procedures in the same quadrant, should not exceed the reimbursement for one quadrant of osseous surgery.	
D4271	Free soft tissue graft procedure (including donor site surgery)	CDT: Gingival or masticatory mucosa is grafted to create or augment the gingival at another site, with or without root coverage. This graft may also be used to eliminate the pull of frena and muscle attachments, to extend the vestibular fornix, and to correct localized gingival recession.	Tooth numbers, current periodontal charting (no more than 12 months old) showing measurements of recession, and amount of pre-surgical attached gingiva
		Limitation:	
		This procedure is subject to a 60-month time limitation at the same site. Deny.	
		Two (2) millimeters or less of attached gingiva normally indicates the need for this procedure. No additional benefits are allowed for harvesting the graft from the donor site. Use of synthetic tissue is not included in the allowance and is chargeable to the patient as a non-covered benefit. (Process as code D4999). If one or two contiguous teeth are grafted, a benefit for one tooth segment (a tooth segment is defined as two contiguous teeth) is allowed. If a third contiguous tooth is grafted, it will be benefited an additional 50% of the Altus allowance for a tooth segment. If a fourth contiguous tooth is grafted, it also will be benefited an additional 50% of the Altus Dental allowance for a tooth segment. No additional allowance is made after the fourth contiguous tooth (in one quadrant) and the patient may not be billed any difference. DISALLOW - par/DENY - non par. (see examples under D4270)	
		A tissue graft performed exclusively to repair an extraction site is not a covered benefit – DENY.	
		Benefits for a soft tissue graft can be made available if there is an implant present, or if the graft is being done for preparation of implant due to lack of keratinized tissue. A narrative is required. Deny if done for aesthetic purposes. Update 3/19/07	
		When reviewing procedures D4270 and D4271 count the tooth bounded spaces between contiguous teeth being treated as part of a site. Example: #18 & #20 are being treated; #19 is missing. Benefit as 1 1/2 sites. Depending on the dimensions of the defect, up to two contiguous tooth positions may be considered as part of the site.	

		If the edentulous bounded space is greater than two teeth, consider the bounding teeth being grafted as two separate sites. For par dentists, the patient cannot be billed for the difference. For non-par dentists, the patient is responsible for any difference between the dentist's charge and Altus's allowance. Facial and lingual surfaces are considered two separate surgical sites.	
		** Edentulous tooth bounded spaces included in the graft procedure should be identified as tooth "X" in order to capture graft history (using tooth # in an edentulous space is prohibited as extraction may be in history).	
		Crown lengthening, D4249, performed on the same date of service in conjunction with soft tissue graft procedures in the same quadrant, should not exceed the reimbursement for one quadrant of osseous surgery.	
D4273	Subepithelial connective tissue graft procedures, per tooth	CDT: This procedure is performed to create or augment gingiva, to obtain root coverage to eliminate sensitivity and to prevent root caries, to eliminate frenum pull to extend the vestibular fornix, to augment collapsed ridges, to provide an adequate gingival interface with a restoration or to cover bone or ridge regeneration sites when adequate gingival tissues are not available for effective closure. There are two surgical sites. The recipient site utilizes a split thickness incision, retaining the overlying flap of gingiva and/or oral mucosa. The connective tissue is dissected from the donor site leaving an epithelialized flap for closure. After the graft is placed on the recipient site, it is covered with the retained overlying flap.	Tooth numbers, current periodontal charting (no more than 12 months old) showing measurements of recession, and amount of pre-surgical attached gingival
		This procedure is benefited per tooth and subject to a 60-month time limitation. Deny.	
		Allow up to two teeth per quadrant. No additional allowance is made after the second tooth (in one quadrant) and the patient may not be billed any difference.	
		Ex: Dentist submits D4273 for teeth #'s 11 & 13. Charting indicates #12 treated also. To maintain history of all three teeth process as follows:	
		#11 - 4273 approve full allowance	
		#13 - 4273 approve full allowance	
		A tissue graft performed exclusively to repair an extraction site is not a covered benefit – Deny.	
		Benefits for a soft tissue graft can be made available if there is an implant present, or if the graft is being done for preparation of implant due to lack of keratinized tissue. A narrative is required. Deny if done for aesthetic purposes. Update 3/19/07	
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	CDT: This procedure is performed in an edentulous area adjacent to a periodontally involved tooth. Gingival incisions are utilized to allow removal of a tissue wedge to gain access and correct the underlying osseous defect and to permit close flap adaptation.	Narrative and pre-operative periapical x-ray
		Not a separate benefit when performed in conjunction with surgical procedures in the same anatomical area. Procedure is limited to once in a 24-month period. A healing period of at least 14 days is required before any other definitive treatment at the site is considered. When approving on a pre-treatment estimate.	
		<u>If distal wedge is submitted in conjunction with other surgical procedures on the same date of service and in the same surgical site,</u> specifically: osseous surgery (D4260/D4261), gingivectomy (D4210/D4211), gingival flap procedures (D4240/D4245), crown lengthening (D4249) and/or mucogingival surgery (D4250), it should be DISALLOWED to a par dentist as part of the greater surgical procedure/ DENIED to the non-par dentist.	
		<u>Limitation:</u>	
		This procedure is limited to once in 24 months on the same tooth. If performed again within that time period by the same par dentist, must be reviewed by Consultant for determination of DISALLOW/DENY .	
D4275	Soft tissue allograft	CDT: Procedure is performed to create or augment the gingiva, with or without root coverage. This may be used to eliminate the pull of the frena and muscle attachments, to extend the vestibular fornix and correct localized gingival recession. There is no donor site.	Tooth numbers, current periodontal charting (no more than 12 months old) showing measurements of recession, and amount of pre-surgical attached gingiva
		Beginning with dates of service on or after 3/1/04, Altus Dental will make an alternate benefit allowance of a D4271 (soft tissue graft) towards this procedure. The patient is responsible for the balance up to the dentist's charge.	

D4276	Combined connective tissue and double pedicle graft, per tooth	CDT: Advanced gingival recession often cannot be corrected with a single procedure. Combined tissue grafting procedures are needed to achieve the desired outcome. Altus will make an alternate benefit allowance of a D4273 (subepithelial connective tissue graft) towards this procedure. The patient is responsible for the balance up to the dentist's charge.	Tooth numbers, current periodontal charting (no more than 12 months old) showing measurements of recession, and amount of pre-surgical attached gingiva
NON-SURGICAL PERIODONTAL SERVICE			
D4320	Provisional splinting - intracoronal	CDT: This is an interim stabilization of mobile teeth. A variety of methods and appliances may be employed for this purpose. Identify the teeth involved and the nature of the splint.	
D4321	Provisional splinting - extracoronal	CDT: This is an interim stabilization of mobile teeth. A variety of methods and appliances may be employed for this purpose. Identify the teeth involved and the nature of the splint.	
		Not a covered benefit unless specified under the group contract.	
D4341	Periodontal scaling & root planing-four or more teeth per quadrant	CDT: This procedure involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. It is indicated for patients with periodontal disease and is therapeutic, not prophylactic, in nature. Root planing is the definitive procedure designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or microorganisms. Some soft tissue removal occurs. This procedure may be used as a definitive treatment in some stages of periodontal disease and/or as a part of pre-surgical procedures in others.	Full mouth perio charting including 4 to 6 probing depths per tooth; indication of furcation involvement, mobility, or bleeding upon probing.
D4342	Periodontal scaling & root planing-one to three teeth per quadrant	Scaling and root planing in the same quadrant once every 24 months (certain groups allow scaling and root planing once every 12 months).	
		If a perio maintenance (D4910) or adult prophy (D1110) is performed on the same date of service as scaling and root planing (D4341 and D4242), reduce the reimbursement on the preventive procedure in accordance with the number of quadrants having scaling and root planing. Example: the patient has scheduled their preventive procedure on the same date as a quadrant of scaling and root planing. In this case, the allowance for the preventive procedure should be reduced by 1/4.	
		If scaling and root planing is performed on the same date of service as gingival flap (D4240/D4245), DISALLOW the scaling and root planing. Benefit is based upon the most comprehensive procedure performed on a given date.	
		Benefit only two full quadrants scaling and root planing on the same date of service. Additional documentation, including a treatment chart and explanation of treatment plan, are required when more than two quadrants are done on the same day. Disallow. A healing period of at least 14 days should be allowed after scaling and root planing before osseous surgery can be performed.	
		If the treatment chart does not support the need for 4 quads on same day, and in absence of narrative refer to Consultant, potential disallow.	
		Do not count tooth bounded spaces. In order to qualify for benefits probing depths must be 4mm or greater on 4 or more teeth. If only 1-3 teeth qualify, use partial quadrant code (D4342). If no teeth in the quadrant qualify, the Dental Consultant will DENY.	
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	CDT: The gross removal of plaque and calculus that interfere with the ability of the dentist to perform a comprehensive oral evaluation. This preliminary procedure does not preclude the need for additional procedures.	
		Not a covered benefit.	
		1. If D1110-adult prophy, D1120-child prophy, D4341/D4342-scaling and root planing, D4355-full mouth debridement, or D4910-periodontal maintenance has been paid within the past 24 months to the same par dentist/dental office, benefit as D1110 with no patient liability (except for co-insurance if applicable).	
		2. If a dentist/dental office is performing the D4355 and routine services were performed by a different dentist/dental office within 24 months, benefit as an alternate benefit of procedure D1110 <u>with the patient being responsible for the difference up to the submitted charge of the D4355.</u>	
		3. If none of the procedures listed above have been performed in the past 24 months, process as an alternate benefit of procedure D1110 <u>with the patient being responsible up to the submitted charge for the D4355.</u>	
		In all cases above, the D1110 counts toward one of the two cleanings allowed under the group contract.	

		If procedures D4355 and D1110 are submitted on the same date of service, the submitted fees will be combined and processed according to the above listed guidelines.	
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report	CDT: FDA approved subgingival delivery devices containing antimicrobial medication(s) are inserted into periodontal pockets to suppress the pathogenic microbiota. These devices slowly release the pharmacological agents so they can remain at the intended site of action in a therapeutic concentration for a sufficient length of time. Not a covered benefit unless specified under the group contract. For those groups with coverage, after a 30 day healing period, this procedure is covered once per tooth per 24 months for patients with a history of scaling and root planing. D4341, D4342.	
OTHER PERIODONTAL SERVICES			
D4910	Periodontal maintenance	CDT: This procedure is instituted following periodontal therapy and continues at varying intervals, determined by the clinical evaluation of the dentist, for the life of the dentition or any implant replacements. It includes removal of the bacterial plaque and calculus from supragingival and subgingival regions, site specific scaling and root planing where indicated and polishing the teeth. If new or recurring periodontal disease appears, additional diagnostic and treatment procedures must be considered. Benefits are allowed if there is evidence of periodontal therapy in history (procedures D4240, D4241, D4260, D4261, D4341, D4342, D4910) or documentation from the treating dentist that active periodontal treatment has been performed. If there is no evidence of periodontal therapy in history, deny D4910. Perio maintenance will be benefited up to 2 times per calendar year or once every 6 months. If the patient receives a third and/or fourth perio maintenance procedure, allow an alternate benefit of procedure D1110 with the patient responsible up to the dentist's submitted charge for D4910. If a perio maintenance (D4910) or adult prophy (D1110) is performed on the same date of service as scaling and root planing (D4341/D4242) or osseous surgery (D4260/D4261), reduce the reimbursement on the preventive procedure in accordance with the number of quadrants being treated. Example: the patient has scheduled their preventive procedure on the same date as a quadrant of scaling and root planing. In this case, the allowance for the preventive procedure should be reduced by 1/4. <u>An office may pre-treat both perio maintenance (D4910) with scaling and root planing (code D4341) and/or osseous surgery (code D4260) on the same pre-treatment form. A 3 month waiting period after the D4341 or D4260 is required.</u>	
D4920	Unscheduled dressing change (by someone other than treating dentist)	Not a covered benefit.	
D4999	Unspecified periodontal procedure, be report	CDT: Use for periodontal procedure that is not adequately described by a code. Describe procedure. May require IC review by Dental Consultant.	Narrative
PROSTHODONTICS (Removable) D5000-D5899			
		If the procedure reported was the result of an accident, it should be submitted to the patient's medical and/or liability insurer first.	
		Benefits are payable on the date the denture is delivered.	
		Pre-treatment estimates are recommended for all prosthodontic procedures.	
COMPLETE DENTURES (Including routine post-delivery care)			
D5110	Complete denture-maxillary	Dentures are benefited once in a 60-month period and include any relin/rebase, adjustment or repair required within 6 months of delivery. Immediate dentures are exempt from this time limitation.	
D5120	Complete denture-mandibular	Tissue conditioning is not a benefit if performed on the same day the denture is delivered. Specialized techniques, personalization or characterization, dolder bars, hader bars and swinglocks are not covered and if performed should be done with the prior agreement of the patient to assume the additional cost. Any enhancements should be submitted on the claim form using code D5999.	
D5130	Immediate denture-maxillary	CDT: Includes limited follow-up care only; does not include required future rebasing/relining procedure(s) or a complete new denture.	
D5140	Immediate denture-mandibular	For immediate dentures, one chairside or laboratory-processed relin is benefited 3 months after the denture is delivered.	
PARTIAL DENTURES (Including routine post-delivery care)			

D5211	Maxillary partial denture-resin base (including any conventional clasps, rests and teeth)	<p>CDT: Includes acrylic resin base denture with resin or wrought wire clasps.</p> <p>Partial dentures are benefited once per arch per 60 months and include any reline/rebase, adjustment or repair required within 6 months of delivery. Benefit allowance includes frame, clasps, rests and teeth.</p> <p>Tissue conditioning is not a benefit if performed on the same day the denture is delivered.</p> <p>Specialized techniques, personalization or characterization, dolder bars, hader bars and swinglocks are not covered and if performed should be done with the prior agreement of the patient to assume the additional cost. Any enhancements should be submitted on the claim form using code D5999.</p>	
D5212	Mandibular partial denture-resin base (including any conventional clasps, rests and teeth)	See D5211 for Guidelines.	
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	See D5211 for Guidelines.	
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	See D5211 for Guidelines.	
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	<p>To be used for Valplast partial dentures. Same limitations as resin or cast partials.</p> <p>If a narrative states metal enforcements or another specialized technique is included with the Valplast partial, the dentist may bill the patient up to charge.</p>	
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	<p>To be used for Valplast partial dentures. Same limitations as resin or cast partials.</p> <p>If a narrative states metal enforcements or another specialized technique is included with the Valplast partial, the dentist may bill the patient up to charge.</p>	
		*Altus Dental will not allow an additional benefit for a posterior bridge in conjunction with an allowance for a partial denture in the same arch. If performed, the service must be done with the agreement of the patient to assume the cost.	
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	<p>Partial dentures are benefited once per arch per 60 months and include any reline/rebase, adjustment or repair required within 6 months of delivery. Benefit allowance includes frame, clasps, rests and teeth.</p>	
		Scenario 1: If a provider submits a claim for two Nesbit partial dentures (code D5281) in the <u>same arch on the same day</u> , combine the office charges and process with the appropriate cast partial denture procedure code (D5213 or D5214). Apply an alternate benefit of the cast partial. The patient is responsible up to the dentist's charge.	
		Scenario 2: If two Nesbit partials are rendered on different dates of services within 60 months of each other:	
		~First Nesbit is paid as procedure code D5281.	
		~The allowance for the two Nesbit partials can not exceed the allowance for a cast partial denture. To calculate the allowance for the 2nd Nesbit: take allowance for cast partial denture, and subtract what was allowed for the Nesbit = the amount allowed for the second Nesbit.	

		Process the second Nesbit as an alternate benefit by using the calculated amount from the above equation as the allowed amount. The approved would be the office charge. The patient is responsible for the difference up to the dentist's charge. Also, the 60 month time limitation starts from the insert date of the second Nesbit.	
ADJUSTMENTS TO DENTURES			
D5410	Adjust complete denture - maxillary	Full or partial dentures include any adjustments, repairs, rebases and relines within 6 months of delivery except in the case of immediate dentures. Immediate dentures are exempt from the time limitation. Two denture/partial adjustments per calendar year are covered after the first 6 months following initial placement. Any additional adjustments are the patient's responsibility.	
D5411	Adjust complete denture - mandibular		
D5421	Adjust partial denture - maxillary		
D5422	Adjust partial denture - mandibular		
REPAIRS TO COMPLETE DENTURES			
D5510	Repair broken complete broken complete denture base	Full or partial dentures include any adjustments, repairs, rebases and relines within 6 months of delivery except in the case of immediate dentures. Immediate dentures are exempt from the time limitation. One denture/partial repair per calendar year is covered after the first 6 months following initial placement. Any additional repairs are the patient's responsibility. The total benefit allowed for the repair of the denture should not exceed half of the prevailing amount of a new denture.	
D5520	Replace missing or broken teeth - complete denture (each tooth)		
REPAIRS TO PARTIAL DENTURES			
D5610	Repair resin denture base	Full or partial dentures include any adjustments, repairs, rebases and relines within 6 months of delivery except in the case of immediate dentures. Immediate dentures are exempt from the time limitation. One denture/partial repair per calendar year is covered after the first 6 months following initial placement. Any additional repairs are the patient's responsibility. The total benefit allowed for the repair of the denture should not exceed half of the prevailing amount of a new denture.	
D5620	Repair cast framework		
D5630	Repair or replace broken clasp	Since special prosthetic devices are not a covered benefit, repairs to these devices are excluded. The patient is responsible for the additional cost.	
D5640	Replace broken teeth-per tooth		
D5650	Add tooth to existing partial denture		
D5660	Add clasp to existing partial denture		
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	Benefits for D5670 and D5671 are allowed only if the existing partial is over 60 months old.	
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	If a new partial is submitted within 60 months of procedure codes D5670 and D5671, it will be denied.	
DENTURE REBASE PROCEDURES			
		Rebase - process of refitting a denture by replacing the base material	
D5710	Rebase complete maxillary denture	Rebase includes adjustments and relines required within 6 months of delivery of the rebased denture. Benefits are allowed once in a 60 month period. Immediate dentures are exempt from the time limitation.	
D5711	Rebase complete mandibular denture		

D5720	Rebase maxillary partial denture		
D5721	Rebase mandibular partial denture		
DENTURE RELINE PROCEDURES			
		Reline is the process of resurfacing the tissue side of a denture with new base material	
D5730	Reline complete maxillary denture (chairside)	Reline includes all adjustments required within 6 months of delivery of the relined denture. Benefits for reline are allowed once in a 60 month period. Immediate dentures are exempt from the time limitation.	
D5731	Reline complete mandibular denture (chairside)		
D5740	Reline maxillary partial denture (chairside)		
D5741	Reline mandibular partial denture (chairside)		
D5750	Reline complete maxillary denture (laboratory)		
D5751	Reline complete mandibular denture (laboratory)		
D5760	Reline maxillary partial denture (laboratory)		
D5761	Reline mandibular partial denture (laboratory)		
INTERIM PROSTHESIS			
		A provisional prosthesis designed to use over a limited period of time, after which it is to be replaced by a more definitive restoration.	
D5810	Interim complete denture-maxillary	Not a covered benefit.	
D5811	Interim complete denture-mandibular	Not a covered benefit.	
D5820	Interim partial denture-maxillary	<p>CDT: Includes any necessary clasps and rests.</p> <p>An interim partial is benefited when replacing missing permanent anterior teeth, 6-11 and 22-27. If criteria not met deny.</p> <p>If the interim partial is paid and is followed by a permanent prosthesis (i.e., second partial denture, an implant or a bridge) within 6 months, the amount Altus paid for the interim partial will be deducted from the allowed amount for the permanent prosthesis (temporaries are considered as part of the permanent procedure). If the permanent prosthesis is placed after 6 months, pay with no deduction.</p>	
D5821	Interim partial denture-mandibular	If the reason for this procedure is the result of an accident, disallow.	
OTHER REMOVABLE PROSTHETIC SERVICES			
D5850	Tissue conditioning - maxillary	CDT: Treatment reline using materials designed to heal unhealthy ridges prior to more definitive final restoration.	
D5851	Tissue conditioning - mandibular	Tissue conditioning is a benefit twice per calendar year; not a benefit if performed on the same day the denture is delivered or a reline/rebase is provided.	
D5860	Overdenture - complete, by report	CDT: Describe and document procedures as performed. Other separate procedures may be required concurrent to D5860.	

		Overdentures, complete or partial, are not covered. Altus will make an alternate benefit allowance of a complete/partial denture. Patients are responsible for the balance up to the dentist's charge. Root canal therapy, post and core, copings and precision attachments done in conjunction with an overdenture are not covered benefits. Benefits for root canals on teeth supporting an overdenture are only allowed if pathology warrants such therapy.	
D5861	Overdenture - partial, by report	CDT: Describe and document procedures as performed. Other separate procedures may be required concurrent to D5861.	
D5862	Precision attachment, by report	CDT: Each set of male and female components should be reported as one precision attachment. Describe the type of attachment used.	
		Not a covered benefit.	
D5867	Replacement of replaceable part of semi-precision or precision attachment (male or female component)	Not a covered benefit.	
D5875	Modification of removable prosthesis following implant surgery.	CDT: The modification of existing removable prosthesis is sometimes necessary at the time of implant placement and bone graft surgery and is always necessary at the time of the placement of the healing caps. This code could also be used to report the modification of an existing prosthesis when the abutments are placed and retentive elements are placed into the removable prosthesis, thereby reducing the need for a new prosthesis. Covered for those groups with Implant Rider. Once in a lifetime benefit.	
D5899	Unspecified removable prosthodontic procedure, by report	CDT: Use for a prosthodontic procedure that is not adequately described by a code. Describe procedure. May require IC review by Dental Consultant.	Narrative

MAXILLOFACIAL PROSTHETICS D5900-D5999

Procedure codes D5911 through D5988: Not a covered benefit.

For full definitions of procedure codes refer to Current Dental Terminology (CDT) Book

D5911	Facial moulage (sectional)		
D5912	Facial moulage (complete)		
D5913	Nasal prosthesis		
D5914	Auricular prosthesis		
D5915	Orbital prosthesis		
D5916	Ocular prosthesis		
D5919	Facial prosthesis		
D5922	Nasal septal prosthesis		
D5923	Ocular prosthesis		
D5924	Cranial prosthesis		
D5925	Facial augmentation implant prosthesis		
D5926	Nasal prosthesis, replacement		
D5927	Auricular prosthesis replacement		
D5928	Orbital prosthesis replacement		

D5929	Facial prosthesis replacement		
D5931	Obturator prosthesis, surgical		
D5932	Obturator prosthesis, definitive		
D5933	Obturator prosthesis, modification		
D5934	Mandibular resection prosthesis with guide flange		
D5935	Mandibular resection prosthesis without guide flange		
D5936	Obturator prosthesis, interim		
D5937	Trismus appliance (not for TMD treatment)		
D5951	Feeding aid		
D5952	Speech aid prosthesis, pediatric		
D5953	Speech aid prosthesis, adult		
D5954	Palatal augmentation prosthesis		
D5955	Palatal lift prosthesis, definitive		
D5958	Palatal lift prosthesis, interim		
D5959	Palatal lift prosthesis, modification		
D5960	Speech aid prosthesis, modification		
D5982	Surgical stent		
D5983	Radiation carrier		
D5984	Radiation shield		
D5985	Radiation cone locator		
D5986	Fluoride gel carrier		
D5987	Commissure splint		
D5988	Surgical splint		
D5991	Topical medicament carrier	<p>CDT: A custom fabricated carrier that covers the teeth and alveolar mucosa, or alveolar mucosa alone, and is used to deliver topical corticosteroids and similar effective medicaments for maximum sustained contact with the alveolar ridge and/or attached gingival tissues for the control and management of immunologically mediated vesicubullous mucosal, chronic recurrent ulcerative, and other desquamative diseases of the gingiva and oral mucosa.</p> <p>Not a covered benefit unless specified by the group contract.</p>	
D5999	Unspecified maxillofacial prosthesis, by report	<p>CDT: Used for a procedure that is not adequately described by a code. Describe procedure. May require IC review by Dental Consultant.</p>	Narrative

IMPLANT SERVICES D6000-D6199

		If the procedure reported was the result of an accident, it should be submitted to the patient's medical and/or liability insurer first.	
		Limitation: One implant per tooth site per lifetime.	
		<u>*Note:</u> Tissue grafts, sinus lifts and nerve repositioning are not covered benefits and are the patient's responsibility.	
		Fees for study models used in preparation of implant placement are included in the fee for the surgical placement.	
		<u>*Note:</u> The placement of "mini implants" or "transitional implants" is not a covered benefit. If submitted, these procedures are coded as D6199 and DENIED. Mini implants are considered transitional or temporary; used as a provisional fixture to support an interim prosthesis. Crowns supported by the mini-implant, non-covered.	
		If the group has Prosthodontic coverage, the following Implant codes are a standard benefit: D6010, D6056, D6057.	
		If the group has an Implant Rider the following codes are covered: D5875, D6010, D6040, D6050, D6055, D6056, D6057, D6091, D6095, D6100, D6199 and D6080.	

PRE-SURGICAL SERVICES

D6190	Radiographic/surgical implant index, by report	CDT: An appliance, designed to relate osteotomy or fixture position to existing anatomic structures, to be utilized during radiographic exposure for treatment planning and/or during osteotomy creation for fixture installation.	
		Not a covered benefit.	

SURGICAL SERVICES

Report surgical implant procedures using codes in this section.

D6010	Surgical placement of implant body: endosteal implant	CDT: Includes second stage surgery and placement of healing cap.	
		Altus Dental will only make payment for the replacement of missing natural teeth. Implants done solely to restore a space beyond the normal complement of natural teeth is optional. The patient is responsible for the entire cost of the implant.	
D6012	Surgical placement of interim implant body for transitional prosthesis: endosteal implant	CDT: Includes removal during later therapy to accommodate the definitive restoration, which may include placement of other implants.	
		Not a covered benefit.	
D6040	Surgical placement: eposteal implant	CDT: An eposteal (subperiosteal) framework of a biocompatible material designed and fabricated to fit on the surface of the bone of the mandible or maxilla with permucosal extensions that provide support and attachment of a prosthesis. This may be a complete arch or unilateral appliance. Eposteal implants rest upon the bone and under the periosteum.	
		Not a covered benefit unless the group has an Implant Rider.	
D6050	Surgical placement: transosteal implant	CDT: A transosteal (transosseous) biocompatible device with threaded posts penetrating both the superior and inferior cortical bone plates of the mandibular symphysis and exiting through the permucosa providing support and attachment for a dental prosthesis. Transosteal implants are placed completely through the bone and into the oral cavity from extraoral or intraoral.	
		Not a covered benefit unless the group has an Implant Rider.	
D6100	Implant removal, by report	CDT: This procedure involves the surgical removal of an implant. Describe procedure. Not a covered benefit unless the group has an Implant Rider.	Narrative

IMPLANT SUPPORTED PROSTHETICS

Supporting Structures

D6055	Dental implant supported connecting bar	CDT: A device attached to transmucosal abutments to stabilize and anchor a removable overdenture prosthesis.	
		Benefits for a placement of an implant to a natural tooth bridge are denied for long term prognosis. The risk associated with the placement of a bridge with one abutment on a natural tooth and the second on an implant are substantial.	
		Not a covered benefit unless the group has an Implant Rider.	
D6056	Prefabricated abutment- includes placement	CDT: A connection to an implant that is a manufactured component, usually made of machined high noble metal, titanium, titanium alloy or ceramic. Modification of a prefabricated abutment may be necessary and is accomplished by altering its shape using dental burs/diamonds.	
D6057	Custom abutment- includes placement	CDT: A connection to an implant that is a fabricated component, usually by a laboratory, specific for an individual application. A custom abutment is typically fabricated using a casting process and usually is made of noble or high noble metal. A "UCLA abutment" is an example of this type abutment.	
		Implant/Abutment Supported Removable Dentures	
		Implant supported dentures or partials are not covered; however, an <u>alternate benefit</u> allowance is made of a conventional denture or partial denture with the patient being responsible for the difference up to the dentist's charge.	
D6053	Implant abutment supported <u>removable</u> denture for completely edentulous arch	X-ray must reveal successful implant placement.	Panoramic film and/or appropriate periapical x-ray
D6054	Implant abutment supported <u>removable</u> denture for a partially edentulous arch	X-ray must reveal successful implant placement.	Panoramic film and/or appropriate periapical x-ray
		Benefits for a placement of an implant to a natural tooth for removable prosthetics are denied for long term prognosis. The risk associated with the placement of a bridge with one abutment on a natural tooth and the second on an implant are substantial.	
		Implant/Abutment Supported Fixed Dentures (Hybrid Prosthesis)	
D6078	Implant abutment supported fixed denture for completely edentulous arch	CDT: A prosthesis that is retained, supported and stabilized by implants or abutments placed on implants but does not have specific relationships between implant positions and replacement teeth; may be screw retained or cemented; commonly referred to as a "hybrid prosthesis."	Panoramic film and/or appropriate periapical x-ray
		An implant supported denture is not covered; however an <u>alternate benefit</u> allowance will be made of a conventional denture with the patient being responsible for the difference up to the dentist's charge.	
D6079	Implant abutment supported fixed denture for partially edentulous arch	CDT: A prosthesis that is retained, supported and stabilized by implants or abutments placed on implants but does not have specific relationships between implant positions and replacement teeth; may be screw retained or cemented; commonly referred to as a "hybrid prosthesis."	Panoramic film and/or appropriate periapical x-ray
		An implant supported partial denture is not covered; however an <u>alternate benefit</u> allowance will be made of a conventional partial denture with the patient being responsible for the difference up to the dentist's charge.	
		Benefits for a placement of an implant to a natural tooth for fixed prosthetics are denied for long term prognosis. The risk associated with the placement of a bridge with one abutment on a natural tooth and the second on an implant are substantial.	
		Single Crowns, Abutment Supported	
D6058	Abutment supported porcelain/ceramic crown	CDT: A single crown restoration that is retained, supported and stabilized by an abutment on an implant; may be screw retained or cemented.	
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	CDT: A single metal-ceramic crown restoration that is retained, supported and stabilized by an abutment on an implant; may be screw retained or cemented.	

D6060	Abutment supported porcelain fused to metal crown (predominately base metal)	CDT: A single metal-ceramic crown restoration that is retained, supported and stabilized by an abutment on an implant; may be screw retained or cemented.	
D6061	Abutment supported porcelain fused to metal crown (noble metal)	CDT: A single metal-ceramic crown restoration that is retained, supported and stabilized by an abutment on an implant; may be screw retained or cemented.	
D6062	Abutment supported cast metal crown (high noble metal)	CDT: A single cast metal crown restoration that is retained, supported and stabilized by an abutment on an implant; may be screw retained or cemented.	
D6063	Abutment supported cast metal crown (predominately base metal)	CDT: A single cast metal crown restoration that is retained, supported and stabilized by an abutment on an implant; may be screw retained or cemented.	
D6064	Abutment supported cast metal crown (noble metal)	CDT: A single cast metal crown restoration that is retained, supported and stabilized by an abutment on an implant; may be screw retained or cemented.	
D6094	Abutment supported crown - (titanium)	CDT: A single crown restoration that is retained, supported and stabilized by an abutment on an implant. May be cast or milled and is screw retained or cemented.	
		Single Crowns, Implant Supported	
D6065	Implant supported porcelain/ceramic crown	CDT: A single crown restoration that is retained, supported and stabilized by an implant; may be screw retained or cemented.	
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	CDT: A single metal-ceramic crown restoration that is retained, supported and stabilized by an implant; may be screw retained or cemented.	
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	CDT: A single cast or milled metal crown restoration that is retained, supported and stabilized by an implant; may be screw retained or cemented.	
		Fixed Partial Denture, Abutment Supported	
		Benefits for a placement of an implant to a natural tooth for fixed prosthetics are denied for long term prognosis. The risk associated with the placement of a bridge with one abutment on a natural tooth and the second on an implant are substantial.	
D6068	Abutment supported retainer for porcelain/ceramic FPD	CDT: A ceramic retainer for a fixed partial denture that gains retention, support and stability from an abutment on an implant; may be screw retained or cemented. An alternate benefit of a D6069 will be made.	Pre-operative periapical x-ray (for pre tx) and x-ray showing implant (for claim)
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	CDT: A metal-ceramic retainer for a fixed partial denture that gains retention, support and stability from an abutment on an implant; may be screw retained or cemented.	Pre-operative periapical x-ray (for pre tx) and x-ray showing implant (for claim)

D6070	Abutment supported retainer for porcelain fused to metal FPD (predominately base metal)	CDT: A metal-ceramic retainer for a fixed partial denture that gains retention, support and stability from an abutment on an implant; may be screw retained or cemented.	Pre-operative periapical x-ray (for pre tx) and x-ray showing implant (for claim)
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	CDT: A metal-ceramic retainer for a fixed partial denture that gains retention, support and stability from an abutment on an implant; may be screw retained or cemented.	Pre-operative periapical x-ray (for pre tx) and x-ray showing implant (for claim)
D6072	Abutment supported retainer for cast metal FPD (high noble)	CDT: A cast metal retainer for a fixed partial denture that gains retention, support and stability from an abutment on an implant; may be screw retained or cemented.	Pre-operative periapical x-ray (for pre tx) and x-ray showing implant (for claim)
D6073	Abutment supported retainer for cast metal FPD (predominately base metal)	CDT: A cast metal retainer for a fixed partial denture that gains retention, support and stability from an abutment on an implant; may be screw retained or cemented.	Pre-operative periapical x-ray (for pre tx) and x-ray showing implant (for claim)
D6074	Abutment supported retainer for cast metal FPD (noble metal)	CDT: A cast metal retainer for a fixed partial denture that gains retention, support and stability from an abutment on an implant; may be screw retained or cemented.	Pre-operative periapical x-ray (for pre tx) and x-ray showing implant (for claim)
D6194	Abutment supported retainer for FPD - (titanium)	CDT: A retainer for a fixed partial denture that gains retention, support and stability from an abutment on an implant; may be screw retained or cemented.	Pre-operative periapical x-ray (for pre tx) and x-ray showing implant (for claim)
Fixed Partial Denture, Implant Supported			
D6075	Implant supported retainer for ceramic FPD	CDT: A ceramic retainer for a fixed partial denture that gains retention, support and stability from an implant; may be screw retained or cemented. An alternate benefit of a D6076 will be made.	Pre-operative periapical x-ray (for pre tx) and x-ray showing implant (for claim)
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy or high noble metal)	CDT: A metal-ceramic retainer for a fixed partial denture that gains retention, support and stability from an implant; may be screw retained or cemented.	Pre-operative periapical x-ray (for pre tx) and x-ray showing implant (for claim)
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy or high noble metal)	CDT: A cast metal retainer for a fixed partial denture that gains retention, support and stability from an implant; may be screw retained or cemented.	Pre-operative periapical x-ray (for pre tx) and x-ray showing implant (for claim)
Benefits for a placement of an implant to a natural tooth for fixed prosthetics are denied for long term prognosis. The risk associated with the placement of a bridge with one abutment on a natural tooth and the second on an implant are substantial.			
OTHER IMPLANT SERVICES			

D6080	Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis	CDT: This procedure includes a prophylaxis to provide active debriding of the implant and examination of all aspects of the implant system, including the occlusion and stability of the superstructure. The patient is also instructed in through daily cleansing of the implant. Not a covered benefit unless the group has an Implant Rider.	Narrative
D6090	Repair implant supported prosthesis, by report	CDT: This procedure involves the repair or replacement of any part of the implant supported prosthesis.	Narrative and x-rays
		Repairs are covered once every 60 months.	
D6095	Repair implant abutment, by report	CDT: This procedure involves the repair or replacement of an implant abutment.	Narrative
		Not a covered benefit unless the group has an Implant Rider.	
D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment	CDT: This procedure applies to the replaceable male or female component of the attachment. There is a 60-month time limitation for replacement of precision attachments. Not a covered benefit unless the group has an Implant Rider.	Narrative
D6092	Recement implant/abutment supported crown	A recementation performed after 6 months of delivery by the same or different dentist/dental office is benefited once per 60 months. Recementations are benefited for permanent prosthesis only. ~If recementation is done within 6 months of delivery and is done by a different dentist - pay. ~If recementation is done within 6 months by the original par dentist - DISALLOW-par/DENY - non par dentist.	
D6093	Recement implant/abutment supported fixed partial denture		
D6199	Unspecified implant procedure, by report	CDT: Use for an implant procedure that is not adequately described by a code. Describe procedure. Certain procedures may be covered if the patient has an Implant Rider. May require IC review by Dental Consultant.	Narrative

PROSTHODONTICS, FIXED D6200-D6999

		If the procedure reported was the result of an accident, it should be submitted to the patient's medical and/or liability insurer first.	
		The term "fixed partial denture" replaces the words "bridge" and "bridgework" throughout this section.	
		Classification Of Materials	
		Classification of Metals (Source: ADA Council on Scientific Affairs)	
		The noble metal classification system has been adopted as a more precise method of reporting various alloys used in dentistry. The alloys are defined on the basis of the percentage of metal content: high noble - Gold (Au), Palladium (Pd), and/or Platinum (Pt) ≥ 60% (with at least 40% Au); titanium and titanium alloys - Titanium (Ti) > 85%; noble - Gold (Au), Palladium (Pd), and/or Platinum (Pt) ≥ 25%; predominantly base - Gold (Au), Palladium (Pd), and/or Platinum (Pt) < 25%.	
		Porcelain/ceramic	
		Refers to those non-metal, non-resin inorganic refractory compounds processed at high temperatures (600°C/1112°F and above) and pressed, polished or milled - including porcelains, glasses and glass-ceramics.	
		Resin	
		Refers to any resin-based composite, including fiber or ceramic/reinforced polymer compounds.	

FIXED PARTIAL DENTURE PONTICS

D6205	Pontic - indirect resin based composite	CDT: Not to be used as a temporary or provisional prosthesis. Not a covered benefit.	
D6210	Pontic - cast high noble metal	*If within the 60-month time period, the bridge is replaced with additional units, benefits will only be made for the new units of the bridge.	Tooth number and pre-operative periapical x-rays showing the entire treatment site
D6211	Pontic - cast predominantly base metal		Tooth number and pre-operative periapical x-rays showing the entire treatment site
D6212	Pontic - cast noble metal		Tooth number and pre-operative periapical x-rays showing the entire treatment site
D6214	Pontic - titanium		Tooth number and pre-operative periapical x-rays showing the entire treatment site
D6240	Pontic - porcelain fused to high noble metal		Tooth number and pre-operative periapical x-rays showing the entire treatment site
D6241	Pontic - porcelain fused to predominantly base metal		Tooth number and pre-operative periapical x-rays showing the entire treatment site
D6242	Pontic - porcelain fused to noble metal		Tooth number and pre-operative periapical x-rays showing the entire treatment site
D6245	Pontic - porcelain/ceramic	An alternate benefit of procedure D6240 will be made toward this procedure.	Tooth number and pre-operative periapical x-rays showing the entire treatment site
D6250	Pontic - resin with high noble metal		Tooth number and pre-operative periapical x-rays showing the entire treatment site
D6251	Pontic - resin with predominantly base metal		Tooth number and pre-operative periapical x-rays showing the entire treatment site
D6252	Pontic - resin with noble metal		Tooth number and pre-operative periapical x-rays showing the entire treatment site
D6253	Provisional pontic	CDT: Pontic utilized as an interim of at least six months duration during restorative treatment to allow adequate time for healing or completion of other procedures. This is not to be used as a temporary pontic for routine prosthetic fixed partial dentures.	X-ray and narrative

		If a temporary bridge is placed for an extended period of time (e.g., 6 months or longer), this is considered a provisional bridge. The dentist may submit a claim for Dental Consultant review to determine whether the dentist can bill the patient as opposed to including the provisional bridge as part of the greater procedure, and therefore disallowed. Circumstances that would be considered include: a patient in perio treatment or undergoing extensive prosthodontic work, orthodontic cases in conjunction with crown and bridge, and lab processed temporary crowns for long-span bridges.	
		If the Dental Consultant determines that the treatment plan is appropriate and a provisional bridge is warranted, the claim should be denied as a patient responsibility.	
		If provider submits for a temporary bridge because patient never returned for insertion, allow D6253 and D6793.	
FIXED PARTIAL DENTURE RETAINERS - INLAYS/ONLAYS			
D6545	Retainer - cast metal for resin bonded fixed prosthesis	Limitation: Benefits are allowed once every 60 months. If within the 60 months a new bridge is made with additional units, benefits will only be made for the new units of the bridge.	Tooth number, and pre-operative periapical x-rays showing the entire treatment site
D6548	Retainer – porcelain/ceramic for resin bonded fixed prosthesis	An alternate benefit of a D6545 will be made toward procedure D6548.	Tooth number, and pre-operative periapical x-rays showing the entire treatment site
D6600	Inlay - porcelain ceramic-two surfaces	An alternate benefit of an amalgam restoration will be made toward procedures D6600 and D6601.	
D6601	Inlay - porcelain/ceramic, three or more surfaces	An alternate benefit of an amalgam restoration will be made toward procedures D6600 and D6601.	
D6602	Inlay - cast high noble metal-two surfaces	An alternate benefit allowance of an amalgam restoration will be made towards the cost of all metallic inlays. Patient is responsible for the difference up to the dentist's charge.	
D6603	Inlay - cast high noble metal-three or more surfaces		
D6604	Inlay - cast predominately base metal-two surfaces		
D6605	Inlay - cast predominately base metal-three or more surfaces		
D6606	Inlay - cast noble metal-two surfaces		
D6607	Inlay - cast noble metal-three or more surfaces		
D6608	Onlay - porcelain ceramic-two surfaces	Allow as alternate benefit of D6610. Patient is responsible for difference up to dentist's charge. An alternate benefit of a metallic onlay (D6610) will be made only if the tooth meets the requirements for a bridge abutment. Benefits for either one onlay or one crown per tooth will be allowed in a 60 month period.	Tooth number, and pre-operative periapical x-rays showing the entire treatment site
D6609	Onlay - porcelain ceramic-three or more surfaces	Allow as alternate benefit of D6611. Patient is responsible for difference up to dentist's charge. An alternate benefit of a metallic onlay (D6611) will be made only if the tooth meets the requirements for a bridge abutment. Benefits for either one onlay or one crown per tooth will be allowed in a 60 month period.	Tooth number, and pre-operative periapical x-rays showing the entire treatment site
D6610	Onlay - cast high noble metal-two surfaces	Must meet the requirements for bridge placement.	Tooth number, and pre-operative periapical x-rays showing the entire treatment site

D6611	Onlay - cast high noble metal-three or more surfaces	see D6610 for guidelines	Tooth number, and pre-operative periapical x-rays showing the entire treatment site
D6612	Onlay - cast predominantly base metal, two surfaces	see D6610 for guidelines	Tooth number, and pre-operative periapical x-rays showing the entire treatment site
D6613	Onlay - cast predominantly base metal-three or more surfaces	see D6610 for guidelines	Tooth number, and pre-operative periapical x-rays showing the entire treatment site
D6614	Onlay - cast noble metal, two surfaces	see D6610 for guidelines	Tooth number, and pre-operative periapical x-rays showing the entire treatment site
D6615	Onlay - cast noble metal, three surfaces	see D6610 for guidelines	Tooth number, and pre-operative periapical x-rays showing the entire treatment site
D6624	Inlay - titanium	An alternate benefit allowance of an amalgam restoration will be made towards the cost of a titanium inlay. Patient is responsible for the difference up to the dentist's charge.	
D6634	Onlay - titanium	see D6610 for guidelines	Tooth number, and pre-operative periapical x-rays showing the entire treatment site
FIXED PARTIAL DENTURE RETAINERS - CROWNS			
		Only one cast restoration per tooth will be covered in a 60- month period.	
		Cast restorations include all models, temporaries, final x-rays and other associated procedures.	
		Benefits are payable on the insertion date.	
		If within the 60-month time period, additional units must be added to a new bridge, benefits will only be made for the new units.	
D6710	Crown - indirect resin based composite	Not to be used as a temporary or provisional prosthesis. Not a covered benefit.	
D6720	Crown - resin with high noble metal		Tooth number, and pre-operative periapical x-rays showing the entire treatment site
D6721	Crown - resin with predominantly base metal		Tooth number, and pre-operative periapical x-rays showing the entire treatment site
D6722	Crown - resin with noble metal		Tooth number, and pre-operative periapical x-rays showing the entire treatment site
D6740	Crown - porcelain/ ceramic	Allow alternate benefit of D6750.	Tooth number, and pre-operative periapical x-rays showing the entire treatment site

D6750	Crown - porcelain fused to high noble metal		Tooth number, and pre-operative periapical x-rays showing the entire treatment site
D6751	Crown - porcelain fused to predominantly base metal		Tooth number, and pre-operative periapical x-rays showing the entire treatment site
D6752	Crown - porcelain fused to noble metal		Tooth number, and pre-operative periapical x-rays showing the entire treatment site
D6780	Crown - 3/4 cast high noble metal		Tooth number, and pre-operative periapical x-rays showing the entire treatment site
D6781	Crown - 3/4 cast predominantly base metal		Tooth number, and pre-operative periapical x-rays showing the entire treatment site
D6782	Crown - 3/4 cast noble metal		Tooth number, and pre-operative periapical x-rays showing the entire treatment site
D6783	Crown - 3/4 porcelain/ceramic	Allow alternate benefit of D6780.	Tooth number, and pre-operative periapical x-rays showing the entire treatment site
D6790	Crown - full cast high noble metal		Tooth number, and pre-operative periapical x-rays showing the entire treatment site
D6791	Crown - full cast predominantly base metal		Tooth number, and pre-operative periapical x-rays showing the entire treatment site
D6792	Crown - full cast noble metal		Tooth number, and pre-operative periapical x-rays showing the entire treatment site
D6793	Provisional retainer crown	CDT: Retainer crown utilized as an interim of at least six months duration during restorative treatment to allow adequate time for healing or completion of other procedures. This is not to be used as a temporary retainer crown for routine prosthetic fixed partial dentures.	Tooth number, and pre-operative periapical x-rays showing the entire treatment site and a narrative
		If a temporary bridge is placed for an extended period of time (e.g., 6 months or longer), this is considered a provisional bridge. The dentist may submit a claim for Dental Consultant review to determine whether the dentist can bill the patient as opposed to including the provisional bridge as part of the greater procedure, and therefore disallowed. Circumstances that would be considered include: a patient in perio treatment or undergoing extensive prosthodontic work, orthodontic cases in conjunction with crown and bridge, and lab processed temporary crowns for long-span bridges.	

		If the Dental Consultant determines that the treatment plan is appropriate and a provisional bridge is warranted, the claim should be denied as a patient responsibility.	
		If provider submits for a temporary bridge because patient never returned for insertion, allow D6253 and D6793.	
D6794	Crown - titanium	Benefit same as proc D6790.	Tooth number, and pre-operative periapical x-rays showing the entire treatment site
OTHER FIXED PARTIAL DENTURE SERVICES			
D6920	Connector bar	CDT: A device attached to fixed partial denture retainer or coping that serves to stabilize and anchor a removable overdenture prosthesis.	
D6930	Recement fixed partial denture	A recementation performed after 6 months of delivery by the same or different dentist/dental office is benefited once per 60 months. Recementations are benefited for permanent prosthesis only. ~If recementation is done within 6 months of delivery and is done by a different dentist - pay. ~If recementation is done within 6 months by the original dentist ~ DISALLOW - par/DENY - non par.	
D6940	Stress breaker	CDT: A non-rigid connector.	Pre-operative x-ray and narrative
D6950	Precision attachment	CDT: Report attachment separately from crown; a male and female pair constitutes one precision attachment. Describe type of attachment used. Not a covered benefit.	
D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated	CDT: Post and core are custom fabricated as a single unit. Post and core is a benefit once in a 60-month period provided the tooth has been successfully treated endodontically and only when necessary to retain a cast restoration. *If a post & core is benefited and the tooth subsequently requires endo retreatment, a new post & core will be allowed (60-month time limitation is waived).	Tooth number and post-operative endo periapical x-ray
D6972	Prefabricated post and core in addition to fixed partial denture retainer	Prefabricated post and core is a benefit once in a 60- month period provided the tooth has been successfully treated endodontically and only when necessary to retain a cast restoration.	Tooth number and post-operative endo periapical x-ray
D6973	Core buildup for retainer, including any pins	Benefited when necessary to retain a cast restoration due to extensive loss of tooth structure.	Pre-operative x-ray
D6975	Coping - metal	To be used as a definitive restoration when coping is an integral part of a fixed prosthesis. Considered a specialized technique and is not a covered benefit.	
D6976	Each additional indirectly fabricated post - same tooth	CDT: To be used with D6970.	Tooth number, pre-operative periapical x-ray and narrative
D6977	Each additional prefabricated post - same tooth	CDT: To be used with D6972.	Tooth number, pre-operative periapical x-ray and narrative
D6980	Fixed partial denture repair, by report	A narrative detailing the surface(s) repaired and material(s) used for bridge repair are required for benefit consideration. Also, this code is to be used for an "overcrown" or "sleeve." If the repair is beyond the norm, e.g., an extensive bridge repair, then send the claim to the Consultant for Individual Consideration. In determining an appropriate fee, the Consultant may want to request a lab bill or call the dentist directly. Fee for repair of a fixed partial denture cannot exceed one-half of the fee for a new fixed partial denture. One repair (per unit) is allowed in a 60 month period. Recementation is a separate benefit.	Narrative
D6985	Pediatric partial denture - fixed	CDT: This prosthesis is used primarily for aesthetic purposes. Not a covered benefit.	

D6999	Unspecified fixed prosthodontic procedure, by report	CDT: Used for procedure that is not adequately described by a code. Describe procedure. May require IC review by Dental Consultant.	Narrative
		60 MONTHS TIME LIMITATION ON CROWNS AND FIXED BRIDGES	
		Replacement: Benefits are allowed for one bridge per tooth in a 60-month period.	
		CONTRACTUAL LIMITATIONS	
		<u>Extra Abutments</u>	
		Altus will benefit for replacement of missing natural teeth using the normal amount of abutments for the span. Additional abutments necessary due to special conditions or for splinting are optional and if performed, the patient will be responsible for the additional cost.	
		Altus will benefit for additional abutments if the tooth serving as the single abutment is considered a "weak abutment", including maxillary lateral incisors, mandibular lateral incisors or mandibular central incisors. In these cases, a DOUBLE ABUTMENT will be allowed.	
		<u>Example:</u> If there are two missing lower centrals, lower laterals are usually inadequate support. The cuspids on each side should be used as additional support. When there are missing upper centrals and the upper laterals appear to be inadequate supports due to small roots, (or missing centrals were extremely large), the cuspids may be needed as additional supports. These cases will be reviewed on an I.C. basis with consideration for mobility, crown/root ratio and tipping.	
		<u>Extra Pontics</u>	
		Altus will only make payment for the replacement of missing natural teeth. Any pontic required because of spaces in excess of those resulting from the extraction of the normal complement of natural teeth is a special condition of that patient's mouth and the patient must be responsible for the cost necessary to replace such teeth. <u>The patient is responsible for the entire cost of the prosthesis (3 unit bridge).</u>	
		Examples of "beyond the normal complement": a) Loss of a supernumerary tooth; b) Space created by a hemisection of a multi-rooted tooth. c) space created from orthodontic movement	
		Replacement of a congenitally missing tooth or impacted tooth may be benefited.	
		<u>The Periodontally Involved Tooth</u>	
		As a guideline, any tooth with only 50% of the bone remaining should be considered questionable in terms of long-term prognosis.	
		A narrative explaining the patient's periodontal history or an evaluation by a periodontist will be considered.	
		<u>Posterior Fixed Bridges with Partial Dentures</u>	
		A posterior bridge performed in conjunction with a partial in the same arch is not a benefit. The patient is responsible up to the dentist's charge. However; an anterior bridge in conjunction with a posterior partial in the same arch is allowed.	
		<u>Fixed Bridge for Patients Under Age 16</u>	
		Fixed bridges are not a benefit, the patient is responsible for the cost. An allowance for an interim partial denture may be made for anterior cases only.	
		<u>Insufficient Pontic Space</u>	
		If there does not appear to be sufficient tooth space to accommodate a pontic involved in a three unit bridge, refer to the Dental Consultant. If Consultant determines there is insufficient pontic space deny entire bridge.	
		If the bridge involves more than 2 pontics, and there is only enough space for 1 pontic, deny one of the pontics, approve other units of the bridge.	
		A bridge fabricated for the purpose of periodontal splinting is not a covered benefit.	
		<u>Cantilever Bridges</u>	
		Maxillary anterior cantilever bridges listing canines or central incisors as an abutment and replacing the lateral are a benefit. <i>This is a case where <u>one abutment</u> for a cantilever bridge is customary.</i>	
		Cantilever bridges that include <u>canine or bicuspid teeth as the cantilever pontic</u> may be considered appropriate after Dental Consultant review. There may be enough support from the adjacent abutments to support a cantilever bridge. If sufficient support is not determined, the Dental Consultant will DENY the bridge.	

		Cantilever bridges that include <u>molar teeth as the cantilever pontic</u> should be given Dental Consultant consideration. The Dental Consultant will review the crown to root ratio and adequacy of bone level. If the treatment is determined to be within acceptable dental practice standards, it can be approved. If sufficient support is not demonstrated or the treatment is NOT within acceptable dental practice standards, DENY the bridge.	
		NOTE: Cantilevering a 2 nd molar pontic off of a single molar abutment is NOT a benefit. DCM Analysts may DENY.	
		<u>Labially/Lingually Displaced Tooth (to be extracted-no pathology) & Fixed Bridge Placed</u>	
		If treatment is due to pathology, treatment would be allowed, yet subject to bridge guidelines.	
		<u>Targis/Vectris Bridges, Monodont Bridges and Other Fiber Reinforced Composite Bridges</u>	
		All Targis/Vectris bridges, Monodont bridges and other fiber reinforced composite bridge systems should be processed using procedure code D6999 and denied.	
		REPLACEMENT RULES	
		(A) Crown => Bridge Abutment – If a single crown is benefited and within 60 months the tooth next to it is extracted and a fixed bridge is being placed, Altus will deny the abutment. The patient is responsible for the balance up to the dentist's charge.	
		(B) Crown => Pontic – If a single crown is benefited and within 60 months the same tooth is extracted and is being replaced by a pontic as part of a fixed bridge, Altus will deny the pontic. The patient is responsible for the balance up to the dentist's charge.	
		(C) Bridge => New Bridge – If a fixed bridge is benefited and within 60 months one or more of the abutments is extracted and a new bridge is being placed, only the new units will be benefited. Deny the other units.	
		(D) Maryland Bridge => Conventional Bridge – If a Maryland Bridge is placed and within 60 months is replaced with a conventional bridge, benefit the difference between the allowance for the conventional bridge abutments and amount paid for the Maryland Bridge retainers. The patient is responsible for the balance up to the dentist's allowance (par dentist) or charge (non-par dentist) for the replacement unit(s). Deny pontic(s).	
		(E) Bridge => Partial – If a bridge is paid and within 60 months it is being replaced with a partial, deny the partial. The patient is responsible for the balance up to the dentist's charge.	
		(F) Partial => Bridge – If a partial is paid and within 60 months the same teeth are being replaced with a bridge, deny the bridge. The patient is responsible for the balance up to the dentist's charge.	
		(G) Onlay => Crown – If an onlay is paid and within 60 months the same tooth is being replaced with a single tooth crown, deny the crown. The patient is responsible for the balance up to the dentist's charge.	
		No exceptions will be provided for the following:	
		Partial => Complete Denture - Deny.	
		3/4 Crown => Full Crown - Deny.	
		Crown/Pontic => Crown over Implant - Deny.	
		MISSING TOOTH EXCLUSION	
		A group may elect to have a missing tooth exclusion. The missing tooth exclusion will apply if the tooth being replaced was missing prior to the date the patient's effective date of coverage.	
ORAL AND MAXILLOFACIAL SURGERY D7000-D7999			
		Benefit allowance includes local anesthesia and routine post-operative care	
		Supernumerary Teeth – Extraction of supernumerary teeth are a benefit. These teeth are identified by an "X".	
		Unsuccessful extractions - A claim should not be filed for an extraction if the whole tooth is not removed. The claim should be filed by the dentist who successfully extracted the tooth.	
		Treatment of Dry Socket – The fee for an extraction includes up to three (3) post-operative visits (dry socket). Each additional treatment of a dry socket is benefited as a palliative treatment.	
		Surgical Correction of Congenital or Developmental Malformations – Not a covered benefit.	
		Treatment of Temporomandibular Joint Disorders – Not a covered benefit, unless specified by the group contract.	
EXTRACTIONS (INCLUDES LOCAL ANESTHESIA, SUTURING, IF NEEDED AND ROUTINE POSTOPERATIVE CARE)			

D7111	Extraction, coronal remnants - deciduous tooth	CDT: Removal of soft tissue-retained coronal remnants.	
		Considered part of any other primary surgery in the same site, by the same dentist, on the same day.	
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	CDT: Includes routine removal of tooth structure, minor smoothing of socket bone and closure, as necessary. Benefit allowance includes local anesthesia and routine post-operative care (i.e. dry socket).	
SURGICAL EXTRACTIONS (INCLUDES LOCAL ANESTHESIA, SUTURING , IF NEEDED AND ROUTINE POSTOPERATIVE CARE)			
**See Benefit Check for group specific information regarding medical prime procedures.			
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	CDT: Includes cutting of gingiva and bone, removal of tooth structure, minor smoothing of socket bone and closure.	Tooth number, pre-operative periapical x-ray
D7220	Removal of impacted tooth - soft tissue	CDT: Occlusal surface of tooth covered by soft tissue; requires mucoperiosteal flap elevation.	Tooth number and pre-operative periapical x-ray
D7230	**Removal of impacted tooth - partially bony	CDT: Part of crown covered by bone; requires mucoperiosteal flap elevation and bone removal.	Tooth number and pre-operative periapical x-ray
D7240	**Removal of impacted tooth - complete bony	CDT: Most or all of crown covered by bone; requires mucoperiosteal flap elevation and bone removal.	Tooth number and pre-operative periapical x-ray
D7241	**Removal of impacted tooth - complete bony, with unusual surgical complications	CDT: Most or all of crown covered by bone; unusually difficult or complicated due to factors such as nerve dissection required, separate closure of maxillary sinus required or aberrant tooth position.	Tooth number and pre-operative periapical x-ray and detailed narrative
D7250	Surgical removal of residual roots (cutting procedure)	CDT: Includes cutting of soft tissue and bone, removal of tooth structure, and closure. <u>CDT definition of residual root:</u> Remaining root structure following the loss of the major portion (over 75%) of the crown. No benefits are allowed for root recovery in addition to the extraction when performed by the same dentist/dental office.	Tooth number and pre-operative periapical x-ray
		*All third molars do not qualify as surgical extractions. Each case will be considered individually and based on anatomical position.	
		<u>Criteria for Surgical Extractions:</u>	
		D7210) Includes cutting gingiva and bone, removal of bone and/or tooth and closure.	
		D7220) Not fully erupted, but tooth may be removed with a soft tissue flap and no bone removal.	
		D7230) Part of crown covered by bone: Bone interfering with removal of tooth requiring removal of some bone and mucoperiosteal flap elevation.	
		D7240) Bone covering most (> 75%) or all of the crown - requiring mucoperiosteal flap elevation and bone removal.	
		D7241) Submission <u>must</u> have narrative describing surgical complications.	
		<u>Definitive list of criteria should include:</u>	
		1. Radiographic evidence of thick, dense bone which makes elevation of exposure of the tooth difficult. This would include (in narrative) mention of exostosis buccal or palatal, complicating the removal.	
		2. Radiographic evidence of pathologic conditions such as cysts or tumors which may displace impacted teeth making access extremely difficult and necessitating removal through the sinus or other anatomic structures.	

		3. Relationship to adjacent teeth. A third molar may be positioned near the apical third of adjacent teeth, necessitating removal through the lateral maxillary sinus wall. Fusion of the third molars to adjacent teeth occasionally occurs necessitating removal of both teeth or sectioning one tooth from another.	
		4. Relationship to the maxillary sinus, inferior alveolar nerve or nasal cavity requiring modifications of incisions and approach to gain access for removal.	
		5. Radiographic evidence of ectopic positioning of third molars requiring complicated techniques for removal.	
		6. Radiographic evidence of dilacerations of roots.	
		The documentation for review should include a narrative detailing the unusual nature of the procedure and radiographs showing evidence of one or more of the criteria above.	
		Mention needs to be made to sectioning of a tooth; relationship is important to anatomic structures, i.e., nerves, sinus, nasal cavity, infratemporal fossa, etc., and the position of the tooth, i.e., distoangular, inverted, or lingual/palatal/buccal (sideways).	
OTHER SURGICAL PROCEDURES			
		If the procedure reported was the result of an accident, it should be submitted to the patient's medical and/or liability insurer first.	
		**See Benefit Check for group specific information regarding medical prime procedures.	
D7260	**Oroantral fistula closure	CDT: Excision of fistulous tract between maxillary sinus and oral cavity and closure by advancement flap.	
D7261	**Primary closure of a sinus perforation	CDT: Subsequent to surgical removal of tooth, exposure of sinus requiring repair or immediate closure of oroantral or oralnasal communication in absence of fistulous tract.	
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	CDT: Includes splinting and/or stabilization.	
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization)	Not a covered benefit under most group contracts. If covered, Medical Prime first. (6/08)	
D7280	Surgical access of an unerupted tooth	CDT: An incision is made and the tissue is reflected and bone removed as necessary to expose the crown of an impacted tooth not intended to be extracted.	
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	CDT: To move/luxate teeth to eliminate ankyolosis; not in conjunction with an extraction.	
D7283	Placement of device to facilitate eruption of impacted tooth	CDT: Placement of an orthodontic bracket, band or other device on an unerupted tooth after its exposure, to aid in its eruption. Report the surgical exposure separately using D7280.	
D7285	**Biopsy of oral tissue - hard (bone, tooth)	CDT: For removal of specimen only. This code involves biopsy of osseous lesions and is not used for apicoectomy/periradicular surgery.	
D7286	**Biopsy of oral tissue - soft	CDT: For surgical removal of an architecturally intact specimen only. This code is not used at the same time as codes for apicoectomy/periradicular curettage.	
D7287	Exfoliative cytology sample collection	CDT: For collection of non-transepithelial cytology sample via mild scraping of the oral mucosa.	
D7288	Brush biopsy-transepithelial sample collection	CDT: For collection of oral disaggregated transepithelial cells via rotational brushing of the oral mucosa.	

D7290	Surgical repositioning of teeth	CDT: Grafting procedure(s) is/are additional. Not a covered benefit.	
D7291	Transeptal fiberotomy, by report	CDT: The supraosseous connective tissue attachment is surgically severed around the involved teeth. Where there are adjacent teeth, the transeptal fiberotomy of a single tooth will involve a minimum of three teeth. Since the incisions are within the gingival sulcus and tissue and the root surface is not instrumented, this procedure heals by the reunion of connective tissue with the root surface on which viable periodontal tissue is present (reattachment). Not a covered benefit.	
D7292	Surgical placement: temporary anchorage device [screw retained plate] requiring surgical flap	CDT: Insertion of a temporary skeletal anchorage device that is attached to the bone by screws and requires a surgical flap. Includes device removal. Not a covered benefit.	
D7293	Surgical placement: temporary anchorage device requiring surgical flap	CDT: Insertion of a device for temporary skeletal anchorage when a surgical flap is required. Includes device removal. Not a covered benefit.	
D7294	Surgical placement: temporary anchorage device without surgical flap	CDT: Insertion of a device for temporary skeletal anchorage when a surgical flap is not required. Includes device removal. Not a covered benefit.	
ALVEOLOPLASTY - SURGICAL PREPARATION OF RIDGE			
		Pre-treatment estimate is recommended. Benefit allowance includes sutures, local anesthesia and routine post-operative care.	
		Benefits are allowed once in a 60 month period.	
D7310	Alveoplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	CDT: The alveoplasty is distinct (separate procedure) from extractions and/or surgical extractions. Usually in preparation for a prosthesis or other treatments such as radiation therapy and transplant surgery.	Quadrant identification/ treatment site(s), pre-operative x-rays
D7311	Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	CDT: The alveoplasty is distinct (separate procedure) from extractions and/or surgical extractions. Usually in preparation for a prosthesis or other treatments such as radiation therapy and transplant surgery.	
D7320	Alveoplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	CDT: No extractions performed in an edentulous area. See D7310 if teeth are being extracted concurrently with the alveoplasty. Usually in preparation for a prosthesis or other treatments such as radiation therapy and transplant surgery.	Quadrant identification/ treatment site(s), pre-operative x-rays
D7321	Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	CDT: No extractions performed in an edentulous area. See D7310 if teeth are being extracted concurrently with the alveoplasty. Usually in preparation for a prosthesis or other treatments such as radiation therapy and transplant surgery.	
VESTIBULOPLASTY			
D7340	**Vestibuloplasty-ridge extension (secondary epithelization)	Benefit allowance includes sutures, local anesthesia and routine post-operative care. Benefits are allowed once in a 60 month period.	Quadrant or arch identification/ treatment site(s), pre-operative x-rays

D7350	**Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)		Quadrant or arch identification/ treatment site(s), pre-operative x-rays
SURGICAL EXCISION OF SOFT TISSUE LESIONS			
Benefit allowance includes local anesthesia and routine post-operative care			
D7410	**Excision of benign lesion up to 1.25 cm		
D7411	**Excision of benign lesion greater than 1.25 cm		
D7412	**Excision of benign lesion, complicated	CDT: Requires extensive undermining with advancement or rotational flap closure	
D7413	**Excision of malignant lesion up to 1.25 cm		
D7414	**Excision of malignant lesion greater than 1.25 cm		
D7415	**Excision of malignant lesion, complicated	CDT: Requires extensive undermining with advancement or rotational flap closure.	
SURGICAL EXCISION OF INTRA-OSSEOUS LESIONS			
D7440	**Excision of malignant tumor - lesion diameter up to 1.25 cm		
D7441	**Excision of malignant tumor - lesion diameter greater than 1.25 cm		
D7450	**Removal of benign odontogenic cyst or tumor lesion diameter up to 1.25cm		
D7451	**Removal of benign odontogenic cyst or tumor lesion diameter greater than 1.25cm		
D7460	**Removal of benign non-odontogenic cyst or tumor lesion diameter up to 1.25cm		

D7461	**Removal of benign non-odontogenic cyst or tumor-lesion diameter greater than 1.25cm		
D7465	Destruction of lesion(s) by physical or chemical method, by report	CDT: Examples include using cryo, laser or electro surgery. Not a covered benefit.	
EXCISION OF BONE TISSUE			
D7471	**Removal of lateral exostosis (maxilla or mandible)	Procedures include removal of tori, tuberosity and other protuberances.	
D7472	**Removal of torus palatinus		
D7473	**Removal of torus mandibularis		
D7485	**Surgical reduction of osseous tuberosity		
D7490	Radical resection of mandible with bone graft	CDT: Partial resection of maxilla or mandible; removal of lesion and defect with margin of normal appearing bone. Reconstruction and bone grafts should be reported separately. Not a covered benefit.	
SURGICAL INCISION			
D7510	Incision and drainage of abscess - intraoral soft tissue	CDT: Involves incision through mucosa, including periodontal origins. Incision and drainage requires incision with a blade and placement of a drain and suture. Incision and drainage is NOT intended for gingival curettage of a periodontal abscess (use D9110, palliative treatment).	
D7511	Incision and drainage of abscess-intraoral soft tissue-complicated (includes drainage of multiple fascial spaces)	CDT: Incision is made intraorally and dissection is extended into adjacent fascial space(s) to provide adequate drainage of abscess/cellulitis.	
D7520	**Incision and drainage of abscess - extraoral soft tissue	CDT: Involves incision through skin. Incision and drainage requires incision with a blade and placement of a drain and suture.	
D7521	**Incision and drainage of abscess-extraoral soft tissue-complicated (includes drainage of multiple fascial spaces)	CDT: Incision is made extraorally and dissection is extended into adjacent fascial space(s) to provide adequate drainage of abscess/cellulitis.	
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	Not a covered benefit.	
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	CDT: May include, but is not limited to, removal of splinters, pieces of wire, etc., from muscle and/or bone. Not a covered benefit.	
D7550	**Partial ostectomy/sequelae for removal of non-vital bone	CDT: Removal of loose or sloughed-off dead bone caused by infection or reduced blood supply.	

D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	Not a covered benefit.	
TREATMENT OF FRACTURES - SIMPLE			
D7610	**Maxilla - open reduction (teeth immobilized, if present)	CDT: Teeth may be wired, banded or splinted together to prevent movement. Surgical incision required for interosseous fixation.	
D7620	**Maxilla-closed reduction (teeth immobilized if present)	CDT: No incision required to reduce fracture. See D7610 if interosseous fixation is applied.	
D7630	**Mandible-open reduction (teeth immobilized if present)	CDT: Teeth may be wired, banded or splinted together to prevent movement. Surgical incision required to reduce fracture.	
D7640	**Mandible-closed reduction (teeth immobilized if present)	CDT: No incision required to reduce fracture. See D7630 if interosseous fixation is applied.	
D7650	**Malar and/or zygomatic arch - open reduction		
D7660	**Malar and/or zygomatic arch - closed reduction		
D7670	**Alveolus - closed reduction, may include stabilization of teeth	CDT: Teeth may be wired, banded or splinted together to prevent movement.	
D7671	**Alveolus-open reduction, may include stabilization of teeth	CDT: Teeth may be wired, banded or splinted together to prevent movement.	
D7680	Facial bones-complicated reduction with fixation and multiple surgical approaches	CDT: Facial bones include upper and lower jaw, cheek and bones around eyes, nose and ears. Not a covered benefit.	
TREATMENT OF FRACTURES - COMPOUND			
D7710	**Maxilla - open reduction	CDT: Surgical incision required to reduce fracture.	
D7720	**Maxilla - closed reduction		
D7730	**Mandible - open reduction	CDT: Surgical incision required to reduce fracture.	
D7740	**Mandible closed reduction		
D7750	**Malar and/or zygomatic arch - open reduction	CDT: Surgical incision required to reduce fracture.	
D7760	**Malar and/or zygomatic arch - closed reduction		

D7770	**Alveolus - open reduction stabilization of teeth	CDT: Fractured bone(s) are exposed to mouth or outside the face. Surgical incision required to reduce fracture.	
D7771	**Alveolus - closed reduction stabilization of teeth		
D7780	Facial bones - complicated reduction with fixation and multiple surgical approaches	CDT: Surgical incision required to reduce fracture. Facial bones include upper and lower jaw, cheek and bones around eyes, nose and ears. Not a covered benefit.	
REDUCTION OF DISLOCATION AND MANAGEMENT OF OTHER TEMPOROMANDIBULAR JOINT DYSFUNCTIONS			
TMJ Rider Codes (D7810, D7820, D7830, D7880, D9942, D9950, D9951, D9952)			
D7810	**Open reduction of dislocation	CDT: Access to TMJ via surgical opening. Not a covered benefit unless the group has a TMJ rider.	
D7820	**Closed reduction of dislocation	CDT: Joint manipulated into place; no surgical exposure. Not a covered benefit unless the group has a TMJ rider.	
D7830	**Manipulation under anesthesia	CDT: Usually done under general anesthesia or intravenous sedation. covered benefit unless the group has a TMJ rider.	Not a
Procedure codes D7840-D7880: Not a covered benefit.			
D7840	Condylectomy	CDT: Surgical removal of all or portion of the mandibular condyle (separate procedure).	
D7850	Surgical disectomy, with/without implant	CDT: Excision of the intra-articular disc of a joint.	
D7852	Disc repair	CDT: Repositioning and/or sculpting of disc; repair of perforated posterior attachment.	
D7854	Synovectomy	CDT: Excision of a portion or all of the synovial membrane of a joint.	
D7856	Myotomy	CDT: Cutting of muscle for therapeutic purposes (separate procedure).	
D7858	Joint reconstruction	CDT: Reconstruction of osseous components including or excluding soft tissues of the joint with autogenous, homologous, or alloplastic materials.	
D7860	Arthrotomy	CDT: Cutting into joint (separate procedure).	
D7865	Arthroplasty	CDT: Reduction of osseous components of the joint to create a pseudoarthrosis or eliminate an irregular remodeling pattern (osteophytes).	
D7870	Arthrocentesis	CDT: Withdrawal of fluid from a joint space by aspiration.	
D7871	Non-arthroscopic lysis and lavage	CDT: Inflow and outflow catheters are placed into the joint space. The joint is lavaged and manipulated as indicated in an effort to release minor adhesions and synovial vacuum phenomenon as well as to remove inflammation products from the joint space.	
D7872	Arthroscopy- diagnosis, with or without biopsy		
D7873	Arthroscopy- surgical lavage and lysis of adhesions	CDT: Removal of adhesions using the arthroscope and lavage of the joint cavities.	
D7874	Arthroscopy - surgical disc repositioning and stabilization	CDT: Repositioning and stabilization of disc using arthroscopic techniques.	
D7875	Arthroscopy - surgical: synovectomy	CDT: Removal of inflamed and hyperplastic synovium (partial/complete) via an arthroscopic technique.	
D7876	Arthroscopy - surgical: disectomy	CDT: Removal of disc and remodeled posterior attachment via the arthroscope.	
D7877	Arthroscopy - surgical: debridement	CDT: Removal of pathologic hard and/or soft tissue using the arthroscope.	

D7880	Occlusal orthotic device, by report	CDT: Presently includes splints provided for treatment of temporomandibular joint dysfunction. Not a covered benefit unless the group has a TMJ rider.	
D7899	Unspecified TMD therapy, by report	CDT: Used for procedure that is not adequately described by a code. Describe procedure.	Narrative
		May require IC review by Dental Consultant.	
REPAIR OF TRAUMATIC WOUNDS			
Excludes closure of surgical incisions			
D7910	**Suture of recent small wounds up to 5cm		
COMPLICATED SUTURING			
D7911	Complicated suture - up to 5 cm	Not a covered benefit.	
D7912	Complicated suture - greater than 5 cm	Not a covered benefit.	
OTHER REPAIR PROCEDURES			
Procedure codes D7920 through D7951: Not a covered benefit.			
D7920	Skin graft (identify defect covered, location and type of graft)		
D7940	Osteoplasty - for orthognathic deformities	CDT: Reconstruction of jaws for correction of congenital, developmental or acquired traumatic or surgical deformity.	
D7941	Osteotomy - mandibular rami		
D7943	Osteotomy - mandibular rami with bone graft; includes obtaining the graft		
D7944	Osteotomy - segmented or subapical	CDT: Report by range of tooth numbers within segment.	
D7945	Osteotomy - body of mandible	CDT: Surgical section of lower jaw. This includes the surgical exposure, bone cut, fixation, routine wound closure and normal post-operative follow-up care.	
D7946	Lefort I (maxilla - total)	CDT: Surgical section of the upper jaw. This includes the surgical exposure, bone cuts, downfracture, repositioning, fixation, routine wound closure and normal post-operative follow-up care.	
D7947	Lefort I (maxilla - segmented)	CDT: When reporting a surgically assisted palatal expansion without downfracture, this code would entail a reduced service and should be "by report."	
D7948	Lefort II or Lefort III (osteoplasty of facial bones for midface hypoplasia or retrusion) - without bone graft	CDT: Surgical section of upper jaw. This includes the surgical exposure, bone cuts, downfracture, segmentation of maxilla, repositioning, fixation, routine wound closure and normal post-operative follow-up care.	
D7949	Lefort II or Lefort III - with bone graft	CDT: Includes obtaining autografts.	

D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla-autogenous or nonautogenous, by report	CDT: This code may be used for ridge augmentation or reconstruction to increase height, width and/or volume or residual alveolar ridge. It includes obtaining autograft and/or allograft material. Placement of a barrier membrane, if used, should be reported separately.	
D7951	Sinus augmentation with bone or bone substitutes	CDT: The augmentation of the sinus cavity to increase alveolar height for reconstruction of edentulous portions of the maxilla. This includes obtaining the bone or bone substitutes. Placement of a barrier membrane, if used, should be reported separately.	
D7953	Bone replacement graft for ridge preservation - per site	CDT: Osseous autograft, allograft or non-osseous graft is placed in an extraction site at the time of the extraction to preserve ridge integrity (e.g. clinically indicated in preparation for implant reconstruction or where alveolar contour is critical to planned prosthetic reconstruction). Membrane, if used, should be reported separately.	
D7955	Repair of maxillofacial soft and/or hard tissue defect	CDT: Reconstruction of surgical, traumatic, or congenital defects of the facial bones, including the mandible, may utilize autograft, allograft, or alloplastic materials in conjunction with soft tissue procedures to repair and restore the facial bones to form and function. This does not include obtaining the graft and these procedures may require multiple surgical approaches. This procedure does not include edentulous maxilla and mandibular reconstruction for prosthetic considerations. See code D7950. Not a covered benefit.	
D7960	**Frenulectomy (frenectomy or frenotomy) separate procedure	CDT: The frenum may be excised when the tongue has limited mobility; for large diastemas between teeth; or when the frenum interferes with a prosthetic appliance; or when it is the etiology of periodontal tissue disease. A half allowance, may be benefited when performed in conjunction with other surgical procedures (D4210; D4211;D4270; D4271; D4273; D4275; D4276; D7285-D7291; D7310-D7350; D7510-D7560; and D7955-D7971) performed on the same day. If no narrative is submitted, disallow.	
D7963	**Frenuloplasty	CDT: Excision of frenum with accompanying excision or repositioning of aberrant muscle and z-plasty or other local flap closure.	
D7970	**Excision of hyperplastic tissue - per arch	This procedure is included in the fee for other surgical procedures that are performed on the same day in the same area.	Narrative (only if no other procedures done on the same day)
D7971	Excision of pericoronal gingiva	CDT: Surgical removal of inflammatory or hypertrophied tissues surrounding partially erupted/impacted teeth.	
Procedure codes D7972 through D7998: Not a covered benefit.			
D7972	Surgical reduction of fibrous tuberosity		
D7980	Sialolithotomy	CDT: Surgical procedure by which a stone within a salivary gland or its duct is removed, either intraorally or extraorally.	
D7981	Excision of salivary gland, by report		
D7982	Sialodochoplasty	CDT: Surgical procedure for the repair of a defect and/or restoration of a portion of a salivary gland duct.	
D7983	Closure of salivary fistula		
D7990	Emergency tracheotomy	CDT: Surgical formation of a tracheal opening usually below the cricoid cartilage to allow for respiratory exchange.	
D7991	Coronoidectomy	CDT: Surgical removal of the coronoid process of the mandible.	
D7995	Synthetic graft - mandible or facial bones, by report	CDT: Includes allogenic material.	
D7996	Implant-mandible for augmentation purposes (excluding alveolar ridge), by report		

D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar		
D7998	Intraoral placement of a fixation device not in conjunction with a fracture	CDT: The placement of intermaxillary fixation appliance for documented medically accepted treatments not in association with fractures. Not a covered benefit.	
D7999	Unspecified oral surgery procedure, by report	CDT: Used for a procedure that is not adequately described by a code. Describe procedure. May require IC review by Dental Consultant.	Narrative

ORTHODONTICS D8000-D8999

A pre-treatment estimate is recommended for all orthodontic treatment plans.

The fee for orthodontic treatment includes all diagnostic procedures (exam, photographs, etc.), appliances, post-treatment stabilization, etc.

Administration of Monthly Orthodontic Benefit

Monthly payments, made quarterly, are payable beginning with the banding date. Upon banding, an initial payment of 30% of the patient's ortho maximum is made. (Prior to 01/01/04 initial payment was 25%). The initial payment is deducted from the patient's ortho maximum and then divided by the number of treatment months to calculate a monthly payment.

Example:

Orthodontic Benefit = \$1200

24 month treatment plan

Date of banding: Altus pays initial pmt. of \$360. ($\$1200 \times 30\% = \360)

Monthly payments calculated as follows:

$\$1,200 - \$360 = \$840 \div 24 \text{ months} = \$35 \text{ monthly payment}$

Rationale:

Altus pays the initial payment (IP) and the first monthly payment on the date of banding.

The second and third months are paid 62 days later.

The next three months are paid 92 days later. Subsequent quarterly payments are made every 92 days.

For takeover business

Cases in progress will be prorated as follows:

Example: Previous carrier had a \$1,500 orthodontic maximum/Altus has a \$1,500 orthodontic maximum

Previous carrier paid \$800 for 6 months of a 24 month treatment plan prior to coverage ending.

Altus calculates as follows:

$\$1,500 - \$800 = \$700$ divided by 18 months remaining in treatment = \$38.89 monthly payment. (Paid quarterly)

If a patient is not covered by Altus at the time of banding, they are not eligible for the 30% initial payment.

For new business with no prior coverage for orthodontics or groups adding orthodontics

Cases in progress will be prorated as follows:

- Altus calculates the case as if the patient had coverage at time of banding, then subtracts the IP and the ineligible months.

Example: Altus ortho benefit = \$1,200.

Patient completed 6 months of a 24-month treatment plan before coverage went into effect.

Altus calculates as follows:

$\$1,200$ orthodontic benefit less $\$360$ initial payment for banding (30% of orthodontic benefit) = $\$840$ divided by 24 months for a monthly payment of $\$35$ over a 24-month period. 6 months no coverage times $\$35 = \210 . Ineligible amount $\$360 + 210 = \570 .

$\$1,200 - \$570 = \$630$ paid quarterly over the remaining 18 months ($\$35$ per month)

Timely Filing		
		Every monthly payment is considered a new claim. If a patient is banded on 7/1/04 and the claim is received on 9/1/05, we will consider eligible months from 9/1/04. The patient is not eligible for an initial payment.
		<u>Example:</u>
	Date of banding	7/1/2004
	Claim filing receipt date	9/1/2005
	Length of treatment	24 months
	Ortho Maximum	\$1200.00
		Initial payment (30% of \$1200) = \$360~~~ Monthly payments (\$1200 - \$360 = \$840) over 24 months = \$35 per month
		Altus will pay monthly benefits (quarterly) from September 1, 2004 through the remaining 22 months of treatment @ \$35 each. The Initial Payment and the 1st and 2nd months are not eligible for benefits.
Diagnostic Records		
		Orthodontics diagnostic records usually includes codes D0330-panoramic film , D0340-cephalometric film, D0470 diagnostic casts/models, D0350-oral/facial images and D9310 specialty consultation.
		If the patient agrees to treatment, no separate fee is allowed for these diagnostic records; the fee is included in the total case fee.
		What happens when an exam & panoramic film are done separately for an evaluation only? In this case, a full work-up is not performed, and the exam and panoramic film can be billed separately.
Guideline For Allowing Payment of Diagnostic Records		
		If the patient has either elected not to return to the office or to delay treatment, the office can submit a claim for D8660 and the benefit will be allowed.
		If treatment is initiated by the same participating dental office within 12 months from the date the diagnostic records were taken and paid, the allowance for the records will be deducted from the dentist's approved amount. After 12 months, no deduction is made.
		If the patient has NO ORTHODONTIC COVERAGE and orthodontic records are submitted using procedure codes D0330 and D0470, the claim will be paid as submitted. If orthodontic records are submitted using the orthodontic records code (D8660), the system will automatically deny.
Required Documentation		
		All orthodontic claims should contain the following information:
		1. Procedure code
		2. Months of treatment
		3. Total case fee
		4. Date of banding
General Limitations		
		Post-treatment stabilization (retainers) is not a separately paid benefit. If submitted by the same dental office, it is included in the fee for the comprehensive treatment. If submitted by a different dental office and the patient has benefits available in their ortho max - allow.
		Invisalign – Not a covered benefit. An alternate benefit allowance of a comprehensive orthodontic case (D8090) will be given. The patient is responsible for any difference up to the dentist's charge.
Custom made orthodontic functional appliances ie: Cemented, Hebst, MARA, M2M, etc.		A custom made orthodontic functional appliance is not included in the total case fee and can be billed separately (may be billed as (D8050, D8060 or D8220).
LIMITED ORTHODONTIC TREATMENT		

		CDT: Orthodontic treatment with a limited objective, not involving the entire dentition. It may be directed at the only existing problem, or at only one aspect of a larger problem in which a decision is made to defer or forego more comprehensive therapy. Examples of this type of treatment would be treatment in one arch only to correct crowding, partial treatment to open spaces or upright a tooth for a bridge or implant and partial treatment for closure of a space(s).	
D8010	Limited orthodontic treatment of the primary dentition	Includes panoramic and cephalometric films, diagnostic casts, photos and consultation (records). If the patient agrees to treatment, the fee for the records is included in the total treatment fee and is not separately payable.	
D8020	Limited orthodontic treatment of the transitional dentition		
D8030	Limited orthodontic treatment of the adolescent dentition		
D8040	Limited orthodontic treatment of the adult dentition		
INTERCEPTIVE ORTHODONTIC TREATMENT			
		CDT: Treatment using codes for interceptive orthodontic treatment are for procedures to lessen the severity or future effects of a malformation and to eliminate its cause. An extension of preventive orthodontics that may include localized tooth movement. Such treatment may occur in the primary of transitional dentition and may include such procedures as the redirection of ectopically erupting teeth, correction of isolated dental crossbite or recovery of recent minor space loss where overall space is adequate. The key to successful interception is intervention in the incipient stages of a developing problem to lessen the severity of the malformation and eliminate its cause. Complicating factors such as skeletal disharmonies, overall space deficiency, or other conditions may require full comprehensive therapy. Early phases of comprehensive therapy may utilize some procedures that might also be used interceptively, but such procedures are not considered interceptive in those applications.	
D8050	Interceptive orthodontic treatment of the primary dentition		
D8060	Interceptive orthodontic treatment of the transitional dentition		
COMPREHENSIVE ORTHODONTIC TREATMENT			
		CDT: These codes should be used when there are multiple phases of treatment provided at different stages of dentofacial development. For example, the use of an activator is generally stage one of a two-stage treatment. In this situation, placement of fixed appliances will generally be stage two of a two-stage treatment. Both phases should be listed as comprehensive treatment modified by the appropriate stage of dental development. This is used to report the coordinated diagnosis and treatment leading to the improvement of a patient's craniofacial dysfunction and/or dentofacial deformity including anatomical, functional and aesthetic relationships. Treatment usually, but not necessarily, utilizes fixed orthodontic appliances. Adjunctive procedures, such as extractions, maxillofacial surgery, nasopharyngeal surgery, myofunctional or speech therapy and restorative or periodontal care, may be coordinated disciplines. Optimal care requires long-term consideration of patient's needs and periodic re-evaluation. Treatment may incorporate several phases with specific objectives at various stages 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		
MINOR TREATMENT TO CONTROL HARMFUL HABITS			
D8210	Removable appliance therapy	CDT: Removable indicates patient can remove; includes appliances for thumb sucking and tongue thrusting.	
D8220	Fixed appliance therapy	CDT: Fixed indicates patient cannot remove appliance; includes appliances for thumb sucking and tongue thrusting.	
OTHER ORTHODONTIC SERVICES			
D8660	Pre-orthodontic treatment visit		Narrative
D8670	Periodic orthodontic treatment visit (as part of contract)		
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))		
D8690	Orthodontic treatment (alternative billing to a contract fee)	CDT: Services provided by dentist other than original treating dentist. A method of payment between the provider and responsible party for services that reflect an open-ended fee arrangement. Not a covered benefit.	
D8691	Repair of orthodontic appliance	CDT: Does not include bracket and standard fixed ortho appliances. It does include functional appliances and palatal expanders. (Included in the total case fee).	
D8692	Replacement of lost or broken retainer		
D8693	Rebonding or recementing; and/or repair, as required, or fixed retainers		
D8999	Unspecified orthodontic procedure, by report	CDT: Used for procedure that is not adequately described by a code. Describe procedure. May require IC review by Dental Consultant.	Narrative
D9000-D9999 ADJUNCTIVE GENERAL SERVICES			
		If the procedure reported was the result of an accident, it should be submitted to the patient's medical and/or liability insurer first.	
UNCLASSIFIED TREATMENT			
D9110	Palliative (emergency) treatment of dental pain - minor procedure	CDT: This is typically reported on a "per visit" basis for emergency treatment of dental pain. Benefits are available only if no other service is rendered during the visit except any type of an exam, pulp test and x-rays necessary to diagnose the emergency condition. A separate fee for palliative treatment cannot be charged to the patient. Palliative treatment in conjunction with root canal therapy by the same dental office is included in the fee for the root canal and is not separately billable. Palliative treatment is limited to two (2) occurrences per calendar year.	

		Palliative treatment may include:	
		-Limited occlusal adjustment	
		-Desensitizing medicaments	
		-Scaling and curettage of a periodontal abscess in a tooth segment	
		-Pulpotomy performed on a patient over the age of 14	
		-Dry socket – fourth visit (first three are considered part of the post-operative care and are not separately billable.)	
D9120	Fixed partial denture sectioning	CDT: Separation of one or more connections between abutments and/or pontics when some portion of a fixed prosthesis is to remain intact and serviceable following sectioning and extraction or other treatment. Includes all recontouring and polishing of retained portions.	Tooth number, x-ray and narrative
		This procedure is only a benefit if a portion of a fixed prosthesis is to remain intact and serviceable following sectioning and extraction or other treatment. If the procedure is part of the process of removing and/or replacing a fixed prosthesis, it is considered part of the comprehensive procedure and is DISALLOWED - par dentist/DENIED - non par dentist.	
ANESTHESIA			
		Local anesthesia is used to allow the patient more comfort in performing operative and surgical procedures. It has become a basic part of restorative and surgical procedures and should be an integral part of the procedure and not a separate benefit.	
D9210	Local anesthesia not in conjunction with operative or surgical procedures	Local anesthesia when rendered in conjunction with codes D1110, D4355, D4910 is denied. Anesthesia performed with all other codes is DISALLOWED - par/DENIED - non par.	
D9211	Regional block anesthesia	Disallow with all procedures.	
D9212	Trigeminal division block anesthesia	Disallow with all procedures.	
D9215	Local anesthesia	Local anesthesia when rendered in conjunction with codes D1110, D4355, D4910 is denied. Anesthesia performed with all other codes is DISALLOWED - par/DENIED - non par.	
D9220	Deep sedation/general anesthesia - first 30 minutes	CDT: Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients or duties. The level of anesthesia is determined by the anesthesia provider's documentation of the anesthetic's effects upon the central nervous system and not dependent upon the route of administration.	
D9221	Deep sedation/general anesthesia - each additional 15 minutes	CDT: Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients or duties. The level of anesthesia is determined by the anesthesia provider's documentation of the anesthetic's effects upon the central nervous system and not dependent upon the route of administration.	
		[The difference between general anesthesia and intravenous sedation is that the patient cannot support his/her own airway while under general anesthesia.]	
		Drugs typically used: Fentanyl, Versed or Valium, Sodium Bretival	
		General anesthesia is allowed with these services: (when the procedure is a covered benefit): Apicoectomy (D3410-D3426); Retrograde filling (D3430); Root amputation (D3450); Hemisection (D3920); Surgical extractions (D7210-D7241); Root recovery (D7250); Other oral surgery procedures (D7260-D7291); Alveoplasty (D7310-D7321); Vestibuloplasty (D7340-D7350); Removal of tumors, cysts and neoplasms (D7410-D7461); Excision of bone tissue (D7471-D7490); Surgical Incision (D7510-D7560); Treatment of fractures-simple (D7610-D7680); Treatment of fractures-compound (D7710-D7780); Reduction of dislocation of temporomandibular joint (D7810-D7877); Repair of traumatic wounds (D7910); Excision of hyperplastic tissue (D7970).	
		<u>Limitation:</u>	

		Anesthesia time over (2) hours requires DCM review of an operative report and/or narrative. General anesthesia time is measured from start of the IV to when the patient goes to the recovery room.	
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	Not a covered benefit.	
D9241	Intravenous conscious sedation/analgesia - first 30 minutes	CDT: Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients or duties. The level of anesthesia is determined by the anesthesia provider's documentation of the anesthetic's effects upon the central nervous system and not dependent upon the route of administration.	
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes	CDT: Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients or duties. The level of anesthesia is determined by the anesthesia provider's documentation of the anesthetic's effects upon the central nervous system and not dependent upon the route of administration.	
		[The difference between general anesthesia and intravenous sedation is that the patient cannot support his/her own airway while under general anesthesia.]	
		IV Sedation is allowed with these services: (when the procedure is a covered benefit): Apicoectomy (D3410-D3426); Retrograde filling (D3430); Root amputation (D3450); Hemisection (D3920); Surgical extractions (D7210-D7241); Root recovery (D7250); Other oral surgery procedures (D7260-D7291); Alveoloplasty (D7310-D7321); Vestibuloplasty (D7340-D7350); Removal of tumors, cysts and neoplasms (D7410-D7461); Excision of bone tissue (D7471-D7490); Surgical Incision (D7510-D7560); Treatment of fractures-simple (D7610-D7680); Treatment of fractures-compound (D7710-D7780); Reduction of dislocation of temporomandibular joint (D7810-D7877); Repair of traumatic wounds (D7910); Excision of hyperplastic tissue (D7970).	
		Limitation:	
		IV sedation time over 1.5 hours requires DCM review of an operative report and/or narrative. IV sedation time is measured from start of the IV to when the patient goes to the recovery room.	
D9248	Non-intravenous conscious sedation	CDT: A medically controlled state of depressed consciousness while maintaining the patient's airway, protective reflexes and the ability to respond to stimulation or verbal commands. It includes non-intravenous administration of sedative and/or analgesic agents(s) and appropriate monitoring. The level of anesthesia is determined by the anesthesia provider's documentation of the anesthetic's effects upon the central nervous system and not dependent upon the route of administration.	
		Not a covered benefit.	
PROFESSIONAL CONSULTATION			
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	CDT: A patient encounter with a practitioner whose opinion or advice regarding evaluation and/or management of a specific problem; may be requested by another practitioner or appropriate source. The consultation includes an oral evaluation. The consulted practitioner may initiate diagnostic and/or therapeutic services. Consultations are allowed when done by a specialist other than an orthodontist or pedodontist. A specialty consultation is not a covered benefit in conjunction with other services performed on the same date. One consultation per specialty per year.	
PROFESSIONAL VISITS			
D9410	House/extended care facility call	CDT: Includes visits to nursing homes, long-term care facilities, hospice sites, institutions, etc. Report in addition to reporting appropriate code numbers for actual services performed.	
D9420	Hospital call	CDT: May be reported when providing treatment in hospital or ambulatory surgical center, in addition to reporting appropriate code numbers for actual services performed.	

D9430	Office visit for observation (during regularly scheduled hours) – no other services performed	Not a covered benefit.	
D9440	Office visit - after regularly scheduled hours	Not a covered benefit.	
D9450	Case presentation, detailed and extensive treatment planning	CDT: Established patient. Not performed on same day as evaluation. Not a covered benefit.	
DRUGS			
D9610	Therapeutic parenteral drug, single administration	CDT: Includes single administration of antibiotics, steroids, anti-inflammatory drugs, or other therapeutic medications. This code should not be used to report administration of sedative, anesthetic or reversal agents. Not a covered benefit unless specified under the group contract. For those groups with coverage, this procedure is limited to once per calendar year.	
D9612	Therapeutic parenteral drug, two or more administrations, different medications	CDT: Includes multiple administration of antibiotics, steroids, anti-inflammatory drugs or other therapeutic medications. This code should not be used to report administration of sedatives, anesthetic or reversal agents. This code should be reported when two or more different medications are necessary and should not be reported in addition to code D9610 on the same date. Not a covered benefit.	
D9630	Other drugs and/or medicaments, by report	CDT: Includes, but is not limited to oral antibiotics, oral analgesics, and topical fluoride dispensed in the office for home use; does not include writing prescriptions. Not a covered benefit unless specified under the group contract.	
MISCELLANEOUS SERVICES			
D9910	Application of desensitizing medicament	CDT: Includes in-office treatment for root sensitivity. Typically reported on a “per visit” basis for application of topical fluoride. This code is not to be used for bases, liners or adhesives used under restorations. Not a covered benefit under most group contracts. For those groups that do provide coverage, one visit per calendar year and must have history of any of the following: D4240, D4241, D4260, D4261, D4341, D4342.	
D9911	Application of desensitizing resin for cervical and/or root surface	CDT: Typically reported on a “per tooth” basis for application of adhesive resins. This code is not to be used for bases, liners or adhesives used under restorations. Not a covered benefit.	
D9920	Behavior management, by report	CDT: May be reported in addition to treatment provided. Should be reported in 15- minute increments. Not a covered benefit.	
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report	CDT: For example, treatment of a dry socket following extraction or removal of bone sequestrum. Routine post-operative visits are considered part of the total surgical procedure and a participating dentist may not make a separate charge to the patient; DISALLOW - par/DENY- non-par.	
D9940	Occlusal guard, by report	CDT: Removable dental appliances, which are designed to minimize the effects of bruxism (grinding) and other occlusal factors. *Not a covered benefit under <u>most</u> contracts. <u>For those groups that do cover occlusal guards the following guidelines apply and are subject to 36 month time limitation:</u> ~ Allowed in cases of bruxism only. ~ Occlusal guards submitted in conjunction with TMJ therapy are not covered. Deny. (If the group has a TMJ rider, this procedure should be processed as a D7880).	

D9941	Fabrication of athletic mouthguard	Not a covered benefit.	
D9942	Repair and/or relining of occlusal guard	Covered once in a 12 month period for those groups who have coverage for an occlusal guard or who have a TMJ rider. This procedure is part of the initial procedure if performed within 6 months of delivery. DISALLOW - par/DENY - non-par.	
D9950	Occlusion analysis - mounted case	CDT: Includes, but is not limited to, facebow, interocclusal records tracings and diagnostic wax-up; for diagnostic casts, see D0470.	
		Not a covered benefit unless the group has a TMJ rider.	
D9951	Occlusal adjustment - limited	CDT: May also be known as equilibration; reshaping the occlusal surfaces of teeth to create harmonious contact relationships between the maxillary and mandibular teeth. Presently includes discing/odontoplasty/enamoplasty. Typically reported on a "per visit" basis. This should not be reported when the procedure only involves bite adjustment in the routine post-delivery care for a direct/indirect restoration or fixed/removable prosthodontics.	
		Not a covered benefit for most groups. For those groups with coverage (ie: TMJ rider), this procedure is limited to once per calendar year.	
D9952	Occlusal adjustment - complete	CDT: Occlusal adjustment may require several appointments of varying length, and sedation may be necessary to attain adequate relaxation of the musculature. Study casts mounted on an articulating instrument may be utilized for analysis of occlusal disharmony. It is designed to achieve functional relationships and masticatory efficiency in conjunction with restorative treatment, orthodontics, orthognathic surgery, or jaw trauma when indicated. Occlusal adjustment enhances the healing potential of tissues affected by the lesions of occlusal trauma.	
		Not a covered benefit for most groups. For those groups with coverage (ie: TMJ rider), this procedure is limited to once per calendar year.	
D9970	Enamel microabrasion	CDT: The removal of discolored surface enamel defects resulting from altered mineralization or decalcification of the superficial enamel layer. Submit per treatment visit.	
		Not a covered benefit.	
D9971	Odontoplasty 1-2 teeth; includes removal of enamel projections	Not a covered benefit.	
D9972	External bleaching - per arch	Not a covered benefit.	
D9973	External bleaching - per tooth	Not a covered benefit.	
D9974	Internal bleaching - per tooth	Not a covered benefit.	
D9999	Unspecified adjunctive procedure, by report	CDT: Used for procedure that is not adequately described by a code. Describe procedure.	Narrative
		May require IC review by Dental Consultant.	

EVIDENCE BASED DENTISTRY (EBD)

		The following is a list of procedures that are considered EBD. A group may elect to add one or more of these benefits.	
		1 - Single Tooth Implants: Codes D6010, D6056 and D6057	
		Single tooth implants are a standard benefit for all Altus benefit plans that include Prosthodontic coverage once per 60 months <u>per tooth</u> , subject to the calendar year maximum. This benefit includes the surgical placement of the implant body and the prefab or custom abutment. The crown over the implant is benefited once every 60 months.	
		Note: A group cannot have coverage for a Single Tooth Implant and a separate Implant Rider.	
		2 - Sealants: Code D1351	
		Sealants are covered 100% for dependent children under age 16 for all unrestored permanent molars and bicuspid once every 24 months.	
		Teeth included: Molars - 2, 3, 14, 15, 18, 19, 30 and 31.	
		Bicuspid - 4, 5, 12, 13, 20, 21, 28 and 29.	
		3 - Oral Exams: Code D0120, D0140, D0150, D0160, D0170 and D0180	

		One oral exam is covered every 6 months regardless of specialty.	
		4 - Topical Fluoride Varnish: Code D1206	
		Topical Fluoride Varnish is covered 100% once per 12 months for all members over the age of 16 following gingival flap and/or osseous surgery (D4240, D4241, D4260 and D4261).	
		5 - Cleanings: Codes D1110, D4910	
		At Risk Benefit	
		Members are eligible for 4 cleanings (D1110) per year (administered as 1 every 3 months), if the member is in the "at risk" population. A diabetic/immuno-suppressed member with no evidence of previous periodontal disease will receive coverage for a 3rd and 4th routine cleaning (D1110) per year. A pregnant woman with no evidence of previous periodontal disease will receive coverage for a 3rd routine cleaning (D1110) per year (since administered as 1 cleaning per 3 months, pregnant women are limited to 3 cleanings during the 9-month pregnancy). All other patients who are not deemed "at risk" are eligible for the current standard benefit of 1 cleaning every 6 months.	
		Conditions that qualify: Diabetes, Organ Transplants, Pregnancy, HIV/Aids, chemotherapy for cancer	
		Periodontal Benefit	
		Members who have undergone osseous surgery (D4260, D4261), scaling and root planing (D4341, D4342) or gingival flap surgery (D4240, D4241) will now be eligible for 4 periodontal maintenance (D4910) procedures per year (administered as 1 every 3 months).	
		6 - X-Rays: Codes D0330 and D0210	
		Panorex and Full Mouth X-Rays will be subject to a 60-month time limitation (5 years). Single tooth x-rays will remain covered as needed. Bitewing x-rays will be covered once every 12 months (a change from the current policy of once per calendar year).	
		7 - Crowns: Codes D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D2950, D2952 and D2954.	
		Single tooth crowns, buildups and post and cores will be subject to a 60 month time limitation (5 years) for replacement.	
		8 - Bone Replacement Graft and Guided Tissue Regeneration: Codes D4263, D4264, D4266 and D4267	
		Coverage for bone grafts at an extraction site along with guided tissue regeneration in preparation for an implant as well as for natural teeth.	
		9 - Maximum Carryover Provision	
		This provision will permit accounts to allow members to carry over a set dollar amount that can be used in a future year. The following conditions apply:	
		~ Group MUST have coverage for both crowns and prosthodontics.	
		~ Member (subscriber and enrolled dependents are eligible) must be enrolled in a plan for the entire previous calendar/policy year.	
		~ Member must have had a preventive service (D1120 - child cleaning, D1110 - adult cleaning, D4910 - perio maintenance) within the previous calendar/policy year to qualify for a carry over.	
		~ Total claim activity cannot exceed the paid claims threshold (group determined) during the calendar year.	
		~ Determination of carryover amounts will be calculated in March of the following year. This amount will be made available for members at that time.	
		~ The Maximum Carryover Provision only applies to the benefits paid through the <u>calendar year</u> maximum.	
		~ The yearly maximum must be \$1,000.00 or more.	
		~ Claims are processed using the dollars available in the yearly maximum first.	
		~ There are additional benefit dollars available (stipend) if the member has had all their work performed by participating dentists.	