

Delta Dental of Virginia

Participating Dentists' Handbook

DELTA DENTAL®

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Foreword

This handbook has been prepared to provide information to Virginia dentists and their office staff regarding the policies, practices and procedures employed by Delta Dental of Virginia (Delta Dental). It is not intended as a legal basis for interpreting any Delta Dental contract. It is designed to provide helpful information on the completion of the various documents employed in the administration of Delta Dental's programs.

Keep a copy of the *Participating Dentists' Handbook* as a reference for Delta Dental of Virginia's dental care programs. It has been written with you in mind.

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

Provider Relations
Delta Dental of Virginia
4818 Starkey Road, SW
Roanoke, VA 24018
800.367.3531

The information in this *Participating Dentists' Handbook* is for claims administration and billing purposes only. Neither the *Participating Dentists' Handbook* nor the information contained in the *Participating Dentists' Handbook* (both of which are referred to hereinafter as the "Handbook") constitutes the rendering of dental services or professional dental advice to any patient by Delta Dental of Virginia or any director, officer, employee or consultant of Delta Dental.

In addition, and unless otherwise expressly noted herein, the Handbook is Delta Dental of Virginia's sole and exclusive property. The Handbook may not be reproduced or otherwise shared with anyone other than the dentist(s) and other dental professionals in the practice to which the Handbook is furnished, members of that dentist's or other professional's office staff, his or her outside billing service, and professional consultants to the practice, without Delta Dental's prior written consent. The dentist or other professional to whom Delta Dental furnishes the Handbook must make any other individual with whom he or she shares it aware of Delta Dental's proprietary interest.

A Delta Dental Overview

Established by dentists in 1964 as the Virginia Dental Service Plan, Delta Dental of Virginia (Delta Dental) is a not-for-profit service corporation specializing in providing the best dental benefits at an affordable cost. As the "Delta Dental" for Virginia, we are affiliated with the nation's oldest and largest dental benefit system, Delta Dental Plans Association (DDPA). Dental prepayment programs were pioneered by Delta Dental, services more than 80 million Americans, or 31 percent of the estimated 254 million people with dental insurance in the United States and Puerto Rico. Delta Dental services all 50 states and several U.S. territories, covering people in more than 141,000 groups across the nation.

Delta Dental Service Benefit Concept

Delta Dental's unique relationship with the dental profession sets us apart from commercial dental insurance companies. Delta Dental enrolls participating dentists like you to provide services to covered patients, allowing Delta Dental to partner with you in the delivery of care.

The professional adjudication of contract benefits, the basing of payments on the lesser of the true provider fee of the participating dentist or Delta Dental's payment allowance, and the amount of the patient's payment obligation are all-inclusive in our plan. Employees covered under Delta Dental appreciate this difference. Not only are they getting the highest quality of professional care, but their only cost responsibility is for the applicable co-payment and deductibles. The service benefit concept is the reason why so many have chosen Delta Dental of Virginia for their employee benefit program.

Delta Dental of Virginia Mission Statement

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

Delta Dental of Virginia Belief Statement: Dentists

Delta Dental acknowledges that the dentists' leadership and support helped found our organization and contributes to our success through their participation. We highly value their input into our organization and give them a voice in its governance. In return, we design dental benefit programs that enable dentists to adequately maintain the oral health of their patients. We reimburse our participating dentists directly, in a timely fashion and based on their provider fees.

Delta Dental Plans Association Mission Statement

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

Information Directory

The following directory is for your reference when seeking quick and convenient answers to Delta Dental questions. For patients covered by other Delta Dental member companies, contact the control plan directly.

Provider Relations Department

Call 800.367.3531 for information on:
- Membership/Participation
- Change of Address or Tax ID Number
- Workshop Information

Benefit Services Department

Call 800.237.6060 for assistance with patients covered under Delta Dental of Virginia:
- Claim Payment Explanation
- Coordination of Benefits
- Orthodontic Claim Inquiries
- Processing Policy Explanation

DeltaDentalVA.com

Visit our website for:
- Patient Eligibility and Benefits
- Claim Status Information and New Claims Submission
- Dentist Forms

Automated Claim Information System

Delta Dental of Virginia's **Automated Claim Information System (ACIS)** is available by dialing 800.237.6060 and pressing "1" at the main menu for:
- Patient Eligibility
- Claims Status
- Benefit Fax-Back

DeltaDentalVA.com

DeltaDentalVA.com helps you streamline your office efficiency with 24/7 access to patient benefits, online claims submission, claims status, payment tracking and more. If you do not have an account on our website, click "New Users Register Here" on the provider page to register. If you need assistance, call Provider Relations at 800.367.3531.

If you have not yet registered for a National Provider Identifier (NPI), you will need to do so in order to register on our website. Visit https://nppes.cms.hhs.gov/NPPES/Welcome.do to obtain your NPI.

Why use our website?

- Patient Benefits
- Claims Status
- Claims Submission
- Recent Payments
- Practice Information
- Patient Appointment Tool
- Clinical Policies
- Newsletter Library
- Forms and Documents
- FAQ's and Practice Resources

What if a patient is insured by another Delta Dental member company?

If you have a patient who is covered by another Delta Dental member company, you may access their eligibility, claims and benefits information from our national website at DeltaDental.com using the same user name user ID and password you use on DeltaDentalVA.com.

Dentist Participation

Record Keeping

Delta Dental of Virginia requires that the following data be made available to us upon request:

- All entries in treatment records should be completed within 36 hours of the date of service.
- Office must submit original records only.
- Records must be unaltered.
- Edits or corrections should ONLY be for clarification and must be clearly indicated with the date of the edit and signed by the doctor.

Delta Dental Participating Dentists

To become and remain a Delta Dental Participating Dentist, you must:

- Be licensed and actively practicing in the state of Virginia;
- Not be under suspension by this Corporation, the Virginia Board of Dentistry or any other similar regulatory body;
- File claims for eligible Delta Dental patients and accept payment from Delta Dental, regardless of Delta Dental's benefit determination, based on the Maximum Plan Allowance fee (MPA) concept as described later in this handbook;
- Agree to abide by the by-laws, rules and regulations established by Delta Dental's Board of Directors;
- Agree to abide by Delta Dental claim processing policies;
- Sign a participation agreement;
- When required, allow Delta Dental to examine and copy office records and/or provide information to determine compliance with the terms of the agreement; and
- Meet and continue to satisfy all of Delta Dental's credentialing and acceptance requirements.

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

The Participating Dentist agrees to file claims for all Delta Dental patients, regardless of which Delta Dental administers the patient's benefits and regardless of whether Delta Dental is the patient's primary or secondary insurance carrier.

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

If you discount your fees for Dental Services, whether as a professional courtesy to the patient or as part of a commercial arrangement that provides for discounted fees, you agree to bill us no more than the discounted fee for the service that you provide to our enrollee. Claims for Dental Services should be submitted directly to the enrollee's Delta Dental member company if that company is other than Delta Dental of Virginia.

Participating Dentists are held to the current MPA for all Delta Dental covered benefits, even when the patient has exceeded their maximum annual benefit, or contractual time limitations, or in cases when benefit criteria are not met. For all non-covered benefits, Participating Dentists are not held to the MPA.

Participating Dentist Benefits

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

1. Payment issued directly to you, alleviating collection problems

2. Access to approximately 80 million members in more than 141,000 groups throughout the United States and its territories. Your name and office location(s) can be found by members who use our Find a Dentist tool at DeltaDentalVA.com and on our national website at DeltaDental.com.

3. Discounts on many popular dental office services and supplies (available to PPO dentists only).

4. Access to claim status, benefits and eligibility at DeltaDentalVA.com or through our fax back service.

5. Direct deposit ensuring prompt payment and security.

Credentialing Requirements

As a third party payer, Delta Dental of Virginia is routinely requested by consultants, brokers and group purchasers to provide assurances that our networks are delivering high-quality dental services, that we monitor for changes in our network dentists' credentials and that we address issues if and when they occur. They also inquire about our specific credentialing requirements.

There is a national focus on health and dental issues among groups, individuals and state governments, as well as at the federal level, on the quality of care and patient rights. Lawmakers on state levels have implemented credentialing requirements for certain network products; therefore, Delta Dental Plans Association mandated that all Delta Dental Companies credential their networks every three years based on the network(s) in which you participate.

The credentialing process, which Delta Dental Plans Association requires all Delta Dental member companies to perform, provide a baseline from which to build a current database (i.e. same information from all dentists at the same time). This will allow us to address individual issues that may surface, provide assurances based on the results of this process, and that the care available in our network(s) meets or exceeds expectations.

The Virginia Department of Health also adopted regulations that now require all managed care plans credential and **re-credential their PPO and DHMO network providers every three years**.

Some of the information requested on the Facility Profile is not required for credentialing, but is helpful information to members. We maintain this information which is commonly asked by many of our enrollees/your patients. For example, we will be able to provide callers with your office hours, if you have wheelchair access, or if you speak a language other than English, etc. All other information is held in the strictest of confidence.

When you become a Participating Delta Dental Dentist, Delta Dental of Virginia requires the following information in order to comply with Delta Dental and Virginia state rules and regulations governing dentist credentialing:

- Legible copy of **DEA license**
- Copy of certification page of **malpractice insurance** (must include renewal date and coverage amount)
- Completed and signed **Individual Practitioner Profile**
- **Work History** for the past five years
- **Specialty documentation** (Board certified or Board eligible), if applicable
- **Completed Facility Profile** (Only one per office needed for multiple dentist offices)
- Specialty certificate (if applicable)
- Anesthesia permit issued by the Virginia Board of Dentistry (if applicable)
- Direct Deposit Enrollment Form

We must re-credential our dentist network every three years to be sure we maintain current information. Delta Dental of Virginia will be audited for compliance with these new standards, so it is mandatory that we receive this information from you when requested. Failure to submit credentialing information means you will be in non-compliance with Delta Dental Participating Dentist rules and DeltaUSA standards. We appreciate your prompt cooperation with any credentialing requests you receive from Delta Dental.

Dentist Reimbursement and Fee Information

Maximum Plan Allowance Fees

"Maximum Plan Allowance" (MPA) is the maximum dollar amount payable (per procedure). Delta Dental of Virginia has the state divided into five geographical regions for MPA purposes. Delta Dental also factors in the current CPI (consumer price index) when calculating annual MPA's.

Guidelines for completing the W-9 form correctly

It is necessary that we have a current W-9 on file. Only one W-9 is needed per Tax ID number. Since this information is used for IRS tax reporting purposes, it is imperative we have correct information for your office. Complete the W-9 form with the Tax ID number that your office uses for IRS tax reporting purposes. TIN numbers must be submitted on claim forms to Delta Dental. You should fill in the NAME line with the name associated with that tax ID number **exactly** as it appears on form 941 filed with the IRS. The second line, BUSINESS NAME, is used only if you have a DBA (doing business as) name. The address line should be completed with the address that your 1099 should be mailed to. Sign the form and submit it to Delta Dental of Virginia.

Direct Deposit

As a Delta Dental Participating Dentist, you qualify to have your claims paid directly into your bank account without having to wait for a paper check. To take advantage of this time-saving benefit, download the direct deposit form from DeltaDentalVA.com.

Delta Dental Networks

The Delta Dental system is the largest dental benefits provider in the country, which means many of your patients are likely to be covered by us. However, when your patient says "*I am covered with Delta Dental*," it is important to ask which networks are covered by their plan. This can be found on their ID card. Determining this in advance will enable the patient to know if you participate in the network(s) and will help to avoid misunderstandings.

Delta Dental Premier®

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

Delta Dental PPO™

Delta Dental PPO is our reduced fee-for-service program commonly referred to as a "PPO." PPO dentists agree to accept payment based on the lesser of their submitted fee or the PPO fee schedule. Like Delta Dental Premier, dentists file claims and receive direct payment, regardless of which Delta Dental processes the claim. There is generally a financial incentive for PPO patients to seek services from a participating PPO dentist; however, PPO patients may choose to incur higher out-of-pocket expenses and seek services from a participating Delta Dental Premier-only dentist **if their group contract allows**. Please check this prior to treatment.

DeltaCare®

DeltaCare is our managed care program commonly referred to as a DHMO (Dental Health Maintenance Organization). Reimbursement is based on capitation and member co-payment (Delta Dental will also pay an encounter fee per patient visit). DeltaCare patients must seek care from their selected DeltaCare dentist and any necessary specialty care referrals must be pre-authorized by DeltaCare. If you are not the patient's selected DeltaCare dentist, ask the patient to call DeltaCare at (800) 862-0838. Any service rendered by a dentist other than a selected DeltaCare dentist becomes the patient's full financial responsibility.

Delta Dental National Coverage

When you sign a Delta Dental Participating Dentist Agreement, your participation is honored throughout the national Delta Dental system. Keep in mind that if your patient is covered under a Delta Dental National Coverage program (Delta Dental Premier, Delta Dental PPO or DeltaCare), claims must be submitted to the appropriate Delta Dental for processing. You are still guaranteed direct payment based on Virginia MPAs.

Audits and Utilization Reviews

Contract Compliance Program Overview

Audits may be conducted on site at the dentist's office or facility or by requesting that dental records be mailed to Delta Dental of Virginia. Delta Dental will typically provide at least two weeks advance written notice of intent to conduct an on-site audit. Audits are performed during regular business hours and with as little disruption to the dentist's operations as possible. Auditors will remain on-site until the audit is complete, typically one to two days. Delta Dental may request to review records for services extending back two years prior to the date of the request. Exceptional circumstances may necessitate review of records beyond the two-year period (e.g. occurrence of systemic billing errors, material misrepresentation, potential for fraud, etc.) In addition, certain group accounts or government programs may require longer audit periods.

An audit may seek to verify that:

- The patient was eligible at the time of service;
- The service billed was a covered service;
- Billed services were dentally/medically necessary and appropriate;
- Billed tests and procedures were in fact ordered, performed and received;
- Billed charges were consistent with approved charges (e.g. charge master), where applicable;
- Charges were not discriminatory;
- Coding accurately reflected services performed;
- Coding adhered to recognized guidelines and practices;
- Services billed were supported by necessary and appropriate dentist orders, medical records and other documentation;
- Payment was made at the reimbursement rate or allowed amount established in the dentist contract;
- Incorrect payments (duplicates, over/underpayments) were identified; and
- Overpayments were recovered and underpaid amounts were paid.

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

Financial Investigations and Dentist Review

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

of calls to CCU via our toll-free Fraud and Abuse hotline, 888.227.6004. The Fraud and Abuse hotline number is included on Explanation of Benefit ("EOB") forms sent to Delta Dental members. Dentists should be alert to improper use of identification cards or other practices that defraud Delta Dental, the dentist or other third party payors. Anyone who becomes aware of a group account, member or dentist who may be engaging in these practices should notify CCU.

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

CCU staff can be contacted through the Fraud and Abuse hotline, 888.227.6004.

Pre- and Post-Payment Audits

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

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

Typically, a certified professional coder and/or registered dental hygienist performs the audit. However, external consultants may on occasion be contracted to perform such audits on behalf of Delta Dental of Virginia. Similarly, CCU staff may on occasion pend and audit a dentist's claims for dental practice codes or other services on a pre-payment basis.

Criteria Used in Audits

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

- The applicable CDT Codes published by the American Dental Association (ADA) in the *Current Dental Terminology ("CDT")* book
- The requirement in Delta Dental of Virginia group and individual Policies and Dentist contracts that services be Dentally/Medically Necessary

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

Documentation of Findings

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

Sampling and Extrapolation

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

Review of Results with Providers

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

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

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

Retention of Records

CCU staff will maintain audit worksheets and findings for a period of seven (7) years, in accordance with Delta Dental of Virginia's corporate record retention policy.

Claims

Accurate and complete preparation of claim forms is the first step toward prompt and satisfactory claims processing. Participating Dentists agree to submit claims directly to Delta Dental on behalf of all Delta Dental Premier, Delta Dental PPO™ or DeltaCare® patients, regardless of whether Delta Dental of Virginia is their primary or secondary insurance, and *regardless* of which Delta Dental administers the patient's benefits.

The claim form provided by Delta Dental of Virginia contains the information to calculate payable benefits and are for your use *when filing Delta Dental claims*. If it is currently your office policy to file claims electronically, use standard ADA, or computer-generated claim forms, feel free to continue to do so. Claim forms for Delta Dental groups are provided to participating dentists at no cost. **Claim forms are available at DeltaDentalVA.com** or by calling Benefit Services at 800.237.6060.

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

Completion of the Delta Dental Claim Form

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

Claim Submission Tips

For dentists, fast claim processing means fast payment. For Delta Dental of Virginia, fast claim processing means less handling, tracking and expense. Claims filled out completely and accurately by dental offices are the key to rapid claim processing.

When a claim is submitted without required documentation and a benefit determination cannot be made, the claim will be denied. Dental offices can help speed payment by submitting claims with complete and correct information.

The tips on the next page have been developed for dental offices to ensure faster and more accurate processing of claims and correspondence.

- Use the subscriber and patient's full names and birthdates.
- **Verify patient eligibility** before providing service. Call Delta Dental of Virginia or the appropriate Delta Dental Benefit Services Department, or visit DeltaDentalVA.com if there is a question of eligibility.
- Submit the subscriber's Social Security or Identification number and date of birth on all claims and correspondence.
- Include the patient's full mailing address, including ZIP code, on all claims.
- Use the attending dentist's license number (the last 4-5 digits of his/her Virginia Dental License Number) on every claim.
- The Tax ID Number (either your SSN OR your EIN) submitted on the claim form MUST match the Tax ID Number (TIN) on file with Delta Dental of Virginia. Using a different TIN, using your SSN when your EIN is filed, or using your EIN when you filed your SSN can result in claims processing delays or cause your claim to process incorrectly. Contact Provider Relations to determine the TIN on file or to change the TIN on file. **Your TIN is used for 1099 (IRS) tax reporting purposes and must match what is on file with the IRS.**
- Submit a separate claim for each patient.
- Use the universal tooth code where appropriate (1-32 for permanent teeth, A-T for primary teeth).
- Use valid surface codes for restorations (M, I, D, L, F, B or O).
- **Do not submit duplicate claims.** Contact Benefit Services or visit DeltaDentalVA.com to determine receipt of a claim.
- Always submit for all services rendered with a charge, even if the service may not be covered.
- **Submit claim forms within twelve (12) months of the date of service.**
- **Always use the final, completion, delivery or seat date as the date of service for multiple visit procedures. Delta Dental only pays for completed procedures.**
- Provide documentation for emergency and "by report" procedures. If possible, document only on the claim form.
- Use the procedure code appropriate to the patient's age when there are different codes for adults and children. If submitting an adult code for a child due to extenuating circumstances, be sure to note this on the claim form.
- If you are charging more than your dentist fee for any procedure, please document extenuating or unusual circumstances in the comments section of claim form or submit a narrative.
- OSHA, infection control, and/or sterilization charges are an integral and inseparable part of the general office overhead and should be incorporated into the overall fee schedule. **A separate fee may not be charged by a participating Delta Dental dentist.**

- Please file surgical extraction claims with medical insurance first. Be sure to submit the medical carrier's statement with claim. If surgical extractions are not covered by the medical carrier, indicate this on the claim form.
- If there is other coverage, indicate relationship of the insured to the patient and the insured's date of birth. Indicate amount paid by other carrier, by enclosing a copy of the explanation of Benefits from the primary carrier. Bill the primary carrier first (determined by the "birthday rule"). If the procedure(s) is not covered by the other carrier, please indicate this on the claim.
- Corrections to an incorrectly-submitted claim can be done by contacting our Benefit Services Department. **Please do not submit a new claim form.**
- When submitting a **Predetermination Benefit Voucher** for payment, submit only the original predetermination voucher. **Please do not also submit a claim form.**
- Radiographs should be of diagnostic quality; mounted; dated; labeled left to right, or with tooth numbers; and identified with both patient and dentist name.
- Verify whether pre-operative/post-operative X-rays are required for the procedure and submit with the claim. If radiographs are not available, provide supporting documentation for the necessity of the procedure. ***Photocopies of X-rays, scanned X-rays or digital X-rays printed on paper are acceptable for benefit determination and will not be returned unless requested.***

Requirements for Claims

X-rays are required for the following procedures:

- Surgical extractions
- Partial Dentures
- Bridges (full arch or bite wings of both sides of the arch)
- Implants
- Inlays, onlays and veneers
- Four canal RCT or retreat RCT (if a covered benefit) 3920, 4249, 4260, 4263, 4264, 4266, 4267 and 4268
- Crowns, core build-up, cast or prefab post and core

Narratives are required for:

- 3331, 3332, 3333, 4355, 4211, 7320, 7910
- 7911, 7912, 9920, 9930
- All “By Report” procedures

Perio Charting is required for:

- 4210, 4211, 4240, 4241, 4245
- 4249, 4260, 4261, 4263, 4264
- 4266, 4267, 4268, 4270, 4271
- 4273, 4274, 4341, 4342

Additional clinical documentation is available upon request.

Electronic Claims

Our Payer ID number is 54084.

Electronic claims processing saves your office money by reducing costs associated with generating paper claims, allows for faster processing of claims, and enables your staff to spend more time with patients and other duties. To submit claims electronically you will need a computer with a modem, and an agreement with a practice management software vendor or an Electronic Data Interchange (EDI) vendor. There are many vendors to choose from, offering a variety of products and services to suit any budget.

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

If you use a clearinghouse from which we currently do not accept claims, the clearinghouse will automatically generate and mail a paper claim for processing. **If you submit claims electronically, do not submit a paper copy of the same claim.** This will slow the claims processing. If you are unsure of whether a claim transmitted successfully, call Benefit Services at 800.237.6060 or log into DeltaDentalVA.com to verify receipt of your claim. Your software vendor should also be able to provide a list of claims that were successfully transmitted.

Electronically-submitted claims are typically available on DeltaDentalVA.com the day after submittal. Paper claims are typically available on the website within three (3) days of receipt.

For claims requiring attachments (X-rays, perio charting, etc.), submit the claim and all attachments at the same time, using the same method. If you do not use electronic attachments, submit a paper claim ONLY with the attachment.

Electronic Attachments

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

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

Electronic Claims and Attachments Contact Information

Company	Website	Phone Number
NEA	www.Fast-Attach.com	800.782.5150
Envoy	www.envoy.com	800.366.5716
CPS	www.cpsedi.com	888.255.7293

Claim Denial Request for Information

Each day a number of claims submitted for payment or predetermination are delayed and cannot be processed due to missing, incomplete or illegible information. These claims are denied and Delta Dental of Virginia produces a Claim Denial Request for Information that indicates the missing information. Review and follow the instructions on the form. If you do not understand the instructions, contact Benefit Services at 800.237.6060. To avoid delays of your claims, read the “Claims Submission Tips” section on page 18.

Claim Payment

Payment for care provided to a Delta Dental patient is made directly to you, the Participating Dentist, thereby improving your cash flow. Because of this direct payment mechanism, we require Participating Dentists to seek payment from Delta Dental before billing patients for anything other than the appropriate co-payment, deductibles, or other obligations stated under the group contract.

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

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

Delta Dental also includes Performance Guarantees in contracts with groups that purchase coverage. These guarantees include claim turnaround, claim accuracy, average call wait time, and customer satisfaction. Our performance goal for "clean" claims turnaround time is 90% of claims in fifteen (15) calendar days and 99% in thirty (30) calendar days which we continue to meet on a regular basis.

Check Disbursements

The checks Delta Dental of Virginia mails to your office include payment on behalf of those patients whose claims are processed in the current payment cycle. Checks are mailed on a weekly basis. The Check Disbursement that accompanies the check contains the following information:

Business Name: The Business Name on file with Delta Dental associated with your Tax ID

Tax ID Number: The EIN or SSN on file with Delta Dental, used for tax reporting purposes

Check Number: The check number of the attached check

Amount: The total amount of the check attached

Subscriber Name: Name under which the claim was processed

Subscriber ID: The ID number of the subscriber

Provider ID/Loc: The treating dentist's provider ID and the number of the location where services were performed

Patient Name: The patient receiving services

Birthdate: Patient's birthdate

Group ID: Employer group identification number

Claim Number: Claim number assigned by Delta Dental of Virginia

Code: The CDT code submitted and/or the CDT code services were processed under

Tooth: The tooth number services were performed on, if applicable

Date of Service: The date this service was completed

Submitted: The amount submitted to Delta Dental for this service

Approved: The MPA-based fee participating dentists agree to accept for this service

Allowed: The amount Delta Dental will consider for this service based on plan design and dentist status

Deduct: Indicates deductible, if any, applied to the claim

Over Max: The dollar amount the patient has exceeded for their benefit period designated by their plan

COB: The amount primary insurance paid, if there was coordination of benefits

Withhold Amount: Used by Delta Dental of Virginia for states that require withholding monies from claim payment

Delta Dental of Virginia Payment: Delta Dental's payment responsibility for this service

Patient Pays: The amount which the patient is responsible for this service

Provider Adjustment: The amount to be adjusted for this service by the participating provider office

Delta Dental of Virginia Co-pay: The percentage used to calculate Delta Dental's portion of the benefits based on the group contract

Processing Policies: Processing policies, when needed, are applied for proper benefit allowance according to the group dental contract. If a policy number appears, refer to bottom of the disbursement. If there are multiple pages, refer to the last page for an explanation.

Total: Provides a total of line items for the claim above by column

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

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

Orthodontic Claims

Claims for orthodontic services need only be submitted once to Delta Dental of Virginia for payment. Dentists should not submit the same claim each month. Diagnostic and preparatory services are payable from the patient's orthodontic benefits and claims submitted for these services should include "for orthodontic purposes" written on the claim form. Fees for records should be listed with the appropriate CDT codes and the fee charged.

An orthodontic claim should include the following information:

- Date of initial banding or initial aligner delivery*
- Total case fee**
- Initial down payment amount
- Number of months estimated treatment time

**An orthodontic claim should also include if the patient was banded prior to eligibility. If so, please submit the total paid by the prior carrier.*

***The total case fee may or may not include records, but should include the cost of the retainers.*

Medically-Necessary Orthodontic Claims

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

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

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

Co-payments/Overbilling

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

Besides being a violation of the Participating Dentist Agreement, overbilling violates the contract between an employer and his employees concerning their dental benefits. The employer winds up paying 100% of the cost of the service, rather than the percentage negotiated.

Over-billing has not become a widespread problem in Virginia, and Delta Dental of Virginia hopes you will do your part to prevent it from becoming one.

Coordination of Benefits

Coordination of Benefits (COB) was developed to eliminate the potential for profit when a person is covered by more than one group health care plan. It limits the total benefits received to the actual amount incurred for care.

Individual states have jurisdiction over insurance law. Each state has its own commissioner, who is charged with enforcing the insurance laws of the state. All the insurance commissioners belong to an organization called the National Association of Insurance Commissioners (NAIC). The NAIC meets periodically to draft "model" insurance provisions that they recommend for adoption by all the states to ensure uniformity of legislation.

Birthday Rule

In the past, the father's plan was considered the primary plan or carrier for any children covered under health insurance programs and the mother's plan was secondary. The guidelines in effect in Virginia are intended to replace the male/female distinction with what is called the "birthday" rule. This ruling states that children will be considered primary by the plan of the parent whose birthday (month and day) occurs earlier in the calendar year. Therefore, the plan covering the parent whose birthday falls later in the year pays second. If the parents' birthdays are identical, the primary carrier will be the one that has covered the child for the longest time.

Custody Cases

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

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

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

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

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

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

Where Coordination of Benefits (COB) occurs between a carrier within your state and one outside of your state, the previous primary/secondary rules will apply if the other state has no birthday rules.

Dual Coverage on Predetermination Cases

In a case where Delta Dental is the secondary carrier and a claim is submitted for predetermination, Delta Dental of Virginia will advise you of the amount Delta Dental would pay as if there were *no dual coverage*. When Delta Dental's **Predetermined Benefit Voucher** is submitted for *payment*, attach a copy of the primary carrier's payment. Delta Dental will issue its payment subject to contractual limitations, so that the combined payments do not exceed 100% of the allowed amount. Please do not submit the primary carrier's predetermination when submitting a pre-determination to Delta Dental. Coordination of benefits is calculated only on actual payments from the primary carrier, and not pre-determined benefits.

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

Coordination of Benefits with Capitation

If both Delta Dental and a capitation plan cover your patient, all rules for determining which plan is primary still apply.

When Delta Dental is the primary carrier, we will process the claim up to our full liability under the patient's group contract. When Delta Dental is the secondary carrier, benefits are calculated based on the patient's actual out-of-pocket co-payments. For this reason, it's important that you include a copy of the patient's particular program indicating services provided by the capitation plan and the applicable co-payments when submitting the Attending Dentist's Statement to Delta Dental for payment. Two examples of coordination of benefits with a capitation plan as primary and Delta Dental as secondary are provided as follows:

Example 1

Procedure Code	2750
Maximum Plan Allowance	$450
Patient's Contractual Co-Payment	50%
Delta Dental's Liability	$450 x 50% = $225
Capitation Plan Co-Payment*	$200
Delta Dental's Payment	$200

**Since Delta Dental's payment will never exceed the patient's co-payment in a capitation plan, Delta Dental's payment was $200.*

Example 2

Procedure Code	2750
Maximum Plan Allowance	$450
Patient's Contractual Co-Payment	50%
Delta Dental's Liability**	$450 x 50% = $225
Capitation Plan Co-Payment	$150
Delta Dental's Payment	$150

***Since Delta Dental's true liability exceeds the patient's actual out-of-pocket expense, Delta Dental's payment is reduced to $150. If the patient's out-of-pocket expense had been $225 or above, Delta Dental would be liable for the entire $225. But in no case will our co-payment exceed our full liability under the patient's group contract.*

Coordination of Benefits with Medical Plans

Services performed by a licensed dentist are sometimes covered under a patient's medical benefit plan, as well as his or her dental plan. This occurs most often with oral surgery procedures, particularly when performed in the hospital.

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

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

Overpayments

The combined payments by all dental carriers may not exceed your total fee for the services provided. If you or your patient receives more than 100 percent of your fee, the amount in excess doesn't belong legally to either you or your patient, and must be refunded to the secondary carrier.

Tips on Submitting Dual Dental Coverage Claims

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

1. File the claim with the carrier who has primary responsibility to pay the claim. Information about the first plan's payment is used by the other plan to determine its payment.

2. If the other carrier has primary responsibility, file the claim with Delta Dental after payment is received from the other carrier.
   a. Complete the coordination of benefits information on the claim form in addition to all other items and attach a copy of the primary carrier's Explanation of Benefits (EOB) form. **Note**: If the primary carrier's EOB does not include a breakdown of charges per line of service, please indicate the primary carrier's telephone number.

   b. Mail the claim form to the appropriate Delta Dental processing site.

If it is unclear whether Delta Dental is the primary carrier, contact Benefit Services at 800.237.6060.

Predetermination of Benefits

Predetermination was pioneered by Delta Dental and has proven to be of such value that it has been incorporated in most group dental care programs. The submission of the treatment plan and pre-operative radiographs to Delta Dental prior to completion of various dental services will allow the patient the opportunity to make proper financial arrangements for their portion of the treatment costs before the actual work is begun. It eliminates confusion on the part of the patient and produces goodwill between the dentist, patient and Delta Dental. **Delta Dental strongly urges the dentist to make predetermination a habit, except in emergency and routine situations.** Participating dentists will not charge a fee to the patient or Delta Dental for submitting predetermination of benefits Predetermination is recommended for treatment plans that involve prosthetic and orthodontic procedures, individual crowns (except stainless steel), gold restorations, surgical periodontics, endodontics and oral surgery, except for simple extraction of a single tooth. **Predetermination of benefits is valid for ninety (90) days.**

When Delta Dental receives a treatment plan for predetermination, it proceeds through the following steps:

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

Delta Dental will issue a computer-generated **Predetermined Benefit Voucher** to the dentist. This form is notification of Delta Dental's estimated liability *and should then be reviewed with your patient.*

Once the services have been performed, the dentist need only fill in the service dates, sign the form and return it to Delta Dental for payment. Use of this form will expedite payment. **Please do not submit a claim form for services that have been preauthorized.**

Delta Dental encourages the treating dentist to discuss any predetermination he does not understand with our dental consultant or Benefit Service representatives.

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

Diagnostic Aids

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

Optional or Alternative Treatment Plans

The condition of the patient's mouth will usually dictate the course of treatment selected. In some cases, however, you may have a choice of treatment plans. After consulting with the patient, you may select a more expensive Covered Benefit than the one Delta Dental determines is Delta Dental's MPA for the diagnosis or treatment of the patient's condition. Payment will be made only for the applicable percentage of the least costly course of adequate treatment. The patient may be responsible for the entire balance of your fee for the more expensive Covered Benefit.

In all cases in which the Primary Subscriber or eligible dependent selects a more expensive service or benefit than is deemed necessary, Delta Dental will pay the applicable percentage of the fee for the service or benefit which is needed to restore the tooth or dental arch to contour and function. The Primary Subscriber or eligible dependent shall be responsible for the remainder of the dentist's dentist fee. This need not change the plan of treatment, but establishes a cost allowance toward the service upon which patient and dentist decide.

Claims Processing

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

Professional Review

Delta Dental's Professional Review staff has dental business experience and/or education and receives extensive training in dental procedures and claims review. Staff members review routine claims and their supporting radiographs and/or narratives when processing claims. Their professional judgment is required to process claims according to DeltaUSA guidelines and group contracts.

More complex claims, those involving extensive work or unusual circumstances, are reviewed by Dental Consultants. Dental Consultants are licensed dentists who assist the Professional Review staff in the processing of claims. Delta Dental of Virginia's Dental Director oversees the Professional Review department, assists in the review process and handles all quality of care issues in accordance with state MCHIP laws.

Appeals

Delta Dental of Virginia will, upon written request by the treating dentist, or on behalf of the subscriber, re-evaluate initial claim decisions when appropriate. The review will be premised on the submission of "additional" information, documentation, or narrative, by the treating dentist, which would affect the benefit determination previously made, according to group benefits and utilization review guidelines.

Requirements for claim benefit re-evaluation include:

- Narration or other additional documentation supported by narrative, addressing the prior decision and stating why this should alter the prior benefit/consultant decision;
- Original claim number;
- Re-submission of all documentation, as required, per procedural guidelines.

Delta Dental of Virginia will not alter records of services performed or dates of treatment, from the original claim form without written request from the dentist office. Requests by dental offices to alter the original claim, indicating clerical error in the entry of services performed, or treatment dates, will be by exception only.

All appeals must be received in writing within 180 days of the date of service and sent to:

Appeals Department
Delta Dental of Virginia
4818 Starkey Road, SW
Roanoke, VA 24018

Delta Dental of Virginia Processing Policy Codes and Descriptions

The procedure codes and descriptions that follow are used by Delta Dental of Virginia in processing claims. If, in an individual case, they cause a change in benefit coverage and/or payment, the relevant processing policy numbers are indicated on the Predetermination Benefit Vouchers, Check Disbursements and patient Explanation of Benefits.

Dental Benefit Terminology

ALLOWABLE FEES: The amount of payment for Covered Services, which are provided to Covered Persons, as determined by the company.

ALTERNATE TREATMENT/BENEFITS: Procedures that are not covered benefits, but are performed on an elective basis. In such a case, the Service Corporation will pay the appropriate percentage of the covered treatment and the additional cost of the service selected by the dentist and patient becomes the responsibility of the patient.

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

BENEFIT PERIOD: The twelve (12) month period used in determining service limitations and renewals of the individual and family deductibles and maximums is identified as follows:

1. Subscriber Year — each participant's benefit period begins on their original date of enrollment, in the dental program, and is renewed every 12 months thereafter based on the anniversary of their effective date of Delta Dental of Virginia coverage.

2. Contract Year — all members of the group have benefits renewed on the same date.

3. Calendar Year — January 1 to December 31

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

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

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

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

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

CO-PAYMENT: The amount or percentage of the total approved amount that the subscriber is obligated to pay.

COVERAGE YEAR: A 12-month period of time over which deductibles and maximums apply for each covered person. (Could be a contract year, subscriber year, or calendar year).

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

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

DENTAL CONSULTANTS: Dentists employed by Delta Dental to review claims to determine the covered benefits, and to examine patients to determine if treatment was completed as stated.

DENTAL PLAN: An organization established for the financing of dental care.

DENTAL PREPAYMENT: A system for budgeting the cost of dental services in advance of their receipt.

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

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

ELIGIBLE INDIVIDUAL: A person entitled to benefits under a dental plan.

EXCLUSION: Dental services not provided under a dental plan.

EXPLANATION OF BENEFITS: Notice of payment that is mailed to the subscriber showing benefits paid.

EXPIRATION DATE: The date on which the dental benefits contract terminates.

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

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

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

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

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

MAXIMUM PLAN ALLOWANCE (MPA): The fee based on what Participating Dentists charge in their geographic region. Delta Dental of Virginia has the state divided into five geographical regions for MPA purposes. Delta Dental also factors in the current CPI (current price index).

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

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

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

PROVIDER: The dentist providing the dental services.

SCHEDULED ALLOWANCES: A list of specified amounts which will be paid toward the cost of dental services rendered; the patient pays the difference between the allowance and the actual cost of service, up to the, Maximum Plan Allowance.

STUDENT AGE (Student Age Limitations): See CHILD AGE definition.

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

Processing Policies

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

3. Service(s) performed after the dental coverage terminated. Refer to the exclusion section of your dental plan document for more information.

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

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

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

7. Patient is not eligible for service due to limitations specified in this plan. Advise the patient of their responsibility for the fee. Refer to the limitations section of your dental plan document for more information.

8. This plan provides benefits for a full mouth series or panorex once every 36 months, not both. Any fee in excess of a full mouth series is not billable to patient. Participating Dentists have agreed to charge the patient only the amount indicated as Patient Pays. Please refer to the limitations section of your dental plan document for more information.

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

10. The patient's maximum benefits payable has been reached for this contract/calendar year. Please advise patient of responsibility for fee. Refer to the limitations section of your dental plan document for more information.

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

12. This procedure is only covered once every twelve (12) months. Please advise patient of responsibility for fee. Refer to the limitations section of your dental plan document for more information.

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

14. The procedure submitted is not covered under this plan. An allowance has been made based on a less extensive covered procedure. Please advise patient of responsibility for fee.

15. The maximum allowance for dental prosthesis under the Dental Accident Plan is $250. Please advise patient of responsibility for fee. Refer to the limitations and exclusions section of your dental plan document for more information.

16. The Dental Accident Plan does not cover routine dental services. Please advise patient of responsibility for fee. Refer to the limitations and exclusions section of your dental plan document for more information.

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

18. Payment denied because of late submission. Refer to the limitations section of your dental plan document for more information.

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

20. Benefits are payable only upon completion of services (upon the cementation date of single crowns or fixed bridgework or upon the insertion date of any removable prosthesis). Return the predetermination form with the insertion date for payment.

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

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

23. Replacing tooth structure lost by abrasion, erosion, attrition or abfraction is excluded under this plan. Please advise patient of responsibility for fee. Refer to the exclusion section of your dental plan document for more information.

24. Realignment of teeth is not a covered benefit.

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

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

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

28. Temporomandibular joint (TMJ) syndrome and related treatment are excluded under this plan. Please advise patient of responsibility for fee. Refer to the exclusion section of your dental plan document for more information.

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

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

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

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

33. Sealants are not covered benefits under this plan. Please advise patient of responsibility for fee. Refer to the exclusion section of your dental plan document for more information.

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

35. Payment is made for a tooth surface once only in each episode of treatment regardless of the number or combination of restorations placed. Participating Dentists have agreed to charge the patient only the amount indicated as Patient Pays. Refer to the limitations section of your dental plan document for more information.

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

37. Payment for this procedure was made to another dentist during the same course of treatment. Reimbursement is based on the remaining allowance for this procedure.

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

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

40. Benefits are not provided for fixed bridgework and partial dentures in the same arch. Use of a fixed bridge duplicates the replacement of teeth, which are replaceable by a partial denture. Please advise patient of responsibility for fee. Refer to the exclusion section of your dental plan document for more information.

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

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

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

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

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

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

47. Claim history indicates a crown, buildup, fixed bridge, denture, partial, inlay, onlay, cast or prefabricated post and core has been placed on this tooth. Any additional restorations are not a benefit.

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

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

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

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

52. Based on consultant review of the submitted procedure, if an amalgam or composite restoration can satisfactorily restore tooth function then patient will be responsible for fee of inlay, onlay, crown or gold restoration. Refer to the limitations section of your dental plan document for more information.

53. Restorations not involving the occlusal surface (class V) restorations are considered single surface restorations. Participating Dentists have agreed to charge the patient only the amount indicated as Patient Pays.

54. Replacement of amalgam or composite restorations on the same tooth within 24 months is not billable to patient if performed by the same dentist/dental office. Participating Dentists have agreed to charge the patient only the amount indicated as Patient Pays. Refer to the limitations section of your dental plan document for more information.

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

56. In the absence of diagnostic information allowance based on consultant evaluation. Participating Dentists have agreed to charge the patient only the amount indicated as Patient Pays. Refer to the exclusion section of your dental plan document for more information.

57. In the absence of requested diagnostic information we cannot determine benefits. This claim will be reopened when required documentation is received. Refer to the exclusion section of your dental plan document for more information.

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

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

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

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

62. Procedure classification modified by consultant evaluation.

63. Procedure classification modified for processing only.

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

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

66. Emergency treatment includes the exam when definitive treatment is performed on the same date. Participating Dentists have agreed to charge the patient only the amount indicated as Patient Pays. Refer to the exclusion section of your dental plan document for more information.

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

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

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

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

71. Tooth number corrected by dental consultant as indicated by the X-ray or prior tooth history.

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

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

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

75. Orthodontic treatment started prior to the patient's eligibility is excluded from coverage under this plan's DeltaCare contract. Please advise patient of responsibility for fee. Refer to the exclusion section of your dental plan document for more information.

76. Submitted periodontal procedure is included in the fee for the osseous surgery when performed in the same quadrant (area). Participating Dentists have agreed to charge the patient only the

amount indicated in Patient Pays. Refer to the exclusion section of your dental plan document for more information.

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

78. Benefits for scaling and root planing are limited to two quadrants on the same date of service. Participating Dentists have agreed to charge the patient only the amount indicated as Patient Pays. Refer to the limitations section of your dental plan document for more information.

79. Prophylaxis procedures are not payable as a separate benefit when provided on the same date as root planing, periodontal cleaning or gingival curettage. Participating Dentists have agreed to charge the patient only the amount indicated as Patient Pays. Refer to the exclusion section of your dental plan document for more information.

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

81. Gold or cast restorations and laminate veneers are excluded under this plan. Allowance made for amalgam restoration. Please advise patient of responsibility for fee. Refer to the exclusion section of your dental plan document for more information.

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

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

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

85. Prophys and fluoride treatments are limited by this plan to two in a calendar year. Please advise patient of responsibility for fee. Refer to the limitations section of your dental plan document for more information.

86. The payment for this crown has been reduced by the restoration amount allowed on this tooth within the past 12 months. Participating Dentists have agreed to charge the patient only the amount indicated as Patient Pays.

87. Assignment of Benefits was honored on this claim.

88. The amount on the predetermination is subject to change pending the amount paid by the primary carrier. Please return the predetermination form with the primary payment statement when requesting payment. Refer to the coordination of benefits section of your dental plan document for more information.

89. These services were performed prior to the patient's effective date with Delta Dental. Please file the claim with the previous dental carrier for benefit determination. Refer to the exclusion section of your dental plan document for more information.

90. DeltaCare® services performed by a non-panel dentist are not covered. Please advise patient of responsibility for fee. Refer to the exclusion section of your dental plan document for more information.

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

92. These services are the responsibility of the contracted DeltaCare office.

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

94. Under the DeltaCare program, services provided for teeth with questionable prognosis are not covered. Please advise patient of responsibility for fee. Refer to the exclusion section of your dental plan document for more information.

95. By procedure definition, Delta Dental cannot predetermine emergency treatment or examinations. Participating Dentists have agreed to charge the patient only the amount indicated in Patient Pays.

96. Orthodontic benefits are covered only by a DeltaCare panel orthodontist. Please advise patient of responsibility for fee. Refer to the limitations and exclusions section of your dental plan document for more information.

97. Your $5 co-payment for diagnostic exams is reflected in the deductible field on this explanation of benefits statement.

98. Under the DeltaCare program, treatment by specialists must be predetermined; our records indicate no predetermination is on file for these services. Please advise patient of responsibility for fee. Refer to the exclusion section of your dental plan document for more information.

99. Under the terms of the DeltaCare contract, all routine services must be completed by a participating DeltaCare provider. Refer to the exclusion section of your dental plan document for more information.

100. DeltaCare Encounter payment.

101. Specialty DeltaCare referrals for definitive periodontal procedures require: 1) completion and documentation of all preliminary root planning and scaling and/or gingival curettage and; 2) demonstration of satisfactory oral hygiene; prior to referral.

102. Periodontal scaling and root planing is to be performed by the general dentist under the DeltaCare guidelines. Specialty referral to the periodontist has been denied.

104. Please submit for pre-determination with the entire treatment plan, X-rays and charting/narrative prior to performing additional services.

105. Please insert the CDT code for the extractions, your fee and the date of service for completed treatment rendered.

106. Benefit allowed and requires subscriber pay co-payment plus half of the allowed amount according to this plan.

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

108. Extractions solely for the purpose of orthodontics are not a covered benefit of this plan. Please advise patient of responsibility for fee. Refer to the exclusion section of your dental plan document for more information.

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

110. Accidental injury is not a covered benefit of this group policy. Please advise patient of responsibility for fee. Refer to the exclusion section of your EOC or SPD for more information.

111. Patient payment will be the copayment responsibility for the procedure code(s) submitted by the specialist.

112. When services are completed, please insert the date(s) of service on this predetermined voucher and return for processing.

119. DeltaCare Supplemental Payment.

121. Osseous grafts are limited to the repair of periodontally diseased defects around natural teeth. Refer to the exclusion section of your EOC or SPD for more information.

122. Preventive restorations are not covered benefits. An allowance has been made for sealant(s). Please advise patient of responsibility for fee. Refer to the exclusion section of your dental plan document for more information.

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

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

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

126. Cast or pre-fabricated post and cores are a benefit in anterior teeth only when there is insufficient tooth structure to support a cast restoration. Participating Dentists have agreed to charge the patient only the amount indicated as Patient Pays. Refer to the exclusion section of your dental plan document for more information.

127. Periodontal procedures include all necessary postoperative care and evaluations for 3 months, as well as any surgical reentry for three (3) years. Participating Dentists have agreed to charge the patient only the amount indicated as Patient Pays. Refer to the exclusion section of your dental plan document for more information.

128. Allowance for gingival curettage, surgical gingivectomy/gingivoplasty, grafts, osseous or mucogingival surgery generally includes surgical reentry for three (3) years. Participating Dentists have agreed to charge the patient only the amount indicated as Patient Pays. Refer to the exclusion section of your dental plan document for more information.

129. Payment allowance for this perio procedure is based on the presence of four (4) or more diseased teeth in a quadrant and has been prorated accordingly. Participating Dentists have agreed to charge the patient only the amount indicated as Patient Pays. Refer to the exclusion section of your dental plan document for more information.

130. A consultation is payable only when no other service is being provided by the same dentist on the same date. Participating Dentists have agreed to charge the patient only the amount indicated as Patient Pays.

131. Benefits for osseous surgery are limited to two quadrants on the same date of service. Participating Dentists have agreed to charge the patient only the amount indicated as Patient Pays.

133. Fee for repair of a full or partial denture cannot exceed one half of the initial placement fee allowance. Participating Dentists have agreed to charge the patient only the amount indicated as Patient Pays. Refer to the limitations section of your dental plan document for more information.

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

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

136. Fee for root recovery or alveoloplasty is considered a component of the surgical extraction and is included in the fee. Participating Dentists have agreed to charge the patient only the amount indicated as Patient Pays. Refer to the exclusion section of your dental plan document for more information.

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

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

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

140. Allowance for dentures and partial dentures include relines and rebases for six (6) months. Participating Dentists have agreed to charge the patient only the amount indicated as Patient Pays. Refer to the exclusion section of your dental plan document for more information.

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

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

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

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

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

146. Specialized techniques such as porcelain inlays/onlays are not covered benefits and are considered optional. Allowance made for metallic inlay/onlay. Please advise patient of responsibility for fee. Refer to the exclusion section of your dental plan document for more information.

147. Specialized techniques such as resin inlays/onlays are not covered benefits and considered optional. Allowance made for metallic inlay/onlay. Please advise patient of responsibility for fee. Refer to the exclusion section of your dental plan document for more information.

148. An implant is a benefit of this plan once in a three (3) year period. Our records indicate this service was previously performed within this period. Please advise patient of responsibility for fee. Refer to the limitations section of your dental plan document for more information.

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

150. Cutting or sectioning bridge is not a benefit. Please advise patient of responsibility for fee. Refer to the exclusion of your dental plan document for more information.

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

152. Waiting period not met for the submitted procedure. Please advise patient of responsibility for fee. Refer to the limitations section of your dental plan document.

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

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

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

156. Allowance has been made based on a conventional (non-implant) crown. Please advise patient of responsibility for fee.

157. Exams and cleanings are limited by this plan to two (2) per calendar year. Please advise patient of responsibility for fee. Refer to the limitations section of your dental plan document.

158. Exams and cleanings are limited by this plan to two (2) in twelve (12) consecutive months. Please advise patient of responsibility for fee. Refer to the limitations section of your dental plan document.

159. A panoramic film with or without supplemental films, including bitewings, will be paid based on fee for a full mouth series. Participating Dentists have agreed to charge the patient only the amount indicated as Patient Pays.

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

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

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

163. Code 7110 is the first tooth extracted. Additional extractions on the same day are coded 7120. Code modified to match description.

164. Code 0220 is for an intraoral periapical first film. Additional single films on the same day are coded 0230. Code modified to match description.

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

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

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

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

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

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

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

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

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

174. The information provided to the consultant indicates there is an existing crown/bridge. This claim will be reopened with documentation supporting the need for replacement. Refer to the exclusion section of your dental plan document.

175. Please submit for pre-determination with the entire treatment plan, X-rays and charting/narrative prior to performing additional services.

176. Please insert the ADA code for the extractions, your fee and the date of service for completed treatment rendered

177. Benefit allowed and requires subscriber pay co-payment plus half of the allowed amount according to this groups contract

178. Submitted subscriber social security number not on file. We have corrected the number for this subscriber. Please correct your records for future claims.

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

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

181. Payment reflects coordination of benefits with Delta Dental as the secondary carrier. Being secondary to a capitation plan requires consideration of patient co-pay only. Refer to the coordination of benefits section of your dental plan document.

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

183. This procedure is not covered under this dental plan. Please file with the medical carrier. Refer to the exclusion section of your dental plan document.

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

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

186. All predeterminations for procedures that require pathology reports must be submitted with the completion date and pathology report attached in order to make a final benefit determination. Claim will be reconsidered when treatment has been performed. Refer to the claims and appeal procedures of your dental plan document.

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

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

189. Accidents must be reported to Delta Dental of Virginia within thirty (30) days from the date of the accident. Refer to the limitations and exclusions section of your dental plan document.

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

191. Procedure code has been recoded to the current CDT code published by the ADA. Please use current CDT codes on future filings.

192. Benefits for sealants include repair or replacement within two (2) years. Participating Dentists have agreed to charge the patient only the amount indicated as Patient Pays. Refer to the limitations section of your dental plan document.

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

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

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

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

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

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

200. Payment not billable to patient. Processing of any claims submitted from prior carrier (MetLife) ended as of 6/30/2005.

201. Delta Dental's obligation for processing of claims has ceased. Please contact your benefits administrator. Refer to the exclusion section of your dental plan document.

202. Accidental injuries to natural teeth are not covered under dental. Please file with the patient's Medical Plan. Refer to the exclusion section of your dental plan document.

203. Payment reflects DeltaCare agreement minus patient co-pay.

204. Procedure D0150 is for comprehensive oral evaluation for new patients; established patients who have had a significant change in health conditions, by report, or established patients who have been absent from active treatment for three (3) or more years. Refer to the exclusion section of your dental plan document.

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

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

207. This patient may be due a refund if the service has already been paid by the patient. The patient is only responsible for the amount in the "patient pays" column.

208. Procedures with missing or invalid info cannot be processed. Please submit a new claim for the procedure/s with required data [current CDT code, surface, tooth area (quad, arch, and tooth)]. Report of the following procedures requires a narrative, X-rays and/or perio charting — crowns, onlays, prosthodontics, bridges, implants, surgical ext., perio.

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

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

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

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

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

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

215. Prophylaxis is considered an integral part of and is included in the fee for periodontal maintenance procedure. Therefore no additional benefits are available. Participating Dentist(s) have agreed to charge the patient only the amount indicated as patient pays. Refer to the exclusion section of your dental plan document

216. Benefit allowance for osseous surgery is limited to two quadrants on the same date of service. To reconsider, please submit perio charting, full mouth or panorex X-rays, and length of time surgery was performed. Please advise patient of responsibility for fee. Refer to the exclusion section of your dental plan document.

217. Benefit allowance for scaling and root planing is limited to two quadrants on the same date of service. To reconsider, please submit patient chart notes, perio charting and length of time therapy was performed. Please advise patient of responsibility for fee. Refer to the exclusion section of your dental plan document.

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

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

220. Contract limitation for the replacement of amalgam or composite restorations on the same tooth is not billable to patient if performed by the same dentist/dental office. Participating Dentists have agreed to charge the patient only the amount indicated as Patient Pays.

221. Confirmation of renewal of Virginia State License has been obtained. Claim has been reprocessed.

222. FRef ##### — Full refund for designated check number has been satisfied. Please refer to request for refund letter notification sent prior to this action.

223. PRef ##### — Partial refund for designated check number has been partially satisfied. Additional monies are still owed. Please refer to request for refund letter notification sent prior to this action.

224. This payment reflects an adjustment to the above listed service(s). The original claim was incorrectly paid at 50% rather than 80%. Please accept our apology for any inconvenience this may have caused.

225. This lump sum payment is the final payment for this orthodontic case.

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

227. Brush Biopsy procedures are limited by this plan contract to two (2) in 24 months. Please advise patient of responsibility for fee. Refer to the limitations section of your dental plan document for more information.

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

229. Claim denied because plan account has insufficient funds.

230. This cleaning is allowed due to your enrollment in the *Healthy Smile, Healthy You*® Pregnancy Benefit.

231. This cleaning is allowed due to your enrollment in the *Healthy Smile, Healthy You*®
Diabetes Benefit.

232. This cleaning is allowed due to your enrollment in the *Healthy Smile, Healthy You*®
Risk Cardiac Conditions Benefit.

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

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

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

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

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

263. The primary pays amount has been adjusted to take into account the provider's contracted allowance.

264. This procedure code has been reprocessed at a 90% benefit level resulting in a claim adjustment.

265. Patient not eligible. Please refer to the terms and conditions of the Individual Plan Application. Records indicate policyholder is eligible for group dental coverage.

266. Individual policy excludes services that are eligible under medical. Please see exclusion in the limitations and exclusions section of the policy.

267. Payment reflects Altegrity Special In-progress Orthodontic Benefit for Kroll.

268. This cleaning is allowed due to your enrollment in the *Healthy Smile, Healthy You*®
Cancer Therapy Benefit.

269. This fluoride application is allowed due to your enrollment in the *Healthy Smile, Healthy You*®
Cancer Therapy Benefit.

270. This exam is allowed due to your enrollment in the *Healthy Smile, Healthy You*®
Pregnancy Benefit.

271. This exam is allowed due to your enrollment in the *Healthy Smile, Healthy You*® Diabetes Benefit.

272. This exam is allowed due to your enrollment in the *Healthy Smile, Healthy You*® High Risk Cardiac Conditions Benefit.

273. This exam is allowed due to your enrollment in the *Healthy Smile, Healthy You*® Cancer Therapy Benefit.

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

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

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

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

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

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

280. Benefits for a full mouth X-ray include periapical X-rays and may not be billed separately. Please refer to the Exclusion section of your dental plan document.

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

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

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

284. Services have been denied to reflect Delta Dental's MPA dental practices. Participating Dentist(s) have agreed to charge the patient only the amount indicated as Patient Pays. Please refer to the Exclusion section of your dental plan document.

285. As a courtesy, this claim was processed for this out of network provider as a one-time exception. To avoid possible future claim denials, please contact our office at 1.800.862.0838 so that we may assist you with selecting a DeltaCare network provider.

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

287. Procedure(s) performed does not meet CDT definition or criteria for this code. Treatment is not billable to patient and not chargeable to the patient. Participating Dentist have agreed to charge the patient only the amount indicated as patient pays.

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

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

290. The orthodontic case is approved and meets the required minimum Salzmann Index score for medical necessity.

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

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

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

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

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

296. Based on consultant review the restoration appears to have a poor long term prognosis. Please advise patient of responsibility for fee.

297. Procedure(s) does not meet criteria for treatment. In the absence of extraordinary circumstances, soft tissue grafting requires a minimum of 2mm of recession and absence of attached gingiva. Please advise patient of responsibility for fee.

298. Soft tissue and osseous grafting is limited to two teeth per quadrant per date of service. Grafts performed on subsequent teeth would be considered inclusive. Participating dentists have agreed to charge only the amount indicated as Patient Pays.

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

300. Procedure(s) performed does not meet CDT definition or criteria for this code, benefit is denied.

301. Implant placement for second molars will be considered only if the implant is occlusally functional and if the implant is necessary to prevent passive eruption of the opposing molar(s). Please advise patient of responsibility for fee.

302. Implant placement is limited to four implants per arch and two implants per quadrant. Please advise patient of responsibility for fee.

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

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

305, Non diagnostic X-rays are not billable to patient. Participating dentists have agreed to charge the patient only the amount indicated as Patient Pays.

306. Consultation and/or extraction(s) denied per contract. DeltaCare® dentists are required to perform simple extractions D7140 and surgical extraction procedures including D7210-D7220, D7250. Please advise patient of responsibility for fee. Refer to the exclusion section of your dental plan document.

307. Referral and/or extraction(s) denied per contract. Referral for an extraction of third molars require teeth to be bone impacted and symptomatic. Documentation of specific symptomology must be submitted for each individual bone impaction. Please advise patient of responsibility for fee. Refer to the exclusion section of your dental plan document.

308. Consultation denied per contract. Referral requires documentation of completion of initial therapy and post therapy evaluation by the DeltaCare dentist. History indicates no periodontal therapy by this provider. Please advise patient of responsibility for fee.

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

310. X-rays do not appear to meet clinical necessity guidelines. Participating dentists have agreed to charge the patient only the amount indicated a Patient Pays.

311. Procedure(s) do not indicate medical necessity for more than one hour of anesthesia. Any anesthesia in excess of one hour may not be billed separately. Participating dentists have agreed to charge the patient only the amount indicated as Patient Pays.

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

313. Various claims received between 05/04/15 and 07/07/15 have been adjudicated and reprocessed.

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

315. Patient history indicates that an initial root canal has been performed on this tooth.

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

2000. Due to updated information, adjustment has been made to a precious claim payment or denial which may result in additional co-pay responsibility. Please refer to Patient Pays.

National Processing Policies

Introductory Note

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

General Policies.

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

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

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

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

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

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

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

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

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

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

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

All services provided to Delta Dental members are subject to the following general policies:

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

CDT Codes

DIAGNOSTIC D0100 — D0999

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Clinical Oral Evaluations

GP The number and type of evaluations available for benefits are based on group contract.

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

D0120 Periodic oral evaluation — established patient.
The fees for consultation, diagnosis, and routine treatment planning are NOT BILLABLE TO PATIENT as components of the fee for the evaluation, by the same dentist/dental office.

D0140 Limited oral evaluation — problem focused.

D0145 Oral evaluation for a patient under three years of age and counseling with primary caregiver
This evaluation is not a comprehensive evaluation. Therefore, a comprehensive oral evaluation (D0150) is allowed for the same patient and by the same dentist at a subsequent date.

Oral evaluation includes any caries susceptibility tests (D0425) or oral hygiene instructions (D1330) provided on the same date. When performed on the same date, any fees for D0425 and D1330 are NOT BILLABLE TO PATIENT.

Benefits for D0145 for a child three years of age or older will be DENIED.
For patients under the age of three, any other comprehensive exam code submitted (D0150, D0160, D0180) is payable as D0145. Subsequent D0145 is D0120.

D0150 Comprehensive oral evaluation — new or established patient.
A comprehensive oral evaluation is payable once per patient per dentist. Additional comprehensive evaluations of any type when billed by the same dentist/dental office are processed as periodic evaluations, and any fee charged in excess of the approved amount for the periodic evaluation is NOT BILLABLE TO PATIENT.

The fees for consultation, diagnosis, and routine treatment planing are NOT BILLABLE TO PATIENT as components of the fee for the evaluation, by the same dentist/dental office.

If the patient has not received any services for three years from the same dentist/dental office, a comprehensive evaluation may be benefited.

D0160 Detailed and extensive oral evaluation-problem focused, by report.
Detailed and extensive oral evaluation-problem focused, by report is processed as submitted for the first encounter with the dentist/dental office and subsequent submissions are processed as periodic oral evaluations (D0120).

Any fees in excess of the approved amount for a detailed and extensive oral evaluation, problem focused, by report (D0160) or periodic oral evaluation (D0120) are NOT BILLABLE TO PATIENT.

If the patient has not received any services for three years from the same dentist/dental office, a comprehensive evaluation may be benefited.

D0170 Re-evaluation-limited, problem focused (established patient, not post-op visit).
The fees for re-evaluation are NOT BILLABLE TO PATIENT.

D0180 Comprehensive periodontal evaluation — new or established patient.
A comprehensive periodontal evaluation is payable once per patient, per dentist. Additional comprehensive evaluations of any type when billed by the same dentist/dental office are processed as periodic evaluations, and any fee charged in excess for the approved amount for the periodic evaluation is NOT BILLABLE TO PATIENT.

This evaluation code will be used primarily by a periodontist for a referred patient from a general dentist and should not be reported in addition to a comprehensive oral evaluation (D0150) by the same dentist in the same treatment series. This procedure is not intended for use as a separate code for periodontal charting.

If a D0180 is submitted with D4910 by the same dentist/dental office it is benefited as a D0120 and the difference in the approved amount between D0120 and D0180 is NOT BILLABLE TO PATIENT unless the D0180 is the initial evaluation by the dentist rendering the D4910.

Pre-Diagnostic Services

GP Benefits are determined by group contract

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

D0190 Screening of a patient.
When reported in conjunction with an evaluation code, the fee for screening of a patient is NOT BILLABLE TO PATIENT.

D0191 Assessment of a patient. When reported in conjunction with an evaluation, the fee for the assessment of a patient is NOT BILLABLE TO PATIENT.

Diagnostic Imaging

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

GP Fees for duplication (copying) of diagnostic images for insurance purposes are NOT BILLABLE TO PATIENT.

GP Fees for non-diagnostic images, as determined by consultant review, are NOT BILLABLE TO PATIENT.

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

GP When image capture only procedures are submitted with capture and interpretation procedures, the fee for the image capture only procedure will be NOT BILLABLE TO PATIENT.

GP When interpretation of a diagnostic image procedure (D0391) is submitted with the capture and interpretation procedures, the fee for the interpretation of a diagnostic image (D0391) will be NOT BILLABLE TO PATIENT.

D0210 Intraoral-complete series radiographic images.
The fee for any type of bitewings submitted with a full mouth series are considered part of the full mouth series for payment and benefit purposes. Any fee in excess of a full mouth series is NOT BILLABLE TO PATIENT.

In the absence of contract language for bitewing frequency limitation, bitewings, of any type, are NOT BILLABLE TO PATIENT within 12 months of a full mouth series.

A separate fee for a panoramic radiographic image (D0330) in conjunction with D0210 by the same dentist/dental office is NOT BILLABLE TO PATIENT as a component part of D0210.

When bitewings are processed as part of an intraoral complete series, a separate benefit for bitewings will not be allowed if the full mouth time limitation has been met.

D0220 Intraoral-periapical — first radiographic image

D0230 Intraoral-periapical — each additional radiographic image.
Routine working and final treatment radiographic images taken by the same dentist/dental office for endodontic therapy are considered a component of the complete treatment procedure. Separate fees for these images are NOT BILLABLE TO PATIENT.

D0240 Intraoral — occlusal radiographic image D0250 Extraoral — first radiographic image.

D0250 Extraoral — 2D projection radiographic image

D0251 Extraoral posterior dental radiographic image

D0270 Bitewing — single radiographic image

D0272 Bitewings — two radiographic images

D0273 Bitewings — three radiographic images

D0274 Bitewings — four radiographic images

D0277 Vertical bitewings — seven to eight radiographic images.
Vertical bitewings are considered bitewings for benefit purposes. If the fee for the vertical bitewings with or without additional radiographic images equals or exceeds the fee for a complete series, it would be considered a complete series for payment, benefit, and time limitation purposes. The fee in excess of the fee for a complete series of radiographic images is NOT BILLABLE TO PATIENT.

D0320 Temporomandibular joint arthrogram including injection.

D0321 Other temporomandibular joint radiographic images, by report D0322 Tomographic survey.

D0330 Panoramic radiographic image.
A panoramic radiographic image, with or without supplemental radiographic images (such as periapicals, bitewings, and/or occlusal radiographic images) is considered a complete series for time limitation purposes and any fee charged in excess of the allowance for a complete series (D0210) is NOT BILLABLE TO PATIENT.

Benefits for subsequent panoramic radiographic images taken within the contractual time limitation for a full mouth series are DENIED and the approved amount is collectable from the patient.

D0340 2D Cephalometric radiographic image.
A cephalometric radiographic image is payable only in conjunction with orthodontic benefits. The fee for a cephalometric radiographic image taken in conjunction with services other than orthodontic treatment is DENIED and the approved amount is collectable from the patient.

D0350 2D oral/facial photographic image obtained intra-orally or extra-orally.
Oral/facial images are benefited only once per case in conjunction with orthodontic services. The fees for additional images taken during or after orthodontic treatment by the same dentist/dental office are included in the fee for orthodontics and NOT BILLABLE TO PATIENT.

The fees for oral/facial images taken in conjunction with any other procedure are DENIED, and the approved amount is collectable from the patient.

D0363 Cone beam — three dimensional image reconstruction using existing data, includes multiple images.

The fee for the cone beam — three dimensional image reconstruction using existing data, includes multiple images is DENIED. If covered by contract, by report.

GP When image capture only procedures are submitted with capture and interpretation procedures, the fee for the image capture only procedure will be NOT BILLABLE TO PATIENT.

GP When interpretation of a diagnostic image procedure (D0391) is submitted with the capture and interpretation procedures, the fee for the interpretation of a diagnostic image (D0391) will be NOT BILLABLE TO PATIENT.

D0364 Cone beam CT capture and interpretation with limited field of view — less than one whole jaw. The fee for the cone beam CT capture and interpretation with limited field of view — less than one whole jaw is DENIED.

D0365 Cone beam CT capture and interpretation with field of view of one full dental arch — mandible.

The fee for cone beam CT capture and interpretation with field of view of one full dental arch — mandible is DENIED.

D0366 Cone beam CT capture and interpretation with field of view of one full dental arch — maxilla with or without cranium.

The fee for cone beam CT capture and interpretation with field of view of one full dental arch — maxilla with or without cranium is DENIED.

D0367 Cone beam CT capture and interpretation with field of view of both jaws, with and without cranium.

The fee for cone beam CT capture and interpretation with field of view of both jaws, with and without cranium is DENIED.

D0368 Cone beam CT capture and interpretation for TMJ series including two or more exposures. The fee for cone beam CT capture and interpretation for TMJ series including two or more exposures is DENIED.

D0369 Maxillofacial MRI capture and interpretation. The fee for maxillofacial MRI capture and interpretation is DENIED.

D0370 Maxillofacial ultrasound capture and interpretation. The fee for maxillofacial ultrasound, capture and interpretation is DENIED.

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

Diagnostic Imaging — Image Capture Only

GP When image capture only procedures are submitted with capture and interpretation procedures, the fee for the image capture only procedure will be NOT BILLABLE TO PATIENT.

D0380 Cone beam CT image capture with limited field of view — less than one whole jaw. The fee for cone beam CT image capture with limited field of view — less than one whole jaw is DENIED.

D0381 Cone beam CT image capture with field of view one full dental arch — mandible. The fee for cone beam CT image capture with field of view one full dental arch — mandible is DENIED.

D0382 Cone beam CT image capture with field of view one full dental arch — maxilla, with and without cranium.

The fee for cone beam CT image capture with field of view one full dental arch — maxilla, with and without cranium is DENIED.

D0383 Cone beam CT image capture field of view both jaws, with or without cranium. The fee for cone beam CT image capture field of view both jaws, with or without cranium is DENIED.

D0384 Cone beam CT image capture for TMJ series including two or more exposures. The fee for cone beam CT image capture for TMJ series including two or more exposures is DENIED.

D0385 Maxillofacial MRI image capture.
The fee for maxillofacial MRI image capture is DENIED.

D0386 Maxillofacial ultrasound image capture.
The fee for maxillofacial ultrasound image capture is DENIED.

Interpretation and Report Only

D0391 Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report.

The fee for interpretation of diagnostic image by a practitioner not associated with capture of the image, including report is DENIED. In all other instances the interpretation is NOT BILLABLE TO PATIENT.

Tests and Examinations

D0411 HbA1c In-office point of service testing. Benefits are DENIED unless covered by group/individual contract.

D0412 Blood glucose level test, in office using a glucose meter.
Benefits are DENIED unless covered by group/individual contract.
D0412 is NOT BILLABLE TO PATIENT on the same day as D0411.

D0414 Laboratory processing of microbial specimen to include culture and sensitivity studies, preparation and transmission of written report.

Benefits for laboratory processing of microbial specimens are DENIED unless covered by the group/individual contract.

D0415 Collection of microorganisms for culture and sensitivity.
The fees for bacteriologic studies for determination of sensitivity of pathologic agents to antibiotics are DENIED and the approved amount is collectable from the patient.

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

D0417 Collection and preparation of saliva sample for laboratory diagnostic testing.
The fees for the collection and preparation of a saliva sample are DENIED and the approved amount is collectable from the patient.

D0418 Analysis of saliva sample.
The fee for the analysis of a saliva sample are DENIED and the approved amount is collectable from the patient.

D0422 Collection and preparation of genetic sample material for lab analysis and report.

D0423 Genetic test for susceptibility to disease — specimen analysis

D0425 Caries susceptibility tests.
The fees for caries susceptibility tests are DENIED and the approved amount is collectable from the patient.

D0431 Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures.

Code D0431 is considered experimental and/or investigational and fees are DENIED.
D0460 Pulp vitality tests.

Pulp vitality tests are payable per visit, not per tooth, and only for the diagnosis of emergency conditions.

Fees for pulp tests are NOT BILLABLE TO PATIENT when performed on the same date by the same
dentist/dental office as any other definitive procedure except radiographic images, limited oral evaluation — problem focused (D0140), protective restoration (D2940) or palliative treatment (D9110).

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

Oral Pathology Laboratory (use codes D0472 – D0483)

GP All oral pathologic procedures must be accompanied by a pathology report to be considered for payment. The fee for an oral pathologic procedure not accompanied by a pathology report is NOT BILLABLE TO PATIENT.

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

GP When more than two procedures are performed on the same area of the mouth on the same day, benefits are based upon, but not limited to, the most inclusive procedure.

GP Fees for the included procedures are NOT BILLABLE TO PATIENT and not billable to the patient by a Participating Dentist. These inter-related procedures include, but are not limited to, the following hierarchy: D0474, Most inclusive D0473, D0472

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

GP All oral pathology procedures must be accompanied by a pathology report to be considered for payment. A fee for pathology procedure not accompanied by a pathology report is NOT BILLABLE TO PATIENT.

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

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

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

D0475 Decalcification procedure

D0476 Special stains for microorganisms

D0477 Special stains, not for microorganisms

D0478 Immunohistochemical stains

D0479 Tissue in-site hybridization, including interpretation

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

D0481 Electron microscopy

D0482 Direct immunoflourescence

D0483 Indirect immunofluorescence

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

D0485 Consultation, including preparation of slides from biopsy material supplied by referring Source.

Benefits should be administered with the same processing policies, system edits and paid as codes D0472, D0473 or D0474 based on the complexity of the report.

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

D0502 Other oral pathology procedures, by report.
The fees for other oral pathology procedures for routine surgical procedures are DENIED and the approved amount is collectable from the patient.

D0600 Non-Ionizing diagnostic procedure capable of quantifying, monitoring and recording changes in structure of enamel, dentin and cementum.

The fees for D0600 are NOT BILLABLE TO PATIENT when submitted with an evaluation. When submitted separately from an evaluation benefits are DENIED unless covered by group.

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

PREVENTIVE D1000 – D1999

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

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

GP Periodontal maintenance (D4910) is counted toward the contract limitation for prophylaxis and full mouth debridement (D4355).

Dental Prophylaxis

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

D1110 Prophylaxis — adult

D1120 Prophylaxis — child

Topical Fluoride Treatment (office procedure)

GP Using prophylaxis paste containing fluoride, a fluoride rinse, or fluoride swish in conjunction with a prophylaxis is considered a prophylaxis only and a separate fee for topical fluoride application is NOT BILLABLE TO PATIENT.

GP The age limitation for topical fluoride gel or varnish treatments is limited by contract usually up to age 19.

GP Fluoride gels, rinses, tablets, or other preparations intended for home applications are DENIED and the approved amount is collectable from the patient.

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

D1208 Topical application of fluoride — excluding varnish.
Benefits for fluoride treatment are defined by group contract.

Other Preventive Services

D1310 Nutritional counseling for the control of dental disease.
The fee for nutritional counseling is DENIED and the approved amount is collectable from the patient.

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

D1330 Oral hygiene instructions.
The fee for oral hygiene instruction is DENIED and the approved amount is collectable from t he patient.

D1351 Sealant — per tooth.
Sealants are payable once per tooth on the occlusal surface of permanent first and second molars for patients through age 15. The teeth must be free from overt dentinal caries (incipient caries sealing is preferred) or restorations on the occlusal surface. Special consideration for late eruption can be given by report.

A separate fee for sealant done on the same date of service and on the same surface as a restoration by the same dentist/dental office is considered a component of the restoration and is NOT BILLABLE TO PATIENT.

The fees for sealants are DENIED and the approved amount is collectable from the patient when submitted documentation or the patient's claim history indicates an existing restoration on the occlusal surface of the same tooth.

The fee for repair or replacement of a sealant or preventive resin restoration by the same dentist within two years of initial placement is included in the fee for the initial placement and is NOT BILLABLE TO PATIENT. The fee for repair or replacement of a sealant by a different dentist within two years of initial placement is DENIED and the approved amount is collectable from the patient.

Benefits for repair or replacement of sealants requested after 24 months have elapsed since initial placement are DENIED and the approved amount is collectable from the patient.

D1352 Preventive resin restoration in a moderate to high caries risk patient — permanent tooth
Preventive resin restorations are payable once per tooth on the occlusal surface of permanent first and second molars.

When covered by group contract fees for preventive resin restoration completed on the same date of service and on the same surface as a restoration by the same dentist/dental office are NOT BILLABLE TO PATIENT as a component of the restoration.

Fees for replacement of preventive resin restoration are not billable to patient if performed within two years of initial placement of preventive resin restoration and/sealant by the same dentist/dental office.

D1353 Sealant repair — per tooth.
Benefits for sealants include repair or replacement within 24 months by the same dentist/dental office. Fees for repair or replacement of a sealant are NOT BILLABLE TO PATIENT if performed within 24 months of initial placement by same dentist/dental office.

D1354 Interim caries arresting medicament application — per tooth

Space Maintenance (passive appliances)

GP The fee for repair or replacement of a space maintainer is DENIED and the approved amount is collectable from the patient.

GP Only one space maintainer is provided for a space. Additional appliances are DENIED and the approved amount is collectable from the patient.

GP Space maintainers for missing primary anterior teeth, missing permanent teeth, or for persons age 14 or over are DENIED and the approved amount is collectable from the patient.

GP Space maintainer fees include all teeth, clasps and rests. Any fee charged in excess of the approved amount for the appliance by the same dentist/dental office is NOT BILLABLE TO PATIENT.

D1510 Space maintainer — fixed, unilateral — per quadrant

D1516 Space maintainer — fixed, bilateral — maxillary

D1517 Space maintainer — fixed, bilateral — mandibular

D1520 Space maintainer — removable, unilateral — per quadrant

D1526 Space maintainer — removable, bilateral — maxillary

D1527 Space maintainer — removable, bilateral — mandibular

D1575 Distal shoe space maintainer — fixed, unilateral — per quadrant
Limited to children up to age eight (8). Fees for repairs and adjustments by the same dentist/dental office are NOT BILLABLE TO PATIENT.

RESTORATIVE D2000-D2999

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

GP The fee for a restoration includes services such as, but not limited to, adhesives, etching, liners, bases, direct and indirect pulp caps, local anesthesia, polishing, occlusal adjustment, caries removal, and gingivectomy done on the same date of service as the restoration. A separate fee for any of these procedures by the same dentist/dental office is NOT BILLABLE TO PATIENT.

GP A fee for the replacement of amalgam or composite restorations, same tooth and same surface(s), is NOT BILLABLE TO PATIENT if done by the same dentist within 24 months of the initial restoration. Benefits may be DENIED and the approved amount for the restoration collectable from the patient if done by a different dentist/dental office.

GP When multiple restorations involving the proximal and occlusal surfaces of the same tooth are requested or performed, the allowance is limited to that of a multi-surface restoration. Any fee charged in excess of the allowance for the multi-surface restoration by the same dentist/dental office is NOT BILLABLE TO PATIENT. A separate benefit may be allowed for a noncontiguous restoration on the buccal or lingual surface(s) of the same tooth.

GP Any restoration involving two or more contiguous surfaces should be reported using the appropriate multiple surface restoration code.

GP When restorations not involving the occlusal surface are requested or performed on posterior teeth, the allowance is limited to that of a one surface restoration. Any fee charged in excess of the allowance for the one-surface restoration is NOT BILLABLE TO PATIENT.

GP Benefits are allowed only once per surface in a 24 month interval, irrespective of the number or combination of procedures requested or performed. A fee for restoration of a surface within 24 months of previous treatment is NOT BILLABLE TO PATIENT if done by the same dentist/dental office and DENIED and the approved amount is collectable from the patient if done by a different dentist/dental office.

GP Multistage procedures are reported and benefited upon completion. The completion date is the date of insertion for removable prosthetic appliances. The completion date for fixed partial dentures and crowns, onlays, and inlays is the cementation date regardless of the type of cement utilized.

GP If an indirectly fabricated restoration is performed by the same dentist within 24 months of the placement of an amalgam or composite restoration the Delta Dental payment and patient co-payment allowance for the amalgam or composite restorations will be deducted from the indirectly fabricated restoration benefit.

GP Tooth preparation, temporary restorations, cement bases, impressions, laboratory fees and material, occlusal adjustment, gingivectomies (on the same date of service), and local anesthesia are considered to be included in the fee for all restorations, and a separate fee for any of these procedures by the same dentist/dental office is NOT BILLABLE TO PATIENT. Fees for buildups, not required for retention are NOT BILLABLE TO PATIENT.

GP The fees for restorations for altering occlusion, involving vertical dimension, replacing tooth structure lost by attrition, erosion, abrasion, abfraction, corrosion, TMD or for periodontal, orthodontic, or other splinting are DENIED and the approved amount is collectable from the patient.

GP Biomimetic restorations (e.g. Biodentine) are DENIED as experimental and/or investigational.

Definitions

Attrition

1. The frictional wearing of the teeth over time. Severe attrition, due to bruxing may be evident. (Treatment Planing in Dentistry; Mosby 2006).

2. The loss of tooth structure from tooth to tooth contact (Lee, Eakle. J Prosthet Dent 1996; 75:487).

Abrasion

1. Wearing away or notching of the teeth by a mechanical means, such as tooth brushing (Treatment Planing in Dentistry; Mosby 2006).

2. The grinding or wearing away of tooth substance by mastication, incorrect brushing methods, bruxism or similar causes (Mosby's Dental Dictionary).

3. The abnormal wearing away of a substance or tissue by a mechanical process. (Mosby's Dental Dictionary).

4. The loss of tooth structure from the mechanical rubbing of teeth by some object or objects (no source).

5. The act or result of the grinding or wearing away of a substance, such as a tooth worn by mastication, bruxing or tooth brushing (The Glossary of Operative Dentistry Terms).

Erosion

1. The wasting away or loss of substance of a tooth by a chemical process that does not involve known bacterial action. (Treatment Planing in Dentistry; Mosby 2006)

2. The process and the results of loss of dental hard tissue that is chemically etched away from the tooth surface, by acid and/or chelation, without bacterial involvement (ten Cate & Imfeld, Eur J Oral Sci 1996; 104:241)

Abfraction

Wedge-shaped lesions occurring in the cervical enamel. Can result from occlusal loading and flexure in the area. (Dorland's Illustrated Medical Dictionary, 25th edition 1975). For classification of metals see the ADA CDT Manual.

Amalgam Restorations (including polishing)

D2140 Amalgam — one surface, primary or permanent D2150 Amalgam — two surfaces, primary or permanent

D2160 Amalgam — three surfaces, primary or permanent

D2161 Amalgam — four or more surfaces, primary or permanent

Resin–Based Composite Restorations — Direct

GP 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.

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 the incisal angle (anterior).

D2390 Resin-based composite crown, anterior

D2391 Resin-based composite — one surface, posterior

D2392 Resin-based composite — two surfaces, posterior

D2393 Resin-based composite — three or more surfaces, posterior

D2394 Resin-based composite — four or more surfaces, posterior

GP Resin restorations on posterior teeth are a benefit only on the buccal surfaces of bicuspids. If done on posterior teeth, an alternate benefit allowance up to that for amalgam is made and any fee charged in excess of the allowance is DENIED and is collectable from the patient up to the approved amount for the resin-based posterior composite restoration.

Gold Foil Restorations

GP An alternate benefit allowance is made for an amalgam or resin restoration, according to the policies for amalgam or resin restorations. The difference between the allowance for the amalgam or resin restoration and the approved amount for the gold foil restoration is DENIED and collectable from the patient.

D2410 Gold foil — one surface D2420 Gold foil — two surfaces D2430 Gold foil — three surfaces

Inlay/Onlay Restorations

GP When the retentive quality of a tooth qualifies for an onlay, benefits are based on the submitted procedure. If an alternate benefit allowance is applied, the difference between the allowance for the alternative benefit and the approved amount for the inlay/onlay restoration is DENIED and collectable from the patient.

GP For inlay restorations, an alternate benefit allowance is made for an amalgam or resin restoration, according to the policies for amalgam and resin restorations. The difference between the allowance for the amalgam or resin restoration and the approved amount for the inlay restoration is DENIED and collectable from the patient.

GP Crowns and indirectly fabricated restorations are optional benefits unless the tooth is damaged by decay or fracture to the point it cannot be restored by an amalgam or resin restoration. If the fee for a cast crown or indirectly fabricated restoration is not allowed, an alternate benefit allowance for an amalgam or resin restoration is made according to the policies for those restorations and the difference between the allowance for the amalgam or resin restoration and the approved amount for the cast crown or indirectly fabricated restoration is DENIED and collectable from the patient.

GP The fees for crowns and onlays are DENIED and the approved amount is collectable from the patient for children under 12 years of age.

GP Onlays are considered to cover one or more cusps and include the inlay. Onlays are only benefited when the tooth would otherwise qualify for a crown based on degree of breakdown.

GP Tooth preparation, temporary restorations, laboratory fees and material cement bases, impressions, occlusal adjustment, gingivectomies (on the same date of service) and local anesthesia are considered to be included in the fee for an onlay or crown restoration. Separate fees for these procedures by the same dentist/dental office are NOT BILLABLE TO PATIENT on the same date of service.

D2510 Inlay — metallic — one surface D2520 Inlay — metallic — two surfaces

D2530 Inlay — metallic — three or more surfaces D2542 Onlay — metallic — two surfaces

D2543 Onlay — metallic — three surfaces D2544 Onlay — metallic — four or more surfaces Porcelain/ceramic inlays/onlays include all indirect ceramic and porcelain type inlays/onlays.

D2610 Inlay — porcelain/ceramic — one surface

D2620 Inlay — porcelain/ceramic — two surfaces

D2630 Inlay — porcelain/ceramic — three or more surfaces D2642 Onlay — porcelain/ceramic — two surfaces

D2643 Onlay — porcelain/ceramic — three surfaces D2644 Onlay — porcelain/ceramic — four or more surfaces

Resin-based composite inlays/onlays must utilize indirect technique. D2650 Inlay — resin-based composite — one surface

D2651 Inlay — resin-based composite — two surfaces

D265 Inlay — resin-based composite — three or more surfaces D2662 Onlay — resin-based composite — two surfaces

D2663 Onlay — resin-based composite — three surfaces

D2664 Onlay — resin-based composite — four or more surfaces

Crowns* — Single Restorations Only

GP Crowns and indirectly fabricated restorations are optional benefits unless the tooth is damaged by decay or fracture to the point it cannot be restored by an amalgam or resin restoration. If the fee for a crown or indirectly fabricated restoration is not allowed, an alternate benefit allowance for an amalgam or resin restoration is made according to the policies for those restorations and the difference between the allowance for the amalgam or resin restoration and the approved amount for the crown or cast or indirectly fabricated restoration is DENIED and collectable from the patient.

GP The fees for crowns and onlays are DENIED and the approved amount is collectable from the patient for children under 12 years of age.

GP Tooth preparation, temporary restorations, laboratory fees and material cement bases, impressions, occlusal adjustment, gingivectomies (on the same date of service) and local anesthesia are considered to be included in the fee for an onlay or crown restoration. Separate fees for these procedures by the same dentist/dental office are NOT BILLABLE TO PATIENT on the same date of service.

D2710 Crown — resin-based composite (indirect)

D2712 Crown — ¾ resin-based composite (indirect)

D2720 Crown — resin with high noble metal

D2721 Crown — resin with predominantly base metal

D2722 Crown — resin with noble metal

D2740 Crown — porcelain/ceramic

D2750 Crown — porcelain fused to high noble metal

D2751 Crown — porcelain fused to predominantly base metal

D2752 Crown — porcelain fused to noble metal

D2780 Crown — ¾ cast high noble metal

D2781 Crown — ¾ cast predominantly base metal D2782 Crown – ¾ cast noble metal

D2783 Crown — ¾ porcelain/ceramic D2790 Crown — full cast high noble metal

D2791 Crown — full cast predominantly base metal D2792 Crown — full cast noble metal

D2794 Crown — titanium/titanium alloy

D2799 Provisional crown

The fee for a provisional crown by the same dentist/dental office is NOT BILLABLE TO PATIENT as a component of the fee for a permanent crown.

When a temporary or provisional crown is billed as a therapeutic measure for a fractured tooth, it may be benefited subject to individual consideration.

Other Restorative Services

GP Delta Dental member companies consider the cementation date to be that date upon which the completed or indirectly fabricated post, prefabricated post and core, inlay, onlay, crown, or fixed partial denture is first delivered to the mouth. The type of cement used is not a determining factor (whether permanent or temporary).

GP Fees for recementation of indirectly fabricated or prefabricated post and cores, inlays, onlays, crowns, and fixed partial dentures are NOT BILLABLE TO PATIENT if done within six months of the initial seating date by the same dentist or dental office.

GP Benefits may be paid for one recementation after six (6) months have elapsed since initial placement. Subsequent requests for recementation by the same provider are DENIED and the approved amount is collectable from the patient. Benefits may be paid when billed by a provider other than the one who seated the bridge or performed the previous recementation.

GP D2915 (post recementation) and D2920 (crown recementation) are not allowed on the same tooth on the same day by the same dentist/dental office. The allowance will be made only for D2920 when D2915 and D2920 are submitted together. The fee for D2915 will be NOT BILLABLE TO PATIENT.

D2910 Re-cement or re-bond inlay, onlay, veneer, or partial coverage restoration

D2915 Re-cement or re-bond indirectly fabricated or pre-fabricated post and core

D2920 Re-cement or re-bond crown

D2929 Prefabricated porcelain/ceramic crown — primary tooth

A fee for replacement of a prefabricated porcelain/ceramic crown by the same dentist/dental office within 24 months is included in the initial crown placement and is NOT BILLABLE TO PATIENT.

D2930 Prefabricated stainless steel crown — primary tooth

A fee for replacement of a stainless steel crown on a primary tooth by the same dentist/dental office within 24 months is included in the initial crown placement and is NOT BILLABLE TO PATIENT.

**For classification of metals see the ADA CDT Manual.*

D2931 Prefabricated stainless steel crown — permanent tooth. A fee for replacement of a stainless steel crown on a permanent tooth by the same dentist/dental office within 24 months is included in the initial crown placement and is NOT BILLABLE TO PATIENT.

D2932 Prefabricated resin crown
A prefabricated resin crown is a benefit only on anterior primary teeth. If submitted for a posterior primary tooth or for a permanent tooth, an alternate benefit allowance for D2930 or D2931 is made. The difference between the allowance for the D2930 or D2931and the approved amount for the D2932 is DENIED and collectable from the patient.

D2933 Prefabricated stainless steel crown with resin window
A prefabricated stainless steel crown with resin window is a benefit only on anterior primary teeth. If submitted for a posterior primary tooth or for a permanent tooth, an alternate benefit allowance for D2930 or D2931 is made. The difference between the allowance for the D2930 or D2931and the approved amount for the D2933 is DENIED and collectable from the patient.

A fee for replacement of a stainless steel crown on a primary or permanent tooth by the same dentist/dental office within 24 months is included in the initial crown placement and is NOT BILLABLE TO PATIENT.

D2934 Prefabricated esthetic coated stainless steel crown — primary tooth
A prefabricated aesthetic coated stainless steel crown is a benefit only on anterior primary teeth.

If submitted for a posterior primary tooth or for a permanent tooth, an alternate benefit allowance for D2930 or D2931 is made.

The difference between the allowance for the D2930 or D2931and the approved amount for the D2934 is DENIED and collectable from the patient.

A fee for replacement of a stainless steel crown on a primary or permanent tooth by the same dentist/dental office within 24 months is included in the initial crown placement and is NOT BILLABLE TO PATIENT.

Benefits may be allowed with the same processing policies and edits as a D2933 if performed on permanent teeth and subject to individual consideration.

D2940 Protective restoration
Protective restorations are a benefit for emergency relief of pain.

A separate fee for protective restoration is NOT BILLABLE TO PATIENT when performed in conjunction with a definitive restoration or endodontic access closure by the same dentist/dental office.

02950 Core buildup, including any pins
Substructures are a benefit only when necessary to retain an indirectly fabricated restoration due to extensive loss of tooth structure from caries or fracture. The procedure should not be reported when the procedure only involves a filler to eliminate any undercut, box form, or concave irregularity in the preparation. Fees for buildups not required for retention are NOT BILLABLE TO PATIENT.

A separate fee for a buildup is NOT BILLABLE TO PATIENT when radiographs indicate sufficient tooth structure remains to support a cast or indirectly fabricated restoration.

D2951 Pin retention — per tooth, in addition to restoration
Pin retention is a benefit once per tooth when necessary on a permanent tooth and when completed at the same appointment. Fees for additional pins on the same tooth by the same dentist/dental office are NOT BILLABLE TO PATIENT as a component of the initial pin placement.

A fee for pin retention when billed in conjunction with a buildup by the same dentist/dental office is NOT BILLABLE TO PATIENT as a component of the buildup procedure.

D2952 Post and core in addition to crown, indirectly fabricated
An indirectly fabricated post and core in addition to crown is a benefit only on a successful endodontically treated tooth. The fee for an indirectly fabricated post and core is NOT BILLABLE TO PATIENT when radiographs indicate an absence of endodontic treatment, incompletely filled canal space, or unresolved pathology associated with the involved tooth.

An indirectly fabricated post and core in anterior teeth is a benefit only when there is insufficient tooth structure to support a cast or indirectly fabricated restoration. If sufficient tooth structure remains, a fee for a post and core is NOT BILLABLE TO PATIENT.

D2953 Each additional indirectly fabricated post — same tooth
Each additional indirectly fabricated post is considered a component of an indirectly fabricated post.

D2954 Prefabricated post and core in addition to crown
A prefabricated post and core in addition to crown is a benefit only on a successful endodontically treated tooth.

The fee for a prefabricated post and core is NOT BILLABLE TO PATIENT when radiographs indicate an absence of endodontic treatment, incompletely filled canal space, or unresolved pathology associated with the involved tooth.

A prefabricated post and core in anterior teeth is a benefit only when there is insufficient tooth structure to support a cast or indirectly restoration.

If sufficient tooth structure remains, a fee for a post and core is NOT BILLABLE TO PATIENT.

D2955 Post removal
The fee for post removal when the procedure is rendered by the same dentist/office rendering retreatment is NOT BILLABLE TO PATIENT as a component of the fee for the retreatment.

D2957 Each additional prefabricated post in the same tooth.
The fee for each additional prefabricated post is NOT BILLABLE TO PATIENT as a component of a prefabricated post.

D2960 Labial veneer (resin laminate) — chairside D2961 Labial veneer (resin laminate) — laboratory

D2962 Labial veneer (porcelain laminate) — laboratory
A veneer could be a benefit in cases where the criterion for a crown has been met. In such a case the policies for cast restorations apply.

D2971 Additional procedures to construct new crown under existing partial denture framework.

D2975 Coping — A thin covering of the coronal portion of a tooth, usually devoid of anatomic contour, that can be used as a definitive restoration. Copings are considered an integral part of the final restoration. Additional fees are DENIED.

D2980 Crown repair, necessitated by restorative material failure

D2981 Inlay repair, necessitated by restorative material failure

D2982 Onlay repair, necessitated by restorative material failure

D2983 Veneer repair, necessitated by restorative material failure

D2990 Resin infiltration of incipient smooth surface lesions.
Fees for resin infiltration of incipient smooth surface lesions are DENIED as experimental and/or investigational.

D2999 Unspecified restorative procedure, by report

ENDODONTICS D3000-D3999

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GP Endodontic retreatment may include the removal of a post, pin(s), old root canal filling material, and the procedures necessary to prepare the canals and place the canal filling.

This includes complete root canal therapy. Separate fees for these procedures by the same dentist/dental office are NOT BILLABLE TO PATIENT as included in the fees for the retreatment.

Pulp Capping

GP A separate fee for a pulp cap by the same dentist/dental office is NOT BILLABLE TO PATIENT when submitted in conjunction with protective resin restoration or with final restoration on the same tooth.

GP Fees for direct or indirect pulp caps are NOT BILLABLE TO PATIENT when provided by the same dentist/dental office in conjunction with the final restoration for the same tooth.

GP The fees for root canal therapy done in conjunction with an overdenture are DENIED and the approved amount is collectable from the patient.

D3110 Pulp cap-direct (excluding final restoration)

D3120 Pulp cap-indirect (excluding final restoration) Pulpotomy

D3220 Therapeutic pulpotomy (excluding final restoration) — removal of pulp coronal to the dentinocemental junction and application of medicament.

A therapeutic pulpotomy is only benefited when performed on primary teeth. The fee for a pulpotomy provided on a permanent tooth is DENIED and the approved amount is collectable from the patient.

D3221 Pulpal debridement, primary and permanent teeth
The fee for gross pulpal debridement is NOT BILLABLE TO PATIENT when endodontic treatment is completed on the same tooth on the same day by the same dentist/dental office. Unusual cases may be referred for individual consideration.

D3222 Partial pulpotomy for apexogenesis — permanent tooth with incomplete root development
DISALLOW the fee for D3222 when performed within 30 days/same tooth/same provider/same office as root canal therapy or codes D3351-D3353

Endodontic Therapy on Primary Teeth

D3230 Pulpal therapy (resorbable filling) — anterior, primary tooth (excluding final restoration)

D3240 Pulpal therapy (resorbable filling) — posterior, primary tooth (excluding final restoration)
Endodontic Therapy (including treatment plan, clinical procedures and follow-up care)

GP The fee for a root canal includes treatment X-rays and temporary restorations. Any additional fee charged by the same dentist/dental office is NOT BILLABLE TO PATIENT.

GP When a radiograph indicates obturation of an endodontically treated tooth has been performed without the use of a biologically acceptable nonresorbable semisolid or solid core material, fees for the endodontic therapy and/or restoration of the tooth are NOT BILLABLE TO PATIENT.

GP The completion date for endodontic therapy is the date that the canals are permanently filled.

D3310 Endodontic therapy — anterior (excluding final restoration)

D3320 Endodontic therapy — premolar (excluding final restorations)

D3330 Endodontic therapy — molar tooth (excluding final restorations)
A separate fee for palliative treatment is NOT BILLABLE TO PATIENT when done in conjunction with root canal therapy by the same dentist/dental office on the same date of service.

Incompletely filled root canals are not a benefit and the fee for the endodontic therapy is NOT BILLABLE TO PATIENT.

D3331 Treatment of root canal obstruction; non-surgical access

D3331 is considered a component of a root canal.
The fee for the procedure by the same dentist/dental office is NOT BILLABLE TO PATIENT.

Post removal is not included in this procedure.

D3332 Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth

D3332 is subject to individual consideration, by report.

D3333 Internal root repair of perforation defects
Internal root repair is considered apexification/recalcification — initial visit (D3351) for benefit purposes. It is subject to the same processing policies as apexification/recalcification — initial visit.

The fee for the procedure (D3333) is NOT BILLABLE TO PATIENT when done in conjunction with an apicoectomy and/or retrograde filling by the same dentist/dental office.

The fee for D3333 is DENIED if reported on a primary tooth.

Endodontic Retreatment

GP Endodontic retreatment may include the removal of a post, pin(s), old root canal filling material, and the procedures necessary to prepare the canals and place the canal filling. This includes complete root canal therapy. Separate fees for these procedures by the same dentist/dental office are NOT BILLABLE TO PATIENT as included in the fees for the retreatment.

GP The fee for retreatment of root canal therapy or retreatment of apical surgery by the same dentist/dental office within 24 months of initial treatment is NOT BILLABLE TO PATIENT as a component of the fee for the original procedure.

D3346 Retreatment of previous root canal therapy — anterior

D3347 Retreatment of previous root canal therapy — premolar

D3348 Retreatment of previous root canal therapy — molar

Apexification/Recalcification and Pulpal Regeneration Procedures

D3351 Apexification/recalcification — initial visit (apical closure/calcific repair of perforations, root resorption, etc.)

Includes opening tooth, preparation of canal spaces first placement of medication and necessary radiographs.

This procedure may include first phase of complete root canal therapy.

Apexification is eligible for benefits on permanent teeth with incomplete root development or for repair of a perforation.

D3352 Apexification/recalcification/pulpal regeneration - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)

D3353 Apexification/recalcification — final visit (includes completed root canal therapy- apical closure/calcific repair of perforations, root resorption, etc.)

Apexification/recalcification — final visit benefits are administered as the same processing policies as D3310, D3320, or D3330 (depending on tooth type) and any fee charged in excess of the approved amount for the D3310, D3320, or D3330 (depending on the tooth type) is NOT BILLABLE TO PATIENT.

D3354 Pulpal regeneration — (Completion of regenerative treatment in a immature permanent tooth with necrotic pulp); does not include final restoration

Pulpal regeneration is considered experimental and/or investigational. The fees are DENIED and the approved amount is collectable from the patient.

Apicoectomy/Periradicular Services

GP The fee for biopsy of oral tissue is NOT BILLABLE TO PATIENT as included in the fee for a surgical procedure (e.g. apicoectomy) when performed in the same location and on the same date of service by the same dentist/dental office.

D3410 Apicoectomy/periradicular surgery — anterior

D3421 Apicoectomy/periradicular surgery — premolar (first root)

D3425 Apicoectomy/periradicular surgery — molar (first root)

D3426 Apicoectomy/periradicular surgery (each additional root)

D3430 Retrograde filling — per root
Retrograde filling includes all retrograde procedures per root. Any fee charged in excess of the allowance for a retrograde filling by the same dentist/dental office is NOT BILLABLE TO PATIENT.

D3450 Root amputation — per root
A separate fee for root amputation is NOT BILLABLE TO PATIENT when performed in conjunction with an apicoectomy by the same dentist/dental office.

D3460 Endodontic endosseous implant

D3470 Intentional re-implantation (including necessary splinting)
Intentional reimplantation is considered a specialized procedure. The fees are DENIED and the approved amount is collectable from the patient.

Other Endodontic Procedures

D3910 Surgical procedure for isolation of tooth with rubber dam
A separate fee for isolation of a tooth with a rubber dam by the same dentist/dental office is NOT BILLABLE TO PATIENT as a component of the fee for the procedure performed.

D3920 Hemisection (including any root removal), not including root canal therapy

D3950 Canal preparation and fitting of preformed dowel or post

A separate fee for canal preparation and fitting of preformed dowel or post by the same dentist/dental office is NOT BILLABLE TO PATIENT as a component of the fee for the post or root canal therapy.

D3999 Unspecified endodontic procedure, by report

PERIODONTICS D4000-D4999

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GP When more than one surgical procedure is provided on the same teeth on the same day, benefits are based upon, but not limited to, the most inclusive procedure.

GP The fee for the following services: D1110, D1120, D4355, and/or D4910 will be NOT BILLABLE TO PATIENT if the services are rendered by the same dentist/dental office within 30 days after the most recent scaling and root planing (D4341, D4342) or other periodontal therapy.

GP Fees for the included procedures are NOT BILLABLE TO PATIENT and not billable to the patient by a Participating Dentist/dental office. These inter-related services include, but are not limited to, the following hierarchy: D4260 (most inclusive), D4261, D6102, D4249, D4245, D4268, D4240, D4241, D6101, D4274, D4230, D4231, 4210, D4211, D4212, D4341, D4342, D4355, D4910, D1110, D1120 (least inclusive)

GP Periodontal services are only benefited when performed on natural teeth for treatment of periodontal disease. Unless otherwise specified by contract, benefits for these procedures when billed in conjunction with implants, ridge augmentation, extraction sites (teeth) and/or periradicular surgery are DENIED and the approved amount is collectable from the patient.

GP The fee for biopsy (D7285, D7286), frenulectomy (D7960) and excision of hard and soft tissue lesions (D7410, D7411, D7450, D7451) are NOT BILLABLE TO PATIENT when the procedures are by the same dentist/ dental office performed on the same date, same surgical site/area, and any other surgical procedure. Request for individual consideration can always be submitted by report for the dental consultant for review.

GP Laser disinfection is a technique, not a procedure. Fees for laser disinfection are NOT BILLABLE TO PATIENT. If done as a standalone procedure, the fee for laser disinfection is DENIED and the approved amount is collectable from the patient.

GP The fees for low level laser therapy when performed as part of another procedure are NOT BILLABLE TO PATIENT. When billed as a standalone procedure, the fees for low level laser therapy are DENIED as experimental and/or investigational.

Periodontal therapy includes the following: previous periodontal surgery, osseous flap, scaling and root planing.

GP The following categorizes procedures for reporting and adjudicating by quadrant, site or individual tooth in order to enhance standard benefit determinations and expedite claim processing.

Diseased teeth/periodontium definition:

For processing purposes, periodontally involved teeth that would qualify for surgical pocket reduction benefits under procedure codes D4210, D4211, D4240, D4241, D4260, D4261, D6101 and D6102 must be documented to have at least 5mm pocket depths. If pocket depths are less than 5mm, the surgical procedure is DENIED and the approved amount collectable from the patient.

In the case of procedure codes D4341 and D4342, there must be documentation of at least 4mm pockets on the diseased teeth/periodontium involved. In the absence of 4mm pockets, a benefit allowance for a prophylaxis (D1110) is made and any fee in excess of the approved amount for D1110 is NOT BILLABLE TO PATIENT and not chargeable to the patient.

Quadrant: D4210, D4230, and D4341: Four or more diseased teeth/periodontium distal to the midline are considered a quadrant. Tooth bounded spaces are not counted in making this determination. When these periodontal procedures do not meet all of these criteria use codes D4211, D4231 and D4342 respectively.

D4240, D4260: Four or more diseased teeth/periodontium or bounded tooth spaces distal to the midline are considered a quadrant. A tooth bounded space counts as one space irrespective of the number of teeth that would normally exist in the space. When these procedures do not meet all of these criteria use codes D4241 and D4261 respectively.

Site: a site is defined by the current ADA CDT manual.

Site: D4245, D4249, D4263, D4264, D4265, D4266, D4267, D4270, D4274, and D4275

One to three diseased teeth/periodontium per quadrant: D4211, D4231 D4241, D4261, D4342 Per tooth: D4212, D4268, D4273, D4276, D4277, D4278, D4381, D6101, D6102, D6103

Per implant: D6101, D6102, D6103

Surgical Services (including usual postoperative care)

GP A separate fee for all necessary postoperative care, finishing procedures (D1110, D1120, D4341, D4342, D4355, D4910), evaluations, or other surgical procedures (except soft tissue grafts) on the same date of service or for three months following the initial periodontal surgery by the same dentist/dental office is NOT BILLABLE TO PATIENT. In the absence of documentation of extraordinary circumstances, the fee for additional surgery or for any surgical re-entry (except soft tissue grafts) by the same dentist/dental office for three years is NOT BILLABLE TO PATIENT.

If extraordinary circumstances are present the benefits will be DENIED and are the patient's responsibility up to the approved amount for the surgery.

GP If periodontal surgery is performed less than six weeks after scaling and root planing, the fee for the surgical procedure or the scaling and root planing may be NOT BILLABLE TO PATIENT following consultant review.

GP Benefits for periodontal surgical services are available only when billed for natural teeth. Benefits for these procedures when billed in conjunction with implants, ridge augmentation, extraction sites (teeth), peradicular surgery, etc., are DENIED as a specialized or elective procedure.

GP Providing more than two D4245, D4265, D4266, D4267, D4268, D4270, D4273, D4275, D4276, D4277, D4278, D6101, D6102, or osseous grafts (D4263,D4264, D6103) within any given quadrant should be highly unusual and additional submissions will only be considered on a by-report basis. Requested fees for more than two sites (teeth) in a quadrant may be NOT BILLABLE TO PATIENT. When documentation of exceptional circumstances is submitted, benefits may be DENIED, unless covered, dependent on group contract language.

D4210 Gingivectomy or gingivoplasty — four or more contiguous teeth or tooth bounded spaces per quadrant.

D4211 Gingivectomy or gingivoplasty — one to three contiguous teeth or tooth bounded spaces per quadrant, A separate fee for gingivectomy or gingivoplasty — per tooth is NOT BILLABLE TO PATIENT when performed in conjunction with the preparation of a crown or other restoration by the same dentist/dental office. Only diseased teeth/periodontium, (see definition on page 69) are eligible for benefit consideration. Bounded tooth spaces are not counted as the procedure does not require a flap extension.

D4212 Gingivectomy or gingivoplasty — to allow access for restorative procedures — per tooth. A separate fee for any gingivectomy or gingivoplasty procedure — per tooth is NOT BILLABLE TO PATIENT when performed in conjunction with the preparation of a crown or other restoration by the same dentist/dental office.

D4230 Anatomical crown exposure — four or more contiguous teeth or bounded tooth spaces per quadrant.

D4231 Anatomical crown exposure — one to three teeth or bounded tooth spaces per quadrant.

Anatomical crown exposure is considered cosmetic in nature and therefore DENIED by group contracts that exclude cosmetic services.

D4240 Gingival flap procedure, including root planing — four or more contiguous teeth or tooth bounded spaces per quadrant

D4241 Gingival flap procedure, including root planing — one to three contiguous teeth, or tooth bounded spaces per quadrant.

Benefits are based upon, but not limited to, the most inclusive procedure. A tooth bounded space counts as one space irrespective of the number of teeth that would normally exist in the space. Only diseased teeth/periodontium are eligible for benefit consideration.

D4245 Apically positioned flap — Benefits are based upon, but not limited to, the most inclusive procedure. D4249 Clinical crown lengthening — hard tissue.

A separate fee for crown lengthening is NOT BILLABLE TO PATIENT when performed in conjunction with osseous surgery on the same teeth by the same dentist/dental office.

Crown lengthening is a benefit per site, not per tooth, and only when bone is removed and sufficient time is allowed for healing. Any fee for crown lengthening is NOT BILLABLE TO PATIENT when performed on the same date as crown preparation or restorations by the same dentist/ dental office without adequate documentation.

It is generally recommended that a minimum of six weeks be allowed for sufficient healing.

D4249 Clinical crown lengthening — hard tissue. This procedure is employed to allow a restorative procedure on a tooth with little or no tooth structure exposed to the oral cavity.

Crown lengthening requires reflection of a full thickness flap and removal of bone, altering the crown to root ratio. It is performed in a healthy periodontal environment, as opposed to osseous surgery, which is performed in the presence of periodontal disease.

A separate fee for crown lengthening is NOT BILLABLE TO PATIENT when performed in conjunction with osseous surgery on the same teeth by the same dentist/dental office Crown Lengthening is a benefit per site, not per tooth, and only when bone is removed and sufficient time is allowed for healing.

Any fee for crown lengthening is NOT BILLABLE TO PATIENT when performed on the same date as crown preparation or restorations by the same dentist/dental office without adequate documentation.

It is generally recommended that a minimum of six weeks be allowed for sufficient healing.

D4260 Osseous surgery (including elevation of a full thickness flap and closure) — four or more contiguous teeth or tooth bounded spaces per quadrant.

D4261 Osseous surgery (including elevation of a full thickness flap and closure) — one to three contiguous teeth, or tooth bounded spaces per quadrant.

No more than two quadrants of osseous surgery on the same date of service are benefited, in the absence of a narrative explaining exceptional circumstance.

For benefit purposes, the fee for osseous surgery includes crown lengthening, osseous contouring, distal or proximal wedge surgery, scaling and root planing, gingivectomy, frenectomy, frenuloplasty, debridements, periodontal maintenance, prophylaxis, anatomical crown exposure, surgical drainage and flap procedures. A separate fee for any of these procedures done on the same date, in the same surgical area by the same dentist/dental office, as D4260 is NOT BILLABLE TO PATIENT.

A separate benefit may be available for soft tissue grafts, bone replacement grafts, guided tissue regeneration, biologic materials with demonstrated efficacy in aiding periodontal tissue regeneration, exostosis removal, hemisection, extraction, apicoectomy, root amputations.

For dental benefit reporting purposes a quadrant is defined as four or more contiguous teeth and tooth bounded spaces per quadrant.

A tooth bounded space counts as one space irrespective of the number of teeth that would normally exist in the space.

Only diseased teeth/periodontium are eligible for benefit consideration.

D4263 Bone replacement graft — retained natural tooth — first site in quadrant.

D4264 Bone replacement graft — retained natural tooth — each additional site in quadrant
Benefits for bone grafting are available only when billed for natural teeth and performed for periodontal purposes.

When billed in conjunction with implants, ridge augmentations, extraction sites (teeth), periradicular surgery, etc., the fee for bone grafting is DENIED and the approved amount is collectable from the patient.

D4265 Biologic materials to aid in soft and osseous tissue regeneration
Biologic materials may be eligible for stand-alone benefits when reported with periodontal flap surgery and only when billed for natural teeth and performed for periodontal purposes.

Benefits for these procedures when billed in conjunction with implants, ridge augmentation, extraction sites (teeth), periradicular surgery, etc. are DENIED as a specialized or elective procedure.

When submitted with a D4263, D4264, D4267, D4270, D4273, D4275 or D4276 in the same surgical site, the fee for the D4265 is DENIED.

When a D4265 is submitted with an extraction or periradicular surgery, the D4265 is DENIED and the approved amount is collectable from the patient. If a D4265 is reported with D7950, D7951 or D7955 refer to medical.

D4266 Guided tissue regeneration — resorbable barrier, per site.

D4267 Guided tissue regeneration — nonresorbable barrier, per site, (includes membrane removal)
Benefits for GTR are DENIED in conjunction with soft tissue grafts in the same surgical area.

Benefits are available only when billed for natural teeth.

Benefits for these procedures when billed in conjunction with implants, ridge augmentation, extraction sites (teeth), periradicular surgery, etc., are DENIED and the approved amount collectible from the patient.

D4268 Surgical revision procedure, per tooth.
The fee for D4268 is considered a component of the surgical procedure and is NOT BILLABLE TO PATIENT.

If D4268 is performed by the same dentist/dental office within 36 months of previous periodontal surgery, the fee for the procedure is NOT BILLABLE TO PATIENT.

It may be eligible for consideration under dentist consultant review.

If D4268 is performed within the specified time limits by a different office/dentist, the contractual time limits would apply and the fee is DENIED and the approved amount is collectable from the patient.

D4270 Pedicle soft tissue graft procedure.
When multiple grafts are provided within a single quadrant, a maximum of two sites (teeth) are benefited. The fee for more than two sites (teeth) is not billable to patient.

D4273 Autogenous connective tissue graft procedure(including donor and recipient surgical site) first tooth, implant or endentualous tooth position. When multiple grafts are provided within a single quadrant, a maximum of two teeth are benefited. The fee for more than two sites (teeth) is not billable to patient.

D4274 Mesial/Distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area).

Distal wedge procedure is limited to the distal aspect of a periodontally affected tooth adjacent to an edentulous site. Based on pocket depths, benefits will be allowed as submitted for a D4274.

D4275 Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant or endentulous tooth position in graft. When multiple sites (teeth) are provided within a single quadrant, a maximum of two sites (teeth) are benefited. Benefits for frenulectomy (D7960) or frenuloplasty (D7963) are NOT BILLABLE TO PATIENT when performed in conjunction with D4275 or D4276.

D4276 Combined connective tissue and double pedicle graft per tooth
This procedure may be eligible for consideration in lieu of D4265, D4266, D4267, D4270, D4273, D4275, D4277 or D4278 under dentist consultant review based upon documentation of clinical conditions (Miller Class III).

When multiple teeth are grafted within a single quadrant, a maximum of two teeth are benefited.

Benefits for frenulectomy (D7960) or frenuloplasty (D7963) are NOT BILLABLE TO PATIENT when performed in conjunction with D4275 or D4276.

D4277 Free soft tissue graft procedure (including donor site surgery) — first tooth or edentulous tooth site in graft.

When multiple grafts are provided within a single quadrant, a maximum of two teeth are benefited.

D4278 Free soft tissue graft procedure (including donor site surgery) — each additional contiguous tooth position in same graft site.

When multiple grafts are provided within a single quadrant, a maximum of two teeth are benefited. The fee for more than two sites (teeth) is not billable to patient.

D4283 Autogenous connective tissue graft procedure (including donor and recipient surgical sites) each additional contiguous tooth, implant or endentulous tooth position in same graft site

D4285 Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) each additional contiguous tooth, implant or edentualous tooth position in same graft site.

Non-surgical periodontal services

D4320 Provisional splinting — intracoronal

D4321 Provisional splinting — extracoronal
The fee for splinting is DENIED and the approved amount is collectable from the patient.

D4341 Periodontal scaling and root planing — four or more sites (teeth) or spaces per quadrant

D4342 Periodontal scaling and root planing — one to three sites (teeth), per quadrant
There must be documentation of at least 4mm pocket depths on the diseased teeth/periodontium involved. In the absence of 4mm pockets, D4341 is processed as prophylaxis (D1110) and any fee in excess of the approved amount for D1110 is NOT BILLABLE TO PATIENT.

A tooth bounded space does not count for benefit consideration as the procedure does not require flap extension. Only diseased teeth/periodontium are eligible for benefit consideration.

In the absence of a contractual time limitation on frequency of benefits for D4341, any fee for retreatment performed by the same dentist within 24 months of initial therapy is NOT BILLABLE TO PATIENT.

Retreatment done by a different dentist within 24 months is DENIED and the approved amount is collectable from the patient.

A separate fee for prophylaxis (D1110) is NOT BILLABLE TO PATIENT when done during the same episode of treatment as D4341 by the same dentist/dental office.

For interim root planing, see D4910.

A separate fee for D4341 billed in conjunction with (30 days prior or 90 days following periodontal surgery procedures by the same dentist/dental office is NOT BILLABLE TO PATIENT as a component of the surgical procedure.

D4346 Scaling in presence of generalized moderate or severe gingival inflammation-full mouth, after oral evaluation.

Benefits for D4346 include prophylaxis, fees for D1110, D1120 or D4355 are NOT BILLABLE TO PATIENT when submitted with the D4346 by the same dentist/dental office.

Fees for D4346 are NOT BILLABLE TO PATIENT when submitted with D4910 by the same dentist/dental office.

D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis on subsequent visit. In absence of group contract language, the procedure is benefited once in a lifetime.
A D4355 may be benefited in order to do a proper evaluation and diagnosis if the patient has not been to the dentist in several years, and the dentist is unable to accomplish an effective prophylaxis under normal conditions.

D4381 Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth.

Localized delivery of chemotherapeutic agents is DENIED and the approved amount is collectable from the patient.

A D4381 may be a contractual benefit, for refractory cases by individual consideration.

When covered contractually, D4381 is subject to the following processing policies:

1. A D4381 may be benefited, subject to dental consultant review if the following conditions exist:

a. It is being performed six weeks to six months following initial therapy (scaling and root planing or periodontal surgery).

b. It is being performed for a patient of record on periodontal maintenance following initial therapy (scaling and root planing or periodontal surgery).

c. It is indicated for refractory cases for patients of record post planning or where refractory with no more than two sites per quadrant.

d. If either a or b are met, benefits are available for no more than two refractory sites (teeth) per quadrant with pocket depths of at least 5mm and less than 10 mm.

2. If different sites (teeth) are treated in the quadrant, within twelve months, benefits are DENIED and the approved amount is collectable from the patient.

3. If the same sites (teeth) are re-treated within 24 months, benefits are DENIED and the approved amount is collectable from the patient.

4. Teeth must have five to ten millimeter pocketing to be eligible for benefits. If less than five millimeters pocketing, benefits are DENIED and the approved amount is collectable from the patient.

5. Benefits are provided for up to two sites (teeth) per quadrant. If three or more sites (teeth) are submitted, the entire case may be DENIED and the approved amount is collectable from the patient.

6. When submissions are requested outside time parameters, benefits are DENIED and the approved amount is collectable from the patient.

Other Periodontal Services

D4910 Periodontal maintenance.
Benefits for D4910 include prophylaxis and site specific scaling and root planing procedures. Separate fees for these procedures by the same dentist/dental office are

NOT BILLABLE TO PATIENT when billed in conjunction with periodontal maintenance (D4910).

The fee for a separate evaluation is eligible for benefit consideration based on group contract.

If a D0180 is submitted with a D4910 it is benefited as a D0120 and the difference in the approved amount between the D0120 and the D0180 is NOT BILLABLE TO PATIENT unless the D0180 is the initial evaluation by the dentist rendering the D4910.

A separate feel for all necessary postoperative care, finishing procedures (D1110, D1120, D4341, D4342, D4355, D4910), evaluations, or other surgical procedures (except soft tissue grafts) on the same date of service or for three months following the initial periodontal surgery by the same dentist/dental office is NOT BILLABLE TO PATIENT.

D4920 Unscheduled dressing change (by someone other than the treating dentist).
The definition of the same dentist includes providers in the same dental office. A fee for dressing change submitted by a doctor of the same office is NOT BILLABLE TO PATIENT within thirty days following the surgical procedure.

D4999 Unspecified periodontal procedure, by report

PROSTHODONTICS (REMOVABLE) D5000 - D5899

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

GP Characterizations, staining, overdentures, or metal bases are considered specialized techniques or procedures. An alternate benefit allowance is made for a conventional denture. Any fee charged in excess of the allowance for conventional denture is DENIED and the difference between the allowance for the conventional denture and the approved amount for the procedure performed is collectable from the patient.

GP The fees for full or partial dentures include any reline/rebase, adjustment or repair required within six (6) months of delivery by the same dentist/dental office, except in the case of immediate dentures. Except in the case of immediate dentures, the fees for these services by the same dentist/dental office are NOT BILLABLE TO PATIENT.

GP Benefits may be DENIED and the approved amount is collectable from the patient if repair or replacement within contractual time limitations is the patient's fault.

GP The fees for restorations for altering occlusion, involving vertical dimension, treating TMD, replacing tooth structure lost by attrition, erosion, abrasion (wear), abfraction, corrosion or for periodontal, orthodontic or other splinting are DENIED and the approved amount is collectable from the patient.

GP The fees for cast or indirectly fabricated restorations and prosthetic procedures include all models, temporaries and other associated procedures. Any fees charged for these procedures in excess of the approved amounts for the cast or indirectly fabricated restorations or prosthetic procedures by the same dentist/dental office are NOT BILLABLE TO PATIENT.

GP Multistage procedures are reported and benefited upon completion. The completion date is the date of insertion for removable prosthetic appliances. The completion date for immediate dentures is the date that the remaining teeth are removed and the denture is inserted. The completion date for fixed partial dentures and crowns, onlays, and inlays is the cementation date regardless of the type of cement utilized.

Complete Dentures (including routine post-delivery care)

D5110 Complete denture, maxillary

D5120 Complete denture, mandibular

D5130 Immediate denture, maxillary

D5140 Immediate denture, mandibular

Partial Dentures (including routine post-delivery care)

GP A posterior fixed bridge and a removable partial denture are not a benefit in the same arch within a five year period. An allowance for a removable partial denture is made and any fee charged in excess of the allowance is DENIED and the approved amount is collectable from the patient.

GP The fees for fixed bridges or removable cast partials are DENIED and the approved amount is collectable from the patient, for patients under age 16.

D5211 Maxillary partial denture — resin base (including, retentive/clasping materials, rests and teeth).

D5212 Mandibular partial denture — resin base (including, retentive/clasping materials, rests and teeth).

D5213 Maxillary partial denture — cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth).

D5214 Mandibular partial denture — cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth).

D5221 Immediate maxillary partial denture — resin base (including retentive/clasping materials, rests and teeth).

D5222 Immediate mandibular partial denture — resin base (including retentive/clasping materials, rests and teeth).

D5223 Immediate maxillary partial denture — cast metal framework with resin denture base (including retentive/clasping materials, rests and teeth).

D5224 Immediate mandibular partial denture — cast metal framework with resin denture base (including retentive/clasping materials, rests and pins).

D5225 Maxillary partial denture — flexible base (including any clasps, rests, and teeth).

D5226 Mandibular partial denture — flexible base (including any clasps, rests, and teeth).

D5282 Removable unilateral partial denture — one piece cast metal (including clasps and teeth), maxillary

D5283 Removable unilateral partial denture — one piece cast metal (including clasps and teeth), mandibular

Adjustments to Dentures

GP The fees for full or partial dentures include any adjustments or repairs required within six months of delivery, except in the case of immediate dentures. If performed by the same dentist/dental office within six (6) months of initial placement, fees for adjustments or repairs are NOT BILLABLE TO PATIENT.

GP The fees for adjustments to complete or partial dentures are limited to two adjustments per denture per twelve months (after six (6) months has elapsed since initial placement). More frequent adjustments are DENIED and the approved amount is collectable from the patient.

D5410 Adjust complete denture — maxillary

D5411 Adjust complete denture — mandibular

D5421 Adjust partial denture — maxillary

D5422 Adjust partial denture — mandibular repairs to complete denture

GP The fee for the repair of a complete denture cannot exceed one-half of the fee for a new appliance, and any excess fee by the same dentist/dental office is NOT BILLABLE TO PATIENT.

GP The fees for full or partial dentures include any adjustments or repairs required within six months of delivery, except in the case of immediate dentures.

If performed by the same dentist/dental office within six months of initial placement, fees for adjustments or repairs are NOT BILLABLE TO PATIENT.

D5511 Repair broken complete denture base, mandibular. Fees for repairs of complete dentures, if performed within six months of initial placement by the same dentist/dental office are NOT BILLABLE TO PATIENT.

D5512 Repair broken complete denture base, maxillary. Fees for repairs of complete dentures, if performed within six months of initial placement by the same dentist/dental office are NOT BILLABLE TO PATIENT.

Repairs to Partial Dentures

GP The fee for the repair of a partial denture cannot exceed one-half of the fee for a new appliance, and any excess fee by the same dentist/dental office is NOT BILLABLE TO PATIENT.

GP The fees for full or partial dentures include any adjustments or repairs required within six months of delivery, except in the case of immediate dentures.

If performed by the same dentist/dental office within six months of initial placement, fees for the adjustments or repairs are NOT BILLABLE TO PATIENT.

D5611 Repair resin partial denture base, mandibular. Fees for repairs of resin partial dentures, if performed within six months of initial placement by the same dentist/dental office are NOT BILLABLE TO PATIENT.

D5612 Repair resin partial denture base, maxillary. Fees for repairs of complete dentures, if performed within six months of initial placement by the same dentist/dental office are NOT BILLABLE TO PATIENT.

D5621 Repair cast partial framework, mandibular. Fees for repairs of cast partial dentures, if performed within six months of initial placement by the same dentist/dental office are NOT BILLABLE TO PATIENT.

D5622 Repair cast partial framework, maxillary. Fees for repairs of cast partial dentures, if performed within six months of initial placement by the same dentist/dental office are NOT BILLABLE TO PATIENT.

D5630 Repair or replace broken retentive clasping materials, per tooth

D5640 Replace broken teeth, per tooth

D5650 Add tooth to existing partial denture

D5660 Add clasp to existing partial denture, per tooth

D5670 Replace all teeth and acrylic on cast metal framework (maxillary)

D5671 Replace all teeth and acrylic on cast metal framework (mandibular).
The fee for a D5670 or D5671 cannot exceed two- thirds of the fee for a new appliance, and any excess fee by the same dentist/dental office is NOT BILLABLE TO PATIENT.

Denture Rebase Procedures

GP The fee for the rebase includes the fee for relining.
When the fee for a reline performed in conjunction with rebase (within six months of) by the same dentist/dental office the fee for the reline is NOT BILLABLE TO PATIENT.

GP The fee for a rebase includes adjustments required within six months of delivery.
A fee for an adjustment performed within six months of a reline or rebase by the same dentist/dental office is NOT BILLABLE TO PATIENT.

D5710 Rebase complete maxillary denture D5711 Rebase complete mandibular denture.

D5720 Rebase maxillary partial denture D5721 Rebase mandibular partial denture.

Denture Reline Procedures

GP The fee for a reline includes adjustments required within six (6) months of delivery. A fee for an adjustment billed within six (6) months of a reline by the same dentist/dental office is NOT BILLABLE TO PATIENT.

GP The fee for the rebase includes the fee for relining.
The fee for a reline performed in conjunction with (within six (6) months of) a rebase by the same dentist/dental office is NOT BILLABLE TO PATIENT.

D5730 Reline complete maxillary denture (chairside)

D5731 Reline complete mandibular denture (chairside)

D5740 Reline maxillary partial denture (chairside)

D5741 Reline mandibular partial denture (chairside)

D5750 Reline complete maxillary denture (laboratory)

D5751 Reline complete mandibular denture (laboratory)

D5760 Reline maxillary partial denture (laboratory)

D5761 Reline mandibular partial denture (laboratory) Interim Prosthesis

D5810 Interim complete denture (maxillary)

D5811 Interim complete denture (mandibular).
The fees for interim complete dentures are DENIED and the approved amount is collectable from the patient.

D5820 Interim partial denture (maxillary)

D5821 Interim partial denture (mandibular).
An interim partial denture is a benefit only in children age 16 or under for missing anterior permanent teeth.

If submitted for any other reasons, the fees for D5820 and D5821 are DENIED and the approved amount is collectable from the patient.

Other Removable Prosthetic Services

D5850 Tissue conditioning, maxillary

D5851 Tissue conditioning, mandibular
A separate fee for tissue conditioning is NOT BILLABLE TO PATIENT if performed by the same dentist/dental office on the same day the denture is delivered or a reline/rebase is provided.

Tissue conditioning is not a benefit more than twice per denture unit per thirty-six months, and the fee for tissue conditioning is DENIED and the approved amount is collectable from the patient if done more frequently.

D5860 Overdenture — complete, by report

D5861 Overdenture — partial, by report
An overdenture is considered a specialized procedure and is not a benefit.

Any fee charged in excess of the allowance is DENIED and the approved amount is collectable from the patient up to the approved amount for the overdenture.

D5862 Precision attachment, by report
Precision attachments are considered a specialized elective procedure.

The fee for a precision attachment is DENIED and the approved amount for the precision attachment is collectable from the patient.

D5867 Replacement of replaceable part of semi-precision or precision attachment (male or female component).

Precision attachments are considered a specialized elective procedure. The fee for this procedure (D5867) is DENIED, and the approved amount for D5867 is collectable from the patient.

D5875 Modification of a removable prosthesis following implant surgery
The fees for implant services for most groups are DENIED.

This procedure is considered a specialized technique.

The approved amount for the D5875 is collectable from the patient unless contract specifies that implants are a benefit.

The fees for implant services are DENIED, and the approved amount is collectable from the patient.

D5876 Add metal substructure to acrylic full denture (per arch).
Non-invasive TMD physical therapies are DENIED unless covered by group/individual contract. If covered by group/individual contract, benefit once every twelve (12) months.

D5899 Unspecified removable prosthodontic procedure, by report

MAXILLOFACIAL PROSTHETICS D5900 - D5999

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GP The fees for maxillofacial prosthetics are DENIED and the approved amount is collectable from the patient unless the group contract specifies that maxillofacial prosthetics are a benefit.

D5911 Facial moulage (sectional)

D5912 Facial moulage (complete)

D5913 Nasal prosthesis

D5914 Auricular prosthesis

D5915 Orbital prosthesis

D5916 Ocular prosthesis

D5919 Facial prosthesis

D5922 Nasal septal prosthesis

D5923 Ocular prosthesis, interim

D5924 Cranial prosthesis

D5925 Facial augmentation implant prosthesis

D5926 Nasal prosthesis, replacement

D5927 Auricular prosthesis, replacement

D5928 Orbital prosthesis, replacement

D5929 Facial prosthesis, replacement

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

D5992 Adjust maxillofacial prosthetic appliance, by report

D5993 Maintenance and cleaning of a maxillofacial prosthesis (extra or intraoral) other than required adjustments, by report

D5999 Unspecified maxillofacial prosthesis, by report

IMPLANT SERVICES D6000 – D6199 IMPLANT SERVICES

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GP Unless the group contract specifies implants are covered, the fees for implant services are DENIED and the approved amount is collectable from the patient.

GP When benefited, implant time limitations are established by contract GP When benefited, the surgical procedure includes the dental implant.

D6010 Surgical placement of implant body: endosteal implant

D6012 Surgical placements of interim implant body for transitional prosthesis: endosteal implant Benefits are DENIED and the approved amount is collectible from the patient.

This procedure is considered part of the transitional prosthesis, which is not a covered benefit.

D6040 Surgical placement: eposteal implant

D6050 Surgical placement: transosteal implant Implant

Supported Prosthetics

GP Where benefited by contract, fees for the placement of an implant to natural tooth bridge are NOT BILLABLE TO PATIENT. Special consideration may be given by report particularly where there is documentation of semi-ridged fixation between the tooth and implant and where other risk factors are not present.

D6051 Interim abutment

D6055 Connecting bar — implant supported or abutment supported

D6056 Prefabricated abutment — includes modification and placement
Benefits for a D6056 are DENIED as a specialized procedure and the approved amount is collectable from the patient unless implants are covered by contract.

D6057 Custom fabricated abutment — includes placement
Benefits for a D6057 are DENIED as a specialized procedure and the approved amount is collectable from the patient unless implants are covered by contract.

D6058 Abutment supported porcelain/ceramic crown

D6059 Abutment supported porcelain fused to metal crown (high noble metal)

D6060 Abutment supported porcelain fused to metal crown (predominantly base metal)

D6061 Abutment supported porcelain fused to metal crown (noble metal)

D6062 Abutment supported cast metal crown (high noble metal)

D6063 Abutment supported cast metal crown (predominantly base metal)

D6064 Abutment supported cast metal crown (noble metal)

D6065 Implant supported porcelain/ceramic crown

D6066 Implant supported porcelain fused to metal crown (high noble alloys)

D6067 Implant supported metal crown (high noble alloys)

D6068 Abutment supported retainer for porcelain/ceramic FPD

D6069 Abutment supported retainer for porcelain fused to metal FPD (high noble metal)

D6070 Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)

D6071 Abutment supported retainer for porcelain fused to metal FPD (noble metal)

D6072 Abutment supported retainer for cast metal FPD (high noble metal)

D6073 Abutment supported retainer for cast metal FPD (predominantly base metal)

D6074 Abutment supported retainer for cast metal FPD (noble metal)

D6075 Implant supported retainer for ceramic FPD

D6076 Implant supported retainer for porcelain fused to metal FPD (high noble alloys)

D6077 Implant supported retainer for cast metal FPD (high noble alloys)

Other Implant Services

D6080 Implant maintenance procedures, including: removal of prosthesis, cleansing of prosthesis and abutments, reinsertion of prosthesis.

D6081 Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure.

Benefits for D6081 are DENIED unless implants are covered by the group/individual contract.

Fees for D6081 are NOT BILLABLE TO PATIENT when performed in the same quadrant by the same dentist/dental office as D4341/D4342 or D4240/D4241, D4260/D4261 or D6101/D6102.

Fees for D6081 are NOT BILLABLE TO PATIENT when performed within 12 months of restoration (D6058-D6094) placement by same dentist/dental office.

Fees for D6081 are NOT BILLABLE TO PATIENT when performed in conjunction with D1110, D4346 or D4910.

D6085 Provisional implant crown
Temporary or provisional fixed prostheses by the same dentist/dental office are not separate benefits and should be included in the fee for the permanent prosthesis. Fees for provisional crown are NOT BILLABLE TO PATIENT upon submission.

D6090 Repair implant supported prosthesis, by report

D6091 Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment.

Benefits are DENIED as a specialized procedure unless the contract specifies that implant procedures are covered benefits.

D6092 Re-cement or re-bond implant/abutment supported crown
Fee for the recementation of crowns are NOT BILLABLE TO PATIENT if done within six (6) months of the initial seating date by the same dentist/dental office.

Benefits may be paid for one recementation after six (6) months have elapsed since the initial placement.

Subsequent requests for recementation by the same dentist are DENIED.

Benefits may be paid when billed by a dentist other than the one who seated the crown or performed the previous recementation.

D6093 Re-cement or re-bond implant/abutment supported fixed partial denture
Fee for recementation for fixed partial dentures are NOT BILLABLE TO PATIENT if done within six months of the initial seating date by the same dentist/dental office.

Benefits may be paid for one recementation after six months have elapsed since the initial placement.

Subsequent requests for recementation by the same dentist are DENIED.

Benefits may be paid when billed by a dentist other than the one who seated the crown or performed the previous recementation.

D6094 Abutment supported crown (titanium alloys)

D6095 Repair implant abutment, by report

D6096 Remove broken implant retaining screw. Benefits are DENIED unless implants are covered by group/individual contract.

D6100 Implant removal, by report

D6101 Debridement of a peri-implant defect or defects surrounding a single implant, and surface cleaning of the exposed implant surfaces, including flap and closure.

GP This procedure is NOT BILLABLE TO PATIENT when performed in the same surgical site by the same dentist/dental office on the same day as D6102.

D6102 Debridement and osseous contouring of a peri-implant defect or defects surrounding a single implant and includes surface cleaning of the exposed implant surfaces, including flap entry and closure.

GP Bone graft for repair of peri-implant defect or at time of implant placement procedures are by report and are subject to coverage available under the medical plan.

Benefit for these procedures when billed in conjunction with implants, implant removal, ridge augmentation or preservation, in extraction site, periradicular surgery, etc. are DENIED.

GP In conjunction with D4260 or D4261, this procedure is NOT BILLABLE TO PATIENT when billed separately.

D6103 Bone graft for repair of peri-implant defect — does not include flap entry and closure. Placement of a barrier membrane or biologic materials to aid in osseous regeneration are reported separately.

GP All procedures are by report and are subject to coverage available under the medical plan. Benefits for these procedures when billed in conjunction with implants, implant removal, ridge augmentation or preservation in extraction sites, periradicular surgery are DENIED. Sufficient longitudinal study data on outcomes is not available.

D6104 Bone graft at time of implant placement

GP All procedures are by report and are subject to coverage available under the medical plan. Benefits for these procedures when billed in conjunction with implants, implant removal, ridge augmentation or preservation in extraction sites, periradicular surgery are DENIED.

D6110 Implant/abutment supported removable denture for edentulous arch — maxillary. Benefit is based on the accepted fee for D5110 (upper) or D5120 (lower). Any additional fee up to the approved amount for the D6110 is DENIED and is chargeable to the patient.

D6111 Implant/abutment supported removable denture for edentulous arch — mandibular. Benefit is based on the accepted fee for D5110 (upper) or D5120 (lower).

Any additional fee up to the approved amount for the D6111 is DENIED and is chargeable to the patient.

D6112 Implant/abutment supported removable denture for partially edentulous arch — maxillary. Benefit is based on the accepted fee for D5213 (upper) or D5214 (lower).

Any additional fee up to the approved amount for the D6112 is DENIED and is chargeable to the patient.

D6113 Implant/abutment supported removable denture for partially edentulous arch — mandibular. Benefit is based on the accepted fee for D5213 (upper) or D5214 (lower).

Any additional fee up to the approved amount for the D6112 is DENIED and is chargeable to the patient.

D6114 Implant/abutment supported fixed denture for edentulous arch — maxillary. Benefit is based on the accepted fee for D5110 (upper) or D5120 (lower).

Any additional fee up to the approved amount for the D6114 is DENIED and is chargeable to the patient.

D6115 Implant/abutment supported fixed denture for edentulous arch — mandibular. Benefit is based on the accepted fee for D5110 (upper) or D5120 (lower).

Any additional fee up to the approved amount for the D6115 is DENIED and is chargeable to the patient.

D6116 Implant/abutment supported fixed denture for partially edentulous arch — maxillary. Benefit is based on the accepted fee for D5213 (upper) or D5214 (lower).

Any additional fee up to the approved amount for the D6116 is DENIED and is chargeable to the patient.

D6117 Implant/abutment supported fixed denture for partially edentulous arch — mandibular. Benefit is based on the accepted fee for D5213 (upper) or D5214 (lower).

Any additional fee up to the approved amount for the D6117 is DENIED and is chargeable to the patient.

D6118 Implant/abutment supported interim fixed denture for edentulous arch — mandibular. Benefits for implant/abutment supported interim fixed denture for edentulous arch — mandibular are DENIED.

D6119 Implant/abutment supported interim fixed denture for edentulous arch — maxillary. Benefits for implant/abutment supported interim fixed denture for edentulous arch — maxillary are DENIED.

D6190 Radiographic/surgical implant index, by report Benefits are DENIED as a specialized procedure.

D6194 Abutment supported retainer crown for FPD (titanium alloys)

D6199 Unspecified implant procedure, by report

PROSTHODONTICS, FIXED D6200 - D6999

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GP Fixed prosthodontics are subject to contractual time limits.

GP Benefits will be based on the number of pontics necessary for the space, not to exceed the normal complement of teeth.

GP A posterior fixed bridge and a removable partial denture are not benefits in the same arch within the group contract limitation. An allowance for a removable partial denture is made and any fee charged in excess of the allowance is DENIED and the approved amount is collectable from the patient.

GP The fees for cast or indirectly fabricated restorations and prosthetic procedures include all models, temporaries, laboratory charges and materials, and other associated procedures. Any fees charged for these procedures by the same dentist/dental office in excess of the approved amounts for the cast or indirectly fabricated restorations or prosthetic procedures are NOT BILLABLE TO PATIENT.

GP The fees for fixed prosthodontics are DENIED and the approved amount is collectable from the patient for children under 16 years of age.

GP Cementation date is the delivery date. The type of cement used is not a determining factor (whether permanent or temporary).

GP The fees for restorations for altering occlusion, involving vertical dimension, treating TMD, replacing tooth structure lost by attrition, erosion, abrasion (wear), abfraction, corrosion or for periodontal, orthodontic or other splinting are DENIED and the approved amount is collectable from the patient.

GP Multistage procedures are reported and benefited upon completion.
The completion date is the date of insertion for removable prosthetic appliances.

The completion date for fixed partial dentures and crowns, onlays, and inlays is the cementation date regardless of the type of cement utilized.

GP An allowance of a conventional fixed prosthesis is provided for porcelain/ceramic or resin bridges.

The difference between the allowance for the conventional fixed prosthesis and the approved amount for the porcelain/ceramic or resin bridge is collectable from the patient.

Fixed Partial Denture Pontics

D6205 Pontic-indirect resin-based composite.
Benefits will be considered for a conventional fixed prosthesis.

The difference between the allowance for the conventional prosthesis and the approved amount for the D6205 is DENIED and collectable from the patient.

D6210 Pontic-cast high noble metal

D6211 Pontic-cast predominantly base metal

D6212 Pontic-cast noble metal

D6214 Pontic-titanium or titanium alloys

D6240 Pontic-porcelain fused to high noble metal

D6241 Pontic-porcelain fused to predominantly base metal

D6242 Pontic-porcelain fused to noble metal

D6245 Pontic-porcelain/ceramic.
Benefits will be considered for a conventional fixed prosthesis.

The difference between the allowance for the conventional prosthesis and the approved amount for the D6245 is DENIED and collectable from the patient.

D6250 Pontic-resin with high noble metal

D6251 Pontic-resin with predominantly base metal

D6252 Pontic-resin with noble metal

D6253 Provisional pontic
Temporary and provisional fixed prostheses are not separate benefits and are included in the fee for the permanent prostheses.

The fees for the temporary fixed prostheses by the same dentist/dental office are NOT BILLABLE TO PATIENT.

Fixed Partial Denture Retainers — Inlays/Onlays

D6545 Retainer — cast metal for resin bonded fixed prosthesis

D6548 Retainer — porcelain/ceramic for resin bonded fixed prosthesis.
Benefits will be considered for a conventional fixed prosthesis.

The difference between the allowance for the conventional prosthesis and the approved amount for the D6548 is DENIED and collectable from the patient.

D6549 Resin retainer — for resin bonded fixed prosthesis

D6600 Inlay — porcelain/ceramic, two surfaces.
Benefits will be considered for a conventional fixed prosthesis.

The difference between the allowance for the conventional prosthesis and the approved amount for the D6600 is DENIED and collectable from the patient.

D6601 Inlay — porcelain/ceramic, three or more surfaces.
Benefits will be considered for a conventional fixed prosthesis.

The difference between the allowance for the conventional prosthesis and the approved amount for the D6601 is DENIED and collectable from the patient.

D6602 Inlay — cast high noble metal, two surfaces

D6603 Inlay — cast high noble metal, three or more surfaces

D6604 Inlay — cast predominantly base metal, two surfaces

D6605 Inlay — cast predominantly 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.
Benefits will be considered for a conventional fixed prosthesis.

The difference between the allowance for the conventional prosthesis and the approved amount for the D6608 is DENIED and collectable from the patient.

D6609 Onlay — porcelain/ceramic, three or more surfaces.
Benefits will be considered for a conventional fixed prosthesis.

The difference between the allowance for the conventional prosthesis and the approved amount for the D6609 is DENIED and collectable from the patient.

D6610 Onlay — cast high noble metal, two surfaces

D6611 Onlay — cast high noble metal, three or more surfaces

D6612 Onlay — cast predominantly base metal, two surfaces

D6613 Onlay — cast predominantly base metal, three or more surfaces

D6614 Onlay — cast noble metal, two surfaces

D6615 Onlay — cast noble metal, three or more surfaces

D6624 Inlay — titanium

D6634 Onlay — titanium

Fixed Partial Denture Retainers-Crowns

D6710 Crown — indirect resin based composite.
An alternate benefit will be allowed for a D6721.

The difference between the allowance and the approved amount for the D6710 is DENIED and collectable from the patient.

D6720 Crown — resin with high noble metal

D6721 Crown — resin with predominantly base metal

D6722 Crown — resin with noble metal

D6740 Crown — porcelain/ceramic.
Benefits will be considered for a conventional fixed prosthesis (D6721).

The difference between the allowance for the conventional prosthesis and the approved amount for the D6740 is DENIED and collectable from the patient.

D6750 Crown — porcelain fused to high noble metal

D6751 Crown — porcelain fused to predominantly base metal

D6752 Crown — porcelain fused to noble metal

D6780 Crown — ¾ cast high noble metal

D6781 Crown — ¾ cast predominantly base metal D6782 Crown- ¾ cast noble metal

D6783 Crown — ¾ porcelain/ceramic.
Benefits will be considered for a conventional fixed prosthesis.

The difference between the allowance for the conventional prosthesis and the approved amount for the D6783 is DENIED and collectable from the patient.

D6790 Crown — full cast high-noble metal

D6791 Crown — full cast predominantly-base metal

D6792 Crown — full cast noble metal

D6793 Provisional retainer crown.
Temporary fixed prostheses are not separate benefits and are included in the fee for the permanent prostheses.

The fees for the temporary fixed prostheses by the same dentist/dental office are NOT BILLABLE TO PATIENT.

D6794 Crown — titanium or titanium alloys.
Other Fixed Partial Denture Services

D6920 Connector bar.
The fee for a connector bar is DENIED as a specialized technique and the approved amount is collectable from the patient.

D6930 Re-cement or re-bond fixed partial denture.

Delta Dental member companies consider the cementation date to be that date upon which the completed bridge is first delivered to the mouth.

The type of cement used is not a determining factor (whether permanent or temporary).

Fees for recementation of inlays, onlays, crowns, and fixed partial dentures are NOT BILLABLE TO PATIENT if done within six months of the initial seating date by the same dentist or dental office.

Benefits may be paid for one recementation after six months have elapsed since initial placement. Subsequent requests for recementation by the same provider are DENIED and the approved amount is collectable from the patient.

Benefits may be paid when billed by a provider other than the one who seated the bridge or performed the previous recementation.

D6940 Stress breaker.

The fee for a stress breaker is DENIED as a specialized technique and the approved amount for the stress breaker is collectable from the patient.

D6950 Precision attachment

The fee for a precision attachment is DENIED as a specialized technique and the approved amount for the precision attachment is collectable from the patient.

D6980 Fixed partial denture repair necessitated by restorative material failure

The fee for the repair of a fixed partial denture cannot exceed one-half of the fee for a new appliance, and any fee charged in excess of the allowance by the same dentist/dental office is NOT BILLABLE TO PATIENT.

D6985 Pediatric partial denture, fixed.

The fee for a pediatric partial denture, fixed is DENIED as a cosmetic procedure and the approved amount is collectable from the patient.

D6999 Unspecified fixed prosthodontic procedure, by report

ORAL AND MAXILLOFACIAL SURGERY D7000 - D7999

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GP The fee for all oral and maxillofacial surgery includes local anesthesia, suturing if needed, and routine postoperative care, including treatment of dry sockets. Separate fees for these procedures when performed in conjunction with oral and maxillofacial surgery are NOT BILLABLE TO PATIENT. If performed by another dentist these procedures are DENIED and the approved amount is collectable from the patient.

GP Fees for exploratory surgery or unsuccessful attempts at extractions are NOT BILLABLE TO PATIENT.

GP Impaction codes are based on the anatomical position of the tooth, rather than the surgical procedure necessary for removal.

GP The fees for biopsy (D7285, D7286), frenulectomy (D7960), frenuloplasty (D7963) and excision of hard and soft tissue lesions (D7210, D7411, D7450, D7451) are NOT BILLABLE TO PATIENT when the procedure is performed on the same day, same surgical site/area, by the same dentist/dental office and any other surgical procedure. Requests for individual consideration can always be submitted by report for dental consultant review.

GP By report and subject to coverage under medical: When a procedure is by report and subject to coverage under medical, it should be submitted to the patient's medical carrier first. When submitting to Delta Dental, a copy of the explanation of payment or payment voucher from the medical carrier should be included with the claim, plus a narrative describing the procedure performed, reasons for performing the procedure, pathology report if appropriate, and any other information deemed pertinent. In the absence of such information, the procedure will not be benefited by Delta Dental.

Extractions (includes local anesthesia, suturing if needed, and routine postoperative care).

D7111 Extraction, coronal remnants — primary tooth. D7111 is considered part of any other primary surgery in the same surgical area on the same date and the fee is NOT BILLABLE TO PATIENT if performed by the same dentist/dental office.

D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal). Surgical Extractions (includes local anesthesia, suturing if needed, and routine postoperative care).

D7210 Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth and including elevation of mucoperiosteal flap if indicated.

D7220 Removal of impacted tooth — soft tissue D7230 Removal of impacted tooth — partially bony.

D7240 Removal of impacted tooth — completely bony

D7241 Removal of impacted tooth — completely bony, with unusual surgical complications

D7250 Removal of residual tooth roots (cutting procedure). Includes cutting of soft tissue and bone, removal of tooth structure and closure.

The fee for root recovery is NOT BILLABLE TO PATIENT if submitted in conjunction with a surgical extraction (in the same surgical area) by the same dentist/dental office.

D7251 Coronectomy — intentional partial tooth removal.
Depending on the group coverage, coronectomy may be benefited under individual consideration and only for documented probable neurovascular complications as proximity to mental foramen, inferior alveolar nerve, sinus, etc.

OTHER SURGICAL PROCEDURES

D7260 Oroantral fistula closure

D7261 Primary closure of a sinus perforation

D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth

D7270 Includes anesthesia, suturing, postoperative care and removal of the splint by the same dentist/dental office.

D7272 Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization).

The fee for tooth transplantation is DENIED and the approved amount is collectable from the patient.

D7280 Exposure of an unerupted tooth

D7280 May be considered under orthodontic benefits by dental consultant review.

D7282 Mobilization of erupted or malpositioned teeth to aid eruption.
The fee for D7282 is NOT BILLABLE TO PATIENT when performed by the same dentist/dental office in conjunction with other surgery in immediate area.

D7283 Placement of device to facilitate eruption of impacted tooth.

D7285 Incisional biopsy of oral tissue — hard (bone, tooth) D7286 Biopsy of oral tissue — soft (all others).

A fee for biopsy of oral tissue is NOT BILLABLE TO PATIENT if not submitted with a pathology report.

The fee for biopsy of oral tissue is NOT BILLABLE TO PATIENT as included in the fee for a surgical procedure (e.g. apicoectomy, extractions, etc.) when performed by the same dentist/dental office in the same surgical area and on the same date of service.

Biopsy of oral tissue is only benefited for oral structures.

D7286 Incisional biopsy of oral tissue — soft

D7287 Exfoliative cytological sample collection.
By report and subject to coverage under the medical plan.

D7288 Brush biopsy — transepithelial sample collection.
By report and subject to coverage under the medical plan. If covered under dental, the following guidelines should be considered regarding the lesion being biopsied:

1. Erythroplakia (red), leukoplakia (white) or mixed erythroleukoplakia lesion(s) which has not resolved or displayed clinical signs of resolving over a two-week observational period.

2. Ulceration which has not resolved or displayed signs of resolving over a two-week observational period.

3. Tobacco use at a rate of one or more pack(s) of cigarettes per day or an aggregate history of 20 pack years.

4. Use of smokeless tobacco, pipes or cigars.

5. Alcohol use greater than three drinks per day over a one-year period.

D7290 Surgical repositioning of teeth

D7291 Transseptal fiberotomy, supra crestal fiberotomy by report

D7292 Placement of temporary anchorage device: (screw retained plate) requiring flap; includes device removal.

Benefits are DENIED as a specialized technique and the approved fee is chargeable to the patient.

D7293 Placement of temporary anchorage device requiring flap; includes device removal.
Benefits are DENIED as a specialized technique and the approved fee is chargeable to the patient.

D7294 Placement of temporary anchorage device without flap; includes device removal.
Benefits are DENIED as a specialized technique and the approved fee is chargeable to the patient.

If the group contract includes orthognathic surgery, these procedures are included in the surgery.

D7295 Harvest of bone for use in autogenous grafting procedure

D7296 Corticotomy — one to three teeth or tooth spaces, per quadrant. Benefits for corticotomy procedures are DENIED as a specialized procedure.

D7297 Corticotomy four or more teeth or tooth spaces, per quadrant. Benefits for corticotomy procedures are DENIED as a specialized procedure.

D7979 Non-surgical sialolithotomy

Alveoloplasty-Surgical Preparation of Ridge for Dentures

GP A quadrant for oral surgery purposes is defined as four or more contiguous teeth and/or teeth spaces distal to the midline.

D7310 Alveoloplasty in conjunction with extractions — four or more teeth or tooth spaces per quadrant.

The fee for D7310 performed by the same dentist/dental office in the same surgical area on the same date of service as surgical extractions (D7210-D7230) is NOT BILLABLE TO PATIENT.

D7311 Alveoloplasty in conjunction with extractions — one to three teeth or tooth spaces per quadrant.

The fee for D7311 performed by the same dentist/dental office in the same surgical area on the same date of service as surgical extractions (D7210-D7230) is NOT BILLABLE TO PATIENT.

Count tooth bounded spaces for D7311 partial quadrant code.

D7320 Alveoloplasty not in conjunction with extractions — four or more teeth or tooth spaces per quadrant.

D7321 Alveoloplasty not in conjunction with extractions — one to three teeth or tooth spaces per quadrant.

Count tooth bounded spaces for D7321 partial quadrant code.

Vestibuloplasty

GP All procedures are by report and subject to coverage under the medical plan.

D7340 Vestibuloplasty — ridge extension (secondary epithelialization)

D7350 Vestibuloplasty — ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)

Surgical Excision of Soft Tissue Lesions

GP All procedures are by report and subject to coverage under the medical plan.

GP The fee for D7410 and D7411 is NOT BILLABLE TO PATIENT as included in the fee for another surgery performed in the same area of the mouth on the same day by the same dentist/dental office.

GP Pathology laboratory report is required. If no report is submitted, the fee for the procedure is NOT BILLABLE TO PATIENT.

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

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.

D7465 Destruction of lesion(s) by physical or chemical method, by report

Surgical Excision of Intra-Osseous Lesions

GP All procedures are by report and subject to coverage under the medical plan.

GP Pathology laboratory report is required. If no report is submitted, the fee for the procedure is NOT BILLABLE TO PATIENT.

GP The fee for D7450 and D7451 is NOT BILLABLE TO PATIENT as included in the fee for another surgery performed in the same area of the mouth on the same day by the same dentist/ dental office.

D7440 Excision of malignant tumor — lesion diameter up to 1.25 cm

D7441 Excision of malignant tumor — lesion diameter greater than 1.25 cm

D7450 Removal of benign odontogenic cyst or tumor — lesion diameter up to 1.25 cm

D7451 Removal of benign odontogenic cyst or tumor — lesion diameter greater than 1.25 cm

D7460 Removal of benign nonodontogenic cyst or tumor — lesion diameter up to 1.25 cm

D7461 Removal of benign nonodontogenic cyst or tumor — lesion diameter greater than 1.25 cm

Excision of Bone Tissue

GP All procedures are by report and subject to coverage under the medical plan.

D7471 Removal of lateral exostosis (maxilla or mandible)

D7471 Is benefited based on individual consideration, by report.

D7472 Removal of torus palatinus D7473 Removal of torus mandibularis.

D7485 Reduction of osseous tuberosity

D7490 Radical resection of maxilla or mandible.
If considered under dental, the fee for D7490 is NOT BILLABLE TO PATIENT unless pathology laboratory report is submitted.

Surgical Incision

GP All procedures are by report and are subject to coverage under the medical plan. If not covered under medical, procedures D7530-D7560 require a pathology report.

D7510 Incision and drainage of abscess — intraoral soft tissue.
The fee for surgical incision is NOT BILLABLE TO PATIENT when done on the same date (in the same operative area) and by the same dentist/dental office as endodontics (D3000-D3999), oral surgery (D7000-D7999), palliative treatment and surgical periodontal procedures (D4210-D4276).

D7511 Incision and drainage of abscess-intraoral soft tissue — complicated (includes drainage of multiple fascial spaces).

The fee for surgical incision is NOT BILLABLE TO PATIENT when done on the same date (in the same operative area) and by the same dentist/dental office as endodontics, extractions, palliative treatment or other definitive service.

D7520 Incision and drainage of abscess — extraoral soft tissue

D7521 Incision and drainage of abscess — extraoral soft tissue — complicated (includes drainage of multiple fascial spaces).

Incision and drainage of abscess — extraoral soft tissue is a benefit only if a dentally related infection is present.

If it is not related to a dental infection, the fee for treatment is DENIED and the approved amount is collectable from the patient.

D7530 Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue

D7540 Removal of reaction producing foreign bodies, musculoskeletal system

D7550 Partial ostectomy/sequestrectomy for removal of non-vital bone

D7560 Maxillary sinusotomy for removal of tooth fragment or foreign body

Treatment of Fractures — Simple

GP All procedures are by report and are subject to coverage under the medical plan.

GP A separate fee for splinting, wiring or banding is NOT BILLABLE TO PATIENT when performed by the same dentist/dental office rendering the primary procedure.

D7610 Maxilla — open reduction (teeth immobilized if present)

D7620 Maxilla — closed reduction (teeth immobilized if present)

D7630 Mandible — open reduction (teeth immobilized if present)

D7640 Mandible — closed reduction (teeth immobilized if present)

D7650 Malar and/or zygomatic arch — open reduction

D7660 Malar and/or zygomatic arch — closed reduction

D7670 Alveolus — closed reduction, may include stabilization of teeth

D7671 Alveolus — open reduction, may include stabilization of teeth

D7680 Facial bones — complicated reduction with fixation and multiple surgical approaches

Treatment of Fractures — Compound

GP All procedures are by report and are subject to coverage under the medical plan.

GP A separate fee for splinting, wiring or banding is NOT BILLABLE TO PATIENT when performed by the same dentist/dental office rendering the primary procedure.

D7710 Maxilla — open reduction

D7720 Maxilla — closed reduction

D7730 Mandible — open reduction

D7740 Mandible — closed reduction

D7750 Malar and/or zygomatic arch — open reduction

D7760 Malar and/or zygomatic arch — closed reduction

D7770 Alveolus — open reduction stabilization of teeth

D7771 Alveolus — closed reduction stabilization of teeth

D7780 Facial bones — complicated reduction with fixation and multiple approaches

Reduction of Dislocation and Management of Other Temporomandibular Joint Dysfunctions

GP All procedures are DENIED and the approved amount is collectable from the patient unless covered by the subscriber's group contact and are subject to coverage under the medical plan.

GP When covered by the subscriber's group contract all procedures are by report and subject to coverage under the medical plan. The fees for procedures that are an integral part of a primary procedure should not be reported separately and are NOT BILLABLE TO PATIENT.

D7810 Open reduction of dislocation

D7820 Closed reduction of dislocation

D7830 Manipulation under anesthesia

D7840 Condylectomy

D7850 Surgical discectomy, with/without implant

D7852 Disc repair

D7854 Synovectomy

D7856 Myotomy

D7858 Joint reconstruction

D7860 Arthrotomy

D7865 Arthroplasty

D7870 Arthrocentesis

D7871 Non-arthroscopic lysis and lavage

D7872 Arthroscopy: diagnosis, with or without biopsy

D7873 Arthroscopy: lavage and lysis of adhesions

D7874 Arthroscopy: disc repositioning and stabilization

D7875 Arthroscopy: synovectomy

D7876 Arthroscopy: discectomy

D7877 Arthroscopy: debridement

D7880 Occlusal orthotic device, by report

D7881 Occlusal orthotic device adjustment

D7899 Unspecified TMD therapy, by report

Repair of Traumatic Wounds

GP Repair of traumatic wounds is limited to oral structures. D7910 Suture of recent small wounds up to 5 cm.

Complicated Suturing (reconstruction requiring delicate handling of tissues and wide undermining for meticulous closure).

GP Complicated suturing is limited to oral structures.

D7911 Complicated suture — up to 5 cm

D7912 Complicated suture — greater than 5 cm

OTHER REPAIR PROCEDURES

GP All procedures except D7960, D7970, and D7971 are by report and subject to coverage under medical plan.

D7920 Skin grafts (identify defect covered, location and type of graft)

D7921 Collection and application of autologous blood concentrate product.
The fee for collection and application of autologous blood concentrate product is DENIED as investigational and is not a covered benefit.

D7940 Osteoplasty — for orthognathic deformities

D7941 Ostectomy — mandibular rami

D7943 Ostectomy — mandibular rami with bone graft; includes obtaining the graft

D7944 Ostectomy — segmented or subapical — per sextant or quadrant

D7945 Ostectomy — body of mandible D7946 LeFort I (maxilla — total)

D7947 LeFort I (maxilla — segmented)

D7948 LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retusion) — without bone graft

D7949 LeFort II or LeFort III — with bone graft

D7950 Osseous, osteoperiosteal, or cartilage graft of the mandible — autogenous or nonautogenous, by report.

D7951 Sinus augmentation with bone or bone substitutes via lateral open approach

D7952 Sinus augmentation via vertical approach

D7953 Bone replacement graft for ridge preservation — per site.
Benefits for osseous autografts and/or osseous allografts are available only when billed for natural teeth for periodontal purposes using periodontal procedure codes (D4263-D4264).

Benefits for these procedures when billed in conjunction with implants, implant removal, ridge augmentation, extraction sites (teeth), periradicular surgery etc., are DENIED as an experimental and/or investigational procedure.

If the contract covers dental implants this procedure may be a benefit at the time of extraction.

D7955 Repair of maxillofacial soft and hard tissue defect

D7960 Frenulectomy — also known as frenectomy or frenotomy — separate procedure not incidental to another procedure.

A separate fee for frenulectomy is NOT BILLABLE TO PATIENT when billed in conjunction with any other surgical procedure(s) in the same surgical area, by the same dentist/dental office.

D7963 Frenuloplasty

A separate fee for frenuloplasty is NOT BILLABLE TO PATIENT when billed in conjunction with any other surgical procedure(s) in the same surgical area by the same dentist/dental office.

D7970 Excision of hyperplastic tissue, per arch.

The fee for excision of hyperplastic tissue is NOT BILLABLE TO PATIENT when billed in conjunction with other surgical procedure(s) in the same surgical area by the same dentist/dental office.

D7971 Excision of pericoronal gingiva.

The fee for excision of pericoronal gingiva is NOT BILLABLE TO PATIENT when billed in conjunction with other surgical procedure(s) in the same surgical area by the same dentist/dental office.

D7972 Surgical reduction of fibrous tuberosity

D7980 Surgical sialolithotomy

D7981 Excision of salivary gland, by report

D7982 Sialodochoplasty

D7983 Closure of salivary fistula

D7990 Emergency tracheotomy

D7991 Coronoidectomy

D7995 Synthetic graft — mandible or facial bones, by report

D7996 Implant-mandible for augmentation purposes (excluding alveolar ridge), by report

D7997 Appliance removal (not by dentist who placed appliance), includes removal of archbar.

The fee for appliance removal is DENIED as a non-covered procedure unless the contract specifies that the related oral surgery services are a benefit. If covered, DISALLOW 45 days following appliance placement.

D7998 Intraoral placement of a fixation devise not in conjunction with fracture.

This procedure is by report and subject to coverage under the medical plan.

This procedure is NOT BILLABLE TO PATIENT by the same dentist/dental office when billed in conjunction with any surgical procedure not in conjunction with fractures for which splinting, wiring or banding is considered part of the complete procedure (e.g., D7270, D7272).

D7999 Unspecified oral surgery procedure, by report

ORTHODONTICS D8000-D8999

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

GP Surgical procedures should be reported separately under the appropriate procedure codes.

GP The benefit is based on the approved fee for conventional orthodontics. Any additional fee up to the submitted amount for Invisalign is DENIED and collectible from the patient.

Limited orthodontic treatment should be used with:

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 on 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).

Interceptive orthodontic treatment should be used with:

Treatment using codes for interceptive treatment are for procedures to lessen the severity or future effects of a malformation and to eliminate its cause. An extension of preventive orthodontics includes localized tooth movement. Such treatment may occur in the primary or 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 future comprehensive therapy. Early phased comprehensive therapy may utilize some procedures that might also be used interceptively, but such procedures are not considered in those applications.

Comprehensive orthodontic treatment should be used with:

There are multiple phases of orthodontic treatment provided at different states of dentofacial development. For example, the use of an activator is generally stage one of a two-stage treatment.

In this situation, placement of fixed appliances will generally be stage two of a two-stage treatment. Both phases should be listed as comprehensive treatment modified by the appropriate stage of dental development. This is used to report coordinated diagnosis and treatment leading to the improvement of the patient's craniofacial dysfunction and/or dentofacial deformity including

anatomical, functional, aesthetic relationships. Treatment usually, but not necessarily, utilizes fixed orthodontic appliances. Adjunctive procedures, such as extractions, maxillofacial surgery, nasopharyngeal surgery, myofunctional or speech therapy and restorative or periodontal care may be coordinated disciplines. Optimal care requires long-term consideration of patient's need and periodic reevaluation. Treatment may incorporate several phases with specific objectives at various stages of dentofacial development.

Limited Orthodontic Treatment

D8010 Limited orthodontic treatment of the primary dentition

D8020 Limited orthodontic treatment of the transitional dentition

D8030 Limited orthodontic treatment of the adolescent dentition

D8040 Limited orthodontic treatment of the adult dentition. Interceptive Orthodontic Treatment

D8050 Interceptive orthodontic treatment of the primary dentition

D8060 Interceptive orthodontic treatment of the transitional dentition. Comprehensive Orthodontic Treatment.

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

D8220 Fixed appliance therapy

Other Orthodontic Services

D8660 Pre-orthodontic treatment examination to monitor growth and development

D8670 Periodic orthodontic treatment visit

D8680 Orthodontic retention (removal of appliances, construction and placement of retainer(s). A separate fee for orthodontic retention is NOT BILLABLE TO PATIENT unless performed by a different dentist and the lifetime orthodontic maximum have not been reached.

D8681 Removable orthodontic retainer adjustment

D8690 Orthodontic treatment (alternative billing to a contract fee)

D8695 Removal of fixed orthodontic appliance(s) — other than at conclusion of treatment. Benefits for patient requested removal of fixed orthodontic appliance(s) are DENIED.

D8999 Unspecified Orthodontic procedure, by report

ADJUNCTIVE GENERAL SERVICES D9000 - D9999

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Unclassified Treatment

D9110 Palliative (emergency) treatment of dental pain-minor procedures.
The fee for palliative treatment is NOT BILLABLE TO PATIENT when any other definitive treatment is performed on the same date by the same dentist/dental office.

Limited radiographic images (D0210-D0391) and tests necessary to diagnose the emergency condition are considered separately.

Palliative treatment is a benefit on a per visit basis, once on the same date, and includes all procedures necessary for the relief of pain. Evaluation is not considered as the relief of pain.

A separate fee for palliative treatment is NOT BILLABLE TO PATIENT when billed on the same date as root canal therapy by the same dentist/dental office.

D9120 Fixed partial denture sectioning.
This procedure is only a benefit if a portion of the fixed prosthesis is to remain intact and serviceable following sectioning and extraction or other treatment.

If this code is part of the process or removing and replacing a fixed prosthesis, it is considered integral to the fabrication of the fixed prosthesis and a separate fee for this code is NOT BILLABLE TO PATIENT.

Polishing and recontouring are considered an integral part of the fixed partial denture sectioning. Additional fees are NOT BILLABLE TO PATIENT.

D9130 Temporomandibular joint dysfunction — non-invasive physical therapies

Anesthesia

D9210 Local anesthesia not in conjunction with operative or surgical procedures

D9211 Regional block anesthesia

D9212 Trigeminal division block anesthesia

D9215 Local anesthesia in conjunction with operative or surgical procedures.
A separate fee for local anesthesia is NOT BILLABLE TO PATIENT whether stand alone or in conjunction with any other procedure.

D9219 Evaluation for moderate sedation, deep sedation or general anesthesia.

D9222 deep sedation/general anesthesia — first 15 minutes

D9223 Deep sedation/general anesthesia — each subsequent 15-minute increments. General anesthesia is a benefit only when administered by a properly licensed dentist in a dental office in conjunction with specific oral surgery procedures (D7000-D7999) when covered or when necessary due to concurrent medical conditions.

Otherwise, the fee for general anesthesia is DENIED and the approved amount is collectable from the patient.

The fee for general anesthesia is DENIED and the approved amount is collectable from the patient when billed by anyone other than a properly licensed dentist.

D9230 Inhalation of nitrous oxide/anxiolysis, analgesia.
The fee for analgesia is DENIED and the approved amount is collectable from the patient.

When covered by group contract inhalation of nitrous oxide/anxiolysis, analgesia is NOT BILLABLE TO PATIENT when submitted more than once on the same date, and/or in conjunction with IV sedation and general anesthesia.

D9239 Intravenous moderate (conscious) sedation/analgesia — first 15 minutes.

D9243 Intravenous moderate (conscious) sedation/analgesia — each subsequent 15-minute increments. Intravenous sedation/analgesia is a benefit only when administered by a properly licensed dentist in a dental office in conjunction with specific oral surgery procedures (D7000-D7999) when covered or when necessary due to concurrent medical conditions. Otherwise the fee for intravenous conscious sedation/analgesia is DENIED and the approved amount is collectable from the patient.

Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in continuous attendance of the patient.

Anesthesia services are considered completed when the patient may be safely left under the observation of a trained personnel and the doctor may safely leave the room to attend to other patients or duties.

The fee for intravenous sedation/analgesia is DENIED and the approved amount is collectable from the patient when billed by anyone other than a licensed dentist.

D9248 Non-intravenous moderate (conscious) sedation.
The fee for non-intravenous conscious sedation is DENIED, and the approved amount is collectable from the patient.

Professional Consultation

D9310 Consultation (diagnostic service provided by dentist or physician other than requesting dentist or physician).

A separate fee for a consultation is NOT BILLABLE TO PATIENT when billed in conjunction with an examination/evaluation by the same dentist/dental office.

The fee for a consultation in connection with non-covered services is DENIED and the approved amount is collectable from the patient.

Consultation (D9310) may be benefited when the service is provided by a dentist whose opinion or advice regarding an evaluation and/or management of a specific problem may be requested by another dentist, physician or appropriate service. The dentist performing the consultation may initiate diagnostic or therapeutic services.

When covered, the consultation is subject to the same frequency limitations and processing policies as a comprehensive evaluation (D0150).

D9311 Consultation with medical healthcare professional.
Fees for the consultation with a healthcare professional concerning medical issues is NOT BILLABLE TO PATIENT.

Professional Visits

GP The fees for all procedures are DENIED and the approved amount is collectable from the patient.

D9410 House/extended care facility call

D9420 Hospital or ambulatory surgical center call

D9430 Office visit for observation (during regularly scheduled hours) — no other services performed

D9440 Office visit — after regularly scheduled hours

D9450 Case presentation, detailed and extensive treatment planning.
The fee for extensive treatment planing is DENIED and the approved amount is collectable from the patient.

The fees for routine treatment planning and case presentation are considered inclusive in an evaluation and are NOT BILLABLE TO PATIENT.

The fee for extensive treatment planning may be benefited for complex treatment planning cases involving multiple treatment disciplines and multiple providers of care.

When covered, the D9450 is subject to the same frequency limitations and processing policies as a comprehensive evaluation (D0150).

Drugs

GP The fees for all procedures are DENIED and the approved amount is collectable from the patient.

D9610 Therapeutic drug injection, by report

D9612 Therapeutic parenteral drugs, two or more administrations, different medications

D9613 Infiltration of sustained release therapeutic drug — single or multiple sites
Benefits for infiltration of sustained release therapeutic drug are DENIED as a specialized procedure unless covered by group/individual contract.
When covered: benefit D9613 once per date of service when submitted with extractions (D7220-D7241).

D9630 Drugs or medicaments dispensed in the office for home use.

MISCELLANEOUS SERVICES

D9910 Application of desensitizing medicament.
The fee for application of desensitizing medicaments is DENIED and the approved amount is collectable from the patient.

D9911 Application of desensitizing resin for cervical and/or root surface, per tooth
The fee for application of a desensitizing resin is DENIED, and the approved amount is collectable from the patient.

D9920 Behavior management, by report.
The fee for behavior management is DENIED and the approved amount is collectable from the patient.

D9930 Treatment of complications (postsurgical) — unusual circumstances, by report.
The fee for treatment of routine postsurgical complications is NOT BILLABLE TO PATIENT when done by the first treating dentist.

Benefits for dry socket are NOT BILLABLE TO PATIENT and are included in the fee for the extraction by the same dentist/dental office.

D9932 Cleaning and inspection of removable complete denture, maxillary

D9933 Cleaning and inspection of removable complete denture, mandibular

D9934 Cleaning and inspection of removable partial denture, maxillary

D9935 Cleaning and inspection of removable partial denture, mandibular

D9941 Fabrication of athletic mouthguard D9942. Repair or reline of occlusal guard.
Occlusal guard and related repair and/or reline is not a covered benefit unless it is contract specific. The fee is DENIED.

If covered contractually, the fee for the occlusal guard includes any adjustment or repair required with six months of delivery. Fees for the adjustment or repair of the occlusal guard are NOT BILLABLE TO PATIENT if performed by the same dentist/dental office within six months of initial placement.

GP If covered contractually, the fee for repair of an occlusal guard cannot exceed one-half of the fee for a new appliance and any excess fee is NOT BILLABLE TO PATIENT.

D9943 Occlusal guard adjustment

D9944 Occlusal guard — hard appliance, full arch.
Benefits for occlusal guard are DENIED unless covered by group/individual contract.
If covered by group contract, allow once every five years.

D9945 Occlusal guard — soft appliance, full arch.
Benefits for occlusal guard is DENIED unless covered by group/individual contract.
If covered by group contract, allow once every five years.

D9946 Occlusal guard — hard appliance, partial arch.
Occlusal guard is not a covered benefit unless it is group/individual contract specified and is DENIED. If covered by group contract, allow once every five years.

D9950 Occlusion analysis — mounted case

D9951 Occlusal adjustment — limited

D9952 Occlusal adjustment — complete

D9961 Duplicate/copy patient's records. Benefits for patient record duplications are DENIED.

D9970 Enamel microabrasion.
The fees for procedure codes D9940-D9970 are DENIED and the approved amount is collectable from the patient.

D9971 Odontoplasty one to two teeth includes removal of enamel projections
The fee for odontoplasty is DENIED and is the approved amount is collectable from the patient.

D9972 External bleaching per arch — performed in office.
The fee for bleaching is DENIED, and the approved amount is collectable from the patient.

D9973 External bleaching per tooth. The fee for bleaching is DENIED, and the approved amount is collectable from the patient.

D9974 Internal bleaching per tooth. The fee for bleaching is DENIED, and the approved amount is collectable from the patient.

D9975 External bleaching for home application, per arch — includes materials and fabrication of custom tray.

D9990 Certified translation or sign language services — per visit.
The fees for translation services are considered inclusive in overall patient management and are NOT BILLABLE TO PATIENT, unless covered by group/individual contract.

D9991 Dental case management-addressing appointment compliance barriers.
Fees for action taken to schedule and assure compliance with patient appointments are inclusive with office operations and are NOT BILLABLE TO PATIENT.

D9992 Dental case management-care coordination.
Fees for care coordination are considered inclusive in overall patient management and are NOT BILLABLE TO PATIENT.

D9993 Dental case management-motivational interviewing.
Motivational interviewing is not a covered benefit and is DENIED.

D9994 Dental case management-patient eduction to improve oral health literacy.
Patient education is not a benefit and is DENIED.

D9995 Teledentistry — synchronous; real-time encounter. The fees for teledentistry — synchronous are considered inclusive in overall patient management and are NOT BILLABLE TO PATIENT.

D9996 Teledentistry — asynchronous; information stored and forwarded to dentist for subsequent review. The fees for teledentistry — asynchronous are considered inclusive in overall patient management and are NOT BILLABLE TO PATIENT.

D9999 Unspecified adjunctive procedure, by report.



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