

## Current Dental Terminology 2013 Manual of Criteria

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**Manual of Criteria  
for  
Medi-Cal Authorization  
(Dental Services)**

Archive

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## Current Dental Terminology 13 (CDT 13) Codes – Preface (ARCHIVED)

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**IMPORTANT:** Adult dental services were limited between July 1, 2009 and December 31, 2017.

Effective January 1, 2018, Senate Bill 97 (Chapter 52, Statutes of 2017) required the Department of Health Care Services to fully restore adult dental services. Unless specifically identified in the Senate Bill as a change, the criteria contained in this next section, Manual of Criteria for Medi-Cal Authorization (Dental Services) will remain in effect. Refer to Section 4 to view Table 1: Federally Required Adult Dental Services for the exemptions that apply to services prior to January 1, 2018, and the 2018 benefits chart on page 4-10.

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**Diagnostic General Policies (D0100-D0999)**

1. Radiographs (D0210-D0340):
  - a) According to accepted standards of dental practice, the lowest number of radiographs needed to provide the diagnosis shall be taken.
  - b) Original radiographs shall be a part of the patient's clinical record and shall be retained by the provider at all times.
  - c) Radiographs shall be made available for review upon the request of the Department of Health Services or its fiscal intermediary.
  - d) Pursuant to Title 22, CCR, Section 51051, dental radiographic laboratories shall not be considered providers under the Medi-Cal Dental Program.
  - e) Radiographs shall be considered current as follows:
    - i) radiographs for treatment of primary teeth within the last eight months.
    - ii) radiographs for treatment of permanent teeth (as well as over-retained primary teeth where the permanent tooth is congenitally missing or impacted) within the last 14 months.
    - iii) radiographs to establish arch integrity within the last 36 months. Arch radiographs are not required for patients under the age of 21.
  - f) All radiographs or paper copies of radiographs shall be of diagnostic quality, properly mounted, labeled with the date the radiograph was taken, the provider's name, the provider's billing number, the patient's name, and with the tooth/quadrant/area (as applicable) clearly indicated.
  - g) Multiple radiographs of four or more shall be mounted. Three or fewer radiographs properly identified (as stated in "e" above) in a coin envelope are acceptable when submitted for prior authorization and/or payment.
  - h) Paper copies of multiple radiographs shall be combined on no more than four sheets of paper.
  - i) All treatment and post treatment radiographs are included in the fee for the associated procedure and are not payable separately.
  - j) A panoramic radiograph alone is considered non-diagnostic for prior authorization and/or payment of restorative, endodontic, periodontic, removable partial and fixed prosthodontic procedures.
  - k) When arch integrity radiographic images are required for a procedure and exposure to radiation should be minimized due to a medical condition, only a periapical radiograph shall be required. Submitted written documentation shall include a statement of the medical condition such as the following:
    - i) pregnancy,
    - ii) recent application of therapeutic doses of ionizing radiation to the head and neck areas,
    - iii) hypoplastic or aplastic anemia.

- l) Prior authorization for procedures other than fixed partial dentures, removable prosthetics and implants is not required when a patient's inability to respond to commands or directions would necessitate sedation or anesthesia in order to accomplish radiographic procedures. However, required radiographs shall be obtained during treatment and shall be submitted for consideration for payment.
2. Photographs (D0350):
  - a) Photographs are a part of the patient's clinical record and the provider shall retain original photographs at all times.
  - b) Photographs shall be made available for review upon the request of the Department of Health Care Services or its fiscal intermediary.
3. Prior authorization is not required for examinations, radiographs or photographs.

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**Diagnostic Procedures (D0100-D0999)**

**PROCEDURE D0120  
PERIODIC ORAL  
EVALUATION - ESTABLISHED  
PATIENT**

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit:
  - a. for patients under the age of 21.
  - b. once every six months, per provider, or
  - c. after six months have elapsed following comprehensive oral evaluation (D0150), same provider.
3. This procedure is not a benefit when provided on the same date of service with procedures:
  - a. limited oral evaluation-problem focused (D0140),
  - b. comprehensive oral evaluation- new or established patient (D0150),
  - c. Detailed and extensive oral evaluation-problem focused, by report (D0160),

- d. re-evaluation-limited, problem focused (established patient; not post-operative visit) (D0170),
- e. office visit for observation (during regularly scheduled hours)-no other services performed (D9430).

**PROCEDURE D0140  
LIMITED ORAL EVALUATION  
-PROBLEM FOCUSED**

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit:
  - a. for patients under the age of 21.
  - b. once per patient per provider.
  - c. when provided by a Medi-Cal Dental Program certified orthodontist.
3. Submission of the Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form, DC016 (06/09) is not required for payment.
4. The following procedures are not a benefit, for the same rendering provider, when provided on the same date of service with procedure D0140:
  - a. periodic oral evaluation (D0120),
  - b. comprehensive oral evaluation- new or

- established patient (D0150),
  - c. Detailed and extensive oral evaluation- problem focused, by report (D0160),
  - d. re-evaluation- limited, problem focused (established patient; not post-operative visit) (D0170),
  - e. office visit for observation (during regularly scheduled hours)-no other services performed (D9430).
5. This examination procedure shall only be billed for the initial orthodontic evaluation with the completion of the Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form DC016 (06/09).

**PROCEDURE D0145  
ORAL EVALUATION FOR A  
PATIENT UNDER THREE  
YEARS OF AGE AND  
COUNSELING WITH  
PRIMARY CAREGIVER**

This procedure can only be billed as periodic oral evaluation-established patient (D0120) or comprehensive oral

evaluation-new or established patient (D0150)-and is not payable separately.

**PROCEDURE D0150  
COMPREHENSIVE ORAL  
EVALUATION - NEW OR  
ESTABLISHED PATIENT**

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit once per patient per provider for the initial evaluation.
3. This procedure is not a benefit when provided on the same date of service with procedures:
  - a. limited oral evaluation (D0140),
  - b. Detailed and extensive oral evaluation-problem focused, by report (D0160),
  - c. re-evaluation- limited, problem focused (established patient; not post-operative visit) (D0170).
4. The following procedures are not a benefit when provided on the same date of service with D0150:

- a. periodic oral evaluation (D0120),
- b. office visit for observation (during regularly scheduled hours)-no other services performed (D9430).

**PROCEDURE D0160  
DETAILED AND EXTENSIVE  
ORAL EVALUATION -  
PROBLEM FOCUSED, BY  
REPORT**

1. Written documentation for payment- shall include documentation of findings that supports the existence of one of the following:
  - a. Dento-facial anomalies,
  - b. complicated perio-prosthetic conditions,
  - c. complex temporomandibular dysfunction,
  - d. facial pain of unknown origin,
  - e. severe systemic diseases requiring multi-disciplinary consultation.
2. A benefit once per patient per provider.
3. The following procedures are not a benefit when provided on the same date of service with D0160:

- a. periodic oral evaluation (D0120),
  - b. limited oral evaluation-problem focused (D0140),
  - c. comprehensive oral evaluation- new or established patient (D0150),
  - d. re-evaluation- limited, problem focused (established patient; not post-operative visit) (D0170),
  - e. office visit for observation (during regularly scheduled hours-no other services performed (D9430).
- b. up to a maximum of 12 in a 12-month period.
- 3. This procedure is not a benefit when provided on the same date of service with a detailed and extensive oral evaluation (D0160).
  - 4. The following procedures are not a benefit when provided on the same date of service with D0170:
    - a. periodic oral evaluation (D0120),
    - b. limited oral evaluation-problem focused (D0140),
    - c. comprehensive oral evaluation-new or established patient (D0150),
    - d. office visit for observation (during regularly scheduled hours)-no other services performed (D9430).

**PROCEDURE D0170  
RE-EVALUATION – LIMITED,  
PROBLEM FOCUSED  
(ESTABLISHED PATIENT;  
NOT POST-OPERATIVE  
VISIT)**

- 1. Written documentation for payment- shall include an evaluation and diagnosis justifying the medical necessity.
- 2. A benefit for the ongoing symptomatic care of temporomandibular joint dysfunction:
  - a. up to six times in a three month period.

**PROCEDURE D0180  
COMPREHENSIVE  
PERIODONTAL EVALUATION  
- NEW OR ESTABLISHED  
PATIENT**

This procedure can only be billed as comprehensive oral evaluation-new or established patient

(D0150)-and is not payable separately.

**PROCEDURE D0190  
SCREENING OF A PATIENT**

This procedure is not a benefit.

**PROCEDURE D0191  
ASSESSMENT OF A PATIENT**

This procedure is not a benefit.

**PROCEDURE D0210  
INTRAORAL - COMPLETE  
SERIES OF RADIOGRAPHIC  
IMAGES**

- 1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
- 2. A benefit once per provider every 36 months.
- 3. Not a benefit to the same provider within six months of bitewings (D0272 and D0274).
- 4. A complete series shall be at least:
  - a. ten (10) periapicals (D0230) and bitewings (D0272 or D0274), or
  - b. eight (8) periapicals (D0230), two (2) occlusals (D0240) and bitewings (D0272 or D0274), or

- c. a panoramic radiographic image (D0330) plus bitewings (D0272 or D0274) and a minimum of two (2) periapicals (D0230).
- 5. When multiple radiographs are taken on the same date of service, or if an intraoral-complete series of radiographic images (D0210) has been paid in the last 36 months, the maximum payment shall not exceed the total fee allowed for an intraoral complete series.

**PROCEDURE D0220  
INTRAORAL - PERIAPICAL  
FIRST RADIOGRAPHIC  
IMAGE**

- 1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
- 2. A benefit to a maximum of 20 periapicals in a 12-month period by the same provider, in any combination of the following: intraoral-periapical first radiographic image (D0220) and intraoral-periapical each

additional radiographic image (D0230).  
Periapicals taken as part of an intraoral-complete series of radiographic images (D0210) are not considered against the maximum of 20 periapicals in a 12-month period.

- 3. This procedure is payable once per provider per date of service. All additional periapicals shall be billed as intraoral-periapical each additional radiographic image (D0230).
- 4. Periapicals taken in conjunction with bitewings, occlusal or panoramic radiographs shall be billed as intraoral-periapical each additional radiographic image (D0230).

**PROCEDURE D0230  
INTRAORAL - PERIAPICAL  
EACH ADDITIONAL  
RADIOGRAPHIC IMAGE**

- 1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
- 2. A benefit to a maximum of 20 periapicals in a 12-

month period to the same provider, in any combination of the following: intraoral-periapical first radiographic image (D0220) and intraoral-periapical each additional radiographic image (D0230).  
Periapicals taken as part of an intraoral complete series of radiographic images (D0210) are not considered against the maximum of 20 periapical films in a 12 month period.

- 3. Periapicals taken in conjunction with bitewings, occlusal or panoramic radiographs shall be billed as intraoral-periapical each additional radiographic image (D0230).

**PROCEDURE D0240  
INTRAORAL - OCCLUSAL  
RADIOGRAPHIC IMAGE**

- 1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
- 2. A benefit up to a maximum of two in a six-month period per provider.

3. If any radiographic image size other than 2 1/4" x 3" (57mm x 76mm) is used for an intraoral-occlusal radiographic image (D0240), it shall be billed as a intraoral-periapical first radiographic image (D0220) or intraoral-periapical each additional radiographic image (D0230) as applicable.

**PROCEDURE D0250  
EXTRAORAL - FIRST  
RADIOGRAPHIC IMAGE**

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit once per date of service.

**PROCEDURE D0260  
EXTRAORAL - EACH  
ADDITIONAL  
RADIOGRAPHIC IMAGE**

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.

2. A benefit up to a maximum of four on the same date of service.

**PROCEDURE D0270  
BITEWING - SINGLE  
RADIOGRAPHIC IMAGE**

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit once per date of service.
3. Not a benefit for a totally edentulous area.

**PROCEDURE D0272  
BITEWINGS - TWO  
RADIOGRAPHIC IMAGES**

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit once every six months per provider.
3. Not a benefit:
  - a. within six months of intraoral-complete series of radiographic images (D0210), same provider.
  - b. for a totally edentulous area.

**PROCEDURE D0273**

**BITEWINGS - THREE  
RADIOGRAPHIC IMAGES**

This procedure can only be billed as bitewing-single radiographic image (D0270) and bitewings- two radiographic images (D0272)

**PROCEDURE D0274  
BITEWINGS - FOUR  
RADIOGRAPHIC IMAGES**

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit once every six months per provider.
3. Not a benefit:
  - a. within six months of intraoral-complete series of radiographic images (D0210), same provider.
  - b. for patients under the age of 10
  - c. for a totally edentulous area.

**PROCEDURE D0277  
VERTICAL BITEWINGS - 7 TO  
8 RADIOGRAPHIC IMAGES**

This procedure can only be billed as bitewings-four radiographic images (D0274). The maximum payment is for four bitewings.

**PROCEDURE D0290  
POSTERIOR - ANTERIOR OR  
LATERAL SKULL AND FACIAL  
BONE SURVEY  
RADIOGRAPHIC IMAGE**

1. Submission of radiographs, photographs or written

- documentation demonstrating medical necessity is not required for payment.
2. A benefit:
  3. for the survey of trauma or pathology.
  4. for a maximum of three per date of service.

**PROCEDURE D0310  
SIALOGRAPHY**

Submit radiology report or radiograph(s) for payment.

**PROCEDURE D0320  
TEMPOROMANDIBULAR  
JOINT ARTHROGRAM,  
INCLUDING INJECTION**

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit:
  - a. for the survey of trauma or pathology.
  - b. for a maximum of three per date of service.

**PROCEDURE D0321  
OTHER  
TEMPOROMANDIBULAR  
JOINT RADIOGRAPHIC  
IMAGES, BY REPORT**

This procedure is not a benefit.

**PROCEDURE D0322  
TOMOGRAPHIC SURVEY**

1. Written documentation for payment-shall include the radiographic findings and diagnosis to justify the medical necessity.

2. The tomographic survey shall be submitted for payment.
3. A benefit twice in a 12-month period per provider.
4. This procedure shall include three radiographic views of the right side and three radiographic views of the left side representing the rest, open and closed positions.

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**PROCEDURE D0330  
PANORAMIC  
RADIOGRAPHIC IMAGE**

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit once in a 36-month period per provider, except when documented as essential for a follow-up/post-operative exam (such as after oral surgery).
3. Not a benefit, for the same provider, on the same date of service as an intraoral-complete series of radiographic images (D0210).
4. This procedure shall be considered part of an intraoral- complete series of radiographic images (D0210) when taken on the same date of service with bitewings (D0272 or D0274) and a minimum of two (2) intraoral- periapicals each additional radiographic image (D0230).

**PROCEDURE D0340  
CEPHALOMETRIC  
RADIOGRAPHIC IMAGE**

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit twice in a 12-month period per provider.

**PROCEDURE D0350  
ORAL/FACIAL  
PHOTOGRAPHIC IMAGES**

1. Photographs shall be submitted, with the claim or Treatment Authorization Request (TAR) for the procedure that it supports, for payment.
2. A benefit up to a maximum of four per date of service.
3. Not a benefit when used for patient identification, multiple views of the same area, treatment progress and post-operative photographs.
4. Photographs shall be necessary for the diagnosis and treatment of the specific clinical condition of the patient that is not readily apparent on radiographs.
5. Photographs shall be of diagnostic quality, labeled with the date the

- photograph was taken, the provider's name, the provider's billing number, the patient's name and with the tooth/quadrant/area (as applicable) clearly indicated.
6. This procedure is included in the fee for pre-orthodontic treatment visit (D8660) and comprehensive orthodontic treatment of the adolescent dentition (D8080) and is not payable separately.

**PROCEDURE D0363  
CONE BEAM- THREE-  
DIMENSIONAL IMAGE  
RECONSTRUCTION USING  
EXISTING DATA, INCLUDES  
MULTIPLE IMAGES**

This procedure is not a benefit.

**PROCEDURE D0364  
CONE BEAM CT CAPTURE  
AND INTERPRETATION  
WITH LIMITED FIELD OF  
VIEW - LESS THAN ONE  
WHOLE JAW**

This procedure is not a benefit.

**PROCEDURE D0365  
CONE BEAM CT CAPTURE  
AND INTERPRETATION  
WITH FIELD OF VIEW OF  
ONE FULL DENTAL ARCH -  
MANDIBLE**

This procedure is not a benefit.

**PROCEDURE D0366  
CONE BEAM CT CAPTURE  
AND INTERPRETATION  
WITH FIELD OF VIEW OF  
ONE FULL DENTAL ARCH -  
MAXILLA, WITH OR  
WITHOUT CRANIUM**

This procedure is not a benefit.

**PROCEDURE D0367  
CONE BEAM CT CAPTURE  
AND INTERPRETATION  
WITH FIELD OF VIEW OF  
BOTH JAWS WITH OR  
WITHOUT CRANIUM**

This procedure is not a benefit.

**PROCEDURE D0368  
CONE BEAM CT CAPTURE  
AND INTERPRETATION FOR  
TMJ SERIES INCLUDING  
TWO OR MORE EXPOSURES**

This procedure is not a benefit.

**PROCEDURE D0369  
MAXILLOFACIAL MRI  
CAPTURE AND  
INTERPRETATION**

This procedure is not a benefit.

**PROCEDURE D0370  
MAXILLOFACIAL  
ULTRASOUND CAPTURE  
AND INTERPRETATION**

This procedure is not a benefit.

**PROCEDURE D0371  
SIALOENDOSCOPY CAPTURE  
AND INTERPRETATION**

This procedure is not a benefit.

**PROCEDURE D0380  
CONE BEAM CT IMAGE  
CAPTURE WITH LIMITED  
FIELD OF VIEW - LESS THAN  
ONE WHOLE JAW**

This procedure is not a benefit.

**PROCEDURE D0381  
CONE BEAM CT IMAGE  
CAPTURE WITH FIELD OF  
VIEW OF ONE FULL DENTAL  
ARCH- MANDIBLE**

This procedure is not a benefit.

**PROCEDURE D0382  
CONE BEAM CT IMAGE  
CAPTURE WITH FIELD OF  
VIEW OF ONE FULL DENTAL  
ARCH- MAXILLA, WITH OR  
WITHOUT CRANIUM**

This procedure is not a benefit.

**PROCEDURE D0383  
CONE BEAM CT IMAGE  
CAPTURE WITH FIELD OF  
VIEW OF BOTH JAWS, WITH  
OR WITHOUT CRANIUM**

This procedure is not a benefit.

**PROCEDURE D0384  
CONE BEAM CT IMAGE  
CAPTURE FOR TMJ SERIES  
INCLUDING TWO OR MORE  
EXPOSURES**

This procedure is not a benefit.

**PROCEDURE D0385  
MAXILLOFACIAL MRI IMAGE  
CAPTURE**

This procedure is not a benefit.

**PROCEDURE D0386  
MAXILLOFACIAL  
ULTRASOUND IMAGE  
CAPTURE**

This procedure is not a benefit.

**PROCEDURE D0391  
INTERPRETATION OF  
DIAGNOSTIC IMAGE BY A  
PRACTITIONER NOT  
ASSOCIATED WITH  
CAPTURE OF THE IMAGE,  
INCLUDING REPORT**

This procedure is not a benefit.

**PROCEDURE D0415  
COLLECTION OF  
MICROORGANISMS FOR  
CULTURE AND SENSITIVITY**

This procedure is not a benefit.

**PROCEDURE D0416  
VIRAL CULTURE**

This procedure is not a benefit.

**PROCEDURE D0417  
COLLECTION AND  
PREPARATION OF SALIVA  
SAMPLE FOR LABORATORY  
DIAGNOSTIC TESTING**

This procedure is not a benefit.

**PROCEDURE D0418  
ANALYSIS OF SALIVA  
SAMPLE**

This procedure is not a benefit.

**PROCEDURE D0421  
GENETIC TEST FOR  
SUSCEPTIBILITY TO ORAL  
DISEASES**

This procedure is not a benefit

**PROCEDURE D0425  
CARIES SUSCEPTIBILITY  
TESTS**

This procedure is not a benefit.

**PROCEDURE D0431  
ADJUNCTIVE PRE-  
DIAGNOSTIC TEST THAT  
AIDS IN DETECTION OF  
MUCOSAL ABNORMALITIES  
INCLUDING PREMALIGNANT  
AND MALIGNANT LESIONS,  
NOT TO INCLUDE  
CYTOLOGY OR BIOPSY  
PROCEDURES**

This procedure is not a benefit.

**PROCEDURE D0460  
PULP VITALITY TESTS**

This procedure is included in the fees for diagnostic, restorative, endodontic and emergency procedures and is not payable separately.

**PROCEDURE D0470  
PROCEDURE DIAGNOSTIC  
CASTS**

1. Diagnostic casts are for the evaluation of orthodontic benefits

only. Unless specifically requested by the Medi-Cal Dental Program, diagnostic casts submitted for other than orthodontic treatment shall be discarded and not reviewed.

2. Diagnostic casts are required to be submitted for orthodontic evaluation and are payable only upon authorized orthodontic treatment. Do not send original casts, as casts will not be returned.
3. A benefit:
  - a. once per provider unless special circumstances are documented (such as trauma or pathology which has affected the course of orthodontic treatment).
  - b. for patients under the age of 21.
  - c. for permanent dentition (unless over the age of 13 with primary teeth still present or has a cleft palate or craniofacial anomaly).
  - d. only when provided by a Medi-Cal Dental

Program certified orthodontist.

4. Diagnostic casts shall be free of voids and be properly trimmed with centric occlusion clearly marked on the casts. Casts shall be cleaned, treated with an approved EPA disinfectant and dried before being placed in a sealed bag for shipping to the Medi-Cal Dental Program.

**PROCEDURE D0472  
ACCESSION OF TISSUE,  
GROSS EXAMINATION,  
PREPARATION AND  
TRANSMISSION OF  
WRITTEN REPORT**

This procedure is not a benefit.

**PROCEDURE D0473  
ACCESSION OF TISSUE,  
GROSS AND MICROSCOPIC  
EXAMINATION,  
PREPARATION AND  
TRANSMISSION OF  
WRITTEN REPORT**

This procedure is not a benefit.

**PROCEDURE D0474  
ACCESSION OF TISSUE,  
GROSS AND MICROSCOPIC  
EXAMINATION, INCLUDING  
ASSESSMENT OF SURGICAL  
MARGINS FOR PRESENCE  
OF DISEASE, PREPARATION**

**AND TRANSMISSION OF  
WRITTEN REPORT**

This procedure is not a  
benefit.

**PROCEDURE D0475  
PROCEDURE  
DECALCIFICATION  
PROCEDURE**

This procedure is not a  
benefit.

**PROCEDURE D0476  
SPECIAL STAINS FOR  
MICROORGANISMS**

This procedure is not a  
benefit.

**PROCEDURE D0477  
SPECIAL STAINS, NOT FOR  
MICROORGANISMS**

This procedure is not a  
benefit.

**PROCEDURE D0478  
IMMUNOHISTOCHEMICAL  
STAINS**

This procedure is not a  
benefit.

**PROCEDURE D0479  
TISSUE IN-SITU  
HYBRIDIZATION,  
INCLUDING  
INTERPRETATION**

This procedure is not a  
benefit.

**PROCEDURE D0480  
ACCESSION OF EXFOLIATIVE  
CYTOLOGIC SMEARS,  
MICROSCOPIC  
EXAMINATION,  
PREPARATION AND  
TRANSMISSION OF  
WRITTEN REPORT**

This procedure is not a  
benefit.

**PROCEDURE D0481  
ELECTRON MICROSCOPY**

This procedure is not a  
benefit.

**PROCEDURE D0482  
PROCEDURE DIRECT  
IMMUNOFLUORESCENCE**

This procedure is not a  
benefit.

**PROCEDURE D0483  
INDIRECT  
IMMUNOFLUORESCENCE**

This procedure is not a  
benefit.

**PROCEDURE D0484  
CONSULTATION ON SLIDES  
PREPARED ELSEWHERE**

This procedure is not a  
benefit.

**PROCEDURE D0485  
CONSULTATION,  
INCLUDING PREPARATION  
OF SLIDES FROM BIOPSY  
MATERIAL SUPPLIED BY  
REFERRING SOURCE**

This procedure is not a  
benefit.

**PROCEDURE D0486  
ACCESSION OF  
TRANSEPITHELIAL  
CYTOLOGIC SAMPLE,  
MICROSCOPIC  
EXAMINATION,  
PREPARATION AND  
TRANSMISSION OF  
WRITTEN REPORT**

This procedure is not a benefit.

**PROCEDURE D0502  
OTHER ORAL PATHOLOGY  
PROCEDURES BY REPORT**

1. Submission of the pathology report is required for payment.
2. A benefit only when provided by a Medi-Cal Dental Program certified oral pathologist.
3. This procedure shall be billed only for a histopathological examination.

**PROCEDURE D0999  
UNSPECIFIED DIAGNOSTIC  
PROCEDURE, BY REPORT**

1. This procedure does not require prior authorization.
2. Radiographs for payment - submit radiographs as applicable for the type of procedure.
3. Photographs for payment- submit photographs as

applicable for the type of procedure.

4. Written documentation for payment shall describe the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.

5. D0999 shall be used:
  - a. for a procedure which is not adequately described by a CDT code, or
  - b. for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity.

Documentation shall include the medical condition and the specific CDT code associated with the treatment.

**Preventive Procedures (D1000-D1999)**

**Preventive General Policies (D1000-D1999)**

1. Dental Prophylaxis and Fluoride Treatment (D1110-D1208):
  - a) Dental prophylaxis (D1110 and D1120) is defined as the preventive dental procedure of coronal scaling and polishing which includes the complete removal of calculus, soft deposits, plaque, stains and smoothing of unattached tooth surfaces.
  - b) Fluoride treatment (D1206 and D1208) is a benefit only for prescription strength fluoride products.
  - c) Fluoride treatments do not include treatments that incorporate fluoride with prophylaxis paste, topical application of fluoride to the prepared portion of a tooth prior to restoration and applications of aqueous sodium fluoride.
  - d) The application of fluoride is only a benefit for caries control and is payable as a full mouth treatment regardless of the number of teeth treated.
  - e) Prophylaxis and fluoride procedures (D1120, D1206 and D1208) are a benefit once in a six-month period without prior authorization under the age of 21.
  - f) Prophylaxis and fluoride procedures (D1110, D1206 and D1208) are a benefit once in a 12-month period without prior authorization for age 21 or older.
  - g) Additional requests, beyond the stated frequency limitations, for prophylaxis and fluoride procedures (D1110, D1120, D1206 and D1208) shall be considered for prior authorization when documented medical necessity is justified due to a physical limitation and/or an oral condition that prevents daily oral hygiene.

### Preventive Procedures (D1000-D1999)

#### **PROCEDURE D1110**

#### **PROPHYLAXIS - ADULT**

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
  2. A benefit once in a 12-month period for patients age 21 or older. Frequency limitations shall apply toward prophylaxis procedure D1120.
  3. Not a benefit when performed on the same date of service with:
    - a. gingivectomy or gingivoplasty (D4210 and D4211).
    - b. osseous surgery (D4260 and D4261).
    - c. periodontal scaling and root planing (D4341 and D4342).
  4. Not a benefit to the same provider who performed periodontal maintenance (D4910) in the same calendar quarter.
1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
  2. A benefit once in a six-month period for patients under the age of 21.
  3. Not a benefit when performed on the same date of service with:
    - a. gingivectomy or gingivoplasty (D4210 and D4211).
    - b. osseous surgery (D4260 and D4261).
    - c. periodontal scaling and root planing (D4341 and D4342).
  4. Not a benefit to the same provider who performed periodontal maintenance (D4910) in the same calendar quarter.
2. A benefit:
    - a. once in a six month period for patients under the age of 21. Frequency limitations shall apply toward topical application of fluoride (D1208).
    - b. once in a 12 month period for patients age 21 or older. Frequency limitations shall apply toward topical application of fluoride (D1208).
  3. Payable as a full mouth treatment regardless of the number of teeth treated.

#### **PROCEDURE D1120**

#### **PROPHYLAXIS - CHILD**

#### **PROCEDURE D1206**

#### **TOPICAL APPLICATION OF FLUORIDE VARNISH**

1. Submission of radiographs, photographs or written documentation demonstrating medical

**Preventive Procedures (D1000-D1999)**

**PROCEDURE D1208  
TOPICAL APPLICATION OF  
FLUORIDE**

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit:
  - a. once in a six month period for patients under the age of 21. Frequency limitations shall apply toward topical application of fluoride varnish (D1206).
  - b. once in a 12 month period for patients age 21 or older. Frequency limitations shall apply toward topical application of fluoride varnish (D1206).
3. Payable as a full mouth treatment regardless of the number of teeth treated.

**PROCEDURE D1310  
NUTRITIONAL COUNSELING  
FOR CONTROL OF DENTAL  
DISEASE**

This procedure is to be performed in conjunction with diagnostic, preventive,

and periodontal procedures and is not payable separately.

**PROCEDURE D1320  
TOBACCO COUNSELING FOR  
THE CONTROL AND  
PREVENTION OF ORAL  
DISEASE**

This procedure is to be performed in conjunction with diagnostic, preventive, and periodontal procedures and is not payable separately.

**PROCEDURE D1330  
ORAL HYGIENE  
INSTRUCTIONS**

This procedure is to be performed in conjunction with diagnostic, preventive, and periodontal procedures and is not payable separately.

**PROCEDURE D1351  
SEALANT - PER TOOTH**

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. Requires a tooth code and surface code.
3. A benefit:
  - a. for first, second and third permanent molars that occupy

the second molar position.

- b. only on the occlusal surfaces that are free of decay and/or restorations.
  - c. for patients under the age of 21.
  - d. once per tooth every 36 months per provider regardless of surfaces sealed.
4. The original provider is responsible for any repair or replacement during the 36-month period.

**PROCEDURE D1352  
PREVENTIVE RESIN  
RESTORATION IN A  
MODERATE TO HIGH CARIES  
RISK PATIENT- PERMANENT  
TOOTH**

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. Requires a tooth code and surface code.
3. A benefit:
  - a. for first, second and third permanent molars that occupy the second molar position.
  - b. only for an active cavitated lesion in a

**Preventive Procedures (D1000-D1999)**

- pit or fissure that does not cross the DEJ.
  - c. for patients under the age of 21.
  - d. once per tooth every 36 months per provider regardless of surfaces sealed.
4. The original provider is responsible for any repair or replacement during the 36-month period.

**PROCEDURE D1510  
SPACE MAINTAINER - FIXED  
UNILATERAL**

1. This procedure does not require prior authorization.
2. Radiographs for payment - submit a diagnostic preoperative periapical or bitewing radiograph to document the presence of the erupting permanent tooth and to verify there is enough space to allow the eruption of the permanent tooth.
3. Written documentation for payment - shall include the identification of the missing primary molar.
4. Requires a quadrant code.
5. A benefit:

- a. once per quadrant per patient.
  - b. for patients under the age of 18.
  - c. only to maintain the space for a single tooth.
6. Not a benefit:
- a. when the permanent tooth is near eruption or is missing.
  - b. for upper and lower anterior teeth.
  - c. for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.
7. Replacement space maintainers shall be considered for payment when documentation identifies an unusual circumstance (such as lost or non-repairable).
8. The fee for space maintainers includes the band and loop.
9. When prefabricated crowns (D2930, D2931, D2932 and D2933) are necessary for space maintainer abutment teeth they first shall meet the Medi-Cal Dental Program's criteria for prefabricated crowns and shall be billed

separately from the space maintainer.

**PROCEDURE D1515  
SPACE MAINTAINER - FIXED  
- BILATERAL**

1. This procedure does not require prior authorization.
2. Radiographs for payment - submit a diagnostic preoperative periapical or bitewing radiograph to document the presence of the erupting permanent tooth and to verify there is enough space to allow the eruption of the permanent tooth.
3. Written documentation for payment - shall include the identification of the missing primary molars.
4. Requires an arch code.
5. A benefit:
  - a. once per arch when there is a missing primary molar in both quadrants or when there are two missing primary molars in the same quadrant.
  - b. for patients under the age of 18.
6. Not a benefit:
  - a. when the permanent tooth is near

**Preventive Procedures (D1000-D1999)**

- eruption or is missing.
  - b. for upper and lower anterior teeth.
  - c. for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.
7. Replacement space maintainers shall be considered for payment when documentation identifies an unusual circumstance (such as lost or non-repairable).
8. The fee for space maintainers includes the band and loop.
9. When prefabricated crowns (D2930, D2931, D2932 and D2933) are necessary for space maintainer abutment teeth they first shall meet the Medi-Cal Dental Program's criteria for prefabricated crowns and shall be billed separately from the space maintainer.

**PROCEDURE D1520  
SPACE MAINTAINER -  
REMOVABLE - UNILATERAL**

- 1. This procedure does not require prior authorization.
- 2. Radiographs for payment - submit a diagnostic

- preoperative periapical or bitewing radiograph to document the presence of the erupting permanent tooth and to verify there is enough space to allow the eruption of the permanent tooth.
3. Written documentation for payment - shall include the identification of the missing primary molar.
4. Requires a quadrant code.
5. A benefit:
- a. once per quadrant per patient.
  - b. for patients under the age of 18.
  - c. only to maintain the space for a single tooth.
6. Not a benefit:
- a. when the permanent tooth is near eruption or is missing.
  - b. for upper and lower anterior teeth.
  - c. for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.
7. Replacement space maintainers shall be considered for payment

- when documentation identifies an unusual circumstance (such as lost or non-repairable).
8. All clasps, rests and adjustments are included in the fee for this procedure.

**PROCEDURE D1525  
SPACE MAINTAINER -  
REMOVABLE - BILATERAL**

- 1. This procedure does not require prior authorization.
- 2. Radiographs for payment - submit a diagnostic preoperative periapical or bitewing radiograph to document the presence of the erupting permanent tooth and to verify there is enough space to allow the eruption of the permanent tooth.
- 3. Written documentation for payment - shall include the identification of the missing primary molars.
- 4. Requires an arch code.
- 5. A benefit:
  - a. once per arch when there is a missing primary molar in both quadrants or when there are two missing primary molars in the same quadrant.

**Preventive Procedures (D1000-D1999)**

- b. for patients under the age of 18.
  - 6. Not a benefit:
    - a. when the permanent tooth is near eruption or is missing.
    - b. for upper and lower anterior teeth.
    - c. for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.
  - 7. Replacement space maintainers shall be considered for payment when documentation identifies an unusual circumstance (such as lost or non-repairable).
  - 8. All clasps, rests and adjustments are included in the fee for this procedure.
- 3. Requires a quadrant code or arch code, as applicable.
  - 4. A benefit:
    - a. once per provider, per applicable quadrant or arch.
    - b. for patients under the age of 18.
  - 5. Additional requests beyond the stated frequency limitations shall be considered for payment when the medical necessity is documented and identifies an unusual condition (such as displacement due to a sticky food item).

**PROCEDURE D1555  
REMOVAL OF FIXED SPACE  
MAINTAINER**

**PROCEDURE D1550  
RECEMENTATION OF SPACE  
MAINTAINER**

- 1. This procedure does not require prior authorization.
  - 2. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
- 1. This procedure does not require prior authorization.
  - 2. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
  - 3. Requires a quadrant code or arch code, as applicable.
  - 4. Not a benefit to the original provider who placed the space maintainer.

**Restorative General Policies (D2000-D2999)**

**Restorative General Policies (D2000-D2999)**

1. Amalgam and Resin-Based Composite Restorations (D2140-D2394):
  - a) Restorative services shall be a benefit when medically necessary, when carious activity or fractures have extended through the dentinoenamel junction (DEJ) and when the tooth demonstrates a reasonable longevity.
  - b) Amalgam and resin-based composite restoration procedures shall require submission of pre-operative radiographs for payment, contingent upon the following rules:
    - i) the first three amalgam and/or resin-based composite restorations that a patient receives in a 12-month period do not require radiographs,
    - ii) the fourth and additional amalgam and/or resin-based composite restorations that a patient receives in a 12-month period do require radiographs. However, when a submitted claim includes the fourth amalgam and/or resin-based composite restoration in a 12-month period then all amalgam and/or resin-based composite restorations on that claim require radiographs.
  - c) The submitted radiographs shall clearly demonstrate that the destruction of the tooth is due to such conditions as decay, fracture, endodontic access or missing or defective restorations. Payment for restorative procedures shall be modified or denied when the medical necessity is not evident.
  - d) Anterior proximal restorations (amalgam/composite) submitted as a two or three surface restoration shall be clearly demonstrated on radiographs that the tooth structure is involved to a point one-third the mesial–distal width of the tooth.
  - e) Should the submitted radiographs fail to demonstrate the medical necessity for the restoration, intraoral photographs shall also be submitted as further documentation.
  - f) When radiographs are medically contraindicated due to recent application of therapeutic doses of ionizing radiation to the head and neck areas, the reason for the contraindication shall be fully documented by the patient's attending physician and submitted for payment. If this condition exists, intraoral photographs shall also be submitted to demonstrate the medical necessity for the restoration.
  - g) When radiographs fail to demonstrate the medical necessity, providers shall also submit adjunctive documentation for consideration for payment such as: fiber optic transillumination photographs, DIAGNOdent readings, caries detection dye photographs, caries risk assessment data or operating room reports.
  - h) Restorative services provided solely to replace tooth structure lost due to attrition, abrasion, erosion or for cosmetic purposes are not a benefit.
  - i) Restorative services are not a benefit when the prognosis of the tooth is questionable due to non-restorability or periodontal involvement.
  - j) Restorations for primary teeth near exfoliation are not a benefit.
  - k) The five valid tooth surface classifications are mesial, distal, occlusal/incisal, lingual and facial (including buccal and labial).

**Restorative General Policies (D2000-D2999)**

- l) Each separate non-connecting restoration on the same tooth for the same date of service shall be submitted on separate Claim Service Lines (CSLs). All surfaces on a single tooth restored with the same restorative material shall be considered connected, for payment purposes, if performed on the same date of service.
  - m) Payment is made for a tooth surface only once for the same date of service regardless of the number or combination of restorative materials placed on that surface.
  - n) Tooth and soft tissue preparation, crown lengthening, cement bases, direct and indirect pulp capping, bonding agents, lining agents, occlusal adjustments (D9951), polishing, local anesthesia and any other associated procedures are included in the fee for a completed restorative service.
  - o) The original provider is responsible for any replacement restorations necessary in primary teeth within the first 12 months and permanent teeth within the first 36 months, except when failure or breakage results from circumstances beyond the control of the provider (such as due to a patient's oral habits). Radiographs (and photographs, as applicable) shall be submitted to demonstrate the need for replacement.
  - p) Replacement of otherwise satisfactory amalgam restorations with resin-based composite restorations is not a benefit unless a specific allergy has been documented by a medical specialist (allergist) on their professional letterhead or prescription and submitted for payment.
2. Prefabricated Crowns (D2929-D2933):
- A. Primary Teeth:
    - a) Prefabricated crowns (D2929, D2930, D2932 and D2933) are a benefit only once in a 12-month period.
    - b) Primary teeth do not require prior authorization. Pre-operative radiographs shall be submitted for payment. At least one of the following criteria shall be met for payment:
      - i) Decay, fracture or other damage involving three or more tooth surfaces,
      - ii) Decay, fracture or other damage involving one interproximal surface when the damage has extended extensively buccolingually or mesiodistally,
      - iii) the prefabricated crown is submitted for payment in conjunction with therapeutic pulpotomy or pulpal therapy (D3220, D3230 and D3240) or the tooth has had previous pulpal treatment.
    - c) Prefabricated crowns for primary teeth near exfoliation are not a benefit.
    - d) When prefabricated crowns are utilized to restore space maintainer abutment teeth they shall meet Medi-Cal Dental Program criteria for prefabricated crowns and shall be submitted separately for payment from the space maintainer.
  - B. Permanent Teeth:
    - a) Prefabricated crowns (D2931, D2932 and D2933) are a benefit only once in a 36-month period.

**Restorative General Policies (D2000-D2999)**

- b) Permanent teeth do not require prior authorization. Pre-operative periapical and arch radiographs shall be submitted for payment. At least one of the following criteria shall be met for payment:
    - i) anterior teeth shall show traumatic or pathological destruction of the crown of the tooth which involves four or more tooth surfaces including at least the loss of one incisal angle,
    - ii) bicuspid (premolars) shall show traumatic or pathological destruction of the crown of the tooth which involves three or more tooth surfaces including at least one cusp,
    - iii) molars shall show traumatic or pathological destruction of the crown of the tooth which involves four or more tooth surfaces including at least two cusps,
    - iv) the prefabricated crown shall restore an endodontically treated bicuspid or molar tooth.
  - c) Arch integrity and the overall condition of the mouth, including the patient's ability to maintain oral health, shall be considered based upon a supportable 36-month prognosis for the permanent tooth to be crowned.
  - d) Indirectly fabricated or prefabricated posts (D2952 and D2954) are benefits when medically necessary for the retention of prefabricated crowns on root canal treated permanent teeth.
  - e) Prefabricated crowns on root canal treated teeth shall be considered for payment only after satisfactory completion of root canal therapy. Post root canal treatment radiographs shall be submitted for prior authorization.
  - f) Prefabricated crowns are not a benefit for abutment teeth for cast metal framework partial dentures (D5213 and D5214).
- C. Primary and Permanent Teeth:
- a) Prefabricated crowns provided solely to replace tooth structure lost due to attrition, abrasion, erosion or for cosmetic purposes are not a benefit.
  - b) Prefabricated crowns are not a benefit when the prognosis of the tooth is questionable due to non-restorability or periodontal involvement.
  - c) Prefabricated crowns are not a benefit when a tooth can be restored with an amalgam or resin-based composite restoration.
  - d) Tooth and soft tissue preparation, crown lengthening, cement bases, direct and indirect pulp capping, amalgam or acrylic buildups, pins (D2951), bonding agents, occlusal adjustments (D9951), local anesthesia (D9210) and any other associated procedures are included in the fee for a prefabricated crown.
  - e) The original provider is responsible for any replacement prefabricated crowns necessary in primary teeth within the first 12 months and permanent teeth within the first 36 months, except when failure or breakage results from circumstances beyond the control of the provider (such as due to a patient's oral habits).
3. Laboratory Processed Crowns (D2710-D2792):

**Restorative General Policies (D2000-D2999)**

- a) Laboratory processed crowns on permanent teeth (or over-retained primary teeth with no permanent successor) are a benefit only once in a 5 year period except when failure or breakage results from circumstances beyond the control of the provider (such as due to a patient's oral habits).
- b) Prior authorization with current periapical and arch radiographs is required. Arch films are not required for crown authorizations if the Medi-Cal Dental Program has paid for root canal treatment on the same tooth within the last six months. Only a periapical radiograph of the completed root canal treatment is required.
- c) A benefit for patients age 13 or older when a lesser service will not suffice because of extensive coronal destruction. The following criteria shall be met for prior authorization:
  - i) Anterior teeth shall show traumatic or pathological destruction to the crown of the tooth, which involves at least one of the following:
  - ii) the involvement of four or more surfaces including at least one incisal angle. The facial or lingual surface shall not be considered involved for a mesial or proximal restoration unless the proximal restoration wraps around the tooth to at least the midline,
  - iii) the loss of an incisal angle which involves a minimum area of both half the incisal width and half the height of the anatomical crown,
  - iv) an incisal angle is not involved but more than 50% of the anatomical crown is involved.
  - v) Bicuspid (premolars) shall show traumatic or pathological destruction of the crown of the tooth, which involves three or more tooth surfaces including one cusp.
  - vi) Molars shall show traumatic or pathological destruction of the crown of the tooth, which involves four or more tooth surfaces including two or more cusps.
  - vii) Posterior crowns for patients age 21 or older are a benefit only when they act as an abutment for a removable partial denture with cast clasps or rests (D5213 and D5214) or for a fixed partial denture which meets current criteria.
- d) Restorative services provided solely to replace tooth structure lost due to attrition, abrasion, erosion or for cosmetic purposes are not a benefit.
- e) Laboratory crowns are not a benefit when the prognosis of the tooth is questionable due to non-restorability or periodontal involvement.
- f) Laboratory processed crowns are not a benefit when the tooth can be restored with an amalgam or resin-based composite.
- g) When a tooth has been restored with amalgam or resin-based composite restoration within 36 months, by the same provider, written documentation shall be submitted with the TAR justifying the medical necessity for the crown request. A current periapical radiograph dated after the restoration is required to demonstrate the medical necessity along with arch radiographs.
- h) Tooth and soft tissue preparation, crown lengthening, cement bases, direct and indirect pulp capping, amalgam or acrylic buildups, pins (D2951), bonding agents, lining agents,

**Restorative General Policies (D2000-D2999)**

impressions, temporary crowns, occlusal adjustments (D9951), polishing, local anesthesia (D9210) and any other associated procedures are included in the fee for a completed laboratory processed crown.

- i) Arch integrity and overall condition of the mouth, including the patient's ability to maintain oral health, shall be considered for prior authorization, which shall be based upon a supportable 5 year prognosis for the teeth to be crowned.
- j) Indirectly fabricated or prefabricated posts (D2952 and D2954) are a benefit when medically necessary for the retention of allowable laboratory processed crowns on root canal treated permanent teeth.
- k) Partial payment will not be made for an undelivered laboratory processed crown. Payment shall be made only upon final cementation.

Archive

Restorative Procedures (D2000-D2999)

**Restorative Procedures (D2000-D2999)**

**PROCEDURE D2140  
AMALGAM - ONE SURFACE,  
PRIMARY OR PERMANENT**

Primary teeth:

1. This procedure does not require prior authorization.
2. Radiographs for payment-refer to Restorative General Policies for specific requirements.
3. Requires a tooth code and surface code.
4. A benefit once in a 12-month period.

Permanent teeth:

1. This procedure does not require prior authorization.
2. Radiographs for payment- Refer to Restorative General Policies for specific requirements.
3. Requires a tooth code and surface code.
4. A benefit once in a 36-month period.

**PROCEDURE D2150  
AMALGAM - TWO  
SURFACES, PRIMARY OR  
PERMANENT**

See the criteria under  
Procedure D2140.

**PROCEDURE D2160**

**AMALGAM - THREE  
SURFACES, PRIMARY OR  
PERMANENT**

See the criteria under  
Procedure D2140.

**PROCEDURE D2161  
AMALGAM - FOUR OR  
MORE SURFACES, PRIMARY  
OR PERMANENT**

See the criteria under  
Procedure D2140.

**PROCEDURE D2330  
RESIN-BASED COMPOSITE -  
ONE SURFACE, ANTERIOR**

Primary teeth:

1. This procedure does not require prior authorization.
2. Radiographs for payment-refer to Restorative General Policies for specific requirements.
3. Requires a tooth code and surface code.
4. A benefit once in a 12-month period.

Permanent teeth:

1. This procedure does not require prior authorization.
2. Radiographs for payment- Refer to Restorative General Policies for specific requirements.

3. Requires a tooth code and surface code.
4. A benefit once in a 36-month period.

**PROCEDURE D2331  
RESIN-BASED COMPOSITE -  
TWO SURFACES, ANTERIOR**

Primary teeth:

1. This procedure does not require prior authorization.
2. Radiographs for payment-refer to Restorative General Policies for specific requirements.
3. Requires a tooth code and surface code.
4. A benefit once in a 12-month period.
5. Each unique tooth surface is only payable once per tooth per date of service.

Permanent teeth:

1. This procedure does not require prior authorization.
  2. Radiographs for payment- Refer to Restorative General Policies for specific requirements.
  3. Requires a tooth code and surface code.
  4. A benefit once in a 36-month period.
  5. Each unique tooth surface is only payable once per tooth per date of service.
2. Radiographs for payment- refer to Restorative General Policies for specific requirements.
  3. Requires a tooth code.
  4. At least four surfaces shall be involved.
  5. A benefit once in a 12-month period.

**PROCEDURE D2332  
RESIN-BASED COMPOSITE -  
THREE SURFACES,  
ANTERIOR**

See the criteria under  
Procedure D2331.

**PROCEDURE D2335  
RESIN-BASED COMPOSITE -  
FOUR OR MORE SURFACES  
OR INVOLVING INCISAL  
ANGLE (ANTERIOR)**

See the criteria under  
Procedure D2331.

**PROCEDURE D2390  
RESIN-BASED COMPOSITE  
CROWN, ANTERIOR**

Primary teeth:

1. This procedure does not require prior authorization.

Permanent teeth:

1. This procedure does not require prior authorization.
2. Radiographs for payment- refer to Restorative General Policies for specific requirements.
3. Requires a tooth code.
4. At least four surfaces shall be involved.
5. A benefit once in a 36-month period.

**PROCEDURE D2391  
RESIN-BASED COMPOSITE -  
ONE SURFACE, POSTERIOR**

Primary teeth:

1. This procedure does not require prior authorization.
2. Radiographs for payment- refer to Restorative General Policies for specific requirements.
3. Requires a tooth code and surface code.
4. A benefit once in a 12-month period.

Permanent teeth:

1. This procedure does not require prior authorization.
2. Radiographs for payment- Refer to Restorative General

Policies for specific requirements.

3. Requires a tooth code and surface code.
4. A benefit once in a 36-month period.

**PROCEDURE D2392  
RESIN-BASED COMPOSITE -  
TWO SURFACES, POSTERIOR**

See the criteria under Procedure D2391.

**PROCEDURE D2393  
RESIN-BASED COMPOSITE -  
THREE SURFACES,  
POSTERIOR**

See the criteria under Procedure D2391.

**PROCEDURE D2394  
RESIN-BASED COMPOSITE -  
FOUR OR MORE SURFACES,  
POSTERIOR**

See the criteria under Procedure D2391.

**PROCEDURE D2410  
GOLD FOIL - ONE SURFACE**

This procedure is not a benefit.

**PROCEDURE D2420  
GOLD FOIL - TWO SURFACES**

This procedure is not a benefit.

**PROCEDURE D2430  
GOLD FOIL - THREE  
SURFACES**

This procedure is not a benefit.

**PROCEDURE D2510  
INLAY - METALLIC - ONE  
SURFACE**

This procedure is not a benefit.

**PROCEDURE D2520  
INLAY - METALLIC - TWO  
SURFACES**

This procedure is not a benefit.

**PROCEDURE D2530**

**INLAY - METALLIC - THREE  
OR MORE SURFACES**

This procedure is not a  
benefit.

**PROCEDURE D2542  
ONLAY - METALLIC - TWO  
SURFACES**

This procedure is not a  
benefit.

**PROCEDURE D2543  
ONLAY - METALLIC - THREE  
SURFACES**

This procedure is not a  
benefit.

**PROCEDURE D2544  
ONLAY - METALLIC - FOUR  
OR MORE SURFACES**

This procedure is not a  
benefit.

**PROCEDURE D2610  
INLAY -  
PORCELAIN/CERAMIC - ONE  
SURFACE**

This procedure is not a  
benefit.

**PROCEDURE D2620  
INLAY -  
PORCELAIN/CERAMIC -  
TWO SURFACES**

This procedure is not a  
benefit.

**PROCEDURE D2630  
INLAY -  
PORCELAIN/CERAMIC -  
THREE OR MORE SURFACES**

This procedure is not a  
benefit.

**PROCEDURE D2642  
ONLAY -  
PORCELAIN/CERAMIC -  
TWO SURFACES**

This procedure is not a  
benefit.

**PROCEDURE D2643  
ONLAY -  
PORCELAIN/CERAMIC -  
THREE SURFACES**

This procedure is not a  
benefit.

**PROCEDURE D2644  
ONLAY -  
PORCELAIN/CERAMIC -  
FOUR OR MORE SURFACES**

This procedure is not a  
benefit.

**PROCEDURE D2650  
INLAY - RESIN-BASED  
COMPOSITE - ONE SURFACE**

This procedure is not a benefit.

**PROCEDURE D2651  
INLAY - RESIN-BASED  
COMPOSITE - TWO  
SURFACES**

This procedure is not a benefit.

**PROCEDURE D2652  
INLAY - RESIN-BASED  
COMPOSITE - THREE OR  
MORE SURFACES**

This procedure is not a benefit.

**PROCEDURE D2662  
ONLAY - RESIN BASED  
COMPOSITE- TWO  
SURFACES**

This procedure is not a benefit.

**PROCEDURE D2663  
ONLAY - RESIN-BASED  
COMPOSITE - THREE  
SURFACES**

This procedure is not a benefit.

**PROCEDURE D2664  
ONLAY - RESIN-BASED  
COMPOSITE - FOUR OR  
MORE SURFACES**

This procedure is not a benefit.

**PROCEDURE D2710**

**CROWN – RESIN– BASED  
COMPOSITE (INDIRECT)**

Permanent anterior teeth (age 13 or older) and permanent posterior teeth (ages 13 through 20):

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs.
3. Requires a tooth code.
4. A benefit:
  - a. once in a five-year period.
  - b. for any resin based composite crown that is indirectly fabricated.
5. Not a benefit:
  - a. for patients under the age of 13.
  - b. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.
6. for use as a temporary crown.

Permanent posterior teeth (age 21 or older):

1. Prior authorization is required.
2. Radiographs for prior authorization - submit

arch and periapical radiographs.

3. Photographs for prior authorization – a photograph shall be submitted when there is an existing removable partial denture and the cast clasp or rest is not evident on a radiograph.
4. Requires a tooth code.
5. A benefit:
  - a. once in a five-year period.
  - b. for any resin based composite crown that is indirectly fabricated.
  - c. only for the treatment of posterior teeth acting as an abutment for an existing removable partial denture with cast clasps or rests (D5213 and D5214), or
  - d. when the treatment plan includes an abutment crown and removable partial denture (D5213 or D5214). Both shall be submitted on the same TAR for prior authorization.
6. Not a benefit:
  - a. for 3rd molars, unless the 3rd molar

is an abutment for an existing removable partial denture with cast clasps or rests.

- b. for use as a temporary crown.

**PROCEDURE D2712  
CROWN – 3/4 RESIN- BASED  
COMPOSITE (INDIRECT)**

Permanent anterior teeth (age 13 or older) and permanent posterior teeth (ages 13 through 20):

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs.
3. Requires a tooth code.
4. A benefit:
  - a. once in a five-year period.
  - b. for any resin based composite crown that is indirectly fabricated.
5. Not a benefit:
  - a. for patients under the age of 13.
  - b. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.

- c. for use as a temporary crown.

Permanent posterior teeth (age 21 or older):

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs.
3. Photographs for prior authorization – a photograph shall be submitted when there is an existing removable partial denture and the cast clasp or rest is not evident on a radiograph.
4. Requires a tooth code.
5. A benefit:
  - a. once in a five-year period.
  - b. for any resin based composite crown that is indirectly fabricated.
  - c. only for the treatment of posterior teeth acting as an abutment for an existing removable partial denture with cast clasps or rests (D5213 and D5214), or
  - d. when the treatment plan includes an abutment crown and

removable partial denture (D5213 or D5214). Both shall be submitted on the same TAR for prior authorization.

6. Not a benefit:
  - a. for 3rd molars, unless the 3rd molar is an abutment for an existing removable partial denture with cast clasps or rests.
  - b. for use as a temporary crown.

**PROCEDURE D2720  
CROWN - RESIN WITH HIGH  
NOBLE METAL**

This procedure is not a benefit.

**PROCEDURE D2721  
CROWN - RESIN WITH  
PREDOMINANTLY BASE  
METAL**

Permanent anterior teeth (age 13 or older) and permanent posterior teeth (ages 13 through 20):

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs.
3. Requires a tooth code.
4. A benefit once in a five-year period.
5. Not a benefit:
  - a. for patients under the age of 13.
  - b. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.

Permanent posterior teeth (age 21 or older):

1. Prior authorization is required.

2. Radiographs for prior authorization - submit arch and periapical radiographs.
3. Photographs for prior authorization- a photograph shall be submitted when there is an existing removable partial denture and the cast clasps or rest is not evident on a radiograph.
4. Requires a tooth code.
5. A benefit:
  - a. once in a five-year period.
  - b. only for the treatment of posterior teeth acting as an abutment for an existing removable partial denture with cast clasps or rests (D5213 and D5214), or
  - c. when the treatment plan includes an abutment crown and removable partial denture (D5213 or D5214). Both shall be submitted on the same TAR for prior authorization.
6. Not a benefit for 3rd molars, unless the 3rd molar is an abutment for an existing removable

partial denture with cast clasps or rests.

**PROCEDURE D2722  
CROWN - RESIN WITH  
NOBLE METAL**

This procedure is not a benefit.

**PROCEDURE D2740  
CROWN -  
PORCELAIN/CERAMIC  
SUBSTRATE**

Permanent anterior teeth (age 13 or older) and permanent posterior teeth (ages 13 through 20):

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs.
3. Requires a tooth code.
4. A benefit once in a five-year period.
5. Not a benefit:
  - a. for patients under the age of 13.
  - b. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.

Permanent posterior teeth (age 21 or older):

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs.
3. Photographs for prior authorization- a photograph shall be submitted when there is an existing removable partial denture and the cast clasps or rest is not evident on a radiograph.
4. Requires a tooth code.
5. A benefit:
  - a. once in a five-year period.
  - b. only for the treatment of posterior teeth acting as an abutment for an existing removable partial denture with cast clasps or rests (D5213 and D5214), or
  - c. when the treatment plan includes an abutment crown and removable partial denture (D5213 or D5214). Both shall be submitted on the same TAR for prior authorization.
6. Not a benefit for 3rd molars, unless the 3rd molar is an abutment for

an existing removable partial denture with cast clasps or rests.

**PROCEDURE D2750  
CROWN - PORCELAIN FUSED  
TO HIGH NOBLE METAL**

This procedure is not a benefit.

**PROCEDURE D2751  
CROWN - PORCELAIN FUSED  
TO PREDOMINANTLY BASE  
METAL**

Permanent anterior teeth (age 13 or older) and permanent posterior teeth (ages 13 through 20):

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs.
3. Requires a tooth code.
4. A benefit once in a five-year period.
5. Not a benefit:
  - a. for beneficiaries under the age of 13.
  - b. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.

Permanent posterior teeth (age 21 or older):

1. Prior authorization is required.

- |   |  |   |
|---|--|---|
| <p>2. Radiographs for prior authorization - submit arch and periapical radiographs.</p> <p>3. Photographs for prior authorization- a photograph shall be submitted when there is an existing removable partial denture and the cast clasps or rest is not evident on a radiograph.</p> <p>4. Requires a tooth code.</p> <p>5. A benefit:</p> <ol style="list-style-type: none"> <li>a. once in a five-year period.</li> <li>b. only for the treatment of posterior teeth acting as an abutment for an existing removable partial denture with cast clasps or rests (D5213 and D5214), or</li> <li>c. when the treatment plan includes an abutment crown and removable partial denture (D5213 or D5214). Both shall be submitted on the same TAR for prior authorization.</li> </ol> <p>6. Not a benefit for 3rd molars, unless the 3rd molar is an abutment for an existing removable</p> | <p>partial denture with cast clasps or rests.</p> <p><b>PROCEDURE D2752<br/>CROWN - PORCELAIN FUSED TO NOBLE METAL</b></p> <p>This procedure is not a benefit.</p> <p><b>PROCEDURE D2780<br/>CROWN - 3/4 CAST HIGH NOBLE METAL</b></p> <p>This procedure is not a benefit.</p> <p><b>PROCEDURE D2781<br/>CROWN - 3/4 CAST PREDOMINANTLY BASE METAL</b></p> <p>Permanent anterior teeth (age 13 or older) and permanent posterior teeth (ages 13 through 20):</p> <ol style="list-style-type: none"> <li>1. Prior authorization is required.</li> <li>2. Radiographs for prior authorization - submit arch and periapical radiographs.</li> <li>3. Requires a tooth code.</li> <li>4. A benefit once in a five-year period.</li> <li>5. Not a benefit: <ol style="list-style-type: none"> <li>a. for patients under the age of 13.</li> <li>b. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable</li> </ol> </li> </ol> | <p>partial denture with cast clasps or rests.</p> <p>Permanent posterior teeth (age 21 or older):</p> <ol style="list-style-type: none"> <li>1. Prior authorization is required.</li> <li>2. Radiographs for prior authorization - submit arch and periapical radiographs.</li> <li>3. Photographs for prior authorization- a photograph shall be submitted when there is an existing removable partial denture and the cast clasps or rest is not evident on a radiograph.</li> <li>4. Requires a tooth code.</li> <li>5. A benefit: <ol style="list-style-type: none"> <li>a. once in a five- year period.</li> <li>b. only for the treatment of posterior teeth acting as an abutment for an existing removable partial denture with cast clasps or rests (D5213 and D5214), or</li> <li>c. when the treatment plan includes an abutment crown and removable partial denture (D5213 or D5214). Both shall be submitted on the</li> </ol> </li> </ol> |
|---|--|---|

same TAR for prior authorization.

6. Not a benefit for 3rd molars, unless the 3rd molar is an abutment for an existing removable partial denture with cast clasps or rests.

**PROCEDURE D2782  
CROWN - 3/4 CAST NOBLE  
METAL**

This procedure is not a benefit.

**PROCEDURE D2783  
CROWN - 3/4 PORCELAIN /  
CERAMIC**

Permanent anterior teeth (age 13 or older) and permanent posterior teeth (ages 13 through 20):

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs.
3. Requires a tooth code.
4. A benefit once in a five-year period.
5. Not a benefit:
  - a. for patients under the age of 13.
  - b. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable

partial denture with cast clasps or rests.

Permanent posterior teeth (age 21 or older):

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs.
3. Photographs for prior authorization- a photograph shall be submitted when there is an existing removable partial denture and the cast clasps or rest is not evident on a radiograph.
4. Requires a tooth code.
5. A benefit:
  - a. once in a five- year period.
  - b. only for the treatment of posterior teeth acting as an abutment for an existing removable partial denture with cast clasps or rests (D5213 and D5214), or
  - c. when the treatment plan includes an abutment crown and removable partial denture (D5213 or D5214). Both shall be submitted on the

same TAR for prior authorization.

6. Not a benefit for 3rd molars, unless the 3rd molar is an abutment for an existing removable partial denture with cast clasps or rests.

**PROCEDURE D2790  
CROWN - FULL CAST HIGH  
NOBLE METAL**

This procedure is not a benefit.

**PROCEDURE D2791  
CROWN - FULL CAST  
PREDOMINANTLY BASE  
METAL**

Permanent anterior teeth (age 13 or older) and permanent posterior teeth (ages 13 through 20):

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs.
3. Requires a tooth code.
4. A benefit once in a five-year period.
5. Not a benefit:
  - a. for patients under the age of 13.
  - b. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable

partial denture with  
cast clasps or rests.

Permanent posterior teeth  
(age 21 or older):

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs.
3. Photographs for prior authorization- a photograph shall be submitted when there is an existing removable partial denture and the cast clasps or rest is not evident on a radiograph.
4. Requires a tooth code.
5. A benefit:
  - a. once in a five- year period.
  - b. only for the treatment of posterior teeth acting as an abutment for an existing removable partial denture with cast clasps or rests (D5213 and D5214), or
  - c. when the treatment plan includes an abutment crown and removable partial denture (D5213 or D5214). Both shall be submitted on the

same TAR for prior  
authorization.

6. Not a benefit for 3rd molars, unless the 3rd molar is an abutment for an existing removable partial denture with cast clasps or rests.

**PROCEDURE D2792  
CROWN - FULL CAST NOBLE  
METAL**

This procedure is not a benefit.

**PROCEDURE D2794  
CROWN - TITANIUM**

This procedure is not a benefit.

**PROCEDURE D2799  
PROVISIONAL CROWN -  
FURTHER TREATMENT OR  
COMPLETION OF  
DIAGNOSIS NECESSARY  
PRIOR TO FINAL  
IMPRESSION**

This procedure is not a benefit.

**PROCEDURE D2910  
RECEMENT INLAY, ONLAY,  
OR PARTIAL COVERAGE  
RESTORATION**

1. This procedure does not require prior authorization.
2. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
3. Requires a tooth code.
4. A benefit once in a 12-month period, per provider.

**PROCEDURE D2915**

**RECEMENT CAST OR  
PREFABRICATED POST AND  
CORE**

This procedure is to be performed in conjunction with the recementation of an existing crown or of a new crown and is not payable separately.

**PROCEDURE D2920  
RECEMENT CROWN**

1. This procedure does not require prior authorization.
2. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
3. Requires a tooth code.
4. The original provider is responsible for all re-cementations within the first 12 months following the initial placement of prefabricated or laboratory processed crowns.
5. Not a benefit within 12 months of a previous re-cementation by the same provider.

**PROCEDURE D2929  
PREFABRICATED  
PORCELAIN/CERAMIC  
CROWN - PRIMARY TOOTH**

1. This procedure does not require prior authorization.
2. Radiographs for payment- submit pre-operative radiographs. Refer to Restorative General Policies for specific requirements.
3. Requires a tooth code.

4. A benefit once in a 12-month period.

**PROCEDURE D2930  
PREFABRICATED STAINLESS  
STEEL CROWN - PRIMARY  
TOOTH**

1. This procedure does not require prior authorization.
2. Radiographs for payment- submit pre-operative radiographs. Refer to Restorative General Policies for specific requirements.
3. Requires a tooth code.
4. A benefit once in a 12-month period.

**PROCEDURE D2931  
PREFABRICATED STAINLESS  
STEEL CROWN -  
PERMANENT TOOTH**

1. This procedure does not require prior authorization.
2. Radiographs for payment- submit arch and pre-operative periapical radiographs. Refer to Restorative General Policies for specific requirements.
3. Requires a tooth code.
4. A benefit once in a 36-month period.
5. Not a benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.

**PROCEDURE D2932  
PREFABRICATED RESIN  
CROWN**

Primary teeth:

1. This procedure does not require prior authorization.
2. Radiographs for payment- submit pre-operative radiographs. Refer to Restorative General Policies for specific requirements.
3. Requires a tooth code.
4. A benefit once in a 12-month period.

Permanent teeth:

1. This procedure does not require prior authorization.
2. Radiographs for payment- submit arch and pre-operative periapical radiographs. Refer to Restorative General Policies for specific requirements.
3. Requires a tooth code.
4. A benefit once in a 36-month period.
5. Not a benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.

**PROCEDURE D2933  
PREFABRICATED STAINLESS  
STEEL CROWN WITH RESIN  
WINDOW**

Primary teeth:

1. This procedure does not require prior authorization.
2. Radiographs for payment- submit pre-operative radiographs. Refer to Restorative General Policies for specific requirements.
3. Requires a tooth code.
4. A benefit once in a 12-month period.
5. This procedure includes the placement of a resin-based composite.

Permanent teeth:

1. This procedure does not require prior authorization.
2. Radiographs for payment- submit arch and pre-operative periapical radiographs. Refer to Restorative General Policies for specific requirements.
3. Requires a tooth code.
4. A benefit once in a 36-month period.
5. Not a benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.
6. This procedure includes the placement of a resin-based composite.

**PROCEDURE D2934**

**PREFABRICATED ESTHETIC  
COATED STAINLESS STEEL  
CROWN - PRIMARY TOOTH**

This procedure is not a benefit.

**PROCEDURE D2940  
PROTECTIVE RESTORATION**

1. This procedure cannot be prior authorized.
2. Radiographs for payment - submit pre-operative radiographs. Refer to Restorative General Policies for specific requirements.
3. Requires a tooth code.
4. A benefit once per tooth in a six-month period, per provider.
5. Not a benefit:
  - a. when performed on the same date of service with a permanent restoration or crown, for same tooth.
  - b. on root canal treated teeth.
6. This procedure is for a temporary restoration and is not to be used as a base or liner under a restoration.

**PROCEDURE D2950  
CORE BUILDUP, INCLUDING  
ANY PINS**

This procedure is included in the fee for restorative procedures

and is not payable separately.

**PROCEDURE D2951  
PIN RETENTION - PER  
TOOTH, IN ADDITION TO  
RESTORATION**

1. This procedure does not require prior authorization.
2. Radiographs for payment- submit pre-operative radiographs.
3. Requires a tooth code.
4. A benefit:
  - a. for permanent teeth only.
  - b. when billed with an amalgam or composite restoration on the same date of service.
  - c. once per tooth regardless of the number of pins placed.
  - d. for a posterior restoration when the destruction involves three or more connected surfaces and at least one cusp, or
  - e. for an anterior restoration when extensive coronal destruction involves the incisal angle.

**PROCEDURE D2952**

**POST AND CORE IN  
ADDITION TO CROWN,  
INDIRECTLY FABRICATED**

1. This procedure does not require prior authorization.
2. Radiographs for payment- submit arch and periapical radiographs.
3. Requires a tooth code.
4. A benefit:
  - a. once per tooth regardless of number of posts placed.
  - b. only in conjunction with allowable crowns (prefabricated or laboratory processed) on root canal treated permanent teeth.
5. This procedure shall be submitted on the same claim/TAR as the crown request.

**PROCEDURE D2953  
EACH ADDITIONAL  
INDIRECTLY FABRICATED  
POST - SAME TOOTH**

This procedure is to be performed in conjunction with D2952 and is not payable separately.

**PROCEDURE D2954**

**PREFABRICATED POST AND  
CORE IN ADDITION TO  
CROWN**

1. This procedure does not require prior authorization.
2. Radiographs for payment- submit arch and periapical radiographs.
3. Requires a tooth code.
4. A benefit:
  - a. once per tooth regardless of number of posts placed.
  - b. only in conjunction with allowable crowns (prefabricated or laboratory processed) on root canal treated permanent teeth.
5. This procedure shall be submitted on the same claim/TAR as the crown request.

**PROCEDURE D2955  
POST REMOVAL**

This procedure is included in the fee for endodontic and restorative procedures and is not payable separately.

**PROCEDURE D2957  
EACH ADDITIONAL  
PREFABRICATED POST -  
SAME TOOTH**

This procedure is to be performed in conjunction with D2954 and is not payable separately.

**PROCEDURE D2960  
LABIAL VENEER (RESIN  
LAMINATE) – CHAIRSIDE**

This procedure is not a benefit.

**PROCEDURE D2961  
LABIAL VENEER (RESIN  
LAMINATE) - LABORATORY**

This procedure is not a benefit.

**PROCEDURE D2962  
LABIAL VENEER (PORCELAIN  
LAMINATE) - LABORATORY**

This procedure is not a benefit.

**PROCEDURE D2970  
TEMPORARY CROWN  
(FRACTURED TOOTH)**

1. This procedure cannot be prior authorized.
2. Radiographs for payment - submit a pre-operative periapical radiograph.
3. Written documentation for payment - shall include a description of the circumstances leading to the traumatic injury.
4. Requires a tooth code.
5. A benefit:
  - a. once per tooth, per provider.
  - b. for permanent teeth only.
6. Not a benefit on the same date of service as:
  - a. palliative (emergency) treatment of dental pain- minor procedure (D9110).
  - b. office visit for observation (during

regularly scheduled hours) - no other services performed (D9430).

7. This procedure is limited to the palliative treatment of traumatic injury only and shall meet the criteria for a laboratory processed crown (D2710-D2792).

**PROCEDURE D2971  
ADDITIONAL PROCEDURES  
TO CONSTRUCT NEW  
CROWN UNDER EXISTING  
PARTIAL DENTURE  
FRAMEWORK**

This procedure is included in the fee for laboratory processed crowns and is not payable separately.

**PROCEDURE D2975  
COPING**

This procedure is not a benefit.

**PROCEDURE D2980  
CROWN REPAIR  
NECESSITATED BY  
RESTORATIVE MATERIAL  
FAILURE**

1. This procedure does not require prior authorization.
2. Radiographs for payment - submit a pre-operative periapical radiograph.

3. Photographs for payment - submit a pre-operative photograph.
4. Written documentation for payment - describe the specific conditions addressed by the procedure (such as broken porcelain).
5. Requires a tooth code.
6. A benefit for laboratory processed crowns on permanent teeth.
7. Not a benefit within 12 months of initial crown placement or previous repair for the same provider.

**PROCEDURE D2981  
INLAY REPAIR  
NECESSITATED BY  
RESTORATIVE MATERIAL  
FAILURE**

This procedure is not a benefit.

**PROCEDURE D2982  
ONLAY REPAIR  
NECESSITATED BY  
RESTORATIVE MATERIAL  
FAILURE**

This procedure is not a benefit.

**PROCEDURE D2983  
VENEER REPAIR  
NECESSITATED BY  
RESTORATIVE MATERIAL  
FAILURE**

This procedure is not a benefit.

**PROCEDURE D2990  
RESIN INFILTRATION OF  
INCIPIENT SMOOTH  
SURFACE LESIONS**

This procedure is not a benefit.

**PROCEDURE D2999  
UNSPECIFIED RESTORATIVE  
PROCEDURE, BY REPORT**

1. This procedure does not require prior authorization.
2. Radiographs for payment - submit radiographs as applicable for the type of procedure.
3. Photographs for payment - submit photographs as applicable for the type of procedure.
4. Written documentation for payment – shall describe the specific

conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed or actual treatment.

5. Requires a tooth code.
6. D2999 shall be used:
  - a. for a procedure which is not adequately described by a CDT code, or
  - b. for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity.Documentation shall include the medical condition and the specific CDT code associated with the treatment.

**Endodontic Procedures (D3000-D3999)**

**Endodontic General Policies (D3000-D3999)**

- a) Prior authorization with current periapical radiographs is required for initial root canal therapy (D3310, D3320 and D3330), root canal retreatment (D3346, D3347 and D3348), partial pulpotomy for apexogenesis (D3222), apexification/recalcification (D3351) and apicoectomy/periradicular surgery (D3410, D3421, D3425 and D3426) on permanent teeth.
- b) Prior authorization for root canal therapy (D3310, D3320 and D3330) is not required when it is documented on a claim for payment that the permanent tooth has been accidentally avulsed or there has been a fracture of the crown exposing vital pulpal tissue. Preoperative radiographs (arch and periapicals) shall be submitted for payment.
- c) Root canal therapy (D3310, D3320, D3330, D3346, D3347 and D3348) is a benefit for permanent teeth and over-retained primary teeth with no permanent successor, if medically necessary. It is medically necessary when the tooth is non-vital (due to necrosis, gangrene or death of the pulp) or if the pulp has been compromised by caries, trauma or accident that may lead to the death of the pulp.
- d) The prognosis of the affected tooth and other remaining teeth shall be evaluated in considering endodontic procedures for prior authorization and payment. Endodontic procedures are not a benefit when the prognosis of the tooth is questionable (due to non-restorability or periodontal involvement).
- e) Endodontic procedures are not a benefit when extraction is appropriate for a tooth due to non-restorability, periodontal involvement or for a tooth that is easily replaced by an addition to an existing or proposed prosthesis in the same arch.
- f) Endodontic procedures are not a benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar positions or is an abutment for an existing fixed or removable partial denture with cast clasps or rests.
- g) The fee for endodontic procedures includes all treatment and post treatment radiographs, any temporary restorations and/or occlusal seals, medicated treatments, bacteriologic studies, pulp vitality tests, removal of root canal obstructions (such as posts, silver points, old root canal filling material, broken root canal files and broaches and calcifications), internal root repairs of perforation defects and routine postoperative care within 30 days.
- h) Endodontic procedures shall be completed prior to payment. The date of service on the payment request shall reflect the final treatment date. A post treatment radiograph is not required for payment.
- i) Satisfactory completion of endodontic procedures is required prior to requesting the final restoration.

**Endodontic Procedures (D3000-D3999)**

**Endodontic Procedures (D3000-D3999)**

**PROCEDURE D3110  
PULP CAP - DIRECT  
(EXCLUDING FINAL  
RESTORATION)**

This procedure is included in the fees for restorative and endodontic procedures and is not payable separately.

**PROCEDURE D3120  
PULP CAP - INDIRECT  
(EXCLUDING FINAL  
RESTORATION)**

This procedure is included in the fees for restorative and endodontic procedures and is not payable separately.

**PROCEDURE D3220  
THERAPEUTIC PULPOTOMY  
(EXCLUDING FINAL  
RESTORATION) - REMOVAL  
OF PULP CORONAL TO THE  
DENTINOCEMENTAL  
JUNCTION AND  
APPLICATION OF  
MEDICAMENT**

1. This procedure does not require prior authorization.
2. Submission of radiographs, photographs or written documentation demonstrating medical

necessity is not required for payment.

3. Requires a tooth code.
4. A benefit once per primary tooth.
5. Not a benefit:
  - a. for a primary tooth near exfoliation.
  - b. for a primary tooth with a necrotic pulp or a periapical lesion.
  - c. for a primary tooth that is non-restorable.
  - d. for a permanent tooth.
6. This procedure is for the surgical removal of the entire portion of the pulp coronal to the dentinocemental junction with the aim of maintaining the vitality of the remaining radicular portion by means of an adequate dressing.

**PROCEDURE D3221  
PULPAL DEBRIDEMENT,  
PRIMARY AND PERMANENT  
TEETH**

1. This procedure does not require prior authorization.
2. Submission of radiographs, photographs or written documentation

demonstrating medical necessity is not required for payment.

3. Requires a tooth code.
4. A benefit:
  - a. for permanent teeth.
  - b. for over-retained primary teeth with no permanent successor.
  - c. once per tooth.
5. Not a benefit on the same date of service with any additional services, same tooth.
6. This procedure is for the relief of acute pain prior to conventional root canal therapy and is not a benefit for root canal therapy visits. Subsequent emergency visits, if medically necessary, shall be billed as palliative (emergency) treatment of dental pain- minor procedure (D9110).

**PROCEDURE D3222  
PARTIAL PULPOTOMY FOR  
APEXOGENESIS-  
PERMANENT TOOTH WITH  
INCOMPLETE ROOT  
DEVELOPMENT**

1. Prior authorization is required.
2. Radiographs for prior authorization - submit periapical radiographs.
3. Requires a tooth code.
4. A benefit:
  - a. once per permanent tooth.
  - b. for patients under the age of 21.
5. Not a benefit:
  - a. for primary teeth.
  - b. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.
  - c. on the same date of service as any other endodontic procedures for the same tooth.
6. This procedure is for vital teeth only.

**PROCEDURE D3230  
PULPAL THERAPY  
(RESORBABLE FILLING) -  
ANTERIOR, PRIMARY**

**TOOTH (EXCLUDING FINAL  
RESTORATION)**

1. This procedure does not require prior authorization.
2. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
3. Requires a tooth code.
4. A benefit once per primary tooth.
5. Not a benefit:
  - a. for a primary tooth near exfoliation.
  - b. with a therapeutic pulpotomy (excluding final restoration) (D3220), same date of service, same tooth.
  - c. with pulpal debridement, primary and permanent teeth (D3221), same date of service, same tooth.

**PROCEDURE D3240  
PULPAL THERAPY  
(RESORBABLE FILLING) -  
POSTERIOR, PRIMARY  
TOOTH (EXCLUDING FINAL  
RESTORATION)**

1. This procedure does not require prior authorization.
2. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
3. Requires a tooth code.
4. A benefit once per primary tooth.
5. Not a benefit:
  - a. for a primary tooth near exfoliation.
  - b. with a therapeutic pulpotomy (excluding final restoration) (D3220), same date of service, same tooth.
  - c. with pulpal debridement, primary and permanent teeth (D3221), same date of service, same tooth.

**PROCEDURE D3310  
ENDODONTIC THERAPY,  
ANTERIOR TOOTH  
(EXCLUDING FINAL  
RESTORATION)**

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs.
3. Requires a tooth code.
4. A benefit once per tooth for initial root canal therapy treatment. For root canal therapy retreatment use retreatment of previous root canal therapy-anterior (D3346).
5. The fee for this procedure includes all treatment and post treatment radiographs, any temporary restoration and/or occlusal seal.

**PROCEDURE D3320  
ENDODONTIC THERAPY,  
BICUSPID TOOTH  
(EXCLUDING FINAL  
RESTORATION)**

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs.
3. Requires a tooth code.

4. A benefit once per tooth for initial root canal therapy treatment. For root canal therapy retreatment use retreatment of previous root canal therapy-bicuspid (D3347).
5. The fee for this procedure includes all treatment and post treatment radiographs, any temporary restoration and/or occlusal seal.

**PROCEDURE D3330  
ENDODONTIC THERAPY,  
MOLAR TOOTH (EXCLUDING  
FINAL RESTORATION)**

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs.
3. Requires a tooth code.
4. A benefit once per tooth for initial root canal therapy treatment. For root canal therapy retreatment use retreatment of previous root canal therapy-molar (D3348).
5. Not a benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.
6. The fee for this procedure includes all treatment and post treatment radiographs, any temporary restoration and/or occlusal seal.

**PROCEDURE D3331  
TREATMENT OF ROOT  
CANAL OBSTRUCTION;  
NON-SURGICAL ACCESS**

This procedure is to be performed in conjunction with endodontic procedures and is not payable separately.

**PROCEDURE D3332  
INCOMPLETE ENDODONTIC  
THERAPY; INOPERABLE,  
UNRESTORABLE OR  
FRACTURED TOOTH**

Endodontic treatment is only payable upon successful completion of endodontic therapy.

**PROCEDURE D3333  
INTERNAL ROOT REPAIR OF  
PERFORATION DEFECTS**

This procedure is to be performed in conjunction with endodontic procedures and is not payable separately.

**PROCEDURE D3346  
RETREATMENT OF  
PREVIOUS ROOT CANAL  
THERAPY - ANTERIOR**

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs demonstrating the medical necessity for retreatment.
3. Written documentation for prior authorization -

if the medical necessity is not evident on the radiographs, documentation shall include the rationale for retreatment.

4. Requires a tooth code.
5. Not a benefit to the original provider within 12 months of initial treatment.
6. The fee for this procedure includes all treatment and post treatment radiographs, any temporary restoration and/or occlusal seal.

**PROCEDURE D3347  
RETREATMENT OF  
PREVIOUS ROOT CANAL  
THERAPY - BICUSPID**

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs demonstrating the medical necessity for retreatment.
3. Written documentation for prior authorization - if the medical necessity is not evident on the radiographs, documentation shall include the rationale for retreatment.
4. Requires a tooth code.

5. Not a benefit to the original provider within 12 months of initial treatment.
6. The fee for this procedure includes all treatment and post treatment radiographs, any temporary restoration and/or occlusal seal.

**PROCEDURE D3348  
RETREATMENT OF  
PREVIOUS ROOT CANAL  
THERAPY - MOLAR**

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs demonstrating the medical necessity for retreatment.
3. Written documentation for prior authorization - if the medical necessity is not evident on the radiographs, documentation shall include the rationale for retreatment.
4. Requires a tooth code.
5. Not a benefit:
  - a. to the original provider within 12 months of initial treatment.
  - b. for 3rd molars, unless the 3rd molar

occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.

6. The fee for this procedure includes all treatment and post treatment radiographs, any temporary restoration and/or occlusal seal.

**PROCEDURE D3351  
APEXIFICATION/  
RECALCIFICATION/PULPAL  
REGENERATION - INITIAL  
VISIT (APICAL  
CLOSURE/CALCIFIC REPAIR  
OF PERFORATIONS, ROOT  
RESORPTION, PULP SPACE  
DISINFECTION ETC.)**

1. Prior authorization is required.
2. Radiographs for prior authorization - submit periapical radiographs.
3. Requires a tooth code.
4. A benefit:
  - a. once per permanent tooth.
  - b. for patients under the age of 21.
5. Not a benefit:
  - a. for primary teeth.
  - b. for 3rd molars, unless the 3rd molar occupies the 1st or

2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.

- c. on the same date of service as any other endodontic procedures for the same tooth.
6. This procedure includes initial opening of the tooth, performing a pulpectomy, preparation of canal spaces, placement of medications and all treatment and post treatment radiographs.
7. If an interim medication replacement is necessary, use apexification/recalcification- interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.) (D3352).
8. Upon completion of apexification/recalcification, prior authorization for the final root canal therapy shall be submitted along with the post-treatment radiograph to demonstrate sufficient apical formation.

**PROCEDURE D3352  
APEXIFICATION/  
RECALCIFICATION/PULPAL  
REGENERATION - INTERIM  
MEDICATION  
REPLACEMENT**

1. Prior authorization is required for D3351, which shall be completed before D3352 is payable.
2. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
3. Requires a tooth code.
4. A benefit:
  - a. only following apexification/recalcification- initial visit (apical closure/calcific repair of perforations, root resorption, etc.) (D3351).
  - b. once per permanent tooth.
  - c. for patients under the age of 21.
5. Not a benefit:
  - a. for primary teeth.
  - b. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial

denture or removable partial denture with cast clasps or rests.

- c. on the same date of service as any other endodontic procedures for the same tooth.
6. This procedure includes reopening the tooth, placement of medications and all treatment and post treatment radiographs.
7. Upon completion of apexification/recalcification, prior authorization for the final root canal therapy shall be submitted along with the post treatment radiograph to demonstrate sufficient apical formation.

**PROCEDURE D3353  
APEXIFICATION/  
RECALCIFICATION - FINAL  
VISIT (INCLUDES  
COMPLETED ROOT CANAL  
THERAPY - APICAL  
CLOSURE/CALCIFIC REPAIR  
OF PERFORATIONS, ROOT  
RESORPTION, ETC.)**

This procedure is not a benefit. Upon completion of apexification/recalcification, prior authorization for the

final root canal therapy shall be submitted along with the post treatment radiograph to demonstrate sufficient apical formation.

**PROCEDURE D3354  
PULPAL REGENERATION -  
(COMPLETION OF  
REGENERATIVE TREATMENT  
IN AN IMMATURE  
PERMANENT TOOTH WITH  
A NECROTIC PULP); DOES  
NOT INCLUDE FINAL  
RESTORATION**

This procedure is not a benefit.

**PROCEDURE D3410  
APICTOMY/  
PERIRADICULAR SURGERY -  
ANTERIOR**

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs demonstrating the medical necessity.
3. Written documentation for prior authorization - if the medical necessity is not evident on the radiographs, documentation shall include the rationale for treatment.
4. Requires a tooth code.
5. A benefit for permanent anterior teeth only.
6. Not a benefit:
  - a. to the original provider within 90 days of root canal therapy except when a medical necessity is documented.
  - b. to the original provider within 24 months of a prior apicoectomy/periradicular surgery.
7. The fee for this procedure includes the placement of retrograde filling material and all

treatment and post  
treatment radiographs.

**PROCEDURE D3421  
APICOECTOMY/  
PERIRADICULAR SURGERY -  
BICUSPID (FIRST ROOT)**

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs demonstrating the medical necessity.
3. Written documentation for prior authorization - if the medical necessity is not evident on the radiographs, documentation shall include the rationale and the identity of the root that requires treatment.
4. Requires a tooth code.
5. A benefit for permanent bicuspid teeth only.
6. Not a benefit:
  - a. to the original provider within 90 days of root canal therapy except when a medical necessity is documented.
  - b. to the original provider within 24 months of a prior apicoectomy/periradicular surgery, same root.

7. The fee for this procedure includes the placement of retrograde filling material and all treatment and post treatment radiographs.
8. If more than one root is treated, use apicoectomy/periradicular surgery - each additional root (D3426).

**PROCEDURE D3425  
APICOECTOMY/  
PERIRADICULAR SURGERY -  
MOLAR (FIRST ROOT)**

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs demonstrating the medical necessity.
3. Written documentation for prior authorization - if the medical necessity is not evident on the radiographs, documentation shall include the rationale and the identity of the root that requires treatment.
4. Requires a tooth code.
5. A benefit for permanent 1st and 2nd molar teeth only.
6. Not a benefit:
  - a. to the original provider within 90 days of root canal

therapy except when a medical necessity is documented.

- b. to the original provider within 24 months of a prior apicoectomy/periradicular surgery, same root.
- c. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.

7. The fee for this procedure includes the placement of retrograde filling material and all treatment and post treatment radiographs.
8. If more than one root is treated, use apicoectomy/periradicular surgery - each additional root (D3426).

**PROCEDURE D3426  
APICOECTOMY/  
PERIRADICULAR SURGERY  
(EACH ADDITIONAL ROOT)**

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs

- demonstrating the medical necessity.
3. Written documentation for prior authorization - if the medical necessity is not evident on the radiographs, documentation shall include the rationale and the identity of the root that requires treatment.
  4. Requires a tooth code.
  5. A benefit for permanent teeth only.
  6. Not a benefit:
    - a. to the original provider within 90 days of root canal therapy except when a medical necessity is documented.
    - b. to the original provider within 24 months of a prior apicoectomy/ periradicular surgery, same root.
    - c. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.
  7. Only payable the same date of service as

procedures D3421 or D3425.

8. The fee for this procedure includes the placement of retrograde filling material and all treatment and post treatment radiographs.

**PROCEDURE D3430  
RETROGRADE FILLING - PER  
ROOT**

This procedure is to be performed in conjunction with endodontic procedures and is not payable separately.

**PROCEDURE D3450  
ROOT AMPUTATION – PER  
ROOT**

This procedure is not a benefit.

**PROCEDURE D3460  
ENDODONTIC ENDOSSEOUS  
IMPLANT**

This procedure is not a benefit.

**PROCEDURE D3470  
INTENTIONAL  
REIMPLANTATION  
(INCLUDING NECESSARY  
SPLINTING)**

This procedure is not a benefit.

**PROCEDURE D3910  
SURGICAL PROCEDURE FOR  
ISOLATION OF TOOTH WITH  
RUBBER DAM**

This procedure is included in the fees for restorative and endodontic procedures and is not payable separately.

**PROCEDURE D3920  
HEMISECTION (INCLUDING  
ANY ROOT REMOVAL), NOT  
INCLUDING ROOT CANAL  
THERAPY**

This procedure is not a benefit.

**PROCEDURE D3950  
CANAL PREPARATION AND  
FITTING OF PREFORMED  
DOWEL OR POST**

This procedure is not a benefit.

**PROCEDURE D3999  
UNSPECIFIED ENDODONTIC  
PROCEDURE, BY REPORT**

1. This procedure does not require prior authorization.
2. Radiographs for payment - submit arch and pre-operative periapical radiographs as applicable for the type of procedure.
3. Photographs for payment- submit as applicable for the type of procedure.
4. Written documentation for payment – shall describe the specific conditions addressed by

the procedure, the rationale demonstrating the medical necessity, any pertinent history and the actual treatment.

5. Requires a tooth code.
6. Procedure D3999 shall be used:
  - a. for a procedure which is not adequately described by a CDT code, or
  - b. for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity.

Documentation shall include the medical condition and the specific CDT code associated with the treatment.

**Periodontal Procedures (D4000-D4999)**

**Periodontal General Policies (D4000-D4999)**

- a) Periodontal procedures shall be a benefit for patients age 13 or older. Periodontal procedures shall be considered for patients under the age of 13 when unusual circumstances exist such as aggressive periodontitis and drug-induced hyperplasia and the medical necessity has been fully documented on the TAR.
- b) Prior authorization is required for all periodontal procedures except for unscheduled dressing change (by someone other than the treating dentist) (D4290) and periodontal maintenance (D4910).
- c) Current periapical radiographs of the involved areas and bitewing radiographs are required for periodontal scaling and root planing (D4341 and D4342) and osseous surgery (D4260 and D4261) for prior authorizations. A panoramic radiographic image alone is non-diagnostic for periodontal procedures.
- d) Photographs are required for gingivectomy or gingivoplasty (D4210 and D4211) for prior authorizations.
- e) Only teeth that qualify as diseased are to be considered in the count for the number of teeth to be treated in a particular quadrant. A qualifying tooth shall have a significant amount of bone loss, presence of calculus deposits, be restorable and have arch integrity and shall meet Medi-Cal Dental Program criteria for the requested procedure. Qualifying teeth include implants. Teeth shall not be counted as qualifying when they are indicated to be extracted. Full or partial quadrants are defined as follows:
  - i) a full quadrant is considered to have four or more qualifying diseased teeth,
  - ii) a partial quadrant is considered to have one, two, or three diseased teeth,
  - iii) third molars shall not be counted unless the third molar occupies the first or second molar position or is an abutment for an existing fixed or removable partial denture with cast clasps or rests.
- f) Tooth bounded spaces shall only be counted in conjunction with osseous surgeries (D4260 and D4261) that require a surgical flap. Each tooth bounded space shall only count as one tooth space regardless of the number of missing natural teeth in the space.
- g) Scaling and root planing (D4341 and D4342) are a benefit once per quadrant in a 24 month period. Patients shall exhibit connective tissue attachment loss and radiographic evidence of bone loss and/or subgingival calculus deposits on root surfaces.
- h) Gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261) are a benefit once per quadrant in a 36 month period and shall not be authorized until 30 days following scaling and root planing (D4341 and D4342) in the same quadrant. Patients shall exhibit radiographic evidence of moderate to severe bone loss to qualify for osseous surgery.
- i) Gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261) includes three months of post-operative care and any surgical re-entry for 36 months.

**Periodontal Procedures (D4000-D4999)**

Documentation of extraordinary circumstances and/or medical conditions will be given consideration on a case-by- case basis.

- j) Scaling and root planing (D4341 and D4342) can be authorized in conjunction with prophylaxis procedures (D1110 and D1120). However, payment shall not be made for any prophylaxis procedure if the prophylaxis is performed on the same date of service as the scaling and root planing.
- k) Gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261) includes frenulectomy (frenectomy or frenotomy) (D7960), frenuloplasty (D7963) and/or distal wedge performed in the same area on the same date of service.
- l) Procedures involved in acquiring graft tissues (hard or soft) from extra-oral donor sites are considered part of the fee for osseous surgery (D4260 and D4261) and are not payable separately.
- m) Gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261) performed in conjunction with a laboratory crown, prefabricated crown, amalgam or resin-based composite restoration or endodontic therapy is included in the fee for the final restoration or endodontic therapy and is not payable separately.

ARCHIVE

**Periodontal Procedures (D4000-D4999)**

**Periodontal Procedures (D4000-D4999)**

**PROCEDURE D4210  
GINGIVECTOMY OR  
GINGIVOPLASTY- FOUR OR  
MORE CONTIGUOUS TEETH  
OR TOOTH BOUNDED  
SPACES PER QUADRANT**

1. Prior authorization is required.
2. Photographs for prior authorization- submit photographs of the involved areas.
3. Requires a quadrant code.
4. If three or fewer diseased teeth are present in the quadrant, use gingivectomy or gingivoplasty (D4211).
5. A benefit:
  - a. for patients age 13 or older.
  - b. once per quadrant every 36 months.
6. This procedure cannot be prior authorized within 30 days following periodontal scaling and root planing (D4341 and D4342) for the same quadrant.

**PROCEDURE D4211  
GINGIVECTOMY OR  
GINGIVOPLASTY - ONE TO  
THREE CONTIGUOUS TEETH,  
OR TOOTH BOUNDED  
SPACES PER QUADRANT**

1. Prior authorization is required.
2. Photographs for prior authorization- submit photographs of the involved areas.
3. Requires a quadrant code.
4. If four or more diseased teeth are present in the quadrant, use gingivectomy or gingivoplasty (D4210).
5. A benefit:
  - a. for patients age 13 or older.
  - b. once per quadrant every 36 months.
6. This procedure cannot be prior authorized within 30 days following periodontal scaling and root planing (D4341 and D4342) for the same quadrant.

**PROCEDURE D4212  
GINGIVECTOMY OR  
GINGIVOPLASTY TO ALLOW  
ACCESS FOR RESTORATIVE  
PROCEDURE, PER TOOTH**

This procedure is not a benefit.

**PROCEDURE D4230  
ANATOMICAL CROWN  
EXPOSURE- FOUR OR MORE  
CONTIGUOUS TEETH PER  
QUADRANT**

This procedure is not a benefit.

**PROCEDURE D4231  
ANATOMICAL CROWN  
EXPOSURE- ONE TO THREE  
TEETH PER QUADRANT**

This procedure is not a benefit.

**PROCEDURE D4240  
GINGIVAL FLAP  
PROCEDURE, INCLUDING  
ROOT PLANING- FOUR OR  
MORE CONTIGUOUS TEETH  
OR TOOTH BOUNDED  
SPACES PER QUADRANT**

This procedure is not a benefit.

**PROCEDURE D4241  
GINGIVAL FLAP  
PROCEDURE, INCLUDING  
ROOT PLANING- ONE TO  
THREE CONTIGUOUS TEETH  
OR TOOTH BOUNDED  
SPACES, PER QUADRANT**

This procedure is not a benefit.

**PROCEDURE D4245  
APICALLY POSITIONED FLAP**

This procedure is not a benefit.

**PROCEDURE D4249  
CLINICAL CROWN  
LENGTHENING – HARD  
TISSUE**

This procedure is included in the fee for a completed restorative service.

**PROCEDURE D4260  
OSSEOUS SURGERY  
(INCLUDING FLAP ENTRY  
AND CLOSURE)- FOUR OR  
MORE CONTIGUOUS TEETH  
OR TOOTH BOUNDED  
SPACES PER QUADRANT**

1. Prior authorization is required.
2. Radiographs for prior authorization- submit periapical radiographs of the involved areas and bitewing radiographs.
3. Requires a quadrant code.
4. If three or fewer diseased teeth are

present in the quadrant, use osseous surgery (D4261).

5. A benefit:
  - a. for patients age 13 or older.
  - b. once per quadrant every 36 months.
6. This procedure cannot be prior authorized within 30 days following periodontal scaling and root planing (D4341 and D4342) for the same quadrant.
7. This procedure can only be prior authorized when preceded by periodontal scaling and root planing (D4341 and D4342) in the same quadrant within the previous 24 months.

**PROCEDURE D4261  
OSSEOUS SURGERY  
(INCLUDING FLAP ENTRY  
AND CLOSURE) - ONE TO  
THREE CONTIGUOUS TEETH  
OR TOOTH BOUNDED  
SPACES, PER QUADRANT**

1. Prior authorization is required.
2. Radiographs for prior authorization- submit periapical radiographs of the involved areas and bitewing radiographs.
3. Requires a quadrant code.

4. If four or more diseased teeth are present in the quadrant, use osseous surgery (D4260).
5. A benefit:
  - a. for patients age 13 or older.
  - b. once per quadrant every 36 months.
6. This procedure cannot be prior authorized within 30 days following periodontal scaling and root planing (D4341 and D4342) for the same quadrant.
7. This procedure can only be prior authorized when preceded by periodontal scaling and root planing (D4341 and D4342) in the same quadrant within the previous 24 months.

**PROCEDURE D4263  
BONE REPLACEMENT GRAFT  
– FIRST SITE IN QUADRANT**

This procedure is not a benefit.

**PROCEDURE D4264  
BONE REPLACEMENT GRAFT  
– EACH ADDITIONAL SITE IN  
QUADRANT**

This procedure is not a benefit.

**PROCEDURE D4265  
BIOLOGIC MATERIALS TO  
AID IN SOFT AND OSSEOUS  
TISSUE REGENERATION**

This procedure is included in the fees for other periodontal procedures and is not payable separately.

**PROCEDURE D4266  
GUIDED TISSUE  
REGENERATION –  
RESORBABLE BARRIER, PER  
SITE**

This procedure is not a benefit.

**PROCEDURE D4267  
GUIDED TISSUE  
REGENERATION –  
NONRESORBABLE BARRIER,  
PER SITE (INCLUDES  
MEMBRANE REMOVAL)**

This procedure is not a benefit.

**PROCEDURE D4268  
SURGICAL REVISION  
PROCEDURE, PER TOOTH**

This procedure is not a benefit.

**PROCEDURE D4270  
PEDICLE SOFT TISSUE GRAFT  
PROCEDURE**

This procedure is not a benefit.

**PROCEDURE D4273  
SUBEPITHELIAL  
CONNECTIVE TISSUE GRAFT  
PROCEDURES, PER TOOTH**

This procedure is not a benefit.

**PROCEDURE D4274  
PROCEDURE DISTAL OR  
PROXIMAL WEDGE  
PROCEDURE (WHEN NOT  
PERFORMED IN  
CONJUNCTION WITH  
SURGICAL PROCEDURES IN  
THE SAME ANATOMICAL  
AREA)**

This procedure is not a benefit.

**PROCEDURE D4275  
SOFT TISSUE ALLOGRAFT**

This procedure is not a benefit.

**PROCEDURE D4276  
COMBINED CONNECTIVE  
TISSUE AND DOUBLE  
PEDICLE GRAFT, PER TOOTH**

This procedure is not a benefit.

**PROCEDURE D4277  
FREE SOFT TISSUE GRAFT  
PROCEDURE (INCLUDING  
DONOR SITE SURGERY),  
FIRST TOOTH OR  
EDENTULOUS TOOTH  
POSITION IN GRAFT**

This procedure is not a benefit.

**PROCEDURE D4278**

**FREE SOFT TISSUE GRAFT  
PROCEDURE (INCLUDING  
DONOR SITE SURGERY),  
EACH ADDITIONAL  
CONTIGUOUS TOOTH OR  
EDENTULOUS TOOTH  
POSITION IN SAME GRAFT  
SITE**

This procedure is not a benefit.

**PROCEDURE D4320  
PROVISIONAL SPLINTING –  
INTRACORONAL**

This procedure is not a benefit.

**PROCEDURE D4321  
PROVISIONAL SPLINTING –  
EXTRACORONAL**

This procedure is not a benefit.

**PROCEDURE D4341  
PERIODONTAL SCALING  
AND ROOT PLANING - FOUR  
OR MORE TEETH PER  
QUADRANT**

1. Prior authorization is required.
2. Radiographs for prior authorization - submit periapical radiographs of the involved areas and bitewing radiographs.
3. Requires a quadrant code.
4. If three or fewer diseased teeth are present in the quadrant, use periodontal scaling and root planing (D4342).
5. A benefit:
  - a. for patients age 13 or older.
  - b. once per quadrant every 24 months.
6. Gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and

D4261) cannot be prior authorized within 30 days following this procedure for the same quadrant.

7. Prophylaxis (D1110 and D1120) are not payable on the same date of service as this procedure.

**PROCEDURE D4342  
PERIODONTAL SCALING  
AND ROOT PLANING - ONE  
TO THREE TEETH PER  
QUADRANT**

1. Prior authorization is required.
2. Radiographs for prior authorization - submit periapical radiographs of the involved areas and bitewing radiographs.
3. Requires a quadrant code.
4. If four or more diseased teeth are present in the quadrant, use periodontal scaling and root planing (D4341).
5. A benefit:
  - a. for patients age 13 or older.
  - b. once per quadrant every 24 months.
6. Gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261) cannot be prior authorized within 30 days following this procedure for the same quadrant.
7. Prophylaxis (D1110 and D1120) are not payable on the same date of service as this procedure.

**PROCEDURE D4355**

**FULL MOUTH  
DEBRIDEMENT TO ENABLE  
COMPREHENSIVE  
EVALUATION AND  
DIAGNOSIS**

This procedure is included in the fees for other periodontal procedures and is not payable separately.

**PROCEDURE D4381  
LOCALIZED DELIVERY OF  
ANTIMICROBIAL AGENTS  
VIA A CONTROLLED  
RELEASE VEHICLE INTO  
DISEASED CREVICULAR  
TISSUE, PER TOOTH**

This procedure is included in the fees for other periodontal procedures and is not payable separately.

**PROCEDURE D4910  
PERIODONTAL  
MAINTENANCE**

1. This procedure does not require prior authorization.
2. A benefit:
  - a. only for patients residing in a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF).
  - b. only when preceded by a periodontal scaling and root planing (D4341-D4342).
  - c. only after completion of all necessary scaling and root planings.
  - d. once in a calendar quarter.
  - e. only in the 24 month period following the last scaling and root planing.

3. Not a benefit in the same calendar quarter as scaling and root planing.
4. Not payable to the same provider in the same calendar quarter as prophylaxis- adult (D1110) or prophylaxis-child (D1120).
5. This procedure is considered a full mouth treatment.

**PROCEDURE D4920  
UNSCHEDULED DRESSING  
CHANGE (BY SOMEONE  
OTHER THAN TREATING  
DENTIST)**

1. This procedure cannot be prior authorized.
2. Written documentation for payment – shall include a brief description indicating the medical necessity.
3. A benefit:
  - a. for patients age 13 or older.
  - b. once per patient per provider.
  - c. within 30 days of the date of service of gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261).
4. Unscheduled dressing changes by the same provider are considered part of, and included in the fee for gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261).

**PROCEDURE D4999  
UNSPECIFIED PERIODONTAL  
PROCEDURE, BY REPORT**

1. Prior authorization is required.
2. Radiographs for prior authorization- submit as

applicable for the type of procedure.

3. Photographs for prior authorization- shall be submitted.
4. Written documentation for prior authorization – shall include the specific treatment requested and etiology of the disease or condition.
5. Requires a tooth or quadrant code, as applicable for the type of procedure.
6. A benefit for patients age 13 or older.
7. Procedure D4999 shall be used:
  - a. for a procedure which is not adequately described by a CDT code, or
  - b. for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity.Documentation shall include the medical condition and the specific CDT code associated with the treatment.

**Prosthodontics (Removable) General Policies (D5000-D5899)**

**Prosthodontics (Removable) General Policies (D5000-D5899)**

1. Complete and Partial Dentures (D5110-D5214 and D5860):
  - a) Prior authorization is required for removable prostheses except for immediate dentures (D5130 and D5140).
  - b) Prior authorization shall be considered for a new prosthesis only when it is clearly evident that the existing prosthesis cannot be made serviceable by repair, replacement of broken and missing teeth or reline.
  - c) Current radiographs of all remaining natural teeth and implants and a properly completed prosthetic Justification of Need For Prosthesis Form, DC054 (10/05) are required for prior authorization. A panoramic radiographic image shall be considered diagnostic for edentulous areas only.
  - d) Complete and partial dentures are prior authorized only as full treatment plans. Payment shall be made only when the full treatment has been completed. Any revision of a prior authorized treatment plan requires a new TAR.
  - e) New complete or partial dentures shall not be prior authorized when it would be highly improbable for a patient to utilize, care for or adapt to a new prosthesis due to psychological and/or motor deficiencies as determined by a clinical screening dentist (see "g" below).
  - f) All endodontic, restorative and surgical procedures for teeth that impact the design of a removable partial denture (D5211, D5212, D5213 and D5214) shall be addressed before prior authorization is considered.
  - g) The need for new or replacement prosthesis may be evaluated by a clinical screening dentist.
  - h) Providers shall use the laboratory order date as the date of service when submitting for payment of a prior authorized removable prosthesis. The laboratory order date is the date when the prosthesis is sent to the laboratory for final fabrication. Full payment shall not be requested until the prosthesis is delivered and is in use by the patient.
  - i) Partial payment of an undeliverable completed removable prosthesis shall be considered when the reason for non-delivery is adequately documented on the Notice of Authorization (NOA) and is accompanied by a laboratory invoice indicating the prosthesis was processed. The completed prosthesis shall be kept in the provider's office, in a deliverable condition, for a period of at least one year.
  - j) A removable prosthesis is a benefit only once in a five year period. When adequately documented, the following exceptions shall apply:
    - i) Catastrophic loss beyond the control of the patient. Documentation must include a copy of the official public service agency report (fire or police), or
    - ii) A need for a new prosthesis due to surgical or traumatic loss of oral-facial anatomic structure, or

**Prosthodontics (Removable) General Policies (D5000-D5899)**

- iii) The removable prosthesis is no longer serviceable as determined by a clinical screening dentist.
  - k) Prosthodontic services provided solely for cosmetic purposes are not a benefit.
  - l) Temporary or interim dentures to be used while a permanent denture is being constructed are not a benefit.
  - m) Spare or backup dentures are not a benefit.
  - n) Evaluation of a denture on a maintenance basis is not a benefit.
  - o) The fee for any removable prosthesis, reline, tissue conditioning or repair includes all adjustments necessary for six months after the date of service by the same provider.
  - p) Immediate dentures should only be considered for a patient when one or more of the following conditions exist:
    - i) extensive or rampant caries are exhibited in the radiographs,
    - ii) severe periodontal involvement is indicated in the radiographs,
    - iii) numerous teeth are missing resulting in diminished masticating ability adversely affecting the patient's health.
  - q) There is no insertion fee payable to an oral surgeon who seats an immediate denture.
  - r) Preventative, endodontic or restorative procedures are not a benefit for teeth to be retained for overdentures. Only extractions for the retained teeth will be a benefit.
  - s) Partial dentures are not a benefit to replace missing 3rd molars.
2. Relines and Tissue Conditioning (D5730-D5761, D5850 and D5851):
- a) Laboratory relines (D5750, D5751, D5760 and D5761) are a benefit six months after the date of service for immediate dentures (D5130 and D5140), an immediate overdenture (D5860) and cast metal partial dentures (D5213 and D5214) that required extractions.
  - b) Laboratory relines (D5750, D5751, D5760 and D5761) are a benefit 12 months after the date of service for complete (remote) dentures (D5110 and D5120), a complete (remote) overdenture (D5860) and cast metal partial dentures (D5213 and D5214) that did not require extractions.
  - c) Laboratory relines (D5760 and D5761) are not a benefit for resin based partial dentures (D5211 and D5212).
  - d) Laboratory relines (D5750, D5751, D5760 and D5761) are not a benefit within 12 months of chairside relines (D5730, D5731, D5740 and D5741).
  - e) Chairside relines (D5730, D5731, D5740 and D5741) are a benefit six months after the date of service for immediate dentures (D5130 and D5140), an immediate overdenture (D5860), resin based partial dentures (D5211 and D5212) and cast metal partial dentures (D5213 and D5214) that required extractions.
  - f) Chairside relines (D5730, D5731, D5740 and D5741) are a benefit 12 months after the date of service for complete (remote) dentures (D5110 and D5120), a complete (remote) overdenture (D5860), resin based partial dentures (D5211 and D5212) and cast metal partial dentures (D5213 and D5214) that did not require extractions.

**Prosthodontics (Removable) General Policies (D5000-D5899)**

- g) Chairsides relines (D5730, D5731, D5740 and D5741) are not a benefit within 12 months of laboratory relines (D5750, D5751, D5760 and D5761).
- h) Tissue conditioning (D5850 and D5851) is only a benefit to heal unhealthy ridges prior to a definitive prosthodontic treatment.
- i) Tissue conditioning (D5850 and D5851) is a benefit the same date of service as an immediate prosthesis that required extractions.

Archive

**Prosthodontic (Removable) Procedures (D5000-D5899)**

**Prosthodontic (Removable) Procedures (D5000-D5899)**

**PROCEDURE D5110  
COMPLETE DENTURE –  
MAXILLARY**

1. Prior authorization is required.
2. Radiographs for prior authorization –submit radiographs of all opposing natural teeth.
3. A current and complete Justification of Need For Prosthesis Form, DC054 (10/05) is required for prior authorization.
4. A benefit once in a five year period from a previous complete, immediate or overdenture- complete denture.
5. For an immediate denture, use immediate denture-maxillary (D5130) or overdenture-complete, by report (D5860) as applicable for the type of procedure.
6. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
7. A laboratory reline (D5750) or chairside reline (D5730) is a benefit 12 months after

the date of service for this procedure.

**PROCEDURE D5120  
COMPLETE DENTURE –  
MANDIBULAR**

1. Prior authorization is required.
2. Radiographs for prior authorization –submit radiographs of all opposing natural teeth.
3. A current and complete Justification of Need For Prosthesis Form, DC054 (10/05) is required for prior authorization.
4. A benefit once in a five year period from a previous complete, immediate or overdenture- complete denture.
5. For an immediate denture, use immediate denture-mandibular (D5140) or overdenture-complete, by report (D5860) as applicable for the type of procedure.
6. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
7. A laboratory reline (D5751) or chairside reline (D5731) is a

benefit 12 months after the date of service for this procedure.

**PROCEDURE D5130  
IMMEDIATE DENTURE –  
MAXILLARY**

1. Prior authorization is not required.
2. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
3. A benefit once per patient.
4. Not a benefit as a temporary denture. Subsequent complete dentures are not a benefit within a five-year period of an immediate denture.
5. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
6. A laboratory reline (D5750) or chairside reline (D5730) is a benefit six months after the date of service for this procedure.

**PROCEDURE D5140**

**IMMEDIATE DENTURE –  
MANDIBULAR**

1. Prior authorization is not required.
2. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
3. A benefit once per patient.
4. Not a benefit as a temporary denture. Subsequent complete dentures are not a benefit within a five-year period of an immediate denture.
5. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
6. A laboratory reline (D5751) or chairside reline (D5731) is a benefit six months after the date of service for this procedure.

**PROCEDURE D5211  
MAXILLARY PARTIAL  
DENTURE – RESIN BASE  
(INCLUDING ANY  
CONVENTIONAL CLASPS,  
RESTS AND TEETH)**

1. Prior authorization is required.
2. Radiographs for prior authorization –submit radiographs of all remaining natural teeth and periapical radiographs of abutment teeth.
3. A current and complete Justification of Need For Prosthesis Form, DC054 (10/05) is required for prior authorization.
4. A benefit once in a five-year period.
5. A benefit when replacing a permanent anterior tooth/teeth and/or the arch lacks posterior balanced occlusion. Lack of posterior balanced occlusion is defined as follows:
  - a. five posterior permanent teeth are missing, (excluding 3rd molars), or
  - b. all four 1st and 2nd permanent molars are missing, or
  - c. the 1st and 2nd permanent molars and 2nd bicuspid are

missing on the same side.

6. Not a benefit for replacing missing 3rd molars.
7. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
8. Laboratory reline (D5760) is not a benefit for this procedure.
9. Chairside reline (D5740) is a benefit:
  - a. once in a 12-month period.
  - b. six months after the date of service for a partial denture that required extractions, or
  - c. 12 months after the date of service for a partial denture that did not require extractions.

**PROCEDURE D5212  
MANDIBULAR PARTIAL  
DENTURE – RESIN BASE  
(INCLUDING ANY  
CONVENTIONAL CLASPS,  
RESTS AND TEETH)**

1. Prior authorization is required.
2. Radiographs for prior authorization –submit radiographs of all remaining natural teeth

and periapical radiographs of abutment teeth.

3. A current and complete Justification of Need For Prosthesis Form, DC054 (10/05) is required for prior authorization.
4. A benefit once in a five-year period.
5. A benefit when replacing a permanent anterior tooth/teeth and/or the arch lacks posterior balanced occlusion. Lack of posterior balanced occlusion is defined as follows:
  - a. five posterior permanent teeth are missing, (excluding 3rd molars), or
  - b. all four 1st and 2nd permanent molars are missing, or
  - c. the 1st and 2nd permanent molars and 2nd bicuspid are missing on the same side.

6. Not a benefit for replacing missing 3rd molars.
7. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.

8. Laboratory reline (D5761) is not a benefit for this procedure.
9. Chairside reline (D5741) is a benefit:
  - a. once in a 12-month period.
  - b. six months after the date of service for a partial denture that required extractions, or
  - c. 12 months after the date of service for a partial denture that did not require extractions.
4. A benefit once in a five-year period.
5. A benefit when opposing a full denture and the arch lacks posterior balanced occlusion. Lack of posterior balanced occlusion is defined as follows:
  - a. five posterior permanent teeth are missing, (excluding 3rd molars), or
  - b. all four 1st and 2nd permanent molars are missing, or
  - c. the 1st and 2nd permanent molars and 2nd bicuspid are missing on the same side.
6. Not a benefit for replacing missing 3rd molars.
7. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
8. Laboratory reline (D5760) is a benefit:
  - a. once in a 12-month period.
  - b. six months after the date of service for a cast partial denture that required extractions, or
  - c. 12 months after the date of service for a cast partial denture that did not require extractions.
9. Chairside reline (D5740) is a benefit:
  - a. once in a 12 month period.
  - b. six months after the date of service for a partial denture that required extractions, or
  - c. 12 months after the date of service for a partial denture that did not require extractions.

**PROCEDURE D5213  
MAXILLARY PARTIAL  
DENTURE – CAST METAL  
FRAMEWORK WITH RESIN  
DENTURE BASES  
(INCLUDING ANY  
CONVENTIONAL CLASPS,  
RESTS AND TEETH)**

1. Prior authorization is required.
2. Radiographs for prior authorization –submit radiographs of all remaining natural teeth and periapical radiographs of abutment teeth.
3. A current and complete Justification of Need For Prosthesis Form, DC054 (10/05) is required for prior authorization.

**PROCEDURE D5214  
MANDIBULAR PARTIAL  
DENTURE – CAST METAL  
FRAMEWORK WITH RESIN  
DENTURE BASES  
(INCLUDING ANY  
CONVENTIONAL CLASPS,  
RESTS AND TEETH)**

1. Prior authorization is required.
2. Radiographs for prior authorization –submit radiographs of all remaining natural teeth and periapical radiographs of abutment teeth.
3. A current and complete Justification of Need For Prosthesis Form, DC054 (10/05) is required for prior authorization.
4. A benefit once in a five-year period.
5. A benefit when opposing a full denture and the arch lacks posterior balanced occlusion. Lack of posterior balanced occlusion is defined as follows:
  - a. five posterior permanent teeth are missing, (excluding 3rd molars), or
  - b. all four 1st and 2nd permanent molars are missing, or
  - c. the 1st and 2nd permanent molars

and 2nd bicuspid are missing on the same side.

6. Not a benefit for replacing missing 3rd molars.
7. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
8. Laboratory reline (D5761) is a benefit:
  - a. once in a 12-month period.
  - b. six months after the date of service for a cast partial denture that required extractions, or
  - c. 12 months after the date of service for a cast partial denture that did not require extractions.
9. Chairside reline (D5741) is a benefit:
  - a. once in a 12-month period.
  - b. six months after the date of service for a partial denture that required extractions, or
  - c. 12 months after the date of service for a partial denture that did not require extractions.

**PROCEDURE D5225  
MAXILLARY PARTIAL  
DENTURE – FLEXIBLE BASE  
(INCLUDING ANY  
CONVENTIONAL CLASPS,  
RESTS AND TEETH)**

This procedure is not a benefit.

**PROCEDURE D5226  
MANDIBULAR PARTIAL  
DENTURE – FLEXIBLE BASE  
(INCLUDING ANY  
CONVENTIONAL CLASPS,  
RESTS AND TEETH)**

This procedure is not a benefit.

**PROCEDURE D5281  
REMOVABLE UNILATERAL  
PARTIAL DENTURE – ONE  
PIECE CAST METAL  
(INCLUDING CLASPS AND  
TEETH)**

This procedure is not a benefit.

**PROCEDURE D5410  
ADJUST COMPLETE  
DENTURE - MAXILLARY**

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit:
  - a. once per date of service per provider.
  - b. twice in a 12-month period per provider.
3. Not a benefit:
  - a. same date of service or within six months of the date of service of a complete denture- maxillary (D5110), immediate denture- maxillary (D5130) or overdenture- complete (D5860).
  - b. same date of service or within six months of the date of service of a reline complete maxillary denture (chairside) (D5730), reline complete maxillary denture (laboratory) (D5750) and tissue conditioning, maxillary (D5850).
  - c. same date of service or within six months

of the date of service of repair broken complete denture base (D5510) and replace missing or broken teeth- complete denture (D5520).

**PROCEDURE D5411  
ADJUST COMPLETE  
DENTURE – MANDIBULAR**

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit:
3. once per date of service per provider.
4. twice in a 12-month period per provider.
5. Not a benefit:
6. same date of service or within six months of the date of service of a complete denture- mandibular (D5120), immediate denture- mandibular (D5140) or overdenture- complete (D5860).
7. same date of service or within six months of the date of service of a reline complete mandibular denture (chairside) (D5731), reline complete mandibular denture (laboratory) (D5751) and tissue conditioning, mandibular (D5851).
8. same date of service or within six months of the date of service of repair broken complete denture base (D5510)

and replace missing or broken teeth-complete denture (D5520).

**PROCEDURE D5421  
ADJUST PARTIAL DENTURE  
– MAXILLARY**

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit:
3. once per date of service per provider.
4. twice in a 12-month period per provider.
5. Not a benefit:
6. same date of service or within six months of the date of service of a maxillary partial- resin base (D5211) or maxillary partial denture- cast metal framework with resin denture bases (D5213).
7. same date of service or within six months of the date of service of a relined maxillary partial denture (chairside) (D5740), relined maxillary partial denture (laboratory) (D5760) and tissue conditioning, maxillary (D5850).
8. same date of service or within six months of the

date of service of repair resin denture base (D5610), repair cast framework (D5620), repair or replace broken clasp (D5630), replace broken teeth- per tooth (D5640), add tooth to existing partial denture (D5650) and add clasp to existing partial denture (D5660).

**PROCEDURE D5422  
ADJUST PARTIAL DENTURE -  
MANDIBULAR**

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit:
3. once per date of service per provider.
4. twice in a 12 month period per provider.
5. Not a benefit:
6. same date of service or within six months of the date of service of a mandibular partial-resin base (D5212) or mandibular partial denture- cast metal framework with resin denture bases (D5214).
7. same date of service or within six months of the date of service of a relined

mandibular partial denture (chairside) (D5741), relined mandibular partial denture (laboratory) (D5761) and tissue conditioning, mandibular (D5851).

8. same date of service or within six months of the date of service of repair resin denture base (D5610), repair cast framework (D5620), repair or replace broken clasp (D5630), replace broken teeth- per tooth (D5640), add tooth to existing partial denture (D5650) and add clasp to existing partial denture (D5660).

**PROCEDURE D5510  
REPAIR BROKEN COMPLETE  
DENTURE BASE**

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. Requires an arch code.
3. A benefit:
4. once per arch, per date of service per provider.
5. twice in a 12-month period per provider.
6. Not a benefit on the same date of service as

reline complete maxillary denture (chairside) (D5730), reline complete mandibular denture (chairside) (D5731), reline complete maxillary denture (laboratory) (D5750) and reline complete mandibular denture (laboratory) (D5751).

7. All adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.

**PROCEDURE D5520  
REPLACE MISSING OR  
BROKEN TEETH – COMPLETE  
DENTURE (EACH TOOTH)**

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. Requires an arch code.
3. A benefit:
  - a. up to a maximum of four, per arch, per date of service per provider.
  - b. twice per arch, in a 12-month period per provider.
4. All adjustments made for six months after the date of repair, by the same

provider and same arch, are included in the fee for this procedure.

**PROCEDURE D5610  
REPAIR RESIN DENTURE  
BASE**

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. Requires an arch code.
3. A benefit:
  - a. once per arch, per date of service per provider.
  - b. twice per arch, in a 12-month period per provider.
  - c. for partial dentures only.
4. Not a benefit same date of service as reline maxillary partial denture (chairside) (D5740), reline mandibular partial denture (chairside) (D5741), reline maxillary partial denture (laboratory) (D5760) and reline mandibular partial denture (laboratory) (D5761).
5. All adjustments made for six months after the date of repair, by the same provider and same arch,

are included in the fee for this procedure.

**PROCEDURE D5620  
REPAIR CAST FRAMEWORK**

1. Requires a laboratory invoice for payment.
2. Requires an arch code.
3. A benefit:
  - a. once per arch, per date of service per provider.
  - b. twice per arch, in a 12-month period per provider.
4. All adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.

**PROCEDURE D5630  
REPAIR OR REPLACE  
BROKEN CLASP**

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. Requires an arch code.
3. A benefit:
  - a. up to a maximum of three, per date of service per provider.
  - b. twice per arch, in a 12- month period per provider.
4. All adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.

**PROCEDURE D5640  
REPLACE BROKEN TEETH –  
PER TOOTH**

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. Requires an arch code.
3. A benefit:
  - a. up to a maximum of four, per arch, per

date of service per provider.

- b. twice per arch, in a 12- month period per provider.
- c. for partial dentures only.
4. All adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.

**PROCEDURE D5650  
ADD TOOTH TO EXISTING  
PARTIAL DENTURE**

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment
2. Requires a tooth code.
3. A benefit:
  - a. for up to a maximum of three, per date of service per provider.
  - b. once per tooth.
4. Not a benefit for adding 3rd molars.
5. All adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.

**PROCEDURE D5660  
ADD CLASP TO EXISTING  
PARTIAL DENTURE**

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment
2. Requires an arch code.
3. A benefit:
  - a. for up to a maximum of three, per date of service per provider.

- b. twice per arch, in a 12-month period per provider.
- 4. All adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.

**PROCEDURE D5670  
REPLACE ALL TEETH AND  
ACRYLIC ON CAST METAL  
FRAMEWORK (MAXILLARY)**

This procedure is not a benefit.

**PROCEDURE D5671  
REPLACE ALL TEETH AND  
ACRYLIC ON CAST METAL  
FRAMEWORK  
(MANDIBULAR)**

This procedure is not a benefit.

**PROCEDURE D5710  
REBASE COMPLETE  
MAXILLARY DENTURE**

This procedure is not a benefit.

**PROCEDURE D5711  
REBASE COMPLETE  
MANDIBULAR DENTURE**

This procedure is not a benefit.

**PROCEDURE D5720  
REBASE MAXILLARY  
PARTIAL DENTURE**

This procedure is not a benefit.

**PROCEDURE D5721  
REBASE MANDIBULAR  
PARTIAL DENTURE**

This procedure is not a benefit.

**PROCEDURE D5730  
RELINE COMPLETE  
MAXILLARY DENTURE  
(CHAIRSIDE)**

- 1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
- 2. A benefit:
  - a. once in a 12-month period.
  - b. six months after the date of service for a immediate denture-maxillary (D5130) or immediate overdenture-complete (D5860) that required extractions, or
  - c. 12 months after the date of service for a complete (remote) denture-maxillary (D5110) or overdenture (remote)-complete (D5860) that did not require extractions.
- 3. Not a benefit within 12 months of a reline complete maxillary denture (laboratory) (D5750).
- 4. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.

**PROCEDURE D5731**

**RELINE COMPLETE  
MANDIBULAR DENTURE  
(CHAIRSIDE)**

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit:
  - a. once in a 12-month period.
  - b. six months after the date of service for a immediate denture-mandibular (D5140) or immediate overdenture-complete (D5860) that required extractions, or
  - c. 12 months after the date of service for a complete (remote) denture- mandibular (D5120) or overdenture (remote)- complete (D5860) that did not require extractions.
3. Not a benefit within 12 months of a reline complete mandibular denture (laboratory) (D5751).
4. All adjustments made for six months after the date of service, by the same provider, are included in

the fee for this procedure.

**PROCEDURE D5740  
RELINE MAXILLARY PARTIAL  
DENTURE (CHAIRSIDE)**

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit:
  - a. once in a 12-month period.
  - b. six months after the date of service for maxillary partial denture- resin base (D5211) or maxillary partial denture- cast metal framework with resin denture bases (D5213) that required extractions, or
  - c. 12 months after the date of service for maxillary partial denture- resin base (D5211) or maxillary partial denture- cast metal framework with resin denture bases (D5213) that did not require extractions.
3. Not a benefit within 12 months of a reline

maxillary partial denture (laboratory) (D5760).

4. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.

**PROCEDURE D5741  
RELINE MANDIBULAR  
PARTIAL DENTURE  
(CHAIRSIDE)**

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit:
  - a. once in a 12-month period.
  - b. six months after the date of service for mandibular partial denture- resin base (D5212) or mandibular partial denture- cast metal framework with resin denture bases (D5214) that required extractions, or
  - c. 12 months after the date of service for mandibular partial denture- resin base (D5212) or mandibular partial

- denture- cast metal framework with resin denture bases (D5214) that did not require extractions.
3. Not a benefit within 12 months of a reline mandibular partial denture (laboratory) (D5761).
  4. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.

**PROCEDURE D5750  
RELINING COMPLETE  
MAXILLARY DENTURE  
(LABORATORY)**

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit:
  - a. once in a 12-month period.
  - b. six months after the date of service for a immediate denture-maxillary (D5130) or immediate overdenture-complete (D5860) that required extractions, or

- c. 12 months after the date of service for a complete (remote) denture- maxillary (D5110) or overdenture (remote)- complete (D5860) that did not require extractions.
3. Not a benefit within 12 months of a reline complete maxillary denture (chairside) (D5730).
4. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.

**PROCEDURE D5751  
RELINING COMPLETE  
MANDIBULAR DENTURE  
(LABORATORY)**

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit:
  - a. once in a 12-month period.
  - b. six months after the date of service for a immediate denture-mandibular (D5140) or immediate overdenture-

- complete (D5860) that required extractions, or
- c. 12 months after the date of service for a complete (remote) denture - mandibular (D5120) or overdenture (remote) - complete (D5860) that did not require extractions.
  3. Not a benefit within 12 months of a reline complete mandibular denture (chairside) (D5731).
  4. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.

**PROCEDURE D5760  
RELINING MAXILLARY PARTIAL  
DENTURE (LABORATORY)**

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit:
  - a. once in a 12-month period.
  - b. six months after the date of service for maxillary partial denture- cast metal

- framework with resin denture bases (D5213) that required extractions, or
  - c. 12 months after the date of service for maxillary partial denture- cast metal framework with resin denture bases (D5213) that did not require extractions.
3. Not a benefit:
- a. within 12 months of a reline maxillary partial denture (chairside) (D5740).
  - b. for a maxillary partial denture- resin base (D5211).
4. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.

**PROCEDURE D5761  
RELINING MANDIBULAR  
PARTIAL DENTURE  
(LABORATORY)**

- 1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
- 2. A benefit:

- a. once in a 12-month period.
  - b. six months after the date of service for mandibular partial denture- cast metal framework with resin denture bases (D5214) that required extractions, or
  - c. 12 months after the date of service for mandibular partial denture- cast metal framework with resin denture bases (D5214) that did not require extractions.
3. Not a benefit:
- a. within 12 months of a reline mandibular partial denture (chairside) (D5741).
  - b. for a mandibular partial denture- resin base (D5212).
4. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.

**PROCEDURE D5810  
INTERIM COMPLETE  
DENTURE (MAXILLARY)**

This procedure is not a benefit.

**PROCEDURE D5811**

**INTERIM COMPLETE  
DENTURE (MANDIBULAR)**

This procedure is not a benefit.

**PROCEDURE D5820  
INTERIM PARTIAL DENTURE  
(MAXILLARY)**

This procedure is not a benefit.

**PROCEDURE D5821  
INTERIM PARTIAL DENTURE  
(MANDIBULAR)**

This procedure is not a benefit.

**PROCEDURE D5850  
TISSUE CONDITIONING,  
MAXILLARY**

- 1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
- 2. A benefit twice per prosthesis in a 36-month period.
- 3. Not a benefit:
  - a. same date of service as reline complete maxillary denture (chairside) (D5730), reline maxillary partial denture (chairside) (D5740), reline complete maxillary denture (laboratory) (D5750)

- and relines maxillary partial denture (laboratory) (D5760).
  - b. same date of service as a prosthesis that did not require extractions.
  - 4. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
  - 5. Tissue conditioning is designed to heal unhealthy ridges prior to a more definitive treatment.
- PROCEDURE D5851  
TISSUE CONDITIONING,  
MANDIBULAR**
- 1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
  - 2. A benefit twice per prosthesis in a 36-month period.
  - 3. Not a benefit:
    - a. same date of service as relines complete mandibular denture (chairside) (D5731), relines mandibular partial denture (chairside) (D5741), relines complete
- PROCEDURE D5860  
OVERDENTURE –  
COMPLETE, BY REPORT**
- 1. Prior authorization is required.
  - 2. Radiographs for prior authorization –submit all radiographs of remaining natural teeth including periapical radiographs of teeth to be retained.
  - 3. A current and complete Justification of Need For Prosthesis Form, DC054 (10/05) is required, that includes which teeth are to be retained, for prior authorization.
  - 4. Requires an arch code.
- mandibular denture (laboratory) (D5751) and relines mandibular partial denture (laboratory) (D5761).
  - b. same date of service as a prosthesis that did not require extractions.
  - 4. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
  - 5. Tissue conditioning is designed to heal unhealthy ridges prior to a more definitive treatment.
- PROCEDURE D5750  
COMPLETE DENTURE  
LABORATORY RELINES**
- 5. A benefit once in a five-year period.
  - 6. Complete denture laboratory relines (D5750 and D5751) are a benefit:
    - a. six months after the date of service for an immediate overdenture that required extractions, or
    - b. 12 months after the date of service for a complete overdenture that did not require extractions.
  - 7. Complete denture chairside relines (D5730 and D5731) are a benefit:
    - a. six months after the date of service for an immediate overdenture that required extractions, or
    - b. 12 months after the date of service for a complete overdenture that did not require extractions.
  - 8. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.

9. Teeth to be retained are not eligible for preventative, periodontal, endodontic or restorative procedures. Only extractions for the retained teeth shall be a benefit.

**PROCEDURE D5861  
OVERDENTURE – PARTIAL,  
BY REPORT**

This procedure is not a benefit.

**PROCEDURE D5862  
PRECISION ATTACHMENT,  
BY REPORT**

This procedure is included in the fee for prosthetic and restorative procedures and is not payable separately.

**PROCEDURE D5867  
REPLACEMENT OF  
REPLACEABLE PART OF  
SEMI-PRECISION OR  
PRECISION ATTACHMENT  
(MALE OR FEMALE  
COMPONENT)**

This procedure is not a benefit.

**PROCEDURE D5875  
MODIFICATION OF  
REMOVABLE PROSTHESIS  
FOLLOWING IMPLANT  
SURGERY.**

This procedure is not a benefit.

**PROCEDURE D5899  
UNSPECIFIED REMOVABLE  
PROSTHODONTIC  
PROCEDURE, BY REPORT**

1. Prior authorization is required for non-emergency procedures.
2. Radiographs for prior authorization or payment – submit radiographs if applicable for the type of procedure.
3. Photographs for prior authorization or payment – submit photographs if applicable for the type of procedure.
4. Submit a current and complete Justification of Need For Prosthesis Form, DC054 (10/05), if applicable for the type of procedure, for prior authorization.
5. Written documentation for prior authorization or payment – describe the specific conditions addressed by the procedure, the rationale

demonstrating the medical necessity, any pertinent history and the proposed or actual treatment.

6. Procedure D5899 shall be used:
- a. for a procedure which is not adequately described by a CDT code, or
  - b. for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity.
- Documentation shall include the medical condition and the specific CDT code associated with the treatment

**Maxillofacial Prosthetic Procedures (D5900-D5999)**

**Maxillofacial Prosthetics General Policies (D5900-D5999)**

- a) Maxillofacial prosthetic services are for the anatomic and functional reconstruction of those regions of the maxilla and mandible and associated structures that are missing or defective because of surgical intervention, trauma (other than simple or compound fractures), pathology, developmental or congenital malformations.
- b) All maxillofacial prosthetic procedures require written documentation for payment or prior authorization. Refer to the individual procedures for specific requirements.
- c) Prior authorization is required for the following procedures:
  - i) trismus appliance (D5937),
  - ii) palatal lift prosthesis, interim (D5958),
  - iii) fluoride gel carrier (D5986),
  - iv) surgical splint (D5988).
- d) All maxillofacial prosthetic procedures include routine postoperative care, revisions and adjustments for 90 days after the date of delivery.

ARCHIVE

**Maxillofacial Prosthetic Procedures (D5900-D5999)**

**Maxillofacial Prosthetic Procedures (D5900-D5999)**

**PROCEDURE D5911  
FACIAL MOULAGE  
(SECTIONAL)**

1. Written documentation for payment - shall include:
  - a. the etiology of the disease and/or condition, and
  - b. a description of the associated surgery or an operative report, and
  - c. a description of the prosthesis.

**PROCEDURE D5912  
FACIAL MOULAGE  
(COMPLETE)**

1. Written documentation for payment - shall include:
  - a. the etiology of the disease and/or condition, and
  - b. a description of the associated surgery or an operative report, and
  - c. a description of the prosthesis.

**PROCEDURE D5913  
NASAL PROSTHESIS**

1. Written documentation for payment - shall include:

- a. the etiology of the disease and/or condition, and
- b. a description of the associated surgery or an operative report.

**PROCEDURE D5914  
AURICULAR PROSTHESIS**

1. Written documentation for payment - shall include:
  - a. the etiology of the disease and/or condition, and
  - b. a description of the associated surgery or an operative report.

**PROCEDURE D5915  
ORBITAL PROSTHESIS**

1. Written documentation for payment - shall include:
  - a. the etiology of the disease and/or condition, and
  - b. a description of the associated surgery or an operative report.

**PROCEDURE D5916  
OCULAR PROSTHESIS**

1. Written documentation for payment - shall include:
  - a. the etiology of the disease and/or condition, and

- b. a description of the associated surgery or an operative report.
- c. Not a benefit on the same date of service as ocular prosthesis, interim (D5923).

**PROCEDURE D5919  
FACIAL PROSTHESIS**

1. Written documentation for payment - shall include:
  - a. the etiology of the disease and/or condition, and
  - b. a description of the associated surgery or an operative report, and
  - c. a description of the prosthesis.

**PROCEDURE D5922  
NASAL SEPTAL PROSTHESIS**

1. Written documentation for payment - shall include:
  - a. the etiology of the disease and/or condition, and
  - b. a description of the associated surgery or an operative report.

**PROCEDURE D5923  
OCULAR PROSTHESIS,  
INTERIM**

1. Written documentation for payment - shall include:
  - a. the etiology of the disease and/or condition, and
  - b. a description of the associated surgery or an operative report.
  - c. Not a benefit on the same date of service with an ocular prosthesis (D5916).

**PROCEDURE D5924  
CRANIAL PROSTHESIS**

1. Written documentation for payment - shall include:
  - a. the etiology of the disease and/or condition, and
  - b. a description of the associated surgery or an operative report.

**PROCEDURE D5925  
FACIAL AUGMENTATION  
IMPLANT PROSTHESIS**

1. Written documentation for payment - shall include:
  - a. the etiology of the disease and/or condition, and
  - b. a description of the associated surgery or an operative report, and
  - c. a description of the prosthesis.

**PROCEDURE D5926  
NASAL PROSTHESIS,  
REPLACEMENT**

Written documentation for payment – shall include the medical necessity for replacement.

**PROCEDURE D5927  
AURICULAR PROSTHESIS,  
REPLACEMENT**

Written documentation for payment – shall include the medical necessity for replacement.

**PROCEDURE D5928  
ORBITAL PROSTHESIS,  
REPLACEMENT**

Written documentation for payment – shall include the medical necessity for replacement.

**PROCEDURE D5929  
FACIAL PROSTHESIS,  
REPLACEMENT**

Written documentation for payment – shall include the medical necessity for replacement.

**PROCEDURE D5931  
OBTURATOR PROSTHESIS,  
SURGICAL**

1. Written documentation for payment - shall include:

- a. the etiology of the disease and/or condition, and
  - b. a description of the associated surgery or an operative report, and
  - c. a description of the prosthesis.
2. Not a benefit on the same date of service as obturator prosthesis, definitive (D5932) and obturator prosthesis, interim (D5936).

**PROCEDURE D5932  
OBTURATOR PROSTHESIS,  
DEFINITIVE**

1. Written documentation for payment - shall include:
  - a. the etiology of the disease and/or condition, and
  - b. a description of the associated surgery or an operative report, and
  - c. a description of the prosthesis.
2. Not a benefit on the same date of service as obturator prosthesis, surgical (D5931) and obturator prosthesis, interim (D5936).

**PROCEDURE D5933  
OBTURATOR PROSTHESIS,  
MODIFICATION**

1. Written documentation for payment - shall include the medical necessity for the modification.
2. A benefit twice in a 12 month period.
3. Not a benefit on the same date of service as obturator prosthesis, surgical (D5931), obturator prosthesis, definitive (D5932) and obturator prosthesis, interim (D5936).

**PROCEDURE D5934  
MANDIBULAR RESECTION  
PROSTHESIS WITH GUIDE  
FLANGE**

1. Written documentation for payment - shall include:
  - a. the etiology of the disease and/or condition, and
  - b. a description of the associated surgery or an operative report, and
  - c. a description of the prosthesis.

**PROCEDURE D5935  
MANDIBULAR RESECTION  
PROSTHESIS WITHOUT  
GUIDE FLANGE**

1. Written documentation for payment - shall include:

- a. the etiology of the disease and/or condition, and
- b. a description of the associated surgery or an operative report, and
- c. a description of the prosthesis.

**PROCEDURE D5936  
OBTURATOR PROSTHESIS,  
INTERIM**

1. Written documentation for payment - shall include:
  - a. the etiology of the disease and/or condition, and
  - b. a description of the associated surgery or an operative report, and
  - c. a description of the prosthesis.
2. Not a benefit on the same date of service as obturator prosthesis, surgical (D5931) and obturator prosthesis, definitive (D5932).

**PROCEDURE D5937  
TRISMUS APPLIANCE (NOT  
FOR TMD TREATMENT)**

1. Prior authorization is required.
2. Written documentation for prior authorization - shall include:

- a. the etiology of the disease and/or condition, and
- b. a description of the associated surgery.

**PROCEDURE D5951  
FEEDING AID**

1. Written documentation for payment - shall include the treatment performed.
2. A benefit for patients under the age of 18.

**PROCEDURE D5952  
SPEECH AID PROSTHESIS,  
PEDIATRIC**

1. Written documentation for payment - shall include the treatment performed.
2. A benefit for patients under the age of 18.

**PROCEDURE D5953  
SPEECH AID PROSTHESIS,  
ADULT**

1. Written documentation for payment - shall include the treatment performed.
2. A benefit for patients age 18 or older.

**PROCEDURE D5954  
PALATAL AUGMENTATION  
PROSTHESIS**

Written documentation for payment - shall include the treatment performed.

**PROCEDURE D5955  
PALATAL LIFT PROSTHESIS,  
DEFINITIVE**

1. Written documentation for payment - shall include the treatment performed.
2. Not a benefit on the same date of service as palatal lift prosthesis, interim (D5958).'

**PROCEDURE D5958  
PALATAL LIFT PROSTHESIS,  
INTERIM**

1. Prior authorization is required.
2. Written documentation for prior authorization - shall include the treatment to be performed.
3. Not a benefit on the same date of service with palatal lift prosthesis, definitive (D5955).

**PROCEDURE D5959  
PALATAL LIFT PROSTHESIS,  
MODIFICATION**

1. Written documentation for payment - shall include the treatment performed.
2. A benefit twice in a 12-month period.
3. Not a benefit on the same date of service as palatal lift prosthesis, definitive (D5955) and

palatal lift prosthesis, interim (D5958).

**PROCEDURE D5960  
SPEECH AID PROSTHESIS,  
MODIFICATION**

1. Written documentation for payment - shall include the treatment performed.
2. A benefit twice in a 12-month period.
3. Not a benefit on the same date of service as speech aid prosthesis, pediatric (D5952) and speech aid prosthesis, adult (D5953).

**PROCEDURE D5982  
SURGICAL STENT**

Written documentation for payment - shall include the treatment performed.

**PROCEDURE D5983  
RADIATION CARRIER**

1. Written documentation for payment - shall include the etiology of the disease and/or condition.
2. Requires an arch code.

**PROCEDURE D5984  
RADIATION SHIELD**

Written documentation for payment - shall include the etiology of the disease and/or condition.

**PROCEDURE D5985  
RADIATION CONE LOCATOR**

Written documentation for payment - shall include the etiology of the disease and/or condition.

**PROCEDURE D5986  
FLUORIDE GEL CARRIER**

1. Prior authorization is required.
2. Written documentation for prior authorization - shall include the etiology of the disease and/or condition and the

treatment to be performed.

3. Requires an arch code.
4. A benefit only in conjunction with radiation therapy directed at the teeth, jaws or salivary glands.

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**PROCEDURE D5987  
COMMISSURE SPLINT**

Written documentation for payment - shall include the etiology of the disease and/or condition.

**PROCEDURE D5988  
SURGICAL SPLINT**

1. Prior authorization is required.
2. Radiographs for prior authorization – submit radiographs.
3. Written documentation for prior authorization – shall include the medical necessity and the treatment to be performed.

**PROCEDURE D5991  
TOPICAL MEDICAMENT  
CARRIER**

1. Written documentation for payment - shall include the etiology of the disease and/or condition.
2. Requires an arch code.

**PROCEDURE D5992  
ADJUST MAXILLOFACIAL  
PROSTHETIC APPLIANCE, BY  
REPORT**

This procedure is not a benefit.

**PROCEDURE D5993  
MAINTENANCE AND  
CLEANING OF A**

**MAXILLOFACIAL  
PROSTHESIS (EXTRA OR  
INTRAORAL) OTHER THAN  
REQUIRED ADJUSTMENTS,  
BY REPORT**

This procedure is not a benefit.

**PROCEDURE D5999  
UNSPECIFIED  
MAXILLOFACIAL  
PROSTHESIS, BY REPORT**

1. Prior authorization is required for non-emergency procedures.
2. Radiographs for prior authorization or payment – submit radiographs if applicable for the type of procedure.
3. Photographs for prior authorization or payment – submit photographs if applicable for the type of procedure.
4. Written documentation or operative report for prior authorization or payment – shall describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed or actual treatment.
5. Procedure D5999 shall be used:
  - a. for a procedure which is not adequately described by a CDT code, or
  - b. for a procedure that has a CDT code that is not a benefit but

the patient has an exceptional medical condition to justify the medical necessity.

Documentation shall include the medical condition and the specific CDT code associated with the treatment.

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**Implant Service Procedures (D6000-D6199)**

**Implant Services General Policies (D6000-D6199)**

- a) Implant services are a benefit only when exceptional medical conditions are documented and shall be reviewed by the Medi-Cal Dental Program for medical necessity for prior authorization. Exceptional medical conditions include, but are not limited to:
  - i) cancer of the oral cavity requiring ablative surgery and/or radiation leading to destruction of alveolar bone, where the remaining osseous structures are unable to support conventional dental prostheses.
  - ii) severe atrophy of the mandible and/or maxilla that cannot be corrected with vestibular extension procedures or osseous augmentation procedures, and the patient is unable to function with conventional prostheses.
  - iii) skeletal deformities that preclude the use of conventional prostheses (such as arthrogryposis, ectodermal dysplasia, partial anodontia and cleidocranial dysplasia).
  - iv) traumatic destruction of jaw, face or head where the remaining osseous structures are unable to support conventional dental prostheses.
- b) Providers shall submit complete case documentation (such as radiographs, scans, operative reports, craniofacial panel reports, diagnostic casts, intraoral/extraoral photographs and tracings) necessary to demonstrate the medical necessity of the requested implant services.
- c) Single tooth implants are not a benefit of the Medi-Cal Dental Program.
- d) Implant removal, by report (D6100) is a benefit. Refer to the procedure for specific requirements.

**Implant Service Procedures (D6000-D6199)**

**Implant Service Procedures (D6000-D6199)**

**PROCEDURE D6010  
SURGICAL PLACEMENT OF  
IMPLANT BODY:  
ENDOSTEAL IMPLANT**

1. Implant services are a benefit only when exceptional medical conditions are documented and shall be reviewed for medical necessity. Refer to Implant Services General policies for specific requirements.
2. Prior authorization is required.
3. Radiographs for prior authorization - submit arch, pre-operative periapical and/or panoramic radiographs as applicable.
4. Photographs for prior authorization - submit as applicable.
5. Written documentation for prior authorization – shall describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed treatment.
6. Requires a tooth or arch code, as applicable for the type of procedure.

**PROCEDURE D6040  
SURGICAL PLACEMENT:  
EPOSTEAL IMPLANT**

See the criteria for Procedure D6010.

**PROCEDURE D6050  
SURGICAL PLACEMENT:  
TRANSOSTEAL IMPLANT**

See the criteria for Procedure D6010.

**PROCEDURE D6051  
INTERIM ABUTMENT**

This procedure is not a benefit.

**PROCEDURE D6053  
IMPLANT/ABUTMENT  
SUPPORTED REMOVABLE  
DENTURE FOR COMPLETELY  
EDENTULOUS ARCH**

See the criteria for Procedure D6010.

**PROCEDURE D6054  
IMPLANT/ABUTMENT  
SUPPORTED REMOVABLE  
DENTURE FOR PARTIALLY  
EDENTULOUS ARCH**

See the criteria for Procedure D6010.

**PROCEDURE D6055  
CONNECTING BAR –  
IMPLANT SUPPORTED OR  
ABUTMENT SUPPORTED**

See the criteria for Procedure D6010.

**PROCEDURE D6056**

**PREFABRICATED  
ABUTMENT - INCLUDES  
MODIFICATION AND  
PLACEMENT**

See the criteria for Procedure D6010.

**PROCEDURE D6057  
CUSTOM FABRICATED  
ABUTMENT - INCLUDES  
PLACEMENT**

See the criteria for Procedure D6010.

**PROCEDURE D6058  
ABUTMENT SUPPORTED  
PORCELAIN/CERAMIC  
CROWN**

See the criteria for  
Procedure D6010.

**(PREDOMINANTLY BASE  
METAL)**

See the criteria for  
Procedure D6010.

**PROCEDURE D6059  
ABUTMENT SUPPORTED  
PORCELAIN FUSED TO  
METAL CROWN (HIGH  
NOBLE METAL)**

See the criteria for  
Procedure D6010.

**PROCEDURE D6060  
ABUTMENT SUPPORTED  
PORCELAIN FUSED TO  
METAL CROWN  
(PREDOMINANTLY BASE  
METAL)**

See the criteria for  
Procedure D6010.

**PROCEDURE D6061  
ABUTMENT SUPPORTED  
PORCELAIN FUSED TO  
METAL CROWN (NOBLE  
METAL)**

See the criteria for  
Procedure D6010.

**PROCEDURE D6062  
ABUTMENT SUPPORTED  
CAST METAL CROWN (HIGH  
NOBLE METAL)**

See the criteria for  
Procedure D6010.

**PROCEDURE D6063  
ABUTMENT SUPPORTED  
CAST METAL CROWN**

**PROCEDURE D6064  
ABUTMENT SUPPORTED  
CAST METAL CROWN  
(NOBLE METAL)**

See the criteria for  
Procedure D6010.

**PROCEDURE D6065  
IMPLANT SUPPORTED  
PORCELAIN/CERAMIC  
CROWN**

See the criteria for  
Procedure D6010.

**PROCEDURE D6066  
IMPLANT SUPPORTED  
PORCELAIN FUSED TO  
METAL CROWN (TITANIUM,  
TITANIUM ALLOY, HIGH  
NOBLE METAL)**

See the criteria for  
Procedure D6010.

**PROCEDURE D6067  
IMPLANT SUPPORTED  
METAL CROWN (TITANIUM,  
TITANIUM ALLOY, HIGH  
NOBLE METAL)**

See the criteria for  
Procedure D6010.

**PROCEDURE D6068  
ABUTMENT SUPPORTED  
RETAINER FOR  
PORCELAIN/CERAMIC FPD**

See the criteria for  
Procedure D6010.

**PROCEDURE D6069  
ABUTMENT SUPPORTED  
RETAINER FOR PORCELAIN  
FUSED TO METAL FPD (HIGH  
NOBLE METAL)**

See the criteria for  
Procedure D6010.

**PROCEDURE D6070  
ABUTMENT SUPPORTED  
RETAINER FOR PORCELAIN  
FUSED TO METAL FPD  
(PREDOMINANTLY BASE  
METAL)**

See the criteria for  
Procedure D6010.

**PROCEDURE D6071  
ABUTMENT SUPPORTED  
RETAINER FOR PORCELAIN  
FUSED TO METAL FPD  
(NOBLE METAL)**

See the criteria for  
Procedure D6010.

**PROCEDURE D6072  
ABUTMENT SUPPORTED  
RETAINER FOR CAST METAL  
FPD (HIGH NOBLE METAL)**

See the criteria for  
Procedure D6010.

**PROCEDURE D6073  
ABUTMENT SUPPORTED  
RETAINER FOR CAST METAL  
FPD (PREDOMINANTLY  
BASE METAL)**

See the criteria for  
Procedure D6010.

**PROCEDURE D6074  
ABUTMENT SUPPORTED  
RETAINER FOR CAST METAL  
FPD (NOBLE METAL)**

See the criteria for  
Procedure D6010.

**PROCEDURE D6075**

**IMPLANT SUPPORTED  
RETAINER FOR CERAMIC  
FPD**

See the criteria for  
Procedure D6010.

**PROCEDURE D6076  
IMPLANT SUPPORTED  
RETAINER FOR PORCELAIN  
FUSED TO METAL FPD  
(TITANIUM, TITANIUM  
ALLOY, OR HIGH NOBLE  
METAL)**

See the criteria for  
Procedure D6010.

**PROCEDURE D6077  
IMPLANT SUPPORTED  
RETAINER FOR CAST METAL  
FPD (TITANIUM, TITANIUM  
ALLOY, OR HIGH NOBLE  
METAL)**

See the criteria for  
Procedure D6010.

**PROCEDURE D6078  
IMPLANT/ABUTMENT  
SUPPORTED FIXED  
DENTURE FOR COMPLETELY  
EDENTULOUS ARCH**

See the criteria for  
Procedure D6010.

**PROCEDURE D6079  
IMPLANT/ABUTMENT  
SUPPORTED FIXED  
DENTURE FOR PARTIALLY  
EDENTULOUS ARCH**

See the criteria for  
Procedure D6010.

**PROCEDURE D6080**

**IMPLANT MAINTENANCE PROCEDURES, INCLUDING REMOVAL OF PROSTHESIS, CLEANSING OF PROSTHESIS AND ABUTMENTS AND REINSERTION OF PROSTHESIS**

See the criteria for Procedure D6010.

**PROCEDURE D6090 REPAIR IMPLANT SUPPORTED PROSTHESIS, BY REPORT**

See the criteria for Procedure D6010.

**PROCEDURE D6091 REPLACEMENT OF SEMI-PRECISION OR PRECISION ATTACHMENT (MALE OR FEMALE COMPONENT) OF IMPLANT/ABUTMENT SUPPORTED PROSTHESIS, PER ATTACHMENT**

See the criteria for Procedure D6010.

**PROCEDURE D6092 RECEMENT IMPLANT/ABUTMENT SUPPORTED CROWN**

1. This procedure does not require prior authorization.
2. Submission of radiographs, photographs or written documentation demonstrating medical

necessity is not required for payment.

3. Requires a tooth code.
4. The original provider is responsible for all re-cementations within the first 12 months following the initial placement of implant/abutment supported crowns.
5. Not a benefit within 12 months of a previous re-cementation by the same provider.

**PROCEDURE D6093 RECEMENT IMPLANT/ABUTMENT SUPPORTED FIXED PARTIAL DENTURE**

1. This procedure does not require prior authorization.
2. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
3. Requires a quadrant code.
4. The original provider is responsible for all re-cementations within the first 12 months following the initial placement of implant/abutment supported fixed partial dentures.

5. Not a benefit within 12 months of a previous re-cementation by the same provider.

**PROCEDURE D6094 ABUTMENT SUPPORTED CROWN (TITANIUM)**

See the criteria for Procedure D6010.

**PROCEDURE D6095  
REPAIR IMPLANT  
ABUTMENT, BY REPORT**

See the criteria for  
Procedure D6010.

**PROCEDURE D6100  
IMPLANT REMOVAL, BY  
REPORT**

1. Prior authorization is not required.
2. Radiographs for payment – submit a radiograph of the implant to be removed.
3. Written documentation for payment –shall include the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
4. Requires a tooth code.

**PROCEDURE D6101  
PROCEDURE DEBRIDEMENT  
OF A PERIIMPLANT DEFECT  
AND SURFACE CLEANING OF  
EXPOSED IMPLANT  
SERVICES, INCLUDING FLAP  
ENTRY AND CLOSURE**

This procedure is not a  
benefit.

**PROCEDURE D6102  
PROCEDURE DEBRIDEMENT  
AND OSSEOUS  
CONTOURING OF A  
PERIIMPLANT DEFECT;  
INCLUDES SURFACE**

**CLEANING OF EXPOSED  
IMPLANT SURFACES AND  
FLAP ENTRY AND CLOSURE**

This procedure is not a  
benefit.

**PROCEDURE D6103  
BONE GRAFT FOR REPAIR  
OF PERIIMPLANT DEFECT -  
NOT INCLUDING FLAP  
ENTRY AND CLOSURE OR,  
WHEN INDICATED,  
PLACEMENT OF A BARRIER  
MEMBRANE OR BIOLOGIC  
MATERIALS TO AID IN  
OSSEOUS REGENERATION**

This procedure is not a  
benefit.

**PROCEDURE D6104  
BONE GRAFT AT TIME OF  
IMPLANT PLACEMENT**

This procedure is not a  
benefit.

**PROCEDURE D6190  
RADIOGRAPHIC/SURGICAL  
IMPLANT INDEX, BY REPORT**

This procedure is  
included in the fee for  
surgical placement of  
implant body: endosteal  
implant (D6010).

**PROCEDURE D6194  
ABUTMENT SUPPORTED  
RETAINER CROWN FOR FPD  
(TITANIUM)**

See the criteria for  
Procedure D6010.

**PROCEDURE D6199  
UNSPECIFIED IMPLANT  
PROCEDURE, BY REPORT**

1. Implant services are a  
benefit only when  
exceptional medical  
conditions are

documented and shall be reviewed for medical necessity.

2. Prior authorization is required.
3. Radiographs for prior authorization - submit arch and pre-operative periapical radiographs.
4. Photographs for prior authorization - submit as applicable for the type of procedure.
5. Written documentation for prior authorization – shall describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed treatment.
6. Requires a tooth or arch code, as applicable for the type of procedure.

**Fixed Prosthodontic Procedures (D6200-D6999)**

**Fixed Prosthodontic General Policies (D6200-D6999)**

- a) Fixed partial dentures (bridgework) are considered beyond the scope of the Medi-Cal Dental Program. However, the fabrication of a fixed partial denture shall be considered for prior authorization only when medical conditions or employment preclude the use of a removable partial denture. Most importantly, the patient shall first meet the criteria for a removable partial denture before a fixed partial denture will be considered.
- b) Medical conditions, which preclude the use of a removable partial denture, include:
  - i) the epileptic patient where a removable partial denture could be injurious to their health during an uncontrolled seizure,
  - ii) the paraplegia patient who utilizes a mouth wand to function to any degree and where a mouth wand is inoperative because of missing natural teeth,
  - iii) patients with neurological disorders whose manual dexterity precludes proper care and maintenance of a removable partial denture.
- c) Documentation for medical conditions shall be submitted for prior authorization that includes a written, signed and dated statement from the patient's physician, on their professional letterhead, describing the patient's medical condition and the reason why a removable partial denture would be injurious to the patient's health.
- d) Documentation for obtaining employment shall be submitted for prior authorization that includes a written statement from the patient's case manager or eligibility worker stating why the nature of the employment precludes the use of a removable partial denture.
- e) Fixed partial dentures are a benefit once in a five-year period only on permanent teeth when the above criteria are met.
- f) Current periapical radiographs of the retainer (abutment) teeth and arch radiographs are required for prior authorization.
- g) Fixed partial dentures are not a benefit when the prognosis of the retainer (abutment) teeth is questionable due to non-restorability or periodontal involvement.
- h) Posterior fixed partial dentures are not a benefit when the number of missing teeth requested to be replaced in the quadrant does not significantly impact the patient's masticatory ability.
- i) Tooth and soft tissue preparation, crown lengthening, cement bases, direct and indirect pulp capping, amalgam or acrylic buildups, pins (D2951), bonding agents, lining agents, impressions, temporary crowns, adjustments (D9951), polishing, local anesthesia (D9210) and any other associated procedures are included in the fee for a completed fixed partial denture.
- j) Arch integrity and overall condition of the mouth, including the patient's ability to maintain oral health, shall be considered for prior authorization. Prior authorization shall be based upon a supportable five-year prognosis for the fixed partial denture retainer (abutment).
- k) Fixed partial denture retainers (abutments) on root canal treated teeth shall be considered only after satisfactory completion of root canal therapy. Post root canal treatment

**Fixed Prosthodontic Procedures (D6200-D6999)**

periapical and arch radiographs shall be submitted for prior authorization of fixed partial dentures.

- l) Partial payment will not be made for an undelivered fixed partial denture. Payment will be made only upon final cementation.
- m) Fixed partial denture inlay/onlay retainers (abutments) (D6545-D6634) are not a benefit.
- n) Cast resin bonded fixed partial dentures (Maryland Bridges) are not a benefit.

Archive

**Fixed Prosthodontic Procedures (D6200-D6999)**

**Fixed Prosthodontic Procedures (D6200-D6999)**

**PROCEDURE D6205  
PONTIC – INDIRECT RESIN  
BASED COMPOSITE**

This procedure is not a benefit.

**PROCEDURE D6210  
PONTIC – CAST HIGH NOBLE  
METAL**

This procedure is not a benefit.

**PROCEDURE D6211  
PONTIC – CAST  
PREDOMINANTLY BASE  
METAL**

1. Prior authorization is required.
2. Radiographs for prior authorization –submit arch and periapical radiographs.
3. Written documentation for prior authorization- shall be submitted for employment or medical reasons. Refer to Fixed Prosthodontic General Policies for specific requirements.
4. Requires a tooth code.
5. A benefit:
  - a. once in a five year period.
  - b. only when the criteria are met for a resin partial denture or cast partial denture (D5211,

D5212, D5213 and D5214).

- c. only when billed on the same date of service with fixed partial denture retainers (abutments) (D6721, D6740, D6751, D6781, D6783 and D6791).

6. Not a benefit for patients under the age of 13.

**PROCEDURE D6212  
PONTIC – CAST NOBLE  
METAL**

This procedure is not a benefit.

**PROCEDURE D6214  
PONTIC – TITANIUM**

This procedure is not a benefit.

**PROCEDURE D6240  
PONTIC – PORCELAIN FUSED  
TO HIGH NOBLE METAL**

This procedure is not a benefit.

**PROCEDURE D6241  
PONTIC – PORCELAIN FUSED  
TO PREDOMINANTLY BASE  
METAL**

1. Prior authorization is required.
2. Radiographs for prior authorization –submit arch and periapical radiographs.
3. Written documentation for prior authorization- shall be submitted for employment or medical reasons. Refer to Fixed Prosthodontic General Policies for specific requirements.
4. Requires a tooth code.
5. A benefit:
  - a. once in a five year period.

- b. only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214).
  - c. only when billed on the same date of service with fixed partial denture retainers (abutments) (D6721, D6740, D6751, D6781, D6783 and D6791).
6. Not a benefit for patients under the age of 13.

**PROCEDURE D6242  
PONTIC – PORCELAIN FUSED  
TO NOBLE METAL**

This procedure is not a benefit.

**PROCEDURE D6245  
PONTIC –  
PORCELAIN/CERAMIC**

- 1. Prior authorization is required.
- 2. Radiographs for prior authorization –submit arch and periapical radiographs.
- 3. Written documentation for prior authorization–shall be submitted for employment or medical reasons. Refer to Fixed Prosthodontic General

- Policies for specific requirements.
- 4. Requires a tooth code.
  - 5. A benefit:
    - a. once in a five year period.
    - b. only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214).
    - c. only when billed on the same date of service with fixed partial denture retainers (abutments) (D6721, D6740, D6751, D6781, D6783 and D6791).
6. Not a benefit for patients under the age of 13.

**PROCEDURE D6250  
PONTIC – RESIN WITH HIGH  
NOBLE METAL**

This procedure is not a benefit.

**PROCEDURE D6251  
PONTIC – RESIN WITH  
PREDOMINANTLY BASE  
METAL**

- 1. Prior authorization is required.
- 2. Radiographs for prior authorization –submit

- arch and periapical radiographs.
  - 3. Written documentation for prior authorization–shall be submitted for employment or medical reasons. Refer to Fixed Prosthodontic General Policies for specific requirements.
  - 4. Requires a tooth code.
  - 5. A benefit:
    - a. once in a five year period.
    - b. only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214).
    - c. only when billed on the same date of service with fixed partial denture retainers (abutments) (D6721, D6740, D6751, D6781, D6783 and D6791).
6. Not a benefit for patients under the age of 13.

**PROCEDURE D6252  
PONTIC – RESIN WITH  
NOBLE METAL**

This procedure is not a benefit.

**PROCEDURE D6253**

**PROVISIONAL PONTIC -  
FURTHER TREATMENT OR  
COMPLETION OF  
DIAGNOSIS NECESSARY  
PRIOR TO FINAL  
IMPRESSION**

This procedure is not a  
benefit.

**PROCEDURE D6545  
RETAINER – CAST METAL  
FOR RESIN BONDED FIXED  
PROSTHESIS**

This procedure is not a  
benefit.

**PROCEDURE D6548  
RETAINER –  
PORCELAIN/CERAMIC FOR  
RESIN BONDED FIXED  
PROSTHESIS**

This procedure is not a  
benefit.

**PROCEDURE D6600  
INLAY –  
PORCELAIN/CERAMIC, TWO  
SURFACES**

This procedure is not a  
benefit.

**PROCEDURE D6601  
INLAY –  
PORCELAIN/CERAMIC,  
THREE OR MORE SURFACES**

This procedure is not a  
benefit.

**PROCEDURE D6602  
INLAY – CAST HIGH NOBLE  
METAL, TWO SURFACES**

This procedure is not a  
benefit.

**PROCEDURE D6603  
INLAY – CAST HIGH NOBLE  
METAL, THREE OR MORE  
SURFACES**

This procedure is not a  
benefit.

**PROCEDURE D6604**

**INLAY – CAST  
PREDOMINANTLY BASE  
METAL, TWO SURFACES**

This procedure is not a  
benefit.

**PROCEDURE D6605  
INLAY – CAST  
PREDOMINANTLY BASE  
METAL, THREE OR MORE  
SURFACES**

This procedure is not a benefit.

**PROCEDURE D6606  
INLAY – CAST NOBLE  
METAL, TWO SURFACES**

This procedure is not a benefit.

**PROCEDURE D6607  
INLAY – CAST NOBLE  
METAL, THREE OR MORE  
SURFACES**

This procedure is not a benefit.

**PROCEDURE D6608  
ONLAY –  
PORCELAIN/CERAMIC, TWO  
SURFACES**

This procedure is not a benefit.

**PROCEDURE D6609  
ONLAY –  
PORCELAIN/CERAMIC,  
THREE OR MORE SURFACES**

This procedure is not a benefit.

**PROCEDURE D6610  
ONLAY – CAST HIGH NOBLE  
METAL, TWO SURFACES**

This procedure is not a benefit.

**PROCEDURE D6611**

**ONLAY – CAST HIGH NOBLE  
METAL, THREE OR MORE  
SURFACES**

This procedure is not a benefit.

**PROCEDURE D6612  
ONLAY – CAST  
PREDOMINANTLY BASE  
METAL, TWO SURFACES**

This procedure is not a benefit.

**PROCEDURE D6613  
ONLAY – CAST  
PREDOMINANTLY BASE  
METAL, THREE OR MORE  
SURFACES**

This procedure is not a benefit.

**PROCEDURE D6614  
ONLAY – CAST NOBLE  
METAL, TWO SURFACES**

This procedure is not a benefit.

**PROCEDURE D6615  
ONLAY – CAST NOBLE  
METAL, THREE OR MORE  
SURFACES**

This procedure is not a benefit.

**PROCEDURE D6624  
INLAY- TITANIUM**

This procedure is not a benefit.

**PROCEDURE D6634  
ONLAY- TITANIUM**

This procedure is not a benefit.

**PROCEDURE D6710  
CROWN- INDIRECT RESIN  
BASED COMPOSITE**

This procedure is not a benefit.

**PROCEDURE D6720  
CROWN – RESIN WITH HIGH  
NOBLE METAL**

This procedure is not a benefit.

**PROCEDURE D6721  
CROWN – RESIN WITH  
PREDOMINANTLY BASE  
METAL**

1. Prior authorization is required.
2. Radiographs for prior authorization –submit arch and periapical radiographs.
3. Written documentation for prior authorization- shall be submitted for employment or medical reasons. Refer to Fixed Prosthodontic General Policies for specific requirements.
4. Requires a tooth code.
5. A benefit:
  - a. once in a five year period.
  - b. only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214).

6. Not a benefit for patients under the age of 13.

**PROCEDURE D6722  
CROWN – RESIN WITH  
NOBLE METAL**

This procedure is not a benefit.

**PROCEDURE D6740  
CROWN –  
PORCELAIN/CERAMIC**

1. Prior authorization is required.
2. Radiographs for prior authorization –submit arch and periapical radiographs.
3. Written documentation for prior authorization- shall be submitted for employment or medical reasons. Refer to Fixed Prosthodontic General Policies for specific requirements.
4. Requires a tooth code.
5. A benefit:
  - a. once in a five year period.
  - b. only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214).
6. Not a benefit for patients under the age of 13.

**PROCEDURE D6750  
CROWN – PORCELAIN  
FUSED TO HIGH NOBLE  
METAL**

This procedure is not a benefit.

**PROCEDURE D6751  
CROWN – PORCELAIN  
FUSED TO PREDOMINANTLY  
BASE METAL**

1. Prior authorization is required.
2. Radiographs for prior authorization –submit arch and periapical radiographs.
3. Written documentation for prior authorization- shall be submitted for employment or medical reasons. Refer to Fixed Prosthodontic General Policies for specific requirements.
4. Requires a tooth code.
5. A benefit:
  - a. once in a five year period.
  - b. only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214).
6. Not a benefit for patients under the age of 13.

**PROCEDURE D6752**

**CROWN – PORCELAIN  
FUSED TO NOBLE METAL**

This procedure is not a benefit.

**PROCEDURE D6780  
CROWN – ¾ CAST HIGH  
NOBLE METAL**

This procedure is not a benefit.

**PROCEDURE D6781  
CROWN – ¾ CAST  
PREDOMINANTLY BASE  
METAL**

1. Prior authorization is required.
2. Radiographs for prior authorization –submit arch and periapical radiographs.
3. Written documentation for prior authorization- shall be submitted for employment or medical reasons. Refer to Fixed Prosthodontic General Policies for specific requirements.
4. Requires a tooth code.
5. A benefit:
  - a. once in a five year period.
  - b. only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214).
6. Not a benefit for patients under the age of 13.

**PROCEDURE D6782  
CROWN – ¾ CAST NOBLE  
METAL**

This procedure is not a benefit.

**PROCEDURE D6783**

**CROWN – ¾ PORCELAIN/  
CERAMIC**

1. Prior authorization is required.
2. Radiographs for prior authorization –submit arch and periapical radiographs.
3. Written documentation for prior authorization- shall be submitted for employment or medical reasons. Refer to Fixed Prosthodontic General Policies for specific requirements.
4. Requires a tooth code.
5. A benefit:
  - a. once in a five year period.
  - b. only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214).
6. Not a benefit for patients under the age of 13.

**PROCEDURE D6790  
CROWN – FULL CAST HIGH  
NOBLE METAL**

This procedure is not a benefit.

**PROCEDURE D6791  
CROWN – FULL CAST  
PREDOMINANTLY BASE  
METAL**

1. Prior authorization is required.
2. Radiographs for prior authorization –submit arch and periapical radiographs.
3. Written documentation for prior authorization- shall be submitted for employment or medical reasons. Refer to Fixed Prosthodontic General Policies for specific requirements.
4. Requires a tooth code.
5. A benefit:
  - a. once in a five year period.
  - b. only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214).
6. Not a benefit for patients under the age of 13.

**PROCEDURE D6792  
CROWN – FULL CAST NOBLE  
METAL**

This procedure is not a benefit.

**PROCEDURE D6793  
PROVISIONAL RETAINER  
CROWN - FURTHER  
TREATMENT OR  
COMPLETION OF  
DIAGNOSIS NECESSARY  
PRIOR TO FINAL  
IMPRESSION**

This procedure is not a benefit.

**PROCEDURE D6794  
CROWN- TITANIUM**

This procedure is not a benefit.

**PROCEDURE D6920  
CONNECTOR BAR**

This procedure is not a benefit.

**PROCEDURE D6930  
RECEMENT FIXED PARTIAL  
DENTURE**

1. This procedure does not require prior authorization.
2. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
3. Requires a quadrant code.
4. The original provider is responsible for all recementations within the first 12 months following the initial placement of a fixed partial denture.

5. Not a benefit within 12 months of a previous recementation by the same provider.

**PROCEDURE D6940  
STRESS BREAKER**

This procedure is not a benefit.

**PROCEDURE D6950  
PRECISION ATTACHMENT**

This procedure is not a benefit.

**PROCEDURE D6975  
COPING**

This procedure is not a benefit.

**PROCEDURE D6980  
FIXED PARTIAL DENTURE  
REPAIR NECESSITATED BY  
RESTORATIVE MATERIAL  
FAILURE**

1. This procedure does not require prior authorization.
2. Radiographs for payment –submit pre-operative radiographs of the retainers.
3. Photographs for payment –submit a pre-operative photograph.
4. Written documentation for payment- describe the specific conditions addressed by the procedure.
5. Submit a laboratory invoice, if applicable for the type of procedure, for payment.
6. Requires a tooth code.
7. Not a benefit within 12 months of initial placement or previous repair, same provider.

**PROCEDURE D6985**

**PEDIATRIC PARTIAL  
DENTURE, FIXED**

This procedure is not a benefit.

**PROCEDURE D6999  
UNSPECIFIED, FIXED  
PROSTHODONTIC  
PROCEDURE, BY REPORT**

1. Prior authorization is required.
2. Radiographs for prior authorization –submit periapical radiographs.
3. Photographs for prior authorization – submit photographs if applicable for the type of procedure.
4. Written documentation for prior authorization – describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed treatment.
5. Requires a tooth code.
6. Not a benefit within 12 months of initial placement, same provider.
7. Procedure D6999 shall be used:
  - a. for a procedure which is not adequately described by a CDT code, or
  - b. for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical

condition to justify  
the medical  
necessity.

Documentation shall  
include the medical  
condition and the  
specific CDT code  
associated with the  
treatment.

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**Oral and Maxillofacial Surgery General Policies (D7000-D7999)**

**Oral and Maxillofacial Surgery General Policies (D7000-D7999)**

- a) Diagnostic pre-operative radiographs are required for all hard tissue surgical procedures that are submitted for prior authorization and/or payment. Refer to the individual procedure for specific requirements.
  - b) Local anesthetic, sutures and routine postoperative care within 30 days following an extraction procedure (D7111-D7250) are considered part of, and included in, the fee for the procedure. All other oral and maxillofacial surgery procedures include routine postoperative care for 90 days.
  - c) The level of payment for multiple surgical procedures performed on the same date of service shall be modified to the most inclusive procedure.
1. Extractions (D7111-D7250):
    - a) The following conditions shall be considered medically necessary and shall be a benefit:
      - i) full bony impacted supernumerary teeth or mesiodens that interfere with the alignment of other teeth,
      - ii) teeth which are involved with a cyst, tumor or other neoplasm,
      - iii) unerupted teeth which are severely distorting the normal alignment of erupted teeth or causing the resorption of the roots of other teeth,
      - iv) the extraction of all remaining teeth in preparation for a full prosthesis,
      - v) extraction of third molars that are causing repeated or chronic pericoronitis
      - vi) extraction of primary teeth required to minimize malocclusion or malalignment when there is adequate space to allow normal eruption of succedaneous teeth,
      - vii) perceptible radiologic pathology that fails to elicit symptoms,
      - viii) extractions that are required to complete orthodontic dental services excluding prophylactic removal of third molars,
      - ix) when the prognosis of the tooth is questionable due to non-restorability or periodontal involvement.
    - b) The prophylactic extraction of 3rd molars is not a benefit.
    - c) The fee for surgical extractions includes the removal of bone and/or sectioning of tooth, and elevation of mucoperiosteal flap, if indicated.
    - d) Classification of surgical extractions and impactions shall be based on the anatomical position of the tooth rather than the surgical technique employed in the removal.
    - e) The level of payment for surgical extractions shall be allowed or modified based on the degree of difficulty as evidenced by the diagnostic radiographs. When radiographs do not accurately depict the degree of difficulty, written documentation and/or photographs shall be considered.
  2. Fractures (D7610-D7780):
    - a) The placement and removal of wires, bands or splints is included in the fee for the associated procedure.

**Oral and Maxillofacial Surgery General Policies (D7000-D7999)**

- b) Routine postoperative care within 90 days is included in the fee for the associated procedure.
  - c) When extensive multiple or bilateral procedures are performed at the same operative session, each procedure shall be valued as follows:
    - i) 100% (full value) for the first or major procedure, and
    - ii) 50% for the second procedure, and
    - iii) 25% for the third procedure, and
    - iv) 10% for the fourth procedure, and
    - v) 5% for the fifth procedure, and
    - vi) over five procedures, by report.
  - d) Assistant surgeons are paid 20% of the surgical fee allowed to the surgeon. Hospital call (D9420) is not payable to assistant surgeons.
3. Temporomandibular Joint Dysfunctions (D7810-D7899):
- a) TMJ dysfunction procedures are limited to differential diagnosis and symptomatic care. Not included as a benefit are those TMJ treatment modalities that involve prosthodontia, orthodontia and full or partial occlusal rehabilitation.
  - b) Most TMJ dysfunction procedures require prior authorization. Submission of sufficient diagnostic information to establish the presence of the dysfunction is required. Refer to the individual procedures for specific submission requirements.
  - c) TMJ dysfunction procedures solely for the treatment of bruxism is not a benefit.
4. Repair Procedures (D7910-D7998):
- a) Suture procedures (D7910, D7911 and D7912) are not a benefit for the closure of surgical incisions.

**Oral and Maxillofacial Surgery Procedures (D7000-D7999)**

**Oral and Maxillofacial Surgery Procedures (D7000-D7999)**

**PROCEDURE D7111  
EXTRACTION, CORONAL  
REMNANTS – DECIDUOUS  
TOOTH**

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. Requires a tooth code.
3. Not a benefit for asymptomatic teeth.

**PROCEDURE D7140  
EXTRACTION, ERUPTED  
TOOTH OR EXPOSED ROOT  
(ELEVATION AND/OR  
FORCEPS REMOVAL)**

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. Requires a tooth code.
3. Not a benefit to the same provider who performed the initial tooth extraction.

**PROCEDURE D7210  
SURGICAL REMOVAL OF  
ERUPTED TOOTH  
REQUIRING REMOVAL OF  
BONE AND/OR SECTIONING  
OF TOOTH, AND INCLUDING  
ELEVATION OF**

**MUCOPERIOSTEAL FLAP IF  
INDICATED**

1. Radiographs for payment –submit a current, diagnostic preoperative periapical or panoramic radiograph depicting the entire tooth.
2. Requires a tooth code.
3. A benefit when the removal of any erupted tooth requires the elevation of a mucoperiosteal flap and the removal of substantial alveolar bone or sectioning of the tooth.

**PROCEDURE D7220  
REMOVAL OF IMPACTED  
TOOTH – SOFT TISSUE**

1. Radiographs for payment –submit a current, diagnostic preoperative periapical or panoramic radiograph depicting the entire tooth.
2. Requires a tooth code.
3. A benefit when the major portion or the entire occlusal surface is covered by mucogingival soft tissue.

**PROCEDURE D7230  
REMOVAL OF IMPACTED  
TOOTH – PARTIALLY BONY**

1. Radiographs for payment –submit a current, diagnostic preoperative periapical or panoramic radiograph depicting the entire tooth.
2. Requires a tooth code.
3. A benefit when the removal of any impacted tooth requires the elevation of a mucoperiosteal flap and the removal of substantial alveolar bone. One of the proximal heights of contour of the crown shall be covered by bone.

**PROCEDURE D7240  
REMOVAL OF IMPACTED  
TOOTH – COMPLETELY  
BONY**

1. Radiographs for payment –submit a current, diagnostic preoperative periapical or panoramic radiograph depicting the entire tooth.
2. Requires a tooth code.
3. A benefit when the removal of any impacted tooth requires the elevation of a mucoperiosteal flap and the removal of substantial alveolar bone

**Oral and Maxillofacial Surgery Procedures (D7000-D7999)**

covering most or all of the crown.

**PROCEDURE D7241  
REMOVAL OF IMPACTED  
TOOTH – COMPLETELY  
BONY, WITH UNUSUAL  
SURGICAL COMPLICATIONS**

1. Radiographs for payment –submit a current, diagnostic preoperative periapical or panoramic radiograph depicting the entire tooth.
2. Written documentation for payment – shall justify the unusual surgical complication.
3. Requires a tooth code.
4. A benefit when the removal of any impacted tooth requires the elevation of a mucoperiosteal flap and the removal of substantial alveolar bone covering most or all of the crown. Difficulty or complication shall be due to factors such as nerve dissection or aberrant tooth position.

**PROCEDURE D7250  
SURGICAL REMOVAL OF  
RESIDUAL TOOTH ROOTS  
(CUTTING PROCEDURE)**

1. Radiographs for payment –submit a current, diagnostic preoperative periapical or panoramic

radiograph depicting the entire root.

2. Requires a tooth code.
3. A benefit when the root is completely covered by alveolar bone.
4. Not a benefit to the same provider who performed the initial tooth extraction.

**PROCEDURE D7251  
CORONECTOMY-  
INTENTIONAL PARTIAL  
TOOTH REMOVAL**

This procedure is not a benefit.

**PROCEDURE D7260  
ORAL ANTRAL FISTULA  
CLOSURE**

1. Radiographs for payment - submit a current, diagnostic preoperative radiograph.
2. Written documentation or operative report for payment – shall describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. Requires a quadrant code.
4. A benefit for the excision of a fistulous tract between the maxillary sinus and oral cavity.

5. Not a benefit in conjunction with extraction procedures (D7111 – D7250).

**PROCEDURE D7261  
PRIMARY CLOSURE OF A  
SINUS PERFORATION**

1. Radiographs for payment - submit a current, diagnostic preoperative radiograph.
2. Written documentation or operative report for payment – shall describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. Requires a tooth code.
4. A benefit in the absence of a fistulous tract requiring the repair or immediate closure of the oroantral or oralnasal communication, subsequent to the removal of a tooth.

**PROCEDURE D7270  
TOOTH REIMPLANTATION  
AND/OR STABILIZATION OF  
ACCIDENTALLY EVULSED OR  
DISPLACED TOOTH**

1. Radiographs for payment –submit a preoperative periapical radiograph.
2. Written documentation for payment – shall

**Oral and Maxillofacial Surgery Procedures (D7000-D7999)**

describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the tooth/teeth reimplanted.

3. Requires an arch code.
4. A benefit:
  - a. once per arch regardless of the number of teeth involved, and
  - b. for permanent anterior teeth only.
5. The fee for this procedure includes splinting and/or stabilization, postoperative care and the removal of the splint or stabilization, by the same provider.

**PROCEDURE D7272  
TOOTH TRANSPLANTATION  
(INCLUDES  
REIMPLANTATION FROM  
ONE SITE TO ANOTHER AND  
SPLINTING AND/OR  
STABILIZATION)**

This procedure is not a benefit.

**PROCEDURE D7280  
SURGICAL ACCESS OF AN  
UNERUPTED TOOTH**

1. Prior authorization is required.

2. Radiographs for prior authorization –submit a pre-operative radiograph depicting the impacted tooth.
3. Written documentation for prior authorization – shall describe the specific conditions addressed by the procedure and the rationale demonstrating the medical necessity.
4. Requires a tooth code.
5. Not a benefit:
  - a. for patients age 21 or older.
  - b. for 3rd molars.

**PROCEDURE D7282  
MOBILIZATION OF ERUPTED  
OR MALPOSITIONED TOOTH  
TO AID ERUPTION**

This procedure is not a benefit.

**PROCEDURE D7283  
PLACEMENT OF DEVICE TO  
FACILITATE ERUPTION OF  
IMPACTED TOOTH**

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a pre-operative radiograph depicting the impacted tooth.
3. Written documentation for prior authorization – shall indicate that the

patient is under active orthodontic treatment.

4. Requires a tooth code.
5. A benefit only for patients in active orthodontic treatment.
6. Not a benefit:
  - a. for patients age 21 years or older.
  - b. for 3rd molars unless the 3rd molar occupies the 1st or 2nd molar position.

**PROCEDURE D7285  
BIOPSY OF ORAL TISSUE –  
HARD (BONE, TOOTH)**

1. Radiographs for payment –submit a pre-operative radiograph.
2. A pathology report from a certified pathology laboratory is required for payment.
3. Requires an arch code.
4. A benefit:
  - a. for the removal of the specimen only.
  - b. once per arch, per date of service regardless of the areas involved.
5. Not a benefit with an apicoectomy/periradicular surgery (D3410-D3426), an extraction (D7111-D7250) and an excision of any soft tissues or intraosseous lesions (D7410-D7461) in the same area or region

**Oral and Maxillofacial Surgery Procedures (D7000-D7999)**

on the same date of service.

**PROCEDURE D7286  
BIOPSY OF ORAL TISSUE –  
SOFT**

1. Written documentation for payment – shall include the area or region and individual areas biopsied.
2. A pathology report from a certified pathology laboratory is required for payment.
3. A benefit:
  - a. for the removal of the specimen only.
  - b. up to a maximum of three per date of service.
4. Not a benefit with an apicoectomy/periradicular surgery (D3410-D3426), an extraction (D7111-D7250) and an excision of any soft tissues or intraosseous lesions (D7410-D7461) in the same area or region on the same date of service.

**PROCEDURE D7287  
EXFOLIATIVE CYTOLOGICAL  
SAMPLE COLLECTION**

This procedure is not a benefit.

**PROCEDURE D7288**

**BRUSH BIOPSY-  
TRANSEPIHELIAL SAMPLE  
COLLECTION**

This procedure is not a benefit.

**PROCEDURE D7290  
SURGICAL REPOSITIONING  
OF TEETH**

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a pre-operative radiograph.
3. Written documentation for prior authorization – shall indicate that the patient is under active orthodontic treatment.
4. Requires an arch code.
5. A benefit:
  - a. for permanent teeth only.
  - b. once per arch.
  - c. only for patients in active orthodontic treatment.
6. Not a benefit:
  - a. for patients age 21 years or older.
  - b. for 3rd molars unless the 3rd molar occupies the 1st or 2nd molar position.

**PROCEDURE D7291  
TRANSEPTAL  
FIBEROTOMY/ SUPRA  
CRESTAL FIBEROTOMY, BY  
REPORT**

1. Written documentation for payment – shall indicate that the patient is under active orthodontic treatment.
2. Requires an arch code.
3. A benefit:
  - a. once per arch.
  - b. only for patients in active orthodontic treatment.
4. Not a benefit for patients age 21 or older.

**PROCEDURE D7292  
SURGICAL PLACEMENT:  
TEMPORARY ANCHORAGE  
DEVICE [SCREW RETAINED  
PLATE] REQUIRING  
SURGICAL FLAP**

This procedure is not a benefit.

**PROCEDURE D7293  
SURGICAL PLACEMENT:  
TEMPORARY ANCHORAGE  
DEVICE REQUIRING  
SURGICAL FLAP**

This procedure is not a benefit.

**PROCEDURE D7294  
SURGICAL PLACEMENT:  
TEMPORARY ANCHORAGE  
DEVICE WITHOUT SURGICAL  
FLAP**

**Oral and Maxillofacial Surgery Procedures (D7000-D7999)**

This procedure is not a benefit.

**PROCEDURE D7295  
HARVEST OF BONE FOR USE  
IN AUTOGENOUS GRAFTING  
PROCEDURE**

This procedure is not a benefit.

**PROCEDURE D7310  
ALVEOLOPLASTY IN  
CONJUNCTION WITH  
EXTRACTIONS – FOUR OR  
MORE TEETH OR TOOTH  
SPACES, PER QUADRANT**

1. Radiographs for payment –submit radiographs of the involved areas.
2. Requires a quadrant code.
3. A benefit on the same date of service with two or more extractions (D7140-D7250) in the same quadrant.
4. Not a benefit when only one tooth is extracted in the same quadrant on the same date of service.

**PROCEDURE D7311  
ALVEOLOPLASTY IN  
CONJUNCTION WITH  
EXTRACTIONS – ONE TO  
THREE TEETH OR TOOTH  
SPACES, PER QUADRANT**

This procedure can only be billed as alveoloplasty in conjunction with extractions- four or more teeth or tooth spaces, per quadrant (D7310).

**PROCEDURE D7320  
ALVEOLOPLASTY NOT IN  
CONJUNCTION WITH  
EXTRACTIONS – FOUR OR  
MORE TEETH OR TOOTH  
SPACES, PER QUADRANT**

1. Radiographs for payment- submit radiographs of the involved areas if photographs do not demonstrate the medical necessity.
2. Photographs for payment- submit photographs of the involved areas.
3. Requires a quadrant code.
4. A benefit regardless of the number of teeth or tooth spaces.
5. Not a benefit within six months following extractions (D7140-D7250) in the same quadrant, for the same provider.

**PROCEDURE D7321  
ALVEOLOPLASTY NOT IN  
CONJUNCTION WITH  
EXTRACTIONS – ONE TO  
THREE TEETH OR TOOTH  
SPACES, PER QUADRANT**

This procedure can only be billed as alveoloplasty not in conjunction with extractions- four or more teeth or tooth spaces, per quadrant (D7320).

**PROCEDURE D7340  
VESTIBULOPLASTY-RIDGE  
EXTENSION (SECONDARY  
EPITHELIALIZATION)**

**Oral and Maxillofacial Surgery Procedures (D7000-D7999)**

1. Prior authorization is required.
2. Radiographs for prior authorization –submit radiographs.
3. Photographs for prior authorization –submit photographs.
4. Written documentation for prior authorization shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed prosthodontic treatment.
5. Requires an arch code.
6. A benefit once in a five year period per arch.
7. Not a benefit:
  - a. on the same date of service with a vestibuloplasty – ridge extension (D7350) same arch.
  - b. on the same date of service with extractions (D7111-D7250) same arch.

**PROCEDURE D7350  
VESTIBULOPLASTY – RIDGE  
EXTENSION (INCLUDING  
SOFT TISSUE GRAFTS,  
MUSCLE REATTACHMENT,  
REVISION OF SOFT TISSUE  
ATTACHMENT AND  
MANAGEMENT OF**

**HYPERTROPHIED AND  
HYPERPLASTIC TISSUE)**

1. Prior authorization is required.
2. Radiographs for prior authorization –submit radiographs.
3. Photographs for prior authorization –submit photographs.
4. Written documentation for prior authorization shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed prosthodontic treatment.
5. Requires an arch code.
6. A benefit once per arch.
7. Not a benefit:
  - a. on the same date of service with a vestibuloplasty – ridge extension (D7340) same arch.
  - b. on the same date of service with extractions (D7111-D7250) same arch.

**Oral and Maxillofacial Surgery Procedures (D7000-D7999)**

**PROCEDURE D7410  
EXCISION OF BENIGN  
LESION UP TO 1.25 CM**

1. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
2. A pathology report from a certified pathology laboratory is required for payment.

**PROCEDURE D7411  
EXCISION OF BENIGN  
LESION GREATER THAN 1.25  
CM**

1. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
2. A pathology report from a certified pathology laboratory is required for payment.

**PROCEDURE D7412  
EXCISION OF BENIGN  
LESION, COMPLICATED**

1. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
2. A pathology report from a certified pathology laboratory is required for payment.
3. A benefit when there is extensive undermining with advancement or rotational flap closure.

**PROCEDURE D7413  
EXCISION OF MALIGNANT  
LESION UP TO 1.25 CM**

1. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
2. A pathology report from a certified pathology laboratory is required for payment.

**PROCEDURE D7414  
EXCISION OF MALIGNANT  
LESION GREATER THAN 1.25  
CM**

1. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
2. A pathology report from a certified pathology laboratory is required for payment.

**PROCEDURE D7415  
EXCISION OF MALIGNANT  
LESION, COMPLICATED**

1. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
2. A pathology report from a certified pathology laboratory is required for payment.
3. A benefit when there is extensive undermining with advancement or rotational flap closure.

**PROCEDURE D7440  
EXCISION OF MALIGNANT  
TUMOR – LESION  
DIAMETER UP TO 1.25 CM**

**Oral and Maxillofacial Surgery Procedures (D7000-D7999)**

1. Radiographs for payment- submit a radiograph of the tumor.
2. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. A pathology report from a certified pathology laboratory is required for payment.

**PROCEDURE D7441  
EXCISION OF MALIGNANT  
TUMOR – LESION  
DIAMETER GREATER THAN  
1.25 CM**

1. Radiographs for payment- submit a radiograph of the tumor.
2. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. A pathology report from a certified pathology laboratory is required for payment.

**PROCEDURE D7450  
REMOVAL OF BENIGN  
ODONTOGENIC CYST OR  
TUMOR – LESION  
DIAMETER UP TO 1.25 CM**

1. Radiographs for payment- submit a radiograph of the cyst or tumor.
2. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. A pathology report from a certified pathology laboratory is required for payment.

**PROCEDURE D7451  
REMOVAL OF BENIGN  
ODONTOGENIC CYST OR  
TUMOR – LESION  
DIAMETER GREATER THAN  
1.25 CM**

1. Radiographs for payment- submit a radiograph of the cyst or tumor.
2. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale

demonstrating the medical necessity and any pertinent history.

3. A pathology report from a certified pathology laboratory is required for payment.

**PROCEDURE D7460  
REMOVAL OF BENIGN  
NONODONTOGENIC CYST  
OR TUMOR – LESION  
DIAMETER UP TO 1.25 CM**

1. Radiographs for payment- submit a radiograph of the cyst or tumor.
2. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. A pathology report from a certified pathology laboratory is required for payment.

**PROCEDURE D7461  
REMOVAL OF BENIGN  
NONODONTOGENIC CYST  
OR TUMOR – LESION  
DIAMETER GREATER THAN  
1.25 CM**

1. Radiographs for payment- submit a

**Oral and Maxillofacial Surgery Procedures (D7000-D7999)**

radiograph of the cyst or tumor.

2. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. A pathology report from a certified pathology laboratory is required for payment.

**PROCEDURE D7465  
PROCEDURE DESTRUCTION  
OF LESION(S) BY PHYSICAL  
OR CHEMICAL METHOD, BY  
REPORT**

1. Photographs for payment –submit a pre-operative photograph.
2. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. Examples include using cryo, laser or electro surgery.

**PROCEDURE D7471  
REMOVAL OF LATERAL  
EXOSTOSIS (MAXILLA OR  
MANDIBLE)**

1. Photographs for payment –submit pre-operative photographs.
2. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed prosthodontic treatment.
3. Requires a quadrant code.
4. A benefit:
  - a. once per quadrant.
  - b. for the removal of buccal or facial exostosis only.

**PROCEDURE D7472  
REMOVAL OF TORUS  
PALATINUS**

1. Photographs for payment –submit pre-operative photographs.
2. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the

medical necessity, any pertinent history and the proposed prosthodontic treatment.

3. A benefit once in the patient's lifetime.

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**PROCEDURE D7473  
REMOVAL OF TORUS  
MANDIBULARIS**

1. Photographs for payment –submit pre-operative photographs.
2. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed prosthodontic treatment.
3. Requires a quadrant code.
4. A benefit once per quadrant.

**PROCEDURE D7485  
SURGICAL REDUCTION OF  
OSSEOUS TUBEROSITY**

1. Radiographs for payment –submit preoperative radiographs.
2. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed prosthodontic treatment.

3. Requires a quadrant code.
4. A benefit once per quadrant.

**PROCEDURE D7490  
RADICAL RESECTION OF  
MAXILLA OR MANDIBLE**

1. Radiographs for payment –submit radiographs.
2. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed or actual treatment.

**PROCEDURE D7510  
INCISION AND DRAINAGE  
OF ABSCESS – INTRAORAL  
SOFT TISSUE**

1. Written documentation for payment- shall include the tooth involved, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
2. Requires a quadrant code.

3. A benefit once per quadrant, same date of service.
4. Not a benefit when any other definitive treatment is performed in the same quadrant on the same date of service, except necessary radiographs and/or photographs.
5. The fee for this procedure includes the incision, placement and removal of a surgical draining device.

**PROCEDURE D7511  
INCISION AND DRAINAGE  
OF ABSCESS – INTRAORAL  
SOFT TISSUE- COMPLICATED  
(INCLUDES DRAINAGE OF  
MULTIPLE FASCIAL SPACES)**

1. Written documentation for payment- shall include the tooth involved, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
2. Requires a quadrant code.
3. A benefit once per quadrant, same date of service.
4. Not a benefit when any other definitive treatment is performed

**Oral and Maxillofacial Surgery Procedures (D7000-D7999)**

in the same quadrant on the same date of service, except necessary radiographs and/or photographs.

5. The fee for this procedure includes the incision, placement and removal of a surgical draining device.

**PROCEDURE D7520  
INCISION AND DRAINAGE  
OF ABSCESS – EXTRAORAL  
SOFT TISSUE**

1. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
2. The fee for this procedure includes the incision, placement and removal of a surgical draining device.

**PROCEDURE D7521  
INCISION AND DRAINAGE  
OF ABSCESS – EXTRAORAL  
SOFT TISSUE- COMPLICATED  
(INCLUDES DRAINAGE OF  
MULTIPLE FASCIAL SPACES)**

1. Written documentation for payment- shall include the tooth involved, describe the

specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.

2. The fee for this procedure includes the incision, placement and removal of a surgical draining device.

**PROCEDURE D7530  
REMOVAL OF FOREIGN  
BODY FROM MUCOSA,  
SKIN, OR SUBCUTANEOUS  
ALVEOLAR TISSUE**

1. Radiographs for payment –submit a pre-operative radiograph.
2. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. A benefit once per date of service.
4. Not a benefit when associated with the removal of a tumor, cyst (D7440-D7461) or tooth (D7111-D7250).

**PROCEDURE D7540  
REMOVAL OF REACTION  
PRODUCING FOREIGN**

**BODIES,  
MUSCULOSKELETAL SYSTEM**

1. Radiographs for payment –submit a pre-operative radiograph.
2. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. A benefit once per date of service.
4. Not a benefit when associated with the removal of a tumor, cyst (D7440-D7461) or tooth (D7111-D7250).

**Oral and Maxillofacial Surgery Procedures (D7000-D7999)**

**PROCEDURE D7550  
PARTIAL OSTECTOMY/  
SEQUESTRECTOMY FOR  
REMOVAL OF NON-VITAL  
BONE**

1. Radiographs for payment –submit a pre-operative radiograph.
2. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. Requires a quadrant code.
4. A benefit:
  - a. once per quadrant per date of service.
  - b. only for the removal of loose or sloughed off dead bone caused by infection or reduced blood supply.
5. Not a benefit within 30 days of an associated extraction (D7111-D7250).

**PROCEDURE D7560  
MAXILLARY SINUSOTOMY  
FOR REMOVAL OF TOOTH  
FRAGMENT OR FOREIGN  
BODY**

1. Radiographs for payment –submit a pre-operative radiograph.
2. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. Not a benefit when a tooth fragment or foreign body is retrieved from the tooth socket.

**PROCEDURE D7610  
MAXILLA – OPEN  
REDUCTION (TEETH  
IMMOBILIZED, IF PRESENT)**

1. Radiographs for payment –submit a postoperative radiograph.
2. Operative report for payment – shall include a copy of the operative report, which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.

4. Anesthesia procedures (D9220-D9248) are a separate benefit when necessary for the surgical removal of wires, bands, splints or arch bars.

**PROCEDURE D7620  
MAXILLA – CLOSED  
REDUCTION (TEETH  
IMMOBILIZED, IF PRESENT)**

1. Radiographs for payment –submit a postoperative radiograph.
2. Operative report for payment – shall include a copy of the operative report, which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.
4. Anesthesia procedures (D9220-D9248) are a separate benefit when necessary for the surgical removal of wires, bands, splints or arch bars.

**PROCEDURE D7630  
MANDIBLE – OPEN  
REDUCTION (TEETH  
IMMOBILIZED, IF PRESENT)**

**Oral and Maxillofacial Surgery Procedures (D7000-D7999)**

1. Radiographs for payment –submit a postoperative radiograph.
2. Operative report for payment – shall include a copy of the operative report, which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.
4. Anesthesia procedures (D9220-D9248) are a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

**PROCEDURE D7640  
MANDIBLE – CLOSED  
REDUCTION (TEETH  
IMMOBILIZED, IF PRESENT)**

1. Radiographs for payment –submit a postoperative radiograph.
2. Operative report for payment – shall include a copy of the operative report, which describes the specific conditions addressed by the procedure, the rationale demonstrating the

medical necessity and any pertinent history.

3. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.
4. Anesthesia procedures (D9220-D9248) are a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

**PROCEDURE D7650  
MALAR AND/OR  
ZYGOMATIC ARCH – OPEN  
REDUCTION**

1. Radiographs for payment –submit a postoperative radiograph.
2. Operative report for payment – shall include a copy of the operative report, which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
3. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.
4. Anesthesia procedures (D9220-D9248) are a

separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

**PROCEDURE D7660  
MALAR AND/OR  
ZYGOMATIC ARCH –  
CLOSED REDUCTION**

1. Radiographs for payment –submit a postoperative radiograph.
2. Operative report for payment – shall include a copy of the operative report, which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
3. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.
4. Anesthesia procedures (D9220-D9248) are a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

**PROCEDURE D7670  
ALVEOLUS – CLOSED  
REDUCTION, MAY INCLUDE  
STABILIZATION OF TEETH**

**Oral and Maxillofacial Surgery Procedures (D7000-D7999)**

1. Radiographs for payment –submit a postoperative radiograph.
2. Operative report for payment – shall include a copy of the operative report, which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. Requires an arch code.
4. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.
5. Anesthesia procedures (D9220-D9248) are a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

**PROCEDURE D7671  
ALVEOLUS – OPEN  
REDUCTION, MAY INCLUDE  
STABILIZATION OF TEETH**

1. Radiographs for payment –submit a postoperative radiograph.
2. Operative report for payment – shall include a copy of the operative report which describes the specific conditions addressed by the procedure, the rationale

- demonstrating the medical necessity and any pertinent history.
3. Requires an arch code.
4. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.
5. Anesthesia procedures (D9220-D9248) are a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

**PROCEDURE D7680  
FACIAL BONES –  
COMPLICATED REDUCTION  
WITH FIXATION AND  
MULTIPLE SURGICAL  
APPROACHES**

1. Radiographs for payment –submit a postoperative radiograph.
2. Operative report for payment – shall include a copy of the operative report, which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
3. A benefit for the treatment of simple fractures.

4. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.
5. Anesthesia procedures (D9220-D9248) are a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

**PROCEDURE D7710  
MAXILLA – OPEN  
REDUCTION**

1. Radiographs for payment –submit a postoperative radiograph.
2. Operative report for payment – shall include a copy of the operative report, which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.
4. Anesthesia procedures (D9220-D9248) are a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

**Oral and Maxillofacial Surgery Procedures (D7000-D7999)**

**PROCEDURE D7720  
MAXILLA – CLOSED  
REDUCTION**

1. Radiographs for payment –submit a postoperative radiograph.
2. Operative report for payment – shall include a copy of the operative report, which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.
4. Anesthesia procedures (D9220-D9248) are a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

**PROCEDURE D7730  
MANDIBLE – OPEN  
REDUCTION**

1. Radiographs for payment –submit a postoperative radiograph.
2. Operative report for payment – shall include a copy of the operative report, which describes the specific conditions addressed by the

procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.

3. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.
4. Anesthesia procedures (D9220-D9248) are a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

**PROCEDURE D7740  
MANDIBLE – CLOSED  
REDUCTION**

1. Radiographs for payment –submit a postoperative radiograph.
2. Operative report for payment – shall include a copy of the operative report, which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
3. The fee for this procedure includes the placement and removal

of wires, bands, splints and arch bars.

4. Anesthesia procedures (D9220-D9248) are a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

**PROCEDURE D7750  
MALAR AND/OR  
ZYGOMATIC ARCH – OPEN  
REDUCTION**

1. Radiographs for payment –submit a postoperative radiograph.
2. Operative report for payment – shall include a copy of the operative report, which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
3. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.
4. Anesthesia procedures (D9220-D9248) are a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

**Oral and Maxillofacial Surgery Procedures (D7000-D7999)**

**PROCEDURE D7760  
MALAR AND/OR  
ZYGOMATIC ARCH –  
CLOSED REDUCTION**

1. Radiographs for payment –submit a postoperative radiograph.
2. Operative report for payment – shall include a copy of the operative report, which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
3. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.
4. Anesthesia procedures (D9220-D9248) are a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

**PROCEDURE D7770  
ALVEOLUS – OPEN  
REDUCTION STABILIZATION  
OF TEETH**

1. Radiographs for payment –submit a radiograph.
2. Operative report for payment – shall include a copy of the operative

report, which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.

3. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.
4. Anesthesia procedures (D9220-D9248) are a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

**PROCEDURE D7771  
ALVEOLUS – CLOSED  
REDUCTION STABILIZATION  
OF TEETH**

1. Radiographs for payment –submit a radiograph.
2. Operative report for payment – shall include a copy of the operative report, which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.

3. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.
4. Anesthesia procedures (D9220-D9248) are a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

**PROCEDURE D7780  
FACIAL BONES –  
COMPLICATED REDUCTION  
WITH FIXATION AND  
MULTIPLE SURGICAL  
APPROACHES**

1. Radiographs for payment –submit a radiograph.
2. Operative report for payment – shall include a copy of the operative report, which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
3. A benefit for the treatment of compound fractures.
4. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.

**Oral and Maxillofacial Surgery Procedures (D7000-D7999)**

5. Anesthesia procedures (D9220-D9248) are a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

**PROCEDURE D7810  
OPEN REDUCTION OF  
DISLOCATION**

Written documentation or operative report for payment – shall describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.

**PROCEDURE D7820  
CLOSED REDUCTION OF  
DISLOCATION**

Written documentation or operative report for payment – shall describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.

**PROCEDURE D7921  
COLLECTION AND  
APPLICATION OF**

**AUTOLOGOUS BLOOD  
CONCENTRATE PRODUCT**

This procedure is not a benefit.

**PROCEDURE D7830  
MANIPULATION UNDER  
ANESTHESIA**

1. Written documentation or operative report for payment – shall describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
2. Anesthesia procedures (D9220-D9248) are a separate benefit, when necessary.

**PROCEDURE D7840  
CONDYLECTOMY**

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a radiograph.
3. Written documentation for prior authorization – shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.

**PROCEDURE D7850**

**SURGICAL DISCECTOMY,  
WITH/WITHOUT IMPLANT**

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a radiograph.
3. Written documentation for prior authorization – shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
4. An operative report shall be submitted for payment.

**PROCEDURE D7852  
PROCEDURE DISC REPAIR**

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a radiograph.
3. Written documentation for prior authorization – shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.

**Oral and Maxillofacial Surgery Procedures (D7000-D7999)**

4. An operative report shall be submitted for payment.

**PROCEDURE D7854  
SYNOVECTOMY**

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a radiograph.
3. Written documentation for prior authorization – shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
4. An operative report shall be submitted for payment.

**PROCEDURE D7856  
MYOTOMY**

Written documentation or operative report for payment – shall describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.

**PROCEDURE D7858  
JOINT RECONSTRUCTION**

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a radiograph.

3. Written documentation for prior authorization – shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
4. An operative report shall be submitted for payment.

**PROCEDURE D7860  
ARTHROTOMY**

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a radiograph.
3. Written documentation for prior authorization – shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
4. An operative report shall be submitted for payment.

**PROCEDURE D7865  
ARTHROPLASTY**

1. Prior authorization is required.

**Oral and Maxillofacial Surgery Procedures (D7000-D7999)**

2. Radiographs for prior authorization –submit a radiograph.
3. Written documentation for prior authorization – shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
4. An operative report shall be submitted for payment.

**PROCEDURE D7870  
ARTHROCENTESIS**

Written documentation or operative report for payment – shall describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.

**PROCEDURE D7871  
NON-ARTHROSCOPIC LYSIS  
AND LAVAGE**

This procedure is included in the fee for other procedures and is not payable separately.

**PROCEDURE D7872**

**ARTHROSCOPY –  
DIAGNOSIS, WITH OR  
WITHOUT BIOPSY**

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a radiograph.
3. Written documentation for prior authorization– shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
4. An operative report shall be submitted for payment.
5. This procedure includes the fee for any biopsies performed.

**PROCEDURE D7873  
ARTHROSCOPY – SURGICAL:  
LAVAGE AND LYSIS OF  
ADHESIONS**

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a radiograph.
3. Written documentation for prior authorization– shall describe the specific conditions to be addressed by the

procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.

4. An operative report shall be submitted for payment.

**PROCEDURE D7874  
ARTHROSCOPY – SURGICAL:  
DISC REPOSITIONING AND  
STABILIZATION**

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a radiograph.
3. Written documentation for prior authorization– shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.

4. An operative report shall be submitted for payment.

**PROCEDURE D7875  
ARTHROSCOPY – SURGICAL:  
SYNOVECTOMY**

1. Prior authorization is required.

**Oral and Maxillofacial Surgery Procedures (D7000-D7999)**

2. Radiographs for prior authorization –submit a radiograph.
3. Written documentation for prior authorization– shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
4. An operative report shall be submitted for payment.

Archive

**Oral and Maxillofacial Surgery Procedures (D7000-D7999)**

**PROCEDURE D7876  
ARTHROSCOPY – SURGICAL:  
DISCECTOMY**

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a radiograph.
3. Written documentation for prior authorization– shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
4. An operative report shall be submitted for payment.

**PROCEDURE D7877  
ARTHROSCOPY – SURGICAL:  
DEBRIDEMENT**

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a radiograph.
3. Written documentation for prior authorization– shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right)

- and any pertinent history.
4. An operative report shall be submitted for payment.

**PROCEDURE D7880  
OCCLUSAL ORTHOTIC  
DEVICE, BY REPORT**

1. Prior authorization is required.
2. Radiographs for prior authorization –submit tomograms or a radiological report.
3. Written documentation for prior authorization – shall include the specific TMJ conditions to be addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
4. A benefit for diagnosed TMJ dysfunction.
5. Not a benefit for the treatment of bruxism.

**PROCEDURE D7899  
UNSPECIFIED TMD  
THERAPY, BY REPORT**

1. Prior authorization is required for non-emergency procedures.
2. Radiographs for prior authorization – submit radiographs and/or tomograms, if applicable, for the type of procedure.

3. Written documentation for prior authorization – shall include the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
4. Not a benefit for procedures such as acupuncture, acupressure, biofeedback and hypnosis.

**PROCEDURE D7910  
SUTURE OF RECENT SMALL  
WOUNDS UP TO 5 CM**

1. Written documentation or operative report for payment – shall include the specific conditions addressed by the procedure and the length of the wound.
2. Not a benefit for the closure of surgical incisions.

**PROCEDURE D7911  
COMPLICATED SUTURE – UP  
TO 5 CM**

1. Written documentation or operative report for payment – shall include the specific conditions addressed by the procedure and the length of the wound.

**Oral and Maxillofacial Surgery Procedures (D7000-D7999)**

2. Not a benefit for the closure of surgical incisions.

**PROCEDURE D7912  
COMPLICATED SUTURE –  
GREATER THAN 5 CM**

1. Written documentation or operative report for payment – shall include the specific conditions addressed by the procedure and the length of the wound.
2. Not a benefit for the closure of surgical incisions.

**PROCEDURE D7920  
SKIN GRAFT (IDENTIFY  
DEFECT COVERED,  
LOCATION AND TYPE OF  
GRAFT)**

1. Written documentation or operative report for payment – shall include the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the actual treatment.
2. Not a benefit for periodontal grafting.

**PROCEDURE D7921  
COLLECTION AND  
APPLICATION OF  
AUTOLOGOUS BLOOD  
CONCENTRATE PRODUCT**

This procedure is not a benefit

**PROCEDURE D7940  
OSTEOPLASTY – FOR  
ORTHOGNATHIC  
DEFORMITIES**

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a radiograph.
3. Written documentation for prior authorization – shall include the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed treatment.
4. An operative report shall be submitted for payment.

**PROCEDURE D7941  
OSTEOTOMY –  
MANDIBULAR RAMI**

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a radiograph.
3. Written documentation for prior authorization – shall include the specific conditions to be addressed by the procedure, the rationale demonstrating the

medical necessity and any pertinent history.

4. An operative report shall be submitted for payment.

**PROCEDURE D7943  
OSTEOTOMY –  
MANDIBULAR RAMI WITH  
BONE GRAFT; INCLUDES  
OBTAINING THE GRAFT**

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a radiograph.
3. Written documentation for prior authorization – shall include the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
4. An operative report shall be submitted for payment.

**PROCEDURE D7944  
OSTEOTOMY – SEGMENTED  
OR SUBAPICAL**

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a radiograph.
3. Written documentation for prior authorization – shall include the specific conditions to be

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addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.

4. Requires a quadrant code.
5. An operative report shall be submitted for payment.

**PROCEDURE D7945  
OSTEOTOMY – BODY OF  
MANDIBLE**

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a radiograph.
3. Written documentation for prior authorization – shall include the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
4. An operative report shall be submitted for payment.

**PROCEDURE D7946  
LEFORT I (MAXILLA –  
TOTAL)**

1. Radiographs for payment –submit a pre-operative radiograph.
2. An operative report shall be submitted for payment.

**PROCEDURE D7947  
LEFORT I (MAXILLA –  
SEGMENTED)**

1. Radiographs for payment –submit a pre-operative radiograph.
2. An operative report shall be submitted for payment.
3. When reporting a surgically assisted palatal expansion without downfracture, use unspecified oral surgery procedure, by report (D7999).

**PROCEDURE D7948  
LEFORT II OR LEFORT III  
(OSTEOPLASTY OF FACIAL  
BONES FOR MIDFACE  
HYPOPLASIA OR  
RETRUSION) – WITHOUT  
BONE GRAFT**

1. Radiographs for payment –submit a pre-operative radiograph.
2. An operative report shall be submitted for payment.

**PROCEDURE D7949  
LEFORT II OR LEFORT III –  
WITH BONE GRAFT**

1. Radiographs for payment –submit a pre-operative radiograph.
2. An operative report shall be submitted for payment.

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**PROCEDURE D7950  
OSSEOUS,  
OSTEOPERIOSTEAL, OR  
CARTILAGE GRAFT OF THE  
MANDIBLE OR FACIAL  
BONES – AUTOGENOUS OR  
NONAUTOGENOUS, BY  
REPORT**

3. Prior authorization is required.
4. Radiographs for prior authorization –submit a radiograph.
5. Written documentation for prior authorization – shall include the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed treatment.
6. Not a benefit for periodontal grafting.
7. An operative report shall be submitted for payment.

**PROCEDURE D7951  
SINUS AUGMENTATION  
WITH BONE OR BONE  
SUBSTITUTES VIA A  
LATERAL OPEN APPROACH**

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a radiograph.
3. Written documentation for prior authorization –

shall include the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.

4. A benefit only for patients with authorized implant services.
5. An operative report shall be submitted for payment.

**PROCEDURE D7952  
SINUS AUGMENTATION  
WITH BONE OR BONE  
SUBSTITUTE VIA A VERTICAL  
APPROACH**

1. Prior authorization is required.
2. Radiographs for prior authorization -submit a radiograph.
3. Written documentation for prior authorization - shall include the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
4. A benefit only for patients with authorized implant services.
5. An operative report shall be submitted for payment.

**PROCEDURE D7953  
BONE REPLACEMENT GRAFT  
FOR RIDGE PRESERVATION-  
PER SITE**

This procedure is not a benefit.

**PROCEDURE D7955  
REPAIR OF MAXILLOFACIAL  
SOFT AND/OR HARD TISSUE  
DEFECT**

1. Prior authorization is required.

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2. Radiographs for prior authorization –submit a radiograph.
3. Written documentation for prior authorization – shall include the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed treatment.
4. Not a benefit for periodontal grafting.
5. An operative report shall be submitted for payment.

**PROCEDURE D7960  
FRENULECTOMY ALSO  
KNOWN AS FRENECTOMY  
OR FRENOTOMY –  
SEPARATE PROCEDURE NOT  
IDENTICAL TO ANOTHER**

1. Photographs for payment –submit a pre-operative photograph.
2. Written documentation for payment – shall include the rationale demonstrating the medical necessity and the specific area the treatment was performed.
3. Requires an arch code.
4. A benefit
  - a. once per arch per date of service

- b. only when the permanent incisors and cuspids have erupted.

**PROCEDURE D7963  
FRENULOPLASTY**

1. Photographs for payment –submit a pre-operative photograph.
2. Written documentation for payment – shall include the rationale demonstrating the medical necessity and the specific area the treatment was performed.
3. Requires an arch code.
4. A benefit
  - a. once per arch per date of service.
  - b. only when the permanent incisors and cuspids have erupted.

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**PROCEDURE D7970  
EXCISION OF HYPERPLASTIC  
TISSUE – PER ARCH**

1. Photographs for payment –submit a pre-operative photograph.
2. Written documentation for payment – shall include the rationale demonstrating the medical necessity and the specific area the treatment was performed.
3. Requires an arch code.
4. A benefit once per arch per date of service.
5. Not a benefit for drug induced hyperplasia or where removal of tissue requires extensive gingival recontouring.
6. This procedure is included in the fees for other surgical procedures that are performed in the same area on the same date of service.

**PROCEDURE D7971  
EXCISION OF PERICORONAL  
GINGIVA**

1. Radiographs for payment- submit a pre-operative periapical radiograph.
2. Photographs for payment –submit a pre-operative photograph only when the

radiograph does not adequately demonstrate the medical necessity.

3. Written documentation for payment – shall include the rationale demonstrating the medical necessity.
4. Requires a tooth code.
5. This procedure is included in the fee for other associated procedures that are performed on the same tooth on the same date of service.

**PROCEDURE D7972  
SURGICAL REDUCTION OF  
FIBROUS TUBEROSITY**

1. Photographs for payment –submit a pre-operative photograph.
2. Written documentation for payment – shall include the rationale demonstrating the medical necessity and the actual or proposed prosthodontic treatment.
3. Requires a quadrant code.
4. A benefit once per quadrant per date of service.
5. This procedure is included in the fees for other surgical procedures that are performed in the same

quadrant on the same date of service.

**PROCEDURE D7980  
SIALOLITHOTOMY**

1. Radiographs for payment –submit a pre-operative radiograph.
2. Written documentation or operative report for payment – shall include the area or region the treatment was performed, the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.

**PROCEDURE D7981  
EXCISION OF SALIVARY  
GLAND, BY REPORT**

Operative report for payment – shall include the area or region the treatment was performed, the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.

**PROCEDURE D7982  
SIALODOCHOPLASTY**

Operative report for payment – shall include the area or region the treatment was

**Oral and Maxillofacial Surgery Procedures (D7000-D7999)**

performed, the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.

**PROCEDURE D7983  
CLOSURE OF SALIVARY  
FISTULA**

Operative report for payment – shall include the area or region the treatment was performed, the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.

**PROCEDURE D7990  
EMERGENCY  
TRACHEOTOMY**

Operative report for payment – shall include the specific conditions addressed by the procedure.

**PROCEDURE D7991  
CORONOIDECTOMY**

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a radiograph.
3. Written documentation for prior authorization – shall include the specific

conditions to be addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.

4. An operative report shall be submitted for payment.

**PROCEDURE D7995  
SYNTHETIC GRAFT –  
MANDIBLE OR FACIAL  
BONES, BY REPORT**

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a radiograph.
3. Written documentation for prior authorization – shall include the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
4. Not a benefit for periodontal grafting.
5. An operative report shall be submitted for payment.

**PROCEDURE D7996  
IMPLANT – MANDIBLE FOR  
AUGMENTATION PURPOSES  
(EXCLUDING ALVEOLAR  
RIDGE), BY REPORT**

This procedure is not a benefit.

**PROCEDURE D7997  
APPLIANCE REMOVAL (NOT  
BY DENTIST WHO PLACED  
APPLIANCE), INCLUDES  
REMOVAL OF ARCH BAR**

1. Radiographs for payment –submit a pre-operative radiograph.
2. Written documentation for payment – shall include the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. Requires an arch code.
4. A benefit:
  - a. once per arch per date of service.
  - b. for the removal of appliances related to surgical procedures only.
5. Not a benefit for the removal of orthodontic appliances and space maintainers.

**PROCEDURE D7998  
INTRAORAL PLACEMENT OF  
A FIXATION DEVICE NOT IN  
CONJUNCTION WITH A  
FRACTURE**

This procedure is not a benefit.

**PROCEDURE D7999**

**Oral and Maxillofacial Surgery Procedures (D7000-D7999)**

**UNSPECIFIED ORAL  
SURGERY PROCEDURE, BY  
REPORT**

associated with the  
treatment.

1. Radiographs for payment  
– submit radiographs if  
applicable for the type of  
procedure.
2. Photographs for  
payment – submit  
photographs if  
applicable for the type of  
procedure.
3. Written documentation  
or operative report–  
describe the specific  
conditions addressed by  
the procedure, the  
rationale demonstrating  
the medical necessity,  
any pertinent history and  
the actual treatment.
4. Procedure D7999 shall  
be used:
  - a. for a procedure  
which is not  
adequately described  
by a CDT code, or
  - b. for a procedure that  
has a CDT code that  
is not a benefit but  
the patient has an  
exceptional medical  
condition to justify  
the medical  
necessity.  
Documentation shall  
include the medical  
condition and the  
specific CDT code

**Orthodontic General Policies (D8000-D8999)**

**Orthodontic General Policies (D8000-D8999)**

**Orthodontic Procedures (D8080, D8660, D8670 and D8680)**

- a) Orthodontic procedures shall only be performed by dentists who qualify as orthodontists under the California Code of Regulations, Title 22, Section 51223(c).
- b) Orthodontic procedures are benefits for medically necessary handicapping malocclusion, cleft palate and facial growth management cases for patients under the age of 21 and shall be prior authorized.
- c) Only those cases with permanent dentition shall be considered for medically necessary handicapping malocclusion, unless the patient is age 13 or older with primary teeth remaining. Cleft palate and craniofacial anomaly cases are a benefit for primary, mixed and permanent dentitions. Craniofacial anomalies are treated using facial growth management.
- d) All necessary procedures that may affect orthodontic treatment shall be completed before orthodontic treatment is considered.
- e) Orthodontic procedures are a benefit only when the diagnostic casts verify a minimum score of 26 points on the Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form, DC016 (06/09) or one of the six automatic qualifying conditions below exist or when there is written documentation of a craniofacial anomaly from a credentialed specialist on their professional letterhead.
- f) The automatic qualifying conditions are:
  - i) cleft palate deformity. If the cleft palate is not visible on the diagnostic casts written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,
  - ii) craniofacial anomaly. Written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,
  - iii) a deep impinging overbite in which the lower incisors are destroying the soft tissue of the palate,
  - iv) a crossbite of individual anterior teeth causing destruction of soft tissue,
  - v) an overjet greater than 9 mm or reverse overjet greater than 3.5 mm,
  - vi) a severe traumatic deviation (such as loss of a premaxilla segment by burns, accident or osteomyelitis or other gross pathology). Written documentation of the trauma or pathology shall be submitted with the prior authorization request.
- g) When a patient transfers from one orthodontist to another orthodontist, a new TAR for prior authorization shall be submitted:
  - i) when the patient has already qualified under the Medi-Cal Dental Program and has been receiving treatment, the balance of the originally authorized treatment shall be authorized to the new orthodontist to complete the case. Diagnostic casts, Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score

**Orthodontic General Policies (D8000-D8999)**

- Sheet Form, DC016 (06/09), and photographs are not required for a transfer case that has already been approved, or
- ii) when a patient has been receiving orthodontic treatment that has not been previously approved by the Medi-Cal Dental Program, pre-treatment diagnostic casts and current photographs are required. If pre-treatment diagnostic casts are not available then current diagnostic casts shall be submitted. Prior authorization for the balance of the orthodontic treatment shall be allowed or denied based on the Medi-Cal Dental Program's evaluation of the diagnostic casts and photographs.
  - h) When additional periodic orthodontic treatment visit(s) (D8670) are necessary beyond the maximum allowed to complete the case, prior authorization is required. Current photographs are required to justify the medical necessity.
  - i) If the patient's orthodontic treatment extends beyond the month of their 21st birthday or they become ineligible during treatment, then it is the patient's responsibility to pay for their continued treatment.
  - j) If the patient's orthodontic treatment is interrupted and orthodontic bands are prematurely removed, then the patient no longer qualifies for continued orthodontic treatment.
  - k) If the patient's orthodontic bands have to be temporarily removed and then replaced due to a medical necessity, a claim for comprehensive orthodontic treatment of the adolescent dentition (D8080) for rebanding shall be submitted along with a letter from the treating physician or radiologist, on their professional letterhead, stating the reason why the bands needed to be temporarily removed.

**Orthodontic Procedures (D8000-D8999)****PROCEDURE D8010  
LIMITED ORTHODONTIC  
TREATMENT OF THE  
PRIMARY DENTITION**

This procedure is not a benefit.

**PROCEDURE D8020  
LIMITED ORTHODONTIC  
TREATMENT OF THE  
TRANSITIONAL DENTITION**

This procedure is not a benefit.

**PROCEDURE D8030  
LIMITED ORTHODONTIC  
TREATMENT OF THE  
ADOLESCENT DENTITION**

This procedure is not a benefit.

**PROCEDURE D8040  
LIMITED ORTHODONTIC  
TREATMENT OF THE ADULT  
DENTITION**

This procedure is not a benefit.

**PROCEDURE D8050  
INTERCEPTIVE  
ORTHODONTIC TREATMENT  
OF THE PRIMARY  
DENTITION**

This procedure is not a benefit.

**PROCEDURE D8060  
INTERCEPTIVE  
ORTHODONTIC TREATMENT  
OF THE TRANSITIONAL  
DENTITION**

This procedure is not a benefit.

**PROCEDURE D8070  
COMPREHENSIVE  
ORTHODONTIC TREATMENT  
OF THE TRANSITIONAL  
DENTITION**

This procedure is not a benefit.

**PROCEDURE D8080  
COMPREHENSIVE  
ORTHODONTIC TREATMENT  
OF THE ADOLESCENT  
DENTITION**

1. Prior authorization is required. The following shall be submitted together for prior authorization:
  - a. comprehensive orthodontic treatment of the adolescent dentition (D8080), and
  - b. periodic orthodontic treatment visit(s) (D8670), and
  - c. orthodontic retention (D8680), and
  - d. the diagnostic casts (D0470), and
  - e. a completed Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form, DC016 (06/09).

2. No treatment will be authorized and no payment will be allowed after the month of the patient's 21st birthday.
  3. Written documentation for prior authorization for cleft palate and facial growth management cases shall be submitted:
    - a. cleft palate cases require documentation from a credentialed specialist, on their professional letterhead, if the cleft palate is not visible on the diagnostic casts, or
    - b. facial growth management cases require documentation from a credentialed specialist, on their professional letterhead, of the craniofacial anomaly.
  4. A benefit:
    - a. for handicapping malocclusion, cleft palate and facial growth management cases.
    - b. for patients under the age of 21.
    - c. for permanent dentition (unless the patient is age 13 or older with primary teeth still present or has a cleft palate or craniofacial anomaly).
  5. All appliances (such as bands, arch wires, headgear and palatal expanders) are included in the fee for this procedure. No additional charge to the patient is permitted.
  6. This procedure includes the replacement, repair and removal of brackets, bands and arch wires by the original provider.
- PROCEDURE D8090  
COMPREHENSIVE  
ORTHODONTIC TREATMENT  
OF THE ADULT DENTITION**
- This procedure is not a benefit.
- PROCEDURE D8210  
REMOVABLE APPLIANCE  
THERAPY**
1. Prior authorization is required.
  2. Radiographs for prior authorization –submit current periapical radiographs of the maxillary anterior teeth.
  3. Written documentation for prior authorization – shall justify the medical
- necessity for the appliance and the presence of a harmful oral habit such as thumb sucking and/or tongue thrusting.
4. A benefit:
    - a. for patients ages 6 through 12.
    - b. once per patient.
  5. Not a benefit:
    - a. for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.
    - b. for space maintainers in the upper or lower anterior region.
  6. This procedure includes all adjustments to the appliance.
- PROCEDURE D8220  
FIXED APPLIANCE THERAPY**
1. Prior authorization is required.
  2. Radiographs for prior authorization –submit current periapical radiographs of the maxillary anterior teeth.
  3. Written documentation for prior authorization – shall justify the medical necessity for the appliance and the presence of a harmful oral habit such as thumb

sucking and/or tongue thrusting.

4. A benefit:
  - a. for patients ages 6 through 12.
  - b. once per patient.
5. Not a benefit:
  - a. for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.
  - b. for space maintainers in the upper or lower anterior region.
6. This procedure includes all adjustments to the appliance.

**PROCEDURE D8660  
PRE-ORTHODONTIC  
TREATMENT VISIT**

1. This procedure is for the observation of the patient's oral and/or facial growth for craniofacial anomalies prior to starting orthodontic treatment for facial growth management cases.
2. Prior authorization is required. The following shall be submitted together for authorization:
  - a. comprehensive orthodontic treatment of the

adolescent dentition (D8080), and

- b. pre-orthodontic treatment visit(s) (D8660) indicating the quantity of treatment visits required up to a maximum of six during the patient's lifetime, and
  - c. periodic orthodontic treatment visit(s) (D8670), and
  - d. orthodontic retention (D8680), and
  - e. a completed Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form, DC016 (06/09).
3. Written documentation for prior authorization shall include a letter from a credentialed specialist, on their professional letterhead, confirming a craniofacial anomaly.
  4. A benefit:
    - a. prior to comprehensive orthodontic treatment of the adolescent dentition (D8080) for the initial

treatment phase for facial growth

management cases regardless of how many dentition phases are required.

- b. once every three months.
- c. for patients under the age of 21.
- d. for a maximum of six.

**PROCEDURE D8670  
PERIODIC ORTHODONTIC  
TREATMENT VISIT (AS PART  
OF CONTRACT)**

1. Prior authorization is required. Refer to Orthodontic General Policies for specific authorization requirements.
2. The start of payments for this procedure shall be the next calendar month following the date of service for comprehensive orthodontic treatment of the adolescent dentition (D8080).
3. A benefit:
  - a. for patients under the age of 21.
  - b. for permanent dentition (unless the patient is age 13 or older with primary teeth still present or has a cleft palate or

- craniofacial anomaly).
- c. once per calendar quarter.
- 4. The maximum quantity of monthly treatment visits for the following phases are:
  - a. Malocclusion- up to a maximum of 8 quarterly visits. (4 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity), or
  - b. Cleft Palate:
    - i) Primary dentition – up to a maximum of 4 quarterly visits. (2 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).
    - ii) Mixed dentition - up to a maximum of 5 quarterly visits. (3 additional quarterly visits shall be authorized when
  - c. Facial Growth Management:
    - i) Primary dentition- up to a maximum of 4 quarterly visits. (2 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).
    - ii) Mixed dentition- up to a maximum of 5 quarterly visits. (3 additional quarterly visits shall be
  - documentation and photographs justify the medical necessity).
  - iii) Permanent dentition- up to a maximum of 10 quarterly visits. (5 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity), or
  - authorized when documentation and photographs justify the medical necessity).
  - iii) Permanent dentition- up to a maximum of 8 quarterly visits. (4 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).

**PROCEDURE D8680  
ORTHODONTIC RETENTION  
(REMOVAL OF APPLIANCES,  
CONSTRUCTION AND  
PLACEMENT OF  
RETAINER(S))**

1. Prior authorization is required. Refer to Orthodontic General Policies for specific authorization requirements.
2. This procedure shall be paid only following the completion of periodic orthodontic treatment visit(s) (D8670) which is considered to be the active phase of orthodontic treatment.
3. Requires an arch code.

4. A benefit:
  - a. for patients under the age of 21.
  - b. for permanent dentition (unless the patient is age 13 or older with primary teeth still present or has a cleft palate or craniofacial anomaly).
  - c. once per arch for each authorized phase of orthodontic treatment.
5. Not a benefit until the active phase of orthodontic treatment (D8670) is completed. If fewer than the authorized number of periodic orthodontic treatment visit(s) (D8670) are necessary because the active phase of treatment has been completed early, then this shall be documented on the claim for orthodontic retention (D8680).
6. The removal of appliances, construction and placement of retainers, all observations and necessary adjustments are included in the fee for this procedure.

**ORTHODONTIC TREATMENT  
(ALTERNATIVE BILLING TO A  
CONTRACT FEE)**

This procedure is not a benefit.

**PROCEDURE D8690**

**PROCEDURE D8691  
REPAIR OF ORTHODONTIC  
APPLIANCE**

1. This procedure does not require prior authorization.
2. Written documentation for payment – indicate the type of orthodontic appliance and a description of the repair.
3. Requires an arch code.
4. A benefit:
  - a. for patients under the age of 21.
  - b. once per appliance.
5. Not a benefit to the original provider for the replacement and/or repair of brackets, bands, or arch wires.

**PROCEDURE D8692  
REPLACEMENT OF LOST OR  
BROKEN RETAINER**

1. This procedure does not require prior authorization.
2. Written documentation for payment – indicate how the retainer was lost or why it is no longer serviceable.
3. Requires an arch code.
4. A benefit:
  - a. for patients under the age of 21.
  - b. once per arch.
  - c. only within 24 months following the

date of service of orthodontic retention (D8680).

5. This procedure is only payable when orthodontic retention (D8680) has been previously paid by the program.

**PROCEDURE D8693  
REBONDING OR  
RECEMENTING: AND/OR  
REPAIR, AS REQUIRED, OF  
FIXED RETAINERS**

1. This procedure does not require prior authorization.
2. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
3. Requires an arch code.
4. A benefit:
  - a. for patients under the age of 21.
  - b. once per provider.
5. Additional requests beyond the stated frequency limitations shall be considered for payment when the medical necessity is documented and identifies an unusual condition (such as displacement due to a sticky food item).

**PROCEDURE D8999  
UNSPECIFIED  
ORTHODONTIC  
PROCEDURE, BY REPORT**

1. Prior authorization is required for non-emergency procedures.

2. Radiographs for prior authorization or payment- submit radiographs if applicable for the type of procedure.
3. Photographs for prior authorization or payment- submit photographs if applicable for the type of procedure.
4. Written documentation for prior authorization or payment – describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed or actual treatment.
5. A benefit for patients under the age of 21.
6. Not a benefit to the original provider for the adjustment, repair, replacement or removal of brackets, bands or arch wires.
7. Procedure D8999 shall be used:
  - a. for a procedure which is not adequately described by a CDT code, or
  - b. for a procedure that has a CDT code that is not a benefit but

the patient has an exceptional medical condition to justify the medical necessity.

Documentation shall include the medical condition and the specific CDT code associated with the treatment.

**Adjunctive Service Procedures (D9000-D9999)**

**Adjunctive General Policies (D9000-D9999)**

- a) Anesthesia (D9210-D9248)
- b) General anesthesia (D9220 and D9221) is defined as a controlled state of unconsciousness, accompanied by a partial or complete loss of protective reflexes, including the loss of the ability to independently maintain an airway and respond purposefully to physical stimulation or verbal command, produced by a pharmacologic or non-pharmacologic method or combination thereof.
- c) Intravenous sedation/analgesia (D9241 and D9242) is a medically controlled state of depressed consciousness while maintaining the patient's airway, protective reflexes and the ability to respond to stimulation or verbal commands. It includes intravenous (IV) administration of sedative and/or analgesic agent(s) and appropriate monitoring.
- d) Non-intravenous conscious sedation (D9248) is a medically controlled state of depressed consciousness while maintaining the patient's airway, protective reflexes and the ability to respond to stimulation or verbal commands. It includes administration of sedative and/or analgesic agent(s) by a route other than IV (oral, patch, intramuscular or subcutaneous) and appropriate monitoring.
- e) Deep sedation/general anesthesia (D9220 and D9221) and intravenous conscious sedation/analgesia (D9241 and D9242) shall be considered for payment when it is documented why local anesthesia is contraindicated. Such contraindications shall include the following:
  - i) a severe mental or physical handicap,
  - ii) extensive surgical procedures,
  - iii) an uncooperative child,
  - iv) an acute infection at an injection site,
  - v) a failure of a local anesthetic to control pain.
- f) The administration of deep sedation/general anesthesia (D9220 and D9221), nitrous oxide (D9230), intravenous conscious sedation/analgesia (D9241 and D9242) and therapeutic parenteral drug (D9610) is a benefit in conjunction with payable associated procedures. Prior authorization or payment shall be denied if all associated procedures by the same provider are denied.
- g) Only one anesthesia procedure is payable per date of service regardless of the methods of administration or drugs used. When one or more anesthesia procedures are performed only the most profound procedure will be allowed. The following anesthesia procedures are listed in order from most profound to least profound:
  - i) Procedure D9220/D9221 (Deep Sedation/General Anesthesia),
  - ii) Procedure D9241/D9242 (Intravenous Conscious Sedation/Analgesia),
  - iii) Procedure D9248 (Non-Intravenous Conscious Sedation),
  - iv) Procedure D9230 (Inhalation Of Nitrous Oxide/Analgesia, Anxiolysis).

**Adjunctive Service Procedures (D9000-D9999)**

- h) Providers who administer general anesthesia (D9220 and D9221) and/or intravenous conscious sedation/analgesia (D9241 and D9242) shall have valid anesthesia permits with the California Dental Board.
- i) The cost of analgesic and anesthetic agents and supplies are included in the fee for the analgesic/ anesthetic procedure.
- j) Anesthesia time for general anesthesia and intravenous conscious sedation is defined as the period between the beginning of the administration of the anesthetic agent and the time that the anesthetist is no longer in personal attendance.
- k) Sedation is a benefit in conjunction with the surgical removal of wires, bands, splints and arch bars.

Archive

**Adjunctive Service Procedures (D9000-D9999)**

**Adjunctive Service Procedures (D9000-D9999)**

**PROCEDURE D9110  
PALLIATIVE (EMERGENCY)  
TREATMENT OF DENTAL  
PAIN – MINOR**

1. This procedure cannot be prior authorized.
2. Written documentation for payment –shall include the tooth/area, condition and specific treatment performed.
3. A benefit once per date of service per provider regardless of the number of teeth and/or areas treated.
4. Not a benefit when any other treatment is performed on the same date of service, except when radiographs/photographs are needed of the affected area to diagnose and document the emergency condition.

**PROCEDURE D9120  
FIXED PARTIAL DENTURE  
SECTIONING**

1. This procedure does not require prior authorization.
2. Radiographs for payment- submit pre-operative radiographs.
3. Requires a tooth code for the retained tooth.

4. A benefit when at least one of the abutment teeth is to be retained.

**PROCEDURE D9210  
LOCAL ANESTHESIA NOT IN  
CONJUNCTION WITH  
OPERATIVE OR SURGICAL  
PROCEDURES**

1. This procedure cannot be prior authorized.
2. Written documentation for payment –shall include the medical necessity for the local anesthetic injection.
3. A benefit:
  - a. once per date of service per provider.
  - b. only for use in order to perform a differential diagnosis or as a therapeutic injection to eliminate or control a disease or abnormal state.
4. Not a benefit when any other treatment is performed on the same date of service, except when radiographs/photographs are needed of the affected area to diagnose and document the emergency condition.

**PROCEDURE D9211**

**REGIONAL BLOCK  
ANESTHESIA**

This procedure is included in the fee for other procedures and is not payable separately.

**PROCEDURE D9212  
TRIGEMINAL DIVISION  
BLOCK ANESTHESIA**

This procedure is included in the fee for other procedures and is not payable separately.

**PROCEDURE D9215  
LOCAL ANESTHESIA IN  
CONJUNCTION WITH  
OPERATIVE OR SURGICAL  
PROCEDURES**

This procedure is included in the fee for other procedures and is not payable separately.

**PROCEDURE D9220  
PROCEDURE DEEP  
SEDATION/GENERAL  
ANESTHESIA – FIRST 30  
MINUTES**

1. This procedure does not require prior authorization.
2. Written documentation for payment –shall justify the medical necessity based on a mental or physical limitation or contraindication to a local anesthetic agent. The anesthetic induction agent shall also be documented.
3. An anesthesia record that indicates the anesthetic agent(s) and the anesthesia time shall be submitted for payment.
4. Not a benefit:
  - a. on the same date of service as analgesia, anxiolysis, inhalation of nitrous oxide (D9230), intravenous conscious sedation/analgesia (D9241 and D9242) or non-intravenous conscious sedation (D9248).
  - b. when all associated procedures on the same date of service

by the same provider are denied.

**PROCEDURE D9221  
PROCEDURE DEEP  
SEDATION/GENERAL  
ANESTHESIA – EACH  
ADDITIONAL 15 MINUTES**

1. This procedure does not require prior authorization.
2. Written documentation for payment –shall justify the medical necessity based on a mental or physical limitation or contraindication to a local anesthetic agent. The anesthetic induction agent shall also be documented.
3. An anesthesia record that indicates the anesthetic agent(s) and the anesthesia time shall be submitted for payment.
4. The quantity, in 15-minute increments, that was necessary to complete the treatment shall be indicated on the claim.
5. Not a benefit:
  - a. on the same date of service as analgesia, anxiolysis, inhalation of nitrous oxide (D9230), intravenous conscious

sedation/analgesia (D9241 and D9242) or non-intravenous conscious sedation (D9248).

- b. when all associated procedures on the same date of service by the same provider are denied.

**PROCEDURE D9230  
INHALATION OF NITROUS  
OXIDE/ANXIOLYSIS,  
ANALGESIA**

1. This procedure does not require prior authorization.
2. Written documentation for payment for patients age 13 or older- shall indicate the physical, behavioral, developmental or emotional condition that prohibits the patient from responding to the provider's attempts to perform treatment.
3. A benefit:
  - a. for uncooperative patients under the age of 13, or
  - b. for patients age 13 or older when documentation specifically identifies the physical, behavioral, developmental or emotional condition

that prohibits the patient from responding to the provider's attempts to perform treatment.

4. Not a benefit:
  - a. on the same date of service as deep sedation/general anesthesia (D9220 and D9221), intravenous conscious sedation/analgesia (D9241 and D9242) or non-intravenous conscious sedation (D9248).
  - b. when all associated procedures on the same date of service by the same provider are denied.

**PROCEDURE D9241  
INTRAVENOUS CONSCIOUS  
SEDATION/ANALGESIA –  
FIRST 30 MINUTES**

1. This procedure does not require prior authorization.
2. Written documentation for payment –shall justify the medical necessity based on a mental or physical limitation or contraindication to a local anesthetic agent.

3. An anesthesia record that indicates the anesthetic agent(s) and the anesthesia time shall be submitted for payment.

4. Not a benefit:
  - a. on the same date of service as deep sedation/general anesthesia (D9220 and D9221), analgesia, anxiolysis, inhalation of nitrous oxide (D9230) or non-intravenous conscious sedation (D9248).
  - b. when all associated procedures on the same date of service by the same provider are denied.

**PROCEDURE D9242  
INTRAVENOUS CONSCIOUS  
SEDATION/ANALGESIA –  
EACH ADDITIONAL 15  
MINUTES**

1. This procedure does not require prior authorization.
2. Written documentation for payment –shall justify the medical necessity based on a mental or physical limitation or contraindication to a local anesthetic agent.

3. An anesthesia record that indicates the anesthetic agent(s) and the anesthesia time shall be submitted for payment.

4. The quantity, in 15-minute increments, that was necessary to complete the treatment shall be indicated on the claim.

5. Not a benefit:
  - a. on the same date of service as deep sedation/general anesthesia (D9220 and D9221), analgesia, anxiolysis, inhalation of nitrous oxide (D9230) or non-intravenous conscious sedation (D9248).
  - b. when all associated procedures on the same date of service by the same provider are denied.

**PROCEDURE D9248  
NON-INTRAVENOUS  
CONSCIOUS SEDATION**

1. This procedure does not require prior authorization.
2. Written documentation for payment for patients of all ages- shall indicate the specific anesthetic agent administered and

- the method of administration.
3. Written documentation for payment for patients age 13 or older- shall indicate the physical, behavioral, developmental or emotional condition that prohibits the patient from responding to the provider's attempts to perform treatment.
  4. A benefit:
    - a. for uncooperative patients under the age of 13, or
    - b. for patients age 13 or older when documentation specifically identifies the physical, behavioral, developmental or emotional condition that prohibits the patient from responding to the provider's attempts to perform treatment.
    - c. for oral, patch, intramuscular or subcutaneous routes of administration.
    - d. once per date of service.
  5. Not a benefit:
    - a. on the same date of service as deep

- sedation/general anesthesia (D9220 and D9221), analgesia, anxiolysis, inhalation of nitrous oxide (D9230) or intravenous conscious sedation/analgesia (D9241 and D9242).
- b. when all associated procedures on the same date of service by the same provider are denied.

**PROCEDURE D9310  
CONSULTATION -  
(DIAGNOSTIC SERVICE  
PROVIDED BY DENTIST OR  
PHYSICIAN OTHER THAN  
REQUESTING DENTIST OR  
PHYSICIAN**

This procedure shall only be billed as diagnostic procedures D0120, D0140, D0150, or D0160.

**PROCEDURE D9410  
HOUSE/EXTENDED CARE  
FACILITY CALL**

1. Written documentation for payment – shall include the name, phone number, and address of the facility. When requesting treatment for a patient who cannot leave their private residence due to a medical condition, the

patient's physician shall submit a letter on their professional letterhead with the following information documented:

- a. the patient's specific medical condition, and
  - b. the reason why the patient cannot leave their private residence, and
  - c. the length of time the patient will be homebound.
2. A benefit:
    - a. once per patient per date of service.
    - b. only in conjunction with procedures that are payable.
  3. When this procedure is submitted for payment without associated procedures, the medical necessity for the visit shall be documented and justified.

**PROCEDURE D9420  
HOSPITAL OR AMBULATORY  
SURGICAL CENTER CALL**

1. The operative report for payment – shall include the total time in the operating room or ambulatory surgical center.
2. A benefit for each hour or fraction thereof as

documented on the operative report.

3. Not a benefit:
  - a. for an assistant surgeon.
  - b. for time spent compiling the patient history, writing reports or for post-operative or follow up visits.

**PROCEDURE D9430  
OFFICE VISIT FOR  
OBSERVATION (DURING  
REGULARLY SCHEDULED  
HOURS) – NO OTHER  
SERVICES PERFORMED**

1. This procedure cannot be prior authorized.
2. Written documentation for payment – shall include the tooth/area, the chief complaint and the non-clinical treatment taken.
3. A benefit once per date of service per provider.
4. Not a benefit:
  - a. when procedures other than necessary radiographs and/or photographs are provided on the same date of service.
  - b. for visits to patients residing in a house/extended care facility.

**PROCEDURE D9440**

**OFFICE VISIT – AFTER  
REGULARLY SCHEDULED  
HOURS**

1. This procedure cannot be prior authorized.
2. Written documentation for payment – shall include justification of the emergency (chief complaint) and be specific to an area or tooth. The time and day of the week shall also be documented.
3. A benefit
  - a. once per date of service per provider.
  - b. only with treatment that is a benefit.
4. This procedure is to compensate providers for travel time back to the office for emergencies outside of regular office hours.

**PROCEDURE D9450  
CASE PRESENTATION,  
DETAILED AND EXTENSIVE  
TREATMENT PLANNING**

This procedure is not a benefit.

**PROCEDURE D9610  
THERAPEUTIC PARENTERAL  
DRUG, SINGLE  
ADMINISTRATION**

1. Written documentation for payment – shall include the specific drug name and classification.
2. A benefit for up to a maximum of four injections per date of service.
3. Not a benefit:
  - a. for the administration of an analgesic or sedative when used in conjunction with deep sedation/general anesthesia (D9220 and D9221), analgesia, anxiolysis, inhalation of nitrous oxide (D9230), intravenous conscious sedation/analgesia (D9241 and D9242) or non-intravenous conscious sedation (D9248).
  - b. when all associated procedures on the same date of service by the same provider are denied.

**PROCEDURE D9612  
THERAPEUTIC PARENTERAL  
DRUG, TWO OR MORE**

**ADMINISTRATIONS,  
DIFFERENT MEDICATIONS**

This procedure can only be billed as therapeutic parenteral drug, single administration (D9610).

**PROCEDURE D9630  
OTHER DRUGS AND/OR  
MEDICAMENTS, BY REPORT**

This procedure is not a benefit.

**PROCEDURE D9910  
APPLICATION OF  
DESENSITIZING  
MEDICAMENT**

1. This procedure cannot be prior authorized.
2. Written documentation for payment –shall include the tooth/teeth and the specific treatment performed.
3. A benefit:
  - a. once in a 12-month period per provider.
  - b. for permanent teeth only.
4. Not a benefit:
  - a. when used as a base, liner or adhesive under a restoration.
  - b. the same date of service as fluoride (D1206 and D1208).

**PROCEDURE D9911  
APPLICATION OF  
DESENSITIZING RESIN FOR  
CERVICAL AND/OR ROOT  
SURFACE, PER TOOTH**

This procedure is not a benefit.

**PROCEDURE D9920  
BEHAVIOR MANAGEMENT,  
BY REPORT**

This procedure is not a benefit.

**PROCEDURE D9930  
TREATMENT OF  
COMPLICATIONS (POST-  
SURGICAL) – UNUSUAL  
CIRCUMSTANCES, BY  
REPORT**

1. This procedure cannot be prior authorized.
2. Written documentation for payment – shall include the tooth, condition and specific treatment performed.
3. Requires a tooth code.
4. A benefit:
  - a. once per date of service per provider.
  - b. for the treatment of a dry socket or excessive bleeding within 30 days of the date of service of an extraction.
  - c. for the removal of bony fragments within 30 days of the date of service of an extraction.
5. Not a benefit:
  - a. for the removal of bony fragments on the same date of

service as an extraction.

- b. for routine post-operative visits.

**PROCEDURE D9940  
OCCLUSAL GUARD, BY  
REPORT**

This procedure is not a benefit.

**PROCEDURE D9941  
FABRICATION OF ATHLETIC  
MOUTHGUARD**

This procedure is not a benefit.

**PROCEDURE D9942  
REPAIR AND/OR RELINE OF  
OCCLUSAL GUARD**

This procedure is not a benefit.

**PROCEDURE D9950  
OCCLUSION ANALYSIS –  
MOUNTED CASE**

1. Prior authorization is required.
2. Written documentation for prior authorization – shall describe the specific symptoms with a detailed history and diagnosis.
3. A benefit:
  - a. once in a 12-month period.
  - b. for patients age 13 or older.
  - c. for diagnosed TMJ dysfunction only.

- d. for permanent dentition.
- 4. Not a benefit for bruxism only.
- 5. The fee for this procedure includes face bow, interocclusal record tracings, diagnostic wax up and diagnostic casts.

**PROCEDURE D9951  
OCCLUSAL ADJUSTMENT - LIMITED**

- 1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
- 2. Requires a quadrant code.
- 3. A benefit:
  - a. once in a 12-month period per quadrant per provider.
  - b. for patients age 13 or older.
  - c. for natural teeth only.
- 4. Not a benefit within 30 days following definitive restorative, endodontic, removable and fixed prosthodontic treatment in the same or opposing quadrant.

**PROCEDURE D9952  
OCCLUSAL ADJUSTMENT - COMPLETE**

- 1. Prior authorization is required.
- 2. Written documentation for prior authorization – submit interocclusal record tracings that demonstrate the medical necessity to eliminate destructive occlusal forces.
- 3. A benefit:
  - a. once in a 12-month period following occlusion analysis-mounted case (D9950).
  - b. for patients age 13 or older.
  - c. for diagnosed TMJ dysfunction only.
  - d. for permanent dentition.
- 4. Not a benefit in conjunction with an occlusal orthotic device (D7880).
- 5. Occlusion analysis-mounted case (D9950) must precede this procedure.

**PROCEDURE D9970  
ENAMEL MICROABRASION**

This procedure is not a benefit.

**PROCEDURE D9971  
ODONTOPLASTY 1 – 2  
TEETH; INCLUDES REMOVAL  
OF ENAMEL PROJECTIONS**

This procedure is not a benefit.

**PROCEDURE D9972  
EXTERNAL BLEACHING –  
PER ARCH - PERFORMED IN  
OFFICE**

This procedure is not a benefit.

**PROCEDURE D9973  
EXTERNAL BLEACHING –  
PER TOOTH**

This procedure is not a benefit.

**PROCEDURE D9974  
INTERNAL BLEACHING – PER  
TOOTH**

This procedure is not a benefit.

**PROCEDURE D9975  
EXTERNAL BLEACHING FOR  
HOME APPLICATION, PER  
ARCH; INCLUDES  
MATERIALS AND  
FABRICATION OF CUSTOM  
TRAYS**

This procedure is not a benefit.

**PROCEDURE D9999  
UNSPECIFIED ADJUNCTIVE  
PROCEDURE, BY REPORT**

- 1. Prior authorization is required for non-emergency procedures.
- 2. Radiographs for prior authorization or payment – submit radiographs if applicable

for the type of  
procedure.

3. Photographs for prior authorization or payment – submit photographs if applicable for the type of procedure.
4. Written documentation for prior authorization or payment – shall include a full description of the proposed or actual treatment and the medical necessity.
5. Procedure D9999 shall be used:
  - a. for a procedure which is not adequately described by a CDT code, or
  - b. for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity.  
Documentation shall include the medical condition and the specific CDT code associated with the treatment.

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