



Provider Bulletin

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THIS ISSUE

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Coding and Policy
Changes Effective
May 1

CDT-26 Update Coding and Policy Changes Effective May 1

Effective **May 1, 2026**, Medi-Cal Dental’s procedure codes are updating to align with the Current Dental Terminology (CDT) Codes for 2026.

This update reflects the American Dental Association’s updated CDT Codes. The changes are listed under the following four categories: New Benefit Codes, New Global Codes, New NonBenefit Codes, or Deleted Codes.

Added Codes:

New Benefit Codes (6 total)

CDT Codes	Procedure Code Description and Criteria
D5909	<p>Maxillary guidance prosthesis with guide flange</p> <ol style="list-style-type: none"> 1. Written documentation for payment – shall include: <ol style="list-style-type: none"> 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.

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D5930	<p>Maxillary guidance prosthesis without guide flange</p> <ol style="list-style-type: none">1. Written documentation for payment – shall include:<ol style="list-style-type: none">a. the etiology of the disease and/or condition, andb. a description of the associated surgery or an operative report, andc. a description of the prosthesis.
D9244	<p>In-office administration of minimal sedation – single drug – enteral</p> <ol style="list-style-type: none">1. This procedure does not require prior authorization.2. Written documentation for payment for patients of all ages – must indicate the specific anesthetic agent administered, dose and route of administration.3. Written documentation for patients age 13 or older – must indicate the physical, behavioral, developmental or emotional condition that prohibits the patient from responding to the provider’s attempts to perform treatment.4. Current permit for oral conscious sedation or pediatric minimal sedation or another appropriate permit must be on file with Medi-Cal Dental.5. A benefit:<ol style="list-style-type: none">a. for uncooperative patients under the age of 13, orb. 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 enteral route of administration.d. once per date of service.6. Not payable:<ol style="list-style-type: none">a. on the same date of service as other sedation procedures.b. when all associated procedures on the same date of service by the same provider are denied.

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D9245	<p>Administration of moderate sedation - enteral</p> <ol style="list-style-type: none">1. This procedure does not require prior authorization.2. Written documentation for payment for patients of all ages – must indicate the specific anesthetic agents administered, doses and route of administration.3. Written documentation for patients age 13 or older – must indicate the physical, behavioral, developmental or emotional condition that prohibits the patient from responding to the provider’s attempts to perform treatment.4. Current permit for moderate sedation or another appropriate permit must be on file with Medi-Cal Dental.5. A benefit:<ol style="list-style-type: none">a. for uncooperative patients under the age of 13, orb. 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 enteral route of administration.d. once per date of service.6. Not payable:<ol style="list-style-type: none">a. on the same date of service as other sedation procedures.b. when all associated procedures on the same date of service by the same provider are denied.
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D9246	Administration of moderate sedation – non-intravenous parenteral – first 15 minute increment, or any portion thereof
	<ol style="list-style-type: none">1. This procedure does not require prior authorization.2. Written documentation for payment for patients of all ages – must indicate the specific anesthetic agents administered, doses and route of administration.3. Written documentation for patients age 13 or older – must indicate the physical, behavioral, developmental or emotional condition that prohibits the patient from responding to the provider’s attempts to perform treatment.4. Current permit for moderate sedation or another appropriate permit must be on file with Medi-Cal Dental.5. For payment, submission of an anesthesia record that meets all the documentation requirements mandated by the California Dental Board for anesthesia documentation is required.6. A benefit:<ol style="list-style-type: none">a. for uncooperative patients under the age of 13, orb. 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 non-intravenous parenteral routes of administration.d. once per date of service.7. Not payable:<ol style="list-style-type: none">a. on the same date of service as other sedation procedures.b. when all associated procedures on the same date of service by the same provider are denied.

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D9247	<p>Administration of moderate sedation – non-intravenous parenteral – each subsequent 15 minute increment, or any portion thereof</p> <ol style="list-style-type: none">1. This procedure does not require prior authorization.2. Written documentation for payment for patients of all ages – must indicate the specific anesthetic agents administered, doses and route of administration.3. Written documentation for patients age 13 or older – must indicate the physical, behavioral, developmental or emotional condition that prohibits the patient from responding to the provider’s attempts to perform treatment.4. Current permit for moderate sedation or another appropriate permit must be on file with Medi-Cal Dental.5. For payment, submission of an anesthesia record that meets all the documentation requirements mandated by the California Dental Board for anesthesia documentation is required.6. The quantity, in 15 minute increments, that was necessary to complete the treatment shall be indicated on the claim.7. A benefit:<ol style="list-style-type: none">a. for uncooperative patients under the age of 13, orb. for patients age 13 or older when documentation specifically identifies the physical, behavioral, developmental or emotional condition prohibits the patient from responding to the provider’s attempts to perform treatment.c. for non-intravenous parenteral routes of administration.d. once per date of service.8. Not payable:<ol style="list-style-type: none">a. on the same date of service as other sedation procedures.b. when all associated procedures on the same date of service by the same provider are denied.
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New Global Codes (14 total)

CDT Codes	Procedure Code Description
D0461	Testing for cracked tooth
D5942	Resection prosthesis, maxillary implant/abutment supported removable prosthesis for edentulous arch
D5943	Resection prosthesis, mandibular implant/abutment supported removable prosthesis for edentulous arch
D5944	Resection prosthesis, maxillary implant/abutment supported removable prosthesis for the partial edentulous arch
D5945	Resection prosthesis, mandibular implant/abutment supported removable prosthesis for the partial edentulous arch
D5946	Resection prosthesis, maxillary implant/abutment supported fixed prosthesis for edentulous arch
D5947	Resection prosthesis, mandibular implant/abutment supported fixed prosthesis for edentulous arch
D5948	Resection prosthesis, maxillary implant/abutment supported fixed prosthesis for the partial edentulous arch
D5949	Resection prosthesis, mandibular implant/abutment supported fixed prosthesis for the partial edentulous arch
D6049	Scaling and debridement of a single implant in the presence of peri-implantitis inflammation, bleeding upon probing and increased pocket depths, including cleaning of the implant surfaces, without flap entry and closure
D6196	Removal of an indirect restoration on an implant retained abutment
D6280	Implant maintenance procedures when a full arch removable implant/abutment supported denture is removed and reinserted, including cleansing of prosthesis and abutments - per arch
D9224	Administration of general anesthesia with advanced airway - first 15 minute increment, or any portion thereof
D9225	Administration of general anesthesia with advanced airway - each subsequent 15 minute increment, or any portion thereof

New Non-Benefit Codes (11 total)

CDT Codes	Procedure Code Description
D0426	Collection, preparation, and analysis of saliva sample - point-of-care
D1720	Influenza vaccine administration

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D5877	Duplication of complete denture - maxillary
D5878	Duplication of complete denture - mandibular
D5938	Resection prosthesis, maxillary complete removable
D5939	Resection prosthesis, mandibular complete removable
D5940	Resection prosthesis, maxillary partial removable
D5941	Resection prosthesis, mandibular partial removable
D9128	Photobiomodulation therapy - first 15 minute increment, or any portion thereof
D9129	Photobiomodulation therapy - each subsequent 15 minute increment, or any portion thereof
D9936	Cleaning and inspection of occlusal guard - per appliance

Deleted Codes:

These six deleted codes will remain valid only for dates of service before the implementation date. For TARs, authorization of deleted codes will end on May 1, 2026. For claims, deleted codes will be payable only when the date of service is April 30, 2026 or earlier. Any deleted code billed with a date of service on or after May 1, 2026 will be adjudicated as invalid.

CDT Codes	Procedure Code Description
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth
D1705	AstraZeneca Covid-19 vaccine administration - first dose
D1706	AstraZeneca Covid-19 vaccine administration - second dose
D1707	Janssen Covid-19 vaccine administration
D1712	Janssen Covid-19 vaccine administration - booster dose
D9248	Non-intravenous conscious sedation

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Policy Changes (10 total):

CDT Codes	Procedure Code Description and Criteria
D7310	<p>ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS - FOUR OR MORE TEETH OR TOOTH SPACES, PER QUADRANT</p> <ol style="list-style-type: none"> 1. Radiographs and photographs for payment – submit radiographs and photographs of the involved areas demonstrating the need for an alveoloplasty. Submit a diagnostic pretreatment radiographic image of the area and diagnostic and appropriately labeled photographs of the treatment area before, during, and after the procedure. 2. Operative Report for payment - submit operative report with the details of the procedure that was done which must include the justification of the need for the procedure. 3. Requires a quadrant code. 4. A benefit on the same date of service with two or more extractions (D7140-D7250) in the same quadrant. 5. Not a benefit when only one tooth is extracted in the same quadrant on the same date of service. 6. Not a benefit when only minor smoothing of socket bone has occurred which is considered a routine part of an extraction procedure.
D3950	<p>CANAL PREPARATION AND FITTING OF PREFORMED DOWEL OR POST</p> <p>This procedure is not a benefit.</p> <p>This procedure is included in the fee for endodontic procedures and is not payable separately (global).</p>

**D9920****BEHAVIOR MANAGEMENT, BY REPORT**

1. Written documentation for payment shall include documentation that the patient is a patient with special healthcare needs who requires additional time for a dental visit. Patients with special healthcare needs are defined as those patients who have a physical, behavioral, developmental or emotional condition that prohibits them from adequately responding to a provider's attempts to perform a dental visit. Documentation shall include the patient's medical diagnosis of such a condition and the reason for the need of additional time for the dental visit.
2. A benefit:
 - a. for four visits in a 12-month period to compensate the provider for additional time needed for providing services to patients with special health care needs.
 - b. only in conjunction with procedures that are payable.
3. Not a benefit:
 - a. when sedation is used as a behavior modification modality.



D4260

OSSEOUS SURGERY (INCLUDING ELEVATION OF A FULL THICKNESS FLAP AND CLOSURE) - FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT

1. Prior authorization is required.
2. Requires radiographs for prior authorization - submit current, diagnostic periapical and bitewing radiographs of the involved areas.
3. Requires periodontal charting for prior authorization - charting must be performed within the last 12 months of submission and must be after the most recent scaling and planing (SRP). Periodontal chart must include:
 - a. pocket depth (six-point periodontal charting)
 - b. clinical attachment loss (CAL)
 - c. bleeding on probing
 - d. mobility
4. Documentation for payment must include:
 - a. photograph(s) which demonstrate that a full thickness flap and closure was performed
 - b. chart notes detailing the surgery - such as flap design, bone recontouring, sutures used, etc.
- ~~3~~. 5. Requires a quadrant code.
- ~~4~~. 6. If three or fewer diseased teeth are present in the quadrant, use osseous surgery (D4261).
- ~~5~~. 7. A benefit:
 - a. for patients age 13 or older for the treatment of moderate to severe bone loss.
 - b. once per quadrant every 36 months.
- ~~6~~. 8. This procedural scaling and root planing (D4341 and D4342) for the same quadrant.
- ~~7~~. 9. 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.

**D4261****OSSEOUS SURGERY (INCLUDING ELEVATION OF A FULL THICKNESS FLAP AND CLOSURE) - ONE TO THREE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT**

1. Prior authorization is required.
2. Requires radiographs for prior authorization - submit current, diagnostic periapical and bitewing radiographs of the involved areas.
3. Requires periodontal charting for prior authorization - charting must be performed within the last 12 months of submission and must be after the most recent scaling and planing (SRP).

Periodontal chart must include:

- a. pocket depth (six-point periodontal charting)
 - b. clinical attachment loss (CAL)
 - c. bleeding on probing
 - d. mobility
4. Documentation for payment must include:
 - a. photograph(s) which demonstrate that a full thickness flap and closure was performed.
 - b. chart notes detailing the surgery - such as flap design, bone recontouring, sutures used, etc.
- ~~3~~ 5. Requires a quadrant code.
- ~~4~~ 6. If four or more diseased teeth are present in the quadrant, use osseous surgery (D4260).
- ~~5~~ 7. A benefit:
- a. for patients age 13 or older for the treatment of moderate to severe bone loss.
 - b. once per quadrant every 36 months.
- ~~6~~ 8. This procedure cannot be prior authorized within 30 days following periodontal scaling and root planing (D4341 and D4342) for the same quadrant.
- ~~7~~ 9. 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.

**D1354****APPLICATION OF CARIES ARRESTING MEDICAMENT - PER TOOTH**

1. Radiographs and photographs for payment:
 - a. for patients under the age of 7, submit a current intraoral photograph demonstrating the medical necessity.
 - b. for patients age 7 or older, in addition to a current intraoral photograph, submit a current, diagnostic **periapical** radiograph and document the underlying conditions that exist which indicate that nonrestorative caries treatment is optimal.
 - c. photographs may be used in lieu of radiographs for patients with special healthcare needs in situations where radiographs cannot be obtained because of the patient's medical condition, physical ability, or cognitive function. Specific documentation of why radiographs could not be obtained must accompany the TAR or claim.
2. Requires a tooth code.
3. A benefit:
 - a. for patients under the age of 7.
 - b. for patients age 7 or older when documentation shows underlying conditions such that nonrestorative caries treatment may be optimal.
 - c. once every six months, up to ten teeth per visit, for a maximum of four treatments per tooth.
4. Not a benefit:
 - a. when the prognosis of the tooth is questionable due to nonrestorability.
 - b. when a tooth is near exfoliation.

**D3410****APICOECTOMY - 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.
 - c. ~~when a periradicular surgery (D3427) has been performed on the same root.~~ when a surgical repair of root resorption (D3471) has been performed on the same root.
7. The fee for this procedure includes the placement of retrograde filling material and all treatment and post treatment radiographs.



D3421	APICOECTOMY - PREMOLAR (FIRST ROOT) <ol style="list-style-type: none">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 premolar teeth only.6. Not a benefit:<ol style="list-style-type: none">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, same root.c. when a periradicular surgery (D3427) has been performed on the same root. when a surgical repair of root resorption (D3472) has been performed on the 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 - each additional root (D3426).
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D3425	APICOECTOMY - MOLAR (FIRST ROOT) <ol style="list-style-type: none">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 first and second molar teeth only.6. Not a benefit:<ol style="list-style-type: none">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, same root.c. for third molars, unless the third molar occupies the first or second molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.d. when a periradicular surgery (D3427) has been performed on the same root. when a surgical repair of root resorption (D3473) has been performed on the 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- each additional root (D3426).
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D3426	APICOECTOMY (EACH ADDITIONAL ROOT) <ol style="list-style-type: none">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:<ol style="list-style-type: none">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, same root.c. for third molars, unless the third molar occupies the first or second molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.d. when a periradicular surgery (D3427) has been performed on the same root; when a surgical repair of root resorption (D3472 or D3473) has been performed on the same root.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.
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[Section 5 - Manual of Criteria and Schedule of Maximum Allowances](#) of the [Provider Handbook](#) will be updated on May 1, 2026 when the codes and policy changes become effective.

If you have questions or need additional support, please contact the Medi-Cal Dental Telephone Service Center (TSC) toll-free at (800) 423-0507. Medi-Cal Dental representatives are available to answer phone calls between 8:00 a.m. to 5:00 p.m., Monday through Friday to assist you. For general program information, the Medi-Cal Dental Interactive Voice Response System (IVR) is available 24 hours a day, seven days a week, using the automated system. For assistance with claims submission and documentation, please visit the [California Outreach Map](#) to contact your regional representative.