Blue Cross Dental Coverage and Clinical Policy

Blue Cross Dental has outlined our coverage guidelines and clinical policies to promote our members' health. We have based these guidelines on professional standards and the input of our Dental Constituency Advisory Committee (DCAC), which includes licensed, practicing Rhode Island dentists. DCAC gives significant input regarding clinical parameters of care and helps to define the dental community's standard of care. We review our policies annually, and more frequently if needed, to determine clinical appropriateness.

This document utilizes the most current ADA Current Dental Terminology (CDT) coding. For each code, we have outlined coverage guidelines including frequency, age limitations, clinical criteria and relationship to other codes, when applicable. We have also noted:

- When procedures are ***not covered*** benefits and thus become billable to the member.
- When procedures are ***considered integral*** to a greater procedure and therefore a Blue Cross Dental participating dentist may not bill the member.
- Codes that require supporting documentation, including details on the documentation, for Dentist Advisor review. Participating dentists that are part of our Provider Off Review Program are exempt from these requirements with the exception of all Implant services (D6000-D6199) and Unlisted procedures (D x999).

Please note that member benefits are determined by our coverage guidelines and clinical policies and the terms of the member's Subscriber Agreement. However, some employers customize their employees' benefits, making it important to always check benefits and eligibility before performing services at My Patients' Benefits on www.unitedconcordia.com.

Additionally, coverage guidelines for qualified plans under the Affordable Care Act are set forth by the Federal government and may differ from Blue Cross Dental guidelines. Please refer to the Pediatric Dental Benefit section at the end of this guide.

Please use this guide to determine the correct code to describe the services you have provided to your patient. For additional information about billing, please refer to our Participating Dentist Administrative Manual at www.bcbsri.com/providers/dental.

DENTAL COVERAGE POLICY – Additional Procedures to construct new Crown under existing partial denture framework

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION:

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

CRITERIA:

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:
1 per 5 years
Additional procedures within the 5 years are not covered and are member liability.

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2025

DENTAL COVERAGE POLICY - Adjustments to Dentures

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION:

Adjustments to complete/partial dentures within six months of delivery are considered part of the initial placement and not billable to the patient. After the six-month period, benefits are limited to one adjustment in a 12-month period.

CODES:

D5410 Adjust complete denture-maxillary
D5411 Adjust complete denture-mandibular
D5421 Adjust partial denture-maxillary
D5422 Adjust partial denture-mandibular

CRITERIA:

No review required.

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

Limited to one (1) adjustment in a 12-month period. Additional adjustments are not covered and are member liability.

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2025

DENTAL COVERAGE POLICY- Alveoloplasty

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION:

Alveoloplasties are limited to once per quadrant in a five-year period.

CODES:

D7310 Alveoloplasty in conjunction with extractions-four or more teeth or tooth spaces, per quadrant
D7311 Alveoloplasty in conjunction with extractions-one to three teeth or tooth spaces, per quadrant
D7320 Alveoloplasty not in conjunction with extractions-four or more teeth or tooth spaces, per quadrant
D7321 Alveoloplasty not in conjunction with extractions-one to three teeth or tooth spaces, per quadrant

CRITERIA:

No review required.

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

D7311 is considered integral to extractions if performed by same dentist on same date. A participating dentist may not bill the member.

PER ADA CDT 2025

DENTAL COVERAGE POLICY – Amalgams and Composites

EFFECTIVE DATE: 09/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION:

Amalgam and composite restorations are placed to restore functionality to a tooth that has been broken down by caries (decay) or fractured. Restorations may be made to permanent and/or primary teeth and may involve one to four or more surfaces of a tooth.

The placement of amalgam or composite restorations includes liners, base, pulp cap, bonding adhesive and polishing. Local anesthesia is considered to be part of the restorative procedure. Most subscriber contracts state that composite (white) restorations on posterior teeth are not a covered benefit; however, the allowance for the corresponding amalgam (silver) restoration (same tooth surfaces) is made for this restoration, with the patient responsible for payment of the difference between the amalgam allowance and the dentist's charge for the composite restoration. As of January 1, 2023, all BCBSRI plans will include coverage for composite (white) restorations on all teeth.

When restorations with multiple surfaces on the same tooth are submitted, processing is as follows:

- For anterior and/or posterior teeth, a combination of occlusal (or incisal) surfaces and interproximal surfaces - pay as **one** multi-surfaced restoration with each submitted surface represented, (i.e., #3 MOB), each surface considered ONCE for a restoration.

The buccal surface on a posterior restoration may be considered as a separate one-surface restoration if it is NOT connected to the other restoration(s) and a different material is used

CODES:

D2140 Amalgam-one surface, primary or permanent
D2150 Amalgam-two surfaces, primary or permanent
D2160 Amalgam-three surfaces, primary or permanent
D2161 Amalgam-four or more surfaces, primary or permanent
D2330 Resin-based composite-one surface, anterior
D2331 Resin-based composite-two surfaces, anterior
D2332 Resin-based composite-three surfaces, anterior
D2335 Resin-based composite-four or more surfaces, anterior
D2390 Resin-based composite crown, anterior
D2391 Resin-based composite-one surface, posterior
D2392 Resin-based composite-two surfaces, posterior
D2393 Resin-based composite-three surfaces, posterior
D2394 Resin-based composite-four or more surface, posterior
D2976 Band stabilization, per tooth: Not covered and is considered member liability.
D2989 Excavation of a tooth resulting in the determination of non-restorability: Not covered and is considered member liability.
D2990 Resin infiltration of incipient smooth surface lesions: Not covered and is considered member liability.

D2991 Application of hydroxyapatite regeneration medicament – per tooth: 2 per tooth, per 12 months, ages 1 thru 6; 1 per tooth, per 12 months, ages 7 thru 12.

CRITERIA:
No review required.

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:
Benefits for the replacement of an existing amalgam/composite restoration are payable after 12 months have passed since the previous placement the restoration. If a filling (same surfaces) is replaced within a 12-month period by same participating dentist/office, it is considered integral to the initial filling placement. A participating dentist may not bill the member.

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2025

DENTAL COVERAGE POLICY – Anatomical Crown Exposure

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION:

This procedure is utilized in an otherwise periodontally healthy area to remove enlarged gingival tissue and bone (ostectomy) to provide an anatomically correct gingival relationship.

CODES:

D4230 Anatomical crown exposure-four or more contiguous teeth per quadrant: Not covered and is member liability.

D4231 Anatomical crown exposure-one to three teeth per quadrant: Not covered and is member liability.

CRITERIA:

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2025

DENTAL COVERAGE POLICY - Anesthesia

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION

Local anesthesia is considered integral to the operative procedure(s) performed, and there is no separate benefit. A participating dentist may not bill a member for integral services. General anesthesia and intravenous sedation are a separate benefit when performed in conjunction with specific oral surgery procedures.

CODES:

D9210 Local anesthesia not in conjunction with operative or surgical procedures: Integral to the greater procedure. A participating dentist may not bill the member.
D9211 Regional block anesthesia: Integral to the greater procedure. A participating dentist may not bill the member.
D9212 Trigeminal division block anesthesia: Integral to the greater procedures. A participating dentist may not bill the member.
D9215 Local anesthesia in conjunction with operative or surgical procedures: Integral to the greater procedure. A participating dentist may not bill the member.
D9219 Evaluation for deep sedation or general anesthesia: Integral to administration of the anesthesia. A participating dentist may not bill the member.
D9222 Deep sedation/general anesthesia – first 15 minutes
D9223 Deep sedation/general anesthesia – each additional 15 minutes
D9230 Inhalation of nitrous oxide / anxiolysis, analgesia: Not covered and is considered member liability.
D9239 Intravenous conscious sedation/analgesia- first 15 minutes
D9243 Intravenous conscious sedation/analgesia – each additional 15 minutes
D9248 Non-intravenous conscious sedation: Not covered and is considered member liability.

CRITERIA:

LIMITATIONS: Benefits for general anesthesia and IV sedation are limited to coverage only when performed in conjunction with the following procedure codes:
D7210-D7251; D7260-D7261; D7280-D7286; D7290; D7340-D7350; D7471-D7473; D7485; D7520 & D7521; D7610-D7671; D7830; D7999 - if determined by Dental Consultant
D9220/9221: Limited to 60 minutes. Any charge exceeding 60 minutes is not covered and is considered member liability.
If additional units are needed, consideration will be made for coverage on an individual basis with rationale and treatment notes.

FREQUENCY: N/A

DOCUMENTATON: A detailed narrative, along with any clinical documentation that is available, including X-rays, treatment chart, photo, etc.

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2025

DENTAL COVERAGE POLICY - Apexification/Recalcification

EFFECTIVE DATE: 09/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION

Apexification and recalcification procedures are performed in circumstances of traumatic injuries to the apices, or incomplete closure of the apex/apices of a permanent tooth. X-rays and intra-canal medication are necessary in these cases.

CODES:

D3351 Apexification/recalcification– initial visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.) Includes opening tooth, preparation of canal spaces, first placement of medication and necessary radiographs. (This procedure may include first phase of complete root canal therapy.)

D3352 Apexification/recalcification - For visits in which the intra-canal medication is replaced with new medication and necessary radiographs. (This procedure may include first phase of complete root canal therapy)

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

D3355 Pulpal regeneration - initial visit (includes opening tooth, preparation of canal spaces, placement of medication)

D3356 Pulpal regeneration - interim medication replacement

D3357 Pulpal regeneration - completion of treatment (does not include final restoration)

CRITERIA:

No review required.

LIMITATIONS:

Not covered on primary teeth and permanent teeth of members over age 15.

DOCUMENTATION:

FREQUENCY:

D3355, D3356, D3357- Covered once per tooth per lifetime.

RELATIONSHIP TO OTHER CODES: (for payment purposes)

Root canal treatment will be offset by the amount benefitted for pulpal regeneration when pulpal regeneration was done within 12 months prior to the root canal treatment.

PER ADA CDT 2025

DENTAL COVERAGE POLICY – Apically Positioned Flap

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION:

This procedure is used to preserve kerantinized gingiva in conjunction with osseous resection and second stage implant procedure. Procedure may also be used to preserve keratinized/attached gingiva during surgical exposure of labially impacted teeth and may be used during treatment of peri-implantitis.

CODES:

D4245 Apically positioned flap

CRITERIA:

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

Considered integral to the greater procedure. A participating dentist may not bill a member.

PER ADA CDT 2025

DENTAL COVERAGE POLICY-Apicoectomy/Perirad Surgery

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION

Periradicular surgery is a term used to describe surgery to the root at the apex or along the root surface, e.g., apicoectomy, repair of a root perforation or resorptive defect, exploratory curettage to look for root fractures, removal of extruded filling material or instruments, removal of broken root fragments, sealing of accessory canals, etc. This does not include retrograde filling material placement.

CODES:

D3410 Apicoectomy-anterior
D3421 Apicoectomy-bicuspid (first root)
D3425 Apicoectomy-molar (first root)
D3426 Apicoectomy-(each additional root)
D3427 Periradicular surgery without apicoectomy
D3432 Guided tissue regeneration, resorbable barrier, per site, in conjunction with periradicular surgery: Not covered and is considered member liability.

CRITERIA:

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

Retrograde filling is considered a separate procedure.
Not allowed within 30 days following RCT treatment. A participating dentist may not bill a member.

PER ADA CDT 2025

DENTAL COVERAGE POLICY - Complete Dentures

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION:

Benefits for complete dentures include adjustments, reline/rebase, or repairs for six months following delivery of the denture to the patient. Insertion date (delivered to the mouth) is considered the completion date for a partial denture and benefits are payable for that date of service (not impression date). **Specialized procedures -** Specialized procedures are considered non-covered by Blue Cross Dental and the patient is responsible for payment. These services are to be performed with the consent of the patient **prior** to initiation of treatment. Documentation of the patient's acceptance of the treatment plan and payment responsibility is recommended.

CODES:

D5110 Complete denture-maxillary
D5120 Complete denture-mandibular

CRITERIA:

No review required.

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

Benefit once, per arch, in 5-year period.
Additional dentures during the 5-year period are not covered and are considered member liability.

RELATIONSHIP TO OTHER CODES: (for payment purposes)

One removable partial denture, complete or immediate denture or replacement of all teeth and acrylic on a cast metal framework (D5670, D5671) is allowed per arch per five-year period

PER ADA CDT 2025

DENTAL COVERAGE POLICY- Coping

EFFECTIVE DATE: 03/21/2009
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION:

Not a covered benefit; patient liable for payment.

CODES:

D2975 Coping: Not covered and is considered member liability.

CRITERIA:

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2025

DENTAL COVERAGE POLICY – Core Buildups

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION:

A core build-up provides a foundation upon which a crown will be fabricated. A tooth is deemed in need of a core build-up if it requires the replacement of missing tooth structure for the purpose of obtaining adequate resistance and retention for the crown. If the purpose of the restoration involves pulpal insulation, undercut elimination, cast bulk reduction, box formation or eliminating concave irregularities in the preparation, or for any other purposes other than obtaining adequate retention, the replacement of tooth structure should not be considered a core build-up.

CODES:

D2950 Core buildup, including any pins

CRITERIA:

The Dentist Advisor will review for large restorations mesial-distal with substantial depth, or with little supporting tooth structure buccal-lingual, also validating the need for a core build-up. If a tooth has been fractured or decayed, leaving minimal tooth structure to adequately provide retention for crown placement, a core build-up is indicated.

LIMITATIONS:

Not covered for members under age 14 unless clinical rationale is provided and is considered member liability.
Not covered on primary teeth and is considered member liability.

DOCUMENTATION:

Pre-operative periapical X-ray and photo (if applicable and available)

FREQUENCY:

Replacement limited to once in 5 years
Replacements within the 5 years are not covered and are considered member liability.

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2025

DENTAL COVERAGE POLICY – Crown Lengthening

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION:

This procedure is employed to allow access to sound tooth structure for a restorative procedure or crown placement for adequate crown height and/or margins. Crown lengthening requires reflection of a flap and bone removal, and is performed in a healthy periodontal environment, (as opposed to osseous surgery, which is performed in the presence of periodontal disease.) Where there are adjacent teeth, the flap design may involve a larger surgical area.

CODES:

D4249 Clinical crown lengthening-hard tissue

CRITERIA:

Two or more on same date of service requires Dentist Advisor review.

LIMITATIONS:

DOCUMENTATION:

Pre-operative periapical x-ray

FREQUENCY:

Benefit once per tooth per lifetime
Additional crown lengthening procedures on the same tooth are not covered and are considered member liability.

RELATIONSHIP TO OTHER CODES: (for payment purposes)

D4346 when performed within 6 months of D4355, D4910, D4341/D4342 or surgical periodontal procedures is considered integral. A participating dentist may not bill the member

PER ADA CDT 2025

DENTAL COVERAGE POLICY- Crown Repair

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION:

Crown repairs are subject to individual consideration by Dental Consultant review. The review requires adequate clinical documentation.

CODES:

D2980 Crown repair necessitated by restorative material failure
D2981 Inlay repair necessitated by restorative material failure
D2982 Onlay repair necessitated by restorative material failure
D2983 Veneer repair necessitated by restorative material failure: Not covered and is considered member liability.

CRITERIA:

The allowance for a crown repair will be determined by considering the time, difficulty and materials used in the process to repair the crown.

LIMITATIONS:

DOCUMENTATION:

X-rays, treatment notes, detailed narrative, photo if available, copy of the lab charges (if applicable)

FREQUENCY:

Considered integral to the crown benefit if performed within 12 months of insertion by the same dentist/dental office. A participating dentist may not bill the member.
Thereafter, Repairs are limited to once in 36 months. Additional repairs are not covered and are considered member liability.

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2025

DENTAL COVERAGE POLICY – Crowns

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION:

Blue Cross Dental recommends that the most conservative treatment should be attempted to restore a tooth. Crowns are covered when a tooth is decayed or fractured to the degree that an amalgam or composite filling is inadequate to restore the tooth's functionality. A tooth must have a sound endodontic and periodontal prognosis to be considered eligible for crown coverage.
Cementation/insertion date (delivered to the mouth) is considered the completion date for a crown and benefits are payable for that date of service (not prep date).
There is a five-year time limitation for replacement of a crown and/or other major restorative procedures. Study models and temporary crowns are considered part of the overall major restorative procedure. The benefit for a crown includes the preparation, impressions, insertion and post-operative care.
Recementation of a crown, within 12 months of delivery of the crown, is considered part of the comprehensive procedure and the patient is not responsible for payment.
Generally, crowns are allowed only on permanent teeth. In the case of a retained deciduous tooth without a permanent successor, consideration for a crown is given if the tooth has sufficient periodontal support. Individual consideration review by the Dental Consultant is required in these cases.
A crown may be contractually denied with the patient responsible for payment if the following conditions exist:

- Treatment to restore tooth structure that is lost due to attrition, erosion and/or abrasion (unless imminent pulpal danger)
- Placement of a crown on a "peg lateral" for cosmetic reasons (consideration if fractured/decayed per guidelines)
- Placement of a crown on a tooth for reasons deemed cosmetic in nature
- Crowns placed solely to increase vertical dimension, restore occlusion, or correct congenital defects

Specialized procedures - Specialized procedures are considered non-covered by Blue Cross Dental and the patient is responsible for payment. These services are to be performed with the consent of the patient **prior** to initiation of treatment. Documentation of the patient's acceptance of the treatment plan and payment responsibility is recommended. A porcelain labial margin (porcelain butt joint) is an example of a specialized restorative procedure.

CODES:

D2710 Crown-resin-based composite (indirect)
D2712 Crown-3/4 resin-based composite (indirect)
D2720 Crown-resin with high noble metal
D2721 Crown-resin with predominantly base metal
D2722 Crown-resin with noble metal
D2740 Crown-porcelain/ceramic substrate
D2750 Crown-porcelain fused to high noble metal

D2751 Crown-porcelain fused to predominantly base metal
D2752 Crown-porcelain fused to noble metal
D2753 Crown – porcelain fused to titanium and titanium alloys
D2780 Crown-3/4 cast high noble metal
D2781 Crown-3/4 cast predominantly base metal
D2782 Crown-3/4 cast noble metal
D2783 Crown-3/4 porcelain/ceramic
D2790 Crown-full cast high noble metal
D2791 Crown-full cast predominantly base metal
D2792 Crown-full cast noble metal
D2794 Crown-titanium and titanium alloys

CRITERIA:

Dentist Advisor Review

Specific criteria for crown treatment includes:

- Any large existing restorations must involve at least 50% of the tooth structure
- Additional surface exhibits large area of decay
- Cuspal fracture/incisal fracture (of at least 50% of incisal angle)
- Extensive recurrent decay
- Posterior teeth – existing restoration of at least three surfaces, leaving thin walls on other surfaces
- Anterior teeth – existing restoration of at least two surfaces or with proximity to the pulp
- Radiographic evidence of a poor endodontic prognosis will result in the denial of major restorative procedures (patient responsible for payment)
- If there is inadequate bone support (approximately 2/3's or more loss at site) demonstrated in the x-ray(s), the treatment site will be considered at risk for a long-term periodontal prognosis and denied (patient responsible for payment) for major restorative procedures. Adequate bone support is evaluated based upon the following:
- pocket depths
- mobility
- bone density
- vertical and/or horizontal bone loss
- length and condition of the roots
- furcation involvement
- on-going treatment by a periodontist
- age of patient

Craze lines do not qualify as a "crack" in a tooth.

Cerec crowns are considered a covered benefit and should be reported using code D2740 and indicated on the submission (notation at bottom) as "Cerec".

LIMITATIONS:

Not covered for members under age 14 (unless clinical rationale is provided) and is considered member liability.

DOCUMENTATION:

Pre-operative periapical x-ray or if tooth is endodontically treated, a post-operative endo periapical x-ray showing all apices, detailed narrative (if applicable)

FREQUENCY:

One onlay **OR** crown per tooth in a five-year period.
Replacements within the 5 years are not covered and are considered member liability.

RELATIONSHIP TO OTHER CODES: (for payment purposes)

Study models and temporary crowns are considered integral to the crown. A participating dentist may not bill the member.

Recementation of a crown, within 12months of delivery of the crown, is considered integral to the crown procedure. A participating dentist may not bill the member.

PER ADA CDT 2025

DENTAL COVERAGE POLICY -Dental Prophylaxis

EFFECTIVE DATE: 1/1/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION:

Most groups cover two (2) dental prophylaxis per member in a calendar year. There is no special consideration for "difficult" prophylaxis.

CODES:

D1110 Prophylaxis - adult (age 13 or older are eligible for this code)
D1120 Prophylaxis - child (no upper age limit)

CRITERIA:

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

Two (2) cleanings per member per calendar year.
D4346 is considered part of the routine prophylaxis limitation; the combination of routine prophylaxis and D4346 cannot exceed the prophylaxis calendar year limitation.

RELATIONSHIP TO OTHER CODES: (for payment purposes)

Considered integral when performed on the same day, by the same dentist, as two or more limited sites, or one or more quadrants of scaling and root planing.

PER ADA CDT 2025

DENTAL COVERAGE POLICY - Denture Rebase and Reline

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION:

A rebase or reline to a complete or partial denture, performed within six months of delivery of the denture (exception: allowed for immediate denture D5130; D5140), is considered part of the initial fee for the denture and a participating dentist may not charge the member.

CODES:

Denture Rebase Procedures:
D5710 Rebase complete maxillary denture
D5711 Rebase complete mandibular denture
D5720 Rebase maxillary partial denture
D5721 Rebase mandibular partial denture
Denture Reline Procedures:
D5730 Reline complete maxillary denture (chairside)
D5731 Reline complete mandibular denture (chairside)
D5740 Reline maxillary partial denture (chairside)
D5741 Reline mandibular partial denture (chairside)
D5750 Reline complete maxillary denture (laboratory)
D5751 Reline complete mandibular denture (laboratory)
D5760 Reline maxillary partial denture (laboratory)
D5761 Reline mandibular partial denture (laboratory)

CRITERIA:

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

Benefit for rebase or reline once in a 36-month period, per arch.
Additional rebase or reline procedures within the 36 month period are not covered and are considered member liability.

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2025

DENTAL COVERAGE POLICY - Distal or Proximal Wedge Procedure

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION:

This procedure is performed in an edentulous area adjacent to a periodontally involved tooth. Gingival incisions are utilized to allow removal of a tissue wedge to gain access and correct the underlying osseous defect and to permit close flap adaptation.

CODES:

D4274 Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)

CRITERIA:

No review required.

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

Once per site per 36 months.
When performed more than once per 36 months, distal wedge procedures (same site) are not covered and are considered member liability.

RELATIONSHIP TO OTHER CODES: (for payment purposes)

Distal wedge procedure is considered integral if performed on same day, same dentist as other periodontal treatment. A participating dentist may not bill the member.
D4346 when performed within 6 months of D4355, D4910, D4341/D4342 or surgical periodontal procedures is considered integral. A participating dentist may not bill the member

PER ADA CDT 2025

DENTAL COVERAGE POLICY - Drugs

EFFECTIVE DATE: 09/17/2009
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION

Coverage does not include drugs as dental benefits.

CODES:

D9610 Therapeutic parenteral drug, single administration: Not covered and is considered member liability.

D9612 Therapeutic parenteral drugs, two or more administrations, different medications: Not covered and is considered member liability.

D9613 Infiltration of sustained release therapeutic drug- single or multiple sites: Not covered and is considered member liability.

D9630 Other drugs and/or medicaments, by report: Not covered and is considered member liability.

CRITERIA:

LIMITATIONS: N/A

FREQUENCY: N/A

DOCUMENTATON: N/A

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2025

DENTAL COVERAGE POLICY - Endodontic Retreatment

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION

Retreatment of a root canal, when performed by the same dentist as the original treatment, is considered integral to the original root canal for up to 12 months. A participating dentist may not bill the member.

CODES:

D3346 Retreatment of previous root canal therapy - anterior
D3347 Retreatment of previous root canal therapy - bicuspid
D3348 Retreatment of previous root canal therapy – molar

CRITERIA:

Dentist Advisor Review required only when provided within 30 days prior to an extraction.

LIMITATIONS:

Once per tooth per lifetime.

DOCUMENTATION: Pre-operative, post-operative periapical x-rays and narrative

FREQUENCY:

Benefits for retreatment of a root canal by a different dentist (than performed the original endodontic treatment) are allowed.
Retreatment by the same dentist (that performed the original root canal) is considered integral to the initial RCT if performed within 12months. A participating dentist may not bill the member.

RELATIONSHIP TO OTHER CODES: (for payment purposes)
Exams, palliative treatment, pulp tests, apical curettage, x-rays (related to root canal retreatment), local anesthetic are considered integral to the treatment. A participating dentist may not bill the member.
Post removal (D2955) is considered integral to endodontic retreatment if performed on same day, by same dentist. A participating dentist may not bill the member.

PER ADA CDT 2025

DENTAL COVERAGE POLICY - Endodontics on Primary Teeth

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION

Blue Cross Dental covers endodontic treatment on permanent teeth only. Therefore, root canal therapy on primary teeth is not a covered benefit and is considered member liability.

Exception: If a primary tooth is in need of a root canal and there is no permanent successor to the primary tooth, consideration for benefits will be made. The Dentist Advisor will review these exceptions.

CODES:

D3230 Pulpal therapy (resorbable filling)-anterior, primary tooth (excluding final restoration): Not covered and is considered member liability.

D3240 Pulpal therapy (resorbable filling)-posterior, primary tooth (excluding final restoration): Not covered and is considered member liability.

CRITERIA:

If a primary tooth is in need of a root canal and there is no permanent successor to the primary tooth, consideration for benefits will be made. The Dentist Advisor will review these exceptions.

LIMITATIONS:

DOCUMENTATION:

Preoperative periapical x-ray

FREQUENCY:

Once per tooth per lifetime when there is no permanent tooth to replace the primary tooth.

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2025

DENTAL COVERAGE POLICY - Extractions

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION:

Extractions include local anesthesia, suturing if needed, and routine post-operative care. If an attempt to extract a tooth fails, it is not considered a completed procedure and should not be submitted for benefits. The entire tooth and roots must be extracted to be considered for benefits.

CODES:

D7111 Extraction, coronal remnants-deciduous tooth
D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal)

CRITERIA:

No review required.

LIMITATIONS:

Some groups may have coverage for simple extractions (non-surgical) only. The coverage may/ may not apply an alternate benefit of a simple extraction allowance for surgical extractions-D7210 with the member liable for the difference in payment up to the dentist's charge for the surgical extraction.

DOCUMENTATION:

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

D7111 is considered integral to extraction if reported by the same dentist who extracted the tooth. A participating dentist may not bill the member.

PER ADA CDT 2025

DENTAL COVERAGE POLICY - Fixed Partial Dentures

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION

No replacement of teeth beyond the normal complement if allowed. Benefits for a fixed bridge are applicable in one calendar year, and individual units of the bridge may not be applied to multiple calendar years. Benefits are payable upon insertion/delivery of the fixed bridge.

CODES:

Fixed Partial Denture Pontics:

D6205 Pontic-indirect resin-based composite- (Not be used as a temporary or provisional prosthesis)
D6210 Pontic-cast high noble metal
D6211 Pontic-cast predominantly base metal
D6212 Pontic-cast noble metal
D6214 Pontic-titanium
D6240 Pontic-porcelain fused to high noble metal
D6241 Pontic-porcelain fused to predominantly base metal
D6242 Pontic-porcelain fused to noble metal
D6243 Pontic- porcelain fused to titanium and titanium alloys
D6245 Pontic-porcelain/ceramic
D6250 Pontic-resin with high noble metal
D6251 Pontic-resin with predominantly base metal
D6252 Pontic-resin with noble metal
D6253 Provisional pontic-further treatment or completion of diagnosis necessary prior to final impression: Not covered and are considered member liability.

Fixed Partial Denture Retainers - Inlays/Onlays:

D6545 Retainer-cast metal for resin bonded fixed prosthesis
D6548 Retainer-porcelain/ceramic for resin bonded fixed prosthesis
D6549 Resin retainer- for resin bonded fixed prosthesis
D6600 Inlay-porcelain/ceramic, two surfaces
D6601 Inlay-porcelain/ceramic, three or more surfaces
D6602 Inlay-cast high noble metal, two surfaces
D6603 Inlay-porcelain/ceramic, three or more surfaces
D6604 Inlay-cast predominantly base metal, two surfaces
D6605 Inlay-cast predominantly base metal, three or more surfaces
D6606 Inlay-cast noble metal, two surfaces
D6607 Inlay-cast noble metal, three or more surfaces
D6624 Inlay-titanium: *Porcelain/ceramic onlays are given an alternate benefit of an amalgam or metallic onlay, determined by the Dentist Advisor review based on criteria for full crown coverage. Patient is responsible for difference in payment up to dentist's charge.*
D6608 Onlay-porcelain/ceramic, two surfaces
D6609 Onlay-porcelain/ceramic, three or more surfaces

D6610 Onlay-cast high noble metal, two surfaces
D6611 Onlay-cast high noble metal, three or more surfaces
D6612 Onlay-cast predominantly base metal, two surfaces
D6613 Onlay-cast predominantly base metal, three or more surfaces
D6614 Onlay-cast noble metal, two surfaces
D6615 Onlay-cast noble metal, three or more surfaces
D6634 Onlay-titanium

Fixed Partial Denture Retainers-Crowns:

D6710 Crown-indirect resin-based composite (not to be used as a temporary or provisional prosthesis)
D6720 Crown-resin with high noble metal
D6721 Crown-resin with predominantly base metal
D6722 Crown-resin with noble metal
D6740 Crown-porcelain/ceramic
D6750 Crown-porcelain fused to high noble metal
D6751 Crown-porcelain fused to predominantly base metal
D6752 Crown-porcelain fused to noble metal
D6753 Retainer crown- porcelain fused to titanium and titanium alloys
D6780 Crown-3/4 cast high noble metal
D6781 Crown-3/4 cast predominantly base metal
D6782 Crown-3/4 cast noble metal
D6783 Crown-3/4 porcelain/ceramic
D6784 Retainer crown ¾- porcelain fused to titanium and titanium alloys
D6790 Crown-full cast high noble metal
D6791 Crown-full cast predominantly base metal
D6792 Crown-full cast noble metal
D6793 Provisional retainer crown-further treatment or completion of diagnosis necessary prior to final impression: Not covered and is considered member liability.
D6794 Crown-titanium and titanium alloys

CRITERIA:

Dentist Advisor Review

The need for pontics will be evaluated based on the amount of space between the abutment teeth, and the number of natural teeth being replaced.

Pontics are not benefitted when replacing teeth beyond the normal complement. Extra pontics are not covered and are considered member liability.

In the case where an abutment tooth does not appear to provide adequate support for the bridge in terms of crown/root ratio, the Dentist Advisor may deny the entire bridge. Double abutments may be considered upon Dentist Advisor review.

LIMITATIONS:

Not covered for members under age 14 unless clinical rationale is provided and are considered member liability.

DOCUMENTATION:

Preoperative periapical X-rays of the entire treatment site (all teeth in the treatment plan) or if abutment tooth is endodontically treated, a post-operative endo periapical x-ray showing all apices.

If there are special circumstances related to the treatment, a detailed narrative is recommended.

FREQUENCY:

One per site 60 months.

A bridge placed in the same treatment area within the 5 years will not be covered and is considered member liability.

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2025

DENTAL COVERAGE POLICY – Fixed Partial Denture Sectioning

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION:

Fixed partial denture sectioning involves the separation of one or more of the connections between bridge abutments and/or pontics, while a portion of the bridge is to remain intact. The remaining portion is to be serviceable and functional following the sectioning of the bridge. This procedure includes all recontouring and polishing of the remaining bridge units.

CODES:

D9120 Fixed partial denture sectioning: Not covered and is considered member liability.

CRITERIA:

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2025

DENTAL COVERAGE POLICY - Frenulectomy

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION:

CODES:

D7960 Frenulectomy (also known as a frenectomy or frenotomy)
D7963 Frenuloplasty

CRITERIA:

No review required

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

Frenulectomy and frenuloplasty are integral to each other. A participating dentist may not bill the member. If performed on same day, same dentist as endodontic, oral surgery and/or periodontal surgery, it is considered integral to the greater procedure. A participating dentist may not bill the member.

PER ADA CDT 2025

DENTAL COVERAGE POLICY – Full Mouth Debridement

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION:

CODES:

D4355 Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit.

CRITERIA:

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

Once per lifetime
If additional debridement is performed (outside of the below exceptions), it is not covered and is considered member liability.

RELATIONSHIP TO OTHER CODES: (for payment purposes)

Denied as integral if performed on same day, same dentist as prophylaxis (D1110) or scaling and root planing (D4341/D4342). A participating dentist may not bill the member.

D4346 when performed within 6 months of D4355, D4910, D4341/D4342 or surgical periodontal procedures is considered integral. A participating dentist may not bill the member

Payment will not be made if reported on same day, same dentist as periodontal maintenance or within 12 months FOLLOWING routine prophylaxis, periodontal maintenance or scaling and root planing as this is inappropriate treatment sequence. A participating dentist may not bill the member.

PER ADA CDT 2025

DENTAL COVERAGE POLICY – Gingival Flap Procedure

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION:

A soft tissue flap is reflected or resected to allow debridement of the root surface and the removal of granulation tissue. Osseous recontouring is not accomplished in conjunction with this procedure. May include open flap curettage, reverse bevel flap surgery, modified Kirkland flap procedure, and modified Widman surgery. This procedure is performed in the presence of moderate to deep probing depths, loss of attachment, need to maintain esthetics, need for increased access to the root surface and alveolar bone, or to determine the presence of a cracked tooth, or fractured root. Other procedure may be required concurrent to D4240/D4241 and should be reported separately using their own unique codes.

CODES:

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

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

CRITERIA:

Dentist Advisor review required.

LIMITATIONS:

Limited to once per 36 months per mouth area.
Additional periodontal procedure(s) performed (same site) within the 36 months, are not covered and are considered member liability.

DOCUMENTATION:

Pre-treatment radiographs
Periodontal charting
More than two quadrants provided on the same date require an explanation as to why services were provided on the same date.

FREQUENCY:

If submitted by the same dentist on the same date of service in the same mouth area as extractions, periodontal surgery (except soft tissue grafts) and oral surgery procedures, this procedure will be considered integral to the more comprehensive procedure. A participating dentist may not bill the member.
Not covered within 36 months following gingival flap, surgical procedures or scaling and root planing in the same mouth area and is considered member liability.
D4346 when performed within 6 months of D4355, D4910, D4341/D4342 or surgical periodontal procedures is considered integral. A participating dentist may not bill the member

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2025

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DENTAL COVERAGE POLICY - Gingivectomies

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION:

Gingivectomy involves the excision of gingiva by an internal or external bevel or laser therapy. This procedure will assist in the elimination of suprabony pockets, and/or allow access for the placement of restorations. In cases of gingival enlargement, a gingivectomy may be performed to restore normal architecture to the soft tissues and may also be referred to as "gingivoplasty".

A gingivectomy is performed when there is evidence of gingival hyperplasia and/or diseased soft tissue conditions which require excision to restore the health of the tissue or access to sound tooth structure. Both gingivectomy and gingivoplasty procedures are surgical procedures and are usually performed in the early stages of periodontal disease to prevent progression to more serious periodontal conditions.

CODES:

D4210 Gingivectomy or gingivoplasty-four or more contiguous teeth or tooth bounded tooth spaces per quadrant
D4211 Gingivectomy or gingivoplasty-one to three contiguous teeth or tooth bounded tooth spaces per quadrant
D4212 Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth: Considered integral to the restorative procedure. A participating dentist may not bill the member.

CRITERIA:

D4210, D4211 - Requires Dentist Advisor review

LIMITATIONS:

DOCUMENTATION:

Periapical x-ray
Periodontal charting
Detailed clinical narrative including diagnosis

FREQUENCY:

One treatment per site/area in a 36-month period
If additional periodontal procedure(s) are performed (same site) within the 36 months, the gingivectomy is not covered and is considered member liability.

RELATIONSHIP TO OTHER CODES: (for payment purposes)

If performed in the same treatment area, on the same date of service as periodontal scaling and root planing, osseous surgery, or flap surgery, the gingivectomy is considered integral to the more comprehensive procedure A participating dentist may not bill the member.
A gingivectomy is not benefitted at the same treatment site as a crown lengthening procedure.

If a restoration (filling, crown, etc.) is performed at the same treatment site, on the same date of service as D4211, no separate benefit is allowed. A participating dentist may not bill the member.

PER ADA CDT 2025

DENTAL COVERAGE POLICY – Gold Foil Restorations and Inlays

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION:

Gold foil restorations and inlays are considered alternative restorations. Gold foil restorations are not covered and are considered member liability. Metallic and composite inlays are restorations that may be composed of precious metals, semi-precious metals, non-precious metals, or composite materials. These restorations are not a covered benefit, however, the allowance for the corresponding amalgam restoration (same tooth surfaces) is made for this restoration, with the patient responsible for payment of the difference of reimbursement up to the dentist's charge for the inlay.
These services should be performed with the consent of the patient **prior** to the initiation of treatment. Documentation of the patient's acceptance of the treatment plan and payment responsibility is recommended.

CODES:

D2410 Gold foil-one surface: Not covered and is considered member liability.
D2420 Gold foil-two surface: Not covered and is considered member liability.
D2430 Gold foil-three surface: Not covered and is considered member liability.
D2510 Inlay-metallic-one surface
D2520 Inlay-metallic-two surfaces
D2530 Inlay-metallic-three or more surfaces
D2610 Inlay-porcelain/ceramic-one surface
D2620 Inlay-porcelain/ceramic-two surfaces
D2630 Inlay-porcelain/ceramic-three or more surfaces
D2650 Inlay-resin-based composite-one surface
D2651 Inlay-resin-based composite-two surfaces
D2652 Inlay-resin-based composite-three or more surface

CRITERIA:

No review required

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2025

DENTAL COVERAGE POLICY - Guided Tissue Regeneration

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION:

A membrane is placed over the root surfaces or defect area following surgical exposure and debridement. The mucoperiosteal flaps are then adapted over the membrane and sutured. The membrane is placed to exclude epithelium and gingival connective tissue from the healing wound. This procedure may require subsequent surgical procedures to correct the gingival contours. Guided tissue regeneration may also be carried out in conjunction with bone replacement grafts or to correct deformities resulting from inadequate faciolingual bone width in an edentulous area. When guided tissue regeneration is used in association with a tooth, each site on a specific tooth should be reported separately. Other separate procedures may be required concurrent to D4266/D4267 and should be reported using their own unique codes.

CODES:

D4266 Guided tissue regeneration, natural teeth - resorbable barrier, per site: This procedure does not include flap entry and closure, or when indicated, wound debridement, osseous contouring, bone replacement grafts, and placement of biologic materials to aid in osseous regeneration. This procedure can be used for periodontal defects around natural teeth.

D4267 Guided tissue regeneration, natural teeth– non-resorbable barrier, per site: This procedure does not include flap entry and closure, or when indicated, wound debridement, osseous contouring, bone replacement grafts, and placement of biologic materials to aid in osseous regeneration. This procedure can be used for periodontal defects around natural teeth.

CRITERIA:

Covered to treat specific periodontal defects.

LIMITATIONS:

DOCUMENTATION:

Current pre-operative radiographs
Periodontal charting
Detailed narrative.

FREQUENCY:

Allow once per site per lifetime.
Additional GTR performed in the same site is not covered and considered member liability.

RELATIONSHIP TO OTHER CODES: (for payment purposes)

Not covered in conjunction with extraction, cyst removal, apicoectomy or implants and is considered member liability

Not covered when provided in conjunction with a soft tissue graft for root coverage and is considered member liability.
Guided tissue regeneration provided in conjunction with peri-radicular surgery should be reported under D3432.
D4346 when performed within 6 months of D4355, D4910, D4341/D4342 or surgical periodontal procedures is considered integral. A participating dentist may not bill the member.

PER ADA CDT 2025

DENTAL COVERAGE POLICY - Hemisection

EFFECTIVE DATE: 03/23/2009
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION

Hemisection involves the separation of a multi-rooted tooth into separate sections containing the root and overlying portion of the crown. It may include the removal of one or more of those sections. Replacement of the missing section of the tooth with a crown or pontic is not a covered benefit and is considered member liability.

CODES:

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

CRITERIA:

Dentist Advisor Review

The Dentist Advisor evaluates the treatment site to determine if the remaining tooth structure has a sound periodontal prognosis, and generally a good long-term prognosis.

LIMITATIONS:

DOCUMENTATION:

Predetermination: Pre-operative periapical x-ray.
Claim for services: Pre-operative and post-operative periapical x-ray.

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

A root amputation performed on the same day/same tooth by the same dentist as a hemisection is considered integral. A participating dentist may not bill the member.

PER ADA CDT 2025

DENTAL COVERAGE POLICY - Immediate Dentures

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION:

For immediate dentures, benefits for one laboratory reline is allowed within six months of insertion of the denture.
Insertion date (delivered to the mouth) is considered the completion date for a partial denture and benefits are payable for that date of service (not impression date).
Specialized procedures - Specialized procedures are considered non-covered by Blue Cross Dental and the patient is responsible for payment. These services are to be performed with the consent of the patient **prior** to initiation of treatment. Documentation of the patient's acceptance of the treatment plan and payment responsibility is recommended.

CODES:

D5130 Immediate denture-maxillary
D5140 Immediate denture-mandibular

CRITERIA:

No review required.

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

Once per arch in a 5-year period.
Additional dentures within the 5-year period are not covered and are considered member liability.

RELATIONSHIP TO OTHER CODES: (for payment purposes)

One removable partial denture, complete or immediate denture or replacement of all teeth and acrylic on a cast metal framework (D5670, D5671) is allowed per arch per five-year period

PER ADA CDT 2025

DENTAL COVERAGE POLICY - Implant Services

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION:

Implant services are not a covered benefit unless specified in the group contract. If a group purchases an Implant Rider, there is a $3,500 lifetime maximum benefit for implant services. Coverage is at 50% and all implant services are subject to Dentist Advisor review for all dentists.

See also Single Tooth Implant policy.

The listed procedure codes are covered if there is an implant rider:

CODES:

D6010 Surgical placement of implant body: endosteal implant
D6011 Second stage implant surgery
D6012 Surgical placement of interim implant body for transitional prosthesis: endosteal implant
D6013 Surgical placement: mini-implant
D6040 Surgical placement: eposteal implant
D6050 Surgical placement: transosteal implant
D6051 Placement of interim implant abutment
D6052 Semi-precision attachment abutment
D6055 Connecting bar – implant supported, or abutment supported utilized to stabilize and anchor a prosthesis.
D6056 Prefabricated abutment-includes modification and placement
D6057 Custom fabricated abutment-includes placement
D6068 Abutment supported retainer for porcelain/ceramic FPD
D6069 Abutment supported retainer for porcelain fused to metal FPD (high noble metal)
D6070 Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)
D6071 Abutment supported retainer for porcelain fused to metal FPD (noble metal)
D6072 Abutment supported retainer for cast metal FPD (high noble metal)
D6073 Abutment supported retainer for cast metal FPD (predominantly base metal)
D6074 Abutment supported retainer for cast metal FPD (noble metal)
D6075 Implant supported retainer for ceramic FPD
D6076 Implant supported retainer for FPD- porcelain fused to high noble alloys
D6077 Implant supported retainer for metal FPD - high noble alloys
D6080 Implant maintenance procedures, when a full arch fixed hybrid prosthesis is removed and reinserted, including cleansing of prosthesis and abutments
D6081 Scaling and debridement of a single implant in the presence of mucositis, including inflammation, bleeding upon probing and increased pocket depths includes cleaning of the implant surfaces, without flap entry and closure
D6090 Repair of implant/abutment supported prosthesis
D6091 Replacement of semi-precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment
D6096 Remove broken implant retaining screw
D6098 Implant supported retainer- porcelain fused to predominately base alloys

D6099 Implant supported retainer for FPD- porcelain fused to noble alloys
D6100 Implant removal, by report
D6101 Debridement of peri-implant defect and surface cleaning of exposed implant surfaces, including flap entry and closure
D6102 Debridement and osseous contouring of peri-implant defect; includes surface cleaning of exposed implant surfaces and flap entry and closure
D6103 Bone graft for repair of peri-implant defect- not including entry and closure or, when indicated, placement of a barrier membrane or biologic materials to aid in osseous regeneration
D6104 Bone graft at time of implant placement
D6105 Removal of implant body not requiring bone removal nor flap elevation
D6110 Implant/abutment supported removable denture for edentulous arch-maxillary
D6111 Implant/abutment supported removable denture for edentulous arch-mandibular
D6112 Implant/abutment supported removable denture for partially edentulous arch-maxillary
D6113 Implant/abutment supported removable denture for partially edentulous arch-mandibular
D6114 Implant/abutment supported fixed denture for edentulous arch-maxillary
D6115 Implant/abutment supported fixed denture for edentulous arch-mandibular
D6116 Implant/abutment supported fixed denture for partially edentulous arch-maxillary
D6117 Implant/abutment supported fixed denture for partially edentulous arch-maxillary
D6120 Implant supported retainer- porcelain fused to titanium and titanium alloys
D6121 Implant supported retainer for metal FPD – predominately base alloys
D6122 Implant supported retainer for metal FPD – noble alloys
D6123 Implant supported retainer for metal FPD – titanium and titanium alloys
D6180 Implant maintenance procedures when a full arch fixed hybrid prosthesis is not removed including cleansing of prosthesis and abutments. Limited to 2 per calendar year, unless reported on same day, by same provider as a D1110, D4910, or D4346.
D6190 Radiographic/surgical implant index, by report
D6193 Replacement of an implant screw. Considered integral when reported on the same tooth, by the same dentist within 12 months of recementation of abutment or implant supported crown, retainer, or implant/abutment supported fixed denture.
D6194 Abutment supported retainer crown for FPD –titanium and titanium alloys
D6195 Abutment supported retainer – porcelain fused to titanium and titanium alloys
D6197 Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant: Not covered if same provider, same implant site within 6 months of history of payment for initial prosthetic and maintenance services D6051-D6199

The below codes are always considered non-covered and are considered member liability:
D6081 Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure
D6085 Provisional implant crown

D6106 Guided tissue regeneration – resorbable barrier, per implant
D6107 Guided tissue regeneration – non-resorbable barrier, per implant
D6118 Implant/abutment supported interim fixed denture for edentulous arch- mandibular
D6119 Implant/abutment supported interim fixed denture for edentulous arch- maxillary
D7252 Partial extraction for immediate implant placement

CRITERIA:
Successful implant placement to support/stabilize the prosthesis. The Dentist Advisor reviews removal of an implant on an individual consideration (IC) basis. Individual consideration is given for time, degree of difficulty and materials used to complete the procedure.

DOCUMENTATION:
Post-operative panorex or set of periapical X-rays

FREQUENCY:
Five-year limitation for replacement
There is a five-year limitation for replacement of the abutment supported retainers for fixed bridges. Replacement within the five years is not covered and is considered member liability.

LIMITATIONS:

RELATIONSHIP TO OTHER CODES: (for payment purposes)
If replacing an existing conventional prosthesis, allowance may be reduced if within the five-year limitation.

PER ADA CDT 2025

DENTAL COVERAGE POLICY – Incomplete Endodontic Therapy

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION

Considerable time is necessary to determine diagnosis and/or provide initial treatment before the fracture makes the tooth unretainable. This procedure is not covered and is considered member liability.

CODES:

D3332 Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth: Not covered and is considered member liability.

CRITERIA:

LIMITATIONS:

DOCUMENTATION:

FREQUENCY: N/A

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2025

DENTAL COVERAGE POLICY - Infection Control

EFFECTIVE DATE: 05/05/2008
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION:

Infection control includes, but is not limited to, the use of supplies and techniques i.e., surgical gloves, paper goods, instruments, disposables, sterilization procedures, etc., and the cost for these are considered integral in the reimbursement for dental services. A participating dentist may not bill the member.

CODES:

D9999 Unspecified adjunctive procedure, by report
(May be submitted under other D x999 codes)

CRITERIA:

LIMITATIONS:

Considered integral to comprehensive procedure(s). A participating dentist may not bill the member.

DOCUMENTATION:

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2025

DENTAL COVERAGE POLICY - Interim Prosthesis

EFFECTIVE DATE: 10/15/2009
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION:

Interim prostheses are not a covered benefit and are considered member liability.

CODES:

D5810 Interim complete denture (maxillary): Not covered and is considered member liability.
D5811 Interim complete denture (mandibular): Not covered and is considered member liability.
D5820 Interim partial denture (maxillary): Not covered and is considered member liability.
D5821 Interim partial denture (mandibular): Not covered and is considered member liability.

CRITERIA:

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2025

DENTAL COVERAGE POLICY - Internal Root Repair of Perf. Defects

EFFECTIVE DATE: 02/19/2009
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION

Perforation repairs, (recalicification), is considered integral to the overall root canal treatment if the perforation occurred during the root canal treatment (iatrogenic occurrence) and is being performed by the same dentist. A participating dentist may not bill the member for integral procedures.

Treatment of a natural resorptive defect (due to natural resorption or decay), would be considered as a separate benefit. In these cases, the perforation repair is an attempt to allow the periodontal ligament to re-attach and allow bone healing in the area. (This is differential between perforation repair and apexification in an immature tooth that is an attempt to form an apical calcium bridge.)

CODES:

D3333 Internal root repair of perforation defects

CRITERIA:

Dentist Advisor Review
I.C. review based on specific scenario (above), time, materials used and difficulty of treatment.

LIMITATIONS:

DOCUMENTATION:

Pre-operative, post-operative periapical x-rays and narrative

FREQUENCY:

N/A

RELATIONSHIP TO OTHER CODES: (for payment purposes)

May be considered integral to the overall endodontic treatment, per review. A participating dentist may not bill the member for integral procedures.

PER ADA CDT 2025

DENTAL COVERAGE POLICY – Labial Veneers

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION:

Labial veneers are often performed for cosmetic purposes.

CODES:

D2960 Labial veneer (resin laminate)-chairside: Not covered and is considered member liability.
D2961 Labial veneer (resin laminate)-laboratory: Not covered and is considered member liability.
D2962 Labial veneer (porcelain laminate)-laboratory: Not covered and is considered member liability.

CRITERIA:

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2025

DENTAL COVERAGE POLICY - Miscellaneous Services

EFFECTIVE DATE: 09/17/2009
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION

CODES:

D9130 Temporomandibular joint dysfunction- non-invasive physical therapies: Not covered and is considered member liability.
D9910 Application of desensitizing medicament: Not covered and is considered member liability.
D9911 Application of desensitizing resin for cervical and/or root surface, per tooth: Not covered and is considered member liability.
D9913 Administration of neuromodulators: Not covered and is considered member liability.
D9914 Administration of dermal fillers: Not covered and is considered member liability.
D9920 Behavior management, by report: Not covered and is considered member liability.
D9930 Treatment of complications (post-surgical)-unusual circumstances, by report: Not covered and is considered member liability.
D9932 Cleaning and inspection of removable complete denture, maxillary: Considered integral to the examination. A participating dentist may not bill the member.
D9933 Cleaning and inspection of removable complete denture, mandibular: Considered integral to the examination. A participating dentist may not bill the member.
D9934 Cleaning and inspection of removable partial denture, maxillary: Considered integral to the examination. A participating dentist may not bill the member.
D9935 Cleaning and inspection of removable partial denture, mandibular: Considered integral to the examination. A participating dentist may not bill the member.
D9941 Fabrication of athletic mouthguard: Not covered and is considered member liability.
D9942 Repair and/or reline of occlusal guard: Not covered and is considered member liability.
D9950 Occlusion analysis-mounted case: Not covered and is considered member liability.
D9951 Occlusal adjustment-limited: Not covered and is considered member liability.
D9952 Occlusal adjustment-complete: Not covered and is considered member liability.
D9961 Duplicate/copy patient's records: Not covered and is considered member liability.
D9970 Enamel microabrasion: Not covered and is considered member liability.
D9971 Odontoplasty 1-2 teeth; includes removal of enamel projections: Not covered and is considered member liability.
D9972 External bleaching-per arch-performed in office: Not covered and is considered member liability.
D9973 External bleaching-per tooth: Not covered and is considered member liability.
D9974 Internal bleaching-per tooth: Not covered and is considered member liability.
D9975 External bleaching for home application, per arch; includes materials and fabrication of custom trays: Not covered and is considered member liability.
D9985 Sales tax: Not covered and is considered member liability.
D9986 Missed appointment: Not covered and is considered member liability.
D9987 Cancelled appointment- Not covered and is considered member liability.
D9990 Certified translation or sign language services, per visit: Not covered and is considered member liability.

D9991 Dental case management - addressing appointment compliance barriers- Not covered and is considered member liability.
D9992 Dental case management - care coordination- Not covered and is considered member liability.
D9993 Dental case management - motivational interviewing- Not covered and is considered member liability.
D9994 Dental case management - patient education to improve oral health literacy- Not covered and is considered member liability.
D9995 Teledentistry- synchronous; real time encounter- Not covered and is considered member liability.
D9996 Teledentistry – asynchronous; information stored and forwarded to another dentist for subsequent review- Not covered and is considered member liability.
D9997 Dental case management- patients with special health care needs- Not covered and is considered member liability.

CRITERIA:

LIMITATIONS: N/A

FREQUENCY: N/A

DOCUMENTATON: N/A

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2025

DENTAL COVERAGE POLICY - Non-Covered Endodontics

EFFECTIVE DATE: 03/23/2009
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION

Procedures listed are non-covered and are considered member liability.

CODES:

D3428 Bone graft in conjunction with periradicular surgery - per tooth, single site: Not covered and is considered member liability.
D3429 Bone graft in conjunction with periradicular surgery - each additional contiguous tooth in same surgical site: Not covered and is considered member liability.
D3431 Biologic materials to aid in soft and osseous tissue regeneration in conjunction with periradicular surgery: Not covered and is considered member liability.
D3460 Endodontic endosseous implant: Not covered and is considered member liability.
D3470 Intentional reimplantation (including necessary splinting): Not covered and is considered member liability.
D3910 Surgical procedure for isolation of tooth with rubber dam: Not covered and is considered member liability.
D3950 Canal preparation and fitting of performed dowel or post: Not covered and is considered member liability.

CRITERIA:

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2025

DENTAL COVERAGE POLICY – Non-covered Maxillofacial Prosthetics

EFFECTIVE DATE: 09/16/2009
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION:

Maxillofacial Prosthetics are non-covered dental benefits and are considered member liability.

CODES:

D5911 Facial moulage (sectional)
D5912 Facial moulage (complete)
D5913 Nasal prosthesis
D5914 Auricular prosthesis
D5915 Orbital prosthesis
D5916 Ocular prosthesis
D5919 Facial prosthesis
D5922 Nasal septal prosthesis
D5923 Ocular prosthesis, interim
D5924 Cranial prosthesis
D5925 Facial augmentation implant prosthesis
D5926 Nasal prosthesis, replacement
D5927 Auricular prosthesis, replacement
D5928 Orbital prosthesis, replacement
D5929 Facial prosthesis, replacement
D5931 Obturator prosthesis, surgical
D5932 Obturator prosthesis, definitive
D5933 Obturator prosthesis, modification
D5934 Mandibular resection prosthesis with guide flange
D5935 Mandibular resection prosthesis without guide flange
D5936 Obturator prosthesis, interim
D5937 Trismus appliance (not for TMD treatment)
D5951 Feeding aid
D5952 Speech aid prosthesis, pediatric
D5953 Speech aid prosthesis, adult
D5954 Palatal augmentation prosthesis
D5955 Palatal lift prosthesis, definitive
D5958 Palatal lift prosthesis, interim
D5959 Palatal lift prosthesis, modification
D5960 Speech aid prosthesis, modification
D5982 Surgical stent
D5983 Radiation carrier
D5984 Radiation shield
D5985 Radiation cone locator
D5986 Fluoride gel carrier
D5987 Commissure splint

D5988 Surgical splint
D5991 Vesiculobullous medicament carrier
D5992 Adjust maxillofacial prosthetic appliance
D5993 Maintenance and cleaning of a maxillofacial prosthesis (extra or intraoral) other than required adjustments, by report. Maintenance and cleaning of a maxillofacial prosthesis.
D5994 Periodontal medicament carrier with peripheral seal - laboratory processed.

CRITERIA:

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2025

DENTAL COVERAGE POLICY - Non-Covered Non-Surgical Perio

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION:

CODES:

D4320 Provisional splinting - intracoronal: This is an interim stabilization of mobile teeth. A variety of methods and appliances may be employed for this purpose. Identify the teeth involved: Not covered and is considered member liability.

D4321 Provisional splinting – extracoronal: This is an interim stabilization of mobile teeth. A variety of methods and appliances may be employed for this purpose. Identify the teeth involved: Not covered and is considered member liability.

D4381 Localized delivery of anitmicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report: Not covered and is considered member liability. (See below)

D4921 Gingival irrigation with a medicinal agent -per quadrant: Considered integral to greater procedures. A participating dentist may not bill the member.

CRITERIA:

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

D4921 considered integral to greater procedure. A participating dentist may not bill the member. D4381 is considered integral when reported with D7000-D7999. A participating dentist may not bill the member.

PER ADA CDT 2025

DENTAL COVERAGE POLICY – Osseous Grafting

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION:

CODES:

D4263 Bone replacement graft - first site in quadrant-This procedure involves the use of osseous autografts, osseous allografts, or non-osseous grafts to stimulate periodontal regeneration when the disease process has led to a deformity of the bone. This procedure does not include flap entry and closure, wound debridement, osseous contouring, or the placement of biologic materials to aid in osseous tissue regeneration or barrier membranes. Other separate procedures may be required concurrent to D4263 and should be reported using their own unique codes.

D4264 Bone replacement graft - each additional site in quadrant This procedure involves the use of osseous autografts, osseous allografts, or non-osseous grafts to stimulate periodontal regeneration when the disease process has led to a deformity of the bone. This procedure does not include flap entry and closure, wound debridement, osseous contouring, or the placement of biologic materials to aid in osseous tissue regeneration or barrier membranes. This code is used if performed concurrently with D4263 and allows reporting of the exact number of sites involved.

D4265 Biologic materials to aid in soft and osseous tissue regeneration: Not covered and is considered member liability.

CRITERIA:

Dentist advisor review required for multiple bone grafts on the same day by the same dentist. A single site for reporting bone replacement grafts consists of one contiguous area regardless of the number of teeth involved. Another site on the same tooth is considered part of the first site reported. Non-contiguous areas involving different teeth may be reported as additional sites.

LIMITATIONS:

DOCUMENTATION:

Current periapical x-rays
Current periodontal charting

FREQUENCY:

1 per site per 36 months.
Not covered within 36 months following periodontal surgery in the same mouth area and is considered member liability.

RELATIONSHIP TO OTHER CODES: (for payment purposes)

D4346 when performed within 6 months of D4355, D4910, D4341/D4342 or surgical periodontal procedures is considered integral. A participating dentist may not bill the member

Bone grafts provided on other than natural teeth should be reported with the appropriate codes:
D3428, D3429 – Bone graft in conjunction with periradicular surgery
D6103 – Bone graft for repair of peri-implant defect
D6104 – Bone graft at time of implant placement.
D7950 – Osseous, osteoperiosteal or cartilage graft of the mandible or maxilla
D7953 – Bone replacement graft for ridge augmentation
D7955 – Repair of maxillofacial soft and/or hard tissue defect

PER ADA CDT 2016

DENTAL COVERAGE POLICY – Occlusal Guards

EFFECTIVE DATE: 09/17/2009
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION:

A nightguard is a removable dental appliance that has been designed to minimize the effects of bruxism (grinding), and other occlusal factors, on the dentition. This appliance would be covered when evidence of clenching and/or grinding has damaged the dentition to reduce further damage/breakdown.

Occlusal guards are covered only when specified by the group/plan. If covered, occlusal guards are limited to once in a 5-year period.
A nightguard is not used, and will not be a covered benefit, to treat temporomandibular joint dysfunction, sleep apnea or snoring. Appliances used to treat TMJ dysfunction, sleep apnea or snoring are not covered and are considered member liability.

This appliance also does not serve as an athletic mouthguard or orthodontic retainer. Athletic mouthguards are not covered and are considered member liability. Benefits may be available for an orthodontic retainer if the member has orthodontic coverage.

CODES:

D9938 Fabrication of a custom removable clear plastic temporary aesthetic appliance: Not covered and is considered member liability.
D9939 Placement of a custom removable clear plastic temporary aesthetic appliance: Not covered and is considered member liability.
D9943 Occlusal guard adjustment: Not covered and is considered member liability.
D9944 Occlusal guard- hard appliance, full arch: Not covered (unless group/ plan specified) and is considered member liability.
D9945 Occlusal guard- soft appliance, full arch: Not covered (unless group/ plan specified) and is considered member liability.
D9946 Occlusal guard-hard appliance, partial arch: Not covered (unless group/ plan specified) and is considered member liability.
D9953 Reline custom sleep apnea appliance: Not covered and is considered a member liability.
D9954 Fabrication and delivery of oral appliance therapy (OAT) morning repositioning device: Not covered and is considered member liability.
D9955 Oral appliance therapy (OAT) titration visit: Not covered and is considered member liability.
D9956 Administration of home sleep apnea test: Not covered and is considered member liability.
D9957 Screening for sleep related breathing disorders: Not covered and is considered member liability.
D9959 Unspecified sleep apnea services procedure, by report: Not covered and is considered member liability.

CRITERIA:

No review required.

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

Once in a 5-year period (if covered).
If covered, replacement within 5 years is not covered and is considered member liability.

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2025

DENTAL COVERAGE POLICY – Onlays

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION:

Onlays are used as restorations on posterior teeth and involve coverage of at least one cusp. Teeth must have three surfaces involved in order to qualify for an onlay benefit. There is a five-year time limitation for replacement of an onlay and/or other major restorative procedures. Benefits for an onlay **or** a crown per tooth are allowed in a five-year period. Additional crown or onlay (same tooth) within the 5-year period is not covered and are considered member liability
Cementation/insertion date (delivered to the mouth) is considered the completion date for an onlay and benefits are payable for that date of service (not prep date.) Study models and temporary restorations are considered integral to the major restorative procedure. A participating dentist may not bill the member. This benefit also includes preparation, impressions, insertion and post-operative care. Recementation of an onlay, within 12 months of delivery of the onlay, is considered integral to the comprehensive procedure. A participating dentist may not bill the member. Onlays are allowed only on permanent teeth. An onlay may be contractually not covered, with the member responsible for payment, if the following conditions exist:

- Treatment to restore tooth structure that is lost due to attrition, erosion and/or abrasion (unless imminent pulpal danger)
- Placement of an onlay on a tooth for reasons deemed cosmetic in nature.
- Onlays placed solely to increase vertical dimension, restore occlusion, or correct congenital defects.

CODES:

D2542 Onlay-metallic-two surfaces: Not covered; may receive alternate benefit of amalgam.
D2543 Onlay-metallic-three surfaces
D2544 Onlay-metallic-four or more surfaces
D2642 Onlay-porcelain/ceramic-two surfaces: Not covered; may receive alternate benefit of amalgam.
D2643 Onlay-porcelain/ceramic-three surfaces
D2644 Onlay-porcelain/ceramic-four or more surfaces
D2662 Onlay-resin-based composite-two surfaces: Not covered; may receive alternate benefit of amalgam.
D2663 Onlay-resin-based composite-three surfaces
D2664 Onlay-resin-based composite-four or more surfaces

CRITERIA:

Dentist Advisor Review

The advisor will consider for benefits when a tooth is decayed or fractured to the degree that an amalgam or composite filling is inadequate to restore the tooth. A tooth must have a sound endodontic and periodontal prognosis to be considered eligible for crown coverage. Specific guideline criteria for a crown must be met to qualify for this service.
Craze lines do not qualify as a "crack" in a tooth.

LIMITATIONS:

DOCUMENTATION:
A pre-operative periapical x-ray or bitewing x-ray (if tooth is not endo-treated), detailed narrative (if applicable)

FREQUENCY:
One onlay **OR** crown per tooth in a five-year period.
Additional crown or onlay (same tooth) within the 5 year period are not covered and are considered member liability

RELATIONSHIP TO OTHER CODES: (for payment purposes)
Recementation of an onlay, within 12 months of delivery of the onlay, is considered integral to the comprehensive procedure. A participating provider may not bill the member.

PER ADA CDT 2025

DENTAL COVERAGE POLICY - Oral Evaluations

EFFECTIVE DATE: 1/1/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION

Most groups cover one (1) oral examination per calendar year (first oral evaluation code received for processing in the calendar year) performed by a general dentist (to include pedodontists and prosthodontists). Exams by other specialists are not covered and are considered member liability.

CODES:

D0120 Periodic oral evaluation-established patient
D0140 Limited oral evaluation-problem focused
D0145 Oral evaluation for a patient under three years of age and counseling with primary caregiver:
D0150 Comprehensive oral evaluations-new or established patient: full allowance if the patient has no history of active treatment (including exams) by the same dentist/dental office in the past 3 years; if patient has had treatment in this time period, allowance will be equal to that of a periodic oral evaluation and the participating dentist cannot charge the patient for the difference.
D0160 Detailed and extensive oral evaluation-problem focused: Not covered and is considered member liability.
D0170 Re-evaluation-limited, problem focused (established patient; not post-operative visit): Considered integral to initial procedure. A participating dentist may not bill the member.
D0171 Re-evaluation – post operative visit: Considered integral to initial procedure. A participating dentist may not bill the member.
D0180 Comprehensive periodontal evaluation-new or established patient: usually performed by a specialist -Not covered and is considered member liability.
D0190 Screening of a patient - A screening, including state or federally mandated screenings, to determine an individual's need to be seen by a dentist for diagnosis - Not covered and is considered member liability.
D0191 Assessment of a patient - A limited clinical inspection that is performed to identify possible signs of oral or systemic disease, malformation, or injury, and the potential need for referral for diagnosis and treatment - Not covered and is considered member liability.

CRITERIA:

LIMITATIONS:

FREQUENCY: Once per calendar year, unless otherwise specified by contract.

DOCUMENTATON:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2025

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DENTAL COVERAGE POLICY - Oral Pathology Laboratory

EFFECTIVE DATE: 11/26/2008
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION

The procedure codes listed are generally performed in a pathology laboratory and do not include the removal of a tissue sample from the patient, therefore are not covered procedures and are considered member liability.

CODES:

D0472 Accession of tissue, gross examination, preparation and transmission of written report
D0473 Accession of tissue, gross and microscopic examination, preparation and transmission of written report
D0474 Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report
D0480 Accession of exfoliative cytologic smears, microscopic examination, preparation and transmission of written report
D0486 Accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report" "Pathological analysis, and written report of findings, of cytologic sample of disaggregated transepithelial cells
D0475 Decalcification procedureD0476 -Special stains for microorganisms
D0477 Special stains, not for microorganisms
D0478 Immunohistochemical stains
D0479 Tissue in-situ hybridization, including interpretation
D0481 Electron microscopy-diagnostic
D0482 Direct immunofluorescence
D0483 Indirect immunofluorescence
D0484 Consultation on slides prepared elsewhere
D0485 Consultation, including preparation of slides from biopsy material supplied by a referring source
D0502 Other oral pathology procedures, by report
D0999 Unspecified diagnostic procedure, by report: I.C. review (individual consideration) may be made.

CRITERIA:

LIMITATIONS:

FREQUENCY:

DOCUMENTATON:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2025

DENTAL COVERAGE POLICY - Orthodontics

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION

Dependents up to the age of 19 are eligible for orthodontic benefits if the specific contract includes orthodontic coverage. Benefits continue until December 31st in the year of the member's 19th birthday and is subject to a separate lifetime orthodontic maximum allowance. Adult orthodontic coverage may be available but is group specific and not part of the customary orthodontic benefits.
Initial payment for orthodontic services will be made upon receipt of initial banding date. Orthodontic payments are generally based on the length of treatment. If the length of treatment is six months or less, Blue Cross Dental's allowance will be made in one payment. Lump sum payments may be made on treatment plans over six months in length if Blue Cross Dental's total liability is $1000 or less. In most cases, orthodontic treatment will involve an initial payment followed by quarterly payments. Quarterly payments are processed automatically, and no further claims are required.
Payments are generally issued as follows (contractual or group specific exceptions may apply):

- 25% of the total amount payable by Blue Cross Dental will be paid upon placement of the bands or appliance as the initial payment.
- The remaining 75% is paid by Blue Cross Dental in equal quarterly payments and one final payment based on the estimated length of treatment and the patient's benefits.
- The subscriber/patient must be enrolled with Blue Cross Dental during each month that payment is made.
- Quarterly payments are automatically processed- it is not necessary to submit claims for quarterly payments.
- If the patient's lifetime maximum has been met before the payment schedule has been completed, further payments are discontinued.

Orthodontic treatment "in progress" is calculated the following ways:

- New Enrollee
  - The subscriber/patient must be enrolled on the date of banding or appliance placement to receive payment for these services.
  - If the patient is enrolled after appliance placement, they may be eligible to receive quarterly payments for treatment "in progress"
  - As soon as the patient becomes eligible for Blue Cross Dental orthodontic benefits, a claim should be submitted for the orthodontic treatment "in progress" including diagnosis, treatment plan, total fee, banding or appliance date and estimated total duration of treatment on the claim.
  - Blue Cross Dental then calculates the amount the plan will cover for the remaining treatment in quarterly payments. The Dental Explanation of Benefits indications the amount the plan will cover for the remainder of the "in progress" treatment.
- Transferring from another Dentist

- If the patient transfers from a different dentist, the new dentist must submit a claim to Blue Cross Dental indicating the total remaining months of treatment, total fee and the banding date if the patient was rebanded.
- Payments for services provided by the new dentist will be calculated based on the remaining orthodontic benefits and remaining length of treatment.
- It is the dentist's and the patient's responsibility to notify Dental Customer Service if orthodontic treatment is discontinued, completed sooner than anticipated or if the patient transfers to another dentist.
- When rebanding a transfer patient, it should be indicated that the patient was rebanded and the rebanding date.
- If the patient was not rebanded, it should be indicated the date that the new dentist assumed responsibility for the treatment plan.

CODES:

D8010 Limited orthodontic treatment of the primary dentition
D8020 Limited orthodontic treatment of the transitional dentition
D8030 Limited orthodontic treatment of the adolescent dentition
D8040 Limited orthodontic treatment of the adult dentition
D8050 Interceptive orthodontic treatment of the primary dentition
D8060 Interceptive orthodontic treatment of the transitional dentition
D8070 Comprehensive orthodontic treatment of the transitional dentition
D8080 Comprehensive orthodontic treatment of the adolescent dentition
D8090 Comprehensive orthodontic treatment of the adult dentition
D8091 Comprehensive orthodontic treatment with orthognathic surgery
D8210 Removable appliance therapy
D8220 Fixed appliance therapy
D8660 Pre-orthodontic treatment visit: Not covered and is considered member liability.
D8670 Periodic orthodontic treatment visit (as part of contract): Considered integral to complete orthodontic treatment. A participating dentist may not bill a member. D8680 - Orthodontic retention (removal of appliances, construction and placement of retainer(s))
D8671 Periodic orthodontic treatment with orthognathic surgery
D8681 Removable orthodontic retainer adjustment: Not covered and is considered member liability.
D8690 Orthodontic treatment (alternative billing to a contract fee): Not covered and is considered member liability.
D8694 Repair of fixed retainers, includes reattachment: Not covered and is considered member liability.
D8695 Removal of fixed orthodontic appliances for reasons other than completion of treatment: Not c overed and is considered member liability.
D8696 Repair of orthodontic appliance, maxillary: Not covered and is considered member liability.
D8697 Repair of orthodontic appliance, mandibular: Not covered and is considered member liability.
D8698 Re-cement or re-bond fixed retainer, maxillary: Not covered and is considered member liability.
D8699 Re-cement or re-bond fixed retainer, mandibular: Not covered and is considered member liability.
D8701 Repair of fixed retainers, includes reattachment- maxillary: Not covered and is considered member liability.
D8702 Repair of fixed retainers, includes reattachment-mandibular: Not covered and is considered member liability.

D8703 Replacement of lost or broken retainer, maxillary: Not covered and is considered member liability.
D8704 Replacement of lost or broken retainer, mandibular: Not covered and is considered member liability.

CRITERIA:

LIMITATIONS:
Periodic orthodontic treatment visits are considered integral to the complete orthodontic treatment plan.
All retention and case finishing procedures are considered integral to the total case fee.
Observations and adjustments are considered integral to the payment for retention appliances.
A participating dentist may not bill a member for integral services.

DOCUMENTATION:

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)
Payment for diagnostic services in conjunction with orthodontic services is applied to the member's orthodontic maximum.

PER ADA CDT 2025

DENTAL COVERAGE POLICY - Osseous Surgery

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION:

Osseous surgery is a benefit when a patient exhibits moderate to advanced periodontal disease. It is performed to modify the bony support of teeth by reshaping the alveolar process in order to achieve a more physiologic form.

CODES:

D4260 Osseous surgery (including flap entry and closure)-four or more contiguous teeth or tooth bounded spaces per quadrant

D4261 Osseous surgery (including flap entry and closure)-one to three contiguous teeth or tooth bounded spaces per quadrant

CRITERIA:

Dentist Advisor review required.
Pocket depths of 5mm or more and radiographic evidence of interproximal bone loss and/or vertical bone loss support the need for osseous surgery. The number of teeth within a quadrant, with qualifying pocket depths and radiographic evidence of bone loss, determines the appropriate code, D4260 or D4261.

LIMITATIONS:

DOCUMENTATION:

Current periodontal charting and x-rays
More than 2 quadrants performed on the same day requires explanation as to why services were provided on the same date.

FREQUENCY:

Once per mouth area per 36 months.
Not covered if performed within 36-months of osseous surgery, grafting or guided tissue regeneration in the same mouth area and member is liable for payment.

RELATIONSHIP TO OTHER CODES: (for payment purposes)

Crown lengthening procedures performed by the same dentist on the same date of service as osseous surgery (same treatment site) are considered integral to the osseous surgery. A participating dentist may not bill the member.
If performed within 36 months of gingival flap or gingivectomy (same treatment site), payment for osseous surgery will be offset with gingival flap or gingivectomy.
D4346 when performed within 6 months of D4355, D4910, D4341/D4342 or surgical periodontal procedures is considered integral. A participating dentist may not bill the member

PER ADA CDT 2025

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DENTAL COVERAGE POLICY- Other Covered Surgical Procedures

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION:

CODES:

D7280 Surgical access of an unerupted tooth
D7283 Placement of device to facilitate eruption of impacted tooth
D7284 Excisional biopsy of minor salivary glands
D7285 Incisional biopsy of oral tissue- hard (bone, tooth)
D7286 Incisional biopsy of oral tissue- soft
D7291 Transseptal fiberotomy/supra crestal fiberotomy, by report
D7970 Excision of hyperplastic tissue - per arch
D7971 Excision of pericoronal gingiva

CRITERIA:

No review required.

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

Allowed once per procedure per tooth per lifetime. Additional procedures (same procedure, same tooth) are not covered and are considered member liability.
Fiberotomy (D7291) limited to permanent anterior teeth and first bicuspids. D7291 in other areas is not covered and is considered member liability.
D7971 will be considered integral to endodontic and/or periodontal surgical procedures on the same date, same dentist, same mouth area. A participating dentist may not bill a member.

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2025

DENTAL COVERAGE POLICY- Other Fixed Partial Denture Services

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION:

Additional posts used in conjunction with post and cores for bridge abutments are considered part of the comprehensive service and there is no additional benefit. Participating dentists may not charge the member. Repairs to fixed partial dentures are reviewed on an I.C. basis by the Dental Consultant and consideration for time, materials and degree of difficulty is given to determine benefits.

CODES:

D6920 Connector bar: Not covered and is considered member liability.
D6940 Stress breaker: Not covered and is considered member liability.
D6980 Fixed partial denture repair necessitated by restorative material failure: IC Review
D6985 Pediatric partial denture, fixed: Not covered and is considered member liability.

CRITERIA:

Dentist Advisor Review
D6980: Individual consideration is given for time, degree of difficulty and materials used to complete the procedure.

LIMITATIONS:

DOCUMENTATION:

Narrative and copy of laboratory charges (if applicable)
Pre-operative periapical, if available

FREQUENCY:

D6980 is considered integral within 12 months of insertion. After 12 months, allowed once per 36 months per tooth. Additional repairs are not covered and are considered member liability.

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2025

DENTAL COVERAGE POLICY - Other Non-Covered Removable Prosthetics

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION:

The listed procedure codes are **non-covered** dental benefits and are considered member liability.

CODES:

D5850 Tissue conditioning, maxillary
D5851 Tissue conditioning, mandibular
D5875 Modification of removable prosthesis following implant surgery
D5876 Add metal substructure to acrylic full denture (per arch)

CRITERIA:

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2025

DENTAL COVERAGE POLICY - Non-Covered Surgical Procedures

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION:

The listed procedure codes are **non-covered** dental benefits and are considered member liability.

CODES:

D7260	Oral antral fistula closure
D7261	Primary closure of a sinus perforation
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization)
D7282	Mobilization of erupted or malpositioned tooth to aid eruption: not covered.
D7287	Exfoliative cytological sample collection
D7288	Brush biopsy-transepithelial sample collection
D7290	Surgical repositioning of teeth: not covered.
D7292	Surgical placement: temporary anchorage device [screw retained plate] requiring surgical flap
D7293	Surgical placement: temporary anchorage device requiring surgical flap
D7294	Surgical placement: temporary anchorage device without surgical flap
D7295	Harvest of bone for use in autogenous grafting procedure
D7296	Corticotomy – one to three teeth or tooth spaces, per quadrant
D7297	Corticotomy – four or more teeth or tooth spaces, per quadrant
D7410	Radical excision - lesion diameter up to 1.25 cm
D7411	Excision of benign lesion greater than 1.25 cm
D7412	Excision of benign lesion, complicated
D7413	Excision of malignant lesion up to 1.25 cm
D7414	Excision of malignant lesion greater than 1.25 cm
D7415	Excision of malignant lesion, complicated
D7440	Excision of malignant tumor- lesion diameter up to 1.25 cm
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm
D7465	Destruction of lesion(s) by physical or chemical method, by report
D7461	Removal of nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm
D7490	Radical resection of maxilla or mandible
D7520	Incision and drainage of abscess - extraoral soft tissue
D7521	Incision and drainage of abscess - extraoral soft tissue (includes drainage of multiple facial spaces)
D7530	Removal of foreign body, skin, or subcutaneous alveolar tissue
D7540	Removal of reaction-producing foreign bodies - musculoskeletal system
D7550	Sequestrectomy for osteomyelitis
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body
D7610	Maxilla, open reduction (teeth immobilized if present)
D7620	Maxilla, closed reduction (teeth immobilized if present)

D7630 Mandible, open reduction (teeth immobilized if present)
D7640 Mandible, closed reduction (teeth immobilized if present)
D7650 Malar and/or zygomatic arch, open reduction
D7660 Malar and/or zygomatic arch, closed reduction
D7670 Alveolus, closed reduction, may include stabilization of teeth
D7671 Alveolus, open reduction, may include stabilization of teeth
D7680 Facial bone-complicated reduction with fixation and multiple surgical approaches
D7710 Maxilla - open reduction
D7720 Maxilla - closed reduction
D7730 Mandible - open reduction
D7740 Mandible - closed reduction
D7750 Malar and/or zygomatic arch - open reduction
D7760 Malar and/or zygomatic arch - closed reduction
D7770 Alveolus, open reduction, may include stabilization of teeth
D7771 Alveolus, closed reduction stabilization of teeth
D7780 Facial bones-complicated reduction with fixation and multiple surgical approaches
D7810 Open reduction of dislocation
D7820 Closed reduction of dislocation
D7830 Manipulation under anesthesia
D7840 Condylectomy
D7850 Surgical discectomy, with/without implant
D7852 Disc repair
D7854 Synovectomy
D7856 Myotomy
D7858 Joint reconstruction
D7860 Arthrotomy
D7865 Arthroplasty
D7870 Arthrocentesis
D7871 Non-arthroscopic lysis and lavage
D7872 Arthroscopy-diagnosis, with or without biopsy
D7873 Arthroscopy-surgical; lavage and lysis of adhesions
D7874 Arthroscopy-surgical; disc repositioning and stabilization
D7875 Arthroscopy-surgical; synovectomy
D7876 Arthroscopy-surgical; discectomy
D7877 Arthroscopy-surgical; debridement
D7880 Occlusal orthotic device, by report
D7881 Occlusal orthotic device adjustment
D7899 Unspecified TMD therapy, by report
D7910 Suture of recent small wounds up to 5 cm
D7911 Complicated suture - up to 5 cm
D7912 Complicated suture - greater than 5 cm
D7920 Skin graft (identify defect covered, location and type of graft)
D7921 Collection and application of autologous blood concentrate product
D7939 Indexing for osteotomy using dynamic robotic assisted or dynamic navigation
D7940 Osteoplasty-for orthognathic deformities
D7941 Osteotomy-mandibular rami
D7943 Osteotomy-mandibular rami with bone graft; includes obtaining the graft
D7944 Osteotomy-segmented or subapical

D7945	Osteotomy-body of mandible
D7946	LeFort I (maxilla-total)
D7947	LeFort I (maxilla-segmented)
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion)-without bone graft
D7949	LeFort II or LeFort III-with bone graft
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla-autogenous or nonautogenous, by report
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach
D7952	Sinus augmentation via a vertical approach
D7953	Bone replacement graft for ridge preservation – per site
D7955	Repair of maxillofacial soft and/or hard tissue defect
D7956	Guided tissue regeneration, edentulous area – resorbable barrier, per site
D7957	Guided tissue regeneration, edentulous area – non-resorbable barrier, per site
D7979	Non-surgical Sialolithotomy
D7980	Sialolithotomy
D7981	Excision of salivary gland, by report
D7982	Sialodochoplasty
D7983	Closure of salivary fistula
D7990	Emergency tracheotomy
D7991	Coronoidectomy
D7995	Synthetic graft-mandible or facial bones, by report
D7996	Implant-mandible for augmentation purposes (excluding alveolar ridge), by report
D7997	Appliance removal (not by dentist who place appliance), includes removal of archbar
D7998	Intraoral placement of a fixation device not in conjunction with a fracture

CRITERIA:

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2025

DENTAL COVERAGE POLICY - Oral Surgical Procedures

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION:

ALSO SEE POLICY: OTHER NON-COVERED SURGICAL PROCEDURES

CODES:

D7270	Tooth reimplantation and/or stabilization of accidentally avulsed or displaced tooth
D7450	Removal of odontogenic cyst or tumor - lesion diameter up to 1.25 cm
D7451	Removal of odontogenic cyst or tumor - lesion diameter greater than 1.25 cm
D7460	Removal of nonodontogenic cyst or tumor-lesion diameter up to 1.25 cm
D7471	Removal of exostosis - maxilla or mandible
D7472	Removal of torus palatinus
D7473	Removal of torus mandibularis
D7485	Surgical reduction of osseous tuberosity
D7509	Marsupialization of odontogenic cyst
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization: Integral to the greater procedure(s). A participating dentist may not bill the member.
D7972	Surgical reduction of fibrous tuberosity

CRITERIA:

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

Removal of small cysts (D7450) are considered integral to extractions and surgical procedures if performed in the same area of the mouth on the same day by the same dentist. A participating dentist may not bill a member.

PER ADA CDT 2025

DENTAL COVERAGE POLICY - Other Preventive Services

Blue Cross Blue Shield of Rhode Island

EFFECTIVE DATE: 11/26/2008
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION:

CODES:

D1301 Immunization counseling: Considered integral to the comprehensive procedure. A participating dentist may not bill the member.
D1310 Nutritional counseling for control of dental disease: Not covered and is considered member liability.
D1320 Tobacco counseling for the control and prevention of oral disease: Not covered and is considered member liability.
D1330 Oral hygiene instruction: Not covered and is considered member liability.
D1708 Pfizer-BioNTech Covid-19 vaccine administration – third dose: Not covered and is considered a member liability.
D1709 Pfizer-BioNTech Covid-19 vaccine administration – booster dose: Not covered and is considered a member liability.
D1710 Moderna Covid-19 vaccine administration – third dose: Not covered and is considered a member liability.
D1711 Moderna Covid-19 vaccine administration – booster dose: Not covered and is considered a member liability.
D1712 Janssen Covid-19 vaccine administration – booster dose: Not covered and is considered a member liability.
D1713 Pfizer-BioNTech Covid-19 vaccine administration tris-sucrose pediatric – first dose: Not covered and is considered a member liability.
D1714 Pfizer-BioNTech Covid-19 vaccine administration tris-sucrose pediatric – second dose: Not covered and is considered a member liability.
D1781 Vaccine administration – human papillomavirus – dose 1: Not covered and is considered a member liability.
D1782 Vaccine administration – human papillomavirus – dose 2: Not covered and is considered a member liability.
D1783 Vaccine administration – human papillomavirus – dose 3: Not covered and is considered a member liability.

CRITERIA:

No review required.

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2025

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DENTAL COVERAGE POLICY - Overdentures

EFFECTIVE DATE: 09/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION:

An alternate benefit of a conventional complete/partial denture will be made for overdentures. The member is responsible for the difference between the allowance and the dentist's overdenture charge.

CODES:

D5863 Overdenture - complete maxillary
D5864 Overdenture - partial maxillary
D5865 Overdenture - complete mandibular
D5866 Overdenture - partial mandibular

CRITERIA:

No review required.

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

Five-year limitation on replacement.
Additional dentures during the five-year time period are not covered and are considered member liability.

RELATIONSHIP TO OTHER CODES: (for payment purposes)

One removable partial denture, complete or immediate denture or replacement of all teeth and acrylic on a cast metal framework (D5670, D5671) is allowed per arch per five-year period

PER ADA CDT 2025

DENTAL COVERAGE POLICY - Palliative Treatment

EFFECTIVE DATE: 09/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION

Palliative treatment is treatment that relieves pain but it not curative; services do not have distinct procedure codes. The dentist must provide treatment to alleviate the member's problem. If the only service provided is to evaluate the member to another dentist and/or prescribe medication, it will be considered a limited oral evaluation – problem focused (D0140). If any definitive procedure is performed on the same date of service as palliative treatment, the palliative will be considered integral to the definitive procedure. A participating dentist may not bill the member.

CODES:

D9110 Palliative treatment of dental pain, per visit

CRITERIA:

No review required; if submitted with a narrative, reason for palliative is recorded for tracking/audit purposes.

LIMITATIONS: N/A

One palliative treatment per date of service

FREQUENCY:

2 per calendar year - in combination with pulpal debridement (D3221). Only two of either of these procedures are covered in a calendar year. Additional procedures are not covered and are considered member liability.

RELATIONSHIP TO OTHER CODES: (for payment purposes)

Inclusive of any definitive treatment performed same date of service. A participating dentist may not bill the member.

PER ADA CDT 2025

DENTAL COVERAGE POLICY - Partial Dentures

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION:

Benefits for partial dentures include adjustments, reline/rebase or repair within six months following the delivery of the partial denture to the patient. Flexible base partial dentures are considered an alternative covered treatment to a conventional partial denture. Benefits are made for additional teeth that must be added to a partial due to tooth loss.

Insertion date (delivered to the mouth) is considered the completion date for a partial denture and benefits are payable for that date of service (not impression date).

CODES:

D5211 Maxillary partial denture-resin base (including any conventional clasps, rest and teeth)
D5212 Mandibular partial denture-resin base (including any conventional clasps, rest and teeth)
D5213 Maxillary partial denture-cast metal framework with resin denture bases (including retentive/clasping materials, rest and teeth)
D5214 Mandibular partial denture-cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)
D5221 Immediate maxillary partial denture- resin base (including retentive/clasping materials, rest and teeth)
D5222 Immediate mandibular partial denture- resin base (including retentive/clasping materials, rest and teeth)
D5223 Immediate maxillary partial denture- cast metal framework with resin denture bases (including retentive/clasping materials, rest and teeth)
D5224 Immediate mandibular partial denture- cast metal framework with resin denture bases (including retentive/clasping materials, rest and teeth)
D5225 Maxillary partial denture-flexible base (including any clasps, rests and teeth)
D5226 Mandibular partial denture-flexible base (including any clasps, rests and teeth)
D5282 Removable unilateral partial denture-one piece cast metal (including clasps and teeth), maxillary
D5283 Removable unilateral partial denture-one piece cast metal (including clasps and teeth), mandibular
D5284 Removable unilateral partial denture-one piece flexible base (including clasps and teeth), per quadrant
D5285 Removable unilateral partial denture-one piece resin (including clasps and teeth), per quadrant

CRITERIA:

No review required.

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

Once per arch per five-year period.
Additional dentures during the five-year period are not covered and are considered member liability.

RELATIONSHIP TO OTHER CODES: (for payment purposes)
One removable partial denture, complete or immediate denture or replacement of all teeth and acrylic on a cast metal framework (D5670, D5671) is allowed per arch per five-year period

PER ADA CDT 2025

DENTAL COVERAGE POLICY – Periodontal Maintenance

EFFECTIVE DATE: 09/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION:

This procedure is instituted following periodontal therapy and continues at varying intervals, determined by the clinical evaluation of the dentist, for the life of the dentition. It includes removal of the bacterial plaque and calculus from supragingival and subgingival regions, site specific scaling and root planing and polishing the teeth.

CODES:

D4910 Periodontal maintenance

CRITERIA:

No review required.

LIMITATIONS:

Allowed under periodontal benefit, if available.

DOCUMENTATION:

If previous perio treatment is not in Blue Cross Dental history: chart notes demonstrating history of previous periodontal services

FREQUENCY:

Limited to two (2) services in a calendar year.

RELATIONSHIP TO OTHER CODES: (for payment purposes)

At least one of the following procedures must be in patient's history to qualify for perio maintenance: osseous surgery, gingivectomy/gingivoplasty by quadrant, flap procedures, tissue grafts, root planing and scaling.
Routine prophylaxis (D1110) should not be performed on the same day and will be considered integral. A participating dentist may not bill the member.
D4910 will be considered integral to scaling and root planing or surgical periodontal procedures on same day, same dentist. A participating dentist may not bill the member.
D4346 when performed within 6 months of D4355, D4910, D4341/D4342 or surgical periodontal procedures is considered integral. A participating dentist may not bill the member.

PER ADA CDT 2025

DENTAL COVERAGE POLICY - Periodontal Scaling & Root Planing

EFFECTIVE DATE: 09/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION:

This is the most frequently reported non-surgical adjunctive periodontal procedure. Plaque and calculus are removed from the crown and root surfaces of teeth through instrumentation as a therapeutic approach to periodontal disease. Root planing involves the removal of cementum and dentin that is rough and may have calculus, toxins or microorganisms attached to the surfaces. Some soft tissue debridement may occur during scaling and root planing; however, this is incidental curettage of the soft tissues. Scaling and root planing has been shown to reduce pocket depth and gingival inflammation associated with periodontal disease.
Periodontal scaling and root planing may be subject to Dentist Advisor review

Codes:

D4341 Periodontal scaling and root planing-four or more teeth per quadrant
D4342 Periodontal scaling and root planing-one to three teeth per quadrant
D4346 Scaling in the presence of generalized moderate or severe inflammation- full mouth, after oral evaluation

CRITERIA:

Pocket depths of 4mm or more and radiographic evidence of calculus and interproximal bone loss) for scaling and root planing. The number of teeth within a quadrant with qualifying pocket depths and demonstrated bone loss determines the appropriate code, D4341 or D4342.

LIMITATIONS:

D4346 for members under age require radiographs, periodontal charting and narrative with rationale.

DOCUMENTATION:

Current periodontal charting and X-rays

FREQUENCY:

Allow one (1) D4341, D4342 or D4346 per quadrant within 36 months .
D4346 is considered part of the routine prophylaxis limitation; the combination of routine prophylaxis and D4346 cannot exceed the prophylaxis calendar year limitation.
If D4341 or D4342 is performed within 36 months (same site) of SCRP or surgical periodontal procedures, it is not covered and the member is liable for payment.

RELATIONSHIP TO OTHER CODES: (for payment purposes)

If D4341, D4342 or D4346 is performed on the same day as periodontal surgery, it is considered integral to the more comprehensive procedure. A participating dentist may not bill the member.
D4346 when performed within 6 months of D4355, D4910, D4341/D4342 or surgical periodontal procedures is considered integral. A participating dentist may not bill the member.

When periodontal scaling and root planing (D4341) is billed with a prophylaxis (D1110) on the same date of service, and by the same provider, D1110 will be considered integral. A participating dentist may not bill the member.
D4342 in one site performed on the same day, same dentist as D1110 will be considered integral. A participating dentist may not bill the member.
Consideration will be made by a dentist advisor for D1110 on same day, same dentist as two limited sites of D4342.

PER ADA CDT 2025

DENTAL COVERAGE POLICY – Pins and Posts

EFFECTIVE DATE: 12/16/2008
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION:

Pin placement in conjunction with amalgam and/or composite restorations are allowed on a per tooth basis (regardless of the number of pins used). Pins used in conjunction with a core build-up are included in the fee for the build-up and are not separately billable.

CODES:

D2951 Pin retention-per tooth, in addition to restoration

CRITERIA:

No review required

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2025

DENTAL COVERAGE POLICY – Post and Cores

EFFECTIVE DATE: 09/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION:

A post and core provides a foundation upon which a crown will be fabricated. A tooth is deemed in need of a post and core if it has been endodontically treated and requires the replacement of missing tooth structure for the purpose of obtaining adequate resistance and retention for the crown. Additional posts (indirectly fabricated or prefabricated) are considered integral to the post and core. A participating dentist may not bill the member.

CODES:

D2952 Post and core in addition to crown, indirectly fabricated
D2953 Each additional indirectly fabricated post -same tooth: Considered integral to D2952. A participating dentist may not bill the member.
D2954 Prefabricated post and core in addition to crown
D2957 Each additional prefabricated post-same tooth: Considered integral to D2954. A participating dentist may not bill the member.

CRITERIA:

Dentist Advisor Review
The Dentist Advisor evaluates the endodontic treatment (well-condensed, complete fill, etc.) and the periodontal condition of the treatment site to assure the tooth is periodontally sound to support a crown. Most teeth, once endodontically treated, will qualify for the post and core.

LIMITATIONS:

Not covered for members under age 14 (unless clinical rationale is provided) and is considered member liability.

DOCUMENTATION:

Endodontic post-operative periapical X-ray

FREQUENCY:

One post and core per tooth in a five-year period.
Replacements within the 5 years are not covered and are considered member liability.

RELATIONSHIP TO OTHER CODES: (for payment purposes)

Core build-up on same date of service as a post and core is considered integral to the post and core. A participating dentist may not bill the member.

Additional pins and posts required for a post and core are considered integral to the comprehensive procedure. A participating dentist may not bill the member.

PER ADA CDT 2025

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DENTAL COVERAGE POLICY – Post Removal

EFFECTIVE DATE: 09/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION:

CODES:
D2955 Post removal

CRITERIA:

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:
Once per tooth per 5 years.

RELATIONSHIP TO OTHER CODES: (for payment purposes)
Considered integral to endodontic retreatment (D3346; D3347; D3348) if performed on same day by same dentist. A participating dentist may not bill the member.

PER ADA CDT 2025

DENTAL COVERAGE POLICY - Precision Attachment

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION

CODES:

D5862 Precision attachment (removable prosthetics): Not covered and is considered member liability.
D5867 Replacement of replaceable part of semi-precision or precision attachment (male or female component): Not covered and is considered member liability.
D6950 Precision attachment "A male and female pair constitutes one precision attachment and is separate from the prosthesis.": Not covered and is considered member liability.

CRITERIA:

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2025

DENTAL COVERAGE POLICY - Professional Consultations

EFFECTIVE DATE: 09/17/2009
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION

Consultations may be covered if group-specified. Otherwise, consultations generally are not covered and are member liability.

CODES:

D9310 Consultation-diagnostic service provided by dentist or physician other than requesting dentist or physician: Not covered unless group-specified and is considered member liability.

D9311 Consultation with a medical health care professional: Not covered unless group specified and is considered member liability.

D9410 House/extended care facility call: Not covered unless group-specified and is considered member liability.

D9420 Hospital or ambulatory surgical center call Care provided outside the dentist's office to a patient who is in a hospital or ambulatory surgical center. Services delivered to the patient on the date of service are documented separately using the applicable procedure codes: Not covered unless group-specified and are considered member liability.

D9430 Office visit for observation (during regularly scheduled hours)-no other services performed: Not covered unless group-specified and are considered member liability.

D9440 Office visit-after regularly scheduled hours: Not covered unless group-specified and are considered member liability.

D9450 Case presentation, subsequent to detailed and extensive treatment planning: Not covered unless group-specified and are considered member liability.

CRITERIA:

LIMITATIONS: N/A

FREQUENCY: N/A

DOCUMENTATON: N/A

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2025

DENTAL COVERAGE POLICY – Protective/Sedative Fillings

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION:

Sedative fillings are used as a temporary restoration intended to relieve pain to attempt to prevent the need for endodontic treatment.

CODES:

D2940 Placement of interim direct restoration Not covered and is considered member liability.
D2949 Restorative foundation for an indirect restoration. Considered integral to the restorative procedure. A participating dentist may not bill the member.
D2956 Removal of an indirect restoration on a natural tooth. Considered integral to the restorative procedure. A participating dentist may not bill the member.

CRITERIA:

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2025

DENTAL COVERAGE POLICY – Provisional Crowns

Blue Cross Blue Shield of Rhode Island

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION:

A provisional crown is used as an interim restoration for a period of at least six (6) months, usually during a healing period or for completion of other related procedures or for aesthetics.

A provisional crown is not to be considered as a temporary crown used for routine prosthetic services.

CODES:

D2799 Provisional crown: Not covered and are considered member liability.

CRITERIA:

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2025

DENTAL COVERAGE POLICY - Pulp Capping

EFFECTIVE DATE: 01/12/2009
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION

Pulp caps are considered integral to the minor or major restorative procedures, sedative fillings or stainless-steel crowns. A participating dentist may not bill the member.

CODES:

D3110 Pulp cap-direct (excluding final restoration): Considered integral to restoration. A participating dentist may not bill the member.

D3120 Pulp cap-indirect (excluding final restoration): Considered integral to restoration. A participating dentist may not bill the member.

CRITERIA:

LIMITATIONS:

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2025

DENTAL COVERAGE POLICY - Pulpotomy

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION

Therapeutic pulpotomy is performed on primary or permanent teeth with the goal to maintain the vitality of the tooth. This procedure involves the removal of pulpal tissue from the chamber/coronal area, with no instrumentation of the canals, and is very effective in relieving pain. While the intention is to maintain the vitality of the tooth, a root canal may be required at a later date.

Pulpal debridement is performed to relieve acute pain prior to conventional root canal therapy. If performed on the same date of service as a root canal, or within90 days, by the same dentist/dental office, it is considered integral to the fee for the root canal procedure. A participating dentist may not bill the member.

CODES:

D3220 Therapeutic pulpotomy (excluding final restoration)-removal of pulp coronal to the dentinocemental junction and application of medicament - Pulpotomy is the surgical removal of a portion of the pulp with the aim of maintaining the vitality of the remaining portion by means of an adequate dressing.
- To be performed on primary teeth.
- This is not to be construed as the first stage of root canal therapy
- Not to be used for apexogenesis

D3221 Pulpal debridement, primary and permanent teeth - Pulpal debridement for the relief of acute pain prior to conventional root canal therapy. This procedure is not to be used when endodontic treatment is completed on the same day.

D3222 Partial pulpotomy for apexogenesis-permanent tooth with incomplete root development - Removal of a portion of the pulp and application of a medicament with the aim of maintaining the vitality of the remaining portion to encourage continued physiological development and formation of the root. This procedure is not to be construed as the first stage of root canal therapy.

CRITERIA:

Pre and post operative periapical

LIMITATIONS:

D3220 – applicable only to primary teeth
D3221 – two per calendar year in combination with palliative treatment (D9110). Only two of either of these procedures are covered in a calendar year. Additional procedures are not covered and are considered member liability.
D3222 - applicable only to permanent teeth with incomplete root development

FREQUENCY:

D3222- Once per tooth per lifetime

RELATIONSHIP TO OTHER CODES: (for payment purposes)
If a pulpotomy is performed within a 90-day period prior to a root canal, or same date of service, by the same dentist/dental office, it is considered integral to the root canal. A participating provider may not bill the member.
If partial pulpectomy for apexogenesis is performed within 90-days prior to a root canal, or same date of service, by the same dentist/dental office, it is considered integral to the root canal. A participating provider may not bill the member.
Frequency for pulpal debridement is considered in combination with palliative treatment (D9110).

PER ADA CDT 2025

DENTAL COVERAGE POLICY - Radiographs

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION

X-rays should be taken only for clinical necessity and must be of acceptable diagnostic quality, properly identified (tooth#, L/R side) and dated. As part of the patient's clinical record, original images should be retained by the dentist, and copies submitted for use to fulfill claim review requirements. BCBSRI does not reimburse for copying costs for any part of clinical records. It is reasonable to expect that X-rays submitted for claims review are taken within a year of the treatment.

Most groups cover a FMX **or** a panoramic film once in 60 months. However, some groups vary in their time limitations. The specific subscriber coverage should be checked for the applicable time limitation. In all cases, the need for full mouth radiographs should be determined by the patient's oral condition, rather than the contract benefit.

Most plans have a limit of one (1) set of bitewings in a calendar year, but may vary with specific group coverage.

A maximum of four (4) periapical X-rays are payable in a calendar year. X-rays taken in addition to, or in excess of the limits as outlined in this policy are not covered and are considered member liability.

CODES:

D0210 Intraoral-comprehensive series of radiograph images (including bitewings): one (1) in 60 months -varies by contract (or one (1) panorex taken in that same time period)
D0220 Intraoral-periapical first radiographic images: four (4) periapical X-rays per calendar year.
D0230 Intraoral-periapical each additional radiographic image: four (4) periapical X-rays per calendar year.
D0240 Intraoral-occlusal radiographic image: limited to two (2) occlusal films in a 24-month period under age seven
D0250 Extraoral-first radiographic image: Not covered and are considered member liability.
D0251 Extraoral posterior dental radiographic image: Not covered and is considered member liability.
D0260 Extraoral-each additional radiographic image: Not covered and is considered member liability.
D0270 Bitewing-single radiographic image: One set of BWX per calendar year
D0272 Bitewings-two radiographic images: One set of BWX per calendar year
D0273 Bitewings-three radiographic images: One set of BWX per calendar year
D0274 Bitewings-four radiographic images: One set of BWX per calendar year
D0277 Vertical bitewings - 7 to 8 radiographic images: One set of BWX per calendar year
D0310 Sialography: Not covered and is considered member liability.
D0320 Temporomandibular joint arthrogram, including injection: Not covered and is considered member liability.
D0321 Other temporomandibular joint films, by report: Not covered and is considered member liability.
D0322 Tomographic survey: Not covered

D0330 Panoramic radiographic image: one (1) in 60 months-varies by contract (or one (1) FMX in the same time period).
D0340 Cephalometric radiographic image: one (1) per lifetime.
D0350 Oral/facial photographic images obtained intraorally or extraorally: Not covered and is considered member liability.
D0364 Cone beam CT capture and interpretation with field of view of one full dental arch - less than one whole jaw: Not covered and is considered member liability.
D0365 Cone beam CT capture and interpretation with field of view of one full dental arch - mandible: Not covered and is considered member liability.
D0366 Cone beam CT capture and interpretation with field of view of one full dental arch - maxilla, with or without cranium: Not covered and is considered member liability.
D0367 Cone beam CT capture and interpretation with field of view of both jaws; with or without cranium: Not covered and is considered member liability.
D0368 Cone beam CT capture and interpretation for TMJ series including two or more exposures: Not covered and is considered member liability.
D0369 Maxillofacial MRI capture and interpretation: Not covered and is considered member liability.
D0370 Maxillofacial ultrasound capture and interpretation: Not covered and is considered member liability.
D0371 Sialoendoscopy capture and interpretation: Not covered and is considered member liability.
D0372 Intraoral tomosynthesis – comprehensive series of radiographic images: Not covered; may receive alternate benefit of FMX (D0210)
D0373 Intraoral tomosynthesis – bitewing radiographic image: Not covered; may receive alternate benefit of bitewing (D0270)
D0374 Intraoral tomosynthesis – periapical radiographic image: Not covered; may receive alternate benefit of periapical (D0220)
D0380 Cone beam CT capture with limited field of view - less than one whole jaw: Not covered and is considered member liability.
D0381 Cone beam CT capture with field of view of one full dental arch - mandible: Not covered and is considered member liability.
D0382 Cone beam CT capture with field of view of one full dental arch - maxilla, with or without cranium: Not covered and is considered member liability.
D0383 Cone beam CT capture with field of view of one full dental arch: Not covered and is considered member liability.
D0384 Cone beam CT capture for TMJ series including two or more exposures: Not covered and is considered member liability.
D0385 Maxillofacial MRI capture: Not covered and is considered member liability.
D0386 Maxillofacial ultrasound capture: Not covered and is considered member liability.
D0387 Intraoral tomosynthesis – comprehensive series of radiographic images – image capture only: Not covered and is considered a member liability.
D0388 Intraoral tomosynthesis – bitewing radiographic image – image capture only: Not covered and is considered a member liability.
D0389 Intraoral tomosynthesis – periapical radiographic image – image capture only: Not covered and is considered a member liability.
D0391 Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report: Not covered and is considered member liability.
D0393 Virtual simulation using 3D image volume or surface scan: Not covered and is considered member liability.

D0394 Digital subtraction of two or more images or image volumes of the same modality: Not covered and is considered member liability.
D0395 Fusion of two or more 3D image volumes of one or more modalities: Not covered and is considered member liability.
D0396 3D printing of a 3D dental surface scan: Considered integral to the comprehensive procedure. A participating dentist may not bill the member.
D0709 Intraoral comprehensive series of radiographic images – image capture only: Not covered and is considered member liability.
D0801 3D intraoral surface scan – direct: Not covered and is considered a member liability.
D0802 3D dental surface scan – indirect: Not covered and is considered a member liability.
D0803 3D facial surface scan – direct: Not covered and is considered a member liability.
D0804 3D facial surface scan – indirect: Not covered and is considered a member liability.

CRITERIA:
No review required.

LIMITATIONS:
Members under age 6 are not eligible for more than 2 BWX (not eligible D0273; D0274) in a calendar year.
D0240 limited to members age 7 and younger, 2 films per 24 month period
D0330 – for members under age 5, rationale must be submitted for consideration for payment

FREQUENCY:
Specific to the type of radiograph and the member contract

DOCUMENTATON:

RELATIONSHIP TO OTHER CODES: (for payment purposes):
A full-mouth series of X-rays (FMX) includes ten (10) or more periapical films and a set of bitewing X-rays. Periapical radiographs taken on the same day, by the same dentist as a full mouth series are considered integral to the FMX. A participating dentist may not bill the member.
Bitewing X-rays taken on the same date of service/within the same calendar year as a FMX (D0210) are considered integral to the FMX. A participating dentist may not bill the member.

For benefit purposes, bitewings taken as part of a full mouth series are considered an occurrence of bitewings.

A panoramic film and bitewing X-rays taken within 30 days of each other are benefitted up to the allowance for a FMX. If the pano and bwx are taken by the same dentist/dental office, a participating dentist may not bill the member for the difference of allowance for FMX and charge for pano and bwx. If taken by a different dentist, the member is liable for the difference.

Radiographs taken as a post operative film, as part of root canal treatment or the fabrication and insertion of prosthetic procedures are considered integral to the greater procedure. A participating dentist may not bill the member.

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provider call center. This policy is current at the time of publication; however, medical practices, technology, and knowledge are constantly changing. BCBSRI reserves the right to review and revise this policy for any reason and at any time, with or without notice. Blue Cross & Blue Shield of Rhode Island is an independent licensee of the Blue Cross and Blue Shield Association.

DENTAL COVERAGE POLICY – Recementations

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION:

Recementation for inlays, onlays, post and cores and crowns and bridges are considered integral to the comprehensive procedure if performed within twelve (12) months of the insertion (delivery date) by the same dentist. A participating dentist may not bill the member. If a different dentist/dental office performs the recementation in this time period, an allowance for a separate benefit will be made. After the twelve-month time period, benefit for one recementation (per tooth) in a 36-month period. Additional recementations (same tooth) within 36 months are not covered are a member liability.

CODES:

D2910 Recement inlay, onlay or partial coverage restoration
D2915 Recement cast or prefabricated post and core
D2920 Recement crown
D2921 Reattach tooth fragment, incisal edge or cusp - Not covered and is considered member liability.
D6089 Accessing and retorquing loose implant screw – per screw
D6092 Recement implant/abutment supported crown
D6093 Recement implant/abutment supported fixed partial denture
D6930 Recement fixed partial denture

CRITERIA:

No review required

LIMITATIONS:

Considered integral to insertion when performed within 12 months of delivery date if performed by the same dentist.

DOCUMENTATION:

FREQUENCY:

One in a 36-month period per tooth.
Additional recementations (same tooth) within 36 months are not covered are a member liability.

RELATIONSHIP TO OTHER CODES: (for payment purposes)

Recementation of a post is considered integral to recementation of a crown if provided on the same day by the same dentist. A participating dentist may not bill the member.

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DENTAL COVERAGE POLICY - Repairs to Dentures

Blue Cross Blue Shield of Rhode Island

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION:

Repairs to complete/partial dentures within six months of delivery are considered integral to the initial placement. A participating dentist may not bill the member.

CODES:

Complete Dentures:
D5511 Repair broken complete denture base, mandibular
D5512 Repair broken complete denture base, maxillary
D5520 Replace missing or broken teeth-complete denture, per tooth
Partial Dentures:
D5611 Repair resin denture base, mandibular
D5612 Repair resin denture base, maxillary
D5621 Repair cast framework, mandibular
D5622 Repair cast framework, maxillary
D5630 Repair or replace broken clasp
D5640 Replace missing or broken teeth – partial denture, per tooth
D5650 Add tooth to existing partial denture, per tooth
D5660 Add clasp to existing partial denture
D5670 Replace all teeth and acrylic on cast metal framework (maxillary)
D5671 Replace all teeth and acrylic on cast metal framework (mandibular)

CRITERIA:

No review required.

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

Considered integral within 6 months of delivery. A participating dentist may not bill the member.
Repairs are allowed once per 36-month period, per arch. Additional repairs are not covered and are considered member liability.
Replacement of all teeth (D5670. D5671) is limited once per arch per 60 months. Additional occurrences of D5670, D5671 are not covered and are considered member liability.

RELATIONSHIP TO OTHER CODES: (for payment purposes)

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employer agreement, and those documents will supersede the provisions of this dental policy. For information on member-specific benefits, call the provider call center. This policy is current at the time of publication; however, medical practices, technology, and knowledge are constantly changing. BCBSRI reserves the right to review and revise this policy for any reason and at any time, with or without notice. Blue Cross & Blue Shield of Rhode Island is an independent licensee of the Blue Cross and Blue Shield Association.

DENTAL COVERAGE POLICY - Retrograde Fillings

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION

A retrograde filling is not always required following an apicoectomy but is usually performed to assist in sealing the apices and preventing further infection.

CODES:

D3430 Retrograde filling - per root

CRITERIA:

No review required.

LIMITATIONS:

Limited based on the number of roots per tooth.
One retrograde filling per root.

DOCUMENTATION:

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

Separate payment allowed for apicoectomy.
Not covered within 30 days following root canal treatment and is considered member liability.

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DENTAL COVERAGE POLICY - Root Amputation

EFFECTIVE DATE: 02/19/2009
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION

Root amputations are usually performed to preserve a tooth that has a large bony defect and loss of periodontal support around one root of a multi-rooted tooth. A root amputation may be appropriate treatment when one root appears to be cracked and the others are healthy. To be considered successful, the crown of the tooth and at least one healthy root of the tooth must remain intact. Total success of this treatment is difficult to assess immediately. "Complete" healing may require 6-12 months, and the area of the root amputation would exhibit bone healing, minimal pocketing/tissue inflammation.

CODES:

D3450 Root amputation - per root

CRITERIA:

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

Considered integral to a hemisection if performed on same tooth/same day by the same dentist. A participating dentist may not bill the member.

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DENTAL COVERAGE POLICY - Treatment of Root Canal Obstruction

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION

This procedure is considered integral to the root canal procedure

CODES:

D3331 Treatment of root canal obstruction; non-surgical access

CRITERIA:

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

Considered integral to root canal treatment when performed by the same dentist/dental office. A participating dentist may not bill the member.

PER ADA CDT 2025

DENTAL COVERAGE POLICY - Root Canals

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION

Root canals are performed to treat a diseased, injured or non-vital pulp in a tooth. Patients may experience varying levels of pain when a root canal is needed, some requiring immediate treatment. This procedure involves removing the pulp canal, cleaning, shaping and filling the canals. Final restoration of an endodontically-treated tooth may include an amalgam, composite, post & core and/or often, a crown.

Root canals include all procedures required to complete the service. Exams, palliative treatment, pulp test, extirpation of pulp, pulpotomy, and pulpal debridement performed 90 days within the date of service of the root canal, and all pre-operative, working and post-operative x-rays, and local anesthetic by the same dentist, are considered integral to the root canal. A participating dentist may not bill the member. The final restoration is excluded. Benefits are payable upon completion of the root canal and based on the tooth treated, not the number of canals treated, (i.e., anterior, bicuspid, molar).

Root canals that are performed only to accommodate use of a precision attachment, (or other device), are not a covered benefit and are considered member liability.

CODES:

D3310 Endodontic therapy, anterior tooth (excluding final restoration)
D3320 Endodontic therapy, bicuspid tooth (excluding final restoration)
D3330 Endodontic therapy, molar (excluding final restoration)

CRITERIA:

LIMITATIONS:

Group Limitations: Some groups may have coverage for root canals on anterior (front) teeth only. The coverage may/may not apply an alternate benefit of an anterior root canal allowance for root canals performed on posterior teeth, with the member liable for the difference in allowance and the dentist's charge.

DOCUMENTATION:

FREQUENCY:

Once per tooth per lifetime. (Additional procedures on the same tooth will be considered retreatment).

RELATIONSHIP TO OTHER CODES: (for payment purposes)

Exams, palliative treatment, pulp tests, pulpotomy, pulpal debridement, x-rays (related to root canal), local anesthetic are considered integral to the root canal treatment. A participating dentist may not bill the member.
Benefits for retreatment of a root canal by a different dentist (than who performed the original endodontic treatment) are allowed.
Retreatment by the same dentist (that performed the original root canal) is considered integral to the initial RCT if performed within 12months. A participating dentist may not bill the member.
Root canal treatment will be offset by the amount benefitted for pulpal regeneration when pulpal regeneration was done within 12 months prior to the root canal treatment.

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DENTAL COVERAGE POLICY - Sealants

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION:

CODES:

D1351 Sealant-per tooth: if covered by contract, sealants performed on permanent molars for patients through the age of 15; replacements limited to once per three-year time period.

D1352 Preventive resin restoration in a moderate to high caries risk patient – permanent tooth Conservative restoration of an active cavitated lesion in a pit or fissure that does not extend into dentin; includes placement of a sealant in any radiating non-carious fissures or pits: Not covered and is considered member liability.

D1353 Sealant repair- per tooth: Not covered and is considered member liability.

D1354 Interim caries arresting medicament application

CRITERIA:

No review required.

LIMITATIONS:

D1351 -Covered through age 15

D1354 – Covered through age 12, Silver Nitrate and Silver Diamine Fluoride only

DOCUMENTATION:

FREQUENCY:

D1351 -Once per site in a 36-month period.

D1354 – Two per 12 months ages 1-6; once per 12 months ages 7-12.

Additional applications within the frequency or beyond the age limit are not covered and are considered member liability.

RELATIONSHIP TO OTHER CODES: (for payment purposes)

Considered integral if placed on the same tooth, same day by the same provider as a restoration, or when replaced within 12 months following initial sealant placement by the same dentist. A participating dentist may not bill the member.

A sealant provided within 3 years following a preventive restoration is not covered and is considered member liability.

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DENTAL COVERAGE POLICY - Single Crowns: Implant/Abutment Supported

EFFECTIVE DATE: 09/21/2009
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION:

Crowns over implants are covered if the member's contract includes prosthodontic coverage. The service should be submitted for benefits with the appropriate implant crown code(s).

CODES:

D6058 Abutment supported porcelain/ceramic crown
D6059 Abutment supported porcelain fused to metal crown (high noble metal)
D6060 Abutment supported porcelain fused to metal crown (predominantly base metal)
D6061 Abutment supported porcelain fused to metal crown (noble metal)
D6062 Abutment supported cast metal crown (high noble metal)
D6063 Abutment supported cast metal crown (predominantly base metal)
D6064 Abutment supported cast metal crown (noble metal)
D6094 Abutment supported crown –titanium and titanium alloys
D6065 Implant supported porcelain/ceramic crown
D6066 Implant supported crown- porcelain fused to high noble alloys
D6067 Implant supported crown -high noble alloys
D6082 Implant supported crown –porcelain fused to predominately base alloys
D6083 Implant supported crown –porcelain fused to noble alloys
D6084 Implant supported crown –porcelain fused to titanium and titanium alloys
D6086 Implant supported crown –predominately base alloys
D6087 Implant supported crown –noble alloys
D6088 Implant supported crown –titanium and titanium alloys

CRITERIA:

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

Once per tooth per 5 years.

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2025

DENTAL COVERAGE POLICY - Single Tooth Implant Benefit

EFFECTIVE DATE: 05/13/2009
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION:

A single tooth implant may be covered if the member has prosthodontic coverage and meets the BCBSRI criteria (see below).

CODES:

D6010 Surgical placement of implant body: endosteal implant
D6056 Prefabricated abutment-includes placement
D6057 Custom abutment-includes placement

CRITERIA:

Dentist Advisor Review (All providers)
The treatment site is evaluated for the following:

- Only one missing tooth in treatment area; two adjacent teeth present. (A conventional three-unit bridge could also be placed in this area).
- This benefit does not apply for replacement of a single tooth that is the most distal tooth in the quadrant as two adjacent teeth are not present.
- Remaining adjacent teeth and periodontal tissues appear to be healthy; no indication, in x-rays or other clinical documentation reviewed, that adjacent teeth are in need of major dental services, i.e., major restorative or periodontal services, or extraction
- Bone and surrounding periodontal tissues at treatment site are healthy, and existing conditions indicate a single tooth implant can be supported.

Implants in treatment sites that do not meet this criterion (in the absence of an Implant Rider) are not covered and are considered member liability.

LIMITATIONS:

Limited to replacement of a single missing tooth where natural teeth are present on either side. As of January 1, 2023, limited to replacement of a single missing tooth where natural teeth, or sound dental implant exists on either side.

DOCUMENTATION:

Predetermination: Pre-operative periapical x-ray or panorex, a narrative, if applicable.
Payment of claim: Post-operative periapical x-ray or panorex, narrative, if applicable.

FREQUENCY:

Limited to a five-year replacement of the implant services

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2025

DENTAL COVERAGE POLICY - Space Maintainers

EFFECTIVE DATE: 1/1/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION:

Space maintainers are a covered benefit for patients through age 13. The removal of a space maintainer is covered if the removal is performed by a different dentist/dental office that placed the space maintainer. If performed by the same dentist/dental office that placed the appliance, the benefit is considered integral to the initial placement. A participating dentist may not bill the member. If a space maintainer is lost, the replacement is not covered and is considered member liability.

CODES:

D1510 Space maintainer-fixed-unilateral- per quadrant
D1516 Space maintainer-fixed-bilateral, maxillary
D1517 Space maintainer-fixed-bilateral, mandibular
D1520 Space maintainer-removable-unilateral- per quadrant
D1526 Space maintainer-removable-bilateral, maxillary
D1527 Space maintainer-removable-bilateral, maxillary
D1551 Re-cement or re-bond bilateral space maintainer- maxillary
D1552 Re-cement or re-bond bilateral space maintainer- mandibular
D1553 Re-cement or re-bond bilateral space maintainer- per quadrant
D1556 Removal of fixed unilateral space maintainer- per quadrant
D1557 Removal of fixed unilateral space maintainer- maxillary
D1558 Removal of fixed unilateral space maintainer- mandibular
D1575 Distal shoe space maintainer - fixed unilateral- per quadrant

CRITERIA:

No review required.

LIMITATIONS:

Covered through age 13
Limited to premature loss of primary molars and permanent first molars, or primary molars and permanent first molars that have not/will not develop.
Repairs are not covered and are considered member liability.

DOCUMENTATION:

FREQUENCY:

Once appliance per site in a 5-year period. Additional appliances (same site) are not covered and are considered member liability.
Re-cementation is considered integral within 6 months of initial placement if re-cemented by the same dentist/office that delivered the appliance. Thereafter, covered once in a 6-month period. More frequent recementations are not covered and are considered member liability.

RELATIONSHIP TO OTHER CODES: (for payment purposes)

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This dental policy is made available to you for informational purposes only. It is not a guarantee of payment or a substitute for your clinical judgment in the treatment of your patients. Benefits and eligibility are determined by the member's subscriber agreement or member certificate and/or the employer agreement, and those documents will supersede the provisions of this dental policy. For information on member-specific benefits, call the provider call center. This policy is current at the time of publication; however, medical practices, technology, and knowledge are constantly changing. BCBSRI reserves the right to review and revise this policy for any reason and at any time, with or without notice. Blue Cross & Blue Shield of Rhode Island is an independent licensee of the Blue Cross and Blue Shield Association.

DENTAL COVERAGE POLICY – Stainless Steel/Pre-Fab Crowns

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION:

The stainless steel and pre-fabricated crowns (listed) are covered only when a tooth cannot be restored by a filling. Some of the crowns are specifically for deciduous teeth and limited to coverage for patients to 14 years of age. Other specific limitations are listed with each code, as applicable. Stainless steel crowns, unlike other crowns, are considered a minor restorative procedure and are benefitted at the same level as amalgam and resin composite restoration coverage.

CODES:

D2929 Prefabricated porcelain/ceramic crown-primary tooth
D2930 Prefabricated stainless-steel crown-primary tooth
D2931 Prefabricated stainless-steel crown-permanent tooth
D2932 Prefabricated resin crown
D2933 Prefabricated stainless-steel crown with resin window
D2934 Prefabricated esthetic coated stainless-steel crown-primary tooth

CRITERIA:

Dentist Advisor will consider coverage for a retained deciduous tooth for members age 14 and older with a pre-operative periapical x-ray to evaluate long term prognosis.

LIMITATIONS:

Covered to age 14.
D2932, D2933, D2934 Eligible on primary teeth C-H and M-R. All other teeth will be allowed benefit of D2930, D2931 and subject to same benefit limitation of regular stainless-steel crown with the member liable for the difference of allowance and dentist's charge.

DOCUMENTATION:

FREQUENCY:

Once per tooth per lifetime
Replacements within the 5 years are not covered and are considered member liability.

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2025

DENTAL COVERAGE POLICY - Surgical Extractions

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION:

Blue Cross Dental treatment guidelines for each specific extraction/impaction procedure code are in accordance with the CDT descriptors for extractions and impactions.

General anesthesia and IV sedation are covered benefits with specified oral surgery procedures (see anesthesia policy). Local anesthetic, elevation of the flap, bone removal, sectioning of tooth, removal of the tooth structure, closure and suturing, suture removal and routine post-operative care are included in the global fee for the surgical extraction or the impaction. Treatment for dry socket is considered postoperative care and is included in the benefit for the surgical procedure - for three visits.

If an attempt to extract a tooth fails, it is not considered a completed procedure and should not be submitted for benefit consideration. The entire tooth must be extracted.

Removal of residual roots (root is encased in bone) requires incision into the gingiva area, and possibly bone, to access the root for extraction and is considered integral if performed by the same dentist who extracted the tooth.

CODES:

D7210 Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated" "Includes related cutting of gingiva and bone, removal of tooth structure, minor smoothing of socket bone and closure
D7220 Removal of impacted tooth - soft tissue
D7230 Removal of impacted tooth - partially bony
D7240 Removal of impacted tooth - completely bony
D7241 Removal of impacted tooth - completely bony, with unusual surgical complications
D7250 Surgical removal of residual tooth roots (cutting procedure)
D7251 Coronectomy – intentional partial tooth removal, impacted teeth only. Intentional partial tooth removal is performed when a neurovascular complication is likely if the entire tooth is removed
D7259 Nerve dissection

CRITERIA:

Dentist Advisor Review required for the following procedures for members under age 15 or over age 30.

D7230 - part of crown covered by bone; requires flap elevation and bone removal
D7240 - most or all of crown is covered by bone; requires flap elevation and bone removal

Dental consultant review required for all members:

D7241 - most or all of crown covered by bone; unusually difficult or complicated due to factors such as nerve dissection, separate closure of maxillary sinus required, or aberrant tooth position

D7251- Coronectomy – intentional partial tooth removal, impacted teeth only. Intentional partial tooth removal is performed when a neurovascular complication is likely if the entire tooth is removed.
D7259 - Nerve dissection. Considered integral when reported on same tooth, same day, by same dentist as removal of impacted tooth - completely bony, with unusual complications (D7241)

LIMITATIONS:
Third molar partial and complete bony impaction removal is not routinely covered for members under age 15 or over age 30. Documentation can be submitted for consideration.
Coronectomy (D7251) only eligible on impacted teeth.

DOCUMENTATION:
D7241 -Pre-treatment radiographs and narrative required for all patients D7241
Bony impactions for members 14 and under/over age 30 – pre-treatment radiographs and narrative
D7251 – Pre and post treatment x-ray, clinic notes and operative report

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)
Surgical removal of roots (D7250) is considered integral to the extraction if performed by the same dentist that that performed extraction. A participating dentist may not bill the member.
See anesthesia policy.

PER ADA CDT 2025

DENTAL COVERAGE POLICY - Surgical Incision

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION:

CODES:

D7510 Incision and drainage of abscess-intraoral soft tissue
D7511 Incision and drainage of abscess-intraoral soft tissue-complicated (includes drainage of multiple fascial spaces)

CRITERIA:

Dentist Advisor review required.

LIMITATIONS:

DOCUMENTATION:

Narrative and/or operative report.

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

Considered integral to other surgical procedures provided on same day, same dentist. A participating dentist may not bill the member.

PER ADA CDT 2025

DENTAL COVERAGE POLICY - Surgical Revision, per tooth

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION:

This procedure is to refine the results of a previously provided surgical procedure and is considered integral to the initial surgical procedure. A participating dentist may not bill the member. This may require a surgical procedure to modify the irregular contours of hard or soft tissue. A mucoperiosteal flap may be elevated to allow access to reshape alveolar bone. The flaps are replaced or repositioned and sutured.

CODES:

D4268 Surgical revision procedure, per tooth

CRITERIA:

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

Considered integral to initial procedure. A participating dentist may not bill the member.

PER ADA CDT 2025

DENTAL COVERAGE POLICY – Tests and Examinations

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION:

Tests and analysis related to the following procedures are conducted in the dental office and/or laboratory. Most are non-covered procedures and are considered member liability.

CODES:

D0411 HbA1c in-office point of service testing: Not covered and is considered member liability.
D0412 Blood glucose level test- in-office using a glucose meter: Not covered and is considered member liability.
D0414 Laboratory processing of microbial specimen to include culture and sensitivity studies, preparation and transmission of written report: Not covered and is considered member liability.
D0415 Collection of microorganisms for culture and sensitivity: Not covered and is considered member liability.
D0416 Viral culture: Not covered and is considered member liability.
D0417 Collection and preparation of saliva sample for laboratory diagnostic testing: Not covered and is considered member liability.
D0418 Analysis of saliva sample: Not covered and is considered member liability.
D0422 Collection and preparation of genetic sample material for laboratory analysis and report: Not covered and is considered member liability.
D0423 Genetic test for susceptibility to diseases – specimen analysis: Not covered and is considered member liability.
D0425 Caries susceptibility tests: Not covered and is considered member liability.
D0431 Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures: Not covered and is considered member liability.
D0460 Pulp vitality tests: Considered integral to the comprehensive procedure. A participating dentist may not bill the member.
D0470 Diagnostic casts: Considered integral to the comprehensive procedure. A participating dentist may not bill the member.
D0600 Non-ionizing diagnostic procedure capable of quantifying, monitoring and recording changes in structure of enamel, dentin and cementum: Not covered and is considered member liability.
D0601 Caries risk assessment and documentation, with a finding of low risk: Not covered and is considered member liability.
D0602 Caries risk assessment and documentation, with a finding of moderate risk: Not covered and is considered member liability.
D0603 Caries risk assessment and documentation, with a finding of high risk: Not covered and is considered member liability.

CRITERIA:

No review required.

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2025

DENTAL COVERAGE POLICY – Tissue Grafts

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION:

These procedures are performed on teeth that have inadequate or no attached gingiva, to cover an exposed root, eliminate a gingival defect, eliminate the pull of frena and muscle attachments, to extend the vestibular fornix or to correct localized gingival recession.
These procedures are reimbursed by the number of "sites" treated. The following information is related to CDT defined "sites":

- If three contiguous teeth have areas of soft tissue recession, each area of recession is a single site.
- If three contiguous teeth have adjacent but separate osseous defects, each defect is a single site.
- If three contiguous teeth have a communicating interproximal osseous defect, it should be considered a single site.
- All non-communicating osseous defects are single sites.
- All edentulous non-communicating tooth positions are single sites.
- Depending on the dimensions of the defect, up to three contiguous edentulous tooth positions may be considered a single site.

Tooth Bounded Space is defined as a space created by one or more missing teeth that has a tooth on each side.

CODES:

D4270 Pedicle soft tissue graft procedure
D4273 Subepithelial connective tissue graft procedures, per tooth
D4275 Soft tissue allograft
D4276 Combined connective tissue and double pedicle graft, per tooth
D4277 Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft
D4278 Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in the same graft.
D4283 Autogenous connective tissue graft procedure (used with D4273)
D4285 Non-autogenous connective tissue graft procedure (used with D4275)
D4286 Removal of non-resorbable barrier: Not covered and is considered a member liability

CRITERIA:

Dentist Advisor review required.

LIMITATIONS:

DOCUMENTATION:

Current periodontal charting

Narrative

FREQUENCY:
Not covered if performed within 36-months on the same treatment sites.
If the service is performed within 36 months, the member is liable for payment.

RELATIONSHIP TO OTHER CODES: (for payment purposes)
Considered integral if performed on the same day, same site, same dentist as osseous surgery. A participating dentist may not bill the member.
Not covered in conjunction with an implant (either to accommodate the placement of the implant or anytime thereafter) and is considered member liability.
Connective tissue grafts, combined connective tissue grafts are allowed as free grafts. The member is liable for the difference between the allowance and the dentist's charge.
Distal wedge procedure is considered integral if performed on same day, same site, same dentist as other periodontal treatment. A participating dentist may not bill the member.
D4346 when performed within 6 months of D4355, D4910, D4341/D4342 or surgical periodontal procedures is considered integral. A participating dentist may not bill the member

PER ADA CDT 2025

DENTAL COVERAGE POLICY - Topical Fluoride Treatment

EFFECTIVE DATE: 11/01/2010
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION:

Fluoride treatments are paid as a separate procedure, although almost always performed in conjunction with dental prophylaxis. Benefits are contract specific. The benefit is limited to patients up to age 19. Effective 1/1/2023, fluoride treatment is covered on all BlueCHiP for Medicare Advantage plans.

CODES:

D1206 Topical fluoride varnish; therapeutic application for moderate to high caries risk patients
D1208 Topical application of fluoride

CRITERIA:

No review required.

LIMITATIONS:

Covered through age 19 (most groups)

DOCUMENTATION:

FREQUENCY:

One (1) per member up to age 19 per calendar year (most groups).
Additional fluoride treatments in the same calendar year are not covered and are considered member liability.

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2025

DENTAL COVERAGE POLICY - Unscheduled Dressing Change

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION:

Considered inclusive with periodontal procedures and extractions

CODES:

D4920 Unscheduled dressing change (by someone other than treating dentist): Not covered and is considered member liability.

CRITERIA:

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

Considered integral when performed by same participating dentist/dental office as the initial procedure. A participating dentist may not bill the member.

PER ADA CDT 2025

DENTAL COVERAGE POLICY - Unspecified Adjunctive Procedure

EFFECTIVE DATE: 09/17/2009
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION

This code is used for a procedure that does not fit a description of an existing CDT code.

CODES:

D9999 Unspecified adjunctive procedure, by report

CRITERIA:

Individual consideration is given for time, degree of difficulty and materials used to complete the procedure. If the Dentist Advisor determines that the procedure performed meets the description of an existing CDT code, the dentist may be contacted to re-submit the claim with the appropriate code.

LIMITATIONS:

FREQUENCY:

DOCUMENTATON:

A detailed narrative, along with any clinical documentation that is available, including X-rays, treatment chart, photo, etc.

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2025

DENTAL COVERAGE POLICY - Unspecified Maxillofacial Prosthesis Procedure

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION

This code is used for a procedure that does not fit a description of an existing CDT code.

CODES:

D5999 Unspecified maxillofacial prosthesis, by report: Not covered and is considered member liability.

CRITERIA:

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2025

DENTAL COVERAGE POLICY - Unspecified Oral Surgery Procedure

EFFECTIVE DATE: 03/25/2009
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION

This code is used for a procedure that does not fit a description of an existing CDT code.

CODES:

D7999 Unspecified oral surgery procedure, by report

CRITERIA:

Individual consideration is given for time, degree of difficulty and materials used to complete the procedure. If the Dentist Advisor determines that the procedure performed meets the description of an existing CDT code, the dentist may be contacted to re-submit the claim with the appropriate code.

LIMITATIONS:

DOCUMENTATION:

A detailed narrative, along with any clinical documentation that is available, including X-rays, treatment chart, photo, etc.

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2025

DENTAL COVERAGE POLICY - Unspecified Endodontic Procedure

EFFECTIVE DATE: 03/23/2009
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION

This code is used for a procedure that does not fit a description of an existing CDT code.

CODES:

D3999 Unspecified endodontic procedure, by report

CRITERIA:

Individual consideration is given for time, degree of difficulty and materials used to complete the procedure. If the Dentist Advisor determines that the procedure performed meets the description of an existing CDT code, the dentist may be contacted to re-submit the claim with the appropriate code.

LIMITATIONS:

DOCUMENTATION:

A detailed narrative, along with any clinical documentation that is available, including X-rays, treatment chart, photo, etc.

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2025

DENTAL COVERAGE POLICY - Unspecified Implant Procedure

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION

This code is used for a procedure that does not fit a description of an existing CDT code.

CODES:

D6199 Unspecified implant procedure, by report: Not covered and is considered member liability without implant rider.

CRITERIA:

Individual consideration is given for time, degree of difficulty and materials used to complete the procedure. If the Dentist Advisor determines that the procedure performed meets the description of an existing CDT code, the dentist may be contacted to re-submit the claim with the appropriate code.

LIMITATIONS:

This code will only be considered when the member has an implant rider benefit.

DOCUMENTATION:

A detailed narrative, along with any clinical documentation that is available, including X-rays, treatment chart, photo, etc.

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2025

DENTAL COVERAGE POLICY - Unspecified Orthodontics

EFFECTIVE DATE: 03/25/2009
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION

This code is used for a procedure that does not fit a description of an existing CDT code.

CODES:

D8999 Unspecified orthodontic procedure, by report

CRITERIA:

Individual consideration is given for time, degree of difficulty and materials used to complete the procedure. If the Dentist Advisor determines that the procedure performed meets the description of an existing CDT code, the dentist may be contacted to re-submit the claim with the appropriate code.

LIMITATIONS:

DOCUMENTATION:

Detailed narrative, along with any clinical documentation that is available, including X-rays, treatment chart, photo, etc.

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2025

DENTAL COVERAGE POLICY - Unspecified Periodontal Procedure

EFFECTIVE DATE: 03/24/2009
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION

This code is used for a procedure that does not fit a description of an existing CDT code.

CODES:

D4999 Unspecified periodontal procedure, by report

CRITERIA:

Individual consideration is given for time, degree of difficulty and materials used to complete the procedure. If the Dentist Advisor determines that the procedure performed meets the description of an existing CDT code, the dentist may be contacted to re-submit the claim with the appropriate code.

LIMITATIONS:

DOCUMENTATION:

A detailed narrative, along with any clinical documentation that is available, including X-rays, treatment chart, photo, etc.

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2025

DENTAL COVERAGE POLICY - Unspecified Preventive Procedure

EFFECTIVE DATE: 10/02/2013
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION

This code is used for a procedure that does not fit a description of an existing CDT code.

CODES:

D1999 Unspecified preventive procedure, by report

CRITERIA:

Individual consideration is given for time, degree of difficulty and materials used to complete the procedure. If the Dentist Advisor determines that the procedure performed meets the description of an existing CDT code, the dentist may be contacted to re-submit the claim with the appropriate code.

LIMITATIONS:

DOCUMENTATION:

A detailed narrative, along with any clinical documentation that is available, including X-rays, treatment chart, photo, etc.

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2025

DENTAL COVERAGE POLICY - Unspecified Prosthodontic Procedure

EFFECTIVE DATE: 03/25/2009
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION

This code is used for a procedure that does not fit a description of an existing CDT code.

CODES:

D6999 Unspecified fixed prosthodontic procedure, by report

CRITERIA:

Individual consideration is given for time, degree of difficulty and materials used to complete the procedure. If the Dentist Advisor determines that the procedure performed meets the description of an existing CDT code, the dentist may be contacted to re-submit the claim with the appropriate code.

LIMITATIONS:

DOCUMENTATION:

A detailed narrative, along with any clinical documentation that is available, including X-rays, treatment chart, photo, etc.

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2025

DENTAL COVERAGE POLICY - Unspecified Removable Prosthetics

EFFECTIVE DATE: 03/25/2009
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION

This code is used for a procedure that does not fit a description of an existing CDT code.

CODES:

D5899 Unspecified removal prosthodontic procedure, by report

CRITERIA:

Individual consideration is given for time, degree of difficulty and materials used to complete the procedure. If the Dentist Advisor determines that the procedure performed meets the description of an existing CDT code, the dentist may be contacted to re-submit the claim with the appropriate code.

LIMITATIONS:

DOCUMENTATION:

A detailed narrative, along with any clinical documentation that is available, including X-rays, treatment chart, photo, etc.

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2025

DENTAL COVERAGE POLICY - Unspecified Restorative Procedure

EFFECTIVE DATE: 12/16/2008
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION

This code is used for a procedure that does not fit a description of an existing CDT code.

CODES:

D2999 Unspecified restorative procedure, by report

CRITERIA:

Individual consideration is given for time, degree of difficulty and materials used to complete the procedure. If the Dentist Advisor determines that the procedure performed meets the description of an existing CDT code, the dentist may be contacted to re-submit the claim with the appropriate code.

LIMITATIONS:

DOCUMENTATION:

A detailed narrative, along with any clinical documentation that is available, including X-rays, treatment chart, photo, etc.

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2025

DENTAL COVERAGE POLICY- Vestibuloplasty

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 01/01/2025

INTERNAL POLICY DESCRIPTION:

Benefits for vestibuloplasty are limited to once in a lifetime, per arch.

CODES:

D7340 Vestibuloplasty-ridge extension (secondary epithelialization)
D7350 Vestibuloplasty-ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)

CRITERIA:

Complex vestibuloplasty and vestibuloplasty reported with removal of hyperplastic tissue requires Dentist Advisor review.

LIMITATIONS:

DOCUMENTATION:

Operative notes

FREQUENCY:

Once per lifetime, per arch.
Additional procedures are not covered and are considered member liability.

RELATIONSHIP TO OTHER CODES: (for payment purposes)

Considered integral to periodontal surgery in the same mouth area, same day, same dentist. A participating dentist may not bill the member.

PER ADA CDT 2025

DENTAL COVERAGE POLICY - Pediatric Dental Benefit

Blue Cross Blue Shield of Rhode Island

EFFECTIVE DATE: 10/01/2015
POLICY LAST UPDATED: 01/01/2025

OVERVIEW

Effective January 1, 2014, Pediatric Services including oral care has been defined as an Essential Health Benefit. For those plans that have coverage for essential health benefits, this policy defines the oral care services that will be covered for children from the ages of 0 up to the child's 19th birthday.

Note: member does not need to be a dependent

DENTAL REVIEW CRITERIA

Please refer to the coding section for the specific service that requires dental consultant review. If review is required, refer to the corresponding category of service below for the documentation requirements.

Major Restorative Services
Criteria:
- Periodontally and endodontically sound permanent tooth
- Sufficient breakdown as demonstrated on a radiograph

Required documentation:
- Pre-operative periapical X-ray
- Intra-oral photo (if available)
- Detailed narrative (if applicable)

Endodontic Services
Criteria:
- Sound periodontal prognosis
- If post service review:
  - Complete fill to the apex of each canal or calcification that prevent complete fill

Required documentation:
- Pre-operative and post-operative periapical X-rays.
- A working film may not be substituted for a post-operative film.

Periodontal Services
Criteria:
- Scaling and root planning – Pocket depths of 4mm or more or radiographic evidence of calculus and interproximal bone loss (the number of teeth with qualifying pocket depths determine the appropriate code D4341; D4342)
- Osseous surgery - Pocket depths of 5mm or more and radiographic evidence of interproximal bone loss (the number of teeth with qualifying pocket depths determine the appropriate code D4260; D4261)
- Tissue grafts – 2mm of less of attached gingiva per treatment site

Required documentation:
- Periapical X-rays of treatment area
- Full mouth periodontal chart
- Detailed narrative (if applicable)

Removable Prosthodontic Services
Required documentation:
- Detailed narrative.

Implant Services
Criteria:
- If an arch can be restored with a standard prosthesis or restoration, no benefits will be allowed for the implant or implant related services.

Required documentation:
- Pre-operative panorex or intraoral complete series
- Detailed narrative.
- If payment of claim: Post-operative film of implant, with above documentation is required for review.

Fixed Prosthodontics
Criteria:
- Periodontally and endodontically sound permanent abutment teeth

Required documentation:
- Pre-operative periapical X-rays of entire treatment site
- If there are special circumstances related to the treatment, a detailed narrative is recommended.

Oral Surgery
Required documentation:
- Pre-Operative X-ray of treatment site
- Narrative (if applicable)

Orthodontic Services
***Services will not be covered when the dentition contains any more primary teeth than the primary second molars.**

In addition: One of the following criteria must be met for services to be covered under this benefit:

- Maxillary/Mandibular incisor relationship: over jet of 9 mm or more with impingement where the lower incisors are impinging the palate.

- Anterior cross bite equal to or greater than 5mm (short term, interceptive therapy covered only)
  - Anterior open bite (canine to canine)
  - More than 1 impacted permanent tooth when the dentition contains no more primary teeth than the primary second molars.
  - Posterior-unilateral cross bite involving three or more adjacent, permanent teeth, one of which must be a molar (no eruption/dentition requirements for this qualifier).
  - Cleft palate deformities submitted by the surgical team.
  - Treatment for skeletal deformities will be considered on an individual basis and must be submitted by the surgical team.

Required documentation for dental consultant review:

- Extra-oral photos – including frontal and profile
  - 5 Intra-oral photos – R/L buccal, U/L occlusal, and front incisor view

- Panoramic film
- Lateral cephalometric film
- Frontal cephalometric film (for surgical cases)

- Consultation report with diagnosis and treatment plan

Major Restorative Services

The following services are limited to 1 tooth per 60 months:

- onlay metallic
- core buildup
- prefabricated post and core
- crowns

Endodontic Services

- Therapeutic pulpotomy (excluding final restoration) – If a root canal is performed within 90 days of the pulpotomy, the pulpotomy is not a covered service and will be considered part of the root canal procedure
- Partial pulpotomy for apexogenesis – permanent tooth with incomplete root formation- If a root canal is performed within 90 days of the pulpotomy, the pulpotomy is not a covered service and will be considered part of the root canal procedure
- Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration) – Up to age 6 for primary incisors, up to age 11 for primary canines- Limited to once per tooth per lifetime
- Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration) – Up to age 11 for primary molars – Limited to once per tooth per lifetime

Periodontal Services

- Gingivectomy or gingivoplasty – four or more teeth
- Gingivectomy or gingivoplasty – one to three teeth 36 months
- Gingival flap procedure, including root planing, four or more teeth
- Clinical crown lengthening-hard tissue
- Osseous surgery (including flap entry and closure), four or more contiguous teeth or bounded teeth spaces per quadrant
- Pedicle soft tissue graft – Limited to once, per site, per 36 months
- Subepithelial connective tissue graft procedures- Limited to once per site, per 36 months
- Periodontal scaling and root planning-four or more teeth per quadrant-Limited to once per site per 24 months
- Periodontal scaling and root planning-one to three teeth per quadrant-Limited to once per site per 24 months
- Full mouth debridement to enable comprehensive evaluation and diagnosis-Limited to one per lifetime
- Periodontal maintenance – Limited to 4 per 12 months

Implant Services

- Implants and related services are allowed once, per type of service (i.e., endosteal OR eposteal, porcelain OR metal crown), per treatment site per 60 months.

Fixed Prosthodontics

- One fixed partial denture per treatment area per 60 months.

Oral Surgery

Orthodontic Services

- Orthodontic services are not covered for:
- Repair of damaged orthodontic appliances
- Replacement of lost or missing appliances
- Services to alter vertical dimension and/or restore or maintain the occlusion, such as procedures that include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation and restoration for misalignment of teeth.

PRIOR AUTHORIZATION

Dental Consultant review required.

POLICY STATEMENT

Pediatric oral care services listed in this policy are covered as part of the member's medical coverage for children from the ages of 0 up to child's 19th birthday when the benefit plan includes coverage for essential health benefits

No coverage is available under the member's medical coverage for services not listed in this policy. These procedures would be considered not covered and are the member's responsibility up to the dentist's charge.

Orthodontic Services

Orthodontic services are not covered for:

- Repair of damaged orthodontic appliances
- Replacement of lost or missing appliances
- Services to alter vertical dimension and/or restore or maintain the occlusion, such as procedures that include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation and restoration for misalignment of teeth.

If a member has started orthodontic treatment with coverage by another carrier, or no insurance coverage at all, and the treatment meets BCBSRI medical criteria for coverage, the benefit maximum for orthodontic services will be prorated according to the length of time remaining in the treatment plan. *Example:* The member has completed 12 months of a 24-month orthodontic treatment plan before becoming enrolled. BCBSRI will pay 50% (12 months remaining/24 months total) of the allowable fee towards the orthodontic treatment.

For members who began orthodontic treatment with coverage under a BCBSRI dental plan and transitioned to the Pediatric Dental Benefit without coverage disruption, orthodontic payments will be made in accordance with the terms of the plan that was in place when treatment began. Should additional orthodontic benefits be requested, the dental necessity criteria for coverage under the EHB-Pediatric Dental Benefit must be met. Payment will never exceed the Blue Cross Dental allowance for treatment rendered.

COVERAGE

Benefits may vary between groups/contracts. Please refer to the appropriate Benefit Booklet or Subscriber Agreement for applicable pediatric dental benefits/coverage.

BACKGROUND

Effective January 1, 2014, Qualified Health Plans (QHPs) are required to cover Essential Health Benefits (EHBs), as defined in Section 1302(b) of the Patient Protection and Affordable Care Act. Pediatric Services including oral and vision care has been defined as essential Health Benefits. This policy defines the oral care services that will be covered for members from the ages of 0 up to the members 19th birthday.

As groups renew in 2014, most benefit plans will need to include these EHBs (some exceptions may apply to certain large groups; consult your Subscriber Agreement or Benefit Booklet for details).

CODING

Claims are filed on CDT forms and if approved, will be processed under the member's medical benefit.

Diagnostic Services

D0120	Periodic oral evaluation (2 exams, any type, per calendar year)
D0140	Limited oral evaluation (2 exams, any type, per calendar year)
D0150	Comprehensive oral evaluation (2 exams, any type, per calendar year, one per 3 years)
D0160	Detailed and extensive oral evaluation, problem focused, by report (one per patient, per provider per 12 months per eligible diagnosis)
D0180	Comprehensive periodontal evaluation (2 exams, any type, per calendar year, one per 3 years)
D0210	Intraoral – comprehensive series of radiographic images (one per 5 years, not eligible under age 5)
D0220	Intraoral – periapical first radiographic image (4 per calendar year)
D0230	Intraoral – periapical each additional radiographic image (4 per calendar year)
D0240	Intraoral – occlusal film (2 in 24 months, not eligible age 8 and over)
D0270	Bitewing – single radiographic image (maximum of 4 bitewings per occurence, 2 per calendar year)
D0272	Bitewings – two radiographic images (maximum of 4 bitewings per occurrence, 2 per calendar year)
D0273	Bitewings – three radiographic images (maximum of 4 bitewings per occurrence, 2 per calendar year)
D0274	Bitewings – four radiographic images (maximum of 4 bitewings per occurrence, 2 per calendar year)
D0277	Vertical Bitewings – 7 to8 radiographic images (maximum of 4 bitewings per occurrence, 2 per calendar year)
D0330	Panoramic radiographic image (one per 5 years,)
D0350	Oral/Facial photographic images
D0372	Intraoral tomosynthesis – comprehensive series of radiographic images
D0373	Intraoral tomosynthesis – bitewing radiographic image
D0374	Intraoral tomosynthesis – periapical radiographic image
D0391	Interpretation of diagnostic image by a practitioner not associated with capture of the image
D0396	3D printing of a 3D dental surface scan
D0470	Diagnostic casts

Preventive Services

D1110	Prophylaxis – Adult (age 13 or older) (three per calendar year, in combination with D4346)
D1120	Prophylaxis – Child (three per calendar year, in combination with D4346)
D1206	Topical application of fluoride varnish (2 per calendar year)
D1208	Topical application of fluoride, excluding varnish (2 per calendar year)
D1351	Sealant-per tooth – unrestored permanent molars (1 per tooth per 36 months)
D1352	Preventive resin restoration in a moderate to high caries risk patient – permanent tooth (under age 16, permanent molars only) (once per tooth per lifetime)
D1354	Interim caries arresting medicament application (one per 12 months ages 7-12; two per 12 months ages 1-6)
D1510	Space maintainer – fixed- unilateral – per quadrant (under age 14,- primary molars and permanent first molars only) (once per tooth per 5 years)
D1516	Space maintainer-fixed-bilateral, maxillary (under age 14,- primary molars and permanent first molars only) (once per tooth per 5 years)

D1517 Space maintainer-fixed-bilateral, mandibular (under age 14,- primary molars and permanent first molars only) (once per tooth per 5 years)
D1520 Space maintainer-removable-unilateral –per quadrant (under age 14, primary molars and permanent first molars only) (once per tooth per 5 years)
D1526 Space maintainer-removable-bilateral, maxillary (under age 14, primary molars and permanent first molars only) (once per tooth per 5 years)
D1527 Space maintainer-removable-bilateral, mandibular(under age 14, primary molars and permanent first molars only) (once per tooth per 5 years)

D1551 Re-cement or re-bond bilateral space maintainer-maxillary
D1552 Re-cement or re-bond bilateral space maintainer-mandibular
D1553 Re-cement or re-bond bilateral space maintainer-per quadrant
D1556 Removal of fixed unilateral space maintainer- per quadrant
D1557 Removal of fixed unilateral space maintainer-maxillary
D1558 Removal of fixed unilateral space maintainer-mandibular
D1575 Distal shoe space maintainer – fixed- unilateral – per quadrant (under age 14, primary molars and permanent first molars only) (once per tooth per 5 years)

Minor Restorative Services (once per surface, per tooth per 12 months)
D2140 Amalgam – one surface, primary or permanent
D2150 Amalgam – two- surface, primary or permanent
D2160 Amalgam – three surface, primary or permanent
D2161 Amalgam – four or more surfaces, primary or permanent
D2330 Resin-based composite – one surface, anterior
D2331 Resin-based composite – two surface, anterior
D2332 Resin-based composite – three surface anterior
D2335 Resin-based composite – four or more surfaces, anterior
D2391 Resin-based composite – one surface, posterior
D2392 Resin-based composite – two surface, posterior
D2393 Resin-based composite – three surface, posterior
D2394 Resin-based composite – four or more surfaces, posterior
D2940 Placement of interim direct restoration
D2951 Pin retention – per tooth, in addition to restoration
D2955 Post Removal (1 per 5 years)

Major Restorative Services (allowed once per tooth per 5 years) (Dental Consultant review required for all major restorative services)
D2510 Inlay – metallic-one surface (allowed at amalgam restoration allowance)
D2520 Inlay – metallic-two surfaces (allowed at amalgam restoration allowance)
D2530 Inlay – metallic-three surfaces (allowed at amalgam restoration allowance)
D2542 Onlay – metallic-two surfaces (allowed at amalgam restoration allowance)
D2543 Onlay – metallic-three surfaces
D2544 Onlay – metallic-four or more surfaces
D2740 Crown – porcelain/ceramic substrate
D2750 Crown – porcelain fused to high noble metal
D2751 Crown – porcelain fused to predominantly base metal
D2752 Crown – porcelain fused to noble metal
D2753 Crown- porcelain fused to titanium and titanium alloys
D2780 Crown – 3/4 cast high noble metal
D2781 Crown – 3/4 cast predominantly base metal
D2782 Crown – Crown ¾ cast noble metal
D2783 Crown – 3/4 porcelain/ceramic

D2790 Crown – full cast high noble metal
D2791 Crown – full cast predominantly base metal
D2792 Crown – full cast noble metal
D2794 Crown – titanium and titanium alloys
D2910 Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration
D2920 Re-cement or re-bond crown
D2929 Prefabricated porcelain/ceramic crown-primary tooth
D2930 Prefabricated stainless steel crown – primary tooth (once per tooth per 36 months)
D2931 Prefabricated stainless steel crown – permanent tooth (once per tooth per 36 months)D2950 Core buildup, including any pins (not covered on primary teeth)
D2954 Prefabricated post and core, in addition to crown (not covered on primary teeth)
D2976 Band stabilization, per tooth
D2980 Crown repair necessitated by restorative material failure
D2981 Inlay repair necessitated by restorative material failure
D2982 Onlay repair necessitated by restorative material failure
D2983 Veneer repair necessitated by restorative material failure
D2989 Excavation of a tooth resulting in the determination of non-restorability
D2990 Resin infiltration of incipient smooth surface lesions
D2991 Application of hydroxyapatite regeneration medicament – per tooth

Endodontic Services

D3220 Therapeutic pulpotomy (excluding final restoration)
D3222 Partial pulpotomy for apexogenesis – permanent tooth with incomplete root formation)
D3230 Pulpal therapy (resorbable filling) – (anterior, primary tooth under age 6; posterior primary tooth under age 11) (once per tooth per lifetime)
D3240 Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration) (anterior, primary tooth under age 6; posterior primary tooth under age 11) (once per tooth per lifetime)
D3310 Endodontic therapy, anterior tooth (excluding final restoration) (once per tooth per lifetime) (Dental Consultant review required)
D3320 Endodontic therapy, bicuspid tooth (excluding final restoration) (once per tooth per lifetime) (Dental Consultant review required)
D3330 Endodontic therapy, molar (excluding final restoration) (once per tooth per lifetime) (Dental Consultant review required)
D3346 Retreatment of previous root canal therapy-anterior (once per tooth per lifetime) (Dental Consultant review required)
D3347 Retreatment of previous root canal therapy-bicuspid (once per tooth per lifetime) (Dental Consultant review required)
D3348 Retreatment of previous root canal therapy-molar (once per tooth per lifetime) (Dental Consultant review required)
D3351 Apexification/recalcification/pulpal regeneration – initial visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)
D3352 Apexification/recalcification/pulpal regeneration – interim medication replacement
D3353 Apexification/recalcification/pulpal regeneration – final visit (includes completed root canal therapy- apical closure/calcific repair of perforations, root resorption, etc.)
D3355 Pulpal regeneration – initial visit
D3356 Pulpal regeneration – interim medication replacement
D3357 Pulpal regeneration – completion of treatment (eligible on permanent teeth only, under age 15) (once per tooth per lifetime)
D3410 Apicoectomy/periradicular surgery – anterior
D3421 Apicoectomy/periradicular surgery – bicuspid (first root)

D3425 Apicoectomy/periradicular surgery – molar (first foot)
D3426 Apicoectomy/periradicular surgery – (each additional root)
D3450 Root amputation-per root (Dental Consultant review required)
D3920 Hemisection (including any root removal)-not including root canal therapy (Dental Consultant review required)

Periodontal Services (allowed once per area of the mouth per 36 months) (Dental Consultant review required for periodontal services)

D4210 Gingivectomy or gingivoplasty – four or more teeth
D4211 Gingivectomy or gingivoplasty – one to three teeth
D4212 Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth
D4240 Gingival flap procedure, including root planing, four or more teeth
D4241 Gingival flap procedure, including root planing-one to three contiguous teeth or tooth bounded spaces per quadrant
D4249 Clinical crown lengthening-hard tissue
D4260 Osseous surgery (including flap entry and closure), four or more contiguous teeth or bounded teeth spaces per quadrant)
D4261 Osseous surgery (including flap entry and closure), one to three contiguous teeth or tooth bounded spaces per quadrant
D4266 Guided tissue regeneration, natural teeth - resorbable barrier, per site
D4267 Guided tissue regeneration, natural teeth – non-resorbable barrier, per site (includes membrane removal)
D4270 Pedicle soft tissue graft
D4273 Subepithelial connective tissue graft procedures
D4277 Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in a graft
D4278 Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site
D4283 Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site
D4341 Periodontal scaling and root planning-four or more teeth per quadrant (once per site per 24 months)
D4342 Periodontal scaling and root planning-one to three teeth per quadrant (once per site per 24 months)
D4346 Scaling in the presence of generalized moderate or severe gingival inflamamation- full mouth (age 16 and older; combination of D1110/D4346 cannot exceed 3 per year)
D4355 Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit (one per lifetime)
D4910 Periodontal maintenance (4 per 12 months)

Prosthodontic Services (Prostheses limited to once per arch per 5 years)

D5110 Complete denture – maxillary
D5120 Complete denture – mandibular
D5130 Immediate denture – maxillary
D5140 Immediate denture – mandibular
D5211 Maxillary partial denture – resin base (including any conventional clasps, rests and teeth)
D5212 Mandibular partial denture – resin base (including any conventional clasps, rests and teeth)
D5213 Maxillary partial denture – cast metal framework with resin denture base (including any retentive/clasping materials, rests and teeth)
D5214 Mandibular partial denture – cast metal framework with resin denture base (including any retentive/clasping materials, rests and teeth)

D5221	Immediate maxillary partial denture – resin base (including any retentive/clasping materials, rests and teeth)
D5222	Immediate mandibular partial denture – resin base (including any retentive/clasping materials, rests and teeth)
D5223	Immediate maxillary partial denture – cast metal framework with resin denture bases
D5224	Immediate mandibular partial denture – cast metal framework with resin denture bases
D5282	Removable unilateral partial denture – one piece cast metal, maxillary (including clasps and teeth)
D5283	Removable unilateral partial denture – one piece cast metal, mandibular (including clasps and teeth)
D5284	Removable unilateral partial denture- one piece flexible base (including clasps and teeth –per quadrant
D5286	Removable unilateral partial denture-one piece resin (including clasps and teeth)- per quadrant
D5410	Adjust complete denture – maxillary
D5411	Adjust complete denture – mandibular
D5421	Adjust partial denture – maxillary
D5422	Adjust partial denture – mandibular
D5511	Repair broken complete denture base, mandibular
D5512	Repair broken complete denture base, maxillary
D5520	Replace missing or broken teeth – complete denture, per tooth
D5611	Repair resin denture base, mandibular
D5612	Repair resin denture base, maxillary
D5621	Repair cast framework, mandibular
D5622	Repair cast framework, maxillary
D5630	Repair or replace broken clasp
D5640	Replace missing or broken teeth – partial denture, per tooth
D5650	Add tooth to existing partial denture, per tooth
D5660	Add clasp to existing partial denture
D5710	Rebase complete maxillary denture – Limited to once per 36 months
D5711	Rebase complete mandibular denture-Limited to once per 36 months
D5720	Rebase maxillary partial denture – Limited to once per 36 months
D5721	Rebase mandibular partial denture – Limited to once per 36 months
D5730	Reline complete maxillary denture (chairside) – Limited to once per 36 months
D5731	Reline complete mandibular denture (chairside) – Limited to once per 36 months
D5740	Reline maxillary partial denture (chairside) – Limited to once per 36 months
D5741	Reline mandibular partial denture (chairside) – Limited to once per 36 months
D5750	Reline complete maxillary denture (laboratory) – Limited to once per 36 months
D5751	Reline complete mandibular denture (laboratory) – Limited to once per 36 months
D5760	Reline maxillary partial denture (laboratory) – Limited to once per 36 months
D5761	Reline mandibular partial denture (laboratory) – Limited to once per 36 months
D5850	Tissue conditioning, maxillary
D5851	Tissue conditioning, mandibular

Implant Services (limited to one per tooth/site per 5 years) (Dental Consultant review required)

D6010	Endosteal implant (once per tooth per lifetime)
D6011	Second stage implant surgery (once per tooth per lifetime)
D6012	Surgical placement of interim implant body for transitional prosthesis (once per tooth per lifetime)
D6013	Surgical placement of mini-implant (once per tooth per lifetime)
D6040	Eposteal Implant (once per tooth per lifetime)
D6050	Transosteal Implant, including hardware (once per tooth per lifetime)

D6051	Placement of interim implant abutment
D6055	Connecting bar – implant or abutment supported
D6056	Prefabricated abutment
D6057	Custom fabricated abutment
D6058	Abutment supported porcelain ceramic crown
D6059	Abutment supported porcelain fused to high noble metal crown
D6060	Abutment supported porcelain fused to predominantly base metal crown
D6061	Abutment supported porcelain fused to noble metal crown
D6062	Abutment supported cast high noble metal crown
D6063	Abutment supported cast predominantly base metal crown
D6064	Abutment supported cast noble metal crown
D6065	Implant supported porcelain ceramic crown
D6066	Implant supported porcelain fused to high noble alloys
D6067	Implant supported crown –high noble alloys
D6068	Abutment supported retainer for porcelain/ceramic fixed partial denture
D6069	Abutment supported retainer for porcelain fused to high noble metal fixed partial denture
D6070	Abutment supported retainer for porcelain fused to predominantly base metal fixed partial denture
D6071	Abutment supported retainer for porcelain fused to noble metal fixed partial denture
D6072	Abutment supported retainer for cast high noble metal fixed partial denture
D6073	Abutment supported retainer for cast predominantly base metal fixed partial denture
D6074	Abutment supported retainer for cast noble metal fixed partial denture
D6075	Implant supported retainer for ceramic fixed partial denture
D6076	Implant supported retainer for porcelain fused to high noble alloys
D6077	Implant supported retainer for metal fixed partial denture-high noble alloys
D6080	Implant maintenance procedure when a full arch fixed hybrid prosthesis is removed and reinserted, including cleansing of prosthesis and abutments
D6081	Scaling and debridement of a single implant in the presence of mucositis, including inflammation, bleeding upon probing and increased pocket depths includes cleaning of the implant surfaces, without flap entry and closure
D6082	Implant supported crown- porcelain fused to predominately base alloys
D6083	Implant supported crown- porcelain fused to noble alloys
D6084	Implant supported crown- porcelain fused to titanium and titanium alloys
D6086	Implant supported crown – predominately base alloys
D6087	Implant supported crown – noble alloys
D6088	Implant supported crown – titanium and titanium alloys
D6089	Accessing and retorquing loose implant screw – per screw
D6090	Repair of implant/abutment supported prosthesis
D6091	Replacement of semi-precision or precision attachment
D6094	Abutment supported crown- titanium and titanium alloys
D6097	Abutment supported crown- porcelain fused to titanium and titanium alloys
D6098	Implant supported retainer- porcelain fused to predominately base alloys
D6099	Implant supported retainer for FPD- porcelain fused to noble alloys
D6100	Implant removal
D6101	Debridement of peri-implant defect or defects surrounding a single implant
D6102	Debridement and osseous contouring of a peri-implant defect or defects surrounding a single implant
D6103	Bone graft for repair of peri-implant defect
D6104	Bone graft at time of implant placement
D6105	Removal of implant body not requiring bone removal nor flap elevation

D6110 Implant /abutment supported removable denture for edentulous arch – maxillary
D6111 Implant/abutment supported removable denture for edentulous arch – mandibular
D6112 Implant/abutment supported removable denture for partially edentulous arch – maxillary
D6113 Implant/abutment supported removable denture for partially edentulous arch – mandibular
D6114 Implant/abutment supported fixed denture for edentulous arch – maxillary
D6115 Implant/abutment supported fixed denture for edentulous arch – mandibular
D6116 Implant/abutment supported fixed denture for partially edentulous arch – maxillary
D6117 Implant/abutment supported fixed denture for partially edentulous arch – mandibular
D6120 Implant supported retainer- porcelain fused to titanium and titanium alloys
D6121 Implant supported retainer for metal FPD – predominately base alloys
D6122 Implant supported retainer for metal FPD – noble alloys
D6123 Implant supported retainer for metal FPD – titanium and titanium alloys
D6180 Implant maintenance procedures when a full arch fixed hybrid prosthesis is not removed including cleansing of prosthesis and abutments
D6190 Radiographic/surgical implant index, by report
D6193 Replacement of an implant screw
D6194 Abutment supported retainer crown for FPD – titanium and titanium alloys
D6195 Abutment supported retainer- porcelain fused to titanium and titanium alloys
D6197 Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant (Not covered if same provider, same implant site within 6 months of history of payment for initial prosthetic and maintenance services D6051 – D6199)

Fixed Prosthodontics (limited to one per tooth per 5 years) (Dental Consultant review required)
D6210 Pontic – cast high noble metal
D6211 Pontic – cast predominantly base metal
D6212 Pontic –cast noble metal
D6214 Pontic – titanium and titanium alloys
D6240 Pontic – porcelain fused to high noble metal
D6241 Pontic –porcelain fused to predominantly base metal
D6242 Pontic – porcelain fused to noble metal
D6243 Pontic- porcelain fused to titanium and titanium alloys
D6245 Pontic – porcelain/ceramic
D6545 Retainer – cast metal for resin bonded fixed prosthesis
D6548 Retainer – porcelain/ceramic for resin bonded fixed prosthesis
D6549 Resin retainer – porcelain/ceramic for resin bonded fixed prosthesis
D6600 Inlay – porcelain/ceramic, two surfaces
D6601 Inlay – porcelain/ceramic, three or more surfaces
D6602 Inlay – cast high noble metal, two surfaces
D6603 Inlay – cast high noble metal, three or more surfaces
D6604 Inlay – cast predominantly base metal, two surfaces
D6605 Inlay – cast predominantly metal, three or more surfaces
D6606 Inlay – cast noble metal, two surfaces
D6607 Inlay – cast noble metal, three or more surfaces
D6608 Onlay – porcelain/ceramic, two or more surfaces
D6609 Onlay – porcelain/ceramic, three or more surfaces
D6610 Onlay – cast high noble metal, two surfaces
D6611 Onlay – cast high noble metal, three or more surfaces
D6612 Onlay – cast predominantly base metal, two surfaces
D6613 Onlay – cast predominantly base metal, three or more surfaces
D6614 Onlay – cast noble metal, two surfaces
D6615 Onlay – cast noble metal, three or more surfaces

D6740	Crown – porcelain/ceramic
D6750	Crown – porcelain fused to high noble metal
D6751	Crown – porcelain fused to predominantly base metal
D6752	Crown – porcelain fused to noble metal
D6753	Retainer Crown- porcelain fused to titanium and titanium alloys
D6780	Crown – 3/4 cast high noble metal
D6781	Crown – 3/4 cast predominantly base metal
D6782	Crown – 3/4 cast noble metal
D6783	Crown – 3/4 porcelain/ceramic
D6784	Retainer crown ¾- porcelain fused to titanium and titanium alloys
D6790	Crown – full cast high noble metal
D6791	Crown – full cast predominantly metal
D6792	Crown – full cast noble metal
D6794	Retainer crown- titanium and titanium alloys
D6930	Re-cement fixed partial denture
D6980	Fixed partial denture repair necessitated by restorative material failure

Oral Surgery (Dental Consultant review required)

D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
D7220	Removal of impacted tooth – soft tissue
D7230	Removal of impacted tooth – partially bony
D7240	Removal of impacted tooth – completely bony
D7241	Removal of impacted tooth-completely bony with unusual surgical complications
D7250	Surgical removal of residual tooth roots (cutting procedure)
D7251	Coronectomy –Intentional partial tooth removal, impacted teeth only. Intentional partial tooth removal is performed when a neurovascular complication is likely if the entire tooth is removed.
D7252	Partial extraction for immediate implant placement.
D7270	Tooth reimplantation and/or stabilization of accidentally avulsed or displaced tooth
D7280	Surgical access of an unerupted tooth
D7310	Alveoloplasty in conjunction with extractions-per quadrant
D7311	Alveoloplasty in conjunction with extractions-one to three teeth or tooth spaces, per quadrant
D7320	Alveoloplasty not in conjunction with extractions – per quadrant
D7321	Alveoloplasty not in conjunction with extractions-one to three teeth or tooth spaces, per quadrant
D7471	Removal of lateral exostosis (maxilla or mandible)
D7509	Marsupialization of odontogenic cyst
D7510	Incision and drainage of abscess – intraoral soft tissue
D7910	Suture of recent small wounds – up to 5 cm
D7921	Collection and application of autologous blood concentrate product (once per 36 months)
D7971	Excision of pericoronal gingival

Adjunctive Services

D9110	Palliative treatment of dental pain, per visit
D9222	Deep sedation/general anesthesia – first 15 min – Limited to 30 minutes
D9223	Deep sedation/general anesthesia – each additional 15 min – Limited to 30 minutes
D9239	Intravenous conscious sedation/analgesia – first 15 min – Limited to 30 minutes
D9243	Intravenous conscious sedation/analgesia – each additional 15 min – Limited to 30 minutes

D9310	Consultation- diagnostic service provided by a dentist or physician other than requesting dentist or physician (1 per patient per provider per 12 months for specialties other than pedodontist or orthodontist)
D9610	Therapeutic drug injection, by report
D9930	Treatment of complications (post-surgical) – unusual circumstances, by report (Dental Consultant review required)
D9943	Occlusal guard adjustment (age 13 and older; once per 24 months)
D9944	Occlusal guard, hard appliance, full arch (age 13 and older; once per 12 months)
D9945	Occlusal guard, soft appliance, full arch (age 13 and older; once per 12 months)
D9946	Occlusal guard, hard appliance, partial arch (age 13 and older; once per 12 months)
D9954	Fabrication and delivery of oral appliance therapy (OAT) morning repositioning device
D9955	Oral appliance therapy (OAT) titration visit

Orthodontic Services (Dental Consultant review required)
The following services are covered under medical only when the services meet the criteria for coverage in this policy (see above)

D0340	Cephalometric radiographic image
D8010	Limited orthodontic treatment of the primary dentition
D8020	Limited orthodontic treatment of the transitional dentition
D8030	Limited orthodontic treatment of the adolescent dentition
D8050	Interceptive orthodontic treatment of the primary dentition
D8060	Interceptive orthodontic treatment of the transitional dentition
D8070	Comprehensive orthodontic treatment of the transitional dentition
D8080	Comprehensive orthodontic treatment of the adolescent dentition
D8091	Comprehensive orthodontic treatment with orthognathic surgery
D8210	Removable appliance therapy
D8220	Fixed appliance therapy
D8660	Pre-orthodontic examination to monitor growth and development
D8670	Periodic orthodontic treatment visit *
D8671	Periodic orthodontic treatment with orthognathic surgery
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s)
D8999	Unspecified orthodontic procedure, by report

* These services are typically reimbursed as part of the global services

RELATED POLICIES
Not applicable

PUBLISHED
Provider Update, January 2020
Provider Update, January 2018
Provider Update. August 2017
Provider Update, October 2016
Provider Update. December 2015
Provider Update, November 2013

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http://ebn.benefitnews.com/news/hhs-defines-essential-health-benefits-ppaca-2729494-1.html