

**HCR
BlueDental
Choice
CDT Guide**

2026



**Florida Combined Life Dental Procedure Guidelines
And Claim Submission Requirements**



**Florida
Combined Life**
An Independent Licensee of the
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ABOUT THIS GUIDE

This guide is organized according to the latest and most current edition of the American Dental Association (ADA) Current Dental Terminology (CDT) procedure codes. We accept only coding that is consistent with the verbal descriptors of CDT. However, the presence of a code in the CDT does not mean that a subscriber has coverage available. We determine member benefits on the basis of our administrative policies and the terms of the subscriber's certificate. As always, we remind you to check benefits and eligibility before performing services.

Some of the categories of service have introductory sections to explain what information you need to provide to facilitate our claim processing. For a more complete description of procedures, please refer to the *American Dental Association, Current Dental Terminology 2026*.

We've designed these administrative guidelines and policies to promote our members' long-term oral health. We review our policies on an ongoing basis to determine clinical appropriateness and to reflect significant technical advances.

For each code, we have provided specific guidelines and recommendations with respect to time, age, or other contractual limitations or exclusions. We have also noted when procedures are not covered benefits. We also indicate procedure codes that require radiographic (X-ray) imaging documentation and other supplementary documentation. Please use this guide to determine the correct code to describe the service you provided to your patient. We hope that making our policies and guidelines clear and easily available will enable your office to receive the appropriate compensation for the services provided to our members, your patients.

If you need additional information on how to submit a claim, you can:

- ✓ Refer to the Dental Administrative Manual
- ✓ Go to [Plans and documents | Florida Blue Dental](#) to access administrative information
- ✓ Call the Dental Information Center at 1-866-445-5148

UTILIZATION MANAGEMENT

While we continue to conduct utilization review on submitted claims, we will no longer routinely require submission of radiographs or periodontal charting from participating Florida Combined Life PPO/EPO providers. Please refer to the *Submission Requirements* column for any specific requirements needed when submitting claims for treatment.

What is “Necessary and Appropriate Treatment?”

Our members’ certificates of coverage specify that all dental care must be “necessary and appropriate to diagnose or treat a dental condition”; and defines dental care as inclusive of services, procedures, supplies, and appliances.” In addition, the certificates identify the criteria used to determine the necessity and appropriateness of the member’s dental care as follows:

- ✓ Consistent with the prevention and treatment of oral disease or with the diagnosis and treatment of teeth that are decayed or fractured, or where the supporting structure is weakened by disease (including periodontal, endodontic, and related diseases).
- ✓ Furnished in accordance with standards of good dental practice.
- ✓ Not solely for the member’s or dentist’s convenience.

How Do We Determine Necessity and Appropriateness of Treatment?

Based on a review of the submitted documentation, our dental consultants determine available benefits for certain types of procedures, including, but not limited to, cast restorations, periodontal services, oral surgery services, implants, orthodontics and fixed and removable prosthetics. A dental consultant reviews the treatment plan objectively and determines whether the services are within the scope of benefits, and whether these services appear to be necessary and appropriate for the member. Based on these findings, we may determine that a service is not *necessary and appropriate* for the member, even if a dentist has recommended, approved, prescribed, ordered, or furnished the service.

Services That Are Non-covered Due to Contractual Limitations

There are situations in which specific services are not covered regardless of whether the procedure is a covered benefit. These are considered contractual limitations and are outlined in the Subscriber Certificate under “Limitations and Exclusions.” Examples include a service performed for cosmetic purposes rather than for tooth decay or fracture; or a service that is exploratory in nature.

Information We Need to Review a Procedure

To thoroughly review a procedure, we may need pertinent documentation supporting your patient's treatment. This *Guide* identifies the information you must submit for any procedure that requires review. In cases where we request a detailed narrative, please supply details about the patient's condition that will help us evaluate your claim and reimburse you appropriately.

When Documentation Is Requested

As previously stated while we continue to conduct utilization review on submitted claims, we no longer routinely require submission of radiographs or periodontal charting from participating Florida Combined Life providers however, we may request them from time to time. You will be contacted should we require them to review a particular case. Please refer to the *Submission Requirements* column for any specific requirements needed when submitting claims for treatment.

When we do request documentation, please remember that radiographs must be:

- ✓ Preoperative radiographic images that are current and dated
- ✓ Labeled "left" or "right" side if they are duplicates
- ✓ Mounted if they are a full series
- ✓ Of diagnostic quality

Please remember to include:

- ✓ The member's name and ID
- ✓ The dentist's name and address

Refer to the specific code listing to determine what additional documentation is required.

		HCR Pediatric Plan BlueDental Choice Q and QF ages 0 through 19		HCR Adult Plan BlueDental Choice QF ages 19+		All HCR Plans
CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
CDT D0100 - D0999 DIAGNOSTIC SERVICES - The codes in this section recognize the cognitive skills necessary for patient evaluation. The collection and recording of some data and components of the dental examination may be delegated; however, the evaluation, which includes diagnosis and treatment planning, is the responsibility of the dentist. As with all ADA procedure codes, there is no distinction made between the evaluations provided by general practitioners and specialists. Report additional diagnostic and/or definitive procedures separately.						
D0120	Periodic oral evaluation - established patient evaluation, update dental and medical health status, oral cancer evaluation, periodontal screening where indicated, and interpretation of information acquired through additional diagnostic procedures. The findings are discussed with the patient	Two per benefit period (any combination with D0140, D0180)	None	Two per benefit period	None	None
D0140	Limited oral evaluation: problem- focused	Two per benefit period (any combination with D0120, D0150, D0180)	None	Two per benefit period	None	Limited to a specific oral health problem or complaint
D0145	Oral evaluation for a patient under 3 years of age and counseling with primary caregiver	Not a covered procedure	None	Not a covered procedure	None	None
D0150	Comprehensive oral evaluation, new or established patient	Two per benefit period (any combination with D0120, D0140, D0180)	None	One per lifetime per provider	None	The exam is a thorough evaluation and recording of the extraoral hard and soft tissues. Includes an evaluation for oral cancer, evaluation and recording of dental and medical history a general health assessment, evaluation and recording of dental caries, missing or un-erupted teeth, restorations, existing prostheses, occlusal relationships, periodontal conditions (including periodontal screening and/or charting), hard and soft tissue anomalies, etc.

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CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D0160	Detailed, extensive oral evaluation- problem focused, by report	By report	None	Two per benefit period	None	Includes focused evaluation, extensive diagnostic and cognitive modalities based on the findings of a comprehensive oral evaluation
D0170	Re-evaluation: limited, problem focused (established patient, not post-operative visit)	Not a covered procedure	None	Two per benefit period	None	None
D0171	Re-evaluation – post – operative office visit	Not a covered procedure	None	Not a covered procedure	None	None
D0180	Comprehensive periodontal evaluation: new or established patient A comprehensive evaluation of periodontal conditions, including full mouth probing and periodontal charting. Indicated for patients exhibiting signs or symptoms of periodontal disease, systemic medical conditions, or patients with social risk factors. It includes an evaluation for oral cancer, an evaluation of the patient's medical history, a general wellness assessment, and includes an evaluation of current dental conditions.	Two per benefit period (any combination with D0120, D0140, D0150)	None	Two per benefit period	None	Includes evaluation of periodontal conditions, probing and charting, the evaluation of oral cancer and evaluation and recording of dental and medical history and general health assessment, the evaluation and recording of dental caries, missing or un-erupted teeth, restorations and occlusal relationships
PRE-DIAGNOSTIC SERVICES						
D0190	Screening of a patient	Not a covered procedure	None	Not a covered procedure	None	A screening, including state or federally mandated screenings, to determine an individual's need to be seen by a dentist for diagnosis
D0191	Assessment of a patient	Not a covered procedure	None	Not a covered procedure	None	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

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NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage. Not all Benefit plans include Enhanced benefits.

		<u>HCR Pediatric Plan</u> <u>BlueDental Choice Q and QF</u> <i>ages 0 through 19</i>		<u>HCR Adult Plan</u> <u>BlueDental Choice QF</u> <i>ages 19+</i>		<u>All HCR Plans</u>
CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines/ Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
DIAGNOSTIC IMAGING - Should be taken only for clinical reasons as determined by the patient's dentist. Should be of diagnostic quality and properly identified and dated. Is a part of the patient's clinical record and the original images should be retained by the dentist. Originals should not be used to fulfill requests made by patients or third parties for copies of records						
IMAGE CAPTURE WITH INTERPRETATION						
D0210	Intraoral - comprehensive series of radiographic images	One (1) every sixty (60) months	None	One (1) every thirty-six (36) months	None	Coverage is based on last service date. Not covered if performed on same day as Panoramic x-ray image.
D0220	Intraoral - periapical first radiographic image	None	None	As Needed	None	Periapical films, for diagnostic purposes, covered subject to clinical necessity. Intra-operative "working" radiographs are included with complete root canal therapy
D0230	Intraoral - periapical – each additional radiographic image	None	None	As Needed	None	Periapical films, for diagnostic purposes, covered subject to clinical necessity. Intra-operative "working" radiographs are included with complete root canal therapy
D0240	Intraoral - occlusal radiographic image	None	None	Not a covered procedure	None	Not payable as a substitute for children's complete series of intraoral radiographs
D0250	Extra oral - 2D projection radiographic image created using a stationary radiation source and detector	Not a covered procedure	None	Not a covered procedure	None	None

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CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D0251	Extra-oral posterior dental radiographic image	Not a covered procedure	None	Not a covered procedure	None	None
D0270	Bitewing – single radiographic image	One (1) set every six (6) months	None	One (1) per benefit period	None	Plan benefits include an annual set of bitewings per benefit period. Any of these codes constitute a set of bitewings
D0272	Bitewings – two (2) radiographic images	One (1) set every six (6) months	None	One (1) per benefit period	None	
D0273	Bitewings – three (3) radiographic images	Not a covered procedure	None	One (1) per benefit period	None	
D0274	Bitewings – four (4) radiographic images	One (1) set every six (6) months	None	One (1) per benefit period	None	
D0277	Vertical bitewings – seven (7) to eight (8) radiographic images	One (1) set every six (6) months	None	One (1) per benefit period	None	
D0310	Sialography	Not a covered procedure	None	Not a covered procedure	None	None
D0320	Temporomandibular joint arthrogram, including injection	Not a covered procedure	None	Not a covered procedure	None	None
D0321	Other temporomandibular joint radiographic images by report	Not a covered procedure	None	Not a covered procedure	None	None
D0322	Tomographic survey	Not a covered procedure	None	Not a covered procedure	None	None
D0310	Sialography	Not a covered procedure	None	Not a covered procedure	None	None

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CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D0320	Temporomandibular joint arthrogram, including injection	Not a covered procedure	None	Not a covered procedure	None	None
D0321	Other temporomandibular joint radiographic images by report	Not a covered procedure	None	Not a covered procedure	None	None
D0322	Tomographic survey	Not a covered procedure	None	Not a covered procedure	None	None
D0330	Panoramic radiographic image	One (1) every sixty (60) months	None	One (1) every sixty (60) months	None	Panoramic imaging is allowable in place of a complete series (D0210) based on the last service date, with the frequency depending upon the terms of the dental plan. Allowance for a complete series one (1) in a thirty-six (36) month benefit period. Additional panoramic film may be allowed for oral surgeons.
D0340	2D Cephalometric radiographic image – acquisition, measurement and analysis	Covered for ortho and non-ortho patients	None	Not a covered procedure	None	None
D0350	2D Oral/facial photographic image obtained intraorally or extra orally	Covered for ortho and non-ortho patients	None	Not a covered procedure	None	None
D0364	Cone beam CT capture and interpretation with limited field of view – less than one whole jaw	Not a covered procedure	None	Not a covered procedure	None	None
D0365	Cone beam CT capture and interpretation with field of view of one full dental arch – mandible	Not a covered procedure	None	Not a covered procedure	None	None
D0366	Cone beam CT capture and interpretation with field of view of one full dental arch – maxilla, with or without cranium	Not a covered procedure	None	Not a covered procedure	None	None

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CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D0367	Cone beam CT capture and interpretation with field of view of both jaws, with or without cranium	Not a covered procedure	None	Not a covered procedure	None	None
D0368	Cone beam CT capture and interpretation for TMJ series including two or more exposures	Not a covered procedure	None	Not a covered procedure	None	None
D0369	Maxillofacial MRI capture and interpretation	Not a covered procedure	None	Not a covered procedure	None	None
D0370	Maxillofacial ultrasounds capture and interpretation	Not a covered procedure	None	Not a covered procedure	None	None
D0371	Sialoendoscopy capture and interpretation	Not a covered procedure	None	Not a covered procedure	None	None
D0372	Intraoral tomosynthesis - comprehensive series of radiographic images	Alternate Benefit (L.E.A.T.) D0210	None	Not a covered procedure	None	None
D0373	Intraoral tomosynthesis – bitewing radiographic image	Cover as L.E.A.T. benefit for D0270 BWXR	None	Not a covered procedure	None	None
D0374	Intraoral tomosynthesis – periapical radiographic image	Cover as L.E.A.T. benefit for D0220 PAXR	None	Not a covered procedure	None	None
IMAGE CAPTURE ONLY – Capture by a practitioner not associated with Interpretation and Report.						
D0380	Cone beam CT image capture with limited field of view – less than one whole jaw	Not a covered procedure	None	Not a covered procedure	None	None
D0381	Cone beam CT image capture with field of view of one full dental arch – mandible	Not a covered procedure	None	Not a covered procedure	None	None

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CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D0381	Cone beam CT image capture with field of view of one full dental arch – mandible	Not a covered procedure	None	Not a covered procedure	None	None
D0382	Cone beam CT image capture with field of view of one full dental arch – maxilla, with or without cranium	Not a covered procedure	None	Not a covered procedure	None	None
D0383	Cone beam CT image capture with field of view of both jaws, with or without cranium	Not a covered procedure	None	Not a covered procedure	None	None
D0384	Cone beam CT image capture for TMJ series including two or more exposures	Not a covered procedure	None	Not a covered procedure	None	None
D0385	Maxillofacial MRI image capture	Not a covered procedure	None	Not a covered procedure	None	None
D0386	Maxillofacial ultrasound image capture	Not a covered procedure	None	Not a covered procedure	None	None
D0387	Intraoral tomosynthesis – comprehensive series of radiographic images – image capture only	Not a covered procedure	None	Not a covered procedure	None	None
D0388	Intraoral tomosynthesis – bitewing radiographic image – image capture only	Not a covered procedure	None	Not a covered procedure	None	None
D0389	Intraoral tomosynthesis – periapical radiographic image – image capture only	Not a covered procedure	None	Not a covered procedure	None	None
<i>INTERPRETATION AND REPORT ONLY – Interpretation and Report by a Practitioner not associated with Image Capture.</i>						
D0391	Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report	No limitations	None	Not a covered procedure	None	None

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CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
POST PROCESSING OF IMAGE OR IMAGE SETS						
D0393	Virtual treatment simulation using 3D image volume or surface scan	Not a covered procedure	None	Not a covered procedure	None	None
D0394	Digital subtraction of two or more images or image volumes of the same modality	Not a covered procedure	None	Not a covered procedure	None	None
D0395	Fusion of two or more 3D image volumes of one or more modalities	Not a covered procedure	None	Not a covered procedure	None	None
D0396	3D printing of a 3D dental surface scan	Not a covered procedure	None	Not a covered procedure	None	None
TESTS AND EXAMINATIONS						
D0411	Hb A1c in-office point of service testing	Not a covered procedure	None	Not a covered procedure	None	None
D0412	Blood glucose level test- in-office using a glucose meter	Not a covered procedure	None	Not a covered procedure	None	None
D0414	Laboratory processing of microbial specimen to include culture and sensitivity studies, preparation and transmission of written report	Not a covered procedure	None	Not a covered procedure	None	None
D0415	Collection of microorganisms	Not a covered procedure	None	Not a covered procedure	None	None
D0416	Viral Culture	Not a covered procedure	None	Not a covered procedure	None	None

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CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D0417	Collection and preparation of saliva sample for laboratory analysis	Not a covered procedure	None	Not a covered procedure	None	None
D0418	Analysis of saliva sample - laboratory	Not a covered procedure	None	Not a covered procedure	None	None
D0419	Assessment of salivary flow by measurement	Not a covered procedure	None	Not a covered procedure	None	None
D0422	Collection and preparation of genetic sample material for laboratory analysis and report	Not a covered procedure	None	Not a covered procedure	None	None
D0423	Genetic test for susceptibility to diseases – specimen analysis	Not a covered procedure	None	Not a covered procedure	None	None
D0425	Caries susceptibility tests	Not a covered procedure	None	Not a covered procedure	None	None
D0426	Collection, preparation, and analysis of saliva sample – point-of-care	Not a covered procedure	Yes	Not a covered procedure	Yes	None
Requires new suspension message and criteria; Please Coordinate with Clinical; Clinical to recommend criteria for diagnostic materials						
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions; does not include cytology or biopsy procedures	Not a covered procedure *Note: If a member has oral cancer or Sjogren's® Syndrome and is enrolled in Oral Health for Overall Health, D0431 is covered once every six months.	None	Not a covered procedure *Note: If a member has oral cancer or Sjogren's® Syndrome and is enrolled in Oral Health for Overall Health, D0431 is covered once every six months.	None	None
D0460	Pulp vitality tests	Not a covered procedure	None	Not a covered procedure	None	None
D0461	Testing for cracked tooth	Integral	None	Integral	None	Yes
D0470	Diagnostic casts	Covered for ortho and non-ortho casts	None	As Needed	None	None

CDT Code	Description of Service	<u>HCR Pediatric Plan</u> <u>BlueDental Choice Q and QF</u> <i>ages 0 through 19</i>		<u>HCR Adult Plan</u> <u>BlueDental Choice QF</u> <i>ages 19+</i>		<u>All HCR Plans</u>
		Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D0472	Accession of tissue, gross examination, preparation and transmission of written report	Not a covered procedure	None	Not a covered procedure	None	None
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	Not a covered procedure	None	Not a covered procedure	None	None
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	Not a covered procedure	None	Not a covered procedure	None	None
D0475	Decalcification procedure	Not a covered procedure	None	Not a covered procedure	None	None
D0476	Special stains for microorganisms	Not a covered procedure	None	Not a covered procedure	None	None
D0477	Special stains, not for microorganisms	Not a covered procedure	None	Not a covered procedure	None	None
D0478	Immunohistochemical stains	Not a covered procedure	None	Not a covered procedure	None	None
D0479	Tissue in-situ hybridization, including interpretation	Not a covered procedure	None	Not a covered procedure	None	None
D0480	Accession of exfoliative cytologic smears, microscopic examination, preparation and transmission of written report	Not a covered procedure	None	Not a covered procedure	None	None
D0481	Electron microscopy	Not a covered procedure	None	Not a covered procedure	None	None
D0482	Direct immunofluorescence	Not a covered procedure	None	Not a covered procedure	None	None
D0483	Indirect immunofluorescence	Not a covered procedure	None	Not a covered procedure	None	None

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CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D0484	Consultation on slides prepared elsewhere	Not a covered procedure	None	Not a covered procedure	None	None
D0485	Consultation, including preparation of slides from biopsy material supplied by referring source	Not a covered procedure	None	Not a covered procedure	None	None
D0486	Laboratory accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report	Not a covered procedure	None	Not a covered procedure	None	None
D0502	Other oral pathology procedures, by report	Not a covered procedure	None	Not a covered procedure	None	None
D0600	Non-ionizing diagnostic procedure capable of quantifying, monitoring and recording changes in the structure of enamel, dentin and cementum	Not a covered procedure	None	Not a covered procedure	None	None
D0601	Carries risk assessment and documentation, with a finding of low risk	Not a covered procedure	None	Not a covered procedure	None	None
D0602	Carries risk assessment and documentation, with a finding of moderate risk	Not a covered procedure	None	Not a covered procedure	None	None
D0603	Carries risk assessment and documentation, with a finding of high risk	Not a covered procedure	None	Not a covered procedure	None	None
D0604	Antigen testing for a public health related pathogen including coronavirus	Not a covered procedure	None	Not a covered procedure	None	None

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CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D0605	Antibody testing for a public health related pathogen, including coronavirus	Not a covered Procedure	None	Not a covered procedure	None	None
D0701	Panoramic radiographic image – image capture only	Not a covered procedure	None	Not a covered procedure	None	None
D0702	2-D cephalometric radiographic image – image capture only	Not a covered procedure	None	Not a covered procedure	None	None
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally – image capture only	Not a covered procedure	None	Not a covered procedure	None	None
D0705	Extra-oral posterior dental radiographic image – capture only	Not a covered procedure	None	Not a covered procedure	None	None
D0706	Intraoral – occlusal radiographic image, image capture only	Not a covered procedure	None	Not a covered procedure	None	None
D0707	Intraoral – periapical radiographic image, image capture only	Not a covered procedure	None	Not a covered procedure	None	None
D0708	Intraoral – bitewing radiographic image, image capture only	Not a covered Procedure	None	Not a covered procedure	None	None
D0709	Intraoral – comprehensive series of radiographic images – capture only	Not a covered procedure	None	Not a covered procedure	None	None
D0801	3D dental surface scan – direct	Not a covered Procedure	None	Not a covered Procedure	None	None
D0802	3D dental surface scan – indirect	Not a covered Procedure	None	Not a covered Procedure	None	None
D0803	3D facial surface scan – direct	Not a covered Procedure	None	Not a covered Procedure	None	None
D0804	3D facial surface scan – indirect	Not a covered Procedure	None	Not a covered Procedure	None	None
D0999	Unspecified diagnostic procedure, by report	Not a covered procedure	None	Not a covered procedure	None	None

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CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
DENTAL PROPHYLAXIS						
D1110	Prophylaxis adult	Two per benefit period *Note: If a member is enrolled in Oral Health for Overall Health, D1110, D1120 or D4346 or D4910 is covered once every three months	None	Two per benefit period includes periodontal maintenance. *Note: If a member is enrolled in Oral Health for Overall Health, D1110 / D1120 or D4346 or D4910 is covered once every three months	None	Removal of plaque, calculus and stains from the tooth structures and implants in the permanent and transitional dentitions
D1120	Prophylaxis child	Two per benefit period Any combo with D0140, D0180, D0150 *Note: If a member is enrolled in Oral Health for Overall Health, D1110, D1120 or D4346 or D4910 is covered once every three months.	None	Not a covered procedure	None	Removal of plaque, calculus and stains from the tooth structures and implants in the primary and transitional dentition
TOPICAL FLUORIDE TREATMENT OFFICE PROCEDURE						
D1206	Topical application of fluoride varnish	Two (2) per benefit period Oral Health *Note: If a member has oral cancer or Sjogrens® Syndrome and is enrolled in Oral Health for Overall Health, D1206 or D1208 is covered once every three months	None	Not a covered procedure *Note: If a member has oral cancer or Sjogrens® Syndrome and is enrolled in Oral Health for Overall Health, D1206 or D1208 is covered once every three months	None	Fluoride must be applied separately from prophylaxis paste
D1208	Topical application of fluoride – excluding varnish	Two (2) per benefit period *Note: If a member has oral cancer or Sjogrens® Syndrome and is enrolled in Oral Health for Overall Health, D1206 or D1208 is covered once every three months	None	Not a covered procedure *Note: If a member has oral cancer or Sjogrens® Syndrome and is enrolled in Oral Health for Overall Health, D1206 or D1208 is covered once every three months	None	Fluoride must be applied separately from prophylaxis paste

		<u>HCR Pediatric Plan</u> <u>BlueDental Choice Q and QF</u> <i>ages 0 through 19</i>		<u>HCR Adult Plan</u> <u>BlueDental Choice QF</u> <i>ages 19+</i>		<u>All HCR PLANS</u>
CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
OTHER PREVENTIVE SERVICES						
D1301	Immunization counseling	Not a covered procedure	None	Not a covered procedure	None	None
D1310	Nutritional counseling for control of dental disease	Not a covered procedure	None	Not a covered procedure	None	None
D1320	Tobacco counseling for control and prevention of oral disease	Not a covered procedure	None	Not a covered procedure	None	None
D1321	Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance abuse	Not a covered procedure	None	Not a covered procedure	None	None
D1330	Oral hygiene instructions	Not a covered procedure	None	Not a covered procedure	None	None
OTHER PREVENTIVE SERVICES						
D1351	Sealant – per tooth	One (1) per permanent tooth every thirty-six (36) months underage 19	Tooth Number	Not a covered procedure	None	None
D1353	Sealant repair – per tooth	Not a covered procedure	Tooth number and date of initial placement	Not a covered procedure	None	If sealant fails within twelve (12) months of initial placement procedure will deny as provider liability. If sealant fails after twelve (12) months of initial placement procedure will deny as member liability.
D1354	Application of caries arresting medicament –per tooth. Conservative treatment of an active, non- symptomatic carious lesion by topical application of a caries arresting or inhibiting medicament and without mechanical removal of sound tooth structure.	Two (2) applications per tooth per year for members – No age limit.	None	Two (2) applications per tooth per year for members – No age limit.	None	Two (2) per tooth per calendar year. Excludes 3rd molars.

		<u>HCR Pediatric Plan BlueDental Choice Q and QF</u> <i>ages 0 through 19</i>		<u>HCR Adult Plan BlueDental Choice QF</u> <i>ages 19+</i>		<u>All HCR PLANS</u>
CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D1355	Caries preventive medicament application per tooth	Not a covered procedure	None	Not a covered procedure	None	None
SPACE MAINTENANCE (PASSIVE APPLIANCES): Designed to prevent tooth movement						
D1510	Space maintainer – fixed, unilateral	Limited to children under age nineteen (19)	Quadrant Identification	Not a covered procedure	None	None
D1516	Space maintainer – fixed, bilateral, maxillary	Limited to children under age nineteen (19)	Quadrant Identification	Not a covered procedure	None	None
D1517	Space maintainer – fixed, bilateral, mandibular	Limited to children under age nineteen (19)	Quadrant Identification	Not a covered procedure	None	None
D1520	Space maintainer – removable, unilateral	Limited to children under age nineteen (19)	Quadrant Identification	Not a covered procedure	None	None
D1526	Space maintainer – removable, bilateral, maxillary	Limited to children under age nineteen (19)	Quadrant Identification	Not a covered procedure	None	None
D1527	Space maintainer – removable, bilateral, mandibular	Limited to children under age nineteen (19)	Quadrant Identification	Not a covered procedure	None	None
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	Limited to children under age nineteen (19)	Quadrant Identification	Not a covered procedure	None	None
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	Limited to children under age nineteen (19)	Quadrant Identification	Not a covered procedure	None	None
D1553	Re-cement or re-bond unilateral space maintainer – per quadrant	Limited to children under age nineteen (19)	Quadrant Identification	Not a covered procedure	None	None

		<u>HCR Pediatric Plan</u> <u>BlueDental Choice Q and QF</u> <i>ages 0 through 19</i>		<u>HCR Adult Plan</u> <u>BlueDental Choice QF</u> <i>ages 19+</i>		<u>ALL HCR PLANS</u>
CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
SPACE MAINTENANCE (PASSIVE APPLIANCES): Designed to prevent tooth movement						
D1556	Removal of fixed unilateral space maintainer – per quadrant	Not a covered procedure	None	Not a covered procedure	None	None
D1557	Removal of fixed bilateral space maintainer – maxillary	Not a covered procedure	None	Not a covered procedure	None	None
D1558	Removal of fixed bilateral space maintainer – mandibular	Not a covered procedure	None	Not a covered procedure	None	None
D1575	Distal shoe space maintainer-fixed-unilateral	Not a covered procedure	None	Not a covered procedure	None	None
D1708	Pfizer-BioNTech Covid- 19 vaccine administration – third dose	Not a covered procedure	None	Not a covered procedure	None	None
D1709	Pfizer-BioNTech Covid- 19 vaccine administration – booster dose	Not a covered procedure	None	Not a covered procedure	None	None
D1710	Moderna Covid-19 vaccine administration – third dose	Not a covered procedure	None	Not a covered procedure	None	None
D1711	Moderna Covid-19 vaccine administration – booster dose	Not a covered procedure	None	Not a covered procedure	None	None
D1713	Pfizer-BioNTech Covid-19 vaccine administration tris-sucrose pediatric – first dose	Not a covered procedure	None	Not a covered procedure	None	None

		<u>HCR Pediatric Plan</u> <u>BlueDental Choice Q and QF</u> <i>ages 0 through 19</i>		<u>HCR Adult Plan</u> <u>BlueDental Choice QF</u> <i>ages 19+</i>		<u>All HCR PLANS</u>
CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D1714	Pfizer-BioNTech Covid-19 vaccine administration tris-sucrose pediatric – second dose	Not a covered procedure	None	Not a covered procedure	None	None
D1720	Influenza vaccine administration	Covered – will be added to the fee schedules - allowance once per plan / Calendar Year	None	Covered – will be added to the fee schedules - allowance once per plan / Calendar Year	None	None
D1781	Vaccine administration – human papillomavirus – Dose 1	Not a covered procedure	None	Not a covered procedure	None	None
D1782	Vaccine administration – human papillomavirus – Dose 1	Not a covered procedure	None	Not a covered procedure	None	None
D1783	Vaccine administration – human papillomavirus – Dose 1	Not a covered procedure	None	Not a covered procedure	None	None
D1999	Unspecified preventive procedure by report	Not a covered procedure	None	Not a covered procedure	None	None
AMALGAM RESTORATIONS (INCLUDING POLISHING): Amalgam restorations include tooth preparation, localized tissue removal, base, indirect pulp cap, local anesthesia and all adhesives (including amalgam bonding agents, liners, and bases) included as part of the restoration. If used, pins should be reported separately (see D2951). Restorations only allowed for fracture or decay. Restorations for erosion, attrition, or abrasion are not covered benefits.						
D2140	Amalgam – one surface, primary or permanent	None	Tooth number and surface(s)	One (1) per tooth surface per tooth per twelve (12) months	Tooth number and surface(s)	None
D2150	Amalgam – two surfaces, primary or permanent	None	Tooth number and surface(s)	One (1) per tooth surface per tooth per twelve (12) months	Tooth number and surface(s)	None
D2160	Amalgam – three surfaces, primary or permanent	None	Tooth number and surface(s)	One (1) per tooth surface per tooth per twelve (12) months	Tooth number and surface(s)	None
D2161	Amalgam – four or more surfaces, primary or permanent	None	Tooth number and surface(s)	One (1) per tooth surface per tooth per twelve (12) months	Tooth number and surface(s)	None

		<u>HCR Pediatric Plan</u> <u>BlueDental Choice Q and QF</u> <i>ages 0 through 19</i>		<u>HCR Adult Plan</u> <u>BlueDental Choice QF</u> <i>ages 19+</i>		<u>All HCR PLANS</u>
CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
RESIN-BASED COMPOSITE RESTORATIONS: Resin based composite refers to a broad category of materials including, but not limited to, composites. May include bonded composite, light-cured composite, etc. Light curing, acid-etching, and adhesives (including resin bonding agents) are included as part of the restoration. Resin restorations include tooth preparation, localized tissue removal, base, indirect pulp cap and local anesthesia. Glass ionomers, when used as restorations, should be reported with these codes. If pins are used, please report them separately (see D2951). Restorations are only allowed for fracture or decay. Restorations for erosion, attrition, or abrasion are not covered benefits.						
D2330	Resin-based composite, one surface, anterior	None	Tooth number and surface(s)	One (1) per tooth surface per tooth per twelve (12) months	Tooth number and surface(s)	None
D2331	Resin-based composite, two surfaces, anterior	None	Tooth number and surface(s)	One (1) per tooth surface per tooth per twelve (12) months	Tooth number and surface(s)	None
D2332	Resin-based composite, three surfaces, anterior	None	Tooth number and surface(s)	One (1) per tooth surface per tooth per twelve (12) months	Tooth number and surface(s)	None
D2335	Resin-based composite, four or more surfaces or involving incisal angle, anterior	None	None	One (1) per tooth surface per twelve (12) months	Tooth number and surface(s)	None
D2390	Resin-based composite crown, anterior	Not a covered procedure	None	Not a covered procedure	None	None
D2391	Resin-based composite, one surface, posterior	Alternate benefit paid as D2140	None	One (1) per tooth surface per tooth per twelve (12) months	Tooth number and surface(s)	None
D2392	Resin-based composite, two surfaces, posterior	Alternate benefit paid as D2150	None	One (1) per tooth surface per tooth per twelve (12) months	Tooth number and surface(s)	None
D2393	Resin-based composite, three surface, posterior	Alternate benefit paid as D2160	None	One (1) per tooth surface per tooth per twelve (12) months	Tooth number and surface(s)	None
D2394	Resin-based composite, four or more surfaces, posterior	Alternate benefit paid as D2161	None	One (1) per tooth surface per tooth per twelve (12) months	Tooth number and surface(s)	None

		HCR Pediatric Plan BlueDental Choice Q and QF <i>ages 0 through 19</i>		HCR Adult Plan BlueDental Choice QF <i>ages 19+</i>		All HCR PLANS
CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
GOLD FOIL RESTORATIONS						
D2410	Gold foil, one surface	Not a covered procedure	None	Not a covered procedure	None	Not a covered procedure
D2420	Gold foil, two surfaces	Not a covered procedure	None	Not a covered procedure	None	Not a covered procedure
D2430	Gold foil, three surfaces	Not a covered procedure	None	Not a covered procedure	None	Not a covered procedure
INLAY/ONLAY RESTORATIONS						
When services are covered:						
<ul style="list-style-type: none"> To restore fractured or severely diseased teeth that cannot properly be restored by direct amalgam or resin restorations. Teeth must be endodontically and periodontally sound. Onlays are defined as needing buccal and or lingual cusp reduction and coverage. 						
When services are not covered:						
<ul style="list-style-type: none"> Cosmetic purposes or to restore or treat complications of non-covered procedures. To treat TMJ dysfunction. Increase vertical dimension. Restore occlusion lost through erosion, abrasion, or attrition. Correction of congenital or developmental abnormalities. 						
Benefit criteria and limitations:						
<ul style="list-style-type: none"> Restoration is covered only once every sixty (60) months. Members fifteen (15) years or older Permanent teeth only. Service or completion date is the cementation date. Service includes preparation of teeth, indirect pulp caps, bases, liners, laboratory costs, temporary crowns/bridges, cementation and local anesthesia. If an alternate benefit is paid, the member is responsible for the difference between The Plan allowance and provider's billed charge. Gingivectomy performed in conjunction with an inlay/onlay is considered a part of the procedure and cannot be billed separately. 						

		HCR Pediatric Plan BlueDental Choice Q and QF ages 0 through 19		HCR Adult Plan BlueDental Choice QF ages 19+		All HCR PLANS
CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D2510	Inlay – metallic, one surfaces	One (1) per tooth per sixty (60) months	Tooth number and surface(s)	One (1) per tooth per sixty (60) months	Tooth number and surface(s)	None
D2520	Inlay – metallic, two surfaces	No Limits Alt Benefit D2140	Tooth number and surface(s)	One (1) per tooth per sixty (60) months	Tooth number and surface(s)	None
D2530	Inlay – metallic, three or more surfaces	No Limits Alt Benefit D2150	Tooth number and surface(s)	One (1) per tooth per sixty (60) months	Tooth number and surface(s)	None
D2542	Onlay – metallic, two surfaces	No Limits Alt Benefit D2150	Tooth number and surface(s)	One (1) per tooth per sixty (60) months	Tooth number and surface(s)	None
D2543	Onlay – metallic, three surfaces	One (1) per tooth per sixty (60) months	Tooth number and surface(s)	One (1) per tooth per sixty (60) months. Not payable in conjunction with D2510, D2520, D2530	Tooth number and surface(s)	None
D2544	Onlay – metallic, four or more surfaces	One (1) per tooth per sixty (60) months	Tooth number and surface(s)	One (1) per tooth per sixty (60) months. Not payable in conjunction with D2510, D2520, D2530	Tooth number and surface(s)	None
D2610	Inlay – porcelain/ceramic, one surface	Not a covered procedure	None	One (1) per tooth per sixty (60) months	None	None
D2620	Inlay – porcelain/ceramic, two surfaces	Not a covered procedure	None	One (1) per tooth per sixty (60) months	Tooth number and surface(s)	None
D2630	Inlay – porcelain/ceramic, three or more surfaces	Not a covered procedure	None	One (1) per tooth per sixty (60) months	Tooth number and surface(s)	None
D2642	Onlay – porcelain/ceramic, two surfaces	Not a covered procedure	None	One (1) per tooth per sixty (60) months	Tooth number and surface(s)	None

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		HCR Pediatric Plan BlueDental Choice Q and QF <i>ages 0 through 19</i>		HCR Adult Plan BlueDental Choice QF <i>ages 19+</i>		All HCR PLANS
CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D2643	Onlay – porcelain / ceramic, three surfaces	Not a covered procedure	None	One (1) per tooth per sixty (60) months	Tooth number and surface(s)	None
D2644	Onlay – porcelain / ceramic, four or more surfaces	Not a covered procedure	None	One (1) per tooth per sixty (60) months	Tooth number and surface(s)	None
D2650	Inlay – resin-based composite, one surface	Not a covered procedure	None	Not a covered procedure	None	None
D2651	Inlay – resin-based composite, two surfaces	Not a covered procedure	None	Not a covered procedure	None	None
D2652	Inlay – resin-based composite, three or more surfaces	Not a covered procedure	None	Not a covered procedure	None	None
D2662	Onlay – resin-based composite, two surfaces	Not a covered procedure	None	Not a covered procedure	None	None
D2663	Onlay – resin-based composite, three surfaces	Not a covered procedure	None	Not a covered procedure	None	None
D2664	Onlay – resin-based composite, four or more surfaces	Not a covered procedure	None	Not a covered procedure	None	None

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		HCR Pediatric Plan BlueDental Choice Q and QF <i>ages 0 through 19</i>		HCR Adult Plan BlueDental Choice QF <i>ages 19+</i>		All HCR PLANS
CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
CROWNS, SINGLE RESTORATIONS ONLY						
When services are covered:						
<ul style="list-style-type: none"> To restore fractured or severely diseased teeth which cannot properly be restored by direct amalgam or resin restorations. Teeth must be endodontically and periodontally sound. 						
When services are not covered:						
<ul style="list-style-type: none"> Cosmetic purposes or to restore or treat complications of non-covered procedures. To treat TMJ dysfunction. Increase vertical dimension. Restore occlusion lost through erosion, abrasion, or attrition. Correction of congenital or developmental abnormalities. 						
Benefit criteria and limitations:						
<ul style="list-style-type: none"> Restorations are covered only once every sixty (60) months. Members fifteen (15) years or older. Only Applies to Crown Codes D2710-2799 Permanent teeth only. Service or completion date is the cementation date. Service includes preparation of teeth, indirect pulp cap, bases, liners, laboratory costs, temporary crowns/bridges, cementation, and local anesthesia. Gingivectomy performed in conjunction with a crown preparation is considered a part of the procedure and cannot be billed separately. 						
D2710	Crown – resin-based composite (indirect)	Not a covered procedure	None	One (1) per tooth per sixty (60) months	Tooth number(s)	None
D2712	Crown - ¾ resin-based composite (indirect) does not include facial veneers	Not a covered procedure	None	One (1) per tooth per sixty (60) months	Tooth number(s)	None
D2720	Crown – resin with high-noble metal	Not a covered procedure	None	Not a covered procedure	None	None
D2721	Crown – resin with predominantly base metal	Not a covered procedure	None	Not a covered procedure	None	None

		HCR Pediatric Plan BlueDental Choice Q and QF <i>ages 0 through 19</i>		HCR Adult Plan BlueDental Choice QF <i>ages 19+</i>		All HCR PLANS
CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D2722	Crown – resin with noble metal	Not a covered procedure	None	Not a covered procedure	None	None
D2740	Crown – porcelain/ceramic	One (1) per tooth per sixty (60) months	Tooth number(s)	One (1) per tooth per sixty (60) months	Tooth number(s)	None
D2750	Crown – porcelain fused to high-noble metal	One (1) per tooth per sixty (60) months	Tooth number(s)	One (1) per tooth per sixty (60) months	Tooth number(s)	None
D2751	Crown – porcelain fused to predominantly base metal	One (1) per tooth per sixty (60) months	Tooth number(s)	One (1) per tooth per sixty (60) months	Tooth number(s)	None
D2752	Crown – porcelain fused to noble metal	One (1) per tooth per sixty (60) months	Tooth number(s)	One (1) per tooth per sixty (60) months	Tooth number(s)	None
D2753	Crown – porcelain fused to titanium and titanium alloys	Not a covered procedure	Tooth number(s)	One (1) per tooth per sixty (60) months	Tooth number(s)	None
D2780	Crown – ¾ cast high noble metal	One (1) per tooth per sixty (60) months	Tooth number(s)	Not a covered procedure	None	None
D2781	Crown – ¾ cast predominantly base metal	One (1) per tooth per sixty (60) months	Tooth number(s)	One (1) per tooth per sixty (60) months	None	None
D2782	Crown – ¾ cast noble metal	Not a covered procedure	None	Not a covered procedure	None	None
D2783	Crown – ¾ porcelain / ceramic (not veneers)	One (1) per tooth per sixty (60) months	Tooth number(s)	Not a covered procedure	None	None
D2790	Crown – full cast high- noble metal	One (1) per tooth per sixty (60) months	Tooth number(s)	One (1) per tooth per sixty (60) months	Tooth number(s)	None
D2791	Crown – full-cast predominantly base metal	One (1) per tooth per sixty (60) months	Tooth number(s)	One (1) per tooth per sixty (60) months	Tooth number(s)	None

		HCR Pediatric Plan BlueDental Choice Q and QF <i>ages 0 through 19</i>		HCR Adult Plan BlueDental Choice QF <i>ages 19+</i>		All HCR PLANS
CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D2792	Crown – full-cast noble metal	One (1) per tooth per sixty (60) months	Tooth number(s)	One (1) per tooth per sixty (60) months	Tooth number(s)	None
D2794	Crown – titanium	One (1) per tooth per sixty (60) months	Tooth number(s)	Not a covered procedure	None	None
D2799	Interim crown - further treatment or completion of diagnosis necessary prior to final impression. Not to be used as a temporary crown for a routine prosthetic restoration.	Not a covered procedure	None	Not a covered procedure	None	None
OTHER RESTORATIVE SERVICES						
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	None Veneers are not a covered benefit	Tooth number(s)	As Needed Veneers are not a covered benefit	Tooth number(s)	None
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	Not a covered procedure	None	Not a covered procedure	None	None
D2920	Re-cement or re-bond crown	None	Tooth number(s)	Payable six (6) months post insertion. Twelve (12) months wait between service and maximum two (2) per restoration per sixty (60) months	Tooth number(s)	None
D2921	Reattachment of tooth fragment, incisal edge or cusp	Not a covered procedure	None	Not a covered procedure	None	None

		HCR Pediatric Plan BlueDental Choice Q and QF ages 0 through 19		HCR Adult Plan BlueDental Choice QF ages 19+		All HCR PLANS
CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D2928	Prefabricated porcelain/ceramic crown – permanent tooth	Not a covered procedure	None	None	None	None
D2929	Prefabricated porcelain/ceramic crown- primary tooth	One (1) per tooth in sixty (60) months	Tooth number(s)	Not a covered procedure	None	None
D2930	Prefabricated stainless steel crown – primary tooth	One (1) per tooth in sixty (60) months; underage 15	Tooth number(s)	Not a covered procedure	Tooth number(s)	None
D2931	Prefabricated stainless steel crown – permanent tooth	One (1) per tooth in sixty (60) months, underage 15	Tooth number(s)	Not a covered procedure	None	None
D2932	Prefabricated resin crown	Not a covered procedure	None	Not a covered procedure	None	None
D2933	Prefabricated stainless steel crown with resin window	Not a covered procedure	None	Not a covered procedure	None	None
D2934	Prefabricated esthetic coated stainless steel crown – primary tooth	Not a covered procedure	None	Not a covered procedure	None	None
D2940	Protective restoration	None	Tooth number(s)	As Needed	Tooth number(s)	None
D2941	Interim therapeutic restoration – primary dentition	Not a covered procedure	None	Not a covered procedure	None	None
D2949	Restorative foundation for an indirect restoration	Not a covered procedure	None	Not a covered procedure	None	None
D2950	Core build-up, including any pins when required	One (1) per tooth per sixty (60) months	Tooth number(s)	One (1) per sixty (60) months	Tooth number(s)	None

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		<u>HCR Pediatric Plan</u> <u>BlueDental Choice Q and QF</u> <i>ages 0 through 19</i>		<u>HCR Adult Plan</u> <u>BlueDental Choice QF</u> <i>ages 19+</i>		<u>All HCR PLANS</u>
CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D2951	Pin retention – per tooth, in addition to restoration	One (1) per tooth. No frequency limitations	Tooth number(s)	Once per twelve (12) consecutive months	Tooth number(s)	None
D2952	Post and core in addition to crown; indirectly fabricated	Not a covered procedure	None	One (1) per tooth per sixty (60) months	Tooth number(s)	None
D2953	Each additional indirectly fabricated cast post – same tooth	Not a covered procedure	None	One (1) per tooth per sixty (60) months	Tooth number(s)	None
D2954	Prefabricated post and core in addition to crown	One (1) per tooth per sixty (60) months	Tooth number(s)	One (1) per tooth per sixty (60) months	Tooth number(s)	None
D2955	Post removal	Not a covered procedure	None	Not a covered procedure	None	None
D2957	Each additional prefabricated post – same tooth	Not a covered procedure	None	One (1) per tooth per sixty (60) months	None	None
D2960	Labial veneer (resin laminate) – Direct	Not a covered procedure	None	Not a covered procedure	None	None
D2961	Labial veneer (resin laminate) – Indirect	Not a covered procedure	None	Not a covered procedure	None	None
D2962	Labial veneer (porcelain laminate) – Indirect	Not a covered procedure	None	Not a covered procedure		None
D2971	Additional procedures to customize a crown to fit under an existing partial denture framework. This procedure is in addition to the separate crown procedure documented with its own code	Not a covered procedure	None	By report	Detailed narrative	None

		HCR Pediatric Plan BlueDental Choice Q and QF <i>ages 0 through 19</i>		HCR Adult Plan BlueDental Choice QF <i>ages 19+</i>		All HCR PLANS
CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D2975	Coping	Not a covered procedure	None	Not a covered procedure	None	None
D2976	Band stabilization – per tooth	Not a covered procedure	None	Not a covered procedure	None	None
D2980	Crown repair necessitated by restorative material failure	By report	Detailed narrative	By report	Detailed narrative	None
D2981	Inlay repair necessitated by restorative material failure	As Needed	Tooth number(s)	Not a covered procedure	None	None
D2982	Onlay repair necessitated by restorative material failure	As Needed	Tooth number(s)	Not a covered procedure	None	None
D2983	Veneer repair necessitated by restorative material failure	As Needed	Tooth number(s)	Not a covered procedure	None	None
D2989	Excavation of a tooth resulting in the determination of non-restorability	Not a covered procedure	None	Not a covered procedure	None	None
D2990	Resin infiltration of incipient smooth surface lesions	One (1) in thirty-six (36) months	Tooth number(s)	Not a covered procedure	None	None
D2991	Application of hydroxyapatite regeneration medicament – per tooth	Not a covered procedure	None	Not a covered procedure	None	None
D2999	Unspecified restorative procedure, by report	Not a covered procedure	None	Not a covered procedure	None	None

Endodontics

Please note the following:

- Endodontic procedures include exams, pulp tests, pulpotomy, pulpectomy, extirpation of pulp, and pre-operative, operative, and post-operative radiographs/diagnostic images, filling of canals, bacteriologic cultures and local anesthesia.
- Endodontic therapy performed specifically for coping or overdenture is not covered.
- Please bill claims for multiple-stage procedures only on the date of completion/insertion.
- Payment for endodontic services does not mean that benefits will be available for subsequent restorative services. Coverage for those services is still subject to exclusions listed under major restorative guidelines.

		HCR Pediatric Plan BlueDental Choice Q and QF <i>ages 0 through 19</i>		HCR Adult Plan BlueDental Choice QF <i>ages 19+</i>		ALL HCR PLANS
CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
PULP CAPPING						
D3110	Pulp-cap direct (excluding final restoration)	As Needed	Tooth number(s)	Not a covered procedure	None	None
D3120	Pulp-cap indirect (excluding final restoration)	Not a covered procedure	None	Not a covered procedure	None	None
PULPOTOMY: Therapeutic pulpotomy (excluding final restoration)						
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to dentinocemental junction and application of medicament	Not payable within 45 days of root canal	Tooth number(s)	One (1) per tooth per lifetime	Tooth number(s)	None
D3221	Pulpal debridement, primary and permanent teeth	Not a covered procedure	None	One (1) per tooth per lifetime	Tooth number(s)	None

		<u>HCR Pediatric Plan</u> <u>BlueDental Choice Q and QF</u> <i>ages 0 through 19</i>		<u>HCR Adult Plan</u> <u>BlueDental Choice QF</u> <i>ages 19+</i>		<u>ALL HCR PLANS</u>
CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D3222	Partial pulpotomy for apexogenesis – permanent tooth with incomplete root development	Not payable within 45 days of root canal	Tooth number(s)	Not a covered procedure	None	None
D3230	Pulpal therapy (resorbable filling) anterior, primary tooth (excluding final restoration)	One (1) per tooth. Limited to primary incisor teeth to age six (6) and primary molars and cuspids to age eleven (11).	Tooth number(s)	One (1) per tooth per lifetime	Tooth number(s)	None
D3240	Pulpal therapy (resorbable filling) posterior primary tooth (excluding final restoration)	One (1) per tooth Limited to primary incisor teeth to age six (6) and primary molars and cuspids to age eleven (11).	Tooth number(s)	One (1) per tooth per lifetime	Tooth number(s)	None
ENDODONTIC THERAPY (including treatment plan, clinical procedures and follow-up care)						
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	As Needed	Tooth number(s)	One (1) per tooth per lifetime	Tooth number(s)	None
D3320	Endodontic therapy, Premolar tooth (excluding final restoration)	As Needed	Tooth number(s)	One (1) per tooth per lifetime	Tooth number(s)	None
D3330	Endodontic therapy, molar tooth (excluding final restoration)	As Needed	Tooth number(s)	One (1) per tooth per lifetime	Tooth number(s)	None
D3331	Treatment of root canal obstruction; non-surgical access in lieu of surgery	Not a covered procedure	None	One (1) per tooth per lifetime	Tooth number(s)	None
D3332	Incomplete endodontic therapy; inoperable, unrestorable, or fractured tooth	Not a covered procedure	None	As Needed	None	None

		<u>HCR Pediatric Plan</u> <u>BlueDental Choice Q and QF</u> <i>ages 0 through 19</i>		<u>HCR Adult Plan</u> <u>BlueDental Choice QF</u> <i>ages 19+</i>		<u>All HCR PLANS</u>
CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D3333	Internal root repair of perforation defects	Not a covered procedure	None	As Needed	None	None
ENDODONTIC RETREATMENT						
D3346	Retreatment of previous root canal therapy, anterior	As Needed	Tooth number(s)	One (1) per tooth per lifetime, twelve (12) months post root canal therapy	Tooth number(s)	None
D3347	Retreatment of previous root canal therapy, premolar	As Needed	Tooth number(s)	One (1) per tooth per lifetime, twelve (12) months post root canal therapy	Tooth number(s)	None
D3348	Retreatment of previous root canal therapy, molar	As Needed	Tooth number(s)	One (1) per tooth per lifetime, twelve (12) months post root canal therapy	Tooth number(s)	None
APEXIFICATION/RECALCIFICATION AND PULPAL REGENERATION PROCEDURES						
D3351	Apexification / recalcification - initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	As Needed	Tooth number(s)	Not a covered procedure	None	None
D3352	Apexification / recalcification - interim medication replacement	As Needed	Tooth number(s)	Not a covered procedure	None	None
D3353	Apexification / recalcification - final visit (includes completed root canal therapy – apical closure / calcific repair of perforations, root resorption, etc.)	As Needed	Tooth number(s)	Not a covered procedure	None	None
D3355	Pulpal regeneration – initial visit	As Needed	Tooth number(s)	Not a covered procedure	None	None

		HCR Pediatric Plan BlueDental Choice Q and QF <i>ages 0 through 19</i>		HCR Adult Plan BlueDental Choice QF <i>ages 19+</i>		All HCR PLANS
CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D3356	Pulpal regeneration – interim medication replacement	As Needed	Tooth number(s)	Not a covered procedure	None	None
D3357	Pulpal regeneration – completion of treatment	As Needed		Not a covered procedure	None	None
APICTOMY/PERIRADICULAR SERVICES: Includes all pre-operative radiographs, bacteriologic cultures, local anesthesia, and routine follow-up care						
D3410	Apicoectomy – anterior	As Needed	Tooth number(s)	As Needed	Tooth number(s)	
D3421	Apicoectomy – premolar (first root)	As Needed	Tooth number(s)	As Needed	Tooth number(s)	None
D3425	Apicoectomy – molar (first root)	As Needed	Tooth number(s)	As Needed	Tooth number(s)	None
D3426	Apicoectomy – (each additional root)	As Needed	Tooth number(s)	As Needed	Tooth number(s)	None
D3428	Bone graft in conjunction with periradicular surgery – per tooth, single site	Not a covered procedure	None	Not a covered procedure	None	None
D3429	Bone graft in conjunction with periradicular surgery – each additional contiguous tooth in the same surgical site	Not a covered procedure	None	Not a covered procedure	None	None
D3430	Retrograde filling – per root	Not a covered procedure	None	As Needed	Tooth number(s)	None
D3431	Biologic materials to aid in soft and osseous tissue regeneration in conjunction with periradicular surgery	Not a covered procedure	None	Not a covered procedure	None	None
D3432	Guided tissue regeneration, resorbable barrier, per site, in conjunction with periradicular surgery	Not a covered procedure	None	Not a covered procedure	None	None

		<u>HCR Pediatric Plan</u> <u>BlueDental Choice Q and QF</u> <i>ages 0 through 19</i>		<u>HCR Adult Plan</u> <u>BlueDental Choice QF</u> <i>ages 19+</i>		<u>All HCR PLANS</u>
CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D3450	Root amputation – per root	As Needed	Tooth number(s)	As Needed	Tooth number(s)	None
D3460	Endodontic endosseous implant	Not a covered procedure	None	Not a covered procedure	None	None
D3470	Intentional re-implantation (including necessary splinting)	Not a covered procedure	None	Not a covered procedure	None	None
D3471	Surgical repair of root resorption – anterior	Not a covered procedure	None	Not a covered procedure	None	None
D3472	Surgical repair of root resorption – premolar	Not a covered procedure	None	Not a covered procedure	None	None
D3473	Surgical repair of root resorption – molar	Not a covered procedure	None	Not a covered procedure	None	None
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption – anterior	Not a covered procedure	None	D3427 is not covered in 2020 so this code is not covered for 2021	None	None
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption – pre-molar	Not a covered procedure	None	D3427 is not covered in 2020 so this code is not covered for 2021	None	None
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption – molar	Not a covered procedure	None	D3427 is not covered in 2020 so this code is not covered for 2021	None	None

		<u>HCR Pediatric Plan</u> <u>BlueDental Choice Q and QF</u> <i>ages 0 through 19</i>		<u>HCR Adult Plan</u> <u>BlueDental Choice QF</u> <i>ages 19+</i>		<u>All HCR PLANS</u>
CPT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
OTHER ENDODONTIC PROCEDURES						
D3910	Surgical procedure for isolation of tooth with rubber dam	Not a covered procedure	None	Not a covered procedure	None	None
D3911	Intraorifice barrier Not to be used as a final restoration	Not a covered procedure	None	Not a covered procedure	None	None
D3920	Hemisection (including any root removal), not including root canal therapy	As Needed	Tooth number(s)	As Needed	Tooth number(s)	None
D3921	Decoronation or submergence of an erupted tooth Intentional removal of coronal tooth structure for preservation of the root and surrounding bone	Covered same a D7210 Eligible for GA/IV sedation	Tooth Number(s)	As Needed	Tooth Number(s)	None
D3950	Canal preparation and fitting of preformed dowel or post	Not a covered procedure	None	As Needed	None	None
D3999	Unspecified endodontic procedure, by report	Not a covered procedure	None	Not a covered procedure	None	None

Periodontics

Procedure Billing Guidelines

- A quadrant is defined as four (4) or more contiguous teeth in a quadrant. A partial quadrant is defined as one (1) to three (3) teeth in a quadrant.
- For billing purposes, a sextant is not a recognized designation by the American Dental Association.
- To be covered, alveolar crestal bone loss must be evident radiographically for scaling and root planing.
- When more than one (1) periodontal service (codes D4000-D4999) is completed within the same site or quadrant on the same date of service, The Plan will pay for the more extensive treatment as payment for the total service.
- Benefits for all periodontal services are limited to two (2) quadrants per date of service. If you wish to request an exception due to a medical condition that may require your patient to receive extended treatment, please include a detailed narrative including general or intravenous anesthesia record, medical condition and length of appointment time for consideration.

Payment for Surgical Services

- Payment for definitive periodontal service includes follow-up evaluation for both surgical and non-surgical procedures.
- We provide payment only for one (1) surgical procedure per quadrant per thirty-six (36) months. No more than two (2) quadrants of surgical or non-surgical services may be covered when done on the same date of service. To request an exception due to a medical condition that may require your patient to receive extended periodontal treatment, please submit a detailed narrative including general or intravenous anesthesia record, medical condition, and length of appointment time for consideration with the claim form.
- When localized procedures are performed in the same quadrant within thirty-six (36) months, the payment will not exceed the full quadrant allowance.
- **Periodontal services are benefits when performed for the treatment of periodontal disease around natural teeth. There are no benefits for these procedures when billed in conjunction with or in preparation for implants, ridge augmentation, extractions sites and endodontic surgeries.**
- When localized surgical or pre-surgical services are performed in the same quadrants within coverage time guidelines, payment for the services will not exceed the full quadrant allowance.

		<u>HCR Pediatric Plan</u> <u>BlueDental Choice Q and QF</u> <i>ages 0 through 19</i>		<u>HCR Adult Plan</u> <u>BlueDental Choice QF</u> <i>ages 19+</i>		<u>All HCR PLANS</u>
CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
SURGICAL SERVICES (INCLUDING USUAL POST-OPERATIVE SERVICES) Coverage includes placement and removal of periodontal pack, suture removal, local anesthesia and postoperative care.						
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces, per quadrant	One (1) per quadrant per thirty-six (36) months	Quadrant Identification	As Needed Minimum age eighteen (18)	Quadrant Identification	None
D4211	Gingivectomy or gingivoplasty – one (1) to three (3) contiguous teeth or tooth bounded spaces per quadrant	One (1) per quadrant per thirty-six (36) months	Quadrant Identification	As Needed Minimum age eighteen (18)	Quadrant Identification	None
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth.	One (1) every thirty-six (36) months	Tooth number(s)	Not a covered procedure	None	None
D4230	Anatomical crown exposure – four (4) or more contiguous teeth or bounded tooth spaces per quadrant	Not a covered procedure	None	Not a covered procedure	None	None
D4231	Anatomical crown exposure – one (1) to three (3) teeth or bounded tooth spaces per quadrant.	Not a covered procedure	None	Not a covered procedure	None	None
D4240	Gingival flap procedure, including root planning – four (4) or more contiguous teeth or tooth bound spaces per quadrant	One (1) per quadrant per thirty-six (36) months	Quadrant Identification	One (1) per quadrant per thirty-six (36) months Minimum age eighteen (18)	Quadrant Identification	None

		HCR Pediatric Plan BlueDental Choice Q and QF <i>ages 0 through 19</i>		HCR Adult Plan BlueDental Choice QF <i>ages 19+</i>		All HCR PLANS
CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D4241	Gingival flap procedure, including root planning - one (1) to three (3) contiguous teeth or tooth bound spaces per quadrant	One (1) per quadrant per thirty-six (36) months	Quadrant Identification	One (1) per quadrant per thirty-six (36) months Minimum age eighteen (18)	Quadrant Identification	None
D4245	Apically repositioned flap	Not a covered procedure	None	Not a covered procedure	None	None
D4249	Clinical crown lengthening-hard tissue	One (1) every thirty-six (36) months	Tooth number(s)	One (1) per tooth per lifetime Minimum age eighteen (18)	Tooth number(s)	Requires office notes and consultant approval
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four (4) or more contiguous teeth or tooth bounded spaces per quadrant	One (1) every thirty-six (36) months	Quadrant Identification	One (1) per quadrant per thirty-six (36) months Minimum age eighteen (18)	Quadrant Identification	None
D4261	Osseous surgery, (including elevation of a full thickness flap and closure) one (1) to three (3) contiguous teeth or tooth bounded spaces per quadrant	One (1) every thirty-six (36) months	Quadrant Identification	One (1) per quadrant per thirty-six (36) months Minimum age eighteen (18)	Quadrant Identification	None
D4263	Bone replacement graft – retained natural tooth – first site in quadrant	One (1) per quadrant per thirty-six (36) months	Quadrant Identification	One (1) per quadrant per thirty-six (36) months. Minimum age eighteen (18)	Quadrant Identification	None
D4264	Bone replacement graft – each additional site in quadrant	Not a covered procedure	None	One (1) per quadrant per thirty-six (36) months. Minimum age eighteen (18)	Quadrant Identification	None

		<u>HCR Pediatric Plan</u> <u>BlueDental Choice Q and QF</u> <i>ages 0 through 19</i>		<u>HCR Adult Plan</u> <u>BlueDental Choice QF</u> <i>ages 19+</i>		<u>All HCR PLANS</u>
CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D4265	Biologic materials may be used alone or with other regenerative substrates	Not a covered procedure	None	Not a covered procedure	None	None
SURGICAL SERVICES (INCLUDING USUAL POST-OPERATIVE SERVICES) Coverage includes placement and removal of periodontal pack, suture removal, local anesthesia, and postoperative care.						
D4266	Guided tissue regeneration, natural teeth resorbable barrier, per site	Not a covered procedure	None	One (1) per quadrant per thirty-six (36) months Minimum age eighteen (18)	Tooth number(s)	None
D4267	Guided tissue regeneration, natural teeth non-resorbable barrier, per site	Not a covered procedure	None	Not a covered procedure	None	None
D4268	Surgical revision procedure, per tooth	Not a covered procedure	None	Not a covered procedure	None	None
D4270	Pedicle soft tissue graft procedure	As Needed	Tooth / space number(s)	One (1) per site per thirty-six (36) months Minimum age eighteen (18)	Tooth number(s)	None
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant or edentulous tooth position	As Needed	Tooth number(s)	One (1) per tooth per thirty-six (36) months Minimum age eighteen (18)	Tooth number(s)	None
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures on the same anatomical area)	Not a covered procedure	None	Not a covered procedure	None	None

		HCR Pediatric Plan BlueDental Choice Q and QF ages 0 through 19		HCR Adult Plan BlueDental Choice QF ages 19+		<u>All HCR PLANS</u>
CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D4275	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft	One (1) per tooth per thirty-six (36) months	Tooth number(s)	One (1) per tooth per thirty-six (36) months Minimum age eighteen (18)	Tooth number(s)	None
D4276	Combined connective tissue and pedicle graft, per tooth Advanced gingival recession often cannot be corrected with a single procedure. Combined tissue grafting procedures are needed to achieve the desired outcome.	Not a covered procedure	None	One (1) per tooth per thirty-six (36) months Minimum age eighteen (18)	Tooth number(s)	None
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	As Needed	None	One (1) per tooth per thirty-six (36) months Minimum age eighteen (18)	Tooth number(s)	None
NON-SURGICAL PERIODONTAL SERVICES						
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant, or edentulous tooth position in same graft site	As Needed	Tooth number(s)	One (1) per site per thirty-six (36) months Minimum age eighteen (18).	None	None

		<u>HCR Pediatric Plan</u> <u>BlueDental Choice Q and QF</u> <i>ages 0 through 19</i>		<u>HCR Adult Plan</u> <u>BlueDental Choice QF</u> <i>ages 19+</i>		<u>All HCR PLANS</u>
CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in the same graft site	Not a covered procedure	Tooth number(s)	Not a covered procedure	None	None
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant, or edentulous tooth position in same graft site	Not a covered procedure	Tooth number(s)	Not a covered procedure	None	None
D4286	Removal of non-resorbable barrier	Not a covered procedure	Tooth number(s)	Not a covered procedure	None	None
OTHER PERIODONTAL SERVICES						
D4322	Splint – intra-coronal; natural teeth or prosthetic crowns Additional procedure at physically links individual teeth or prosthetic crowns to provide stabilization and additional strength	Not a covered procedure	None	Not a covered procedure	None	None
D4323	Splint – extra-coronal; natural teeth or prosthetic crowns Additional procedure that physically links individual teeth or prosthetic crowns to provide stabilization and additional strength	Not a covered procedure	None	Not a covered procedure	None	None

		HCR Pediatric Plan BlueDental Choice Q and QF <i>ages 0 through 19</i>		HCR Adult Plan BlueDental Choice QF <i>ages 19+</i>		ALL HCR PLANS
CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D4341	Periodontal scaling and root planning, four or more teeth per quadrant	One (1) every twenty-four months. If a member has diabetes, CAD, stroke or is pregnant and is enrolled in Oral Health for Overall Health, D4341 or D4342 is covered once per quadrant every 24 months.	Quadrant Identification	One (1) every twenty-four (24) months. Minimum age eighteen (18) *Note: If a member has diabetes, CAD, stroke or is pregnant and is enrolled in Oral Health for Overall Health, D4341 or D4342 is covered once per quadrant every 24 months.	Quadrant Identification	None
D4342	Periodontal scaling and root planning, one – three teeth per quadrant					
OTHER PERIODONTAL SERVICES						
D4346	Scaling in presence of generalized moderate or severe gingival inflammation- full mouth, after oral evaluation	Two per benefit period. Any combination with D1110, D1120, or D4910, age 18 and older *Note: If a member is enrolled in Oral Health for Overall Health, D1110/D1120 or D4346 or D4910 is covered once every three months	None	Two per benefit period. Any combination with D1110, D1120, or D4910, age 18 and older *Note: If a member is enrolled in Oral Health for Overall Health, D1110/D1120 or D4346 or D4910 is covered once every three months	None	None
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis	Once (1) per thirty-six (36) months	None	One (1) per thirty-six (36) months. Minimum age eighteen (18)	None	Not to be completed on same day as D0150, D0160 or D0180
D4381	Localized delivery of antimicrobial agents via controlled-release vehicle into diseased crevicular tissue, per tooth. Not intended for use in cases of generalized periodontitis	Not a covered procedure	None	Not a covered procedure	None	None

		HCR Pediatric Plan BlueDental Choice Q and QE ages 0 through 19		HCR Adult Plan BlueDental Choice QE ages 19+		All HCR PLANS
CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D4910	Periodontal maintenance	Four (4) in twelve (12) months combined with prophylaxis, age eighteen (18) or older*Note: If a member is enrolled in Oral Health for Overall Health, D1110 / D1120 or D4346 or D4910 is covered once every three months	None	Two per benefit period includes D1110. Minimum age eighteen (18). *Note: If a member is enrolled in Oral Health for Overall Health, D1110 / D1120 or D4346 or D4910 is covered once every three months	None	Includes prophylaxis
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)	Not a covered procedure	None	Not a covered procedure	None	None
D4921	Gingival irrigation with a medicinal agent – per quadrant	Not a covered procedure	None	Not a covered procedure	None	Gingival irrigation is integral to codes D1110, D4910, D4341, D4342, D4346, and D4355. Dentist may not bill the member
D4999	Unspecified periodontal procedure, by report	Not a covered procedure	None	Not a covered procedure	None	None

Prosthodontics, Removable

Please bill claims for multiple-stage procedures on the date of completion/insertion. Please verify the members' eligibility and benefits prior to rendering services as a waiting period and a missing tooth clause may be applicable. Services may be non-covered for the following conditions:

- Untreated bone loss: An abutment tooth has poor-to-hopeless prognosis from either a restorative or periodontal perspective
- Periapical pathology or unresolved, incomplete, or failed endodontic therapy
- Treatment of TMJ to increase vertical dimension or restore occlusion

		<u>HCR Pediatric Plan</u> <u>BlueDental Choice Q and QF</u> <i>ages 0 through 19</i>		<u>HCR Adult Plan</u> <u>BlueDental Choice QF</u> <i>ages 19+</i>		<u>All HCR PLANS</u>
CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
COMPLETE DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)						
D5110	Complete denture – maxillary	One (1) per sixty (60) months	None	One (1) per sixty (60) months	None	None
D5120	Complete denture – mandibular	One (1) per sixty (60) months	None	One (1) per sixty (60) months	None	None
D5130	Immediate denture – maxillary	One (1) per sixty (60) months	None	One (1) per sixty (60) months	None	None
D5140	Immediate denture – mandibular	One (1) per sixty (60) months	None	One (1) per sixty (60) months	None	None
PARTIAL DENTURES: For the following codes, denture base presumed to include any conventional clasps, rests, and teeth						
D5211	Maxillary partial denture – resin base	One (1) per sixty (60) months	None	One (1) per sixty (60) months	None	None
D5212	Mandibular partial denture – resin base	One (1) per sixty (60) months	None	One (1) per sixty (60) months	None	None
D5213	Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	One (1) per sixty (60) months	None	One (1) per sixty (60) months	None	None
D5214	Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	One (1) per sixty (60) months	None	One (1) per sixty (60) months	None	None

		<u>HCR Pediatric Plan</u> <u>BlueDental Choice Q and QF</u> <i>ages 0 through 19</i>		<u>HCR Adult Plan</u> <u>BlueDental Choice QF</u> <i>ages 19+</i>		<u>All HCR PLANS</u>
CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D5221	Immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	Not a covered procedure	None	Not a covered procedure	None	None
D5222	Immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	Not a covered procedure	None	Not a covered procedure	None	None
D5223	Immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	Not a covered procedure	None	Not a covered procedure	None	None
D5224	Immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	Not a covered procedure	None	Not a covered procedure	None	None
D5225	Maxillary partial denture - flexible base (including Retentive / clasping materials and teeth)	Not a covered procedure	None	One (1) per sixty (60) months	None	None
D5226	Mandibular partial denture – flexible base (including Retentive / clasping materials and teeth)	Not a covered procedure	None	One (1) per sixty (60) months	None	None
D5227	Immediate maxillary partial denture - flexible base (including any clasps, rests and teeth)	Not a covered procedure	None	One (1) per sixty (60) months	None	None

		HCR Pediatric Plan BlueDental Choice Q and QF ages 0 through 19		HCR Adult Plan BlueDental Choice QF ages 19+		All HCR PLANS
CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D5228	Immediate mandibular partial denture - flexible base (including any clasps, rests and teeth)	Not a covered procedure	None	One (1) per sixty (60) months	None	None
D5282	Removable unilateral partial denture – one	One (1) per sixty (60) months	Tooth number(s)	Not a covered procedure	None	One (1) piece cast metal (including retentive/clasping materials and teeth), maxillary
D5283	Removable unilateral partial denture – one (1) piece cast metal (including retentive / clasping materials and teeth)	One (1) per sixty (60) months	Tooth number(s)	Not a covered procedure	None	None
D5284	Removable unilateral partial denture – one (1) piece flexible base (including retentive / clasping materials and teeth) per quadrant	One (1) per sixty (60) months	Tooth number(s)	Not a covered procedure	None	None
D5286	Removable unilateral partial denture – one (1) piece resin (including retentive / clasping materials and teeth) per quadrant	One (1) per sixty (60) months	Tooth number(s)	Not a covered procedure	None	None
D5410	Adjust complete denture – maxillary	None	None	Two per benefit period. Allowed six months after placement	None	None
D5411	Adjust complete denture – mandibular	None	None	Two per benefit period. Allowed six months after placement	None	None

		<u>HCR Pediatric Plan</u> <u>BlueDental Choice Q and QF</u> <i>ages 0 through 19</i>		<u>HCR Adult Plan</u> <u>BlueDental Choice QF</u> <i>ages 19+</i>		<u>All HCR PLANS</u>
CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D5421	Adjust partial denture maxillary	None	None	Two per benefit period. Allowed six months after placement	None	None
D5422	Adjust partial denture mandibular	None	None	Two per benefit period. Allowed six months after placement	None	None
REPAIRS TO DENTURES						
D5511	Repair broken complete denture base, mandibular	None	Arch Identification	As Needed	Arch Identification	None
D5512	Repair broken complete denture base, maxillary	None	Arch Identification	As Needed	Arch Identification	None
D5520	Replace missing or broken teeth complete denture, (each tooth)	None	Tooth number(s)	As Needed	Tooth number(s)	None
D5611	Repair resin partial denture base, mandibular	None	Arch Identification	As Needed	Arch Identification	None
D5612	Repair resin partial denture base, maxillary	None	Arch Identification	As Needed	Arch Identification	None
D5621	Repair cast framework, mandibular	None	Arch Identification	As Needed	Arch Identification	None
D5622	Repair cast framework, maxillary	None	Arch Identification	As Needed	Arch Identification	None
D5630	Repair or replace broken clasp – per tooth	None	Arch Identification	None	Arch Identification	None

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CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D5640	Repair broken teeth – per tooth	None	Tooth number(s)	As Needed	Tooth number(s)	None
D5650	Add tooth to existing partial denture	None	Tooth number(s)	As Needed	Tooth number(s)	None
D5660	Add clasp to existing partial denture – per tooth	None	Tooth number(s)	As Needed	Tooth number(s)	None
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	Not a covered procedure	None	One (1) per thirty-six (36) months. Sixty (60) month replacement rule (denture must be sixty (60) months old for service to be covered)	None	None
D5671	Replace all teeth and acrylic on cast metal framework- mandibular	Not a covered procedure	None	One (1) per thirty-six (36) months. Sixty (60) month replacement rule (denture must be sixty (60) months old for service to be covered)	None	None
DENTURE REBASE PROCEDURES: Process of refitting a denture by replacing the base material						
D5710	Rebase complete maxillary denture	One (1) per thirty-six (36) months, payable six (6) months after initial placement	None	One (1) per thirty-six (36) months, payable six (6) months after initial placement	None	None
D5711	Rebase complete mandibular denture	One (1) per thirty-six (36) months, payable six (6) months after initial placement	None	One (1) per thirty-six (36) months allowed six (6) months after initial placement	None	None
D5720	Rebase maxillary Partial denture	One (1) per thirty-six (36) months, payable six (6) months after initial placement	None	One (1) per thirty-six (36) months allowed six (6) months after initial placement	None	None
D5721	Rebase mandibular partial denture	One (1) per thirty-six (36) months, payable six (6) months after initial placement	None	One (1) per thirty-six (36) months allowed six (6) months after initial placement	None	None

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CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions	
D5725	Rebase hybrid prosthesis replacing the base material connected to the framework	Covered same as D5720/5721	None	One (1) per thirty-six (36) months allowed six (6) months after initial placement	None	Replacing the base material connected to the framework.	
DENTURE RELINE PROCEDURES: The process of resurfacing the tissue side of a denture with new base material							
D5730	Reline complete maxillary denture (Direct)	One (1) per thirty-six (36) months, payable six (6) months after initial placement	None	One (1) per thirty-six (36) months allowed six (6) months after initial placement	None	None	
D5731	Reline complete mandibular denture (Direct)	One (1) per thirty-six (36) months, payable six (6) months after initial placement	None	One (1) per thirty-six (36) months allowed six (6) months after initial placement	None	None	
D5740	Reline maxillary partial denture (direct)	One (1) per thirty-six (36) months, payable six (6) months after initial placement	None	One (1) per thirty-six (36) months allowed six (6) months after initial placement	None	None	
D5741	Reline mandibular partial denture (direct)	One (1) per thirty-six (36) months, payable six (6) months after initial placement	None	One (1) per thirty-six (36) months allowed six (6) months after initial placement	None	None	
D5750	Reline complete maxillary denture (Indirect)	One (1) per thirty-six (36) months, payable six (6) months after initial placement	None	One (1) per thirty-six (36) months allowed six (6) months after initial placement	None	None	
D5751	Reline complete mandibular denture (Indirect)	One (1) per thirty-six (36) months, payable six (6) months after initial placement	None	One (1) per thirty-six (36) months allowed six (6) months after initial placement	None	None	

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CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D5760	Reline upper maxillary denture (Indirect)	One (1) per thirty-six (36) months, payable six (6) months after initial placement	None	One (1) per thirty-six (36) months allowed six (6) months after initial placement	None	None
D5761	Reline mandibular partial denture (Indirect)	One (1) per thirty-six (36) months, payable six (6) months after initial placement	None	One (1) per thirty-six (36) months allowed six (6) months after initial placement	None	None
D5765	Soft liner for complete or partial removable denture – indirect	Not covered in addition to D5730 / D5761 One (1) per thirty-six (36) months, payable six (6) months after initial placement	None	Not covered in addition to D5730-D5761 One (1) per thirty-six (36) months, payable six (6) months after initial placement	None	None
OTHER REMOVABLE PROSTHETIC SERVICES						
D5810	Interim complete denture (maxillary)	Not a covered procedure	None	Not a covered procedure	None	None
D5811	Interim complete denture (mandibular)	Not a covered procedure	None	Not a covered procedure	None	None
D5820	Interim partial denture	Not a covered procedure	None	Not a covered procedure	None	(including retentive/clasping materials, rests and teeth), maxillary
D5821	Interim partial denture	Not a covered procedure	None	Not a covered procedure	None	(including retentive/clasping materials, rests and teeth), mandibular
D5850	Tissue conditioning, maxillary	As Needed	None	Two (2) times per benefit period	None	None
D5820	Interim partial denture	Not a covered procedure	None	Not a covered procedure	None	(including retentive/clasping materials, rests and teeth), maxillary
D5821	Interim partial denture	Not a covered procedure	None	Not a covered procedure	None	(including retentive/clasping materials, rests and teeth), mandibular
D5850	Tissue conditioning, maxillary	As Needed	None	Two (2) times per benefit period	None	None

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CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D5851	Tissue conditioning, mandibular	As Needed	None	Two (2) times per benefit period	None	None
D5862	Precision attachment, by report. Each pair of components reported is one precision attachment. Describe the type of attachment used.	Not a covered procedure	None	Not a covered procedure	None	None
D5863	Overdenture – complete maxillary – natural tooth borne	Not a covered procedure	None	Not a covered procedure	None	None
D5864	Overdenture – partial maxillary - natural tooth borne	Not a covered procedure	None	Not a covered procedure	None	None
D5865	Overdenture – complete mandibular - natural tooth borne	Not a covered procedure	None	Not a covered procedure	None	None
D5866	Overdenture – partial mandibular - natural tooth borne	Not a covered procedure	None	Not a covered procedure	None	None
D5867	Replacement of replaceable part of semi- precision or precision attachment of natural tooth borne prosthesis, per attachment	Not a covered procedure	None	Not a covered procedure	None	None
D5875	Modification of removable prosthesis following implant surgery	Not a covered procedure	None	Not a covered procedure	None	None
D5876	Add metal substructure to acrylic complete denture (per arch)	Not a covered procedure	None	Not a covered procedure	None	None
D5877	Duplication of a complete denture – maxillary	Not a covered procedure	None	Not a covered procedure	None	None
D5878	Duplication of a complete denture – mandibular	Not a covered procedure	None	Not a covered procedure	None	None

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CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
MAXILLOFACIAL PROSTHETICS						
D5899	Unspecified removable prosthodontic procedure, by report	Not a covered procedure	None	Not a covered procedure	None	None
D5909	Maxillary guidance prosthesis with guide flange	Not a covered procedure	None	Not a covered procedure	None	None
D5911	Facial moulage (sectional)	Not a covered procedure	None	Not a covered procedure	None	None
D5912	Facial moulage (complete)	Not a covered procedure	None	Not a covered procedure	None	None
D5913	Nasal prosthesis	Not a covered procedure	None	Not a covered procedure	None	None
D5914	Auricular prosthesis	Not a covered procedure	None	Not a covered procedure	None	None
D5915	Orbital prosthesis	Not a covered procedure	None	Not a covered procedure	None	None
D5916	Ocular prosthesis	Not a covered procedure	None	Not a covered procedure	None	None
D5919	Facial prosthesis	Not a covered procedure	None	Not a covered procedure	None	None
D5922	Nasal septal prosthesis	Not a covered procedure	None	Not a covered procedure	None	None
D5923	Ocular prosthesis, interim	Not a covered procedure	None	Not a covered procedure	None	None
D5924	Cranial prosthesis	Not a covered procedure	None	Not a covered procedure	None	None
D5925	Facial augmentation implant prosthesis	Not a covered procedure	None	Not a covered procedure	None	None
D5926	Nasal prosthesis, replacement	Not a covered procedure	None	Not a covered procedure	None	None

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CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D5927	Auricular prosthesis, replacement	Not a covered procedure	None	Not a covered procedure	None	None
D5928	Orbital prosthesis, replacement	Not a covered procedure	None	Not a covered procedure	None	None
D5929	Facial prosthesis, replacement	Not a covered procedure	None	Not a covered procedure	None	None
D5930	Maxillary guidance prosthesis without guide flange	Not a covered procedure	None	Not a covered procedure	None	None
D5931	Obturator prosthesis, surgical	Not a covered procedure	None	Not a covered procedure	None	None
D5932	Obturator prosthesis, definitive	Not a covered procedure	None	Not a covered procedure	None	None
D5933	Obturator prosthesis, modification	Not a covered procedure	None	Not a covered procedure	None	None
D5934	Mandibular guidance prosthesis with guide flange	Not a covered procedure	None	Not a covered procedure	None	None
D5935	Mandibular guidance prosthesis without guide flange	Not a covered procedure	None	Not a covered procedure	None	None
D5936	Obturator prosthesis, interim	Not a covered procedure	None	Not a covered procedure	None	None
D5937	Trismus appliance (not for TMD treatment)	Not a covered procedure	None	Not a covered procedure	None	None
D5938	Resection prosthesis, maxillary complete removable	Not a covered procedure	None	Not a covered procedure	None	None
D5939	Resection prosthesis, mandibular complete removable	Not a covered procedure	None	Not a covered procedure	None	None

		<u>HCR Pediatric Plan</u> <u>BlueDental Choice Q and QF</u> <i>ages 0 through 19</i>		<u>HCR Adult Plan</u> <u>BlueDental Choice QF</u> <i>ages 19+</i>		<u>All HCR PLANS</u>
CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D5940	Resection prosthesis, maxillary partial removable	Not a covered procedure	None	Not a covered procedure	None	None
D5941	Resection prosthesis, mandibular partial removable	Not a covered procedure	None	Not a covered procedure	None	None
D5942	Resection prosthesis, maxillary implant / abutment supported removable prosthesis for edentulous arch	Not a covered procedure	None	Not a covered procedure	None	None
D5943	Resection prosthesis, mandibular implant / abutment supported removable prosthesis for edentulous arch	Not a covered procedure	None	Not a covered procedure	None	None
D5944	Resection prosthesis, maxillary implant / abutment supported removable prosthesis for the partial edentulous arch	Not a covered procedure	None	Not a covered procedure	None	None
D5945	Resection prosthesis, mandibular implant / abutment supported removable prosthesis for the partial edentulous arch	Not a covered procedure	None	Not a covered procedure	None	None
D5946	Resection prosthesis, maxillary implant/abutment supported fixed prosthesis for edentulous arch	Not a covered procedure	None	Not a covered procedure	None	None
D5947	Resection prosthesis, mandibular implant / abutment supported fixed prosthesis for edentulous arch	Not a covered procedure	None	Not a covered procedure	None	None

		HCR Pediatric Plan BlueDental Choice Q and QE <i>ages 0 through 19</i>		HCR Adult Plan BlueDental Choice QE <i>ages 19+</i>		All HCR PLANS
CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D5948	Resection prosthesis, maxillary implant/abutment supported fixed prosthesis for the partial edentulous arch	Not a covered procedure	None	Not a covered procedure	None	None
D5949	Resection prosthesis, mandibular implant / abutment supported fixed prosthesis for the partial edentulous arch	Not a covered procedure	None	Not a covered procedure	None	None
D5951	Feeding aid	Not a covered procedure	None	Not a covered procedure	None	None
D5952	Speech aid prosthesis, pediatric	Not a covered procedure	None	Not a covered procedure	None	None
D5953	Speech aid prosthesis, adult	Not a covered procedure	None	Not a covered procedure	None	None
D5954	Palatal augmentation prosthesis	Not a covered procedure	None	Not a covered procedure	None	None
D5955	Palatal lift prosthesis, definitive	Not a covered procedure	None	Not a covered procedure	None	None
D5958	Palatal lift prosthesis, interim	Not a covered procedure	None	Not a covered procedure	None	None
D5959	Palatal lift prosthesis, modification	Not a covered procedure	None	Not a covered procedure	None	None
D5960	Speech aid prosthesis, modification	Not a covered procedure	None	Not a covered procedure	None	None
D5982	Surgical stent for soft tissue healing	Not a covered procedure	None	Not a covered procedure	None	None
D5983	Radiation carrier	Not a covered procedure	None	Not a covered procedure	None	None

		HCR Pediatric Plan BlueDental Choice Q and QF <i>ages 0 through 19</i>		HCR Adult Plan BlueDental Choice QF <i>ages 19+</i>		All HCR PLANS
CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D5984	Radiation shield	Not a covered procedure	None	Not a covered procedure	None	None
D5985	Radiation cone locator	Not a covered procedure	None	Not a covered procedure	None	None
D5986	Fluoride gel carrier	Not a covered procedure	None	Not a covered procedure	None	None
D5987	Commissure splint	Not a covered procedure	None	Not a covered procedure	None	None
D5988	Surgical splint	Not a covered procedure	None	Not a covered procedure	None	None
D5991	Vesiculobullous disease medicament carrier	Not a covered procedure	None	Not a covered procedure	None	None
D5992	Adjust maxillofacial prosthetic appliance, by report	Not a covered procedure	None	Not a covered procedure	None	None
D5993	Maintenance and cleaning of a maxillofacial prosthesis (extra or intra-oral) other than required adjustments, by report	Not a covered procedure	None	Not a covered procedure	None	None
D5995	periodontal medicament carrier with peripheral seal – laboratory processed - maxillary	Not a covered procedure	None	Not a covered procedure	None	None
D5996	periodontal medicament carrier with peripheral seal – laboratory processed - mandibular	Not a covered procedure	None	Not a covered procedure	None	None
D5999	Unspecified maxillofacial prosthesis, by report	Not a covered procedure	None	Not a covered procedure	None	None

Implant Services

Medically Necessary Implant Services: This benefit is available to pediatric patients only. To qualify for medically necessary implant services, it must be demonstrated that the patient's arch cannot be restored with a standard prosthesis or restoration, removable or fixed; or that the patient is unable to function in speech and mastication without a prosthesis or restoration. Please verify the members' eligibility and benefits prior to rendering services as a waiting period and a missing tooth clause may be applicable. Prior authorization and approval are required before services are rendered. Claim review is conducted by a licensed dentist who will review the clinical documentation submitted by the treating dentist.

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CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
IMPLANT SERVICES: Verify member coverage code and eligibility prior to providing implant services not all plans include implant benefits.						
D6010	Surgical placement of implant body: endosteal implant	One (1) per sixty (60) months	Medically Necessary only. Preauthorization Required	Not a covered procedure	None	Preauthorization Required
D6011	Second stage implant surgery	Not a covered procedure	None	Not a covered procedure	None	This procedure, also known as second stage implant surgery, involves removal of tissue that covers the implant body so that a fixture of any type can be placed, or an existing fixture be replaced with another. Examples of fixtures include but are not limited to healing caps, abutments shaped to help contour the gingival margins or the final restorative prosthesis
D6012	Surgical placement of interim implant body for transitional prosthesis, endosteal implant	One (1) per sixty (60) months	Medically Necessary only. Preauthorization Required	Not a covered procedure	None	Preauthorization Required
D6013	Surgical placement of mini-implant	Not a covered procedure	None	Not a covered procedure	None	
D6040	Surgical placement, endosteal implant	One (1) per sixty (60) months	Medically Necessary only. Preauthorization Required	Not a covered procedure	None	Preauthorization Required

		<u>HCR Pediatric Plan</u> <u>BlueDental Choice Q and QF</u> <i>ages 0 through 19</i>		<u>HCR Adult Plan</u> <u>BlueDental Choice QF</u> <i>ages 19+</i>		<u>All HCR PLANS</u>
CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D6049	Scaling and debridement of a single implant in the presence of peri-implantitis inflammation, bleeding upon probing and increased pocket depths, including cleaning of the implant surfaces, without flap entry and closure	Integral with 4341/4342 in same quadrant: otherwise same reimbursement rate as 4342. Basic service regardless of implant coverage	None	Integral with 4341/4342 in same quadrant: otherwise same reimbursement rate as 4342. Basic service regardless of implant coverage	None	Integral with 4341/4342 in same quadrant: otherwise, same reimbursement rate as 4342. Basic service regardless of implant coverage
D6050	Surgical placement, transosteal implant	One (1) per sixty (60) months	Medically Necessary only	Not a covered procedure	None	Preauthorization Required
D6051	Interim Implant abutment placement. A healing cap is not an interim abutment	Not a covered procedure	None	Not a covered procedure	None	Not a covered procedure
D6055	Connecting bar – implant supported, or abutment supported	One (1) per sixty (60) months	Medically Necessary only	Not a covered procedure	None	Preauthorization Required
D6056	Prefabricated abutment, includes placement	One (1) per sixty (60) months	Medically Necessary only	Not a covered procedure	None	Preauthorization Required
D6057	Custom abutment	One (1) per sixty (60) months	Medically Necessary only	Not a covered procedure	None	Preauthorization Required
D6058	Abutment supported porcelain/ceramic crown	One (1) per sixty (60) months	Medically Necessary only	Not a covered procedure	None	Preauthorization Required
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	One (1) per sixty (60) months	Medically Necessary only	Not a covered procedure	None	Preauthorization Required
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	One (1) per sixty (60) months	Medically Necessary only	Not a covered procedure	None	Preauthorization Required

		HCR Pediatric Plan BlueDental Choice Q and QF <i>ages 0 through 19</i>		HCR Adult Plan BlueDental Choice QF <i>ages 19+</i>		All HCR PLANS
CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D6061	Abutment supported porcelain fused to metal crown (noble metal)	One (1) per sixty (60) months	Medically Necessary only. Preauthorization Required	Not a covered procedure	None	Preauthorization Required
D6062	Abutment supported cast metal crown (high noble metal)	One (1) per sixty (60) months	Medically Necessary only. Preauthorization Required	Not a covered procedure	None	Preauthorization Required
D6063	Abutment supported cast metal crown (predominantly base metal)	One (1) per sixty (60) months	Medically Necessary only. Preauthorization Required	Not a covered procedure	None	Preauthorization Required
D6064	Abutment supported cast metal crown (noble metal)	One (1) per sixty (60) months	Medically Necessary only. Preauthorization Required	Not a covered procedure	None	Preauthorization Required
D6065	Implant supported porcelain/ceramic crown	One (1) per sixty (60) months	Medically Necessary only. Preauthorization Required	Not a covered procedure	None	Preauthorization Required
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	One (1) per sixty (60) months	Medically Necessary only. Preauthorization Required	Not a covered procedure	None	Preauthorization Required
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	One (1) per sixty (60) months	Medically Necessary only. Preauthorization Required	Not a covered procedure	None	Preauthorization Required
D6068	Abutment supported retainer for porcelain/ceramic FPD	One (1) per sixty (60) months	Medically Necessary only. Preauthorization Required	Not a covered procedure	None	Preauthorization Required
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	One (1) per sixty (60) months	Medically Necessary only. Preauthorization Required	Not a covered procedure	None	Preauthorization Required

		<u>HCR Pediatric Plan</u> <u>BlueDental Choice Q and QF</u> <i>ages 0 through 19</i>		<u>HCR Adult Plan</u> <u>BlueDental Choice QF</u> <i>ages 19+</i>		<u>All HCR PLANS</u>
CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominately base metal)	One (1) per sixty (60) months	Medically Necessary only	Not a covered procedure	None	Preauthorization Required
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	One (1) per sixty (60) months	Medically Necessary only	Not a covered procedure	None	Preauthorization Required
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	One (1) per sixty (60) months	Medically Necessary only	Not a covered procedure	None	Preauthorization Required
D6073	Abutment supported retainer for cast metal FPD (predominately base metal)	One (1) per sixty (60) months	Medically Necessary only	Not a covered procedure	None	Preauthorization Required
D6074	Abutment supported retainer for cast metal FPD (noble metal)	One (1) per sixty (60) months	Medically Necessary only	Not a covered procedure	None	Preauthorization Required
D6075	Implant supported retainer for ceramic FPD	One (1) per sixty (60) months	Medically Necessary only	Not a covered procedure	None	Preauthorization Required
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)	One (1) per sixty (60) months	Medically Necessary only	Not a covered procedure	None	Preauthorization Required
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	One (1) per sixty (60) months	Medically Necessary only	Not a covered procedure	None	Preauthorization Required

		<u>HCR Pediatric Plan</u> <u>BlueDental Choice Q and QF</u> <i>ages 0 through 19</i>		<u>HCR Adult Plan</u> <u>BlueDental Choice QF</u> <i>ages 19+</i>		<u>All HCR PLANS</u>
CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
OTHER IMPLANT SERVICES: Verify member coverage code and eligibility prior to providing implant services, not all plans include implant benefits.						
D6080	Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments	One (1) per sixty (60) months	Medically Necessary only. Preauthorization Required	Not a covered procedure	None	Preauthorization Required
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	Not a covered procedure	None	Not a covered procedure	None	None
D6082	Implant supported crown – porcelain fused to predominantly base alloys	Not a covered procedure	None	Not a covered procedure	None	Preauthorization Required
D6083	Implant supported crown – porcelain fused to noble alloys	Not a covered procedure	None	Not a covered procedure	None	Preauthorization Required
D6084	Implant supported crown – porcelain fused to titanium and titanium alloys	Not a covered procedure	None	Not a covered procedure	None	Preauthorization Required
D6085	Interim implant crown Placed when a period of healing is necessary prior to fabrication and placement of the definitive prosthesis	Not a covered procedure	None	Not a covered procedure	None	None
D6086	Implant supported crown – predominantly base alloys	Not a covered procedure	None	Not a covered procedure	None	Preauthorization Required

		<u>HCR Pediatric Plan</u> <u>BlueDental Choice Q and QF</u> <i>ages 0 through 19</i>		<u>HCR Adult Plan</u> <u>BlueDental Choice QF</u> <i>ages 19+</i>		<u>All HCR PLANS</u>
CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D6087	Implant supported crown – noble alloys	Not a covered procedure	None	Not a covered procedure	None	Preauthorization Required
D6088	Implant supported crown – titanium and titanium alloys	Not a covered procedure	None	Not a covered procedure	None	Preauthorization Required
D6089	Accessing and retorquing loose implant screw – per screw					
D6090	Repair implant supported prosthesis, by report	One (1) per sixty (60) months	Medically Necessary only	Not a covered procedure	None	Preauthorization Required
D6091	Replacement of replaceable part of semi- precision attachment of implant / abutment supported prosthesis	One (1) per sixty (60) months	Medically Necessary only	One (1) per sixty (60) months	Not a covered procedure	Preauthorization Required
D6092	Re-cement or re-bond implant / abutment-supported crown	Not a covered procedure	None	Not a covered procedure	None	None
D6093	Re-cement or re-bond ant/abutment-supported fixed partial denture	Not a covered procedure	None	Not a covered procedure	None	None
D6094	Abutment supported crown (titanium)	Not a covered procedure	None	Not a covered procedure	None	None
D6095	Repair implant abutment, by report	One (1) per sixty (60) months	Medically Necessary only	Not a covered procedure	None	Preauthorization Required
D6096	Remove broken implant retaining screw	Not a covered procedure	None	Not a covered procedure	None	Preauthorization Required
D6097	Abutment supported crown – porcelain fused to titanium and titanium alloys	Not a covered procedure	None	Not a covered procedure	None	Preauthorization Required

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CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D6098	Implant supported retainer – porcelain fused to predominantly base alloys	Not a covered procedure	None	Not a covered procedure	None	Preauthorization Required
D6099	Implant supported retainer for FPD – porcelain fused to noble alloys	Not a covered procedure	None	Not a covered procedure	None	None
D6100	Surgical removal of Implant body. This procedure is in addition to the separate crown procedure documented with its own code.	One (1) per sixty (60) months	Medically Necessary only	Not a covered procedure	None	Preauthorization Required
D6101	Debridement of a peri-implant defect or defects surrounding a single implant, and surface cleaning of the exposed implant surfaces, including flap entry and closure	One (1) per sixty (60) months	Medically Necessary only	Not a covered procedure	None	Preauthorization Required
D6102	Debridement and osseous contouring of a peri-implant defect or defects surrounding a single implant and includes surface cleaning of the exposed implant surfaces, including flap entry and closure	One (1) per sixty (60) months	Medically Necessary only	Not a covered procedure	None	Preauthorization Required

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CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D6103	Bone graft for repair of peri-implant defect – does not include flap entry and closure	One (1) per sixty (60) months	Medically Necessary only	Not a covered procedure	None	Preauthorization Required
D6104	Bone graft a time of implant placement	One (1) per sixty (60) months	Medically Necessary only	Not a covered procedure	None	Preauthorization Required
D6105	Removal of implant body not requiring bone removal nor flap elevation	Not a covered procedure	None	Not a covered procedure	None	None
D6106	Guided tissue regeneration – resorbable barrier, per implant	Not a covered procedure	None	Not a covered procedure	None	None
D6107	Guided tissue regeneration – non-resorbable barrier per implant	Not a covered procedure	None	Not a covered procedure	None	None
D6110	Implant/abutment supported removable denture for edentulous arch - maxillary	One (1) per sixty (60) months	Medically Necessary only.	Not a covered procedure	None	Preauthorization Required
D6111	Implant/abutment supported removable denture for edentulous arch - mandibular	One (1) per sixty (60) months	Medically Necessary only.	Not a covered procedure	None	Preauthorization Required
D6112	Implant/abutment supported removable denture for partially edentulous arch - maxillary	One (1) per sixty (60) months	Medically Necessary only	Not a covered procedure	None	Preauthorization Required
D6113	Implant/abutment supported removable denture for partially edentulous arch - mandibular	One (1) per sixty (60) months	Medically Necessary only	Not a covered procedure	None	Preauthorization Required

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CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D6114	Implant / abutment supported fixed denture for edentulous arch - maxillary	One (1) per sixty (60) months	Medically Necessary only	Not a covered procedure	None	Preauthorization Required
D6115	Implant / abutment supported fixed denture for edentulous arch - mandibular	One (1) per sixty (60) months	Medically Necessary only	Not a covered procedure	None	Preauthorization Required
D6116	Implant / abutment supported fixed denture for partially edentulous arch – maxillary	One (1) per sixty (60) months	Medically Necessary only	Not a covered procedure	None	Preauthorization Required
D6117	Implant / abutment supported fixed denture for partially edentulous arch – mandibular	One (1) per sixty (60) months	Medically Necessary only	Not a covered procedure	None	Preauthorization Required
D6118	Implant / abutment supported interim fixed denture for edentulous arch - mandibular	Not a covered procedure	None	Not a covered procedure	None	None
D6119	Implant/abutment supported interim fixed denture for edentulous arch – maxillary	Not a covered procedure	None	Not a covered procedure	None	None
D6120	Implant supported retainer – porcelain fused to titanium and titanium alloys	Not Covered	None	Not a covered procedure	None	Preauthorization Required
D6121	Implant supported retainer for metal FPD – predominantly base alloys	Not Covered	None	Not a covered procedure	None	Preauthorization Required
D6122	Implant supported retainer for metal FPD – noble alloys	Not Covered	None	Not a covered procedure	None	Preauthorization Required
D6123	Implant supported retainer for metal FPD titanium and titanium alloys	Not Covered	None	Not a covered procedure	None	Preauthorization Required

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CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D6190	Radiographic/surgical implant index	One (1) per sixty (60) months	Medically necessary only	Not a covered procedure	None	Preauthorization Required
D6191	Semi-precision abutment-placement	Not a covered procedure	None	Not a covered procedure	None	None
D6192	Semi-precision attachment - placement	Not a covered procedure	None	Not a covered procedure	None	None
D6194	Abutment supported retainer crown for FPD, titanium	Not a covered procedure	None	Not a covered procedure	None	None
D6195	Abutment supported retainer	Not a covered procedure	None	Not a covered procedure	None	Porcelain fused to titanium and alloys
D6196	Removal of an indirect restoration on an implant retained abutment	Integral	None	Integral	None	None
D6197	Replacement of restorative material used to close an access opening of a screw retained	Must have Implant Rider. Same limitations apply	None	Must have Implant Rider. Same limitations apply	None	Not Covered if same provider, same implant site within 6 mos. of history of payment for initial prosthetic and maintenance services D6051 – D6199

When services are covered:

- Coverage to restore the normal compliment of teeth.
- Edentulous space must have adequate mesial-distal and vertical dimension to accommodate a functional pontic.
- Abutment teeth must be endodontically and periodontally sound.

When services are not covered:

- Cosmetic purposes or to restore or treat complications of non-covered procedures.
- To treat TMJ dysfunction.
- Increase vertical dimension.
- Restore occlusion lost through erosion, abrasion, or attrition.
- Correction of congenital or developmental abnormalities.

Benefit criteria and limitations:

- Restoration is covered only once every sixty (60) months.
- Members fifteen (15) years or older.
- Permanent teeth only.
- Service or completion date is the cementation date.
- Service includes preparation of teeth, indirect pulp cap, bases, liners, laboratory costs, temporary crowns/bridges, cementation and local anesthesia.
- If an alternate benefit is paid, the member is responsible for the difference between The Plan allowance and provider's billed charge.
- Gingivectomy performed in conjunction with an inlay/onlay is considered a part of the procedure and cannot be billed separately.
- Verify the member's eligibility and benefits prior to rendering services as a waiting period and a missing tooth clause may be applicable.

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CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D6198	Removal of implant component (e.g., interim abutment; provisional implant crown)	Not a covered procedure	None	Not a covered procedure	None	None
D6199	Unspecified implant procedure, by report	Not a covered procedure	None	Not a covered procedure	None	None
FIXED PARTIAL DENTURE PONTICS						
D6205	Pontic – indirect resin-based composite	Not a covered procedure	None	Not a covered procedure	None	None
D6210	Pontic - cast high noble metal	One (1) per sixty (60) months	Tooth number(s)	One (1) per sixty (60) months	Tooth number(s)	Medically Necessary only. Preauthorization Required
D6211	Pontic – cast predominantly base metal	One (1) per sixty (60) months	Tooth number(s)	One (1) per sixty (60) months	Tooth number(s)	Medically Necessary only. Preauthorization Required
D6212	Pontic – cast noble metal	One (1) per sixty (60) months	Tooth number(s)	Not a covered procedure	None	Medically Necessary only. Preauthorization Required
D6214	Pontic – titanium	One (1) per sixty (60) months	Tooth number(s)	Not a covered procedure	None	Medically Necessary only. Preauthorization Required
D6240	Pontic – porcelain fused to high noble metal	One (1) per sixty (60) months	Tooth number(s)	One (1) per sixty (60) months	Tooth number(s)	Medically Necessary only. Preauthorization Required
D6241	Pontic – porcelain fused to predominantly base metal	One (1) per sixty (60) months	Tooth number(s)	One (1) per sixty (60) months	Tooth number(s)	Medically Necessary only. Preauthorization Required
D6242	Pontic – porcelain fused to noble metal	One (1) per sixty (60) months	Tooth number(s)	One (1) per sixty (60) months	Tooth number(s)	Medically Necessary only. Preauthorization Required
D6243	Pontic – porcelain fuse to titanium and titanium alloys	Not a covered procedure	Tooth number(s)	One (1) per sixty (60) months	Tooth number(s)	Medically Necessary only. Preauthorization Required
D6245	Pontic – porcelain / ceramic	One (1) per sixty (60) months	Tooth number(s)	One (1) per sixty (60) months	Tooth number(s)	Medically Necessary only. Preauthorization Required
D6250	Pontic – resin with high noble metal	Not a covered procedure	None	Not a covered procedure	None	None

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CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D6251	Pontic – resin with predominantly base metal	Not a covered procedure	None	Not a covered procedure	None	None
D6252	Pontic – resin with noble metal	Not a covered procedure	None	Not a covered procedure	None	None
D6253	Interim pontic further treatment or completion of diagnosis necessary prior to final impression Not to be used as a temporary pontic for routine prosthetic restoration	Not a covered procedure	None	Not a covered procedure	None	None
D6280	Implant maintenance procedures when a full arch removable implant/abutment supported denture is removed and reinserted, including cleansing of prosthesis and abutments- per arch	2X/yr per arch procedure is similar to a prophylaxis regardless of implant coverage		2X/yr per arch procedure is similar to a prophylaxis regardless of implant coverage		
FIXED PARTIAL DENTURE RETAINERS – INLAYS/ONLAYS						
D6545	Retainer – cast metal for resin bonded fixed prosthesis	One (1) per sixty (60) months	Tooth number(s)	One (1) per sixty (60) months	Tooth number(s)	Medically Necessary only. Preauthorization Required
D6548	Retainer – porcelain/ceramic for resin bonded fixed prosthesis	One (1) per sixty (60) months	Tooth number(s)	Not a covered procedure	None	Medically Necessary only. Preauthorization Required
D6549	Resin retainer – for resin bonded fixed prosthesis	Not a covered procedure	None	Not a covered procedure	None	None
D6600	Retainer Inlay – porcelain / ceramic, two surfaces	One (1) per sixty (60) months	Tooth number and surface(s)	One (1) per sixty (60) months	Tooth number(s) and surface(s)	None
D6601	Retainer Inlay – porcelain / ceramic, three or more surfaces	Not a covered procedure	None	One (1) per sixty (60) months	Tooth number(s) and surface(s)	None
D6602	Retainer Inlay – high-noble metal, two surfaces	Not a covered procedure	None	Not a covered procedure	None	None

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CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D6603	Retainer Inlay – cast high-noble metal, three or more surfaces	Not a covered procedure	None	Not a covered procedure	None	None
D6604	Retainer Inlay - cast, predominately base metal, two surfaces	One (1) per sixty (60) months	Tooth number and surface(s)	Not a covered procedure	None	None
FIXED PARTIAL DENTURE RETAINERS – INLAYS/ONLAYS						
D6605	Retainer Inlay – cast, predominately base metal, three or more surfaces	One (1) per sixty (60) months	Tooth number and surface(s)	Not a covered procedure	None	None
D6606	Retainer Inlay - cast noble metal, two surfaces	Not a covered procedure	None	One (1) per sixty (60) months	Tooth number(s) and surface(s)	None
D6607	Retainer Inlay - cast noble metal, three or more surfaces	Not a covered procedure	None	One (1) per sixty (60) months	Tooth number(s) and surface(s)	None
D6608	Retainer Onlay - porcelain ceramic, two surface	Not a covered procedure	None	One (1) per sixty (60) months	Tooth number(s) and surface(s)	None
D6609	Retainer Onlay - porcelain ceramic, three or more surfaces	Not a covered procedure	None	One (1) per sixty (60) months	Tooth number(s) and surface(s)	None
D6610	Retainer Onlay – cast high noble metal, two surface	Not a covered procedure	None	Not a covered procedure	None	None

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CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D6611	Retainer Onlay - cast high noble, three or more surfaces	Not a covered procedure	None	Not a covered procedure	None	None
D6612	Retainer Onlay - cast predominately base metal, two surfaces	Not a covered procedure	None	Not a covered procedure	None	None
D6613	Retainer Onlay - cast predominately base metal, three or more surfaces	Not a covered procedure	None	Not a covered procedure	None	None
D6614	Retainer Onlay - cast noble metal, two surfaces	Not a covered procedure	None	Not a covered procedure	None	None
D6615	Retainer Onlay - cast noble metal, three or more surfaces	Not a covered procedure	None	Not a covered procedure	None	None
D6624	Retainer Inlay - titanium	Not a covered procedure	None	Not a covered procedure	None	None
D6634	Retainer Onlay – titanium	Not a covered procedure	None	Not a covered procedure	None	None
FIXED PARTIAL DENTURE RETAINERS – CROWNS						
D6710	Retainer Crown – indirect resin-based composite	Not a covered procedure	None	Not a covered procedure	None	None
D6720	Retainer Crown – resin with high noble metal	Not a covered procedure	None	One (1) per sixty (60) months	Tooth number(s)	None
D6721	Retainer Crown – resin with predominantly base metal	Not a covered procedure	None	One (1) per sixty (60) months	Tooth number(s)	None
D6722	Retainer Crown – resin with noble metal	Not a covered procedure	None	One (1) per sixty (60) months	Tooth number(s)	None
D6740	Retainer Crown – porcelain / ceramic	One (1) per sixty (60) months	Tooth number(s)	One (1) per sixty (60) months	Tooth number(s)	None
D6750	Retainer Crown – porcelain fused to high noble metal	One (1) per sixty (60) months	Tooth number(s)	One (1) per sixty (60) months	Tooth number(s)	None

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CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D6751	Retainer Crown – porcelain fused to predominantly base metal	One (1) per sixty (60) months	Tooth number(s)	One (1) per sixty (60) months	Tooth number(s)	None
D6752	Retainer Crown – porcelain fused to noble metal	One (1) per sixty (60) months	Tooth number(s)	One (1) per sixty (60) months	Tooth number(s)	None
D6753	Retainer Crown – porcelain fused titanium and titanium alloys	Not a covered procedure	None	Not a covered procedure	Tooth number(s)	None
D6780	Retainer Crown – ¾ cast high noble metal	One (1) per sixty (60) months	Tooth number(s)	Not a covered procedure	None	None
D6781	Retainer Crown – ¾ cast predominately base metal	One (1) per sixty (60) months	Tooth number(s)	One (1) per sixty (60) months	Tooth number(s)	None
D6782	Retainer Crown – ¾ cast noble metal	One (1) per sixty (60) months	Tooth number(s)	Not a covered procedure	None	None
D6783	Retainer Crown – ¾ porcelain/ceramic	One (1) per sixty (60) months	Tooth number(s)	Not a covered procedure	None	None
D6784	Retainer Crown – ¾ titanium and titanium alloys	Not a covered procedure	None	Not a covered procedure	None	None
D6790	Retainer Crown – full cast high noble metal	One (1) per sixty (60) months	Tooth number(s)	One (1) per sixty (60) months	Tooth number(s)	None
D6791	Retainer Crown – full cast predominantly base metal	One (1) per sixty (60) months	Tooth number(s)	One (1) per sixty (60) months	Tooth number(s)	None
D6792	Retainer Crown – full cast noble metal	One (1) per sixty (60) months	Tooth number(s)	One (1) per sixty (60) months	Tooth number(s)	None

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CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D6793	Interim retainer crown –further treatment or completion of diagnosis necessary prior to final impression. Not to be used as a temporary retainer crown for routine prosthetic restoration.	Not a covered procedure	None	Not a covered procedure	None	None
D6794	Retainer Crown – titanium	Not a covered procedure	None	Not a covered procedure	None	Not to be used as a temporary retainer crown for routine prosthetic restoration.
OTHER FIXED PARTIAL DENTURE SERVICES						
D6920	Connector bar	Not a covered procedure	None	Not a covered procedure	None	None
D6930	Re-cement or re-bond fixed partial denture	As Needed	Arch Identification	Payable six (6) month post insertion. Twelve (12) month wait between service and maximum two (2) per restoration per sixty (60) months	Arch Identification	None
D6940	Stress breaker	Not a covered procedure	None	Not a covered procedure	None	None
D6950	Precision attachment; a pair of components constitutes one precision attachment that is separate from the prosthesis	Not a covered procedure	None	Not a covered procedure	None	None
D6980	Fixed partial denture repair necessitated by restorative material failure	As Needed	Arch Identification	By report	narrative	None

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CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D6985	Pediatric partial denture, fixed	Not a covered procedure	None	Not a covered procedure	None	None
D6999	Unspecified fixed prosthodontic procedure, by report	Not a covered procedure	None	Not a covered procedure	None	None
Bone grafts (D4263, D4264, D4265) and GTR membranes (D4266, D4267) are not covered in conjunction with oral surgery codes (D7000-D7999).						
Palliative (emergency treatment of dental pain – minor procedures (D9110)) is a covered procedure and paid separately unless submitted in conjunction with a definitive procedure on the same date of service.						
EXTRACTIONS: (Includes local anesthesia, suturing if needed, and routine post-operative care.)						
D7111	Extraction coronal remnants, primary tooth	Not a covered procedure	None	One (1) per tooth per lifetime	Tooth number(s)	The Plan coverage includes local anesthetic, suturing if needed and routine postoperative care. Once per tooth
D7140	Extraction erupted tooth or exposed root (elevation and/or forceps removal)	One (1) per tooth	Tooth number(s)	One (1) per tooth per lifetime	Tooth number(s)	The Plan coverage includes local anesthetic, suturing if needed and routine postoperative care. Once per tooth
SURGICAL EXTRACTIONS (Includes local anesthesia, suturing, if needed, and routine postoperative care)						
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	One (1) per tooth Eligible for GA/IV sedation	Tooth number(s)	One (1) per tooth per lifetime	Tooth number(s)	Surgical removal of an erupted tooth requiring removal of bone and/or sectioning of tooth and including elevation of mucoperiosteal flap if indicated. Procedures include local anesthesia, suturing if needed and routine postoperative care. Once per tooth
D7220	Removal of impacted tooth – soft tissue	One (1) per tooth	Tooth number(s)	One (1) per tooth per lifetime	Tooth number(s)	Surgical removal of an erupted tooth requiring removal of bone and/or sectioning of tooth and including elevation of mucoperiosteal flap if indicated. Procedures include local anesthesia, suturing if needed and routine postoperative care. Once per tooth

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CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D7230	Removal of impacted tooth – partially bony	One (1) per tooth	Tooth number(s)	One (1) per tooth per lifetime	Tooth number(s)	Surgical removal of an erupted tooth requiring removal of bone and/or sectioning of tooth and including elevation of mucoperiosteal flap if indicated. Procedures include local anesthesia, suturing if needed and routine postoperative care. Once per tooth
D7240	Removal of impacted tooth – completely bony	One (1) per tooth	Tooth number(s)	One (1) per tooth per lifetime	Tooth number(s)	
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications	One (1) per tooth	Tooth number(s)	One (1) per tooth per lifetime	Tooth number(s)	
D7250	Surgical removal of residual tooth roots (cutting procedure)	One (1) per tooth	Tooth number(s)	One (1) per tooth per lifetime	Tooth number(s)	
D7251	Coronectomy: intentional partial tooth removal impacted teeth only	One (1) per tooth	Tooth number(s)	One (1) per tooth per lifetime	Tooth number(s)	
OTHER SURGICAL PROCEDURES						
D7260	Oroantral fistula closure	Not a covered procedure	None	Not a covered procedure	None	None
D7261	Primary closure of a sinus perforation	Not a covered procedure	None	Not a covered procedure	None	None
D7270	Tooth re-implantation and/or stabilization of accidentally avulsed or displaced tooth	As Needed	Preauthorization Required	Not a covered procedure	None	None
D7272	Tooth transplantation (includes re-implantation from one site to another and splinting and/or stabilization)	Not a covered procedure	None	Not a covered procedure	None	None

		<u>HCR Pediatric Plan</u> <u>BlueDental Choice Q and QF</u> <i>ages 0 through 19</i>		<u>HCR Adult Plan</u> <u>BlueDental Choice QF</u> <i>ages 19+</i>		<u>All HCR PLANS</u>
CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D7280	Surgical access of an un-erupted tooth	As Needed	Tooth number(s)	As Needed	Tooth number(s)	Preauthorization Required Procedures include local anesthesia, suturing if needed and routine postoperative care. Once per tooth
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	Not a covered procedure	Tooth number(s)	As Needed	Tooth number(s)	Procedures include local anesthesia, suturing if needed and routine postoperative care. Once per tooth
D7283	Placement of device to facilitate eruption of impacted tooth	Not a covered procedure	None	As Needed	Preauthorization Required	Preauthorization Required Procedures include local anesthesia, suturing if needed and routine postoperative care. Once per tooth
D7284	Excisional biopsy of minor salivary glands	Not a covered procedure	None	Not a covered procedure	None	None
D7285	Incisional biopsy of oral tissue – hard (bone, tooth)	Not a covered procedure	None	Not a covered procedure	None	None
D7286	Incisional biopsy of oral tissue - soft	Not a covered procedure	None	Not a covered procedure	None	None
D7287	Exfoliative cytological sample collection	Not a covered procedure	None	Not a covered procedure	None	None
D7288	Brush biopsy – trans epithelial sample collection	Not a covered procedure	None	Not a covered procedure	None	None
D7290	Surgical repositioning of teeth	Not a covered procedure	None	Not a covered procedure	None	None
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	Not a covered procedure	None	Not a covered procedure	None	None
D7292	Placement of temporary anchorage device (screw retained plate) requiring flap	Not a covered procedure	None	Not a covered procedure	None	None

		<u>HCR Pediatric Plan</u> <u>BlueDental Choice Q and QF</u> <i>ages 0 through 19</i>		<u>HCR Adult Plan</u> <u>BlueDental Choice QF</u> <i>ages 19+</i>		<u>All HCR PLANS</u>
CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D7293	Placement of temporary anchorage device requiring flap	Not a covered procedure	None	Not a covered procedure	None	None
D7294	Placement of temporary anchorage device without flap	Not a covered procedure	None	Not a covered procedure	None	None
D7295	Harvest of bone for use in autogenous grafting procedures	Not a covered procedure	None	Not a covered procedure	None	None
D7296	Corticotomy – one to three teeth or tooth spaces, per quadrant.	Not a covered procedure	None	Not a covered procedure	None	None
D7297	Corticotomy – four or more teeth or tooth spaces, per quadrant.	Not a covered procedure	None	Not a covered procedure	None	None
D7298	Removal of temporary anchorage device [screw retained plate], requiring flap	Not a covered procedure	None	Not a covered procedure	None	None
D7299	Removal of temporary anchorage device, requiring flap	Not a covered procedure	None	Not a covered procedure	None	None
D7300	Removal of temporary anchorage device without flap	Not a covered procedure	None	Not a covered procedure	None	None
ALVEOPLASTY: SURGICAL PREPARATION OF RIDGE						
D7310	Alveoplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	As Needed	Quadrant Identification	As Needed	Quadrant Identification	Coverage includes suturing, local anesthetic, and routine postoperative care. For reporting purposes, a quadrant is defined as four (4) or more contiguous teeth and/or tooth spaces distal to the midline
D7311	Alveoplasty in conjunction with extractions – one (1) to three (3) teeth spaces, per quadrant	As Needed	Quadrant Identification	As Needed	Quadrant Identification	

		<u>HCR Pediatric Plan</u> <u>BlueDental Choice Q and QF</u> <i>ages 0 through 19</i>		<u>HCR Adult Plan</u> <u>BlueDental Choice QF</u> <i>ages 19+</i>		<u>All HCR PLANS</u>
CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D7320	Alveoloplasty, not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	As Needed	Quadrant Identification	As Needed	Quadrant Identification	None
D7321	Alveoloplasty, not in conjunction with extractions – one (1) to three (3) teeth or tooth spaces, per quadrant	As Needed	Quadrant Identification	As Needed	Quadrant Identification	Coverage includes suturing, local anesthetic and routine postoperative care. For reporting purposes, a quadrant is defined as four (4) or more contiguous teeth and/or tooth spaces distal to the midline
VESTIBULOPLASTY						
D7340	Vestibuloplasty – ridge extension (secondary epithelialization)	Not a covered procedure	None	Not a covered procedure	None	None
D7350	Vestibuloplasty – ridge extension (incl. soft tissue grafts, muscle re-attachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	Not a covered procedure	None	Not a covered procedure	None	None
SURGICAL EXCISION OF REACTIVE SOFT TISSUE LESIONS						
D7410	Excision of benign lesion, up to 1.25 cm	Not a covered procedure	None	Not a covered procedure	None	None
D7411	Excision of benign lesion > 1.25 cm	Not a covered procedure	None	Not a covered procedure	None	None
D7412	Excision of benign lesion, complicated	Not a covered procedure	None	Not a covered procedure	None	None
D7413	Excision of malignant lesion up to 1.25 cm	Not a covered procedure	None	Not a covered procedure	None	None

		<u>HCR Pediatric Plan</u> <u>BlueDental Choice Q and QE</u> <i>ages 0 through 19</i>		<u>HCR Adult Plan</u> <u>BlueDental Choice QE</u> <i>ages 19+</i>		<u>All HCR PLANS</u>
CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D7414	Excision of malignant lesion > 1.25 cm	Not a covered procedure	None	Not a covered procedure	None	None
D7415	Excision of malignant lesion, complicated	Not a covered procedure	None	Not a covered procedure	None	None
SURGICAL EXCISION OF INTRA-OSSEOUS LESIONS						
D7440	Excision of malignant tumor- lesion diameter up to 1.25 cm	Not a covered procedure	None	Not a covered procedure	None	None
D7441	Excision of malignant tumor - lesion, diameter > 1.25 cm	Not a covered procedure	None	Not a covered procedure	None	None
D7450	Removal of benign odontogenic cyst or tumor - lesion, diameter up to 1.25 cm	Not a covered procedure	None	Not a covered procedure	None	None
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter > 1.25 cm	Not a covered procedure	None	Not a covered procedure	None	None
D7460	Removal of benign non-odontogenic cyst or tumor - lesion, diameter up to 1.25 cm	Not a covered procedure	None	Not a covered procedure	None	None
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm	Not a covered procedure	None	Not a covered procedure	None	None
D7465	Destruction of lesion(s) by physical or chemical methods, by report	Not a covered procedure	None	Not a covered procedure	None	None

		<u>HCR Pediatric Plan</u> <u>BlueDental Choice Q and QF</u> <i>ages 0 through 19</i>		<u>HCR Adult Plan</u> <u>BlueDental Choice QF</u> <i>ages 19+</i>		<u>All HCR PLANS</u>
CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
EXCISION OF BONE TISSUE						
D7471	Removal of lateral exostosis (maxilla or mandible)	As Needed	Arch Identification	Not a covered procedure	Not a covered procedure	None
D7472	Removal of torus palatinus	Not a covered procedure	None	Not a covered procedure	None	None
D7473	Removal of torus mandibularis	Not a covered procedure	None	Not a covered procedure	None	None
D7485	Surgical reduction of osseous tuberosity	Not a covered procedure	None	Not a covered procedure	None	None
D7490	Radical resection of maxilla or mandible	Not a covered procedure	None	Not a covered procedure	None	None
SURGICAL INCISION						
D7509	Marsupialization of odontogenic cyst	Same Benefit coverage D7451	None	Same Benefit coverage D7451	None	None
D7510	Incision and drainage of abscess – intraoral soft tissue	As Needed	Arch Identification	As Needed	Arch Identification	Procedure is not to be used for endodontic access and drainage through a tooth or for open and broach.

		<u>HCR Pediatric Plan</u> <u>BlueDental Choice Q and QE</u> <i>ages 0 through 19</i>		<u>HCR Adult Plan</u> <u>BlueDental Choice QE</u> <i>ages 19+</i>		<u>All HCR PLANS</u>
CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple facial spaces)	Not a covered procedure	None	Not a covered procedure	None	None
D7520	Incision and drainage of abscess – extra oral soft tissue	Not a covered procedure	None	Not a covered procedure	None	None
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	Not a covered procedure	None	Not a covered procedure	None	None
D7530	Removal of foreign body, mucosa, skin, or subcutaneous alveolar tissue	Not a covered procedure	None	Not a covered procedure	None	None
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	Not a covered procedure	None	Not a covered procedure	None	None
D7550	Partial ostectomy/ sequestrectomy for removal of non-vital bone	Not a covered procedure	None	Not a covered procedure	None	None
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	Not a covered procedure	None	Not a covered procedure	None	None

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		<u>HCR Pediatric Plan</u> <u>BlueDental Choice Q and QE</u> <i>ages 0 through 19</i>		<u>HCR Adult Plan</u> <u>BlueDental Choice QE</u> <i>ages 19+</i>		<u>All HCR PLANS</u>
CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
TREATMENT OF FRACTURES – SIMPLE						
D7610	Maxilla – open reduction (teeth immobilized, if present)	Not a covered procedure	None	Not a covered procedure	None	None
D7620	Maxilla – closed reduction (teeth immobilized, if present)	Not a covered procedure	None	Not a covered procedure	None	None
D7630	Mandible – open reduction (teeth immobilized, if present)	Not a covered procedure	None	Not a covered procedure	None	None
D7640	Mandible – closed reduction (teeth immobilized, if present)	Not a covered procedure	None	Not a covered procedure	None	None
D7650	Malar and/or zygomatic arch – open reduction	Not a covered procedure	None	Not a covered procedure	None	None
D7660	Malar and/or zygomatic arch – closed reduction	Not a covered procedure	None	Not a covered procedure	None	None
D7670	Alveolus - closed reduction, may include stabilization of teeth	Not a covered procedure	None	Not a covered procedure	None	None
D7671	Alveolus - open reduction, may include stabilization of teeth	Not a covered procedure	None	Not a covered procedure	None	None
D7680	Facial bones – complicated reduction with fixation and multiple surgical approaches	Not a covered procedure	None	Not a covered procedure	None	None

		<u>HCR Pediatric Plan</u> <u>BlueDental Choice Q and QE</u> <i>ages 0 through 19</i>		<u>HCR Adult Plan</u> <u>BlueDental Choice QE</u> <i>ages 19+</i>		<u>All HCR PLANS</u>
CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
TREATMENT OF FRACTURES – COMPOUND						
D7710	Maxilla – open reduction	Not a covered procedure	None	Not a covered procedure	None	None
D7720	Maxilla – closed reduction	Not a covered procedure	None	Not a covered procedure	None	None
D7730	Mandible – open reduction	Not a covered procedure	None	Not a covered procedure	None	None
D7740	Mandible – closed reduction	Not a covered procedure	None	Not a covered procedure	None	None
D7750	Malar and/or zygomatic arch – open reduction	Not a covered procedure	None	Not a covered procedure	None	None
D7760	Malar and/or zygomatic arch –closed reduction	Not a covered procedure	None	Not a covered procedure	None	None
D7770	Alveolus – open reduction stabilization of teeth	Not a covered procedure	None	Not a covered procedure	None	None
D7771	Alveolus - closed reduction, stabilization of teeth	Not a covered procedure	None	Not a covered procedure	None	None
D7780	Facial bones – complicated reduction with fixation and multiple surgical approaches	Not a covered procedure	None	Not a covered procedure	None	None

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber’s plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage. Not all Benefit plans include Enhanced benefits.

		<u>HCR Pediatric Plan</u> <u>BlueDental Choice Q and QE</u> <i>ages 0 through 19</i>		<u>HCR Adult Plan</u> <u>BlueDental Choice QE</u> <i>ages 19+</i>		<u>All HCR PLANS</u>
CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
REDUCTION OF DISLOCATION AND MANAGEMENT OF OTHER TEMPOROMANDIBULAR JOINT DYSFUNCTIONS: Procedures that are an integral part of the primary procedure should not be reported separately						
D7810	Open reduction of dislocation	Not a covered procedure	None	Not a covered procedure	None	None
D7820	Closed reduction of dislocation	Not a covered procedure	None	Not a covered procedure	None	None
D7830	Manipulation under anesthesia	Not a covered procedure	None	Not a covered procedure	None	None
D7840	Condylectomy	Not a covered procedure	None	Not a covered procedure	None	None
D7850	Surgical discectomy; with/ without implant	Not a covered procedure	None	Not a covered procedure	None	None
D7852	Disc repair	Not a covered procedure	None	Not a covered procedure	None	None
D7854	Synovectomy	Not a covered procedure	None	Not a covered procedure	None	None
D7856	Myotomy	Not a covered procedure	None	Not a covered procedure	None	None
D7858	Joint reconstruction	Not a covered procedure	None	Not a covered procedure	None	None
D7860	Arthrotomy	Not a covered procedure	None	Not a covered procedure	None	None
D7865	Arthroplasty	Not a covered procedure	None	Not a covered procedure	None	None
D7870	Arthrocentesis	Not a covered procedure	None	Not a covered procedure	None	None
D7871	Non-arthroscopic lysis and lavage	Not a covered procedure	None	Not a covered procedure	None	None
D7872	Arthroscopy – diagnosis, with or without biopsy	Not a covered procedure	None	Not a covered procedure	None	None

		<u>HCR Pediatric Plan</u> <u>BlueDental Choice Q and QE</u> <i>ages 0 through 19</i>		<u>HCR Adult Plan</u> <u>BlueDental Choice QE</u> <i>ages 19+</i>		<u>All HCR PLANS</u>
CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D7873	Arthroscopy – surgical: lavage and lysis of adhesions	Not a covered procedure	None	Not a covered procedure	None	None
D7874	Arthroscopy – surgical: disc repositioning and stabilization	Not a covered procedure	None	Not a covered procedure	None	None
D7875	Arthroscopy – surgical: synovectomy	Not a covered procedure	None	Not a covered procedure	None	None
D7876	Arthroscopy – surgical: discectomy	Not a covered procedure	None	Not a covered procedure	None	None
D7877	Arthroscopy – surgical: debridement	Not a covered procedure	None	Not a covered procedure	None	None
D7880	Occlusal orthotic device, by report	Not a covered procedure	None	Not a covered procedure	None	None
D7881	Occlusal orthotic device adjustment	Not a covered procedure	None	Not a covered procedure	None	None
D7899	Unspecified TMD therapy, by report	Not a covered procedure	None	Not a covered procedure	None	None

		<u>HCR Pediatric Plan</u> <u>BlueDental Choice Q and QE</u> <i>ages 0 through 19</i>		<u>HCR Adult Plan</u> <u>BlueDental Choice QE</u> <i>ages 19+</i>		<u>All HCR Plans</u>
CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
REPAIR OF TRAUMATIC WOUNDS - Excludes closure of surgical incisions						
D7910	Suture of recent small wounds up to 5 cm	As Needed	Quadrant Identification	Not a covered procedure	None	None
COMPLICATED SUTURING - Reconstruction requiring delicate handling of tissues and wide undermining for meticulous closure						
D7911	Complicated suture - up to 5 cm	Not a covered procedure	None	Not a covered procedure	None	None
D7912	Complicated suture - > 5 cm	Not a covered procedure	None	Not a covered procedure	None	None
OTHER REPAIR PROCEDURES						
D7920	Skin grafts (identify defect covered, location, and type of graft)	Not a covered procedure	None	Not a covered procedure	None	None
D7921	Collection and application of autologous blood concentrate product.	One (1) every thirty-six (36) months	Quadrant, Tooth or Tooth Space Identification	Not a covered procedure	None	None
D7922	Placement of intra- socket biological dressing to aid in hemostasis or clot stabilization, per site	Always integral	Quadrant, Tooth or Tooth Space Identification	Always integral	None	None
D7939	Indexing for osteotomy using dynamic robotic assisted or dynamic navigation	Not a covered procedure	None	Not a covered procedure	None	None
D7940	Osteoplasty – for orthognathic deformities	Not a covered procedure	None	Not a covered procedure	None	None
D7941	Osteotomy – mandibular rami	Not a covered procedure	None	Not a covered procedure	None	None

		<u>HCR Pediatric Plan</u> <u>BlueDental Choice Q and QF</u> <i>ages 0 through 19</i>		<u>HCR Adult Plan</u> <u>BlueDental Choice QF</u> <i>ages 19+</i>		<u>All HCR PLANS</u>
CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D7943	Osteotomy – mandibular rami with bone graft; includes obtaining the graft	Not a covered procedure	None	Not a covered procedure	None	None
D7944	Osteotomy – segmented or sub-apical	Not a covered procedure	None	Not a covered procedure	None	None
D7945	Osteotomy – body of mandible	Not a covered procedure	None	Not a covered procedure	None	None
D7946	Lefort I (maxilla – total)	Not a covered procedure	None	Not a covered procedure	None	None
D7947	Lefort I (maxilla – segmented)	Not a covered procedure	None	Not a covered procedure	None	None
D7948	Lefort II or Lefort III (osteoplasty of facial bones for midface hypoplasia or retrusion) – without bone graft	Not a covered procedure	None	Not a covered procedure	None	None
D7949	Lefort II or Lefort II – with bone graft	Not a covered procedure	None	Not a covered procedure	None	None
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla, autogenous or non-autogenous, by report	Not a covered procedure	None	Not a covered procedure	None	None
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	Not a covered procedure	None	Not a covered procedure	None	None
D7952	Sinus augmentation via a vertical approach	Not a covered procedure	None	Not a covered procedure	None	None
D7953	Bone replacement graft for ridge preservation – per site	None	None	Not a covered procedure	None	None

		<u>HCR Pediatric Plan</u> <u>BlueDental Choice Q and QF</u> <i>ages 0 through 19</i>		<u>HCR Adult Plan</u> <u>BlueDental Choice QF</u> <i>ages 19+</i>		<u>All HCR PLANS</u>
CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D7955	Repair of maxillofacial soft and/or hard tissue defect	Not a covered procedure	None	Not a covered procedure	None	None
D7956	Guided tissue regeneration, edentulous area – resorbable barrier, per site	Not a covered procedure	None	Not a covered procedure	None	None
D7957	Guided tissue regeneration, edentulous area – non-resorbable barrier, per site	Not a covered procedure	None	Not a covered procedure	None	None
D7961	Buccal / labial frenectomy (frenulectomy)	Major - no limits for adults; not covered under 18	None	Not a covered procedure	None	None
D7962	Lingual frenectomy (frenulectomy)	Major - no limits for adults; not covered under 18	None	Not a covered procedure	None	None
D7963	Frenuloplasty	Not a covered procedure	None	As Needed	Arch Identification	Includes excision or repositioning of aberrant muscle and z-plasty or other local flap closure
D7970	Excision of hyperplastic tissue – per arch	Not a covered procedure	None	Not a covered procedure	None	None
D7971	Excision of pericoronal gingiva	As Needed	Tooth number(s)	Not a covered procedure	None	None
D7972	Surgical reduction of fibrous tuberosity	Not a covered procedure	None	Not a covered procedure	None	None
D7979	Non-surgical sialolithotomy	Not a covered procedure	None	Not a covered procedure	None	None
D7980	Surgical Sialolithotomy	Not a covered procedure	None	Not a covered procedure	None	None
D7981	Excision of salivary gland, by report	Not a covered procedure	None	Not a covered procedure	None	None
D7982	Sialodochoplasty	Not a covered procedure	None	Not a covered procedure	None	None

		<u>HCR Pediatric Plan</u> <u>BlueDental Choice Q and QF</u> <i>ages 0 through 19</i>		<u>HCR Adult Plan</u> <u>BlueDental Choice QF</u> <i>ages 19+</i>		<u>All HCR PLANS</u>
CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D7983	Closure of salivary fistula	Not a covered procedure	None	Not a covered procedure	None	None
D7990	Emergency tracheotomy	Not a covered procedure	None	Not a covered procedure	None	None
D7991	Coronoidectomy	Not a covered procedure	None	Not a covered procedure	None	None
D7993	Surgical placement of craniofacial implant – extra oral	Not a covered procedure	None	Not a covered procedure	None	None
D7994	Surgical placement: zygomatic implant	Not a covered procedure	None	Not a covered procedure	None	None
D7995	Synthetic graft, mandible or facial bones, by report	Not a covered procedure	None	Not a covered procedure	None	None
D7996	Implant – mandible for augmentation purposes (excluding alveolar ridge), by report	Not a covered procedure	None	Not a covered procedure	None	None
D7997	Appliance removal (not by dentist who placed appliance), includes removal of arch bar	Not a covered procedure	None	Not a covered procedure	None	None
D7998	Intraoral placement of a fixation device not in conjunction with a fracture	Not a covered procedure	None	Not a covered procedure	None	None
D7999	Unspecified oral surgery procedure, by report	Not a covered procedure	None	Not a covered procedure	None	None

Medically Necessary Orthodontic Services: This benefit is available to pediatric patients only. To qualify for medically necessary orthodontia services, treatment must result from congenital or developmental malformations related to or developed as a result of cleft palate, with or without cleft lip. Treatment must be rendered by an orthodontist and prior authorization and approval is required before services are rendered. Claim review is conducted by a licensed dentist who will review the clinical documentation submitted by the treating dentist.

All the following orthodontic treatment codes D8000-D8999 may be used more than once for the treatment of a particular patient depending on the particular circumstance. A patient may require more than one limited or comprehensive procedure depending on their particular problems. LIMITED ORTHODONTIC TREATMENT.

		<u>HCR Pediatric Plan</u> <u>BlueDental Choice Q and QF</u> <i>ages 0 through 19</i>		<u>HCR Adult Plan BlueDental</u> <u>Choice QF</u> <i>ages 19+</i>		<u>All HCR PLANS</u>
CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
ORTHODONTICS						
D8010	Limited orthodontic treatment of the primary dentition	In conjunction with Medically Necessary Orthodontia services	Preauthorization Required	Not a covered procedure	None	None
D8020	Limited orthodontic treatment of the transitional dentition	In conjunction with Medically Necessary Orthodontia services	Preauthorization Required	Not a covered procedure	None	None
D8030	Limited orthodontic treatment of the adolescent dentition	In conjunction with Medically Necessary Orthodontia services	Preauthorization Required	Not a covered procedure	None	None
D8040	Limited orthodontic treatment of the adult dentition	Not a covered procedure	Preauthorization Required	Not a covered procedure	None	None
D8070	Comprehensive orthodontic treatment of the transitional dentition	In conjunction with Medically Necessary Orthodontia services	Preauthorization Required	Not a covered procedure	None	None

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		HCR Pediatric Plan BlueDental Choice Q and QF <i>ages 0 through 19</i>		HCR Adult Plan BlueDental Choice QF <i>ages 19+</i>		All HCR PLANS
CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D8080	Comprehensive orthodontic treatment of the adolescent dentition	In conjunction with Medically Necessary Orthodontia services	Preauthorization Required	Not a covered procedure	None	None
D8090	Comprehensive orthodontic treatment of adult dentition	In conjunction with Medically Necessary Orthodontia services	Preauthorization Required	Not a covered procedure	None	None
D8210	Removable appliance therapy	In conjunction with Medically Necessary Orthodontia services	Preauthorization Required	Not a covered procedure	None	None
D8220	Fixed appliance therapy	In conjunction with Medically Necessary Orthodontia services	Preauthorization Required	Not a covered procedure	None	None
OTHER ORTHODONTIC SERVICES						
D8660	Pre-orthodontic treatment examination to monitor growth and development	Medically Necessary only	Preauthorization Required	Not a covered procedure	None	None
D8670	Periodic orthodontic treatment visit	Medically Necessary only	Preauthorization Required	Not a covered procedure	None	None
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	In conjunction with Medically Necessary Orthodontia services	Preauthorization Required	Not a covered procedure	None	None
D8681	Removable orthodontic retainer adjustment	Not a covered procedure	None	Not a covered procedure	None	None

		<u>HCR Pediatric Plan</u> <u>BlueDental Choice Q and QF</u> <i>ages 0 through 19</i>		<u>HCR Adult Plan</u> <u>BlueDental Choice QF</u> <i>ages 19+</i>		<u>All HCR PLANS</u>
CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D8695	Removal of fixed orthodontic appliances for reasons other than completion of treatment	Not a covered procedure	None	Not a covered procedure	None	None
D8696	Repair of orthodontic appliance - maxillary	Not a covered procedure	None	Not a covered procedure	None	None
D8697	Repair of orthodontic appliance - mandibular	Not a covered procedure	None	Not a covered procedure	None	None
D8698	Re-cement or re-bond fixed retainer- maxillary	Not a covered procedure	None	Not a covered procedure	None	None
D8699	Re-cement or re-bond fixed retainer- mandibular	Not a covered procedure	None	Not a covered procedure	None	None
D8701	Repair of fixed retainer, includes reattachment - maxillary	Not a covered procedure	None	Not a covered procedure	None	None
D8702	Repair of fixed retainer, includes reattachment - mandibular	Not a covered procedure	None	Not a covered procedure	None	None
D8703	Replacement of lost or broken retainer - maxillary	Not a covered procedure	None	Not a covered procedure	None	None
D8704	Replacement of lost or broken retainer - mandibular	Not a covered procedure	None	Not a covered procedure	None	None
D8999	Unspecified orthodontic procedure, by report; used for procedures not adequately described by a code	Not a covered procedure	None	Not a covered procedure	None	None

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CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D9110	Palliative treatment of dental pain – per visit	As Needed	Tooth Quadrant or Arch identification, narrative description of procedure must accompany the claim	As Needed	Tooth Quadrant or Arch identification, narrative description of procedure must accompany the claim	Treatment that relieves pain but is not curative; services provided do not have distinct procedure codes
D9120	Fixed partial denture sectioning	Not a covered procedure	None	Not a covered procedure	None	None
D9128	Photo biomodulation therapy – first 15-minute increment, or any portion	Not a covered procedure	None	Not a covered procedure	None	None
D9129	Photo biomodulation therapy – each subsequent 15-minute increment, or any portion thereof	Not a covered procedure	None	Not a covered procedure	None	None
D9130	Temporomandibular joint dysfunction – non- invasive physical therapies	Not a covered procedure	None	Not a covered procedure	None	None
ANESTHESIA						
D9210	Local anesthesia not in conjunction with operative or surgical procedures	Not a covered procedure	None	Not a covered procedure	None	None
D9211	Regional block anesthesia	Not a covered procedure	None	Not a covered procedure	None	Considered integral to operative or surgical procedures done on same date of service
D9212	Trigeminal division block anesthesia	Not a covered procedure	None	Not a covered procedure	None	Considered integral to operative or surgical procedures done on same date of service
D9215	Local anesthesia in conjunction with operative or surgical procedures	Not a covered procedure	None	Not a covered procedure	None	None

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CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D9219	Evaluation for deep sedation or general anesthesia	Not a covered procedure	None	Not a covered procedure	None	Considered integral to D9220 process as non-covered provider liability
D9222	Administration of deep sedation / general anesthesia – first 15-minute increments, or any portion thereof With or without co-administration of nitrous oxide	As Needed	None	As Needed. Payable with covered surgical procedures only	None	General anesthesia will be paid only when performed in conjunction with a covered oral surgical procedure code on the same date of service and reported on the same claim
D9223	Administration of deep sedation / general anesthesia – each subsequent 15-minute increments, or any portion thereof	As Needed	None	As Needed. Payable with covered surgical procedures only	None	General anesthesia will be paid only when performed in conjunction with a covered oral surgical procedure code on the same date of service and reported on the same claim
D9224	Administration of general anesthesia with advanced airway – first 15-minute increment, or any portion	Not a covered procedure	None	Not a covered procedure	None	None
D9225	General anesthesia with advanced airway – each subsequent 15-minute increment, or any portion thereof	Not a covered procedure	None	Not a covered procedure	None	None

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CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D9230	Administration of nitrous oxide When nitrous oxide is administered as a single agent	Not a covered procedure	None	Not a covered procedure	None	None
D9239	Administration of moderate sedation - intravenous – first 15-minute increments, or any portion thereof	As Needed	None	As Needed. Payable with covered surgical procedures only	None	Intravenous conscious sedation/analgesia will be paid only when performed in conjunction with a covered oral surgical procedure code on the same date of service and reported on the same claim
D9243	Intravenous administration of moderate (conscious) sedation/analgesia – intravenous – each subsequent 15-minute increment, or any portion thereof	As Needed	None	As Needed. Payable with covered surgical procedures only	None	Intravenous conscious sedation/analgesia will be paid only when performed in conjunction with a covered oral surgical procedure code on the same date of service and reported on the same claim
D9244	In-office administration of minimal sedation – single drug – enteral	Not a covered benefit	None	Not a covered benefit	None	None

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CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D9245	Administration of moderate sedation – enteral	Not a covered benefit	None	Not a covered benefit	None	None
D9246	Administration of moderate sedation – non-intravenous parenteral – first 15-minute increment, or any portion thereof	Not a covered benefit	None	Not a covered benefit	None	None
D9247	Administration of moderate sedation – non-intravenous parenteral – each subsequent 15-minute increment, or any portion thereof	Not a covered benefit	None	Not a covered benefit	None	None

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber’s plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage. Not all Benefit plans include Enhanced benefits.

		<u>HCR Pediatric Plan</u> <u>BlueDental Choice Q and QF</u> <i>ages 0 through 19</i>		<u>HCR Adult Plan</u> <u>BlueDental Choice QF</u> <i>ages 19+</i>		<u>ALL HCR PLANS</u>
CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
PROFESSIONAL CONSULTATION						
D9310	Consultation - diagnostic service provided by dentist or physician other than the requested dentist or physician	Diagnostic service. No frequency limitations when provided by dentist other than practitioner providing treatment.	Detailed narrative including the treating dentist's name	Two (2) times per benefit period	Detailed narrative including the treating dentist's name	None
D9311	Consultation with a medical health care professional	Not a covered procedure	None	Not a covered procedure	None	None
PROFESSIONAL CONSULTATION						
D9310	Consultation - diagnostic service provided by dentist or physician other than the requested dentist or physician	Diagnostic service. No frequency limitations when provided by dentists other than practitioner providing treatment	Detailed narrative including the treating dentist's name	Two (2) times per benefit period	Detailed narrative including the treating dentist's name	None

NOTE: These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage. Not all Benefit plans include Enhanced benefits.

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CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D9311	Consultation with a medical health care professional	Not a covered procedure	None	Not a covered procedure	None	None
PROFESSIONAL VISITS						
D9410	House / extended care facility call	Not a covered procedure	None	Not a covered procedure	None	None
D9420	Hospital or ambulatory surgical center call	Not a covered procedure	None	Not a covered procedure	None	None
D9430	Office visit for observation (during regularly scheduled hours) – no other services performed	Not a covered procedure	None	Two (2) times per benefit period	None	None
D9440	Office visit – after regularly scheduled hours	Not a covered procedure	None	Not a covered procedure	None	None
D9450	Case presentation, subsequent to detailed and extensive treatment planning	Not a covered procedure	None	Not a covered procedure	None	None
DRUGS						
D9610	Therapeutic parenteral drug, single administration	By report	None	Not a covered procedure	None	None
D9612	Therapeutic parenteral drugs, two (2) or more administrations, different medications	Not a covered procedure	None	Not a covered procedure	None	None
D9613	Infiltration of sustained release therapeutic drug – per quadrant Infiltration of a sustained release pharmacologic agent for long-acting surgical site pain control. Anesthesia purposes	Not a covered procedure	None	Not a covered procedure	None	None

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CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D9630	Other drugs and/or medicaments, by report	Not a covered procedure	None	Not a covered procedure	None	None
MISCELLANEOUS SERVICES						
D9910	Application of desensitizing medicament	Not a covered procedure	None	As Needed	None	None
D9911	Application of desensitizing resin for cervical and/or root surface, per tooth	Not a covered procedure	None	Not a covered procedure	None	None
D9912	Documentation of a patient's health status prior to or on the scheduled date of service to evaluate risk of infectious disease transmission if the patient to be treated within the dental practice	Not a covered procedure	None	Not a covered procedure	None	None
D9920	Behavior management, by report	Not a covered procedure	None	Not a covered procedure	None	None
D9930	Treatment of complications (post- surgical) – unusual circumstances, by report	As Needed	Narrative	Not a covered procedure	None	None
D9932	Cleaning and inspection of removable complete denture, maxillary	Not a covered procedure	None	Not a covered procedure	None	None

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CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D9933	Cleaning and inspection of removable complete denture, mandibular	Not a covered procedure	None	Not a covered procedure	None	None
D9934	Cleaning and inspection of removable partial denture, maxillary	Not a covered procedure	None	Not a covered procedure	None	None
D9935	Cleaning and inspection of removable partial denture, mandibular	Not a covered procedure	None	Not a covered procedure	None	None
D9936	Cleaning and inspection of occlusal guard – per appliance	Not a covered procedure	None	Integral	None	None
D9938	Fabrication of a custom removable clear plastic temporary aesthetic appliance	Not a covered procedure	None	Not a covered procedure	None	None
D9939	Placement of a custom removable clear plastic temporary aesthetic appliance	Not a covered procedure	None	Not a covered procedure	None	None
D9941	Fabrication of athletic mouth guard	Not a covered procedure	None	Not a covered procedure	None	None
D9942	Repair and/ or reline of occlusal guard	Not a covered procedure	None	Not a covered procedure	None	None
D9943	Occlusal guard adjustment	Not a covered procedure	None	Not a covered procedure	None	None

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CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D9944	Occlusal guard hard appliance, full arch. Removable dental appliance designed to minimize the effects of bruxism or other occlusal factors. Not to be reported for any type of sleep apnea, snoring or TMD appliances.	One (1) in twelve (12) months for patients thirteen (13) and thru eighteen (18)	None	Not a covered procedure	None	None
D9945	Occlusal guard soft appliance, full arch. Removable dental appliance designed to minimize the effects of bruxism or other occlusal factors. Not to be reported for any type of sleep apnea, snoring or TMD appliances	Not a covered procedure	None	Not a covered procedure	None	None
D9946	Occlusal guard hard appliance, partial arch. Removable dental appliance designed to minimize the effects of bruxism or other occlusal factors. Provides only partial occlusal coverage such as anterior deprogrammer. Not to be reported for any type of sleep apnea, snoring or TMD appliances	Not a covered procedure	None	Not a covered procedure	None	None

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CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D9947	Custom sleep apnea appliance fabrication and placement	Not a covered procedure	None	Not a covered procedure	None	None
D9948	Adjustment of custom sleep apnea appliance	Not a covered procedure	None	Not a covered procedure	None	None
D9949	Repair of custom sleep apnea appliance	Not a covered procedure	None	Not a covered procedure	None	None
D9950	Occlusion analysis - mounted case	Not a covered procedure	None	Not a covered procedure	None	None
D9951	Occlusal adjustment - limited	Not a covered procedure	None	Not a covered procedure	None	None
D9952	Occlusal adjustment - complete	Not a covered procedure	None	Not a covered procedure	None	None
D9953	Reline custom sleep apnea appliance (indirect)	Not a covered procedure	None	Not a covered procedure	None	None
D9954	Fabrication and delivery of oral appliance therapy (OAT) morning repositioning device	Not a covered procedure	None	Not a covered procedure	None	None
D9955	Oral appliance therapy (OAT) titration visit	Not a covered procedure	None	Not a covered procedure	None	None
D9956	Administration of home sleep apnea test	Not a covered procedure	None	Not a covered procedure	None	None
D9957	Screening for sleep related breathing disorders	Not a covered procedure	None	Not a covered procedure	None	None
D9961	Duplicate/copy patient's records	Not a covered procedure	None	Not a covered procedure	None	None
D9970	Enamel microabrasion	Not a covered procedure	None	Not a covered procedure	None	None
D9971	Odontoplasty per tooth	Not a covered procedure	None	Not a covered procedure	None	Includes removal of enamel projections
D9972	External bleaching – per arch	Not a covered procedure	None	Not a covered procedure	None	Performed in-office
D9973	External bleaching – per tooth	Not a covered procedure	None	Not a covered procedure	None	None

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CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D9974	Internal bleaching – per tooth	Not a covered procedure	None	Not a covered procedure	None	None
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays	Not a covered procedure	None	Not a covered procedure	None	None
D9985	Sales Tax	Not a covered procedure	None	Not a covered procedure	None	None
D9986	Missed Appointment	Not a covered procedure	None	Not a covered procedure	None	None
D9987	Cancelled appointment	Not a covered procedure	None	Not a covered procedure	None	None
D9990	Certified translation or sign-language services	Not a covered procedure	None	Not a covered procedure	None	None
D9991	Dental case management – addressing appointment compliance barriers	Not a covered procedure	None	Not a covered procedure	None	None
D9992	Dental case management – care coordination	Not a covered procedure	None	Not a covered procedure	None	None
D9993	Dental case management – motivational interviewing	Not a covered procedure	None	Not a covered procedure	None	None
D9994	Dental case management – patient education to improve oral health literacy	Not a covered procedure	None	Not a covered procedure	None	None
D9995	Teledentistry – synchronous: real-time encounter	Not a covered procedure	None	Not a covered procedure	None	None
D9996	Teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review.	Not a covered procedure	None	Not a covered procedure	None	None

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CDT Code	Description of Service	Procedure Guidelines / Frequency Limitation	Submission Requirements	Procedure Guidelines / Frequency Limitation	Submission Requirements	Integral Considerations and/or Exclusions
D9997	Dental case management- Patients with special health care needs Special treatment considerations or patients/individuals with physical, medical, developmental, or cognitive conditions resulting in substantial functional limitations or incapacitation, which require that modifications be made to delivery of treatment to provide customized or comprehensive oral health care services	Not a covered procedure	None	Not a covered procedure	None	None
D9999	Unspecified adjunctive procedure by report	Not a covered procedure	None	Not a covered procedure	None	None