OVERVIEW

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

Note: member does not need to be a dependent

DENTAL REVIEW CRITERIA

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- Maxillary/Mandibular incisor relationship: over jet of 9 mm or more with impingement where the lower incisors are impinging the palate.
- Anterior cross bite equal to or greater than 5mm (short term, interceptive therapy covered only)
  - Anterior open bite (canine to canine)
  - More than 1 impacted permanent tooth when the dentition contains no more primary teeth than the primary second molars.
  - Posterior-unilateral cross bite involving three or more adjacent, permanent teeth, one of which must be a molar (no eruption/dentition requirements for this qualifier).
  - Cleft palate deformities submitted by the surgical team.
  - Treatment for skeletal deformities will be considered on an individual basis and must be submitted by the surgical team.

Required documentation for dental consultant review:
- Extra-oral photos – including frontal and profile
  - 5 Intra-oral photos – R/L buccal, U/L occlusal, and front incisor view
• Panoramic film
• Lateral cephalometric film
• Frontal cephalometric film (for surgical cases)
• Consultation report with diagnosis and treatment plan

Major Restorative Services
The following services are limited to 1 tooth per 60 months:
  o onlay metallic
  o core buildup
  o prefabricated post and core
  o crowns

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

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

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

Fixed Prosthodontics
  o One fixed partial denture per treatment area per 60 months.

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

PRIOR AUTHORIZATION
Dental Consultant review required.

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

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

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

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

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

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

BACKGROUND
Effective January 1, 2014, Qualified Health Plans (QHPs) are required to cover Essential Health Benefits (EHBs), as defined in Section 1302(b) of the Patient Protection and Affordable Care Act. Pediatric Services including oral and vision care has been defined as essential Health Benefits. This policy defines the oral care services that will be covered for members from the ages of 0 up to the members 19th birthday.
As groups renew in 2014, most benefit plans will need to include these EHBs (some exceptions may apply to certain large groups; consult your Subscriber Agreement or Benefit Booklet for details).

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

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

**Preventive Services**
- **D1110**: Prophylaxis – Adult (age 13 or older) (three per calendar year, in combination with D4346)
- **D1120**: Prophylaxis – Child (three per calendar year, in combination with D4346)
- **D1206**: Topical application of fluoride varnish (2 per calendar year)
- **D1208**: Topical application of fluoride, excluding varnish (2 per calendar year)
- **D1351**: Sealant-per tooth – unrestored permanent molars (1 per tooth per 36 months)
- **D1352**: Preventive resin restoration in a moderate to high caries risk patient – permanent tooth (under age 16, permanent molars only) (once per tooth per lifetime)
- **D1354**: Interim caries arresting medicament application (one per 12 months ages 7-12; two per 12 months ages 1-6)
- **D1510**: Space maintainer – fixed- unilateral (under age 14,- primary molars and permanent first molars only) (once per tooth per 5 years)
- **D1515**: Space maintainer-fixed-bilateral (under age 14,- primary molars and permanent first molars only) (once per tooth per 5 years)
- **D1520**: Space maintainer-removable-unilateral (under age 14, primary molars and permanent first molars only) (once per tooth per 5 years)
- **D1525**: Space maintainer-removable-bilateral (under age 14, primary molars and permanent first molars only) (once per tooth per 5 years)
- **D1550**: Re-cementation of fixed space maintainer
D1575 Distal shoe space maintainer – fixed- unilateral (under age 14, primary molars and permanent first molars only) (once per tooth per 5 years)
D1555 Removal of fixed spaced maintainer
D2990 Resin infiltration of incipient smooth surface lesions

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

Major Restorative Services (allowed once per tooth per 5 years) (Dental Consultant review required for all major restorative services)
D2510 Inlay – metallic-one surface (allowed at amalgam restoration allowance)
D2520 Inlay – metallic-two surfaces (allowed at amalgam restoration allowance)
D2530 Inlay – metallic-three surfaces (allowed at amalgam restoration allowance)
D2542 Onlay – metallic-two surfaces (allowed at amalgam restoration allowance)
D2543 Onlay – metallic-three surfaces
D2544 Onlay – metallic-four or more surfaces
D2740 Crown – porcelain/ceramic substrate
D2750 Crown – porcelain fused to high noble metal
D2751 Crown – porcelain fused to predominantly base metal
D2752 Crown – porcelain fused to noble metal
D2780 Crown – 3/4 cast high noble metal
D2781 Crown – 3/4 cast predominantly base metal
D2782 Crown – 3/4 cast noble metal
D2783 Crown – 3/4 porcelain/ceramic
D2790 Crown – full cast high noble metal
D2791 Crown – full cast predominantly base metal
D2792 Crown – full cast noble metal
D2794 Crown – titanium
D2910 Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration
D2920 Re-cement or re-bond crown
D2930 Prefabricated porcelain/ceramic crown-primary tooth (once per tooth per 36 months)
D2931 Prefabricated stainless steel crown – primary tooth (once per tooth per 36 months)
D2950 Core buildup, including any pins (not covered on primary teeth)
D2954 Prefabricated post and core, in addition to crown (not covered on primary teeth)
D2980 Crown repair necessitated by restorative material failure
D2981  Inlay repair necessitated by restorative material failure  
D2982  Onlay repair necessitated by restorative material failure  
D2983  Veneer repair necessitated by restorative material failure  
D2990  Resin infiltration of incipient smooth surface lesions

Endodontic Services
D3220  Therapeutic pulpotomy (excluding final restoration)  
D3222  Partial pulpotomy for apexogenesis – permanent tooth with incomplete root formation  
D3230  Pulpal therapy (resorbable filling) – (anterior, primary tooth under age 6; posterior primary tooth under age 11) (once per tooth per lifetime)  
D3240  Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration) (anterior, primary tooth under age 6; posterior primary tooth under age 11) (once per tooth per lifetime)  
D3310  Endodontic therapy, anterior tooth (excluding final restoration) (once per tooth per lifetime) (Dental Consultant review required)  
D3320  Endodontic therapy, bicuspid tooth (excluding final restoration) (once per tooth per lifetime) (Dental Consultant review required)  
D3330  Endodontic therapy, molar (excluding final restoration) (once per tooth per lifetime) (Dental Consultant review required)  
D3346  Retreatment of previous root canal therapy-anterior (once per tooth per lifetime) (Dental Consultant review required)  
D3347  Retreatment of previous root canal therapy-bicuspid (once per tooth per lifetime) (Dental Consultant review required)  
D3348  Retreatment of previous root canal therapy-molar (once per tooth per lifetime) (Dental Consultant review required)  
D3351  Apexification/recalcification/pulpal regeneration – initial visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)  
D3352  Apexification/recalcification/pulpal regeneration – interim medication replacement  
D3353  Apexification/recalcification/pulpal regeneration – final visit (includes completed root canal therapy- apical closure/calcific repair of perforations, root resorption, etc.)  
D3355  Pulpal regeneration – initial visit  
D3356  Pulpal regeneration – interim medication replacement  
D3357  Pulpal regeneration – completion of treatment (eligible on permanent teeth only, under age 15) (once per tooth per lifetime)  
D3410  Apicoectomy/periradicular surgery – anterior  
D3421  Apicoectomy/periradicular surgery – bicuspid (first root)  
D3425  Apicoectomy/periradicular surgery – molar (first foot)  
D3426  Apicoectomy/periradicular surgery – (each additional root)  
D3450  Root amputation-per root (Dental Consultant review required)  
D3920  Hemisection (including any root removal)-not including root canal therapy (Dental Consultant review required)

Periodontal Services (allowed once per area of the mouth per 36 months) (Dental Consultant review required for periodontal services)  
D4210  Gingivectomy or gingivoplasty – four or more teeth  
D4211  Gingivectomy or gingivoplasty – one to three teeth  
D4212  Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth  
D4240  Gingival flap procedure, including root planing, four or more teeth  
D4241  Gingival flap procedure, including root planing-one to three contiguous teeth or tooth bounded spaces per quadrant  
D4249  Clinical crown lengthening-hard tissue
D4260 Osseous surgery (including flap entry and closure), four or more contiguous teeth or bounded teeth spaces per quadrant
D4261 Osseous surgery (including flap entry and closure), one to three contiguous teeth or tooth bounded spaces per quadrant
D4266 Guided tissue regeneration - resorbable barrier, per site
D4267 Guided tissue regeneration – non-resorbable barrier, per site (includes membrane removal)
D4270 Pedicle soft tissue graft
D4273 Subepithelial connective tissue graft procedures
D4277 Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in a graft
D4278 Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site
D4283 Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site
D4341 Periodontal scaling and root planning-four or more teeth per quadrant (once per site per 24 months)
D4342 Periodontal scaling and root planning-one to three teeth per quadrant (once per site per 24 months)
D4346 Scaling in the presence of generalized moderate or severe gingival inflammation- full mouth (age 16 and older; combination of D1110/D4346 can not exceed 3 per year)
D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis (one per lifetime)
D4910 Periodontal maintenance (4 per 12 months)

**Prosthodontic Services (Prostheses limited to once per arch per 5 years)**
D5110 Complete denture – maxillary
D5120 Complete denture – mandibular
D5130 Immediate denture – maxillary
D5140 Immediate denture – mandibular
D5211 Maxillary partial denture – resin base (including any conventional clasps, rests and teeth)
D5212 Mandibular partial denture – resin base (including any conventional clasps, rests and teeth)
D5213 Maxillary partial denture – cast metal framework with resin denture base (including any conventional clasps, rests and teeth)
D5214 Mandibular partial denture – cast metal framework with resin denture base (including any conventional clasps, rests and teeth)
D5221 Immediate maxillary partial denture – resin base
D5222 Immediate mandibular partial denture – resin base
D5223 Immediate maxillary partial denture – cast metal framework with resin denture bases
D5224 Immediate mandibular partial denture – cast metal framework with resin denture bases
D5281 Removable unilateral partial denture – one piece cast metal (including clasps and teeth)
D5410 Adjust complete denture – maxillary
D5411 Adjust complete denture – mandibular
D5421 Adjust partial denture – maxillary
D5422 Adjust partial denture – mandibular
D5510 Repair broken complete denture base
D5520 Replace missing or broken teeth – complete denture (each tooth)
D5610 Repair resin denture base
D5620 Repair cast framework
D5630 Repair or replace broken clasp
D5640 Replace broken teeth – per tooth
D5650 Add tooth to existing partial denture
D5660 Add clasp to existing partial denture
D5710  Rebase complete maxillary denture – Limited to once per 36 months  
D5711  Rebase complete mandibular denture–Limited to once per 36 months  
D5720  Rebase maxillary partial denture – Limited to once per 36 months  
D5721  Rebase mandibular partial denture – Limited to once per 36 months  
D5730  Reline complete maxillary denture (chairside) – Limited to once per 36 months  
D5731  Reline complete mandibular denture (chairside) – Limited to once per 36 months  
D5740  Reline maxillary partial denture (chairside) – Limited to once per 36 months  
D5741  Reline mandibular partial denture (chairside) – Limited to once per 36 months  
D5750  Reline complete maxillary denture (laboratory) – Limited to once per 36 months  
D5751  Reline complete mandibular denture (laboratory) – Limited to once per 36 months  
D5760  Reline maxillary partial denture (laboratory) – Limited to once per 36 months  
D5761  Reline mandibular partial denture (laboratory) – Limited to once per 36 months  
D5850  Tissue conditioning, maxillary  
D5851  Tissue conditioning, mandibular  

**Implant Services (limited to one per tooth/site per 5 years)** (Dental Consultant review required)  
D6010  Endosteal implant (once per tooth per lifetime)  
D6011  Second stage implant surgery (once per tooth per lifetime)  
D6012  Surgical placement of interim implant body for transitional prosthesis (once per tooth per lifetime)  
D6013  Surgical placement of mini implant (once per tooth per lifetime)  
D6040  Eposteal Implant (once per tooth per lifetime)  
D6050  Transosteal Implant, including hardware (once per tooth per lifetime)  
D6055  Connecting bar – implant or abutment supported  
D6056  Prefabricated abutment  
D6057  Custom fabricated abutment  
D6058  Abutment supported porcelain ceramic crown  
D6059  Abutment supported porcelain fused to high noble metal crown  
D6060  Abutment supported porcelain fused to predominantly base metal crown  
D6061  Abutment supported porcelain fused to noble metal crown  
D6062  Abutment supported cast high noble metal crown  
D6063  Abutment supported cast predominantly base metal crown  
D6064  Abutment supported cast noble metal crown  
D6065  Implant supported porcelain ceramic crown  
D6066  Implant supported porcelain fused to high noble metal crown  
D6067  Implant supported metal crown  
D6068  Abutment supported retainer for porcelain/ceramic fixed partial denture  
D6069  Abutment supported retainer for porcelain fused to high noble metal fixed partial denture  
D6070  Abutment supported retainer for porcelain fused to predominantly base metal fixed partial denture  
D6071  Abutment supported retainer for porcelain fused to noble metal fixed partial denture  
D6072  Abutment supported retainer for cast high noble metal fixed partial denture  
D6073  Abutment supported retainer for cast predominantly base metal fixed partial denture  
D6074  Abutment supported retainer for cast noble metal fixed partial denture  
D6075  Implant supported retainer for ceramic fixed partial denture  
D6076  Implant supported retainer for porcelain fused to high noble metal fixed partial denture  
D6077  Implant supported retainer for cast metal fixed partial denture  
D6080  Implant maintenance procedures  
D6090  Repair implant supported prosthesis  
D6091  Replacement of semi-precision or precision attachment
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D6095</td>
<td>Repair implant abutment</td>
</tr>
<tr>
<td>D6100</td>
<td>Implant removal</td>
</tr>
<tr>
<td>D6101</td>
<td>Debridement of peri-implant defect or defects surrounding a single implant</td>
</tr>
<tr>
<td>D6102</td>
<td>Debridement and osseous contouring of a peri-implant defect or defects surrounding a single implant</td>
</tr>
<tr>
<td>D6103</td>
<td>Bone graft for repair of peri-implant defect</td>
</tr>
<tr>
<td>D6104</td>
<td>Bone graft at time of implant placement</td>
</tr>
<tr>
<td>D6110</td>
<td>Implant /abutment supported removable denture for edentulous arch – maxillary</td>
</tr>
<tr>
<td>D6111</td>
<td>Implant/abutment supported removable denture for edentulous arch – mandibular</td>
</tr>
<tr>
<td>D6112</td>
<td>Implant/abutment supported removable denture for partially edentulous arch – maxillary</td>
</tr>
<tr>
<td>D6113</td>
<td>Implant/abutment supported removable denture for partially edentulous arch – mandibular</td>
</tr>
<tr>
<td>D6114</td>
<td>Implant/abutment supported fixed denture for edentulous arch – maxillary</td>
</tr>
<tr>
<td>D6115</td>
<td>Implant/abutment supported fixed denture for edentulous arch – mandibular</td>
</tr>
<tr>
<td>D6116</td>
<td>Implant/abutment supported fixed denture for partially edentulous arch – maxillary</td>
</tr>
<tr>
<td>D6117</td>
<td>Implant/abutment supported fixed denture for partially edentulous arch – mandibular</td>
</tr>
<tr>
<td>D6190</td>
<td>Radiographic/surgical implant index, by report</td>
</tr>
</tbody>
</table>

**Fixed Prosthodontics (limited to one per tooth per 5 years)** (Dental Consultant review required)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D6210</td>
<td>Pontic – cast high noble metal</td>
</tr>
<tr>
<td>D6211</td>
<td>Pontic – cast predominantly base metal</td>
</tr>
<tr>
<td>D6212</td>
<td>Pontic – cast noble metal</td>
</tr>
<tr>
<td>D6214</td>
<td>Pontic – titanium</td>
</tr>
<tr>
<td>D6240</td>
<td>Pontic – porcelain fused to high noble metal</td>
</tr>
<tr>
<td>D6241</td>
<td>Pontic – porcelain fused to predominantly base metal</td>
</tr>
<tr>
<td>D6242</td>
<td>Pontic – porcelain fused to noble metal</td>
</tr>
<tr>
<td>D6245</td>
<td>Pontic – porcelain/ceramic</td>
</tr>
<tr>
<td>D6548</td>
<td>Retainer – porcelain/ceramic for resin bonded fixed prosthesis</td>
</tr>
<tr>
<td>D6549</td>
<td>Resin retainer – porcelain/ceramic for resin bonded fixed prosthesis</td>
</tr>
<tr>
<td>D6600</td>
<td>Inlay – porcelain/ceramic, two surfaces</td>
</tr>
<tr>
<td>D6601</td>
<td>Inlay – porcelain/ceramic, three or more surfaces</td>
</tr>
<tr>
<td>D6602</td>
<td>Inlay – cast high noble metal, two surfaces</td>
</tr>
<tr>
<td>D6603</td>
<td>Inlay – cast high noble metal, three or more surfaces</td>
</tr>
<tr>
<td>D6604</td>
<td>Inlay – cast predominantly base metal, two surfaces</td>
</tr>
<tr>
<td>D6605</td>
<td>Inlay – cast predominantly metal, three or more surfaces</td>
</tr>
<tr>
<td>D6606</td>
<td>Inlay – cast noble metal, two surfaces</td>
</tr>
<tr>
<td>D6607</td>
<td>Inlay – cast noble metal, three or more surfaces</td>
</tr>
<tr>
<td>D6608</td>
<td>Onlay – porcelain/ceramic, two or more surfaces</td>
</tr>
<tr>
<td>D6609</td>
<td>Onlay – porcelain/ceramic, three or more surfaces</td>
</tr>
<tr>
<td>D6610</td>
<td>Onlay – cast high noble metal, two surfaces</td>
</tr>
<tr>
<td>D6611</td>
<td>Onlay – cast high noble metal, three or more surfaces</td>
</tr>
<tr>
<td>D6612</td>
<td>Onlay – cast predominantly base metal, two surfaces</td>
</tr>
<tr>
<td>D6613</td>
<td>Onlay – cast predominantly base metal, three or more surfaces</td>
</tr>
<tr>
<td>D6614</td>
<td>Onlay – cast noble metal, two surfaces</td>
</tr>
<tr>
<td>D6615</td>
<td>Onlay – cast noble metal, three or more surfaces</td>
</tr>
<tr>
<td>D6740</td>
<td>Crown – porcelain/ceramic</td>
</tr>
<tr>
<td>D6750</td>
<td>Crown – porcelain fused to high noble metal</td>
</tr>
<tr>
<td>D6751</td>
<td>Crown – porcelain fused to predominantly base metal</td>
</tr>
<tr>
<td>D6752</td>
<td>Crown – porcelain fused to noble metal</td>
</tr>
<tr>
<td>D6780</td>
<td>Crown – 3/4 cast high noble metal</td>
</tr>
<tr>
<td>D6781</td>
<td>Crown – 3/4 cast predominantly base metal</td>
</tr>
<tr>
<td>D6782</td>
<td>Crown – 3/4 cast noble metal</td>
</tr>
<tr>
<td>D6783</td>
<td>Crown – 3/4 porcelain/ceramic</td>
</tr>
</tbody>
</table>
D6790  Crown – full cast high noble metal  
D6791  Crown – full cast predominantly metal  
D6792  Crown – full cast noble metal  
D6930  Re-cement fixed partial denture  
D6980  Fixed partial denture repair necessitated by restorative material failure  

**Oral Surgery** *(Dental Consultant review required)*  
D7140  Extraction, erupted tooth or exposed root (elevation and/or forceps removal)  
D7210  Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth  
D7220  Removal of impacted tooth – soft tissue  
D7230  Removal of impacted tooth – partially bony  
D7240  Removal of impacted tooth – completely bony  
D7241  Removal of impacted tooth-completely bony with unusual surgical complications  
D7250  Surgical removal of residual tooth roots (cutting procedure)  
D7251  Coronectomy – intentional partial tooth removal  
D7270  Tooth reimplantation and/or stabilization of accidentally avulsed or displaced tooth  
D7280  Surgical access of an unerupted tooth  
D7310  Alveoloplasty in conjunction with extractions-per quadrant  
D7311  Alveoloplasty in conjunction with extractions-one to three teeth or tooth spaces, per quadrant  
D7320  Alveoloplasty not in conjunction with extractions – per quadrant  
D7321  Alveoloplasty not in conjunction with extractions-one to three teeth or tooth spaces, per quadrant  
D7471  Removal of lateral exostosis (maxilla or mandible)  
D7510  Incision and drainage of abscess – intraoral soft tissue  
D7910  Suture of recent small wounds – up to 5 cm  
D7921  Collection and application of autologous blood concentrate product (once per 36 months)  
D7971  Excision of pericoronal gingival  

**Adjunctive Services**  
D9110  Palliative (emergency) treatment of dental pain-minor procedure  
D9223  Deep sedation/general anesthesia – 15 min increments – Limited to 30 minutes  
D9243  Intravenous conscious sedation/analgesia – 15 min increments – Limited to 30 minutes  
D9310  Consultation- diagnostic service provided by a dentist or physician other than requesting dentist or physician (1 per patient per provider per 12 months for specialties other than pedodontist or orthodontist)  
D9610  Therapeutic drug injection, by report  
D9930  Treatment of complications (post-surgical) – unusual circumstances, by report *(Dental Consultant review required)*  
D9940  Occlusal guard, by report (age 13 and older; once per 12 months)  
D9943  Occlusal guard adjustment (age 13 and older; once per 24 months)  

**Orthodontic Services** *(Dental Consultant review required)*  
The following services are covered under medical only when the services meet the criteria for coverage in this policy (see above)  
D0340  Cephalometric radiographic image  
D8010  Limited orthodontic treatment of the primary dentition  
D8020  Limited orthodontic treatment of the transitional dentition  
D8030  Limited orthodontic treatment of the adolescent dentition  
D8040  Limited orthodontic treatment of the adult dentition  
D8050  Interceptive orthodontic treatment of the primary dentition
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D8060</td>
<td>Interceptive orthodontic treatment of the transitional dentition</td>
</tr>
<tr>
<td>D8070</td>
<td>Comprehensive orthodontic treatment of the transitional dentition</td>
</tr>
<tr>
<td>D8080</td>
<td>Comprehensive orthodontic treatment of the adolescent dentition</td>
</tr>
<tr>
<td>D8210</td>
<td>Removable appliance therapy</td>
</tr>
<tr>
<td>D8220</td>
<td>Fixed appliance therapy</td>
</tr>
<tr>
<td>D8660</td>
<td>Pre-orthodontic examination to monitor growth and development</td>
</tr>
<tr>
<td>D8670</td>
<td>Periodic orthodontic treatment visit *</td>
</tr>
<tr>
<td>D8680</td>
<td>Orthodontic retention (removal of appliances, construction and placement of retainer(s))</td>
</tr>
<tr>
<td>D8999</td>
<td>Unspecified orthodontic procedure, by report</td>
</tr>
</tbody>
</table>

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

**RELATED POLICIES**
Not applicable

**PUBLISHED**
Provider Update, August 2017
Provider Update, October 2016
Provider Update, December 2015
Provider Update, November 2013

**REFERENCES**