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Dental Coding With Confidence

Charles Blair, DDS, Greg Grobmyer, DDS
& James DiMarino, DMD, MSEd, CDC, FACD

CDT 2025

practicebooster.com

Expires December 31, 2025

Thank you for purchasing *Dental Coding with Confidence (2025 Edition).*
We trust you will find this to be an invaluable resource for your practice!

> ***It is important for a practice to not only purchase new coding resources annually, but to also review the entire CDT code set. In addition to the new, revised, editorial revisions and deleted codes for CDT 2025, each CDT code in this publication has been reviewed and updated as applicable to ensure the most up-to-date information possible to assist the doctor and team in maintaining coding compliance. This Guide is current through December 31, 2025.***
>
> ***This Guide is subject to all US Copyright laws. See copyright notice on page 3.***

FOR DOCTORS

All doctors should review and refer to this Guide often. The treating doctor listed on the claim form is responsible for all information submitted on the claim, including but not limited to procedure codes, diagnoses codes, and narratives. This is true even if the treating doctor is an employee of the practice. Additionally, the team member primarily responsible for billing and/or the office manager responsible for training can be held accountable as well. It is the responsibility of the practice owner to invest in proper training and coding resources for the team. Develop written protocols and documentation of training to aid in compliance. Lack of investment in training and resources can be problematic for a practice. It is recommended that this Guide be used for new and existing team member training annually.

Our goal is to provide you with the most up-to-date and accurate information available at the time of printing this Guide and throughout the year. To achieve this goal, your purchase also includes online access to any new, updated, or revised information that becomes available through December 31, 2025.

Information will include, but not be limited to, bonus material and any revisions as applicable. See below for instructions on how to access bonus resources online for this Guide.

Access Exclusive Online Bonus Content
Available January 1, 2025

CDT 2025 EDITION

Dental Coding

With Confidence

The "Go To" Dental Coding Guide

Dramatically Cut Coding Errors and Boost Legitimate Reimbursement

2025 EDITION

Practice Booster Advisors:

Greg Grobmyer, DDS

Tiffany Wesley, FAADOM, RMTC

Amara Cashion

James DiMarino, DMD, MSEd, CDC, FACD

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Welcome

Thank you for purchasing Dr. Charles Blair's ***Dental Coding with Confidence (2025 Edition)***. We trust you will find this to be a valuable resource for your entire dental team!

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- Interpretations can be difficult due to the variability of interpretation and application of CDT (Current Dental Terminology) codes and insurance administration issues.
- Within the dental profession and insurance industry there is a degree of disagreement on the uses and application of various codes and insurance administration issues.
- Third-party contract language dictates reimbursement and in some cases, coordination of benefits.

By using this Guide, you agree that the interpretation and application of each code is made by the individual doctor and their supporting employees. Discounts, copay forgiveness, COB, and other matters are controlled by state, federal, payor contracts, and self-funded plans. The publisher is in no way responsible for any interpretation or final judgment made in conjunction using the information contained in this book. This Guide does not render legal advice. Seek an attorney's advice in all legal matters.

Insurance codes and code interpretations are updated by the American Dental Association (ADA) annually. Always rely on the most recent CDT version when reporting any dental procedure. Each annual CDT update includes new, deleted, and revised codes. It is essential that your practice reports exactly what is performed and documented as such using the most recent CDT code set. Accordingly, per the ADA Code of Ethics "code for what you do, and do what you coded for." Insurance companies vary in their interpretation of codes, and UCR (usual, customary and reasonable) or MPA (maximum plan allowance) fees vary among payors and from contract to contract. Reimbursement levels are determined by the purchased plan and its subsequent reimbursement schedule.

Contract provisions vary widely from contract to contract, and payor to payor. Always contact the individual insurance company or employer for specific contract provisions if you are unsure of its policy, reimbursement schedule, or exclusions. Benefits coverage is becoming increasingly more difficult to predict due to numerous and subtle exclusions, limitations, and alternate benefits designed to correspond with the employer's desire to reduce the premium level, or to limit a current premium increase. The bottom line is that employees will be paying more, out-of-pocket, for both dental and medical coverage in the future. Seek out state and federal law, and State Dental Board regulations as to discounts, copay forgiveness, patient referral gifts, and advertising restrictions.

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DENTAL CODING WITH CONFIDENCE ERROR CORRECTION UPDATES

With each annual update of new CDT codes there are disagreements among various industry experts and authorities as to the interpretation of the language of a given code, nomenclature, its descriptor, and other administrative matters. As a user, if you discover any recognized dental authority is at issue with the interpretations herein, please email info@practicebooster.com. The publisher's intent is for this Guide to be as accurate as possible. Each Guide should be registered (see previous registration page). If errors are identified, revisions and updates are available for registered users. This Guide is revised annually to reflect the most current information available, and to coincide with annual CDT code revisions. This Guide is current through December 31, 2025 and becomes obsolete January 1, 2026.

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Meet the Advisors



Greg Grobmyer, DDS
Editor-in-Chief/Senior Advisor

Dr. Greg Grobmyer practiced clinical dentistry for more than a decade before having to exit due to a cancer battle. After many years in practice management coaching, he now serves as Editor-in-Chief of Dr. Charles Blair's annually updated Dental Coding with Confidence publication and Practice Booster's Insurance Solutions Newsletter, a contributing editor to the Dental Administration with Confidence and Dental Documentation with Confidence publications, a course creator and lecturer for DentalZing.com, lead Revenue Enhancement Program Private Consulting Specialist, and host of The Dental Code Advisor Podcast. His dynamic career and unique expertise make him a sought-after speaker and consultant in the dental field.



Tiffany Wesley, FAADOM, RMTC
Integrator/Senior Advisor

As the Integrator at Practice Booster and Dental Zing, Tiffany works hand in hand with the team to create results through organizational transparency, cross-department integration, communication, and consistency. She oversees production and serves as a contributor/ editor for the Confidence series publications, and is a main contributor and curriculum creator for Practice Booster training programs. Tiffany also serves as a Practice Booster Advisor and Speaker empowering dental teams with confidence to maximize legitimate insurance reimbursement. She began her journey in dentistry in 2004 and is the Founder and CEO of Elevation Dental Consulting, LLC as well as a Robbins-Madanes Trained Coach in Strategic Intervention. Tiffany is a Fellow of the American Association of Dental Office Management and a member of the AADOM Speaker/ Consultant Alliance and Speaking Consulting Network. As a self-proclaimed recovering awkward person, her first published book, Little Miss Ava (2015), was dedicated to her oldest daughter with the hope of inspiring all little girls to dream big and never give up.



Amara Cashion
Advisor

Amara has passionately served the dental community since 2011 as a Dental Assistant in General Dentistry, Pediatrics, Oral Surgery, and Periodontics, as well as an Orthodontic Manager in a multi-specialty practice. She uses her vast knowledge and experience to teach and speak on insurance coding and administration as a Practice Booster Advisor, Editor/Contributor of Dental Administration With Confidence and Dental Documentation With Confidence, and a main contributor and curriculum creator for Practice Booster's Orthodontic Coding With Confidence training program. Amara takes her passion for education beyond dentistry, homeschooling her three amazing children and as a certified birth doula (CD), childbirth educator (CBE), breastfeeding counselor (CBC), and Spinning Babies® Certified Parent Educator (SpBCPE). As a birth doula, she has attended over 100 live births! She is also a Success Consultant and former Connection Coach and Talent Management Onboarding Specialist at eAssist Dental Solutions, Inc.

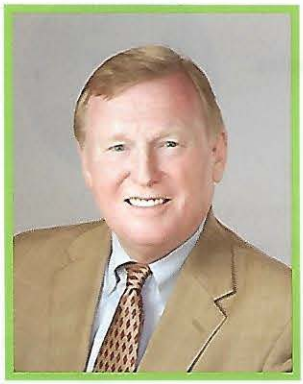


James DiMarino, DMD, MSEd, CDC, FADC

Chief Executive Officer/Senior Advisor

Dr. DiMarino is an international speaker and the Chief Executive Officer at Practice Booster and Dental Zing. He holds a Dental degree and a Master's degree in Education from the University of Pennsylvania. He completed a General Practice Residency and became a solopreneur practicing general dentistry, all while researching and implementing advanced dental technologies and consulting as a Dentrix and Schick trainer. Dr. DiMarino has worked in the dental insurance industry as a dental benefits consultant, State Dental Director, and National Dental Director. In 2018 he completed the certification requirements to become an AADC Certified Dental Consultant.

Dr. DiMarino served as the Director of Medical Affairs for GlaxoSmithKline, ensuring the effective deployment of safety, compliance, and governance standards across GSK's Consumer Healthcare business, which included: Sensodyne, ProNamel, Biotene, Parodontax, and Aquafresh in the USA, Canada, and Puerto Rico. As the Director of Clinical Affairs for Premier Dental Products, Dr. DiMarino coordinated product launch strategies, sales team, and dealer representative training, led their key opinion leader (KOL) engagement program, and participated in new product development. Dr. DiMarino is also a patented inventor, trainer, educator, publisher, and lecturer, having presented across the USA, Japan, Germany, London, Poland, Mexico, and Finland.



Our Founder: **Dr. Charles Blair**

"...visionary, mentor, friend, father-figure, and inspiration..."

Practice Booster was founded by Dr. Charles Blair, whose contributions to dentistry are unparalleled. As a pioneer in the field, he played a pivotal role in reshaping dental practice management. His expertise in dental insurance coding strategies and unwavering commitment to fair reimbursement practices revolutionized the business aspects of dentistry. Through his consultancy, he elevated the standards of countless dental practices, ensuring optimal patient care while fostering economic success.

Dr. Blair believed in the power of knowledge and continuous growth, his passion for education evident with degrees in Accounting, Business Administration, Mathematics, and Dental Surgery. Hand-selected and mentored by Dr. Blair himself, the Practice Booster team of Advisors are honored to continue his legacy and committed to remaining the industry's most trusted resource in insurance coding and administration.

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Acknowledgments

Thank you to the following for this current 2025 edition: Mandi Krasowski (design/layout), Dr. Greg Grobmyer (Editor-in-Chief), Mason Blair (production/design/editing), Tiffany Wesley (production/design/editing), Amara Cashion, and Dr. James DiMarino.

Thank you to the *entire* Practice Booster team for your dedication and hard work!

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Dental coding updates, tips, & tricks

It is our mission to bring peace of mind to dentists and their staff. Providing top-notch education is one of the many ways we do that.

DENTAL EDUCATION FROM A TO ZING

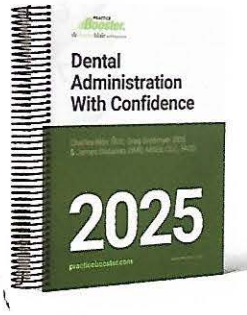
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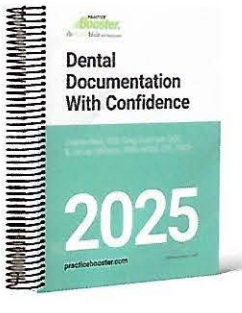
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Additional Publications & Resources

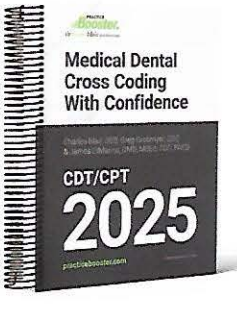
Coding Resources



Successfully navigate the hurdles of everyday dental insurance administration.



The clinical team's guide to successful documentation with procedure specific charting samples.



The expert resource for assistance in cross-coding dental procedures to medical procedures for the submission of medical claims.



Exclusive online membership with access to Code Advisor, a powerful online database of CDT codes, includes the ***Insurance Solutions Newsletter*** (with archives), plus valuable online resource center of Q&As and much more.

To purchase these additional resources and boost your practice profitability, go to *www.practicebooster.com/store* or scan the QR code.

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Introduction

There are several useful references available regarding CDT 2025 coding and dental terminology in the marketplace, cross-coding references, and other coding-related topics. You may very well have a library filled with them in your office. So why buy or use another Guide like this one?

Why this Guide is Different

This Guide is different in that it was written to specifically predict, and therefore prevent the typical coding errors, misuse, and common coding mistakes made by dental practices.

In this Guide the use and application of **Predictive Error Correction** is applied. Dr. Charles Blair developed **Predictive Error Correction** as the end result of the clinical protocol, code reporting, clinical procedure count and fee analyses of thousands of dental practices across the country. In addition to his analysis of this vast amount of practice data, his study also included seminars with thousands of doctors and front office team members. This resulted in the emergence of utilization patterns allowing him to design this Guide to assist you in dramatically preventing coding errors and to maximize legitimate insurance reimbursement.

As experienced business teams and dentists know, the *Current Dental Terminology* (CDT) system was designed to establish standardized codes and descriptions to report dental procedures. However, guidance as to the specific application of many of these codes is limited. In particular, there is not a publication that is designed to identify and correct common coding errors. This Guide provides that "missing link," with guidance and strategies for proper application and reporting of the current CDT 2025 codes, while greatly decreasing code reporting errors. This Guide contains an exhaustive Index at the end of the Guide, including products by trade name. This Guide's information is targeted to reduce errors and to optimize legitimate reimbursement.

Philosophy of Publication

As a consultant with experience in assisting thousands of dental practices in becoming more profitable and productive, Dr. Charles Blair and his team have "seen it all." They share their vast experience and expertise with the dental community through this 16th edition, **Dental Coding with Confidence: The "Go To" Dental Coding Guide for CDT 2025**, which has been specifically designed to:

- Provide extensive information regarding the proper use of reporting CDT 2025 codes.
- Offer advice and strategy to prevent coding errors, to encourage proper reporting, and to streamline clinical protocols using **Predictive Error Correction**.
- Provide supplemental information to the additions, revisions, and deletions in CDT 2025.
- Offer guidance on how to implement proper documentation and proven clinical protocols in the practice.

Take action today to REDUCE coding errors, prevent costly mistakes, limit audit exposure and improve legitimate reimbursement. Discover what you are doing well, but could be doing better, as well as what you should NOT be doing at all. Finally, learn how to implement this information to maximize long-term profitability and productivity, and to report codes and documentation accurately.

Other Publications/Resources

Dental Administration With Confidence - 2025 Edition is a must-have companion to this Guide. Successfully navigate the ins and outs of dental insurance administration and provide your team with solutions to the daily challenges faced by dental practices nationwide. Receive invaluable information on managing PPOs, calculating write-offs, COBs, top coding and administrative Q&As, and much more!

Dental Documentation with Confidence - 2025 Edition is the "go-to" guide for effective documentation and record-keeping for the dentist and clinical team. Access everything you need to know when obtaining and recording proper documentation.

Medical Dental Cross Coding with Confidence - 2025 Edition is the "go-to" source for expert assistance in cross coding dental procedures to medical procedures. It is designed to assist the beginner or experienced team member to effectively and efficiently submit dental procedures to the patient's medical plan with the application of ICD-10-CM codes. This Guide assumes the dental team understands proper CDT dental coding and reporting, then elevates that knowledge to cross coding CDT dental code(s) to the appropriate CPT® medical procedure code(s) and proper application of ICD-10-CM codes for the medical and dental claim.

PracticeBooster.com - the premier online resource that includes exclusive access to Code Advisor, a powerful online database of CDT codes, featuring an in-depth review of proper CDT coding, billing tips, and more. Also included is the **Insurance Solutions Newsletter**, access to the online resource center featuring Q & As, sample forms and checklists, call center support and much more! To order our invaluable publications and resources to boost your practice profitability, visit *www.practicebooster.com/store.*

New, Revised, Editorial Revisions and Deleted Procedures for CDT 2025

This book outlines 10 new procedures, 8 code revisions, 4 editorial revisions and 2 code deletions in CDT 2025. It is recommended that the reader quickly scan all of the code changes in this section to determine if any apply to your particular practice. The page numbers for these codes have been provided. Turn to the proper page for the code changes. The subject code will be highlighted in red as **"new procedure," "revised," "editorial revision,"** or **"deleted."** Read, in depth, the additions, revisions, and deletions of codes that apply to your practice. Refer to code tabs in the Guide to locate these new procedures, code revisions, and deletions. Some codes, particularly important, may NOT appear in numerical order because this is the order they are listed in CDT 2025. This is particularly true in the Implant code section. See the first page of the implant section for implant procedure page numbers which correlate with the various implant procedures.

NEW PROCEDURE TEN

CODE	Nomenclature/Descriptor	PAGE
D2956	REMOVAL OF AN INDIRECT RESTORATION ON A NATURAL TOOTH Not to be used for a temporary or provisional restoration.	144
D6180	IMPLANT MAINTENANCE PROCEDURES WHEN A FULL ARCH FIXED HYBRID PROSTHESIS IS NOT REMOVED, INCLUDING CLEANSING OF PROSTHESIS AND ABUTMENTS This procedure includes active debriding of the implant(s) and prosthesis. The patient is also instructed in thorough daily cleansing of the implant(s).	336
D6193	REPLACEMENT OF AN IMPLANT SCREW	338
D7252	PARTIAL EXTRACTION FOR IMMEDIATE IMPLANT PLACEMENT Sectioning the root of a tooth vertically, then extracting the palatal portion of the root. The buccal section of the root is retained in order to stabilize the buccal plate prior to immediate implant placement. Also known as the Socket Shield Technique.	382
D7259	NERVE DISSECTION Involves the separation or isolation of a nerve from surrounding tissues. Performed to gain access to and protect nerves during surgical procedures.	383
D8091	COMPREHENSIVE ORTHODONTIC TREATMENT WITH ORTHOGNATHIC SURGERY Treatment of craniofacial syndromes or orthopedic discrepancies that require multiple phases of orthodontic treatment including monitoring growth and development between active phases of treatment.	437
D8671	PERIODIC ORTHODONTIC TREATMENT VISIT ASSOCIATED WITH ORTHOGNATHIC SURGERY	440
D9913	ADMINISTRATION OF NEUROMODULATORS	467
D9914	ADMINISTRATION OF DERMAL FILLERS	468
D9959	UNSPECIFIED SLEEP APNEA SERVICES PROCEDURE, BY REPORT	496

REVISED EIGHT

CODE	Nomenclature/Descriptor/Subcategory	PAGE
D0160	DETAILED AND EXTENSIVE ORAL EVALUATION - PROBLEM FOCUSED, BY REPORT A detailed and extensive problem focused evaluation entails extensive diagnostic and cognitive modalities based on the findings of a comprehensive oral evaluation. Integration of more extensive diagnostic modalities to develop a treatment plan for a specific problem is required. The condition requiring this type of evaluation should be described and documented. Examples of conditions requiring this type of evaluation may include dentofacial anomalies, complicated perio-prosthetic conditions, complex temporomandibular dysfunction, facial pain of unknown origin, sleep related breathing disorders, conditions requiring multi-disciplinary consultation, etc.	20
D0801	3D INTRAORAL SURFACE SCAN – DIRECT A surface scan of any aspect of the intraoral anatomy.	44
D1330	ORAL HYGIENE INSTRUCTIONS	84
D2940	PLACEMENT OF INTERIM DIRECT RESTORATION Direct placement of a restorative material to protect tooth and/or tissue form. This procedure may be used to relieve pain, promote healing, manage caries, create a seal for endodontic isolation, or prevent further deterioration until definitive treatment can be rendered. Not to be used for endodontic access closure, or as a base or liner under a restoration.	138
D6011	SURGICAL ACCESS TO AN IMPLANT BODY (SECOND STAGE IMPLANT SURGERY) 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.	291
D6080	IMPLANT MAINTENANCE PROCEDURES WHEN A FULL ARCH FIXED HYBRID PROSTHESIS IS REMOVED AND REINSERTED, INCLUDING CLEANSING OF PROSTHESIS AND ABUTMENTS This procedure includes active debriding of the implant(s) and examination of all aspects of the implant system, including the occlusion and stability of the superstructure. The patient is also instructed in thorough daily cleansing of the implant(s).	331
D6081	SCALING AND DEBRIDEMENT OF A SINGLE IMPLANT IN THE PRESENCE OF MUCOSITIS, INCLUDING INFLAMMATION, BLEEDING UPON PROBING AND INCREASED POCKET DEPTHS; INCLUDES CLEANING OF THE IMPLANT SURFACES, WITHOUT FLAP ENTRY AND CLOSURE This procedure is not performed in conjunction with D1110, D4910, or D4346.	332
D6090	REPAIR OF IMPLANT/ABUTMENT SUPPORTED PROSTHESIS	334

EDITORIAL REVISION FOUR

D5520	REPLACE MISSING OR BROKEN TEETH - COMPLETE DENTURE - PER TOOTH	251
D5640	REPLACE MISSING OR BROKEN TEETH – PARTIAL DENTURE – PER TOOTH	253
D5650	ADD TOOTH TO EXISTING PARTIAL DENTURE – PER TOOTH	254
D6051	PLACEMENT OF INTERIM IMPLANT ABUTMENT A healing cap is not an interim abutment.	300

DELETED TWO

D2941	INTERIM THERAPEUTIC RESTORATION – PRIMARY DENTITION This is a deleted code. See D2940 for further details.	139
D6095	REPAIR IMPLANT ABUTMENT, BY REPORT This is a deleted code. See D6090 for further details.	336

Explanation of the Use of the Legends

Throughout the CDT 2025 Code section of this Guide, you will find Coding Correction Warning, Watch, and Match legends depicting many common mistakes, as well as specific Comments, Limitations, Tips, Narratives, Photos, and Clinical Flow Chart legends. In addition, New Procedure, Revised, Editorial Revision, Deleted Code, Previously Deleted Code, and the Author's Comments comprise the other legends. Each legend's description and purpose is as follows:

LEGENDS	DESCRIPTIONS
CDT 2025	This legend designates the official CDT 2025 code, nomenclature, and descriptor. The Code and nomenclature is always enclosed in a solid "bar", plus a "box", if applicable, which contains the descriptor. Current Dental Terminology (CDT) ©2025 American Dental Association. All rights reserved.
 WARNING	This legend signifies a serious misuse of reporting the code, which could be considered fraudulent or at the minimum, misleading. The legend's description may offer correct, alternate coding and in some cases offer another legitimate approach for better reimbursement.
WATCH	This legend can signify a misuse of reporting the code. The economic result of the misuse may be financially positive in the short term, but misuse is always costly in the long run. In most cases, the correct or alternate code is listed for reference.
 MATCH	This legend identifies a code which is a "match" for an associated or complimentary code. For instance, this legend would illustrate the proper code match for the pontic and retainer crown of a bridge.
COMMENTS	The "Comments" legend offers commentary and information about the code.
LIMITATIONS	The "Limitations" legend spells out common limitations and exclusions of the use of this code in insurance contract language.
TIPS	The "Tips" legend signifies a legitimate approach that may result in improved benefit coverage.
NARRATIVES	The "Narratives" legend offers suggestions regarding narratives and documentation.
 PHOTO	This legend identifies a photograph of an appliance, restoration, implant, model, or radiographic image.
CLINICAL FLOW CHARTS	This legend illustrates a scenario in which the code is used in a proper clinical sequence associated with other procedures.
NEW PROCEDURE	This legend identifies a new procedure code. There are 10 new procedure codes in CDT 2025.
REVISED	This legend identifies a substantive revision in the nomenclature and/or the descriptor of a code. Be sure to read the entire description of the revised code. There are 8 code revisions in CDT 2025.
EDITORIAL REVISION	This legend identifies editorial code changes made by the Code Maintenance Committee for CDT 2025. There are 4 editorial revisions in CDT 2025.
DELETED CODE	This legend identifies a procedure code that was deleted. There are 2 deleted codes in CDT 2025.
PREVIOUSLY DELETED CODE	This legend identifies a procedure code that was previously deleted. The Guide continues to carry previously deleted codes for reference and to guide the reader to a current code, if applicable.
AUTHOR'S COMMENTS	This legend identifies the author's general comments.

CODE ON DENTAL PROCEDURES AND NOMENCLATURE

DIAGNOSTIC CDT 2025

CLINICAL ORAL EVALUATIONS CDT 2025

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 CDT 2025

An evaluation performed on a patient of record to determine any changes in the patient's dental and medical health status since a previous comprehensive or periodic evaluation. This includes an oral cancer evaluation, periodontal screening where indicated, and may require interpretation of information acquired through additional diagnostic procedures. The findings are discussed with the patient. Report additional diagnostic procedures separately.



WARNING

1. It is improper to report a periodic oral evaluation (D0120) or any other evaluation unless *the doctor* completed the clinical evaluation (on the patient) and performed the evaluation. A hygienist can *screen* but not *diagnose* unless specifically permitted by state law.
2. It is improper to charge insurance patients for a periodic oral evaluation (D0120), while the evaluation is "free" for non-insured patients. Treatment and fee protocols should always be identical for both insured *and* non-insured patients.
3. The periodic oral evaluation (D0120) code includes an oral cancer evaluation (OCE). *The fact that the oral cancer evaluation was done and any significant findings* should be documented in the clinical notes.
4. D0120 is reported only for a patient of record (established patient), not a new patient.

WATCH

1. Some offices *do not* report periodic oral evaluation (D0120) or the comprehensive periodontal evaluation (D0180) in conjunction with periodontal maintenance (D4910). The oral evaluation is *not* included in D4910. Oral evaluations may be reported in addition to D4910, periodontal maintenance, when completed. The clinician may choose to perform an oral evaluation every other visit for a three-month periodontal recare patient, twice per year, or as deemed necessary.
2. The reimbursement frequency for D0120 is almost always limited. See limitations below.
3. Do not report a new patient child comprehensive oral evaluation (D0150) using a lower fee periodic oral evaluation (D0120). See Tip #6 below.
4. If the child is *less* than three years of age, see D0145 to report an oral evaluation. Counseling (diet, fluoride, oral hygiene, etc.) with a primary caregiver is required to report D0145. D0145 is not considered a "comprehensive" oral evaluation.

COMMENTS The findings are discussed with the patient.

LIMITATIONS

1. D0120, as all evaluations, is typically subject to the "two evaluations per year" or "one per six months" limitation, as established by the plan document. However, some payors will reimburse for a *third* oral evaluation when performed in a different office or if there is an *additional* problem focused oral evaluation during the limitation period. To control costs, some employers are choosing plans that have a "one evaluation per year" limitation.
2. Periodontal maintenance (D4910) does not include any type of oral evaluation as part of the procedure. Most doctors perform and report two periodic oral evaluations (D0120) per year for both periodontal and non-periodontal patients. The comprehensive periodontal evaluation (D0180) may also be used to describe a periodontal evaluation for an established periodontal patient under certain circumstances, particularly in conjunction with D4910. See D0180 for specific reporting requirements and patient criteria. Note that some new contracts are trending toward the global "one evaluation per year" limitation.

3. Some payors process orthodontic consultations as D0120, D0150, D0160, D8660, or D9310. These codes are generally subject to the overall "two evaluations per year" limitation. Reimbursement may be limited to the maximum plan allowance (MPA) of a D0120 periodic oral evaluation, regardless of the *specific* evaluation code submitted. If a *third* evaluation is reimbursable in a different office, the orthodontic evaluation may be reimbursed. This reimbursement, when paid, may or may not be processed under a separate orthodontic maximum. In some cases, consultation (D9310) whether by a specialist or general practitioner is reimbursed in addition to the "one" per six months or "two" oral evaluations per year. See D9310.

Note: Either D0150 or D0180 may be reported for comprehensive oral evaluations of *established* patients under *specific* circumstances. However, some payors will reimburse these comprehensive evaluations at the lower periodic oral evaluation (D0120) maximum plan allowance (MPA) fee. See D0150/D0180 for specific details for their limited use with *established* patients.

TIPS

1. The periodic oral evaluation (D0120) includes "periodontal screening, where indicated." A periodontal screening may, or may not be performed at a D0120 visit. This does not mean complete periodontal probing and charting is required at each periodic oral evaluation in order to report the periodic oral evaluation code. There is no separate (stand-alone) code for full mouth periodontal probing and it is included (when performed) in all oral evaluation procedures. If a full mouth probing and charting is performed on a separate, stand-alone visit, see both D0180 and D4999 for reporting. Some patients may not require a periodontal screening (e.g., young children or edentulous patients).
2. The periodic oral evaluation (D0120) includes mandatory oral cancer evaluation by the dentist, which should always be noted in the clinical record.
3. If the need for active periodontal treatment (SRP or osseous surgery) is diagnosed at the periodic oral evaluation, a comprehensive periodontal evaluation and full probing and charting should be performed to document the necessity of treatment for SRP. This evaluation should be reported as D0180 (provided a full mouth probing and charting is performed), but the reimbursement level may be limited to the D0120 fee by payors.
4. If the doctor's productivity is suffering due to frequent interruption for hygiene check oral evaluations, consider a periodic oral evaluation (D0120) of the low-risk patient *once* per year, as generally permitted by state law.
5. For low-risk hygiene patients, with a clean mouth, consider extending the routine six-month prophylaxis interval to seven-nine months. This would help to open hygiene time for more productive periodontal hygiene appointments.
6. Some offices *erroneously* report a *periodic* oral evaluation (D0120) rather than a *comprehensive* oral evaluation performed on children who are new patients (D0150) in an effort to hold down the initial comprehensive oral evaluation fee. This is a common error. The child evaluation is simpler (quicker) and prophylaxis, fluoride, and diagnostic radiographic images are typically performed on the same service date. The total visit fee could be priced appropriately. Doctors should establish two consistent fees (adult and child) for code D0150. To distinguish between the two, use D0150A (child) and D0150B (adult), or similar coding to distinguish the fee structure within your software program. The computer software will not post the "A" or "B" code for reporting purposes on the walk-out statement or electronic claim form. With this approach, the reimbursement will be higher for the child comprehensive evaluation (D0150) while the proper code is reported. Report D0150 for ages three and up.
7. An oral evaluation (either initial or recare) for a child under three years of age must include counseling with a caregiver if reporting D0145. If the periodic oral evaluation for a child under three years of age does not include counseling with the caregiver, report D0120.
8. Additional diagnostic procedures should be reported separately. Although generally not covered by dental plans, it is considered appropriate to bill caries susceptibility tests (D0425), viral cultures (D0416), etc., separately.

D0140 LIMITED ORAL EVALUATION - PROBLEM FOCUSED — CDT 2025

An evaluation limited to a specific oral health problem or complaint. This may require interpretation of information acquired through additional diagnostic procedures. Report additional diagnostic procedures separately. Definitive procedures may be required on the same date as the evaluation.

Typically, patients receiving this type of evaluation present with a specific problem and/or dental emergencies, trauma, acute infections, etc.



WATCH

1. Limited oral evaluation - problem focused (D0140) should not be used to report a routine periodic hygiene evaluation (D0120); however, should a routine periodic oral evaluation turn into a more complex problem focused evaluation requiring *additional* diagnostic time, then D0140 may be reported rather than D0120. The additional time spent and specific concerns addressed should be documented in the patient record.

2. Reporting a single bitewing (BW) image taken at the D0140 appointment may potentially exhaust the annual "once per year" BWX allowance. Periapical (PA) diagnostic images exposed at the *emergency* evaluation typically do not count against the annual BWX limitation. PAs are considered separate *stand-alone procedures*. Periapicals may have a deductible and a maximum fee limitation applied if multiple periapical films are exposed on the same service date or if multiple PAs or a Full Mouth Series (FMX) have been taken within the plan's limitation period.
3. Consider D0140 for new patient evaluations when a self-referring patient requests a second opinion related to a problem focused complaint. Consider a D0150/D0180 oral evaluation if the self-referred patient has been provided a comprehensive treatment plan by another dentist and the patient is seeking a second opinion.
4. Some doctors perform a *procedure* at a visit, but erroneously report this procedure as a problem focused limited oral evaluation (D0140). D0140 is an oral evaluation code, not a treatment code. If a *procedure* was performed due to discomfort, sensitivity, or pain as reported by the patient, D9110 may be reported (see palliative (D9110) for further details). In some cases, D9110 and D0140 may not be reimbursed if reported on the same service date. Likewise, the problem focused oral evaluation (D0140) may be denied if reported on the same service date that definitive treatment is performed. Some practices do not use D0140 but save the evaluation allowance for the comprehensive oral evaluation (D0150/D0180) or periodic evaluation (D0120) visit. This billing/coding decision is sometimes influenced by the fact that the D0150 and D0180 have a higher UCR (usual, customary and reasonable) fee. However, D0140 is a stand-alone code and may be reported in *addition* to any other treatment procedures rendered on the same service date, i.e., extraction, filling, or palliative (D9110), etc., but remember the reimbursement is subject to the plan's limitations.

COMMENTS

1. The limited oral evaluation - problem focused (D0140) may be used to evaluate *one* problem or complaint (emergency). Specialists may also report D0140. A periodontist could report this evaluation code for a limited evaluation in association with a crown lengthening, bone graft procedure, or frenectomy. An endodontist may report D0140 in association with an evaluation for a root canal. The use of, and reimbursement for, D0140 in these examples is highly variable.
2. Under certain circumstances involving referral from a different healthcare practitioner, consultation (D9130) may be reported instead of D0140. See D9310.

LIMITATIONS

1. Many payors limit evaluations (of any type) to "two evaluations per year/12 months" or "one per six months." This type of evaluation (D0140) is often denied as an "extra" evaluation. There are exceptions to this general rule. Some payors will reimburse a problem focused evaluation (D0140) or evaluation with a specialist in *addition* to the two annual periodic oral evaluation visits per year. In addition, there are a few plans that allow up to three limited oral evaluations per year. A very few plans have no frequency limitations. Sometimes a consultation (D9310) is reimbursed for a visit to a specialist in addition to the typical "two oral evaluations per year." Thus, the reimbursement for D0140 or D9310 is highly variable.
2. Some payors will not reimburse D0140 in conjunction with a definitive procedure (e.g., extractions, fillings, etc.) on the same service date. For example, the extraction and periapical diagnostic images are typically reimbursed, while D0140 performed on the same service date may be denied. However, D0140 *is* a *stand-alone* code and always may be charged in *addition* to the clinical procedure provided. If the doctor is out-of-network, the patient can be expected to pay out-of-pocket for the D0140 evaluation under this scenario.

TIPS

1. Some offices charge for D0140 in conjunction with an extraction when the patient is not a patient of record as the new emergency patient requires additional time and effort to process and set up a chart. This being the case, the office policy and protocol should be *consistent* for both insured and non-insured patients.
2. Palliative (D9110) and periapical diagnostic images (D0220/D0230) could go *hand-in-hand* for emergency and other evaluations when the situation involves a non-definitive procedure. Conversely, even reporting a bitewing - single radiographic image (D0270) in conjunction with a problem focused evaluation (D0140) or any other visit may apply toward a plan's bitewing limitation and impact reimbursement for bitewings taken at a subsequent visit. See D0270/D0272/D0273/D0274 for further details. Even so, always report what you do; never change a code for reporting purposes or just to gain higher reimbursement.
3. Pulp vitality test (D0460) is a *stand-alone* code. The payor's fee for D0460 is often a little less than D0140. Some payors limit the benefits to *either* D0140 or the pulp vitality test (D0460) reported on the same service date. *When the "two evaluations per year" are exhausted, D0460 may possibly be reimbursed on a "stand-alone" basis. See D0460 for further details on reporting this code on a "stand-alone" basis at the emergency visit.*

4. Consider limiting the use of problem focused limited oral evaluations (D0140) as they often count toward the "one evaluation per six months" or "two evaluations per year/12 months" limitation. Consider reporting palliative treatment of dental pain - per visit (D9110) along with any necessary periapical radiographic images (D0220/D0230) as an alternative to D0140 when a procedure is performed to relieve pain communicated by the patient. See D9110 for comments about the proper usage of the palliative code, D9110. D0140 can *always* be reported in conjunction with D9110; however, payors may have plan-specific limitations in place regarding the reimbursement of D0140 when performed on the same date of service by the same dentist/ dental office as D9110.

NARRATIVES

Separate diagnostic procedures may be reported in addition to, and apart from, D0140. Radiographs and viral cultures (D0416) are examples of services that may be reported separately. The additional procedures must be deemed necessary by the doctor to evaluate the specific problem/complaint and be supported by a narrative derived from the dentist's clinical notes.

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

CDT 2025

Diagnostic services performed for a child under the age of three, preferably within the first six months of the eruption of the first primary tooth, including recording the oral and physical health history, evaluation of caries susceptibility, development of an appropriate preventive oral health regimen and communication with and counseling of the child's parent, legal guardian and/or primary caregiver.

COMMENTS

1. Key elements of D0145:
    a. The goal is early intervention/development of a prevention plan - performed on patients under three years of age.
    b. Includes diagnostic services:
        i. Recording the oral and physical health history.
        ii. Evaluation of caries susceptibility (risk assessment).
        iii. Does the child have developmental problems?
        iv. Does the primary caregiver have active caries?
        v. Development of a plan to reduce the child's risk of caries.
    c. Must also include counseling with the child's primary caregiver, which might include:
        i. Instructions for cleaning child's teeth.
        ii. Fluoride recommendations.
        iii. Diet recommendations.
        iv. Recommendations to reduce transmission of bacteria (e.g., antibacterial rinses, xylitol, saliva substitutes, etc.).
2. D0145 is an oral evaluation code for the patient who has not reached the age of three and must include counseling with the primary caregiver. Note that the D0145 oral evaluation is not identified as either "comprehensive" or "periodic." D0145 should be reported for the initial oral evaluation and may also be used for subsequent oral evaluation visits so long as the child remains under the age of three and *counseling* is provided at each visit. The code *specifically* includes preventive counseling with the primary caregiver.
3. Once the child reaches three years of age the periodic oral evaluation (D0120) would be reported. If the child is under three years of age at the time of the periodic oral evaluation, consider D0120 if *no counseling* is provided to the primary caregiver at the visit.

LIMITATIONS

1. When the child reaches three years of age or older report the comprehensive oral evaluation (D0150) at the first visit, or periodic oral evaluation (D0120), whichever applies to the child's current evaluation status. If D0145 has been reported previously, then a *comprehensive* evaluation has not technically been performed. However, if D0150 is reported at age three for the patient, many payors will provide the downgraded alternate benefit of D0120.
2. D0145 is often subject to the "one evaluation per six months" or "two evaluations per year" contract limitation each year.

TIPS

1. The descriptor for D0145 does not prevent one from reporting a prophylaxis (D1120) separately when performed on the same day as an oral evaluation of a patient under three years of age. If plaque is removed from a child's teeth, regardless of the technique, it can be reported as D1120. Likewise, if topical fluoride treatment (any type, except fluoride varnish) is applied, regardless of the number of teeth, report D1208. Report D1206 if fluoride varnish is applied. For children under the age of six, fluoride varnish (D1206) is now recommended by both the ADA and AAPD. Preventive procedures such as toothbrush deplaquing and fluoride applications can be reported separately when performed on the same service date as D0145.
2. D0145 may be reimbursed at the D0120 fee level by some payors. However, in most cases the reimbursement for D0145 is higher than D0120. Note that in some states Medicaid reimburses D0145 at a higher Maximum Plan Allowance (MPA) level than D0150.

D0150 COMPREHENSIVE ORAL EVALUATION - NEW OR ESTABLISHED PATIENT CDT 2025

Used by a general dentist and/or a specialist when evaluating a patient comprehensively. This applies to new patients; established patients who have had a significant change in health conditions or other unusual circumstances, by report, or established patients who have been absent from active treatment for three or more years. It is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues. It may require interpretation of information acquired through additional diagnostic procedures. Additional diagnostic procedures should be reported separately.

This includes an evaluation for oral cancer, the evaluation and recording of the patient's dental and medical history and a general health assessment. It may include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, existing prostheses, occlusal relationships, periodontal conditions (including periodontal screening and/or charting), hard and soft tissue anomalies, etc.



WARNING

1. It is improper to report a comprehensive oral evaluation (D0150) or any other oral evaluation unless the doctor has physically *(hands in mouth!)* evaluated the patient.
2. It is improper to charge insured patients for a comprehensive oral evaluation (D0150) while the evaluation is "free" for non-insured patients. Treatment and fee protocols should be identical for both insured and non-insured patients. Otherwise, this practice may be considered "discriminatory" and may be deemed "overbilling" by payors, a potentially fraudulent billing activity. PPO contracts commonly require charges be consistant between patients regardless of insured status.
3. D0150 should only be repeated if a patient has been absent from the practice for three years or has had significant changes to their health. Do not routinely repeat D0150 every three years for all patients.
4. The comprehensive oral evaluation (D0150) code includes an oral cancer evaluation (OCE). The fact that the oral cancer evaluation was completed and any significant findings should always be documented in the clinical notes.
5. If the patient has signs or symptoms of periodontal disease or risk factors such as smoking or diabetes, consider reporting D0180 comprehensive periodontal evaluation instead of D0150. D0180 would be the more accurate code and the fee and reimbursement may be higher.

WATCH

1. Consider reporting D0150/D0180 when the *self-referring* patient has already been treatment planned by a previous dentist for *comprehensive* treatment and is requesting a second opinion. If the patient has been referred by another provider, consider reporting D9310.
2. D0150 may be reported on the same service date with scaling in the presence of generalized moderate or severe gingival inflammation - full mouth, after oral evalutation (D4346). See D4346.
3. In cases where there are access to care issues, D0150 may be reported on the same service date as full mouth debridement (D4355), but this should not include periodontal records or diagnosis. See D4355.

LIMITATIONS

1. The comprehensive oral evaluation (D0150) is *comprehensive* and extensive in nature and *may* include periodontal screening and/or charting, depending on the age/circumstances of the patient. The comprehensive evaluation includes mandatory evaluation for oral cancer. The general dentist would either report D0150 or D0180 for most new patients since these evaluations by definition are all encompassing and extensive. A general dentist or periodontist would generally use D0180 for the new and established patient if he/she exhibit signs and symptoms of periodontal disease, or has risk factors such as smoking or diabetes. Nothing precludes the general practitioner from using D0180 for the new and established patient, provided the patient has signs and symptoms of periodontal disease or risk factors such as smoking or diabetes. If D0180 is reported, a mandatory full mouth (six points/tooth) probing and charting is necessary and should be completed on the day D0180 is reported. D0180 is encouraged in the GP office for new patients exhibiting signs or symptoms of periodontal disease as it is the more accurate code and the fee and reimbursement may be higher. D0150 applies to both new child and adult patients. (For a child less than three years of age, see D0145 for an oral evaluation.) The benefit for the comprehensive oral evaluation (D0150) is generally subject to the "one per six months" or "two evaluations per year" limitation. Some payors will reimburse a third evaluation within the limitation period when a specialist performs the oral evaluation in a different office or if the evaluation is a problem focused oral evaluation (D0140) or a consultation (D9310).
2. D0150 may be reported again for an extensive evaluation of an *established* patient in *very limited* circumstances. Generally, this requires a significant change in health status (these can include, but are not limited to, a new diagnosis of cancer, HIV/AIDS, diabetes, Sjögren's syndrome, GERD, bulimia, epilepsy, heart disease, asthma, etc.) or *absence* from *active* treatment for a period of three years or more. In spite of criteria in the descriptor, many payors still remap D0150 down to D0120, at the lower fee. The payor may consider D0150 to be "once per lifetime" per office. Others use an every "three" or "five" year reimbursement rule for D0150. Some payors reimburse consultation (D9310) on a case-by-case basis to specialists. D9310 should generally be reported when rendering a consultation by a specialist or general practitioner who may or may not provide treatment. See "consultation" (D9310) for further details.
3. Some payors reimburse orthodontic evaluations (consultations) as either D0120 or D0150 and limit the reimbursement to the lower UCR fee. These evaluations are generally subject to the "one per six months" or "two evaluations per year" limitation. In some cases, a third oral evaluation may be reimbursed if it is provided by a different office or a specialist.

TIPS

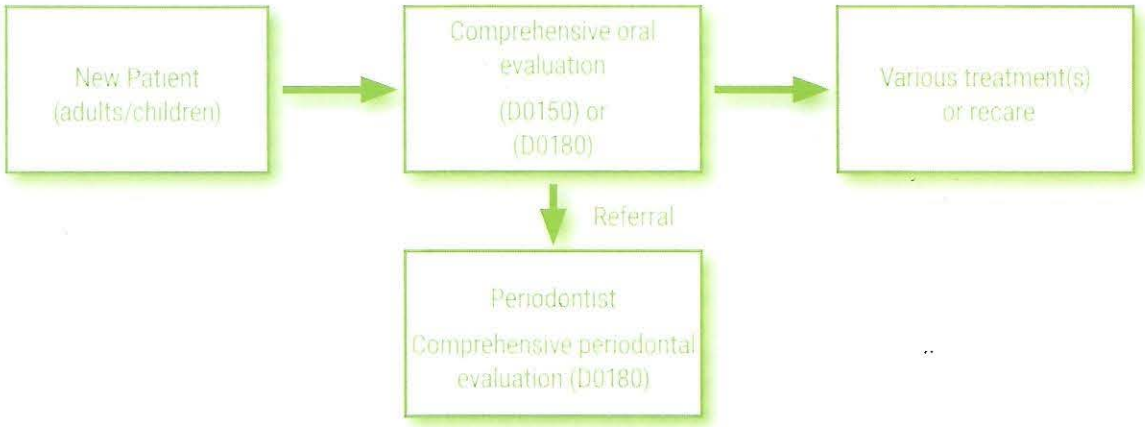
1. The vast majority of payors reimburse the *same* fee for a comprehensive oral evaluation (D0150), whether for child or adult. The first visit for a child the age of 3 years and above may include the comprehensive oral evaluation (D0150), as well as billing out a prophylaxis, fluoride, and diagnostic radiographic images. Some practices charge less for the child's comprehensive oral evaluation (D0150). Practices may establish two fees (child and adult) for D0150. To distinguish between the two scenarios, establish separate in-office codes with different fees. The office may establish "in house" codes of D0150A (child) and D0150B (adult) with different fees. Using this approach, the corresponding code is reported (D0150A, child or D0150B, adult). By implementing this system, the reimbursement level will typically be higher for the D0150A, child evaluation, than the periodic oral evaluation (D0120). This will allow the fee for the child comprehensive evaluation to be less than the adult comprehensive evaluation. If configured correctly, the computer software will reference the "A" or "B" from the code when assigning the fee but remove the "A" or "B" from the code when posting the procedure on the claim form. For a child less than three years of age, see D0145 for reporting an oral evaluation. Note that counseling must be provided to the primary caregiver at the D0145 visit.
2. A comprehensive oral evaluation (D0150) may include a periodontal screening and/or charting:
    a. Periodontal screening includes selected six-points-per-tooth probing. The words "may include" in the descriptor, simply acknowledges that some patients may not require a periodontal screening or charting (e.g., young children or edentulous patients).
    b. Periodontal charting includes, but is not limited to, recording six-points-per-tooth pocket depths, recessions, furcations, areas of mobility, bleeding points, minimal attached gingiva notations, suppuration, etc.
        i. A dentist "may" determine a full-mouth periodontal charting is not necessary if the periodontal screening was within normal limits.
        ii. A dentist "may" decide not to perform a full-mouth periodontal charting if he/she intends to refer the patient to a periodontist based on the results of the periodontal screening.
    c. If the patient has signs and symptoms of periodontal disease and/or risk factors such as smoking or diabetes, and periodontal records are obtained, consider reporting D0180 comprehensive periodontal evaluation instead of D0150, as D0180 may carry a higher fee and reimbursement.
3. Additional diagnostic procedures should be reported separately such as radiographs, caries susceptibility tests, genetic tests, viral cultures, diagnostic casts, etc.

NARRATIVES

If a comprehensive oral evaluation (D0150) is reported for an *established* patient, list the significant change(s) in health status or the number of years the patient has been absent from active treatment (must be three years or more). Note that many payors consider D0150 "once in a lifetime" and will downgrade the payment based on the fee schedule for D0120.

CLINICAL FLOW CHARTS

Typical new patient scenario (assuming that calculus/debris still permits the comprehensive oral evaluation (D0150) or comprehensive periodontal evaluation (D0180) at the initial visit):



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

CDT 2025

A detailed and extensive problem focused evaluation entails extensive diagnostic and cognitive modalities based on the findings of a comprehensive oral evaluation. Integration of more extensive diagnostic modalities to develop a treatment plan for a specific problem is required. The condition requiring this type of evaluation should be described and documented.

Examples of conditions requiring this type of evaluation may include dentofacial anomalies, complicated perio-prosthetic conditions, complex temporomandibular dysfunction, facial pain of unknown origin, sleep related breathing disorders, conditions requiring multi-

LIMITATIONS

1. Many payors limit oral evaluations of any type to "two evaluations per year" or "one per six months." D0160, as all oral evaluation codes, is typically subject to the oral evaluation limitation.
2. D0160 requires a report/copy of the complex diagnosis.
3. D0160 requires the use of more extensive diagnostic modalities, and treatment is usually performed over an extended length of time.
4. Frequency limitations for D0160 vary widely. Some dental plans provide a benefit once per dentist/dental office. Some apply it to their D0150 or D0180 frequency limit. Others consider it part of the plan's evaluation limitation policy. Most plans require a report whenever D0160 is submitted while others only request a report if they feel the code is being abused. Note: Some plans require the evaluation history of the patient that may include the date(s) of previous comprehensive oral evaluation(s) (D0150/D0180) before paying for D0160.
5. Consultation (D9310) may also be reimbursed to specialists by some payors. See Consultation (D9310).
6. D9450 (case presentation, detailed and extensive treatment planning) can be reported subsequently since D0160 requires the use of more extensive diagnostic modalities. Also note, however, that most payors do not pay for D9450 and most dentists do not charge for the case presentation unless an upfront laboratory expense is incurred. See D9450.

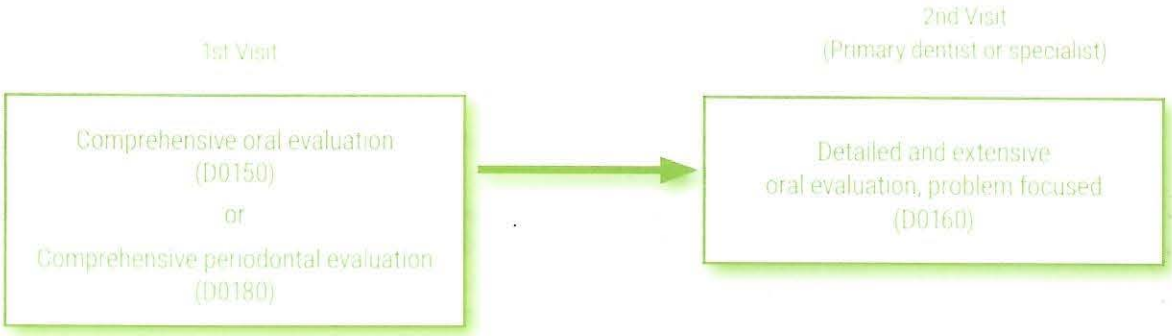
NARRATIVES

Provide a complete narrative for D0160 that supports the need for this detailed and extensive evaluation. History of the comprehensive oral evaluation (D0150/D0180) may be required prior to reporting D0160 for reimbursement.

CLINICAL FLOW CHARTS

Detailed and extensive oral evaluation, problem focused (D0160) scenario:

The patient presents at a second evaluation appointment with *extensive* problems based on the findings of an initial comprehensive oral or periodontal evaluation (D0150/D0180). An example of a condition not fully covered (in depth) in the routine comprehensive oral evaluation would be a complex TMJ case. An in-depth, detailed, and extensive oral evaluation (D0160) is necessary to *further evaluate* a *previously* discovered condition at a previous evaluation appointment.



Notes: The detailed and extensive oral evaluation (D0160) can be preceded by a comprehensive oral evaluation (D0150 or D0180). D0160 is a *detailed* and *extensive* oral evaluation following the *discovery* of a complex periodontal, TMJ, restorative, etc. condition. Write a complete report and document time spent in determining the diagnosis and treatment plan. However, some payors continue to reimburse D0160 at the lower subsequent periodic oral evaluation (D0120) fee subject to any frequency limitations and availability.

A specialist could report D0160 for a complex case referred by a GP who previously performed a D0150 or D0180.

D0170 RE-EVALUATION - LIMITED, PROBLEM FOCUSED (ESTABLISHED PATIENT; NOT POST-OPERATIVE VISIT) CDT 2025

Assessing the status of a previously existing condition. For example: A traumatic injury where no treatment was rendered but patient needs follow-up monitoring; evaluation for undiagnosed continuing pain; soft tissue lesion requiring follow-up evaluation.

WATCH

1. Based on the nomenclature and descriptor language, the re-evaluation - limited, problem focused (D0170) should not be reported following definitive treatment (i.e., periodontal, root canal, extraction post-op). The fee for any initial periodontal treatment, such as scaling and root planing (SRP), usually includes any post-operative evaluation associated with said procedure. Likewise, a post-operative (within thirty days) routine evaluation after oral surgery would generally be considered inclusive in the surgery fee. However, an extensive infection following surgery, for instance, could be reported separately. See treatment of complications (post-surgical), D9930.
2. D0170 should not be used to report a post-operative re-evaluation. In other words, it should not be used when re-evaluating a patient following surgical extraction, root canal, implant surgery, etc. D0171 reports re-evaluation - post operative office visit (D0171). Both D0170 and D0171 could not be reported on the same service date. D0171 would generally be a no charge as the post-operative visit is part of the global fee.
3. D0170 should not be used to report a periodontal re-evaluation of charting and probing. The nomenclature of D0170 specifically indicates it is *not* for a post-operative visit. Currently, there is no *specific* code to report a stand-alone periodontal re-evaluation by a hygienist, so unspecified periodontal procedure, by report (D4999) could be used to report this procedure, if done by a hygienist. However, D4999 is rarely reimbursed. Those doctors who do not participate in the patient's dental plan may hold the patient responsible for payment of the unspecified D4999. If a comprehensive periodontal evaluation is performed *by the dentist* including complete charting and probing, D0180 could be reported. A fee that is $10-$15 above the D0120 fee is suggested. However, D0180 would be subject to any reimbursement limitations, like any evaluation. If the doctor is just doing a cursory exam, a re-evaluation (D0171) may be appropriate.
4. If reporting an "office visit" that is not a re-evaluation and where no other work is performed, consider D9430. See the entry for D9430 for more information.

MATCH

D0170 should be reported when "assessing the status of a previously existing condition," such as a soft tissue lesion or trauma requiring a *follow-up* evaluation. Typically, D0170 would be *preceded* by the comprehensive oral evaluation (D0150), comprehensive periodontal evaluation (D0180), the limited oral evaluation - problem focused (D0140) visit, periodic oral evaluation (D0120), or pallative (D9110).

COMMENTS

1. Key elements of D0170:
   a. Involves the re-evaluation of an *established* patient for a specific problem and is not a post-operative visit.
   b. Typically used to report the follow-up monitoring of soft tissue abnormalities, such as an aphthous ulcer, leukoplakia, erythroplakia, etc.
   c. Can also be used to report follow-up appointments to monitor/evaluate trauma to soft tissue or teeth following an accident, root development after apexogenesis, and continuing undiagnosed pain.
2. Consider limiting the use of re-evaluation - limited, problem focused (D0170), since the payor's fee is generally *lower* than other evaluations. This procedure generally is subject to the "two evaluations per year/12 months" or "one evaluation per six months" limitation. Occasionally payors will reimburse a third evaluation, if the evaluation occurs in a *different* billing office or the patient sees a specialist. See the palliative (D9110), consultation (D9310), and re-evaluation - post-operative office visit (D0171) codes for other reporting options that might be applicable.

LIMITATIONS

1. All periodontal, endodontic, and oral surgery procedure codes generally include any routine follow up (to check healing, etc.) within thirty days of initial treatment (six months if a prosthesis or implant placement) as a policy limitation. Unusual return visits, such as a follow-up visit due to extensive infection and complications for instance, could be reported separately. See treatment of complications (D9930). However, D9930 generally is not paid as a separate procedure by payors to the doctor who provided the initial treatment. This post-op evaluation is often considered a part of the treatment procedure unless provided by a different billing entity.
2. The fee for D0170 may be excluded by payors if reported in conjunction with other procedures on the same service date. However, D0170 is a "stand-alone" oral evaluation code and may always be reported separately.
3. Many plans consider D0170 part of the patient's two evaluations per year allowance. However, some plans will consider payment for D0170 if a narrative verifies that it was not a post-operative re-evaluation.

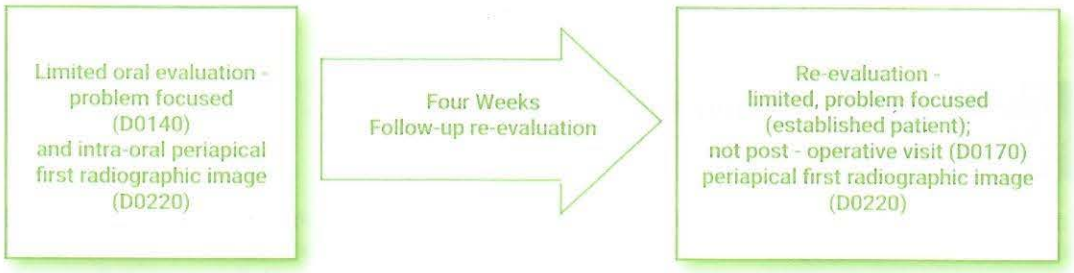
NARRATIVES

A narrative for D0170 could state, "This evaluation was conducted to complete a more in depth, thorough evaluation of a soft tissue lesion adjacent to #3. Patient was last examined for this condition on mm/dd/yy."

CLINICAL FLOW CHARTS

Re-evaluation, limited problem focused (D0170) scenario:

Scenario: On the playground a child's tooth is "bumped." The mother takes the child to the office for an oral evaluation. The doctor examines the child (D0140) and takes necessary diagnostic radiographs. Four weeks later the child returns for a *follow-up* re-evaluation visit with the dentist (D0170), which includes the taking of a periapical diagnostic image (D0220). Everything looks okay, the child is dismissed and instructed to return for his/her routine periodic check-up. This second follow-up visit would be reported as re-evaluation, limited problem focused (D0170) plus a periapical first film (D0220).



D0171 RE-EVALUATION - POST OPERATIVE OFFICE VISIT

CDT 2025

WATCH

1. If reporting a re-evaluation as a follow up to a previous evaluation where no operative work was performed, report D0170 re-evaluation - limited, problem focused. See D0170.
2. If reporting an "office visit" that is not a re-evaluation and where no other work is performed, consider D9430. See the entry for D9430 for more information.

MATCH

1. D0171 could be reported when "assessing the status of a previously performed procedure," such as grafts, oral surgery, implants, periodontal surgery, removable prosthodontics, and endodontics which may indicate a *follow-up* post-operative visit. For example, D0171 may report a periodontal re-evaluation to monitor post-operative tissue healing following scaling and root planing.
2. Based on the nomenclature language, the re-evaluation - post-operative visit (D0171) could be reported following definitive treatment (i.e., periodontal, graft, root canal, extraction post-op) or palliative D9110 treatment. The fee for any initial periodontal treatment, such as scaling and root planing (SRP), usually includes any post-operative evaluation associated with said procedure. Likewise, a post-operative (within thirty days) routine evaluation after oral surgery or a root canal would generally be considered inclusive in the global fee.
3. D0171 could be used to report a periodontal re-evaluation that includes charting and probing. The nomenclature of D0171 specifically indicates it is for a post-operative visit. Currently, there is no *specific* code to report a stand-alone periodontal re-evaluation by a hygienist, so unspecified periodontal procedure, by report (D4999) could be used to report this procedure. D4999 is rarely reimbursed. Those doctors who do not participate in the patient's dental plan may hold the patient responsible for payment of the unspecified procedure, D4999. However, if a comprehensive periodontal evaluation is performed by the dentist including complete charting and probing, D0180 may be reported, which should have a higher fee than D0171. However, D0180 (just like D0171) would be subject to any frequency limitations.
4. D0171 could be used to report a post-operative visit to check the stability of an implant after placement. D0171 would include the use of technology, such as Osstell IDx, to check stability. Checking stability as a stand-alone procedure is generally considered inclusive to the global fee of the implant placement.

LIMITATIONS

1. All periodontal, endodontic, and oral surgery procedure codes generally include any routine follow up (to check healing, etc.) within thirty days of initial treatment (six months if a prosthesis) as a policy limitation, so D0171 will probably not be reimbursed.
2. Most plans will consider D0171 part of the patient's two evaluations per year allowance or one evaluation per six months if charged and reported.
3. The fee for D0171 may be excluded by payors if reported in conjunction with other definitive procedures on the same service date. However, D0171 is a "stand-alone" oral evaluation code and may always be reported separately.

TIPS

1. Consider limiting the billing of re-evaluation - post-operative visit (D0171), since the payor's fee will be *lower* than other oral evaluations. This procedure generally is subject to the "two evaluations per year/12 months" or "one evaluation per six months" limitation. Occasionally payors will reimburse a third evaluation, if the evaluation occurs in a *different* billing office or the patient sees a specialist. See the palliative (D9110) and consultation (D9310) codes for other reporting options that might be applicable.
2. Unusual return visits, such as a follow-up visit due to extensive infection and complications for instance, could be reported separately. See treatment of complications (D9930). However, D9930 generally is not paid as a separate procedure by payors unless a different office (provider) performs the service. A follow-up evaluation is considered a part of the global treatment procedure unless provided by a different billing entity.

D0180 COMPREHENSIVE PERIODONTAL EVALUATION - NEW OR ESTABLISHED PATIENT

CDT 2025

This procedure is indicated for patients showing signs or symptoms of periodontal disease and for patients with risk factors such as smoking or diabetes. It includes evaluation of periodontal conditions, probing and charting, an evaluation for oral cancer, the evaluation and recording of the patient's dental and medical history, and general health assessment. It may include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, and occlusal relationships.



WARNING

1. Do not report D0180 in *addition* to the comprehensive oral evaluation (D0150) on the *same* service date. However, the general practitioner can always report D0180 provided the patient exhibits signs and symptoms of periodontal disease, or risk factors such as smoking or diabetes. The dentist or hygienist performs a detailed full mouth periodontal charting with six points/tooth probing on the same evaluation date.
2. D0180 is not used to report a periodontal screening record (PSR) since *periodontal screening*, where indicated, is now specifically described as a component of periodic oral evaluation (D0120). D0180 is more detailed and includes "six point per tooth probing (full mouth) and charting," and also identifies furcations, wear facets, abfraction lesions, areas of mobility, bleeding on probing, areas and amounts of recession, amounts of remaining attached gingiva, etc. D0180 may be reported for both new and established patients according to the nomenclature. See comments and limitations below.



MATCH

D0180 should be reported for a comprehensive evaluation instead of D0150 if the patient has signs or symptoms of periodontal disease and/or risk factors such as smoking or diabetes and full periodontal charting is performed. D0180 would be the more accurate code and the fee and reimbursement may be higher.

COMMENTS

1. Key elements of D0180:
   a. Reported when performing a comprehensive periodontal evaluation only on a "qualified" patient who shows signs and symptoms of periodontal disease, or risk factors such as smoking and diabetes.
      i. May be performed on both new or established patients.
      ii. May be reported by general dentists or periodontists as all codes are available to any dentist practicing within his/her scope of license.
   b. Requires all the components of a comprehensive oral evaluation (D0150) *plus* a complete and comprehensive periodontal charting (of all teeth).
      iii. D0150 gives the option of periodontal screening or charting, as deemed necessary.
      iv. D0180 requires complete periodontal charting, which includes, but is not necessarily limited to six-points-per-tooth pocket depths, recessions, furcations, areas of mobility, bleeding points, purulent discharge, minimal attachments, (i.e., amount of remaining attached gingiva) and/or a periodontal diagnosis.
2. The comprehensive periodontal evaluation (D0180) may be reported for *new* or *established* periodontal patients presenting with signs, symptoms, and risk factors (such as smoking or diabetes) of periodontal disease. Practices may establish two distinct in-office codes with different fees for the two uses of D0180. For example, the office may establish a custom code of D0180A for when the code is used for qualified new patients, with a fee slightly higher than D0150. They may then use D0180B for recare visits on qualified established patients (such as D4910 periodontal maintenance patients) when full periodontal records are performed along with an evaluation, with a fee set slightly higher than that of D0120. If configured correctly, the computer software will reference the "A" or "B" from the code when assigning the fee but remove the "A" or "B" from the code when posting the procedure on the claim form. See "Limitations" below for reimbursement considerations.

3. The comprehensive periodontal evaluation (D0180) is not specialty-specific. The general practitioner can always report it, as with any CDT code. However, the general practitioner would generally report more of the comprehensive, extensive, and all-encompassing comprehensive oral evaluations (D0150) for most new patients. D0180 may be reported for the *qualified* periodontal patient and the Maximum Plan Allowance (MPA) may be higher for it than for D0150.
4. The comprehensive periodontal evaluation (D0180) is indicated for patients showing signs/symptoms of periodontal disease, or for patients with risk factors such as smoking or diabetes. If evident, list these signs/symptoms and/or risk factors in the patient chart. Reporting the D0180 code indicates that extra time and effort were spent in making an in-depth evaluation of the overall periodontal condition, including charting and "full mouth" probing. D0180 may be reported either for the initial (comprehensive) new patient evaluation or for the recare visit. However, D0180 is typically subject to the "two evaluations per year/12 months" or "one per six months" limitation. Some payors will reimburse a third evaluation, if the evaluation occurs in a different office or with a specialist. Some payors will "downcode" D0180 or "remap" it to the D0150 or D0120 lower fee for reimbursement.
5. The comprehensive periodontal evaluation (D0180) requires a mandatory evaluation for oral cancer which should always be noted in the clinical notes.

LIMITATIONS

1. D0180 may be reported for the established periodontal patient or patient with periodontal risk factors and requires that a *full*, complete, and detailed periodontal evaluation be completed. Reimbursement for D0180 is typically *remapped* and *limited* by many payors to the D0120 lower fee for *established* patients seen at the periodontal (D4910) recare visit.
2. Some general practice and periodontal offices establish two *consistent* fee levels for D0180. The higher fee is charged for the *new* patient comprehensive periodontal evaluation (taking more time). A lower fee is charged for the *established* patient's annual periodontal oral evaluation at the periodontal maintenance (D4910) visit. Some offices *alternate* the D0120 and D0180 oral evaluations each six months to differentiate the more extensive periodontal evaluation performed once per year. D0180 reported at the perio recare visit may be *remapped* and *limited* by some payors to the lower fee D0120 as reimbursed for established patients.
3. Some payors reimburse D0180 every 12 or 24 months, others every three to five years, and some once in a "lifetime." Reimbursement for D0180 varies widely. D0180 may be reimbursed only "once" per lifetime (like D0150) per doctor or billing entity by a *few* payors.
4. D0180 may be reported on the same service date as active periodontal maintenance therapy (D4910), but is subject to the "one per six months" or "two evaluations per year/12 months" limitation. In some cases, reimbursement will be made at the lower D0120 fee. Some plans occasionally reimburse at a higher fee. Some offices perform a detailed and extensive *annual* evaluation on the *established* periodontal patient and report the more extensive D0180 once per year. D0180 encompasses all elements of the comprehensive oral evaluation (D0150) and must include mandatory full mouth probing with extensive periodontal charting and a comprehensive periodontal evaluation by the dentist.

TIPS

See full mouth debridement (D4355) for applicability of D0180.

NARRATIVES

List the patient's sign(s) or symptom(s) of periodontal disease and/or risk factors (e.g., smoking or diabetes) in the patient's chart. Generally, a narrative on the claim form is not required but may be helpful, especially if qualifications are based on risk factors alone.

PRE-DIAGNOSTIC SERVICES — CDT 2025

D0190 SCREENING OF A PATIENT — CDT 2025

A screening, including state or federally mandated screening, to determine an individual's need to be seen by a dentist for diagnosis.

COMMENTS

1. While diagnosis and treatment are the responsibilities of the dentist, a dental screening may be performed by other medical or dental professionals who are acting within the scope of their state licenses (i.e., mid-level provider, hygienist, physician, physician's assistant, nurse, or other authorized personnel). A dental screening typically involves a brief oral examination (with a tongue depressor) to check for decay, injury, pain, developmental problems, and other abnormal oral conditions or risk factors (i.e., poor oral home care) that require a subsequent evaluation by a dentist.

2. A screening is NOT an assessment, since there is no recording of dental restorations or conditions. See D0191 assessment of a patient.
3. A screening only determines the need for further evaluation. A dental screening may or may not lead to a referral to a dentist.

D0191 ASSESSMENT OF A PATIENT — CDT 2025

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.

COMMENTS

1. An oral assessment commonly includes a review and documentation of the patient's medical and dental history, a limited clinical examination (recording dental restorations and conditions that should be called to the attention of a dentist), and collection of other oral health data to assist in the development of a professional treatment plan if a referral to a dentist for diagnosis and treatment is necessary.
2. A dental assessment involves a limited clinical examination typically by an independent hygienist or other mid-level provider acting within the scope of his/her state license. However, a dentist may report D0191 for circumstances in which a cursory exam is performed to determine the need for subsequent treatment, like full mouth debridement (D4355). See D4355.
3. Frequently, a cursory exam is performed at no charge and is only documented using D0191. If charging a fee, it may be better to report D0140 limited oral evaluation-problem focused. See "Tips" section below.
4. A dental assessment is distinct from oral evaluations in that it does not involve interpretation or diagnosis and is performed to determine if the patient needs to be referred to a dentist for a subsequent diagnosis and treatment.
5. For a screening that does not include limited recording of restorations or conditions but instead ONLY determining need for further evaluation, see D0190 screening of a patient.

TIPS

1. D0191 should be used in limited circumstances where only a cursory exam is required. D0191 has uncertain reimbursement and other evaluation codes would be more appropriate in the vast majority of circumstances.
2. As noted in comment #2, D0191 could be reported for a cursory exam prior to full mouth debridement (D4355), however D0140 could be reported for the same situation. The fee for D0140 is typically higher than D0191. See D4355.

DIAGNOSTIC IMAGING — CDT 2025

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 — CDT 2025

D0210 INTRAORAL - COMPREHENSIVE SERIES OF RADIOGRAPHIC IMAGES — CDT 2025

A radiographic survey of the whole mouth intended to display the crowns and roots of all teeth, periapical areas, interproximal areas and alveolar bone including edentulous areas.

WARNING

It is misleading to report an extra-oral panoramic radiographic image (D0330) and bitewing images (D0272/D0273/D0274) as an intra-oral comprehensive series (D0210). The dental office should not combine these two procedures (panoramic film and bitewings) and report as an intra-oral comprehensive series. A panoramic image is *extra-oral*, not intra-oral. Always report exactly what you do and the correct service date the service is performed. **Note: It is not illegal or improper for an insurance company to "remap" a submitted code to another code for payment purposes.** This modification is in accordance with the *contract language*. Payors routinely convert the extra-oral panoramic images and intra-oral bitewing images to a complete series (D0210) for reimbursement purposes. See (D0330) for further details. However, the frequency of (D0210) or any other radiographic imaging should always be determined by the dentist based on the needs of the patient and ADA/FDA guidelines; not by insurance frequency limitations.

Note: The date of service of any radiograph is the date they are interpreted, not the date they are taken. However, when panoramic and bitewing radiographs are taken on the same service date but then routinely split into different dates for interpretation in order to circumvent remapping by the payor to comprehensive series (D0210), this may be seen as a misrepresentation of treatment dates to gain increased reimbursement.

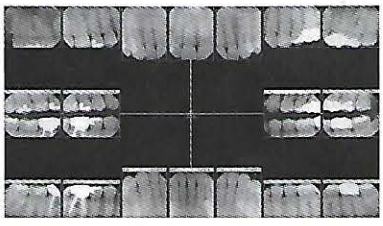
COMMENTS

1. What constitutes a comprehensive series of radiographs may vary from patient to patient. The critical component is that it should be a combination of intra-oral diagnostic quality radiographs that display the crown and roots of all teeth, periapical areas, interproximal areas, and alveolar bone, including edentulous areas.
2. A comprehensive series (D0210) is *inclusive of bitewings*, but bitewings are not necessarily required. The comprehensive series is *intra-oral*.
3. A comprehensive series (D0210) is most often ordered *after* the oral evaluation of the new patient by the dentist at the comprehensive or comprehensive periodontal oral evaluation (D0150) or (D0180). Radiographic images are ordered by the dentist per the needs of the patient. A comprehensive series (D0210) helps to determine a diagnostic baseline. The comprehensive series (D0210) is generally repeated on a three to five-year basis per the needs of the patient. In some cases, a full series is alternated with a panoramic image (D0330) every three or five years. Many payors are trending toward a five-year reimbursement limitation rather than the more traditional three-year benefit exclusion. This limitation period varies among plans.
4. The type and sequence of diagnostic images should be determined and ordered by the doctor on a patient-by-patient basis. This determination is based on risk assessment, observation, and medical necessity. Images should not be taken based on the patient's plan benefits or limitations. Patient documentation should contain the dentist's written evaluation of the diagnostic images taken. If there is no documentation of the radiographic interpretation in the chart, the payor may deny payment of the claim or ask for reimbursement in the event of an audit.
5. For intraoral - comprehensive series of radiographic images, image capture only, see D0709.
6. For intraoral tomosynthesis - comprehensive series of radiographic images, see D0372. For image capture only, see D0388.

LIMITATIONS

1. If a number of periapicals and bitewing images are taken on the same service date and the fee for those images is equal to or greater than the comprehensive series, the fee reimbursed by the payor will often be limited to that of the comprehensive series. The payment of the comprehensive series will trigger the "once every three to five-year limitation." If a comprehensive series is reimbursed, a notation should be made in the patient's billing record for future reference.
2. If either a comprehensive series (D0210) *or* panoramic image (D0330) is taken and then a new comprehensive series and/or panoramic image is taken during the exclusion period (typically three or five years), the second radiographic image service will not be reimbursed. Both services are usually subject to the same three to five-year limitation.
3. Many plans have a one-year limitation exclusion for bitewing radiographic images taken *after the service date* of a comprehensive series (D0210) or a panoramic radiographic image (D0330).

PHOTO



This is a comprehensive intra-oral series (including bitewings).

Courtesy DEXIS, LLC and DEXIS®

D0220 INTRA-ORAL - PERIAPICAL FIRST RADIOGRAPHIC IMAGE CDT 2025

COMMENTS

1. D0220 is only for the *first* periapical (PA) radiograph taken on any date of service.
2. Report D0230 for each *additional* periapical radiographic image taken *after* the first image on the same service date.
3. Periapicals associated with an endodontic *diagnosis* on a date prior to definitive treatment are typically reimbursed. "Working and post-treatment" images associated with endodontic treatment are part of the global endodontic fee. Post-operative diagnostic images taken of the treated tooth within 30 days of the completion of a root canal are typically included in the global endodontic fee.
4. The type and sequence of diagnostic images should be determined and ordered by the dentist based on the patient needs. This determination is based on risk assessment, observation, and dental necessity. Images should not be taken based on the patient's plan benefits or limitations. Patient documentation should contain the dentist's written evaluation of the diagnostic images taken. If there is no documentation of the dentist's radiographic interpretation in the chart, the payor may deny payment of the claim or ask for reimbursement in the event of an audit.
5. Enter the tooth number or range of teeth numbers being evaluated in Box 27 of the 2024 ADA Dental Claim Form.

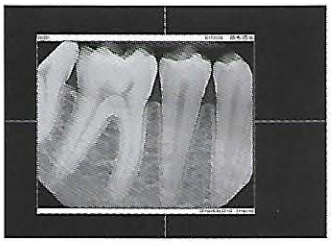
LIMITATIONS

1. Periapical radiographic images at emergency visits are routinely reimbursed. However, periapicals at checkups may require a narrative and/or chart notes and the actual image (required more and more). A caries risk assessment demonstrating increased risk, if appropriate (D0602/D0603) may help justify periapicals at a checkup taken in conjunction with bitewings. Several payors are cracking down on periapicals routinely taken with bitewings at a recare visit.
2. If a number of periapicals and bitewing radiographic images are taken on the same service date and the fee for those images is equal to or greater than the comprehensive series, the fee reimbursed will be limited to that of the comprehensive series. The payment of the comprehensive series will trigger the "once every three to five-year limitation." If a comprehensive series is reimbursed, a notation should be made in the patient's billing record for future reference.
3. Reimbursement for periapical images, if reported in conjunction with bitewing images, may be limited by some payors.
4. For intraoral - periapical radiographic image, image capture only, see D0707.
5. For intraoral tomosynthesis - periapical radiographic image see D0374. For image capture only, see D0389.

TIPS

1. One, two, or three periapical images may be reimbursed on a problem focused evaluation (D0140) service date. Periapical images taken at the problem focused visit typically do not affect the "once per year/12 months" limitations for *bitewing* images associated with recare visits.
2. Intra-oral periapical first image (D0220) and an additional periapical image(s) (D0230) are often payable at any visit (including recare), if medically necessary. At an emergency, problem focused oral evaluation (D0140) or periodic oral evaluation (D0120) recare visit, the periapical image reimbursement may be subject to a deductible as well as the maximum fee limitation for multiple diagnostic images.
3. Periapicals, particularly at different "angles," are often necessary to provide alternate views of the anatomy of an area for a complete diagnosis. Two periapicals are a better choice at the emergency visit from a reimbursement perspective and often from the clinical perspective as well. Billing a single bitewing at the emergency visit may trigger limititations preventing reimbursement of two/four bitewings at the recare visit.

PHOTO



This is a periapical intra-oral radiographic image.

Courtesy DEXIS, LLC and DEXIS®

D0230 INTRA-ORAL - PERIAPICAL EACH ADDITIONAL RADIOGRAPHIC IMAGE CDT 2025

WARNING

The use of a dual pack (two images taken with a single radiation) is not reported as an *additional* radiograph.

COMMENTS

1. Report D0230 for each additional periapical radiographic image taken *after* the first image on the same service date.
2. Periapicals associated with an endodontic *diagnosis* on a date prior to endodontic definitive treatment are typically reimbursed. If the diagnostic PA is taken on the day endodontic treatment is started, report the (PA) periapical radiograph as it still may be reimbursed. "Working and post-treatment" images associated with endodontic treatment are part of the global endodontic fee. Post-operative diagnostic images taken of the treated tooth within 30 days of the completion of a root canal are typically included in the overall, global endodontic fee.
3. The type and sequence of diagnostic images should be determined and ordered by the dentist based on the patient's needs. This determination is based on risk assessment, observation, and dental necessity. Images should not be taken based on the patient's plan benefits or limitations. Patient documentation should contain the dentist's written evaluation of the diagnostic images taken.
4. Enter the tooth number or range of teeth numbers being evaluated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Periapical radiographic images at emergency visits are routinely reimbursed. However, the taking of routine periapicals with bitewings at checkups may require a narrative (required more and more). A caries risk assessment demonstrating increased risk, if appropriate, (D0602/D0603) may help justify periapicals at the recare visit taken in conjunction with bitewings. Several payors are cracking down on periapicals routinely taken with bitewings at a recare visit by some payors.
2. If a number of periapicals and bitewing radiographic images are taken on the same service date and the fee for those images is equal to or greater than the comprehensive series, the fee reimbursed will generally be limited to that of the comprehensive series. The payment of the comprehensive series will trigger the "once every 3-5 year limitation." If a comprehensive series is reimbursed, a notation should be made in the patient's billing record for future reference.
3. Reimbursement for periapical images, if reported in conjunction with bitewing images, may be limited by some players. Some plans now require a narrative for periapicals and the findings for periapicals taken at the recare visit.
4. For intraoral - periapical radiographic image, image capture only, see D0707.
5. For intraoral tomosynthesis - periapical radiographic image, see D0374. For image capture only, see D0389.

TIPS

1. One, two, or three periapical images may be reimbursed on a problem focused evaluation (D0140) service date. Periapical images taken at the problem focused visit typically do not affect the "once per year/12 months" limitations for *bitewing* images associated with recare visits.
2. Intra-oral periapical first image (D0220) and an additional periapical image(s) (D0230) are often payable at *any* visit (including recare), if medically necessary. At an emergency, problem focused oral evaluation (D0140) or periodic oral evaluation (D0120) recare visit, the periapical image reimbursement may be subject to a deductible as well as the maximum fee limitation for multiple diagnostic images. Some plans limit reimbursement for periapical images taken in conjunction with bitewing images on the same service date.
3. Periapicals, particularly at different "angles," are often necessary to provide alternate views of the anatomy of an area for a complete diagnosis. Two periapicals may be a better choice at the emergency visit from a reimbursement perspective as well as from the clinical perspective. A billed single bitewing at the emergency visit may trigger limitations, affecting two/four bitewing reimbursement at the recare visit.

D0240 INTRA-ORAL - OCCLUSAL RADIOGRAPHIC IMAGE

CDT 2025

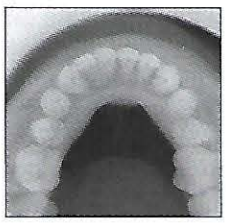
COMMENTS

1. Intra-oral - occlusal radiographic image (D0240) is also taken on young children (at the initial new patient evaluation) and later as needed for a full arch or anterior segment view and may be taken in conjunction with bitewing radiographic images. At the initial visit, typically two occlusals are taken, one of the maxillary teeth and one of the mandibular teeth.
2. The type and sequence of diagnostic images should be determined and ordered by the dentist based on the patient's needs. This determination is based on risk assessment, observation, and medical necessity. Radiographs should not be taken based on the patient's plan benefits or limitations. Patient documentation should contain the dentist's written evaluation of the diagnostic radiograph(s).
3. For intraoral - occlusal radiographic image, image capture only, see D0706.
4. Enter the arch designation or range of teeth numbers being evaluated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. D0240 is typically reimbursed and is often limited to the comprehensive series (D0210) UCR fee at the initial oral evaluation and by the comprehensive series limitations. If an occlusal radiographic image (D0240) and a number of other images are taken on the same service date, and the fee for those images is equal to or greater than the comprehensive series, the fee reimbursed will typically be limited to that of the comprehensive series. The payment of the comprehensive series will trigger the "once every 3-5 year limitation." If a comprehensive series is reimbursed, a notation should be made in the patient's chart for future reference.
2. Typically, an occlusal radiographic image (D0240) plus two bitewing images (D0272) are reimbursed as submitted. Note: The total fee reimbursed for all images reported in a period determined by the payor may be subject to the fee and frequency limitations placed on the comprehensive series (D0210) or recare interval radiographs.

PHOTO



This is a mandibular arch occlusal intra-oral radiographic image.

Courtesy Gendex™ Dental Systems and DenOptix®

D0250 EXTRA-ORAL - 2D PROJECTION RADIOGRAPHIC IMAGE CREATED USING A STATIONARY RADIATION SOURCE, AND DETECTOR

CDT 2025

These images include, but are not limited to: Lateral Skull; Posterior-Anterior Skull; Submentovertex; Waters; Reverse Tomes; Oblique Mandibular Body; Lateral Ramus.

WARNING

With the extra-oral - radiographic image (D0250), the radiographic image/sensor/film is positioned *outside* the oral cavity when the radiograph is taken. The image must be created using a stationary radiation source and detector. Note that extra-oral - each additional radiographic image (D0260) is a previously deleted code.

LIMITATIONS

1. If existing oral conditions suggest reporting D0250, the service may be reimbursed; however, this reimbursement is subject to the plan's limitations. Conditions relating to trauma or suspected pathology could justify the dental necessity of this service.
2. The type and sequence of diagnostic radiographic images should be determined and ordered by the dentist based on the patient's needs. This determination is based on risk assessment, observation, and medical necessity. Images should not be taken based on the patient's plan benefits or limitations. Patient documentation should contain the dentist's written evaluation of the diagnostic radiograph(s).

NARRATIVES

1. For reporting multiple images on the same service date, enter the quantity in Box 29b. If your software will not accept the entry, then enter each image on a separate line. Provide a narrative.
2. Conditions relating to trauma or suspected pathology could justify the medical necessity of this service. The narrative should include the specific observations made by the provider that made this radiograph necessary to diagnose the pathology.

D0251 EXTRA-ORAL POSTERIOR DENTAL RADIOGRAPHIC IMAGE CDT 2025

Image limited to exposure of complete posterior teeth in both dental arches. This is a unique image that is not derived from another image.

WATCH

D0251 is used to describe an extra-oral posterior dental radiograph that produces an image of the posterior teeth area of both dental arches. This D0251 image is not to be derived from another image. D0251 describes an image that is unique and not produced from, or a duplicate produced from, another existing image (e.g., not produced from cone beam CT reconstruction of the data captured in the scan).

COMMENTS

1. D0251 reports a posterior radiographic image which includes both the upper and lower jaws of the posterior area of the mouth. If both right and left images are produced, report D0251 twice and identify the right or left side represented by each image.
2. Posterior bitewing images taken with a panoramic or CBCT in dedicated bitewing mode are most accurately reported using D0251. Even though each image contains both premolars and molars, it is a single image and may only be reported once per side. See "Limitations" below for more information.
3. For extra-oral posterior dental radiographic image - image capture only, see D0705.
4. Enter the quadrant and/or range of teeth numbers being evaluated in the appropriate box of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Because this is a fairly recent code, some existing plans will not provide reimbursement. When reporting, include a narrative stating, "If benefits are not available for D0251, pay the alternate benefit of D0270." Report a quantity of two if both sides are imaged.
2. When benefited, D0251 frequently has a higher reimbursement than corresponding bitewing codes.
3. It may also help to include a reason why D0251 was used, such as the patient not being able to tolerate an intraoral sensor.

D0260 PREVIOUSLY DELETED CODE EXTRA-ORAL - EACH ADDITIONAL RADIOGRAPHIC IMAGE

This is a previously deleted code. See D0250 and D0251 for further details.

D0270 BITEWING - SINGLE RADIOGRAPHIC IMAGE CDT 2025

COMMENTS

1. Also see D0272/D0273/D0274 for further details.
2. The single bitewing can be a horizontal or vertical view.
3. The single bitewing can be intra-oral or extra-oral, however posterior bitewing images taken with a panoramic or CBCT in dedicated bitewing mode are most accurately reported using D0251. See D0251.
4. For intraoral - bitewing radiographic image - image capture only, see D0708. Note that D0708 indicates "intraoral".
5. For intraoral tomosynthesis - bitewing radiographic image, see D0373. For image capture only, see D0388.
6. Enter the tooth number or range of teeth numbers being evaluated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

If a single bitewing (BW) image is reported at a given recare or emergency visit, subsequent bitewing images *may be denied. Be aware that any number of bitewings taken at any particular visit may "trigger"* the "once per year/12 months" limitation by most plans. One bitewing, two bitewings, three bitewings, or four bitewings taken at a particular visit date could be subject to the plan's bitewing frequency limitation. Be careful to report the number and date of diagnostic images accurately. The reimbursement for bitewings, according to the limitations of different plans is highly variable.

TIPS

1. For diagnostic purposes, two periapical (D0220/D0230) radiographs taken at different angulations or views are most often the preferred choice at the problem focused oral evaluation (D0140) or emergency visit.
2. Some dentists will choose to take both a periapical and a bitewing radiographic image at the D0140 visit. This is determined and ordered by the doctor. Note that the reporting of a single bitewing image may trigger the "once per year" bitewing image limitation and render the bitewings taken at a subsequent recare visit non-reimbursable. Consider taking the bitewing at no charge to avoid this issue, if applicable. Also refer to periapical radiographic image D0220 for certain limitations in combination with bitewing radiographic images.

PHOTO



This is a bitewing - single radiographic image.

Courtesy DEXIS, LLC and DEXIS®

D0272 BITEWINGS - TWO RADIOGRAPHIC IMAGES CDT 2025

WARNING

1. Unless a patient has recent *history* of caries or other factors, such as *progressing* periodontal disease, routine six-month or annual bitewing images may be considered unnecessary. Some payors may request refunds for the bitewings, stating the diagnostic images were "medically unnecessary" when documentation does not support the medical necessity of taking the images. When bitewings are taken at six-month intervals, be careful to document the reason the images were taken such as caries risk assessment, *recent* decay or other caries *risk* factors. A caries risk assessment demonstrating increased risk, if appropriate (D0602/D0603) should be reported (often at "zero" fee) to support a six-month interval. Documentation supporting the need for bitewings taken in 12-24 month intervals should be made as well.
2. It is misleading to report panoramic radiographic images (D0330) and bitewing images (D0272, D0273 or D0274) as a comprehensive series (D0210). Always report the panoramic/bitewing images *separately*. The payor may "remap" this radiograph combination to a comprehensive (D0210) series as an alternate benefit. This remapping typically occurs as a result of policy limitations and exclusions in the contract language. For further information on reimbursement policies, see panoramic image (D0330).

   Note: The date of service of any radiograph is the date they are interpreted, not the date they are taken. However, when panoramic and bitewing radiographs are taken on the same service date but then routinely split into different dates for interpretation in order to circumvent remapping by the payor to comprehensive series (D0210), this may be seen as a misrepresentation of treatment dates to gain increased reimbursement.

COMMENTS

1. Many offices do not establish, maintain, and adhere to proper bitewing radiographic image protocol as determined and prescribed by the dentist. The type, sequence, and frequency of diagnostic images should be determined by the dentist for each individual patient, based on diagnosis, not based on the patient's plan benefits or limitations. Clinical notation in the patient's chart should reflect the dentist's diagnosis. Diagnostic image guidelines for radiographic images may be found at https://www.ada.org/resources/practice/practice-management/radiographic-imaging.
2. Most offices take bitewing radiographic images every 12 months. The most common clinical protocol is to take two bitewing images (D0272) for children, three bitewing images (D0273) or four bitewing images (D0274) for adults (second molars erupted).
3. When the dentist orders a six-month bitewing image interval on a given patient, be careful to document the presence of decay, history of caries, or other risk factors. A caries risk assessment demonstrating increased risk, if appropriate (D0602/D0603) should be reported (often at "zero" fee) to support a six-month interval.
4. Posterior bitewing images taken with a panoramic or CBCT in dedicated bitewing mode are most accurately reported using D0251, reported per radiation. See D0251 for more information.
5. For intraoral - bitewing radiographic image - image capture only, see D0708. Note that D0708 indicates "intraoral".
6. For intraoral tomosynthesis - bitewing radiographic image, see D0373. For image capture only, see D0388.
7. Enter the range of teeth numbers being evaluated in Box 27 of the 2024 ADA Dental Claim Form.

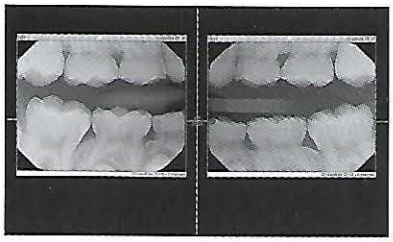
LIMITATIONS

1. There is generally an *annual* limitation for bitewing reimbursement; however, some payors will further limit bitewing image reimbursement to once every 24 months. Some payors may reimburse bitewing images twice annually for high-risk children under 13 years old. The allowances are more generous for children as they are generally at a higher risk for caries. Reimbursement is dictated by the type of plan purchased and dental necessity.
2. Many plans limit reimbursement for bitewings taken after comprehensive series (D0210) to at least 12 months after the comprehensive series.
3. Bitewing images are generally reimbursed as a preventive service at 100% of the UCR fee. However, some payors reimburse bitewing images as basic (80% of the UCR fee).

TIPS

1. Some policies reimburse for a number of periapical diagnostic radiographic images in addition to two bitewing images (D0272), three bitewing images (D0273), or four bitewing images (D0274) at the recare visit. Some offices report two bitewing images (D0272), three bitewing images (D0273) or four bitewing images (D0274) in addition to several periapicals in order to monitor anterior areas for caries and/or periodontal disease. More payors are requiring narratives and caries risk assessment to support taking periapicals with bitewings. See D0220 for further details.
2. If the second molars have erupted, consider four bitewing images (D0274). There is often no *age limitation* for reimbursement for three or four bitewing images. If an adult has missing posterior teeth, 2BWX (D0272) or 3BWX (D0273) may be appropriate.
3. Two periapical (D0220/D0230) diagnostic radiographic images are most often the best clinical choice for an emergency evaluation. If a single bitewing image is taken at the *emergency* evaluation visit, bitewing images *may be denied* at the next recare visit due to the "once per year/12 months" plan limitation.
4. To monitor the bitewing frequency, if 20% of the practice's prophys are child prophys, approximately 20% of total bitewing radiographic images should be two bitewing radiographic images, not four.

PHOTO



These are horizontal bitewings - two radiographic images.

Courtesy DEXIS, LLC and DEXIS®

D0273 BITEWINGS - THREE RADIOGRAPHIC IMAGES CDT 2025

WARNING

1. Unless a patient has recent *history* of caries or other factors, such as *progressing* periodontal disease, routine six-month or annual bitewing radiographic images may be considered medically unnecessary. Some payors may request reimbursement for the bitewings, stating the diagnostic radiographic images were "medically unnecessary" when documentation does not support the dental necessity. When bitewings are taken at six-month intervals, be careful to document any contributing factors such as *recent* decay or other caries *risk* factors. A caries risk assessment demonstrating increased risk, if appropriate, (D0602/D0603) should be reported (often at "zero" fee) to support six-month intervals. Documentation supporting the exposure of 12 to 24 month bitewing radiographic images should be made as well.
2. It is misleading to report panoramic radiographic images (D0330) and bitewing radiographs (D0272, D0273 or D0274) as a comprehensive series (D0210). Always report the panoramic/ bitewing radiographic images *separately*. The payor may "remap" this radiographic combination to a comprehensive (D0210) series as an alternate benefit. This remapping typically occurs as a result of policy limitations and exclusions. For further information on reimbursement policies, also see panoramic radiographic image (D0330).

   Note: The date of service of any radiograph is the date they are interpreted, not the date they are taken. However, when panoramic and bitewing radiographs are taken on the same service date but then routinely split into different dates for interpretation in order to circumvent remapping by the payor to comprehensive series (D0210), this may be seen as a misrepresentation of treatment dates to gain increased reimbursement.

COMMENTS

1. Bitewing - three radiographic images (D0273) code could report one bitewing on one side (missing teeth) and two bitewings taken on the other side of the mouth.
2. Many offices do not establish, maintain and *enforce* proper bitewing image protocol as determined and *prescribed* by the dentist. The type, sequence, and frequency of diagnostic images should be determined by the dentist for each individual patient, based on diagnosis, not based on the patient's plan benefits or limitations. Clinical notation in the patient's chart should reflect the dentist's diagnosis. Diagnostic image guidelines for radiographic images may be found at https://www.ada.org/resources/practice/practice-management/radiographic-imaging.
3. Most offices take bitewing radiographic images every 12-24 months; bitewing radiographic images - two radiographic images (D0272) for children and either bitewings - three radiographic images (D0273) or bitewings - four radiographic images (D0274) for adults (second molars erupted) as an adjunct to diagnosis at the recare visit. This is the most *common* clinical protocol.
4. Generally, age is *not* an issue for reimbursement of either three (D0273) or four (D0274) bitewing radiographic images. However, frequency limits may also be age-related with some payors.
5. When the dentist orders a six-month bitewing radiographic image interval on a given patient, be sure to document the presence of decay, history of caries, or other high-risk factors. A caries risk assessment demonstrating increased risk, if appropritae, (D0602/D0603) should be reported (often at "zero" fee) to support six-month intervals.
6. Posterior bitewing images taken with a panoramic or CBCT in dedicated bitewing mode are most accurately reported using D0251, reported per radiation. See D0251 for more information.
7. For intraoral - bitewing radiographic image - image capture only, see D0708. Note that D0708 indicates "intraoral".
8. For intraoral tomosynthesis - bitewing radiographic image, see D0373. For image capture only, see D0388.
9. Enter the range of teeth numbers being evaluated in Box 27 of the 2024 ADA Dental Claim Form.

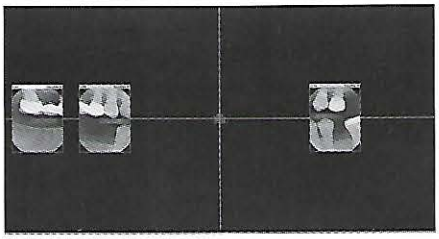
LIMITATIONS

1. There is generally an *annual* limitation for bitewing image reimbursement; however, some payors will further limit bitewing image reimbursement to once every 24 months. Some payors will reimburse bitewing images twice annually for high-risk children under 13 years old. The allowances are more generous for children, as they are generally at a higher risk for caries. Reimbursement is dictated by the type of plan purchased by the employer and by dental necessity.
2. Many plans limit reimbursement for bitewings taken after a comprehensive series (D0210) to at least 12 months after the comprehensive series.
3. Bitewing images are generally reimbursed as a preventive service at 100% of the payor's fee. However, some payors reimburse bitewing images as basic (80% of the payor's fee).

TIPS

1. Some policies reimburse for a number of periapical diagnostic images in addition to two bitewing images (D0272), three bitewing images (D0273), or four bitewing images (D0274) at the recare visit. Some offices report two bitewing images (D0272), three bitewing images (D0273), or four bitewing images (D0274) in addition to several periapicals in order to monitor anterior areas for caries and/or periodontal disease. More payors are requiring narratives and caries risk assessment (D0601, D0602, and D0603) to support taking periapicals with bitewings. See D0220 for further details.
2. If the second molars have erupted, consider taking four bitewing images (D0274). There is often *no age limitation* for reimbursement for three or four bitewing images. If an adult has missing posterior teeth, 2BWX (D0272) or 3BWX (D0273) may be appropriate.
3. Periapical (D0220/D0230) diagnostic radiographic images are most often the best clinical choice for an emergency evaluation. If a single bitewing image is taken at the *emergency* evaluation visit, bitewing images *may be denied* at the next recare service date due to the "once per year/12 months" plan limitation.
4. See full mouth debridement to enable comprehensive evaluation (D4355) for diagnostic image sequence options.
5. To monitor bitewing frequency, if 80% of the practice's prophys are adult prophys, approximately 80% of total bitewing radiographic images should be three or four bitewing radiographic images.

PHOTO



These are vertical bitewings - three radiographic images.

Courtesy DEXIS, LLC and DEXIS®

WARNING

1. Unless a patient has recent *history* of caries or other factors, such as *progressing* periodontal disease, routine six-month or annual bitewing radiographic images may be considered dentally unnecessary. Some payors have requested reimbursement for the bitewings, stating the diagnostic radiographic images were "medically unnecessary" when documentation does not support the medical necessity of taking the images. When bitewings are taken at six-month intervals, be careful to document the reason(s) the images are taken such as *recent* decay or other caries *risk* factors. A caries risk assessment demonstrating increased risk, if appropriate, (D0602/D0603) should be reported (often at "zero" fee) to support six-month intervals. Documentation supporting the exposure of 12 to 24 month bitewing radiographic images should be made as well.
2. It is misleading to report extra-oral panoramic radiographic image (D0330) and intra-oral bitewing radiographic images (D0272, D0273 or D0274) as a comprehensive series (D0210). Always report the panoramic/bitewing radiographic images *separately* as *taken*. The payor may "remap" this radiographic image combination to a comprehensive (D0210) series as an alternative payment. This remapping typically occurs as a result of policy limitations and exclusions in the contract language. For further information on reimbursement policies, also see panoramic radiographic image (D0330).

   Note: The date of service of any radiograph is the date they are interpreted, not the date they are taken. However, when panoramic and bitewing radiographs are taken on the same service date but then routinely split into different dates for interpretation in order to circumvent remapping by the payor to comprehensive series (D0210), this may be seen as a misrepresentation of treatment dates to gain increased reimbursement.

COMMENTS

1. Many offices do not establish, maintain, and *enforce* proper bitewing image protocol as determined and *prescribed* by the dentist. The type, sequence, and frequency of diagnostic images should be determined by the dentist for each individual patient, based on diagnosis, not based on the patient's plan benefits or limitations. Clinical notation in the patient's chart should reflect the dentist's diagnosis. Diagnostic image guidelines for radiographic images may be found at https://www.ada.org/resources/practice/practice-management/radiographic-imaging.
2. Most offices take bitewing radiographic images every 12-24 months; bitewings - two radiographic images (D0272) for children and bitewings - three radiographic images (D0273) or bitewing radiographic images - four radiographic images (D0274) for adults (second molars erupted) as an adjunct to diagnosis at the recare visit. This is the most *common* clinical protocol but no matter the protocol, the dentist must evaluate each patient and then prescribe which radiographic images, if any, should be taken.
3. Generally, age is *not* an issue for reimbursement of either three (D0273) or four (D0274) bitewing radiographic images. However, frequency limits may be age limited with some payors.
4. When the dentist orders a six-month bitewing image interval on a given patient, be sure to document the reason for taking the images (e.g., the presence of decay, history of caries, or other high-risk factors). The type, sequence, and frequency of diagnostic images should be determined by the dentist for each individual patient based on diagnosis, not based on the patient's plan benefits or limitations. Clinical notation in the patient's chart should reflect the dentist's diagnosis.
5. Posterior bitewing images taken with a panoramic or CBCT in dedicated bitewing mode are most accurately reported using D0251, reported per radiation. See D0251 for more information.
6. For intraoral - bitewing radiographic image - image capture only, see D0708. Note that D0708 indicates "intraoral".
7. For intraoral tomosynthesis - bitewing radiographic image, see D0373. For image capture only, see D0388.
8. Enter the range of teeth numbers being evaluated in Box 27 of the 2024 ADA Dental Claim Form.

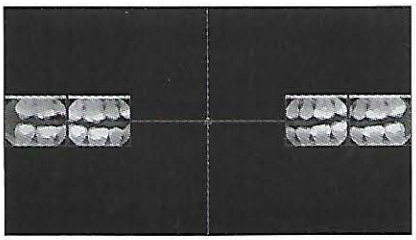
LIMITATIONS

1. There is generally an *annual* limitation for bitewing image reimbursement; however, some payors will further limit bitewing radiographic image reimbursement to once every 24 months. Some payors will reimburse bitewing radiographs twice annually for high risk children under 13 years old. The allowances are more generous for children as they are generally at a higher risk for caries. This determination is based on the plan purchased by the employer and by established dental necessity for the patient.
2. Many plans have a 12-month limitation exclusion for bitewing radiographic images after the exposure of a comprehensive series (D0210).
3. Bitewing radiographic images are generally reimbursed as a preventive service at 100% of the payor's fee. However, some payors reimburse as basic (80% of the payor's fee).

TIPS

1. Some policies reimburse for several periapical diagnostic radiographic images in *addition* to the three bitewing radiographic images (D0273) or four bitewing radiographic images (D0274) at the recare visit. Some offices report three bitewing radiographic images (D0273) or four bitewing radiographic images (D0274) in addition to several periapicals in order to monitor anterior areas of caries and/or periodontal disease. A caries risk assessment demonstrating increased risk, if appropriate, (D0602/D0603) should be reported (often at "zero" fee) to support six-month intervals.
2. If the second molars have erupted for a child, consider four bitewing radiographic images (D0274).
3. Two periapical (D0220/D0230) diagnostic radiographic images are most often the clinical choice at an emergency evaluation. If a bitewing image is reported on an *emergency* evaluation service date, bitewing radiographic images *may be denied* at the next recare service date, due to the "once per year/12 months" limitations, generally in effect for bitewing diagnostic radiographic images.
4. See full mouth debridement to enable comprehensive evaluation (D4355) for diagnostic image sequence options.
5. If 80% of prophylaxis counts are adults, then it would follow that approximately 80% of total bitewings would be three and/or four bitewing radiographic images.
6. Bitewings - three radiographic images (D0273) may be appropriate for the adult patient who is missing posterior teeth on one or both sides.

PHOTO



These are horizontal bitewings - four radiographic images.

Courtesy DEXIS, LLC and DEXIS®

D0277 VERTICAL BITEWINGS - 7 TO 8 RADIOGRAPHIC IMAGES CDT 2025

This does not constitute a full mouth intra-oral radiographic series.

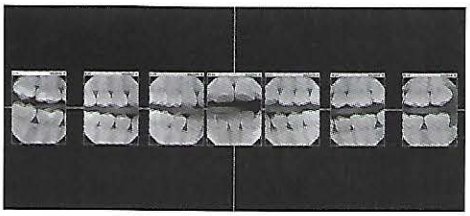
LIMITATIONS

1. Vertical bitewing radiographic images (D0277), depending on the fee, may be subject to the *comprehensive series* (D0210) *limitation*, i.e., once per three to five years.
2. D0277 may be reimbursed as 4BWX (D0274) at a lower fee and subject to the contract benefit limitations (generally "once per year").
3. Vertical bitewing radiographic images (D0277) may be re-mapped by payors to a comprehensive series (D0210) for reimbursement. Note that D0277 may be reimbursed at 80% of the comprehensive series payor's fee. Although the descriptor for D0277 states, "this does not constitute a full mouth intra-oral radiographic series," payors may re-map this service. If this remapping occurs, include a copy of the D0277 code description with the appeal for documentation.
4. If D0277 is reported at a periodic oral evaluation (D0120) visit, this may reset the "three to five-year" limitation for reimbursement of a comprehensive series (D0210). This reset occurs most often if the D0277 fee is 75-80% or more of the comprehensive series (D0210) payor's fee.
5. There is generally an annual limitation for bitewing radiographic image reimbursement; however, some payors limit reimbursement for D0277 to once per 24-month period. Reimbursement is highly variable.
6. D0277 specifies "vertical" bitewings only.
7. If D0277 is reported within six months of full series (D0210), payors may *disallow* the charge considering it a part of the previous full mouth series.
8. Note there are "image capture only" codes. None apply to vertical bitewings, 7 to 8 radiographic images (D0277).
9. Enter the range of teeth numbers being evaluated in Box 27 of the 2024 ADA Dental Claim Form.

TIPS

1. Some contracts reimburse for several periapical diagnostic radiographic images in *addition* to three bitewing radiographic images (D0273) or four bitewing radiographic images (D0274) at the recare visit. Some offices report four bitewing radiographic images (D0274) in addition to several periapicals in order to monitor specific anterior caries and/or periodontal disease areas. A caries risk assessment demonstrating increased risk, if appropriate, (D0602/D0603) should be reported (often at "zero" fee) to support six-month intervals.
2. Some offices alternate four *posterior* vertical bitewings and three or four *anterior* vertical bitewings year to year for periodontal patients. This protocol provides complete diagnostic imaging on a two-year basis (more in line with ADA/FDA radiographic frequency guidelines) and is generally reimbursed without triggering contract limitations for either service.
3. The type, sequence, and frequency of diagnostic radiographic images must be ordered by the dentist, based on risk assessment and specific need, *not* based on the patient's plan benefits or limitations. Clinical need should be established and recorded in the clinical record, as well as the written assessment of the image(s) after they are taken.
4. D0277 specifies 7-8 vertical bitewings. Other numbers of vertical bitewings may be reported using a combination of traditional bitewing codes, which do not specify if they are vertical or horizontal. For example, 6 vertical bitewings may be reported using D0274 and D0272.

PHOTO



These are vertical bitewings - 7 radiographic images.

Courtesy DEXIS, LLC and DEXIS®

D0290 PREVIOUSLY DELETED CODE POSTERIOR-ANTERIOR OR LATERAL SKULL AND FACIAL BONE SURVEY RADIOGRAPHIC IMAGE

This is a previously deleted code. See D0250 for further details.

D0310 SIALOGRAPHY CDT 2025

LIMITATIONS Sialography (D0310) is not typically reimbursed through dental benefits, but may be considered for reimbursement through medical insurance.

D0320 TEMPOROMANDIBULAR JOINT ARTHROGRAM, INCLUDING INJECTION CDT 2025

LIMITATIONS Temporomandibular joint (TMJ) arthrogram (D0320) treatment services or diagnostic services are not typically reimbursed through dental benefits, but they may be considered for reimbursement through medical insurance.

D0321 OTHER TEMPOROMANDIBULAR JOINT RADIOGRAPHIC IMAGES, BY REPORT CDT 2025

LIMITATIONS Other TMJ radiographic images D0321 are not typically reimbursed through dental benefits, but they may possibly be considered for reimbursement through medical insurance.

D0322 TOMOGRAPHIC SURVEY CDT 2025

LIMITATIONS Tomographic surveys are not typically reimbursed through dental benefits, but they may be considered for reimbursement through medical insurance.

D0330 PANORAMIC RADIOGRAPHIC IMAGE



WARNING

1. It is misleading to report or "upcode" an extra-oral panoramic radiographic image (D0330) and bitewing images (D0272/D0273/D0274) to an intra-oral comprehensive series (D0210) if performed on the same service date. Although payors may "remap" or reimburse at a comprehensive series fee level, the provider should not report a procedure that was not performed. If both (D0330) and (D0272/D0273 or D0274) are taken on the same service date, report the procedures separately. Report the procedure(s) performed on the date the service was performed. Note: It is not illegal or improper for a payor to reimburse a submitted code at a rate assigned another code. These alternate benefit reimbursements are explained in that plan's *contract language*. Payors routinely convert separately coded extra-oral panoramic image and intra-oral bitewing radiographic images to the lower, global comprehensive series (D0210) UCR fee.

   Note: The date of service of any radiograph is the date they are interpreted, not the date they are taken. However, when panoramic and bitewing radiographs are taken on the same service date but then routinely split into different dates for interpretation in order to circumvent remapping by the payor to comprehensive series (D0210), this may be seen as a misrepresentation of treatment dates to gain increased reimbursement.

2. A panoramic radiographic image (D0330) is *extra-oral*, not intra-oral. A comprehensive series (D0210) is *intra-oral*.

WATCH

1. Practices should not have a protocol in place to delineate a specific time interval for the panoramic radiographic image (D0330). The panorex interval should be *individually* prescribed and ordered by the dentist based on ADA/FDA radiographic frequency recommendations, not insurance reimbursements. (D0330 is typically reimbursed every three to five years if deemed dentally necessary.)

2. Do not convert or "upcode" a radiographic image (D0330) and bitewing radiographic image (D0272, D0273 or D0274) to a comprehensive series (D0210). A panoramic radiographic image is an extra-oral radiographic image, not intra-oral. A comprehensive series (D0210) is a set of intra-oral radiographic images. It is improper/misleading to report a panorex and bitewings as a full mouth series. Report D0330 and D0274/D0273 or D0274 separately, as actually performed. The payor is allowed to re-map individual diagnostic images to a comprehensive series code as an alternate reimbursement. The payor may do this in accordance with specific policy limitations and exclusions of the contract. The contract may allow:

   a. Conversion or re-mapping a panorex and bitewings to a comprehensive radiographic image series (D0210) payor's fee. (A comprehensive series is typically reimbursed at a lower fee than the panorex and bitewings reimbursed separately.)

   b. Reimbursement for the bitewing radiographic images and panoramic radiographic images *separately*. The best result.

   c. Reimbursement for a panoramic radiographic image only and *nothing* for the bitewing radiographic images. This is the worst result.

3. Some CBCT's can generate a 2D panoramic image (D0330) along with the 3D image simultaneously. If so, only one radiograph may be billed per exposure. Consider reporting the panoramic to dental insurance, as the 3D image may not be reimbursed though dental.

LIMITATIONS

1. Panoramic radiographic images (D0330) are typically reimbursed and payable every three to five years, depending on the specific policy limitations. The trend for many contracts is to reimburse the procedure every five years. If D0330 is taken in conjunction with bitewing images on the *same* service date, it is often converted or "re-mapped" by the payor to a comprehensive series (D0210) and paid at the payor's fee for a comprehensive series. The fee is generally lower than the combined payor's fee for D0330 and D0272/D0273/D0274 when filed *separately*. Some payors will reimburse D0330, while rejecting payment for the bitewing radiographic images performed on the *same* service date. Some payors will reimburse the full payor's fee for *each* procedure D0330 and D0272/D0273/D0274 *separately*, yielding the best result.

2. Most payors will reimburse either D0330 or D0210 during the limitation period, not both.

3. Panoramic image (D0330) may be considered to be a part of orthodontic records. There are no specific codes for orthodontic records. D0330 may be reimbursed under "orthodontic records;" however, the reimbursement may be deducted from either the patient's lifetime orthodontic benefits or general dental benefits. The claim form question, "Is this for orthodontics?" must be answered "yes" to be considered a part of the orthodontic records.

4. There may be an age limitation applicable to the reimbursement for panoramic radiographic image (D0330). Some payors may require that a child be a minimum of five, six or seven years old to provide benefits for this service.

TIPS

1. Some offices take bitewing radiographic images on children at the comprehensive oral evaluation (D0150) and a panoramic radiographic image (D0330) (for growth and development studies) at either a subsequent operative visit or on a later recare service date, as determined by the dentist.
2. Reimbursement for a panoramic radiographic image (D0330) may be better when taken *alone* on a given service date than when taken in *conjunction* with bitewing images on the same service date.
3. Some offices establish a standard panoramic radiographic image (D0330) fee for two clinical situations. A lower standard fee for the panoramic radiographic image taken at the comprehensive oral *evaluation* (D0150) appointment in conjunction with bitewing diagnostic radiographic images. A higher standard fee for the panoramic radiographic image is established for a stand-alone panoramic image. (Set up a D0330A and D0330B fee to reflect whether the panoramic image is stand-alone or in conjunction with bitewings).
4. See full mouth debridement to enable comprehensive oral evaluation and diagnosis (D4355) for diagnostic radiographic image protocol options.
5. For panoramic radiographic image - image capture only, see D0701.

ADDITIONAL INFORMATION

1. Diagnostic images are *adjunctive* to the diagnosis process, and must be medically *necessary*.
2. Diagnostic images should be *individually* ordered by the doctor, following evaluation of the patient and performed for a *specific* reason(s). The justification for the radiographic image(s) should be documented in the chart.
3. Diagnostic radiographic images should be evaluated and *interpreted* by the doctor, and the indications *documented* in the patient's chart.
4. Poor and/or non-existing *documentation* of the dental necessity for diagnostic radiographic images may result in a demand for repayment of benefits for radiographs taken if audited by the payor, even though the diagnostic radiographic images were taken!
5. Radiographs of diagnostic quality should be dated and labeled in the patient's record.
6. Be careful to note the location, left and right (upper/lower), if not otherwise indicated by the radiograph to avoid review errors.

D0340 2D CEPHALOMETRIC RADIOGRAPHIC IMAGE - ACQUISITION, MEASUREMENT AND ANALYSIS

CDT 2025

Image of the head made using a cephalostat to standardize anatomic positioning, and with reproducible x-ray beam geometry.



WARNING

WARNING! A cephalometric cannot be reported as generated by a cone beam CT (CBCT). D0340 requires that the image of the head is made using a cephalostat to standardize anatomic positioning.



MATCH

Cephalometric radiographic image (D0340) is considered to be a *component* of orthodontic records. There are no global or specific codes to report *orthodontic* records. See also photographic images (D0350) and diagnostic casts (D0470). These procedures, added to the cephalometric image, typically constitute orthodontic records.

COMMENTS

1. Cephalometric image (D0340) is often payable as a component of orthodontic records. For reimbursement of this code check "yes" in Box 40 asking "Is this for orthodontics?" on the 2024 ADA Dental Claim Form. Also see diagnostic casts (D0470) and photographic images (D0350), which, together with a cephalometric image, are typically the components of the orthodontic records.
2. For 2-D cephalometric radiographic image - image capture only, see D0702.

LIMITATIONS

Reimbursement for cephalometric image (D0340) may be deducted from the lifetime orthodontic benefit. If orthodontic benefits are available the cephalometric image is typically reimbursed at 50% of the payor's fee. Sometimes the general dental benefit component of the plan will reimburse for orthodontic records separate from the orthodontic benefit. If reimbursed as part of the general dental benefits, D0340 may be paid at 50%, 80%, or 100% of the payor's fee.

PHOTO



This is a cephalometric radiographic image.

D0350 2D ORAL/FACIAL PHOTOGRAPHIC IMAGE OBTAINED INTRA-ORALLY OR EXTRA-ORALLY — CDT 2025

MATCH

Each component of orthodontic records is reported separately. There are no global or specific code(s) to report orthodontic records. 2D oral/facial photographic images (D0350) are considered to be a *component* of orthodontic records. See also cephalometric radiographic images (D0340) and diagnostic casts (D0470), which are common components of orthodontic records.

COMMENTS

1. 2D Intraoral or facial images are essential parts of documentation and are crucial for maximizing reimbursement from insurers.
2. There are no global or specific code(s) for orthodontic records.
3. D0350 includes both traditional photographs and images obtained by intra-oral or extra-oral cameras. These 2D images are a part of the patient's clinical record. D0350 describes 2D oral and/or facial photographic images.
4. For 3D scans, see D0801, D0802, D0803, and D0804.
5. For 2-D oral/facial photographic image obtained intra-orally - image capture only, see D0703.

LIMITATIONS

1. 2D oral/facial photographic images (D0350) are not typically reimbursed except as a component of orthodontic records.
2. The claim form question, "Is this for orthodontics?" must be answered "yes" (Box 40 of the 2024 ADA Dental Claim Form) for D0350 to be considered a part of the orthodontic records. D0350 is considered to be a part of orthodontic records/workup and is typically reimbursed *once* per lifetime. See cephalometric radiographic image (D0340) and diagnostic casts (D0470) for further orthodontic record component details.
3. Reimbursement for 2D oral/facial photographic images (D0350) may reduce the lifetime orthodontic benefit. If orthodontic benefits are available these photographic images are typically reimbursed at 50% of the payor's fee. Sometimes the general dental benefit component of the plan will reimburse for photographic images separate from the orthodontic benefit. If reimbursed as part of the general dental benefits, D0350 may be paid at 50%, 80%, or 100% of the payor's fee.

TIPS

1. While payors do not generally reimburse 2D oral photographic images (D0350), (except when part of orthodontic records) practices can add "value" by charging a "zero" fee and listing it on the walkout statement.
2. Intra-oral photographs often provide documentation that is helpful in proving medical necessity. In particular, photographs can be helpful in documenting the need for soft and connective tissue grafts, crowns and onlays, core buildups, labial veneers, frenectomies, and apically repositioned flaps. If the problem is not obvious on a radiographic image but is seen on the photograph, by all means, send it. Intra oral images are essential.

NARRATIVES

Photos are helpful to document cusp fractures, missing and undermined cusps, and cracks for onlays and crowns. Use a dye to emphasize the crack. Photos can also illustrate pocket depths (with probe in place) for periodontal documentation. Example narrative: "The photograph demonstrates a fractured mesio-buccal cusp that is not visible on the diagnostic film. Crown/onlay coverage is necessary."

D0351 PREVIOUSLY DELETED CODE 3D PHOTOGRAPHIC IMAGE — CDT 2025

This is a previously deleted code. See D0801, D0802, D0803, and D0804 for further details.

COMMENTS REGARDING CONE BEAM CT (CBCT) — AUTHOR'S COMMENTS

1. Cone Beam CT (CBCT) is a relatively new 3D imaging technology adopted by practices that provides a method to evaluate the anatomical positions of teeth and the makeup of the bone in a 3D image. An imaging unit (similar in size to a Panorex machine) has an arm that revolves around the patient's head in about 20 seconds. The CT acquires the axial, coronal, and sagittal data. The patient is exposed to radiation as the data is collected. An actual image is not produced. The data is captured and is stored, collated and compiled into a 2D or 3D data pack. This data may be retrieved, assimilated, and viewed at a later time.
2. 3D imaging allows a dentist to evaluate the exact position of impacted teeth, the position of third molars and their relationship to the inferior alveolar nerve or maxillary sinus, the osseous structure of the TMJ region, etc. While it has endless applications, it is the ultimate diagnostic tool for implant dentistry since the bony architecture and density of edentulous spaces can be clearly visualized.
3. Cone Beam CT scanning technology with 2D or 3D renderings allows the doctor to "see" critical anatomic structures for implant placement, oral surgery, orthodontic, periodontal, endodontic and TMJ procedures.
4. Even when listed as a benefit, coverage is determined by clinical necessity.
5. Situations where Cone Beam CT may be covered include:
    i. Impacted third molars positioned close to the inferior alveolar nerve.
    ii. Proposed implant placement close to the inferior alveolar nerve or sinus.
    iii. Proposed implant placement where there may be inadequate bone.
    iv. TMJ abnormalities/pathology.
6. Reimbursement for Cone Beam CT's is highly variable. Cone Beam CT is not generally reimbursed by dental. A Cone Beam CT may be submitted to medical as primary for reimbursement consideration subject to medical provisions.
7. Some CBCT's can generate a 2D panoramic image (D0330) along with the 3D image simultaneously. If so, only one radiograph may be billed per exposure. Consider reporting the panoramic to dental insurance, as the 3D image may not be reimbursed though dental.
8. Some dental plans have begun to cover one diagnostic CBCT per year per patient. A question about coverage of CBCT could be added to insurance verification process to identify these plans.

D0360 PREVIOUSLY DELETED CODE CONE BEAM CT - CRANIOFACIAL DATA CAPTURE

This is a previously deleted code. See other CBCT codes in this section.

D0362 PREVIOUSLY DELETED CODE CONE BEAM - TWO-DIMENSIONAL IMAGE RECONSTRUCTION USING EXISTING DATA, INCLUDES MULTIPLE IMAGES

This is a previously deleted code. See other CBCT codes in this section.

D0363 PREVIOUSLY DELETED CODE CONE BEAM - THREE-DIMENSIONAL IMAGE RECONSTRUCTION USING EXISTING DATA, INCLUDES MULTIPLE IMAGES

This is a previously deleted code. See other CBCT codes in this section.

D0364 CONE BEAM CT CAPTURE AND INTERPRETATION WITH LIMITED FIELD OF VIEW - LESS THAN ONE WHOLE JAW — CDT 2025

COMMENTS

1. D0364 reports both the Cone Beam CT *capture* and *interpretation* with a limited field of view - less than one whole jaw.
2. Enter the arch/quadrant and tooth number/range of teeth numbers being evaluated in the appropriate box of the 2024 ADA Dental Claim Form.

ADDITIONAL INFORMATION

Important! See Author's Cone Beam Comments prior to code D0360.

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

CDT 2025

COMMENTS D0365 reports both Cone Beam CT *capture* and *interpretation* with a field of view of one full dental arch - mandible.

ADDITIONAL INFORMATION IMPORTANT: See Author's Cone Beam Comments prior to code D0360.

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

CDT 2025

COMMENTS D0366 reports Cone Beam CT *capture* and *interpretation* with a limited field of view of one full dental arch - maxilla, with or without cranium.

ADDITIONAL INFORMATION IMPORTANT: See Author's Cone Beam Comments prior to code D0360.

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

CDT 2025

COMMENTS D0367 reports both Cone Beam CT *capture* and *interpretation* with a field of view of both jaws, with or without cranium.

ADDITIONAL INFORMATION IMPORTANT: See Author's Cone Beam Comments prior to code D0360.

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

CDT 2025

COMMENTS D0368 reports both Cone Beam CT *capture* and *interpretation* for TMJ series including two or more exposures.

ADDITIONAL INFORMATION IMPORTANT: See Author's Cone Beam Comments prior to code D0360.

D0369 MAXILLOFACIAL MRI CAPTURE AND INTERPRETATION

CDT 2025

COMMENTS

1. D0369 reports both the *capture* and the *interpretation* of a maxillofacial MRI (magnetic resonance imaging).
2. MRI is a well-established FDA approved imaging modality that is used to obtain accurate depiction of soft tissues. Within dentistry, maxillofacial MRI can be used to examine the soft tissues in and around the temporomandibular joint and for evaluation of certain oral pathology conditions that may have soft tissue components. In some cases, both the capture and interpretation may be performed by staff at a hospital or radiology clinic. However, in some cases, the MRI capture may be performed at the hospital or radiology clinic and the interpretation may be made by a separate practitioner who has DICOM reading software.

D0370 MAXILLOFACIAL ULTRASOUND CAPTURE AND INTERPRETATION

CDT 2025

COMMENTS

1. D0370 reports maxillofacial ultrasound *capture* and includes *interpretation*. It is often performed in hospitals and radiology clinics.
2. Maxillofacial ultrasonograms may be used to evaluate salivary glands, swollen head and neck soft tissues, zygomatic arch fractures, and salivary gland function/Sjogren's syndrome. In addition, ultrasonography can be used to detect and view boundaries of soft tissue pathology and used for guidance of fine needle aspiration biopsies. They are often performed in hospitals and radiology clinics, but not necessarily so; however, reimbursement is not based on where the procedure is performed.

D0371 SIALOENDOSCOPY CAPTURE AND INTERPRETATION

CDT 2025

COMMENTS

1. D0371 reports both the *capture* and the *interpretation* of a sialoendoscopy.
2. Sialoendoscopy is an FDA approved method for examining the salivary gland duct structures. It requires special equipment which enables direct visualization of the salivary gland using visible light rather than ionizing radiation. It is used for diagnosis and as a surgical guide.

GENERAL COMMENTS FOR TOMOSYNTHESIS

AUTHOR'S COMMENTS

For new codes to be adopted by the Code Maintenance Committee, they must pass scrutiny, the procedure cannot be classified as investigational, and no current code can report the procedure. It is a very vigorous process, and these new tomosynthesis codes have passed scrutiny and been adopted. Tomosynthesis is not a new technology. It has long been used in many other diagnostic medical applications.

Tomosynthesis has significant advantages over traditional radiographs and the procedure warrants these new codes. However, just because there is a new CDT procedure code does not mean it will be reimbursed by payors. In many cases, it can take several years for the payors to benefit the new codes.

Payors are set up to benefit conventional radiographs, so it is imperative that dental offices ask for an alternative benefit or appeal if denied. For 2025, this may be the primary route for reimbursement. For consideration of an alternative benefit, write a narrative stating "Please pay an alternative benefit for _____ (example D0274, D0210, D0220, etc.). You may also include an electronic attachment describing tomosynthesis in depth. If 2D images are simultaneously generated with the PORTRAY software, traditional radiographic codes may be reported instead, but not both. In the dental space, only the PORTRAY System is currently available for purchase. For further information on the appeal process, see our *Dental Administration with Confidence* book.

D0372 INTRAORAL TOMOSYNTHESIS - COMPREHENSIVE SERIES OF RADIOGRAPHIC IMAGES

CDT 2025

A radiographic survey of the whole mouth intended to display the crowns and roots of all teeth, periapical areas, interproximal areas and alveolar bone including edentulous areas.



WARNING

It is inappropriate to report D0372 for a traditional intraoral comprehensive series of radiographs (D0210).

COMMENTS

1. This procedure reports a comprehensive series of radiographs taken using stationary intraoral tomosynthesis (s-IOT) and includes both the capture and interpretation.
2. s-IOT utilizes a specialized x-ray system to produce tomosynthetic radiographs. A digital sensor is placed intraorally depending on the target anatomy. s-IOT requires precise alignment with the target anatomy utilizing an alignment aid that physically mates the receptor holder to the tube head. Multiple low-dose intraoral radiographs of the target anatomy are captured over a fixed angular span. A reconstruction algorithm processes the resulting digital images to produce a tomosynthetic reconstruction. The reconstruction provides a high-resolution 3D volume of the target anatomy. The clinician reviews the resulting images layer-by-layer by scrolling through the generated slices of the targeted anatomy. The resulting images add additional information not provided in conventional intraoral radiography.

LIMITATIONS

For further information, refer to D0210 for typical limitations of comprehensive series of radiographs.

D0373 INTRAORAL TOMOSYNTHESIS - BITEWING RADIOGRAPHIC IMAGE

CDT 2025



WARNING

It is inappropriate to report D0373 for a traditional bitewing image (D0270).

LIMITATIONS For further information, refer to D0274 for typical limitations of bitewing radiographs. For comments, see D0372.

D0374 INTRAORAL TOMOSYNTHESIS - PERIAPICAL RADIOGRAPHIC IMAGE CDT 2025

WARNING It is inappropriate to report D0374 for a traditional intraoral periapical image (D0220/D0230).

LIMITATIONS For further information, refer to D0220/D0230 for typical limitations of periapical radiographs. For comments, see D0372.

D0801 REVISED 3D INTRAORAL SURFACE SCAN – DIRECT CDT 2025

A surface scan of any aspect of the intraoral anatomy.

REVISIONS

3D INTRAORAL ~~DENTAL~~ SURFACE SCAN – DIRECT

A surface scan of any aspect of the intraoral anatomy.

WARNING 3D image capture for CAD/CAM procedures is considered part of the fabrication procedure, much like an impression, and is not to be reported separately.

MATCH

1. A 3D intraoral surface scan - direct reports the capture of a 3-dimensional representation of any aspect of the intraoral anatomy directly in the patient's mouth for diagnostic purposes.
2. There is no global or specific code(s) for orthodontic records. Each component of orthodontic records is reported separately. A 3D intraoral surface scan (D0801) could possibly be considered a component of orthodontic records. Also see 2D photographic image (D0350), cephalometric radiographic image (D0340), and diagnostic casts (D0470), which are common components of orthodontic records. Thus, 3D intraoral surface scan (D0801) might be used in orthodontics or some other diagnosis.
3. 3D printing of a 3D dental surface scan may be reported using D0396. See D0396.
4. D0801 may be reported for a "wellness scan" taken as a part of patient records. Scans taken at different visits may be compared through digital subtraction (D0394) to observe changes over time.
5. Scans may be used as a part of treatment simulation (D0393) with or without fusing with CBCT data (D0395) for the planning of implant surgery, orthodontic treatment, and other procedures.

COMMENTS

1. D0801 can be used to document a dimensionally accurate 3D representation of any aspect of the intraoral anatomy constructed by the integration of multiple photographic images or laser scan.
2. There has been no specific CDT code for 3D visible light images previously. Such images are used independently or in conjunction with other diagnostic modalities such as D0393 (treatment simulation using 3D image volume) or D0395 (fusion of two or more 3D image volumes of one or more modalities). 3D photographic images may also substitute for images made using ionizing radiation for evaluation of dental condition over time, especially following orthodontic or orthognathic treatment.
3. D0801 should not be reported for capture of scans for CAD/CAM procedures as a routine part of the fabrication process.
4. The previous nomenclature of D0801 included the word "dental," which could have been interpreted to limit the use of the code for the capturing of 3D images of the dentition only. This code was revised to make it clear that D0801 may be used for 3D scanning of all anatomic structures of the oral cavity.
5. Enter the area of the oral cavity and tooth number/range of teeth/tooth surface being evaluated in the appropriate box of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. 3D intraoral surface scan - direct (D0801) is not typically reimbursed but may possibly be considered as a component of orthodontic records.
2. The claim form question, "Is this for orthodontics?" must be answered "yes" (Box 40 of the 2024 ADA Dental Claim Form) to be considered a part of the orthodontic records. D0802 might be considered to be a part of orthodontic records/ workup and might be reimbursed once per lifetime. See 2D oral/facial photographic image (D0350), cephalometric radiographic image (D0340), and diagnostic casts (D0470) for further orthodontic record component details.
3. Reimbursement for 3D intraoral surface scan - direct (D0801) may reduce the lifetime orthodontic benefit. If orthodontic benefits are available, these scans are typically reimbursed at 50% of the payor's fee. Sometimes the general dental benefit component of the plan will reimburse for photographic images separate from the orthodontic benefit. If reimbursed as part of the general dental benefits, D0801 may be paid at 50%, 80%, or 100% of the payor's fee.

TIPS

1. While payors do not generally reimburse 3D intraoral surface scan - direct (D0801) (except orthodontic records), practices can add "value" by charging a "zero" fee or a nominal fee as a "wellness scan." More frequent use of this code by practices may result in D0801 being benefited in the future.
2. A 3D surface scan may provide documentation that is helpful in documenting claims. In particular, photographs and 3D scans can be helpful in documenting the need for soft and connective tissue grafts, crowns and onlays, core buildups, labial veneers, frenectomies, and apically repositioned flaps. If the problem is not obvious on a radiographic image, but is seen on the photograph or scan, send it.

NARRATIVES

3D surface scans are helpful to document cusp fractures, missing and undermined cusps, and cracks for onlays and crowns. Example narrative: "The scan demonstrates a fractured mesiobuccal cusp not visible on the radiographic image. Crown is necessary."

D0802 3D DENTAL SURFACE SCAN - INDIRECT CDT 2025

A surface scan of a diagnostic cast.



WARNING

1. 3D image capture for CAD/CAM procedures is considered part of the fabrication process, much like an impression, and is not reported separately.
2. D0802 is not to be used for direct capture of 3D scans intraorally.



MATCH

1. A 3D dental surface scan - indirect reports the capture of a 3-dimensional representation of the dentition for diagnostic or documentation purposes by the scanning of a diagnostic model.
2. There is no global or specific code(s) for orthodontic records. Each component of orthodontic records is reported separately. A 3D dental surface scan - indirect (D0802) could possibly be considered a component of orthodontic records. Also see 2D photographic image (D0350), cephalometric radiographic image (D0340), and diagnostic casts (D0470), which are common components of orthodontic records. Thus, 3D dental surface scans (D0802) might be used in orthodontics or some other diagnosis.
3. 3D printing of a dental surface scan may be reported using D0396. See D0396.

COMMENTS

1. D0802 can be used to document an indirect dimensionally accurate 3D representation of the dentition constructed by the integration of multiple photographic images or laser scan of a diagnostic cast.
2. There has been no specific CDT code for 3D visible light images previously. Such images are used independently or in conjunction with other diagnostic modalities such as D0393 (treatment simulation using 3D image volume) or D0395 (fusion of two or more 3D image volumes of one or more modalities). 3D photographic images may also substitute for images made using ionizing radiation for evaluation of dental condition over time, especially following orthodontic or orthognathic treatment.
3. D0802 should not be reported for capture of scans for CAD/CAM procedures as a routine part of the fabrication process.

LIMITATIONS

1. 3D dental surface scan - indirect (D0802) is not typically reimbursed but may possibly be considered as a component of orthodontic records.
2. The claim form question, "Is this for orthodontics?" must be answered "yes" (Box 40 of the 2024 ADA Dental Claim Form) to be considered a part of the orthodontic records. D0802 might be considered to be a part of orthodontic records/ workup and might be reimbursed once per lifetime. See 2D oral/facial photographic image (D0350), cephalometric radiographic image (D0340), and diagnostic casts (D0470) for further orthodontic record component details.
3. Reimbursement for 3D dental surface scan - indirect (D0802) may reduce the lifetime orthodontic benefit. If orthodontic benefits are available, these scans are typically reimbursed at 50% of the payor's fee. Sometimes the general dental benefit component of the plan will reimburse for photographic images separate from the orthodontic benefit. If reimbursed as part of the general dental benefits, D0802 may be paid at 50%, 80%, or 100% of the payor's fee.

TIPS

1. While payors do not generally reimburse 3D dental surface scan - indirect (D0802) (except orthodontic records), practices can add "value" by charging a "zero" fee.
2. A 3D surface scan may provide documentation that is helpful in documenting claims. In particular, photographs and 3D scans can be helpful in documenting the need for soft and connective tissue grafts, crowns and onlays, core buildups, labial veneers, frenectomies, and apically repositioned flaps. If the problem is not obvious on a radiographic image, but is seen on the photograph or scan of the diagnostic cast, send it.

D0803 3D FACIAL SURFACE SCAN - DIRECT CDT 2025



MATCH

1. A 3D facial surface scan - direct reports the direct capture of a 3-dimensional representation of the patient's face for diagnostic or documentation purposes.
2. There is no global or specific code(s) for orthodontic records. Each component of orthodontic records is reported separately. A 3D facial surface scan (D0803) could possibly be considered a component of orthodontic records. Also see 2D photographic image (D0350), cephalometric radiographic image (D0340), and diagnostic casts (D0470), which are common components of orthodontic records. Thus, a 3D facial surface scan (D0803) might be used in orthodontics or some other diagnosis.

COMMENTS

1. D0803 can be used to document a dimensionally accurate 3D representation of the patient's face constructed by the integration of multiple photographic images or laser scan.
2. There has been no specific CDT code for 3D visible light images previously. Such images are used independently or in conjunction with other diagnostic modalities such as D0393 (treatment simulation using 3D image volume) or D0395 (fusion of two or more 3D image volumes of one or more modalities). 3D photographic images may also substitute for images made using ionizing radiation for evaluation of dental condition over time, especially following orthodontic or orthognathic treatment.

LIMITATIONS

1. 3D facial surface scan - direct (D0803) is not typically reimbursed but may be considered as a component of orthodontic records.
2. The claim form question, "Is this for orthodontics?" must be answered "yes" (Box 40 of the 2024 ADA Dental Claim Form) to be considered a part of the orthodontic records. D0803 might be considered to be a part of orthodontic records/ workup and might be reimbursed once per lifetime. See 2D oral/facial photographic image (D0350), cephalometric radiographic image (D0340), and diagnostic casts (D0470) for further orthodontic record component details.
3. Reimbursement for 3D facial surface scan - direct (D0803) may reduce the lifetime orthodontic benefit. If orthodontic benefits are available, these scans are typically reimbursed at 50% of the payor's fee. Sometimes the general dental benefit component of the plan will reimburse for photographic images separate from the orthodontic benefit. If reimbursed as part of the general dental benefits, D0803 may be paid at 50%, 80%, or 100% of the payor's fee.

TIPS

While payors do not generally reimburse 3D facial surface scan - direct (D0803) (except orthodontic records), practices can add "value" by charging a "zero" fee.

D0804 3D FACIAL SURFACE SCAN - INDIRECT CDT 2025

A surface scan of constructed facial features.

MATCH

1. A 3D facial surface scan - indirect reports the indirect construction of a 3-dimensional representation of the patient's face for diagnostic or documentation purposes.
2. There is no global or specific code(s) for orthodontic records. Each component of orthodontic records is reported separately. A 3D facial surface scan (D0804) could possibly be considered a component of orthodontic records. Also see 2D photographic image (D0350), cephalometric radiographic image (D0340), and diagnostic casts (D0470), which are common components of orthodontic records. Thus, a 3D facial surface scan (D0804) might be used in orthodontic or some other diagnosis.

COMMENTS

1. D0804 can be used to document a dimensionally accurate 3D representation of the patient's face constructed by the integration of multiple photographic images or laser scan.
2. There has been no specific CDT code for 3D visible light images previously. Such images are used independently or in conjunction with other diagnostic modalities such as D0393 (treatment simulation using 3D image volume) or D0395 (fusion of two or more 3D image volumes of one or more modalities). 3D photographic images may also substitute for images made using ionizing radiation for evaluation of dental condition over time, especially following orthodontic or orthognathic treatment.

LIMITATIONS

1. 3D facial surface scan - indirect (D0804) is not typically reimbursed but may be considered as a component of orthodontic records.
2. The claim form question, "Is this for orthodontics?" must be answered "yes" (Box 40 of the 2024 ADA Dental Claim Form) to be considered a part of the orthodontic records. D0804 might be considered to be a part of orthodontic records/ workup and might be reimbursed once per lifetime. See 2D oral/facial photographic image (D0350), cephalometric radiographic image (D0340), and diagnostic casts (D0470) for further orthodontic record component details.
3. Reimbursement for 3D facial surface scan - indirect (D0804) may reduce the lifetime orthodontic benefit. If orthodontic benefits are available, these scans are typically reimbursed at 50% of the payor's fee. Sometimes the general dental benefit component of the plan will reimburse for photographic images separate from the orthodontic benefit. If reimbursed as part of the general dental benefits, D0804 may be paid at 50%, 80%, or 100% of the payor's fee.

TIPS

While payors do not generally reimburse 3D facial surface scan - indirect (D0804) (except orthodontic records), practices can add "value" by charging a "zero" fee.

IMAGE CAPTURE ONLY CDT 2025

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 CDT 2025

COMMENTS

1. D0380 reports the Cone Beam CT image *capture* (only) with limited field of view - less than one whole jaw.
2. The interpretation and report is performed by a practitioner not associated with the capture.
3. The interpretation and report by another practitioner is reported by D0391.
4. Reporting image capture only codes may reduce the liability of the practitioner who took the image. Consider using these codes if a lesion is noted and interpretation of the image will be performed by a different provider.
5. Enter the arch/quadrant and tooth number/range of teeth numbers in the appropriate box of the 2024 ADA Dental Claim Form.

ADDITIONAL INFORMATION

IMPORTANT: See Author's Cone Beam Comments prior to code D0360.

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

CDT 2025

COMMENTS

1. D0381 reports the Cone Beam CT image *capture* (only) with a field of view of one full dental arch - mandible.
2. The interpretation and report is performed by a practitioner not associated with the capture.
3. The interpretation and report by another practitioner is reported by D0391.
4. Reporting image capture only codes may reduce the liability of the practitioner who took the image. Consider using these codes if a lesion is noted and interpretation of the image will be performed by a different provider.

ADDITIONAL INFORMATION

IMPORTANT: See Author's Cone Beam Comments prior to code D0360.

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

CDT 2025

COMMENTS

1. D0382 reports the Cone Beam CT image *capture* (only) with a field of view of one full dental arch - maxilla, with or without cranium.
2. The interpretation and report is performed by a practitioner not associated with the capture.
3. The interpretation and report by another practitioner is reported by D0391.
4. Reporting image capture only codes may reduce the liability of the practitioner who took the image. Consider using these codes if a lesion is noted and interpretation of the image will be performed by a different provider.

ADDITIONAL INFORMATION

IMPORTANT: See Author's Cone Beam Comments prior to code D0360.

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

CDT 2025

COMMENTS

1. D0383 reports the Cone Beam CT image *capture* (only) with a field of view both jaws, with or without cranium.
2. The interpretation and report is performed by a practitioner not associated with the capture.
3. The interpretation and report by another practitioner is reported by D0391.
4. Reporting image capture only codes may reduce the liability of the practitioner who took the image. Consider using these codes if a lesion is noted and interpretation of the image will be performed by a different provider.

ADDITIONAL INFORMATION

IMPORTANT: See Author's Cone Beam Comments prior to code D0360.

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

CDT 2025

COMMENTS

1. D0384 reports the Cone Beam CT image *capture* (only) with a field of view for TMJ series including two or more exposures.
2. The interpretation and report are performed by a practitioner not associated with the capture.
3. The interpretation and report by another practitioner are reported by D0391.
4. Reporting image capture only codes may reduce the liability of the practitioner who took the image. Consider using these codes if a lesion is noted and interpretation of the image will be performed by a different provider.

ADDITIONAL INFORMATION

IMPORTANT: See Author's Cone Beam Comments prior to code D0360.

D0385 MAXILLOFACIAL MRI IMAGE CAPTURE

CDT 2025

COMMENTS

1. D0385 reports the maxillofacial MRI image *capture* (only).
2. MRI is a well-established FDA-approved imaging modality that is used to obtain accurate depiction of soft tissues. Within dentistry, maxillofacial MRI can be used to examine the soft tissues in and around the temporomandibular joint and for evaluation of certain oral pathology conditions that may have soft tissue components. In some cases, both the capture and interpretation may be performed by staff at a hospital or radiology clinic. However, in some cases, the MRI capture may be performed at the hospital or radiology clinic and the interpretation may be made by a separate practitioner who has DICOM reading software.
3. Report D0385 when capturing the MRI image only and sending it to another practitioner at a different location for interpretation and report.
4. Reporting image capture only codes may reduce the liability of the practitioner who took the image. Consider using these codes if a lesion is noted and interpretation of the image will be performed by a different provider.

D0386 MAXILLOFACIAL ULTRASOUND IMAGE CAPTURE

CDT 2025

COMMENTS

1. D0386 reports the maxillofacial ultrasound image *capture* (only).
2. Maxillofacial ultrasonograms may be used to evaluate salivary glands, swollen head and neck soft tissues, zygomatic arch fractures, and salivary gland function/Sjogren's syndrome. In addition, ultrasonography can be used to detect and view boundaries of soft tissue pathology and for guidance of fine needle aspiration biopsies. These are often performed in hospitals and radiology clinics, but not always.
3. D0386 should not be reported if the same provider performs the ultrasound and interprets the image. See D0370.
4. Reporting image capture only codes may reduce the liability of the practitioner who took the image. Consider using these codes if a lesion is noted and interpretation of the image will be performed by a different provider.

D0387 INTRAORAL TOMOSYNTHESIS - COMPREHENSIVE SERIES OF RADIOGRAPHIC IMAGES - IMAGE CAPTURE ONLY

CDT 2025

A radiographic survey of the whole mouth intended to display the crowns and roots of all teeth, periapical areas, interproximal areas and alveolar bone including edentulous areas.



WARNING

1. It is inappropriate to report D0387 for a traditional intraoral comprehensive series of radiographs (D0210), which includes interpretation, or for a traditional intraoral comprehensive series of radiographs - image capture only (D0709).
2. It is inappropriate to report D0387 when images are captured and interpreted by the same provider. D0387 reports image capture only.

COMMENTS

1. This procedure reports a comprehensive series of radiographs taken using stationary intraoral tomosynthesis (s-IOT) and includes image capture only.
2. For intraoral tomosynthesis - comprehensive series of radiographs, image capture and interpretation, see D0372.
3. Reporting image capture only codes may reduce the liability of the practitioner who took the image. Consider using these codes if a lesion is noted and interpretation of the image will be performed by a different provider.
4. It is common for a healthcare provider working in a remote location to perform the image capture only, store the image and send to a dentist for radiographic evaluation and diagnosis. In this instance, the image capture only would be reported by the remote healthcare worker and the dentist performing the interpretation and making the diagnosis would report D0391 interpretation of diagnostic image by a practitioner not associated with capture of the image, including report. Report D9996 for the teledentistry component if it is not a real time encounter. Normally this would be a situation for D9996. However, if it is a real time teledentistry encounter then reporting D9995 would be appropriate.

5. s-IOT utilizes a specialized x-ray system to produce tomosynthetic radiographs. A digital sensor is placed intraorally depending on the target anatomy. s-IOT requires precise alignment with the target anatomy utilizing an alignment aid that physically mates the receptor holder to the tube head. Multiple low-dose intraoral radiographs of the target anatomy are captured over a fixed angular span. A reconstruction algorithm processes the resulting digital images to produce a tomosynthetic reconstruction. The reconstruction provides a high-resolution 3D volume of the target anatomy. The clinician reviews the resulting images layer-by-layer by scrolling through the generated slices of the targeted anatomy. The resulting images add additional information not provided in conventional intraoral radiography.

LIMITATIONS

For further information, refer to D0210 for typical limitations of comprehensive series of radiographs and the comments on tomosynthesis located above D0372.

D0388 INTRAORAL TOMOSYNTHESIS - BITEWING RADIOGRAPHIC IMAGE - IMAGE CAPTURE ONLY

CDT 2025

WARNING

1. It is inappropriate to report D0388 for a traditional intraoral bitewing image (D0274), which includes interpretation, or for a traditional intraoral bitewing image - image capture only (D0706).
2. It is inappropriate to report D0388 when images are captured and interpreted by the same provider. D0388 reports image capture only.

COMMENTS

1. This procedure reports the initial and each subsequent intraoral bitewing radiograph taken using stationary intraoral tomosynthesis (s-IOT) and includes image capture only.
2. For intraoral tomosynthesis - bitewing radiograph, image capture and interpretation, see D0373.
3. Reporting image capture only codes may reduce the liability of the practitioner who took the image. Consider using these codes if a lesion is noted and interpretation of the image will be performed by a different provider.
4. It is common for a healthcare provider working in a remote location to perform the image capture only, store the image and send to a dentist for radiographic evaluation and diagnosis. In this instance, the image capture only would be reported by the remote healthcare worker and the dentist performing the interpretation and making the diagnosis would report D0391 interpretation of diagnostic image by a practitioner not associated with capture of the image, including report. Report D9996 for the teledentistry component if it is not a real time encounter. Normally this would be a situation for D9996. However, if it is a real time teledentistry encounter then reporting D9995 would be appropriate.
5. s-IOT utilizes a specialized x-ray system to produce tomosynthetic radiographs. A digital sensor is placed intraorally depending on the target anatomy. s-IOT requires precise alignment with the target anatomy utilizing an alignment aid that physically mates the receptor holder to the tube head. Multiple low-dose intraoral radiographs of the target anatomy are captured over a fixed angular span. A reconstruction algorithm processes the resulting digital images to produce a tomosynthetic reconstruction. The reconstruction provides a high-resolution 3D volume of the target anatomy. The clinician reviews the resulting images layer-by-layer by scrolling through the generated slices of the targeted anatomy. The resulting images add additional information not provided in conventional intraoral radiography.
6. Enter the range of teeth being evaluated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

For further information, refer to D0274 for typical limitations of bitewing radiographs and the comments on tomosynthesis located above D0372.

D0389 INTRAORAL TOMOSYNTHESIS - PERIAPICAL RADIOGRAPHIC IMAGE - IMAGE CAPTURE ONLY

CDT 2025

WARNING

1. It is inappropriate to report D0389 for a traditional intraoral periapical image (D0220/D0230) or a traditional intraoral periapical image - image capture only (D0707).
2. It is inappropriate to report D0389 when images are captured and interpreted by the same provider. D0389 reports image capture only.

COMMENTS

1. This procedure reports the initial and each subsequent periapical radiograph taken using stationary intraoral tomosynthesis (s-IOT) and includes image capture only.
2. For intraoral tomosynthesis - periapical radiograph, image capture and interpretation, see D0374.
3. Reporting image capture only codes may reduce the liability of the practitioner who took the image. Consider using these codes if a lesion is noted and interpretation of the image will be performed by a different provider.
4. It is common for a healthcare provider working in a remote location to perform the image capture only, store the image and send to a dentist for radiographic evaluation and diagnosis. In this instance, the image capture only would be reported by the remote healthcare worker and the dentist performing the interpretation and making the diagnosis would report D0391 interpretation of diagnostic image by a practitioner not associated with capture of the image, including report. Report D9996 for the teledentistry component if it is not a real time encounter. Normally this would be a situation for D9996. However, if it is a real time teledentistry encounter then reporting D9995 would be appropriate.
5. s-IOT utilizes a specialized x-ray system to produce tomosynthetic radiographs. A digital sensor is placed intraorally depending on the target anatomy. s-IOT requires precise alignment with the target anatomy utilizing an alignment aid that physically mates the receptor holder to the tube head. Multiple low-dose intraoral radiographs of the target anatomy are captured over a fixed angular span. A reconstruction algorithm processes the resulting digital images to produce a tomosynthetic reconstruction. The reconstruction provides a high-resolution 3D volume of the target anatomy. The clinician reviews the resulting images layer-by-layer by scrolling through the generated slices of the targeted anatomy. The resulting images add additional information not provided in conventional intraoral radiography.
6. Enter the tooth number or range of teeth being evaluated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

For further information, refer to D0220/D0230 for typical limitations of periapical radiographs and the comments on tomosynthesis located above D0372.

WARNING! **The following codes, D0701 - D0709 are not listed in numerical order but these codes are properly placed here under the Image Capture Only section.**

D0701 PANORAMIC RADIOGRAPHIC IMAGE - IMAGE CAPTURE ONLY CDT 2025



WARNING

1. It is misleading to report or "upcode" an extra-oral panoramic radiographic image (D0330 or D0701) and bitewing images (D0272/D0273/D0274) to an intra-oral comprehensive series (D0210) if performed on the same service date. Although payors may "remap" or reimburse at a comprehensive series fee level, the provider should not report a procedure that was not performed. If both (D0330) and (D0272/D0273 or D0274) are taken on the same service date, report the procedures separately. Report the procedure(s) performed on the date the service was performed. Note: It is not illegal or improper for a payor to reimburse a submitted code at a rate assigned another code. These alternate benefit reimbursements are explained in that plan's contract language. Payors routinely convert separately coded extra-oral panoramic image and intra-oral bitewing radiographic images to the lower, global comprehensive series (D0210) payor's fee.
2. A panoramic radiographic image (D0330 or D0701) is *extra-oral*, not *intra-oral*. A comprehensive series (D0210) is intra-oral.
3. Do not submit a panoramic image and bitewings on different claims or service dates in order to obtain a better reimbursement.

WATCH

1. Reporting image capture only codes may reduce the liability of the practitioner who took the image. Consider using these codes if a lesion is noted and interpretation of the image will be performed by a different provider.
2. Practices should not have a protocol in place to delineate a specific time interval for the panoramic radiographic image (D0701). The panorex interval should be individually prescribed and ordered by the dentist. (D0701 is typically reimbursed every three to five years if deemed dentally necessary.)

3. Do not convert or "upcode" a radiographic image (D0701) and bitewing radiographic image (D0272, D0273 or D0274) to a comprehensive series (D0210). A panoramic radiographic image is an extra-oral radiographic image, not intraoral. A comprehensive series (D0210) is a set of intra-oral radiographic images. It is improper/misleading to report a panorex and bitewings as a full mouth series. Report D0701and D0274/D0273 or D0274 separately, as actually performed. The payor is allowed to re-map individual diagnostic images to a comprehensive series code as an alternate reimbursement. The dental practice is not. The payor may do this in accordance with specific policy limitations and exclusions of the contract. The contract may allow:
    a. Conversion or re-mapping a panorex and bitewings to a comprehensive radiographic image series (D0210) payor's fee.(A complete series is typically reimbursed at a lower fee than the panorex and bitewings reimbursed separately.)
    b. Plans may allow reimbursement for the bitewing radiographic images and panoramic radiographic images separately. This is the best result.
    c. Reimbursement for a panoramic radiographic image only and nothing for the bitewing radiographic images. This is the worst result.
4. It is common for a healthcare provider working in a remote location to perform the image capture only, store the image and send to a dentist for radiographic evaluation and diagnosis. In this instance, the image capture only would be reported by the remote healthcare worker and the dentist performing the interpretation and making the diagnosis would report D0391 interpretation of diagnostic image by a practitioner not associated with capture of the image, including report. Report D9996 for the teledentistry if it is not a real time encounter. Normally this would be a situation for D9996. However, if it is a real time teledentistry encounter then reporting D9995 would be appropriate.

LIMITATIONS

1. Panoramic radiographic images (D0701) are typically reimbursed and payable every three to five years, depending on the specific policy limitations. The trend for many contracts is to reimburse the procedure every five years. If D0701 is taken in conjunction with bitewing images on the same service date, it is often converted or "re-mapped" by the payor to a comprehensive series (D0210) and paid at the payor's fee for a comprehensive series. The fee is generally lower than the combined payor's fee for D0701 and D0272/D0273/D0274 when filed separately. Some payors will reimburse D0701, while rejecting payment for the bitewing radiographic images performed on the same service date. Some payors will reimburse the full payor's fee for each procedure D0701 and D0272/D0273/D0274 separately, yielding the best result.
2. Most payors will reimburse either D0701 or D0210 during the limitation period, not both.
3. Panoramic image (D0701) may be considered to be a part of orthodontic records. There are no specific codes for orthodontic records. D0701 may be reimbursed under "orthodontic records;" however, the reimbursement may be deducted from either the patient's lifetime orthodontic benefits or general dental benefits. The claim form question, "Is this for orthodontics?" must be answered "yes" to be considered a part of the orthodontic records.
4. There may be an age limitation applicable to the reimbursement for panoramic radiographic image (D0701). Some payors may require that a child be a minimum of five, six or seven years old to provide benefits for this service.

TIPS

1. Some offices take bitewing radiographic images on children at the comprehensive oral evaluation (D0150) and a panoramic radiographic image (D0330 or D0701) (for growth and development studies) at either a subsequent operative visit or on a later recare service date, as determined by the dentist.
2. Reimbursement for a panoramic radiographic image (D0330 or D0701) may be better when taken alone on a given service date than when taken in conjunction with bitewing images on the same service date.
3. Some offices establish a standard panoramic radiographic image (D0330) fee for two clinical situations. A lower standard fee for the panoramic radiographic image taken at the comprehensive oral evaluation (D0150) appointment in conjunction with bitewing diagnostic radiographic images. A higher standard fee for the panoramic radiographic image is established for a stand-alone panoramic image. (Set up a D0330A and D0330B fee to reflect whether the panoramic image is stand-alone or in conjunction with bitewings).
4. See full mouth debridement to enable comprehensive oral evaluation and diagnosis (D4355) for diagnostic radiographic image protocol options.
5. For panoramic radiographic image - image capture and interpretation, see D0330.

ADDITIONAL INFORMATION

1. Diagnostic images are *adjunctive* to the diagnosis process, and must be medically *necessary*.
2. Diagnostic images should be *individually* ordered by the doctor, following evaluation of the patient and performed for a *specific* reason(s). The justification for the radiographic image(s) should be documented in the chart.
3. Diagnostic radiographic images should be evaluated and *interpreted* and the indications *documented* in the patient's chart. If interpretation is performed by a different practitioner than the one that captured the image, use image capture only codes and note any report findings along with the name of the interpreting practitioner.
4. Poor and/or non-existing *documentation* of the dental necessity for diagnostic radiographic images may result in a demand for repayment of benefits for radiographs taken if audited by the payor, even though the diagnostic radiographic images were taken!
5. Radiographs of diagnostic quality should be dated and labeled in the patient's record.
6. Be careful to note the location, left and right (upper/lower), if not otherwise indicated by the radiograph to avoid review errors.

D0702 2-D CEPHALOMETRIC RADIOGRAPHIC IMAGE - IMAGE CAPTURE ONLY CDT 2025

MATCH

Cephalometric radiographic image (D0340/D0702) is considered to be a *component* of orthodontic records. There are no global or specific codes to report *orthodontic* records. See also photographic images (D0350) and diagnostic casts (D0470). These procedures, added to the cephalometric image, typically constitute orthodontic records.

COMMENTS

1. WARNING! A cephalometric (D0340) cannot be reported as generated by a cone beam CT (CBCT). The descriptor of D0340 requires that the image of the head is made using a cephalostat to standardize anatomic positioning. D0702 does not have this descriptor.
2. Cephalometric image (D0702) is often payable as a component of orthodontic records. For reimbursement of this code check "yes" in Box 40 asking "Is this for orthodontics?" on the 2024 ADA Dental Claim Form. Also see diagnostic casts (D0470) and photographic images (D0350), which, together with a cephalometric image, are typically the components of the orthodontic records.
3. For 2-D cephalometric radiographic image including acquisition, measurement, and analysis, see D0340.
4. It is common for a healthcare provider working in a remote location to perform the image capture only, store the image and send to a dentist for radiographic evaluation and diagnosis. In this instance, the image capture only would be reported by the remote healthcare worker and the dentist performing the interpretation and making the diagnosis would report D0391 interpretation of diagnostic image by a practitioner not associated with capture of the image, including report. Report D9996 for the teledentistry if it is not a real time encounter. Normally this would be a situation for D9996. However, if it is a real time teledentistry encounter then reporting D9995 would be appropriate.
5. Reporting image capture only codes may reduce the liability of the practitioner who took the image. Consider using these codes if a lesion is noted and interpretation of the image will be performed by a different provider.

LIMITATIONS

Reimbursement for cephalometric image (D0340/D0702) may be deducted from the lifetime orthodontic benefit. If orthodontic benefits are available, the cephalometric image is typically reimbursed at 50% of the payor's fee. Sometimes the general dental benefit component of the plan will reimburse for orthodontic records separate from the orthodontic benefit. If reimbursed as part of the general dental benefits, D0340 may be paid at 50%, 80%, or 100% of the payor's fee.

PHOTO



This is a cephalometric radiographic image.

D0703 2-D ORAL/FACIAL PHOTOGRAPHIC IMAGE OBTAINED INTRA-ORALLY OR EXTRA-ORALLY - IMAGE CAPTURE ONLY

MATCH

1. There are no global or specific code(s) for orthodontic records.
2. For 3D surface scan, see D0801, D0802, D0803, D0804.
3. For 2-D oral/facial photographic image obtained intra-orally including interpretation, see D0350.

COMMENTS

1. There are no global or specific code(s) for orthodontic records.
2. D0350 and D0703 include both traditional photographs and images obtained by intra-oral or extra-oral cameras. These 2D images are a part of the patient's clinical record. D0350 describes 2D oral and/or facial photographic images.
3. Reporting image capture only codes may reduce the liability of the practitioner who took the image. Consider using these codes if a lesion is noted and interpretation of the image will be performed by a different provider.
4. It is common for a healthcare provider working in a remote location to perform the image capture only, store the image and send to a dentist for radiographic evaluation and diagnosis. In this instance, the image capture only would be reported by the remote healthcare worker and the dentist performing the interpretation and making the diagnosis would report D0391 interpretation of diagnostic image by a practitioner not associated with capture of the image, including report. Report D9996 for the teledentistry if it is not a real time encounter. Normally this would be a situation for D9996. However, if it is a real time teledentistry encounter then reporting D9995 would be appropriate.

LIMITATIONS

1. 2D oral/facial photographic images (D0350 and D0703) are not typically reimbursed except as a component of orthodontic records.
2. The claim form question, "Is this for orthodontics?" must be answered "yes" (Box 40 of the 2024 ADA Dental Claim Form) for D0350 to be considered a part of the orthodontic records. D0350 is considered to be a part of orthodontic records/workup and is typically reimbursed *once* per lifetime. See cephalometric radiographic image (D0340) and diagnostic casts (D0470) for further orthodontic record component details.
3. Reimbursement for 2D oral/facial photographic images (D0350 or D0703) may reduce the lifetime orthodontic benefit.

   If orthodontic benefits are available these photographic images are typically reimbursed at 50% of the payor's fee.

   Sometimes the general dental benefit component of the plan will reimburse for photographic images separate from the orthodontic benefit. If reimbursed as part of the general dental benefits, D0350 may be paid at 50%, 80%, or 100% of the payor's fee.

TIPS

1. While payors do not generally reimburse 2D oral photographic images (D0350 or D0703), (except orthodontic records) practices can add "value" by charging a "zero" fee.
2. Intra-oral photographs often provide documentation that is helpful in proving medical necessity. In particular, photographs can be helpful in documenting the need for soft and connective tissue grafts, crowns and onlays, core buildups, labial veneers, frenectomies, and apically repositioned flaps. If the problem is not obvious on a radiographic image but is seen on the photograph, by all means, send it.

NARRATIVES

Photos are helpful to document cusp fractures, missing and undermined cusps, and cracks for onlays and crowns. Use a dye to emphasize the crack. Photos can also illustrate pocket depths (with probe in place) for periodontal documentation. Example narrative: "The photograph demonstrates a fractured mesio-buccal cusp that is not visible on the diagnostic image. Crown/onlay coverage is necessary."

D0704 PREVIOUSLY DELETED CODE 3-D PHOTOGRAPHIC IMAGE - IMAGE CAPTURE ONLY

This is a previously deleted code. There is no replacement code for image capture only. See D0801, D0802, D0803, and D0804 for image capture with interpretation.

D0705 EXTRA-ORAL POSTERIOR DENTAL RADIOGRAPHIC IMAGE - IMAGE CAPTURE ONLY

CDT 2025

Image limited to exposure of complete posterior teeth in both dental arches. This is a unique image that is not derived from another image.

WATCH

D0251/D0705 is used to describe an extra-oral posterior dental radiograph that produces an image of the posterior teeth area of both dental arches. This D0251/D0705 image is not to be derived from another image. D0251/D0705 describes an image that is unique and not produced from, or a duplicate produced from, another existing image (e.g., not produced from cone beam CT reconstruction of the data captured in the scan).

COMMENTS

1. D0705 reports a posterior radiographic image of both the upper and lower jaws of the posterior area of the mouth. If both right and left images are produced, report D0705 twice and identify the right or left side represented by each image.
2. For extra-oral posterior dental radiographic image including interpretation, see D0251.
3. Reporting image capture only codes may reduce the liability of the practitioner who took the image. Consider using these codes if a lesion is noted and interpretation of the image will be performed by a different provider.
4. It is common for a healthcare provider working in a remote location to perform the image capture only, store the image and send to a dentist for radiographic evaluation and diagnosis. In this instance, the image capture only would be reported by the remote healthcare worker and the dentist performing the interpretation and making the diagnosis would report D0391 interpretation of diagnostic image by a practitioner not associated with capture of the image, including report. Report D9996 for the teledentistry if it is not a real time encounter. Normally this would be a situation for D9996. However, if it is a real time teledentistry encounter then reporting D9995 would be appropriate.
5. Enter the tooth number or range of teeth numbers being evaluated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Because this is a fairly recent code, many existing plans will not provide reimbursement. When reporting, include a narrative stating, "If benefits are not available for D0705, pay the alternate benefit of D0708." Report a quantity of two if both sides are imaged.
2. When benefited, D0705 frequently has a higher reimbursement than corresponding bitewing codes.
3. It may also help to include a reason why D0705 was used, such as the patient not being able to tolerate an intraoral sensor.

D0706 INTRAORAL - OCCLUSAL RADIOGRAPHIC IMAGE - IMAGE CAPTURE ONLY

CDT 2025

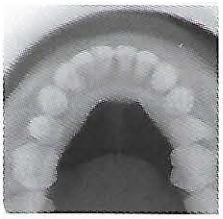
COMMENTS

1. Intra-oral - occlusal radiographic image - image capture only (D0706) is also taken on young children (at the initial new patient evaluation) and later as needed for a full arch or anterior segment view and may be taken in conjunction with bitewing radiographic images. Typically two occlusals are taken, one of the maxillary arch and one of the mandibular arch.
2. The type and sequence of diagnostic images should be determined and ordered by the dentist based on the patient's needs. This determination is based on risk assessment, observation, and medical necessity. Radiographs should not be taken based on the patient's plan benefits or limitations. Patient documentation should contain the dentist's written evaluation of the diagnostic radiograph(s).
3. Reporting image capture only codes may reduce the liability of the practitioner who took the image. Consider using these codes if a lesion is noted and interpretation of the image will be performed by a different provider.
4. It is common for a healthcare provider working in a remote location to perform the image capture only, store the image and send to a dentist for radiographic evaluation and diagnosis. In this instance, the image capture only would be reported by the remote healthcare worker and the dentist performing the interpretation and making the diagnosis would report D0391 interpretation of diagnostic image by a practitioner not associated with capture of the image, including report. Report D9996 for the teledentistry if it is not a real time encounter. Normally this would be a situation for D9996. However, if it is a real time teledentistry encounter then reporting D9995 would be appropriate.
5. For intraoral - occlusal radiographic image including interpretation, see D0240.
6. Enter the arch and/or range of teeth being evaluated in the appropriate box of the ADA Dental Claim Form.

LIMITATIONS

1. D0706 is typically reimbursed and is limited to the comprehensive series (D0210) payor's fee at the initial oral evaluation and by the comprehensive series limitations. If an occlusal radiographic image (D0240/D0706) and a number of other images are taken on the same service date, and the fee for those images is equal to or greater than the comprehensive series, the fee reimbursed will be limited to that of the comprehensive series. The payment of the comprehensive series will trigger the "once every 3-5 year limitation." If a comprehensive series is reimbursed, a notation should be made in the patient's chart for future reference.
2. Typically, an occlusal radiographic image (D0240/D0706) plus two bitewing images (D0272) are reimbursed as submitted. Note: The total fee reimbursed for all images reported in a period determined by the payor may be subject to the fee and frequency limitations placed on the comprehensive series (D0210) or recare interval radiographs.

PHOTO



This is a mandibular arch occlusal intra-oral radiographic image.

Courtesy Gendex™ Dental Systems and DenOptix®

D0707 INTRAORAL - PERIAPICAL RADIOGRAPHIC IMAGE - IMAGE CAPTURE ONLY

CDT 2025

COMMENTS

1. Periapicals associated with an endodontic *diagnosis* on a date prior to definitive treatment are typically reimbursed. "Working and post-treatment" images associated with endodontic treatment are part of the global endodontic fee. Post-operative diagnostic images taken of the treated tooth within 30 days of the completion of a root canal are typically included in the global endodontic fee.
2. The type and sequence of diagnostic images should be determined and ordered by the dentist based on the patient needs. This determination is based on risk assessment, observation, and dental necessity. Images should not be taken based on the patient's plan benefits or limitations. Patient documentation should contain the dentist's written evaluation of the diagnostic images taken. If there is no documentation of the dentist's radiographic evaluation in the chart, the payor may deny payment of the claim or ask for reimbursement in the event of an audit.
3. Reporting image capture only codes may reduce the liability of the practitioner who took the image. Consider using these codes if a lesion is noted and interpretation of the image will be performed by a different provider.
4. It is common for a healthcare provider working in a remote location to perform the image capture only, store the image and send to a dentist for radiographic evaluation and diagnosis. In this instance, the image capture only would be reported by the remote healthcare worker and the dentist performing the interpretation and making the diagnosis would report D0391 interpretation of diagnostic image by a practitioner not associated with capture of the image, including report. Report D9996 for the teledentistry if it is not a real time encounter. Normally this would be a situation for D9996. However, if it is a real time teledentistry encounter then reporting D9995 would be appropriate.
5. Enter the tooth number or range of teeth numbers being evaluated in Box 27 of the 2024 ADA Dental Claim Form.

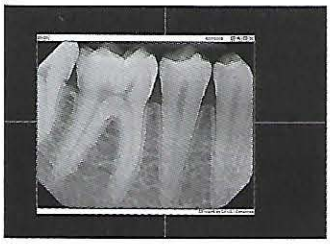
LIMITATIONS

1. Periapical radiographic images at emergency visits are routinely reimbursed. However, periapicals at checkups may require a narrative and/or chart notes and the actual image (required more and more). A caries risk assessment demonstrating increased risk, if appropriate, (D0602 or D0603) may help justify periapicals at a checkup taken in conjunction with bitewings. Several payors are cracking down on periapicals routinely taken with bitewings at a recare visit.
2. If a number of periapicals and bitewing radiographic images are taken on the same service date and the fee for those images is equal to or greater than the comprehensive series, the fee reimbursed will be limited to that of the comprehensive series. The payment of the comprehensive series will trigger the "once every three to five-year limitation." If a comprehensive series is reimbursed, a notation should be made in the patient's billing record for future reference.
3. Reimbursement for periapical images, if reported in conjunction with bitewing images, may be limited by some payors.
4. For intraoral - periapical radiographic images including interpretation, see D0220/D0230.

TIPS

1. One, two, or three periapical images may be reimbursed on a problem focused evaluation (D0140) service date. Periapical images taken at the problem focused visit typically do not affect the "once per year/12 months" limitations for *bitewing* images associated with recare visits.
2. Intra-oral periapical first image (D0220), an additional periapical image(s) (D0230), and intra-oral - periapical radiographic image - image capture only (D0707) are often payable at any visit (including recare), if medically necessary. At an emergency, problem focused oral evaluation (D0140) or periodic oral evaluation (D0120) recare visit, the periapical image reimbursement may be subject to a deductible as well as the maximum fee limitation for multiple diagnostic images.
3. Periapicals, particularly at different "angles," are often necessary to provide alternate views of the anatomy of an area for a complete diagnosis. Two periapicals are a better choice at the emergency visit from a reimbursement perspective as well as from the clinical perspective. Billing a single bitewing at the emergency visit may prevent reimbursement of two/four bitewings at the recare visit.

PHOTO



This is a periapical intra-oral radiographic image.

Courtesy DEXIS, LLC and DEXIS®

D0708 INTRAORAL - BITEWING RADIOGRAPHIC IMAGE - IMAGE CAPTURE ONLY CDT 2025

Image axis may be horizontal or vertical.

COMMENTS

1. Also see D0272/D0273/D0274 for further details.
2. Bitewing can be captured as a horizontal or vertical view.
3. D0708 is reported on a per image basis, and is only "intra-oral."
4. For bitewing radiographic images capture and interpretation, see D0270/D0272/D0273/D0274.
5. Reporting image capture only codes may reduce the liability of the practitioner who took the image. Consider using these codes if a lesion is noted and interpretation of the image will be performed by a different provider.
6. It is common for a healthcare provider working in a remote location to perform the image capture only, store the image and send to a dentist for radiographic evaluation and diagnosis. In this instance, the image capture only would be reported by the remote healthcare worker and the dentist performing the interpretation and making the diagnosis would report D0391 interpretation of diagnostic image by a practitioner not associated with capture of the image, including report. Report D9996 for the teledentistry if it is not a real time encounter. Normally this would be a situation for D9996. However, if it is a real time teledentistry encounter then reporting D9995 would be appropriate.
7. Note that D0708 says "intraoral" while all other bitewing codes are silent as to whether the image is taken intraorally or extraorally.
8. Enter the tooth number or range of teeth numbers being evaluated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

If a single bitewing (BW) image is reported at a given recare or emergency visit, subsequent bitewing images *may be denied. Be aware that any number of bitewings taken at any particular visit may "trigger"* the "once per year/12 months" limitation by most plans. One bitewing, two bitewings, three bitewings, or four bitewings taken at a particular visit date could be subject to the plan's bitewing frequency limitation. Be careful to report the number and date of diagnostic images accurately. The reimbursement for bitewings, according to the limitations of different plans is highly variable.

TIPS

1. For diagnostic purposes, two periapical radiographs taken at different angulations or views are most often the preferred choice at the problem focused oral evaluation (D0140) or emergency visit.
2. Some dentists will choose to take both a periapical and a bitewing radiographic image at the D0140 visit. This is determined and ordered by the doctor. Note that the reporting of a single bitewing image may trigger the "once per year" bitewing image limitation and render the bitewings taken at a subsequent recare visit non-reimbursable. Also refer to periapical radiographic image D0220 for certain limitations in combination with bitewing radiographic images.

D0709 INTRAORAL - COMPREHENSIVE SERIES OF RADIOGRAPHIC IMAGES - IMAGE CAPTURE ONLY

CDT 2025

A radiographic survey of the whole mouth intended to display the crowns and roots of all teeth, periapical areas, interproximal areas and alveolar bone including edentulous areas.



WARNING

It is misleading to report an extra-oral panoramic radiographic image (D0330) and bitewing images (D0272/D0273/D0274) as an intra-oral comprehensive series (D0210 or D0709). The dental office should not combine these two procedures (panoramic film and bitewings) and report as an intra-oral comprehensive series. A panoramic image is *extra-oral*, not intra-oral. Always report exactly what you do and the service date the service is performed. **Note: It is not illegal or improper for an insurance company to "remap" a submitted code to another code for *payment* purposes.** This modification is in accordance with the *contract language*. Payors routinely convert the extra-oral panoramic images and bitewing images to a comprehensive series (D0210) for reimbursement purposes. See (D0330) for further details. However, the frequency of (D0210) or any other radiographic imaging is always determined by the dentist based on the needs of the patient as determined by ADA/FDA guidelines.

COMMENTS

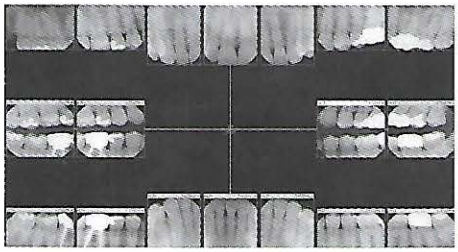
1. What constitutes a comprehensive series of radiographs may vary from patient to patient. The critical component is that it should be a combination of intra-oral diagnostic quality radiographs that display the crown and roots of all teeth, periapical areas, interproximal areas, and alveolar bone, including edentulous areas.
2. A comprehensive series - image capture only (D0709) is *inclusive* of bitewings, but bitewings are not necessarily required. The comprehensive series is *intra-oral*.
3. A comprehensive series (D0709) is most often ordered after the oral evaluation of the new patient by the dentist at the comprehensive or comprehensive periodontal oral evaluation (D0150) or (D0180). Radiographic images are ordered by the dentist per the needs of the patient. A comprehensive series (D0210 or D0709) helps to determine a diagnostic baseline. The comprehensive series (D0210 or D0709) is generally repeated on a three to five-year basis per the needs of the patient. In some cases, a comprehensive series is alternated with a panoramic image (D0330) every three or five years. Many payors are trending toward a five-year reimbursement limitation rather than the more traditional three-year benefit exclusion. This limitation period varies among plans.
4. The type and sequence of diagnostic images should be determined and ordered by the doctor on a patient-by-patient basis. This determination is based on risk assessment, observation, and medical necessity. Images should not be taken based on the patient's plan benefits or limitations. Patient documentation should contain the dentist's written evaluation of the diagnostic images taken. If there is no documentation of the radiographic evaluation in the chart, the payor may deny payment of the claim or ask for reimbursement in the event of an audit.
5. Reporting image capture only codes may reduce the liability of the practitioner who took the image. Consider using these codes if a lesion is noted and interpretation of the image will be performed by a different provider.
6. For intraoral - comprehensive series of radiographic images including interpretation, see D0210.

LIMITATIONS

1. If a number of periapicals and bitewing images are taken on the same service date and the fee for those images is equal to or greater than the comprehensive series, the fee reimbursed by the payor may be limited to that of the comprehensive series. The payment of the comprehensive series will trigger the "once every three to five-year limitation." If a comprehensive series is reimbursed, a notation should be made in the patient's billing record for future reference.
2. If either a comprehensive series (D0709) or panoramic image (D0701) is taken and then a new comprehensive series and/or panoramic image is taken during the exclusion period (typically three or five years), the second radiographic image service will not be reimbursed. Both services are usually subject to the same three to five-year limitation.
3. Many plans have a one-year limitation exclusion for bitewing radiographic images taken after the service date of a comprehensive series (D0709) or a panoramic radiographic image (D0701).

4. It is common for a healthcare provider working in a remote location to perform the image capture only, store the image and send to a dentist for radiographic evaluation and diagnosis. In this instance, the image capture only would be reported by the remote healthcare worker and the dentist performing the interpretation and making the diagnosis would report D0391 interpretation of diagnostic image by a practitioner not associated with capture of the image, including report. Report D9996 for the teledentistry if it is not a real time encounter. Normally this would be a situation for D9996. However, if it is a real time teledentistry encounter then reporting D9995 would be appropriate.

PHOTO



This is a comprehensive intra-oral series (including bitewings).

INTERPRETATION AND REPORT ONLY — CDT 2025

Interpretation and Report by a Practitioner not associated with Image Capture

D0391 INTERPRETATION OF DIAGNOSTIC IMAGE BY A PRACTITIONER NOT ASSOCIATED WITH CAPTURE OF THE IMAGE, INCLUDING REPORT — CDT 2025

COMMENTS

1. D0391 reports the interpretation of *any type of* diagnostic image by a practitioner not associated with the capture of the image.
2. A written report (i.e., record of findings) must be written and sent to the referring practitioner to confirm the interpretation of the diagnostic images.
3. Reporting image capture only codes may reduce the liability of the practitioner who took the image. Consider using these codes if a lesion is noted and interpretation of the image will be performed by a different provider.
4. The interpreting practitioner may report and bill D0391 directly to the patient, or they may pass the costs onto the practitioner who captured the image. If the latter, the capturing practitioner may report and bill D0391. Most often this will result in remapping the reimbursement to that of the capture and interpretation code by the insurer, but always report what you actually do.

POST PROCESSING OF IMAGE OR IMAGE SETS — CDT 2025

D0393 VIRTUAL TREATMENT SIMULATION USING 3D IMAGE VOLUME OR SURFACE SCAN — CDT 2025

Virtual simulation of treatment including, but not limited to, dental implant placement, prosthetic reconstruction, orthognathic surgery and orthodontic tooth movement.

COMMENTS

1. D0393 describes the use of the 3D image to simulate treatment for the dental patient.
2. Cone Beam CT is a relatively new 3D imaging technology that provides a method to evaluate the anatomical positions of teeth and the makeup of the bone in a 3D image. An imaging unit (similar in size to a Panorex machine) has an arm that revolves around the patient's head in 20 seconds. The CT acquires the axial, coronal, and sagittal data.

The patient is exposed to radiation as the data is collected. An actual image is not produced. The data is captured and is stored, collated and compiled into a 2D or 3D data pack. This data may be retrieved, assimilated and viewed at a later time and place. When Cone Beam technology is used to produce a 3D image, that image may be used to simulate treatment. D0393 describes the use of the 3D image to simulate treatment for the dental patient. The technology allows the user to place implants virtually into the 3D image to help determine the size and position of that implant best suited for the application and to identify and avoid any challenges that may exist such as nerves, blood vessels, and any other unfavorable anatomy. Likewise, the 3D image provides the surgeon information about the position and location of structures that may be impacted during orthognathic surgery thus maximizing the end result while minimizing the possible risks by avoiding vital structures. Orthodontists may use the 3D image to maximize the result from appliance placement.

3. D0393, 3D image(s) to simulate treatment may be used:
    a. In the planning placement of dental implants to optimize biomechanics and to avoid damaging anatomic structures , or in the planning of an orthodontic case to simulate outcomes.
    b. In prosthetic reconstruction to simulate final results.
    c. In planning orthognathic surgery by simulating the range of possible esthetic outcomes.
    d. To assess potential outcomes and to plan necessary surgical templates, stents, and retaining devices to expedite treatment and reduce the likelihood of complications.
4. Placing appliances, implants, and other prosthetic devices in the 3D imaging allows a dentist to evaluate that appliance in relation to the inferior alveolar nerve or maxillary sinus, the osseous structure of the TMJ region, etc. While it has endless applications, the CBCT image is the ultimate diagnostic tool for implant dentistry as the bony architecture and density of edentulous spaces can be clearly visualized. The procedure may be used to demonstrate soft tissue details of the skin surface in relation to underlying bony anatomy, or to demonstrate muscles of mastication from MRI images in relation to their points of insertion in the jaws and surrounding tissues, as shown by CBCT or multislice computed tomography (MSCT). It can also be used to fuse 3D intraoral scan images to CBCT to have higher resolution and to avoid radiographic images artifacts, or the skin surface to CBCT, MSCT, or MRI volumes. See D0395 fusion of two or more 3D image volumes of one or more modalities.

LIMITATIONS

1. Reimbursement for Cone Beam CT images and virtual treatment simulation is highly variable and may be limited to applications of a medical (not dental) nature. Even when listed as a benefit, coverage is determined by medical necessity and plan provisions.
2. Situations where Cone Beam CT may be covered include:
    a. Impacted third molars positioned close to the inferior alveolar nerve.
    b. Proposed implant placement close to the inferior alveolar nerve or sinus.
    c. Proposed implant placement where there may be inadequate bone.
    d. TMJ abnormalities/pathology.
    e. Reconstructive surgery due to trauma.

D0394 DIGITAL SUBTRACTION OF TWO OR MORE IMAGES OR IMAGE VOLUMES OF THE SAME MODALITY — CDT 2025

To demonstrate changes that have occurred over time.

COMMENTS

1. 3D intraoral scanning and Cone Beam technology allow the de-construction of an image by subtracting two or more image volumes. D0394 describes this "subtraction" process. When two or more images or image volumes are combined, see D0395. By systematically removing (subtracting) selected images or image volumes from the "hybrid" image produced by the fusing of two or more images or image volumes, the doctor can more accurately assess changes in the structures that may have occurred over a period of time. This information can be particularly important when determining the progression of periodontal disease including gum recession, tooth movement during or after orthodontics, to assess the growth of jaws on a young patient, growth or reduction in the size of a lesion, or the status of site healing after surgery.

2. The procedure may be used to demonstrate soft tissue changes of the skin surface in relation to underlying bony anatomy, or to demonstrate muscles of mastication from MRI images in relation to their points of insertion in the jaws and surrounding tissues (shown by CBCT or MSCT).
3. D0394, subtraction of two or more 3D images of one or more modalities, may also be used to demonstrate changes during growth or subsequent to treatment. It can be used to assess the changes in facial appearance, jaw position, and also for measurement of airway effects from placement of a mandibular advancement device to treat sleep apnea.

LIMITATIONS

1. Reimbursement for Cone Beam CT images is highly variable and may be limited to applications of a medical (not dental) nature. Even when listed as a benefit, coverage is determined by medical necessity and plan provisions.
2. Situations where Cone Beam CT may be covered include:
    a. Impacted third molars positioned close to the inferior alveolar nerve.
    b. Proposed implant placement close to the inferior alveolar nerve or sinus.
    c. Proposed implant placement where there may be inadequate bone.
    d. TMJ abnormalities/pathology.
    e. Reconstructive surgery due to trauma.

D0395 FUSION OF TWO OR MORE 3D IMAGE VOLUMES OF ONE OR MORE MODALITIES

CDT 2025

COMMENTS

1. D0395, fusion of two or more 3D of one or more modalities, involves combining two 3D images of different modalities (i.e., CBCT data with 3D intraoral scan or MRI data) into a single image. Examples of use include precise registration of photographic images to Cone Beam CT volumes or fusion of CBCT volumes to MRI volumes to demonstrate soft tissue and hard tissue anatomy simultaneously. D0395 describes the use of Cone Beam technology to fuse two or more images or image volumes. The "hybrid layered" image can be used to evaluate the differences between the images or image volumes. By systematically adding (D0395) or removing (subtracting D0394) selected images or image volumes from the "hybrid layered," the dentist can more accurately assess changes in the structures that may have occurred over a period of time. This information can be particularly important when determining the progression of periodontal disease, growth or reduction in the size of a lesion, or the status of site healing after surgery.
2. D0395 describes the combining of two 3D images of different modalities (i.e., CBCT data with MRI data). Examples of use include the fusion of CBCT volumes to MRI volumes to simultaneously demonstrate soft tissue and hard tissue anatomy or the fusion of CBCT volumes to 3D intraoral scan data to aid in implant planning.
3. The fusion of images (D0395) may be used to demonstrate soft tissue details of the skin surface in relation to underlying bony anatomy or to demonstrate muscles of mastication from MRI images in relation to their points of insertion in the jaws and surrounding tissues (shown by CBCT or MSCT). It can also be used to fuse optical images to CBCT to have higher resolution and to avoid radiographic image artifacts, or the skin surface to CBCT, MSCT, or MRI volumes.
4. D0395, fusion of two or more 3D images of one or more modalities may also be used to demonstrate changes during growth or subsequent to treatment. It can be used for facial appearance, jaw position, and for measurement of airway effects from placement of a mandibular advancement device to treat sleep apnea.

LIMITATIONS

1. Reimbursement for Cone Beam CT images is highly variable and may be limited to applications of a medical (not dental) nature. Even when listed as a benefit, coverage is determined by medical necessity and plan provisions.
2. Situations where Cone Beam CT may be covered include:
    a. Impacted third molars positioned close to the inferior alveolar nerve.
    b. Proposed implant placement close to the inferior alveolar nerve or sinus.
    c. Proposed implant placement where there may be inadequate bone.
    d. TMJ abnormalities/pathology.
    e. Reconstructive surgery due to trauma.

D0396 3D PRINTING OF A 3D DENTAL SURFACE SCAN CDT 2025

3D printing of a 3D dental surface scan to obtain a physical model.

MATCH

1. D0396 describes the fabrication of a physical 3D printed dental model from digital 3D intraoral or other surface scan data.
2. Physical models may be created for diagnostic study purposes or as a step in the fabrication of a prosthesis. They may also be printed as a copy of an existing physical model.

COMMENTS

1. For the capture of a 3D surface scan, see D0801 for direct (intraoral) or D0802 for indirect (scanning an existing model).
2. For traditional diagnostic study models, including virtual models, see D0470.
3. D0470 addresses other issues related to D0396. See D0470.

LIMITATIONS

1. Payors have typically limited reimbursement for D0470 (diagnostic cast) to orthodontic records or in other very limited situations. D0470 may be the better code to report than D0396 in those circumstances.
2. D0396 will likely not be reimbursed in conjunction with D0470.
3. It is unlikely that dental payors will reimburse for the printing of models as a routine part of the fabrication process of a dental prosthesis but costs may possibly be passed on to the patient, depending on contract language.

TESTS AND EXAMINATIONS CDT 2025

D0411 HbA1c IN-OFFICE POINT OF SERVICE TESTING CDT 2025

WARNING

1. D0411 includes collection, testing, and generation of any appropriate reports related to the patient's HbA1c status. It does not describe the simple testing of the patient's blood sugar levels (today) with a glucometer (see D0412).
2. Be sure to check your state's Dental Practice Act to determine if testing is within the scope of your license. Practices providing testing may also fall under federal regulations under the Clinical Laboratory Improvement Amendments of 1988 (CLIA), and as such may need a CLIA Certificate of Waiver and to use CLIA waived test kits.

WATCH

D0411 describes the **collection** *and* **testing** of an HbA1c sample conducted by a qualified dental professional. Using a glucometer to determine the patient's current blood sugar level (today) would be described using D0412.

MATCH

The hemoglobin A1c test indicates average levels of blood sugar over an interval of time (i.e., 2 to 3 months). It is also called HbA1c, glycated hemoglobin test, and glycohemoglobin.

Diabetic patients are monitored regularly to ensure their overall blood sugar levels are staying within range. The A1c test is used to diagnose and monitor diabetes. This code describes both the collection and interpretation of the HbA1c information.

LIMITATIONS

HbA1C testing would not generally be paid by conventional dental plans.

TIPS

Consider submission to the patient's medical plan for potential reimbursement.

D0412 BLOOD GLUCOSE LEVEL TEST - IN-OFFICE USING A GLUCOSE METER CDT 2025

This procedure provides an immediate finding of a patient's blood glucose level at the time of sample collection for the point-of-service analysis.



WARNING

1. This is not the HbA1c test (D0411) which measures the average blood glucose over several months.
2. Be sure to check your state's Dental Practice Act to determine if testing is within the scope of your license. Practices providing testing may also fall under federal regulations under the Clinical Laboratory Improvement Amendments of 1988 (CLIA), and as such may need a CLIA Certificate of Waiver and to use CLIA waived test kits.

WATCH

1. D0412 reports using an in-office glucometer to determine the immediate finding of a patient's current blood glucose level.
2. D0411 describes the collection and testing of a HbA1c sample conducted by a qualified dental professional.



MATCH

D0412 describes testing the patient's current blood glucose level in the dental practice using the practice's glucose meter.

COMMENTS

1. Diabetes is a widespread chronic disease frequently encountered by practitioners and is on the rise. Many patients will seek care from a dentist at least annually but may not see their physician. According to a recent statistical report published by the Centers for Disease Control (CDC) approximately up to 29.7% of the U. S. population has diabetes. Of the estimated 29.7%, 6% - 8.5% are undiagnosed and 21.1% - 25.1% are diagnosed diabetics. It is critical that the doctor and clinical team know the patient's blood sugar level before initiating dental treatment. While the patient's A1C percentage may be at an acceptable control level over a period of time, their actual blood sugar level *today* may be too low and the patient may be heading toward a hypoglycemic event.
2. If the patients' blood sugar level (which cannot be obtained via an A1C test) is checked with a glucometer prior to treatment, results may show that the patient's blood sugar level is too low. If so, the procedure should be postponed since a hypoglycemic event is likely, placing the patient at risk. Alternately, the patient's current blood sugar level may be too high, even though their A1C level is at an acceptable range. If this is the case, any elective surgical procedure should be postponed since such a high level of blood glucose could lead to delayed healing of the surgical site and infection. Patients presenting with the risk factors of diabetes, but who have not been diagnosed with either pre-diabetes or diabetes should also receive glucometer testing. Additionally, dental teams should receive training to recognize the signs of hypoglycemia and be knowledgeable in treating hypoglycemic patients.
3. While it may not be a covered benefit, it should be a standard vital sign to check on known diabetic patients, particularly prior to invasive treatment. The patient may be monitoring their own levels and be able to share that real time digital data, in which case glucose level testing by the office would be unnecessary. Verbal reporting alone should not be trusted.

LIMITATIONS

This service is generally not covered by dental plans.

TIPS

If a patient presents with risk factors for diabetes but has not yet been diagnosed with pre-diabetes or diabetes, based on the risk factors, the doctor might order an in-office blood glucose level test. If a known diabetic patient arrives for treatment and appears "off" or has a long or stressful procedure scheduled, this patient might also receive an in-office blood glucose test glucometer reading before the doctor begins treatment to avoid a possibly life-threatening hypoglycemic or hyperglycemic event. In either scenario, the patient's blood sugar level should be documented in the patient's clinical record. The patient should be informed of their test results, and based upon the test results, given a medical referral if the doctor deems necessary.

NARRATIVES

The narrative should establish the need for the blood glucose test, outlining the patient's risk factors and/or symptoms as well as the dangers in treating the patient with either a too high or too low blood glucose levels.

D0414 LABORATORY PROCESSING OF MICROBIAL SPECIMEN TO INCLUDE CULTURE AND SENSITIVITY STUDIES, PREPARATION AND TRANSMISSION OF WRITTEN REPORT

CDT 2025

WATCH

1. D0415 describes the collection of microorganisms for culture and sensitivity.
2. D0417 describes the collection and preparation of saliva sample for laboratory diagnostic testing.
3. D0422 describes the collection and preparation of genetic sample material for laboratory analysis and report.

4. D0423 describes the genetic test for susceptibility to diseases - specimen analysis.
5. D0484 describes a consultation on slides prepared elsewhere.

MATCH

D0414 describes the laboratory processing of the microbial specimen that includes culture and sensitivity studies. This requires the preparation and transmission of a written report.

COMMENTS

D0414 describes the laboratory processing of microbial specimen to include culture and sensitivity studies, as well as the preparation and transmission of written report. D0414 would be proceeded by D0415, the collection of microorganisms for culture and sensitivity. D0414 requires that a copy of the results be provided and transmitted to the payor.

TIPS

Consider providing the collection (D0415) and processing (D0414) of the microbial specimen at a low fee as a service for the patient to determine bacterial risk.

NARRATIVES

A narrative establishing the necessity (e.g., an infection of unknown origin by an undetermined microorganism) should be submitted to explain the most effective treatment selected for the condition.

D0415 COLLECTION OF MICROORGANISMS FOR CULTURE AND SENSITIVITY — CDT 2025

LIMITATIONS

Collection of microorganisms for culture and sensitivity (D0415) is reported when testing for the type and concentration of bacteria. For instance, D0415 helps confirm the endpoint of periodontal therapy, but it is rarely reimbursed.

TIPS

Consider providing this test at a low fee as a value-added service to the patient.

NARRATIVES

A narrative should always be submitted when reporting D0415.

D0416 VIRAL CULTURE — CDT 2025

A diagnostic test to identify viral organisms, most often herpes virus.

COMMENTS

1. Viral culture (D0416) is not typically reimbursed by dental insurance.
2. D0416 may be considered for reimbursement by medical insurance.

TIPS

Consider D0416 for OraRisk® HPV.

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D0417 COLLECTION AND PREPARATION OF SALIVA SAMPLE FOR LABORATORY DIAGNOSTIC TESTING — CDT 2025

COMMENTS

1. Saliva sample (D0417) is for the *collection* and *preparation* of a saliva sample for laboratory diagnostic testing.
2. Saliva testing is currently being used to check hormone levels, cholesterol levels, drug levels, etc. Several studies suggest that saliva proteins may also be used to detect oral cancer, HIV infection, and a host of other diseases beyond the oral cavity. D0417 can be used to report the collection and preparation of a saliva sample for laboratory analysis when it involves a technique-sensitive collection and preparation procedure.

3. For example, consider D0417 for: MyPerioPath℠, MyPerioID®, OraRisk® HPV tests.

LIMITATIONS

Saliva sample (D0417) reimbursement is presently limited to reimbursement by the patient's medical plan. It is recommended that the claim be submitted to dental insurance, nonetheless, in an effort to encourage future reimbursement by dental plans.

NARRATIVES

1. Describe the purpose of the saliva sample and analysis to be done.
2. Attach diagnosis to claim. Do not file claim until diagnosis is confirmed.

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D0418 ANALYSIS OF SALIVA SAMPLE — CDT 2025

Chemical or biological analysis of saliva sample for diagnostic purposes.

COMMENTS

1. Analysis of saliva sample (D0418) describes the chemical or biological analysis of a saliva sample for diagnostic purposes.
2. Several chairside saliva testing kits are now available to help dentists determine if the quality or quantity of a patient's saliva is a caries risk factor (e.g., GC America's Saliva-Check, Ivoclar's CRT Buffer Test, etc.). These saliva tests typically measure both resting and stimulated saliva production, saliva consistency/viscosity, resting and stimulated saliva pH, and saliva buffering capacity. These tests usually take about 10-15 minutes and are typically performed during the patient's routine oral evaluation. The results are immediate. D0418 can be used to report the use of these in-office saliva analysis kits.
3. D0425 may also be used to report saliva testing to measure caries susceptibility. D0425 differs from D0418 in that D0418 may be applied in a much broader context as D0418 includes the analysis of saliva for conditions other than caries. Historically, D0425 has not been reimbursed by most dental plans; however, some insurance industry insiders believe this is largely because claim submissions for caries susceptibility tests have been few in number. As more dental payors move toward a "preventive" dental reimbursement model rather than the traditional "restorative" reimbursement model, some believe that dental plans will be more likely to provide a benefit for a saliva-based caries risk test under code D0425 in the near future.
4. For example, consider D0418 for OraRisk® HPV.

NARRATIVES

1. Describe the chemical or biological analysis and the diagnosis.
2. The analysis report should be attached to D0418.

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Innovations in Salivary Diagnostics
A Quest Diagnostics Company

D0419 ASSESSMENT OF SALIVARY FLOW BY MEASUREMENT CDT 2025

This procedure is for identification of low salivary flow in patients at risk for hyposalivation and xerostomia, as well as effectiveness of pharmacological agents used to stimulate saliva production.

COMMENTS

1. Conditions such as xerostomia, commonly referred to as dry mouth are becoming a more prevalent problem for patients and is typically associated with saliva flow, regardless of the underlying cause. Approximately 5% - 8% of the general population suffer from dry mouth with approximately 15% being age 65 or older.
2. Common causes of dry mouth may be linked to a multitude of oral systemic diseases and associated medications used to treat diseases.
3. The technique and technology used to measure the flow may vary. Proper assessment of salivary flow aids in treatment planning to prevent caries and speech issues that are associated with the condition of dry mouth.

LIMITATIONS

Do not expect reimbursement by dental plans.

NARRATIVES

The clinical documentation should include the reason for the assessment, findings of the assessment, and treatment recommended. Also include the condition such as xerostomia and any known underlying causes.

D0421 PREVIOUSLY DELETED CODE GENETIC TEST FOR SUSCEPTIBILITY TO ORAL DISEASES

This is a previously deleted code. See D0422 and D0423 for further details.

D0422 COLLECTION AND PREPARATION OF GENETIC SAMPLE MATERIAL FOR LABORATORY ANALYSIS AND REPORT CDT 2025



WARNING

1. The *collection and preparation* of the genetic sample are reported as D0422, separately from the analysis.
2. The *analysis* of a genetic sample is reported as D0423.

LIMITATIONS

1. Many existing plans will not reimburse the procedure.
2. Payors that provide reimbursement for genetic testing may provide reimbursement for the collection and preparation of the sample while others may only provide reimbursement for the laboratory analysis. D0423 reports analysis.

NARRATIVES

1. Describe the purpose of the genetic sample and the analysis to be performed.
2. The analysis report should be attached to D0422.

D0423 GENETIC TEST FOR SUSCEPTIBILITY TO DISEASES - SPECIMEN ANALYSIS CDT 2025

Certified laboratory analysis to detect specific genetic variations associated with increased susceptibility for diseases.



WARNING

1. The *collection and preparation* of the genetic sample are reported as D0422.
2. The laboratory *analysis* is reported separately as D0423.

COMMENTS

1. D0422 reports the collection and preparation of the sample.
2. D0423 (specimen analysis) is reported separately from the D0422 (collection and preparation) and may be performed by either the same practice or a different entity.
3. Genetic tests for susceptibility include: EasyDNA, MyPerioID®, DNA DrugMap™, etc.

LIMITATIONS

1. Many existing plans will not reimburse this procedure.
2. Payors that provide reimbursement for genetic testing may provide reimbursement for the collection and preparation of the sample (D0422) while others may only provide reimbursement for the laboratory analysis. D0423 reports analysis.

NARRATIVES

1. Describe the purpose of the specimen analysis.
2. Attach the analysis report.

D0425 CARIES SUSCEPTIBILITY TESTS — CDT 2025

Not to be used for carious dentin staining.

WATCH

1. Some practices erroneously report the caries susceptibility test (D0425) to describe a staining test for carious lesions; however, D0425 is a diagnostic test for the susceptibility of caries, not a stain to indicate the presence of caries.
2. For caries risk assessment and documentation, which utilizes a questionaire but does not include direct testing, see D0601/D0602/D0603.

COMMENTS

1. D0425 describes a diagnostic test that tests conditions like dry mouth syndrome or determines the patient's saliva pH using a litmus strip. This type of testing is typically not reimbursed.
2. Several chairside saliva testing kits are available to help dentists determine if the quality or quantity of a patient's saliva is a caries risk factor (tests are available from GC America's Saliva-Check®, Ivoclar's CRT Buffer Test®, etc.). These saliva tests measure both resting and stimulated saliva production, saliva consistency/viscosity, resting and stimulated saliva pH, and saliva buffering capacity. These tests usually take about 10-15 minutes and are typically performed during the patient's routine oral evaluation. The results are immediate.
3. D0425 may also be used to report saliva testing to measure caries susceptibility. D0425 differs from D0418 in that D0418 may be applied in a much broader context as D0418 includes the analysis of saliva for conditions other than caries. Historically, D0425 has not been reimbursed by most dental plans; however, some insurance industry insiders believe this is largely because claim submissions for caries susceptibility tests have been few in number. As more dental payors move toward a "preventive" dental reimbursement model rather than the traditional "restorative" reimbursement model, some believe that dental plans will be more likely to provide a benefit for a saliva-based caries risk test under code D0425 in the future.

LIMITATIONS

This type of test is typically not reimbursed.

TIPS

In limited circumstances, such as presence of rampant caries, a caries susceptibility test (D0425) is sometimes reimbursed if the test immediately follows restorative care.

D0431 ADJUNCTIVE PRE-DIAGNOSTIC TEST THAT AIDS IN DETECTION OF MUCOSAL ABNORMALITIES INCLUDING PREMALIGNANT AND MALIGNANT LESIONS, NOT TO INCLUDE CYTOLOGY OR BIOPSY PROCEDURES — CDT 2025

WATCH

1. Some practices confuse the adjunctive pre-diagnostic test (D0431) with oral brush biopsy (D7288, OralCDx®); however, D0431 is a visual cancer detection screening test, *not* a biopsy.
2. D7288 reports the separate brush biopsy which harvests transepithelial cells.

COMMENTS

1. A basic oral cancer screening includes a visual and physical evaluation. During a visual exam the dentist looks for abnormal color and texture. During a physical exam the dentist feels for abnormal lumps and bumps. This is mandatory for evaluations D0150, D0180, and D0120.
2. An enhanced oral cancer examination involves additional methods to detect mucosal abnormalities. VELscope® uses a special blue light to cause tissue fluorescence, which allows the dentist to differentiate between healthy and abnormal oral tissue responses. ViziLite® Plus with TBlue630® uses a chemiluminescent light source to improve the identification of lesions and uses a blue dye to temporarily mark them. The use of VELscope® and/or ViziLite® Plus with TBlue630® could be reported using code D0431. Other devices are listed below in the photo section.
3. This code also reports the use of staining (toluidine blue) as an adjunctive test. Codes are not brand-name or product-specific. Codes are procedure specific.

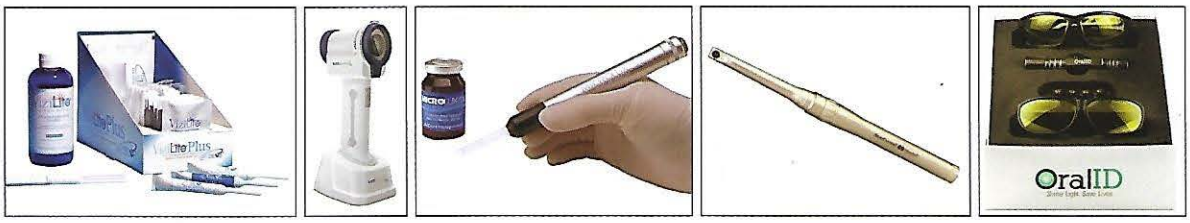
LIMITATIONS

D0431 enhanced cancer screening (not diagnosis) tests are reimbursed by few payors, but charges are normally allowed to be passed on to the patient.

TIPS

1. If the result of D0431 is positive, the dentist may consider a brush biopsy (D7288), an excisional biopsy of oral tissue (D7286), or may refer the patient to an oral surgeon for further evaluation.
2. SInce this procedure is typically not reimbursed, it is recommended to keep the fee low (i.e, $12-$15) and offer it to more patients within the practice.

PHOTO



1 2 3 4 5

1. Vizilite® Plus — Courtesy Zila Pharmaceuticals, Inc.
2. VELscope® — Courtesy LED Dental Inc.
3. Microlux DL — Courtesy AdDent, Inc.
4. Identafi® — Courtesy StarDental
5. OralID™ — Courtesy Forward Sciencew

D0460 PULP VITALITY TESTS — CDT 2025

Includes multiple teeth and contralateral comparison(s), as indicated.

WARNING

It is considered abusive to report a pulp vitality test routinely with crown preparation. The pulp vitality test should be performed when medically necessary and is often considered integral to the oral evaluation.

COMMENTS

D0460 includes the testing of multiple teeth and contralateral comparisons, and should be reported on a *"per visit"* basis, not a "per tooth" basis. However, enter the tooth number being evaluated in Box 27 of the 2024 ADA Dental Claim Form. Most payors will require this information for claim adjudication. Pulp vitality test (D0460) is a stand-alone diagnostic procedure.

LIMITATIONS

1. The pulp vitality test (D0460) may be reimbursed at an emergency visit when a problem focused oral evaluation (D0140) is *not* reported. Many payors will not reimburse for *both* D0460 and the problem focused oral evaluation (D0140) on the same service date. Many payors consider pulp vitality test (D0460) a component of the problem focused evaluation (D0140).

2. Some payors do reimburse pulp vitality test (D0460) in *conjunction* with emergency procedures on the same service date, such as palliative (D9110). Other payors consider D0460 *integral* to all services. Some payors classify the pulp vitality test as a basic procedure (which may be subject to a deductible). Some payors classify the pulp vitality test as a preventive procedure, and others consider it a component of the oral evaluation. Reimbursement for D0460 is highly variable.
3. If a definitive procedure is performed on the same service date as the pulp vitality test (D0460), the pulp vitality test is often considered to be a part of the global fee for the definitive procedure.

TIPS

1. Some payors consider a pulp vitality test (D0460) included with the palliative (D9110) procedure. Typically, only *one* of three codes (D9110, D0140 or D0460) is payable on the same service date with any related diagnostic images.
2. Regardless of reimbursement issues, D0460 is a *stand-alone* diagnostic procedure that can be reported *in addition* to other procedures performed. D0460 may be disallowed when performed on same date of service as diagnostic radiographs.
3. When the "two evaluations per year" limitation has been met, pulp vitality test (D0460) may be reimbursed at the emergency visit as a stand-alone service.

NARRATIVES

Some payors require a narrative that identifies the suspect tooth and its symptoms, the teeth and contra lateral side tested, the methods used, and the results before considering payment for D0460. Indicate tooth number in Box 27 of the 2024 ADA Dental Claim Form.

D0470 DIAGNOSTIC CASTS

CDT 2025

Also known as diagnostic models or study models.



WARNING

It is improper to report diagnostic casts (D0470) in order to gain reimbursement for an athletic mouthguard, tooth whitening trays, splint, prosthesis, or other appliance.



MATCH

Diagnostic casts (D0470) are considered an individual component of orthodontic records. There is no global code(s) to describe orthodontic records. Report the individual components that make up the orthodontic record separately with individual codes. Orthodontic records could include photographs (D0350), diagnostic casts (D0470), and a cephalometric radiographic image (D0340).

COMMENTS

1. For an occlusal analysis of a mounted case, report D9950 in addition to diagnostic casts D0470.
2. For an occlusal adjustment, see both Occlusal Adjustment-Limited (D9951) and Occlusal Adjustment-Complete (D9952).
3. "Virtual" scanned diagnostic casts may be reported as D0470 as long as a hard copy can be produced upon request. Alternatively, virtual models may be reported using 3D scan codes, although reporting D0470 often yields better results when reporting orthodontic records. See D0801-D0804 for more information.
4. 3D printing of a dental scan may be reported as D0396, but it is unlikely to be reimbursed in conjunction with D0470. See D0396.

LIMITATIONS

1. Diagnostic casts (D0470) are not typically reimbursed except as a component of orthodontic records.
2. The claim form question, "Is this for orthodontics?" must be answered "yes" (Box 40) to be considered a part of the orthodontic records. D0470 is considered to be a part of orthodontic records, workup and is typically reimbursed once per lifetime. See cephalometric radiographic image (D0340) and 2D oral/facial photographic images (D0350) for further orthodontic record component details.
3. Reimbursement for diagnostic casts (D0470) may reduce the lifetime orthodontic benefit. If orthodontic benefits are available these photographic images are typically reimbursed 50% of the payor's fee. Sometimes the general dentist benefit component of the plan will reimburse for photographic images separate from the orthodontic benefit. If reimbursed as part of the general dental benefits, D0350 may be paid at 50%,80%, or 100% of the payor's fee.

PHOTO



These are known as study models, diagnostic casts and diagnostic models.

D0600 NON-IONIZING DIAGNOSTIC PROCEDURE CAPABLE OF QUANTIFYING, MONITORING, AND RECORDING CHANGES IN STRUCTURE OF ENAMEL, DENTIN, AND CEMENTUM

CDT 2025

WARNING

D0600 should not be used to report traditional transillumination techniques or methods using ionizing radiation, including use of artificial intelligence to detect decay on digital radiographs.

WATCH

D0600 should only be submitted when the procedure uses an instrument calibrated to quantify structural and mineral changes in tooth structure. The technology used must be capable of quantifying, monitoring, and recording changes in the structure of enamel, dentin, and cementum. It is inappropriate to use this code to report transillumination alone.

MATCH

D0600 describes a non-ionizing diagnostic procedure for quantifying, monitoring, and recording changes in the structure of enamel, dentin, and cementum. This procedure uses an instrument (system) that can be calibrated to quantify structural mineral changes in tooth structure and that assists in diagnosing and monitoring early and advanced caries. Modalities that are capable of providing this service are: CariVu™, DIAGNOcam, DIAGNOdent™, LUM, iTero Element 5D, etc.

COMMENTS

1. Transillumination has been a recognized method of identifying interproximal decay using a light source to shine between the contacts of teeth, especially in the anterior area to identify diseased enamel. This non-ionizing (visible) light, when striking decalcified/decayed areas, is diffused and the diseased enamel appears darker than areas where the enamel is healthy.
2. Technologies that use non-ionizing "light" exist that can quantify, monitor, and record changes in structure of enamel, dentin, and cementum, like CariVu™, DIAGNOcam, LUM, iTero Element 5D, etc. These instruments may use laser or near infrared imaging (NIRI). D0600 reports the use of these technologies.
3. Enter the tooth number or range of teeth being evaluated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

As with more recent codes, it is not likely that payors will consider D0600 for reimbursement until payors are convinced of its efficacy/benefits, and employers are willing to provide reimbursement.

TIPS

If the patient is unable or unwilling to have traditional bitewing (BW) radiographs and/or periapical radiographs taken, consider the use of this technology as an alternative to screen for interproximal decay. This service would be considered an optional service under most plans and an out-of-pocket charge would generally apply. If the service is reimbursed, D0600 would be subject to the same exclusions and limitations as conventional bitewing and periapical radiographic images.

NARRATIVES

If this service is provided in lieu of conventional BW and/or periapical radiographs, establish why this service was provided rather than BW(s) or periapical radiographs. (e.g., gag reflex, restrictive anatomy, radiation exposure history, child, etc.). Ask for an alternate benefit of appropriate BW radiographs. Reporting an elevated risk of caries using D0602/D0603 may increase the odds of payment, but generally do not expect reimbursement. See D0602/D0603.

D0601 CARIES RISK ASSESSMENT AND DOCUMENTATION, WITH A FINDING OF LOW RISK

CDT 2025

Using recognized assessment tools.

COMMENTS

1. D0601 (low risk assessment) is used to describe the process of determining and recording the caries risk assessment of an individual during the evaluation process. Risk assessment is now considered a distinct/separate procedure and is described using codes D0601 (low caries risk), D0602 (moderate caries risk), and D0603 (high caries risk). A risk assessment tool is used during an examination of a new patient or of an established patient who has any of the following attributes:
   a. Has not presented for periodic evaluations.
   b. Has had a significant change in health conditions.
   c. Manifests a risk of caries activity.
2. The ADA and other organizations have published information on caries risk assessment and have developed separate forms for dentists to use with child and adult patients. Although there are a variety of risk classification models, most recognize low, moderate, and high risk categories. The addition of risk assessment codes provides a means to record the service in a machine readable format that supports patient record keeping and transmission to third party payors and/or other providers.
3. Caries risk assessment includes the recording of clinical conditions, general health conditions and contributing conditions present, and evaluation of the overall risk status of the patient based on these conditions. It also includes the development of an appropriate preventive oral health regimen based on the overall assessment of caries risk. According to the National CAMBRA Coalition and American Dental Education Association Cariology Section, 100% of dental schools surveyed reported teaching caries risk assessment.
4. Most third party payors maintain that caries risk assessment is a component of an oral evaluation and do not plan to reimburse the procedure separately.
5. Recognized caries assessment tools include those established by the ADA and AAPD and may be found by searching their websites for caries risk assessment. Many resources have been developed and adapted from the ADA and AAPD. One such resource is below, by 3M company.

   http://multimedia.3m.com/mws/media/591993O/caries-risk-assessment-sample-form.pdf
6. Caries risk assessment and documentation differs from caries susceptibility tests (D0425) as the assessment utilizes a questionaire but does not include physical testing. See D0425.
7. Conditions that affect caries risk may include:
   - Poor oral hygiene (visible plaque).
   - High titers of cariogenic bacteria.
   - Prolonged nursing (bottle/breast).
   - Poor family dental health or dental history.
   - Genetic abnormality of teeth.
   - Chemo/radiation therapy.
   - Many multisurface restorations.
   - Eating disorders.
   - Drug or alcohol abuse.
   - Smokeless tobacco use.
   - Irregular dental care.
   - High sucrose diet.
   - Active orthodontic treatment.
   - Exposed root surfaces.
   - Overhangs and open margins.
   - Physical or mental disability.
   - Low socioeconomic status.
   - Inadequate fluoride exposure.
   - Medication or disease-induced xerostomia.
8. Caries risk assessment may ultimately be used to help determine the type and frequency of treatment allowed. The higher the caries risk, the more frequent the preventive schedule and more aggressive the treatment indicated.

LIMITATIONS

1. Most third party payors maintain that risk assessment is part of a comprehensive oral evaluation (D0150/D0180) or periodic oral evaluation (D0120) and do not reimburse the procedure separately.
2. A caries risk assessment code (D0601, D0602, and D0603) can be reported (typically at "zero" fee) when performed to establish medical necessity for reporting a more frequent radiographic image frequency, adult fluoride, preventive resin restorations, and other procedures.

NARRATIVES

Include a copy of a completed approved assessment form (attachment) with the claim. Report the appropriate caries risk assessment code (D0601/D0602/D0603).

D0602 CARIES RISK ASSESSMENT AND DOCUMENTATION, WITH A FINDING OF MODERATE RISK

CDT 2025

Using recognized assessment tools.

COMMENTS

D0602 describes the completion of the caries risk assessment for a patient resulting in a finding of moderate caries risk.

LIMITATIONS

1. Most third-party payors believe that risk assessment is part of a comprehensive oral evaluation (D0150/D0180) or periodic oral evaluation (D0120) and do not plan to reimburse the procedure separately.
2. A moderate or high caries risk assessment code (D0602/D0603) can be reported (typically at "zero" fee) when performed to establish medical necessity for reporting radiographic image frequency, adult fluoride, preventive resin restorations, and other procedures.

NARRATIVES

Include a copy of a completed approved assessment form (attachment) with the claim.

Important! See D0601 for further explanation of the caries risk assessment process.

D0603 CARIES RISK ASSESSMENT AND DOCUMENTATION, WITH A FINDING OF HIGH RISK

CDT 2025

Using recognized assessment tools.

COMMENTS

D0603 describes the completion of the caries risk assessment for a patient resulting in a finding of high risk.

LIMITATIONS

1. Most third party payors believe that risk assessment is part of a comprehensive oral evaluation (D0150/D0180) or periodic oral evaluation (D0120) and do not plan to reimburse the procedure separately.
2. A moderate or high caries risk assessment code (D0602/D0603) can be reported (typically at "zero" fee) when performed to establish medical necessity for reporting radiographic image frequency, adult fluoride, preventive resin restorations, and other procedures.

NARRATIVES

Include a copy of a completed approved assessment form (attachment) with the claim.

Important! See D0601 for further explanation of the caries risk assessment process.

D0604 ANTIGEN TESTING FOR A PUBLIC HEALTH RELATED PATHOGEN, INCLUDING CORONAVIRUS

CDT 2025

COMMENTS

1. An antigen test is a diagnostic test to detect for an active infection or virus such as Coronavirus. Check with your state dental board to ensure performing an antigen test is within your scope of practice.
2. Clinical Laboratory Improvement Amendment (CLIA) of 1988 applies to a dental practice performing this type of testing, whether there is a charge for the test or the test is provided at no charge. Contact your state department of health CLIA division for details of how to obtain the appropriate CLIA certificate.

LIMITATIONS A dental plan may exclude coverage for D0604. However, D0604 may be considered for reimbursement by the patient's medical plan, including traditional Medicare.

D0605 ANTIBODY TESTING FOR A PUBLIC HEALTH RELATED PATHOGEN, INCLUDING CORONAVIRUS — CDT 2025

COMMENTS

1. An antibody test confirms whether a patient has had an infection or virus. It does not detect an active infection or virus.Check with your state dental board to ensure performing an antigen test is within your scope of practice.
2. Clinical Laboratory Improvement Amendment (CLIA) of 1988 applies to a dental practice performing this type of testing, whether there is a charge for the test or the test is provided at no charge. Contact your state department of health CLIA division for details of how to obtain the appropriate CLIA certificate.

LIMITATIONS A dental plan may exclude coverage for D0605. However, D0605 may be considered for reimbursement by the patient's medical plan, including traditional Medicare.

D0606 MOLECULAR TESTING FOR A PUBLIC HEALTH RELATED PATHOGEN, INCLUDING CORONAVIRUS — CDT 2025

COMMENTS

1. Molecular diagnostics are highly sensitive and specific because they identify the actual presence of the virus.
2. Clinical Laboratory Improvement Amendment (CLIA) of 1988 applies to a dental practice performing this type of testing, whether there is a charge for the test or the test is provided at no charge. Contact your state department of health CLIA division for details of how to obtain the appropriate CLIA certificate.

LIMITATIONS A dental plan may exclude coverage for D0606. However, D0606 may be considered for reimbursement by the patient's medical plan, including traditional Medicare.

WARNING! Many of the Oral Pathology codes are positioned out of numerical order by CDT in the next section - Oral Pathology Laboratory. However, they appear in the correct order.

ORAL PATHOLOGY LABORATORY — CDT 2025

These procedures do not include collection of the tissue sample, which is documented separately.

D0472 ACCESSION OF TISSUE, GROSS EXAMINATION, PREPARATION AND TRANSMISSION OF WRITTEN REPORT — CDT 2025

To be used in reporting architecturally intact tissue obtained by invasive means.

LIMITATIONS This procedure is typically not a covered dental benefit; it may be considered for reimbursement through medical insurance.

D0473 ACCESSION OF TISSUE, GROSS AND MICROSCOPIC EXAMINATION, PREPARATION AND TRANSMISSION OF WRITTEN REPORT — CDT 2025

To be used in reporting architecturally intact tissue obtained by invasive means.

LIMITATIONS This procedure is typically not a covered dental benefit; it may be considered for reimbursement through medical insurance.

D0474 ACCESSION OF TISSUE, GROSS AND MICROSCOPIC EXAMINATION, INCLUDING ASSESSMENT OF SURGICAL MARGINS FOR PRESENCE OF DISEASE, PREPARATION AND TRANSMISSION OF WRITTEN REPORT

CDT 2025

To be used in reporting architecturally intact tissue obtained by invasive means.

LIMITATIONS This procedure is typically not a covered dental benefit; it may be considered for reimbursement through medical insurance.

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

CDT 2025

To be used in reporting disaggregated, non-transepithelial cell cytology sample via mild scraping of the oral mucosa.

LIMITATIONS This procedure is typically not a covered dental benefit; it may be considered for reimbursement through medical insurance.

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

CDT 2025

Analysis, and written report of findings, of cytologic sample of disaggregated transepithelial cells.



WARNING This code does ***NOT*** report brush biopsy collection. See D7288 for the brush biopsy transepithelial sample *collection* procedure.

COMMENTS

1. D0486 reports the microscopic examination, preparation, and transmission of a written report based on transepithelial, disaggregated cell samples which could be obtained by brush biopsy or by another technique.
2. This analytical procedure, with the associated written report, generally is performed in a pathology laboratory and *does not* include the procedure for removal of the sample tissue.
3. This procedure is seldom performed by the dental provider, nor is the cytological study normally done in the dental office.

LIMITATIONS This procedure is typically not a covered dental benefit; it may be considered for reimbursement through medical insurance. When the service is provided by a laboratory, the lab submits the claim to the medical payor. The dentist only submits a claim for the cell/tissue collection.

D0475 DECALCIFICATION PROCEDURE

CDT 2025

Procedure in which hard tissue is processed in order to allow sectioning and subsequent microscopic examination.

LIMITATIONS This procedure is typically not a covered dental benefit; it may be considered for reimbursement through medical insurance.

D0476 SPECIAL STAINS FOR MICROORGANISMS

CDT 2025

Procedure in which additional stains are applied to a biopsy or surgical specimen in order to identify microorganisms.

LIMITATIONS This procedure is typically not a covered dental benefit; it may be considered for reimbursement through medical insurance.

D0477 SPECIAL STAINS, NOT FOR MICROORGANISMS CDT 2025

Procedure in which additional stains are applied to a biopsy or surgical specimen in order to identify such things as melanin, mucin, iron, glycogen, etc.

LIMITATIONS This procedure is typically not a covered dental benefit; it may be considered for reimbursement through medical insurance.

D0478 IMMUNOHISTOCHEMICAL STAINS CDT 2025

A procedure in which specific antibody based reagents are applied to tissue samples in order to facilitate diagnosis.

LIMITATIONS This procedure is typically not a covered dental benefit; it may be considered for reimbursement through medical insurance.

D0479 TISSUE IN-SITU HYBRIDIZATION, INCLUDING INTERPRETATION CDT 2025

A procedure that allows for the identification of nucleic acids, DNA and RNA, in the tissue sample in order to aid in the diagnosis of microorganisms and tumors.

LIMITATIONS This procedure is typically not a covered dental benefit; it may be considered for reimbursement through medical insurance.

D0481 ELECTRON MICROSCOPY CDT 2025

LIMITATIONS This procedure is typically not a covered dental benefit; it may be considered for reimbursement through medical insurance.

D0482 DIRECT IMMUNOFLUORESCENCE CDT 2025

A technique used to identify immunoreactants that are localized to the patient's skin or mucous membranes.

LIMITATIONS This procedure is typically not a covered dental benefit; it may be considered for reimbursement through medical insurance.

D0483 INDIRECT IMMUNOFLUORESCENCE CDT 2025

A technique used to identify circulating immunoreactants.

LIMITATIONS This procedure is typically not a covered dental benefit; it may be considered for reimbursement through medical insurance.

D0484 CONSULTATION ON SLIDES PREPARED ELSEWHERE CDT 2025

A service provided in which microscopic slides of a biopsy specimen prepared at another laboratory are evaluated to aid in the diagnosis of a difficult case or to offer a consultative opinion at the patient's request. The findings are delivered by written report.

LIMITATIONS This procedure is typically not a covered dental benefit; it may be considered for reimbursement through medical insurance.

TIPS	Consultation on slides prepared elsewhere (D0484) may be considered and reimbursed as a consultation (D9310) in some circumstances.
NARRATIVES	D0484 is by written report and requires a narrative. Include the written report with the claim to document the service.

D0485 CONSULTATION, INCLUDING PREPARATION OF SLIDES FROM BIOPSY MATERIAL SUPPLIED BY REFERRING SOURCE — CDT 2025

A service that requires the consulting pathologist to prepare the slides as well as render a written report. The slides are evaluated to aid in the diagnosis of a difficult case or to offer a consultative opinion at the patient's request.

LIMITATIONS	This procedure is typically not a covered dental benefit; it may be considered for reimbursement through medical insurance.
TIPS	Consultation (D9310), including preparation of slides from biopsy material supplied by a referring source (D0485), may be considered for reimbursement in some circumstances.
NARRATIVES	D0485 is by written report and requires a narrative. Include the written report with the claim to document the service.

D0502 OTHER ORAL PATHOLOGY PROCEDURES, BY REPORT — CDT 2025

NARRATIVES	D0502 is a by report code. A written report/narrative **must** accompany the claim.

D0999 UNSPECIFIED DIAGNOSTIC PROCEDURE, BY REPORT — CDT 2025

Used for procedure that is not adequately described by a code. Describe procedure.

NARRATIVES	There is no code for a caries detectability test such as caries indicator dyes. Use D0999, by report. D0999 is a by report code; a report/narrative must accompany the claim.

DENTAL PROPHYLAXIS CDT 2025

D1110 PROPHYLAXIS - ADULT CDT 2025

Removal of plaque, calculus and stains from the tooth structures and implants in the permanent and transitional dentition. It is intended to control local irritational factors.

WATCH

1. If full mouth debridement (D4355) is *necessary* to enable a comprehensive periodontal evaluation, either the prophy (D1110), or scaling and root planing (SRP), whichever is applicable, should *follow* on a separate service date. See D4355 for details.
2. If the patient requires *both an* adult prophylaxis (D1110) as well as a few teeth scaled and root planed (D4342), consider providing the adult prophylaxis at the *first* visit, and then provide the D4342 on a subsequent visit (some payors may require 6 weeks later). Prophylaxis does not preclude subsequent SRP.
3. D4346 scaling in presence of *generalized* moderate or severe gingival inflammation - full mouth after the completion of an oral evaluation is used to report scaling performed on the patient with a documented diagnosis of generalized (>30%) moderate to severe gingival inflammation with no attachment loss. Pseudo pocketing may or may not be present. This is NOT a "difficult" prophy. See D4346 for details.
4. D1110 may be reported for patients with *localized* and/or mild gingivitis defined as not more than 30%. D1110 is not to be reported with D4346 on the same date of service; however, the D1110 procedure follows D4346 at a subsequent visit several weeks later, as determined by the dentist based on the individual patient's need. See D4346 for details.
5. A prophylaxis is a preventive and supportive procedure and is NOT a statement of health. It is not therapeutic or for the treatment of disease itself, but can be performed in addition to other therapeutic procedures.

COMMENTS

1. D1110 includes prophylaxis of implant crowns in conjunction with the permanent and transitional dentition.
2. The D1110 descriptor includes the statement to "control local irritational factors." This procedure is to treat gingival inflammation (localized and mild gingivitis defined as less than 30%) caused by irritational factors. If the tissue only has some mild or localized gingivitis with no bone loss, D1110 is indicated. Gingivitis is the first stage of periodontal disease and *may, or may not*, progress to periodontitis. If there is *generalized* (>30%) moderate or severe gingival inflammation with no bone loss report D4346 instead of D1110. D4346 is NOT a "difficult" prophy. A "difficult" prophy is a prophylaxis requiring more time and effort. See comment #6 regarding a "difficult" prophy. See D4346 for details.
3. Adult prophylaxis (D1110) is *preventive* in nature and includes scaling and polishing of tooth structures (and implants) with the removal of plaque, calculus and stains. The removal of all calculus and plaque above and just below the CEJ is part of a prophylaxis. "Pseudo" pockets may be present, but there should not be bone loss or loss of attachment. If radiographic bone loss is evident and the root has access, see scaling and root planing (D4341/D4342). Instrumentation of the root with SRP is only possible when there is bone loss.
4. Do not report prophylaxis (D1110) for the cleaning and inspection of partial and complete dentures. See D9932, D9933, D9934, and D9935. However, D1110 CAN be reported along with these procedures if cleaning natural teeth or implants on the same date of service. Benefits will vary by plan. See also point 6 under Limitations for more information.
5. A prophylaxis performed on a child having lost *all* his/her deciduous teeth (with only permanant teeeth) must be reported as *adult* prophylaxis (D1110), regardless of age. The D1110 fee for a child who has no "baby teeth" may be adjusted to the lower child prophylaxis fee if deemed appropriate by the dentist. If under age 14 include "permanent dentition only" in the remarks section and indicate the age.
6. Adult prophylaxis (D1110) does not include the application of topical fluoride. Report adult (or child) fluoride treatments, when applied separately from the prophylaxis paste, reporting either code D1208 or D1206. D1206 specifically requires the topical application of fluoride varnish. D1208 would include the topical application of any prescription strength fluoride product, excluding varnish (swish, trays, isolate, and paint-on). The application of fluoride must be applied separately from the prophylaxis paste. See D1206 and D1208 for additional information and how to increase the odds of adult fluoride reimbursement.

7. A "difficult" prophy may be a patient who presents with heavy plaque, calculus, staining, etc. requiring more time and challenging to perform, or even several visits. A "difficult" prophylaxis is accurately reported as a D1110 prophylaxis, regardless of the difficulty and/or the time needed to complete the procedure. The fee may be increased for the extra time spent, but maximum plan allowances will still apply. If greater than 30% of the mouth has inflammation, consider reporting D4346 instead. See D4346.

LIMITATIONS

1. Adult prophylaxis (D1110) includes both *transitional* (mixed) and *permanent* dentition, and implants. Transitional dentition refers to a mixed dentition. Transitional dentition begins with the appearance of the permanent tooth and ends with the exfoliation (loss) of the last deciduous tooth. Permanent dentition refers to the permanent or adult teeth solely in the dental arch. Accordingly, any transitional dentition may be reported as an adult prophylaxis (D1110) regardless of age. However, many payors will apply an arbitrary age limitation (typically at least fourteen years of age) before considering reimbursement at the adult prophylaxis fee level.
2. The ADA's House of Delegates has, in the past, addressed the "age issue" and has passed a resolution that addresses this issue:

   Age of "Child" (1991:635)

   Resolved, that when dental plans differentiate coverage based on the child or adult status of the patient, this determination should be based on clinical development of the patient's dentition, and be it further resolved, that where administrative constraints of a dental plan preclude the use of clinical development so that chronological age must be used to determine child or adult status, the plan defines a patient as an adult beginning at age 12 with the exclusion of treatment for orthodontics and sealants.
3. Adult prophylaxis (D1110) is *not* reimbursed when provided on the same service date with ongoing periodontal maintenance (D4910) or full mouth debridement (D4355).
4. Adult prophylaxis (D1110) is typically reimbursed either on a "one per six months" (to the day!) **or** on a "two per year" basis. Under a few plans, only one prophylaxis per year is benefitted. Please note that other exceptions can apply to the reimbursement of D1110.
5. See periodontal scaling and root planing - one to three teeth per quadrant (D4342) regarding the reporting of prophylaxis (D1110) and SRP (D4342) on the same service date. This is generally a problem, and often requires an appeal indicating extra time was spent. It is not recommended.
6. If the patient has implant/abutment supported restorations only (no natural teeth remaining), D1110 may still apply since the code language includes implants in the descriptor. If denied by payors, report D1999 unspecified preventive service, by report and ask for the alternate benefit of D1110. Results will vary by plan. The exception would be in the case of fixed hybrid restorations, with which implant maintenance procedures would be appropriate. See D6080/D6180 for more information.

TIPS

1. An adult prophylaxis (D1110) provided for a patient with *transitional* (mixed) dentition may be reported no matter the child's age, as long as there is at least one permanent tooth in the mouth. For example, an eleven-year-old boy with braces has "challenging" hygiene. In this scenario, the service may be reported as an adult prophylaxis (D1110); however, contract age limitations may be applied by payors. Alternately, the child prophy (D1120) may be reported in this situation and the fee adjusted accordingly. However, the plan limitations and reimbursement may vary widely from plan to plan.
2. The adult and child prophylaxis codes are dentition specific rather than age specific, and now include any implants or implant crowns. The payor reimbursement, however, is subject to contractual limitations.

NARRATIVES

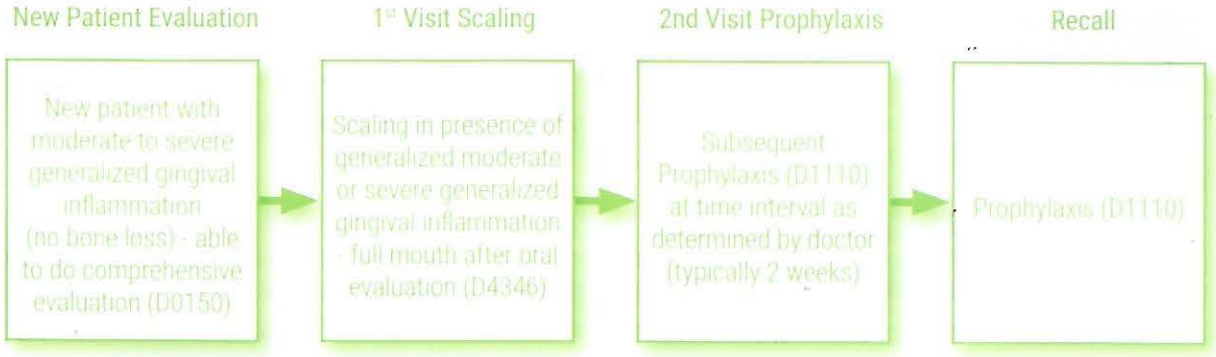
1. Reimbursement for adult prophylaxis (D1110) is typically age specific and is determined by the terms of the insurance plan (plan document). Most payors set the "adult" age threshold at "14 or above." Some will begin recognizing the patient as an adult at "12 or above." A few payors begin to reimburse an adult prophy for those patients "16" years of age and older. A narrative stating "permanent dentition only" may help with the reimbursement process for patients who do not fall within the recognized plan document "norms."
2. If the patient requires extra time because they are an orthodontic patient presenting with calculus, cements and bonding agents remaining after the removal of braces report prophylaxis (D1110/D1120), in addition to an unspecified orthodontic procedure (D8999), with a narrative. PPOs will not reimburse for D8999, but some will allow the dentist to charge the additional unspecified D8999 fee directly to the patient under these circumstances. Thus, the procedure is denied. Review the contract language and the Medicaid or PPO's Processing Policy Manual to gain understanding of the limitations/exclusions.

CLINICAL FLOW CHARTS

1. The flow chart below shows the typical one prophylaxis visit prior to establishing the subsequent recall prophylaxis.



2. D4346 at the time of the comprehensive oral evaluation (D0150) may only be used to report a procedure for the patient with a documented diagnosis of moderate to severe gingival inflammation without attachment loss. The D1110 procedure may follow D4346 at an interval set by the dentist. See flow chart below for an illustration of proper coding protocol. See also D4346.



Notes:

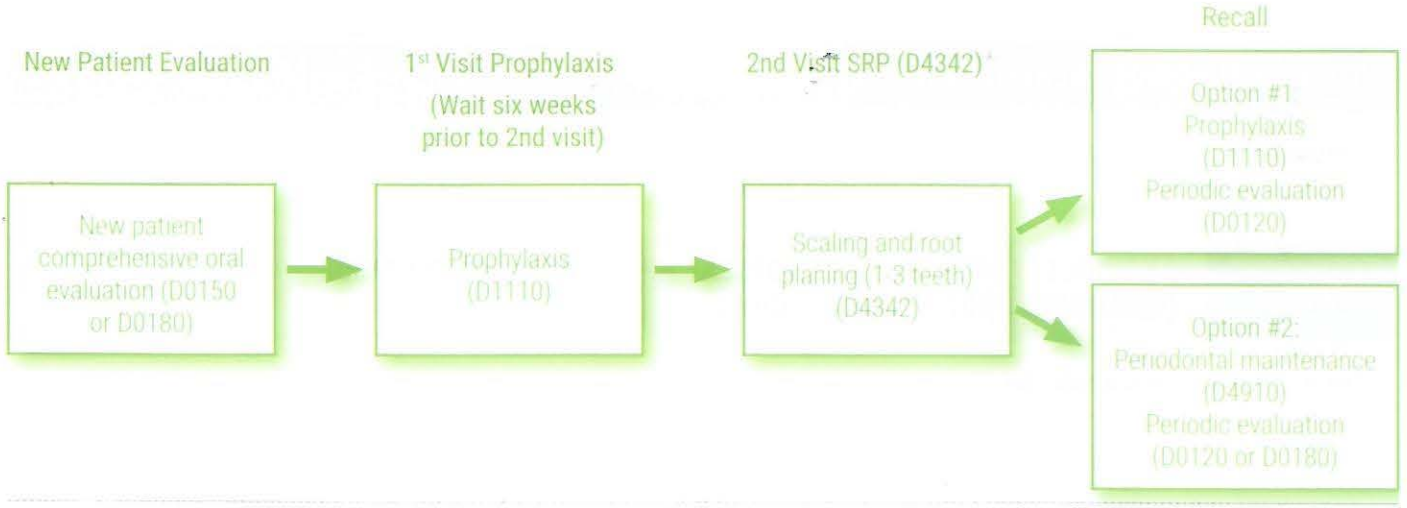
a. If a comprehensive oral evaluation (D0150) can be performed, with light to heavy calculus and debris present and a documented diagnosis of moderate to severe gingivitis without attachment loss, then D4346 may be the appropriate treatment for the first visit. D1110 prophylaxis may follow at the second visit, with the interval set by the dentist (such as two weeks).

b. If a comprehensive oral evaluation (D0150/D0180) is not possible due to excess calculus and debris, see full mouth debridement (D4355) which is performed to enable a subsequent comprehensive periodontal evaluation and diagnosis. See D4355 for details and flow diagram.

c. Ideally, adult prophylaxis (D1110) should not follow periodontal scaling and root planing - one to three teeth (D4342). If the patient requires *both* prophylaxis and a *few* teeth scaled and root planed (D4342), then consider the adult prophylaxis (D1110) for the *first* visit and the D4342 at a subsequent visit (wait at least six weekes after prophylaxis).

Note: Some payors will not reimburse D4910 within a 90-day period following D4341/D4342. See D4342 for further details and the flow chart below:

3. The flow chart below shows the evaluation/prophylaxis visit followed by SRP (D4342). In this circumstance, it may be appropriate to report either a prophy (D1110) or periodontal maintence (D4910) at recall.



Notes:

1. Following a single SRP (D4342) visit, if *very limited* periodontal pockets are involved, the doctor has the latitude to provide adult prophylaxis (D1110) for recall maintenance (should generally be more often than two per year). Be sure and document in the patient's clinical notes the isolated root planing (by tooth) at the adult prophylaxis (D1110) appointment and keep the patient informed of the "limited" nature of the periodontal treatment. On the other hand, ongoing periodontal maintenance (D4910) will be appropriate. However, keep in mind that some payors will not recognize D4910 for reimbursement if less than two initial quadrants (D4341/D4342) were scaled and root planed (SRP). In many cases, a single D4342 quadrant does not qualify for recall perio maintenance (D4910), and at least two full quadrants of D4341 are required. See D4910 for further details.
2. Adult prophylaxis (D1110) will typically have a "one per six months" or "two per year" benefit limitation. Most plans benefit two prophylaxis (D1110) and two periodontal maintenance (D4910). A few plans benefit two prophies and four periodontal maintenance (D4910) per year. See D4910.
3. Be sure to read SRP 1-3 teeth (D4342) for additional details and how this periodontal procedure relates to the adult prophylaxis (D1110) as to timing.

D1120 PROPHYLAXIS - CHILD — CDT 2025

Removal of plaque, calculus and stains from the tooth structures and implants in the primary and transitional dentition. It is intended to control local irritational factors.

COMMENTS

1. Primary dentition refers to the first set of teeth. These are also called baby teeth, or deciduous teeth. Transitional dentition begins with the appearance of the first permanent tooth and ends with the exfoliation (loss) of the last deciduous tooth. D1120 includes prophylaxis of implant crowns in conjunction with the primary and transitional dentition.
2. Child prophylaxis (D1120) may be used to report a prophylaxis of both *primary* and *transitional* (mixed) dentitions including implant crowns. On the other hand, an adult prophylaxis (D1110) reports both *permanent* and *transitional* (mixed) dentitions. See D1110 for further comments in reporting transitional (mixed) dentitions as an adult prophylaxis.
3. Child prophylaxis (D1120) does not include the topical application of fluoride. Report fluoride treatments, when applied separately from the prophylaxis paste, using either code D1208 topical application of fluoride or D1206, if fluoride varnish is applied. D1208 would include any prescription strength fluoride products excluding varnish (swish, trays, isolate and paint on). D1206 specifically requires application of fluoride varnish. Fluoride must be applied separately from the prophylaxis paste. See D1206 and D1208 for additional information.

LIMITATIONS

1. Appropriate reporting of D1120 should be based on the patient's developing dentition. Benefits may be defined by age in the plan document, however dentition defines code usage. If a patient has no primary teeth remaining, an adult prophylaxis (D1110) is appropriate regardless of age. See D1110.
2. Child prophylaxis (D1120) may be reimbursed on either a "one per six months" (to the day!) or on a "two per year" basis.

TIPS

If a patient with a *transitional* dentition presents with "challenging" prophylaxis, regardless of age, consider reporting adult prophylaxis (D1110). See D1110 for details of this scenario as it applies to the transitional dentition.

TOPICAL FLUORIDE TREATMENT (OFFICE PROCEDURE) — CDT 2025

Prescription strength fluoride product designed solely for use in the dental office, delivered to the dentition under the direct supervision of a dental professional. Fluoride must be applied separately from prophylaxis paste.

D1201 PREVIOUSLY DELETED CODE TOPICAL APPLICATION OF FLUORIDE (INCLUDING PROPHYLAXIS) - CHILD

This is a previously deleted code. See D1206 (fluoride varnish) and D1208 to report topical application of fluoride.

D1203 PREVIOUSLY DELETED CODE TOPICAL APPLICATION OF FLUORIDE - CHILD

This is a previously deleted code. See D1206 (fluoride varnish) and D1208 to report topical application of fluoride.

D1204 PREVIOUSLY DELETED CODE TOPICAL APPLICATION OF FLUORIDE - ADULT

This is a previously deleted code. See D1206 (fluoride varnish) and D1208 to report topical application of fluoride.

D1205 PREVIOUSLY DELETED CODE TOPICAL APPLICATION OF FLUORIDE (INCLUDING PROPHYLAXIS) - ADULT

This is a previously deleted code. See D1206 (fluoride varnish) and D1208 to report topical application of fluoride.

D1206 TOPICAL APPLICATION OF FLUORIDE VARNISH CDT 2025



WARNING

1. Some practices erroneously report fluoride application when the prophylaxis paste contains fluoride. For proper reporting, fluoride varnish application must be applied separately from the prophylaxis paste.
2. Fluoride dispensed for home use should not be reported as D1206. See D9630 to report certain take-home products and see D1999 for an unspecified preventive procedure.
3. D1206 should not report desensitization. It is for caries prevention. See D9910 for a desensitization procedure.
4. D1206 should not report a caries preventive medicament application - per tooth. See D1355 for remineralization.
5. D1206 should not be used to report the application of Cervitec® Gel. Fluoride is not listed as a component of Cervitec® Gel, therefore it cannot be reported as Fluoride varnish (D1206). See D9910, D4999, D1999, D6199, for other situations where Cervitec® Gel may be reported.
6. D1206 should not be used to report the application of silver diamine fluoride. See D1354.
7. D1206 should not be reported for application of hydoxyapatite regeneration medicament, such as Curodont Repair. See D2991.

COMMENTS

1. D1206 reports the application of topical fluoride varnish.
2. D1206 reports the therapeutic application of topical fluoride varnish delivered throughout the entire oral cavity in a single visit. The technique used for application is not specified, but *fluoride varnish* application is required to report D1206.
3. The fluoride varnish procedure may be reported in addition to a related prophylaxis (child or adult) or on a stand-alone basis. Fluoride varnish (D1206) may be applied and reported without having provided a prophylaxis. This is typically in a school setting.
4. D1206 is applicable to *both* children and adults. D1206 is specifically recommended for children under age six by the ADA/AAPD. Some payors will not reimburse D1208 under age six, only D1206.
5. Enter "00" for the entire area of the oral cavity in Box 25 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Fluoride varnish application, if a covered benefit, is often reimbursed twice per year; however, the reimbursement *trend* is once per year. Patients age 16 and older are generally not covered. In some cases, the limitation begins at 15 years.
2. In the past D1206 required that the patient have a moderate to high risk for caries. The D1206 code has been revised and a specific caries risk status is no longer required. However, some payors require a moderate to high caries risk to reimburse for adult varnish application. For caries risk assessment, demonstrating increased risk, if appropriate, see D0602 and D0603.
3. D1206 may be reimbursed at a higher fee than D1208 with some plans.

NARRATIVES

Some contracts may reimburse fluoride varnish (D1206) specifically for ages above 18, particularly if the patient is moderate or high caries risk. Be sure to note that "moderate caries risk" or "high caries risk" in the remarks section of the claim form for adults. Confirm that a caries risk assessment has been done and is part of the patient's chart, and report D0602 or D0603 risk assessment code on the claim form. The D0602 or D0603 caries assessment code may be "no charge to the patient" and reported as no charge on the claim form. There is no "special" narrative to gain adult fluoride coverage. Adult fluoride application is either covered or not in the plan document (covered about 10% of time).

D1208 TOPICAL APPLICATION OF FLUORIDE - EXCLUDING VARNISH CDT 2025



WARNING

1. Some practices erroneously report fluoride application when the prophylaxis is provided using a paste containing fluoride. For proper reporting, fluoride must be applied to the teeth in a *separate* procedure afterward, apart from the prophylaxis paste.
2. Fluoride preparations dispensed for home use should not be reported as D1208. See D9630 for take home fluoride application and D1999 for fluoride toothpaste, toothbrushes, etc.
3. D1208 should not be used to report desensitization. See D9910 to report desensitizing.
4. D1208 should not report a caries preventive medicament application - per tooth. See D1355 for remineralization.
5. D1208 should not be used to report the application of Cervitec® Gel. Fluoride is not listed as a component of Cervitec® Gel, therefore it cannot be reported as fluoride (D1208). See D9910, D4999, D1999, D6199 for other situations where Cervitec® Gel may be reported.
6. D1208 should not be used to report the application of silver diamine fluoride. See D1354.
7. D1208 should not be reported for application of hydoxyapatite regeneration medicament, such as Curodont Repair. See D2991.

WATCH

The D1208 code does not specify the *specific* type of fluoride formulation or technique used for the topical application, but it does *exclude* fluoride varnish. For fluoride varnish, see D1206 to report topical application of fluoride varnish for either the child or adult.

COMMENTS

1. Topical application of fluoride - excluding varnish (D1208) reports *any* fluoride application using prescription strength swish, trays, isolate and paint-on. The specific delivery mechanism is not important. The topical application of fluoride must be applied as a separate procedure apart from the prophylaxis. The fluoride formulation and application technique is not specified in this code description but it is assumed that the fluoride utilized must be prescription strength. However, note that the nomenclature of D1208 specifically excludes fluoride varnish.
2. If therapeutic topical fluoride varnish is applied, report D1206 for either the child or adult.
3. Enter "00" for the entire area of the oral cavity in Box 25 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Fluoride application, if a covered benefit, is often reimbursed twice per year. However, the reimbursement trend is once per year. Patients age 16 and older are generally not covered. In some cases, the limitation begins at 15 years.
2. D1206 may be reimbursed at a higher fee than D1208 with some plans. D1206 might be covered for certain plans whereas D1208 is not. On the other hand, D1208 might be covered for certain plans whereas D1206 is not. See D1206, as the overall reporting of this code is often superior.
3. D1206 is recommended for under six years of age by the ADA/AAPD. Certain payors will not reimburse D1208 for children under age six.
4. D1206 may be required specifically for adult coverage, if reimbursed. See D1206.

D1301 IMMUNIZATION COUNSELING

A review of a patient's vaccine and medical history, and discussion of the vaccine benefits, risks, and consequences of not obtaining the vaccine. Counseling also includes a discussion of questions and concerns the patient, family, or caregiver may have and suggestions on where the patient can obtain the vaccine.

COMMENTS

1. D1301 documents the review of and counseling concerning immunizations as outlined in the descriptor above. Although dentists in many states are authorized to administer vaccines, many may choose to provide counseling and refer to other healthcare professionals.
2. New Vaccine Stand-alone Counseling Codes were released by the Centers for Medicaid and Medicare Services on June 9, 2022, and this new dental code mirrors these codes for medical providers.
3. D1301 can be reported on the same date of service as the delivery of an immunization.

LIMITATIONS

1. Reimbursement is expected to be poor for D1301 as a standalone code.
2. Many payors will consider D1301 to be part of a global dental evaluation if done in conjunction with D0150/D0180 on the same service date.

D1310 NUTRITIONAL COUNSELING FOR CONTROL OF DENTAL DISEASE CDT 2025

Counseling on food selection and dietary habits as a part of treatment and control of periodontal disease and caries.

LIMITATIONS Nutritional counseling (D1310) is not typically reimbursed.

D1320 TOBACCO COUNSELING FOR THE CONTROL AND PREVENTION OF ORAL DISEASE CDT 2025

Tobacco prevention and cessation services reduce patient risks of developing tobacco-related oral diseases and conditions and improves prognosis for certain dental therapies.

LIMITATIONS Tobacco counseling (D1320) is not typically reimbursed.

D1321 COUNSELING FOR THE CONTROL AND PREVENTION OF ADVERSE ORAL, BEHAVIORAL, AND SYSTEMIC HEALTH EFFECTS ASSOCIATED WITH HIGH-RISK SUBSTANCE USE CDT 2025

Counseling services may include patient education about adverse oral, behavioral, and systemic effects associated with high-risk substance use and administration routes. This includes ingesting, injecting, inhaling and vaping. Substances used in a high-risk manner may include but are not limited to alcohol, opioids, nicotine, cannabis, methamphetamine and other pharmaceuticals or chemicals.

COMMENTS Documentation should include the type of counseling provided along with details of the substance used and administration route. With the ever increasing use of vaping, e-cigarette and other devices, opioid, and high levels of alcohol consumption the dental provider plays an important role in educating the user regarding the effects of continued use as it relates to oral diseases. This is especially crucial considering that teen usage of these chemicals continues to be on the rise.

LIMITATIONS Most dental plans exclude reimbursement for counseling.

D1330 REVISED ORAL HYGIENE INSTRUCTIONS CDT 2025

REVISIONS

ORAL HYGIENE INSTRUCTIONS

~~This may include instructions for home care. Examples include tooth brushing technique, flossing, and use of special oral hygiene aids.~~

COMMENTS

Oral hygiene instructions are personalized for each patient and may include but are not limited to home care, tooth brushing technique, flossing, and use of special oral hygiene aids.

LIMITATIONS

1. Oral hygiene instruction (D1330) is not typically reimbursed.
2. Some Medicaid programs may reimburse D1330.

TIPS

1. While payors don't generally reimburse D1330, the practice can "add value" by charging out the regular fee and then adjusting the fee to *zero* using a "professional courtesy" adjustment on the patient's walkout statement.
2. For legal and documentation purposes, make a note in the clinical record that, "oral hygiene instruction" was provided even if no fee is charged for the service.

D1351 SEALANT - PER TOOTH CDT 2025

Mechanically and/or chemically prepared enamel surface sealed to prevent decay.

COMMENTS

The differences between a sealant (D1351), preventive resin restoration (D1352), and resin-based composite restoration (D2391) are:

1. Sealant (D1351): Mechanically and/or chemically prepared enamel surface sealed to prevent decay. *The enamel surface is non-carious.* The global fee for a sealant includes a fissurotomy, as a part of the procedure, if it is necessary.
2. Preventive Resin Restoration (D1352): Conservative restoration of an *active cavitated lesion* in a pit or fissure of a permanent tooth which *does not extend into the dentin*; also includes placing a sealant in any of the radiating non-carious fissures or pits. Patient must be moderate to high caries risk. D1352 can only be reported for permanent teeth.
3. Resin-based composite-One surface, posterior (D2391): This is a resin composite restoration where the caries and preparation *extends into the dentin* or a deeply eroded area *into the dentin*.
4. Enter the tooth number being sealed in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Reimbursement of sealants is generally limited to the occlusal surface of the permanent first and second molars. Some plans will provide reimbursement for sealants provided for permanent premolars; however, this is quite rare. There may be exclusions for sealants if the tooth has been previously restored with an occlusal restoration or if caries is present. Sealants are reported on a "per tooth" basis.
2. The sealant replacement exclusion varies from two to five years or to the lifetime of the insured. For sealant repair, per tooth, see D1353.
3. Sealant coverage for permanent molars varies, and may cover the period from eruption to 15 or 18 years of age. Some plans cover first molars only from age 6-10. Most payors have an age limit. The reimbursement for sealants is highly variable. It is recommended that sealant coverage be verified prior to placement.
4. Sealants typically are reimbursed as a preventive procedure. Most plans cover preventive procedures at 100% of the payor's allowance. Other payors consider sealants a basic service and some consider sealants under the "major" category of benefits. If considered a basic or major benefit, the reimbursement will be less than a 100% payor's fee, per the plan's benefit structure. There may be waiting periods, co-payments, deductibles, or other limitations that apply to sealant services. The reimbursement for sealants is highly variable.
5. If amalgams/composites are performed along with sealants on the same tooth, on the same service date, then the sealants are usually considered a part of the global amalgam/composite procedure.
6. Sealants may be applied to primary teeth but typically are not reimbursed.

7. Sealants are not generally covered for adults, but may be beneficial.
8. Enter the tooth number being sealed in Box 27 of the 2024 ADA Dental Claim Form.

TIPS

See also D2990 resin infiltration of incipient smooth surface lesions (DMG Icon) and D2991application of hydroxyapatite regeneration medicament (Curodont Repair). These are both restorative codes, not preventive.

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

CDT 2025

Conservative restoration of an active cavitated lesion in a pit or fissure that does not extend into dentin; includes placement of a sealant in any radiating non-carious fissures or pits.



WARNING

1. Do not report this preventive type resin *restoration* (PRR) if there is no active cavitated lesion (no active decay) in the enamel. See Sealant (D1351) for sealing the enamel surface and any radiating non-carious fissures and pits.
2. Do not report this preventive type resin restoration if the preparation and decay extends into the dentin. See D2391 for a routine resin-based one surface composite restoration where preparation and caries extends into the dentin or a deeply eroded area *into the dentin.*
3. Do not report this preventive resin restoration for a primary tooth. D1352 reports only a permanent tooth and the patient is required to have a moderate to high caries risk.

WATCH

1. The preventive resin restoration (D1352) requires that the patient be in the moderate to high caries risk category. The patient should have had a risk assessment performed and documented and classified as a moderate to high caries risk patient. See caries risk assessment, D0602 or D0603.
2. D1352 is a preventive resin (not amalgam) restoration restricted to the treatment of a permanent tooth. A PRR is used to restore a cavitated lesion in a pit or fissure that does not extend into the dentin or a deeply eroded area *into the dentin.*
3. The global preventive resin restoration (D1352) procedure also includes the placement of a sealant in any of the radiating non-carious fissures or pits of the treated tooth.

COMMENTS

The differences between a sealant (D1351), preventive resin restoration (D1352), and resin-based composite restoration (D2391) are:

1. Sealant (D1351): Mechanically and/or chemically prepared enamel surface sealed to prevent decay. *The enamel surface is non-carious.* The global fee for a sealant includes a fissurotomy as part of the procedure, if it is needed.
2. Preventive Resin Restoration (D1352): Conservative restoration of an *active cavitated lesion* in a pit or fissure of a permanent tooth which *does not extend into the dentin*; also includes placing a sealant in any radiating non-carious fissures or pits. The patient must have moderate to high caries risk. D1352 can only be reported for permanent teeth.
3. Resin-based composite-One surface, posterior (D2391): This is a resin composite restoration where the caries and preparation *extends into the dentin* or a deeply eroded area *into the dentin.*
4. Enter the tooth number being sealed in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Some plans will pay an alternate benefit of a sealant (D1351), while others will pay more than a sealant (up to twice the fee) but generally less than a one-surface posterior composite restoration (D2391).
2. If a PRR is denied, appeal by asking for the alternate benefit of a sealant, D1351.

TIPS

See also D2990 resin infiltration of incipient smooth surface lesions (DMG Icon) and D2991 application of hydroxyapatite regeneration medicament (Curodont Repair). These are both restorative codes, not preventive.

NARRATIVES

"Tooth #X had active cavitated lesion that did not extend into dentin." (Make sure a caries risk assessment form is in the patient's chart. The payer may request it or you may wish to attach a copy of it to the claim form).

D1353 SEALANT REPAIR - PER TOOTH CDT 2025

COMMENTS

1. According to the American Academy of Pediatric Dentistry (AAPD), sealant maintenance and repair are an essential part of an effective caries-control protocol for susceptible teeth and moderate to high-risk populations. "Dental sealants may fail completely (i.e., no sealant material remains bonded to the tooth surface), but most fail incrementally, with partial loss of sealant material. When either occurs, reapplication of sealant material to the now unprotected caries-susceptible pits and fissures is indicated."

   This is consistent with accepted clinical sealant guidelines, including that of the AAPD, which states that sealant maintenance or repair is a clinical procedure distinct from initial sealant placement and which should be separately reported so that the clinical record remains accurate.
2. Electronic health records (EHR) necessitate that dentists have a way to document the services they perform whether dental plans provide a benefit or not. Some payors think the sealant code (D1351) should be reported whether a sealant is repaired or replaced since frequency limits will apply either way. Although many dentists tend not to charge for repairing sealants within a given time frame, the Code Maintenance Committee (CMC) determined that it is important to have a specific code that accurately documents the procedure performed.
3. D1353 provides a way for dentists to document and track sealant repairs separate from new sealant placement in their practice management system even if they repair them free of charge. This code allows dentists to track sealant repairs without skewing fee data for sealants (D1351).
4. Enter the tooth number being repaired in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. The sealant *replacement* exclusion varies from two to five years or to the lifetime of the insured. If paid, a sealant *repair* may trigger the sealant replacement exclusion.
2. The same frequency limits for replacement will more than likely also apply to sealant repair (D1353). Expect poor reimbursement coverage for sealant repairs.

ADDITIONAL INFORMATION

As an example of when D1353 could be reported: One year after placing dental sealants on the occlusal surfaces of the patient's four first permanent molars, the clinical examination reveals that part of the sealant material bonded to the maxillary right first molar has been lost, exposing the pits and fissures to bacteria, oral fluids, and oxygen. The tooth is isolated, existing sealant material that is not well bonded is removed, the enamel surfaces are conditioned by acid etching, and the new sealant material is applied to the caries-susceptible pits and fissures.

D1354 APPLICATION OF CARIES ARRESTING MEDICAMENT - PER TOOTH CDT 2025

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.



WARNING

1. Do not report D1354 if D1355, D2990, or D2991 are more appropriate. See Watch below.
2. Silver diamine fluoride (SDF) may be painted on a crown preparation or the floor of a filling preparation to prevent sensitivity, but this is considered a base or liner and is not reported separately.

WATCH

1. Report topical fluoride or fluoride varnish with codes D1208 and D1206, *not* D1354.
2. D1355 reports caries preventive medicament application - per tooth. This procedure is for prevention or remineralization medicaments NOT including topical fluoride.
3. D2990 reports resin infiltration of incipient smooth surface lesions (DMG Icon).
4. D2991 reports application of hydroxyapatite regeneration medicament (Curodont Repair).
5. Reporting use of SDF to arrest secondary decay around a crown margin may be reported as D1354, since active decay was present.

COMMENTS

1. D1354 reports the application and/or treatment of early non-symptomatic carious lesions using topical medicaments that either arrest or inhibit the progression of the lesion on a tooth. They only arrest, not restore, decayed areas. The area treated would not be prepared (drilled) during this procedure. Caries arresting or inhibiting treatments of this type may include ozone, silver diamine, etc. D1354 is reported on a "per tooth" basis.
2. Enter the tooth number and surface(s) being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. As with all fairly new codes, coverage will vary among dental plans. Some government-funded plans (Medicaid) may provide reimbursement for this treatment. Some plans could pay an alternate benefit of fluoride varnish (D1206).
2. This procedure oftentimes involves multiple visits. Dental plans may include all medicament application visits in the global fee of the single tooth procedure. Reimbursement may be limited to treatment of primary teeth.
3. Some payors may require a moderate to high caries risk for reimbursement of D1354. If so, report D0602 (moderate caries risk) or D0603 (high caries risk). Typically, the fee for D0602/D0603 is zero.
4. Reimbursement of these treatments may preclude reimbursement for subsequent definitive restorations placed on the same tooth on a later service date.
5. Enter the tooth number and surface(s) being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

NARRATIVES

"Tooth X had a non-symptomatic carious lesion." It should also be noted why D1354 was provided rather than a definitive restoration. The clinical record should clearly document the caries diagnosis, indicating an active, non-symptomatic carious lesion. Include the caries risk assessment determination. Some payors may require a copy of this form and the appropriate caries risk code (D0602 or D0603) on the claim.

D1355 CARIES PREVENTIVE MEDICAMENT APPLICATION - PER TOOTH — CDT 2025

For primary prevention or remineralization. Medicaments applied do not include topical fluorides.



WARNING

1. Do not report D1355 for any type of topical fluoride. See D1206 and D1208.
2. Do not report D1355 for desensitization. See D9910 to report desensitization or D9110, which may be applicable in very limited circumstances. See D9110.
3. Do not report D1355 when incipient caries are present. D1355 is used for preventive situations only. See D1354.
4. Silver diamine fluoride (SDF) may be painted on a crown preparation or the floor of a filling preparation to prevent sensitivity, but this is considered a base or liner and is not reported separately.

WATCH

1. D1355 is reported for medicament application for *caries prevention* or *remineralization*. The same or similar medicament may be applied for *arresting* caries but is reported using D1354 interim caries arresting medicament application - per tooth. D1355 is not to be reported when there is a presence of an activated carious lesion.
2. D2990 reports resin infiltration of incipient smooth surface lesions (DMG Icon).
3. D2991 reports application of hydroxyapatite regeneration medicament (Curodont Repair).

COMMENTS

1. D1355 reports primary prevention or remineralization.
2. D1355 is reported on a per tooth basis.
3. Silver diamine has several uses. Among them, silver diamine may be reported using D1355 when used for caries prevention or remineralization.
4. Enter the tooth number and surface(s) being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

Coverage may be limited with D1355. For plans that do provide coverage, expect frequency limitations.

SPACE MAINTENANCE (PASSIVE APPLIANCES) — CDT 2025

Passive appliances are designed to prevent tooth movement.

D1510 SPACE MAINTAINER - FIXED, UNILATERAL - PER QUADRANT — CDT 2025

Excludes a distal shoe space maintainer.

WARNING

For a distal shoe space maintainer - fixed - unilateral - per quadrant, see D1575.

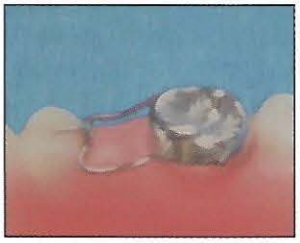
COMMENTS

1. D1510 reports a fixed, unilateral space maintainer, per quadrant. To report a fixed *bilateral* space maintainer, see D1516 or D1517.
2. A space maintainer is considered a *passive* (not active) appliance. No teeth are moved or space regained with a space maintainer. Space is held, not gained by this type of "holding" fixed appliance.
3. Any stainless steel crown or orthodontic band that is part of a fixed space maintainer is generally included in the global space maintainer fee.
4. When a fixed unilateral space maintainer is re-cemented or re-bonded, see D1553.
5. Enter the quadrant in Box 25 and the tooth number or range of teeth the space maintainer is holding space for in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. A fixed space maintainer could be placed in an adult (to stop shifting of teeth) but would generally not be reimbursed.
2. Passive space maintainers often have an age limitation up to 14-18 years.
3. *Removal* of the fixed - unilateral space maintainer (D1510) is not typically reimbursed for the doctor (or office) who initially placed the space maintainer. If the space maintainer is removed by a different office, the service may be payable. To report removal of a fixed unilateral space maintainer, see D1556.
4. Repair or replacement of a fixed unilateral space maintainer (D1510) is not typically reimbursed.
5. The space maintainer - fixed - unilateral (D1510) is often referred to as a "band and loop" or "crown and loop" fixed appliance. D1510 is generally not reimbursed to maintain space solely for missing primary centrals/laterals/canines. Reimbursement for space maintenance generally requires missing first or second primary molars (or permanent molars).
6. D1510 is typically reimbursed on a "once per quadrant" per lifetime basis. If reimbursed, the procedure is typically considered preventive in nature and is reimbursed at 100% of UCR allowance and not subject to the plan's deductible.

PHOTO



1. This is a fixed, unilateral space maintainer - per quadrant.
2. This fixed type of space maintainer is commonly referred to as a "crown and loop or band and loop."

Courtesy Space Maintainers Lab

D1515 PREVIOUSLY DELETED CODE SPACE MAINTAINER - FIXED - BILATERAL

This is a previously deleted code. See D1516 and D1517 for further details.

D1516 SPACE MAINTAINER - FIXED - BILATERAL, MAXILLARY CDT 2025

WARNING

It is misleading to report a fixed pediatric cosmetic partial (with anterior teeth) as a maxillary space maintainer - fixed-bilateral (D1516), without a narrative disclosing the true nature of the cosmetic service. See D6985 for further details concerning a fixed pediatric partial placed for cosmetic purposes.

COMMENTS

1. A fixed bilateral maxillary space maintainer is considered a *passive* (not active) appliance. No teeth are moved or space regained with a space maintainer. Space is held, not gained by this type of "holding" fixed appliance.
2. Any stainless-steel crown or orthodontic band that is a part of a fixed space maintainer is generally included in the global space maintainer fee.

3. When a fixed bilateral maxillary space maintainer is re-cemented or re-bonded, see D1551. To report a fixed-*unilateral* space maintainer, see D1510.
4. Enter the tooth number or range of teeth the space maintainer is holding space for in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. A fixed maxillary space maintainer could be placed in an adult (to stop the shifting of teeth) but would generally not be reimbursed.
2. Passive space maintainers may have an age limitation up to 14-18 years.
3. Removal of the fixed - maxillary bilateral space maintainer (D1516) is not typically reimbursed for the doctor (or office) who initially placed the space maintainer. If the space maintainer is removed by a different office, the service may be payable. For removal of a fixed bilateral maxillary space maintainer, see D1557.
4. Repair or replacement of a fixed maxillary bilateral space maintainer (D1516) is not typically reimbursed.
5. D1516 is often referred to as a maxillary "palatal arch" fixed bilateral space maintainer. D1516 is generally not reimbursed to maintain space solely for missing primary centrals/laterals/canines. Reimbursement for space maintenance generally requires missing first or second primary molars (or permanent molars).
6. D1516 Is typically reimbursed on a "once per arch" per lifetime basis. If reimbursed, the procedure is typically considered preventive in nature and is usually reimbursed at 100% of the UCR allowance and not subject to the plan's deductible.

TIPS

A patient presents with bilateral missing primary molar teeth on the maxillary arch. After an oral evaluation, the doctor recommends placement of a fixed bilateral space maintainer on the maxillary arch. Upon completion of the procedure, D1516 should be reported.

NARRATIVES

The missing tooth number(s) in the upper arch should be identified, the date of their extraction as well as the period between the extractions and the expected eruption of the permanent teeth. Any supportive images should be included with the claim.

D1517 SPACE MAINTAINER - FIXED - BILATERAL, MANDIBULAR CDT 2025



WARNING

It is misleading to report a fixed pediatric cosmetic partial (with anterior teeth) as a mandibular space maintainer - fixed-bilateral (D1517) without a narrative disclosing the true nature of the cosmetic service. See D6985 for further details concerning a fixed pediatric partial placed for cosmetic purposes.

COMMENTS

1. A fixed bilateral mandibular space maintainer is considered a *passive* (not active) appliance. No teeth are moved or space regained with a space maintainer. Space is held, not gained by this type of "holding" fixed appliance.
2. Any stainless-steel crown or orthodontic band that is a part of a fixed space maintainer is generally included in the global space maintainer fee.
3. When a fixed bilateral mandibular space maintainer is re-cemented or re-bonded, see D1552. To report a fixed-*unilateral* space maintainer, see D1510.
4. Enter the tooth number or range of teeth the space maintainer is holding space for in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. A fixed mandibular space maintainer could be placed in an adult (to stop the shifting of teeth) but would generally not be reimbursed.
2. Passive space maintainers may have an age limitation up to 14-18 years.
3. Removal of the fixed - mandibular bilateral space maintainer (D1517) is not typically reimbursed for the doctor (or office) who initially placed the space maintainer. If the space maintainer is removed by a different office, the service may be payable. For removal of a fixed bilateral mandibular space maintainer, see D1558.
4. Repair or replacement of a fixed mandibular bilateral space maintainer (D1517) is not typically reimbursed.
5. D1517 is often referred to as a mandibular "lingual arch" fixed bilateral space maintainer. D1517 is generally not reimbursed to maintain space solely for missing primary centrals/laterals/canines. Reimbursement for space maintenance generally requires missing first or second primary molars (or permanent molars).

6. D1517 Is typically reimbursed on a "once per arch" per lifetime basis. If reimbursed, the procedure is typically considered preventive in nature and is usually reimbursed at 100% of the UCR allowance and not subject to the plan's deductible.

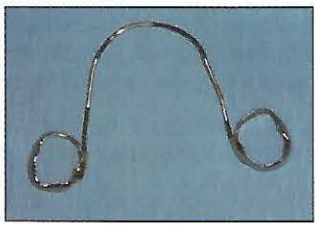
TIPS

A patient presents with badly decayed mandibular molar primary teeth. These bilateral primary molars are extracted. Because the permanent teeth are not expected to erupt for 2.5 years, the doctor recommends placement of a fixed space maintainer on the mandibular arch. Upon completion of the procedure, D1517 should be reported.

NARRATIVES

The missing tooth number(s) in the lower arch should be identified, the date of their extraction as well as the period between the extractions and the expected eruption of the permanent teeth. Any supportive images should be included with the claim.

PHOTO



1. This is a fixed bilateral space maintainer.
2. This fixed type of space maintainer is commonly referred to as a mandibular "lingual arch."

Courtesy Dr. Jill Spurlin

D1520 SPACE MAINTAINER - REMOVABLE, UNILATERAL - PER QUADRANT CDT 2025

COMMENTS

1. A removal of a unilateral space maintainer is considered a *passive* (not active) appliance. No teeth are moved or space regained with a space maintainer. Space is held, not gained by this type of passive appliance.
2. Space maintainers can be metal, resin, clear plastic, acrylic, or any combination of materials, as long as their primary purpose is to maintain space. This purpose should be documented in the clinical record.
3. Enter the quadrant in Box 25 and the tooth number or range of teeth of the space maintainer is holding space for in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. A removable unilateral space maintainer could be placed in an adult (to stop the shifting of teeth) but would generally not be reimbursed.
2. Passive space maintainers often have an age limitation from 14-18 years. To be reimbursed, either the primary first or second primary molar, or permanent first molar must generally be missing. A missing primary central, lateral incisor or cuspid will often not be reimbursed per plan limitations.
3. Space maintainers are typically a one-time only benefit. The space maintainer - removable - unilateral - per quadrant (D1520) is typically reimbursed on a "once per quadrant" per lifetime basis. *Repair or replacement* of a removable unilateral space maintainer (D1520) is not typically reimbursed.
4. If reimbursed, the removable space maintainer service is typically considered preventive in nature and is reimbursed at 100% of the payor's allowance and not subject to the plans deductible.

NARRATIVES

The missing tooth number(s) in the quadrant should be identified, the date of their extraction as well as the period between the extractions and the expected eruption of the permanent teeth. Any supportive images should be included with the claim.

D1525 PREVIOUSLY DELETED CODE SPACE MAINTAINER - REMOVABLE - BILATERAL

This is a previously deleted code. See D1526 and D1527 for further details.

D1526 SPACE MAINTAINER - REMOVABLE - BILATERAL, MAXILLARY CDT 2025

WARNING

A space maintainer is a passive appliance. There is no active tooth movement with a space maintainer.

COMMENTS

1. A space maintainer is considered a *passive* (not active) appliance. No teeth are moved or space regained with a space maintainer. Space is held, not gained by this type of passive appliance.
2. Space maintainers can be metal, resin, clear plastic, acrylic, or any combination of materials, as long as their primary purpose is to maintain space. This purpose should be documented in the clinical record.
3. Enter the tooth number or range of teeth the space maintainer is holding space for in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. A removable space maintainer could be placed in an adult (to stop the shifting of teeth) but would generally not be reimbursed.
2. Passive space maintainers often have an age limitation up to 14-18 years. To be reimbursed, either the primary first or second molar, or permanent first molar must generally be missing. A missing *primary* central, lateral incisor or cuspid will not generally be reimbursed per plan limitations.
3. Space maintainers are typically a one-time only benefit. The space maintainer - removable - bilateral, maxillary (D1526) is typically reimbursed on a "once per arch" per lifetime basis. *Repair or replacement* of a maxillary removable bilateral space maintainer (D1526) is not typically reimbursed.
4. If reimbursed, the removable space maintainer service is typically considered preventive in nature and is usually reimbursed at 100% of the payor's allowance and is not subject to the plan's deductible.

TIPS

1. D1526, space maintainer- removable- bilateral, maxillary describes a scenario where a patient presents with bilateral missing primary molar teeth on the maxillary arch. Following an oral evaluation, the doctor recommends placement of a removable space maintainer on the maxillary arch. Upon completion of the procedure, D1526 should be reported.
2. See interim partial dentures (D5810/D5811) where a removable space maintainer could apply.

NARRATIVES

The missing tooth number(s) in the upper arch should be identified, the date of their extraction as well as the period between the extractions and the expected eruption of the permanent teeth. Any supportive images should be included with the claim.

D1527 SPACE MAINTAINER - REMOVABLE - BILATERAL, MANDIBULAR CDT 2025

WARNING

A space maintainer is a passive appliance. There is no active tooth movement with a space maintainer.

COMMENTS

1. A space maintainer is considered a *passive* (not active) appliance. No teeth are moved or space regained with a space maintainer. Space is held, not gained by this type of passive appliance.
2. Space maintainers can be metal, resin, clear plastic, acrylic, or any combination of materials, as long as their primary purpose is to maintain space. This purpose should be documented in the clinical record.
3. Enter the tooth number or range of teeth the space maintainer is holding space for in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. A removable space maintainer could be placed in an adult (to stop the shifting of teeth) but would generally not be reimbursed.
2. Passive space maintainers often have an age limitation up to 14-18 years. To be reimbursed, either the primary first or second molar, or permanent first molar must generally be missing. A missing *primary* central, lateral incisor or cuspid will not generally be reimbursed per plan limitations.
3. Space maintainers are typically a one-time only benefit. The space maintainer - removable - bilateral, mandibular (D1527) is typically reimbursed on a "once per arch" per lifetime basis. *Repair or replacement* of a mandibular removable bilateral space maintainer (D1527) is not typically reimbursed.
4. If reimbursed, the removable space maintainer service is typically considered preventive in nature and is usually reimbursed at 100% of the payor's allowance and is not subject to the plan's deductible.

TIPS

1. D1527, space maintainer- removable- bilateral, mandibular describes a scenario where a patient presents with primary bilateral missing molar teeth on the mandibular arch. Following an oral evaluation, the doctor recommends placement of a removable space maintainer on the mandibular arch. Upon completion of the procedure, D1527 should be reported.
2. See interim partial dentures (D5810/D5811) where a removable space maintainer could apply.

NARRATIVES

The missing tooth number(s) in the lower arch should be identified, the date of their extraction as well as the period between the extractions and the expected eruption of the permanent teeth. Any supportive images should be included with the claim.

D1550 PREVIOUSLY DELETED CODE RE-CEMENT OR RE-BOND SPACE MAINTAINER

This is a previously deleted code. See D1551, D1552 and D1553 for further details.

D1551 RE-CEMENT OR RE-BOND BILATERAL SPACE MAINTAINER - MAXILLARY CDT 2025



MATCH

Re-cement or re-bond space maintainer (D1551) describes the re-cementation or re-bonding of a fixed bilateral maxillary space maintainer (D1516).

COMMENTS

Enter the tooth number or range of teeth in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Reimbursement for D1551, re-cementation or re-bonding of a fixed bilateral space maintainer may be limited to a period of more than six months after the original placement date. Reimbursement for the re-cement or re-bond of a maxillary fixed bilateral space maintainer (D1551) may be made to the same doctor or office who originally placed the space maintainer if the appliance is re-cemented or re-bonded at some interval six months after the original placement date.
2. If a different office re-cements or re-bonds a fixed space maintainer, the exclusion period from the original placement date may be waived.

NARRATIVES

1. The narrative should include the initial placement date, who originally placed the space maintainer and the reason for the re-cement or re-bond.
2. Re-cement or re-bond of a maxillary fixed bilateral space maintainer (D1551) is typically reimbursed if performed by a different doctor (in a different office) by some payors. The narrative should state that the office who re-cemented or re-bonded the space maintainer is a different office than the one who originally provided the space maintainer.

D1552 RE-CEMENT OR RE-BOND BILATERAL SPACE MAINTAINER - MANDIBULAR CDT 2025

MATCH

Re-cement or re-bond space maintainer (D1552) describes the re-cementation or re-bonding of a fixed bilateral mandibular space maintainer (D1517).

COMMENTS

Enter the tooth number or range of teeth in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Reimbursement for D1552, re-cementation or re-bonding of a fixed bilateral space maintainer may be limited to a period of more than six months after the original placement date. Reimbursement for the re-cement or re-bond of a mandibular fixed bilateral space maintainer (D1552) may be made to the same doctor or office who originally placed the space maintainer if the appliance is re-cemented or re-bonded at some interval six months after the original placement date.
2. If a different office re-cements or re-bonds a fixed space maintainer, the exclusion period from the original placement date may be waived.

NARRATIVES

1. The narrative should include the initial placement date, who originally placed the space maintainer and the reason for the re-cement or re-bond.
2. Re-cement or re-bond of a mandibular fixed bilateral space maintainer (D1552) is typically reimbursed if performed by a different doctor (in a different office) by some payors. The narrative should state that the office who re-cemented or re-bonded the space maintainer is a different office than the one who originally provided the space maintainer.

D1553 RE-CEMENT OR RE-BOND UNILATERAL SPACE MAINTAINER - PER QUADRANT CDT 2025

MATCH

Re-cement or re-bond unilateral space maintainer (D1553) describes the re-cementation or re-bonding of a fixed unilateral space maintainer (D1510) - per quadrant.

COMMENTS

The claim form should indicate the quadrant using the appropriate two-digit code in Box 25 of the 2024 ADA Dental Claim Form (e.g., 30 to indicate the lower left quadrant).

LIMITATIONS

1. Reimbursement for D1553, re-cementation or re-bonding of a fixed unilateral space maintainer may be limited to a period of more than six months after the original placement date. Reimbursement for the re-cement or re-bond of a fixed unilateral space maintainer (D1553) may be made to the same doctor or office who originally placed the space maintainer if the appliance is re-cemented or re-bonded at some interval six months after the original placement date.
2. If a different office re-cements or re-bonds a fixed space maintainer, the exclusion period from the original placement date may be waived.
3. Enter the quadrant in Box 25 and the tooth number or range of teeth in Box 27 of the 2024 ADA Dental Claim Form.

NARRATIVES

1. The narrative should include the initial placement date, quadrant, who originally placed the space maintainer and the reason for the re-cement or re-bond.
2. Re-cement or re-bond of a fixed unilateral space maintainer (D1553) is typically reimbursed if performed by a different doctor (in a different office), by some payors. The narrative should state that the office who re-cemented or re-bonded the space maintainer is a different office than the one who originally provided the space maintainer.
3. The narrative should indicate the tooth number(s) replaced and date of extraction.

D1555 PREVIOUSLY DELETED CODE REMOVAL OF FIXED SPACE MAINTAINER

This is a previously deleted code. See D1556, D1557, and D1558 for further details.

D1556 REMOVAL OF FIXED UNILATERAL SPACE MAINTAINER - PER QUADRANT CDT 2025

WATCH

1. Removal of fixed unilateral space maintainer (D1556) may be reimbursed if removed by a practice other than the practice who originally placed the space maintainer.
2. Removal of fixed unilateral space maintainer (D1556) reports the removal of: a fixed unilateral space maintainer (D1510).

COMMENTS

1. D1556 describes the removal of a bonded or cemented, fixed unilateral space maintainer (D1510).
2. Enter the quadrant in Box 25 and the tooth number or range of teeth in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Removal of a fixed unilateral space maintainer (D1556) may not be reimbursed if the space maintainer is removed by the same dentist or practice who originally delivered and cemented the appliance. Only a different dentist (not in the same office or practice) should report this procedure.
2. Removal of fixed unilateral space maintainer (D1556) is considered as part of the global fee for the space maintainer if removed by the dentist/practice who originally placed the space maintainer.

NARRATIVES

The narrative should include the initial placement date, quadrant, who placed the unilateral space maintainer, and the reason for the removal.

D1557 REMOVAL OF FIXED BILATERAL SPACE MAINTAINER - MAXILLARY CDT 2025

COMMENTS

1. D1557 describes the removal of a bonded or cemented, fixed - bilateral space maintainer, maxillary (D1516).
2. Enter the tooth number or range of teeth in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

Removal of a fixed - bilateral space maintainer, maxillary (D1557) may be considered a part of the global fee for the space maintainer if removed by the dentist/practice who originally placed the space maintainer by some payors.

NARRATIVES

The narrative should include the initial placement date, who placed the space maintainer, and the reason for the removal.

D1558 REMOVAL OF FIXED BILATERAL SPACE MAINTAINER - MANDIBULAR CDT 2025

COMMENTS

1. D1558 describes the removal of a bonded or cemented, fixed - bilateral space maintainer, mandibular (D1517).
2. Enter the tooth number or range of teeth in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

Removal of a fixed - bilateral space maintainer, mandibular (D1558) may be considered a part of the global fee for the space maintainer if removed by the dentist/practice who originally placed the space maintainer by some payors.

NARRATIVES

The narrative should include the initial placement date, who placed the space maintainer, and the reason for the removal.

D1575 DISTAL SHOE SPACE MAINTAINER - FIXED, UNILATERAL - PER QUADRANT CDT 2025

Fabrication and delivery of fixed appliance extending subgingivally and distally to guide the eruption of the first permanent molar. Does not include ongoing follow-up or adjustments, or replacement appliances, once the tooth has erupted.

WATCH

D1510 space maintainer - fixed - unilateral - per quadrant does not describe the distal shoe space maintainer that extends subgingivally and distally to guide the eruption of the first permanent molar. A distal shoe fixed unilateral appliance should be reported as D1575.

MATCH

D1575 describes the fabrication and delivery of a fixed unilateral space maintainer (typically with a portion of wire bent into a shape that looks like a shoe) that extends distally and below the gum line. The shape of the fixed unilateral appliance helps to guide the eruption of the first permanent molar.

COMMENTS

Enter the quadrant in Box 25 and the tooth number or range of teeth in Box 27 of the 2024 ADA Dental Claim Form.

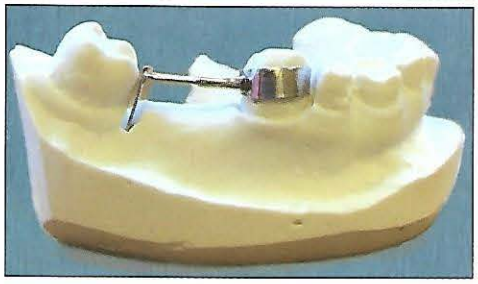
LIMITATIONS

Reimbursement for D1575, if available, is generally limited to once "per quadrant" per lifetime, as are most space maintainers.

NARRATIVES

1. Establish the medical/dental necessity for the appliance by describing why the proper eruption of the permanent first molar is in jeopardy. Send a radiographic image supporting the need for D1575.
2. Note the missing second primary molar on the claim form. If D1575 is not reimbursable, ask for the alternate benefit of D1510.

PHOTO



This is an example of a distal shoe space maintainer.

Courtesy Drake Dental Lab

D1701 PFIZER-BIONTECH COVID-19 VACCINE ADMINISTRATION - FIRST DOSE CDT 2025

SARSCOV2 COVID-19 VAC mRNA 30mcg/0.3mL IM DOSE 1

D1702 PFIZER-BIONTECH COVID-19 VACCINE ADMINISTRATION - SECOND DOSE CDT 2025

SARSCOV2 COVID-19 VAC mRNA 30mcg/0.3mL IM DOSE 2

D1703	MODERNA COVID-19 VACCINE ADMINISTRATION - FIRST DOSE	CDT 2025

SARSCOV2 COVID-19 VAC mRNA 100mcg/0.5mL IM DOSE 1

D1704	MODERNA COVID-19 VACCINE ADMINISTRATION - SECOND DOSE	CDT 2025

SARSCOV2 COVID-19 VAC mRNA 100mcg/0.5mL IM DOSE 2

D1705	ASTRAZENECA COVID-19 VACCINE ADMINISTRATION - FIRST DOSE	CDT 2025

SARSCOV2 COVID-19 VAC rS-ChAdOx1 5x1010 VP/.5mL IM DOSE 1

D1706	ASTRAZENECA COVID-19 VACCINE ADMINISTRATION - SECOND DOSE	CDT 2025

SARSCOV2 COVID-19 VAC rS-ChAdOx1 5x1010 VP/.5mL IM DOSE 2

D1707	JANSSEN COVID-19 VACCINE ADMINISTRATION	CDT 2025

SARSCOV2 COVID-19 VAC Ad26 5x1010 VP/.5mL IM SINGLE DOSE

D1708	PFIZER-BIONTECH COVID-19 VACCINE ADMINISTRATION - THIRD DOSE	CDT 2025

SARSCOV2 COVID-19 VAC mRNA 30mcg/0.3mL IM DOSE 3

D1709	PFIZER-BIONTECH COVID-19 VACCINE ADMINISTRATION - BOOSTER DOSE	CDT 2025

SARSCOV2 COVID-19 VAC mRNA 30mcg/0.3mL IM DOSE BOOSTER

D1710	MODERNA COVID-19 VACCINE ADMINISTRATION - THIRD DOSE	CDT 2025

SARSCOV2 COVID-19 VAC mRNA 100mcg/0.5mL IM DOSE 3

D1711	MODERNA COVID-19 VACCINE ADMINISTRATION - BOOSTER DOSE	CDT 2025

SARSCOV2 COVID-19 VAC mRNA 50mcg/0.25mL IM DOSE BOOSTER

D1712	JANSSEN (JOHNSON & JOHNSON) COVID-19 VACCINE ADMINISTRATION - BOOSTER DOSE	CDT 2025

SARSCOV2 COVID-19 VAC Ad26 5x1010 VP/.5mL IM DOSE BOOSTER

D1713 PFIZER-BIONTECH COVID-19 VACCINE ADMINISTRATION TRIS-SUCROSE PEDIATRIC - FIRST DOSE

CDT 2025

SARSCOV2 COVID-19 VAC mRNA 10mcg/0.2mL tris-sucrose IM DOSE 1

D1714 PFIZER-BIONTECH COVID-19 VACCINE ADMINISTRATION TRIS-SUCROSE PEDIATRIC - SECOND DOSE

CDT 2025

SARSCOV2 COVID-19 VAC mRNA 10mcg/0.2mL tris-sucrose IM DOSE 2

D1781 VACCINE ADMINISTRATION - HUMAN PAPILLOMAVIRUS - DOSE 1

CDT 2025

Gardasil 9 0.5mL intramuscular vaccine injection.

D1782 VACCINE ADMINISTRATION - HUMAN PAPILLOMAVIRUS - DOSE 2

CDT 2025

Gardasil 9 0.5mL intramuscular vaccine injection.

D1783 VACCINE ADMINISTRATION - HUMAN PAPILLOMAVIRUS - DOSE 3

CDT 2025

Gardasil 9 0.5mL intramuscular vaccine injection.

D1999 UNSPECIFIED PREVENTIVE PROCEDURE, BY REPORT

CDT 2025

Used for procedure that is not adequately described by another CDT Code. Describe procedure.

COMMENTS

1. D1999 is an unspecified code used to describe any preventive procedure that is not described by an existing preventive code.
2. The following is a list of unspecified preventive procedures that do not have an existing code to describe them. Report D1999, by report. Some examples include: distribution of non-prescription toothpaste; distribution of xylitol products and floss; and distribution of cleaning devices such as tooth brushes, inter-dental cleaners, and floss threaders.
3. For oral antibiotics, oral analgesics, and prescription-strength topical fluoride rinse or toothpaste dispensed in the office for home use, report D9630. Since D9630 is for other drugs and/or medicaments, by report, then D9630 can also be used to report take home chlorhexidine and Peridex®.
4. D1999 may be used to report the application of Cervitec® Gel, when applied as a preventive measure for a patient with documented high caries risk. Attach a narrative and/or the caries risk assessment document. For caries risk assessment, see D0601, D0602, and D0603.

LIMITATIONS

D1999, Unspecified preventive procedure, by report will not generally be reimbursed. Most states require a sales tax on products sold separately from dental services. See Sales Tax (D9985) and consult with your tax professional.

RESTORATIVE — CDT 2025

Local anesthesia is usually considered to be part of Restorative procedures.

EXPLANATION OF RESTORATIONS — CDT 2025

Anterior 1-Surface - Placed on one of the following five surface classifications - Mesial, Distal, Incisal, Lingual, or Facial (or Labial).

Anterior 2-Surface - Placed, without interruption, on two of the five surface classifications - e.g., Mesial-Lingual.

Anterior 3-Surface - Placed, without interruption, on three of the five surface classifications - e.g., Lingual-Mesial-Facial (or Labial).

Anterior 4 or more-Surface - Placed, without interruption, on four or more of the five surface classifications - e.g., Mesial-Incisal-Lingual-Facial (or Labial).

Posterior 1-Surface - Placed on one of the following five surface classifications - Mesial, Distal, Occlusal, Lingual, or Buccal.

Posterior 2-Surface - Placed, without interruption, on two of the five surface classifications - e.g., Mesial-Occlusal.

Posterior 3-Surface - Placed, without interruption, on three of the five surface classifications - e.g., Lingual-Occlusal-Distal.

Posterior 4 or more-Surface - Placed, without interruption, on four or more of the five surface classifications - e.g., Mesial-Occlusal-Lingual-Distal.

AMALGAM RESTORATIONS (INCLUDING POLISHING) — CDT 2025

Tooth preparation, all adhesives (including amalgam bonding agents), liners and bases are included as part of the restoration. If pins are used, they should be reported separately (see D2951).

D2140 AMALGAM - ONE SURFACE, PRIMARY OR PERMANENT — CDT 2025



WARNING

1. It is misleading to report an amalgam restoration as a filling if the *caries* and *preparation do not* extend into the *dentin* and/or fracture is not involved. Restoration of an active cavitated lesion where the filling material is placed in *enamel* only (not extending into the dentin) is considered a preventive resin restoration (D1352), which would require a resin material.
2. All bases, liners, adhesives, etching, polishing, contact and occlusal adjustments, and the use of caries detection agents are included in the overall amalgam restoration fee. If a pulp cap (D3110/D3120) is reported with an amalgam restoration placed on the same date of service, payors consider the pulp cap (as a base or liner) part of the restoration procedure. A pulp cap's purpose (promotion of *healing* and *repair*) is to assist in the formation of secondary dentin. A routine base or liner decreases sensitivity and protects the pulp. Pulp caps promote healing (secondary dentin) and repair. (See D3110/D3120 for further details.) Most PPOs disallow pulp caps (the patient may not be charged).
3. It is necessary to disclose the reason for a restoration if its purpose is to treat abfraction, erosion, wear, abrasion, attrition, or to improve esthetics/cosmetics. These situations are addressed in, and limited by, most third-party contracts. Most payors require that *decay* and/or *fracture* be present to justify reimbursement for a restoration.
4. It is misleading to report amalgam restorations built to full contour as core buildups (D2950). Core buildups (after the tooth is fully prepared) are justified when they are necessary for the *retention* of the crown. A core buildup is followed by a temporary crown placement or final restoration.
5. When two or more separate restorations are performed on the same tooth on the same date of service, report each restoration *separately*. Reporting separate restorations on the same tooth is *not* considered unbundling. Always "report what you do." Note that many payors will limit reimbursement for restorations placed on the same tooth surface on the same service date.
6. Do not report D2140 for implant access hole closure. See D6197.

COMMENTS

1. Cervical restorations that extend into the dentin are typically considered a one surface restoration.
2. Report pins separately. See D2951.
3. D2140 may be used to report closing endodontic access through a crown when amalgam is used. See TIPS below for more details.
4. Enter the tooth number and surface being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. The exclusion period for replacement of amalgam restorations is typically 24 to 36 months, depending on the contract. In some circumstances involving accidents, new caries, or radiation therapy the typical limitations may not apply. Should one of these situations exist and the reimbursement for the replaced restoration denied, or disallowed, appeal with a written narrative explaining the dental necessity. If a restoration is replaced within the limitation period by a different provider, the new provider may be reimbursed. This, however, is dependent upon contract language.
2. Reimbursement for removing and replacing defective restorations may require that the treated tooth have decay, open margins, and/or fracture.

TIPS

Report D2140 when restoring an endodontic access opening of a natural tooth, crown, or the access opening for the internal bleaching (D9974) of a natural tooth with amalgam. If performed for endodontic access closure of a crown, state, "An occlusal amalgam was placed for endodontic access closure." Do not report core buildup (D2950) or prefabricated post and core when restoring and closing an endodontic access opening where the crown remains intact and in place. Core buildups and prefabricated post and core are reimbursable when they are necessary for the *retention* of the crown, not for closure of an endodontic access opening where the crown remains intact. Do not report crown repair necessitated by material failure either. If the crown is *removed* first or comes off, then core buildup/prefabricated post and core can be reported.

NARRATIVES

A crown placed after an amalgam restoration may be fully reimbursed (without the payor deducting the restoration fee from the crown fee) if an unexpected fracture of that tooth or failure of the restoration placed on that tooth is involved. Should this be the case, a narrative and/or appeal may be necessary to prevent the restoration fee from being deducted from the subsequent crown fee. Some payors deduct the fee for the restoration (in addition to patient co-pay) from the subsequent crown procedure if the restoration was placed within 12 to 24 months prior to the crown being seated.

D2150 AMALGAM - TWO SURFACES, PRIMARY OR PERMANENT CDT 2025



WARNING

1. It is misleading to report an amalgam restoration as a filling if the *caries* and *preparation do not* extend into the *dentin* and/or fracture is not involved. Restoration of an active cavitated lesion where the filling material is placed in *enamel* only (not extending into the dentin) is considered a preventive resin restoration (D1352), which would require a resin material.
2. All bases, liners, adhesives, etching, polishing, contact and occlusal adjustments, and the use of caries detection agents are included in the overall amalgam restoration fee. If a pulp cap (D3110/D3120) is reported with an amalgam restoration placed on the same date of service, payors consider the pulp cap (as a base or liner) part of the restoration procedure. A pulp cap's purpose (promotion of *healing* and *repair*) is to assist in the formation of secondary dentin. A routine base or liner decreases sensitivity and protects the pulp. Pulp caps promote healing (secondary dentin) and repair. (See D3110/D3120 for further details.) Most PPOs disallow pulp caps (the patient may not be charged).
3. It is necessary to disclose the reason for a restoration if its purpose is to treat abfraction, erosion, wear, abrasion, attrition, or to improve esthetics/cosmetics. These situations are addressed in, and limited by most third party contracts. Most payors require that *decay* and/or *fracture* be present to justify reimbursement for a restoration.
4. It is misleading to report amalgam restorations built to full contour as core buildups (D2950). Core buildups (after the tooth is fully prepared) are justified when they are necessary for the *retention* of the crown. A core buildup is followed by a temporary crown placement or final restoration placement.
5. When two or more separate restorations are performed on the same tooth on the same date of service, report each restoration *separately*. Reporting separate restorations on the same tooth is *not* considered unbundling. Always "report what you do." Note that many payors will limit reimbursement for restorations placed on the same tooth surface on the same service date.

COMMENTS

1. Report pins separately. See D2951.
2. Enter the tooth number and surfaces being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. The exclusion period for replacement of amalgam restorations is typically 24 to 36 months, depending on the contract. In some circumstances involving accidents, new caries, or radiation therapy the typical limitations may not apply. Should one of these situations exist and the reimbursement for the replaced restoration denied, or disallowed, appeal with a written narrative explaining the dental necessity. If a restoration is replaced within the limitation period by a different provider, the new provider may be reimbursed. This is, however, dependent on contract language.

2. Reimbursement for removing and replacing defective restorations may require that the treated tooth have decay, open margins, and/or fracture.

NARRATIVES

A crown placed after an amalgam restoration may be fully reimbursed (without the payor deducting the restoration fee from the crown fee) if an unexpected fracture of that tooth or failure of the restoration placed on that tooth is involved. Should this be the case, a narrative and/or appeal may be necessary to prevent the restoration fee from being deducted from the crown fee. Some payors deduct the fee for the restoration (in addition to patient co-pay) from the subsequent crown procedure if the restoration was placed within 12 to 24 months prior to the crown being seated.

D2160 AMALGAM - THREE SURFACES, PRIMARY OR PERMANENT CDT 2025



WARNING

1. It is misleading to report an amalgam restoration as a filling if the *caries* and *preparation do not* extend into the *dentin* and/or fracture is not involved. Restoration of an active cavitated lesion where the filling material is placed in *enamel* only (not extending into the dentin) is considered a preventive resin restoration (D1352), which would require a resin material.
2. All bases, liners, adhesives, etching, polishing, contact and occlusal adjustments, and the use of caries detection agents are included in the overall amalgam restoration fee. If a pulp cap (D3110/D3120) is reported with an amalgam restoration placed on the same date of service, payors consider the pulp cap (as a base or liner) part of the restoration procedure. A pulp cap's purpose (promotion of *healing* and *repair*) is to assist in the formation of secondary dentin. A routine base or liner decreases sensitivity and protects the pulp. Pulp caps promote healing (secondary dentin) and repair. (See D3110/D3120 for further details.) Most PPOs disallow pulp caps (the patient may not be charged).
3. It is necessary to disclose the reason for a restoration if its purpose is to treat abfraction, erosion, wear, abrasion, attrition, or to improve esthetics/cosmetics. These situations are addressed in, and limited by most third party contract(s). Most payors require that *decay* and/or *fracture* be present to justify reimbursement for a restoration.
4. It is misleading to report amalgam restorations built to full contour as core buildups (D2950). Core buildups (after the tooth is fully prepared) are justified when they are necessary for the *retention* of the crown. A core buildup is followed by a temporary crown placement or final restoration placement.
5. When two or more separate restorations are performed on the same tooth on the same date of service, report each restoration *separately*. Reporting separate restorations on the same tooth is *not* considered unbundling. Always "report what you do." Note that many payors will limit reimbursement for restorations placed on the same tooth surface on the same service date.

COMMENTS

1. Report pins separately. See D2951.
2. Enter the tooth number and surfaces being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. The exclusion period for replacement of amalgam restorations is typically 24 to 36 months, depending on the contract. In some circumstances involving accidents, new caries, or radiation therapy the typical limitations may not apply. Should one of these situations exist and the reimbursement for the replaced restoration denied, or disallowed, appeal with a written narrative explaining the dental necessity. If a restoration is replaced within the limitation period by a different provider, the new provider may be reimbursed. This is, however, dependent on contract language.
2. Reimbursement for removing and replacing defective restorations may require that the treated tooth have decay, open margins, and/or fracture.

NARRATIVES

A crown placed after an amalgam restoration may be fully reimbursed (without the payor deducting the restoration fee from the crown fee) if an unexpected fracture of that tooth or failure of the restoration placed on that tooth is involved. Should this be the case, a narrative and/or appeal may be necessary to prevent the restoration fee from being deducted from the crown fee. Some payors deduct the fee for the restoration (in addition to patient co-pay) from the subsequent crown procedure if the restoration was placed within 12 to 24 months prior to the crown being seated.

D2161 AMALGAM - FOUR OR MORE SURFACES, PRIMARY OR PERMANENT — CDT 2025



WARNING

1. It is misleading to report an amalgam restoration as a filling if the *caries* and *preparation do not* extend into the *dentin* and/or fracture is not involved. Restoration of an active cavitated lesion where the filling material is placed in *enamel* only (not extending into the dentin) is considered a preventive resin restoration (D1352), which would require a resin material.
2. All bases, liners, adhesives, etching, polishing, contact and occlusal adjustments, and the use of caries detection agents are included in the overall amalgam restoration fee. If a pulp cap (D3110/D3120) is reported with an amalgam restoration placed on the same date of service, payors consider the pulp cap (as a base or liner) part of the restoration procedure. A pulp cap's purpose (promotion of *healing* and *repair*) is to assist in the formation of secondary dentin. A routine base or liner decreases sensitivity and protects the pulp. Pulp caps promote healing (secondary dentin) and repair. (See D3110/D3120 for further details.) Most PPOs disallow pulp caps (the patient may not be charged).
3. It is necessary to disclose the reason for a restoration if its purpose is to treat abfraction, erosion, wear, abrasion, attrition, or to improve esthetics/cosmetics. These situations are addressed in, and limited by most third party contracts. Most payors require that *decay* and/or *fracture* be present to justify reimbursement for a restoration.
4. It is misleading to report amalgam restorations built to full contour as core buildups (D2950). Core buildups (after the tooth is prepared) are justified when they are necessary for the *retention* of the crown. A core buildup is followed by a temporary crown placement or final restoration placement.
5. When two or more separate restorations are performed on the same tooth on the same date of service, report each restoration *separately*. Reporting separate restorations on the same tooth is *not* considered unbundling. Always "report what you do." Note that many payors will limit reimbursement for restorations placed on the same tooth surface on the same service date.

COMMENTS

1. Report pins separately. See D2951.
2. Enter the tooth number and surfaces being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. The exclusion period for replacement of amalgam restorations is typically 24 to 36 months, depending on the contract. In some circumstances involving accidents, new caries, or radiation therapy the typical limitations may not apply. Should one of these situations exist and the reimbursement for the replaced restoration denied, or disallowed, appeal with a written narrative explaining the dental necessity. If a restoration is replaced within the limitation period by a different provider, the new provider may be reimbursed. This is, however, dependent on contract language.
2. Reimbursement for removing and replacing defective restorations may require that the treated tooth have decay, open margins, and/or fracture.

NARRATIVES

A crown placed after an amalgam restoration may be fully reimbursed (without the payor deducting the restoration fee from the crown fee) if an unexpected fracture of that tooth or failure of the restoration placed on that tooth is involved. Should this be the case, a narrative and/or appeal may be necessary to prevent the restoration fee from being deducted from the crown fee. Some payors deduct the fee for the restoration (in addition to patient coinsurance) from the subsequent crown procedure if the restoration was placed within 12 to 24 months prior to the crown being seated.

RESIN-BASED COMPOSITE RESTORATIONS - DIRECT — CDT 2025

Resin-based composite refers to a broad category of materials including but not limited to composites. May include bonded composite, light-cured composite, etc. Tooth preparation, acid etching, adhesives (including resin bonding agents), liners and bases and curing are included as part of the restoration. Glass ionomers, when used as restorations, should be reported with these codes. If pins are used, they should be reported separately (see D2951).

D2330 RESIN-BASED COMPOSITE - ONE SURFACE, ANTERIOR — CDT 2025



WARNING

1. It is misleading to report *individual* composite restorations (D2330-D2335) for "splinting" of anterior teeth for periodontal reasons. D4322/D4323 are used to report splints for treatment of periodontally involved teeth. For splints associated with the stabilization of *traumatic* injury, see D7270.
2. Do not report D2330 for implant access hole closure. See D6197.

3. It is necessary to disclose the reason for a restoration if its purpose is to close a diastema or to improve esthetics/cosmetics where caries and/or fracture is *not* involved. These situations are addressed in, and limited by, third party contracts. Most payors require that *decay* and/or *fracture* be present to justify reimbursement. To provide a cosmetic service and report them as anterior composites restorations (D2330-D2335) to gain reimbursement could be considered fraud.
4. It is misleading to report composite restorations built to full contour as core buildups (D2950). Core buildups (after the tooth is prepared) are justified when they are necessary for the *retention* of the crown. A core buildup is followed by a temporary crown placement or final restoration placement.
5. When two or more separate restorations are performed on the same tooth on the same date of service, report the restorations *separately*. Reporting separate restorations on the same tooth is *not* considered unbundling. Always "report what you do." Note that many payors will limit reimbursement for restorations placed on the same tooth surface on the same service date. For instance, an MO and separate DO is converted to an MOD for payment.

WATCH

D2330 reports the one surface restored incisal "edge," not the multi-surface incisal "angle." For incisal "angle" (the corner of an anterior tooth), report D2331-D2335 as appropriate based on the number of surfaces involved.

COMMENTS

1. Pins, if placed in an anterior restoration, are billed separately. See D2951.
2. All resin composite codes include light curing, bonding, and any acid etching in the overall restoration fee. The composite restoration codes also include any bases, liners, polishing, and occlusal adjustment provided for the tooth being restored.
3. D2330 may be used to report closing endodontic access through an anterior crown when composite resin is used. See TIPS below for more details.
4. Enter the tooth number and surface being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Resin-based composite (D2330) for an anterior tooth is reimbursed when *decay* and/or *fracture* are present in one surface of an anterior tooth (primary or permanent).
2. Pulp caps (D3110/D3120), when provided, are typically considered a part of, and are included in, the composite restoration fee. Note: there is a difference between a base/liner (which decreases sensitivity and protects the pulp) and a pulp cap. A pulp cap may be used to promote *healing* and *repair of the pulpal tissue*, and may assist in the formation of secondary dentin. If the service provided is a base or liner as a part of an amalgam or composite, do not submit a pulp cap for reimbursement. See D3110/D3120 for further details. Most PPOs disallow pulp caps (the patient may not be charged).
3. Class V restorations are typically reimbursed as single surface facial or lingual restorations.
4. Glass ionomers, when used as restorations, are reported as resin-based composites.
5. Reimbursement for removing and replacing defective restorations may require that the treated tooth have decay, open margins, and/or fracture.

TIPS

Report D2330 when restoring an endodontic access opening of an anterior natural tooth, crown, or the access opening for the internal bleaching (D9974) of an anterior natural tooth with a resin restoration. If performed for endodontic access closure of a crown, state, "An occlusal composite resin was placed for endodontic access closure." Do not report core buildup (D2950) or prefabricated post and core when restoring and closing an endodontic access opening where the crown is intact and in place. Core buildups and prefabricated post and core are reimbursable when they are necessary for the *retention* of the crown, not for closure of an endodontic access opening where the crown remains intact. Do not report crown repair necessitated by material failure either. If the crown is *removed* first or comes off then core buildup/prefabricated post and core can be reported.

NARRATIVES

A crown placed after a composite restoration may be fully reimbursed (without the payor deducting the restoration fee from the crown fee) if an unexpected fracture of that tooth or failure of the restoration placed on that tooth is involved. Should this be the case, a narrative and/or appeal may be necessary to prevent the restoration fee from being deducted from the crown fee. Some payors deduct the fee for the restoration (in addition to patient co-pay) from the subsequent crown procedure if the restoration was placed within 12 to 24 months prior to the crown being seated.

D2331 RESIN-BASED COMPOSITE - TWO SURFACES, ANTERIOR CDT 2025



WARNING

1. It is misleading to report *individual* composite restorations (D2330-D2335) for "splinting" of anterior teeth for periodontal reasons. D4322/D4323 report splints for treatment of periodontally-involved teeth. For splints used in stabilization after *traumatic* injury, see D7270.
2. It is necessary to disclose the reason for a restoration if its purpose is to close a diastema or to improve esthetics/cosmetics where caries and/or fracture is *not* involved. These situations are addressed in, and limited by, third party contracts. Most payors require that *decay* and/or *fracture* be present to justify reimbursement. To provide a cosmetic service and report them as anterior composite restorations (D2330-D2335) to gain reimbursement may be considered fraud.
3. It is misleading to report composite restorations built to full contour as core buildups (D2950). Core buildups (after the tooth is prepared) are justified when they are necessary for the *retention* of the crown.
4. When two or more separate restorations are performed on the same tooth on the same date of service, report the restorations *separately*. Reporting separate restorations on the same tooth is *not* considered unbundling. Always "report what you do." Note that many payors will limit reimbursement for restorations placed on the same tooth surface on the same service date.



WATCH

1. Certain payors may not reimburse anterior multi-surface composite codes, but convert them to a one-surface composite (D2330) for reimbursement. Always report the correct multi-surface code and let the payor re-map for reimbursement purposes.
2. D2331 is used to report a two surface restoration. One of the surfaces may be the incisal "edge" such as FI. For incisal "angle" (the corner of an anterior tooth), report D2331-D2335 as appropriate based on the number of surfaces involved..

COMMENTS

1. Pins, if placed in an anterior restoration, are billed separately. See D2951.
2. All resin composite codes include light curing, bonding, and any acid etching in the overall restoration fee. The composite restoration codes also include any bases, liners, polishing, and occlusal adjustment provided for the tooth being restored.
3. Enter the tooth number and surfaces being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Resin-based composite (D2331) for an anterior tooth is reimbursed when *decay* and/or *fracture* are present in two surfaces of an anterior tooth (primary or permanent).
2. Pulp caps (D3110/D3120), when provided, are typically considered a part of, and are included in, the composite restoration fee. Note: there is a difference between a base/liner (which decreases sensitivity and protects the pulp) and a pulp cap. A pulp cap may be used to promote *healing* and *repair of the pulpal tissue*, and may assist in the formation of secondary dentin. If the service provided is a base or liner as a part of an amalgam or composite, do not submit a pulp cap for reimbursement. See D3110/D3120 for further details. Most PPOs disallow pulp caps (the patient may not be charged).
3. Glass ionomers, when used as restorations, are reported as resin-based composites.
4. Reimbursement for removing and replacing defective restorations may require that the treated tooth have decay, open margins, and/or fracture.

NARRATIVES

A crown placed after a composite restoration may be fully reimbursed (without the payor deducting the restoration fee from the crown fee) if an unexpected fracture of that tooth or failure of the restoration placed on that tooth is involved. Should this be the case, a narrative and/or appeal may be necessary to prevent the restoration fee from being deducted from the crown fee. Some payors deduct the fee for the restoration (in addition to patient co-pay) from the subsequent crown procedure if the restoration was placed within 12 to 24 months prior to the crown being seated.

D2332 RESIN-BASED COMPOSITE - THREE SURFACES, ANTERIOR CDT 2025



WARNING

1. It is misleading to report *individual* composite restorations (D2330-D2335) for "splinting" of anterior teeth for periodontal reasons. D4322/D4323 reports splints for treatment of periodontally involved teeth. For splints used in stabilization after *traumatic* injury, see D7270.

2. It is necessary to disclose the reason for a restoration if its purpose is to close a diastema or to improve esthetics/cosmetics where caries and/or fracture is *not* involved. These situations are addressed in, and limited by, third party contracts. Most payors require that *decay* and/or *fracture* be present to justify reimbursement. To provide a cosmetic service and report them as anterior composites restorations (D2330-D2335) to gain reimbursement may be considered fraud.
3. It is misleading to report composite restorations built to full contour as core buildups (D2950). Core buildups (after the tooth is prepared) are justified when they are necessary for the retention of the crown.
4. When two or more separate restorations are performed on the same tooth on the same date of service, report the restorations *separately*. Reporting separate restorations on the same tooth is *not* considered unbundling. Always "report what you do." Note that many payors will limit reimbursement for restorations placed on the same tooth surface on the same service date.

WATCH

1. Certain payors may not reimburse anterior multi-surface composite codes, but convert them to a one-surface composite (D2330) for reimbursement. Always report the correct multi-surface code and let the payor re-map for reimbursement purposes.
2. D2332 is used to report a three surface restoration. One of the surfaces may be the incisal "edge." For incisal "angle" (the corner of an anterior tooth), report D2331-D2335 as appropriate based on the number of surfaces involved.

COMMENTS

1. Pins, if placed in an anterior restoration, are billed separately. See D2951.
2. All composite codes include light curing, bonding, and any acid etching in the overall restoration fee. The composite restoration codes also include any bases, liners, polishing, and occlusal adjustment provided for the tooth being restored.
3. Enter the tooth number and surfaces being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Resin-based composite (D2332) for an anterior tooth is reimbursed when *decay* and/or *fracture* are present in three surfaces of an anterior tooth (primary or permanent).
2. Pulp caps (D3110/D3120), when provided, are typically considered a part of, and are included in, the composite restoration fee. Note: there is a difference between a base/liner (which decreases sensitivity and protects the pulp) and a pulp cap. A pulp cap may be used to promote *healing* and *repair of the pulpal tissue*, and may assist in the formation of secondary dentin. If the service provided is a base or liner as a part of an amalgam or composite, do not submit a pulp cap for reimbursement. See D3110/D3120 for further details. Most PPOs disallow pulp caps (the patient may not be charged).
3. Glass ionomers, when used as restorations, are reported as resin-based composites.
4. Reimbursement for removing and replacing defective restorations may require that the treated tooth have decay, open margins, and/or fracture.

NARRATIVES

A crown placed after a composite restoration may be fully reimbursed (without the payor deducting the restoration fee from the crown fee) if an unexpected fracture of that tooth or failure of the restoration placed on that tooth is involved. Should this be the case, a narrative and/or appeal may be necessary to prevent the restoration fee from being deducted from the crown fee. Some payors deduct the fee for the restoration (in addition to patient co-pay) from the subsequent crown procedure if the restoration was placed within 12 to 24 months prior to the crown being seated.

D2335 RESIN-BASED COMPOSITE - FOUR OR MORE SURFACES (ANTERIOR) CDT 2025



WARNING

1. It is misleading to report *individual* composite restorations (D2330-D2335) for "splinting" of anterior teeth for periodontal reasons. D4322/D4323 reports splints for treatment of periodontally-involved teeth. For splints used in stabilization after *traumatic* injury, see D7270.
2. It is necessary to disclose the reason for a restoration if its purpose is to close a diastema or to improve esthetics/cosmetics where caries and/or fracture is *not* involved. These situations are addressed in, and limited by, third party contracts. Most payors require that *decay* and/or *fracture* to be present to justify reimbursement. To provide a cosmetic service and report them as anterior composites restorations (D2330-D2335) to gain reimbursement may be considered fraud.
3. It is misleading to report composite restorations built to full contour as core buildups (D2950). Core buildups (after the tooth is prepared) are justified when they are necessary for the *retention* of the crown.

4. When two or more separate restorations are performed on the same tooth on the same date of service, report the restorations *separately*. Reporting separate restorations on the same tooth is *not* considered unbundling. Always "report what you do." Note that many payors will limit reimbursement for restorations placed on the same tooth surface on the same service date.

WATCH

1. Certain payors may not reimburse anterior multi-surface composite codes, but convert them to a one-surface composite (D2330) for reimbursement. Always report the correct multi-surface code and let the payor re-map for reimbursement purposes.
2. D2335 describes a composite restoration involving four or more surfaces of the anterior tooth , which may include the incisal angle.

COMMENTS

1. Pins, if placed in an anterior restoration, are billed separately. See D2951.
2. All composite codes include light curing, bonding, and any acid etching in the overall restoration fee. The composite restoration codes also include any bases, liners, polishing, and occlusal adjustment provided for the tooth being restored.
3. Enter the tooth number and surfaces being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Resin-based composite (D2335) is reimbursed when *decay* and/or *fracture* are present in four or more surfaces of an anterior tooth (primary or permanent).
2. Pulp caps (D3110/D3120), when provided, are typically considered a part of, and are included in, the composite restoration fee. Note: there is a difference between a base/liner (which decreases sensitivity and protects the pulp) and a pulp cap. A pulp cap may be used to promote *healing* and *repair of the pulpal tissue*, and may assist in the formation of secondary dentin. If the service provided is a base or liner as a part of an amalgam or composite, do not submit a pulp cap for reimbursement. See D3110/D3120 for further details. Most PPOs disallow pulp caps (the patient may not be charged).
3. Glass ionomers, when used as restorations, are reported as resin-based composites.
4. Reimbursement for removing and replacing defective restorations may require that the treated tooth have decay, open margins, and/or fracture.

NARRATIVES

1. Enclose a copy of a radiographic image which demonstrates and documents the incisal "angle" is missing (the incisal corner of the tooth). Also, a photograph of the broken incisal angle can verify that the "angle" is broken.
2. A crown placed after a composite restoration may be fully reimbursed (without the payor deducting the restoration fee from the crown fee) if an unexpected fracture of that tooth or failure of the restoration placed on that tooth is involved. Should this be the case, a narrative and/or appeal may be necessary to prevent the restoration fee from being deducted from the crown fee. Some payors deduct the fee for the restoration (in addition to patient co-pay) from the subsequent crown procedure if the restoration was placed within 12 to 24 months prior to the crown being seated.

D2390 RESIN-BASED COMPOSITE CROWN, ANTERIOR — CDT 2025

Full resin-based composite coverage of tooth.

COMMENTS

1. D2390 reports a direct composite anterior "crown" restoration that covers all five surfaces of an anterior tooth MIFLD. It is fabricated using composite resins or glass ionomers. This procedure is typically reimbursed.
2. All composite codes include light curing, adhesive, and any acid etching in the overall restoration fee. The composite restoration codes also include any bases, liners, polishing, and occlusal adjustment provided for the tooth being restored.
3. Pins, if placed in an anterior restoration, are billed separately. See D2951.
4. Enter the tooth number being treated in the appropriate box of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Pulp caps (D3110/D3120), when provided, are typically considered a part of, and are included in, the composite restoration fee. Note: there is a difference between a base/liner (which decreases sensitivity and protects the pulp) and a pulp cap. A pulp cap may be used to promote *healing* and *repair of the pulpal tissue,* and may assist in the formation of secondary dentin. If the service provided is a base or liner as a part of an amalgam or composite, do not submit a pulp cap for reimbursement. See D3110/D3120 for further details. Most PPOs disallow pulp caps (the patient may not be charged).
2. Some payors may classify a direct composite "crown" as a *major* procedure for reimbursement (50% of the payor's fee), rather than a *basic* restorative procedure (80% of the payor's fee) for reimbursement purposes.

NARRATIVES

1. If a (direct) composite crown has been performed on a tooth and the procedure reimbursed by the payor, a crown limitation period may apply. The previously reimbursed composite crown fee may be subtracted from the subsequent crown reimbursement fee or the subsequent crown may be denied completely if the crown limitation period applies. If the direct composite crown fractures and/or recurrent caries is present, the limitation may not apply. Use a narrative when reporting a replacement crown and include a diagnostic radiographic image. A different provider may be fully reimbursed for a subsequent crown.
2. The exclusion period for composite restorations is typically 24 to 36 months; however, if the tooth fractures after the restoration is placed, or if new caries is present, the limitation may *not* apply. Use a narrative when reporting a replacement indirect crown and include a diagnostic image. A different provider may be fully reimbursed for a subsequent crown. If denied, appeal.

D2391 RESIN-BASED COMPOSITE - ONE SURFACE, POSTERIOR CDT 2025

Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure.



WARNING

1. It is misleading to report a resin-based composite restoration where air abrasion or fissurotomy is done without an active cavitated lesion present that extends into dentin. A diagnostic radiographic image or other documentation (photo/narrative) should be a part of the patient's record to support the presence of caries. It is misleading to report D2391 if occlusal caries and the preparation remain in the *enamel*. To report D2391, occlusal caries and *preparation* must extend *into* the *dentin* and/or a fracture *into* the *dentin* and is repaired by the restoration.
2. It is misleading to report composite restorations as core buildups (D2950). Composite restorations are built to full contour and have occlusion, anatomy and depending on the restoration often has proximal contacts. Core buildups on a fully prepared tooth are necessary if there is insufficient retention for a separate extracoronal restorative procedure, e.g., a crown.



WATCH

1. A "preventive" resin-based composite procedure can be erroneously reported as a resin-based composite. A posterior composite code is used to describe the restoration of a carious lesion that extends *into* the *dentin* and/or where fracture is involved. If the occlusal caries and *preparation* are limited to the cavitated pits and fissures of a permanent tooth, not extending to the dentin, the restoration is considered a preventative resin restoration (D1352). Pits and fissures adjacent to the PRR that are sealed are considered a part of the D1352 procedure. If the enamel *surface* is sealed with a resin, and there is no active cavitated lesion in the tooth, the resin is a sealant (D1351). See D1351 and D1352.
2. If two or more separate restorations are performed on the same tooth, on the same service date, report the restorations separately. Reporting separate restorations on the same tooth *is not* considered unbundling. Always "report what you do" but note that some payors may restrict coverage for more than one restoration on the same surface on the same service date.
3. D2391 may be used to report closure of an endodontic access hole through a posterior crown if composite resin is used. See Comment 4 below for more information.

COMMENTS

1. All composite codes include light curing, bonding, acid etching, bases, liners, polishing, and occlusal adjustment in the overall restoration fee.
2. Pulp caps (D3110/D3120), when provided, are typically considered a part of, and are included in, the composite restoration fee. Note: there is a difference between a base/liner (which decreases sensitivity and protects the pulp) and a pulp cap. A pulp cap may be used to promote *healing* and *repair of the pulpal tissue,* and may assist in the formation of secondary dentin. If the service provided is a base or liner as a part of an amalgam or composite, do not submit a pulp cap for reimbursement. See D3110/D3120 for further details. Most PPOs disallow pulp caps (the patient may not be charged).

3. Pins, if placed in a posterior composite restoration, are billed separately. See D2951.
4. Report D2391 when restoring an endodontic access opening of a posterior natural tooth, crown, or the access opening for the internal bleaching (D9974) of a posterior natural tooth with a resin restoration. If performed for endodontic access closure of a crown, state, "An occlusal composite was placed for endodontic access closure." Do not report core buildup (D2950) or prefabricated post and core when restoring and closing an endodontic access opening. Core buildups and prefabricated post and core are reimbursable when they are necessary for the *retention* of the crown, not for closure of an endodontic access opening. Do not report crown repair necessitated by material failure (D2980) either. If the crown is *removed* first then core buildup/prefabricated post and core can be reported if the procedure is performed. If a post is placed through an endodontic access opening, report D2999 unspecified restorative procedure.
5. Enter the tooth number and surface being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. The exclusion period for replacement of composite restorations is typically 12 to 36 months; but, if the tooth fractures after the restoration is placed, or if new caries is present, the limitation may *not* apply. If replacement is necessary, a narrative plus diagnostic image(s) should be submitted when reporting D2391 again for the same tooth. If denied, appeal. A different provider than the one who placed the original restoration may be reimbursed.
2. If a posterior composite restoration has been placed and reimbursed on a tooth that later requires a crown, a limitation may apply (if within a 24 to 36 month period). The previously reimbursed composite restoration fee may be subtracted from the subsequent crown reimbursement fee. If the posterior composite fractures and/or new caries is present, the limitation may not apply. Use a narrative when reporting the need for the crown and include a diagnostic image. A different provider may be fully reimbursed for a subsequent crown.

TIPS

Sealants (D1351), preventive resin restorations (D1352), and resin-based composite restorations (D2391) differ as follows:

1. Sealant (D1351): Mechanically and/or chemically prepared enamel surface sealed to prevent decay. The enamel surface is non-carious.
2. Preventive Resin Restoration (D1352): Conservative restoration of an active cavitated lesion in a pit or fissure of a permanent tooth which does not extend into the dentin. Also includes placing a sealant in any radiating noncarious pits or fissures. Patient must be moderate to high caries risk.
3. Resin-based composite - one surface, posterior (D2391): This is a posterior resin restoration where the caries and preparation extends into the dentin or a deeply eroded area into the dentin.
4. Report D2990 for resin infiltration of incipient smooth surface lesions (i.e., DMG Icon).
5. Report D2991 for application of hydroxyapatite regeneration medicament (I.e., Curodont Repair).

NARRATIVES

If decay is not clearly visible on the diagnostic image, clinical documentation supporting the need for treatment is strongly recommended in the event of third party review. The clinical record might note: "Caries not evident on diagnostic image; however, was "sticky" to the explorer. Caries and preparation extend into the dentin." Also include any Artificial Intelligence or non-ionizing caries detection results or photo(s) where applicable.

D2392 RESIN-BASED COMPOSITE - TWO SURFACES, POSTERIOR CDT 2025



WARNING

It is misleading to report composite restorations as core buildup (D2950). Composite restorations are built to full contour and have occlusion, anatomy and depending on the restoration, often has proximal contacts. Core buildups on a fully prepared tooth are necessary if there is insufficient retention for a separate extracoronal restorative procedure, e.g., a crown.

WATCH

1. A "preventive" resin-based composite procedure can be erroneously reported as a resin-based composite. A posterior composite code is used to describe the restoration of a carious lesion that extends *into* the *dentin* and/or where fracture is involved. If the caries and *preparation* are limited to the cavitated pits and fissures of a permanent tooth, not extending to the dentin, the restoration is considered a preventive resin restoration (D1352). Pits and fissures adjacent to the PRR that are sealed are considered a part of D1352. If the enamel *surface* is sealed with a resin, and there is no cavitated lesion in the tooth, the resin is a sealant (D1351). See D1351 and D1352.

2. If two or more separate restorations are performed on the same tooth, on the same service date, report the restorations separately. Reporting separate restorations on the same tooth *is not* considered unbundling. Always "report what you do" but note that some payors may restrict coverage for more than one restoration on the same surface on the same service date.

COMMENTS

1. All composite codes include light curing, bonding, acid etching, bases, liners, polishing, and occlusal adjustment in the overall restoration fee.
2. Pulp caps (D3110/D3120), when provided, are typically considered a part of, and are included in, the composite restoration fee. Note: there is a difference between a base/liner (which decreases sensitivity and protects the pulp) and a pulp cap. A pulp cap may be used to promote *healing* and *repair of the pulpal tissue,* and may assist in the formation of secondary dentin. If the service provided is a base or liner as a part of an amalgam or composite, do not submit a pulp cap for reimbursement. See D3110/D3120 for further details. Most PPOs disallow pulp caps (the patient may not be charged).
3. Pins, if placed in a posterior composite restoration, are billed separately. See D2951.
4. Enter the tooth number and surfaces being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. The exclusion period for replacement of composite restorations is typically 12 to 36 months; but, if the tooth fractures after the restoration is placed, or if new caries is present, the limitation may *not* apply. If replacement is necessary, a narrative plus diagnostic image(s) should be submitted when reporting D2392 again for the same tooth. If denied, appeal. A different provider than the one who placed the original restoration may be reimbursed.
2. If a posterior composite restoration has been placed and reimbursed on a tooth that later requires a crown, a limitation may apply (if within a 24 to 36 month period). The previously reimbursed composite restoration fee may be subtracted from the subsequent crown reimbursement fee. If the posterior composite fractures and/or recurrent caries is present, the limitation may not apply. Use a narrative when reporting the need for the crown and include a diagnostic image. A different provider may be fully reimbursed for a subsequent crown.

NARRATIVES

If decay is not clearly visible on the diagnostic image, clinical documentation supporting the need for treatment is strongly recommended in the event of third party review. The clinical record might note: "Caries not evident on diagnostic image; however, was "sticky" to the explorer. Caries and preparation extend into the dentin." Also include any Artificial Intelligence or non-ionizing caries detection results or photo(s) where applicable.

D2393 RESIN-BASED COMPOSITE - THREE SURFACES, POSTERIOR CDT 2025



WARNING

It is misleading to report composite restorations as core buildups (D2950). Composite restorations are built to full contour and have occlusion, anatomy and depending on the restoration often has proximal contacts. Core buildups on a fully prepared tooth are necessary if there is insufficient retention for a separate extracoronal restorative procedure, e.g., a crown.



WATCH

1. A "preventive" resin-based composite procedure can be erroneously reported as a resin-based composite. A posterior composite code is used to describe the restoration of a carious lesion that extends *into* the *dentin* and/or where fracture is involved. If the caries and *preparation* are limited to the cavitated pits and fissures of a permanent tooth, not extending to the dentin, the restoration is considered a preventive resin restoration (D1352). Pits and fissures adjacent to the PRR that are sealed are considered a part of D1352. If the enamel *surface* is sealed with a resin and there is no cavitated lesion in the tooth, the resin is a sealant (D1351). See D1351 and D1352.
2. If two or more separate restorations are performed on the same tooth, on the same service date, report the restorations separately. Reporting separate restorations on the same tooth *is not* considered unbundling. Always "report what you do" but note that some payors may restrict coverage for more than one restoration on the same surface on the same service date.
3. Some offices are not aware of the resin-based composite (D2394), which is available for reporting four or more surfaces on a posterior tooth. They think the maximum number of surfaces to report is limited to three surfaces. See D2394 to report four or more surfaces.

COMMENTS

1. All composite codes include light curing, bonding, acid etching, bases, liners, polishing, and occlusal adjustment in the overall restoration fee.

2. Pulp caps (D3110/D3120), when provided, are typically considered a part of, and are included in, the composite restoration fee. Note: there is a difference between a base/liner (which decreases sensitivity and protects the pulp) and a pulp cap. A pulp cap may be used to promote *healing* and *repair of the pulpal tissue,* and may assist in the formation of secondary dentin. If the service provided is a base or liner as a part of an amalgam or composite, do not submit a pulp cap for reimbursement. See D3110/D3120 for further details. Most PPOs disallow pulp caps (the patient may not be charged).
3. Pins, if placed in a posterior composite restoration, are billed separately. See D2951.
4. Enter the tooth number and surfaces being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. The exclusion period for replacement of composite restorations is typically 12 to 36 months; but, if the tooth fractures after the restoration is placed, or if new caries is present, the limitation may *not* apply. If replacement is necessary, a narrative plus diagnostic image(s) should be submitted when reporting D2393 again for the same tooth. If denied, appeal. A different provider than the one who placed the original restoration may be reimbursed.
2. If a posterior composite restoration has been placed and reimbursed on a tooth that later requires a crown, a limitation may apply (if within a 24 to 36 month period). The previously reimbursed composite restoration fee may be subtracted from the subsequent crown reimbursement fee. If the posterior composite fractures and/or new caries is present, the limitation may not apply. Use a narrative when reporting the need for the crown and include a diagnostic image. A different provider may be fully reimbursed for a subsequent crown.

NARRATIVES

If decay is not clearly visible on the diagnostic image, clinical documentation supporting the need for treatment is strongly recommended in the event of third party review. The clinical record might note: "Caries not evident on diagnostic image; however, was "sticky" to the explorer. Caries and preparation extend into the dentin." Also include any Artificial Intelligence or non-ionizing caries detection results or photo(s) where applicable.

D2394 RESIN-BASED COMPOSITE - FOUR OR MORE SURFACES, POSTERIOR CDT 2025



WARNING

It is misleading to report composite restorations as core buildups (D2950). Composite restorations are built to full contour and have occlusion, anatomy and depending on the restoration, often have proximal contacts. Core buildups on a fully prepared tooth are necessary if there is insufficient retention for a separate extracoronal restorative procedure, e.g., a crown.



WATCH

If two or more separate restorations are performed on the same tooth, on the same service date, report the restorations separately. Reporting separate restorations on the same tooth *is not* considered unbundling. Always "report what you do" but note that some payors may restrict coverage for more than one restoration on the same surface on the same service date.

COMMENTS

1. All composite codes include light curing, bonding, acid etching, bases, liners, polishing, and occlusal adjustment in the overall restoration fee.
2. Pulp caps (D3110/D3120), when provided, are typically considered a part of, and are included in, the composite restoration fee. Note: there is a difference between a base/liner (which decreases sensitivity and protects the pulp) and a pulp cap. A pulp cap may be used to promote *healing* and *repair of the pulpal tissue,* and may assist in the formation of secondary dentin. If the service provided is a base or liner as a part of an amalgam or composite, do not submit a pulp cap for reimbursement. See D3110/D3120 for further details. Most PPOs disallow pulp caps (the patient may not be charged).
3. Pins, if placed in a posterior composite restoration, are billed separately. See D2951.
4. D2394 reports *four or more* surfaces on a posterior tooth.
5. Enter the tooth number and surfaces being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. The exclusion period for replacement of composite restorations is typically 12 to 36 months; but, if the tooth fractures after the restoration is placed, or if new caries is present, the limitation may *not* apply. If replacement is necessary, a narrative plus diagnostic image(s) should be submitted when reporting D2394 again for the same tooth. If denied, appeal. A different provider than the one who placed the original restoration may be reimbursed.

2. If a posterior composite restoration has been placed and reimbursed on a tooth that later requires a crown, a limitation may apply (if within a 24 to 36 month period). The previously reimbursed composite restoration fee may be subtracted from the subsequent crown reimbursement fee. If the posterior composite fractures and/or new caries is present, the limitation may not apply. Use a narrative when reporting the need for the crown and include a diagnostic image. A different provider may be fully reimbursed for a subsequent crown.

NARRATIVES

If decay is not clearly visible on the diagnostic image, clinical documentation supporting the need for treatment is strongly recommended in the event of third party review. The clinical record might note: "Caries not evident on diagnostic image; however, was "sticky" to the explorer. Caries and preparation extend into the dentin." Also include any Artificial Intelligence or non-ionizing caries detection results readings or photos where applicable.

GOLD FOIL RESTORATIONS — CDT 2025

D2410 GOLD FOIL - ONE SURFACE — CDT 2025

COMMENTS

Enter the tooth number and surface being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Gold foil (D2410) is not typically reimbursed.
2. Some payors may provide an alternate benefit of an amalgam/composite restoration.

D2420 GOLD FOIL - TWO SURFACES — CDT 2025

COMMENTS

Enter the tooth number and surface being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Gold foil (D2420) is not typically reimbursed.
2. Some payors may provide an alternate benefit of an amalgam/composite restoration.

D2430 GOLD FOIL - THREE SURFACES — CDT 2025

COMMENTS

Enter the tooth number and surface being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Gold foil (D2430) is typically not reimbursed.
2. Some payors may provide an alternate benefit of an amalgam/composite restoration.

INLAY/ONLAY RESTORATIONS — CDT 2025

Inlay: An intra-coronal dental restoration, made outside the oral cavity to conform to the prepared cavity, which does not restore any cusp tips.

Onlay: A dental restoration made outside the oral cavity that covers one or more cusp tips and adjoining occlusal surfaces, but not the entire external surface.

D2510 INLAY - METALLIC - ONE SURFACE — CDT 2025

COMMENTS

Enter the tooth number and surface being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Inlay-metallic-one surface reports *any* type of cast metal.
2. Inlays are rarely reimbursed. However, an alternate benefit is often reimbursed (amalgam/composite restoration). Any additional fee up to the approved amount may be allowed to be passed to the patient.

3. If the practice participates in PPOs, reimbursement may be restricted to the fee schedule applicable to the inlay by the PPO (third-party) although the PPO reimburses the alternate benefit of an amalgam/composite restoration.

D2520 INLAY - METALLIC - TWO SURFACES CDT 2025

COMMENTS

Enter the tooth number and surface being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Inlay-metallic-two surfaces reports *any* type of cast metal.
2. Inlays are rarely reimbursed. However, an alternate benefit is often reimbursed (amalgam/composite restoration). Any additional fee up to the approved amount may be allowed to be passed to the patient.
3. If the practice participates in PPOs, reimbursement may be restricted to the fee schedule applicable to the inlay by the PPO (third-party) although the PPO reimburses the alternate benefit of an amalgam/composite restoration.

D2530 INLAY - METALLIC - THREE OR MORE SURFACES CDT 2025

COMMENTS

Enter the tooth number and surface being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Inlay-metallic - three or more surfaces reports *any* type of cast metal.
2. Inlays are rarely reimbursed. However, an alternate benefit is often reimbursed (amalgam/composite restoration). Any additional fee up to the approved amount may be allowed to be passed to the patient.
3. If the practice participates in PPOs, reimbursement may be restricted to the fee schedule applicable to the inlay by the PPO (third-party) although the PPO reimburses the alternate benefit of an amalgam/composite restoration.

GENERAL COMMENTS FOR ONLAY SERVICES AUTHOR'S COMMENTS

WARNING

1. It is misleading to report an onlay if at least one cusp is not "capped" or "shoed." An onlay requires "capping one or more cusps." Going up the incline more than ½ of the distance from fossa to cusp tip is not an onlay, according to the CDT glossary. Also see the Journal of Prosthodontic Dentistry; the Glossary of Prosthodontic Terms; 9th edition.
2. It is misleading to report a core buildup (D2950) in conjunction with an inlay or onlay. The sole purpose of a core build-up is for crown retention. Thus, D2950 should only be used to report a core buildup for crown retention, not in conjunction with an onlay.

COMMENTS

1. Gold and ceramic onlay materials are the most often reimbursed. A small number of payors exclude reimbursement for laboratory fabricated resin-based onlays; or when reimbursed, the payor's fee is substantially lower than the comparable gold/ceramic onlay reimbursement.
2. Some payors have an age limitation of 13 years and older for reimbursement of onlays and/or crowns.
3. An onlay is determined by the onlay's buccal and/or lingual surfaces extending only to above the height of contour. A crown is determined when the surfaces of the restoration extend below the height of contour.
4. Trauma requiring a new onlay may override the five to 10 year common replacement exclusion for most policies.
5. A small number of payors require that all cusps be capped in order to obtain reimbursement for an onlay. Buccal and/or lingual surfaces, as appropriate, must be entered on the claim form for reimbursement of an onlay. An MOD does not describe an onlay. An MOF, MOL, DOF, DOL, MODL, MODF or MODFL does describe an onlay.
6. Onlay restorations may be excluded (for reimbursement) for esthetic, periodontal (splinting), abrasion, or erosion-related procedures.

TIPS

1. To receive reimbursement for an onlay, the tooth must generally meet the criteria for a crown (missing a cusp, undermined cusp, fractured cusp and breakdown), necessitated by fracture or decay. Onlays are usually reimbursed when reported with full documentation (proper narrative, beginning diagnostic radiographic image/photograph). A narrative should be used when reporting an onlay stating that the onlay is a "conservative option to a full crown, while capping and replacing the cusp(s)." Buccal and/or lingual surfaces, as appropriate, must be entered on the claim form for reimbursement.

2. Belleglass®, Targis®, Vectris®, Sculpture®, ArtGlass®, Concept® and Cristobel® are classified as indirect resin-based composite. Report this type of restoration using resin-based codes (D2662-D2664). Unfortunately, resin-based (indirect) composites are denied as a material by some contracts. Furthermore, the resin-based composite payor's fee allowance may be 30-40% below the same gold or ceramic restoration fee.
3. Porcelain/ceramics include materials such as Empress®, Procera®, InCeram®, Lava®, Lava Ultimate®, Finesse®, Cerinate®, and Opc®. Milled or 3D printed restorations may be reported as porcelain/ceramic provided the material is greater than 50% inorganic filler. Report onlays made of these materials with D2642-D2644.

D2542 ONLAY - METALLIC - TWO SURFACES CDT 2025



WARNING

1. It is misleading to report an onlay if at least one cusp is not "capped" or "shoed." An onlay requires "capping one or more cusps and adjoining occlusal surfaces or the entire occlusal surface" per the glossary of dental terms in the ADA coding manual. A cusp tip must be covered for the restoration to be considered an onlay. Going up the incline "nearly" to the cusp *does not* restore the cusp.
2. It is misleading to report a core buildup (D2950) in conjunction with an inlay or an onlay. A core buildup D2950 should only be used in conjunction with a *crown*.

COMMENTS

1. An onlay has buccal and/or lingual surfaces that terminate above the height of contour and restores/covers at least one cusp.
2. Enter the tooth number and surfaces being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Some payors have an age limitation of 13 years and older for reimbursement of onlays and/or crowns.
2. Trauma requiring a new onlay may override the five to 10 year replacement exclusion contained in most policies.
3. Some payors require that *all* cusps be restored in order to obtain reimbursement for an onlay.
4. Onlay restorations may be excluded (for reimbursement) for esthetic, periodontal (splinting), abrasion, or erosion related reasons.

NARRATIVES

1. To receive reimbursement for an onlay, the tooth must meet the same criteria that justifies payment for a crown. Those criteria include, but may not be limited to, missing a cusp, undermined cusp, fractured tooth or related breakdown and/or in conjunction with decay. Onlays are typically reimbursed when reported with adequately supporting documentation. That documentation should include a narrative, pretreatment diagnostic radiographic image and/or photograph and a photograph of the prepared tooth. The narrative should state that the onlay was a "conservative alternative to a full crown used to replace the defective cusp(s)." Buccal and/or lingual surfaces as appropriate, must be entered on the claim form for reimbursement.
2. *Be careful to report a buccal and/or lingual surface in association with the onlay coding.* An MOD *does not* describe an onlay. An MO*F*, MO*L*, DO*F*, DO*L* MOD*L*, MOD*F* or MOD*FL* describes an onlay.
3. "See attached radiographic image" (if tooth has RCT, send PA radiographic image).
4. List any missing cusps.
5. State the estimated percentage of healthy tooth structure left after fracture, caries and/or any previous restoration removed. If the tooth is diagnosed with cracked tooth syndrome - state method of diagnosis, e.g., Tooth Slooth™ positive on MF cusp.
6. State if tooth has existing or planned RCT (root canal therapy).
7. State if tooth has circumferential decay and amount of decay, e.g., circumferential decay on M, L and D encompassing 270 degrees of tooth.
8. State endodontic and periodontal prognosis for tooth.
9. If this is a replacement onlay, state date that the previous onlay was seated and reason(s) the new onlay is required.
10. If replacing an existing onlay, state the reason for replacement, e.g., tooth has caries, margins are open, porcelain is fractured off, poor contacts are causing food impactions, etc.

See "General Comments for Onlay Services" prior page

D2543 ONLAY - METALLIC - THREE SURFACES CDT 2025

WARNING

1. It is misleading to report an onlay if at least one cusp is not "capped" or "shoed." An onlay requires "capping one or more cusps and adjoining occlusal surfaces or the entire occlusal surface" per the glossary of dental terms in the ADA coding manual. A cusp tip must be covered for the restoration to be considered an onlay. Going up the incline "nearly" to the cusp does not restore the cusp.
2. It is misleading to report a core buildup (D2950) in conjunction with an inlay or an onlay. A core buildup D2950 should only be used in conjunction with a crown.

COMMENTS

1. An onlay has buccal and/or lingual surfaces that terminate above the height of contour and restores/covers at least one cusp.
2. Enter the tooth number and surfaces being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Some payors have an age limitation of 13 years and older for reimbursement of onlays and/or crowns.
2. Trauma requiring a new onlay may override the five to 10 year replacement exclusion contained in most policies.
3. Some payors require that *all* cusps be restored in order to obtain reimbursement for an onlay.
4. Onlay restorations may be excluded (for reimbursement) for esthetic, periodontal (splinting), abrasion, or erosion related reasons.

NARRATIVES

IMPORTANT! See D2542 for onlay narratives/recommendations and Author's Comments prior to D2542.

D2544 ONLAY - METALLIC - FOUR OR MORE SURFACES CDT 2025

WARNING

1. It is misleading to report an onlay if at least one cusp is not "capped" or "shoed." An onlay requires "capping one or more cusps and adjoining occlusal surfaces or the entire occlusal surface" per the glossary of dental terms in the ADA coding manual. A cusp tip must be covered for the restoration to be considered an onlay. Going up the incline "nearly" to the cusp *does not* restore the cusp.
2. It is misleading to report a core buildup (D2950) in conjunction with an inlay or an onlay. A core buildup D2950 should only be used in conjunction with the retention of a *crown*.

COMMENTS

1. An onlay has buccal and/or lingual surfaces that terminate above the height of contour and restores/covers at least one cusp tip.
2. Enter the tooth number and surfaces being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Some payors have an age limitation of 13 years and older for reimbursement of onlays and/or crowns.
2. Trauma requiring a new onlay may override the five to 10 year replacement exclusion contained in most policies.
3. Some payors require that *all* cusps be restored in order to obtain reimbursement for an onlay.
4. Onlay restorations may be excluded (for reimbursement) for esthetic, periodontal (splinting), abrasion, or erosion related reasons.

NARRATIVES

IMPORTANT! See D2542 for onlay narrative recommendations and Author's Comments prior to D2542.

PORCELAIN/CERAMIC INLAYS/ONLAYS INCLUDE ALL INDIRECT CERAMIC AND PORCELAIN TYPE INLAYS/ONLAYS — CDT 2025

D2610 INLAY - PORCELAIN/CERAMIC - ONE SURFACE — CDT 2025



WARNING

It is misleading to report a *resin-based* inlay for this code. D2610 reports a *porcelain/ceramic* one-surface inlay.

COMMENTS

Enter the tooth number and surface being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Inlays are not typically reimbursed; however, an alternate benefit is often reimbursed (amalgam/composite restoration). Any additional fee up to the approved amount may be allowed to be passed to the patient.
2. If the practice is a PPO provider, reimbursement may be restricted to the inlay fee schedule of the PPO (third party), even though the PPO reimburses only the alternate benefit of an amalgam/composite restoration.
3. Porcelain/ceramics include materials such as Vita®, ProCad®, Lava Ultimate®, Empress®, Procera®, InCeram®, Lava®, Finesse®, Cerinate®, and Opc®. They *do not* include Cristobel®, Artglass®, Belleglass®, Targis®, Vectris®, Concept®, and similar materials. Milled or 3D printed restorations may be reported as porcelain/ceramic provided the material is greater than 50% inorganic filler.

TIPS

Inlay (D2610) would also be used to report a CAD/CAM porcelain/ceramic restoration with one surface.

D2620 INLAY - PORCELAIN/CERAMIC - TWO SURFACES — CDT 2025



WARNING

It is misleading to report a *resin-based* inlay for this code. D2620 reports a *porcelain/ceramic* two surface inlay.

COMMENTS

Enter the tooth number and surface being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Inlays are not typically reimbursed. However, an alternate benefit is often reimbursed (amalgam/composite restoration). Any additional fee up to the approved amount may be allowed to be passed to the patient.
2. If the practice is a PPO provider, reimbursement may be restricted to the inlay fee schedule of the PPO (third-party), even though the PPO reimburses only the alternate benefit of an amalgam/composite.
3. Porcelain/ceramics include materials such as Vita®, ProCad®, Lava Ultimate®, Empress®, Procera®, InCeram®, Lava®, Finesse®, Cerinate®, and Opc®. They *do not* include Cristobel®, Artglass®, Belleglass®, Targis®, Vectris®, Concept®, and similar materials. Milled or 3D printed restorations may be reported as porcelain/ceramic provided the material is greater than 50% inorganic filler.

TIPS

Inlay (D2620) would also be used to report a CAD/CAM porcelain/ceramic restoration with two surfaces.

D2630 INLAY - PORCELAIN/CERAMIC - THREE OR MORE SURFACES — CDT 2025



WARNING

It is misleading to report a *resin-based* inlay for this code. D2630 reports a *porcelain/ceramic* three or more surface inlay.

COMMENTS

Enter the tooth number and surface being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Inlays are not typically reimbursed. However, an alternate benefit is often reimbursed (amalgam/composite restoration). Any additional fee up to the approved amount may be allowed to be passed to the patient.
2. If the practice is a PPO provider, reimbursement may be restricted to the inlay fee schedule of the PPO (third-party), even though the PPO reimburses only the alternate benefit of an amalgam/composite.
3. Porcelain/ceramics include materials such as Vita®, ProCad®, Lava Ultimate®, Empress®, Procera®, InCeram®, Lava®, Finesse®, Cerinate®, and Opc®. They *do not* include Cristobel®, Artglass®, Belleglass®, Targis®, Vectris®, Concept®, and similar materials. Milled or 3D printed restorations may be reported as porcelain/ceramic provided the material is greater than 50% inorganic filler.

TIPS

Inlay (D2630) would also be used to report a CAD/CAM porcelain/ceramic restoration with three or more surfaces.

D2642 ONLAY - PORCELAIN/CERAMIC - TWO SURFACES CDT 2025



WARNING

1. It is misleading to report an onlay if at least one cusp is not "capped" or "shoed." An onlay requires "capping one or more cusps and adjoining occlusal surfaces or the entire occlusal surface" per the glossary of dental terms in the ADA coding manual. A cusp tip must be covered for the restoration to be considered an onlay. Going up the incline "nearly" to the cusp *does not* restore the cusp.
2. It is misleading to report a core buildup (D2950) in conjunction with an inlay or an onlay. A core buildup D2950 should only be used in conjunction with a *crown* (required for crown retention).
3. It is misleading to report a *resin-based* onlay code when a porcelain/ceramic material is used. D2642 reports a two surface porcelain/ceramic onlay.

COMMENTS

1. An onlay must include a portion of the buccal and/or lingual surfaces and restores/covers at least one cusp. The margin of the onlay terminates above the height of contour on the buccal and/or lingual surface.
2. Enter the tooth number and surfaces being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Some payors have an age limitation of 13 years and older for reimbursement of onlays and/or crowns.
2. Trauma requiring a new onlay may override the five to 10 year replacement exclusion contained in most policies.
3. Some payors require that *all* cusps be restored in the restoration in order to obtain reimbursement for an onlay.
4. Onlay restorations may be excluded (for reimbursement) for esthetic, periodontal (splinting), abrasion, or erosion related reasons.
5. Porcelain/ceramics include materials such as Vita®, ProCad®, Empress®, Lava Ultimate®, Procera®, InCeram®, Lava®, Finesse®, Cerinate®, and Opc®. They *do not* include resin-based Cristobel®, Artglass®, Belleglass®, Targis®, Vectris®, Concept®, and similar materials. Milled or 3D printed restorations may be reported as porcelain/ceramic provided the material is greater than 50% inorganic filler.
6. Gold and ceramic are the most commonly reimbursed onlay *materials*. A small number of payors *exclude* reimbursement for lab-made or CAD/CAM *resin-based* onlays. Some payors have a payor's fee for resin-based onlays that is much lower than the comparable gold/ceramic onlay's reimbursement.

TIPS

Onlay (D2642) would also be used to report a CAD/CAM porcelain/ceramic-type restoration with two surfaces.

NARRATIVES

IMPORTANT! See D2542 for onlay narrative recommendations and Author's Comments prior to D2542.

D2643 ONLAY - PORCELAIN/CERAMIC - THREE SURFACES CDT 2025



WARNING

1. It is misleading to report an onlay if at least one cusp is not "capped" or "shoed." An onlay requires "capping one or more cusps and adjoining occlusal surfaces or the entire occlusal surface" per the glossary of dental terms in the ADA coding manual. A cusp tip must be covered for the restoration to be considered an onlay. Going up the incline "nearly" to the cusp *does not* restore the cusp.
2. It is misleading to report a core buildup (D2950) in conjunction with an inlay or an onlay. A core buildup D2950 should only be used in conjunction with a *crown* (required for crown retention).
3. It is misleading to report a *resin-based* onlay code when a porcelain/ceramic material is used. This code reports a three surface porcelain/ceramic onlay.

COMMENTS

1. An onlay must include a portion of the buccal and/or lingual surfaces and restore/cover at least one cusp. The margin of the onlay terminates above the height of contour on the buccal and/or lingual surface.
2. Enter the tooth number and surfaces being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Some payors have an age limitation of 13 years and older for reimbursement of onlays and/or crowns.
2. Trauma requiring a new onlay may override the five to 10 year replacement exclusion contained in most policies.
3. Some payors require that *all* cusps be restored in the restoration in order to obtain reimbursement for an onlay.
4. Onlay restorations may be excluded (for reimbursement) for esthetic, periodontal (splinting), abrasion, or erosion related reasons.
5. Porcelain/ceramics include materials such as Vita®, ProCad®, Empress®, Lava Ultimate®, Procera®, InCeram®, Lava®, Finesse®, Cerinate®, and Opc®. They *do not* include resin-based Cristobel®, Artglass®, Belleglass®, Targis®, Vectris®, Concept®, and similar materials. Milled or 3D printed restorations may be reported as porcelain/ceramic provided the material is greater than 50% inorganic filler.
6. Gold and ceramic are the most commonly reimbursed onlay *materials*. A small number of payors *exclude* reimbursement for laboratory made or CAD/CAM resin-based onlays. Some payors have a payor's fee for resin-based onlays that is much lower than the comparable gold/ceramic onlays' reimbursement.

TIPS

Onlay (D2643) would also be used to report a CAD/CAM porcelain/ceramic restoration with three surfaces.

NARRATIVES

IMPORTANT! See D2542 for onlay narrative recommendations and Author's Comments prior to D2542.

D2644 ONLAY - PORCELAIN/CERAMIC - FOUR OR MORE SURFACES CDT 2025



WARNING

1. It is misleading to report an onlay if at least one cusp is not "capped" or "shoed." An onlay requires "capping one or more cusps and adjoining occlusal surfaces or the entire occlusal surface" per the glossary of dental terms in the ADA coding manual. A cusp tip must be covered for the restoration to be considered an onlay. Going up the incline "nearly" to the cusp *does not* restore the cusp.
2. It is misleading to report a core buildup (D2950) in conjunction with an inlay or an onlay. A core buildup D2950 should only be used in conjunction with a *crown* (required for crown retention).
3. It is misleading to report a *resin-based* onlay code when a porcelain/ceramic material is used. This code reports a four or more surface porcelain/ceramic onlay.

COMMENTS

1. An onlay must include a portion of the buccal and/or lingual surfaces and restores/covers the cusp. The margin of the onlay terminates above the height of contour on the buccal and/or lingual surface.
2. Enter the tooth number and surfaces being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Some payors have an age limitation of 13 years and older for reimbursement of onlays and/or crowns.
2. Trauma requiring a new onlay may override the five to 10 year replacement exclusion contained in most policies.
3. Some payors require that all cusps be restored in the restoration in order to obtain reimbursement for an onlay.

4. Onlay restorations may be excluded (for reimbursement) for esthetic, periodontal (splinting), abrasion, or erosion related reasons.
5. Porcelain/ceramics include materials such as Vita®, ProCad®, Empress®, Lava Ultimate®, Procera®, InCeram®, Lava®, Finesse®, Cerinate®, and Opc®. They *do not* include resin-based Cristobel®, Artglass®, Belleglass®, Targis®, Vectris®, Concept®, and similar materials. Milled or 3D printed restorations may be reported as porcelain/ceramic provided the material is greater than 50% inorganic filler.
6. Gold and ceramic are the most commonly reimbursed onlay *materials*. A small number of payors *exclude* reimbursement for laboratory made or CAD/CAM resin-based onlays. Some payors have a payor's fee for resin-based composite onlays that is much lower than the comparable gold/ceramic onlays' reimbursement.

TIPS Onlay (D2644) would also be used to report a CAD/CAM porcelain/ceramic-type restoration with four or more surfaces.

NARRATIVES **IMPORTANT!** See D2542 for onlay narrative recommendations and Author's Comments prior to D2542.

RESIN-BASED COMPOSITE INLAYS/ONLAYS MUST UTILIZE INDIRECT TECHNIQUE CDT 2025

D2650 INLAY - RESIN-BASED COMPOSITE - ONE SURFACE CDT 2025

WARNING

It is misleading to report inlays fabricated from Cristobel®, Artglass®, Belleglass® and similar resin-based materials using the ceramic codes (D2610-D2630). Reporting a resin inlay as a ceramic inlay for reimbursement is improper and misleading. D2650 reports an indirect (laboratory made) *resin* inlay.

COMMENTS Enter the tooth number and surface being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Inlays are rarely reimbursed. However, an alternate benefit may be reimbursed (amalgam/composite restoration). Any additional fee up to the approved amount may be allowed to be passed to the patient.
2. If the practice participates in PPOs, reimbursement may be restricted by the PPO (third-party). The PPO may reimburse the alternate benefit of an amalgam/composite restoration.
3. Resin-based composites include Cristobel®, Artglass®, Belleglass®, Targis®, Vectris®, Concept®, and similar materials.
4. Resin-based composite restorations may be laboratory fabricated, milled, or 3D printed using the appropriate materials.

TIPS A porcelain/ceramic one surface inlay should be reported using D2610.

D2651 INLAY - RESIN-BASED COMPOSITE - TWO SURFACES CDT 2025

WARNING

It is misleading to report inlays fabricated from Cristobel®, Artglass®, Belleglass®, and similar resin-based materials using the ceramic codes (D2610-D2630). Reporting a resin inlay as a ceramic inlay for reimbursement is improper and misleading. D2651 reports an indirect (laboratory fabricated) *resin* inlay, two surfaces.

COMMENTS Enter the tooth number and surface being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Inlays are rarely reimbursed. However, an alternate benefit may be reimbursed (amalgam/composite restoration). Any additional fee up to the approved amount may be allowed to be passed to the patient.
2. If the practice participates in PPOs, reimbursement may be restricted by the PPO (third-party). The PPO may reimburse the alternate benefit of an amalgam/composite restoration.
3. Resin-based composites include Cristobel®, Artglass®, Belleglass®, Targis®, Vectris®, Concept®, and similar materials.
4. Resin-based composite restorations may be laboratory fabricated, milled, or 3D printed using the appropriate materials.
5. Enter the tooth number and surfaces being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

TIPS A porcelain/ceramic two surface inlay should be reported using D2620.

D2652 INLAY - RESIN-BASED COMPOSITE - THREE OR MORE SURFACES CDT 2025



WARNING

It is misleading to report inlays fabricated from Cristobel®, Artglass®, Belleglass®, and similar resin-based materials using the ceramic codes (D2610-D2630). Reporting a resin inlay as a ceramic inlay for reimbursement is improper and misleading. D2652 reports an indirect (laboratory fabricated) *resin* inlay, three or more surfaces.

COMMENTS Enter the tooth number and surface being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Inlays are rarely reimbursed. However, an alternate benefit may be reimbursed (amalgam/composite restoration). Any additional fee up to the approved amount may be allowed to be passed to the patient.
2. If the practice participates in PPOs, reimbursement may be restricted by the PPO (third-party). The PPO may reimburse the alternate benefit of an amalgam/composite restoration.
3. Resin-based composites include Cristobel®, Artglass®, Belleglass®, Targis®, Vectris®, Concept®, and similar materials.
4. Resin-based composite restorations may be laboratory fabricated, milled, or 3D printed using the appropriate materials.

TIPS A porcelain/ceramic three or more surface inlay should be reported using D2630.

D2662 ONLAY - RESIN-BASED COMPOSITE - TWO SURFACES CDT 2025



WARNING

1. It is misleading to report an onlay if at least one cusp is not "capped" or "shoed." An onlay requires "capping one or more cusps and adjoining occlusal surfaces or the entire occlusal surface" per the glossary of dental terms in the ADA coding manual. A cusp tip must be covered for the restoration to be considered an onlay. Going up the incline "nearly" to the cusp *does not* restore the cusp.
2. It is misleading to report a core buildup (D2950) in conjunction with an inlay or an onlay. A core buildup D2950 should only be used in conjunction with a *crown* (required for crown retention).
3. Some practices erroneously report Cristobel®, Artglass®, Belleglass® and similar materials using the ceramic code D2642. Report this resin-based composite restoration as an "indirect" (laboratory fabricated) or CAD/CAM resin, D2662. Reporting a ceramic code for reimbursement when using this resin-based material is improper and misleading.

COMMENTS

1. An onlay must include a portion of the buccal and/or lingual surfaces and restore/cover at least one cusp. The margin of the onlay terminates above the height of contour on the buccal and/or lingual surface.
2. Resin-based composite restorations may be laboratory fabricated, milled, or 3D printed using the appropriate materials.
3. Enter the tooth number and surfaces being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Some payors have an age limitation of 13 years and older for reimbursement of onlays and/or crowns.
2. Trauma requiring a new onlay may override the five to 10 year replacement exclusion contained in most policies.
3. Some payors require that *all* cusps be restored in the restoration in order to obtain reimbursement for an onlay.
4. Onlay restorations may be excluded (for reimbursement) for esthetic, periodontal (splinting), abrasion, or erosion related reasons.
5. Gold and ceramic are the most commonly reimbursed onlay *materials*. A small number of payors *exclude* reimbursement for laboratory made or CAD/CAM resin-based onlays. Some payors have a payor's fee for resin-based composite onlays that is much lower than the comparable gold/ceramic onlays' reimbursement.
6. *Be careful to report a buccal and/or lingual surface in association with the onlay coding.* An MOD *does not* describe an onlay. An MO*F*, MO*L*, DO*F*, DO*L*, MOD*L*, MOD*F* or MOD*FL* describes an onlay.

TIPS A porcelain/ceramic two surface onlay should be reported using D2642.

NARRATIVES **IMPORTANT!** See D2542 for onlay narrative recommendations and Author's Comments prior to D2542.

D2663 ONLAY - RESIN-BASED COMPOSITE - THREE SURFACES CDT 2025



WARNING

1. It is misleading to report an onlay if at least one cusp is not "capped" or "shoed." An onlay requires "capping one or more cusps and adjoining occlusal surfaces or the entire occlusal surface" per the glossary of dental terms in the ADA coding manual. A cusp tip must be covered for the restoration to be considered an onlay. Going up the incline "nearly" to the cusp *does not* restore the cusp.
2. It is misleading to report a core buildup (D2950) in conjunction with an inlay or an onlay. A core buildup D2950 should only be used in conjunction with a *crown* (required for crown retention).
3. Some practices erroneously report Cristobel®, Artglass®, Belleglass® and similar materials using the ceramic code D2643. Report this resin-based composite restoration as an "indirect" (laboratory fabricated) or CAD/CAM resin, D2663. Reporting ceramic coding for reimbursement with this resin material is improper and misleading.

COMMENTS

1. An onlay must include a portion of the buccal and/or lingual surfaces and restores/covers at least one cusp. The margin of the onlay terminates above the height of contour on the buccal and/or lingual surface.
2. Resin-based composite restorations may be laboratory fabricated, milled, or 3D printed using the appropriate materials.
3. Enter the tooth number and surfaces being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Some payors have an age limitation of 13 years and older for reimbursement of onlays and/or crowns.
2. Trauma requiring a new onlay may override the five to 10 year replacement exclusion contained in most policies.
3. Some payors require that *all* cusps be restored in the restoration in order to obtain reimbursement for an onlay.
4. Onlay restorations may be excluded (for reimbursement) for esthetic, periodontal (splinting), abrasion, or erosion related reasons.
5. Gold and ceramic are the most commonly reimbursed onlay *materials*. A small number of payors *exclude* reimbursement for lab-made or CAD/CAM resin-based onlays. Some payors have a payor's fee for resin-based composite onlays that is much lower than the comparable gold/ceramic onlays' reimbursement.
6. Be careful to report a buccal and/or lingual surface in association with the onlay coding. An MOD does not describe an onlay. An MO*F*, MO*L*, DO*F*, DO*L*, MOD*L*, MOD*F* or MOD*FL* describes an onlay.

TIPS A porcelain/ceramic three surface onlay should be reported using D2643.

NARRATIVES **IMPORTANT!** See D2542 for onlay narrative recommendations and Author's Comments prior to D2542.

D2664 ONLAY - RESIN-BASED COMPOSITE - FOUR OR MORE SURFACES CDT 2025



WARNING

1. It is misleading to report an onlay if at least one cusp is not "capped" or "shoed." An onlay requires "capping one or more cusps and adjoining occlusal surfaces or the entire occlusal surface" per the glossary of dental terms in the ADA coding manual. A cusp tip must be covered for the restoration to be considered an onlay. Going up the incline "nearly" to the cusp *does not* restore the cusp.
2. It is misleading to report a core buildup (D2950) in conjunction with an inlay or an onlay. A core buildup D2950 should only be used in conjunction with a crown (required for *crown* retention).
3. Some practices erroneously report Cristobel®, Artglass®, Belleglass® and similar materials using the ceramic code D2644. Report this resin-based composite restoration as an "indirect" (laboratory made) or CAD/CAM resin, D2664. Reporting ceramic coding for reimbursement with this resin material is improper and misleading.

COMMENTS

1. An onlay must include a portion of the buccal and/or lingual surfaces and restore/cover at least one cusp. The margin of the onlay terminates above the height of contour on the buccal and/or lingual surface.
2. Resin-based composite restorations may be laboratory fabricated, milled, or 3D printed using the appropriate materials.
3. Enter the tooth number and surfaces being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Some payors have an age limitation of 13 years and older for reimbursement of onlays and/or crowns.
2. Trauma requiring a new onlay may override the five to 10 year replacement exclusion contained in most policies.
3. Some payors require that *all* cusps be restored in the restoration in order to obtain reimbursement for an onlay.
4. Onlay restorations may be excluded (for reimbursement) for esthetic, periodontal (splinting), abrasion, or erosion related reasons.
5. Gold and ceramic are the most commonly reimbursed onlay *materials*. A small number of payors *exclude* reimbursement for laboratory made or CAD/CAM resin-based onlays. Some payors have a payor's fee for resin-based composite onlays that is much lower than the comparable gold/ceramic onlays' reimbursement.
6. Be careful to report a buccal and/or lingual surface in association with the onlay coding. MOD does not describe an onlay. An MO*F*, MO*L*, DO*F*, DO*L*, MOD*L*, MOD*F* or MOD*FL* describes an onlay.

TIPS

A porcelain/ceramic four or more surface onlay should be reported using D2644.

NARRATIVES

IMPORTANT! See D2542 for onlay narrative recommendations and Author's Comments prior to D2542.

SINGLE RESTORATIONS ONLY — CDT 2025

CLASSIFICATION OF MATERIALS — CDT 2025

Classification of Metals (Source: ADA Council on Scientific Affairs - online at ADA.org/alloys**)**

The noble metal classification system has been adopted as a more precise method of reporting various alloys used in dentistry. The alloys are defined on the basis of the percentage of metal content:

high noble alloys - noble metal content ≥ 60% (gold+platinum group) and gold ≥ 40%;

titanium and titanium alloys - Titanium ≥ 85%;

noble alloys - noble metal content ≥ 25% (gold+platinum group);

predominantly base alloys - noble metal content < 25% (gold+platinum group);

*metals of the platinum group are platinum,palladium, rhodium, iridium, osmium and ruthenium.

Porcelain/ceramic - Refers to materials containing predominantly inorganic refractory compounds including porcelains, glasses, ceramics and glass-ceramics.

Resin - Refers to any resin-based composite, including fiber or ceramic reinforced polymer compounds, and glass ionomers.

GENERAL COMMENTS FOR CROWN SERVICES — AUTHOR'S COMMENTS



WARNING

1. It is misleading to report natural tooth crowns if the restoration is a crown on an implant. Select the appropriate code from the implant services section.
2. It is misleading to report retainer crowns of a fixed bridge as a single crown to receive a higher reimbursement 80% of the payor's fee rather than a 50% payor's fee for a bridge retainer. The reimbursement level, if different, is set by contract.

3. It is misleading to report Cristobel®, Artglass®, Belleglass®, and similar materials using the porcelain/ceramic codes, rather than the correct "indirect" (laboratory processed) resin codes. Cristobel®, Artglass®, and Belleglass® are considered laboratory processed indirect resins, not porcelain/ceramics. Porcelain materials could include Vita®, ProCad®, Empress®, Procera®, InCeram®, Lava®, Lava Ultimate®, Finesse®, Cerinate®, and Opc®. 3D printed restorations may be reported as porcelain/ceramic provided the material is greater than 50% inorganic filler. Resin-based composite restorations may be laboratory fabricated, milled, or 3D printed using the appropriate materials.

WATCH

Many practices commonly miscode the type of metal used in a crown (high noble, noble, base, etc.). The treatment plan, clinical note, and laboratory slip should always document the type of metal. With this information, the correct code can easily be chosen.

COMMENTS

Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form. 3/4 crowns should also include the surfaces involved in Box 28.

LIMITATIONS

1. Crown replacement clause exclusions vary from five to 10 years, with the trend moving towards 10 years, or even lifetime! However, trauma requiring a new crown may override the replacement exclusion.
2. Most payors have an age limitation exclusion. They will not reimburse a permanent crown unless the patient is at least 12-13 years old. If the patient is under 18, always determine if there is an age limitation before starting treatment. Consider a large filling plus D2976 band stabilization as an alternative procedure. See D2976.

TIPS

1. It is essential to include clear, readable (diagnostic) radiographic images, preoperative intraoral images demonstrating pathology (when appropriate), and a narrative (even though some payors do not require one) when reporting a crown to reduce delays and/or claim denials. Note and comment on the existence of caries or other pathology; condition and size of prior restoration; and the remaining tooth structure. Mention missing cusps, fractured cusps and undermined cusps. Comment on any patient symptoms. If fracture is the reason for the crown, document how the fracture was diagnosed, e.g., MB cusp positive to tooth sleuth.
2. Use the term "bridge retainer," not "bridge abutment." Abutments are placed on implants and support abutment-supported implant crowns.
3. If a tooth to be crowned has a root canal, send a periapical radiograph to verify adequate endodontic treatment.

CROWNS - SINGLE RESTORATIONS ONLY — CDT 2025

D2710 CROWN - RESIN-BASED COMPOSITE (INDIRECT) — CDT 2025



WARNING

1. It is misleading to report a crown placed on a *natural* tooth if the restoration is an *abutment supported* or *implant supported* crown.
2. It is misleading to report retainer crowns of a fixed bridge as single crowns in order to receive a higher reimbursement. (Single unit crowns may be reimbursed at 80% of the payor's fee whereas a retainer crown may be reimbursed at 50% of the payor's fee.)
3. It is misleading to report Cristobel®, Artglass®, Belleglass® and similar materials using the porcelain/ceramic codes, rather than the "indirect" (laboratory processed) or CAD/CAM resin-based composite codes. Cristobel®, Artglass®, and Belleglass® are considered laboratory processed indirect resin-based composites, not porcelain/ceramics. Porcelain materials could include Vita®, ProCad®, Empress®, Lava Ultimate®, Procera®, InCeram®, Lava®, Finesse®, Cerinate®, and Opc®. 3D printed restorations may be reported as porcelain/ceramic provided the material is greater than 50% inorganic filler.
4. Do not report D2710 for use as a long term provisional crown. D2710 is a definitive restoration. See D2799.

COMMENTS

1. D2710 is used to report Cristobel®, Artglass®, Fibrecor®, Targis®, Vectris®, Concept®, and Belleglass® type restorations. Resin-based composite restorations may be laboratory fabricated, milled, or 3D printed using the appropriate materials. The payor's fee is often lower for an indirect resin-based composite than for porcelain/ceramic restorations.
2. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Most payors have an age limitation exclusion. They will not reimburse a permanent crown unless the patient is at least 12-13 years old. If the patient is under 18, always determine if there is an age used exclusion before starting treatment. Consider a large filling plus D2976 band stabilization as an alternative procedure. See D2976.
2. Crown replacement may be limited by the plan and can vary from five to 10 years after the prior placement. The trend is moving toward 10 years. Trauma requiring a new crown may override this replacement exclusion.

TIPS

1. The code used to report the restoration should properly reflect the material (resin) used for the restoration. The material used should be the same as recorded in the treatment plan, clinical note, on the lab slip, and the insurance claim form.
2. D2710 would also be used to report a *resin-based* CAD/CAM crown when using a resin block to mill the restoration.

NARRATIVES

1. When submitting a crown claim it is essential that a narrative be included to avoid delays and/or claim denials. The narrative should address the existence of caries or other pathology, condition and size of prior restoration, and the condition of the remaining tooth structure. Make note of any undermined, fractured or missing cusps and any symptoms the patient may be experiencing with the affected tooth.
2. If treating cracked tooth syndrome, indicate how the diagnosis was made, e.g., MF cusp positive.to Tooth Slooth™.
3. Include pre-operative radiographs AND intraoral photos demonstrating pathology necessitating the crown restoration, if applicable. If the tooth has RCT, send a PA as well.
4. List any missing cusps.
5. State the estimated percentage of healthy tooth structure left after fracture, caries and/or any previous restoration is removed.
6. State if tooth has existing or planned RCT (root canal therapy).
7. State if tooth has circumferential decay and amount of decay, e.g., circumferential decay on M, L and D encompassing 270 degrees of tooth.
8. State endodontic and periodontal prognosis for tooth.
9. If this is a replacement crown, state date that the previous crown was seated.
10. If replacing an existing crown, state reason for replacement, e.g., tooth has caries, margins are open, porcelain is fractured off, poor contacts are causing food impactions, etc.

D2712 CROWN - 3/4 RESIN-BASED COMPOSITE (INDIRECT) CDT 2025

This procedure does not include facial veneers.



WARNING

1. It is misleading to report a crown placed on a *natural* tooth if the restoration is an *abutment supported* or *implant supported* crown.
2. It is misleading to report retainer crowns of a fixed bridge as a single crown(s) in order to receive a higher reimbursement. (Single unit crowns may be reimbursed at 80% of the payor's fee whereas a retainer crown may be reimbursed at 50% of the payor's fee.)
3. It is misleading to report Cristobel®, Artglass®, Belleglass® and similar materials using the porcelain/ceramic codes, rather than the "indirect" (laboratory processed) or CAD/CAM resin codes. Cristobel®, Artglass®, and Belleglass® are considered lab processed indirect resins, not porcelain/ceramics. Porcelain materials could include Vita®, ProCad®, Empress®, Procera®, InCeram®, Lava®, Lava Ultimate®, Finesse®, Cerinate®, and Opc®. 3D printed restorations may be reported as porcelain/ceramic provided the material is greater than 50% inorganic filler.
4. Do not report D2712 for use as a long term provisional crown. D2712 is a definitive restoration. See D2799.

COMMENTS

1. ¾ crown (D2712) is used to report Cristobel®, Artglass®, Fibrecor®, Targis®, Vectris®, Concept®, and Belleglass® type restorations. Resin-based composite restorations may be laboratory fabricated, milled, or 3D printed using the appropriate materials. The payor's fee is often lower for an indirect resin-based composite than for porcelain/ceramic restorations.
2. Enter the tooth number and surfaces being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Most payors have an age limitation exclusion. They will not reimburse a permanent crown unless the patient is at least 12-13 years old. If the patient is under 18, always determine if there is an age used exclusion before starting treatment. Consider a large filling plus D2976 band stabilization as an alternative procedure. See D2976.
2. Crown replacement may be limited by the plan and can vary from five to 10 years after the prior placement. The trend is moving toward 10 years. Trauma requiring a new crown may override this replacement exclusion.

TIPS

1. The code used to report the restoration should properly reflect the material (resin) used for the restoration. The material used should be the same as recorded in the treatment plan, on the lab slip, and the insurance claim form.
2. D2712 would also be used to report a *resin-based* CAD/CAM crown when using a resin block to mill the restoration.

NARRATIVES

IMPORTANT! See D2710 for crown narrative recommendations and Author's Comments prior to D2710.

D2720 CROWN - RESIN WITH HIGH NOBLE METAL CDT 2025



WARNING

1. It is misleading to report a crown placed on a *natural* tooth if the restoration is an *abutment supported* or *implant supported* crown.
2. It is misleading to report retainer crowns of a fixed bridge as a single crown(s) in order to receive a higher reimbursement. (Single unit crowns may be reimbursed at 80% of the payor's fee, whereas a retainer crown may be reimbursed at 50% of the payor's fee.)
3. It is misleading to report Cristobel®, Artglass®, Belleglass®, and similar materials using the porcelain/ceramic codes, rather than the "indirect" (lab-processed) or CAD/CAM resin codes. Cristobel®, Artglass®, and Belleglass® are considered lab processed indirect resins, not porcelain/ceramics. Porcelain materials could include Vita®, ProCad®, Empress®, Procera®, InCeram®, Lava®, Lava Ultimate®, Finesse®, Cerinate®, and Opc®.

COMMENTS

1. D2720 is used to report a crown using high noble metal and coated with resin materials such as Cristobel®, Artglass®, Fibrecor®, Targis®, Vectris®, Concept®, and Belleglass®. The payor's fee may be lower for an indirect resin-based composite coating, than for porcelain/ceramic coated restorations.
2. The code used to report the restoration should properly reflect the material (resin with high noble metal) used for the restoration. The material used should be the same as recorded in the treatment plan, clinical note, on the lab slip, and the insurance claim form.
3. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Most payors have an age limitation exclusion. They will not reimburse a permanent crown unless the patient is at least 12-13 years old. If the patient is under 18, always determine if there is an age used exclusion before starting treatment. Consider a large filling plus D2976 band stabilization as an alternative procedure. See D2976.
2. Crown replacement may be limited by the plan and can vary from five to 10 years after the prior placement. The trend is moving toward 10 years. Trauma requiring a new crown may override this replacement exclusion.

NARRATIVES

IMPORTANT! See D2710 for crown narrative recommendations and Author's Comments prior to D2710.

D2721 CROWN - RESIN WITH PREDOMINANTLY BASE METAL CDT 2025



WARNING

1. It is misleading to report a crown placed on a *natural* tooth if the restoration is an *abutment supported* or *implant supported* crown.
2. It is misleading to report retainer crowns of a fixed bridge as a single crown(s) in order to receive a higher reimbursement. (Single unit crowns may be reimbursed at 80% of the payor's fee whereas a retainer crown may be reimbursed at 50% of the payor's fee.)
3. It is misleading to report Cristobel®, Artglass®, Belleglass®, and similar materials using the porcelain/ceramic codes, rather than the "indirect" (lab-processed) or CAD/CAM resin codes. Cristobel®, Artglass®, and Belleglass® are considered lab processed indirect resins, not porcelain/ceramics. Porcelain materials could include Vita®, ProCad®, Empress®, Procera®, InCeram®, Lava®, Finesse®, Lava Ultimate®, Cerinate®, and Opc®.

COMMENTS

1. D2721 is used to report a *base metal* crown coated with materials such as Cristobel®, Artglass®, Fibrecor®, Targis®, Vectris®, Concept®, and Belleglass®. The payor's fee may be lower for an indirect resin-based composite coating than for porcelain/ceramic coated restorations.
2. The code used to report the restoration should properly reflect the material (resin with predominantly base metal) used for the restoration. The material used should be the same as recorded in the treatment plan, clinical note, on the lab slip, and the insurance claim form.
3. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Most payors have an age limitation exclusion. They will not reimburse a permanent crown unless the patient is at least 12-13 years old. If the patient is under 18, always determine if there is an age used exclusion before starting treatment. Consider a large filling plus D2976 band stabilization as an alternative procedure. See D2976.
2. Crown replacement may be limited by the plan and can vary from five to 10 years after the prior placement. (The trend is moving toward 10 years). Trauma requiring a new crown may override this replacement exclusion.

NARRATIVES

IMPORTANT! See D2710 for crown narrative recommendations and Author's Comments prior to D2710.

D2722 CROWN - RESIN WITH NOBLE METAL CDT 2025



WARNING

1. It is misleading to report a crown placed on a *natural* tooth if the restoration is an *abutment supported* or *implant supported* crown.
2. It is misleading to report retainer crowns of a fixed bridge as a single crown(s) in order to receive a higher reimbursement. (Single unit crowns may be reimbursed at 80% of the payor's fee, whereas a retainer crown may be reimbursed at 50% of the payor's fee.)
3. It is misleading to report Cristobel®, Artglass®, Belleglass®, and similar materials using the porcelain/ceramic codes, rather than the "indirect" (lab-processed) or CAD/CAM resin codes. Cristobel®, Artglass®, and Belleglass® are considered lab processed indirect resins, not porcelain/ceramics. Porcelain materials could include Vita®, ProCad®, Empress®, Procera®, InCeram®, Lava®, Finesse®, Cerinate®, and Opc®.

COMMENTS

1. D2722 is used to report a noble *metal* crown coated with materials such as Cristobel®, Artglass®, Fibrecor®, Targis®, Vectris®, Concept®, and Belleglass®. The payor's fee may be lower for an indirect resin-based composite coating than for porcelain/ceramic coated restorations.
2. The code used to report the restoration should properly reflect the material (resin with noble metal) used for the restoration. The material used should be the same as recorded in the treatment plan, clinical note, on the lab slip, and the insurance claim form.
3. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Most payors have an age limitation exclusion. They will not reimburse a permanent crown unless the patient is at least 12-13 years old. If the patient is under 18, always determine if there is an age used exclusion before starting treatment. Consider a large filling plus D2976 band stabilization as an alternative procedure. See D2976.
2. Crown replacement may be limited by the plan and can vary from five to 10 years after the prior placement. (The trend is moving toward 10 years). Trauma requiring a new crown may override this replacement exclusion.

NARRATIVES

IMPORTANT! See D2710 for crown narrative recommendations and Author's Comments prior to D2710.

D2740 CROWN - PORCELAIN/CERAMIC CDT 2025



WARNING

1. It is misleading to report a crown placed on a *natural* tooth if the restoration is an *abutment supported* or *implant supported* crown.
2. It is misleading to report retainer crowns of a fixed bridge as a single crown(s) in order to receive a higher reimbursement. (Single unit crowns may be reimbursed at 80% of the payor's fee whereas a retainer crown may be reimbursed at 50% of the payor's fee.)

3. Porcelain materials could include Vita®, Lava Ultimate®, ProCad®, Empress®, Procera®, InCeram®, Lava®, Finesse®, Cerinate®, Zirconia®, BruxZir®, Opc®, e-max®.
4. Milled or 3D printed restorations may be reported as porcelain/ceramic provided the material is greater than 50% inorganic filler.
5. Porcelain/ceramic crown (D2740) should not be used to describe facial veneers.
6. For a prefabricated porcelain/ceramic crown - permanent tooth, see D2928. Milled or 3D printed restorations may be reported as porcelain/ceramic provided the material is greater than 50% inorganic filler.

COMMENTS

Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Most payors have an age limitation exclusion. They will not reimburse a permanent crown unless the patient is at least 12-13 years old. If the patient is under 18, always determine if there is an age used exclusion before starting treatment. Consider a large filling plus D2976 band stabilization as an alternative procedure. See D2976.
2. Reimbursement for crown replacement may be limited by the plan and can vary from five to 10 years after the prior placement. (The trend is moving toward 10 years). Trauma requiring a new crown may override this replacement exclusion.
3. D2740 may be reimbursed as a porcelain fused to metal crown, or gold metal crown as an alternate benefit.
4. The code used to report the restoration should properly reflect the material (porcelain/ceramic) used for the restoration. The material used should be the same as recorded in the treatment plan, clinical note, on the lab slip, and the insurance claim form.

TIPS

1. D2740 would be used to report a CAD/CAM porcelain/ceramic crown restoration milled from a Vita®/Procad® block.
2. D2740 reports a zirconium crown.
3. 3D printed restorations may be reported as porcelain/ceramic provided the material is greater than 50% inorganic filler.

NARRATIVES

IMPORTANT! See D2710 for crown narrative recommendations and Author's Comments prior to D2710.

PHOTO



The image depicts a porcelain/ceramic crown (D2740).

Courtesy of Keller Dental Lab

D2750 CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL CDT 2025

WARNING

1. It is misleading to report a crown placed on a *natural* tooth if the restoration is an *abutment supported* or *implant supported* crown.
2. It is misleading to report retainer crowns of a fixed bridge as a single crown(s) in order to receive a higher reimbursement. (Single unit crowns may be reimbursed at 80% of the payor's fee, whereas a retainer crown may be reimbursed at 50% of the payor's fee.)
3. Porcelain materials could include Vita®, Lava Ultimate®, ProCad®, Empress®, Procera®, InCeram®, Lava®, Finesse®, Cerinate®, Zirconia®, BruxZir® and Opc®.

COMMENTS

Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Most payors have an age limitation exclusion. They will not reimburse a permanent crown unless the patient is at least 12-13 years old. If the patient is under 18, always determine if there is an age used exclusion before starting treatment. Consider a large filling plus D2976 band stabilization as an alternative procedure. See D2976.

2. Reimbursement for crown replacement may be limited by the plan and can vary from five to 10 years after the prior placement. The trend is moving toward 10 years. Trauma requiring a new crown may override this replacement exclusion.
3. The code used to report the restoration should properly reflect the material (porcelain fused to high noble) used for the restoration. The material used should be the same as recorded in the treatment plan, clinical note, on the lab slip, and the insurance claim form.

TIPS

D2750 may also be used to report a PFM high noble Captek® crown and Gramm crowns. A Gramm crown is a PFM high noble crown that has a thin 24K gold coping.

NARRATIVES

IMPORTANT! See D2710 for crown narrative recommendations and Author's Comments prior to D2710.

D2751 CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL CDT 2025

WARNING

1. It is misleading to report a crown placed on a *natural* tooth if the restoration is an *abutment supported* or *implant supported* crown.
2. It is misleading to report retainer crowns of a fixed bridge as a single crown(s) in order to receive a higher reimbursement. (Single unit crowns may be reimbursed at 80% of the payor's fee whereas a retainer crown may be reimbursed at 50% of the payor's fee.)
3. Porcelain materials could include Vita®, ProCad®, Empress®, Procera®, InCeram®, Lava®, Finesse®, Cerinate®, and Opc®.

COMMENTS

Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Most payors have an age limitation exclusion. They will not reimburse a permanent crown unless the patient is at least 12-13 years old. If the patient is under 18, always determine if there is an age used exclusion before starting treatment. Consider a large filling plus D2976 band stabilization as an alternative procedure. See D2976.
2. Reimbursement for crown replacement may be limited by the plan and can vary from five to 10 years after the prior placement. (The trend is moving toward 10 years). Trauma requiring a new crown may override this replacement exclusion.
3. The code used to report the restoration should properly reflect the material (porcelain fused to predominantly base metal) used for the restoration. The material used should be the same as recorded in the treatment plan, clinical note, on the lab slip, and the insurance claim form.

TIPS

Porcelain/ceramic materials include Empress®, Procera®, Inceram®, Lava®, Lava Ultimate®, Finesse®, Cerestore®, Cerinate®, and Opc®.

NARRATIVES

IMPORTANT! See D2710 for crown narrative recommendations and Author's Comments prior to D2710.

D2752 CROWN - PORCELAIN FUSED TO NOBLE METAL CDT 2025

WARNING

1. It is misleading to report a crown placed on a *natural* tooth if the restoration is an *abutment supported* or *implant supported* crown.
2. It is misleading to report retainer crowns of a fixed bridge as a single crown(s) in order to receive a higher reimbursement. (Single unit crowns may be reimbursed at 80% of the payor's fee whereas a retainer crown may be reimbursed at 50% of the payor's fee.)
3. Porcelain materials could include Vita®, ProCad®, Empress®, Procera®, InCeram®, Lava®, Finesse®, Cerinate®, and Opc®.

COMMENTS

Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Most payors have an age limitation exclusion. They will not reimburse a permanent crown unless the patient is at least 12-13 years old. If the patient is under 18, always determine if there is an age used exclusion before starting treatment. Consider a large filling plus D2976 band stabilization as an alternative procedure. See D2976.
2. Reimbursement for crown replacement may be limited by the plan and can vary from five to 10 years after the prior placement. (The trend is moving toward 10 years). Trauma requiring a new crown may override this replacement exclusion.
3. The code used to report the restoration should properly reflect the material (porcelain fused to noble metal) used for the restoration. The material used should be the same as recorded in the treatment plan, clinical note, on the lab slip, and the insurance claim form.

TIPS

Porcelain/ceramic materials include Empress®, Procera®, Inceram®, Lava®, Lava Ultimate®, Finesse®, Cerestore®, Cerinate®, and Opc®.

NARRATIVES

IMPORTANT! See D2710 for crown narrative recommendations and Author's Comments prior to D2710.

D2753 CROWN - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS CDT 2025



WARNING

1. It is misleading to report a crown placed on a natural tooth if the restoration is an *abutment supported or implant supported crown*.
2. It is misleading to report retainer crowns of a fixed bridge as a single crown(s) in order to receive a higher reimbursement. (Single unit crowns may be reimbursed at 80% of the payor's fee whereas a retainer crown may be reimbursed at 50% of the payor's fee.)
3. Porcelain materials could include Vita®, ProCad®, Empress®, Procera®, InCeram®, Lava®, Finesse®, Cerinate®, and Opc®.

COMMENTS

Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Most payors have an age limitation exclusion. They will not reimburse a permanent crown unless the patient is at least 12-13 years old. If the patient is under 18, always determine if there is an age limitation before initiating treatment. Consider a large filling plus D2976 band stabilization as an alternative procedure. See D2976.
2. Reimbursement for crown replacement may be limited by the plan and can vary from five to ten years after the prior placement. The trend is moving toward ten years. Trauma requiring a new crown may override this replacement exclusion. All trauma related claims should be submitted to the patient's medical plan first.
3. The code used to report the restoration should properly reflect the material (porcelain fused to titanium and titanium alloys) used for the restoration. The material used should be the same as recorded in the treatment plan, clinical note, on the lab slip, and the 2024 ADA Dental Claim Form.

TIPS

Porcelain/ceramic materials include Empress®, Procera®, Inceram®, Lava®, Lava Ultimate®, Finesse®, Cerestore®, Cerinate®, and Opc®.

NARRATIVES

IMPORTANT! See D2710 for crown narrative recommendations and Author's Comments prior to D2710.

D2780 CROWN - 3/4 CAST HIGH NOBLE METAL CDT 2025



WARNING

1. It is misleading to report a crown placed on a *natural* tooth if the restoration is an *abutment supported* or *implant supported* crown.
2. It is misleading to report retainer crowns of a fixed bridge as a single crown(s) in order to receive a higher reimbursement. (Single unit crowns may be reimbursed at 80% of the payor's fee whereas a retainer crown may be reimbursed at 50% of the payor's fee.)

COMMENTS

1. ¾ crown (D2780) is used to report a ¾ cast *high noble metal* crown.
2. ¾ crown (D2780) is typically a restoration on the upper first molar, but can be done on any tooth. This type of crown is sometimes designed to leave the mesio-buccal cusp intact for esthetics.
3. ¾ crown (D2780) covers the occlusal and 3 to 4 of the molar cusps and extends beyond the height of contour of either the facial or lingual surface.
4. Enter the tooth number and surfaces being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Most payors have an age limitation exclusion. They will not reimburse a permanent crown unless the patient is at least 12-13 years old. If the patient is under 18, always determine if there is an age exclusion before starting treatment. Consider a large filling plus D2976 band stabilization as an alternative procedure. See D2976.
2. Reimbursement for crown replacement may be limited by the plan and can vary from five to 10 years after the prior placement. (The trend is moving toward 10 years). Trauma requiring a new crown may override this replacement exclusion.
3. The code used to report the restoration should properly reflect the material (high noble metal) used for the restoration. The material used should be the same as recorded in the treatment plan, clinical note, on the lab slip, and the insurance claim form.

NARRATIVES

IMPORTANT! See D2710 for crown narrative recommendations and Author's Comments prior to D2710.

D2781 CROWN - 3/4 CAST PREDOMINANTLY BASE METAL CDT 2025



WARNING

1. It is misleading to report a crown placed on a *natural* tooth if the restoration is an *abutment supported* or *implant supported* crown.
2. It is misleading to report retainer crowns of a fixed bridge as a single crown in order to receive a higher reimbursement. (Single unit crowns may be reimbursed at 80% of the payor's, whereas a retainer crown may be reimbursed at 50% of the payor's fee.)

COMMENTS

1. ¾ crown (D2781) is used to report a ¾ cast predominately base metal crown.
2. ¾ crown (D2781) is typically a restoration on the upper first molar, but can be done on any tooth. This type of crown is sometimes designed to leave the mesio-buccal cusp intact for esthetics.
3. ¾ crown (D2781) covers the occlusal and 3 to 4 of the molar cusps and extends beyond the height of contour of either the facial or lingual surface.
4. Enter the tooth number and surfaces being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Most payors have an age limitation exclusion. They will not reimburse a permanent crown unless the patient is at least 12-13 years old. If the patient is under 18, always determine if there is an age exclusion before starting treatment. Consider a large filling plus D2976 band stabilization as an alternative procedure. See D2976.
2. Reimbursement for crown replacement may be limited by the plan and can vary from five to 10 years after the prior placement. (The trend is moving toward 10 years). Trauma requiring a new crown may override this replacement exclusion.
3. The code used to report the restoration should properly reflect the material (predominantly base metal) used for the restoration. The material used should be the same as recorded in the treatment plan, clinical note, on the lab slip, and the insurance claim form.

NARRATIVES

IMPORTANT! See D2710 for crown narrative recommendations and Author's Comments prior to D2710.

D2782 CROWN - 3/4 CAST NOBLE METAL

CDT 2025

WARNING

1. It is misleading to report a crown placed on a *natural* tooth if the restoration is an *abutment supported* or *implant supported* crown.
2. It is misleading to report retainer crowns of a fixed bridge as a single crown(s) in order to receive a higher reimbursement. (Single unit crowns may be reimbursed at 80% of the payor's fee, whereas a retainer crown may be reimbursed at 50% of the payor's fee.)

COMMENTS

1. ¾ crown (D2782) is used to report a ¾ cast predominately noble metal crown.
2. ¾ crown (D2782) is typically a restoration on the upper first molar, but can be any tooth. This type of crown is used to leave the mesio-buccal cusp intact for esthetics.
3. ¾ crown (D2782) covers the occlusal and 3 to 4 of the molar cusps and extends beyond the height of contour of either the facial or lingual surface.
4. Enter the tooth number and surfaces being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Most payors have an age limitation exclusion. They will not reimburse a permanent crown unless the patient is at least 12-13 years old. If the patient is under 18, always determine if there is an age exclusion before starting treatment. Consider a large filling plus D2976 band stabilization as an alternative procedure. See D2976.
2. Reimbursement for crown replacement may be limited by the plan and can vary from five to 10 years after the prior placement. (The trend is moving toward 10 years). Trauma requiring a new crown may override this replacement exclusion.
3. The code used to report the restoration should properly reflect the material (noble metal) used for the restoration. The material used should be the same as recorded in the treatment plan, clinical note, on the lab slip, and the insurance claim form.

NARRATIVES

IMPORTANT! See D2710 for crown narrative recommendations and Author's Comments prior to D2710.

D2783 CROWN - 3/4 PORCELAIN/CERAMIC

CDT 2025

This procedure does not include facial veneers.

WARNING

1. It is misleading to report a crown placed on a *natural* tooth if the restoration is an *abutment supported* or *implant supported* crown.
2. It is misleading to report retainer crowns of a fixed bridge as a single crown(s) in order to receive a higher reimbursement. (Single unit crowns may be reimbursed at 80% of the payor's, whereas a retainer crown may be reimbursed at 50% of the payor's fee.)
3. Porcelain material could include Vita®, ProCad®, Empress®, Procera®, InCeram®, Lava®, Lava Ultimate®, Finesse®, Cerinate®, and Opc®. Milled or 3D printed restorations may be reported as porcelain/ceramic provided the material is greater than 50% inorganic filler.

WATCH

It is improper to report ¾ crown (D2783) when a labial veneer (D2962) was placed. The descriptor of the porcelain veneer code (D2962) includes "the extension of the restoration interproximally and/or covering the incisal edge." See D2962 for porcelain laminate veneers.

COMMENTS

1. ¾ crown (D2783) is not synonymous (or interchangeable) with porcelain veneer (D2962). A ¾ porcelain crown (D2783) may be reimbursed in situations where decay, fracture, or failing restorations necessitate a crown. Porcelain veneers (D2962) are generally considered cosmetic in nature and not reimbursed.
2. D2783 would be used to report a CAD/CAM *porcelain/ceramic* crown restoration milled from a Vita®/Procad® block. 3D printed restorations may be reported as porcelain/ceramic provided the material is greater than 50% inorganic filler.
3. Enter the tooth number and surfaces being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. The ¾ ceramic crown (D2783), along with other crowns, may be payable when used to correct significant pathology such as failing restorations, caries and/or fractures, and undermined, fractured or missing cusps.
2. Most payors have an age limitation exclusion. They will not reimburse a permanent crown unless the patient is at least 12-13 years old. If the patient is under 18, always determine if there is an age exclusion before starting treatment. Consider a large filling plus D2976 band stabilization as an alternative procedure. See D2976.
3. Reimbursement for crown replacement may be limited by the plan and can vary from five to 10 years after the prior placement. (The trend is moving toward 10 years). Trauma requiring a new crown may override this replacement exclusion.
4. The code used to report the restoration should properly reflect the material (porcelain/ceramic) used for the restoration. The material used should be the same as recorded in the treatment plan, clinical note, on the lab slip, and the insurance claim form.

NARRATIVES

1. The ¾ crown (D2783) is often reimbursed when supported with full documentation. Include a proper narrative, diagnostic radiographic images, and photographs (pretreatment and postpreparation). To be considered for reimbursement of D2783, some payors require a large pre-existing restoration and/or fracture and/or caries. D2783 would not typically be reimbursed if performed on a virgin anterior tooth.
2. **IMPORTANT!** See D2710 for other crown narrative recommendations and Author's Comments prior to D2710.

D2790 CROWN - FULL CAST HIGH NOBLE METAL

CDT 2025



WARNING

1. It is misleading to report a crown placed on a *natural* tooth if the restoration is an *abutment supported* or *implant supported* crown.
2. It is misleading to report retainer crowns of a fixed bridge as a single crown(s) in order to receive a higher reimbursement. (Single unit crowns may be reimbursed at 80% of the payor's fee, whereas a retainer crown may be reimbursed at 50% of the payor's fee.)

COMMENTS

Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Most payors have an age limitation exclusion. They will not reimburse a permanent crown unless the patient is at least 12-13 years old. If the patient is under 18, always determine if there is an age exclusion before starting treatment. Consider a large filling plus D2976 band stabilization as an alternative procedure. See D2976.
2. Reimbursement for crown replacement may be limited by the plan and can vary from five to 10 years after the prior placement. The trend is moving toward 10 years. Trauma requiring a new crown may override this replacement exclusion.
3. The code used to report the restoration should properly reflect the material (high noble metal) used for the restoration. The material used should be the same as recorded in the treatment plan, clinical note, on the lab slip, and the insurance claim form.

NARRATIVES

IMPORTANT! See D2710 for crown narrative recommendations and Author's Comments prior to D2710.

D2791 CROWN - FULL CAST PREDOMINANTLY BASE METAL

CDT 2025



WARNING

1. It is misleading to report a crown placed on a *natural* tooth if the restoration is an *abutment supported* or *implant supported* crown.
2. It is misleading to report retainer crowns of a fixed bridge as a single crown(s) in order to receive a higher reimbursement. (Single unit crowns may be reimbursed at 80% of the payor's fee, whereas a retainer crown may be reimbursed at 50% of the payor's fee.)

COMMENTS

Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Most payors have an age limitation exclusion. They will not reimburse a permanent crown unless the patient is at least 12-13 years old. If the patient is under 18, always determine if there is an age exclusion before starting treatment. Consider a large filling plus D2976 band stabilization as an alternative procedure. See D2976.
2. Reimbursement for crown replacement may be limited by the plan and can vary from five to 10 years after the prior placement. The trend is moving toward 10 years. Trauma requiring a new crown may override this replacement exclusion.
3. The code used to report the restoration should properly reflect the material (predominantly base metal) used for the restoration. The material used should be the same as recorded in the treatment plan, clinical note, on the lab slip, and the insurance claim form.

NARRATIVES

IMPORTANT! See D2710 for crown narrative recommendations and Author's Comments prior to D2710.

D2792 CROWN - FULL CAST NOBLE METAL

CDT 2025



WARNING

1. It is misleading to report a crown placed on a *natural* tooth if the restoration is an *abutment supported* or *implant supported* crown.
2. It is misleading to report retainer crowns of a fixed bridge as a single crown(s) in order to receive a higher reimbursement. (Single unit crowns may be reimbursed at 80% of the payor's fee, whereas a retainer crown may be reimbursed at 50% of the payor's fee.)

COMMENTS

Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Most payors have an age limitation exclusion. They will not reimburse a permanent crown unless the patient is at least 12-13 years old. If the patient is under 18, always determine if there is an age exclusion before starting treatment. Consider a large filling plus D2976 band stabilization as an alternative procedure. See D2976.
2. Reimbursement for crown replacement may be limited by the plan and can vary from five to 10 years after the prior placement. The trend is moving toward 10 years. Trauma requiring a new crown may override this replacement exclusion.
3. The code used to report the restoration should properly reflect the material (noble metal) used for the restoration. The material used should be the same as recorded in the treatment plan, clinical note, on the lab slip, and the insurance claim form.

NARRATIVES

IMPORTANT! See D2710 for crown narrative recommendations and Author's Comments prior to D2710.

D2794 CROWN - TITANIUM AND TITANIUM ALLOYS

CDT 2025



WARNING

1. It is misleading to report a crown placed on a *natural* tooth if the restoration is an *abutment supported* or *implant supported* crown.
2. It is misleading to report retainer crowns of a fixed bridge as a single crown(s) in order to receive a higher reimbursement. (Single unit crowns may be reimbursed at 80% of the payor's fee, whereas a retainer crown may be reimbursed at 50% of the payor's fee.)

COMMENTS

1. The nomenclature for D2794 - titanium and titanium alloys is *broad*, and reports *any* type of titanium metal crown. D2794 includes full metallic titanium crowns.
2. D2753 reports porcelain fused to titanium and titanium alloy crowns.
3. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Most payors have an age limitation exclusion. They will not reimburse a permanent crown unless the patient is at least 12-13 years old. If the patient is under 18, always determine if there is an age exclusion before starting treatment. Consider a large filling plus D2976 band stabilization as an alternative procedure. See D2976.
2. Reimbursement for crown replacement may be limited by the plan and can vary from five to 10 years after the prior placement. The trend is moving toward 10 years. Trauma requiring a new crown may override this replacement exclusion.
3. The code used to report the restoration should properly reflect the material (titanium metal) used for the restoration. The material used should be the same as recorded in the treatment plan, clinical note, on the lab slip, and the insurance claim form.

NARRATIVES

IMPORTANT! See D2710 for crown narrative recommendations and Author's Comments prior to D2710.

D2799 INTERIM CROWN - FURTHER TREATMENT OR COMPLETION OF DIAGNOSIS NECESSARY PRIOR TO FINAL IMPRESSION

CDT 2025

Not to be used as a temporary crown for a routine prosthetic restoration.



WARNING

1. Do not report an interim crown (D2799) as a temporary crown used for routine crown restoration procedures.
2. Do not report D2799 for resin based crowns intended to be definitive restorations.

WATCH

1. D2799 reports a single unit *interim* crown of any duration on a natural tooth.
2. See D6253/D6793 for a multi-unit *interim* bridge of any duration.
3. See D6085 for an interim implant crown.
4. See D2976 band stabilization—per tooth for interim stabilization of a multisurface restoration.

COMMENTS

1. D2799 reports an interim crown. This type of interim restoration allows time for healing, diagnosis, or completion of other procedures, prior to the fabrication of the final definitive restoration.
2. Interim restorations may be used to change the vertical dimension, complete periodontal therapy, diagnose cracked tooth syndrome, etc.
3. An interim crown (D2799) can be placed on a fractured tooth to see if symptoms subside with full coverage or if endodontic therapy will be necessary.
4. D2799 does not specify the material or fabrication method. It may be made chairside, laboratory fabricated, prefabricated, milled, or 3D printed.
5. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. An interim crown (D2799) is placed as an interim restoration and allows time for healing, diagnosis, or completion of other procedures. An interim bridge (D6253/D6793) functions in like manner. Most dental plans exclude interim procedures but these restorations are utilized as needed and can impact payment of the final prosthesis. This "interim" principal also applies to interim partial dentures (D5820/D5821), e.g., flippers, stayplates, etc., and interim complete dentures (D5810/D5811). Although CDT does not specify a minimum or a maximum amount of time these removable procedures must be in place, be aware that contracts often limit reimbursement based on how long the interim restoration is in the mouth. Some plans may consider the interim restoration a permanent restoration/prosthesis from the reimbursement perspective if the restoration/prosthesis is in place for 12 months or longer. (Some plans consider an interim crown to be permanent after six months.) This means that an interim crown (D2799), bridge, partial, or full denture can be subject to a plan's prosthetic replacement limitation. The submission of a claim for an interim restoration/prosthesis may prevent the patient from receiving coverage on the permanent restoration for up to 10 years depending on the contract's language.

2. D2799 is reimbursed in limited circumstances. D2799 may apply in multi-staged treatment situations or where the interim restoration is being used to diagnose a tooth fracture or some other pathology.
3. Reimbursement for D2799 is highly variable among payors.

TIPS

1. Use D6253 to report an interim pontic and D6793 to report an interim retainer crown of any duration.
2. Use D6085 to report an interim implant crown.

NARRATIVES

1. State necessity for an interim crown, e.g., completing periodontal therapy, cracked tooth syndrome. If diagnosis is cracked tooth syndrome, state method of diagnosis, e.g., Tooth Slooth™ positive on MF cusp. "See attached radiographic image." If tooth has RCT, send PA radiographic image.
2. State how long the interim crown will be utilized as an interim restoration.

OTHER RESTORATIVE SERVICES — CDT 2025

D2990 APPLICATION OF HYDROXYAPATITE REGENERATION MEDICAMENT – PER TOOTH — CDT 2025

Preparation of tooth surfaces and topical application of a scaffold to guide hydroxyapatite regeneration.

Note: D2990 appears here correctly but is not in numerical order. See page 151 for full entry.

D2991 APPLICATION OF HYDROXYAPATITE REGENERATION MEDICAMENT – PER TOOTH — CDT 2025

Preparation of tooth surfaces and topical application of a scaffold to guide hydroxyapatite regeneration.

Note: D2991 appears here correctly but is not in numerical order. See page 151 for full entry.

D2910 RE-CEMENT OR RE-BOND INLAY, ONLAY, VENEER OR PARTIAL COVERAGE RESTORATION — CDT 2025

COMMENTS

1. D2910 reports re-cementing or re-bonding an inlay, onlay, veneer, or partial coverage restoration.
2. See D2920 for re-cementing or re-bonding a *¾ crown or full crown*, which has a comparable fee.
3. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Re-cementation or re-bonding is typically not reimbursed until six to 12 months following initial placement of the restoration.
2. If the re-cementation or re-bonding of the restoration is performed in a *different* office within the exclusion period, it might be reimbursed.

NARRATIVES

If re-cementation or re-bonding occurs in an office by a dentist that did not originally place the restoration, note this in a brief narrative.

D2915 RE-CEMENT OR RE-BOND INDIRECTLY FABRICATED OR PREFABRICATED POST AND CORE

CDT 2025

COMMENTS

1. D2915 reports re-cementing or re-bonding an indirectly fabricated or prefabricated post and core as a stand-alone procedure.
2. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. The re-cement or re-bond is typically not reimbursed until six to 12 months following initial placement of the post and core.
2. If re-cement or re-bond is performed in a *different* office within the exclusion period, it might be reimbursed.

NARRATIVES

If re-cementation or re-bonding occurs in an office by a dentist that did not originally place the post and core, note this in a brief narrative.

D2920 RE-CEMENT OR RE-BOND CROWN

CDT 2025

WATCH

1. D2920 reports the re-cementing or re-bonding of a crown.
2. It is improper to use re-cement or re-bond crown (D2920) to report a re-cementation or re-bonding of an inlay, onlay, or veneer. See D2910 to report the re-cementation or re-bonding of an inlay, onlay, veneer, or partial coverage restoration.
3. *Do not* use this code to report re-cementing or re-bonding an implant or abutment supported crown, report D6092.
4. *Do not* use this code to report re-cementing or re-bonding an implant or abutment supported fixed partial denture (bridge). See D6093.
5. *Do not* use this code to report re-cementing or re-bonding a fixed partial denture (bridge) on natural teeth. See D6930.

COMMENTS

Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Re-cementation or re-bonding is typically not reimbursed until six to 12 months following initial placement of the restoration.
2. If re-cementation or re-bonding is performed in a *different* office within the exclusion period, it might be reimbursed.

TIPS

1. Re-cement or re-bond crown (D2920) reports re-cementing or re-bonding a ¾ *or full coverage* crown.
2. Re-cement or re-bond crown (D2920) also reports re-cementing or re-bonding a stainless steel or prefabricated resin crown.
3. See D2910 to report re-cementing or re-bonding a *partial coverage* restoration, such as inlay, onlay, or veneer.
4. See D6930 to report re-cementing or re-bonding a fixed partial denture (bridge) on natural teeth.
5. See D6092 to report re-cementing or re-bonding an implant or abutment supported crown.
6. See D6093 to report re-cementing or re-bonding an implant or abutment supported fixed partial denture (bridge).

D2921 REATTACHMENT OF TOOTH FRAGMENT, INCISAL EDGE OR CUSP

CDT 2025

COMMENTS

1. D2921 is used to describe the bonding of a broken fragment (incisal edge or cusp) from a fractured tooth back into place rather than restoring the tooth with composite material.
2. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. The reimbursement for this type of procedure is uncertain. It is unlikely that payors will provide reimbursement for the procedure until time for assessment of the utilization and efficacy of the procedure has been determined.
2. See also D9110 palliative treatment of dental pain—per visit.

NARRATIVES

An alternate benefit of a one or two surface composite could be requested, upon appeal.

D2928 PREFABRICATED PORCELAIN/CERAMIC CROWN - PERMANENT TOOTH CDT 2025

WARNING

1. D2928 does not report a custom crown. It must be a stock, prefabricated porcelain crown which is adjusted to fit.
2. Reports a *permanent* tooth prefabricated ceramic crown, not for a *primary* tooth. See D2929 for a primary tooth, prefabricated porcelain/ceramic crown.

COMMENTS

1. Prefabricated porcelain/ceramic crown (D2928) reports a porcelain/ceramic crown for an anterior or posterior *permanent* tooth.
2. Prefabricated porcelain crowns may be purchased pre-made, or instead milled or 3D printed based on a generic crown form using materials with greater than 50% inorganic fillers.
3. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

D2928 may have a 5 year replacement clause or with some plans up to a 10 year replacement clause. The exclusions/ limitations for this code are variable among payors.

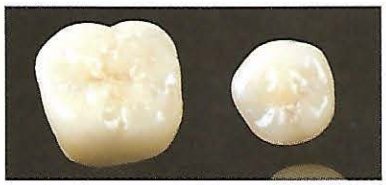
TIPS

1. A core buildup (D2950), if necessary for the *retention* of a prefabricated porcelain/ceramic crown (permanent tooth), may be possibly reimbursed. See D2950.
2. 3D printed prefabricated restorations may be reported as porcelain/ceramic provided the material is greater than 50% inorganic filler.

NARRATIVES

Documentation should include why the crown is necessary. Document the extent of decay, any fractured and missing cusps and % of remaining tooth structure. Use of an intraoral camera is highly recommend to prove necessity of the permanent crown. A pre-op radiograph should also be included as supporting documentation.

PHOTO



This is an example of a prefabricated ceramic (zirconia) crown.

D2929 PREFABRICATED PORCELAIN/CERAMIC CROWN - PRIMARY TOOTH CDT 2025

WARNING

1. D2928 does not report a custom crown. It must be a stock, prefabricated porcelain crown which is adjusted to fit.
2. D2929 reports a *primary tooth* prefabricated ceramic crown, not for a permanent tooth. For prefabricated porcelain/ ceramic crown for a permanant tooth, see D2928.

COMMENTS

1. D2929 reports a prefabricated ceramic/porcelain primary crown for a *primary* anterior or posterior tooth. It is individually milled to a generic tooth preparation model, rather than to a finished tooth preparation.
2. Choices in the past for primary tooth restorations have been a primary stainless steel crown (D2930), exterior esthetic-coated stainless steel crown (D2934), or prefabricated stainless steel crown with resin window (D2933).
3. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

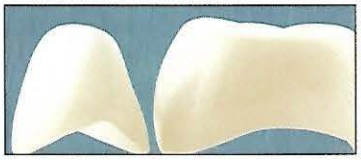
LIMITATIONS

Payers may re-map D2929 to either D2930, D2933, or D2934.

TIPS

3D printed prefabricated restorations may be reported as porcelain/ceramic provided the material is greater than 50% inorganic filler.

PHOTO



This is an example of a pediatric prefabricated ceramic (zirconia) crown.

Courtesy EZPEDO

D2930 PREFABRICATED STAINLESS STEEL CROWN - PRIMARY TOOTH CDT 2025

COMMENTS

1. Prefabricated stainless steel crown (D2930) reports a stainless steel crown for both anterior and posterior *primary* teeth.
2. See D2931 which reports a stainless steel crown for a *permanent* tooth, for both anterior and posterior teeth.
3. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

D2930 often has a lifetime exclusion, i.e., it is only reimbursed once per tooth. Some plans have a 24-month exclusion. The exclusion for D2930 varies among payors.

PHOTO



This is a prefabricated stainless steel crown for a primary tooth.

Courtesy 3M

D2931 PREFABRICATED STAINLESS STEEL CROWN - PERMANENT TOOTH CDT 2025

COMMENTS

1. Prefabricated stainless steel crown (D2931) reports a stainless steel crown for a *permanent* tooth.
2. D2928 reports a prefabricated porcelain/ceramic crown for a *permanent* tooth.
3. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. An age limitation may apply (thirteen to fourteen years).
2. D2931 may have a 2-5 year exclusion or with some plans a 10 year exclusion. The exclusions/limitations for this code are variable among payors.

TIPS

A core buildup (D2950), if necessary for the *retention* of a permanent tooth stainless steel crown, may often be reimbursed. See D2950.

PHOTO



This is a prefabricated stainless steel crown for a permanent tooth.

Courtesy 3M

D2932 PREFABRICATED RESIN CROWN CDT 2025

WATCH

1. D2932 does not report a custom resin crown. It must be a stock, prefabricated resin crown which is adjusted to fit.
2. Prefabricated resin crowns may be purchased pre-made, or instead milled or 3D printed based on a generic crown form using resin based materials.

COMMENTS

1. D2932 reports a *prefabricated resin* crown for *either* a primary or permanent tooth.
2. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Some payors have a lifetime exclusion if performed on a primary tooth or an age limitation (under thirteen-fourteen) if for a permanent tooth.
2. Limitations may not apply when the replacement is a result of an accident or injury.

NARRATIVES

1. An alternate benefit of a stainless steel crown may be reimbursed for D2932. Reimbursement among payors is highly variable for D2932. It is recommended that coverage be verified with the payor prior to rendering treatment. The narrative should outline the conditions that exist to justify the placement of a prefabricated crown along with an estimate of the period of the crown's use.
2. The narrative should clearly describe any accident and/or injury involving the tooth treated with the prefabricated resin crown D2932.

D2933 PREFABRICATED STAINLESS STEEL CROWN WITH RESIN WINDOW CDT 2025

Open-face stainless steel crown with aesthetic resin facing or veneer.

COMMENTS

1. Prefabricated stainless steel crown with resin window (D2933) is generally reimbursed when placed on anterior primary teeth. When placed on posterior primary teeth the service may be considered cosmetic and an alternate benefit of a primary stainless steel crown (D2930) may be reimbursed or (D2931) if placed on a permanent tooth.
2. Prefabricated stainless steel crown with resin window (D2933) may be placed on primary or permanent teeth.
3. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Replacement for prefabricated stainless steel crown with resin window (D2933) may be limited to 24 months on *permanent* teeth. For patients thirteen-fourteen years and younger there is often a two to five year exclusion when the prefabricated stainless steel crown with resin window is performed on an anterior permanent tooth. Reimbursement among payors is highly variable for this procedure. It is recommended that the coverage is verified with the payor prior to rendering the treatment.
2. Reimbursement for prefabricated stainless steel crown with resin window (D2933) is typically once per lifetime when performed on an anterior *primary* tooth.

D2934 PREFABRICATED ESTHETIC COATED STAINLESS STEEL CROWN - PRIMARY TOOTH CDT 2025

Stainless steel primary crown with exterior esthetic coating.

COMMENTS

1. Prefabricated esthetic coated stainless steel crown (D2934) reports a prefabricated, esthetic coated, stainless steel crown for a *primary* anterior or posterior tooth.
2. D2934 cannot report a prefabricated esthetic coated stainless steel crown placed on a *permanent* tooth.
3. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. D2934 may be subject to a 24-month or up to a lifetime exclusion. Exclusions among payors for this code are highly variable. It is recommended that coverage be verified with the payor before rendering treatment.
2. D2934 may be reimbursed when performed on *primary* anterior teeth.
3. For posterior *primary* teeth, an alternate benefit, primary stainless steel crown (D2930), may be reimbursed. Reimbursement among payors is highly variable for this code; verify coverage with the payor before rendering treatment.

PHOTO



This is a prefabricated esthetic coated stainless steel crown primary tooth.

Courtesy Java Crown, Inc.

D2940 REVISED PLACEMENT OF INTERIM DIRECT RESTORATION CDT 2025

Direct placement of a restorative material to protect tooth and/or tissue form. This procedure may be used to relieve pain, promote healing, manage caries, create a seal for endodontic isolation, or prevent further deterioration until definitive treatment can be rendered. Not to be used for endodontic access closure, or as a base or liner under a restoration.

REVISIONS

PLACEMENT OF INTERIM DIRECT ~~PROTECTIVE~~ RESTORATION

Direct placement of a restorative material to protect tooth and/or tissue form. This procedure may be used to relieve pain, promote healing, manage caries, create a seal for endodontic isolation, or prevent further deterioration until definitive treatment can be rendered. Not to be used for endodontic access closure, or as a base or liner under a restoration.

WARNING

1. D2940 should *not* be reported as a base or liner in conjunction with an amalgam/composite restoration or any other type of restoration.
2. D2940 should *not* be reported for definitive endodontic access closure. Report D2140, D2330 or D2391.
3. D2940 should *not* be used to report root desensitization. See application of desensitizing resin for cervical and/or root surface sensitivity (D9911).
4. D2940 should not be used for sealing the pulp chamber after completion of the root canal therapy prior to the buildup or definitive restoration. See D3911 intraorafice barrier.

WATCH

1. The interim direct restoration was formerly termed a protective restoration or a sedative filling, although interim direct restorations include a wider variety of restorative options.
2. D2940 is sometimes used to report a restoration placed at an emergency *evaluation* appointment associated with a fractured tooth. See also palliative (D9110).
3. D2940 should *not* be reported in conjunction with pulp cap (D3110 or D3120). Report either D2940 or a pulp cap, not both on the same service date. See D3110/D3120.
4. Interim therapeutic restorations on primary teeth are now reported using D2940, as the revised code language now encompasses this previously separate procedure.
5. See D2976 band stabilization—per tooth for interim stabilization of a multisurface restoration.

COMMENTS

Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. An interim direct restoration (D2940) reports the direct placement of a temporary restoration to protect the tooth, relieve dental pain, manage caries, create a seal for endodontic isolation, and/or promote healing until definitive treatment can be rendered.
2. Payors may subtract the fee previously reimbursed for D2940 from the reimbursement fee for the final restoration, such as a crown or filling if performed within the exclusion period. That exclusion period is typically thirty days to six months. When applicable, D2940 may be considered a "take-back" code. Reimbursement among payors is highly variable.
3. A separate fee for a pulp cap (direct or indirect) plus an interim direct restoration (D2940) is not typically reimbursed if both are reported on the same service date. See D3110/D3120.

4. Reimbursement for the interim direct restoration (D2940) is highly variable among payors when the procedure is performed on the same tooth on multiple dates. The reimbursement may be limited to once per lifetime per tooth.
5. Use of an interim direct restoration (D2940) for endodontic isolation during treatment will likely be considered an integral part of the global endodontic procedure by payors and not reimbursed separately.

D2941 DELETED INTERIM THERAPEUTIC RESTORATION - PRIMARY DENTITION CDT 2025

This is a deleted code. See D2940 for further details.

D2949 RESTORATIVE FOUNDATION FOR AN INDIRECT RESTORATION CDT 2025

Placement of restorative material to yield a more ideal form, including elimination of undercuts.



WARNING

1. Do not report D2950, core buildup, when placing a restorative foundation to aid in the fabrication of an indirect restoration. D2950 should only be reported when the core buildup is necessary for the *retention* of the indirect restoration (crown).
2. D2949 describes the placement of a "filler" to eliminate undercuts and/or to provide an ideal contour for an indirect restoration. It is not a core buildup.

COMMENTS

1. D2949 is used to describe the placement of a restorative material in a tooth to prepare for the ultimate placement of a crown, bridge, inlay, onlay, veneer and or other type of fixed indirect restoration. The D2949 procedure is performed to provide a more ideal form for the processing and adaptation of the final indirect restoration. The restorative foundation, described by D2949 is provided to establish a more ideal form and/or to eliminate undercuts. However, report D2950 when a buildup is necessary for the *retention* of the final indirect restoration (crown).
2. Enter the tooth number and surfaces being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. It is unlikely that D2949 will be reimbursed. Most payors have determined that a restorative foundation is a part of the global reimbursement provided for the indirect restoration.
2. Most PPO payors will "disallow" this procedure, requiring a write-off.

D2950 CORE BUILDUP, INCLUDING ANY PINS WHEN REQUIRED CDT 2025

Refers to building up of coronal structure when there is insufficient retention for a separate extracoronal restorative procedure. A core buildup is not a filler to eliminate any undercut, box form, or concave irregularity in a preparation.



WARNING

1. It is misleading to report a core buildup (D2950) when the affected tooth after preparation would be retentive enough to support a crown without the core buildup. Core buildups placed to improve "box-form," eliminate "concave irregularity" or "undercuts" and "fillers" should not be submitted for reimbursement. A core buildup must be *necessary* for crown *retention* to be considered a core buildup. The core buildup should rebuild the *internal anatomy* of the tooth structure as prepared for a crown.
2. It is misleading to report a *one-piece* Cerec® or E4D® fabricated crown, as a crown (D2740) *and* a separate core buildup. A core buildup is always a separate component apart and separate from the CAD/CAM crown. Cerec 3D® or E4D® users may report unspecified restorative procedure, by report (D2999) for a *one-piece* "endo-crown." *Do not expect an alternate reimbursement for both a core buildup and crown.* Expect only the alternate benefit of a crown.
3. It is misleading to report a core buildup as a direct amalgam/composite restoration. A restoration is built to *occlusion*, with normal *anatomy*, proximal *contacts*, and is in full *function*. A filling restores the tooth to full form and function. Amalgams and composites reported shortly before the crown preparation may be *deducted* from the subsequent crown reimbursement amount. The restoration is a "take back" procedure if placed just prior to placing a crown. The "take back" provision may vary according to the time period between the restorative procedure and the subsequent crown.

4. It is misleading to report a core buildup in conjunction with an inlay or onlay. A core buildup is only justified when placed in a fully prepared tooth and built up to allow for the *retention* of the extracoronal restorative procedure.



WATCH

1. D2950 also reports a core buildup placed under the retainer crown of a bridge. There is not a separate code to report a core buildup under a retainer crown.
2. It is not permitted to report pin retention (D2951) in *addition* to a core buildup. The core buildup is inclusive of *any* pin placement when required.
3. Report D2330 when restoring an endodontic access opening or the access opening for the internal bleaching (D9974) of a natural tooth. Do not report core buildup (D2950) or prefabricated post and core (D2954) when restoring and closing an endodontic access opening where the crown is intact. Core buildups and prefabricated post and core are reimbursable when they are necessary for the *retention* of the crown, not for closure of an endodontic access opening with an intact crown. Do not report crown repair necessitated by material failure (D2980) either. If the crown is *removed* first then core buildup/prefabricated post and core accomplished, then the D2950 may be reported.
4. Some payors will reimburse D2950 in conjunction with a prefabricated permanent tooth stainless steel crown.

COMMENTS

Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. A core buildup (D2950) may be reimbursed when its *necessity* is objectively determined and properly documented. Some payors will not reimburse a core buildup on a vital tooth. These payors indicate that the core buildup is a part of the crown preparation. If a payor denies reimbursement for this reason, have the patient request a copy of their specific dental insurance contract (Plan Document) from their Human Resources department at work. Use the contract to verify the contract language for the specific exclusion of a core buildup.
2. While core buildups may be performed on vital teeth, coverage may be limited to non-vital posterior teeth. Core buildups performed on non-vital teeth are generally covered, especially if associated with a posterior tooth.

TIPS

1. Some payors require a certain "date sequence" to justify the core buildup (D2950). Report the core buildup (D2950) when performed. Note that *some* payors will not reimburse the core buildup unless a predetermination has been submitted for the planned crown or until the crown has been seated (on a subsequent date). Note: Per the ADA, procedures may be reported either at the *start date*, or at the *completion date*. (See the current language at the bottom of the ADA claim form.) The claim form states "I hereby certify that the procedures as indicated by date are in *progress* (for procedures that require multiple visits) or have been *completed*." Note: The third-party contract (PPO) may dictate that the doctor report the crown on either the *start* or *completion* date. Generally the reporting date is the *completion* date according to almost all PPO contracts. Refer to the contract language for the proper coding/billing.
2. Some practices file a "paper" claim form on the preparation date with the "predetermination" and "statement of actual services" blocks checked (at the top of the form). Enter the core buildup with fee and date. Next, enter the proposed crown to be placed with the date area empty but the fee entered. Many payors will consider the core buildup claim as they have been alerted that the crown is planned and will follow the core buildup on a subsequent date. Note: The core buildup (D2950) must be necessary for retention of the crown.
3. Include intraoral photos of the tooth before preparation (to justify the crown) and after decay removal and preparation (to show extent of tooth loss and justify the buildup).

NARRATIVES

1. Always include a narrative when reporting core buildup (D2950), for example, "a core buildup is *necessary for the retention of the crown*." The narrative should identify the actual percentage of missing tooth structure, after full preparation e.g., "60% of the tooth is missing." Some payors require that 50% or *more* of the tooth be missing for reimbursement. When less than 50% of the tooth is missing, some payors consider the procedure a "filler." Some payors require that less than a 2mm-3mm "collar" (tooth height structure) remain. A supporting diagnostic radiograph/photograph should be included in the documentation for the core buildup. Pretreatment radiographic and photographic images are recommended to also document the necessity for both the crown and the core buildup.

2. A narrative is especially important when reporting a core buildup associated with an endodontically treated or periodontally involved tooth. Some payors reimburse core buildups on non-vital (endodontic) teeth, but *exclude* reimbursement for vital teeth. When reporting a core buildup placed on an endodontically treated tooth, submit the narrative: *"The core buildup was necessary for the retention of the crown. This is an endodontically treated tooth. Endodontics completed mm/dd/yy." Enclose a diagnostic image (periapical) showing the tooth has received adequate endodontic treatment. If D2950 is rejected for an endodontically treated tooth, submit a paper claim form with narrative, "This is an endodontically treated tooth."* When submitting for a core buildup on a periodontally involved tooth, include the date of SRP and a note about mobility. In both of these situations, it is beneficial to give the practitioner's opinion concerning the long term prognosis of the tooth.
3. The payor may refuse reimbursement for a core buildup unless/until the crown has been placed. If a patient has the core buildup but does not plan to have the subsequent crown placed (due to finances or loss of commitment), re-file the claim with an explanation explaining why the patient did not complete the treatment. Request an alternate b*enefit* for a four surface composite restoration (D2335, D2394, or a four surface amalgam D2161). In this situation the core buildup may be reimbursed.
4. Core buildups (D2950) are typically limited to cast or milled crowns. In some limited circumstances, stainless steel crowns on *permanent* teeth provided to a child or adult may require a buildup for *retention* of the stainless steel crown and may be reimbursed. The claim should include a full narrative with diagnostic images as documentation. On the other hand, payors rarely reimburse a core buildup required for the retention of *primary* tooth due to contract limitations.
5. In summary, the narrative could say:
   a. "See attached intraoral photos and radiographic image." (If tooth has RCT, send PA radiographic image).
   b. List any missing cusps. Estimate and state percentage of healthy tooth structure left after fracture, caries and/or any previous restoration is removed.
   c. Document any existing circumferential caries at gingival margin and extensive caries detectable by explorer under existing crown. State if tooth has existing or planned RCT (root canal therapy).
   d. State endodontic and periodontal prognosis for tooth.
   e. If there is less than 2mm of vertical height remaining of the tooth, state that and also state the number of degrees of circumference of the tooth where this exists, e.g., "only 1mm of vertical tooth height remains around 270 degrees of tooth circumference."
   f. State the percentage of the tooth missing after full preparation (more than 50%).

D2951 PIN RETENTION - PER TOOTH, IN ADDITION TO RESTORATION CDT 2025



WARNING

1. It is misleading to *routinely* report pin retention (D2951) in every amalgam/composite restoration when the need is not justified.
2. Do not charge pins in addition to core buildup (D2950), per the nomenclature for D2950. If pins are placed they are considered a part of the global core buildup procedure.

COMMENTS

Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Pin reimbursement is generally excluded for *primary* teeth.
2. Pins placed to aid in the retention of an amalgam/composite restoration are generally reimbursed. Pins are reported on a "per tooth" basis. There could be *several* pins placed in any given restoration, but report D2951 only once per tooth.

NARRATIVES

Report the number of pins placed. (For example, "three pins placed in the amalgam/composite restoration," tooth #3.)

D2952 POST AND CORE IN ADDITION TO CROWN, INDIRECTLY FABRICATED CDT 2025

Post and core are custom fabricated as a single unit.



WARNING

It is inappropriate to report the prefabricated post and core (D2954) as an indirectly fabricated or cast post and core (D2952).

WATCH

1. The same code reports a post and core, indirectly fabricated (D2952) under *either* a single crown **or** the retainer crown of a bridge.
2. The fee for a post and core (D2952) is often higher than a prefabricated post and core (D2954).

COMMENTS

Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Some payors may reimburse the *alternate benefit* of a prefabricated post and core (D2954) for the indirectly fabricated post and core (D2952).
2. For *anterior* teeth with root canals, documentation of insufficient tooth structure to support a crown may be required to justify reimbursement for both D2952 and D2954.

NARRATIVES

1. The indirectly fabricated post and core (D2952) is generally reimbursed for a *posterior* tooth. The reimbursement for an indirectly fabricated post and core (D2952) is typically higher than for a core buildup (D2950) or the prefabricated post and core (D2954). A narrative may not be required when performed on a posterior tooth as it is assumed that the indirectly fabricated post and core is performed on an endodontically treated tooth. The indirect cast post procedure is used less frequently than the prefabricated post and core (D2954). A diagnostic image of the endodontically treated tooth should be submitted. Photographs may be helpful to document need. Payors generally require the endodontic treatment be clinically acceptable and the tooth free of pathology (endodontic and periodontic).
2. If tooth does not have existing RCT (root canal therapy), at the time of the predetermination, state when RCT will be done.
3. Estimate and state percentage of healthy tooth structure left after fracture, caries and/or any previous restoration is removed. "See attached radiographic image." (Send PA radiographic image).

D2953 EACH ADDITIONAL INDIRECTLY FABRICATED POST - SAME TOOTH — CDT 2025

To be used with D2952.

COMMENTS

1. D2953 is used to report each *additional* indirectly fabricated post - same tooth. Report this code in *conjunction* with D2952 for the same tooth. See D2952 for further details.
2. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

Most payors consider D2953 a part of the indirectly fabricated post and core procedure (D2952) and do not provide additional reimbursement for the D2953 placement.

NARRATIVES

1. If the tooth does not have an existing RCT (root canal therapy), at the time of the predetermination, state when RCT will be done.
2. Estimate and state the percentage of healthy tooth structure left after fracture, caries and/or any previous restoration is removed. "See attached radiographic image." (Send PA radiographic image).

D2954 PREFABRICATED POST AND CORE IN ADDITION TO CROWN — CDT 2025

Core is built around a prefabricated post. This procedure includes the core material.



WARNING

1. It is misleading to report a prefabricated post and core (D2954) as an indirectly fabricated post and core (D2952), or vice versa.
2. By definition, prefabricated post and core in addition to crown (D2954) *includes* the core material placed *around* a prefabricated post. Do not report core buildup (D2950) in addition to D2954. When placing a prefabricated post and core in addition to crown, report *only* D2954.

3. It is inappropriate to report the canal preparation and fitting of the post (D3950) if the *same* provider will place the prefabricated post and core in addition to crown (D2954).

WATCH

The reporting of a post and core associated with the retainer crown of a bridge utilizes the same code. Report D2954 to describe a prefabricated post and core for either a single *crown or retainer crown* of a bridge.

COMMENTS

Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

TIPS

If a post and core is placed in an endodontically treated tooth access hole and a filling (amalgam/composite) is placed rather than a crown placed, report D2999 to describe the placement of the post and core and the restoration of the natural tooth.

NARRATIVES

1. For *anterior* teeth, documentation of insufficient tooth structure to support the crown is sometimes required for reimbursement. Provide a narrative similar to the one for a core buildup. See D2950 for further details.
2. The prefabricated post and core (D2954) is generally reimbursed when used to restore an endodontically treated tooth. The reimbursement for D2954 is higher than a core buildup (D2950) and lower than a post and core in addition to crown, indirectly fabricated (D2952). A narrative may not be required for a posterior tooth. It is assumed that the buildup has been performed on an endodontically treated tooth. Many doctors routinely use prefabricated post and core (D2954) on endodontically treated teeth. The carbon Fibercor® post is frequently used as a prefabricated post. A diagnostic image of the endodontically treated tooth should be submitted to document the need for the prefabricated post and core. Photographs may be helpful to justify the need for a prefabricated post and core. Payor's generally require that the endodontic treatment be clinically acceptable and the tooth free of pathology (endodontic and periodontic).
3. If tooth does not have existing RCT (root canal therapy), at the time of the predetermination, state when RCT will be done.
4. Estimate and state percentage of healthy tooth structure left after fracture, caries and/or any previous restoration is removed. "See attached radiographic image." (Send PA radiographic image).

PHOTO



This is a prefabricated post which is placed in an endodontically treated tooth. After placement of the post, a core is built around it.

Courtesy Ultradent®

D2955 POST REMOVAL

CDT 2025

WATCH

D2955 reports a *stand-alone* post removal. Post removal is typically considered by payors to be part of retreatment of a previous root canal therapy.

COMMENTS

Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. The post removal procedure is generally considered *inclusive* by third-party payors for root canal retreatment (D3346, D3347, and D3348).
2. D2955 might be reimbursed if the same billing provider does not perform *both* post removal and the subsequent endodontic retreatment procedure. Reimbursement may be made when the general practitioner removes the post while the endodontist (different practitioner and office) provides the root canal retreatment.

NARRATIVES

1. It is recommended that a narrative be included with a claim for D2955. The narrative should describe the complexity, depth of post, and extra time required for removal.
2. Describe if the same billing provider does not perform both post removal and the endodontic procedure. This may improve the odds for reimbursement of D2955.

D2956 NEW PROCEDURE REMOVAL OF AN INDIRECT RESTORATION ON A NATURAL TOOTH

CDT 2025

Not to be used for a temporary or provisional restoration.

WATCH

1. D2956 reports the REMOVAL of a previously placed indirect restoration on a natural tooth. This may be for the purposes of immediate replacement of a failing restoration or to determine the extent of decay and prognosis of the tooth prior to treatment planning, as examples.
2. D2956 should not be reported for the removal of a temporary or provisional restoration, even if it was indirectly fabricated, per the code descriptor.
3. Indirect restorations are defined as restorations fabricated outside the mouth. The restorations covered by this code may include, but are not limited to, an indirectly fabricated crown, retainer crown, inlay, onlay, or veneer on a natural tooth.
4. When completely removing a fixed bridge on natural teeth, report D2956 for each retainer crown removed.
5. To report the sectioning of a bridge with the intention of leaving a retainer crown or crowns as definitive restorations, see D9120 fixed partial denture sectioning.

COMMENTS

Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

Insurance plans are likely to continue to consider removal of an old indirect restoration as a part of the new indirect restoration procedure and not reimburse it separately.

NARRATIVES

1. Note the reason for the removal of the existing indirect restoration (damage past repair, further assessment of decay noted at margins, etc.).
2. Mention any information concerning unusual situations that would make the removal more difficult than normal.
3. Include intraoral photos that would help justify the removal of the existing restoration.

D2957 EACH ADDITIONAL PREFABRICATED POST - SAME TOOTH

CDT 2025

To be used with D2954.



MATCH

D2957 is used to report each *additional* prefabricated post and core for the same tooth. This procedure code would only be reported in addition to prefabricated post and core (D2954) on the same service date. See D2954 for further details.

COMMENTS

Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

Most payors consider D2957 to be integral to the basic prefabricated post and core (D2954) procedure, and do not provide additional reimbursement for each additional prefabricated post(s) placed in the same tooth, on the same service date.

NARRATIVES

1. If tooth does not have existing RCT (root canal therapy), at the time of the predetermination, state when RCT will be done.
2. Estimate and state percentage of healthy tooth structure left after fracture, caries and/or any previous restoration is removed. "See attached radiographic image." (Send PA radiographic image).

D2960 LABIAL VENEER (RESIN LAMINATE) - DIRECT

CDT 2025

Refers to labial/facial direct resin bonded veneers.

COMMENTS

Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Plan limitations and reimbursements are highly variable for this chairside direct procedure.
2. If the plan has a special policy rider, reimbursement may be provided for this procedure. To be considered for reimbursement, the procedure would treat severe fluorosis, tetracycline staining, pegged laterals, amelogenesis imperfecta, or some other type of pathology.
3. D2960 reports a "free hand" chairside direct resin-bonded veneer. This direct resin-bonded procedure is generally considered *cosmetic* in nature. If decay has been diagnosed or if the procedure is provided to replace a defective restoration with decayed margins, it may be a covered benefit.

NARRATIVES

Photographs, diagnostic images, and a narrative should be submitted with the claim.

D2961 LABIAL VENEER (RESIN LAMINATE) - INDIRECT

CDT 2025

Refers to labial/facial indirect resin bonded veneers.

WATCH

Do not report D2961 for laboratory made or CAD/CAM *porcelain/ceramic* veneers. See D2962 for further details regarding a *porcelain/ceramic* laminate that is indirectly fabricated.

COMMENTS

1. D2961 reports Belleglass®, Cristobal®, Artglass®, Concept®, and Targis/Vectris® resin-type materials. D2961 should not be used to report porcelain/ceramic-type veneers. If reporting a *porcelain* laminate material, see D2962 for further details.
2. The descriptor of a veneer has been expanded to include prepping into the mesial and distal (interproximally) and/or covering the incisal edge. On a virgin tooth, a veneer (D2962) is more appropriate to report, if it only extends interproximally, rather than a reverse ¾ porcelain crown (D2783).
3. Milled or 3D printed restorations may be reported using D2961 if made from an appropriate resin based material.
4. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

If the employer opts to purchases a special policy rider in addition to the basic policy, reimbursement may be provided for this procedure. To be considered for reimbursement, the procedure would be used to treat severe fluorosis, tetracycline staining, pegged laterals, amelogenesis imperfecta, or some other type of pathology.

TIPS

1. Fees charged for labial veneers should reflect the time, laboratory expense and skill required to perform this tedious anterior cosmetic procedure. Although the preparation for a veneer is generally faster than for a crown, temporization and seating is much more difficult. Consider setting a fee for a resin laminate veneer (D2961) comparable to that of a porcelain/ceramic crown (D2740). Consider setting a higher fee than for a *routine* porcelain fused to metal crown.
2. A resin laminate veneer is generally considered a *cosmetic* procedure and is generally not reimbursed. In some limited circumstances, payors may reimburse veneers if the veneer is used to treat decay, cracks or other pathology. Diagnostic images and diagnostic photographs should be submitted with the claim, along with a narrative.
3. Often, a veneer is denied and must be appealed to receive reimbursement, even if necessary to treat pathology. Ask the patient to obtain a copy of the Plan Document from their Human Resources department at work. Review the policy to determine if there is veneer coverage. If veneers are excluded, ask for an alternate benefit.
4. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

NARRATIVES

1. In limited circumstances (with a cosmetic rider), payors may reimburse veneers to correct severe congenital or developmental anomalies. Plan limitations and exclusions vary widely between policies and payors. It is recommended that when veneers are placed, a brief narrative and supporting documentation accompany the claim.
2. Documentation should state, "see attached photo and radiographic image." Identify the surfaces of the tooth that are fractured, have caries and/or have existing restorations that are failing or leaking. If fractured, state how fracture occurred.

D2962 LABIAL VENEER (PORCELAIN LAMINATE) - INDIRECT CDT 2025

Refers also to facial veneers that extend interproximally and/or cover the incisal edge. Porcelain/ceramic veneers presently include all ceramic and porcelain veneers.



WARNING

It is misleading to report anterior porcelain veneers on *virgin* teeth as "reverse" ¾ porcelain/ceramic crowns (D2783). The descriptor for D2962 states that the porcelain veneer code (D2962) now includes prepping and "extending interproximally and/or covering the incisal edge." The "reverse" ¾ porcelain crown preparation is a more aggressive preparation, with less lingual enamel remaining. The tooth might have had previous interproximal composite restorations. See D2783 for further details regarding reporting a ¾ porcelain crown, which may be reimbursed.

COMMENTS

Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. The descriptor of a veneer has been expanded to include prepping into the mesial and distal (interproximally) and/or covering the incisal edge. On a virgin tooth, a veneer (D2962) is more appropriate to report, if it only extends interproximally, rather than a reverse ¾ porcelain crown (D2783).
2. If the employer opts to purchase a special policy rider in addition to the basic policy, reimbursement may be provided for this cosmetic procedure. To be considered for reimbursement, the procedure would be used to treat severe fluorosis, tetracycline staining, pegged laterals, amelogenesis imperfecta, or some other type of pathology.

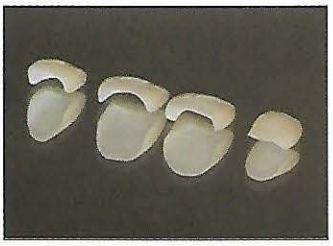
TIPS

1. Fees charged for laboratory labial veneers should reflect the time, laboratory expense and skill required to perform this tedious anterior cosmetic procedure. Although the preparation for a veneer is generally faster, temporization and seating is much more difficult. Consider setting a fee for a porcelain labial veneer (D2962) comparable to that of a porcelain/ceramic crown (D2740). Consider setting a higher fee than for a *routine* porcelain fused to metal crown.
2. A porcelain veneer is generally considered a *cosmetic* procedure and is generally not reimbursed. In some limited circumstances, payors may reimburse veneers if the veneer is used to treat decay, cracks or other pathology. Diagnostic images and diagnostic photographs should be submitted with the claim, along with a narrative.
3. Often, a veneer is denied and must be appealed to receive reimbursement, even if used to treat pathology. Ask the patient to obtain a copy of the full dental coverage contract (plan document) from their Human Resources department. Review the plan document to determine if there is veneer coverage. If veneers are excluded, ask for an alternate benefit. If veneers are not excluded, appeal the denial with the necessary documentation.
4. Milled or 3D printed restorations may be reported as porcelain/ceramic provided the material is greater than 50% inorganic filler.

NARRATIVES

1. In limited circumstances (with a cosmetic rider), payors may reimburse veneers to correct severe congenital or developmental anomalies. Plan limitations and exclusions vary widely between policies and payors. It is recommended that when veneers are placed, a brief narrative and supporting documentation accompany the claim.
2. Documentation should state, "see attached photo and radiographic image." Identify the surfaces of the tooth that are fractured, have caries and/or have existing restorations that are failing or leaking. If fractured, state how fracture occurred.

PHOTO



This is a photograph of four porcelain veneers sitting on a reflective surface.

Courtesy Drake Dental Lab

D2970 PREVIOUSLY DELETED CODE TEMPORARY CROWN (FRACTURED TOOTH)

This is a previously deleted code. See Interim Crown, D2799 for further details.

D2971 ADDITIONAL PROCEDURES TO CUSTOMIZE A CROWN TO FIT UNDER AN EXISTING PARTIAL DENTURE FRAMEWORK

CDT 2025

This procedure is in addition to the separate crown procedure documented with its own code.

MATCH

When placing a crown on a tooth that currently supports a partial denture, use this code to describe the additional procedures necessary to fabricate a customized crown that is made to fit the clasp/rest of the existing partial denture framework. Report this procedure in conjunction with the crown fabrication. Report additional procedures (D2971) separate from the crown restoration.

COMMENTS

1. D2971 reports the additional laboratory and chairside procedures required to construct a new crown under an *existing* partial denture framework.
2. CAD/CAM (Cerec®/E4D®) offices may report D2971 separate from the crown restoration.
3. If the crown is a survey crown for a new partial denture (to be fabricated in the future) there is no code, see D2999.
4. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

D2971 may be reimbursed once per tooth, subject to the same five to 10 year limitation period for a replacement crown. *Report the crown separately, and in addition to D2971.*

TIPS

1. Fabricating a new crown to fit under an *existing* partial denture framework's clasp is challenging. Extra laboratory steps, cost, and time are involved. In addition, extra chairside time is typically required at delivery to properly adjust the new crown to the existing partial denture framework. List *both* the appropriate crown code plus code D2971 as two separate line items, with two separate, distinct fees on the claim form. D2971 requires a tooth number for reimbursement.
2. Report D2971 and the crown as separate codes and submit them on the seat date to decrease any possible confusion, delays, or denials.

NARRATIVES

Include a short narrative describing the additional procedures necessary to construct a new crown under an existing cast partial framework and attach a copy of the lab bill reflecting the extra charge. Also, enter the tooth number of the crown for D2971.

D2975 COPING

CDT 2025

A thin covering of the coronal portion of a tooth, usually devoid of anatomic contour, that can be used as a definitive restoration.

COMMENTS

1. D2975 reports a definitive (final) restoration over the remaining natural tooth. As an example, a removable prosthesis (natural tooth overdenture) fits over two separate and *independent* canine coping abutments. There is no connecting bar and both copings are reported independently as D2975.

2. If a bar connects the copings, each connected coping is reported as D2975. See D6920 to report the connector bar. Note that D6975 has been previously deleted and that D2975 reports all copings.
3. A telescopic crown (D27xx) may be indicated to provide more ideal alignment and support for removable or fixed partial denture cases involving teeth that are badly broken, malpositioned, or tipped. Sometimes referred to as a "double crown retained prostheses," Telescopic retainers appear to have a crown on a crown. The first "crown" is actually a metal coping that is cemented to the prepped tooth and reported as D2975. The second crown-like piece (D27xx), is fabricated to fit over the coping (D2975). It is considered the definitive restoration.
4. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

D2975 is not typically reimbursed unless an alternate benefit is available. However, an alternate benefit is unlikely. This procedure, in all likelihood, will be a patient responsibility and will be "denied." Denied means the payor will not pay but the patient may be billed.

D2976 BAND STABILIZATION – PER TOOTH

A band, typically cemented around a molar tooth after a multi-surface restoration is placed, to add support and resistance to fracture until a patient is ready for the full cuspal coverage restoration.



WARNING

Do not report D2976 for the routine placement of orthodontic bands or stainless steel crowns.

COMMENTS

1. D2976 documents the use of a well-fitting orthodontic band, typically cemented around a molar tooth after a multiwall restoration has been placed, as an interim means to add support and resistance to fracture until a patient is ready for a full cuspal coverage restoration.
2. This procedure is most appropriate for pre-orthodontic age patients or as an interim restorative technique for those with special health care needs but may be reported for patients needing to postpone a crown due to financial reasons.
3. Report D2976 in addition to the multi surface restoration.
4. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Report D2976 in addition to the restoration reported.
2. Some payors may consider the band stabilization a part of the global restoration.

D2980 CROWN REPAIR NECESSITATED BY RESTORATIVE MATERIAL FAILURE CDT 2025



WARNING

1. Do not generally report D2980 for the closure of an endodontic access hole. Endodontic access is not a restorative materials failure. See LIMITATIONS #2 below.
2. A crown repair (D2980) requires a restorative material failure (fracture). It includes any part of the ¾ crown or full crown.
3. If a filling is needed to repair decay below the crown's margins, report the appropriate amalgam or composite code. Include a narrative indicating there was facial decay below the crown's margins. State "A facial composite was placed below the margin of the crown in an area of facial decay."
4. It is misleading to report a core buildup (D2950) in conjunction with crown repair (D2980) when the crown has not been removed to place the core buildup. A core buildup is for retention of the crown.
5. Do not report D2980 for crown repair of an implant supported restoration or a fixed partial denture (bridge). See D6090 and D6980, respectively.
6. Do not report D2980 for repair of an inlay, onlay, or veneer. See D2981, D2982, and D2983, respectively.

COMMENTS

Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. A crown repair (D2980) may be subject to the five to 10 year limitation for a replacement crown and if performed may limit the replacement of that crown by the same term. If reimbursed, the amount may be 50% of the payor's fee.
2. For endodontic access closure (through an existing cemented or bonded posterior crown), consider a single surface amalgam (D2140) or composite (D2391) with a narrative to report this type of service if the crown is intact. These procedures are typically reimbursed at 80% of the payor's fee. However, a few payors could require that D2980 be reported for closure of an intentional endodontic access opening made through an existing crown, but would be rare. D2980 was revised where it is restricted to a materials failure and opening for the endodontic access is not a material failure.

NARRATIVES

A brief narrative should describe the crown repair procedure. The fee reimbursed may be based on the time necessary to perform the service and amount of the laboratory bill, if applicable. It is suggested that the time spent be included in the narrative and a copy of the laboratory bill be attached.

D2981 INLAY REPAIR NECESSITATED BY RESTORATIVE MATERIAL FAILURE CDT 2025

COMMENTS

1. D2981 requires a restorative material failure (fracture) of the inlay. It includes any part of the inlay restoration. A composite restoration that may be required at the inlay's margin to address decay is reported as a composite restoration. Include a narrative indicating there was decay along the inlay's margins.
2. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. An inlay repair (D2981) requires a restorative material failure (fracture). It is suggested that the coverage be verified for this procedure before submitting a claim.
2. An inlay repair (D2981) may be subject to the five to 10 year limitation for a replacement inlay and if performed may limit the replacement of that inlay by the same term. If reimbursed, the amount is typically 50% of the payor's fee. Inlays are typically not benefitted.
3. Plan limitations are generally highly variable, and some may have an exclusion of one tooth per 12 months for inlay repair, if applicable.
4. For endodontic access closure (through an existing cemented or bonded inlay), consider a single surface amalgam (D2140) or composite (D2330 or D2391). These procedures are typically reimbursed at 80% of the payor's fee. However, a few payors could possibly require that you report inlay repair necessitated by restorative material failure (D2981) for closure of an intentional endodontic access opening made through an existing inlay. The inlay repair may be reimbursed at 50% of the payor's fee. This situation would be rare.

NARRATIVES

A brief narrative should describe the inlay repair procedure when reporting this procedure. The fee reimbursed may be based on time necessary to perform the service and amount of the laboratory bill. It is suggested that the time spent be included in the narrative and a copy of the laboratory bill (if applicable) be attached.

D2982 ONLAY REPAIR NECESSITATED BY RESTORATIVE MATERIAL FAILURE CDT 2025

COMMENTS

1. D2982 requires a restorative material failure (fracture) of the onlay. It includes any part of the onlay restoration. A composite restoration that may be required below the onlay's margin to address decay would be reported as a composite restoration. Include a narrative indicating there was facial decay below the onlay's margins. State, "A facial composite was placed below the margin of the onlay."
2. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. An onlay repair (D2982) requires a restorative material failure (fracture). It is suggested that coverage be verified for this procedure before submitting a claim.
2. An onlay repair (D2982) may be subject to the five to 10 year limitation for a replacement onlay and if performed may limit the replacement of that onlay by the same term. If reimbursed, the amount is typically 50% of the payor's fee.
3. Plan limitations are highly variable, and some may have an exclusion of one tooth per 12 months for onlay repair.

4. For endodontic access closure (through an existing cemented or bonded onlay), consider a single surface amalgam (D2140) or composite (D2330 or D2391). These procedures are typically reimbursed at 80% of the payor's fee. However, a few payors could possibly require that you report onlay repair necessitated by restorative material failure (D2982) for closure of an intentional endodontic access opening made through an existing onlay. The onlay repair may be reimbursed at 50% of the payor's fee.

NARRATIVES

A brief narrative should describe the onlay repair procedure when reporting this procedure. The fee reimbursed may be based on time necessary to perform the service and amount of the laboratory bill. It is suggested that the time spent and a copy of the laboratory bill (if applicable) be attached.

D2983 VENEER REPAIR NECESSITATED BY RESTORATIVE MATERIAL FAILURE CDT 2025

COMMENTS

1. D2983 requires a restorative material failure (fracture) of the veneer. It includes any part of the veneer restoration, but does not include a composite filling placed at the margin that may be required to treat decay. Include a narrative indicating there was facial decay at the veneer's margins. State, "A facial composite was placed below the margin of the veneer."
2. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. A veneer repair (D2983) requires a restorative material failure (fracture). It is suggested that coverage be verified for this procedure before submitting a claim.
2. A veneer repair (D2983) may be subject to the five to 10 year limitation for a replacement veneer and if performed may limit the replacement of that veneer by the same term. If reimbursed, the amount is typically 50% of the payor's fee.
3. Plan limitations are highly variable, and some may have an exclusion of one tooth per 12 months for veneer repair.

NARRATIVES

A narrative should describe the veneer repair procedure when reporting this procedure. The fee reimbursed may be based on time necessary to perform the service and amount of the laboratory bill. It is suggested that the time spent and a copy of the laboratory bill (if applicable) be attached.

D2989 EXCAVATION OF A TOOTH RESULTING IN THE DETERMINATION OF NON-RESTORABILITY CDT 2025



WARNING

Do not report D2989 if the tooth is ultimately found restorable. D2989 only applies if the tooth cannot be restored and needs to be extracted.

COMMENTS

1. If the tooth is found restorable, the appropriate CDT codes for the definitive procedures apply. Time spent excavating in this case can be reported using D2999 unspecified restorative procedure, by report.
2. Previously, excavation could only be reported using unspecifed by report codes, no matter the outcome of the tooth. D2989 now applies if the tooth is deemed unrestorable.
3. If endodontic therapy is initiated and the tooth is found inoperable, report D3332. See D3332.
4. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. If the tooth is extracted at the same visit by the same provider, payors will likely benefit the extraction but not D2989.
2. If the extraction is performed by the same provider on a different date of service, benefits may or may not be available.
3. If one billing entity reports D2989 and a different billing entity reports the extraction, then the odds of reimbursement are greater.
4. Reporting D2999 unspecifed restorative procedure, by report will not generally be covered by payors, but may often be passed on to the patient.

D2990 RESIN INFILTRATION OF INCIPIENT SMOOTH SURFACE LESIONS — CDT 2025

Placement of an infiltrating resin restoration for strengthening, stabilizing and/or limiting the progression of the lesion.

This code appears here in numerical order. However, it appears prior to D2910 according to CDT.

COMMENTS

1. D2990 reports the resin infiltration of incipient smooth surface lesions.
2. D2990 resin infilitration is a restoration of a lesion, not just a method of prevention or arresting of caries.
3. The DMG Icon® product is a treatment for incipient lesions or white spot lesions. The infiltrant is applied to arrest caries on smooth surfaces, including proximal surfaces. Resin infiltration allows for the treatment of incipient lesions prior to cavitation taking place. It cannot be used to treat advanced decay of the enamel into the dentin.
4. See D2991 for the application of hydroxyapatite regeneration medicament—per tooth (Curodont Repair).
5. Enter the tooth number and surfaces being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

D2990 may not be reimbursed, and if reimbursed, the payor's fee may be poor. Ask for an alternate benefit of a two surface posterior composite (D2392) or a two surface anterior composite (D2331) should D2990 benefits not be available.

D2991 APPLICATION OF HYDROXYAPATITE REGENERATION MEDICAMENT – PER TOOTH — CDT 2025

Preparation of tooth surfaces and topical application of a scaffold to guide hydroxyapatite regeneration.



WARNING

It is inappropriate to report D2991 for the application of traditional caries arresting (D1354), remineralization (D1355), resin infiltration (D2990), or fluoride treatments (D1206/D1208).



MATCH

D2991 describes the conservative treatment of demineralized tooth structure by the process of guided enamel hydroxyapatite regeneration.

COMMENTS

1. D2991 application of hydroxyapatite regeneration medicament is a restoration of a lesion, not just a method of prevention or arresting of caries.
2. Guided enamel regeneration involves treatment of a non-cavitated demineralization by the topical application of an enamel hydroxyapatite templating scaffold and/or active process without mechanical removal of tooth structure. The material used for guided enamel hydroxyapatite regeneration is most commonly a peptide which soaks into a porous "initial caries lesion" (current ADA term for non-cavitated demineralization that reaches as deep as the outer third of dentin), assembles into fibrils that bridge across the pores of the lesion, and then guides calcium and phosphate from the saliva to catalyze hydroxyapatite formation to fill the lesion. The molecular mechanism is highly similar to natural enamel formation by Amelogenin.
3. The first material for guided enamel hydroxyapatite regeneration has been approved as generally regarded as safe and effective (GRASE) by the FDA (Curodont Repair Fluoride Plus, vVARDIS). Other materials (HysensBio and Mussel Polymers) are entering human trials.
4. Other technologies for this procedure, such as Electrically Assisted Enhanced Remineralization (Reminova), are expected to be marketed soon.
5. Enter the tooth number being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. D2991 may be subject to a frequency limitation.
2. Fluoride varnish (D1206) may be reported in addition to D2991, if used.
3. Because it is a recent code, D2991 may not be reimbursed. You may ask for the alternative benefit of D1354, caries arresting medicament.

D2999 UNSPECIFIED RESTORATIVE PROCEDURE, BY REPORT

Use for procedure that is not adequately described by a code. Describe procedure.

COMMENTS

D2999 may be used to report the following restorative procedures as well as any other restorative procedure, which is not described by any other restorative code(s):

1. An amalgam/composite restoration that is placed over a prefabricated post and core (D2954), not a crown.
2. A CEREC 3D®, Planscan® or E4D® milled one-piece "endo-crown" used to restore an endodontically treated tooth. These one-piece crowns typically extend into the chamber area with a "foot." Expect no additional reimbursement beyond the alternate benefit of a crown payor's fee. Report this crown procedure as D2999.
3. Custom staining of a crown with the patient presenting personally to the outside laboratory. Report the fee for custom staining separately as D2999. For PPO plans, check the Processing Policy Manual as to protocol for billing an optional service.
4. Sealing the endodontic access hole may be reported as a one surface restorative code (amalgam or composite), with a narrative. Only use D2999 as a last resort. Consider reporting an occlusal amalgam or composite restoration first.
5. A survey crown, which involves extra procedures to contour a new crown to receive the clasp assembly of a new (future) partial denture framework. The diagnostic cast (and often the crown itself) is placed on a surveyor and designed so the crown will have minimal interference with the seating and removal of the new partial (to be fabricated). The extra process of surveying a crown increases the laboratory fee. Currently, the process of surveying a crown to fit a new partial should be submitted "by report" using D2999. Use D2999 to describe the process of surveying a *new* crown (an extra charge in addition to crown) so that the new crown is ready to accept a clasp assembly of a planned partial denture. For PPO plans, check the Processing Policy Manual as to protocol for billing an optional service. To report the additional procedures to construct a customized crown under an existing partial denture framework, see D2971.
6. Custom ceramic margin. May be reported using D2999 as instructed and allowed by the PPO under the optional services provision. See the PPO Processing Policy Manual in regards to how to report optional services.
7. D2999 could report creating a partial framework rest in a natural tooth.

NARRATIVES

Always use a brief narrative to describe D2999 unspecified restorative procedure, by report.

Local anesthesia is usually considered to be part of Endodontic procedures.

GENERAL COMMENTS FOR ENDODONTIC SERVICES — AUTHOR'S COMMENTS

From ADA's 2025 Coding Companion: "It is important to understand that procedure codes are meant to describe the treatment rendered, not the means that are used to accomplish the treatment. For example, disinfection of a root canal during endodontic therapy can be accomplished using different techniques, including irrigation with multiple irrigating solutions and devices. The code used for the procedure, however, is the same."

PULP CAPPING — CDT 2025

D3110 PULP CAP - DIRECT (EXCLUDING FINAL RESTORATION) — CDT 2025

Procedure in which the exposed pulp is covered with a dressing or cement that protects the pulp and promotes healing and repair.

WATCH

If a portion of the pulpal tissue is intentionally removed from a permanent tooth while trying to maintain vitality for further root development, consider reporting D3222 partial pulpotomy for apexogenesis. See D3222.

COMMENTS

Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. All adhesives, liners and bases (thermal protection) are *included* in the restorative (amalgam/composite) description and included in the *global* fee for a restoration. However, most payors consider a direct pulp cap performed on the same service date as the restoration to also be a part of the restorative global fee. A direct pulp cap is a procedure where the *exposed* pulp is covered with a dressing or cement that seals and *protects the pulp and promotes healing and repair* of the pulp. There is nothing in the descriptor that prevents a direct pulp cap from being reported in *addition* to the restoration on the same date of service. However, payment is poor. PPO payors typically disallow (must right off) a direct pulp cap on the same service date of the restoration.
2. It is appropriate to report D3110 when the pulp is directly exposed and a dressing material is placed while the tooth heals and repairs for several months. A final restoration may or may not be placed on the same treatment date. In either case, the pulp cap is a stand-alone procedure and is reported separately, even though it may be disallowed by many plans for reimbursement.
3. Do not report D3110 in conjunction with an interim direct restoration (D2940) on the same service date. An interim direct restoration (D2940) may be placed as a temporary restoration to relieve pain. Reimbursement is highly variable for D3110, direct pulp cap and D2940, interim direct restoration. Reporting just D3110 on a stand-alone service date may possibly result in a better reimbursement than reporting an interim direct restoration (D2940). D2940 may not be payable or is a "take-back" code (meaning the fee reimbursed for the interim direct restoration, will be subtracted from the final restoration fee reimbursement if placed on a subsequent treatment date). There may be a time limitation/exclusion for the subsequent restoration. See D2940 for further details.
4. The best approach is to increase the restorative fee if desired so no negative language (related to the direct pulp cap) is noted by the payor. That said, fee schedule limitations will still apply if in network.

NARRATIVES

1. Direct pulp cap procedures may be reported in addition to the restoration on the same service date but the direct pulp cap is typically not reimbursed. If the direct pulp cap is denied, some payors may pay upon appeal if a radiographic image and narrative support the need for the direct pulp cap. The patient would be responsible for payment of the procedure out of pocket if the doctor is not subject to a third party contract. Participating PPO dentists may be required to write off the fee for the direct pulp cap procedure in conjunction with a restoration (disallowed procedure).
2. "See attached radiographic image." State if pulp exposed due to caries or due to fracture. State endodontic prognosis for tooth.

D3120 PULP CAP - INDIRECT (EXCLUDING FINAL RESTORATION) CDT 2025

Procedure in which the nearly exposed pulp is covered with a protective dressing to protect the pulp from additional injury and to promote healing and repair via formation of secondary dentin. This code is not to be used for bases and liners when all caries have been removed.

WATCH

1. The indirect pulp cap code is *not* to be reported to describe the placement of a base and liner when *all* caries has been removed in a restoration procedure on the same service date.
2. All adhesives, liners and bases (thermal protection) are *included* in the restorative code descriptors and included in the global fee of a restoration. The global fee for the restoration may be increased if a base (after removal of deep caries) is required, but the base may not be separately charged. The higher fee will not be permitted by PPOs.

COMMENTS Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. It is appropriate to report an indirect pulp cap (D3120) when caries removal is close to the pulp leaving some remaining decay to prevent exposure and a protective material is placed sealing in the decay and allowing the tooth to heal (via formation of secondary dentin). The indirect pulp cap may be left in place for several months prior to completing the final restoration as a separate treatment procedure. After a healing period and adequate secondary dentin formation, the dressing material and any remaining caries would be removed. A new base or liner would be placed and the tooth would then be restored.
2. Do not report D3120 in conjunction with an interim direct restoration (D2940) on the same service date. An interim direct restoration may be placed as a temporary restoration to relieve pain, promote healing or prevent further deterioration. Sealing the pulp cap is considered a part of the indirect pulp cap and is reimbursed as part of the global fee for the procedure. In some cases, the payor may reimburse the interim direct restoration (if reported), but not the indirect pulp cap (D3120) procedure. Reimbursement for this procedure is highly variable. See D2940 for further details.

TIPS

The CDT descriptor indicates that D3120 should not be used to describe bases and liners when *all caries has been removed.* The CDT does not state that the restoration cannot be performed on the same day as the indirect pulp cap. There are two methods of indirect pulp capping:

1. The first method involves a procedure (D3120) leaving a thin layer of caries (to avoid exposing the pulp) and placing a protective dressing. The tooth is reentered several months later, the protective dressing and remaining demineralized dentin are removed, and a permanent restoration is placed. (If all caries were removed, at the first appointment, an interim direct restoration (sedative filling - D2940) should have been reported instead of D3120).
2. The second method typically involves treating the tooth with stannous fluoride, a calcium hydroxide base and/or IRM, (base/liner) and placing the permanent restoration at the same service date. Dentists often do not want to unnecessarily traumatize the tooth by reentering it a second time, and it is less efficient. PPO payors typically disallow the procedure (D3120). The best approach is to increase the restorative fee if desired so no negative language (related to the direct pulp cap) is noted by the payor. That said, fee schedule limitations will still apply if in network

   D3120 can be used to report either method as long as all the caries were not removed. Note that few dental plans pay for an indirect pulp cap when performed on the same day as the final restoration. Third party contracts often prohibit (disallow) reporting D3120 on the same service date as a restoration. The reason is that indirect restorations include all adhesives, liners, and bases placed on the same service date according to the subcategory headings for amalgam and resin-based composite restorations.

NARRATIVES "See attached radiographic image. Pulp nearly exposed due to deep caries; some caries were left and indirect pulp cap was placed."

D3220 THERAPEUTIC PULPOTOMY (EXCLUDING FINAL RESTORATION) - REMOVAL OF PULP CORONAL TO THE DENTINOCEMENTAL JUNCTION AND APPLICATION OF MEDICAMENT CDT 2025

Pulpotomy is the surgical removal of a portion of the pulp with the aim of maintaining the vitality of the remaining portion by means of an adequate dressing. To be performed on primary or permanent teeth. This is not to be construed as the first stage of root canal therapy. Not to be used for apexogenesis.



WARNING

1. Do not report D3220 for the treatment of necrotic teeth. D3220 reports removal of a portion of the pulp with the aim of maintaining the vitality of the remaining portion.
2. Do not report D3220 if all pulpal tissue is removed. See D3321 pulpal debridement and D3230/D3240 pulpal therapy for more information.

WATCH

1. Pulpotomy is "not to be construed as the first stage of root canal therapy."
2. This code does not describe apexogenesis. Apexogenesis is vital pulp therapy performed to encourage continued physiological formation and development of the tooth root, according to the ADA Glossary. See D3222 for *partial* pulpotomy for apexogenesis. D3222, not D3220 would be performed to save a permanent tooth if the apex is not developed.
3. It is erroneous to open the tooth (remove all pulpal tissue) to relieve acute pain *prior* to root canal treatment, and report it as a pulpotomy (D3220). The purpose of a pulpotomy is to "maintain the *vitality*" of the remaining pulpal tissue in the root(s) of the tooth. A pulpotomy is typically performed when caries removal or trauma results in pulp exposure of a primary tooth. Do not report D3220 *prior* to endodontic therapy. If opening a tooth to relieve acute pain at an emergency visit, see pulpal debridement, primary and permanent teeth (D3221). See palliative (D9110) for further details.
4. Billing *separately* for an interim direct restoration (D2940) and pulpotomy (D3220) on the same date of service could be considered overbilling. D2940 is not a part of the pulpotomy procedure. An interim direct restoration (D2940) is a stand-alone temporary restoration placed to relieve pain, promote healing or prevent further deterioration. A pulpotomy is a separate procedure performed to remove the affected pulpal tissue and maintain the tooth. The access opening made during the pulpotomy procedure may be sealed by IRM or other material prior to the subsequent restoration, and is included in the global pulpotomy fee.
5. A pulpotomy is performed on *vital* primary teeth. Pulpal therapies (D3230 or D3240) or pulpal debridement (D3221) are performed on *necrotic* primary teeth. D3230 and D3240 involve the placement of a resorbable filling placed down the canals of a primary tooth, similar to a root canal procedure but not using gutta-percha. The payor's fee is often higher for D3230 or D3240 than for D3220, so report these codes appropriately when providing pulpal therapy rather than a pulpotomy service. Pulpal debridement (D3221) reports removal of all pulpal tissues only without placement of intracanal filling materials.

COMMENTS

1. If an anterior or posterior primary tooth is necrotic and the decision is to be saved, perform and report (D3230 or D3240) pulpal therapy. Pulpal therapy is similar to a root canal procedure for a permanent tooth with the difference being that it is performed on a primary tooth and resorbable material is placed in the obturated canals. If no intracanal filling material is placed, consider reporting D3221 pulpal debridement. See D3221.
2. Report the final restoration (e.g., stainless steel crown, amalgam, or composite) separately.
3. If a permanent tooth is opened and active endodontic procedures started (a sequence of file measurements and instrumentation), endodontic codes (D3310, D3320, D3330) should be entered in the software. If out of network, it could be reported. If in network, most PPOs require all procedures be completed *prior* to reporting them. Thus, endodontic therapy has been *initiated*. If endodontic therapy has been initiated never report a pulpotomy (D3220).
4. To report a Cvek pulpotomy related to trauma, see D3222.
5. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. The therapeutic pulpotomy (D3220) is generally reported on primary teeth, and is usually reimbursed. The pulpotomy procedure is meant to "maintain the *vitality*" of the remaining pulpal tissue in the roots of the primary tooth. The primary tooth remains as a space maintainer, prior to exfoliation.
2. The pulpotomy is often followed by a restoration such as stainless steel crown, amalgam, or composite. Some payors limit the reimbursement of a pulpotomy to *primary* teeth, even though the code descriptor indicates that it can be performed on either a primary or permanent tooth.

TIPS

1. When performed on permanent teeth, the pulpotomy may be reimbursed in some cases, but note that the fee reimbursed for the pulpotomy may be subtracted from the subsequent endodontic reimbursement. This take-back may apply if the endodontic therapy is performed by either a specialist or general practitioner. Never report D3220 just *prior* to root canal therapy. See D3222 which applies to a pulpotomy for apexogenesis.
2. If the permanent tooth is "opened" to relieve acute pain (removing all pulpal tissue) prior to the definitive RCT at an emergency visit, consider using the pulpal debridement (D3221) code to describe the procedure if the patient is referred to another office. Also consider using palliative (D9110) under very limited circumstances. See D9110.
3. If the primary tooth does not have a succedaneous permanent tooth successor, then a traditional gutta-percha filled (or other non-resorbable material) root canal (D3310 or D3330) could be performed. Write a narrative explaining the reason for the gutta-percha procedure and ask for the anterior or molar root canal (D3310 or D3330) benefit. See D3310 and D3330. Primary teeth dentition does not include premolars.

D3221 PULPAL DEBRIDEMENT, PRIMARY AND PERMANENT TEETH CDT 2025

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



WARNING

1. It is misleading to report D3221 on the *same* service date, *in conjunction* with routine endodontic therapy by the same provider. D3221 reports relief (open, remove pulpal tissue and drain) of acute pain *prior* to *completing* root canal therapy at a *subsequent* visit.
2. It is misleading to routinely report D3221 at the first visit of a regularly scheduled two appointment visit root canal technique when the patient does not have acute pain.

COMMENTS

1. D3221 reports opening and debriding the pulp for relief of acute pain, *prior* to completing endodontic treatment at a later time. The emergency patient frequently "interrupts" the dentist's schedule. Obturation of canals may be performed at this emergency visit. After the pulpal debridement, the patient is then referred to an endodontist or the patient's dentist of record completes the root canal therapy. Note that some payors may "remap" and reimburse the pulpal debridement at the lower palliative (D9110) fee or deduct any reimbursement made for pulpal debridement if root canal therapy is completed in the same office on a later date.
2. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

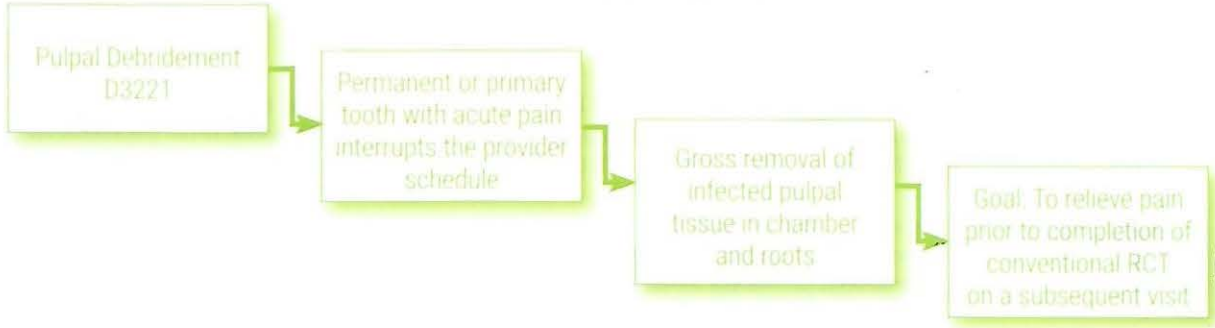
LIMITATIONS

1. D3221 may be a "take-back" code if *the same office* who performs D3221 performs the subsequent completion of endodontic treatment as this may be viewed as the first visit of two visit endodontic therapy. If "taken-back," the previous reimbursement for D3221 is subtracted from the final endodontic reimbursement. If an endodontist at a *different* office (different taxpayer ID) does the endodontic treatment (even on the same service date), it generally is not a "take-back" procedure. Reimbursement for pulpal debridement among payors is highly variable. In some cases, the payor simply "remaps" D3221 to a lower fee palliative (D9110) code for reimbursement.
2. If the patient presents for an *emergency* visit and endodontic treatment has been *initiated*, D3221 can be reported. The emergency visit would be followed by a subsequent visit for *completion* of endodontic treatments (D3310, D3320, D3330). D3221 should not be reported for the scheduled multi-appointment endodontic treatment but rather the unscheduled emergency visit for the relief of acute pain. Definitive endodontic treatment (D3310, D3320, D3330) may be reported on the initiation date, upon the completion date of therapy, or as established by any third party contract provisions. However, most PPO plan's Processing Policy Manuals require reporting on the completion date. The ADA Policy Eligibility and Payment Dates for Endodontic Treatment (1994:674) encourages the completion date as the date of service.

NARRATIVES

1. If the *same* office performs the endodontic treatment on a subsequent service date, following the emergency visit where only partial (not complete) pulpal tissue was removed, palliative (D9110) may apply, and there is no "take back." See D9110 for particular details.
2. If substantial time (at a routine visit) was spent on *instrumentation* prior to the fill, but the *patient does not return* to complete the root canal, at the second visit report D3999 unspecified endodontic procedure, by report. Indicate that the root canal was partially completed. Explain the time taken and the treatment provided. Be careful to document in the chart and report to the payor any cancellations and attempts to reschedule the patient for this treatment. The reimbursement fee may be higher for D3999 (as an alternate benefit) than D3221. See D3999 for further details.

CLINICAL FLOW CHARTS



D3222 PARTIAL PULPOTOMY FOR APEXOGENESIS - PERMANENT TOOTH WITH INCOMPLETE ROOT DEVELOPMENT — CDT 2025

Removal of a portion of the pulp and application of a medicament with the aim of maintaining the vitality of the remaining portion to encourage continued physiological development and formation of the root. This procedure is not to be construed as the first stage of root canal therapy.

COMMENTS

1. D3222 reports a *partial* pulpotomy (vital pulp tissue remains in pulpal chamber) on a *permanent* tooth for *apexogenesis*. Apexogenesis is performed on an immature permanent tooth with a pulp exposure due to caries or trauma. The procedure involves removing only the infected portion of the pulp from the pulp chamber (partial pulpotomy) with the goal of obtaining normal maturation and formation of the root. Apexogenesis encourages the continued development and complete formation of the root.
2. Report as D3999, by report, when performed on a primary tooth that has no permanent successor tooth.
3. For a *pulpal regeneration* of an *immature permanent tooth* with a *necrotic* pulp, see the pulpal regeneration treatment sequence of D3355, D3356 and D3357. For *pulpotomy*, see D3220.
4. Report D3222 to describe Cvek pulpotomy, performed due to trauma.
5. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

ENDODONTIC THERAPY ON PRIMARY TEETH — CDT 2025

Endodontic therapy on primary teeth with succedaneous teeth and placement of resorbable filling. This includes pulpectomy, cleaning, and filling of canals with resorbable material.

D3230 PULPAL THERAPY (RESORBABLE FILLING) - ANTERIOR, PRIMARY TOOTH (EXCLUDING FINAL RESTORATION) — CDT 2025

Primary incisors and cuspids.

WATCH

Do not report pulpal therapy - anterior, primary tooth (D3230) on *necrotic* anterior primary teeth as a pulpotomy (D3220). A pulpotomy is performed on a *vital* tooth, while pulpal therapy (D3230) is performed on *necrotic* primary teeth when *resorbable* material is used to fill the canals. Pulpal therapy (D3230) is similar to a conventional "root canal" but is used to treat necrotic *anterior primary teeth*. The payor's fee is often higher for D3230 than pulpotomy (D3220).

COMMENTS

1. Report D3230 when all the pulpal tissue is removed. D3230 includes instrumentation and placement of some type of *resorbable* root canal filling material in the canal of the anterior primary tooth. It is similar to a root canal but *resorbable* filling material is used in a primary tooth, not gutta-percha.
2. If no intracanal filling material is placed, consider reporting D3221 pulpal debridement. See D3221.
3. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Pulpal therapy (D3230) is typically reimbursed once per primary anterior tooth, per lifetime. Benefits may be available for primary incisors (centrals and laterals) up to age six and primary cuspids up to age 11.
2. Some payors reimburse the lower vital pulpotomy (D3220) allowable fee as an *alternate* benefit, rather than the higher allowable fee of pulpal therapy (D3230).

TIPS

If the pulp is necrotic *and* a resorbable material is placed into the canal after instrumentation, report pulpal therapy; anterior (D3230). D3230 should have a higher payor's fee than a therapeutic (vital) pulpotomy (D3220). D3230 is a more time-consuming procedure as the canals are instrumented and then filled with a *resorbable* filling material.

NARRATIVES

If the anterior primary tooth *has no permanent tooth to follow*, then the endodontic treatment should be reported as a *conventional* root canal if a non-resorbable material (e.g., gutta-percha) is used. For a primary anterior tooth (without a succedaneous permanent tooth), report an anterior root canal (D3310). Be advised that some payors exclude a primary *anterior* tooth from conventional endodontic treatment reimbursement. Write a narrative explaining what was done and why the D3310 procedure was necessary. Always appeal if necessary.

D3240 PULPAL THERAPY (RESORBABLE FILLING) - POSTERIOR, PRIMARY TOOTH (EXCLUDING FINAL RESTORATION) CDT 2025

Primary first and second molars.

WATCH

Do not report pulpal therapy - posterior, primary (D3240) on posterior primary first and second molar teeth that are *vital*. Pulpotomies are performed on *vital* teeth. Pulpal therapy (D3240) is performed on *necrotic* primary first and second molars when *resorbable* material is used to seal the canals. Pulpal therapy (D3240) is similar to a conventional "root canal" but is used to treat necrotic posterior *primary teeth*. The payor's fee is often higher for D3240 than pulpotomy (D3220).

COMMENTS

1. Report D3240 when all the pulpal tissue is removed. D3240 includes instrumentation of canals and placement of some type of *resorbable* filling material in the canals of the posterior primary tooth.
2. If no intracanal filling material is placed, consider reporting D3221 pulpal debridement. See D3221.
3. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Pulpal therapy (D3240) is typically reimbursed once per primary posterior tooth, per lifetime.
2. Some payors reimburse the lower vital pulpotomy (D3220) allowable fee as an *alternate* benefit, rather than the higher allowable fee of D3240.

TIPS

If the primary posterior tooth pulp is non-vital and a *resorbable* material is placed into the canal after instrumentation, report pulpal therapy - posterior (D3240). D3240 should have a higher payor's fee than a therapeutic (vital) pulpotomy (D3220). D3240 is a more time consuming procedure as the primary molar canals are instrumented and then filled with a resorbable filling, not gutta-percha.

NARRATIVES

If the posterior primary tooth *has no permanent succedaneous tooth to follow*, then the endodontic treatment should be reported as a *conventional* root canal if a non-resorbable material, (e.g., gutta-percha) is used. For a primary posterior molar tooth (without a succedaneous tooth), report a molar root canal (D3330). Be advised that some payors exclude a primary *posterior* tooth from conventional endodontic treatment reimbursement. Write a narrative explaining what was done and why this procedure was necessary. Send both pre- and post-op periapical radiographs of the tooth treated.

Includes primary teeth without succedaneous teeth and permanent teeth. Complete root canal therapy: Pulpectomy is part of root canal therapy.

Includes all appointments necessary to complete treatment; also includes intra-operative radiographs. Does not include diagnostic evaluation and necessary radiographs/diagnostic images.

D3310 ENDODONTIC THERAPY, ANTERIOR TOOTH (EXCLUDING FINAL RESTORATION) CDT 2025

WARNING

1. It is inappropriate to report pulpal debridement (D3221) or palliative (D9110) at the initial, regularly scheduled root canal visit to receive a higher overall reimbursement. These codes require the relief of acute pain. If a root canal is initiated (the length determined and the regularly scheduled instrumentation of the canal begun), the root canal codes (D3310, D3320, or D3330) should be used to report the service. Although the terminology used on the current ADA claim form permits reporting of the root canal on the start date, most third party payors often require the root canal be submitted using the completion date. However, the ADA Policy Eligibility and Payment Dates for Endodontic Treatment (1994:674) encourages the completion date as the date of service.
2. For treatment to alleviate acute pain at an *emergency* visit by debriding and removing all the pulpal tissue, consider the pulpal debridement (D3221) code to describe this emergency procedure. Also see palliative (D9110) in situations where only part of the pulpal tissue is removed. The root canal would be completed on a subsequent date.
3. If an endodontic access opening is done through a crown which is already permanently cemented/bonded, it is inappropriate to report restoration of the endodontic *access opening* as a core buildup (D2950). The purpose of a core buildup, reported as D2950, is for retention of a crown. Report a one surface amalgam or composite (see comments below, Limitation #6) to describe the access opening hole closure restorative procedure.
4. A root canal procedure performed to allow the placement of an overdenture attachment in the tooth is an "elective" procedure. An "elective" root canal procedure completed to aid in the delivery of another more "specialized" procedure, like an overdenture, should be submitted, but is generally not reimbursed.
5. For a routine, regularly scheduled visit, do not report pulpal debridement (D3221) at the first visit of a scheduled two appointment root canal. This code requires the relief of acute pain.

WATCH

It is inappropriate to report endodontic therapy, anterior (D3310) for a one canal premolar. It should be reported as D3320. The determination of the endodontic code that describes the endodontic procedure provided is based on the tooth type rather than the number of canals treated. Report D3320 to describe a root canal provided for a premolar, regardless of the *number* of canals treated.

COMMENTS

1. Report a root amputation (D3450) separately.
2. An oral evaluation and preliminary diagnostic radiograph(s) for initial diagnosis should be reported separately from the root canal procedure. An oral evaluation would not be reported if the need for root canal treatment had been previously diagnosed. Only the initial diagnostic radiograph(s) should be reported, not working radiographs. Working radiographs are considered part of the endodontic procedure. If multiple visits are necessary, the diagnostic radiographic images should be reported prior to, or on the first visit date.
3. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. "Working" or intraoperative radiographs and post-treatment images (within thirty days of treatment) are considered a part of the root canal global fee. Note: *diagnostic* images done *prior* to initiation of endodontic treatment are considered a separate diagnostic procedure and may be reimbursed. An evaluation may be submitted at the diagnosis appointment; however, plan limitations may limit reimbursement.
2. Reimbursement for an under filled or over filled root canal may be disallowed by payor.
3. D3310 could be used to report a root canal on an anterior *primary* tooth in a patient who is missing the permanent successor tooth when the primary tooth is sealed using a non-resorbable (gutta-percha type) material.

4. A pulpal debridement (D3221) procedure may be reported when performed to relieve *acute* pain if endodontic treatment is not initiated on the same service date by the same office. "Starting" an endodontic procedure involves establishing working length and beginning the use of a sequence of files to instrument and enlarge the canal. Some payors may "re-map" D3221 to a pulpotomy (D3220) or palliative (D9110) for reimbursement. Also see D9110.
5. A root canal submitted for reimbursement and paid based on the start date that is never completed may be considered overbilling and is subject to a fee adjustment by the third party payor. A refund may be requested by the payor for all or part of the fee. Any cancellations and attempts to reschedule the patient for completion of treatment must be noted in the clinical record. Notify the payor that the root canal was not completed. Submit a request for the alternate benefit D3999, unspecified procedure, by report, to recoup for the time and materials used. Payors typically require the root canal completion date be used when reporting endodontic therapy; however, state law and/or contract language could indicate or require otherwise.
6. The closure of an endodontic access hole is reported as a *separate* procedure. Use codes such as a one surface amalgam or composite to report the restoration for access hole closure if the crown is intact and in place. Restorations to seal the access opening are generally reimbursed at 80% of the payor's fee. Some third party contracts include access closure in the *global* fee for the endodontic procedure. It is recommended that a brief narrative be included with the claim that describes the restoration technique used and reason for the procedure. "An occlusal composite was placed for access hole closure." The payor may have tracked the tooth with a crown and may reject the composite restoration without a narrative.
7. If the crown is removed, or comes off, then a core buildup (D2950) or prefabricated post and core (D2954) may be performed and reported. The exisitng or new crown would be placed subsequently after the core buildup or post and core.
8. The D2980 crown repair code now reports "necessitated by restorative failure" in its nomenclature so now either a one surface amalgam or composite is the code to use to report access hole closure, not crown repair. However, some payor's still reimburse endondontic access closure with D2980.

NARRATIVES

1. If documentation is requested: "See attached pre- and post-op radiographic images."
2. If diagnostic radiographic images are denied, submit a narrative stating they were taken prior to initiation of endodontic therapy and are not "working" or intraoperative radiographs.

D3320 ENDODONTIC THERAPY, PREMOLAR TOOTH (EXCLUDING FINAL RESTORATION) CDT 2025



WARNING

1. It is inappropriate to report pulpal debridement (D3221) or palliative (D9110) at the initial, regularly scheduled root canal visit to receive a higher overall reimbursement. These codes require the relief of acute pain. If a root canal is initiated (the length determined and the regularly scheduled instrumentation of the canal begun), the root canal codes (D3310, D3320, or D3330) should be used to report the service. Although the terminology used on the current ADA claim form permits reporting of the root canal on the start date, most third party payors often require the root canal be submitted using the completion date. However, the ADA Policy Eligibility and Payment Dates for Endodontic Treatment (1994:674) encourages the completion date as the date of service.
2. For treatment to alleviate acute pain at an *emergency* visit by debriding and removing all the pulpal tissue, consider the pulpal debridement (D3221) code to describe this emergency procedure. Also see palliative (D9110) in situations where only part of the pulpal tissue is removed. However, the root canal would be completed on a subsequent visit.
3. If an endontic access opening is done through a crown which is already permanently cemented/bonded, it is inappropriate to report restoration of the endodontic access opening as a core buildup (D2950). The purpose of a core buildup, reported as D2950 is for retention of the crown. Report a one surface amalgam or composite (see comments below, Limitation #5) to describe the access opening hole closure restorative procedure.
4. A root canal procedure performed to allow the placement of an overdenture attachment in the tooth is an "elective" procedure. An "elective" root canal procedure completed to aid in the delivery of another more "specialized" procedure, like an overdenture, should be submitted, but is generally not reimbursed.
5. For a routine, regularly scheduled visit, do not report pulpal debridement (D3221) at the first visit of a scheduled two appointment visit technique. These codes require the relief of acute pain.

WATCH

The determination of the endodontic code that describes the endodontic procedure provided is based on the tooth type rather than the number of canals treated. Report D3320 to describe a root canal provided to a premolar, regardless of the *number* of canals treated.

COMMENTS

1. Report the root amputation (D3450) or hemisection (D3920) separately.
2. Report D3320 for root canals performed on premolars, regardless of the number of canals. Fees vary and dentists may charge an additional $100-$200 fee for a two or three canal premolar, vs. a one canal premolar.
3. An oral evaluation and diagnostic radiograph(s) for initial diagnosis should be reported separately from the root canal procedure. An evaluation would not be reported if the need for root canal treatment had been previously diagnosed. The initial diagnostic radiograph(s) should be reported, not working radiographs. Working and intraoperative radiographs are considered part of the endodontic procedure. If multiple visits are necessary, the diagnostic test(s) should be reported prior to, or on the first visit date.
4. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. "Working" or intraoperative radiographs and post-treatment images (within thirty days of treatment) are considered a part of the root canal global fee. Note: *Diagnostic* images done *prior* to initiation of endodontic treatment are considered a separate diagnostic procedure and may be reimbursed. An oral evaluation may be submitted at the diagnostic appointment; however, plan limitations may limit reimbursement.
2. Reimbursement for an under filled or over filled root canal may be disallowed by a payor.
3. A pulpal debridement (D3221) procedure may be reported when performed to relieve *acute* pain. "Starting" an endodontic procedure involves establishing working length and beginning the use of a sequence of files to instrument and enlarge the canal. This is permitted at the emergency visit. Some payors may "re-map" D3221 to a pulpotomy (D3220) or palliative (D9110) for reimbursement. Also see D9110.
4. A root canal submitted for reimbursement and paid based on the start date that is never completed is considered overbilling and is subject to adjustment by the third party payor. A refund may be requested by the payor for all or part of the fee. Any cancellations and attempts to reschedule the patient for completion of treatment must be noted in the clinical record. Notify the payor that the root canal was not completed. Submit a request for the alternate benefit D3999, unspecified procedure, by report, to recoup for the time and materials used. The ADA *recommends* the root canal completion date be used when reporting endodontic therapy; however, state law and/or contract language could indicate or require otherwise. PPOs typically require the completion date by contract.
5. The closure of an endodontic access hole is reported as a *separate* procedure. Use codes such as a one surface amalgam or composite to report the restoration for access hole closure if the crown is intact and in place. Restorations to seal the access opening are generally reimbursed at 80% of the payor's fee. Some third party contracts include access closure in the *global* fee for the endodontic procedure. It is recommended that a brief narrative be included with the claim that describes the restoration technique used and reason for the procedure. "An occlusal composite was placed for access hole closure." The payor may have tracked the tooth with a crown and may reject the composite restoration without a narrative.
6. If the crown comes off or is removed, then a core buildup (D2950) or pre-fabricated post and core (D2954) could be reported, if performed. The existing or new crown would be placed subsequently.
7. The D2980 crown repair code now reports "necessitated by restorative failure" in its nomenclature so now either a one surface amalgam or composite is the code to use to report endodontic access hole closure, not crown repair. However, some payor's continue to reimburse endodontic access closure with D2980.

NARRATIVES

1. If documentation is requested: "See attached pre- and post-op radiographic images."
2. If diagnostic radiographic images are denied, submit a narrative stating they were taken prior to initiation of endodontic therapy and are not "working" or intraoperative radiographs.

ENDODONTIC THERAPY, MOLAR TOOTH (EXCLUDING FINAL RESTORATION)

WARNING

1. It is inappropriate to report pulpal debridement (D3221) or palliative (D9110) at the initial, regularly scheduled root canal visit to receive a higher overall reimbursement. These codes require the relief of acute pain. If a root canal is initiated (the length determined and the instrumentation of the canal begun), the root canal codes (D3310, D3320, or D3330) should be used to report the service. Although the terminology used on the current ADA claim form permits reporting of the root canal procedure on the start date, the third party payors often may require that the root canal be submitted using the completion date.
2. For treatment to alleviate acute pain at an *emergency* visit by debriding and removing all the pulpal tissue, consider the pulpal debridement (D3221) code to describe this emergency procedure. Also see palliative (D9110) in situations where only part of the pulpal tissue is removed. The molar root canal would be completed on a subsequent visit.
3. If an endodontic access opening is done through an intact crown which is already permanently cemented/bonded, it is inappropriate to report restoration of the endodontic *access opening* as a core buildup (D2950). The purpose of a core buildup, reported as D2950, is for retention of the crown. Report a one surface amalgam or composite (see comments below, Limitation #5) to describe the access opening hole closure restorative procedure.
4. A root canal procedure performed to allow the placement of an overdenture attachment in the tooth is an "elective" procedure. An "elective" root canal procedure completed to aid in the delivery of another more "specialized" procedure, like an overdenture, should be submitted, but is generally not reimbursed.
5. For a routine, regularly scheduled visit, do not report pulpal debridement (D3221) at the first visit of a scheduled two appointment visit technique. This code requires the relief of acute pain.

COMMENTS

1. Report a root amputation (D3450) or hemisection (D3920) separately.
2. Report D3330 for all molar root canals, regardless of the number of canals. Note: Some dentists charge an additional $100-$200 for a four canal molar vs. a three canal molar.
3. D3330 may be used to report a root canal completed on a first or second *primary* molar tooth when the corresponding permanent tooth is not present. In this case the canals must be obturated and filled with a non-resorbable, gutta-percha like material.
4. An oral evaluation and diagnostic radiograph(s) for initial diagnosis should be reported separately from the root canal. An oral evaluation would not be reported if the need for root canal had been previously diagnosed. Only the initial diagnostic radiograph(s) can be reported, not working radiographs. If multiple visits are necessary, the diagnostic test(s) should be reported on the first visit and the root canal procedure upon completion, at the last visit.
5. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. "Working" or intraoperative radiographs and post-treatment images (within thirty days of treatment) are considered as part of the root canal global fee. Note: *Diagnostic* images done *prior* to initiation of endodontic treatment are considered a separate diagnostic procedure and may be reimbursed. An oral evaluation may be submitted at the diagnostic appointment; however, plan limitations may limit reimbursement.
2. Reimbursement for an under filled or over filled root canal may be denied and disallowed by a payor.
3. A pulpal debridement (D3221) procedure may be reported when performed to relieve *acute* pain. "Starting" an endodontic procedure involves establishing working length and beginning the use of a sequence of files to instrument and enlarge the canal. This is permitted at the emergency visit. Some payors may "re-map" D3221 to a pulpotomy (D3220) or palliative (D9110), for reimbursement. Also see D9110.
4. A root canal submitted for reimbursement and paid based on the start date, but never completed, is considered overbilling and is subject to adjustment by the third party payor. A refund may be requested for all or part of the fee. Any cancellations and attempts to reschedule the patient for completion of treatment must be noted in the clinical record. Notify the payor that the root canal was not completed. Submit a request for the alternate benefit of D3999, unspecified procedure, by report, to recoup for the time and materials used. The ADA *recommends* the root canal completion date be used when reporting endodontic therapy; however, state law and/or contract language could indicate or require otherwise. PPOs typically require the completion date by contract.

5. The closure of an endodontic access hole is reported as a *separate* procedure. Use codes such as a one surface amalgam or composite to report the restoration for access hole closure if the crown is intact and in place. Restorations to seal the access opening are generally reimbursed at 80% of the payor's fee. Some third party contracts include access closure in the *global* fee for the endodontic procedure. It is recommended that a brief narrative be included with the claim that describes the restoration technique used and reason for the procedure. "An occlusal composite was placed for access hole closure." The payor may have tracked the tooth with a crown and may reject the composite restoration without a narrative.
6. If the crown comes off or is removed, then a core buildup (D2950) or pre-fabricated post and core (D2954) could be reported, if performed. The exisitng or new crown would be placed subsequently.
7. The D2980 crown repair code now reports "necessitated by restorative failure" in its nomenclature so now either a one surface amalgam or composite reports endodontic access hole closure for an intact crown, not crown repair. However, some payors continue to reimburse endodontic access closure with D2980.

NARRATIVES

1. If documentation is requested: "See attached pre- and post-op radiographic images."
2. If diagnostic radiographic images are denied, submit a narrative stating they were taken prior to initiation of endodontic therapy and are not "working" or intraoperative radiographs.

D3331 TREATMENT OF ROOT CANAL OBSTRUCTION; NON-SURGICAL ACCESS CDT 2025

In lieu of surgery, the formation of a pathway to achieve an apical seal without surgical intervention because of a non-negotiable root canal blocked by foreign bodies, including but not limited to separated instruments, broken posts or calcification of 50% or more of the length of the tooth root.

COMMENTS

1. If the obstruction is iatrogenic, (caused inadvertently by the dentist), it is not appropriate for the dentist who caused the obstruction to report D3331.
2. The descriptor for D3331 indicates separated instruments and broken posts are examples of foreign bodies that can prevent a dentist from negotiating a canal. According to the American Association of Endodontists (AAE) coding recommendations, D3331 is intended for use in cases where there is complete calcification of 50% or more of the canal length (not diameter) and to report the removal of separated files or other obstructions left in the root canal by another practitioner.
3. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. D3331 may be reported in *addition* to the treatment or retreatment of root canals. Note that even though D3331 may be reported with the root canal, D3331 may be considered a part of the global root canal procedure by payors and may not be reimbursed.
2. Reimbursement for D3331, if available, often requires documentation with pretreatment and mid-treatment diagnostic images. It is important to maintain complete records that document the treatment provided.

NARRATIVES

1. Treatment of root canal obstruction (D3331) is not generally reimbursed to the provider who obstructs the canal, but may be reimbursed to a *different* provider overcoming the obstruction. Pretreatment and mid-treatment diagnostic images and a narrative are required for reimbursement by most payors. Also, indicate the *additional* time required to complete the root canal. It is important to maintain complete records that document the need for the D3221 treatment provided.
2. "See attached radiographic image." State why the root canal was non-negotiable/blocked, e.g., canal blocked by separated instrument, broken post or calcification of 50% or more of the length of the root.

D3332 INCOMPLETE ENDODONTIC THERAPY; INOPERABLE, UNRESTORABLE OR FRACTURED TOOTH CDT 2025

Considerable time is necessary to determine diagnosis and/or provide initial treatment before the fracture makes the tooth unretainable.

WARNING

D3332 should not be used to describe a situation where the patient fails to return for the completion of root canal therapy at a subsequent appointment. See D3999, by report, to report an incomplete root canal procedure.

COMMENTS

1. D3332 reports a situation where endodontic therapy is initiated but then terminated when it is determined the tooth is inoperable, unrestorable, or fractured. Occasionally, the initial clinical evaluation and diagnostic radiographs appear to indicate a tooth can be treated successfully with root canal therapy, but once treatment begins, the situation is deemed hopeless. The problem may be due to extensive decay, calcifications, divergences, obstructed canals, or vertical root fractures that were not evident on radiographs or clinically evident. Once the dentist determines that root canal therapy cannot be completed, D3332 may be reported to reimburse for the time invested and the work that was performed.
2. Use D3221 to describe the pulpal debridement of a tooth at an emergency visit when the initial provider determines that they cannot complete treatment at a subsequent visit and that the patient must be referred to an endodontist to complete the root canal therapy.
3. Use D3332 to describe a flap that is laid to diagnose a fracture during endodontic therapy and where the patient is referred back to the GP or to a specialist for an extraction.
4. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. For reimbursement, D3332 often requires pretreatment and mid-treatment diagnostic radiographic images.
2. Some dental plans do not provide a benefit for D3332. A few payors may reimburse for the alternate benefit of palliative treatment (D9110) when incomplete root canal therapy is reported using D3332, at an emergency visit.
3. Payors will not reimburse D3332 and an extraction on the same service date by the same provider.

NARRATIVES

1. If a patient *voluntarily* discontinues endodontic treatment, D3332 should *not* be reported. Consider reporting an endodontic unspecified procedure (D3999) with a narrative when the patient fails to return for completion of root canal therapy. See D3999, by report, for further details.
2. D3332 is a *stand-alone* code and may be reimbursed when a significant amount of time, energy, and effort is spent prior to discovering a fracture or pathology that cannot be resolved. Plan limitations for D3332 are highly variable. It is recommended that a brief narrative be included when reporting D3332. In the narrative, indicate the diagnosis and reason why root canal therapy was not completed.
3. D3332, if reimbursed, is paid at 30-50% of the allowable root canal fee. Payors typically require a narrative that includes any diagnostic findings, radiographs before and during treatment as well as an explanation of why the root canal procedure was not completed. The narrative should include documentation of the time spent in treatment and number of treatment appointments provided before determining that the tooth was inoperable, unrestorable, or fractured. The extraction should be reported separately from D3332 and can be reported on the same date at a different office or on a subsequent appointment date.

D3333 INTERNAL ROOT REPAIR OF PERFORATION DEFECTS CDT 2025

Non-surgical seal of perforation caused by resorption and/or decay but not iatrogenic by same provider.

COMMENTS

1. D3333 reports the non-surgical seal of a perforation caused by resorption and/or decay not caused by the provider performing an endodontic procedure. Payors deny the claim if the perforation defect was caused by the provider (iatrogenic).
2. Some materials used to repair perforations and internal defects include mineral trioxide aggregate (MTA), bioceramics, or biodentine.
3. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. For reimbursement, some payors require obturation, not just removal of decay.
2. Payors may require four to six months healing, with no pathology evident, prior to performing definitive root canal treatment.
3. D3333 is typically not reimbursed in conjunction with an apicoectomy/retrograde filling performed by the same dentist or by the same dental office.

NARRATIVES

A detailed narrative with pre-operative and post-operative radiographs may be required for reimbursement. Evidence of healing four to six months after the repair of the perforation may be necessary for RCT reimbursement.

ENDODONTIC RETREATMENT — CDT 2025

D3346 RETREATMENT OF PREVIOUS ROOT CANAL THERAPY - ANTERIOR — CDT 2025

IMPORTANT! See D3310 for additional information regarding the anterior root canal.

COMMENTS

Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Payors consider retreatment of a previous anterior root canal (D3346) to *include* removal of post, pin(s), old root canal filling material, as well as the finished, re-treated root canal therapy. For post removal prior to root canal retreatment, see D2955. The fee for D3346 is typically several hundred dollars higher than the comparable anterior root canal (D3310).
2. To be reimbursed, most payors require that the retreatment be performed more than six months after the original root canal. Some payors require more than 24 months to have elapsed after the original root canal for the retreatment service to be reimbursed. Time limitations vary.
3. The time limitation may not apply when the retreatment service is performed by a different office.
4. The closure of an endodontic access hole is reported as a *separate* procedure. Use codes such as a one surface amalgam or composite to report the restoration of the access opening if the crown is intact and in place. Restorations to seal the access opening are generally reimbursed at 80% of the payor's fee. Some third party contracts include access closure in the *global* fee for the endodontic procedures. It is recommended that a brief narrative be included with the claim that describes the access hole closure restoration technique used and reason for the procedure.
5. If the crown is removed, or comes off, then a core buildup (D2950) or prefabricated post and core (D2954) may be reported, if performed. The exisitng or new crown would be placed subsequently.

NARRATIVES

1. The narrative should include the approximate date of the previously completed root canal therapy. The narrative should include what portion of the root canal failed, why the overall endo failed, and how retreatment corrected the problem. It is important to include a diagnostic radiographic image taken before the re-treatment and a post-treatment periapical radiographic image.
2. "See attached pre- and post-op radiographic images." State the date that the initial/previous root canal was completed.

D3347 RETREATMENT OF PREVIOUS ROOT CANAL THERAPY - PREMOLAR — CDT 2025

IMPORTANT! See D3320 for additional information regarding the premolar root canal.

COMMENTS

Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Payors consider retreatment of a previous premolar root canal (D3347) to include removal of post, pin(s), old root canal filling material, as well as the finished, retreated root canal therapy. For post removal prior to root canal retreatment, see D2955. The fee for D3347 is typically several hundred dollars higher than the comparable premolar root canal (D3320).
2. To be reimbursed, most payors require that the retreatment be performed more than six months after the original root canal. Some payors require more than 24 months to have elapsed after the original root canal for the retreatment service to be reimbursed. Time limitations vary.
3. The time limitation may not apply when the retreatment service is performed by a different office.
4. The closure of an endodontic access hole is reported as a *separate* procedure. Use codes such as a one surface amalgam or composite to report the restoration of the access opening if the crown is intact. Restorations to seal the access opening are generally reimbursed at 80% of the payor's fee. Some third party contracts include access closure in the *global* fee for the endodontic procedures. It is recommended that a brief narrative be included with the claim that describes the access hole closure restoration technique used and reason for the procedure.
5. If the crown comes off or is removed, then a core buildup (D2950) or pre-fabricated post and core (D2954) could be reported, if performed. The existing or new crown would be placed subsequently.

NARRATIVES

1. The narrative should include the approximate date of the previously completed root canal therapy. The narrative should include what portion of the root canal failed, why the overall endo failed, and how retreatment corrected the problem. It is important to include a diagnostic radiographic image taken before the retreatment and a post-treatment periapical radiographic image.
2. "See attached pre- and post-op radiographic images." State the date that the initial/previous root canal was completed.

D3348 RETREATMENT OF PREVIOUS ROOT CANAL THERAPY - MOLAR CDT 2025

IMPORTANT! See D3330 for additional information regarding the molar root canal.

COMMENTS

Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Payors consider retreatment of a previous molar root canal (D3348) to include removal of post, pin(s), old root canal filling material, as well as the finished, retreated root canal therapy. For post removal prior to root canal retreatment, see D2955. The fee for D3348 is typically several hundred dollars higher than the comparable molar root canal (D3330).
2. To be reimbursed, most payors require that the retreatment be performed more than six months after the original root canal. Some payors require more than 24 months to have elapsed after the original root canal for the retreatment service to be reimbursed. Time limitations vary.
3. The time limitation may not apply when the retreatment service is performed by a different office.
4. The closure of an endodontic access hole is reported as a *separate* procedure. Use codes such as a one surface amalgam or composite to report the restoration of the access opening if the crown is intact. Restorations to seal the access opening are generally reimbursed at 80% of the payor's fee. Some third party contracts include access closure in the *global* fee for the endodontic procedures. It is recommended that a brief narrative be included with the claim that describes the access hole closure restoration technique used and reason for the procedure.
5. If the crown comes off or is removed, then a core buildup (D2950) or pre-fabricated post and core (D2954) could be reported, if performed. The existing or new crown would be placed subsequently.

NARRATIVES

1. The narrative should include the approximate date of the previously completed root canal therapy. The narrative should include what portion of the root canal failed, why the endo failed, and how retreatment corrected the problem. It is important to include a diagnostic radiographic image taken before the retreatment and a post-treatment periapical radiographic image.
2. "See attached pre- and post-op radiographic images." State the date that the initial/previous root canal was completed.

D3351 APEXIFICATION/RECALCIFICATION - INITIAL VISIT (APICAL CLOSURE/ CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, ETC.) CDT 2025

Includes opening tooth, preparation of canal spaces, first placement of medication and necessary radiographs. (This procedure may include first phase of complete root canal therapy.)



WARNING

Do not report apexification codes for the use of stem cell therapy to stimulate the growth of pulp-like tissue into the root canal space. This procedure is instead reported using pulpal regeneration codes. The necrotic pulpal regeneration treatment sequence is: D3355 for initial pulpal regeneration treatment, D3356 for interim pulpal regeneration treatment (may require multiple visits), and D3357 for the final stage of pulpal regenerative treatment. Working radiographs are a part of the treatment and should not be submitted for reimbursement. The final stage of pulpal regeneration includes placement of a seal at the coronal (crown) portion of the root canal system, however, per the descriptor for D3357, it does not include the final restoration. Conventional root canal treatment *is not* performed with pulpal regeneration, D3357.



MATCH

Apexification procedures are a method used to treat non-vital permanent teeth with immature roots or open apices. Treatment normally includes mulitple placements of a material like calcium hydroxide to stimulate formation of a calcified apical barrier seal against which gutta percha may be safely condensed. This may also include the placement of an artificial apical barrier prior to obturation. The apexification treatment sequence is: D3351 for initial treatment, D3352 for interim treatment (may require multiple visits), and D3353 for the final stage of apexification. The final apexification treatment stage includes obturation and placement of root canal filling material.

COMMENTS

1. The ADA Glossary defines apexification as "The process of induced root development to encourage the formation of a calcified barrier in a tooth with immature root formation or an open apex. May involve the placement of an artificial apical barrier prior to nonsurgical endodontic obturation."
2. Apexogenesis is a *partial* pulpotomy of a *vital* tooth performed to encourage and allow for the development of the tooth root. See D3222.
3. Report D3351 for the *initial* visit for apexification/recalcification which includes any working radiographs.
4. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. D3351 only pertains to the permanent dentition.
2. Some payors withhold reimbursement until the *completion* of the apexification and recalcification process. This process may include root canal obturation when required as part of the procedure. Under this scenario, one all-inclusive fee reimburses all visits. It is suggested that the reimbursement policy of the payor be verified *prior* to initiating treatment.
3. Some payors limit reimbursement for the multi stage treatment (and for all treatment visits) to the fee paid for the "regular" root canal performed on that tooth.
4. Working radiographs are included in the treatment fees and should not be submitted separately.

TIPS

The initial diagnostic radiographs may be submitted for reimbursement separately up front, while working radiographs are included in the treatment fees.

NARRATIVES

It is recommended that a comprehensive narrative with the diagnostic radiograph(s) be submitted with the claim form. Any working radiograph(s) can be sent for documentation purposes, but should not be submitted for reimbursement.

D3352 APEXIFICATION/RECALCIFICATION - INTERIM MEDICATION REPLACEMENT (APICAL CLOSURE/CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, PULP SPACE DISINFECTION, ETC.) CDT 2025

For visits in which the intra-canal medication is replaced with new medication. Includes any necessary radiographs.

WARNING

Do not report apexification codes for the use of stem cell therapy to stimulate the growth of pulp-like tissue into the root canal space. This procedure is instead reported using pulpal regeneration codes. The necrotic pulpal regeneration treatment sequence is: D3355 for initial pulpal regeneration treatment, D3356 for interim pulpal regeneration treatment (may require multiple visits), and D3357 for the final stage of pulpal regeneration treatment. Working radiographs are a part of the treatment and should not be submitted for reimbursement. The final stage of pulpal regeneration includes placement of a seal at the coronal (crown) portion of the root canal system, however, per the descriptor for D3357, it does not include the final restoration. Conventional root canal treatment *is not* performed with pulpal regeneration, D3357.

MATCH

Apexification procedures are a method used to treat non-vital permanent teeth with immature roots or open apices. Treatment normally includes mulitple placements of a material like calcium hydroxide to stimulate formation of a calcified apical barrier seal against which gutta percha may be safely condensed. This may also include the placement of an artificial apical barrier prior to obturation. The apexification treatment sequence is: D3351 for initial treatment, D3352 for interim treatment (may require multiple visits), and D3353 for the final stage of apexification. The final apexification treatment stage includes obturation and placement of root canal filling material.

COMMENTS

1. The ADA Glossary defines apexification as "The process of induced root development to encourage the formation of a calcified barrier in a tooth with immature root formation or an open apex. May involve the placement of an artificial apical barrier prior to nonsurgical endodontic obturation."
2. Apexogenesis is a *partial* pulpotomy of a *vital* tooth performed to encourage and allow for the development of the tooth root. See D3222.
3. Report apexification/recalcification (D3352) for an *interim* visit for apexification/recalcification, when a new medication is placed. D3352 includes any working (intra-operative) radiographs.
4. There may be several visits for *interim* medication replacement over a period of months or years.
5. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. D3352 only pertains to the permanent dentition.
2. Some payors withhold reimbursement until the *completion* of the apexification, recalcification or pulpal regeneration process. This process may include root canal obturation when required as part of the procedure. Under this scenario one all-inclusive fee reimburses all visits. It is suggested that the reimbursement policy of the payor be verified *prior* to initiating treatment.
3. Some payors limit reimbursement for the multi stage treatment (and for all treatment visits) to the fee paid for the "regular" root canal performed on that tooth, depending on the anatomic type of tooth, not the number of canals.
4. Working radiographs are included in the treatment fees and should not be submitted separately.

NARRATIVES

It is recommended to send a brief narrative and periodic working radiographs to document the progress of interim treatment. Working radiographic images are not submitted for reimbursement.

D3353 APEXIFICATION/RECALCIFICATION - FINAL VISIT (INCLUDES COMPLETED ROOT CANAL THERAPY - APICAL CLOSURE/CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, ETC.) CDT 2025

Includes removal of intra-canal medication and procedures necessary to place final root canal filling material including necessary radiographs. (This procedure includes last phase of complete root canal therapy.)

WARNING

Do not report apexification codes for the use of stem cell therapy to stimulate the growth of pulp-like tissue into the root canal space. This procedure is instead reported using pulpal regeneration codes. The necrotic pulpal regeneration treatment sequence is: D3355 for initial pulpal regeneration treatment, D3356 for interim pulpal regeneration treatment (may require multiple visits), and D3357 for the final stage of pulpal regeneration treatment. Working radiographs are a part of the treatment and should not be submitted for reimbursement. The final stage of pulpal regeneration includes placement of a seal at the coronal (crown) portion of the root canal system, however, per the descriptor for D3357, it does not include the final restoration. Conventional root canal treatment *is not* performed with pulpal regeneration, D3357.

MATCH

Apexification procedures are a method used to treat non-vital permanent teeth with immature roots or open apices. Treatment normally includes mulitple placements of a material like calcium hydroxide to stimulate formation of a calcified apical barrier seal against which gutta percha may be safely condensed. This may also include the placement of an artificial apical barrier prior to obturation. The apexification treatment sequence is: D3351 for initial treatment, D3352 for interim treatment (may require multiple visits), and D3353 for the final stage of apexification. The final apexification treatment stage includes obturation and placement of root canal filling material.

COMMENTS

1. The ADA Glossary defines apexification as "The process of induced root development to encourage the formation of a calcified barrier in a tooth with immature root formation or an open apex. May involve the placement of an artificial apical barrier prior to nonsurgical endodontic obturation."
2. Apexogenesis is a *partial* pulpotomy of a *vital* tooth performed to encourage and allow for the development of the tooth root. See D3222.
3. Report D3353 for the final visit for apexification/recalcification, which includes completed root canal therapy (last phase). This visit includes any working (intra-operative) radiographs.
4. The fee for the apexification or recalcification final visit (assuming reimbursement for D3351 or D3352 previously) should be about 80-100% of the root canal fee. If the preliminary procedures, D3351/D3352 were not previously reimbursed for initial and interim steps, consider a higher fee for the apexification final visit (D3353) than for the typical root canal fee for the tooth.
5. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. D3353 only pertains to the permanent dentition.
2. Some payors withhold reimbursement until the *completion* of the apexification, recalcification or pulpal regeneration process. This process may include root canal obturation when required as part of the procedure. Under this scenario, one all-inclusive fee reimburses all visits. It is suggested that the reimbursement policy of the payor be verified *prior* to initiating treatment.
3. Some payors limit reimbursement for the multistage treatment (for all apexification or recalcification visits) to the regular endodontic root canal fee reimbursement, depending on the anatomic type of tooth, not the number of canals.
4. Working radiographs are included in the treatment fees.

TIPS

This procedure does not include the final restoration of the tooth. Report the final restoration separately.

NARRATIVES

It is recommended to send a brief narrative and periodic working radiographs to document the progress and completion of the apexification treatment.

PULPAL REGENERATION — CDT 2025

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

This is a previously deleted code. See D3357 for further details.

D3355 PULPAL REGENERATION - INITIAL VISIT — CDT 2025

Includes opening tooth, preparation of canal spaces, placement of medication.

Important: See D3357 comments.

WARNING

Do not report pulpal regeneration codes for procedures intended to induce formation of a calcified barrier in a tooth with immature root formation or an open apex. This procedure is instead reported using apexification codes. The apexification treatment sequence is: D3351 for initial apexification/recalcification treatment, D3352 for interim apexification/recalcification treatment (may require multiple visits), and D3353 for the final stage of apexification/recalcification treatment. The final apexification/recalcification treatment stage includes obturation and placement of root canal filling material.

MATCH

Pulpal regeneration procedures use stem cell therapy to stimulate the growth of pulp-like tissues into the root canal space of non-vital teeth with open apices and immature root formation. The necrotic pulpal regeneration treatment sequence is D3355 for initial pulpal regeneration treatment, D3356 for interim pulpal regeneration treatment (may require multiple visits), and D3357 for the final stage of pulpal regenerative treatment.

COMMENTS

1. The goal of pulpal regeneration (regenerative treatment in an immature permanent tooth with a necrotic pulp) is to induce development of the root apex. Report D3355 for the *initial* visit for pulpal regeneration which includes any working radiographs. Report D3356 for an *interim* visit for pulpal regeneration.
2. The final stage of pulpal regeneration (D3357) includes placement of a seal at the coronal (crown) portion of the root canal system. The final restoration is billed separately. Conventional root canal treatment *is not* performed with pulpal regeneration.
3. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. D3355 only pertains to the permanent dentition.
2. Some payors withhold reimbursement until the *completion* of the pulpal regeneration process. Under this scenario one all-inclusive fee reimburses all visits. It is suggested that the reimbursement policy of the payor be verified *prior* to initiating treatment.
3. Some payors limit reimbursement for the multistage treatment (and for all treatment visits including pulpal regeneration) to the fee paid for the "regular" root canal performed on that tooth.

TIPS

The initial diagnostic radiographs should be submitted for reimbursement separately up front, while working radiographs are included in the treatment fees.

NARRATIVES

It is recommended that a comprehensive narrative with working radiographs be submitted with the pulpal regeneration claims.

D3356 PULPAL REGENERATION - INTERIM MEDICATION REPLACEMENT CDT 2025

Important: See D3357 comments.

WARNING

Do not report pulpal regeneration codes for procedures intended to induce formation of a calcified barrier in a tooth with immature root formation or an open apex. This procedure is instead reported using apexification codes. The apexification treatment sequence is D3351 for initial apexification/recalcification treatment, D3352 for interim apexification/recalcification treatment (may require multiple visits), and D3353 for the final stage of apexification/recalcification treatment. The final apexification treatment stage includes obturation and placement of root canal filling material.

MATCH

Pulpal regeneration procedures use stem cell therapy to stimulate the growth of pulp-like tissues into the root canal space of non-vital teeth with open apices and immature root formation. The necrotic pulpal regeneration treatment sequence is: D3355 for initial pulpal regeneration treatment, D3356 for interim pulpal regeneration treatment (may require multiple visits), and D3357 for the final stage of pulpal regenerative treatment.

COMMENTS

1. The goal of pulpal regeneration (regenerative treatment in an immature permanent tooth with a necrotic pulp) is to induce development of the root apex.
2. Report pulpal regeneration (D3356) for an *interim* visit for pulpal regeneration, when a new medication is placed. D3356 includes any working intraoperative radiographs. There may be several visits for *interim* medication replacement over a period of months or years.
3. Some payors limit reimbursement for the multistage treatment (and for all treatment visits including pulpal regeneration) to the fee paid for the "regular" root canal performed on that tooth.
4. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. D3356 only pertains to the permanent dentition.
2. Some payors withhold reimbursement until the *completion* of the pulpal regeneration process. Under this scenario one all-inclusive fee reimburses all visits. It is suggested that the reimbursement policy of the payor be verified *prior* to initiating treatment.
3. Some payors limit reimbursement for the multistage treatment (and for all treatment visits including pulpal regeneration) to the fee paid for the "regular" root canal performed on that tooth.

NARRATIVES

It is recommended to submit a brief narrative and periodic working radiographs to document the progress of interim treatment visits.

D3357 PULPAL REGENERATION - COMPLETION OF TREATMENT CDT 2025

Does not include final restoration.



WARNING

Do not report pulpal regeneration codes for procedures intended to induce formation of a calcified barrier in a tooth with immature root formation or an open apex. This procedure is instead reported using apexification codes. The apexification treatment sequence is D3351 for initial treatment, D3352 for interim treatment (may require multiple visits), and D3353 for the final stage of apexification. The final apexification treatment stage includes obturation and placement of root canal filling material.



MATCH

Pulpal regeneration procedures use stem cell therapy to stimulate the growth of pulp-like tissues into the root canal space of non-vital teeth with open apices and immature root formation. The sequence of treatment for necrotic pulpal regeneration is D3355 for initial pulpal regeneration treatment, D3356 for interim pulpal regeneration treatment (may require multiple visits), and D3357 for the final stage of pulpal regenerative treatment. The final stage of pulpal regeneration includes placement of a seal at the coronal (crown) portion of the root canal system. The final restoration is billed separately. Conventional root canal treatment *is not* performed with pulpal regeneration.

COMMENTS

1. Pulpal regeneration is performed on a non-vital permanent tooth with incomplete root development, necrotic pulp, and open apex. The tooth is opened, the necrotic pulpal tissue removed, the pulp space disinfected, intra-canal medication placed, and the canal is sealed with temporary cement. When healing and regeneration are complete, the tooth is sealed coronally. Placement of the coronal seal completes the pulpal regeneration sequence. Once completed the tooth is ready for final restoration.
2. The goal of pulpal regeneration is to recreate vital pulp and generate continued root maturation and development. Since the procedure often requires multiple visits and applications of intra-canal medication for successful outcomes, these visits are coded as follows:

   D3355 - Initial visit to open the tooth, prepare the canal spaces, and place the initial medication, includes working radiographs.

   D3356 - Additional pulp disinfection procedures and removal of old medicament and then replacement with new medicament. May require multiple visits. Each visit is reported as D3356.

   D3357 - Final visit may involve reentering the tooth, irrigating the root canal system, reinitiating bleeding, and sealing with MTA, the final coronal restoration will depend on the patient's individual need and is billed separately.
3. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. D3357 only pertains to the permanent dentition.
2. Some payors withhold reimbursement until the *completion* of the pulpal regeneration process. Under this scenario one all-inclusive fee reimburses all visits. It is suggested that the reimbursement policy of the payor be verified *prior* to initiating treatment.
3. Some payors limit reimbursement for the multistage treatment (and for all treatment visits) to the fee paid for the "regular" root canal performed on that tooth.
4. Some payors limit reimbursement for the aggregate fees (for all pulpal regeneration visits) to the regular endodontic root canal fee, depending on the anatomic type of tooth, not the number of canals.

TIPS

This procedure does include a coronal seal but does not include the final definitive restoration of the tooth. Report the final restoration separately.

NARRATIVES It is recommended to submit a brief narrative and periodic working radiographs to document the completion of the pulpal regeneration treatment.

APICOECTOMY/PERIRADICULAR SERVICES — CDT 2025

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

D3410 APICOECTOMY - ANTERIOR — CDT 2025

For surgery on root of anterior tooth. Does not include placement of retrograde filling material.

WATCH

1. The removal of a nonodontogenic cyst or tumor (D7460/D7461) and apicoectomy - anterior may be reported concurrently. It is improper/misleading to report (D7460/D7461), removal of a nonodontogenic cyst or tumor, and D3410, apicoectomy, concurrently if the apicoectomy is not performed.
2. Biopsy of oral tissue - hard (D7285) and biopsy of oral tissue - soft (D7286) prohibits their reporting with apicoectomy/periradicular curettage.

COMMENTS

1. D3410 reports the amputation of the apex (tip) of the root of the previously endodontically treated *anterior* tooth. An apicoectomy is performed when:
   a. It is impossible to do conventional root canal therapy because the canal(s) can't be negotiated, or
   b. Root canal therapy was completed, but it was unsuccessful.
2. A retrograde filling (D3430) is necessary to seal the end of the tooth root when the apex has been surgically amputated, (i.e., an apicoectomy has been done).
3. For surgical repair of root resorption, see D3471, D3472, and D3473.
4. For surgical exposure of root surface without apicoectomy or repair of root resorption, see D3501, D3502, and D3503.
5. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. The retrograde filling (D3430) is a separate procedure. Note, the retrograde filling is often combined with the apicoectomy for reimbursement. See D3430 for further details.
2. Apicoectomy treatment may not be reimbursed if performed on a tooth less than 24 months after the completion of the root canal. Time limitations vary.
3. If the apicoectomy is performed on the same service date as a root canal, only a portion of the apicoectomy fee may be reimbursed.
4. Reimbursement for D3410 is highly variable.

D3421 APICOECTOMY - PREMOLAR (FIRST ROOT) — CDT 2025

For surgery on one root of a premolar. Does not include placement of retrograde filling material. If more than one root is treated, see D3426.

WATCH

1. The removal of a nonodontogenic cyst or tumor (D7460/D7461) and apicoectomy - premolar may be reported concurrently. It is improper/misleading to report (D7460/D7461), removal of a nonodontogenic cyst or tumor, and D3421 apicoectomy, concurrently, if the apicoectomy is not performed.
2. Biopsy of oral tissue - hard (D7285) and biopsy of oral tissue - soft (D7286) prohibits their reporting with apicoectomy/periradicular curettage.

COMMENTS

1. D3421 reports the amputation of the apex (tip) of the root of the previously endodontically treated *premolar* tooth. If more than one root is treated, see D3426. An apicoectomy is performed when:
   a. It is impossible to do conventional root canal therapy because the canal(s) can't be negotiated, or
   b. Root canal therapy was completed, but it was unsuccessful.
2. A retrograde filling (D3430) is necessary to seal the end of the tooth root when the apex has been surgically amputated, (i.e., an apicoectomy has been done)
3. For surgical repair of root resorption, see D3471, D3472, and D3473.
4. For surgical exposure of root surface without apicoectomy or repair of root resorption, see D3501, D3502, and D3503.
5. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. The retrograde filling (D3430) is a separate procedure. Note, the retrograde filling is often combined with the apicoectomy for reimbursement. See D3430 for further details.
2. Apicoectomy treatment may not be reimbursed if performed on a tooth less than 24 months after the completion of the root canal. Time limitations vary.
3. If the apicoectomy is performed on the same service date as a root canal, only a portion of the apicoectomy fee may be reimbursed.
4. Reimbursement for D3421 is highly variable.

D3425 APICOECTOMY - MOLAR (FIRST ROOT) CDT 2025

For surgery on one root of a molar tooth. Does not include placement of retrograde filling material. If more than one root is treated, see D3426.

WATCH

1. The removal of a nonodontogenic cyst or tumor (D7460/D7461) and apicoectomy - molar may be reported concurrently. It is improper/misleading to report (D7460/D7461), removal of a nonodontogenic cyst or tumor, and D3425 apicoectomy, concurrently, if the apicoectomy is not performed.
2. Biopsy of oral tissue - hard (D7285) and biopsy of oral tissue - soft (D7286) prohibits their reporting with apicoectomy/periradicular curettage.

COMMENTS

1. D3425 reports the amputation of the apex (tip) of the root of the previously endodontically-treated *molar* tooth. If more than one root is treated, see D3426. An apicoectomy is performed when:
   a. It is impossible to do conventional root canal therapy because the canal(s) can't be negotiated, or
   b. Root canal therapy was completed, but it was unsuccessful.
2. A retrograde filling (D3430) is necessary to seal the end of the tooth root when the apex has been surgically amputated, (i.e., an apicoectomy has been done).
3. For surgical repair of root resorption, see D3471, D3472, and D3473.
4. For surgical exposure of root surface without apicoectomy, or repair of root resorption, see D3501, D3502, and D3503.
5. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. The retrograde filling (D3430) is a separate procedure. Note, the retrograde filling is often combined with the apicoectomy for reimbursement by payors. See D3430 for further details.
2. Apicoectomy treatment may not be reimbursed if performed on a tooth in less than 24 months after the completion of the root canal. Time limitations vary.
3. If the apicoectomy is performed on the same service date as a root canal, only a portion of the apicoectomy fee may be reimbursed.
4. Reimbursement for D3425 is highly variable.

D3426 APICOECTOMY (EACH ADDITIONAL ROOT) CDT 2025

Typically used for premolar and molar surgeries when more than one root is treated during the same procedure. This does not include retrograde filling material placement.

WATCH

1. The removal of a nonodontogenic cyst or tumor (D7460/D7461) and apicoectomy (each additional root) - molar may be reported concurrently. It is improper/misleading to report (D7460/D7461), removal of a nonodontogenic cyst or tumor, and D3426 apicoectomy, concurrently, if the apicoectomy is not performed.
2. Biopsy of oral tissue - hard (D7285) and biopsy of oral tissue - soft (D7286) prohibits their reporting with apicoectomy/periradicular curettage.

COMMENTS

1. D3426 reports the amputation of the apex of an *additional* root in addition to first root of a previously endodontically treated tooth. (It is not common but an anterior tooth can have more than one root).
2. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. The retrograde filling (D3430) is a separate procedure. Note, the retrograde filling is often combined with the apicoectomy for reimbursement by payors. See D3430 for further details.
2. Apicoectomy treatment may not be reimbursed if performed on a tooth less than 24 months after the completion of the root canal. Time limitations vary.
3. If the apicoectomy is performed on the same service date as a root canal, only a portion of the apicoectomy fee may be reimbursed.
4. Reimbursement for D3426 is highly variable.

D3427 PREVIOUSLY DELETED CODE PERIRADICULAR SURGERY WITHOUT APICOECTOMY

This is a previously deleted code. See D3471, D3472, D3473, D3501, D3502, and D3503 for further details.

D3428 BONE GRAFT IN CONJUNCTION WITH PERIRADICULAR SURGERY - PER TOOTH, SINGLE SITE CDT 2025

Includes non-autogenous graft material.



WARNING

Bone graft in conjunction with periradicular surgery - per tooth, single site (D3428) is used to describe a bone graft placed during periradicular surgery. Do not use periodontal osseous surgery bone replacement grafts codes (D4263 or D4264) to report a bone graft in conjunction with periradicular surgery.

COMMENTS

1. An osseous autograft, allograft or non-osseous graft is placed in a periradicular defect at the time of the periradicular surgery to preserve the alveolar (bone) integrity and to aid in the healing process.
2. Periradicular surgery requires bone removal to access the root area being treated. This type of surgery can remove a significant amount of bone structure and can hinder the long term stability of the tooth. A bone graft placed to augment the bony defect can enhance the healing process and may benefit the overall result. D3428 should be reported when performing a bone graft in conjunction with periradicular surgery - per tooth, single site at the time of the periradicular surgery. D3428 includes any non-autogenous graft material. Separately, biologic materials to aid in soft and osseous tissue regeneration in conjunction with periradicular surgery (D3431) and guided tissue regeneration, resorbable barrier, per site, in conjunction with periradicular surgery (D3432), when placed, are reported separately.
3. If a membrane is placed, the resorbable membrane would be reported separately as guided tissue regeneration procedure (D3432). Thus, guided tissue regeneration is also reported in conjunction with a periradicular surgery. The reimbursement is subject to the plan's limitations.

4. Although the same materials are often used, this endodontic procedure (D3428) is reported with a different code from a bone graft performed to correct deformities caused by *periodontal* disease. This endodontic procedure involves the use of osseous grafts, osseous allografts, or non-osseous grafts to stimulate bone growth when periradicular pathosis has led to a deformity of the bone.
5. Only non-autogenous bone graft material is included in reporting D3428. The harvesting of autogenous graft material (from the body) should be reported as D7295. Typically, autogenous graft material is used less than 1% of the time.
6. D3429, bone graft in conjunction with periradicular surgery-each additional contiguous tooth in the same surgical site, cannot be reported for another site on the same tooth reported for D3428. D3429 can only be used for a tooth contiguous to the tooth reported in D3428.
7. D7955 repair of maxillofacial soft and/or hard tissue defect could apply if the defect extends significantly beyond the treated tooth, but D7955 should not be reported in addition to D3428 or D3429 procedures.
8. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Reimbursement for this procedure in addition to the periradicular surgery is limited and seldom reimbursed.
2. Some contracts stipulate that only one regenerative procedure will be paid per periradicular area. For example, D3428 or D3429 may be paid following periradicular surgery but the biologic materials (D3431) denied. Additionally, payment for GTR (membrane) is often limited to two sites per quadrant. Note: D3429 would not be paid unless D3428 had already been paid. If they pay only one regenerative procedure per periradicular area, D3429 would probably never be paid.

TIPS

1. The material cost of bone grafts varies widely. The fee charged should be the actual material's cost of the graft plus a "labor" charge, plus the GTR resorbable membrane barrier (D3432) fee, if placed. Don't overprice the combination of procedures - keep the total time of all the procedures (plus materials) in mind.
2. D3432, guided tissue regeneration, if done in conjunction with D3428, is reported separately.
3. Terms you should know:

   Allogenic graft - usually freeze-dried cells (from another human being) that are used to repair a defect or supplement a deficiency. Demineralized bone graft products are an example of this (allograft bone material).

   Alloplastic - refers to man-made materials used for tissue grafting and augmentation. Hydroxylapatite bone graft is an example of this type of graft (e.g., OsteoGraft®, etc.).

   Autogenous - a graft taken from one part of a patient's body and transferred to another. Chin, hip, and rib grafts would be examples of an autogenous graft.

   Xenograft - bone graft tissue from another species, such as bovine bone (Bio-oss®).

   Guided tissue regeneration - used to enhance and promote bone growth by placing a resorbable barrier membrane D3432 under gingival tissue and over remaining bone (e.g., Gore-tex®, BioMend®, etc.). GTR is placed to inhibit fast growing soft tissue from filling in the graft area while allowing slower growing bone to fill in the defect.

   Reimbursement is subject to the need and benefit availability. Reimbursement for a bone graft is inconsistent. Payors require the bone graft be done on the same service date as the periradicular surgery.

NARRATIVES

It is recommended that the payor be contacted for specific coverage information/limitations and supporting documentation required for consideration. Most payors request periodontal charting even though pocket depths are irrelevant in terms of endodontic indications for the periradicular surgery procedure.

D3429 BONE GRAFT IN CONJUNCTION WITH PERIRADICULAR SURGERY - EACH ADDITIONAL CONTIGUOUS TOOTH IN THE SAME SURGICAL SITE

CDT 2025

Includes non-autogenous graft material.

COMMENTS

1. Bone graft in conjunction with periradicular surgery - each additional contiguous tooth in the same surgical site (D3429) is used to describe an additional bone graft placed in a tooth contiguous to the tooth reported in D3428. D3429 cannot be reported for another site on the same tooth reported for D3428.
2. See D3428 for additional information regarding a bone graft in conjunction with periradicular surgery.
3. Enter the tooth number or range of teeth being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

Some contracts stipulate that only one regenerative procedure will be paid per periradicular area. For example, D3428 or D3429 may be paid following periradicular surgery but the biologic materials (D3431) denied. Additionally, payment for GTR is often limited to two sites per quadrant. Note: D3429 would not be paid unless D3428 had already been paid. If they pay only one regenerative procedure per periradicular area, D3429 would probably never be paid

D3430 RETROGRADE FILLING - PER ROOT CDT 2025

For placement of retrograde filling material during periradicular surgery procedures. If more than one filling is placed in one root - report as D3999 and describe.

COMMENTS

1. Retrograde filling (D3430) reports a retrograde filling which seals the root apex of an endodontically treated tooth, that has had an apicoectomy
2. D3430 is reported on a *per root* basis.
3. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

NARRATIVES

If more than one retrograde filling is placed in the same root, report as D3999 and provide a brief narrative that describes the procedure.

D3431 BIOLOGIC MATERIALS TO AID IN SOFT AND OSSEOUS TISSUE REGENERATION IN CONJUNCTION WITH PERIRADICULAR SURGERY CDT 2025

COMMENTS

1. Biologic materials may be used alone or with other regenerative substrates such as bone and barrier membranes, depending upon their formulation and the presentation of the periradicular defect. This procedure (D3431) does not include surgical entry and closure, wound debridement, osseous contouring, or the placement of graft materials and/or barrier membranes. Other separate procedures may be required in conjunction with D3431 and should be reported using their own unique codes.
2. During periradicular surgery, biologic materials may be placed in a bony defect to aid in the regeneration of soft and osseous tissue. These materials may include bone morphogenetic protein 2 (BMP-2), Emdogain®, etc. Bone graft materials (D3428/D3429) and/or GTR barrier membranes (D3432) may also be placed at the same time and should be reported separately.
3. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Reimbursement for biologic materials used to aid in soft and osseous tissue regeneration in conjunction with periradicular surgery (D3431) may be limited to the surgical portion of the overall periradicular procedure.
2. Some contracts stipulate that only one regenerative procedure will be paid per periradicular area. For example, D3428 or D3429 may be paid following periradicular surgery but the biologic materials (D3431) denied. Additionally, payment for GTR is often limited to two sites per quadrant.
3. Note: D3429 would not be paid unless D3428 had already been paid. If they pay only one regenerative procedure per periradicular area, D3429 would probably never be paid. Fibrin Glue®, PepGen®, Gem 21®, and Emdogain® are all examples of biologic materials. Some payors limit reimbursement to specific materials such as Emdogain®. Plasma Rich Protein (PRP) could also be considered a biologic material, however when using PRP (also known as autologous blood concentrate product), report D7921.
4. D3431 is seldom reimbursed by payors. This procedure requires consultant review prior to reimbursement.
5. Should payors reimburse D3431, the amount reimbursed for D3431 may be limited to the cost of the materials used.

TIPS

Associated procedures that may be provided along with D3431 may include but are not limited to D3410, D3421, D3425, and D3426.

NARRATIVES

A narrative is required to document this procedure. The narrative should clearly describe the condition of the surgical area being treated by the biologic material and why the treatment was needed. The narrative should identify the material used for regenerative purposes.

D3432 GUIDED TISSUE REGENERATION, RESORBABLE BARRIER, PER SITE, IN CONJUNCTION WITH PERIRADICULAR SURGERY

CDT 2025

COMMENTS

1. This procedure does not include other procedures provided in conjunction with periradicular surgery, including apicoectomy, retrograde filling, grafting, cyst removal, biopsy, or the use of biologic materials to aid in healing. D3432 is used for regeneration of tissue associated with periradicular surgery and is reported as a stand-alone procedure.
2. The process of healing after periradicular surgery is important to the long term success of the periradicular procedure. Bone requires more time to regenerate and mature than soft tissue. A barrier membrane is placed to stabilize the surgery site so that the new bone can mature & heal without interference from the healing soft tissue. The resorbable barrier membrane (D3432) is integrated into the regeneration site and resorbed or broken down by the body in the healing process. This type of barrier membrane does not require a second surgery for removal, and is resorbed.
3. A bone graft is not always required when a barrier membrane is used. Some regeneration techniques encourage bone regrowth without placement of an associated bone graft. Guided Tissue Regeneration (GTR) inhibits faster growing soft tissue from filling in the site, allowing the slower growing bone to fill in the site first.
4. Other procedures may be performed with D3432 and should be reported separately using their unique codes.
5. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Guided tissue regeneration, resorbable barrier, per site, in conjunction with periradicular surgery (D3432) should be reported separately when placed in association with other periradicular procedures. Barrier membranes should be reported separately when placed in concert with bone grafts D3428 and D3429. Tooth number, surface/site, radiographic images (pre- and post-treatment) and clinical notes are typically required to be reported for reimbursement.
2. Some contracts stipulate that only one regenerative procedure will be paid per periradicular area. For example, D3428 or D3429 may be paid following periradicular surgery but the biologic materials (D3431) denied. Additionally, payment for GTR is often limited to two sites per quadrant. Note: D3429 would not be paid unless D3428 had already been paid. If they pay only one regenerative procedure per periradicular area, D3429 would probably never be paid.

D3450 ROOT AMPUTATION - PER ROOT

CDT 2025

Root resection of a multi-rooted tooth while leaving the crown. If the crown is sectioned, see D3920.



WARNING

If the crown is sectioned, *do not* report D3450. See hemisection (D3920) for further details.

COMMENTS

1. The word "crown" in the descriptor does not refer to a restorative crown, but to the anatomical crown portion of the natural tooth.
2. The natural crown is left intact while one of the roots of a multi-rooted tooth is removed.
3. Any endodontic treatment provided is reported separately.
4. Any restorative treatment provided is reported separately.
5. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

If an apicoectomy is performed, the root amputation is often considered a part of the apicoectomy procedure and not reimbursed.

NARRATIVES

1. State necessity for root amputation. Also send a pre-operative periodontal chart and pre-operative radiographic image(s).
2. State endodontic and periodontal prognosis for remaining part of tooth.

D3460 ENDODONTIC ENDOSSEOUS IMPLANT CDT 2025

Placement of implant material, which extends from a pulpal space into the bone beyond the end of the root.

COMMENTS

1. Endodontic endosseous implant (D3460) reports an endodontic implant, which extends through the pulpal space of the tooth beyond the end of the root. This code is often used in association with a natural tooth overdenture and the related metallic coping.
2. Conventional implants are more often indicated than the endodontic endosseous implant (D3460). This procedure is seldom performed and is considered obsolete.
3. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

D3460 is not typically reimbursed.

D3470 INTENTIONAL REIMPLANTATION (INCLUDING NECESSARY SPLINTING) CDT 2025

For the intentional removal, inspection and treatment of the root and replacement of a tooth into its own socket. This does not include necessary retrograde filling material placement.

WATCH

1. It is erroneous to report D3470 for an accident related reimplantation. If reimplantation follows an accident, see D7270 for appropriate coding.
2. It is inappropriate to report D3470 for tooth transplantation (D7272). Transplantation (D7272) describes a situation where a tooth is removed and repositioned in a second tooth's socket. See D7272.

COMMENTS

1. Intentional reimplantation (D3470) reports extracting a tooth and then replacing it in the same socket.
2. D3470 does not include a retrograde filling (D3430) performed on the extracted tooth while in hand. Report the retrograde filling (D3430) procedure separately.
3. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

The intentional reimplantation (D3470) procedure is not typically reimbursed and seldom performed.

D3471 SURGICAL REPAIR OF ROOT RESORPTION - ANTERIOR CDT 2025

For surgery on root of anterior tooth. Does not include placement of restoration.



WARNING

1. Periradicular surgery without apicoectomy (D3427) is deleted.
2. For surgical repair of root resorption, now report D3471, D3472, and D3473 according to the tooth morphology.
3. Do not report D3471 for exploratory surgery. Report D3501 for exploratory surgery on an anterior tooth without apicoectomy or repair of root resorption.

COMMENTS

1. D3471 reports surgical repair of root resorption - Anterior.
2. There is external root resorption with D3471.
3. Report the placement of restoration separately.
4. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Reimbursement for D3471 is highly variable.
2. Coverage is limited for D3471.

D3472 SURGICAL REPAIR OF ROOT RESORPTION - PREMOLAR

CDT 2025

For surgery on root of premolar tooth. Does not include placement of restoration.

WARNING

1. Periradicular surgery without apicoectomy (D3427) is deleted.
2. For surgical repair of root resorption, now report D3471, D3472, and D3473 according to the tooth morphology.
3. Do not report D3472 for exploratory surgery. Report D3502 for exploratory surgery on a premolar tooth without apicoectomy or repair of root resorption.

COMMENTS

1. D3472 reports surgical repair of root resorption - Premolar.
2. There is external root resorption with D3472.
3. Report the placement of restoration separately.
4. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Coverage for D3472 is highly variable.
2. Reimbursement for D3472 will be limited.

D3473 SURGICAL REPAIR OF ROOT RESORPTION - MOLAR

CDT 2025

For surgery on root of molar tooth. Does not include placement of restoration.

WARNING

1. Periradicular surgery without apicoectomy (D3427) is deleted.
2. For surgical repair of root resorption, now report D3471, D3472, and D3473 according to the tooth morphology.
3. Do not report D3473 for exploratory surgery. Report D3503 for exploratory surgery on a molar tooth without apicoectomy or repair of root resorption.

COMMENTS

1. D3473 reports surgical repair of root resorption - Molar.
2. There is external root resorption with D3473.
3. Report the placement of restoration separately.
4. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Coverage for D3473 is highly variable.
2. Reimbursement for D3473 will be limited.

D3501 SURGICAL EXPOSURE OF ROOT SURFACE WITHOUT APICOECTOMY OR REPAIR OF ROOT RESORPTION - ANTERIOR

CDT 2025

Exposure of root surface followed by observation and surgical closure of the exposed area. Not to be used for or in conjunction with apicoectomy or repair of root resorption.

WARNING

1. Do not report D4240/D4241 when laying a flap for the purpose of observing root for possible root fracture.
2. D3501 is not to be reported in conjunction with apicoectomy or repair of a root resorption defect.
3. D4240 and D4241 report a gingival flap procedure related to a periodontal procedure.

COMMENTS

1. D3501 documents and reports exposure of the root surface of an anterior tooth for observation only.
2. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS Reimbursement is highly variable.

NARRATIVES Documentation should include the reason for the exposure and observation and any findings or lack of findings.

D3502 SURGICAL EXPOSURE OF ROOT SURFACE WITHOUT APICOECTOMY OR REPAIR OF ROOT RESORPTION - PREMOLAR

CDT 2025

Exposure of root surface followed by observation and surgical closure of the exposed area. Not to be used for or in conjunction with apicoectomy or repair of root resorption.



WARNING

1. Do not report D4240/D4241 when laying a flap for the purpose of observing root for possible root fracture.
2. D3502 is not to be reported in conjunction with apicoectomy or repair of a root resorption defect.
3. D4240 and D4241 report a gingival flap procedure related to a periodontal procedure.

COMMENTS

1. D3502 documents and reports exposure of the root surface of a premolar for observation only.
2. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS Reimbursement is highly variable.

NARRATIVES Documentation should include the reason for the exposure and observation and any findings or lack of findings.

D3503 SURGICAL EXPOSURE OF ROOT SURFACE WITHOUT APICOECTOMY OR REPAIR OF ROOT RESORPTION - MOLAR

CDT 2025

Exposure of root surface followed by observation and surgical closure of the exposed area. Not to be used for or in conjunction with apicoectomy or repair of root resorption.



WARNING

1. Do not report D4240/D4241 when laying a flap for the purpose of observing root for possible root fracture.
2. D3503 is not to be reported in conjunction with apicoectomy or repair of a root resorption defect.
3. D4240 and D4241 report a gingival flap procedure related to a periodontal procedure.

COMMENTS

1. D3503 documents and reports exposure of the root surface of a molar for observation only.
2. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS Reimbursement is highly variable.

NARRATIVES Documentation should include the reason for the exposure and observation and any findings or lack of findings.

D3910 SURGICAL PROCEDURE FOR ISOLATION OF TOOTH WITH RUBBER DAM CDT 2025

COMMENTS

1. D3910 is reported when the dentist uses a scalpel, laser or electrosurgery to surgically recontour the tissue in order to have access to more tooth structure to support a rubber dam clamp. For example, if the palatal cusp of tooth #5 has fractured off 1-2mm beneath the gingival margin, tissue surgical recontouring (as a procedure) may be necessary, which then justifies billing D3910 separately.
2. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Surgical procedure for isolation of tooth with rubber dam (D3910) which is done on the same day as a root canal or gross pulpal debridement (D3221) is not typically reimbursed. D3910 is considered a part of the global fee by most payors.
2. D3910 may be reimbursed if the isolation is necessary to treat trauma. For example, after a traumatic fracture, D3910 might be required for the isolation of a tooth with rubber dam to treat the fracture and might be reimbursed.
3. D3910 could include a hard tissue procedure as well as soft tissue.
4. D3910 is not limited to use in endodontic treatments. For example, it could be used for wwrestorative purposes when indicated.

NARRATIVES

Write a narrative describing why the tissue surgical procedure was required for the isolation of the tooth with rubber dam.

D3911 INTRAORIFICE BARRIER CDT 2025

Not to be used as a final restoration.



WARNING

1. Placing an Intraorifice barrier is NOT placing an endodontic access hole closure. Permanently closing an endodontic access hole is a restoration, usually a one surface composite or amalgam restoration. Use the appropriate restoration code to describe the endodontic access hole closure.
2. D3911 does not report a direct interim restoration placed to create a seal for endodontic isolation. See D2940.

WATCH

The dentist who performed the endodontic procedure would be the dentist who places an intraorifice barrier at the completion of obturation and filling of the canals. If the dentist who completed the endodontic procedure also places the intraorifice barrier, and the final restoration, the placement of the intraorifice barrier would frequently be considered an integral part of the final restoration and not payable as a separate service.



MATCH

D3911, intraorifice barrier is used to report the placement of a material to seal the opening between the obturation material and the oral cavity prior to subsequent placement of a permanent restoration or new/replacement crown.

COMMENTS

1. To optimize the seal of an endodontically treated tooth, ideally, a permanent restoration is placed immediately after the endodontic procedure is completed all while the tooth remains under a rubber dam. Because of time restraints or the need for referral back to the referring dentist is pending, placing of the permanent restoration at the end of the completion of the endodontic procedure rarely occurs.
2. The intraorifice barrier is placed immediately while under the rubber dam after obturation and filling of the canals. This prevents re-contamination of the canal system before the permanent restoration is placed at a subsequent appointment.
3. The intraorifice barrier is placed over the canal orifice(s) in the chamber floor with the intent of sealing canals from contamination.

4. The permanent restorative material for an intraorifice barrier is usually a flowable composite, resin-modified glass ionomer cement or a bioceramic restorative material. The placement of the intraorifice barrier does not take the place of the final restoration.
5. The restorative dentist either fills the access hole with composite or amalgam as the final restoration or may prep the tooth for a core buildup, cast or milled post, or prefabricated post and core with the subsequent crown then placed
6. Placement of restorative material to prevent contamination DURING the endodontic procedure (for example creating a "wall" of resin to prevent blood or saliva from entering the canal space) is reported using D2940 placement of interim direct restoration. See D2940.
7. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

While a new code may be approved by the Code Maintenance Committee (CMC), the payor is not obligated to reimburse it. With D3911, some payors will maintain that the intraorifice barrier placement is integral to the root canal procedure or an integral part of the final restoration placed at the end of the root canal procedure.

TIPS

If the restorative dentist fills the access hole of a crown, then do not report crown repair D2980. These types of repairs to an existing restoration are not because of material failure, but due to access hole opening. Sealing an endodontic access opening is not made necessary because of a material failure, rather an intentional procedure performed to provide access to the canals. Report an occlusal composite with the narrative, "An occlusal composite was placed for endodontic hole access closure."

NARRATIVES

"The intraorifice barrier was placed to seal and establish a barrier to prevent recontamination of the canal system after obturation."

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

CDT 2025

Includes separation of a multi-rooted tooth into separate sections containing the root and the overlying portion of the crown. It may also include the removal of one or more of those sections.

COMMENTS

1. The word "crown" in the descriptor does not refer to a restorative crown, but to the anatomical crown portion of a natural tooth.
2. Before D3920 is performed, the tooth has typically had root canal treatment.
3. D3920 reports the *sectioning* of the multi-rooted tooth in preparation for the placement of a crown. These sections may contain the roots only. Or they may contain the separate root(s) with their portion of the anatomic crown.
4. D3920 may be used to describe the sectioning of a tooth with the removal of a root or when each part of the tooth is restored.
5. Any restorative treatment provided is reported separately.
6. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

NARRATIVES

Write a narrative describing the procedure.

D3921 DECORONATION OR SUBMERGENCE OF AN ERUPTED TOOTH

CDT 2025

Intentional removal of coronal tooth structure for preservation of the root and surrounding bone.



WARNING

If the coronectomy is performed when a neurovascular complication is likely if an entire impacted tooth is removed, report D7251, coronectomy - intentional partial tooth removal. On the other hand, D3921 reports the intentional removal of coronal tooth structure of an erupted tooth for preservation of the root and surrounding bone.

MATCH

D3921, decoronation or submergence of an erupted tooth describes the intentional partial removal of an erupted tooth so that the bone surrounding the retained root will be maintained. When a tooth is extracted, the bone atrophies over time reducing the amount of support for a prosthesis or placement of an implant.

COMMENTS

1. This procedure is often performed post-trauma with an ankylosed or fractured tooth.
2. The purpose of decoronation or submergence of an erupted tooth and then retention of the root is to preserve ridge height and width of bone surrounding the retained root until the patient is ready for the placement an implant or delivery of another prosthetic device that depends on adequate bone for support.
3. A decoronation or submergence procedure is performed to remove the clinical crown and gutta percha from the roots wherein the remaining root structure and surrounding bone is not affected.
4. After an appropriate interval, the remaining root is removed, and the implant or prosthesis is placed.
5. This procedure may also be performed when an extraction is contraindicated due to the risk of medication or radiation induced osteonecrosis.
6. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

This procedure will often be denied by the payor. D3921 decoronation/submergence may be paid if there is implant coverage once the service is considered standard of care to preserve bone under this type of scenario.

NARRATIVES

1. The narrative should establish that D3921 was performed to preserve the alveolar bone to maintain adequate width and height of the alveolus for future implant placement.
2. The narrative could also establish that D3921 was performed when an extraction is contraindicated due to the risk of medication or radiation induced osteonecrosis.

D3950 CANAL PREPARATION AND FITTING OF PREFORMED DOWEL OR POST CDT 2025

Should not be reported in conjunction with D2952, D2953, D2954 or D2957 by the same practitioner.

WATCH

1. It is inappropriate to report canal preparation and fitting of preformed dowel or post (D3950) if the practitioner providing the root canal treatment is also restoring the tooth.
2. D3950 could be reported by the endodontist who provides the root canal treatment if another dentist restores the tooth.

COMMENTS

1. D3950 is used to report the preparation of the canal for a preformed dowel or post. This service is typically provided by an endodontist after completing a root canal. This allows the restorative dentist to place the preformed post or dowel to restore the endodontically treated tooth. This procedure provides space to accommodate the placement of the preformed dowel or post.
2. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. D3950 is often considered a part of the placement procedure of the prefabricated post and core (D2954) procedure. D3950 is not typically reimbursed.
2. D2952 is reported by the restorative dentist when placing a cast post and core. This procedure is global and includes the canal preparation and seating of a cast post and core.
3. D2954 is reported by the restorative dentist when placing a prefabricated post and core. This procedure is global and includes the canal preparation and seating of a preformed dowel or post.
4. If a dentist is placing a post in a filling (as a final restoration), and not completing a post and buildup in *preparation* for a crown, report D2999, by report, to describe the post.

NARRATIVES

It is important to include a narrative with this procedure that explains that the doctor providing the D3950 procedure is not the provider who subsequently will place the post and core.

D3960 PREVIOUSLY DELETED CODE INTERNAL BLEACHING

This is a previously deleted code. See D9974 for further details.

D3999 UNSPECIFIED ENDODONTIC PROCEDURE, BY REPORT CDT 2025

Used for procedure that is not adequately described by a code. Describe procedure.

NARRATIVES

D3999, by report, may be used to describe the following endodontic and other related procedures. These procedures, at this time, have no specific code to describe the procedure:

1. When a patient does not return to complete endodontic treatment at a subsequent visit, a payor may reimburse up to one-third of the root canal fee. This reimbursement is highly variable. In some cases, the payor may re-map the reimbursement level to coincide with the pulpal debridement (D3221) or palliative (D9110) payor's fee. For reimbursement it is important to include a narrative with the claim. Document any cancellations, no shows, and attempts to reschedule the patient.
2. Removal of a broken instrument. Write a narrative. Plan limitations are highly variable. Also see D3331.
3. Removal of pulp stones. Write a narrative. Plan limitations are highly variable. Also see D3331.
4. Calcified canals that are less than 50% and the service does not qualify for D3331. Write a narrative. Plan limitations are highly variable.
5. Retrograde filling - if *more* than one retrograde filling is placed in one root. Write a narrative and describe. Also, see D3430.
6. A partial pulpotomy for apexogenesis performed on a primary tooth that has no permanent successor tooth. Write a narrative and describe the procedure performed.
7. To record the first visit of two visit endodontic therapy.

1. The old periodontal classification (1989 AAP system), type I, II, III, IV, V was replaced in 1999 with 8 categories. During the 2017 World Workshop on the Classification of Periodontal and Peri-Implant Diseases and Conditions, co-presented by the Academy of Periodontology (AAP) and the European Federation of Periodontology (EFP) the classification system was redesigned and is the current classification system, released in May of 2018. Despite these changes, many payors still ask for the former type I-V description or the system based on the 8 categories. To learn more about the current classification system go to http://www.perio.org/2017wwdc.
2. The definition of "quadrant" requires "four or more contiguous teeth or tooth bound spaces per quadrant." The codes specifying "four or more contiguous teeth or tooth bound spaces per quadrant" are gingivectomy or gingivoplasty (D4210), gingival flap procedure, including root planing (D4240), anatomical crown exposure (D4230) and osseous surgery (including flap entry and closure) (D4260).

   Note: The definition of periodontal scaling and root planing (D4341) *differs* from the other periodontal codes. D4341 describes scaling and root planing provided "for four or more teeth per quadrant" with no reference to the teeth being "contiguous" or to "tooth bound spaces." Simply put, D4341 requires a count of four or more qualified and treated teeth per quadrant.
3. Many periodontal codes apply to less than a quadrant. The codes specifying "one to three contiguous teeth or tooth bound spaces per quadrant" are gingivectomy or gingivoplasty (D4211), anatomical crown exposure (D4231) gingival flap procedure, including root planing (D4241), and osseous surgery (including flap entry and closure) (D4261).

   Note: The definition of periodontal scaling and root planing (D4342) differs from the other periodontal codes. D4342 describes scaling and root planing provided "for one to three teeth per quadrant" with no reference to the teeth being "contiguous" or to "tooth bound spaces." Simply put, D4342 requires a count of one to three qualified and treated teeth per quadrant.
4. If more than one periodontal procedure is provided (in the same area/quadrant) on the same day, only the most complicated or inclusive procedure may be reimbursed. However, many plans pay for osseous surgery with bone grafts.
5. Reimbursements for periodontal procedures are typically limited to procedures provided to natural teeth.
6. Start and Stop times are now required by certain payors on many periodontal procedures, as well as types and amounts of anesthesia given. Be sure to record this information in the clinical notation and subsequent narrative. Copies of the hygiene schedule from the date of service may even be requested.

LANAP/LAPIP® CODING RECOMMENDATIONS

There continues to be controversy about the coding for the Laser Assisted New Attachment Procedure (LANAP®) and Laser Assisted Peri Implantitis Procedure (LAPIP®). To better understand the coding of LANAP/LAPIP, a look at the codes and the procedures themselves should help establish the coding criterion involved.

LANAP involves the use of a laser to target diseased tissue in a periodontal pocket around a natural tooth. After the pocket is sterilized, an ultrasonic scaler and hand instruments are used to remove buildup and to reshape bone, and the laser is again used for hemostasis. LAPIP involves a similiar procedure but is used for the treatment of peri-implantitis. Both treatments are noninvasive therapies performed without surgical flaps while still involving the reshaping of bone.

Since osseous reshaping occurs during the procedure, it would seem like the D4260/D4261 osseous surgery codes would apply. However, codes D4260/D4261 were revised in CDT 2015 to be more specific in their description of the mandatory procedures performed. The ADA's Code Maintenance Committee was clear in that the D4260/D4261 osseous surgery procedure must include:

- A full thickness flap must be laid, as well as
- Modification of the bony support of the teeth by reshaping the alveolar process to achieve a more physiologic form during the surgical procedure, and
- The bony reshaping must include removal of supporting bone (ostectomy) and/or non-supporting bone (osteoplasty).

Therefore, standard, non-invasive LANAP or LAPIP does not meet all the requirements to be reported as osseous surgery (D4260/D4261), as these procedures are performed noninvasively through the dental sulcus and do not include a full thickness flap, even though it does involve bone modification at the time of the procedure. The American Association of Periodontics (AAP) suggest that LANAP/LAPIP be coded using D4999 unspecified periodontal procedure, by report, and then attach a narrative requesting the alternate benefit of D4260/D4261. This allows you to "code for what you do" while still receiving appropriate benefits.

If the laser is used to reflect a full thickness flap for access to the root surfaces, you may report D4341/D4342 as indicated by the number of teeth treated in the quadrant. If, in addition, bone is modified or removed, you may report D4260/D4261 osseous surgery. In these cases the laser is used in place of a scalpel, but the requirements of the codes are met. Neither example here would be considered non-invasive LANAP or LAPIP, however, which do not include a flap.

NOTE: See D4999 comments for more on laser use in dentistry, including Laser Bacterial Reduction (LBR) and Laser Assisted Periodontal Therapy (LAPT).

PERIODONTICS — CDT 2025

Local anesthesia is usually considered to be part of Periodontal procedures.

SURGICAL SERVICES (INCLUDING USUAL POSTOPERATIVE CARE) — CDT 2025

Site: A term used to describe a single area, position, or locus. The word "site" is frequently used to indicate an area of soft tissue recession on a single tooth or an osseous defect adjacent to a single tooth; also used to indicate soft tissue defects and/or osseous defects in edentulous tooth positions.

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

Tooth Bounded Space: A space created by one or more missing teeth that has a tooth on each side.

D4210 GINGIVECTOMY OR GINGIVOPLASTY - FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT — CDT 2025

It is performed to eliminate suprabony pockets, or to restore normal architecture when gingival enlargements or asymmetrical or unaesthetic topography is evident with normal bony configuration.



WARNING

1. It is misleading to report gingivectomies or gingivoplasties (D4210) performed to improve esthetics without a narrative disclosing the cosmetic nature of the procedure.
2. Do not report D4210/D4211 for gingivectomy for restorative access. See D4212.

WATCH

1. To report a gingivectomy performed to allow access for a restorative procedure, see D4212.
2. When removing inflamed or hypertrophied tissue around *partially* erupted or impacted teeth, report excision of pericoronal gingiva (D7971), also known as an operculectomy.
3. When removing gingival overgrowth due to irritation from orthodontic brackets or ill fitting dentures (i.e., an epulis), report D7970 excision of hyperplastic tissue, per arch.
4. For anatomical crown exposure, removing both gingival tissue and supporting bone (generally for esthetics), see D4230 and D4231.

COMMENTS

1. A *gingivectomy* involves the excision of gingiva to reduce gingival hypertrophy or to improve asymmetrical or unaesthetic gingival topography. A *gingivoplasty* is surgically reshaping the gingiva.
2. Pockets deeper than 3mm are difficult to clean and the patient may benefit from the surgical reduction of pocket depths. Gum tissue removed to reduce pocket depths around teeth make the area easier for the patient to maintain/keep clean. The gingivectomy is performed to treat suprabony pockets (pockets that are coronal to the bone level).

3. If the gingival overgrowth is caused by a medication, report the gingivectomy procedure to the *medical* insurance payor for reimbursement consideration.
4. Enter the quadrant and the tooth number range being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Gingivectomies are generally paid when performed as part of periodontal therapy, or for patients currently taking Dilantin, cyclosporine medication or several types of calcium channel blocking agents. Calcium channel blocking agents are often prescribed for patients with hypertension and/or coronary artery disease. Dental plans typically require a current periodontal charting and related diagnosis for reimbursement. Some payors will cover a gingivectomy if the patient is diagnosed as case type II (early periodontitis). Other payors limit reimbursement for periodontal case types III or IV (moderate to severe periodontitis). If SRP (D4341/D4342) is performed in the same quadrant within four weeks of gingivectomy (D4210/D4211), the SRP may be denied as part of the gingivectomy for reimbursement purposes. Some payors consider D4341/D4342 a part of postoperative care (if done within three months) and as well as a part of any additional periodontal surgery for three years post gingivectomy.
2. There is typically a 24 to 36 month exclusion period when providing the same D4210 procedure to the same area of the mouth.
3. A gingivectomy is not generally reimbursed in association with scaling and root planing (SRP), or osseous surgery if performed on the same service date. The gingivectomy is considered to be a part of the global SRP or osseous surgery procedure.
4. A gingivectomy performed with a distal wedge (D4274) or frenectomy procedure (D7961/D7962) is typically considered a part of that procedure.
5. A gingivectomy performed to allow access for a restorative procedure should be reported as D4212, per tooth.
6. Dental plans frequently do not count tooth bounded spaces for reimbursement of gingivectomies or scaling and root planing (D4210, D4211, D4340 and D4342).

TIPS

1. A gingivectomy is usually payable when being performed to treat periodontitis with radiographic evidence of bone loss and periodontal pocketing.
2. D4210 may be performed using a variety of methods: laser, electrosurgery, or scalpel. There is no special code for using a laser to perform this procedure. Payors reimburse for the specific procedure performed and are not concerned about the technique or technology used to accomplish the procedure. See LANAP comments at the beginning of the D4000 section and the comments under D4999 for more information on use of lasers in periodontal treatments.

NARRATIVES

1. Submit a current dated, pre-operative periodontal chart. Most payors require full periodontal probing and charting within the last ninety days and a corresponding periodontal *diagnosis* to approve reimbursement. If the gingivectomy is related to pathology (not cosmetic) it may be reimbursed. To qualify for reimbursement a 4mm or 5mm pocket must be noted on each tooth surgically treated. A gingivoplasty is surgically reshaping the gingiva. Photographs of the probe in place are helpful in obtaining reimbursement. Document that the procedure is not cosmetic related. When gingivectomy/gingivoplasty is performed some payors require thirty days healing prior to a crown preparation visit.
2. "See attached periodontal chart." State necessity for gingivectomy or gingivoplasty, e.g., to eliminate suprabony pockets or to restore normal architecture when gingival enlargements or asymmetrical or unaesthetic topography is evident with normal bony configuration.

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

CDT 2025

It is performed to eliminate suprabony pockets, or to restore normal architecture when gingival enlargements or asymmetrical or unaesthetic topography is evident with normal bony configuration.



WARNING

1. It is misleading to report gingivectomies or gingivoplasties (D4211) performed to improve esthetics without a narrative disclosing the cosmetic nature of the procedure.
2. Do not report D4210/D4211 for gingivectomy for restorative access. See D4212.



WATCH

1. To report a gingivectomy performed to allow access for a restorative procedure, see D4212.
2. When removing inflamed or hypertrophied tissue around *partially* erupted or impacted teeth, report excision of pericoronal gingiva (D7971), also known as an operculectomy.
3. When removing gingival overgrowth due to irritation from orthodontic brackets or ill fitting dentures (i.e., an epulis), report D7970 excision of hyerplastic tissue, per arch.
4. For anatomical crown exposure, removing both gingival tissue and supporting bone (generally for esthetics), see D4230 and D4231.

COMMENTS

1. A *gingivectomy* involves the excision of gingiva to reduce gingival hypertrophy or to improve asymmetrical or unaesthetic gingival topography. A *gingivoplasty* is surgically reshaping the gingiva.
2. Pockets deeper than 3mm are difficult to clean and the patient may benefit from the surgical reduction of pocket depths. Gum tissue removed to reduce pocket depths around teeth make the area easier for patient to maintain/keep cleaner. The gingivectomy is performed to treat suprabony pockets (pockets that are coronal to the bone level).
3. If the gingival overgrowth is caused by a medication, report the gingivectomy procedure to the *medical* insurance payor for reimbursement consideration.
4. Enter the quadrant and the tooth number range being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

D4211

1. Gingivectomies are generally paid when performed as part of periodontal therapy, or for patients currently taking Dilantin, cyclosporine medication or several types of calcium channel blocking agents. Calcium channel blocking agents are often prescribed for patients with hypertension and/or coronary artery disease. Dental plans typically require a current periodontal charting and related diagnosis for reimbursement. Some payors will cover a gingivectomy if the patient is diagnosed as case type II (early periodontitis). Other payors limit reimbursement for periodontal case types III or IV (moderate to severe periodontitis). If SRP (D4341/D4342) is performed in the same quadrant within four weeks of gingivectomy (D4210/D4211), the SRP may be denied as part of the gingivectomy for reimbursement purposes. Some payors consider D4341/D4342 a part of postoperative care (if done within three months) and as well as a part of any additional periodontal surgery for three years post gingivectomy.
2. When reimbursed, D4211 is typically reimbursed at 50-60% of the payor's fee of D4210.
3. There is typically a 24 to 36 month exclusion period when providing the same D4211 procedure to the same area of the mouth.
4. A gingivectomy is not generally reimbursed in association with scaling and root planing (SRP), or osseous surgery if performed on the same service date. The gingivectomy is considered to be a part of global SRP or osseous surgery procedure.
5. A gingivectomy performed with a distal wedge (D4274) or frenectomy procedure (D7961/D7962) is typically considered a part of that procedure.
6. A gingivectomy performed to allow access for a restorative procedure should be reported as D4212, per tooth.
7. Dental plans frequently do not count tooth bounded spaces for reimbursement of gingivectomies or scaling and root planing (D4210, D4211, D4340 and D4342).

TIPS

1. A gingivectomy is usually payable when being performed to treat periodontitis with radiographic evidence of bone loss and periodontal pocketing.
2. D4211 may be performed using a variety of methods: laser, electrosurgery, or scalpel. There is no special code for reporting a laser used to perform this procedure. Payors reimburse for the specific procedure performed and are not concerned about the technique or technology used to accomplish the procedure. See LANAP comments at the beginning of the D4000 section and the comments under D4999 for more information on use of lasers in periodontal treatments.

NARRATIVES

1. Submit a current dated, pre-operative periodontal chart. Most payors require full periodontal probing and charting within the last ninety days and a corresponding periodontal *diagnosis* to approve reimbursement. If the gingivectomy is related to pathology (not cosmetic) it may be reimbursed. To qualify for reimbursement a 4mm or 5mm pocket must be noted for each tooth surgically treated. A gingivoplasty is surgically reshaping the gingiva. Photographs of the probe in place are helpful in obtaining reimbursement. Document that the procedure is not cosmetic related. When gingivectomy/gingivoplasty is performed some payors require thirty days healing prior to a crown preparation visit.

2. "See attached periodontal chart." State necessity for gingivectomy or gingivoplasty, e.g., to eliminate suprabony pockets or to restore normal architecture when gingival enlargements or asymmetrical or unaesthetic topography is evident with normal bony configuration.
3. Treatment for gingival hypertrophy caused by a medication may be billed to the patient's medical plan. Medical plans may cover dental conditions that are either caused by, or exacerbated by, a patient's medication.

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

CDT 2025



WARNING

1. Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant (D4210) and gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant (D4211) report *periodontal* related procedures. Do not report D4210 or D4211 for restorative access, only for periodontal treatment.
2. The D4212 procedure is to allow access for a restorative procedure, and is reported "per tooth."
3. When removing inflamed or hypertrophied tissue around *partially* erupted or impacted teeth, report excision of pericoronal gingiva (D7971), also known as an operculectomy.

COMMENTS

1. D4212 reports gingivectomy or gingivoplasty to allow access for a restorative procedure, per tooth. *The D4212 gingivectomy* removes gingival tissue to provide access to the margins of a crown preparation or cavity preparation and may aid in placing a restoration or to improve the isolation of the preparation while taking an impression. It also includes a gingivectomy to allow access for an amalgam or composite.
2. Gingivectomy D4212 is reported on a "per tooth" basis.
3. During the gingivectomy procedure (D4212) healthy gum tissue is removed to reduce pocket depths around teeth making the area easier to access and restore or to take an impression. The gingivectomy is performed to access and restore suprabony pockets (pockets that are coronal to the bone level).
4. For anatomical crown exposure, removing *both* gingival tissue *and* supporting bone, see D4230 and D4231.
5. For gingivectomy to treat purely periodontal conditions, see D4210 or D4211.
6. For clinical crown lengthening - hard tissue, see D4249.
7. When removing gingival overgrowth due to irritation from orthodontic brackets or ill fitting dentures (i.e., an epulis), report D7970 excision of hyerplastic tissue, per arch.
8. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Most payors include "all soft tissue management procedures" in the global restorative fee. Gingivectomies to allow access for restorative procedures (D4212) are not typically reimbursed in conjunction with routine crown preparations or other restorative procedures, such as an amalgam or composite. Gingivectomies may be considered a part of the crown procedure (soft tissue management or periodontal management) or restorative procedure by most payors when performed on the same day as the preparation of the crown or restorative procedure. Most PPO payors "disallow" the D4212 procedure.
2. Gingivectomy D4212 for restorative access is silent regarding how tissue is removed. It may be removed by a variety of methods, including scalpel, electrosurgery, laser, etc. See LANAP comments at the beginning of the D4000 section and the comments under D4999 for more information on use of lasers in periodontal treatments.

TIPS

Gingivectomies for restorative access should ideally be followed by an appropriate healing period. Failure to allow for an adequate healing period may result in the denial of the gingivectomy for restorative access (D4212) with some payors. However, many PPOs will disallow D4212 even if the restoration is done on a subsequent date.

D4230 ANATOMICAL CROWN EXPOSURE - FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT

CDT 2025

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

WATCH

It is an error to report anatomical crown exposure (D4230) to describe hard tissue crown lengthening. Hard tissue clinical crown lengthening (D4249) is used to report *bony* recontouring to apically reposition the crest of bone and overlying tissue. The result is a more favorable positioning (proper biologic width) of bone and gingival attachment to provide for a proper biologic width.

COMMENTS

1. Anatomical crown exposure (D4230) reports the removal of both enlarged gingival tissue *and* supporting bone. D4230 reports a quadrant (four or more contiguous teeth or tooth bounded spaces per quadrant). The treatment area is periodontally healthy prior to treatment.
2. Note: There are several periodontal procedures not related to the treatment of periodontal disease. D4230 describes a procedure where both bone and gum tissue are removed. Anatomical crown exposure is indicated to provide an anatomically correct gingival relationship. Removing both bone and excess gum tissue leads to the repositioning of the remaining gum tissue to a more anatomically acceptable position. If gum tissue only is removed due to periodontal issues without bone being removed, the appropriate code to describe the procedure is gingivectomy D4210 or D4211.
3. If the procedure involves only soft tissue management, i.e., bony recontouring is not involved, see gingivectomy (D4210) for a quadrant (four or more teeth).
4. Intraoral photos should be taken prior to the procedure.
5. Enter the quadrant and the tooth number range being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

Current periodontal charting and a detailed narrative regarding the necessity for treatment may be required. Dental payors generally consider anatomic crown exposure (D4230) to be cosmetic in nature and not reimbursable.

NARRATIVES

"Bone and enlarged gingival tissue were/will be removed to provide an anatomically correct gingival relationship. See attached periodontal chart."

D4231 ANATOMICAL CROWN EXPOSURE - ONE TO THREE TEETH OR TOOTH BOUNDED SPACES PER QUADRANT

CDT 2025

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

WATCH

It is an error to report anatomical crown exposure (D4231) to describe hard tissue crown lengthening. Clinical crown lengthening (D4249) is used to report *bony* recontouring to apically reposition the crest of bone and overlying tissue. The result is a more favorable positioning of bone and gingival attachment to provide for a proper biologic width.

COMMENTS

1. Anatomical crown exposure (D4231) reports the removal of both enlarged gingival tissue *and* supporting bone. D4231 reports one to three teeth or tooth bounded spaces per quadrant. The treatment area is periodontally healthy prior to treatment.
2. Note: There are several periodontal procedures not related to the treatment of periodontal disease. D4231 describes a procedure where both bone and gum tissue are removed. Anatomical crown exposure is indicated to provide an anatomically correct gingival relationship. Removing both bone and excess gum tissue leads to the repositioning of the remaining gum tissue to a more anatomically acceptable position. If gum tissue *only* is removed due to periodontal issues without bone being removed, the appropriate code to describe the procedure is gingivectomy D4210 or D4211.
3. If the procedure involves only soft tissue management, i.e., bony recontouring is not involved, see gingivectomy (D4211) one to three teeth per quadrant.
4. Intraoral photos should be taken prior to the procedure.
5. Enter the quadrant and the tooth number range being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

Current periodontal charting and a detailed narrative regarding the necessity for treatment may be required. Dental payors generally consider anatomic crown exposure (D4231) to be cosmetic in nature and not reimbursable.

NARRATIVES "Bone and enlarged gingival tissue were/will be removed to provide an anatomically correct gingival relationship. See attached periodontal chart."

D4240 GINGIVAL FLAP PROCEDURE, INCLUDING ROOT PLANING - FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT CDT 2025

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



WARNING

It is misleading to report D4240 for a "closed" soft tissue *laser* procedure. Use this code to describe a procedure where *a flap is reflected* with debridement of the root surface and granulation tissue removal. See LANAP comments at the beginning of the D4000 section and the comments under D4999 for more information on use of lasers in periodontal treatments.

WATCH

1. D3501, D3502, and D3503 report a surgical exposure of the root surface related to root canal treatment or re-treatment.
2. D4240 reports a gingival flap procedure related to a periodontal procedure.
3. D3471, D3472, and D3473 report treatment of root resorption.

COMMENTS

1. A gingival flap procedure reflects the periodontal tissue off the teeth and bone (a flap is laid) in order to have an unimpeded view and access to the root surfaces of the teeth. This allows the provider direct access for more effective removal of plaque and calculus from the roots of the teeth. Once the flap is laid and the teeth are root planed and polished, the dentist may also place a bone graft (D4263/D4264), place biologic materials to aid in soft and osseous tissue regeneration (D4265), and/or place a barrier membrane (D4266/D4267) as part of the treatment provided. Report D4240 if the bone around the teeth has not been reshaped (recontoured) during the procedure. If bone has been modified, report the procedure using the appropriate code for osseous surgery (D4260/D4261). Additionally, D4240 may be reported to describe a flap procedure used to determine the presence of a cracked tooth or fractured root.
2. Scaling and root planing (SRP) does NOT "immediately" precede this procedure. SRP is included with the gingival flap procedure. Typically, there is a four week waiting period, following SRP before a D4240 or D4241 may be benefitted.
3. See LANAP comments at the beginning of the D4000 and the comments under D4999 section for more information on use of lasers in periodontal treatments.
4. Enter the quadrant and the tooth number range being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. There is typically a 24 to 36 month exclusion period for another D4240 procedure provided in the same area of the mouth, on the same teeth.
2. Scaling and root planing is a concurrent part of D4240 and should not be submitted as a separate procedure. Dental plans typically consider three months of postoperative care and any other surgical treatment provided within three years to be a part of and included in the previous reimbursement. Current periodontal charting indicating at least Case Type II periodontal disease (early periodontitis) is typically required for reimbursement.

TIPS Other separate procedures including, but not limited to, D3450, D3920, D4263, D4264, D4265, D4266 and D4267 may be performed along with D4240. Reimbursement will vary.

NARRATIVES Submit a current dated (done within the previous 90 days), pre-operative periodontal charting, bitewings and/or periapicals with the claim. If the gingival flap on each tooth treated is related to pathology (not cosmetic) it may be reimbursed. Typically, evidence of a 4mm or 5mm pocket depth on each tooth treated and evidence of bone loss is required. The payor may want to know if a crown is involved. "See attached periodontal chart."

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

CDT 2025

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



WARNING

It is misleading to report D4241 for a "closed" soft tissue *laser* procedure. Use this code to describe a procedure where *a flap is reflected* with debridement of the root surface and granulation tissue removal. See LANAP comments at the beginning of the D4000 section and the comments under D4999 for more information on use of lasers in periodontal treatments.

WATCH

1. D3501, D3502, and D3503 report a surgical exposure of the root surface related to root canal treatment or re- treatment.
2. D4241 reports a gingival flap procedure related to a periodontal procedure.
3. D3471, D3472, and D3473 report treatment of root resorption.

COMMENTS

1. A gingival flap procedure reflects the periodontal tissue off the teeth and bone (a flap is laid) in order to have an unimpeded view and access to the root surfaces of the teeth. This allows the provider direct access for more effective removal of plaque and calculus from the roots of the teeth. Once the flap is laid and the teeth are root planed and polished, the dentist may also place a bone graft (D4263/D4264), place biologic materials to aid in soft and osseous tissue regeneration (D4265), and/or place a barrier membrane (D4266/D4267) as part of the treatment provided. Report D4241 if the bone around the teeth has not been reshaped (recontoured) during the procedure. If bone has been modified, report the procedure using the appropriate code for osseous surgery (D4260/D4261). Additionally, D4241 may be reported to describe a flap procedure used to determine the presence of a cracked tooth or fractured root.
2. Scaling and root planing (SRP) does *NOT "immediately"* precede this procedure. SRP is *included* with the gingival flap procedure. Typically, there is a four week waiting period, following SRP before a D4240 or D4241 may be benefitted.
3. See LANAP comments at the beginning of the D4000 section and the comments under D4999 for more information on use of lasers in periodontal treatments.
4. Enter the quadrant and the tooth number range being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. There is typically a 24 to 36 month exclusion period for another D4241 procedure provided in the same area of the mouth, on the same teeth.
2. Scaling and root planing is a concurrent part of D4241 and should not be submitted as a separate procedure. Dental plans typically consider three months of postoperative care and any other surgical treatment provided within three years to be a part of and included in the previous reimbursement. Current periodontal charting indicating at least Case Type II periodontal disease (early periodontitis) is typically required for reimbursement.

TIPS

Other separate procedures including, but not limited to, D3450, D3920, D4263, D4264, D4265, D4266 and D4267 may be performed along with D4241. Reimbursement will vary.

NARRATIVES

Submit a current dated (done within the previous 90 days), pre-operative periodontal charting, bitewings and/or periapicals with the claim. If the gingival flap on each tooth treated is related to pathology (not cosmetic), it may be reimbursed. Typically, evidence of a 4mm or 5mm pocket depth on each tooth treated and evidence of bone loss is required. The payer may want to know if a crown is involved. "See attached periodontal chart."

D4245 APICALLY POSITIONED FLAP

CDT 2025

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

COMMENTS

1. An apically positioned flap may be used to expose an impacted permanent tooth by laying a flap which includes the keratinized gingival tissue and repositioning the flap more apically (towards the root). This procedure preserves the attached keratinized tissue while allowing the exposure and eruption of the impacted permanent tooth. If the keratinized gum tissue is simply removed (gingivectomy D4210/D4211) the unkeratinized mucosal tissue next to the tooth will be left to reattach around the erupting tooth leading to insufficient attached gingiva.
2. D4245 may be reported during surgical exposure of labially impacted teeth. This procedure may be associated with surgical exposure of an unerupted tooth (D7280) which is generally related to orthodontic treatment. An orthodontic band, bracket, loop and/or cleat may be attached (D7283) during this procedure to aid in the eruption of the impacted tooth.
3. Enter the range of teeth being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Periodontal charting indicating moderate to severe periodontitis may be required. D4245 is not likely to be reimbursed if performed on the same date as, or within four weeks of, scaling and root planing. Most dental plans will consider D4245 a part of a frenectomy (D7961/D7962) and/or distal wedge (D4274) procedure performed in the same area on the same service date.
2. There now is a code for a second stage implant procedure (D6011) or treatment of peri-implantitis (D6101 and D6102). D4245 is not typically reimbursed if associated with implants unless the plan includes benefits for implant procedures.
3. There is typically a 24 to 36 month exclusion period for reimbursement for the same procedure performed on the same tooth/implant.

D4249 CLINICAL CROWN LENGTHENING - HARD TISSUE CDT 2025

This procedure is employed to allow a restorative procedure on a tooth with little or no tooth structure exposed to the oral cavity. Crown lengthening requires reflection of a full thickness flap and removal of bone, altering the crown to root ratio. It is performed in a healthy periodontal environment, as opposed to osseous surgery, which is performed in the presence of periodontal disease.



WARNING

1. It is misleading to report D4249 for a "closed" hard tissue *laser* procedure unless a full thickness flap is first reflected. (See this code's descriptor: "requires the reflection of a full thickness flap"). To appropriately report this code, a full thickness flap must be reflected and bone *removed* to expose more tooth structure. If using a laser for a portion of this procedure, be aware that payors reimburse according to the procedure performed, not based on the technique or technology used to perform the procedure. See LANAP comments at the beginning of the D4000 section and the comments under D4999 for more information on use of lasers in periodontal treatments.
2. It is improper/misleading to report "soft-tissue crown lengthening" as "hard-tissue crown lengthening." Any *soft tissue* crown lengthening is generally considered a part of the crown procedure and fee by insurance payors. See D4212 for further information. D4212 reports a gingivectomy for restorative access, per tooth. Clinical crown lengthening - hard tissue (D4249) requires reflection of a *full thickness* flap (typically mesial and distal of the subject tooth) and removal of hard tissue (bone) to expose sound tooth structure. This procedure modifies the crown to root ratio. A healing period may be required by payors (typically at least six weeks) before a crown on the same tooth would be considered for reimbursement.
3. If a patient requires clinical crown lengthening - hard tissue (D4249) involving a *healthy site*, it is misleading to report osseous surgery (D4261). Osseous surgery (D4261) is used to describe the treatment of *periodontal* disease. Clinical crown lengthening (D4249) is performed in association with a healthy periodontal *site*.

COMMENTS

1. Per the descriptor, hard tissue crown lengthening is performed in a *healthy periodontal environment*. When treatment is provided in an area with periodontal disease (i.e., bone loss), the procedure should be described by reporting osseous surgery (D4260/D4261) codes.
2. Clinical crown lengthening is performed when a tooth (or part of a tooth) has broken off at, near, or just below the gum line. When this happens, there may not be enough tooth above the bone to retain a crown and maintain proper gingival health. If crown lengthening is not performed, and the margin of the crown is placed too close to the bone, the gum tissue will become inflamed. To prevent this, a *full thickness* flap is lifted, and enough bone is removed so there will be adequate space between the bone and the margin of the crown. This maintains a biologic "width." After approximately six weeks of healing, the final preparation for the crown may be completed, and the impression is taken. Crown lengthening may also be performed when there is caries close to the bone level. In this situation, a full thickness flap is raised and bone removed to provide adequate space between the apical margin of the restoration (edge of the restoration closest to the root tip) and the bone.

3. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. D4249 is typically reimbursed "once per lifetime, per tooth."
2. Many payors require a *minimum* six-week healing period prior to the crown preparation appointment. If the crown lengthening is performed on the same service date as the crown preparation, not allowing for a healing period, D4249 may not be reimbursed.
3. If a distal or proximal wedge procedure (D4274) is performed in conjunction with hard tissue crown lengthening (D4249) on the same service date, it is usually considered *part of* that procedure and not reimbursed separately.
4. If osseous surgery (D4260/D4261) includes a crown lengthening procedure and both procedures are performed on the same service date, then the crown lengthening procedure is typically considered part of the global osseous surgery service and not reimbursed separately.
5. Hard tissue crown lengthening performed for cosmetic reasons is not reimbursed.
6. "Troughing" *soft* tissue as part of the crown preparation *does not* meet the full thickness flap criteria needed to report D4249. D4249 should not be reported. D4249 is not a *soft-tissue* related code. For a gingivectomy for restorative access, report D4212 on a "per tooth" basis. See D4212.

NARRATIVES

1. Periapical radiographs, tooth number, and a current periodontal chart and clinical notes are often necessary for reimbursement of D4249. Photographs should be included with the claim if the tooth is fractured off at or below the gum line and the fracture is not obvious on the radiograph. Dental plans require documentation that bone was removed to create an adequate width between the apical margin of the restoration and the bone. When performed in conjunction with a crown, dental payors often require an adequate healing period prior to the crown preparation. Generally, an acceptable period for healing is six weeks or more.
2. To report a "closed" hard tissue crown lengthening (where a full thickness flap is not reflected) utilizing a hard tissue laser procedure, use unspecified periodontal procedure, by report (D4999).
3. Some payors "re-map" clinical crown lengthening as osseous surgery - one to three teeth (D4261). D4261 is generally reimbursed at a *lower* fee than D4249. Osseous surgery is performed to treat *periodontally* diseased teeth.
4. To be considered for reimbursement most payors require at least six weeks of healing time before the final crown impression is taken. The healing period allows the tissues to shrink and will allow the dentist to determine where to place the final margin. In addition, there are concerns that taking a crown impression too soon after crown lengthening surgery could cause further tissue loss due to the trauma caused by the impression procedure. Be aware of these limitations when developing your narrative or submitting an appeal.
5. State location of decay or lost tooth structure, e.g., M decay at crest of ridge or ML cusp fractured off within 1mm of crest of bone. "Periodontal environment is healthy, see attached periodontal chart and radiographic image."

D4260 OSSEOUS SURGERY (INCLUDING ELEVATION OF A FULL THICKNESS FLAP AND CLOSURE) - FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT

CDT 2025

This procedure modifies the bony support of the teeth by reshaping the alveolar process to achieve a more physiologic form during the surgical procedure. This must include the removal of supporting bone (ostectomy) and/or non-supporting bone (osteoplasty). Other procedures may be required concurrent to D4260 and should be reported using their own unique codes.



WARNING

1. Osseous surgery (D4260) now clarifies that the elevation of a full thickness flap is required as a part of the procedure. In addition, the alveolar process must be reshaped to provide a more physiologic form during the surgical procedure. That is, D4260 must include the removal of supporting bone (ostectomy) and/or non-supporting bone (osteoplasty). If a full thickness flap has not been reflected and bone reshaped to provide a more physiological form, then do not report D4260. D4999, by report, should be reported for a procedure that does not meet the criteria established in the nomenclature and descriptor of D4260. Ask for the alternate benefit of D4261.

2. Do not report D4260 for a non-invasive Laser Assisted New Attachment Procedure (LANAP). See the LANAP Coding Recommendations at the begining of the D4000 section for more information.

COMMENTS

1. Osseous surgery is performed to treat teeth with periodontal pocketing and bone loss to more effectively remove the plaque buildup that causes inflammation and continued attachment/bone loss. It involves removing some of the bone to create easier to clean contours and repositioning the gingival flaps more apically (closer to the root end of the tooth). While the tissue is reflected, the dentist may also place a bone graft (D4263/D4264), place biologic materials to accelerate soft and hard tissue regeneration (D4265), place concentrated blood/growth factor, PRP, (D7921), and/or place a barrier membrane (D4266/D4267).
2. Other separate procedures that may be provided simultaneously can include, but not be limited to, D3450, D3920, D4263, D4264, D4265, D4266, D4267, D6010, D7140 and D7295.
3. Enter the quadrant and the tooth number range being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Comprehensive periodontal charting showing pocket depths of 5mm or more on each tooth to be treated, radiographic evidence of severe and/or irregular bone loss, evidence of furcation involvement and clinical notes may be required to justify reimbursement for osseous surgery. Payors may limit osseous surgery to once every twenty four to thirty six months. Payors may consider the fee reimbursed for D4260 to include scaling and root planing when the SRP is performed within four weeks of osseous surgery. Payors may consider any osseous contouring, distal or proximal wedge surgery, frenectomy, soft tissue grafts, gingivectomy, and/or flap procedures performed in the same quadrant on the same date as the osseous surgery as a part of the osseous surgery.
2. When multiple periodontal procedures are reported on the same service date, the highest UCR fee (most inclusive) may be the only procedure reimbursed. The other, less costly procedures are often considered a part of the more comprehensive procedure or these other procedures may be reimbursed at a lower than usual fee.
3. D4260 requires that four or more contiguous teeth, or tooth bounded spaces be treated, per quadrant. Some payors require five teeth to be considered a quadrant for reimbursement purposes. If less than five contiguous teeth (four) are treated in a quadrant, some payors re-map the procedure and reimburse D4261 for one to three teeth if the plan document specifies five teeth are necessary to qualify for full reimbursement. Direct the patient to request a copy of the plan document (not the summary plan description booklet) from their Human Resources department. Once a copy of the plan document is obtained, examine the contract language and respond accordingly. Bill what you do, but understand that the contract language may allow the payor to modify or reduce the reimbursement.

TIPS

Periodontal scaling and root planing (D4341/D4342), with a subsequent four to six week period for evaluation or a *continuous* period of periodontal maintenance (D4910) should *precede* osseous surgery.

NARRATIVES

1. Some payors may limit reimbursement for D4260 to two quadrants per treatment visit. If there are extraordinary circumstances (medical conditions, travel, general anesthesia, etc.) making the treatment of three or all four quadrants more beneficial for the patient at one visit, write a narrative that describes the extraordinary circumstances that justifies the treatment of more than two quadrants on the same service date. Be sure to pre-determine three or four quadrants on same service date.
2. State the periodontal prognosis and date(s) of prior scaling and root planing. If patient has had continuing periodontal maintenance (D4910), state that also and the dates of the procedures. "See attached periodontal chart and radiographic images." Many payors will not accept narratives for this code, only clinical notes.

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

CDT 2025

This procedure modifies the bony support of the teeth by reshaping the alveolar process to achieve a more physiologic form during the surgical procedure. This must include the removal of supporting bone (ostectomy) and/or non-supporting bone (osteoplasty). Other procedures may be required concurrent to D4261 and should be reported using their own unique codes.

WARNING

1. Osseous surgery (D4261) now clarifies that the elevation of a full thickness flap is required as a part of the procedure. In addition, the alveolar process must be reshaped to provide a more physiologic form during the surgical procedure. That is, D4261 must include the removal of supporting bone (ostectomy) and/or non-supporting bone (osteoplasty). If a full thickness flap has not been reflected and bone reshaped to provide a more physiological form, then do not report D4261. D4999, by report, should be reported for a procedure that does not meet the criteria established in the nomenclature and descriptor of D4261. Ask for the alternate benefit of D4261.
2. Do not report D4260 for a non-invasive Laser Assisted New Attachment Procedure (LANAP®). See the LANAP Coding Recommendations at the beginning of the 4000 section for more information.

COMMENTS

1. Osseous surgery is performed to treat teeth with periodontal pocketing and bone loss to more effectively remove the plaque buildup that causes inflammation and continued attachment/bone loss. It involves removing some of the bone to create easier to clean contours and repositioning the gingival flaps more apically (closer to the root end of the tooth). While the tissue is reflected the dentist may also place a bone graft (D4263/D4264), place biologic materials to accelerate soft and hard tissue regeneration (D4265), place concentrated blood/growth factor PRP (D7921), and/or place a barrier membrane (D4266/D4267).
2. Other separate procedures that may be provided simultaneously can include, but not be limited to, D3450, D3920, D4263, D4264, D4265, D4266, D4267, D6010, D7140 and D7295.
3. The fee for D4261 (one to three contiguous teeth or tooth bounded spaces per quadrant) would typically be 50-60% of the fee for D4260 (four or more teeth per quadrant).
4. Enter the quadrant and the tooth number range being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Comprehensive periodontal charting showing pocket depths of 5mm or more on each tooth to be treated, radiographic evidence of severe and/or irregular bone loss, evidence of furcation involvement and clinical notes may be required to justify reimbursement for osseous surgery. Payors may limit osseous surgery to once every 24 to 36 months. Payors may consider the fee reimbursed for D4261 to include scaling and root planing when the SRP is performed within four weeks of osseous surgery. Payors may consider any osseous contouring, distal or proximal wedge surgery, frenectomy, soft tissue grafts, gingivectomy, and/or flap procedures performed in the same quadrant on the same date as the osseous surgery as a part of the osseous surgery.
2. When multiple periodontal procedures are reported on the same service date, the highest UCR fee (most inclusive) may be the only procedure reimbursed. The other, less costly procedures are often considered a part of the more comprehensive procedure or these other procedures may be reimbursed at a lower than usual fee.

TIPS

Periodontal scaling and root planing (D4341/D4342), with a subsequent four to six week period for evaluation or a *continuous* period of periodontal maintenance (D4910) should *precede* osseous surgery.

NARRATIVES

1. Some payors may limit reimbursement for D4261 to two quadrants per treatment visit. If there are extraordinary circumstances (medical conditions, travel, general anesthesia, etc.) making the treatment of three or all four quadrants more beneficial for the patient at one visit, write a narrative that describes the extraordinary circumstances that justifies the treatment of more than two quadrants on the same service date. Be sure to pre-determine three or four quadrants on the same service date.
2. State the periodontal prognosis and date(s) of prior scaling and root planing. If the patient has had continuing periodontal maintenance (D4910), state this and dates of procedures. "See attached periodontal chart and radiographic images." Many payors will not accept narratives for this code, only clinical notes.

D4263 BONE REPLACEMENT GRAFT - RETAINED NATURAL TOOTH - FIRST SITE IN QUADRANT

CDT 2025

This procedure involves the use of grafts to stimulate periodontal regeneration when the disease process has led to a deformity of the bone. This procedure does not include flap entry and closure, wound debridement, osseous contouring, or the placement of biologic materials to aid in osseous tissue regeneration or barrier membranes. Other separate procedures delivered concurrently are documented with their own codes. Not to be reported for an edentulous space or an extraction site.

WARNING

1. It is an error to report D4263, if the bone replacement graft is placed in an extraction site for ridge preservation. The proper code to report a bone replacement graft placed in an extraction or implant removal site for the purpose of ridge preservation is D7953. For placement of a bone graft in an edentulous area, report D7950. For bone graft at time of implant placement, see D6104
2. See D3428, D3429, D7950, D7951, D7952, D7953, D6103, D6104, and D7955 for other types of bone grafts.

WATCH

1. A bone replacement graft *stimulates periodontal regeneration* of bone. An *associated* and retained natural tooth is required to report D4263 or D4264.
2. Bone grafts are reported "per site." See the Surgical Services box at the beginning of the 4000 section for what constitutes a "site."

COMMENTS

1. D4263 reports a bone replacement graft - delivered to the first site in a quadrant.
2. When bone loss results in deep, narrow pockets (i.e., vertical bone loss or infrabony pockets), a bone replacement graft may be placed to treat the bony defect. The bone replacement graft may be an autograft (from the patient's own body) or an allograft (human bone tissue from a commercially man made available source), a xenograft (tissue from another species, e.g., bovine bone) or an alloplastic graft, which are man made materials used for tissue grafting and augmentation. For access to the bony defect, a flap must be laid. When submitting a code for a bone replacement graft (D4263/D4264), either D4240/D4241 (gingival flap surgery) or D4260/D4261 (osseous surgery) should be reported in addition to the bone graft. Biologic materials (D4265) placed and/or barrier membrane (D4266/D4267) may also be reported separately.
3. The flap entry should always be coded separately using gingival flap procedure (D4240/D4241) or osseous surgery (D4260/D4261). Biologic materials (D4265) and barrier membranes (D4266/D4267), when used, should also be reported separately. Bone grafts placed for socket preservation should be reported as D7953, ridge augmentation for edentulous areas as D7950, and sinus lifts as D7951 and D7952. Also, see bone graft for repair of peri-implant defect (D6103) and bone graft at time of implant placement (D6104). In addition, there are bone grafts associated with periradicular surgery (D3428 and D3429).
4. Harvesting of bone (D7295) to provide the autograft material is reported separately.
5. Enter the quadrant and tooth number being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Payors may impose a 24 to 36 month exclusion period for the same procedure performed in the same area of the mouth.
2. A diagnosis of a type III or type IV periodontal disease is generally required for D4263 to be considered for reimbursement.
3. Bone replacement grafts, as reported by D4263 are limited to *periodontal* defects. A natural tooth must be associated for this procedure to apply. Grafts placed in an associated extraction site (D7953), defects from cyst removal, or an apicoectomy are *not* usually reimbursed, but should still be reported.

TIPS

Associated procedures that may be performed with D4263 include, but are not limited to, D4240, D4241, D4260, D4261, D4265, D4266, D4267 and D7295.

NARRATIVES

D4263 (and D4264) is used to report bone grafts placed to treat *periodontal* defects around retained natural teeth. A tooth number, surface, and current periodontal charting that support a diagnosis of moderate to severe periodontal disease (5mm pocket depths or greater) and a narrative indicating type of grafting material are typically required. Dental plans may limit payment for bone grafts to two sites in a quadrant.

D4264 BONE REPLACEMENT GRAFT - RETAINED NATURAL TOOTH - EACH ADDITIONAL SITE IN QUADRANT

CDT 2025

This procedure involves the use of grafts to stimulate periodontal regeneration when the disease process has led to a deformity of the bone. This procedure does not include flap entry and closure, wound debridement, osseous contouring, or the placement of biologic materials to aid in osseous tissue regeneration or barrier membranes. This procedure is performed concurrently with one or more bone replacement grafts to document the number of sites involved. Not to be reported for an edentulous space or an extraction site.

WARNING

1. It is an error to report D4264 if the bone replacement graft is placed in an extraction site for ridge preservation. The proper code to report a bone replacement graft placed in an extraction or implant removal site for the purpose of ridge preservation is D7953. For placement of a bone graft in an edentulous area, report D7950. For bone graft at time of implant placement, see D6104.
2. See D3428, D3429, D7950, D7951, D7952, D7953, D6103, D6104 and D7955 for other types of bone grafts.

WATCH

1. A bone replacement graft *stimulates periodontal regeneration* of bone. An *associated* and retained natural tooth is required to report D4264 or D4263.
2. Bone grafts are reported "per site." See the Surgical Services box at the beginning of the 4000 section for what constitutes a "site."

COMMENTS

1. D4264 reports additional bone replacement graft(s) delivered to other sites in the same quadrant subsequent to D4263.
2. When bone loss results in deep, narrow pockets (i.e., vertical bone loss or infrabony pockets), a bone replacement graft may be placed to treat the bony defect. The bone replacement graft may be an autograft (from the patient's own body) or an allograft (human bone tissue from a commercially man made available source). A xenograft (tissue from another species, e.g., bovine bone) or an alloplastic graft, which are man made materials used for tissue grafting and augmentation. For access to the bony defect, a flap must be laid. When submitting a code for a bone replacement graft (D4363/D4364), either D4240/D4241 (gingival flap) or D4260/D4261 (osseous surgery) should be reported in addition to the bone graft. Biologic materials (D4265) placed and/or barrier membrane (D4266/D4267) may also be reported separately.
3. The flap entry should always be coded separately using gingival flap procedure (D4240/D4241) or osseous surgery (D4260/D4261). Biologic materials (D4265) and barrier membranes (D4266/D4267), when used, should also be reported separately. Bone grafts placed for socket preservation should be reported as D7953, ridge augmentation for edentulous areas as D7950, and sinus augmentations (lifts) as D7951 and D7952. Also, see bone graft for repair of peri-implant defect (D6103) and bone graft at time of implant placement (D6104). In addition, there are bone grafts associated with periradicular surgery (D3428 and D3429).
4. Harvesting of bone (D7295) to provide the autograft material is reported separately.
5. Enter the quadrant and tooth number being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Payors may impose a 24 to 36 month exclusion period for the same procedure performed in the same area of the mouth.
2. A diagnosis of a type III or type IV periodontal disease is generally required for D4264 to be considered for reimbursement.
3. Bone replacement grafts, as reported by D4264 are limited to *periodontal* defects. A natural tooth must be associated for this procedure to apply. Grafts placed in an extraction site (D7953), defects from cyst removal, or an apicoectomy are *not* usually reimbursed, but still should be reported.

TIPS

Associated procedures that may be performed with D4264 include, but are not limited to, D4240, D4241, D4260, D4261, D4265, D4266, D4267 and D7295.

NARRATIVES

D4264 (and D4263) is used to report bone grafts placed to treat *periodontal* defects around retained natural teeth. A tooth number, surface, and current periodontal charting that support a diagnosis of moderate to severe periodontal disease (5mm pocket depths or greater) and a narrative indicating type of grafting material are typically required. Dental plans may limit payment for bone grafts to two sites in a quadrant.

D4265 BIOLOGIC MATERIALS TO AID IN SOFT AND OSSEOUS TISSUE REGENERATION, PER SITE

CDT 2025

Biologic materials may be used alone or with other regenerative substrates such as bone and barrier membranes, depending upon their formulation and the presentation of the periodontal defect. This procedure does not include surgical entry and closure, wound debridement, osseous contouring, or the placement of graft materials and/or barrier membranes. Other separate procedures may be required concurrent to D4265 and should be reported using their own unique codes.

WARNING

1. Do not use D4265 to report Perio Protect®. D5995/D5996 reports Perio Protect® trays. See D5995/D5996 for comments on periodontal medicament carriers (trays).
2. Platelet rich plasma (PRP) and platelet rich fibrin (PRF) are technically biologic materials, but are created by centrifuging a patient's own blood. For information on reporting these materials, see D7921.
3. Do not use D4265 to report biologic materials to aid soft and osseous tissue regeneration with periradicular surgery, D3431.

COMMENTS

1. After laying a gingival flap (D4240/D4241) and/or during osseous surgery (D4260/D4261), biologic materials may be placed in a periodontal defect to aid in the regeneration of soft and osseous tissue. These materials may include bone morphogenetic protein 2 [BMP-2], Emdogain®, etc. Graft materials and/or barrier membranes (D4266/D4267) may also be placed at the same time and should be reported separately.
2. Biologic materials can also be placed in conjunction with implants and edentulous areas. Graft material and/or barrier membranes (D6106, D6107, D7956, and D7957) may also be placed at the same time and should be reported separately.
3. Biologic materials are reported per site. See the Surgical Services box at the beginning of the 4000 section for what constitutes a "site."
4. Enter the tooth number being treated in Box 27 of the 2024 Dental Claim Form.

LIMITATIONS

1. Reimbursement for biologic materials used to aid in soft and osseous tissue regeneration (D4265) may be limited to periodontally related procedures. Ridge augmentation or implant related procedures are typically excluded from reimbursement.
2. Fibrin Glue®, PepGen®, and Emdogain® are all examples of biologic materials. Some payors limit reimbursement to specific materials such as Emdogain®.
3. D4265 is seldom reimbursed by payors. This procedure requires consultant review prior to reimbursement.
4. Some payors reimburse D4265 if used in *conjunction* with osseous surgery (D4260/D4261) or gingival flap procedures (D4240/D4241). In some cases, the amount reimbursed for D4265 is limited to the cost of the materials used.

TIPS

Associated procedures that may be provided along with D4265 include but are not limited to D4240, D4241, D4260, D4261, D4263, D4264, D4266, and D4267. In addition, other associated procedures would be D6104, D6106, D6107, D7950, D7951, D7952, D7953, D7956, and D7957.

NARRATIVES

1. Clinical notes may be required to document this procedure. The notes should clearly describe the location of the area being treated with the biologic materials and why the treatment was needed. The notes should identify the specific material used for periodontal regenerative purposes.
2. Dental plans often limit reimbursement to one surgical procedure and one regenerative procedure for infrabony defects. For example, a plan may pay for osseous surgery (D4260/D4261) and guided tissue regeneration (D4266/D4267) but deny the biologic materials (D4265).

D4266 GUIDED TISSUE REGENERATION, NATURAL TEETH - RESORBABLE BARRIER, PER SITE

CDT 2025

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

WARNING

1. It is inappropriate to report placement of a collagen plug or collagen tape by reporting D4266. For the placement of a collagen plug or collagen tape, see D7922.
2. It is inappropriate to report a guided tissue regeneration in conjunction with a periradicular surgery. See D3432.
3. It is inappropriate to report D4266 for GTR - resorbable barrier related to implants. See D6106.
4. It is inappropriate to report D4266 for GTR - resorbable for endentulous areas. See D7956.
5. It is inappropriate to report D4266 for GTR - non-resorbable barrier, natural teeth. See D4267.
6. It is inappropriate to report D4266 for GTR - resorbable barrier - per site, with periradicular surgery. See D3432.

COMMENTS

1. The sequence of reattachment after flap and osseous surgery is important to the long term success of the procedure. Bone requires more time to generate and mature than soft tissue. Gingival tissues may attach to the tooth root more rapidly than bone can regenerate. A barrier membrane (GTR) is placed to prevent the fast growing gingiva from attaching to the root before the new bone can mature and attach to the root. The resorbable barrier membrane (D4266) is integrated into the regeneration site and/or resorbed or broken down by the body in the healing process.This type of barrier membrane does not require a second surgery for removal.
2. A bone graft is not always required when a barrier membrane is used. Some regeneration techniques encourage bone regrowth without the need for a bone graft.
3. Guided tissue regeneration (D4266) reports a "guided tissue regeneration, natural teeth - resorbable barrier." D4266 includes any follow up associated with this procedure.
4. Other procedures may be performed with D4266 and should be reported separately using their unique codes. These may include D4263, D4264, and D4265.
5. Barrier membranes are reported "per site." See the Surgical Services box at the beginning of the 4000 section for what constitutes a "site."
6. Enter the tooth number or tooth number range being treated in the appropriate boxes of the 2024 Dental Claim Form.

LIMITATIONS

1. Resorbable barrier membrane (D4266) should be reported separately when placed with periodontal bone replacement grafts, D4263 or D4264. Tooth number, surface/site, and current periodontal charting are typically required to be reported for reimbursement. Some contracts stipulate that only one regenerative procedure will be paid per infrabony defect. For example, D4266 or D4267 may be paid following osseous surgery but the biologic materials (D4265) denied. Additionally, payment for GTR is often limited to two sites per quadrant.
2. There typically is a 24 to 36 month exclusion period for the delivery of the same procedure to treat the same area of the mouth.
3. D4266 may be reimbursed in conjunction with osseous surgery. Reimbursement for this procedure may be limited to two sites per quadrant.
4. Reimbursement for D4266 may be limited to class II furcation involvement/infrabony defects. This code may not be reimbursed if associated with cyst removal, or the extraction of a tooth.

NARRATIVES

Clinical notes are often required. The tooth number, surface of the placement and a current periodontal charting indicating a diagnosis of moderate to severe periodontal disease (5mm pocket depths or greater) with treatable bony defects and indicating the specific type of barrier material used are typically required before reimbursement will be considered. Including diagnostic radiographic images as well as treatment photos is helpful to document the need for this procedure.

D4267 GUIDED TISSUE REGENERATION, NATURAL TEETH - NON-RESORBABLE BARRIER, PER SITE

CDT 2025

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



WARNING

1. It is inappropriate to report placement of a collagen plug or collagen tape by reporting D4267. For the placement of a collagen plug or collagen tape, see D7922.
2. It is inappropriate to report D4267 for GTR non-resorbable barrier related to implants. See D6107.
3. It is inappropriate to report D4267 for GTR non-resorbable barrier for endentulous areas. See D7957.
4. It is inappropriate to report D4267 for GTR - resorbable barrier, natural teeth. See D4266.

COMMENTS

1. Non-resorbable barrier membranes prevent fast healing gingival tissues from encroaching on the surgical site until new bone has had time to fill in the periodontal defect. Filling in the periodontal defect with bone eliminate pockets where plaque and calculus accumulate. Placement of a non-resorbable membrane requires a second surgery to remove it. The membrane is removed four to six weeks after placement and is reported as D4286.
2. A bone graft is not always required when a barrier membrane is used. Some regeneration techniques encourage bone regrowth without the need for a bone graft.
3. Guided tissue regeneration D4267 reports a "guided tissue regeneration, natural teeth - non-resorbable barrier."
4. Other procedures may be performed with D4267 and should be reported separately using their unique codes. These may include D4263, D4264, and D4265.
5. For removal of the non-resorbable barrier, see D4286. Do not expect reimbursement.
6. Barrier membranes are reported "per site." See the Surgical Services box at the beginning of the 4000 section for what constitutes a "site."
7. Enter the tooth number or tooth number range being treated in the appropriate boxes of the 2024 Dental Claim Form.

LIMITATIONS

1. Non-resorbable barrier membrane (D4267) should be reported separately when placed with periodontal bone replacement grafts, D4263 or D4264. Barrier membranes should be reported separately when placed in concert with other grafts D7950, D7951, D7952, and D7953. Tooth number, surface/site, and current periodontal charting are typically required to be reported for reimbursement. Some contracts stipulate that only one regenerative procedure will be paid per infrabony defect. For example, D4266 or D4267 may be paid following osseous surgery but the biologic materials (D4265) denied. Additionally, payment for GTR is often limited to two sites per quadrant.
2. There typically is a 24 to 36 month exclusion period for the delivery of the same procedure to treat the same area of the mouth.
3. D4267 may be reimbursed in conjunction with osseous surgery. Reimbursement for this procedure may be limited to two sites per quadrant.
4. Reimbursement for D4267 may be limited to class II furcation involvement/infrabony defects. This code may not be reimbursed if associated with cyst removal, or extraction of tooth.

NARRATIVES

Clinical notes are often required. The tooth number, surface of placement and a current periodontal charting indicating a diagnosis of moderate to severe periodontal disease (5mm pocket depths or greater) with treatable bony defects and indicating the specific type of barrier material used are typically required before reimbursement will be considered. Including diagnostic radiographic images as well as treatment photos is helpful to document the need for this procedure.

D4268 SURGICAL REVISION PROCEDURE, PER TOOTH CDT 2025

This procedure is to refine the results of a previously provided surgical procedure. This may require a surgical procedure to modify the irregular contours of hard or soft tissue. A mucoperiosteal flap may be elevated to allow access to reshape alveolar bone. The flaps are replaced or repositioned and sutured.

COMMENTS

1. Surgical revision procedure, per tooth (D4268) reports a surgical revision of a previously provided surgical procedure.
2. This procedure may involve either soft and/or hard tissue. A soft tissue flap/graft may need repositioning. When a soft tissue graft heals more apically than hoped and a flap procedure is used to reposition the tissue more coronally, use D4268 to describe this procedure. When a free soft tissue graft heals and the area is thicker than desired, if the area is thinned surgically, use D4268 to describe the thinning procedure.
3. Enter the tooth number being treated in Box 27 of the 2024 Dental Claim Form.

LIMITATIONS

1. D4268 may be considered a global part of other periodontal procedures. Plan limitations for this procedure are highly variable.
2. To receive reimbursement for D4268, at least three to six months must have elapsed since the original surgical procedure. Exclusions limits may be even as long as 24 to 36 months and greater.

NARRATIVES

A narrative and supportive documentation (e.g., current periodontal charting, radiographs, photographs, etc.) should be submitted documenting the need for the revision. Dental plans often consider surgical periodontal follow up and revision a part of the initial procedure. This limit may apply for a period of three to six months following the surgical procedure. Plans may limit reimbursement for surgical re-entry for up to three years. Note: Individual consideration may be given in extraordinary circumstances.

D4270 PEDICLE SOFT TISSUE GRAFT PROCEDURE CDT 2025

A pedicle flap of gingiva can be raised from an edentulous ridge, adjacent teeth, or from the existing gingiva on the tooth and moved laterally or coronally to replace alveolar mucosa as marginal tissue. The procedure can be used to cover an exposed root or to eliminate a gingival defect if the root is not too prominent in the arch.

COMMENTS

1. Gingival grafts are typically performed to cover exposed roots where recession has occurred and/or to widen the zone of attached gingiva. Gingival grafts are performed to improve the topography making the tooth easier to clean and/or to decrease the sensitivity experienced while brushing/eating/drinking by increasing the zone of attached gingiva.

   A portion of the flap serves as a soft tissue graft. Part of the tissue remains attached to the host and therefore only a portion of the blood supply is compromised. The fact that part of the graft remains attached yields a very high success rate.

   Laterally: When a tooth with gingival recession has one or two teeth adjacent with adequate attached gingiva, a flap can be laid from the adjacent area and can be used to cover the adjacent site. This flap may be moved laterally to cover the neighboring tooth to cover the area of recession. A split thickness flap is laid, leaving the periosteum (a layer of connective tissue) attached to the bone in the donor area. New gingiva grows over the periosteum at the donor site. If the tooth with the gingival defect is adjacent to an edentulous space, a flap may be lifted from the edentulous area and moved laterally to cover the root.

   Coronally: If there is enough attached gingival tissue below the area of recession, a flap can be raised and moved coronally (towards the crown of the tooth) to cover the area of recession.

2. D4270 may be associated with surgical access of an unerupted tooth (D7280), related to orthodontics. Surgically uncovering the unerupted tooth (generally a canine) may require a pedicle soft tissue graft procedure.

3. The Chao Pinhole® Surgical Technique (PST) is most commonly reported using D4270 pedicle soft tissue graft procedure. That is the code that seems "closest" to the procedure as it is performed, as there is no free tissue graft involved. That said, some payors do not consider this procedure a proper fit for their plan criteria, and instead require it to be submitted using a D4999 unspecified periodontal procedure by report code. Usually procedures that are reported using unspecified codes are not covered benefits under a policy, and even the D4270 may have limitations on coverage. Consider contacting the payor and asking how they would prefer this procedure be reported.

4. Enter the tooth number or tooth number range being treated in the appropriate boxes of the 2024 Dental Claim Form.

LIMITATIONS

1. Pedicle soft tissue graft (D4270) may be considered a part of osseous surgery (D4260/D4261). Pedicle soft tissue graft (D4270) may not be reimbursed if the procedure is performed in the same area and on the same date of service as osseous surgery. A frenectomy (D7961/D7962) or distal wedge procedure (D4274) performed on the same date of service and in the same area as a pedicle soft tissue graft is often considered a single service for reimbursement purposes.
2. There is typically a 24 to 36 month exclusion period for reimbursement for the same procedure performed in the same area of the mouth.
3. Soft tissue grafts are reimbursed per site or per tooth. Some payors limit reimbursement to two sites in a given quadrant.

NARRATIVES

1. Soft tissue grafts should be reported per tooth. Each graft should be reported on a separate line with tooth numbers and tooth surfaces identified. Despite the fact that the American Academy of Periodontology (AAP) maintains that radiographs and periodontal pocket measurements provide little value in documenting soft tissue pathology, some plans still request current periodontal charting with measurement of the amount of attached gingiva remaining for each tooth to be treated, before paying for soft tissue grafts. At least one plan currently requires a minimum of 3mm of recession to receive a benefit for a soft tissue graft and will pay one benefit for two contiguous grafts. Some payors require at least 4mm of recession with no attached gingiva and will only pay for one soft tissue graft when up to three contiguous teeth have been grafted. Dental plans often consider soft tissue grafts to include three months of post-operative care and surgical reentry for three years. According to the American Academy of Periodontology, claims for soft tissue grafts should ideally include a separate attachment that addresses the following:
   - Tooth number and location of defect
   - Amount of recession (in millimeters)
   - Amount of attached gingiva remaining
   - Amount of keratinized gingiva
   - Statement concerning progressive recession
   - Presence of marginal inflammation
   - Influence of frenum
   - Indications of root sensitivity
   - Cervical caries
   - Relationship to orthodontic care
   - Relationship to existing restorations, e.g., recession on an existing bridge or subgingival restoration
   - Statement that the procedure is not cosmetic
2. If the claim is related to hypersensitivity, document on the claim form that some form of desensitizer application (D9910/D9911) had been used and failed.
3. At a minimum, the narrative must include the number of mm of remaining attached gingiva for each tooth that has been/will be grafted.

D4271 PREVIOUSLY DELETED CODE FREE SOFT TISSUE GRAFT PROCEDURE (INCLUDING DONOR SITE SURGERY)

This is a previously deleted code. See D4277 for a free soft tissue graft procedure (first tooth) or D4278 free soft tissue graft procedure (each additional tooth).

D4273 AUTOGENOUS CONNECTIVE TISSUE GRAFT PROCEDURE (INCLUDING DONOR AND RECIPIENT SURGICAL SITES) FIRST TOOTH, IMPLANT, OR EDENTULOUS TOOTH POSITION IN GRAFT CDT 2025

There are two surgical sites. The recipient site utilizes a split thickness incision, retaining the overlapping flap of gingiva and/or mucosa. The connective tissue is dissected from a separate donor site leaving an epithelialized flap for closure.



WARNING

D4273 reports the treatment provided at both the donor and recipient surgery site.



MATCH

1. D4273 is used to report the first tooth, implant, or edentulous tooth position in the autogenous connective tissue graft.
2. D4283 is used to report each additional contiguous tooth, implant, or edentulous tooth position in an autogenous connective tissue graft.

COMMENTS

1. D4273 reports a subepithelial connective tissue graft, first tooth, implant or edentulous tooth position.
2. Most soft tissue grafts performed today are subepithelial connective tissue grafts, commonly referred to as "CT" grafts. They differ from free soft tissue grafts in that the graft material is taken from the layer of tissue just under the epithelium (the pink layer of soft tissue that you see when you look in the mouth). This graft is usually taken from the hard palate. A flap is raised in the area that needs coverage, the subepithelial connective tissue graft is placed under the flap, and the flap is sutured back in place. Placing the CT graft improves coverage of the exposed root.

3. Enter the tooth number being treated in Box 27 of the 2024 Dental Claim Form.

LIMITATIONS

1. There is typically a 24 to 36 month exclusion period for the reimbursement for the same procedure performed on the same tooth or area.
2. A free soft tissue graft procedure (D4277) may be reimbursed as an alternate benefit for D4273/D4283.
3. D4273/D4283 may be considered an *integral* part of osseous surgery (D4260/D4261). D4273/D4283 may not be reimbursed if the procedure is performed in the same area, on same service date as osseous surgery. A frenectomy or distal wedge performed on the same service date as D4273/D4283 and in the same area is often considered a part of the D4273 procedure.
4. A surgical stent (D5982) used to promote healing of the donor site is also considered a part of the D4273 procedure.
5. If D4273/D4283 is performed for cosmetic reasons, reimbursement may be denied.
6. Reimbursement may be limited two procedures per quadrant.
7. Although connective tissue grafts (D4273/D4283) are considered to be the "gold standard," some dental plans may benefit D4277 as an alternate benefit. Also note that a tunneling procedure is considered part of the D4273/D4283 procedure code, and when performed at the same appointment as a frenulectomy, only one benefit will likely be paid.

NARRATIVES

IMPORTANT! See the D4270 Narrative section for recommendations regarding soft tissue grafts.

D4274

D4274 MESIAL/DISTAL WEDGE PROCEDURE, SINGLE TOOTH (WHEN NOT PERFORMED IN CONJUNCTION WITH SURGICAL PROCEDURES IN THE SAME ANATOMICAL AREA) CDT 2025

This procedure is performed in an edentulous area adjacent to a tooth, allowing removal of a tissue wedge to gain access for debridement, permit close flap adaptation, and reduce pocket depths.



WARNING

When a distal wedge procedure is performed at the same time and in the same area as a gingival flap procedure, a soft tissue graft, or an osseous surgery procedure, do not report D4274 as a *separate* procedure.

COMMENTS

1. D4274, distal or proximal wedge procedure is performed on either the mesial or distal of a tooth. By definition, D4274 cannot be performed on the facial or lingual areas. D4274 is performed in an edentulous area adjacent to a periodontally involved tooth. The procedure involves the removal of a pie shape or rectangular wedge of gingival tissue. The remaining margins left after the wedge is removed are brought together and sutured. Removal of this gingival tissue is intended to reduce the depth of the pocket making the area easier to clean and maintain. D4274 no longer includes ostectomy or osteoplasty. If bone removal or recontouring is neccessary during the performance of a wedge prodecure, the claim should be submitted as a D4261 procedure.
2. Enter the tooth number being treated in Box 27 of the 2024 Dental Claim Form.

LIMITATIONS

1. Benefits are typically limited to treatment of areas where the distal of periodontally involved teeth are adjacent to edentulous areas.
2. D4274 is considered a part of osseous surgery or soft tissue grafts when performed in the same area on the same date of service. Reimbursement is often limited to the most inclusive procedure. D4274's nomenclature states that the procedure is "not performed in conjunction with surgical procedures in the same anatomical area."

TIPS

If D4274 is a *stand-alone* procedure (not performed in conjunction with surgical procedures in the same anatomical area), some payors provide reimbursement equivalent to a gingivectomy (D4211). If bone removal or recontouring is required, the mesial or distal wedge procedure should be submitted as D4261.

NARRATIVES

Include a narrative fully explaining the procedure. Include photographs, current periodontal charting and a pretreatment radiographic image.

D4275 NON-AUTOGENOUS CONNECTIVE TISSUE GRAFT (INCLUDING RECIPIENT SITE AND DONOR MATERIAL) FIRST TOOTH, IMPLANT, OR EDENTULOUS TOOTH POSITION IN GRAFT

CDT 2025

There is only a recipient surgical site utilizing split thickness incision, retaining the overlying flap of gingiva and/or mucosa. A donor surgical site is not present.

MATCH

D4275 is used to report the first tooth, implant, or edentulous tooth position in the non-autogenous connective tissue graft. D4285 is used to report each additional contiguous tooth, implant, or edentulous tooth position in a non-autogenous connective tissue graft.

COMMENTS

1. A non-autogenous connective tissue graft procedure commonly known as a soft tissue allograft is similar to a free soft tissue graft and is performed in situations similar to those where an autogenous connective tissue graft procedure is performed. The difference is that the tissue graft material does not come from the patient. This tissue (allograft material) is available commercially and has been treated so that it will not be rejected by the patient's immune system and is free from pathogens. An allograft material is used in circumstances where the patient either does not have enough gingival tissue available to be used for a graft or when the patient does not want to use his/her tissue for a graft. The graft results are comparable to using the patient's tissue, but healing may take a few weeks longer. More than 50% of connective tissue grafts performed today are non-autogenous.
2. A material such as Alloderm®, Perioderm®, Mucoderm®, etc. may be used.
3. Enter the tooth number being treated in Box 27 of the 2024 Dental Claim Form.

LIMITATIONS

1. Some plans do not provide reimbursement for D4275/D4285. Free soft tissue graft (D4277) may be reimbursed as an alternate benefit.
2. There is typically a 24 to 36 month exclusion period before reimbursement is available again for the same procedure in the same area/tooth.
3. Reimbursement may be limited to two procedures per quadrant.
4. If D4275/D4285 is reported for cosmetic reasons, reimbursement may be denied.

NARRATIVES

1. The narrative should report tooth number, any active recession, description of root exposure, amount of recession, frenum issues, pocket depth, and remaining keratinous tissue. It is recommended that photographs be included to support the need for treatment.
2. The allograft material (e.g., Dermis) is included in D4275/D4285. Some dental plans do not pay for non-autogenous connective tissue grafts but may provide an alternate benefit of a free soft tissue graft (D4277) if a narrative is sent indicating that adequate soft tissue was not available from the patient.
3. **IMPORTANT!** See D4270 for soft tissue graft narrative recommendations.

D4276 COMBINED CONNECTIVE TISSUE AND PEDICLE GRAFT, PER TOOTH

CDT 2025

Advanced gingival recession often cannot be corrected with a single procedure. Combined tissue grafting procedures are needed to achieve the desired outcome.

COMMENTS

1. This procedure involves a connective tissue (CT) graft and pedicle graft(s). This procedure is indicated to treat areas of recession with root exposure. A small pedicle flap is lifted from both sides of the affected tooth. A CT graft is harvested (usually from the palate). The CT graft is placed on the root and the two pedicle grafts are positioned to cover the CT graft. Both pedicle flaps and the CT graft are sutured together and to the surrounding gum tissue to stabilize the flaps while the area heals.
2. Enter the tooth number being treated in Box 27 of the 2024 Dental Claim Form.

LIMITATIONS

1. D4276 is seldom reimbursed.

2. A subepithelial connective tissue graft procedure (D4273) or free soft tissue graft (D4277) may be reimbursed as an alternate benefit.
3. There is typically a 24 to 36 month exclusion period for reimbursement for the same procedure provided on the same tooth.

NARRATIVES

1. The narrative should report tooth number, the presence of active recession, description of root exposure, amount of recession, frenum issues, pocket depth, remaining keratinized tissue and the number of mm of remaining attached gingiva. It is recommended that photographs be included with the claim.
2. If the claim is related to hypersensitivity, note on the claim form that conventional desensitizing treatment (D9910/D9911) to reduce sensitivity had been used and failed.
3. **IMPORTANT!** See D4270 for soft tissue graft narrative recommendations.

D4277 FREE SOFT TISSUE GRAFT PROCEDURE (INCLUDING RECIPIENT AND DONOR SURGICAL SITES) FIRST TOOTH, IMPLANT, OR EDENTULOUS TOOTH POSITION IN GRAFT

CDT 2025



WARNING

The free soft tissue graft procedure (D4277/D4278) *includes* donor site surgery.

COMMENTS

1. Gingival grafts are typically performed to cover exposed roots where recession has occurred and/or to widen the zone of attached gingiva. Gingival grafts are intended to improve the topography making the tooth easier to clean, to decrease the sensitivity experienced by increasing the zone of attached gingiva, and to reduce the possibility of further gingival recession.
2. A free gingival graft refers to the fact that the gingival tissue being grafted is detached or "free" from the blood supply, i.e., excised from the body. The greatest benefit from the use of the free gingival graft technique is that the graft can be taken from a remote part of the mouth and placed in another independent location. A pedicle graft remains attached and must be reattached a few millimeters from where it is harvested. During the graft procedure, the tooth at the recipient site is root planed prior to attaching the graft. Most payors consider the root planing procedure a part of the graft procedure and not payable as a separate procedure. Free gingival grafts may be used to increase the width of the attached gingiva, but they can also be used to deepen the vestibule or eliminate frenum pulls.
3. D4277 may be associated with the surgical access of an unerupted tooth (D7280), related to orthodontics. Surgically uncovering the unerupted tooth may require a free soft tissue graft procedure, D4277.
4. Enter the tooth number being treated in Box 27 of the 2024 Dental Claim Form.

LIMITATIONS

1. If a free soft tissue graft (D4277/D4278) is performed for cosmetic reasons, reimbursement is typically denied.
2. There is typically a 24 to 36 month exclusion period for reimbursement for the same procedure in the same area of the mouth or on the same tooth.
3. Free soft tissue graft procedure (D4277/D4278) may be considered a part of osseous surgery (D4260/D4261). Free soft tissue graft procedure may not be reimbursed in addition to osseous surgery if the graft procedure is performed in the same area on the same service date as the osseous surgery. A frenectomy or distal wedge procedure performed on the same service date in the same area as the free soft tissue graft is often considered a part of the graft procedure.
4. A surgical stent used to promote healing of the donor site is also considered a part of the free soft tissue graft procedure.
5. The preparation of the surgical site and harvesting the graft from the donor site is all a part of the global fee for the free soft tissue graft, D4277/D4278.
6. Soft tissue grafts should be reported per tooth. The first tooth in the graft site is reported as D4277. Each additional graft in the same graft site should be reported as D4278 on a separate line with tooth numbers and tooth surfaces identified.

NARRATIVES

IMPORTANT! See D4270 for soft tissue graft narrative recommendations.

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 CDT 2025

Used in conjunction with D4277.



WARNING

The free soft tissue graft procedure (D4277/D4278) *includes* donor site surgery.

COMMENTS

1. Gingival grafts are typically performed to cover exposed roots where recession has occurred and/or to widen the zone of attached gingiva. Gingival grafts are intended to improve the topography making the tooth easier to clean, to decrease the sensitivity experienced while brushing by increasing the zone of attached gingiva and to reduce the possibility of further gingival recession.
2. A free gingival graft refers to the fact that the gingival tissue being grafted is detached or "free" from the blood supply, i.e., excised from the body. The greatest benefit from the use of the free gingival graft technique is that the graft can be taken from a remote part of the mouth and placed in another independent location. A pedicle graft remains attached and must be sutured a few millimeters from where it is harvested. During the graft procedure, the tooth at the recipient site is root planed prior to attaching the graft. Most payors consider the root planing procedure to be included with the graft procedure and not payable as a separate procedure. Free gingival grafts may be used to increase the width of the attached gingiva, but they can also be used to deepen the vestibule or eliminate frenum pulls.
3. Enter the tooth number being treated in Box 27 of the 2024 Dental Claim Form.

LIMITATIONS

1. If a free soft tissue graft (D4277/D4278) is performed for cosmetic reasons, reimbursement is usually denied.
2. There is typically a 24 to 36 month exclusion period for reimbursement for the same procedure in the same area of the mouth or on the same tooth.
3. Free soft tissue graft procedures (D4277/D4278) may be considered a part of osseous surgery (D4260/D4261). Free soft tissue graft procedure may not be reimbursed in addition to the osseous surgery if the graft procedure is performed in the same area on the same service date as the osseous surgery. A frenectomy or distal wedge procedure performed on the same service date in the same area as the free soft tissue graft is often considered a part of the graft procedure.
4. A surgical stent used to promote healing of the donor site is also considered a part of the free soft tissue graft procedure.
5. The preparation of the surgical site and harvesting the graft from the donor site is all a part of the overall global fee for the free soft tissue graft, D4277/D4278.
6. Soft tissue grafts should be reported per tooth. The first tooth in the graft site is reported as D4277. Each additional graft in the same graft site should be reported as D4278, on a separate line with tooth numbers and tooth surfaces identified.

NARRATIVES

IMPORTANT! See D4270 for soft tissue graft narrative recommendations.

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 CDT 2025

Used in conjunction with D4273.



WARNING

D4273 reports the treatment provided to the donor and recipient surgical sites.

WATCH

1. D4283 reports additional graft sites, following D4273, autogenous connective tissue graft procedures, per tooth, implant or edentulous tooth position when both a subepithelial connective tissue graft is performed and autogenous connective tissue is used to provide graft (filler) material.
2. D4283 includes the preparation, collection, and placement of the connective tissues used in the first graft site (D4273).



MATCH

D4283 is used to report each additional contiguous tooth, implant, or edentulous tooth position in an autogenous connective tissue graft. The first tooth or tooth position in the autogenous connective tissue graft should be reported as D4273.

COMMENTS

1. D4273 and D4283 report subepithelial connective tissue grafts.
2. "CT" grafts differ from free soft tissue grafts in that the graft material is taken from the layer of tissue just under the epithelium (the layer of pink soft tissue) and is completely detached from the donor site before it is repositioned in the graft site.

   This graft is usually taken from the hard palate. A flap is raised in the area that needs coverage, the subepithelial connective tissue graft is placed under the flap is sutured back in place. CT grafts improve coverage of the exposed root.
3. Enter the tooth number being treated in Box 27 of the 2024 Dental Claim Form.

LIMITATIONS

1. There is typically a 24 to 36 month exclusion period for reimbursement for the same procedure performed on the same tooth or position.
2. A free soft tissue graft procedure (D4277) may be reimbursed as an alternate benefit for D4273/D4283.
3. D4273/D4283 may be considered an integral part of osseous surgery (D4260/D4261). D4273/D4283 may not be reimbursed if the procedure is performed in the same area on same date service date as osseous surgery.

   A frenectomy or distal wedge performed on the same service date as D4273/D4283 and in the same area may be considered a part of the D4272/D4283 procedure.
4. A surgical stent used to promote healing of the donor site is considered part of the D4273/D4283 procedure.
5. If D4273/D4283 is performed for cosmetic reasons, reimbursement may be denied.
6. Reimbursement may be limited to two procedures per quadrant.
7. Although autogenous connective tissue grafts (D4273/D4283) are considered the "gold standard," some dental plans pay a free soft tissue graft procedure (D4277) as an alternate benefit. A tunneling procedure is considered part of the D4273/D4283 procedure code, and when performed at the same appointment as a frenulectomy, only one benefit will likely be paid.

NARRATIVES

IMPORTANT! See the D4270 "Narrative" section for recommendations regarding soft tissue graft narratives.

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

CDT 2025

Used in conjunction with D4275.



WARNING

D4285 is reported in conjunction with D4275, non-autogenous connective tissue graft, per tooth, implant or edentulous tooth position when both a subepithelial connective tissue graft is performed and non-autogenous connective tissue is used to provide graft (filler) material.

WATCH

D4285 is to be reported in conjunction with D4275, non-autogenous connective tissue graft, per tooth, implant or edentulous tooth position when both a subepithelial connective tissue graft is performed and non-autogenous connective tissue is used to provide graft (filler) material.

MATCH

D4285 reports each additional contiguous, tooth, implant or edentulous tooth position in a non-autogenous connective tissue graft. The first tooth, implant, or edentulous tooth position in the autogenous connective tissue graft should be reported as D4275.

COMMENTS

1. A non-autogenous connective tissue graft procedure commonly known as a soft tissue allograft is similar to a free soft tissue graft and is performed in situations similar to those where an autogenous connective tissue graft procedure is performed. The difference is that the tissue graft material does not come from the patient.

   Allograft material is available commercially. It has been treated so that it will not be rejected by the patient's immune system and is free from pathogens. An allograft material is used in circumstances where the patient either does not have enough gingival tissue available to be used for a graft or when the patient does not want to use his/her tissue for a graft. The graft results are comparable to using the patient's tissue, but healing may take a few weeks longer. More than 50% of connective tissue grafts performed today are non-autogenous.

2. A material such as Alloderm®, Perioderm®, Mucoderm®, etc. may be used.
3. Enter the tooth number being treated in Box 27 of the 2024 Dental Claim Form.

LIMITATIONS

1. Some plans do not provide reimbursement for D4275/D4285. Free soft tissue graft (D4277) may be reimbursed as an alternate benefit.
2. If D4275/D4285 is performed for cosmetic reasons, reimbursement may be denied.
3. Reimbursement may be limited to two procedures per quadrant.
4. There is typically a 24 to 36 month exclusion period before reimbursement is available again for the same procedure in the same area/tooth.

NARRATIVES

1. Document the tooth number, description of root exposure, any active recession, amount of recession, frenum issues, pocket depth, and remaining keratinous tissue. Photographs should be included to support the need for treatment.
2. The allograft material (e.g., Dermis) is included in the global fee for D4275/D4285. Some payors do not pay for non-autogenous connective tissue grafts but may provide an alternate benefit of a free soft tissue graft (D4277) if a narrative is sent indicating that adequate soft tissue was not available from the patient.
3. **IMPORTANT!** See D4270 "Narrative" section for recommendations regarding soft tissue graft narratives.

D4286 REMOVAL OF NON-RESORBABLE BARRIER CDT 2025

COMMENTS

1. This procedure reports the second-stage surgical removal of a non-resorbable barrier membrane. This may be associated with non-resorbable membranes placed in areas involving natural teeth, implants, or edentulous areas, so it is universal for all non-resorbable membranes.
2. D4286 is appropriate for the removal of the following non-resorbable membranes utilizing a second-stage surgery: D4267, D6107, and D7957.
3. Enter the arch, quadrant, tooth number or tooth number range being treated in the appropriate boxes of the 2024 Dental Claim Form.

LIMITATION

The second stage surgery for the removal of a non-resorbable barrier is typically considered in the global fee for placing the barrier. Do not expect reimbursement.

D4320 PREVIOUSLY DELETED CODE PROVISIONAL SPLINTING - INTRACORONAL

This is a previously deleted code. See D4322 for further details.

D4321 PREVIOUSLY DELETED CODE PROVISIONAL SPLINTING - EXTRACORONAL

This is a previously deleted code. See D4323 for further details.

D4322 SPLINT - INTRA-CORONAL; NATURAL TEETH OR PROSTHETIC CROWNS CDT 2025

Additional procedure that physically links individual teeth or prosthetic crowns to provide stabilization and additional strength.



WARNING

1. It is misleading to report *individual* direct restorations (composites) as interim splinting, even though interconnected to gain reimbursement. Separate *necessary* composite restorations (in occlusion and with adjacent contacts) due to caries may be placed and finished, *prior* to subsequent placement of a *separate* interim splinting procedure.
2. For treatment of mobility due to *bruxism* or other occlusal factors using splints, see D9944, D9945, or D9946.
3. For TMJ/TMD treatment of mobility related to the TMJ/TMD condition using a splint, see D7880.



MATCH

D4322, splint - intra-coronal; natural teeth or prosthetic crowns is used to describe the placement of a continuous connecting material via a prepared "slot" into the enamel of natural teeth, a slotted preparation into existing prosthetic crown(s) , or during the fabrication of new splinted crowns to stabilize and strengthen mobile teeth. The material used to splint the teeth is fabricated inside positioned inside the teeth, not just applied externally.

COMMENTS

1. D4322 is not reported "per tooth" but on a global basis.
2. D4322 is a procedure meant to stabilize natural teeth as well as teeth with prosthetic crowns and/or bridges. While a variety of methods can be used to stabilize teeth, a common method involves cutting a horizontal groove/channel into the mobile teeth and into at least one stable tooth on either side. These teeth involved in the splinting procedure may be a mix of both natural and prosthetic crowns. This groove/channel is filled with composite and either thin wire, polyethylene fibers, or a mesh material. To better understand this type of stabilization, think of a picket fence. When standing individually the uprights of a fence are more easily tipped over. When the horizontal interconnective portion is added tying the uprights together the fence becomes much more stable. Even though the individual groove/channel cuts into the mobile teeth are filled with composite and may appear similar to individual composite restorations, they should not be billed as restorations.
3. Do not confuse stabilization (D4322) with tooth reimplantation and/or stabilization of accidentally avulsed or displaced teeth (D7270). D4322 reports splinting compromised teeth that are mobile due to periodontal disease with loss of bone (or for cosmetics). D7270 reports the stabilization of teeth that are mobile due to trauma.
4. If fabricating new splinted crown restorations with no pontics, report each crown as an individual unit and then report D4322 separately. If there is a pontic, report using fixed partial denture retainer crowns and pontic codes. Reimbursement is unlikely.
5. Enter the tooth number(s) or tooth number range being treated in the appropriate boxes of the 2024 Dental Claim Form.

LIMITATIONS

1. Relatively few dental plans cover periodontal splinting of natural teeth or prosthetic crowns related to bone loss. D4322 is often used to stabilize teeth and crowns that are considered "hopeless" due to mobility caused by advanced periodontal disease. Splinting may also be used when healing is needed after periodontal surgery helping the teeth become stable. The procedure is considered by many payors to be of little long-term value as mobile teeth are difficult to treat successfully.
2. Note that occlusal guards (D9944, D9945, and D9946) fabricated for bruxism or other occlusal factors have better reimbursement.

NARRATIVES

1. For those plans that do offer a benefit for stabilization, a current complete periodontal charting, current radiographic images, and a diagnosis of moderate to severe periodontitis with good to moderate prognosis for perio stabilization is usually required. D4322 may also include the intra-cornal splinting of teeth including a natural tooth "pontic".
2. Natural teeth or prosthetic crowns involved in the splint should be identified on the claim form.

D4323 SPLINT - EXTRA-CORONAL; NATURAL TEETH OR PROSTHETIC CROWNS CDT 2025

Additional procedure that physically links individual teeth or prosthetic crowns to provide stabilization and additional strength.



WARNING

1. It is misleading to report *individual* direct restorations (composites) as interim splinting, even though interconnected to gain reimbursement. Separate *necessary* composite restorations (in occlusion and with adjacent contacts) due to caries may be placed and finished, *prior* to subsequent placement of a *separate* interim splinting procedure.
2. For treatment of mobility due to *bruxism* or other occlusal factors using splints, see D9944, D9945, or D9946.
3. For TMJ/TMD treatment of mobility related to the TMJ/TMD condition using a splint, see D7880.



MATCH

D4323, splint - extra-coronal; natural teeth or prosthetic crowns reports the placement of a continuous connecting material to the external surface (non-prepared) on teeth or bonded to existing prosthetic crown(s) to stabilize and strengthen mobile teeth. The material used to splint the teeth is only applied externally.

COMMENTS

1. D4323 is not reported "per tooth" but on a global basis.
2. D4323 is an extra-coronal procedure meant to stabilize periodontally involved natural teeth or prosthetic crowns. These teeth involved in the splinting procedure may be a mix of both natural and prosthetic crowns. D4323 may also include the extra-coronal splinting of teeth including a natural tooth "pontic".
3. Do not confuse periodontal stabilization (D4323) with tooth reimplantation and/or stabilization of accidentally avulsed or displaced teeth (D7270). D4323 often reports splinting periodontally compromised teeth that are mobile due to periodontal disease with loss of bone. D7270 reports the stabilization of teeth that are mobile due to trauma.
4. Enter the tooth number(s) or tooth number range being treated in the appropriate boxes of the 2024 Dental Claim Form.

LIMITATIONS

1. Relatively few dental plans cover periodontal splinting of natural teeth or prosthetic crowns related to bone loss. D4323 is used to stabilize teeth that are considered "hopeless" due to mobility caused by advanced periodontal disease. Splinting may also be used when healing is needed after periodontal surgery to help the teeth become more stable. The procedure is considered by many payors to be of little long-term value as mobile teeth are difficult to treat successfully.
2. Note that occlusal guards (D9944, D9945, and D9946) fabricated for bruxism or other occlusal factors have better reimbursement.

NARRATIVES

1. For those plans that do offer a benefit for stabilization, a current complete periodontal charting, current radiographic images, and a diagnosis of moderate to severe periodontitis with good to moderate prognosis for perio stabilization is usually required.
2. Natural teeth or prosthetic crowns involved in the splint should be identified on the claim form.

PHOTO



This is an example of extracoronal splinting using the Ribond® splinting material.

Courtesy Ribbond®

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

CDT 2025

This procedure involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. It is indicated for patients with periodontal disease and is therapeutic, not prophylactic, in nature. Root planing is the definitive procedure designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or microorganisms. Some soft tissue removal occurs. This procedure may be used as a definitive treatment in some stages of periodontal disease and/or as a part of pre-surgical procedures in others.

WARNING

1. It is inappropriate to complete four quadrants of periodontal scaling and root planing (SRP) in one hour. Start and Stop times are now required by certain payors on many periodontal procedures.
2. It is improper/misleading to report a "quadrant equivalent" (such as, a few teeth in different quadrants) for reimbursement using D4341. For each quadrant with one to three diseased teeth requiring scaling and root planing, report periodontal scaling and root planing - one to three teeth (D4342). Use D4341 to report scaling and root planing of *four or more* periodontally involved teeth in a given quadrant. There must be at least four teeth in the treated quadrant to report D4341 and those four or more teeth must have specific evidence of periodontal disease. To justify reimbursement the periodontally involved teeth must have radiographic bone loss and pockets of 4mm or more which indicates active periodontal disease. They may also have calculus on the radiographic image.
3. D4346 reports generalized moderate or severe gingivitis without attachment (bone) loss for whole mouth. See D4346.

MATCH

If no periodontal surgery is immediately treatment planned after D4341/D4342, it is expected that regularly scheduled periodontal maintenance (D4910) would follow in the future.

COMMENTS

1. SRP includes the instrumentation of both *crown* and *root* surfaces to remove plaque and calculus. See D1110 for preventive treatment and the removal of plaque, calculus, and stains. It is inappropriate to report D1110 with D4341 on the same service date. SRP (D4341) requires root planing that removes cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or microorganisms. (Chart notes must indicate that root planing was performed, not just scaling.) Some soft tissue curettage will occur during the root planing process.

   A diagnosis of early, moderate, or advanced chronic periodontitis will include some level of clinical attachment loss (CAL). CAL may not be apparent from pocket depth measurements. CAL involves the loss of alveolar bone support and gingival attachment as the periodontal fibers migrate apically from the CEJ (cementoenamel junction) due to periodontal toxins in plaque. Attachment loss is measured from the CEJ to the bottom of the periodontal pocket.

   A periodontal pocket is a *pathologically deepened gingival sulcus* formed when toxins produced by plaque weaken the gingival attachment and connective tissues beneath the gum line. The gingival attachment pulls away from the teeth, forming a deeper pocket. As the disease progresses through the gingiva toward the bone, the pocket fills with plaque and the bacteria causes infection and inflammation. If not treated, the bone and connective tissue surrounding the tooth may become so severely damaged over time that the attachment is lost. If periodontitis continues untreated the tooth may become loose, fall out, or need to be extracted.

   Evidence of active disease may include bleeding on probing (BOP), increased pocket depth, continued attachment loss, purulent discharge, increased tooth mobility, high bacterial count, and/or evidence of sequential radiographic loss of the crestal bone.
2. Scaling and root planing provides *active therapy*. It is not prophylactic (preventive) in nature. Scaling and root planing can be a definitive treatment (followed by periodontal maintenance) for some patients or pre-surgical treatment (prior to osseous surgery) for other patients.

3. Conversely, prophylaxis is preventive in nature and is not a statement of oral health, but instead supports good periodontal health. It therefore does not preclude subsequent SRP.
4. Use D4341 to report scaling and root planing for four or more diseased and qualified teeth in a given quadrant.
5. The code used to report the periodontal therapy should be based on the dentist's diagnosis and the service performed. For example, if the patient exhibits bleeding on probing and radiographic evidence of bone loss in two of the four quadrants, scaling and root planing (SRP) will likely be prescribed for the two affected quadrants. The remaining two quadrants may be treated with a prophylaxis (D1110). D1110 is provided to remove plaque, calculus and stains in areas where there is a lack of evidence of periodontitis.

   In this example, when sequencing treatment, it may be best to complete and report the prophylaxis (D1110) on the two healthy quadrants first and bring the patient back at a separate appointment to perform the two quadrants of SRP. If so, wait six weeks before the SRP visit. This sequencing is beneficial in that it gives the hygiene team more time to educate the patient about periodontal disease, making it clear that more extensive therapy is needed to arrest the bacterial infection in the remaining two quadrants. After SRP has been completed, D4341 should be billed for each quadrant treated with SRP, which include four qualified teeth. If one to three teeth in a quadrant require SRP, D4342 (SRP one to three teeth) should be reported for that quadrant.
6. See LANAP comments at the beginning of the D4000 section and the comments under D4999 for more information on use of lasers in periodontal treatments.
7. Current Periodontal Staging and Grading protocols can be found at http://www.perio.org/2017wwdc. The Stage and Grade of disease should be recorded in the clinical notes and included in communication with payors.
8. Enter the quadrant, tooth number(s), or tooth number range being treated in the appropriate boxes of the 2024 Dental Claim Form.

LIMITATIONS

1. For reimbursement of D4341, bleeding on probing which indicates active periodontal disease, 4 to 5mm pocket depth (plus presence of calculus), attachment loss, radiographic evidence of bone loss must be evident. Some payors do not require diagnostic images, but most do.
2. Some payors require that *five* teeth have evidence of periodontal disease for reimbursement of D4341. If less than five teeth are reported, some payors re-map this code to D4342, ignoring the nomenclature quadrant definition of "four or more" teeth. If four teeth are treated and the payor re-maps the reimbursement to D4342, ask the patient to request a copy of the plan document from their Human Resources department. Once a copy of the plan document is received, review the language as to tooth count requirements and limitations pertaining to D4341 and respond accordingly.
3. Periodontal maintenance (D4910) should follow multi-quadrant (D4341) SRP (generally at least two quadrants). This may not apply for SRP when involving D4342 for a few, isolated teeth. See D4342 for details. Note that there is typically a ninety day exclusion period (to the day) from the last date of SRP and the subsequent date of D4910.
4. Scaling and root planing (D4341) usually has a 24 to 36 month exclusion period for retreatment (a few payors have a 12 month exclusion). Note: reimbursement for scaling and root planing is typically excluded for 24 to 36 months after a gingival flap procedure (D4240/D4241) or osseous surgery (D4260/D4261) provided in the same area.
5. Artificial Intelligence (AI) programs are now being used by many payors to measure bone loss on submitted radiographs. Many are requiring 2mm of bone loss from the CEJ to the crest of bone to consider the site for reimbursement.

TIPS

1. D4921 reports gingival irrigation, per quadrant. Payors typically consider gingival irrigation to be a global component of D4341, D4342 or D4910. The PPO contract may prohibit charging a separate fee for irrigation. See D4921 for comments regarding the clinical use of gingival irrigation.
2. Use D9910 to describe the application of desensitizing medicaments for one tooth or multiple teeth. Payors typically consider D9910 to be a global part of D4341, D4342 or D4910. The PPO contract may prohibit charging a separate fee for the application of desensitizing medicaments. See D9910 for comments.

NARRATIVES

1. A narrative should document *active* disease. This may include, but is not limited to: 4mm or greater pockets that bleed on probing indicating active disease, loss of periodontal attachment, radiographic evidence of alveolar bone loss, gingival recession, furcation involvement, inflammation, tooth mobility, subgingival calculus, suppuration, etc. Enclose diagnostic radiographic images to document bone loss. Also send a current periodontal chart which includes the date(s) that the chart was recorded.

2. When scaling and root planing all four quadrants on the same day, include a narrative to document the treatment of all four quadrants in the same day. This may include time spent; anesthesia required; if pre-medication was necessary; apprehensiveness; medical conditions (i.e., taking blood thinner), extensive travel time, etc. Include any other supporting documentation that might justify the treatment of all four quadrants on the same service date. Generally speaking, forty-five to sixty minutes or more would be required per quadrant to report four quadrants of D4341. Payors are skeptical of four quadrants on one service date and may require extensive documentation for reimbursement. A predetermination is highly recommended.
3. Start and Stop times and types and amounts of local anesthetic are now required by certain payors on many periodontal procedures. Be sure to record this information in the clinical notation and subsequent narrative. Copies of the hygiene schedule from the date of service may even be requested.

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

CDT 2025

This procedure involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. It is indicated for patients with periodontal disease and is therapeutic, not prophylactic, in nature. Root planing is the definitive procedure designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or microorganisms. Some soft tissue removal occurs. This procedure may be used as a definitive treatment in some stages of periodontal disease and/or as a part of pre-surgical procedures in others.



WARNING

1. It is inappropriate to report periodontal scaling and root planing (SRP) for three teeth (D4342), for several quadrants in one hour. Start and Stop times are now required by certain payors on many periodontal procedures.
2. D4346 reports generalized moderate or severe gingivitis without attachment (bone) loss for whole mouth. See D4346.



MATCH

D4342/D4341 should be followed by osseous surgery (D4260/D4261) *or* periodontal maintenance (D4910).

COMMENTS

1. SRP includes the instrumentation of both *crown* and *root* surfaces to remove plaque and calculus. See D1110 for preventive treatment and the removal of plaque, calculus and stains. Nothing prohibits reporting D1110 with D4342 on the same service date. However, it usually requires an appeal with an explanation that establishes why both services were done on the same day and especially time spent. SRP (D4342) requires root planing that removes cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or microorganisms. (Chart notes must indicate that root planing was performed, not just scaling). Some soft tissue curettage will occur during the root planing process.

   A diagnosis of early, moderate, or advanced chronic periodontitis will include some level of clinical attachment loss (CAL). CAL may not be apparent from pocket depth measurements. CAL involves the loss of alveolar bone support and gingival attachment as the periodontal fibers migrate apically from the CEJ (cementoenamel junction) due to periodontal toxins in plaque. Attachment loss is measured from the CEJ to the bottom of the periodontal pocket.

   A periodontal pocket is a pathologically deepened gingival sulcus formed when toxins produced by plaque weaken the gum and connective tissues beneath the gum line. The gingiva pulls away from the teeth, forming a deeper pocket. As the disease progresses through the gingiva toward the bone, the pocket fills with plaque and the plaque causes infection and inflammation. If not treated, the bone and connective tissue surrounding the tooth may become so severely damaged over time that the attachment is lost. If periodontitis continues untreated the tooth may become loose, fall out, or need to be extracted.

   Evidence of active disease may include bleeding on probing (BOP), increased pocket depth, continued attachment loss, purulent discharge, tooth mobility, high bacterial count, and/or evidence of sequential radiographic loss of the crestal bone.
2. Scaling and root planing provides *active therapy.* It is not prophylactic (preventive) in nature. Scaling and root planing can be a definitive treatment (followed by periodontal maintenance) for some patients or pre-surgical treatment (prior to osseous surgery) for other patients.
3. Conversley, prophylaxis is preventive in nature and is not a statement of oral health, but instead supports good periodontal health. It therefore does not preclude subsequent SRP.

4. Use D4342 to report scaling and root planing (active periodontal treatment) for one to three diseased teeth in a given quadrant.
5. The code used to report the periodontal therapy should be based on the dentist's diagnosis and the service performed. For example, if the patient exhibits bleeding on probing (BOP) and radiographic evidence of bone loss in two of the four quadrants, scaling and root planing (SRP) will likely be prescribed for the two affected quadrants. The remaining two quadrants may be treated with a prophylaxis (D1110). D1110 is provided to remove plaque, calculus and stains in areas where there is no evidence of periodontitis.

   In this example, when sequencing treatment, it may be best to complete the prophylaxis (D1110) on the two healthy quadrants first and bring the patient back at a separate appointment to perform the two quadrants of SRP. If so, wait six weeks before the SRP visit. This sequencing is beneficial in that it gives the hygiene team more time to educate the patient about periodontal disease, making it clear that more extensive therapy is needed to arrest the bacterial infection in the remaining two quadrants. After SRP has been completed, D4342 should be billed for each quadrant treated with SRP which include one to three teeth. If four or more teeth in a quadrant require SRP, D4341 (SRP four or more teeth) should be reported for that quadrant.
6. See LANAP comments at the beginning of the D4000 section and the comments under D4999 for more information on use of lasers in periodontal treatments.
7. Current Periodontal Staging and Grading protocols can be found at http://www.perio.org/2017wwdc. The Stage and Grade of disease should be recorded in the clinical notes and included in communication with payors.
8. Enter the quadrant, tooth number(s), or tooth number range being treated in the appropriate boxes of the 2024 Dental Claim Form.

LIMITATIONS

1. For reimbursement of D4342, bleeding on probing which indicates active periodontal disease, 4 to 5mm pocket depth (plus presence of calculus), attachment loss and radiographic evidence of bone loss must be evident. Some payor's do not request diagnostic images, but most do.
2. D4342 is typically reimbursed at 50 to 60% of the D4341 fee.
3. Periodontal maintenance (D4910) almost always follows multiquadrant (D4341), and also after (D4342) scaling and root planing (if at least two quadrants), with a typical ninety day exclusion after active treatment. However, for just a few isolated teeth with D4342 scaling and root planing, it may instead be appropriate to follow with a prophylaxis (D1110) appointment if deemed clinically appropriate by the dentist. If followed with prophylaxis, a frequency of three or four times per year may be most appropriate to maintain health. If prophylaxis (D1110) is provided to the patient with isolated periodontitis, then the clinical notes and "remarks" should note the isolated scaling and root planing areas in the chart notes. In fact, some payors will not reimburse D4910 after a single or two quadrant D4342 visit. Reimbursement in this area is highly variable.
4. Scaling and root planing generally has a 24 to 36 month exclusion period for retreatment (a very few have a 12-month exclusion). Note: Scaling and root planing is typically excluded for 24 to 36 months after a gingival flap (D4240/D4241) or an osseous surgery (D4260/D4261) procedure is performed in the same area.
5. If both scaling and root planing (D4342) and a prophylaxis (D1110) are necessary, consider the sequence of a prophylaxis *first* (at the doctor's discretion), with scaling and root planing at a second visit. Wait six weeks prior to the D4342 visit. This sequencing is beneficial in that it gives the hygiene team more time to educate the patient about periodontal disease, making it clear that more extensive therapy is needed to arrest the bacterial infection in the remaining areas. If D4342 is performed *first*, there could be a ninety-day contract limitation that would affect reimbursement for either a subsequent prophylaxis (D1110) or periodontal maintenance (D4910).
6. Artificial Intelligence (AI) programs are now being used by many payors to measure bone loss on submitted radiographs. Many are requiring 2mm of bone loss from the CEJ to the crest of bone to consider the site for reimbursement.

TIPS

1. D4921 reports gingival irrigation, per quadrant. Payors typically consider gingival irrigation to be a part of D4341, D4342 or D4910. The PPO contract may prohibit charging a separate fee for irrigation. See D4921 for comments, regarding the clinical use of irrigation.
2. Use D9910 to describe the application of desensitizing medicaments. Payors typically consider D9910 to be a global part of D4341, D4342 and D4910. The PPO contract may prohibit charging a separate fee for the application of desensitizing medicaments. See D9910 for comments.

NARRATIVES

1. A narrative should document evidence of *active* disease. Periodontal disease is episodic - it comes and goes. This may include, but is not limited to: 4mm or greater pockets that bleed on probing, radiographic evidence of bone loss, gingival recession, furcation involvement, inflammation, tooth mobility, subgingival calculus, and suppuration. Enclose diagnostic radiographic images to document bone loss. Also send a current periodontal chart which includes the date(s) that the chart was recorded.

2. When scaling and root planing all four quadrants on the same day, include a narrative to document the reason all four quads were treated in the same day, time spent, anesthesia required, pre-medication, apprehensiveness, medical conditions, travel time, etc. Include any supporting documentation that might justify the treatment of all four quadrants on the same service date. Generally speaking, thirty to forty-five minutes or more would be required to complete each quadrant of D4342. A predetermination is highly recommended.

3. If teeth #'s 4 and 5 need SRP one year after teeth #'s 2 and 3 have been treated with SRP, the 24 to 36 month frequency limitation may apply. If reimbursement is initially denied when reporting D4342 for #4 and #5, appeal the denial with an explanation. To aid in this process always include a list of the teeth treated with SRP on the claim form when submitting D4342 even though not necessarily required. Attach a copy of the original D4342 claim form reporting the treatment of teeth #'s 2 and 3 when submitting the subsequent D4342 claim for treatment of #'s 4 and 5. Including the documentation of the first treatment visit may increase the chances of being reimbursed for the second treatment visit.

4. When a patient requires scaling and root planing on one to three teeth in the same quadrant and prophylaxis on the remaining quadrants, and both D4342 and D1110 are provided on the same day, reimbursement for the prophylaxis is usually denied. Always appeal with an explanation outlining circumstances and the time involved, D1110 may be reimbursed upon appeal.

5. Start and Stop times and types and amounts of local anesthetic are now required by certain payors on many periodontal procedures. Be sure to record this information in the clinical notation and subsequent narrative. Copies of the hygiene schedule from the date of service may even be requested.

D4346 SCALING IN PRESENCE OF GENERALIZED MODERATE OR SEVERE GINGIVAL INFLAMMATION - FULL MOUTH, AFTER ORAL EVALUATION

CDT 2025

The removal of plaque, calculus and stains from supra- and sub-gingival tooth surfaces when there is generalized moderate or severe gingival inflammation in the absence of periodontitis. It is indicated for patients who have swollen, inflamed gingiva, generalized suprabony pockets, and moderate to severe bleeding on probing. Should not be reported in conjunction with prophylaxis, scaling and root planing, or debridement procedures.



WARNING

D4346 does not define or report a "difficult prophy." A "difficult prophy" is D1110 taking a longer period of time and maybe requiring two visits. D4346 does not relate to the amount of time or effort required to complete the procedure. The D4346 procedure is applicable when it is used to treat generalized moderate or severe gingival inflammation in the absence of attachment loss. In other words, the procedure is based on the documented diagnosis rather than the intensity of treatment or the time required to complete the procedure.



WATCH

D1110 is applicable for patients with chronic or acute, mild or localized gingivitis (up to 30%), to prevent further progression of the disease, not as a treatment for periodontal conditions. D1110 supports good periodontal health and does not preclude further periodontal treatment.

D4355 enables a subsequent comprehensive oral evaluation (i.e., D4355 is performed upfront prior to the subsequent comprehensive periodontal evaluation appointment). D4355 is provided to remove gross deposits from the tooth surfaces that interfere with the ability of the dentist to perform a comprehensive periodontal evaluation. See D4355 for details.



MATCH

D4346 is a therapeutic service performed after a comprehensive oral evaluation (typically on the same day) has been completed and a diagnosis of *generalized* (more than 30%) moderate or severe gingivitis is made. D4346 is provided to remove all deposits and allows the tissue time to heal following the diagnosis of generalized moderate or severe gingival inflammation without attachment loss. Typically a prophylaxis (D1110) would follow D4346 at an interval set by the dentist (2 - 4 weeks). There is no bone loss with the D4346 patient.

COMMENTS

1. There has been an ongoing debate about how to code for those situations where the treatment is considered more than a prophylaxis, but not rise to the level of scaling and root planing (slight bone loss). When a patient presents with generalized moderate or severe gingival inflammation, but no bone loss, the time and effort needed to treat the condition is typically beyond the standard prophylaxis. The inflammatory condition can be chronic or acute, but it is important to note there are very specific diagnostic criterion for submission (generalized moderate or severe gingival inflammation [gingivitis]). The descriptor clearly indicates that this code should not be submitted with D1110, D4341, D4342, or D4355. In nearly every case, with appropriate treatment and improved hygiene, moderate or severe gingival inflammation is a reversible condition, so the subsequent maintenance visit (a few weeks later) would be reported using the conventional D1110. D1110 would follow D4346 at an interval deemed appropriate by the dentist (typically 2-4 weeks). Note: The existence of a code does not obligate the payor to necessarily reimburse it.

   The delivery of D4346 would only follow a diagnosis of generalized moderate or severe inflammation. Those definitions are generally accepted to be:

   A. The American Academy of Periodontology (AAP) defines generalized chronic periodontitis to be when 30% or more of the patient's teeth at one or more sites are involved, and it is reasonable to extend this definition to a patient with gingivitis.

   B. The Gingival Index of Löe and Silness defines gingival inflammation as follows:

      0 = normal inflammation

      1 = mild inflammation- slight change in color and slight edema but no bleeding on probing

      2 = moderate inflammation- redness, edema, glazing, and bleeding on probing

      3 = severe inflammation- marked redness and edema, ulceration with tendency to spontaneous bleeding

   C. This D4346 procedure is generally expected to be completed on a single date of service, but patient comfort and acceptance may require delivery over more than one visit. Should more than one visit be required, the date of completion is the date of service.

2. D4346 is a full mouth code and does not require reporting of an area of the oral cavity.

LIMITATIONS

1. D4346 is a fairly recent code, and as such reimbursement is not guaranteed. D4346 is generally followed by D1110, prophylaxis, after a short interval of several weeks. There is no set waiting period between D4346 and D1110. D4346 is a therapeutic procedure to bring the patient's periodontium back to a healthy status. Based on the patient's needs, the dentist is in the best position to determine when the patient can assume a regular preventive regimen following the performance of D4346 that would include an oral prophylaxis (D1110) subsequent to D4346.
2. D4346 often falls under the frequency limitations associated with prophylaxis, but not always. This may result in a future prophylaxis appointment not being reimbursed.
3. Some plans may reimburse D4346 at the D1110 level based on thier plan document language.

NARRATIVES

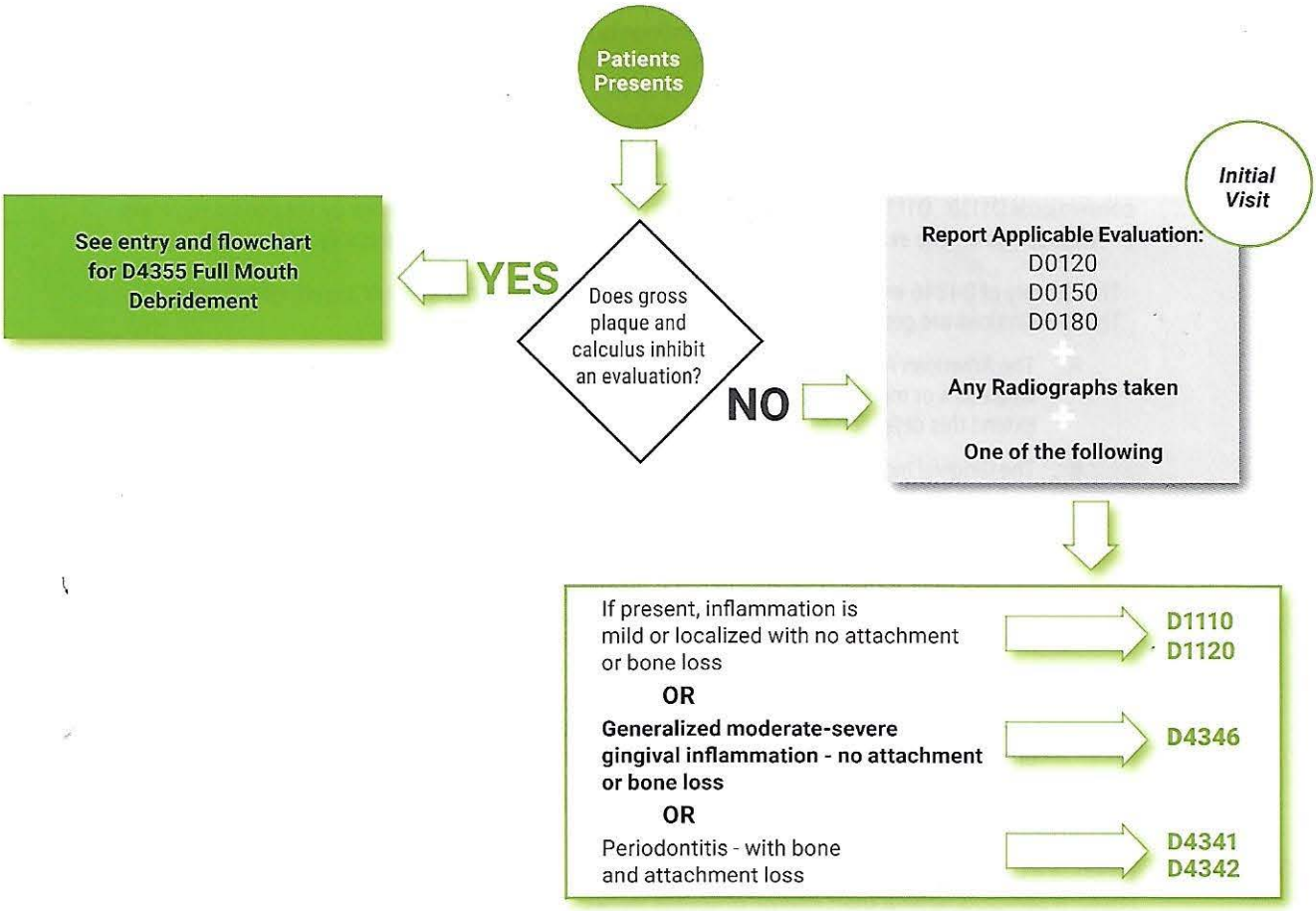
Narratives and supportive documentation should include:

a. Periodontal charting that records (pseudo) pocket depths and bleeding on probing. (Note: Pocket depth may be recorded without loss of attachment.)

b. Photographs are helpful to document the gingiva's condition (e.g., visualize localized vs. generalized inflammation) for retention in the patient's chart.

c. Radiographs are helpful to document no attachment loss.

d. A clinical evaluation is made with a diagnosis of generalized moderate or severe inflammation.



D4355 FULL MOUTH DEBRIDEMENT TO ENABLE A COMPREHENSIVE PERIODONTAL EVALUATION AND DIAGNOSIS ON A SUBSEQUENT VISIT

CDT 2025

WARNING

1. The full mouth debridement code (D4355) should never be reported on every new patient.
2. The full mouth debridement code (D4355) does not report "non-invasive chemical debridement." However, gingival irrigation – per quadrant is reported as D4921.
3. Evaluation codes available to report in conjunction with D4355 have changed as of January 2023. D4355 ADA Guide - Version 2 - January, 2023. Review watch, comments, limitations, and flowchart below.

WATCH

1. Full mouth debridement (D4355) is justified when a periodontal evaluation is warranted but cannot be performed with accuracy due to excessive and bulky calculus, heavy plaque, and debris buildup at the initial visit.
2. At a minimum, a cursory evaluation by the supervising clinician must be noted in the clinical notes to establish the necessity for a D4355. Alternatively, an assessment of a patient (D0191) or limited oral evaluation (D0140) may be performed prior to the debridement on the same date of service. The D0140 may be used to diagnose necessary restorative treatment and create a limited treatment plan until a subsequent evaluation is performed.
3. Ideally, and in most cases, a subsequent visit should be scheduled after a period of healing to obtain accurate periodontal probing and charting along with a comprehensive evaluation. The subsequent visit would preferably be a comprehensive periodontal oral evaluation (D0180) if appropriate, but could be a D0150 or even a D0120 (if it is a patient of record within the last three years) as long as all the components of those code descriptors are met. The sufficient healing time between the D4355 and the subsequent visit evaluation is at the clinical judgment of the clinician, but is often 14 days.

4. In certain cases, for example where there are access to care issues, a D0120 or D0150 may now be performed immediately after the D4355 on the same date of service, as long as all the components of those code descriptors are met. Note that the language in the previous descriptor of D4355, "Not to be completed on the same day as D0150, D0160, or D0180," has been deleted, along with the rest of the descriptor. Also note that the comprehensive periodontal evaluation (D0180) may NOT be performed on the initial visit along with D4355. It must be performed on a subsequent visit. A dentist's selection of the oral evaluation code to report is guided by the descriptor and the scope of the service delivered.
5. If a D0140 or D0191 was performed at the **initial** visit in conjunction with D4355, then report D0120, D0150, or D0180 for the **subsequent** visit. A D0120 is reported for patients of record who have been seen within the last three years.
6. There is no separate code for periodontal probing and charting. If a D0120 or a D0150 were completed in conjunction with D4355 at the initial visit but the periodontal charting and probing cannot be completed until the subsequent visit, then you may report a D0171 (re-evaluation – post-operative visit) or a D0999 (unspecified diagnostic procedure, by report) at the subsequent visit. Generally, this is a no-fee situation and is used to document and record the patient visit.
7. Diagnostic radiographs may be taken **after** the debridement (D4355) on the initial visit or at the subsequent visit, at the discretion of the dentist. **NOTE:** To ensure radiographs are of diagnostic quality, they should be taken **after** the completion of D4355 to avoid calculus obstruction.
8. **NOTE** that D0180 comprehensive periodontal evaluation may be used with patients where signs and symptoms of periodontal disease exist, or who have risk factors such as, but not limited to, smoking and/or diabetes. If the dentist determines the extent of plaque and/or calculus is itself a periodontal risk factor, that would be a basis for reporting a D4355 procedure followed by a subsequent D0180 evaluation. See D0180.
8. D4355 is not a definitive treatment. It is preparatory and preliminary in nature. The procedure is performed to remove calculus to the extent that diagnostic radiographs can be taken and enable the dentist to perform a subsequent comprehensive periodontal evaluation (D0180) if appropriate. Although the D4355 makes it possible to perform a D0180 at the subsequent visit, the appropriate evaluation is guided by the descriptor and the scope of the service.
10. The patient may or may not require subsequent active periodontal treatment. If the dentist determines that the extent of plaque and/or calculus is itself a periodontal risk factor, that would be a basis for reporting a D4355 procedure followed by a subsequent D0180 evaluation. Once the appropriate initial evaluation is completed, the patient may receive either a prophylaxis (D1110/D1120), scaling in presence of generalized moderate or severe gingival inflammation (D4346), scaling and root planing (D4341/D4342), or referral to a periodontist, depending on the dentist's definitive diagnosis of their periodontal health.
11. It is misleading to report D4355 following periodontal maintenance (D4910), unless the patient has been absent from the practice for such a long period that a new periodontal oral evaluation cannot be performed due to excessive plaque and calculus that interferes with the ability of the dentist to perform a comprehensive periodontal oral evaluation.

COMMENTS

1. **Due to the confusing nature of D4355, careful attention to the information provided for this code entry is critical.**
2. If the intent is to:
    a. **enable a comprehensive periodontal evaluation**, even if the gross plaque and/or calculus that inhibits the comprehensive periodontal evaluation is only localized to one area of the mouth, report D4355 as long as the full mouth is debrided.
    b. **treat a localized area of dental pain** (partial mouth debridement) as reported by the patient, reporting palliative (D9110) may possibly be reimbursed. If reimbursed, it generally reimburses at a lower fee than D4355. The use of the palliative D9110 code may result in payment for non-PPO contracted offices since the patient pays any balance of the fee. See D9110.

LIMITATIONS

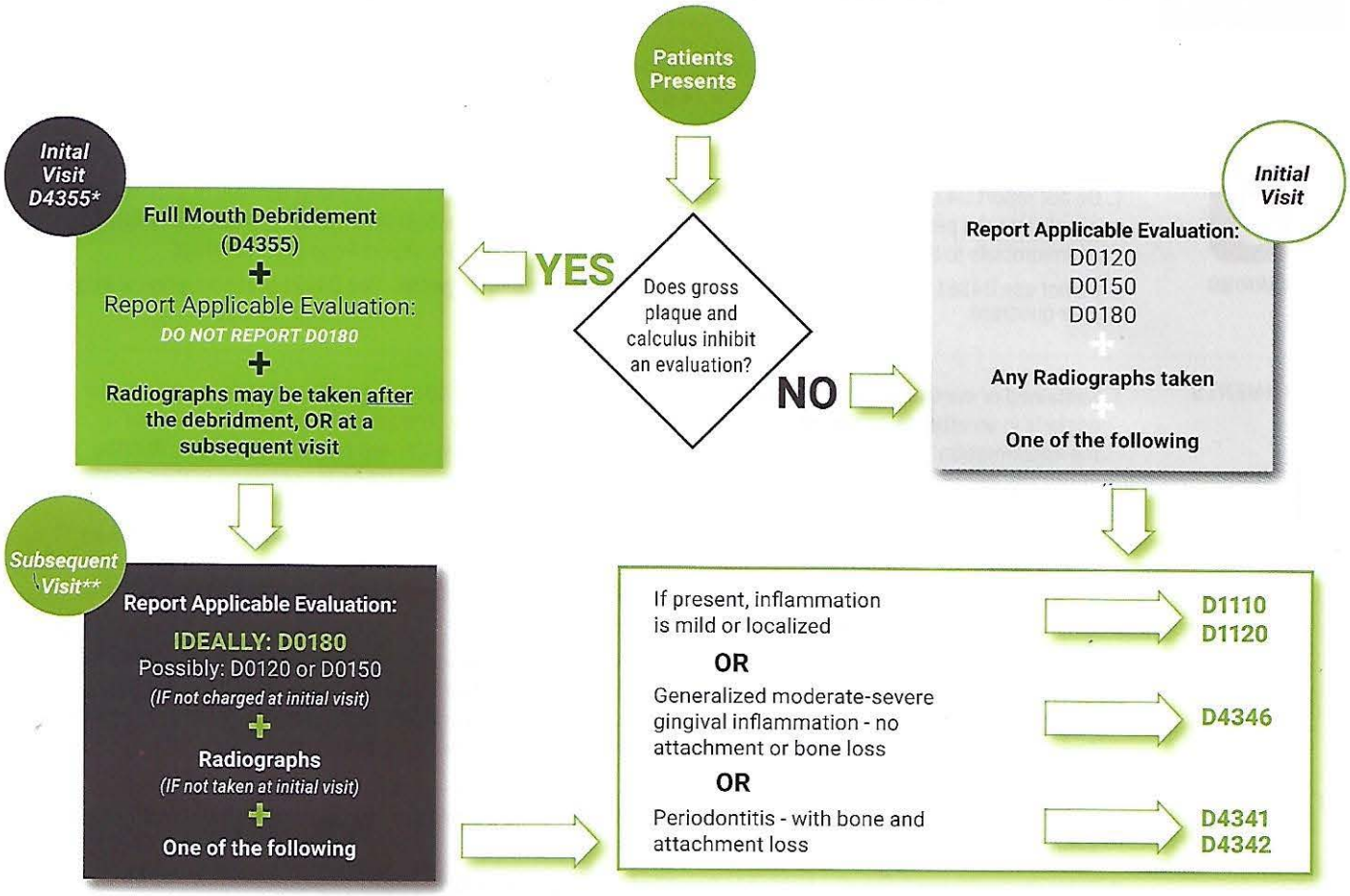
1. If a patient presents with gross plaque and calculus that inhibits a periodontal evaluation, a D4355 full mouth debridement should be performed. In order to establish the need for FMD, a D0191 assessment or a D0140 limited oral evaluation may be performed prior to the D4355. Reporting D0140 on the initial visit may provide the best opportunity for reimbursement, but may "use up" an evaluation. Depending on the payor, the D0191 may reimburse at a lower level than the D0140, if at all.
2. A narrative should be included with the reporting of D4355, as outlined in the next section.
3. Ideally, and in most cases, a subsequent visit should be scheduled after a period of healing to obtain accurate periodontal probing and charting in conjunction with a patient-appropriate evaluation. This subsequent visit would ideally be a D0180 if appropriate, but could possibly be a D0120 (for a patient of record seen within the last three years) or a D0150, as long as all the components of those code descriptors are met. A dentist's selection of the oral evaluation code to report is guided by the descriptor and the scope of the service delivered.
4. In certain cases, for example where there are access to care issues, a D0120 or D0150 may now be performed immediately AFTER the D4355 on the same date of service, as long as all the components of those code descriptors are met. A dentist's selection of the oral evaluation code to report is guided by the descriptor and the scope of the service delivered.
5. Reporting a D0180 for a new patient on the subsequent visit may provide the best opportunity for reimbursement. However, a D0150 may be more appropriate if the services provided better match the descriptor of that code. A D0120 could be reported for the subsequent visit for patients who have been seen in the last three years. If a D0140 or D0191 was reported on the initial visit for D4355, then report D0120, D0150, or a D0180 for the subsequent visit.
6. After proper diagnosis, the patient can then receive a D1110/D1120 (if inflammation is mild or localized), D4346 (if inflammation is generalized moderate to severe with no bone loss), or D4341/D4342 (if bone loss is present).
7. When D4355 is reimbursed, it may be classified as preventive, basic, or major. In some cases, a plan deductible and/or co-pay may apply. Plan limitations are highly variable.
8. Diagnostic radiographs may be taken immediately after the completion of D4355 on the initial visit, or they may be taken on the subsequent visit at the discretion of the dentist. Generally, diagnostic radiographic images may be taken at the initial visit in conjunction with the full mouth debridement (D4355) without negatively affecting reimbursement. There may be exceptions.
9. Plan limitations regarding the frequency of full mouth debridement (D4355) are highly variable. Limitations vary from "once per lifetime" to once every three to five years.
10. Improper sequencing of reported CDT codes may result in delays, denials, re-mapping, or limiting your overall reimbursement.
11. Some payor's processing policies remap a D4355 to a prophy (D1110) as an alternative benefit and may not reimburse a subsequent prophy for at least six months.

NARRATIVES

A narrative should be used when reporting D4355. That narrative might read:

Required to allow comprehensive periodontal evaluation due to excess plaque and/or calculus

(Document heavy plaque and/or calculus with intraoral photographs and include as attachment)



***Initial Visit D4355:**

Reporting a D0140 on the initial visit may provide the best opportunity for reimbursement. D0191 should be documented in the clinical notes if an evaluation is not being charged. A D0120 or a D0150 may be reported when access to care issues make a subsequent visit difficult.

Do NOT report D0180 at the initial visit. This "is a procedure that may only be delivered and reported on a subsequent date of service, not on the same date as delivery of a full mouth debridement (D4355) procedure."

- Reference: D4355 ADA Guide Version 2. January, 2023.

****Subsequent Visit:** Ideally reporting a D0180, or a D0150, for a new patient at the subsequent visit may provide the best opportunity for reimbursement. However, a D0120 could be reported for patients who have been seen in the last three years. If a D0140 or D0191 was charged at the initial visit, then report D0120, D0150, or a D0180 at the subsequent visit (as applicable).

There is no separate code for periodontal probing and charting. If a D0120 or a D0150 were completed in conjunction with D4355 at the initial visit but the periodontal charting and probing cannot be completed until the subsequent visit, then you may report a D0171 (re-evaluation – post-operative visit) or a D0999 (unspecified diagnostic procedure, by report) at the subsequent visit. Generally, this is a no fee situation and is used to document and record the patient visit.

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

CDT 2025

FDA approved subgingival delivery devices containing antimicrobial medication(s) are inserted into periodontal pockets to suppress the pathogenic microbiota. These devices slowly release the pharmacological agents so they can remain at the intended site of action in a therapeutic concentration for a sufficient length of time.



WARNING

1. Do not report D4381 to describe the use of Perio Protect®. D4381 reports the *localized* delivery of antimicrobial agents into the periodontal pocket. The Perio Protect® method utilizes custom trays to facilitate the delivery of antimicrobials to the *entire* upper and lower arches. Use D5995/D5996 to report Perio Protect® trays.
2. Do *not* use D4381 to report chlorhexidine or other medicinal agent irrigation. See D4921 to report gingival irrigation - per quadrant.

COMMENTS

1. Sustained or controlled releases LDAAs (local delivery antimicrobial agents) are placed in deep periodontal pockets in an attempt to reduce the bacterial load in the pocket area. Reducing the bacteria will reduce the inflammation. LDAAs come in the form of powders, gels, or thin wafer-like chips (e.g., Atridox, Arestin, PerioChip, etc.). The American Academy of Periodontology's position on LDAAs is contained in their "Statement on Local Delivery of Sustained or Controlled Release Antimicrobials as Adjunctive Therapy in the Treatment of Periodontics" (May 2006): "Clinicians may consider the use of LDAAs in chronic periodontitis patients as an adjunct to SRP when localized recurrent and/or residual pocket depth greater than or equal to 5mm with inflammation is still present following conventional therapies." The conventional therapies referred to in this quote are scaling and root planing (D4341/D4342).
2. D4381 is reported on a *per tooth* basis. The fee for each tooth should vary by the *number of sites* treated. A flat rate (per site) or sliding scale may be used to set the fee. The narrative should document that the fee is based on number of sites treated. Many payors limit the total payor's fee to one-half of a quadrant SRP reimbursement. Sometimes there is a reimbursement limitation to two or three teeth per quadrant.
3. Chemotherapeutic agents may be used as appropriate to reduce the quantity of microbial pathogens, or to alter the host response through local delivery. D4381 specifies a controlled release vehicle for the delivery of antimicrobial agents.
4. Enter the tooth number being treated in Box 27 of the 2024 Dental Claim Form.

LIMITATIONS

1. Some plans do not provide benefits for local delivery of antimicrobial agents. Generally, to qualify for reimbursement, patients must have moderate to severe periodontal disease and a history of scaling and root planing (SRP) or current treatment of active periodontal disease. Comparative periodontal charting can be helpful in demonstrating conventional therapy (SRP) has not been effective. Be aware that while a few dental plans pay for D4381 when placed at the time of root planing and scaling (SRP), most limit reimbursement for D4381 to areas that continue to bleed on probing at least six weeks following SRP therapy, and generally at the D4910 visit.
2. In some cases, D4381 may be considered a "take back" code by some payors. If osseous surgery (D4260/D4261) is initiated within 12 months of reporting D4341, the fee reimbursed for osseous surgery may be reduced by the amount previously reimbursed for D4381. Reimbursement for D4381 is highly variable among payors.
3. D4381 reimbursement for the same site may be denied for up to 24 months following the initial treatment. Some payors reimburse D4381 on an annual basis. Reimbursement for D4381 is highly variable.
4. When submitting D4381 with a pre-determination, indicate the time interval anticipated between the SRP visit and proposed D4381 treatment date. A six-week minimum after SRP may be required.
5. The insured's medical pharmacy benefit may pay for the antimicrobial agent. Contact an Arestin® representative for further information regarding medical insurance billing.
6. Report D4381 for placement of only FDA approved localized antimicrobial agents such as Arestin®, PerioChip®, and Atridox®. The descriptor of D4381 requires that the agent must be "FDA approved" - so homebrew treatment (non FDA approved) cannot be reported. D4381 is an adjunct to D4341, D4342, or D4910. D4381 is also an adjunct to the prophylaxis (D1110) when used to treat a few isolated pockets. Note: D4381 may *not* be reimbursed if placed at the *initial* scaling and root planing (D4341/D4342) appointment. The patient is usually required to pay out of pocket for the first application, if placed at the initial scaling and root planing (D4341/D4342) appointment. D4381 is most often reimbursed when utilized at the six week evaluation appointment after SRP. D4381 may be reimbursed if placed at a subsequent ongoing periodontal maintenance (D4910) visit when provided in conjunction with site specific scaling and root planing procedures performed to treat unresponsive pockets. Some payors require that the patient be six weeks post SRP before reimbursing D4381. It is recommended that coverage and limitations be verified with the payor before providing D4381.

NARRATIVES

1. The narrative should document that initial scaling and root planing (SRP) *did not resolve* all the pockets. Also mention the actual medication, not the trade name (Minocycline HCL, not Arestin®.) Documentation such as SRP history, charting at all visits, diagnosis, loss of attachment, radiographic evidence of bone loss, bleeding on probing, dates of re-evaluation, etc., with ongoing periodontal charting is typically required. Also, document the desired outcome of the procedure, as well as including any contributing medical factors such as diabetes, heart disease, surgical candidate for hip replacement, etc. If D4381 is used in an attempt to avoid osseous surgery, also *indicate this intent* in the narrative.
2. A narrative should always be submitted when reporting D4381 in association with a periodontal abscess, for possible reimbursement. See table below for documenting D4381 on the ADA Dental Claim Form.

   Documenting on the ADA Dental Claim Form:

   Record of Services Provided

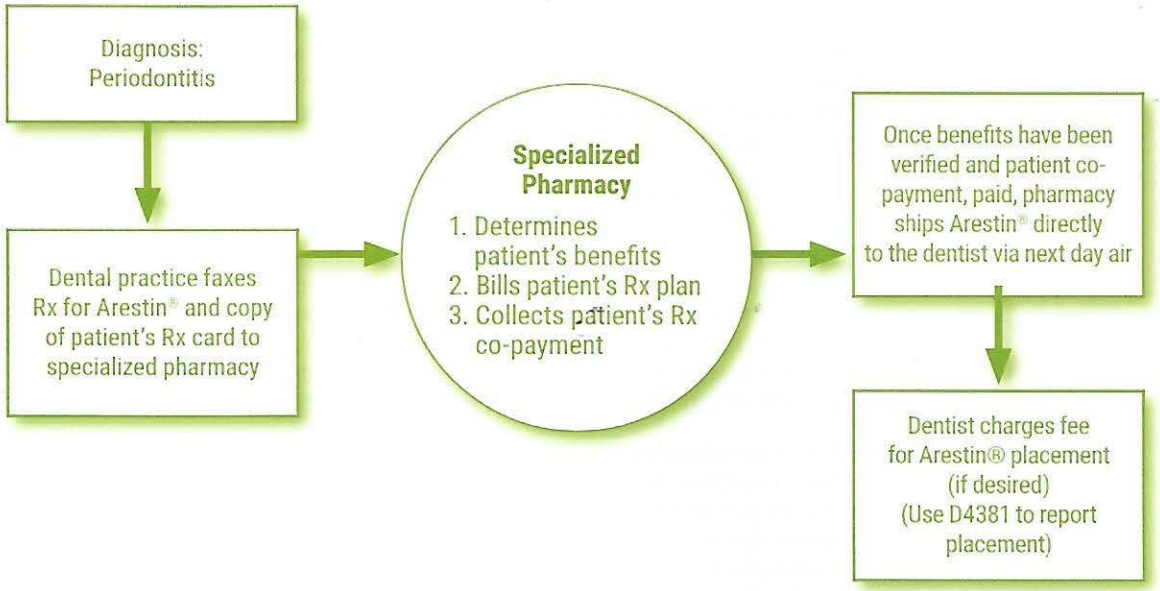
Procedure Date	Tooth Number	Procedure Code	Description	Fee
mm/dd/yy	13	D4381	Localized Delivery	$30
mm/dd/yy	14	D4381	Localized Delivery (2 sites)	$60
mm/dd/yy	15	D4381	Localized Delivery	$30
mm/dd/yy	30	D4381	Localized Delivery	$30

   Remarks: "6mm MB site of #13, 5mm DB and 7mm MB site of #14, 6mm ML site of #15 and 6mm DL site of #30. The fee listed reflects material costs and number of sites treated. Minocycline HCL micro spheres applied."

   Enclosures: Probing charts of mm/dd/yy and mm/dd/yy and radiographs.

3. Reimbursement for D4381 often requires *unresponsive* 5mm to 7mm pockets at least six weeks after SRP, loss of attachment or bone loss, bleeding on probing (BOP). This is indicative of *active* periodontal disease. These unresponsive areas should be limited to two to three specific teeth treated per quadrant. In addition, any increasing pocket depth readings after scaling and root planing (SRP) should be noted. "See attached pre-operative and post-operative periodontal charting." Be sure to document any systemic medical issues, such as diabetes, heart disease, etc.
4. If the Arestin® or other FDA approved agent is furnished by the patient's medical pharmacy benefits, the dentist charges a *placement* fee, reporting D4381. The placement (labor) fee would be less and typically limited to two teeth per quadrant. Full documentation would need to be provided as outlined in the narrative above.

CLINICAL FLOW CHARTS



D4910 PERIODONTAL MAINTENANCE CDT 2025

This procedure is instituted following periodontal therapy and continues at varying intervals, determined by the clinical evaluation of the dentist, for the life of the dentition or any implant replacements. It includes removal of the bacterial plaque and calculus from supragingival and subgingival regions, site specific scaling and root planing where indicated, and polishing the teeth. If new or recurring periodontal disease appears, additional diagnostic and treatment procedures must be considered.

Note: Periodontal maintentance includes implant crowns.



WATCH

1. Ongoing periodontal maintenance (D4910) does *not* include the periodic oral evaluation (D0120) or comprehensive periodontal evaluation (D0180). The periodic oral evaluation (D0120) or D0180 is submitted as a separate procedure on the same date of service. The oral evaluation (D0120 or D0180) is generally provided twice per year, and is subject to the typical "one evaluation per six months" or "two evaluations per year" limitation. For a comprehensive periodontal evaluation of an *established periodontal* patient provided on a periodic basis consider reporting D0180. Note: The reimbursement for D0180 might be re-mapped as D0120 and may create patient confusion. If the more extensive and time consuming D0180 is performed, report what you do.
2. Some offices report one D0180 and one D0120 per year for periodontal recall patients. Some offices have two consistent, but different, fee levels for D0180, depending on whether the procedure is provided for the new (entering the practice) or established (recall) D4910 patient. For instance, the D0180 fee for recall might be $12-$15 higher than the D0120 fee. See D0180 for details.



MATCH

1. Periodontal maintenance (D4910) *follows* active periodontal therapy: scaling and root planing procedures (D4341/D4342), gingival flap surgery (D4240/D4241) or osseous surgery (D4260/D4261). The periodontal maintenance patient (D4910) must have undergone *either* SRP *or* periodontal surgery (gingival flap or osseous surgery) *prior* to periodontal maintenance (D4910). Periodontal maintenance (D4910) is *ongoing and therapeutic* in nature, not *preventive*. It includes implant crowns. Typically there is a ninety day exclusion period following *active* treatment. Active periodontal treatment may be reported as D4341, D4342, D4240, D4241, D4260, or D4261. If a recare appointment is provided to evaluate tissue healing after SRP within the ninety day exclusion period, consider reporting D0171 re-evaluation - post operative. See D0171.

   The ongoing periodontal maintenance (D4910) interval is typically ninety days but the frequency is determined by individual need. Some authorities deem it improper for the same practitioner to alternate D4910 with a prophylaxis (D1110). However, a patient alternating between the GP and periodontist might receive alternating D1110s and D4910s. The periodontist could provide ongoing periodontal maintenance (D4910) while the GP office provides prophylaxis in support of good periodontal health. Prophylaxis is preventive in nature and is not a statement of oral health. It therefore does not preclude subsequent periodontal therapy. Be advised, however, that very few payors *terminate* D4910 coverage if prophylaxis (D1110) is provided in the periodontal treatment sequence. Some payors assert that the patient cannot be a periodontal patient one visit, and a prophy visit the next, alternating between a diseased and healthy state, while other payors could care less, and often encourage it.

2. Once the patient is in ongoing periodontal maintenance (D4910) following active periodontal therapy, they could remain in D4910 status. While bone loss is irreversable, active periodontal disease is *episodic*. It can come and go. If the patient's periodontal status improves (to good health), then a return to regular prophylaxis (D1110) could be appropriate. This change may occur; however it may take one year or more for the issue to resolve following root planing and scaling (D4341) therapy. This change from periodontal disease to health is not the rule, but the exception. When the patient moves from periodontal disease to a condition of health and prophylaxis (D1110) is provided, then a subsequent sequence of SRP (D4341/D4342) could be required before D4910 would be reimbursed again. SRP (D4341 or D4342) typically has a twenty four or thirty six month frequency limitation with most plans.
3. Although most periodontal patients will require periodontal maintenance for a lifetime, the American Dental Association's Council on Dental Benefit Programs gives dentists some discretion when reporting D1110 and D4910. Per the CDT 2025 Coding Companion: "If the dentist determines that the patient's periodontal health can be augmented with periodic routine prophylaxis procedures (removal of plaque, calculus and stains from the tooth structures for the purpose of controlling local irritational factors), then this service should be performed and reported as D1110 or D1120, depending on the state of the dentition". *Nothing in D4910 or D1110/D1120 code nomenclatures or descriptors make these procedures mutually exclusive.*

COMMENTS

1. Patients who require periodontal maintenance have periodontal disease and have been treated non-surgically (D4341/D4342) and/or surgically (D4240/D4241 or D4260/ D4261). Periodontal maintenance is performed in the presence of active disease whereas a prophylaxis (D1110) is performed to *prevent* disease but does not mean no disease is present. D4910 is performed to maintain the periodontal condition of the patient as a result of prior nonsurgical and/or surgical periodontal treatment. Periodontal maintenance includes removing any new plaque and calculus that may have formed since the patient's last periodontal therapy appointment as well as site specific scaling and root planing where indicated, and polishing the teeth. The descriptor clearly states D4910 does not preclude the need for additional diagnostic and treatment procedures if new or recurring periodontal disease develops. Additional scaling and root planing, locally delivered antimicrobials (D4381), or periodontal surgery may be necessary when there is evidence of new disease that presents subsequently.
2. D4910 is a full mouth code and does not require reporting of an area of the oral cavity.

LIMITATIONS

1. Reimbursement for ongoing periodontal maintenance D4910 is highly variable. Some plans may not reimburse D4910 at all or some may reimburse D4910 two to four times during a 12-month period. The average policy provides reimbursements for two D4910 *and* two prophylaxes (D1110) during a 12-month period. Even though the contract reimburses certain procedures at a frequency greater than every six months, you are bound to always report **what you do**. Since plan limitations are highly variable when providing D4910, request an alternate benefit of a prophylaxis (D1110) in the event D4910 is not a covered benefit. Benefits are highly variable. Some plans will provide reimbursement more frequently for diabetic or pregnant patients.
2. Some payors (i.e., some Deltas) will pay D4910 indefinitely. Many other payors may only pay D4910 for a limited period of 24 or 36 months and then the patient must requalify for SRP. If they do requalify for SRP after 24 or 36 months, then typically SRP is reimbursed and can then again be followed by D4910.
3. D4910 may be reimbursed at a 50-80% fee (unlike the typical payor's 100% reimbursement fee for a prophylaxis), and may also be subject to a deductible. Payors may reimburse D4910 as preventive, basic or major. Reimbursement for D4910 is highly variable.
4. A prophylaxis (D1110) may be considered a part of D4910 by payors in the ongoing periodontal maintenance regimen. The clinical record should reflect the fact that a prophylaxis (scaling and polishing) was completed as part of the overall D4910 procedure.
5. Some payors require that only osseous surgery (D4260/D4261) qualifies for D4910 reimbursement. However, in general SRP treatment will qualify for ongoing periodontal maintenance (D4910) reimbursement.
6. D4921 reports periodontal pocket irrigation using medicinal agents, e.g., chlorhexidine, per quadrant. However, payors typically consider gingival irrigation a part of the global D4910. PPO contracts may disallow for the use of gingival irrigation in periodontal maintenance. See D4921 for comments.
7. D9910 describes desensitizing medicaments applied to a single tooth or up to the entire mouth. Payors typically consider the application of desensitizing medicaments to the entire mouth a part of the global D4910. PPO contracts may disallow for the use of D9910 with periodontal treatments.

NARRATIVES

1. If *benefit plans change administrators or there is change in employment*, it is important to provide the new payor a narrative for the *first* D4910 claim (to turn the periodontal coverage switch "on") describing a history of active therapy (scaling and root planing (SRP) or osseous surgery). Provide the same information from the patient's history when the patient returns from the periodontal office. When previous periodontal treatment history is not noted in the "remarks" section, D4910 may be *denied* by the subsequent plan. For documentation, submit current periodontal charting and a narrative stating that the patient is in ongoing periodontal maintenance therapy and the date of active treatment.
2. Consider filing a claim when reporting D4910 with the following narrative: "If periodontal maintenance (D4910) is denied, please provide the alternate benefit of a prophylaxis (D1110). The ongoing periodontal maintenance (D4910) visit included a prophylaxis (D1110)." The clinical notes should reflect the fact that a prophylaxis was provided as a part of the D4910 procedure. Because payors consider D1110 a part of periodontal maintenance, expect reimbursement of the *alternate* benefit of a prophylaxis.
3. When submitting the initial D4910 claim, identify the date that active treatment SRP or osseous surgery was performed. Include a current periodontal chart with a claim of D4910. Consider a narrative: "This patient underwent SRP on mm/dd/yy" or "This patient underwent osseous surgery on mm/dd/yy at Dr. Smith's office." State which quadrants had SRP and on what date. "See attached periodontal chart."

D4920 UNSCHEDULED DRESSING CHANGE (BY SOMEONE OTHER THAN TREATING DENTIST OR THEIR STAFF) CDT 2025

COMMENTS

1. When periodontal surgery is performed, a periodontal dressing is often placed over the surgical area to protect the site while healing. The dressing may look like Silly Putty,® but it provides important protection to the surgical area for healing. The dressing is used to inhibit bacterial growth, prevent irritation of the area, and makes the surgical site more comfortable for the patient during the healing process. The surgical dressing is resilient and usually stays in place until removed by the dentist who performed the surgery. The dressing may loosen prematurely and need replacing. If the dentist who did the surgery (or the staff) is not available, another dentist, in another office, can replace the dressing and report D4920 to describe the procedure.
2. Enter the tooth number or tooth number range being treated in the appropriate boxes of the 2024 Dental Claim Form.

LIMITATIONS

This dressing change may be reimbursed if provided by an office other than the office that did the original surgery and initially placed the dressing.

NARRATIVES

When a dressing is changed by a different dentist (or staff) at a different location, a brief narrative should explain the circumstances.

D4921 GINGIVAL IRRIGATION WITH A MEDICINAL AGENT - PER QUADRANT CDT 2025



WARNING

1. Non-invasive chemical debridement or over the counter mouth rinses should not be reported as D4921.
2. Therapeutic parenteral drug (D9610) should not be reported for gingival irrigation with a medicinal agent - per quadrant.
3. Drugs or medicaments dispensed in the office for home use (D9630) should not be reported for gingival irrigation with a medicinal agent- per quadrant.

COMMENTS

1. Gingival irrigation is used as an adjunct by many practitioners to assist in prophylaxis and periodontal treatment protocols. The procedure delivers a prescription medicinal agent (such as chlorhexidine/Peridex®) into instrumented gingival pockets to help control periodontal disease and gingival inflammation.
2. D4921 is reported *per quadrant*, regardless of the number of teeth and/or sites treated.

LIMITATIONS

1. D4921 reports gingival irrigation with a medicinal agent, per quadrant. Payors typically consider gingival irrigation to be a part of the global fee for D1110, D4341, D4342, D4346, or D4910 procedures. The PPO contract may specifically prohibit charging a separate fee for irrigation. Thus, the PPO considers gingival irrigation to be a part of the global service and the procedure is disallowed, meaning you may not charge the patient.
2. D4921 may not be reimbursed by payors.

D4999 UNSPECIFIED PERIODONTAL PROCEDURE, BY REPORT CDT 2025

Use for procedure that is not adequately described by a code. Describe procedure.

COMMENTS

1. D4999 reports procedures not adequately described by an existing periodontal code.
2. Use D4999, by report for the following periodontal-related procedures that have no specific reporting code:

    a. Periodontal charting and probing. At the charting visit, there is no oral evaluation performed by the dentist. Charting and probing is considered to be inclusive of oral evaluations. D4999 may be reported to describe this charting procedure by a hygienist alone. However, D4999 is not usually reimbursed, and typically disallowed by PPO payors, meaning you may not charge the patient.

    b. Gross debridement to enable comprehensive oral evaluation when a comprehensive periodontal evaluation is not appropriate. This procedure may not be recognized as D4355 but may be considered as D4999 by a few payors. Call the payer to see if D4355 is benefitted. A payer might reimburse D4999. Provide a comprehensive narrative that accurately describes the service provided. Always report **what you do**. See D4355.

c. A "closed" hard tissue laser procedure such as clinical crown lengthening. Report D4999 with full narrative. In this scenario, there is no flap access as D4249's descriptor requires reflection of a full thickness flap. Report D4999 for the closed laser procedure but ask for the alternate benefit of D4249. See D4249 for full details. Payors reimburse according to the procedures performed, not for specific equipment or technology used to perform the procedure.

d. Gingival curettage. The former code for periodontal curettage D4220 was deleted January 1, 2008. D4999 would report curettage treatment. Gingival curettage is generally considered to be a part of the D4240, D4241, D4341 and D4342 procedures. Gingival curettage can be incidental to prophylaxis (D1110).

e. LANAP® (Laser Assisted New Attachment Procedure) or LAPIP/LAPIP (Laser Assisted Peri Implantitis Procedure). See LANAP comments at the beginning of the D4000 section for more information on use of lasers in periodontal treatments.

f. Use D4999 to report adjunctive laser therapy (decontaminating periodontal pockets). LAPT (laser assisted periodontal therapy) and LBR (laser bacterial reduction) are techniques that serve as an addition to a currently recognized procedure. The current CDT coding does not have a separate code for the addition of laser therapy to treatment, and recognizes laser as a tool in the delivery of the procedure. As such, there are no guidelines specific to the reporting of these techniques. You may report each of these techniques using D4999 unspecified periodontal procedure, by report. In the narrative, you should describe the areas treated and the services performed. It is perfectly "legal" to add this service, however reimbursement, or even the ability to charge this to the patient, are dependent on the contractual relationships with the payors.

IMPORTANT: See LANAP comments at the beginning of the D4000 section for more information on use of lasers in periodontal treatments.

g. D4999 may be used to report the application of Cervitec® Gel, when applied to treat a documented diagnosis of gingival inflammation.

3. D4999 is often used in error to report the following:
   a. Products that promote hemostasis by using a collagen matrix would be reported as D7922.
   b. See prescription strength chlorhexidine dispensed for home use, D9630.
   c. Perio Protect Trays® utilize a customized dental tray system used to direct medications (e.g., peroxide) into the gingival sulcus to help manage bioradiographic image. D5995/D5996 reports Perio Protect Trays®.

Local anesthesia is usually considered to be a part of removable prosthodontic procedures.

COMPLETE DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE) CDT 2025

D5110 COMPLETE DENTURE - MAXILLARY CDT 2025

WATCH

1. D5110 reports the delivery of a removable complete *maxillary* denture on an edentulous arch.
2. Do not report D5110 for an *immediate* denture. An *immediate* complete maxillary denture (D5130) or *interim* complete denture (D5810) is inserted immediately after the extraction of the remaining teeth. See both D5130 and D5810 for further details.
3. Do not report D5110 for an overdenture. See D5863 for overdenture - complete maxillary on natural teeth or D6110 for implant/abutment supported removable denture for edentulous arch - maxillary.

MATCH

1. For an *adjustment* of a complete maxillary denture (after six months delivery), see D5410.
2. For a *repair* of a maxillary complete denture *base*, see D5512. For a mandibular, see D5511.
3. For a *replacement* of *missing or broken* teeth (each tooth), see D5520.
4. For a *rebase* of a complete maxillary denture, see D5710.
5. For a *chairside reline* of a complete maxillary denture, see D5730.
6. For a *laboratory* processed hard *reline* of a complete maxillary denture, see D5750.
7. For cleaning and inspection of a removable complete denture - maxillary, report D9932.
8. To add a metal substructure to a new or existing acrylic full denture, per arch, report D5876.

LIMITATIONS

1. Diagnostic casts (D0470) are considered part of the global fee for a maxillary complete denture (D5110).
2. There is typically a five to 10-year exclusion period for a replacement denture. To justify the replacement, the documentation (narrative/photos) must demonstrate why the existing prosthesis cannot be made serviceable.
3. Follow up adjustments within six months of delivery are typically included in the fee for D5110, and are not reimbursed separately. Report D0171 for these post-delivery adjustment visits. An adjustment made by an office not having delivered the denture or after the initial six months period might be reimbursed using code D5410. See D5410.
4. Replacement of a lost denture is not reimbursed except following the typical 5 year exclusion period. Under these circumstances a new denture would be fabricated.

TIPS

1. A patient covered by a PPO plan may choose to pay extra for a "characterized," or a metal base, denture. Generally, the patient must sign and agree with the treatment plan, listing a separate line item (D5899), explaining the additional procedure or pre-authorize the higher fee with the PPO. Refer to your third party contract and their Processing Policy Manual to verify optional services and whether or not optional services are permitted. If there is a question, contact the payor for more information.
2. Use D5110 to report a complete upper denture with a cast metal palate.

PHOTO



This is a maxillary (D5110) complete denture.

Courtesy Drake Dental Lab

WATCH

1. D5120 reports the delivery of a complete *mandibular* denture.
2. Do not report D5120 for an immediate denture. An *immediate* complete mandibular denture (D5140), **or** *interim* complete denture (D5811) is inserted immediately after the extraction of the remaining teeth. See both D5140 and D5811 for further details.
3. Do not report D5120 for an overdenture. See D5865 for overdenture - complete mandibular on natural teeth or D6111 for implant/abutment supported removable denture for edentulous arch - mandibular.

MATCH

1. For an *adjustment* of a complete mandibular denture (after six months delivery), see D5411.
2. For a *repair* of a mandibular complete denture *base*, see D5511. For a maxillary, see D5512.
3. For a *replacement* of *missing or broken* teeth (each tooth), see D5520.
4. For a *rebase* of a complete mandibular denture, see D5711.
5. For a *chairside reline* of a complete mandibular denture, see D5731.
6. For a *laboratory* (processed) *reline* of a complete mandibular denture, see D5751.
7. For cleaning and inspection of a removable complete denture - mandibular, report D9933.
8. To add a metal substructure to a new or existing acrylic full denture, per arch, report D5876.

LIMITATIONS

1. Diagnostic casts (D0470) are considered part of the global fee for a mandibular complete denture (D5120).
2. There is typically a five to 10-year exclusion period for a replacement denture. To justify the replacement, the documentation (narrative/photos) must demonstrate why the existing prosthesis cannot be made serviceable.
3. Follow up adjustments within six months of delivery are typically included in the fee for D5120, and are not reimbursed separately. Report D0171 for post-delivery adjustment visits. An adjustment made by an office not having delivered the denture might be reimbursed.
4. Replacement of a lost denture is not reimbursed except following the typical five year exclusion period. Under these circumstances a new denture would be fabricated.

TIPS

1. A patient covered by a PPO plan may choose to pay extra for a "characterized," or a metal base, denture. Generally, the patient must sign and agree with the treatment plan, listing a separate line item (D5899), explaining the additional procedure or pre-authorize the higher fees with the PPO. Refer to your third party contract and their Processing Policy Manual to verify optional services and whether or not optional services are permitted. If there is a question, contact the payor for more information.
2. Report D5876 for adding a metal substructure to a new or existing denture.

PHOTO



This is a mandibular (D5120) complete denture.

Courtesy Drake Dental Lab

D5130 IMMEDIATE DENTURE - MAXILLARY CDT 2025

Includes limited follow-up care only; does not include future rebasing/relining procedure(s)

WATCH

1. It is proper to report an immediate denture (D5130) when extracting the remaining natural teeth (generally anterior) and immediately inserting the newly fabricated denture on the same date of service. D5130 includes follow up soft healing liners as a part of the global fee. D5130 is *followed*, at an additional fee, by one of these three procedures (*six month healing* is typically required by many payors before one of these subsequent services will be reimbursed):
   a. Reline (most common) - chairside (D5730) or laboratory processed reline (D5750).
   b. Rebase (D5710) (reimbursement at a higher payor's fee than a reline).
   c. *New* complete maxillary denture (D5110).
2. *Interim* complete denture (maxillary) (D5810) can also be provided immediately after extractions. An Interim denture may also be provided for a patient with *an edentulous* arch for a *limited* period awaiting a more definitive restorative procedure, such as a maxillary complete denture (D5110) or an implant/abutment supported removable denture. Use caution when reporting D5810. See tip #2 below.



MATCH

1. For an *adjustment* of an immediate maxillary denture (after six months delivery), see D5410.
2. For a *repair* of a maxillary immediate denture *base*, see D5512. For a mandibular, see D5511.
3. For a *replacement* of *missing or broken* teeth (each tooth), see D5520.
4. For a *rebase* of an immediate maxillary denture, see D5710.
5. For a *chairside reline* of an immediate maxillary denture, see D5730.
6. For a *laboratory* processed hard *reline* of an immediate maxillary denture, see D5750.
7. To add a metal substructure to a new or existing acrylic immediate denture, report D5876.

D5130

COMMENTS

1. The fee for D5130 does not include the follow up hard acrylic reline (D5730 or D5750) or rebase (D5710) procedure or a new complete denture. Many payors will reimburse a reline or rebase six months or more after the delivery of the immediate denture. Note: An alternate benefit (reline/rebase) may be applied toward a subsequent (new) complete denture if the alternate benefit is requested.
2. A hard acrylic reline, rebase, or a completely new denture follows six months after the immediate denture is delivered. The hard acrylic reline, rebase, or a completely new denture is reimbursable separately from the immediate denture. For the completely new denture, typically only an alternate benefit of a reline or rebase would be reimbursed.
3. 3D printed complete maxillary immediate dentures are reported using D5130.

LIMITATIONS

1. Diagnostic casts (D0470) are considered part of the global fee for (D5130).
2. Many payors require a six-month *healing* period after the insertion of an immediate maxillary denture before any subsequent prosthetic procedure is reimbursed for the upper arch. The healing interval begins with the *extraction* date. Normally the remaining teeth are extracted and the maxillary immediate denture is seated on the same appointment. The healing interval ends with the impression date for the subsequent reline, the rebase or for the completely new denture. Some payors require the reline be done within six months of the insertion date. Contact the payor regarding the reline policy for the plan.
3. Follow up adjustments within six months of delivery are typically included in the fee for D5130 and are not reimbursed separately. Report D0171 for post-delivery adjustment visits. An adjustment made by an office not having delivered the denture might be reimbursed.
4. Immediate dentures may be reported on the impression date, but some payors will only reimburse the procedure on the delivery date (when the teeth are extracted) and the immediate denture is seated. Most contracted dentists must report D5130 on the delivery date.

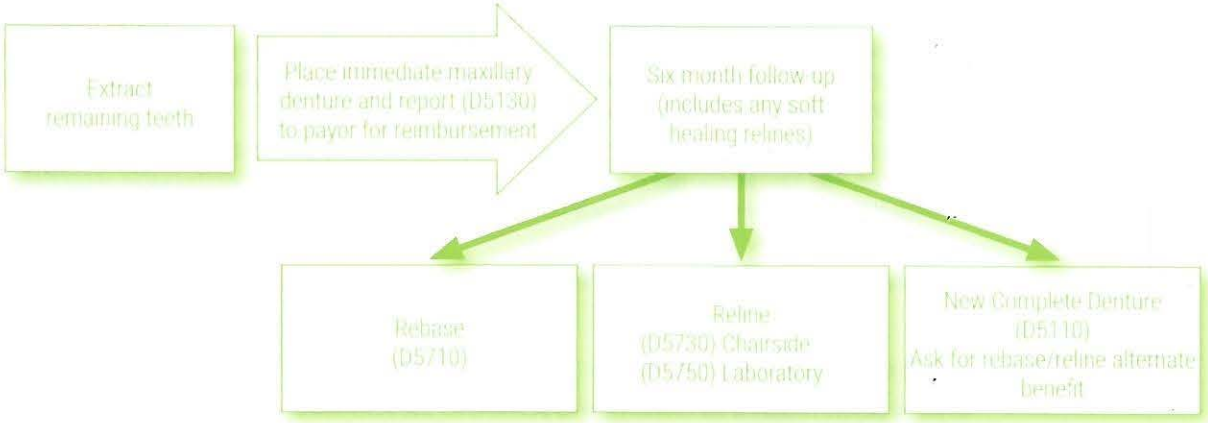
TIPS

1. The immediate denture (D5130) is generally delivered immediately after the extraction of the remaining natural teeth. The fee for immediate dentures is *higher* than a conventional denture. This fee includes healing relines and appropriate follow up care during the subsequent (up to) six-month healing phase. The reimbursement made by payors is typically higher for the immediate maxillary denture (D5130) than for the complete maxillary denture (D5110).

2. If both an immediate and a subsequent complete denture are fabricated, some payors will reimburse an alternate benefit of *either* a hard acrylic laboratory reline (D5750) or rebase (D5710) toward the *second* denture. If allowed, this scenario provides an overall higher reimbursement than the routine complete maxillary denture (D5110) reimbursed alone. Note: Many payors require that *at least* six months elapse between the service dates of the two dentures. The healing interval of the two service dates starts with the extraction (insertion) date and ends with the impression date for the subsequent reline or rebase of the immediate denture or a new complete denture. Reimbursement is maximized using this scenario rather than reporting the *interim* complete denture (D5810) first (with reimbursement), and then the complete denture (D5110) second (with no reimbursement). See also D5810.

CLINICAL FLOW CHARTS

Immediate (Maxillary) Denture Scenario



Steps:

1. An immediate maxillary denture (D5130) is inserted at the appointment when all remaining teeth are extracted. The immediate denture (D5130) fee is *inclusive* of up to six months of follow up care and includes any *healing* (soft) tissue relines.
2. The immediate denture is nearly *always* followed by *either* a rebase, reline, or a new complete maxillary denture (D5110). Some payors require a healing period of at least six months before any of these three post-delivery procedures will be considered for reimbursement.
3. Always consider filing the higher payor's fee for an immediate denture (D5130) first. If a new complete denture is necessary after healing, ask for the alternate benefit of a reline or rebase fee toward the new denture. This approach reports "what you do" and often results in a better and proper, higher reimbursement for the patient.

D5140 IMMEDIATE DENTURE - MANDIBULAR CDT 2025

Includes limited follow-up care only; does not include future rebasing/relining procedure(s).

WATCH

1. It is proper to report an immediate denture (D5140) when extracting the remaining natural teeth (generally anterior) and immediately inserting the newly fabricated denture on the same date of service. D5140 includes follow up soft healing liners as a part of the global fee. D5140 is *followed*, at an additional fee, by one of these three procedures (*six-month healing* is typically required):
   a. Reline (most common) - chairside (D5731) or laboratory processed reline (D5751).
   b. Rebase (D5711) (reimbursement at a higher payor's fee than a reline).
   c. *New* complete mandibular denture (D5120).
2. *Interim* complete denture (mandibular) (D5811) can also be provided immediately after extractions. An interim denture may also be provided for a patient with *an edentulous* arch for a *limited* period awaiting a more definitive restorative procedure, such as a mandibular complete denture (D5120) or an implant/abutment supported removable denture. Use caution when reporting D5811. See tip #2 below.

MATCH

1. For an *adjustment* of an immediate mandibular denture (after six months delivery), see D5411.
2. For a *repair* of a mandibular immediate denture *base*, see D5511. For a maxillary, see D5512.
3. For a *replacement* of *missing or broken* teeth (each tooth), see D5520.
4. For a *rebase* of an immediate mandibular denture, see D5711.
5. For a *chairside reline* of an immediate mandibular denture, see D5731.
6. For a *laboratory* processed hard *reline* of an immediate mandibular denture, see D5751.
7. To add a metal substructure to a new or existing acrylic immediate denture, report D5876.

COMMENTS

1. The fee for D5140 does *not* include the follow up hard acrylic reline (D5731 or D5751) or rebase (D5711) procedure or a new complete denture. Many payors will reimburse a reline or rebase six months or more after the delivery of the immediate denture. Note: An alternate benefit (reline/rebase) may be applied toward a subsequent (new) complete denture if the alternate benefit is requested.
2. A hard acrylic reline, rebase, or a completely new denture follows six months after the immediate denture is delivered. The hard acrylic reline, rebase, or a completely new denture is reimbursable separately from the immediate denture. For the completely new denture, typically only an alternate benefit of a reline or rebase would be reimbursed.
3. 3D printed complete mandibular immediate dentures are reported using D5140.

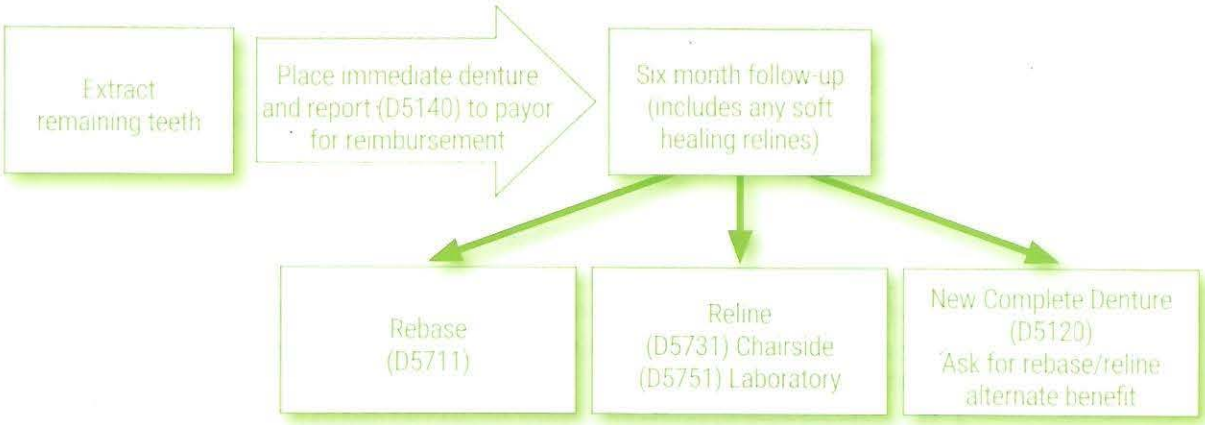
LIMITATIONS

1. Diagnostic casts (D0470) are considered part of the global fee for D5140.
2. Many payors require a six-month *healing* period after the insertion of an immediate mandibular denture before any subsequent prosthetic procedure is reimbursed for the lower arch. The healing interval begins with the *extraction* date. Normally the remaining teeth are extracted and the mandibular immediate denture is seated at the same appointment. The healing interval ends with the impression date for the subsequent reline, the rebase or for the completely new denture. Some payors require the reline be done within six months of the insertion date. Contact the payor regarding the reline policy for the plan.
3. Follow up adjustments within six months of delivery are typically included in the fee for D5140 and are not reimbursed separately. Report D0171 for these post-delivery adjustment visits. An adjustment made by an office not having delivered the denture or after the initial six months period might be reimbursed using code D5411. See D5411.
4. Immediate dentures may be reported on the impression date, but some payors will only reimburse the procedure on the delivery date (when the teeth are extracted) and the immediate denture is seated. Most contracted dentists must report D5140 on the delivery date as outlined in the PPO contract.

TIPS

1. The immediate denture (D5140) is generally delivered immediately after the extraction of the remaining natural teeth. The fee for immediate dentures is typically *higher* than a conventional denture. This fee includes healing relines and appropriate follow up care during the subsequent (up to) six-month healing phase. The reimbursement made by payors is typically higher for the immediate mandibular denture (D5140) than for the complete mandibular denture (D5120).
2. If both an immediate and a subsequent complete denture are fabricated, some payors will reimburse an alternate benefit of *either* a hard acrylic laboratory reline (D5751) or rebase (D5711) toward the *second* denture. If allowed, this scenario provides an overall higher reimbursement than the routine complete mandibular denture (D5120) reimbursed alone. Note: Many payors require that *at least* six months elapse between the service dates of the two dentures. The healing interval of the two service dates starts with the extraction (insertion) date and ends with the impression date for the subsequent reline or rebase of the immediate denture, or a new complete denture. Reimbursement is maximized using this scenario rather than reporting the *interim* complete denture (D5811) first (with reimbursement), and then the complete denture (D5120) second (for no reimbursement). See also D5811.

Immediate (Mandibular) Denture Scenario



Steps:

1. An immediate denture (D5140) is inserted at the appointment when all the remaining teeth are extracted. The immediate denture (D5140) fee is *inclusive* of up to six months of follow-up care and includes any *healing* soft tissue relines.
2. The immediate denture is nearly *always* followed by *either* a rebase, reline, or a new complete denture (D5110). Some payors require a healing period of at least six months before any of these three post-delivery procedures will be considered for reimbursement.
3. Always consider filing the higher payor's fee for an immediate denture (D5140) first. If a new complete denture is necessary after healing, ask for the alternate benefit of a reline or rebase fee toward the new denture. This approach reports "what you do" and often results in a better, and proper, higher reimbursement for the patient.

PARTIAL DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE) CDT 2025

D5211 MAXILLARY PARTIAL DENTURE - RESIN BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH) CDT 2025

WATCH

1. It is misleading to report a maxillary (upper) partial denture (D5211) for a maxillary *interim* partial denture (D5820). D5211 should be used to report a *long term* (definitive) *resin* partial, including clasps. D5211 could be used to describe a "flipper," if the flipper is a definitive treatment.

   Note: Report D5820 for interim (temporary) partial denture that is intended to be in service until the final prosthesis is placed. An interim (temporary) partial is followed by a more definitive procedure such as a "regular" partial, fixed bridge, or implant restoration. See D5820 for further details.
2. For a flexible base (Valplast®/Proplast®) maxillary (upper) partial, see D5225.
3. For an immediate maxillary partial denture - resin base, see D5221.

MATCH

1. For an *adjustment* of a resin maxillary partial denture (after six months delivery), see D5421.
2. For a *repair* of a maxillary resin partial denture *base*, see D5612. For a mandibular, see D5611.
3. For a *repair* or to replace a *broken clasp*, see D5630.
4. For a *replacement* of *missing or broken* teeth (each tooth), see D5640.
5. For *adding a tooth* to an existing resin partial denture, see D5650.
6. For *adding a clasp* to an existing resin partial denture, see D5660.
7. For a *rebase* of a resin maxillary partial denture, see D5720.
8. For a *chairside reline* of a resin maxillary partial denture, see D5740.
9. For a *laboratory* processed hard *reline* of a resin maxillary partial denture, see D5760.

COMMENTS

1. A Cu-Sil® partial is like a regular partial except that there are gaskets that fit over the patient's remaining teeth. Cu-Sil® uses elastomeric gaskets that adapt to the remaining teeth to stabilize and retain the partial denture. The gaskets "hug" the natural teeth, keeping the partial denture stable and preventing food from getting through the openings and under the partial denture. See the narrative section for code reporting guidelines.
2. Enter the teeth number(s) or range of teeth being replaced by the partial denture in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Diagnostic casts (D0470) are considered a part of the global fee for a maxillary partial denture (D5211).
2. There is typically a five to 10-year exclusion period for a replacement partial denture. To justify the replacement, the documentation (narrative/photos) must demonstrate why the existing prosthesis cannot be made serviceable.
3. Follow up adjustments within six months of delivery are typically included in the fee for the prosthesis and are not reimbursed separately.
4. An adjustment made by an office not having delivered the denture might be reimbursed.
5. Replacement of a lost partial denture is not reimbursed except following the typical five year exclusion period. Under these circumstances a new partial denture would be fabricated.
6. D5211 may be subject to age related exclusions (patients must be older than 12 to 16, depending on the plan).

TIPS

1. Some plans may reimburse a "stayplate" for a child (16 years of age and younger), when replacing permanent anterior teeth. Note: A stayplate could be reimbursed under *interim* partial denture (D5820). See D5820 for further details.
2. A resin base partial may be a "low cost" partial denture option for the patient and the cast partial a "higher cost" partial denture option.
3. D5211 reports a *unilateral* or bilateral maxillary resin base partial.

NARRATIVES

A maxillary Cu-Sil® partial would be reported as D5211 that has a simple design.

PHOTO



This is an example of a maxillary acrylic partial denture with wire clasps. It is to be used as a permanent removable partial denture, if reported as D5211.

Courtesy Drake Dental Lab

D5212 MANDIBULAR PARTIAL DENTURE - RESIN BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH) CDT 2025

WATCH

1. It is misleading to report a mandibular (lower) partial denture (D5212) for a mandibular *interim* partial denture D5821. D5212 should be used to report *a long term* (definitive) *resin* partial, including clasps. Use this code to report a "flipper," if the flipper is a definitive treatment.

   Note: Report D5821 for interim (temporary) partial dentures lasting generally less than one year. Interim (temporary) partials are followed by a more definitive restoration, such as a "regular" partial, fixed bridge, or implant restoration. See D5821 for further details.
2. For a flexible base (Valplast®/Proplast®) mandibular (lower) partial, see D5226.
3. For an immediate mandibular partial denture - resin base, see D5222.

MATCH

1. For an *adjustment* of a resin mandibular partial denture (after six months delivery), see D5422.
2. For a *repair* of a mandibular resin partial denture *base*, see D5611. For a maxillary, see D5612.
3. For a *repair* or to replace a *broken clasp*, see D5630.
4. For a *replacement* of *missing or broken* teeth (each tooth), see D5640.
5. For *adding a tooth* to an existing resin partial denture, see D5650.

6. For *adding a clasp* to an existing resin partial denture, see D5660.
7. For a *rebase* of a resin mandibular partial denture, see D5721.
8. For a *chairside reline* of a resin mandibular partial denture, see D5741.
9. For a *laboratory* processed hard reline of a *resin* mandibular partial denture, see D5761.

COMMENTS

1. A Cu-Sil® partial is like a regular partial denture except that there are gaskets that fit over the patient's remaining teeth. Cu-Sil® uses elastomeric gaskets that adapt to the remaining teeth to stabilize and retain the partial denture. The gaskets "hug" the natural teeth, keeping the partial denture stable and preventing food from getting through the openings and under the partial denture. See the narrative section for code reporting guidelines.
2. Enter the teeth number(s) or range of teeth being replaced by the partial denture in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Diagnostic casts (D0470) are considered integral in the global fee for a mandibular partial denture (D5212).
2. There is typically a five to 10-year exclusion period for a replacement partial denture. To justify the replacement, the documentation (narrative/photos) must demonstrate why the existing prosthesis cannot be made serviceable.
3. Follow up adjustments within six months of delivery are also typically included in the fee for the prosthesis, and are not reimbursed separately.
4. An adjustment made by an office not having delivered the denture might be reimbursed.
5. Replacement of a lost partial denture is not reimbursed except following the typical five year exclusion period. Under these circumstances a new partial denture would be fabricated.
6. D5212 may be subject to age related exclusions (patients must be older than 12 to 16, depending on the plan).

TIPS

1. A resin base partial may be a "low cost" partial denture option for the patient and the cast partial a "higher cost" option.
2. D5212 reports a *unilateral* or a bilateral mandibular resin base partial.

NARRATIVES

A mandibular Cu-Sil® partial would be reported as D5212 that has a simple design.

D5213 MAXILLARY PARTIAL DENTURE - CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH) CDT 2025

MATCH

1. For an *adjustment* of a cast framework maxillary partial denture (after six months delivery), see D5421.
2. For a *repair* of a *cast framework* for a maxillary cast framework partial, see D5622. For a mandibular, see D5621.
3. For a *repair* or to replace a *broken clasp*, see D5630.
4. For a *replacement* of *missing or broken* teeth (each tooth), see D5640.
5. For *adding a tooth* to an existing cast framework partial denture, see D5650.
6. For *adding a clasp* to an existing cast framework partial denture, see D5660.
7. For a *rebase* of a cast framework maxillary partial denture, see D5720.
8. For a *chairside reline* of a cast framework maxillary partial denture, see D5740.
9. For a *laboratory* processed hard *reline* of a cast framework maxillary partial denture, see D5760.
10. For replacing all teeth and acrylic on a cast framework maxillary partial denture see D5670.

COMMENTS

1. Maxillary partial denture (D5213) describes a bilateral partial denture with a cast metal framework.
2. For a *unilateral* cast metal partial denture, see D5282, D5283, D5284, or D5286.
3. For an immediate partial denture - cast metal framework, see D5223.
4. Enter the teeth number(s) or range of teeth being replaced by the partial denture in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. D5213 may be subject to age related exclusions (patients must be older than 12 to 16 depending on the plan). These age limitations vary among payors.
2. Diagnostic casts (D0470) are considered a part of the global fee for a maxillary partial denture (D5213).
3. There is typically a five to 10-year exclusion period for a replacement partial denture. To justify the replacement, the documentation (photo(s)/brief narrative) must demonstrate why the existing prosthesis cannot be made serviceable.
4. Follow up adjustments within six months of delivery are typically included in the fee for the prosthesis and are not reimbursed separately.
5. An adjustment made by an office not having delivered the denture might be reimbursed.
6. Replacement of a lost partial denture is not reimbursed except following the typical five year exclusion period. Under these circumstances a new partial denture would be fabricated.

TIPS

1. If flexible Valplast® or Proplast® *clasps* are used in conjunction with a maxillary cast metal framework, report D5213.
2. For a precision partial, report each precision attachment separately. Use D5862 to describe each precision attachment which consists of a male-female pair.

PHOTO



This is an example of a maxillary partial denture with a cast metal framework.

Courtesy Drake Dental Lab

D5214 MANDIBULAR PARTIAL DENTURE - CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH) CDT 2025

MATCH

1. For an *adjustment* of a cast framework mandibular partial denture (after six months delivery), see D5422.
2. For a *repair* of a *cast framework* for a mandibular cast framework partial, see D5621. For a maxillary, see D5622.
3. For a *repair* or to replace a *broken clasp*, see D5630.
4. For a *replacement* of *missing or broken* teeth (each tooth), see D5640.
5. For *adding a tooth* to an existing cast framework partial denture, see D5650.
6. For *adding a clasp* to an existing cast framework partial denture, see D5660.
7. For a *rebase* of a cast framework mandibular partial denture, see D5721.
8. For a *chairside reline* of a cast framework mandibular partial denture, see D5741.
9. For a *laboratory* processed hard *reline* of a cast framework mandibular partial denture, see D5761.
10. For *replacing all teeth* and acrylic on a cast framework mandibular partial denture, see D5671.

COMMENTS

1. Mandibular partial denture (D5214) describes a bilateral partial denture with cast metal framework.
2. For a *unilateral* cast metal partial denture, see D5282, D5283, D5284, or D5286.
3. For an immediate partial denture - cast metal framework, see D5224.
4. Enter the teeth number(s) or range of teeth being replaced by the partial denture in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Diagnostic casts (D0470) are considered a part of the global fee for a mandibular partial denture (D5214).
2. There is typically a five to 10-year exclusion period for a replacement partial denture. To justify the replacement, the documentation (photo(s)/brief narrative) must demonstrate why the existing prosthesis cannot be made serviceable.

3. Follow up adjustments within six months of delivery are typically included in the fee for the prosthesis and are not reimbursed separately.
4. An adjustment made by an office not having delivered the denture might be reimbursed
5. Replacement of a lost partial denture is not reimbursed except following the typical five year exclusion period. Under these circumstances a new partial denture would be fabricated.
6. D5214 may be subject to age related exclusions (patients must be older than 12 to 16 depending on the plan). These age limitations vary among payors.

TIPS

1. If flexible Valplast® or Proplast® *clasps* are used in conjunction with a mandibular cast metal framework, report D5214.
2. For a precision partial, report each precision attachment separately. Use D5862 to describe each precision attachment which consists of a male-female pair.

D5221 IMMEDIATE MAXILLARY PARTIAL DENTURE - RESIN BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH) CDT 2025

Includes limited follow-up care only; does not include future rebasing/relining procedure(s).



WARNING

D5211 reports a conventional maxillary resin removable partial denture. D5221 describes the immediate maxillary resin base partial denture that is placed on the *same date of service as extractions*.



WATCH

1. D5221 reports the immediate maxillary resin partial delivered on the same day the teeth are extracted.
2. Report an immediate maxillary partial (D5221) when extracting natural teeth and immediately placing the resin partial. D5221 may be followed, at an additional fee, by one of these procedures (six-month healing is typically required by many payors before one of these subsequent services will be reimbursed):
   a. Reline (most common) - either chairside (D5740) or laboratory processed reline (D5760).
   b. Rebase (D5720) (generally reimbursed a higher UCR fee than a reline).



MATCH

1. For an *adjustment* of an immediate resin maxillary partial denture (after six months delivery), see D5421.
2. For a *repair* of a maxillary immediate resin partial denture base, see D5612. For a mandibular, see D5611.
3. For a *repair* or to *replace* a broken clasp, see D5630.
4. For a *replacement of missing or broken* teeth (each tooth), see D5640.
5. For *adding a tooth* to an existing immediate resin maxillary partial denture, see D5650.
6. For *adding a clasp* to an existing immediate resin maxillary partial denture, see D5660.
7. For a *rebase* of an immediate resin maxillary partial denture, see D5720.
8. For a *chairside reline* of an immediate resin maxillary partial denture, see D5740.
9. For a *laboratory processed hard reline* of an immediate maxillary partial denture, see D5760.

COMMENTS

1. The fee for D5221 does not include subsequent hard acrylic relines (D5740 or D5760) or rebases (D5720). Many payors will reimburse a reline or rebase six months or more after delivery of the immediate partial denture.
2. Enter the teeth number(s) or range of teeth being replaced by the partial denture in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Many payors require a six-month healing period (to the day) following the placement of an immediate maxillary resin partial denture before any subsequent follow up procedures are reimbursed. The healing interval begins at the extraction/insertion date. The healing interval ends with the impression date for the subsequent reline or rebase. Contact the payor regarding the reline or rebase policy for the plan.

2. Follow up adjustments within six months of delivery are typically included in the fee for the D5221 and are not reimbursed.
3. An adjustment made by an office not having delivered the immediate partial denture might be reimbursed.
4. Immediate resin partial dentures may be reported on the impression date, but some payors will only reimburse the procedure on the delivery date (when the teeth are extracted) and the immediate resin partial denture is delivered. Most PPO contracts require immediate resin partial dentures be submitted on the seat date, not the impression date.

D5222 IMMEDIATE MANDIBULAR PARTIAL DENTURE - RESIN BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH) CDT 2025

Includes limited follow-up care only; does not include future rebasing/relining procedure(s).



WARNING

D5212 reports a conventional mandibular resin removable partial denture. D5222 describes the immediate mandibular resin base partial denture that is placed on the same date of service as extractions.

WATCH

1. D5222 reports the immediate mandibular resin partial delivered on the same day that teeth are extracted.
2. Report an immediate mandibular partial (D5222) when extracting natural teeth and immediately placing the resin partial. D5222 is followed, at an additional fee, by one of these procedures (six-month healing is typically required by many payors before one of these subsequent services will be reimbursed):
   a. Reline (most common) - either chairside (D5741) or laboratory processed reline (D5761).
   b. Rebase (D5721) (generally reimbursed at a higher UCR fee than a reline).



MATCH

1. For an *adjustment* of an immediate resin mandibular partial denture (after six months delivery), see D5422.
2. For a *repair* of a mandibular immediate resin partial denture base, see D5611. For a maxillary, see D5612.
3. For a *repair* or to *replace* a broken clasp, see D5630.
4. For *replacement of missing or broken* teeth (each tooth), see D5640.
5. For *adding a tooth* to an existing immediate resin mandibular partial denture, see D5650.
6. For *adding a clasp* to an existing resin partial denture, see D5660.
7. For a *rebase* of an immediate resin mandibular partial denture, see D5721.
8. For a *chairside reline* of an immediate resin mandibular partial denture, see D5741.
9. For a *laboratory processed hard reline* of an immediate mandibular partial denture, see D5761.

COMMENTS

1. The fee for D5222 does not include subsequent hard acrylic relines (D5741 or D5761) or rebases (D5721). Many payors will reimburse a reline or rebase six months or more after delivery of the immediate partial denture.
2. Enter the teeth number(s) or range of teeth being replaced by the partial denture in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Many payors require a six-month healing period (to the day) following the placement of an immediate mandibular resin partial denture before any subsequent follow up procedures are reimbursed. The healing interval begins at the extraction/insertion date. The healing interval ends with the impression date for the subsequent reline or rebase. Contact the payor regarding the reline or rebase policy for the plan.
2. Follow up adjustments within six months of delivery are typically included in the global fee for the D5222 and are not reimbursed.
3. An adjustment made by an office not having delivered the immediate partial denture might be reimbursed.
4. Immediate resin partial dentures may be reported on the impression date, but some payors will only reimburse the procedure on the delivery date (when the teeth are extracted) and the immediate resin partial denture is delivered. Most PPO contracts require immediate resin partial dentures be submitted on the seat date, not the impression date.

D5223 IMMEDIATE MAXILLARY PARTIAL DENTURE - CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH) CDT 2025

Includes limited follow-up care only; does not include future rebasing/relining procedure(s).



WARNING

D5213 reports a conventional maxillary partial denture - cast metal framework with resin denture base. D5223 describes the immediate maxillary partial denture with cast framework that is placed on the same date of service as extractions.

WATCH

1. D5223 reports the immediate maxillary partial denture - cast metal framework with resin bases delivered on the same day the teeth are extracted.
2. Report an immediate maxillary partial denture (D5223) when extracting natural teeth and immediately placing the cast framework partial. D5223 may be followed, at an additional fee, by one of these procedures (six-month healing is typically required by many payors before one of these subsequent services will be reimbursed):
   a. Reline (most common) - either chairside (D5740) or laboratory processed reline (D5760).
   b. Rebase (D5720) (generally reimbursed a higher UCR fee than a reline).



MATCH

1. For an *adjustment* of an immediate cast metal framework with resin bases maxillary partial denture, (after six months delivery) see D5421.
2. For a *repair* of an immediate cast metal framework with resin bases maxillary partial denture, see D5622.
3. For a *repair* or to *replace* a broken clasp, see D5630.
4. For a *replacement of missing or broken* teeth (each tooth), see D5640.
5. For *adding a tooth* to an existing immediate cast metal framework with resin bases maxillary partial denture, see D5650.
6. For *adding a clasp* to an existing immediate cast metal framework with resin bases maxillary partial denture, see D5660.
7. For a rebase of an immediate cast metal framework with resin bases maxillary partial denture, see D5720.
8. For a *chairside reline* of an immediate cast metal framework with resin bases maxillary partial denture, see D5740.
9. For a *laboratory processed hard reline* of an immediate cast metal framework with resin bases maxillary partial denture, see D5760.

COMMENTS

1. The fee for D5223 does not include subsequent hard acrylic relines (D5740 or D5760) or rebases (D5720). Many payors will reimburse a reline or rebase six months or more after delivery of the immediate partial denture.
2. Enter the teeth number(s) or range of teeth being replaced by the partial denture in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Many payors require a six-month healing period (to the day) following the placement of an immediate maxillary cast framework partial denture before any subsequent follow up procedures are reimbursed. The healing interval begins at the extraction/insertion date. The healing interval ends with the impression date for the subsequent reline or rebase. Contact the payor regarding the reline or rebase policy for the plan.
2. Follow up adjustments within six months of delivery are typically included in the fee for D5223 and are not reimbursed.
3. An adjustment made by an office not having delivered the immediate partial denture might be reimbursed.
4. Immediate cast metal framework partial dentures may be reported on the impression date, but some payors will only reimburse the procedure on the delivery date (when the teeth are extracted) and the immediate partial denture is delivered. Most PPO contracts require immediate partial dentures be submitted on the seat date, not the impression date.

D5224 IMMEDIATE MANDIBULAR PARTIAL DENTURE - CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING RETENTIVE/ CLASPING MATERIALS, RESTS AND TEETH) CDT 2025

Includes limited follow-up care only; does not include future rebasing/relining procedure(s).



WARNING

D5214 reports a conventional mandibular partial denture - cast metal framework with resin denture base. D5224 describes the immediate mandibular partial denture with cast framework that is placed on the same date of service as extractions.

WATCH

1. D5224 reports the immediate mandibular partial denture - cast metal framework with resin bases delivered on the same day the teeth are extracted.
2. Report an immediate mandibular partial (D5224) when extracting natural teeth and immediately placing the cast framework partial. D5224 may be followed, at an additional fee, by one of these procedures (six-month healing is typically required by many payors before one of these subsequent services will be reimbursed):
   a. Reline (most common) - either chairside (D5741) or laboratory processed reline (D5761).
   b. Rebase (D5721) (generally reimbursed a higher UCR fee than a reline).



MATCH

1. For an *adjustment* of an immediate cast metal framework with resin bases mandibular partial denture (after six months delivery), see D5422.
2. For a *repair* of an immediate cast metal framework with resin bases mandibular partial denture, see D5621.
3. For a *repair* or to *replace* a broken clasp, see D5630.
4. For a *replacement of missing or broken* teeth (each tooth), see D5640.
5. For *adding a tooth* to an existing immediate cast metal framework with resin bases mandibular partial denture, see D5650.
6. For *adding a clasp* to an existing immediate cast metal framework with resin bases mandibular partial denture, see D5660.
7. For a *rebase* of an immediate cast metal framework with resin bases mandibular partial denture, see D5721.
8. For a *chairside reline* of an immediate cast metal framework with resin bases mandibular partial denture, see D5741.
9. For a *laboratory processed hard reline* of an immediate cast metal framework with resin bases mandibular partial denture, see D5761.

COMMENTS

1. The fee for D5224 does not include subsequent hard acrylic relines (D5741 or D5761) or rebases (D5721). Many payors will reimburse a reline or rebase six months or more after delivery of the immediate partial denture.
2. Enter the teeth number(s) or range of teeth being replaced by the partial denture in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Many payors require a six-month healing period (to the day) following the placement of an immediate mandibular partial denture before any subsequent follow up procedures are reimbursed. The healing interval begins at the extraction/insertion date. The healing interval ends with the impression date for the subsequent reline or rebase. Contact the payor regarding the reline or rebase policy for the plan.
2. Follow up adjustments within six months of delivery are typically included in the fee for D5224 and are not reimbursed.
3. An adjustment made by an office not having delivered the immediate partial denture might be reimbursed.
4. Immediate cast metal framework partial dentures may be reported on the impression date, but some payors will only reimburse the procedure on the delivery date (when the teeth are extracted) and the immediate partial denture is delivered. Most PPO contracts require immediate partial dentures be submitted on the seat date, not the impression date.

D5225 MAXILLARY PARTIAL DENTURE - FLEXIBLE BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH) CDT 2025

MATCH

1. For an *adjustment* of a flexible base maxillary partial denture (after six months delivery), see D5421.
2. For a *repair* of a maxillary flexible base partial denture *base*, see D5612. For a mandibular, see D5611.
3. For a *repair* or to replace a *broken clasp*, see D5630.
4. For a *replacement* of *missing or broken* teeth (each tooth), see D5640.
5. For *adding a tooth* to an existing flexible base partial denture, see D5650.
6. For *adding a clasp* to an existing flexible base partial denture, see D5660.
7. For a *rebase* of a flexible base maxillary partial denture, see D5720.
8. For a *chairside reline* of a flexible base maxillary partial denture, see D5740.
9. For *laboratory* processed reline of a flexible base maxillary partial denture, see D5760.
10. For *immediate* maxillary partial denture - flexible base, see D5227.

Note: Flexible base resin partials are difficult to adjust, and particularly, repair. Repairs for this type of partial would not be routine. *Confirm* with the doctor that the repairs are in fact for a flexible base resin partial. These would be unusual repairs.

COMMENTS

1. Maxillary partial denture - flexible base (D5225) is used to describe partials fabricated from materials such as Valplast® or Proplast® type materials.
2. Diagnostic casts (D0470) are included in the global fee for D5225.
3. Enter the teeth number(s) or range of teeth being replaced by the partial denture in the appropriate boxes of the 2024 ADA Dental Claim Form.

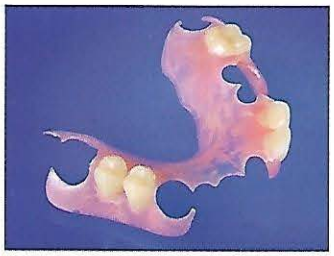
LIMITATIONS

1. There is typically a five to 10-year exclusion period for a replacement partial denture. To justify the replacement, the documentation (photo(s)/brief narrative) must demonstrate why the existing prosthesis cannot be made serviceable.
2. Follow-up adjustments within six months of delivery are typically included in the fee for the prosthesis and are not reimbursed separately.
3. An adjustment made by an office not having delivered the denture might be reimbursed.
4. Replacement of a lost flexible base partial denture is not reimbursed except following the typical five year exclusion period. Under these circumstances a new flexible base partial denture would be fabricated.
5. D5225 may be excluded if the patient is under 12 to 16 years of age. This varies according to the plan.
6. D5225 may be reimbursed with an alternate benefit of D5211. In some cases the reimbursement is equivalent to the fee for a cast metal framework (D5213). Some payors reimburse at a lower rate, 20% below the D5213 fee. Some payors may reimburse at a rate similar to the maxillary partial denture - resin base (D5211) partial denture fee.

TIPS

1. If Valplast® or Proplast® *flexible* clasps are used in conjunction with a cast metal framework partial denture, report D5213.
2. For a maxillary *unilateral* partial using Valplast® or Proplast® flexible base materials report D5225. Thus, the code is used to report *any* type of flexible base maxillary partial denture, whether it is bilateral or unilateral.

PHOTO



This is an example of a flexible base maxillary partial denture made of Valplast®.

Courtesy Keller Dental Lab

D5226 MANDIBULAR PARTIAL DENTURE - FLEXIBLE BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH) CDT 2025

MATCH

1. For an *adjustment* of a flexible base mandibular partial denture (after six months delivery), see D5422.
2. For a *repair* of a mandibular flexible base partial denture *base*, see D5611. For a maxillary, see D5612.
3. For a *repair* or to replace a *broken clasp*, see D5630.
4. For a *replacement* of *missing or broken* teeth (each tooth), see D5640.
5. For *adding a tooth* to an existing flexible base partial denture, see D5650.
6. For *adding a clasp* to an existing flexible base partial denture, see D5660.
7. For a *rebase* of a flexible base mandibular partial denture, see D5721
8. For a *chairside reline* of a flexible base mandibular partial denture, see D5741.
9. For a *laboratory* processed *reline* of a flexible base mandibular partial denture, see D5761.
10. For *immediate* mandibular partial denture - flexible base, see D5228.

Note: Flexible base resin partials are difficult to adjust, and particularly, repair. Repairs for this type of partial would be very unusual. *Confirm* with the doctor that the repairs are in fact for a flexible base resin partial. These would not be routine.

COMMENTS

1. Mandibular partial denture - flexible base (D5226) is used to describe partials fabricated from materials such as Valplast® or Proplast® type materials.
2. Diagnostic casts (D0470) are included in the global fee for D5226.
3. Enter the teeth number(s) or range of teeth being replaced by the partial denture in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. There is typically a five to 10-year exclusion period for a replacement partial denture. To justify the replacement, the documentation (photo(s)/brief narrative) must demonstrate why the existing prosthesis cannot be made serviceable.
2. Follow up adjustments within six months of delivery are typically included in the fee for the prosthesis and are not reimbursed separately.
3. An adjustment made by an office not having delivered the denture might be reimbursed.
4. Replacement of a lost flexible base partial denture is not reimbursed except following the typical five year exclusion period. Under these circumstances a new flexible base partial denture would be fabricated.
5. D5226 may be excluded if the patient is under 12 to 16 years of age. This varies according to the plan.
6. D5226 may be reimbursed with an alternate benefit of code D5212. In some cases the reimbursement is equivalent to the fee for a cast metal framework (D5214). Some payors reimburse at a lower rate, 20% below the D5214 fee. Some payors may reimburse at a rate similar to the mandibular partial denture - resin base (D5212) partial denture fee.

TIPS

1. If Valplast® or Proplast® *flexible* clasps are used in conjunction with a cast metal framework partial denture, report D5214.
2. For a mandibular *unilateral* partial using Valplast® or Proplast® flexible base materials report D5226. Thus, the code is used to report *any* type of flexible base mandibular partial denture, whether it is bilateral or unilateral.

D5227 IMMEDIATE MAXILLARY PARTIAL DENTURE - FLEXIBLE BASE (INCLUDING ANY CLASPS, RESTS AND TEETH) CDT 2025

WARNING

1. D5225 reports a conventional maxillary partial denture - flexible base placed sometime after the extraction appointment.
2. D5227 reports the immediate maxillary partial denture - flexible base that is placed on the same day as extractions.

WATCH

1. For an *adjustment* of an immediate maxillary partial denture - flexible base (six months or more after delivery) see D5421.
2. For a *repair* of an immediate maxillary partial denture - flexible base, see D5612.
3. For a *repair* or to *replace* a *broken clasp*, see D5630.
4. For a *replacement* of *missing or broken* teeth (each tooth), see D5640.
5. For *adding a tooth* to an existing immediate maxillary partial denture - flexible base, see D5650.
6. For *adding a clasp* to an existing immediate maxillary partial denture - flexible base, see D5660.
7. For a *rebase* of an immediate maxillary partial denture - flexible base, see D5720.
8. For a chairside reline of a flexible base maxillary partial denture, see D5740.
9. For a laboratory processed reline of a flexible base maxillary partial denture, see D5760.
10. For maxillary partial denture - flexible base (not immediate), see D5225.

Note: Flexible base unilateral partials are difficult to adjust, and particularly, repair. Repairs for this type of partial would not be routine. *Confirm* with the doctor that the repairs are in fact for a flexible base unilateral partial. These would be unusual repairs.

COMMENTS

1. D5227 is used to report an immediate maxillary partial denture - flexible base (D5227) when the natural teeth are extracted and the partial - flexible base is delivered immediately after the extractions and over the extraction site(s).
2. The fee for D5227 does not include subsequent hard acrylic relines (D5740 or D5760) or rebases (D5720). Some payors will reimburse a reline or rebase six months or more after delivery of the immediate maxillary partial denture-flexible base.
3. Enter the teeth number(s) or range of teeth being replaced by the partial denture in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Many payors require a six-month healing period (to the day) following the placement of an immediate maxillary partial denture-flexible base before any subsequent follow up procedures are reimbursed. The healing interval begins at the extraction/insertion date. The healing interval ends with the impression date for the subsequent reline or rebase. Contact the payor regarding the reline or rebase policy for the plan.
2. Follow up adjustments within six months of delivery are typically included in the fee for D5227 and are not reimbursed. An adjustment made by an office not having delivered the immediate partial denture might be reimbursed. The adjustment code reported would be D5421.
3. Immediate maxillary partial dentures-flexible base may be reported on the impression date if out of network, but some payors will only reimburse the procedure on the delivery date (when the teeth are extracted) and the immediate partial denture is delivered. Most PPO contracts require immediate partial dentures be submitted on the delivery date, not the impression date.
4. Although the lab fee for a flexible prosthesis is generally greater than for conventional (non-flexible) prosthesis, most payors will remap the reimbursement to the less expensive conventional acrylic base appliance. If reimbursement for the flexible base prosthesis is denied, request the alternate benefit of the conventional prosthesis for plans that do reimburse for the conventional prosthesis.

TIPS

1. If flexible clasps are used in conjunction with an immediate maxillary cast metal framework partial denture, report D5223.
2. For an immediate maxillary unilateral partial using Valplast® or Proplast® flexible base materials report D5227. The same code is used to report any type of flexible base maxillary partial denture, whether it is bilateral or unilateral.

D5228 IMMEDIATE MANDIBULAR PARTIAL DENTURE - FLEXIBLE BASE (INCLUDING ANY CLASPS, RESTS AND TEETH) CDT 2025



WARNING

1. D5226 reports a conventional mandibular partial denture - flexible base placed sometime after the extraction appointment.
2. D5228 reports the immediate mandibular partial denture - flexible base that is placed on the same day as extractions.



WATCH

1. For an *adjustment* of an immediate mandibular partial denture - flexible base (six months or more after delivery) see D5422.
2. For a *repair* of an immediate mandibular partial denture - flexible base, see D5611.
3. For a *repair* or to *replace* a *broken clasp*, see D5630.
4. For a *replacement* of *missing or broken* teeth (each tooth), see D5640.
5. For *adding a tooth* to an existing immediate mandibular partial denture - flexible base, see D5650.
6. For *adding a clasp* to an existing existing immediate mandibular partial denture - flexible base, see D5660.
7. For a *rebase* of an immediate mandibular partial denture - flexible base, see D5721.
8. For a chairside reline of a flexible base mandibular partial denture, see D5741.
9. For a laboratory processed reline of a flexible base mandibular partial denture, see D5761.
10. For mandibular partial denture - flexible base (not immediate), see D5226.

Note: Flexible base unilateral partials are difficult to adjust, and particularly, repair. Repairs for this type of partial would not be routine. *Confirm* with the doctor that the repairs are in fact for a flexible base unilateral partial. These would be unusual repairs.

D5228

COMMENTS

1. D5228 is used to report an immediate mandibular partial denture - flexible base (D5228) when the natural teeth are extracted and the partial - flexible base is delivered immediately after the extractions and over the extraction site(s).
2. The fee for D5228 does not include subsequent hard acrylic relines (D5741 or D5761) or rebases (D5721). Some payors will reimburse a reline or rebase six months or more after delivery of the immediate mandibular partial denture-flexible base.
3. Enter the teeth number(s) or range of teeth being replaced by the partial denture in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Many payors require a six-month healing period (to the day) following the placement of an immediate mandibular partial denture-flexible base before any subsequent follow up procedures are reimbursed. The healing interval begins at the extraction/insertion date. The healing interval ends with the impression date for the subsequent reline or rebase. Contact the payor regarding the reline or rebase policy for the plan.
2. Follow up adjustments within six months of delivery are typically included in the fee for D5228 and are not reimbursed. An adjustment made by an office not having delivered the immediate partial denture might be reimbursed. The adjustment code reported would be D5422.
3. Immediate mandibular partial dentures-flexible base may be reported on the impression date if out of network, but some payors will only reimburse the procedure on the delivery date (when the teeth are extracted) and the immediate partial denture is delivered. Most PPO contracts require immediate partial dentures be submitted on the delivery date, not the impression date.
4. Although the lab fee for a flexible prosthesis is generally greater than for conventional (non-flexible) prosthesis, most payors will remap the reimbursement to the less expensive conventional acrylic base appliance. If reimbursement for the flexible base prosthesis is denied, request the alternate benefit of the conventional prosthesis for plans that do reimburse for the conventional prosthesis.

TIPS

1. If flexible clasps are used in conjunction with an immediate mandibular cast metal framework partial denture, report D5224.
2. For an immediate mandibular unilateral partial using Valplast® or Proplast® flexible base materials report D5228. The same code is used to report any type of flexible base mandibular partial denture, whether it is bilateral or unilateral.

D5281 PREVIOUSLY DELETED CODE REMOVABLE UNILATERAL PARTIAL DENTURE - ONE PIECE CAST METAL (INCLUDING CLASPS AND TEETH)

This is a previously deleted code. See D5282 and D5283 for further details.

D5282 REMOVABLE UNILATERAL PARTIAL DENTURE - ONE PIECE CAST METAL (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH), MAXILLARY

CDT 2025



WARNING

D5282 reports a maxillary removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth). For a mandibular removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), see D5283.



MATCH

1. For an *adjustment* of a maxillary unilateral cast partial denture, see D5421.
2. For a *repair* of a maxillary unilateral cast partial framework, see D5622.
3. For a *repair or to replace* a broken clasp (per tooth), see D5630.
4. For a *replacement* of broken teeth (per tooth), see D5640.
5. For *adding a tooth* to an existing maxillary unilateral cast partial denture, see D5650.
6. For *adding a clasp* to an existing maxillary unilateral cast partial denture (per tooth), see D5660.
7. For a *rebase* of a maxillary unilateral cast partial denture, see D5720.
8. For a *chairside reline* of a maxillary unilateral cast partial denture, see D5740.
9. For a *laboratory processed hard reline* of a maxillary unilateral cast partial denture, see D5760.
10. For *replacing all teeth and acrylic* on a maxillary unilateral cast partial denture, see D5670.

COMMENTS

1. D5282 describes a one-piece cast metal *unilateral* maxillary partial denture and is also called a "Nesbit partial." It replaces a missing tooth/teeth on one side of the mouth in the upper arch.
2. See D5284 for removable unilateral partial denture - one piece flexible base - per quadrant.
3. See D5286 for removable unilateral partial denture - one piece resin - per quadrant.
4. Diagnostic casts (D0470) are included in the global fee for D5282.
5. Enter the quadrant and teeth number(s) or range of teeth being replaced by the partial denture in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. There is typically a five to ten-year exclusion period for a replacement partial denture. To justify the replacement, the documentation (photo(s)/brief narrative) must demonstrate why the existing prosthesis cannot be made serviceable.
2. Follow up adjustments within six months of delivery are typically included in the fee for the prosthesis and are not reimbursed separately.
3. An adjustment made by an office not having delivered the denture might be reimbursed.
4. Reimbursement for D5282 may be excluded if the patient is under twelve to sixteen years of age, depending on the plan.

TIPS

1. Use D5282 to report a one piece maxillary cast metal *unilateral* partial with Valplast® or Proplast® type clasps.
2. For a *unilateral* or bilateral Valplast® or Proplast® type flexible base partial, report either D5225 or D5226 to describe this type of partial denture, depending on the arch.
3. For a *unilateral* or bilateral resin base partial, report either D5211 or D5212, depending on the arch.

NARRATIVES

If the partial is a replacement for an existing partial, identify the date of prior placement of the existing partial and why the replacement is necessary.

D5283 REMOVABLE UNILATERAL PARTIAL DENTURE - ONE PIECE CAST METAL (INCLUDING RETENTIVE/CLASPING MATERIAS, RESTS, AND TEETH), MANDIBULAR

CDT 2025

WARNING

D5283 reports a mandibular removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth). For a maxillary removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), see D5282.

MATCH

1. For an *adjustment* of a mandibular unilateral cast partial denture, see D5422.
2. For a *repair* of a mandibular unilateral cast partial framework, see D5621.
3. For a *repair or to replace* a broken clasp (per tooth), see D5630.
4. For a *replacement* of broken teeth (per tooth), see D5640.
5. For *adding a tooth* to an existing mandibular unilateral cast partial denture, see D5650.
6. For *adding a clasp* to an existing mandibular unilateral cast partial denture (per tooth), see D5660.
7. For a *rebase* of a mandibular unilateral cast partial denture, see D5721.
8. For a *chairside reline* of a mandibular unilateral cast partial denture, see D5741.
9. For a *laboratory processed hard reline* of a mandibular unilateral cast partial denture, see D5761.
10. For *replacing all teeth and acrylic* on a mandibular unilateral cast partial denture, see D5671.

COMMENTS

1. D5283 describes a one-piece cast metal *unilateral* mandibular partial denture and is also called a "Nesbit partial." It replaces a missing tooth/teeth on one side of the mouth in the lower arch.
2. See D5284 for removable unilateral partial denture - one piece flexible base - per quadrant.
3. See D5286 for removable unilateral partial denture - one piece resin - per quadrant.
4. Diagnostic casts (D0470) are included in the global fee for D5283.
5. Enter the teeth number(s) or range of teeth being replaced by the partial denture in the appropriate box of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. There is typically a five to ten-year exclusion period for a replacement partial denture. To justify the replacement, the documentation (photo(s)/brief narrative) must demonstrate why the existing prosthesis cannot be made serviceable.
2. Follow up adjustments within six months of delivery are typically included in the fee for the prosthesis and are not reimbursed separately.
3. An adjustment made by an office not having delivered the denture might be reimbursed.
4. Reimbursement for D5283 may be excluded if the patient is under twelve to sixteen years of age, depending on the plan.

TIPS

1. Use D5283 to report a one-piece mandibular cast metal *unilateral* partial with Valplast® or Proplast® type clasps.
2. For a *unilateral* or bilateral Valplast® or Proplast® type flexible base partial, report either D5225 or D5226 to describe this type of partial denture, depending on the arch.
3. For a *unilateral* or bilateral resin base partial, report either D5211 or D5212, depending on the arch.

NARRATIVES

If the partial is a replacement for an existing partial, identify the date of prior placement of the existing partial and why the replacement is necessary.

PHOTO



This is an example of a unilateral (only one side of the arch) partial denture.

Courtesy of Drake Dental Lab

D5284 REMOVABLE UNILATERAL PARTIAL DENTURE - ONE PIECE FLEXIBLE BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH) - PER QUADRANT

CDT 2025

WARNING

D5284 reports a removable unilateral partial denture - one piece flexible base (including retentive/clasping materials, rests, and teeth) - per quadrant. For a removable unilateral partial denture - one piece resin base (including retentive/clasping materials, rests, and teeth) - per quadrant, see D5286. For a removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), see D5282/D5283 maxillary/mandibular, respectively.

WATCH

A class V Applegate type partial crossing the midline is accurately reported as a maxillary or mandibular flexible base partial denture (D5225/D5226) and should not be reported as a unilateral partial.

MATCH

1. For an *adjustment* of a flexible base unilateral partial denture (after six months from delivery), see D5421/D5422 maxillary/mandibular, respectively.
2. For a *repair* of a maxillary flexible base unilateral partial denture, see D5612/D5611 maxillary/mandibular, respectively.
3. For a *repair or to replace* a broken clasp (per tooth), see D5630.
4. For a *replacement* of broken teeth (per tooth), see D5640.
5. For *adding a tooth* to an existing flexible base unilateral partial denture (per tooth), see D5650.
6. For *adding a clasp* to an existing flexible base unilateral partial denture (per tooth), see D5660.
7. For a *rebase* of a flexible base unilateral partial denture, see D5720/D5721 maxillary/mandibular, respectively.

Note: Flexible base unilateral partials are difficult to adjust, and particularly, repair. Repairs for this type of partial would not be routine. *Confirm* with the doctor that the repairs are in fact for a flexible base unilateral partial. These would be unusual repairs.

COMMENTS

1. D5284 describes a one-piece flexible base unilateral partial denture - per quadrant and is also called a "Nesbit partial." It replaces a missing tooth/teeth in one quadrant on either the maxillary or mandibular arch.
2. Diagnostic casts (D0470) are included in the global fee for D5284.
3. Enter the quadrant and teeth number(s) or range of teeth being replaced by the partial denture in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. There is typically a five to ten-year exclusion period for a replacement partial denture. To justify the replacement, the documentation (photo(s)/brief narrative) must demonstrate why the existing prosthesis cannot be made serviceable.
2. Follow up adjustments within six months of delivery are typically included in the fee for the prosthesis and are not reimbursed separately.
3. An adjustment made by an office not having delivered the denture might be reimbursed.
4. Reimbursement for D5284 may be excluded if the patient is under 12 to 16 years of age, depending on the plan.

TIPS

Use D5284 to report a one piece flexible base unilateral partial with Valplast® or Proplast® type clasps.

NARRATIVES

1. If the partial is a replacement for an existing partial, identify the date of prior placement of the existing partial and why the replacement is necessary.
2. The narrative should indicate the tooth number(s) replaced and date of extraction.

D5286 REMOVABLE UNILATERAL PARTIAL DENTURE - ONE PIECE RESIN (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH) - PER QUADRANT CDT 2025



WARNING

D5286 reports a removable unilateral partial denture - one piece resin base (including retentive/clasping materials, rests, and teeth) - per quadrant. For a removable unilateral partial denture - one piece flexible base (including retentive/clasping materials, rests, and teeth) - per quadrant, see D5284. For a removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), see D5282/D5283 maxillary/mandibular, respectively.



WATCH

A class V Applegate type partial crossing the midline is accurately reported as a maxillary or mandibular flexible base partial denture (D5225/D5226) and should not be reported as a unilateral partial.



MATCH

1. For an *adjustment* of a resin base unilateral partial denture (after six months from delivery), see D5421/D5422 maxillary/mandibular, respectively.
2. For a *repair* of a maxillary resin base unilateral partial denture, see D5612/D5611 maxillary/mandibular, respectively.
3. For a *repair or to replace* a broken clasp (per tooth), see D5630.
4. For a *replacement* of broken teeth (per tooth), see D5640.
5. For *adding a tooth* to an existing resin base unilateral partial denture (per tooth), see D5650.
6. For *adding a clasp* to an existing resin base unilateral partial denture (per tooth), see D5660.
7. For a *rebase* of a resin base unilateral partial denture, see D5720/D5721 maxillary/mandibular, respectively.
8. For a *chairside reline* of a resin base unilateral partial denture, see D5740/D5741 maxillary/mandibular, respectively.
9. For *laboratory processed hard reline* of a resin base unilateral partial denture, see D5760/D5761 maxillary/mandibular, respectively.

COMMENTS

1. D5286 describes a one-piece resin base unilateral partial denture - per quadrant and is also called a "Nesbit partial." It replaces a missing tooth/teeth in one quadrant on either the maxillary or mandibular arch.
2. Diagnostic casts (D0470) are included in the global fee for D5286.
3. Enter the quadrant and teeth number(s) or range of teeth being replaced by the partial denture in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. There is typically a five to ten-year exclusion period for a replacement partial denture. To justify the replacement, the documentation (photo(s)/brief narrative) must demonstrate why the existing prosthesis cannot be made serviceable.
2. Follow up adjustments within six months of delivery are typically included in the fee for the prosthesis and are not reimbursed separately.
3. An adjustment made by an office not having delivered the denture might be reimbursed.
4. Reimbursement for D5286 may be excluded if the patient is under 12 to 16 years of age, depending on the plan.

TIPS

Use D5286 to report a one piece resin base unilateral partial with resin type clasps.

NARRATIVES

1. If the partial is a replacement for an existing partial, identify the date of prior placement of the existing partial and why the replacement is necessary.
2. The narrative should indicate the tooth number(s) replaced and date of extraction.

D5410 ADJUST COMPLETE DENTURE - MAXILLARY CDT 2025

MATCH

Use this code to report adjustments made to:

- Maxillary complete denture (D5110).
- Maxillary immediate denture (D5130).
- Maxillary interim complete denture (D5810).
- Maxillary complete (natural tooth) overdenture (D5863).
- Maxillary implant/abutment supported removable denture for completely edentulous arch (D6110).

LIMITATIONS

1. Any maxillary complete denture adjustments provided within six months of delivery of the prosthesis are typically included in the fee for the prosthesis and are not reimbursed separately. Adjustments provided six months *after* delivery may be reimbursed up to twice per 12-month period by some payors. To report a denture adjustment within the initial six months of delivery, consider code D0171.
2. A complete denture adjustment provided by a *different* office than the fabricator of the denture may be reimbursable less than six months after delivery of the complete denture.

D5411 ADJUST COMPLETE DENTURE - MANDIBULAR CDT 2025

MATCH

Use this code to report adjustments made to:

- Mandibular complete denture (D5120).
- Mandibular immediate denture (D5140).
- Mandibular interim complete denture (D5811).
- Mandibular complete (natural tooth) overdenture (D5865).
- Mandibular implant/abutment supported removable denture for completely edentulous arch (D6111).

LIMITATIONS

1. Any mandibular complete denture adjustments provided within six months of delivery of the prosthesis are typically included in the fee for the prosthesis and are not reimbursed separately. Adjustments provided six months *after* delivery may be reimbursed up to twice per 12-month period by some payors. To report a denture adjustment within the initial six months of delivery, consider code D0171.
2. A complete denture adjustment provided by a *different* office than the fabricator of the denture may be reimbursable less than six months after delivery of the complete denture.

D5421 ADJUST PARTIAL DENTURE - MAXILLARY CDT 2025

MATCH

Use this code to report adjustments made to maxillary resin base, cast metal framework, flexible base, unilateral, interim partial dentures and implant/abutment supported removable dentures for partially edentulous arches.

LIMITATIONS

1. Maxillary partial dentures (D5211/D5213/D5221/D5223/D5225/D5820/D5864/D6112): Any maxillary partial denture or overdenture adjustments provided within six months of delivery of the prosthesis are typically included in the fee for the prosthesis and are not reimbursed separately. Adjustments provided six months *after* delivery may be reimbursed up to twice per 12-month period by some payors. To report a denture adjustment within the initial six months of delivery, consider code D0171.
2. A denture adjustment provided by a *different* office than the fabricator of the denture may be reimbursable less than six months after delivery of the complete denture.

D5422 ADJUST PARTIAL DENTURE - MANDIBULAR CDT 2025

MATCH

Use this code to report adjustments made to mandibular resin base, cast metal framework, flexible base, unilateral, interim partial dentures, and implant/abutment supported removable dentures for partially edentulous arches.

LIMITATIONS

1. Mandibular partial dentures (D5212/D5214/D5222/D5224/D5226/D5821/D5866/D6113): Any mandibular partial denture or overdenture adjustments provided within six months of delivery of the prosthesis are typically included in the fee for the prosthesis and are not reimbursed separately. Adjustments provided six months *after* delivery may be reimbursed up to twice per 12-month period by some payors. To report a denture adjustment within the initial six months of delivery, consider code D0171.
2. A denture adjustment provided by a *different* office than the fabricator of the denture may be reimbursable less than six months after delivery of the complete denture.

REPAIRS TO COMPLETE DENTURES CDT 2025

D5510 PREVIOUSLY DELETED CODE REPAIR BROKEN COMPLETE DENTURE BASE

This is a previously deleted code. See D5511 and D5512 for further details.

D5511 REPAIR BROKEN COMPLETE DENTURE BASE, MANDIBULAR CDT 2025

MATCH

This code reports a repair of a broken lower (mandibular) complete denture or overdenture base.

LIMITATIONS

1. Some payors limit reimbursement for the repair fee to less than one half the fee normally reimbursed for a new removable prosthesis.
2. Providing a repair to a mandibular complete denture (D5120/D5140/D5865/D6111) base may extend the replacement limitation period of that prosthesis for 2 to 5 years. The repair may "reset" the common limitation period (typically 5 to 10 years) for replacement of the repaired prosthesis with a new prosthesis. Some payors will reimburse a repair once per arch, per 12 months. The reimbursement for denture repairs for (D5120/D5140/D5865/D6111) is highly variable. It is recommended to verify the coverage and limitations before providing this service.

TIPS

Report the replacement of missing or broken teeth (D5520) in addition to the repair of the mandibular complete denture or overdenture base. Each tooth replaced (D5520) should be reported separately.

NARRATIVES

A brief narrative should describe the procedure performed and identify the original delivery date of the mandibular prosthesis.

D5512 REPAIR BROKEN COMPLETE DENTURE BASE, MAXILLARY CDT 2025

MATCH

This code reports a repair of a broken upper (maxillary) complete denture or overdenture base.

LIMITATIONS

1. Some payors limit reimbursement for the repair fee to less than one half the fee normally reimbursed for a new removable prosthesis.

2. Providing a repair to a maxillary complete denture (D5110/D5130/D5863/D6110) base may extend the replacement limitation period of that prosthesis for 2 to 5 years. The repair may "reset" the common limitation period (typically 5 to 10 years) for replacement of the repaired prosthesis with a new prosthesis. Some payors will reimburse a repair once per arch, per 12 months. The reimbursement for complete denture repairs (D5110/D5130/D5863/D6110) is highly variable. It is recommended to verify coverage and limitations before providing this service.

TIPS Report the replacement of missing or broken teeth (D5520) in addition to the repair of the maxillary complete denture or overdenture base. Each tooth replaced (D5520) should be reported separately.

NARRATIVES A brief narrative should describe the procedure performed and identify the original delivery date of the maxillary prosthesis.

D5520 EDITORIAL REVISION REPLACE MISSING OR BROKEN TEETH - COMPLETE DENTURE - PER TOOTH CDT 2025

MATCH

This code is used to report the replacement of a missing or broken tooth for an upper (maxillary) or lower (mandibular) complete denture or overdenture.

COMMENTS Enter the tooth number being replaced in Box 27 of the 2024 ADA Dental Claim Form.

TIPS Report the replacement/repair of missing or broken teeth (D5520) separately from the repair of base or framework. Each tooth repaired/replaced should be reported as a separate procedure.

NARRATIVES A brief narrative should identify the arch, tooth number, the procedure performed, and the original delivery date of the prosthesis.

REPAIRS TO PARTIAL DENTURES CDT 2025

D5610 PREVIOUSLY DELETED CODE REPAIR RESIN DENTURE BASE

This is a previously deleted code. See D5611 and D5612 for further details.

D5611 REPAIR RESIN PARTIAL DENTURE BASE, MANDIBULAR CDT 2025

MATCH

Use this code to report a resin partial denture base repair for a lower (mandibular) partial denture or overdenture.

LIMITATIONS

1. Some payors limit reimbursement for the repair fee to less than one half the fee normally reimbursed for a new mandibular partial denture.
2. Providing a repair to a partial denture base may extend the replacement limitation period of that prosthesis for 2 to 5 years. Depending on the cost, a repair may "reset" the limitation period (typically 5 to 10 years) for replacement of the repaired prosthesis with a new prosthesis. Some payors will reimburse a repair once per arch, per 12 months. The reimbursement for partial denture repairs is highly variable. Because of this variability, it is recommended to verify the coverage and limitations before providing this service.

TIPS Report the repair of the mandibular resin partial denture or overdenture base separately from any other repairs.

NARRATIVES A brief narrative should identify the procedure performed, and the original delivery date of the mandibular prosthesis. Photo(s) of the damaged prosthesis are recommended.

D5612 REPAIR RESIN PARTIAL DENTURE BASE, MAXILLARY CDT 2025

MATCH

Use this code to report a resin denture base repair for an upper (maxillary) partial denture or overdenture.

LIMITATIONS

1. Some payors limit reimbursement for the repair fee to less than one half the fee normally reimbursed for a new maxillary partial denture.
2. Providing a repair to a partial denture base may extend the replacement limitation period of that prosthesis for 2 to 5 years. Depending on the cost, a repair may "reset" the limitation period (typically 5 to 10 years) for replacement of the repaired prosthesis with a new prosthesis. Some payors will reimburse a repair once per arch, per 12 months. The reimbursement for partial denture repairs is highly variable. Because of this variability, it is recommended to verify the coverage and limitations before providing this service.

TIPS

Report the repair of the maxillary resin partial denture or overdenture base separately from any other repairs.

NARRATIVES

A brief narrative should identify the procedure performed, and the original delivery date of the maxillary prosthesis. Photo(s) of the damaged prosthesis are recommended.

D5620 PREVIOUSLY DELETED CODE REPAIR CAST FRAMEWORK

This is a previously deleted code. See D5621 and D5622 for further details.

D5621 REPAIR CAST PARTIAL FRAMEWORK, MANDIBULAR CDT 2025

MATCH

Use this code to report the repair of a cast partial framework for a lower (mandibular) partial denture or overdenture.

LIMITATIONS

1. Some payors limit reimbursement for the repair fee to less than one half the fee normally reimbursed for a new mandibular removable prosthesis.
2. Providing a repair to a cast framework may extend the replacement limitation period of that prosthesis for 2 to 5 years. Depending on the cost, a repair may "reset" the limitation period (typically 5 to 10 years) for replacement of the repaired prosthesis with a new prosthesis. Some payors will reimburse a repair once per arch, per 12 months. The reimbursement for partial denture repairs is highly variable. Because of this variability, it is recommended to verify the coverage and limitations before providing this service.

TIPS

Report the repair of the mandibular cast partial framework separately from other repairs.

NARRATIVES

A brief narrative should identify the procedure performed, and the original delivery date of the mandibular prosthesis. Photo(s) of the damaged prosthesis are recommended.

D5622 REPAIR CAST PARTIAL FRAMEWORK, MAXILLARY CDT 2025

MATCH

Use this code to report the repair of a cast partial framework for an upper (maxillary) partial denture or overdenture.

LIMITATIONS

1. Some payors limit reimbursement for the repair fee to less than one half the fee normally reimbursed for a new maxillary removable prosthesis.

2. Providing a repair to a cast framework may extend the replacement limitation period of that prosthesis for 2 to 5 years. Depending on the cost, a repair may "reset" the limitation period (typically 5 to 10 years) for replacement of the repaired prosthesis with a new prosthesis. Some payors will reimburse a repair once per arch, per 12 months. The reimbursement for partial denture repairs is highly variable. Because of this variability, it is recommended to verify the coverage and limitations before providing this service.

TIPS Report the repair of the maxillary cast partial framework separately from other repairs.

NARRATIVES A brief narrative should identify the procedure performed, and the original delivery date of the maxillary prosthesis. Photo(s) of the damaged prosthesis are recommended.

D5630 REPAIR OR REPLACE BROKEN RETENTIVE/CLASPING MATERIALS - PER TOOTH CDT 2025

MATCH

Use this code to describe the repair or replacement of a broken clasp per tooth for a partial denture or overdenture.

COMMENTS Enter the tooth number associated with the clasp to identify the location of the clasp in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Some payors limit reimbursement for the repair fee to less than one half the fee normally reimbursed for a new removable prosthesis.
2. Providing a repair or replacement of a broken clasp may extend the replacement limitation period of that prosthesis for two to five years. Depending on the cost, a repair may "reset" the limitation period (typically five to 10-years) for replacement of the repaired prosthesis with a new prosthesis. Some payors will reimburse a repair once per arch, per 12 months. The reimbursement for partial denture repairs is highly variable. Because of this variability, it is recommended that the coverage and limitations be verified before providing this service.

TIPS Report the repair or replacement of a broken clasp separately from other repairs.

NARRATIVES A brief narrative should identify the original delivery date of the prosthesis.

D5640 EDITORIAL REVISION REPLACE MISSING OR BROKEN TEETH - PARTIAL DENTURE - PER TOOTH CDT 2025

MATCH

1. D5640 reports the replacement of a broken tooth on a partial denture or overdenture.
2. Report the replacement of each tooth separately.

COMMENTS Enter the tooth number being replaced in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Some payors may limit reimbursement for the repair fee to less than one half the fee originally reimbursed for a new prosthesis.
2. Replacing broken teeth on an existing partial denture or overdenture may extend the replacement limitation period of that prosthesis for two to five years. Depending on the cost, a repair may "reset" the limitation period (typically five to 10-years) for replacement of the repaired prosthesis with a new prosthesis. Some payors will reimburse a repair once per arch, per 12 months. The reimbursement for broken tooth repairs is highly variable. Because of this variability, it is recommended that the coverage and limitations be verified before providing this service.

TIPS	Report the repair or replacement of broken teeth separately from other repairs.
NARRATIVES	A brief narrative should identify tooth number, the procedure performed, and note the original delivery date of the prosthesis.

D5650 EDITORIAL REVISION ADD TOOTH TO EXISTING PARTIAL DENTURE - PER TOOTH

CDT 2025

MATCH

D5650 reports adding a tooth to an existing partial denture or overdenture. Report each tooth separately.

COMMENTS Enter the tooth number being added in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS Adding a tooth to an existing partial denture or overdenture may extend the replacement limitation period of that prosthesis for two to five years. Depending on the cost, the addition of a tooth to an existing prosthesis may "reset" the limitation period (typically five to 10-years) for replacement of the repaired prosthesis with a new prosthesis. Some payors will reimburse a repair once per arch, per 12 months. The reimbursement for D5650 is highly variable. Because of this variability, it is recommended that the coverage and limitations be verified before providing this service.

NARRATIVES A brief narrative should identify the tooth number, the procedure performed, and the original delivery date of the prosthesis.

D5660 ADD CLASP TO EXISTING PARTIAL DENTURE - PER TOOTH

CDT 2025

MATCH

D5660 reports adding a clasp to an existing partial denture or overdenture, per tooth.

COMMENTS Enter the tooth number associated with the clasp to identify the location of the clasp in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS Adding a clasp to an existing partial denture or overdenture may extend the replacement limitation period of that prosthesis for two to five years. Depending on the cost, the addition of a clasp may "reset" the limitation period (typically five to 10-years) for replacement of the repaired prosthesis with a new prosthesis. Some payors will reimburse a repair once per arch, per 12 months. The reimbursement for D5660 is highly variable. Because of this variability, it is recommended that the coverage and limitations be verified before providing this service.

NARRATIVES A brief narrative should identify the original delivery date of the prosthesis.

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

CDT 2025

MATCH

D5670 describes the full replacement of the existing teeth and acrylic (the pink part) of an existing maxillary (upper) cast metal framework with all new teeth and acrylic.

LIMITATIONS

1. D5670 may be covered once per five to 10-year period as per the contract's replacement language. Replacing all teeth and acrylic on a cast metal framework may "reset" the limitation period (typically five to 10-years) for replacement of the repaired prosthesis with a new prosthesis.
2. The replacement of all teeth and acrylic on a maxillary cast metal framework may be reimbursed at less than one half the fee normally reimbursed for a new prosthesis.

NARRATIVES A brief narrative should identify that all teeth and acrylic was replaced, and the original delivery date of the prosthesis.

D5671 REPLACE ALL TEETH AND ACRYLIC ON CAST METALFRAMEWORK (MANDIBULAR) CDT 2025

MATCH

D5671 describes the full replacement of the existing teeth and acrylic (the pink part) of an existing mandibular (lower) cast metal framework with all new teeth and acrylic.

LIMITATIONS

1. D5671 may be covered once per five to 10-year period as per the contract's replacement language. Replacing all teeth and acrylic on a cast metal framework may "reset" the limitation period (typically five to 10-years) for replacement of the repaired prosthesis with a new prosthesis.
2. The replacement of all teeth and acrylic on a maxillary cast metal framework may be reimbursed at less than one half the fee normally reimbursed for a new prosthesis.

NARRATIVES A brief narrative should identify that all teeth and acrylic was replaced, and the original delivery date of the prosthesis.

DENTURE REBASE PROCEDURES CDT 2025

Rebase - process of refitting a denture by replacing the base material.

D5710 REBASE COMPLETE MAXILLARY DENTURE CDT 2025

MATCH

1. D5710 reports rebasing a complete maxillary (upper) denture.
2. D5710 reports the associated rebase of a maxillary implant/abutment supported prosthesis.

COMMENTS

1. "Rebase" is the process of removing the old denture base material (the pink part of a denture) and replacing it with new denture base material.
2. "Reline" is the process of resurfacing the tissue side of the denture with new denture base material. A rebase replaces the old denture base. A reline resurfaces the old base material.
3. Rebases are laboratory processed.

LIMITATIONS

1. Follow up adjustments within six months of the rebase are typically included in the fee for D5710 and are not reimbursed separately. If an adjustment is made by an office that did not deliver the denture, that office might be reimbursed. This should be noted in a brief narrative.
2. Providing a rebase to a maxillary denture or overdenture may extend the replacement limitation period of that prosthesis for two to five years. The rebase may "reset" the limitation period (typically five to 10-years) for replacement of the rebased prosthesis with a new prosthesis. Some payors will reimburse a rebase once per arch, per 12 months. The reimbursement for the rebase of a complete denture is highly variable. It is recommended that the coverage and limitations be verified before providing this service.
3. A maxillary denture or overdenture rebase may be denied when provided for cosmetic reasons, but may be approved when justified by alveolar ridge resorption and to treat changes in occlusion.

TIPS Reimbursement for a rebase is typically higher than for a chairside or a laboratory processed reline.

D5711 REBASE COMPLETE MANDIBULAR DENTURE CDT 2025

MATCH

1. D5711 reports rebasing a complete mandibular (lower) denture.
2. D5711 reports the associated rebase of a mandibular implant/abutment supported prosthesis.

COMMENTS

1. "Rebase" is the process of removing the old denture base material (the pink part of a denture) and replacing it with new denture base material.
2. "Reline" is the process of resurfacing the tissue side of the denture with new denture base material. A rebase replaces the old denture base. A reline resurfaces the old base material.
3. Rebases are laboratory processed.

LIMITATIONS

1. Follow up adjustments within six months of the rebase are typically included in the fee for D5711 and are not reimbursed separately. If an adjustment is made by an office that did not deliver the denture, that office might be reimbursed. This should be noted in a brief narrative.
2. Providing a rebase to a mandibular denture or overdenture may extend the replacement limitation period of that prosthesis for two to five years. The rebase may "reset" the limitation period (typically five to 10-years) for replacement of the rebased prosthesis with a new prosthesis. Some payors will reimburse a rebase once per arch, per 12 months. The reimbursement for complete denture rebase is highly variable. It is recommended that the coverage and limitations be verified before providing this service.
3. A mandibular denture or overdenture rebase may be denied when provided for cosmetic reasons, but may be approved when justified by alveolar ridge resorption and to treat changes in occlusion.

TIPS

Reimbursement for a rebase is typically higher than for a chairside or laboratory processed reline.

D5720 REBASE MAXILLARY PARTIAL DENTURE CDT 2025

MATCH

1. D5720 reports the associated rebasing of a maxillary (upper) partial denture.
2. D5720 reports the associated rebase of a maxillary implant/abutment supported partial denture.

COMMENTS

1. "Rebase" is the process of removing the old denture base material (the pink part of a partial denture) and replacing it with new denture base material.
2. "Reline" is the process of resurfacing the tissue side of the denture with new denture base material. A rebase replaces the old denture base. A reline resurfaces the old base material.
3. Rebases are laboratory processed.
4. Enter the teeth number(s) or range of teeth being replaced by the partial denture in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Follow up adjustments within six months of the partial denture rebase are typically included in the fee for D5720 and are not reimbursed separately. If an adjustment is made by an office that did not deliver the denture, that office might be reimbursed. This should be noted in a brief narrative.
2. Providing a rebase to a maxillary partial denture or overdenture may extend the replacement limitation period of that prosthesis for two to five years. The rebase may "reset" the limitation period (typically five to 10-years) for replacement of the rebased prosthesis with a new prosthesis. Some payors will reimburse a rebase once per arch, per 12 months. The reimbursement for the rebase of a mandibular partial denture repair is highly variable. It is recommended that the coverage and limitations be verified before providing this service.
3. A maxillary partial denture or overdenture rebase may be denied when provided for cosmetic reasons, but may be approved when justified by alveolar ridge resorption and to treat changes in occlusion.

TIPS

1. Reimbursement for a rebase is typically higher than for a chairside or laboratory processed reline.
2. See D5670 for replacement of all teeth and acrylic base on an existing maxillary cast partial framework.

D5721 REBASE MANDIBULAR PARTIAL DENTURE CDT 2025

MATCH

1. D5721 reports the associated rebasing of a mandibular (lower) partial denture.
2. D5721 reports the associated rebase of a mandibular implant/abutment supported partial denture.

COMMENTS

1. "Rebase" is the process of removing the old denture base material (the pink part of a partial denture) and replacing it with new denture base material.
2. "Reline" is the process of resurfacing the tissue side of the denture with new denture base material. A rebase replaces the old denture base. A reline resurfaces the old base material.
3. Rebases are laboratory processed.
4. Enter the teeth number(s) or range of teeth being replaced by the partial denture in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Follow up adjustments within six months of the partial denture rebase are typically included in the fee for D5721 and are not reimbursed separately. If an adjustment is made by an office that did not deliver the denture, that office might be reimbursed. This should be noted in a brief narrative.
2. Providing a rebase to a mandibular partial denture or overdenture may extend the replacement limitation period of that prosthesis for two to five years. The rebase may "reset" the limitation period (typically five to 10-years) for replacement of the rebased prosthesis with a new prosthesis. Some payors will reimburse a rebase once per arch, per 12 months. The reimbursement for the rebase of a mandibular partial denture repair is highly variable. It is recommended that the coverage and limitations be verified before providing this service.
3. A mandibular partial denture or overdenture rebase may be denied when provided for cosmetic reasons, but may be approved when justified by alveolar ridge resorption and to treat changes in occlusion.

TIPS

1. Reimbursement for a rebase is typically higher than for a chairside or laboratory processed reline.
2. See D5671 for replacement of all teeth and acrylic base on an existing mandibular cast partial framework.

D5725 REBASE HYBRID PROSTHESIS CDT 2025

Replacing the base material connected to the framework.

WARNING

D5710/D5711 reports the rebase of a conventional complete maxillary/mandibular denture or an implant/abutment supported prosthesis where a framework is not utilized in the fabrication of the prosthesis to be rebased.

MATCH

D5725 reports rebasing a hybrid prosthesis. A hybrid prosthesis is an implant supported full arch prosthesis that has both denture teeth, an acrylic base with a metal framework and is often referred to an all-on-4 implant hybrid denture. A rebase describes the replacement of all the pink-acrylic denture base material instead of just relining or replacing a thin layer of the pink acrylic gingival acrylic.

COMMENTS

1. A rebase is a dental lab process wherein all the old denture base material is removed from the denture framework (usually metal) and replacing it with all new denture base material.
2. Enter the arch being rebased on a full arch hybrid prosthesis, or the teeth number(s) or range of teeth being replaced by a partial hybrid prosthesis in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Like nearly every other prosthetic service, most plans have a 5-to-10-year limitation period after the original placement, or any other "major" service/maintenance provided to the prosthesis before another replacement prosthesis or other major service/maintenance will be reimbursed. Follow up adjustments within six months of the rebase are typically included in the fee for D5725 and are not reimbursed separately.
2. If an adjustment is made by an office that did not deliver the rebase of the hybrid prosthesis, that office might be reimbursed. This should be noted in a brief narrative. D5410 (maxillary) and D5411 (mandibular) would report an adjustment.

NARRATIVES

The narrative supporting the need for the D5725, rebase hybrid prosthesis should include photos of the existing hybrid prosthesis prior to rebase inside and outside of the patient's mouth, the date of the original placement of the prosthesis and an explanation of why the rebase is necessary.

DENTURE RELINE PROCEDURES — CDT 2025

Reline is the process of resurfacing the tissue side of a denture with new base material.

D5730 RELINE COMPLETE MAXILLARY DENTURE (DIRECT) — CDT 2025



WATCH

1. Some practices err when reporting a direct *(chairside)* reline code instead of the in office *processed* (oven, pressure bath, etc.) indirect *(laboratory)* reline. Report the laboratory reline code if the reline is *processed* either in the office *or* by an outside laboratory. A Triad® oven processed or a pressurized hot water bath is an indirect (laboratory) reline and should be reported as D5750. Indirect (laboratory) *soft* relines are reported using D5765.
2. It is an error to report a direct (chairside) reline as tissue conditioning. Tissue conditioning is used to promote healing of unhealthy ridges prior to taking an impression for a final prosthesis or *prior* to a rebase or a reline. See D5850 for further details on tissue conditioning (maxillary).

D5730



MATCH

1. D5730 reports the associated chairside relining of a complete maxillary (upper) denture (D5110).
2. D5730 reports the associated chairside relining of a maxillary implant/abutment supported prosthesis.

COMMENTS

1. "Rebase" is the process of removing the old denture base material (the pink part of a denture) and replacing it with new denture base material. See D5710.
2. "Reline" is the process of resurfacing the tissue side of the denture with new denture base material. A reline resurfaces the old base material.
3. Relines can be chairside (direct) or laboratory processed (indirect). D5730 is a direct reline.

LIMITATIONS

1. Follow-up adjustments provided within six months of the reline are typically included in the fee for D5730 and are not reimbursed separately. If an adjustment is made by an office that did not deliver the denture, that office might be reimbursed. This should be noted in a brief narrative.
2. Providing a reline to a maxillary denture or overdenture may extend the replacement limitation period of that prosthesis two to five years. The reline may "reset" the limitation period (typically five to 10-years) for replacement of the relined prosthesis with a new prosthesis. Some payors will reimburse a reline once per arch, per 12 months. The reimbursement for relines is highly variable. Because of this variability, it is recommended that the coverage and limitations be verified before providing this service.
3. A reline may be denied when provided for cosmetic reasons, but may be approved when justified by alveolar ridge resorption and to treat changes in occlusion.

TIPS

1. Reimbursement for a laboratory processed reline is typically higher than for a chairside reline.
2. Reimbursement for a rebase is typically higher than for a chairside reline.

Note:D5765, soft liner for complete or partial removable denture - indirect is found under the section "Other Removable Prosthetic Services"

D5731 RELINE COMPLETE MANDIBULAR DENTURE (DIRECT) CDT 2025

WATCH

1. Some practices err when reporting a direct *(chairside)* reline code instead of the in office *processed* (oven, pressure bath, etc.) indirect *(laboratory)* reline. Report the laboratory reline code if the reline is *processed* either in the office *or* by an outside laboratory. A Triad® oven processed or a pressurized hot water bath is an indirect (laboratory) reline and should be reported as D5751. Indirect (laboratory) *soft* relines are reported using D5765.
2. It is an error to report a direct (chairside) reline as tissue conditioning. Tissue conditioning is used to promote healing of an unhealthy ridge *prior* to taking an impression for a final prosthesis or prior to a rebase or a reline. See D5851 for further details on tissue conditioning (mandibular).



MATCH

1. D5731 reports the chairside relining of a complete mandibular (lower) denture (D5120).
2. D5731 reports the chairside relining of a mandibular implant/abutment supported prosthesis.

COMMENTS

1. "Rebase" is the process of removing the old denture base material (the pink part of a denture) and replacing it with new denture base material. See D5711.
2. "Reline" is the process of resurfacing the tissue side of the denture with new denture base material. A reline resurfaces the old base material.
3. Relines can be chairside (direct) or laboratory processed (indirect). D5731 is a direct reline.

LIMITATIONS

1. Follow up adjustments provided within six months of the reline are typically included in the fee for D5731 and are not reimbursed separately. If an adjustment is made by an office that did not deliver the denture, that office might be reimbursed. This should be noted in a brief narrative.
2. Providing a reline to a mandibular denture or overdenture may extend the replacement limitation period of that prosthesis for two to five years. The reline may "reset" the limitation period (typically five to 10-years) for replacement of the relined prosthesis with a new prosthesis. Some payors will reimburse a reline once per arch, per 12 months. The reimbursement for a reline is highly variable. Because of this variability, it is recommended that the coverage and limitations be verified before providing this service.
3. A reline may be denied when provided for cosmetic reasons, but may be approved when justified by alveolar ridge resorption and to treat changes in occlusion.

TIPS

1. Reimbursement for a laboratory processed reline is typically higher than for a chairside reline.
2. Reimbursement for a rebase is typically higher than for a chairside reline.

Note:D5765, soft liner for complete or partial removable denture- indirect is found under the next section"Other Removable Prosthetic Services"

Note:D5765, soft liner for complete or partial removable denture - indirect is found under the section "Other Removable Prosthetic Services"

D5740 RELINE MAXILLARY PARTIAL DENTURE (DIRECT) CDT 2025

WATCH

1. Some practices err when reporting a direct *(chairside)* reline code instead of the in office *processed* (oven, pressure bath, etc.) indirect *(laboratory)* reline. Report the indirect *(laboratory)* reline code if the reline is *processed* either in the office *or* by an outside laboratory. A Triad® oven processed or a pressurized hot water bath is an indirect (laboratory) reline and should be reported as D5760. Indirect (laboratory) *soft* relines are reported using D5765.
2. It is an error to report a direct (chairside) reline as tissue conditioning. Tissue conditioning is used to promote healing of an unhealthy ridge *prior* to taking an impression for a final prosthesis or prior to a rebase or a reline. See D5850 for further details on tissue conditioning (maxillary).



MATCH

1. D5740 reports the chairside relining of a maxillary (upper) partial denture (D5211 or D5213).
2. D5740 reports the chairside relining of a maxillary implant/abutment supported partial denture.

COMMENTS

1. "Rebase" is the process of removing the old denture base material (the pink part of the partial denture) and replacing it with new denture base material.
2. "Reline" is the process of resurfacing the tissue side of the denture with new denture base material. A reline *resurfaces* the old base material.
3. Relines can be chairside (direct) or laboratory processed (indirect). D5740 is a direct reline.
4. Enter the teeth number(s) or range of teeth being replaced by the partial denture in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Follow up adjustments provided within six months of the reline are typically included in the fee for D5740 and are not reimbursed separately. If an adjustment is made by an office that did not deliver the denture, that office might be reimbursed. This should be noted in a brief narrative.
2. Providing a reline to a maxillary partial denture or overdenture may extend the replacement limitation period of that prosthesis for two to five years. The reline may "reset" the limitation period (typically five to 10-years) for replacement of the relined prosthesis with a new prosthesis. Some payors will reimburse a reline once per arch, per 12 months. The reimbursement for a reline is highly variable. Because of this variability, it is recommended that the coverage and limitations be verified before providing this service.
3. A reline may be denied when provided for cosmetic reasons, but may be approved when justified by alveolar ridge resorption and to treat changes in occlusion.

TIPS

1. Reimbursement for a laboratory processed reline is typically higher than for a chairside reline.
2. Reimbursement for a rebase is typically higher than for a chairside reline.

Note:D5765, soft liner for complete or partial removable denture- indirect is found under the section "Other Removable Prosthetic Services"

D5741

D5741 RELINE MANDIBULAR PARTIAL DENTURE (DIRECT) CDT 2025

WATCH

1. Some practices err when reporting a direct *(chairside)* reline code instead of the in office *processed* (oven, pressure bath, etc.) indirect *(laboratory)* reline. Report the indirect *(laboratory)* reline code if the reline is *processed* either in the office *or* by an outside laboratory. A Triad® oven processed or a pressurized hot water bath is an indirect (laboratory) reline and should be reported a D5761. Indirect (laboratory) *soft* relines are reported using D5765.
2. It is an error to report a direct (chairside) reline as tissue conditioning. Tissue conditioning is used to promote healing of an unhealthy ridge *prior* to taking an impression for a final prosthesis or prior to a rebase or a reline. See D5851 for further details on tissue conditioning (mandibular).

MATCH

1. D5741 reports the chairside relining of a mandibular (lower) partial denture (D5212 or D5214).
2. D5741 reports the chairside relining of a mandibular implant/abutment supported partial denture.

COMMENTS

1. "Rebase" is the process of removing the old denture base material (the pink part of a partial denture) and replacing it with new denture base material.
2. "Reline" is the process of resurfacing the tissue side of the denture with new denture base material. A reline resurfaces the old base material.
3. Relines can be chairside (direct) or laboratory processed (indirect). D5741 is a direct reline.
4. Enter the teeth number(s) or range of teeth being replaced by the partial denture in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Follow up adjustments provided within six months of the reline are typically included in the fee for D5741 and are not reimbursed separately. If an adjustment is made by an office that did not deliver the denture, that office might be reimbursed. This should be noted in a brief narrative.

2. Providing a reline to a mandibular partial denture or overdenture may extend the replacement limitation period of that prosthesis for two to five years. The reline may "reset" the limitation period (typically five to 10-years) for replacement of the relined prosthesis with a new prosthesis. Some payors will reimburse a reline once per arch, per 12 months. The reimbursement for a reline is highly variable. Because of this variability, it is recommended that the coverage and limitations be verified before providing this service.
3. A reline may be denied when provided for cosmetic reasons, but may be approved when justified by alveolar ridge resorption and to treat changes in occlusion.

TIPS

1. Reimbursement for a laboratory processed reline is typically higher than for a chairside reline.
2. Reimbursement for a rebase is typically higher than for a chairside reline.

Note:D5765, soft liner for complete or partial removable denture- indirect is found under the section "Other Removable Prosthetic Services"

D5750 RELINE COMPLETE MAXILLARY DENTURE (INDIRECT) CDT 2025

WATCH

Some practices err when reporting a direct *(chairside)* reline code instead of the in office *processed* (oven, pressure bath, etc.) indirect *(laboratory)* reline. Report the indirect (laboratory) reline code if the reline is *processed* either in the office *or* by an outside lab. A Triad® oven processed or pressurized hot water bath indirect (laboratory) reline of a complete maxillary denture is reported as D5750. Indirect (laboratory) *soft* relines are reported using D5765.



MATCH

1. D5750 reports the laboratory processed hard reline of a complete maxillary (upper) denture (D5110).
2. D5750 reports the laboratory processed hard reline of a maxillary implant/abutment supported prosthesis.

COMMENTS

1. "Rebase" is the process of removing the old base material (the pink part of a denture) and replacing it with new base material.
2. "Reline," is the process of resurfacing the tissue side of the denture with new base material. A reline *resurfaces* the old base material.
3. D5750 is used to report *laboratory processed* (oven or pressurized hot water bath) maxillary complete denture hard acrylic relines. Laboratory processing can occur in office *or in* an outside laboratory.

LIMITATIONS

1. Follow up adjustments provided within six months of the reline are typically included in the fee for D5750 and are not reimbursed separately. If an adjustment is made by an office that did not deliver the denture, that office might be reimbursed. This should be noted in a brief narrative.
2. Providing a reline to a complete maxillary denture or overdenture may extend the replacement limitation period of that prosthesis for two to five years. The reline may "reset" the limitation period (typically five to 10-years) for replacement of the relined prosthesis with a new prosthesis. Some payors will reimburse a reline once per arch, per 12 months. The reimbursement for a reline is highly variable. Because of this variability, it is recommended that the coverage and limitations be verified before providing this service.
3. A reline may be denied when provided for cosmetic reasons, but may be approved when justified by alveolar ridge resorption and to treat changes in occlusion.

TIPS

1. Reimbursement for a laboratory processed reline is typically higher than for a chairside reline.
2. Reimbursement for a laboratory processed reline is lower than for a rebase.

Note:D5765, soft liner for complete or partial removable denture- indirect is found under the section "Other Removable Prosthetic Services"

D5751 RELINE COMPLETE MANDIBULAR DENTURE (INDIRECT) CDT 2025

WATCH

Some practices err when reporting a direct *(chairside)* reline code instead of the in office *processed* (oven, pressure bath, etc.) indirect *(laboratory)* reline. Report the indirect (laboratory) reline code if the reline is *processed* either in the office *or* by an outside lab. A Triad® oven processed or pressurized hot water bath indirect (laboratory) reline of a complete mandibular denture is reported as D5751. Indirect (laboratory) *soft* relines are reported using D5765.

MATCH

1. D5751 reports the laboratory processed hard reline of a complete mandibular (lower) denture (D5120).
2. D5751 reports the laboratory processed hard reline of a mandibular implant/abutment supported prosthesis.

COMMENTS

1. "Rebase" is the process of removing the old base material (the pink part of a denture) and replacing it with new base material.
2. "Reline," is the process of resurfacing the tissue side of the denture with new base material. A reline *resurfaces* the old base material.
3. D5751 is used to report *laboratory processed* (oven or pressurized hot water bath) mandibular complete denture hard acrylic relines. Laboratory processing can occur in office *or in* an outside laboratory.

LIMITATIONS

1. Follow up adjustments provided within six months of the reline are typically included in the fee for D5751 and are not reimbursed separately. If an adjustment is made by an office that did not deliver the denture, that office might be reimbursed. This should be noted in a brief narrative.
2. Providing a reline to a mandibular complete denture or overdenture may extend the replacement limitation period of that prosthesis for two to five years. The reline may "reset" the limitation period (typically five to 10-years) for replacement of the relined prosthesis with a new prosthesis. Some payors will reimburse a reline once per arch, per 12 months. The reimbursement for a reline is highly variable. Because of this variability, it is recommended that the coverage and limitations be verified before providing this service.
3. A reline may be denied when provided for cosmetic reasons, but may be approved when justified by alveolar ridge resorption and to treat changes in occlusion.

TIPS

1. Reimbursement for a laboratory processed reline is considerably higher than for a chairside reline.
2. Reimbursement for a laboratory processed reline is lower than for a rebase.

Note:D5765, soft liner for complete or partial removable denture- indirect is found under the section "Other Removable Prosthetic Services"

D5760 RELINE MAXILLARY PARTIAL DENTURE (INDIRECT) CDT 2025

WATCH

Some practices err when reporting a direct *(chairside)* reline code instead of the in office *processed* (oven, pressure bath, etc.) indirect *(laboratory)* reline. Report the indirect (laboratory) reline code if the reline is *processed* either in the office *or* by an outside lab. A Triad® oven processed or pressurized hot water bath indirect (laboratory) reline of a maxillary partial denture is reported as D5760. Indirect (laboratory) *soft* relines are reported using D5765.

MATCH

1. D5760 reports the laboratory processed hard reline of a maxillary (upper) partial denture (D5211 or D5213).
2. D5760 reports the laboratory processed hard reline of a maxillary implant/abutment supported partial denture.

COMMENTS

1. "Rebase" is the process of removing the old base material (the pink part of a partial denture) and replacing it with new base material.
2. "Reline," is the process of resurfacing the tissue side of the denture with new base material. A reline *resurfaces* the old base material.
3. D5760 is used to report *laboratory processed* (oven or pressurized hot water bath) maxillary partial denture hard acrylic relines. Laboratory processing can occur in office *or in* an outside laboratory.
4. Enter the teeth number(s) or range of teeth being replaced by the partial denture in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Follow up adjustments provided within six months of the reline are typically included in the fee for D5760 and are not reimbursed separately. If an adjustment is made by an office that did not deliver the denture, that office might be reimbursed. This should be noted in a brief narrative.
2. Providing a reline to a maxillary partial denture or overdenture may extend the replacement limitation period of that prosthesis for two to five years. The reline may "reset" the limitation period (typically five to 10-years) for replacement of the relined prosthesis with a new prosthesis. Some payors will reimburse a reline once per arch, per 12 months. The reimbursement for a reline is highly variable. Because of this variability, it is recommended that the coverage and limitations be verified before providing this service.
3. A reline may be denied when provided for cosmetic reasons, but may be approved when justified by alveolar ridge resorption and to treat changes in occlusion.

TIPS

1. Reimbursement for a laboratory processed reline is typically higher than for a chairside reline.
2. Reimbursement for a laboratory processed reline is typically lower than for a rebase.

Note:D5765, soft liner for complete or partial removable denture- indirect is found under the section "Other Removable Prosthetic Services"

D5761 RELINE MANDIBULAR PARTIAL DENTURE (INDIRECT) CDT 2025

WATCH

Some practices err when reporting a direct *(chairside)* reline code instead of the in office *processed* (oven, pressure bath, etc.) indirect *(laboratory)* reline. Report the indirect (laboratory) reline code if the reline is *processed* either in the office *or* by an outside lab. A Triad® oven processed or pressurized hot water bath indirect (laboratory) reline of a mandibular partial denture is reported as D5761. Indirect (laboratory) *soft* relines are reported using D5765.

MATCH

1. D5761 reports the laboratory processed hard reline of a mandibular (lower) partial denture (D5212 or D5214).
2. D5761 reports the laboratory processed hard reline of a mandibular implant/abutment supported partial denture.

COMMENTS

1. "Rebase" is the process of removing the old base material (the pink part of a partial denture) and replacing it with new base material.
2. "Reline," is the process of resurfacing the tissue side of the denture with new base material. A reline *resurfaces* the old base material.
3. D5761 is used to report *laboratory processed* (oven or pressurized hot water bath) mandibular partial denture or overdenture hard acrylic relines. Processing can occur in office *or in* an outside laboratory.
4. Enter the teeth number(s) or range of teeth being replaced by the partial denture in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Follow up adjustments provided within six months of the reline are typically included in the fee for D5761 and are not reimbursed separately. If an adjustment is made by an office that did not deliver the denture, that office might be reimbursed. This should be noted in a brief narrative.
2. Providing a reline to a mandibular partial denture or overdenture may extend the replacement limitation period of that prosthesis for two to five years. The reline may "reset" the limitation period (typically five to 10-years) for replacement of the relined prosthesis with a new prosthesis. Some payors will reimburse a reline once per arch, per 12 months. The reimbursement for a reline is highly variable. Because of this variability, it is recommended that the coverage and limitations be verified before providing this service.
3. A reline may be denied when provided for cosmetic reasons, but may be approved when justified by alveolar ridge resorption and to treat changes in occlusion.

TIPS

1. Reimbursement for a laboratory processed reline is typically higher than for a chairside reline.
2. Reimbursement for a laboratory processed reline is typically lower than for a rebase.

Note: D5765, soft liner for complete or partial removable denture - indirect is found under the section "Other Removable Prosthetic Services"

A prosthesis designed for use over a limited period of time, after which it is replaced by a definitive restoration.

D5810 INTERIM COMPLETE DENTURE (MAXILLARY) CDT 2025

WATCH

1. Some practices opt to report a maxillary *interim* complete denture (D5810), rather than a definitive maxillary *immediate* denture (D5130). When extracting the *remaining* natural teeth and *immediately* placing a maxillary denture, consider reporting an immediate denture (D5130) instead. D5130 is considered the most accurate code to describe this scenario and often results in a higher reimbursement. In addition, a reline/rebase is often reimbursed after the immediate denture after an appropriate waiting period as determined by the payor. Note: An *interim* complete denture (D5810) may still be reported when the interim complete denture is inserted immediately after extractions with the intention of replacing it with a definitive denture after healing, but may result in a lower overall reimbursement.
2. An interim complete denture (D5810) may be provided to rehabilitate an *already* edentulous arch for a limited period. The interim complete denture is provided for a time until a *definitive* prosthesis is fabricated, such as a maxillary complete denture (D5110), a natural tooth maxillary overdenture (D5863) or a maxillary implant/abutment supported removable overdenture (D6110).



MATCH

1. For an *adjustment* of an interim maxillary complete denture (after six months delivery), see D5410.
2. For a *repair* of a broken interim maxillary complete denture *base*, see D5512.
3. For a *replacement of missing or broken teeth* (each tooth), see D5520.
4. For a *rebase* of an interim maxillary complete denture, see D5710.
5. For a *chairside reline* of an interim maxillary complete denture, see D5730.
6. For a laboratory processed hard *reline* of an interim maxillary complete denture, see D5750.

NOTE: Many of these procedures *would not* generally be associated with a maxillary interim complete denture.

COMMENTS

For an interim implant/abutment supported maxillary fixed denture (all-on-four), see D6119.

LIMITATIONS

1. D5810 reports an interim *complete* denture (maxillary) following extractions, implant placement, or for restoration of an *already* edentulous mouth. The interim denture is followed by a long term definitive complete denture, natural tooth overdenture, or implant/abutment supported removable denture. Reporting the interim prosthesis may impact the reimbursement of the final definitive denture or overdenture. Many PPO contracts require all procedures to be billed (even non-covered procedures). The amount reimbursed for the interim complete denture will, in most cases, be deducted from the final denture. In some cases, reimbursement for the interim complete denture will subject the subsequent replacement denture to the five year limitation period for dentures.
2. When an interim complete denture is billed, it is commonly not reimbursed. If reimbursed, any amount paid by the payor may be deducted from the permanent (final) denture reimbursement. Interim dentures in service 12 months or longer are often viewed as permanent dentures by many payors. Thus, reimbursement for the permanent denture may be denied. Inform the patient of this possible limitation. It is important to verify payor policy prior to providing this treatment.

TIPS

Important! When extracting the remaining natural teeth and immediately placing a denture, consider reporting an *immediate* denture (D5130), *not* an interim complete denture. Consider reporting an *immediate* denture even if the immediate denture will be replaced by a complete denture (D5110). See D5130. This approach may increase the level of reimbursement.

CLINICAL FLOW CHARTS

Scenario #1



Scenario #2



D5811 INTERIM COMPLETE DENTURE (MANDIBULAR) CDT 2025

WATCH

1. Some practices opt to report a mandibular *interim* complete denture (D5811), rather than a definitive mandibular *immediate* denture (D5140). When extracting the *remaining* natural teeth and *immediately* placing a mandibular denture, consider reporting an immediate denture (D5140) instead. D5140 is considered the most accurate code to describe this scenario and often results in a higher reimbursement. In addition, a reline/rebase is often reimbursed after the immediate denture after an appropriate waiting period as determined by the payor. Note: An *interim* complete denture (D5811) may still be reported when the interim complete denture is inserted immediately after extractions with the intention of replacing it with a definitive denture after healing, but may result in a lower reimbursement.
2. An interim complete denture (D5811) may be provided to rehabilitate an *already* edentulous arch for a limited period. The interim complete denture is provided for a time until a *definitive* prosthesis is fabricated, such as a mandibular complete denture (D5120), a maxillary natural tooth overdenture (D5864), or a mandibular implant/abutment supported removable overdenture (D6111).

MATCH

1. For an *adjustment* of an interim mandibular complete denture (after six months delivery), see D5411.
2. For a *repair* of a broken mandibular interim complete denture *base*, see D5511.
3. For a *replacement of missing or broken teeth* (each tooth), see D5520.
4. For a *rebase* of an interim mandibular complete denture, see D5711.
5. For a *chairside reline* of an interim mandibular complete denture, see D5731.
6. For a *laboratory* processed hard *reline* of an interim mandibular complete denture, see D5751.

NOTE: Many of these procedures *would not* generally be associated with a mandibular interim complete denture.

COMMENTS

For an interim implant/abutment supported mandibular fixed denture (all-on-four), see D6118.

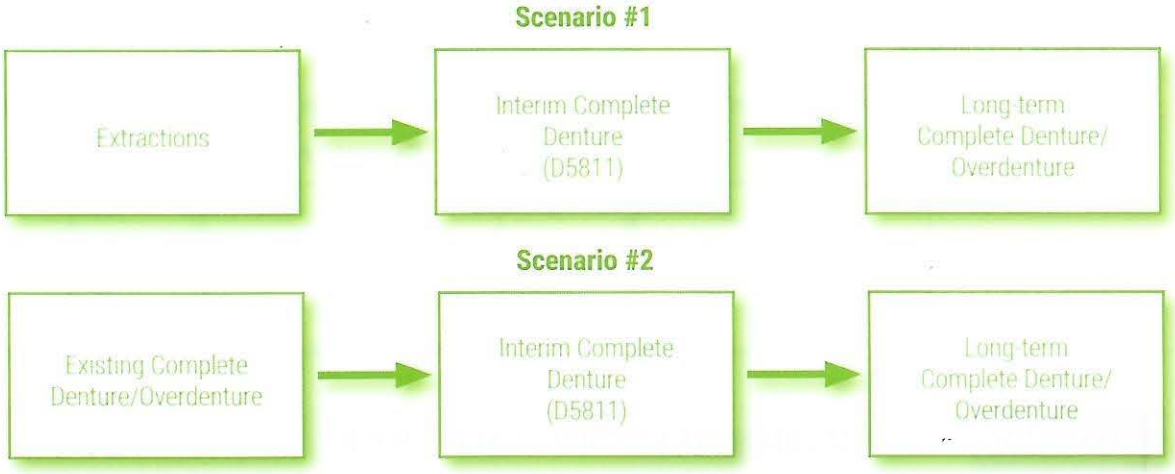
LIMITATIONS

1. D5811 reports an interim *complete* denture (mandibular) following extractions, implant placement, or for restoration of an *already* edentulous mouth. The interim denture is followed by a long term definitive complete denture, natural tooth overdenture, or implant/abutment supported overdenture. Reporting the interim prosthesis may impact the reimbursement of the final, definitive denture or overdenture. Many PPO contracts require all procedures to be billed (even non-covered procedures). The amount reimbursed for the interim complete denture will, in most cases, be deducted from the final denture. In some cases, reimbursement for the interim complete denture will subject the subsequent replacement denture to the five year limitation period for dentures.
2. When an interim complete denture is billed, it is commonly not reimbursed. If reimbursed, any amount paid by the payor may be deducted from the permanent final denture reimbursement. Interim dentures in service 12 months or longer are often viewed as permanent dentures by many payors. Thus, reimbursement for the permanent denture may be denied. Inform the patient of this possible limitation. It is important to verify payor policy prior to providing this treatment.

TIPS

Important! When extracting the remaining natural teeth and immediately placing a denture, consider reporting an *immediate* denture (D5140), *not* an interim complete denture. Consider reporting an immediate denture even if the *immediate* denture will be replaced by a complete denture (D5120). See D5140. This approach may increase the level of reimbursement.

CLINICAL FLOW CHARTS



D5820 INTERIM PARTIAL DENTURE (INCLUDING RETENTIVE/ CLASPING MATERIALS, RESTS, AND TEETH), MAXILLARY — CDT 2025

Includes any necessary clasps and rests.

WATCH

D5820 reports a *short term temporary* prosthesis, not a *long term* resin (acrylic) partial denture. A resin (acrylic) partial denture meant to be in service for a long lasting period should be reported as D5211. See D5211 for further details.

MATCH

1. For an *adjustment* of an interim maxillary partial denture (after six months delivery), see D5421.
2. For a *repair* of a maxillary interim partial denture *base*, see D5612.
3. For a *repair* or to replace a *broken clasp*, see D5630.
4. For a *replacement of missing or broken teeth* (each tooth), see D5640.
5. For *adding a tooth* to an existing interim maxillary partial denture, see D5650.
6. For *adding a clasp* to an existing interim maxillary partial denture, see D5660.
7. For a *rebase* of an interim maxillary partial denture, see D5720.
8. For a *chairside reline* of an interim maxillary partial denture, see D5740.
9. For a *laboratory* processed *reline* of an interim maxillary partial denture, see D5760.

NOTE: Many of these procedures would not generally be associated with a maxillary interim partial denture.

COMMENTS

1. Use D5820 to describe a "temp" or "flipper" maxillary resin (acrylic) partial denture which will be in service while *waiting* for a more definitive treatment. D5820 is intended to report an interim partial denture which is in place for one to 12 months. Many PPO contracts require all services to be billed (even non-covered procedures).
2. D5820 might report a Snap-On Smile® or Essix® interim partial denture (maxillary).
3. Enter the teeth number(s) or range of teeth being replaced by the partial denture in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. In a few cases an anterior "stay plate," placed after an extraction, is reimbursed in addition to a subsequent bridge. The interim partial denture is used to hold space and/or for esthetics while the extraction site heals. Alternatively, consider reporting a removable maxillary space maintainer (D1526), if appropriate, to avoid impacting the reimbursement of the subsequent definitive restoration. The dentist's clinical notes could say, "removable space maintainer placed".

2. A "stay plate" benefit may be limited to patients 16 years of age or younger and only for anterior permanent teeth. Reimbursement may be for D5820 (short term) in this situation, although D5211 may be more appropriate.
3. If the *interim* partial denture is submitted for reimbursement, the amount reimbursed for D5820 will typically be deducted from the subsequent reimbursement for the final restoration. Replacement of the interim partial may be with an implant, bridge, or cast partial denture. The delivery of the interim partial denture could trigger the limitation period (typically five to 10-years) for replacement of the interim prosthesis with a new prosthesis. The reimbursement for an interim partial denture is highly variable. It is recommended that the coverage and limitations be verified before providing this service.

D5821 INTERIM PARTIAL DENTURE (INCLUDING RETENTIVE/ CLASPING MATERIALS, RESTS, AND TEETH), MANDIBULAR

CDT 2025

Includes any necessary clasps and rests.



WATCH

D5821 reports a *short term temporary* prosthesis, not a *long term* resin (acrylic) partial denture. A resin (acrylic) partial denture meant to be in service for long lasting period should be reported as D5212. See D5212 for further details.



MATCH

1. For an *adjustment* of an interim mandibular partial denture (after six months delivery), see D5422.
2. For a *repair* of a mandibular interim partial denture *base*, see D5611.
3. For a *repair* or to replace a *broken clasp*, see D5630.
4. For a *replacement of missing or broken teeth* (each tooth), see D5640.
5. For *adding a tooth* to an existing interim partial denture, see D5650.
6. For *adding a clasp* to an existing interim partial denture, see D5660.
7. For a *rebase* of an interim mandibular partial denture, see D5721.
8. For a *chairside reline* of an interim mandibular partial denture, see D5741.
9. For a *laboratory* processed *reline* of an interim mandibular partial denture, see D5761.

NOTE: Many of these procedures *would not* generally be associated with a mandibular interim partial denture.

COMMENTS

1. Use D5821 to describe a "temp" or "flipper" mandibular resin (acrylic) partial denture which will be in service while *waiting* for a more definitive treatment. D5821 is intended to report an interim partial denture which is in place for one to 12 months. Many PPO contracts require all services to be billed (even non-covered procedures).
2. D5821 might report a Snap-On Smile® or Essix® interim partial denture (mandibular).
3. Enter the teeth number(s) or range of teeth being replaced by the partial denture in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. In a few limited cases an anterior "stay plate," placed after an extraction, is reimbursed in addition to a subsequent bridge. The interim partial denture is used to hold space and/or for esthetics while the extraction site heals. Alternatively, consider reporting a removable mandibular space maintainer (D1527), if appropriate, to avoid impacting the reimbursement of the subsequent definitive restoration. The dentist's clinical notes could say, "removable space maintainer placed".
2. A "stay plate" benefit may be limited to patients 16 years of age or younger and only for anterior permanent teeth. Reimbursement may be for D5821 (short term) in this situation, although D5212 may be more appropriate.
3. If the *interim* partial denture is submitted for reimbursement, the amount reimbursed for D5821 will typically be deducted from the subsequent reimbursement for the final restoration. Replacement of the interim partial may be with an implant, bridge, or cast partial denture. The delivery of the interim partial denture could trigger the limitation period (typically five to 10-years) for replacement of the interim prosthesis with a new prosthesis. The reimbursement for an interim partial is highly variable. It is recommended that the coverage and limitations be verified before providing this service.

PHOTO



This is an example of an interim mandibular acrylic partial denture (without wire clasps). It is to be used for an interim (limited) period, and is to be replaced by a definitive restoration.

Courtesy Drake Dental Lab

OTHER REMOVABLE PROSTHETIC SERVICES — CDT 2025

D5765 SOFT LINER FOR COMPLETE OR PARTIAL REMOVABLE DENTURE - INDIRECT — CDT 2025

A discrete procedure provided when the dentist determines placement of the soft liner is clinically indicated.

COMMENTS

1. D5765 reports an indirect (performed out of the patient's mouth) soft liner for a complete denture or for a partial denture. Clinical indications could include inability to tolerate a hard liner or to provide a relief over areas of thin tissue that cannot support a prosthesis otherwise.
2. D5765 is intended to be a definitive liner. For a short term reline designed to heal unhealthy ridges prior to more definitive final restoration, see D5850/D5851.
3. Enter the arch being lined on a complete denture or the teeth number(s) or range of teeth being replaced by a partial denture in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. D5765 is a procedure completed in a lab, not directly in a patient's mouth.
2. Follow up adjustments provided within six months of the placement of the soft liner are typically included in the fee for D5765. If an adjustment is made by an office that did not deliver the liner, that office might be reimbursed. This should be noted in a brief narrative. For complete denture adjustments use D5410 (maxillary) or D5411 (mandibular). For partial denture adjustments use D5421 (maxillary) or D5422 (mandibular).
3. Providing a soft liner may extend the replacement limitation period of that prothesis for two to five years. The soft liner may "reset" the limitation period (typically five to ten years) for replacement of the relined prosthesis with a new prosthesis.

NARRATIVES

Photos of the prosthesis and tissues before the soft liner was placed, an explanation of why the treatment is needed, what the outcome after providing the soft liner for the patient is expected, current radiographs and the date of prior placement of the original prosthesis that received the soft liner.

D5850 TISSUE CONDITIONING, MAXILLARY — CDT 2025

Treatment reline using materials designed to heal unhealthy ridges prior to more definitive final restoration.

WATCH

It is an error to report a maxillary chairside reline (typically acrylic) as tissue conditioning (D5850). The purpose of tissue conditioning treatment is to promote healing of unhealthy ridge tissues. The conditioner is placed in an *existing* denture, prior to a reline or rebase, or *prior* to fabrication of a new definitive, removable prosthesis. Tissue conditioning is not intended to be a long term service.

LIMITATIONS

1. Tissue conditioning is typically not reimbursed if done within six months of the delivery of a new prosthesis.
2. D5850 may be reimbursed twice per 12 to 36 month period. The frequency of reimbursement is dependent on plan limitations. Some payors do not reimburse tissue conditioning.

D5851 TISSUE CONDITIONING, MANDIBULAR CDT 2025

Treatment reline using materials designed to heal unhealthy ridges prior to more definitive final restoration.

WATCH

It is an error to report a mandibular chairside reline (typically acrylic) as tissue conditioning (D5851). The purpose of tissue conditioning treatment is to promote healing of unhealthy ridge tissues. The conditioner is placed in an *existing* denture, *prior* to a reline or rebase, or prior to fabrication of a new definitive, removable prosthesis. Tissue conditioning is not intended to be a long term service.

COMMENTS

1. D5850/D5851 are not intended to be a definitive liner. For a definitive soft liner in a complete or partial removable denture, see D5765.
2. Enter the arch being lined on a complete denture or the teeth number(s) or range of teeth being replaced by a partial denture in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Tissue conditioning is typically not reimbursed if used within six months of the delivery of a new prosthesis.
2. D5851 may be reimbursed twice per 12 to 36-month period. The frequency of reimbursement is dependent on plan limitations. Some payors do not reimburse tissue conditioning.

D5860 PREVIOUSLY DELETED CODE OVERDENTURE - COMPLETE, BY REPORT

This is a previously deleted code. For maxillary complete overdenture, see D5863. For mandibular complete overdenture, see D5865.

D5861 PREVIOUSLY DELETED CODE OVERDENTURE - PARTIAL, BY REPORT

This is a previously deleted code. For maxillary partial overdenture, see D5864. For mandibular partial overdenture, see D5866.

D5862 PRECISION ATTACHMENT, BY REPORT CDT 2025

Each pair of components is one precision attachment. Describe the type of attachment used.



WARNING

Do not report D5862 associated with an implant supported prosthesis. See D6191/D6192.

WATCH

D5862 documents and reports a "precision" attachment for a precision removable partial on a single natural tooth crown or a pair of components on a natural tooth-borne prosthesis, frequently called a locator.

COMMENTS

1. While D5862 is reported once for a set of both male and female components on a natural tooth borne prosthesis, together called a locator, implant supported locators are coded in two separate halves using D6191 for the abutment and D6192 for the attachment.
2. The D5862 attachment may sometimes be connected to a separate coping, D2975.
3. For a precision attachment related to a fixed partial denture (bridge), see D6950.
4. ERA, ZAAG, Zest, or similar locators on natural teeth are reported using D5862.
5. For replacement of O-rings, gaskets, or similar on a natural tooth borne prosthesis, see D5867. On an implant supported prosthesis, see D6091.

LIMITATIONS This code is not typically reimbursed.

NARRATIVES A narrative should be used when reporting D5862, as it is by report.

D5863 OVERDENTURE - COMPLETE MAXILLARY CDT 2025



WARNING

Do not report D5863 for a maxillary abutment/implant supported complete overdenture. See D6110 for further details regarding an abutment/implant supported maxillary overdenture.



MATCH

1. For an *adjustment* of a complete maxillary overdenture (after six months delivery), see D5410.
2. For a *repair* of a complete maxillary overdenture *base*, see D5512.
3. For a *replacement* of *missing or broken teeth (each tooth), see D5520.*
4. *For a rebase of a complete maxillary overdenture,* see D5710.
5. For a *chairside reline* of a complete maxillary overdenture, see D5730.
6. For a *laboratory* processed hard *reline* of a complete maxillary overdenture, see D5750.
7. If adding a metal substructure to the new overdenture, report D5876 separately in addition to the natural tooth overdenture.

COMMENTS

1. D5863 may report a maxillary complete overdenture fabricated to fit over a retained, endodontically treated, natural tooth root(s). The complete maxillary overdenture may or may not be supported by the retained root(s).
2. For a removable *abutment/implant supported* complete maxillary overdenture, see D6110.

LIMITATIONS Reimbursement for a complete maxillary overdenture (D5863), when available, is typically limited by a five to 10-year replacement period.

TIPS

1. Other procedures may be required prior to the placement of a maxillary overdenture, D5863. A root canal may be necessary on the retained natural tooth (teeth).
2. Precision attachment D5862 reports the ZAAG or ZEST locator attachment affixed to the retained root(s) beneath the overdenture and the attachment in the natural tooth overdenture.
3. An overdenture may be retained by attachment to a connector bar over natural teeth (D6920) using clips (D6192) embedded in the denture.

NARRATIVES

1. An alternate benefit of a maxillary complete denture (D5110) may be reimbursed for the maxillary overdenture (D5863), unless specifically excluded by the contract. Request the alternate benefit of D5110 when fabricating a maxillary overdenture (D5863).
2. Submit a narrative justifying the retention of the natural tooth root(s) and the necessity of the tooth supported complete maxillary overdenture.

D5864 OVERDENTURE - PARTIAL MAXILLARY CDT 2025



WARNING

Do not report D5864 for an abutment/implant-supported maxillary partial overdenture. See D6112 for further details regarding an abutment/implant-supported maxillary partial overdenture.



MATCH

1. For an *adjustment* of a maxillary partial overdenture (after six months delivery), see D5421.
2. For a *repair* of a resin maxillary partial overdenture *base*, see D5612.
3. For a *repair* or to replace a *broken clasp*, see D5630.

4. For a *replacement* of broken *teeth* (each tooth), see D5640.
5. For *adding a tooth* to an existing maxillary partial overdenture, see D5650.
6. For *adding a clasp* to an existing maxillary partial overdenture, see D5660.
7. For a *rebase* of a resin base maxillary partial overdenture, see D5720.
8. For a *chairside reline* of a maxillary partial overdenture, see D5740.
9. For a *laboratory* processed hard *reline* of a maxillary partial overdenture, see D5760.

COMMENTS

1. D5864 may report a maxillary partial overdenture fabricated to fit over natural teeth and/or retained tooth roots.
2. For a removable *abutment/implant supported* partial maxillary overdenture, see D6112.
3. Enter the teeth number(s) or range of teeth being replaced by a partial denture in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

Reimbursement for a natural tooth maxillary partial overdenture (D5864), when available, is typically limited by a five to 10-year period before a replacement overdenture would be considered for reimbursement.

TIPS

1. Other procedures may be required prior to the placement of a maxillary partial overdenture, D5864. A root canal may be necessary on the retained natural tooth (teeth).
2. Precision attachment D5862 reports a ZAAG or ZEST locator attachment affixed to the retained root(s) beneath the overdenture and the attachment in the natural tooth overdenture.
3. An overpartial may be retained by attachment to a connector bar over natural teeth (D6920) using clips (D6192) embedded in the partial.

NARRATIVES

1. An alternate benefit of a conventional cast partial denture (D5213) may be reimbursed for the natural tooth maxillary partial overdenture (D5864), unless specifically excluded by the contract. If D5864 is denied, request the alternate benefit of D5213 on appeal.
2. Submit a narrative describing the necessity of the natural tooth supported maxillary partial overdenture.

D5865 OVERDENTURE - COMPLETE MANDIBULAR CDT 2025



WARNING

Do not report D5865 for a mandibular abutment/implant supported complete overdenture. See D6111 for further details regarding an abutment/implant supported mandibular overdenture.



MATCH

1. For an *adjustment* of a complete mandibular overdenture (after six months delivery), see D5411.
2. For a *repair* of a complete mandibular overdenture *base*, see D5511.
3. For a *replacement* of *missing or broken teeth* (each tooth), see D5520.
4. For a *rebase* of a complete mandibular overdenture, see D5711.
5. For a *chairside reline* of a complete mandibular overdenture, see D5731.
6. For a *laboratory* processed hard *reline* of a complete mandibular overdenture, see D5751.
7. If adding a metal substructure to the new overdenture, report D5876 separately in addition to the natural tooth overdenture.

COMMENTS

1. D5865 may report a mandibular complete denture fabricated to fit over a retained, endodontically treated, natural tooth root(s). The natural tooth mandibular overdenture may or may not be supported by the retained root(s).
2. For a removable *abutment/implant supported* complete mandibular overdenture, see D6111.

LIMITATIONS

Reimbursement for a natural tooth mandibular overdenture (D5865), when available, is typically limited by a five to 10-year replacement period.

TIPS

1. Other procedures may be required prior to the placement of a mandibular overdenture, D5865. A root canal may be necessary on the retained natural tooth (teeth).
2. Precision attachment D5862 reports the ZAAG or ZEST locator attachment affixed to the retained root(s) beneath the overdenture and the attachment in the natural tooth overdenture.
3. An overdenture may be retained by attachment to a connector bar over natural teeth (D6920) using clips (D6192) embedded in the denture.

NARRATIVES

1. An alternate benefit of a mandibular complete denture (D5120) may be reimbursed for the mandibular overdenture (D5865), unless specifically excluded by the contract. If D5865 is denied, request the alternate benefit of D5120 on appeal.
2. Submit a narrative documenting the retention of the natural tooth root(s) and the necessity of the tooth supported complete mandibular overdenture.

D5866 OVERDENTURE - PARTIAL MANDIBULAR CDT 2025



WARNING

Do not report D5866 for an abutment/implant supported mandibular partial overdenture. See D6113 for further details regarding an abutment/implant supported partial overdenture.



MATCH

1. For an *adjustment* of a mandibular partial overdenture (after six months delivery), see D5422.
2. For a *repair* of a resin mandibular partial overdenture *base*, see D5611.
3. For a *repair* or to replace a *broken clasp*, see D5630.
4. For a *replacement* of *broken teeth* (each tooth), see D5640.
5. For *adding a tooth* to an existing mandibular partial overdenture, see D5650.
6. For *adding a clasp* to an existing mandibular partial overdenture, see D5660.
7. For a *rebase* of a resin base mandibular partial overdenture, see D5721.
8. For a *chairside reline* of a mandibular partial overdenture, see D5741.
9. For a *laboratory* processed hard *reline* of a mandibular partial overdenture, see D5761.

COMMENTS

1. D5866 may report a mandibular partial overdenture fabricated to fit over natural teeth and/or retained tooth roots.
2. For a removable abutment/implant supported partial mandibular overdenture, see D6113.
3. Enter the teeth number(s) or range of teeth being replaced by a partial denture in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

Reimbursement for a natural tooth mandibular partial overdenture (D5866), when available, is typically limited by a five to 10-year replacement period.

TIPS

1. Other procedures may be required prior to the placement of a mandibular partial overdenture, D5866. A root canal may be necessary on the retained natural tooth (teeth).
2. Precision attachment D5862 reports a ZAAG or ZEST locator attachment affixed to the retained root(s) beneath the overdenture and the attachment in the natural tooth overdenture.
3. An overpartial may be retained by attachment to a connector bar over natural teeth (D6920) using clips (D6192) embedded in the partial.

NARRATIVES

1. An alternate benefit of a conventional mandibular cast partial denture (D5214) may be reimbursed for the natural tooth mandibular partial overdenture (D5866), unless specifically excluded by the contract. If D5866 is denied, request the alternate benefit of D5214 on appeal.
2. Submit a narrative describing the necessity of the natural tooth supported mandibular partial overdenture.

D5867 REPLACEMENT OF REPLACEABLE PART OF SEMI-PRECISION OR PRECISION ATTACHMENT, PER ATTACHMENT

CDT 2025



WARNING

DO NOT use D5867 to report replacement of a male or female component of a semi-precision or precision attachment in an implant/abutment supported prosthesis. Use D6091 to report the replacement of replaceable part of semi-precision or precision attachment (male or female component) associated with a removable implant/abutment supported overdenture (D6110/6111) or a removable implant/abutment supported partial overdenture (D6112/6113).

COMMENTS

1. D5867 is used to report the replacement of *each replaceable part* replaced of a semi or precision attachment in a removable partial denture or complete *natural tooth* overdenture prosthesis.
2. Enter the quadrant, teeth number(s), or range of teeth being replaced by a partial denture in the appropriate boxes of the 2024 ADA Dental Claim Form.

NARRATIVES

Identify the attachment type and delivery date of the original semi-precision or precision attachment. D5867 is not typically reimbursed unless the replacement is due to damage. Reimbursement for replacement is not available for attachments worn out by normal wear and tear. When replacement is necessary due to damage, request an alternate benefit of a repair.

D5875 MODIFICATION OF REMOVABLE PROTHESIS FOLLOWING IMPLANT SURGERY

CDT 2025

Attachment assemblies are reported using separate codes.

COMMENTS

1. Report D5875 when modifying an existing removable prosthesis to accommodate healing caps or abutments placed in conjunction with implant placement. Providing this modification service of an existing removable prosthesis may eliminate the need for a new prosthesis.
2. For removable implant overdenture locators. See D6191 (male) and D6192 (female).
3. Enter the applicable arch, quadrant, teeth number(s), or range of teeth being replaced by a complete or partial denture in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. D5875 may be reimbursed if the policy has an implant rider.
2. If implant coverage is available, the benefit could be reimbursed as a denture repair.

TIPS

While D5875 is generally not reimbursed, a reline or rebase of the removable prosthesis following implant surgery may be reimbursed.

D5876 ADD METAL SUBSTRUCTURE TO ACRYLIC FULL DENTURE (PER ARCH)

CDT 2025

Use of metal substructure in removable complete dentures without a framework.



WARNING

1. Do not use this code to describe any non-metal materials used in the initial fabrication of a reinforced denture. The substructure must be made of some type of metal.
2. D5876 would not be used to describe metal reinforcement added to a *partial* denture.
3. For adding a metal substructure to an acrylic partial denture, see D5899 by report.

WATCH

The substructure must be metal and would not include other fracture resistant materials like a variety of nonmetal mesh materials currently utilized like carbon fiber.

MATCH

D5876 describes the laboratory procedure performed to add a metal substructure to new or existing full acrylic dentures or overdentures. This procedure is provided for those patients at high risk of breaking their current or new denture due to a disability, bruxism, or other factors.

COMMENTS

1. D5876 can report a scenario when a patient presents with a broken denture with a documented history of heavy bruxism. To prevent this from happening again, the doctor has the laboratory add a metal framework to her denture and would report code D5876 on the claim form, noting the appropriate arch. The doctor could also consider adding a metal substructure to a patient's prosthesis who present with certain disabilities including the lack of fine motor skills or manual dexterity since they may be more prone to dropping and breaking their dentures.
2. D5876 can report adding a metal substructure to an acrylic full denture or overdenture in it's initial fabrication. Report D5876 in addition to the code for the new full acrylic denture or overdenture.
3. Enter the arch being treated in the appropriate box of the 2024 ADA Dental Claim Form.

LIMITATIONS

It would be unlikely that this service would be covered.

TIPS

This service may be considered an "optional service" by PPOs and billable to the patient. Determine the "optional service" policy of Processing Policy Manual (provider handbook) and bill accordingly.

NARRATIVES

The narrative should include any contributing factor(s) that could lead to fracture of a conventional denture such as bruxism, parafunctional habits, etc., as well as any history of a fractured denture. For example: The patient presented with a broken denture. The patient has a history of heavy bruxism and has presented with a broken denture on two previous occasions. To prevent this from happening again, the doctor had the laboratory add a metal framework to her denture. The narrative should also note the appropriate arch. Also note if the patient has certain disabilities including the lack of fine motor skills or manual dexterity since they may be more prone to dropping and breaking their dentures.

D5899 UNSPECIFIED REMOVABLE PROSTHODONTIC PROCEDURE, BY REPORT CDT 2025

Use for a procedure that is not adequately described by a code. Describe procedure.

COMMENTS

D5899 reports a *removable* prosthodontic procedure not adequately described by an existing code. Use D5899, by report, for the following removable prosthodontic related procedures or any other procedure that is not described by an existing code.

1. Characterization of a denture.
2. Fabrication of a duplicate denture.
3. Adding a metal substructure to an acrylic partial denture.
4. Snap on Smile®: How is it reported? The answer depends upon the use of the prosthesis:
   a. D5820 or D5821: In these cases where the Snap on Smile® is used as a maxillary or mandibular interim partial denture.
   b. D7270: In cases where one or more teeth are evulsed or displaced by trauma and stabilization is necessary for the remaining teeth during the healing process.
   c. D8680: If placed for retention after the immediate removal of active orthodontic appliances, the Snap on Smile® prosthesis may be used as a retainer while the case "settles" and there are missing teeth in either or both arches (to be replaced later with definitive implants or a fixed bridge).

TIPS

Also see D5999, unspecified maxillofacial prosthesis, by report.

Warning! Many of the codes in this section are not in numerical order but are in proper sequence. Review the entire section.

D5911 FACIAL MOULAGE (SECTIONAL) CDT 2025

A sectional facial moulage impression is a procedure used to record the soft tissue contours of a portion of the face. Occasionally several separate sectional impressions are made, then reassembled to provide a full facial contour cast. The impression is utilized to create a partial facial moulage and generally is not reusable.

D5912 FACIAL MOULAGE (COMPLETE) CDT 2025

Synonymous terminology: facial impression, face mask impression.

A complete facial moulage impression is a procedure used to record the soft tissue contours of the whole face. The impression is utilized to create a facial moulage and generally is not reusable.

D5913 NASAL PROSTHESIS CDT 2025

Synonymous terminology: artificial nose. A removable prosthesis attached to the skin, which artificially restores part or all of the nose. Fabrication of a nasal prosthesis requires creation of an original mold. Additional prosthesis usually can be made from the same mold, and assuming no further tissue changes occur, the same mold can be utilized for extended periods of time. When a new prosthesis is made from the existing mold, this procedure is termed a nasal prosthesis replacement.

D5926 NASAL PROSTHESIS, REPLACEMENT CDT 2025

Synonymous terminology: replacement nose. An artificial nose produced from a previously made mold. A replacement prosthesis does not require fabrication of a new mold. Generally, several prostheses can be made from the same mold assuming no changes occur in the tissue bed due to surgery or age-related topographical variations.

D5914 AURICULAR PROSTHESIS CDT 2025

Synonymous terminology: artificial ear, ear prosthesis. A removable prosthesis, which artificially restores part or all of the natural ear. Usually, replacement prostheses can be made from the original mold if tissue bed changes have not occurred. Creation of an auricular prosthesis requires fabrication of a mold, from which additional prostheses usually can be made, as needed later (auricular prosthesis, replacement).

D5927 AURICULAR PROSTHESIS, REPLACEMENT CDT 2025

Synonymous terminology: replacement ear. An artificial ear produced from a previously made mold. A replacement prosthesis does not require fabrication of a new mold. Generally, several prostheses can be made from the same mold assuming no changes occur in the tissue bed due to surgery or age-related topographical variations.

D5915 ORBITAL PROSTHESIS CDT 2025

A prosthesis, which artificially restores the eye, eyelids, and adjacent hard and soft tissue, lost as a result of trauma or surgery. Fabrication of an orbital prosthesis requires creation of an original mold. Additional prostheses usually can be made from the same mold, and assuming no further tissue changes occur, the same mold can be utilized for extended periods of time. When a new prosthesis is made from the existing mold, this procedure is termed an orbital prosthesis replacement.

D5928 ORBITAL PROSTHESIS, REPLACEMENT CDT 2025

A replacement for a previously made orbital prosthesis. A replacement prosthesis does not require fabrication of a new mold. Generally, several prostheses can be made from the same mold assuming no changes occur in the tissue bed due to surgery or age-related topographical variations.

D5916 OCULAR PROSTHESIS CDT 2025

Synonymous terminology: artificial eye, glass eye. A prosthesis, which artificially replaces an eye missing as a result of trauma, surgery or congenital absence. The prosthesis does not replace missing eyelids or adjacent skin, mucosa or muscle. Ocular prostheses require semiannual or annual cleaning and polishing. Also, occasional revisions to re-adapt the prosthesis to the tissue bed may be necessary. Glass eyes are rarely made and cannot be re-adapted.

D5923 OCULAR PROSTHESIS, INTERIM CDT 2025

Synonymous terminology: Eye shell, shell, ocular conformer, conformer. A temporary replacement generally made of clear acrylic resin for an eye lost due to surgery or trauma. No attempt is made to re-establish esthetics. Fabrication of an interim ocular prosthesis generally implies subsequent fabrication of an aesthetic ocular prosthesis.

D5919 FACIAL PROSTHESIS CDT 2025

Synonymous terminology: prosthetic dressing. A removable prosthesis, which artificially replaces a portion of the face, lost due to surgery, trauma or congenital absence. Flexion of natural tissues may preclude adaptation and movement of the prosthesis to match the adjacent skin. Salivary leakage, when communicating with the oral cavity, adversely affects retention.

D5929 FACIAL PROSTHESIS, REPLACEMENT CDT 2025

A replacement facial prosthesis made from the original mold. A replacement prosthesis does not require fabrication of a new mold. Generally, several prostheses can be made from the same mold assuming no changes occur in the tissue bed due to further surgery or age related topographical variations.

D5922 NASAL SEPTAL PROSTHESIS CDT 2025

Synonymous terminology: septal plug, septal button. Removable prosthesis to occlude (obturate) a hole within the nasal septal wall. Adverse chemical degradation in this moist environment may require frequent replacement. Silicone prostheses are occasionally subject to fungal invasion.

D5924 CRANIAL PROSTHESIS CDT 2025

Synonymous terminology: skull plate, cranioplasty prosthesis, cranial implant. A biocompatible, permanently implanted replacement of a portion of the skull bones; an artificial replacement for a portion of the skull bone.

D5925 FACIAL AUGMENTATION IMPLANT PROSTHESIS CDT 2025

Synonymous terminology: facial implant. An implantable biocompatible material generally onlayed upon an existing bony area beneath the skin tissue to fill in or collectively raise portions of the overlaying facial skin tissues to create acceptable contours. Although some forms of pre-made surgical implants are commercially available, the facial augmentation is usually custom made for surgical implantation for each individual patient due to the irregular or extensive nature of the facial deficit.

D5931 OBTURATOR PROSTHESIS, SURGICAL CDT 2025

Synonymous terminology: obturator, surgical stayplate, immediate temporary obturator. A temporary prosthesis inserted during or immediately following surgical or traumatic loss of a portion or all of one or both maxillary bones and contiguous alveolar structures (e.g., gingival tissue, teeth). Frequent revisions of surgical obturators are necessary during the ensuing healing phase (approximately six months). Some dentists prefer to replace many or all teeth removed by the surgical procedure in the surgical obturator, while others do not replace any teeth. Further surgical revisions may require fabrication of another surgical obturator (e.g., an initially planned small defect may be revised and greatly enlarged after the final pathology report indicates margins are not free of tumor).

D5936 OBTURATOR PROSTHESIS, INTERIM CDT 2025

Synonymous terminology: immediate postoperative obturator. A prosthesis that is made following completion of the initial healing after a surgical resection of a portion or all of one or both the maxillae; frequently many or all teeth in the defect area are replaced by this prosthesis. This prosthesis replaces the surgical obturator, which is usually inserted at, or immediately following the resection. Generally, an interim obturator is made to facilitate closure of the resultant defect after initial healing has been completed. Unlike the surgical obturator, which usually is made prior to surgery and frequently revised in the operating room during surgery, the interim obturator is made when the defect margins are clearly defined and further surgical revisions are not planned. It is a provisional prosthesis, which may replace some or all lost teeth, and other lost bone and soft tissue structures. Also, it frequently must be revised (termed an obturator prosthesis modification) during subsequent dental procedures (e.g., restorations, gingival surgery) as well as to compensate for further tissue shrinkage before a definitive obturator prosthesis is made.

D5932 OBTURATOR PROSTHESIS, DEFINITIVE CDT 2025

Synonymous terminology: obturator. A prosthesis, which artificially replaces part or all of the maxilla and associated teeth, lost due to surgery, trauma or congenital defects. A definitive obturator is made when it is deemed that further tissue changes or recurrence of tumor are unlikely and a more permanent prosthetic rehabilitation can be achieved; it is intended for long-term use.

D5933 OBTURATOR PROSTHESIS, MODIFICATION CDT 2025

Synonymous terminology: adjustment, denture adjustment, temporary or office reline. Revision or alteration of an existing obturator (surgical, interim, or definitive); possible modifications include relief of the denture base due to tissue compression, augmentation of the seal or peripheral areas to affect adequate sealing or separation between the nasal and oral cavities.

D5934 MANDIBULAR RESECTION PROSTHESIS WITH GUIDE FLANGE CDT 2025

Synonymous terminology: resection device, resection appliance. A prosthesis that guides the remaining portion of the mandible, left after a partial resection, into a more normal relationship with the maxilla. This allows for some tooth-to-tooth or an improved tooth contact. It may also artificially replace missing teeth and thereby increase masticatory efficiency.

D5935 MANDIBULAR RESECTION PROSTHESIS WITHOUT GUIDE FLANGE CDT 2025

A prosthesis which helps guide the partially resected mandible to a more normal relation with the maxilla allowing for increased tooth contact. It does not have a flange or ramp, however, to assist in directional closure. It may replace missing teeth and thereby increase masticatory efficiency. Dentists who treat mandibulectomy patients may prefer to replace some, all or none of the teeth in the defect area. Frequently, the defect's margins preclude even partial replacement. Use of a guide (a mandibular resection prosthesis with a guide flange) may not be possible due to anatomical limitations or poor patient tolerance. Ramps, extended occlusal arrangements and irregular occlusal positioning relative to the denture foundation frequently preclude stability of the prostheses, and thus some prostheses are poorly tolerated under such adverse circumstances.

D5937 TRISMUS APPLIANCE (NOT FOR TMD TREATMENT) CDT 2025

Synonymous terminology: occlusal device for mandibular trismus, dynamic bite opener. A prosthesis, which assists the patient in increasing their oral aperture width in order to eat as well as maintain oral hygiene. Several versions and designs are possible, all intending to ease the severe lack of oral opening experienced by many patients immediately following extensive intra-oral surgical procedures.

D5951 FEEDING AID CDT 2025

Synonymous terminology: feeding prosthesis. A prosthesis, which maintains the right and left maxillary segments of an infant cleft palate patient in their proper orientation until surgery is performed to repair the cleft. It closes the oral-nasal cavity defect, thus enhancing sucking and swallowing. Used on an interim basis, this prosthesis achieves separation of the oral and nasal cavities in infants born with wide clefts necessitating delayed closure. It is eliminated if surgical closure can be affected or, alternatively, with eruption of the deciduous dentition a pediatric speech aid may be made to facilitate closure of the defect.

D5952 SPEECH AID PROSTHESIS, PEDIATRIC CDT 2025

Synonymous terminology: nasopharyngeal obturator, speech appliance, obturator, cleft palate appliance, prosthetic speech aid, speech bulb. A temporary or interim prosthesis used to close a defect in the hard and/or soft palate. It may replace tissue lost due to developmental or surgical alterations. It is necessary for the production of intelligible speech. Normal lateral growth of the palatal bones necessitates occasional replacement of this prosthesis. Intermittent revisions of the obturator section can assist in maintenance of palatalpharyngeal closure (termed a speech aid prosthesis modification). Frequently, such prostheses are not fabricated before the deciduous dentition is fully erupted since clasp retention is often essential.

D5953 SPEECH AID PROSTHESIS, ADULT CDT 2025

Synonymous terminology: prosthetic speech appliance, speech aid, speech bulb. A definitive prosthesis, which can improve speech in adult cleft palate patients either by obturating (sealing off) a palatal cleft or fistula, or occasionally by assisting an incompetent soft palate. Both mechanisms are necessary to achieve velopharyngeal competency. Generally, this prosthesis is fabricated when no further growth is anticipated and the objective is to achieve long-term use. Hence, more precise materials and techniques are utilized. Occasionally such procedures are accomplished in conjunction with precision attachments in crown work undertaken on some or all maxillary teeth to achieve improved aesthetics.

D5954 PALATAL AUGMENTATION PROSTHESIS CDT 2025

Synonymous terminology: superimposed prosthesis, maxillary glossectomy prosthesis, maxillary speech prosthesis, palatal drop prosthesis. A removable prosthesis that alters the hard and/or soft palate's topographical form adjacent to the tongue.

D5955 PALATAL LIFT PROSTHESIS, DEFINITIVE CDT 2025

A prosthesis that elevates the soft palate superiorly and aids in restoration of soft palate functions that may be lost due to an acquired, congenital or developmental defect. A definitive palatal lift is usually made for patients whose experience with an interim palatal lift has been successful, especially if surgical alterations are deemed unwarranted.

D5958 PALATAL LIFT PROSTHESIS, INTERIM CDT 2025

Synonymous terminology: diagnostic palatal lift. A prosthesis that elevates and assists in restoring soft palate function that may be lost due to clefting, surgery, trauma or unknown paralysis. It is intended for interim use to determine its usefulness in achieving palatalpharyngeal competency or enhance swallowing reflexes. This prosthesis is intended for interim use as a diagnostic aid to assess the level of possible improvement in speech intelligibility. Some clinicians believe use of a palatal lift on an interim basis may stimulate an otherwise flaccid soft palate to increase functional activity, subsequently lessening its need.

D5959 PALATAL LIFT PROSTHESIS, MODIFICATION

CDT 2025

Synonymous terminology: revision of lift, adjustment. Alterations in the adaptation, contour, form or function of an existing palatal lift necessitated due to tissue impingement, lack of function, poor clasp adaptation or the like.

D5960 SPEECH AID PROSTHESIS, MODIFICATION

CDT 2025

Synonymous terminology: adjustment, repair, revision. Any revision of a pediatric or adult speech aid not necessitating its replacement. Frequently, revisions of the obturating section of any speech aid are required to facilitate enhanced speech intelligibility. Such revisions or repairs do not require complete remaking of the prosthesis, thus extending its longevity.

D5982 SURGICAL STENT

CDT 2025

Synonymous terminology: periodontal stent, skin graft stent, columellar stent. Stents are utilized to apply pressure to soft tissues to facilitate healing and prevent cicatrization or collapse. A surgical stent may be required in surgical and post-surgical revisions to achieve close approximation of tissues. Usually such materials as temporary or interim soft denture liners, gutta-percha, or dental modeling impression compound may be used.



WARNING

Surgical stent (D5982) does not report an implant surgical guide. See D6190 to report a radiographic/surgical implant index.

COMMENTS

1. The surgical stent (D5982) applies pressure to soft tissues to facilitate healing and prevent collapse.
2. Surgical splints (D5988) use existing teeth and/or bone for anchorage to stabilize and immobilize broken bones during healing.
3. D5982 can be used to report a guide for Alveoloplasty.
4. Enter the arch, quadrant, teeth number(s), or range of teeth being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

D5983 RADIATION CARRIER

CDT 2025

Synonymous terminology: radiotherapy prosthesis, carrier prosthesis, radiation applicator, radium carrier, intracavity carrier, intracavity applicator.

A device used to administer radiation to confined areas by means of capsules, beads or needles of radiation emitting materials such as radium or cesium. Its function is to hold the radiation source securely in the same location during the entire period of treatment. Radiation oncologists occasionally request these devices to achieve close approximation and controlled application of radiation to a tumor deemed amiable to eradication.

Note: D5983 is listed here in numerical order. However, it is also listed below the "Carriers" heading following D5993.

D5984 RADIATION SHIELD

CDT 2025

Synonymous terminology: radiation stent, tongue protector, lead shield.

An intra-oral prosthesis designed to shield adjacent tissues from radiation during orthovoltage treatment of malignant lesions of the head and neck region.

D5985 RADIATION CONE LOCATOR — CDT 2025

Synonymous terminology: docking device, cone locator.

A prosthesis utilized to direct and reduplicate the path of radiation to an oral tumor during a split course of irradiation.

D5986 FLUORIDE GEL CARRIER — CDT 2025

Synonymous terminology: fluoride applicator.

A prosthesis, which covers the teeth in either dental arch and is used to apply topical fluoride in close proximity to tooth enamel and dentin for several minutes daily.

Note: D5986 is listed here in numerical order. However, it is also properly listed below the "Carriers" heading starting with D5983.



WARNING

It is an error to report a fluoride gel carrier (D5986) to be reimbursed for at-home whitening bleaching trays (D9975) or Perio Protect Trays®. See D5995/D5996 to report Perio Protect Trays®.

COMMENTS

1. A fluoride gel carrier is fabricated for the daily application of fluoride to the teeth of high risk caries (or sensitivity) patients. These high risk patients may include seniors, pediatric patients or a patient receiving radiation treatment.
2. For supporting documentation, a high caries risk assessment and documentaion - high risk finding (D0603) is recommended.
3. D5986 is reported on a "per arch" basis. The claim form should indicate the arch using the appropriate two-digit code in Box 25 of the 2024 ADA Dental Claim Form (e.g., 01 to indicate upper arch; 02 to indicate lower arch).

LIMITATIONS

D5986 is typically not reimbursed.

NARRATIVES

Fluoride gel trays may be submitted to the patient's medical plan for reimbursement consideration when related to symptoms related to radiation treatment for head and neck cancer. The clinical documentation should include the reason for the fluoride gel carrier along with the specific cancer diagnosis.

D5987 COMMISSURE SPLINT — CDT 2025

Synonymous terminology: lip splint.

A device placed between the lips, which assists in achieving increased opening between the lips. Use of such devices enhances opening where surgical, chemical or electrical alterations of the lips has resulted in severe restriction or contractures.

D5988 SURGICAL SPLINT — CDT 2025

Synonymous terminology: Gunning splint, modified Gunning splint, labiolingual splint, fenestrated splint, Kingsley splint, cast metal splint. Splints are designed to utilize existing teeth and/or alveolar processes as points of anchorage to assist in stabilization and immobilization of broken bones during healing. They are used to re-establish, as much as possible, normal occlusal relationships during the process of immobilization. Frequently, existing prostheses (e.g., a patient's complete dentures) can be modified to serve as surgical splints. Frequently, surgical splints have arch bars added to facilitate intermaxillary fixation. Rubber elastics may be used to assist in this process. Circummandibular eyelet hooks can be utilized for enhanced stabilization with wiring to adjacent bone.



WARNING

1. This code does not report Perio Protect®. To report Perio Protect®, see D5995/D5996.
2. Many practices err by reporting surgical splint (D5988) to describe a radiographic/surgical implant index. See D6190 for reporting a radiographic/surgical implant index. D5988 is not related to implant procedures.

COMMENTS

1. Surgical splints (D5988) use existing teeth and/or bone for anchorage to stabilize and immobilize broken bones during healing.
2. The surgical stent (D5982) applies pressure to soft tissue to facilitate healing and prevent collapse.
3. Enter the arch, quadrant, teeth number(s), or range of teeth being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

D5991 VESICULOBULLOUS DISEASE MEDICAMENT CARRIER — CDT 2025

A custom fabricated carrier that covers the teeth and alveolar mucosa, or alveolar mucosa alone, and is used to deliver prescription medicaments for treatment of immunologically mediated vesiculobullous disease.

Note: D5991 is listed here in numerical order. However, it is also listed below the "Carriers" heading starting with D5983.



WARNING

D5991 *does not* report Perio Protect Trays®. To report Perio Protect®, see D5995/D5996.

COMMENTS

1. This procedure describes a custom fabricated carrier that covers the teeth and alveolar mucosa, or alveolar mucosa alone. The carrier is used to deliver topical corticosteroids and similar prescription medicaments for maximum sustained contact with the alveolar ridge and/or attached gingival tissues.
2. The prescription medicaments treat and manage the immunologically mediated vesiculobullous mucosal, chronic recurrent ulcerative, and other desquamative diseases of the gingival and oral mucosa.
3. Enter the arch being treated in the appropriate box of the 2024 ADA Dental Claim Form.

TIPS

This service may be considered for reimbursement by a medical plan.

D5992 ADJUST MAXILLOFACIAL PROSTHETIC APPLIANCE, BY REPORT — CDT 2025



WARNING

This code *does not* describe adjustments made to removable partial or full dentures. For adjustments to removable partial or full dentures, see D5410-D5422.

COMMENTS

D5992 describes adjustments made to maxillofacial prosthetic appliances (such as an obturator).

LIMITATIONS

This procedure would not generally be reimbursed by dental insurance.

TIPS

1. For *maintenance and cleaning* of a maxillofacial prosthesis (such as an obturator), see D5993.
2. It is appropriate to report both D5992, adjust maxillofacial prosthetic appliance, and maintenance and cleaning of a maxillofacial prosthesis (D5993) at the same appointment.

D5993 MAINTENANCE AND CLEANING OF A MAXILLOFACIAL PROSTHESIS (EXTRA- OR INTRA-ORAL) OTHER THAN REQUIRED ADJUSTMENTS, BY REPORT — CDT 2025



WARNING

1. D5993 *may not* be reported for maintenance and cleaning of a removable partial or full denture.
2. See D9932, D9933, D9934, D9935 to report cleaning and inspection of removable partial and complete dentures.

COMMENTS

1. Proper maintenance and cleaning of maxillofacial prostheses is critically important to minimize recurrent infections and to prevent tearing and/or breakdown of prostheses. D5993 can be used to describe the maintenance and cleaning of maxillofacial prostheses (intra and extra-oral) that have accumulated calculus and/or other foreign materials that patients cannot safely remove on their own. When a patient presents with hardened calculus on an obturator, hand instrumentation may be necessary in addition to using an ultrasonic cleaner. D5993 would be used to describe this procedure.

   Extra-oral prostheses are especially vulnerable to tearing, discoloration, and breakdown. The cleaning and maintenance of these appliances may require a professional's expertise to ensure the service is performed properly. The removal of adhesives and oils from facial prostheses may be necessary to extend their life. Report this cleaning service using D5993.

2. For adjustments to a maxillofacial prosthesis, see D5992.
3. D5993 and adjust maxillofacial prosthetic appliance (D5992) may be reported on the same date of service.

NARRATIVES

A claim for D5993 is justified "by report." Include a narrative describing the service provided, whether the appliance is an extra oral or intra-oral appliance, and include the method of cleaning used on the maxillofacial prosthesis.

D5994 PREVIOUSLY DELETED CODE PERIODONTAL MEDICAMENT CARRIER WITH PERIPHERAL SEAL - LABORATORY PROCESSED

This is a deleted code. See D5995 and D5996 for further details.

Note: D5995/D5996 are listed below in numerical order. Find D5995 and D5996 in the next section, following "Carriers" according to CDT placement.

D5995 PERIODONTAL MEDICAMENT CARRIER WITH PERIPHERAL SEAL - LABORATORY PROCESSED - MAXILLARY CDT 2025

A custom fabricated, laboratory processed carrier for the maxillary arch that covers the teeth and alveolar mucosa. Used as a vehicle to deliver prescribed medicaments for sustained contact with the gingiva, alveolar mucosa, and into the periodontal sulcus or pocket.



WARNING

1. Some dental practices have mistakenly used D4381 (localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue) to describe the use of Perio Protect Trays®. D4381 is intended to report the localized delivery of time-released antimicrobials such as Arestin®, Atridox®, or PerioChip®.
2. Do not use Topical Medicament Carrier D5991 to report Perio Protect Trays®. D5991 reports a topical medicament carrier that is useful in treating various desquamative diseases of the gingival and oral mucosa.
3. D5986 describes a custom tray used to apply topical fluoride gel. Do not report D5986 to describe the use of Perio Protect Trays®.

COMMENTS

1. D5995 reports a periodontal medicament carrier (tray) with a peripheral seal (maxillary) used in the Perio Protect® dental tray system. This medicament carrier has a peripheral seal, which is substantially different from other carriers due to the laboratory process. A vacuum formed tray does not seal to the tissue. The difference between a peripheral seal and a vacuum formed tray is similar to the difference between a shell crown and a cast crown, both of which are called crowns. One does not seal and has limited uses; the other has a seal and has broader applications. Thus, D5995 was created to distinguish this type of tray from others already in use for other purposes. Note that this is a laboratory processed carrier used to deliver prescribed medicaments for "sustained contact" with the gingiva, alveolar mucosa, and into the periodontal sulcus or pocket.
2. Insurance payors want to know what condition is being treated. Having a separate code makes it clear that this periodontal medicament carrier (D5995) is being used to treat periodontal disease. This type of tray is used to direct medications (e.g., peroxide) into the gingival sulcus to help manage biofilm. This type of tray directs prescribed solutions into periodontal pockets when used at home by the periodontal patient. Although a dentist must choose the most appropriate solution for individual patients, the most commonly prescribed solution with this type of tray has oxidizing and oxygenating agents. Oxidizing agents debride (chemically remove) the slimy coating of a biofilm and also cleanse the oral wounds.
3. Report D5995 for Perio Protect Trays® for the maxillary arch. See D5996 for mandibular arch.

LIMITATIONS The treatment of the periodontal patient using a maxillary periodontal medicament carrier with peripheral seal - laboratory processed (D5995) is seldom covered.

NARRATIVES The claim for D5995 should be supported by the periodontal diagnosis, an outline of the patient's periodontal history, including appropriate periodontal charting, methods previously implemented to control the periodontal condition, and the prescribed solution used in the tray(s).

D5996 PERIODONTAL MEDICAMENT CARRIER WITH PERIPHERAL SEAL - LABORATORY PROCESSED - MANDIBULAR

CDT 2025

A custom fabricated, laboratory processed carrier for the mandibular arch that covers the teeth and alveolar mucosa. Used as a vehicle to deliver prescribed medicaments for sustained contact with the gingiva, alveolar mucosa, and into the periodontal sulcus or pocket.



WARNING

1. Some dental practices have mistakenly used D4381 (localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue) to describe the use of Perio Protect Trays®. D4381 is intended to report the localized delivery of time-released antimicrobials such as Arestin®, Atridox®, or PerioChip®.
2. Do not use Topical Medicament Carrier D5991 to report Perio Protect Trays®. D5991 reports a topical medicament carrier that is useful in treating various desquamative diseases of the gingival and oral mucosa.
3. D5986 describes a custom tray used to apply topical fluoride gel. Do not report D5986 to describe the use of Perio Protect Trays®.

COMMENTS

1. D5996 reports a periodontal medicament carrier (tray) with a peripheral seal (mandibular) used in the Perio Protect® dental tray system. This medicament carrier has a peripheral seal, which is substantially different from other carriers due to the laboratory process. A vacuum formed tray does not seal to the tissue. The difference between a peripheral seal and a vacuum formed tray is similar to the difference between a shell crown and a cast crown, both of which are called crowns. One does not seal and has limited uses; the other has a seal and has broader applications. Thus, D5996 was created to distinguish this type of tray from others already in use for other purposes. Note that this is a laboratory processed carrier used to deliver prescribed medicaments for "sustained contact" with the gingiva, alveolar mucosa, and into the periodontal sulcus or pocket.
2. Insurance payors want to know what condition is being treated. Having a separate code makes it clear that this periodontal medicament carrier (D5996) is being used to treat periodontal disease. This type of tray is used to direct medications (e.g., peroxide) into the gingival sulcus to help manage biofilm. This type of tray directs prescribed solutions into periodontal pockets when used at home by the periodontal patient. Although a dentist must choose the most appropriate solution for individual patients, the most commonly prescribed solution with this type of tray has oxidizing and oxygenating agents. Oxidizing agents debride (chemically remove) the slimy coating of a biofilm and also cleanse the oral wounds.
3. Report D5996 for Perio Protect Trays® for the mandibular arch. See D5995 for the maxillary arch.

LIMITATIONS The treatment of the periodontal patient using a mandibular periodontal medicament carrier with peripheral seal - laboratory processed (D5996) is seldom covered.

NARRATIVES The claim for D5996 should be supported by the periodontal diagnosis, an outline of the patient's periodontal history, including appropriate periodontal charting, methods previously implemented to control the periodontal condition, and the prescribed solution used in the tray(s).

D5983 RADIATION CARRIER CDT 2025

Synonymous terminology: radiotherapy prosthesis, carrier prosthesis, radiation applicator, radium carrier, intracavity carrier, intracavity applicator.

A device used to administer radiation to confined areas by means of capsules, beads or needles of radiation emitting materials such as radium or cesium. Its function is to hold the radiation source securely in the same location during the entire period of treatment. Radiation oncologists occasionally request these devices to achieve close approximation and controlled application of radiation to a tumor deemed amiable to eradication.

D5986 FLUORIDE GEL CARRIER CDT 2025

Synonymous terminology: fluoride applicator.

A prosthesis, which covers the teeth in either dental arch and is used to apply topical fluoride in close proximity to tooth enamel and dentin for several minutes daily.

Note: This code is placed here in this section according to CDT. However, it is out of order numerically.



WARNING

It is an error to report a fluoride gel carrier (D5986) to be reimbursed for at-home whitening bleaching trays (D9975) or Perio Protect Trays®. See D5995/D5996 to report Perio Protect Trays®.

COMMENTS

1. A fluoride gel carrier is fabricated for the daily application of fluoride to the teeth of high risk caries (or sensitivity) patients. These high risk patients may include seniors, pediatric patients or a patient receiving radiation treatment.
2. For supporting documentation, a high caries risk assessment and documentation - high risk finding (D0603) is recommended
3. D5986 is reported on a "per arch" basis. The claim form should indicate the arch using the appropriate two-digit code in Box 25 of the 2024 ADA Dental Claim Form (e.g., 01 to indicate upper arch; 02 to indicate lower arch).

LIMITATIONS

D5986 is typically not reimbursed.

NARRATIVES

Fluoride gel trays may be submitted to the patient's medical plan for reimbursement consideration when related to symptoms related to radiation treatment for head and neck cancer. The clinical documentation should include the reason for the fluoride gel carrier along with the specific cancer diagnosis.

D5991 VESICULOBULLOUS DISEASE MEDICAMENT CARRIER CDT 2025

A custom fabricated carrier that covers the teeth and alveolar mucosa, or alveolar mucosa alone, and is used to deliver prescription medicaments for treatment of immunologically mediated vesiculobullous disease.

Note: This code is placed here in this section according to CDT. However, it is out of order numerically.



WARNING

D5991 *does not* report Perio Protect Trays®. To report Perio Protect®, see D5995/D5996.

COMMENTS

1. This procedure describes a custom fabricated carrier that covers the teeth and alveolar mucosa, or alveolar mucosa alone. The carrier is used to deliver topical corticosteroids and similar prescription medicaments for maximum sustained contact with the alveolar ridge and/or attached gingival tissues.

2. The prescription medicaments treat and manage the immunologically mediated vesiculobullous mucosal, chronic recurrent ulcerative, and other desquamative diseases of the gingival and oral mucosa.
3. Enter the arch being treated in the appropriate box of the 2024 ADA Dental Claim Form.

TIPS

This service may be considered for reimbursement by a medical plan.

D5994 PREVIOUSLY DELETED CODE PERIODONTAL MEDICAMENT CARRIER WITH PERIPHERAL SEAL - LABORATORY PROCESSED

This is a previously deleted code. See D5995 and D5996 for further details.

Note: This code is placed here in this section according to CDT. However, it is out of order numerically.

D5995 PERIODONTAL MEDICAMENT CARRIER WITH PERIPHERAL SEAL - LABORATORY PROCESSED - MAXILLARY

CDT 2025

A custom fabricated, laboratory processed carrier for the maxillary arch that covers the teeth and alveolar mucosa. Used as a vehicle to deliver prescribed medicaments for sustained contact with the gingiva, alveolar mucosa, and into the periodontal sulcus or pocket.

Note: This code is placed here in this section according to CDT. However, it is out of order numerically.



WARNING

1. Some dental practices have mistakenly used D4381 (localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue) to describe the use of Perio Protect Trays®. D4381 is intended to report the localized delivery of time-released antimicrobials such as Arestin®, Atridox®, or PerioChip®.
2. Do not use Topical Medicament Carrier D5991 to report Perio Protect Trays®. D5991 reports a topical medicament carrier that is useful in treating various desquamative diseases of the gingival and oral mucosa.
3. D5986 describes a custom tray used to apply topical fluoride gel. Do not report D5986 to describe the use of Perio Protect Trays®.

COMMENTS

1. D5995 reports a periodontal medicament carrier (tray) with a peripheral seal (maxillary) used in the Perio Protect® dental tray system. This medicament carrier has a peripheral seal, which is substantially different from other carriers due to the laboratory process. A vacuum formed tray does not seal to the tissue. The difference between a peripheral seal and a vacuum formed tray is similar to the difference between a shell crown and a cast crown, both of which are called crowns. One does not seal and has limited uses; the other has a seal and has broader applications. Thus, D5995 was created to distinguish this type of tray from others already in use for other purposes. Note that this is a laboratory processed carrier used to deliver prescribed medicaments for "sustained contact" with the gingiva, alveolar mucosa, and into the periodontal sulcus or pocket.
2. Insurance payors want to know what condition is being treated. Having a separate code makes it clear that this periodontal medicament carrier (D5995) is being used to treat periodontal disease. This type of tray is used to direct medications (e.g., peroxide) into the gingival sulcus to help manage biofilm. This type of tray directs prescribed solutions into periodontal pockets when used at home by the periodontal patient. Although a dentist must choose the most appropriate solution for individual patients, the most commonly prescribed solution with this type of tray has oxidizing and oxygenating agents. Oxidizing agents debride (chemically remove) the slimy coating of a biofilm and also cleanse the oral wounds.
3. Report D5995 for Perio Protect Trays® for the maxillary arch. See D5996 for the mandibular arch.

LIMITATIONS

The treatment of the periodontal patient using a maxillary periodontal medicament carrier with peripheral seal - laboratory processed (D5995) is seldom covered.

NARRATIVES

The claim for D5995 should be supported by the periodontal diagnosis, an outline of the patient's periodontal history, including appropriate periodontal charting, methods previously implemented to control the periodontal condition, and the prescribed solution used in the tray(s).

D5996 PERIODONTAL MEDICAMENT CARRIER WITH PERIPHERAL SEAL - LABORATORY PROCESSED - MANDIBULAR

CDT 2025

A custom fabricated, laboratory processed carrier for the mandibular arch that covers the teeth and alveolar mucosa. Used as a vehicle to deliver prescribed medicaments for sustained contact with the gingiva, alveolar mucosa, and into the periodontal sulcus or pocket.

Note: This code is placed here in this section according to CDT. However, it is out of order numerically.



WARNING

1. Some dental practices have mistakenly used D4381 (localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue) to describe the use of Perio Protect Trays®. D4381 is intended to report the localized delivery of time-released antimicrobials such as Arestin®, Atridox®, or PerioChip®.
2. Do not use Topical Medicament Carrier D5991 to report Perio Protect Trays®. D5991 reports a topical medicament carrier that is useful in treating various desquamative diseases of the gingival and oral mucosa.
3. D5986 describes a custom tray used to apply topical fluoride gel. Do not report D5986 to describe the use of Perio Protect Trays®.

COMMENTS

1. D5996 reports a periodontal medicament carrier (tray) with a peripheral seal (mandibular) used in the Perio Protect® dental tray system. This medicament carrier has a peripheral seal, which is substantially different from other carriers due to the laboratory process. A vacuum formed tray does not seal to the tissue. The difference between a peripheral seal and a vacuum formed tray is similar to the difference between a shell crown and a cast crown, both of which are called crowns. One does not seal and has limited uses; the other has a seal and has broader applications. Thus, D5996 was created to distinguish this type of tray from others already in use for other purposes. Note that this is a laboratory processed carrier used to deliver prescribed medicaments for "sustained contact" with the gingiva, alveolar mucosa, and into the periodontal sulcus or pocket.
2. Insurance payors want to know what condition is being treated. Having a separate code makes it clear that this periodontal medicament carrier (D5996) is being used to treat periodontal disease. This type of tray is used to direct medications (e.g., peroxide) into the gingival sulcus to help manage biofilm. This type of tray directs prescribed solutions into periodontal pockets when used at home by the periodontal patient. Although a dentist must choose the most appropriate solution for individual patients, the most commonly prescribed solution with this type of tray has oxidizing and oxygenating agents. Oxidizing agents debride (chemically remove) the slimy coating of a biofilm and also cleanse the oral wounds.
3. Report D5996 for Perio Protect Trays® for the mandibular arch. See D5995 for the maxillary arch.

LIMITATIONS

The treatment of the periodontal patient using a mandibular periodontal medicament carrier with peripheral seal - laboratory processed (D5996) is seldom covered.

NARRATIVES

The claim for D5996 should be supported by the periodontal diagnosis, an outline of the patient's periodontal history, including appropriate periodontal charting, methods previously implemented to control the periodontal condition, and the prescribed solution used in the tray(s).

D5999 UNSPECIFIED MAXILLOFACIAL PROSTHESIS, BY REPORT

CDT 2025

Used for procedure that is not adequately described by a code. Describe procedure.



WARNING

D5999 reports a unspecified procedure involving a maxillofacial prosthesis (involving the face, not teeth). For procedures involving a unspecified removable prosthodontic procedure (involving teeth), see D5899.

COMMENTS

1. Report D5999 for a Snore Guard Appliance - Typically not a covered dental benefit. Snoring is generally considered *social*, not medical.
2. For sleep apnea appliance fabrication, adjustments, and repair, see the Sleep Apnea category of service.

IMPLANT SERVICES INDEX

Warning!

Many of the Implant Services Codes in this section are not in numerical order, but all are listed under various subcategories. Below is a list of the Implant Services Codes in numerical order with the appropriate page number for reference to help you find the code.

Procedure	Page	Procedure	Page	Procedure	Page
D6010	290	D6075	325	D6104	295
D6011	291	D6076	325	D6105	296
D6012	292	D6077	326	D6106	296
D6013	292	D6078	306	D6107	297
D6040	293	D6079	306	D6110	303
D6050	293	D6080	331	D6111	304
D6051	300	D6081	332	D6112	304
D6052 (Previously Deleted)	301	D6082	315	D6113	305
D6053/D6054 (Previously Deleted)	303	D6083	316	D6114	306
D6055	298	D6084	317	D6115	306
D6056	299	D6085	333	D6116	307
D6057	300	D6086	317	D6117	307
D6058	309	D6087	318	D6118	308
D6059	310	D6088	319	D6119	308
D6060	310	D6089	334	D6120	328
D6061	311	D6090	334	D6121	329
D6062	311	D6091	335	D6122	330
D6063	312	D6092	335	D6123	330
D6064	312	D6093	335	D6180 (New)	336
D6065	314	D6094	313	D6190	289
D6066	314	D6095 (Deleted)	336	D6191	301
D6067	315	D6096	336	D6192	302
D6068	319	D6097	313	D6193 (New)	338
D6069	320	D6098	327	D6194	323
D6070	321	D6099	327	D6195	324
D6071	321	D6100	293	D6197	339
D6072	322	D6101	294	D6198	339
D6073	322	D6102	294	D6199	340
D6074	323	D6103	295		

Important: See page 289 for photo of abutment vs. implant supported crown, the most commonly miscoded procedures.

GENERAL COMMENTS FOR IMPLANT SERVICES — AUTHOR'S COMMENTS



WARNING

1. It is misleading to report "implant type" crowns (D60xx) as individual crowns (D27xx) restoring natural teeth, to gain reimbursement when implants are not a covered benefit.
2. It is misleading to bill a crown plus separate abutment when the lab sends and the dentist seats a one-piece screw-retained implant supported crown unit. See WATCH below for details.

WATCH

1. Do not report abutment supported crowns as implant supported crowns or vice versa. Both abutment supported and implant supported crowns may be cemented or screwed to the supporting structure, but neither of these options is a determining factor in code selection. The determining factor on what to call the restoration and how to code it is determined by if the abutment is or could be attached independently to the implant body, and from where the permanent crown gets its retention.

Abutment supported crowns are attached to and obtain stability from an intermediary abutment, which is SEPARATELY attached to the implant body. The abutment can be attached without the crown. Additionally, the retention of the crown comes only from its attachment to the abutment, and it is not secured to the implant body directly. Ultimately, this system uses two independent pieces which are each coded separately.

Usually these two pieces are each placed in the mouth individually, with the abutment being torqued into place first and the crown being seated as a separate step. The exception to this comes with what is known as a "screwmentable" crown, where the components COULD be placed individually, but the crown is manufactured with an access hole through the occlusal. This allows for the torquing of the abutment screw after extra oral cementation. This is a hybrid of the two types of restorations and is still considered abutment supported since the crown is only retained by cementation to the abutment, not by the screw itself, and the abutment COULD have been placed independently.

Alternatively, implant supported crowns attach DIRECTLY to and gain support from the implant body. The retention of the crown itself comes from attachment directly to the implant, not just to the abutment. The entire unit is placed and torqued to the implant body in one step. Even though a fabrication "abutment" may be used in the manufacturing process, it is delivered as an integral part of the one-piece implant supported crown. This "abutment" could not be placed as an individual step on its own and stand independently without the crown. As such, the whole assembled unit is considered an implant supported crown and the abutment cannot be reported as a separate procedure.

With the first system (abutment supported), you will code for a prefabricated abutment (D6056) or custom abutment (D6057), plus the crown itself. Use the proper code for the correct crown material. For an abutment supported single porcelain ceramic crown, report D6058. If it was an abutment supported implant bridge instead, you would report D6068 for the retainer crowns and D6245 for the pontics.

For the second system, (implant supported), there is no separate abutment reported. The single implant supported porcelain ceramic crown is coded as D6065. If it was an implant supported implant bridge, you would report D6075 for the retainer crowns and D6245 for the pontics.

The fee for an implant supported crown should be set higher (roughly equal to the fee for an abutment plus an abutment supported crown) to offset the increased lab bill and inability to report a separate abutment.

SEE IMAGES AT END OF GENERAL COMMENTS.

2. Do not report implant/abutment supported complete or partial overdentures (D6110/D6111/D6112/D6113) as natural tooth complete and partial overdentures (D5863/D5864/D5865/D5866). Report the implant/abutment supported complete and partial overdenture as provided, then request the alternate benefit of a complete denture (D5110/D5120) or cast framework partial (D5213/D5214) as an alternate benefit if implant overdentures are not a covered benefit.
3. Reporting the abutment-supported implant crown procedure without separately reporting the associated abutment is a common error. If submitting a claim to a PPO, the crown fee may be reduced by the payor to the negotiated PPO crown fee. If the implant abutment (D6051/D6056/D6057) is properly listed *separately* on the claim form, the patient would be responsible for payment since implants are not typically a covered benefit. Many PPO plans have a fee schedule for services that are not covered benefits. The in-network dentist must honor the participating provider contracted fees unless the plan is fully insured and fee capping for non-covered services laws apply. Properly identifying the abutment as a separate service could increase overall reimbursement. Note that non-covered services legislation does not apply to self-funded plans. See *Dental Administration With Confidence* to learn more.
4. Reporting a separate abutment with an implant supported crown or retainer crown is a common error. Implant supported (often screw retained) crowns and retainer crowns attach directly to the implant with no separate abutment. The fee for an implant supported crown should be set higher to offset the increased lab bill and inability to report a separate abutment. See point #1 and photos below for illustration.
5. If reporting a fixed partial denture (bridge) the retainer crown material should be consistent with the pontic material reported (i.e., porcelain fused to metal (PFM), metal, titanium, ceramic, etc.).

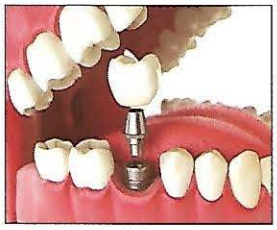
COMMENTS

1. Reimbursement for "implant type" crowns, bridges or overdentures may be denied. *Always appeal* the denial. Ask the insured to obtain a copy of the plan document (not the benefits booklet) from their Human Resources department. Review the contract for language that excludes restorations placed on implants. Review the contract for limitations. Often an alternate benefit will be reimbursed upon appeal.
2. Some PPOs cover implants/implant crowns, subject to plan maximums. The plan document controls.
3. Contact the payor for their policy on Optional Services. If available, this would allow for a legal pathway of charging the patient outside of normal contracted benefits and limitations.
4. Include the tooth number when reporting implant procedure codes, if applicable.

NARRATIVES

1. When submitting a claim for an implant type crown, it is essential that a brief narrative be included. The narrative may help avoid delays and/or claim denials.
2. "See attached radiographic image" of the fully osseointegrated implant.

PHOTO



Abutment-Supported Crown

Abutment Supported Crown: Crown attaches to separate abutment, which is separately attached to implant body. Retention of the crown comes from abutment.



Implant-Supported Crown

Implant Supported Crown: One piece crown attaches directly to implant body. Retention of the crown comes from implant.

IMPLANT SERVICES — CDT 2025

Local anesthesia is usually considered to be part of Implant Services procedures.

Warning!

Many of the Implant Services codes in this section are not in numerical order, but are listed under various subcategory sections. Thumb through this implant section and the Implant Services Index (page 287) to look for the particular implant code you are seeking.

PRE-SURGICAL SERVICES — CDT 2025

D6190 RADIOGRAPHIC/SURGICAL IMPLANT INDEX, BY REPORT — CDT 2025

An appliance, designed to relate osteotomy or fixture position to existing anatomic structures, to be utilized during radiographic exposure for treatment planning and/or during osteotomy creation for fixture installation.

Note: While out of numerical order, D6190 is correctly listed here under the Pre-surgical Services subcategory.

WATCH

1. It is an error to report either a surgical stent (D5982) or surgical splint (D5988) when providing a surgical implant index. D6190 is the correct code to report when a radiographic/surgical implant index (D6190) is provided to guide in the surgical placement of implants. Also use D6190 to report radiographic implant mapping or the implant template guide.
2. For indexing for osteotomy using dynamic robotic assisted or dynamic navigation, see D7939.

COMMENTS

1. D6190 is used to describe a radiographic index or a surgical guide used to assist in surgical implant placement. The index is inserted in the patient's mouth while the radiograph is taken. The index is designed in such a manner that it can also be used during implant placement to guide the positioning of the implant. If this is the case, the radiographic index is also the surgical index.
2. When a surgical index is not also a radiographic index, the index may not be radiopaque. If the index is only a surgical index, it is used as a guide to the osteotomy or for ideal fixture positioning. In some cases, a radiographic index is sufficient. In other cases only the surgical index is needed. Some, more complex cases may require both.
3. A surgical index can be a suck down, acrylic guide, 3D printed, or lab CAD/CAM fabricated (expensive). The patient fee for the implant index varies depending upon the laboratory fee, and generally not marked much above the lab fee for the guide.
4. The patient fee for the implant index varies depending on the laboratory fee, and generally is not much above the lab fee.
5. Enter the arch or quadrant being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Payors may require two or more implants to benefit D6190.
2. Typically, D6190 is not reimbursed unless the patient has a policy with an implant rider. This service is subject to any exclusions, limitations, or maximum reimbursements outlined in the plan.

TIPS

1. The surgeon may request the restorative dentist to make this radiographic/surgical index. The general practitioner might charge $150 to $500 for this procedure, depending on the lab cost.
2. It is suggested that the surgical implant index (D6190) be billed as a separate component of the implant service. Many times the implant procedures are not a covered benefit (unless there is a rider). The index will generally be billable to, and the responsibility of, the patient. Separately billing the implant index is not unbundling.
3. It is not not unbundling to allocate and report D6190 separately. This can make a difference if a PPO is fee capping for non-covered procedures.

NARRATIVES

A brief narrative should be provided when reporting D6190. The service will not be reimbursed unless there is an implant rider in the contract. Should the patient be covered by a policy with an implant rider, this procedure may be considered diagnostic and integral for the implant fee.

PHOTO



This is an example of a radiographic/surgical implant index to guide the surgeon to the proper site to place the implant(s).

Courtesy Drake Dental Lab

SURGICAL SERVICES — CDT 2025

Report surgical implant procedure using codes in this section.

D6010 SURGICAL PLACEMENT OF IMPLANT BODY: ENDOSTEAL IMPLANT — CDT 2025

WARNING

1. Do not report D6010 for interim (transitional) implant body, see D6012 instead.
2. Do not report D6010 to describe the surgical placement of a mini implant, see D6013 instead.
3. Do not report D6010 to report placement of an orthodontic anchorage device, see D7292/D7293/D7294 instead.

COMMENTS

1. D6010 is the most commonly used code to report surgically placed (long term) full size implants into the alveolus or basal bone. Most implant surgeries don't require a second stage surgery since the healing caps are generally exposed. Subsequent placement of the healing cap or abutment (after osseous integration) is NOT included in the initial surgical placement fee for the implant body. Subsequent surgical exposure (after osseous integration) of the implant to enable placement of a healing cap is referred to as "second stage surgery" and is reported separately as D6011, if applicable. Therefore, D6011 reports second stage surgery such as the placement of the healing cap or surgical access to enable placement of an implant abutment. See D6011.
2. The use of technology, such as Osstell IDx, to check stability after implant placement would be inclusive to the global fee of the implant placement. See D0171 to report a post-operative visit to check stability after implant placement, typically at no charge.
3. Enter the tooth number representing the position of implant placement in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. While surgical placement of implant body (D6010) is not *typically* reimbursed by dental insurance, an implant or abutment supported crown may be reimbursed as an *alternate* benefit of a standard crown.

2. When D6010 is not reimbursed by dental insurance, the implant may be reimbursed by medical insurance, but only in very limited circumstances. Medical justification for an implant might be treatment to restore function following cancer or trauma.
3. Subject to the annual reimbursement limitation, the surgical implant placement (D6010) may be paid if there is an implant rider to the policy.

PHOTO



This is an example of a conventional, full size implant reported as D6010.

Courtesy Drake Dental Lab

D6011 REVISED SURGICAL ACCESS TO AN IMPLANT BODY (SECOND STAGE IMPLANT SURGERY) CDT 2025

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.

REVISIONS

SURGICAL ACCESS TO AN IMPLANT BODY (SECOND STAGE IMPLANT SURGERY)

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.~~

COMMENTS

1. D6011 is used to describe the "second stage" surgical process whereby the implant body, i.e., D6010, is exposed, after osseous integration. Typically a healing cap or abutment is placed into the endosteal implant once the body of the implant is surgically exposed after osseous integration. The healing cap maintains an access opening through the gingiva to the endosteal implant body during the subsequent restorative phase. D6011 also describes the surgical procedure to enable access for the placement of an abutment.
2. D6011 is a separate procedure performed after some period of time (months) after the surgical placement of the implant body, and should be submitted.
3. Not every implant case requires second stage surgery, typically a minority. Healing caps are placed in the majority of cases along with the implant placement. A different dentist from the one who placed the implant(s) may also perform the second stage surgery, reporting D6011.
4. The type of fixture being placed or replaced is irrelevant and does not affect the clinical aspects of tissue removal.
5. Enter the tooth number of the implant being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. D6011 is variably reimbursed and is considered by some payors to be a part of the global implant placement service, i.e., D6010.
2. D6011 may be better reimbursed if there is implant coverage, the body of the implant is exposed and the healing cap placed by a dentist other than the dentist who placed the endosteal implant body.
3. D6011 also may be considered for reimbursement if the patient has implant coverage, the original prosthesis was broken or was lost and the gingival tissue had overgrown the retained endosteal implant body.

NARRATIVES

Support the submission of D6011 by identifying the circumstances in which the second stage surgical access was necessary and that another practitioner placed the endosteal implant body, if applicable.

D6012 SURGICAL PLACEMENT OF INTERIM IMPLANT BODY FOR TRANSITIONAL PROSTHESIS: ENDOSTEAL IMPLANT

CDT 2025

COMMENTS

1. D6012 describes *interim* implants that will be placed and then removed when the long term implants are placed. The interim implants are typically smaller in diameter and placed in areas apart from future implant sites. These implants support a temporary prosthesis during the healing process in situations where the patients cannot tolerate a removable prosthesis.
2. Enter the tooth number representing the position of implant placement in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. *Removal* of the interim implant body is included in the global fee for D6012 with most payors if benefited. For removal of interim implant component, see D6198.
2. Interim implants are generally not a covered benefit.

D6013 SURGICAL PLACEMENT OF MINI IMPLANT

CDT 2025

WARNING

1. Do not report mini implant (D6013) as an interim implant; the interim implant (D6012) functions as a component of an interim (transitional) implant system.
2. D6013 is NOT the correct code to describe a temporary anchorage device (TAD) for temporary orthodontic anchorage. The TAD type of implant is even smaller, often has an end for anchorage to attach an orthodontic wire, and should be documented using codes D7292/D7293/D7294. On the other hand, mini implants (D6013) are surgically placed (long term) implants.
3. The use of technology, such as Osstell IDx, to check stability after implant placement would be generally inclusive to the global fee of the implant placement. See D0171 to report a follow-up post-operative visit for checking stability after implant placement, typically at no charge.

COMMENTS

1. D6013 is used to describe the surgical placement of a long term mini implant. A mini implant is smaller than a full sized implant (D6010), and the fee is less (typically one-half).
2. Mini implants are typically used to support removable prostheses, but may also support an implant supported crown. The procedure involves drilling a pilot hole and placing the implant into the pilot hole. The healing period for mini implants is much shorter because osseointegration occurs much more quickly.
3. For a removable implant supported overdenture, the "cap" or locator in the overdenture would be reported as D6192, which is embedded in the overdenture.
4. Enter the tooth number representing the position of implant placement in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. While surgical placement of the mini implant body (D6013) is not typically reimbursed by dental insurance (unless there is an implant rider), the implant supported prosthesis itself may be reimbursed as an alternate benefit of a denture in certain special circumstances.
2. Medical justification for a mini implant might be the treatment of health related digestive disorders by improving masticatory function. Another justification could be treatment for trauma.

PHOTO



This is an example of a mini implant and D6013 is reported. Note the male "ball" on top. The female locator within the overdenture snaps over the "ball" for retention. Do not report D6191 semi-precision abutment with mini implants.

Courtesy Drake Dental Lab

D6020 PREVIOUSLY DELETED CODE ABUTMENT PLACEMENT OR SUBSTITUTION

This is a previously deleted code. The implant abutment global fee includes the "placement" labor. See D6051, D6056, D6057, D6191, and D6192 to report the various implant locators or abutments, which include placement.

D6040 SURGICAL PLACEMENT: EPOSTEAL IMPLANT CDT 2025

An eposteal (subperiosteal) framework of a biocompatible material designed and fabricated to fit on the surface of the bone of the mandible or maxilla with permucosal extensions which provide support and attachment of a prosthesis. This may be a complete arch or unilateral appliance. Eposteal implants rest upon the bone and under the periosteum.

COMMENTS

1. Report D6040 for a subperiosteal implant procedure. This procedure is rarely performed.
2. An eposteal implant is a metal framework surgically placed, resting on the mandible, with posts that protrude through the gum to support a prosthesis.
3. This type of implant is used in cases where inadequate ridge is available in the mandible to support an endosteal implant. Eposteal implants are typically used to support a complete mandibular overdenture.
4. Enter the arch, quadrant, and/or tooth number(s) as applicable representing the position of implant placement in Box 27 of the 2024 ADA Dental Claim Form.

D6050 SURGICAL PLACEMENT: TRANSOSTEAL IMPLANT CDT 2025

A transosteal (transosseous) biocompatible device with threaded posts penetrating both the superior and inferior cortical bone plates of the mandibular symphysis and exiting through the permucosa providing support and attachment for a dental prosthesis. Transosteal implants are placed completely through the bone and into the oral cavity from extra-oral or intra-oral.

COMMENTS

1. A transosteal implant is also called a "staple implant." This type of implant often includes two to four long metal screws surgically placed through the mandible, starting under the chin and extending into the mouth. A plate is fastened to the base of the screws and over the jaw but under the gum. The two to four screws provide anchorage for a lower denture. This type of procedure is rarely performed.
2. Enter the tooth number(s) representing the position of implant placement in Box 27 of the 2024 ADA Dental Claim Form.

D6100 SURGICAL REMOVAL OF IMPLANT BODY CDT 2025

Note: While out of numerical order, D6100 is correctly listed here under the Surgical Services subcategory.



WARNING

Do not use D6100 to report a "simple, non-surgical" removal of an implant body not requiring bone removal or flap elevation. See D6105.

COMMENTS

1. A fee for implant body removal might run $250 - $400. Typically a bone socket graft (D7953) is placed at the time of implant body removal.
2. Report bone grafting (D7953) and barrier membrane (D7956/D7957) separately, if applicable.
3. See D6105 for removal of implant body not requiring bone removal or flap elevation.
4. Enter the tooth number representing the position of implant being removed in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS Surgical removal of implant body (D6100) is typically not reimbursed.

NARRATIVES A brief narrative should identify the arch/location of the implant body removed and include a description of the procedure performed. Include the original delivery date of the implant to be removed in the narrative. Mention the requirement of bone grafting and membrane, which is reported separately, if applicable.

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

CDT 2025

Note: While out of numerical order, D6101 is correctly listed here under the Surgical Services subcategory.



WATCH

If *osseous contouring* of the peri-implant defect area is provided, report D6102, not D6101.

COMMENTS

1. D6101 is used to describe the debridement of the area around an existing single implant where a bony defect has developed.
2. D6101 includes the cleaning of the exposed implant surfaces to eliminate bacterial pathogens. D6101 includes reflecting a surgical flap for access to the area of the defect(s) as well as the closure of the surgical flap once the debridement has been completed.
3. D6081 reports the 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. There is not a bony defect.
4. Enter the tooth number representing the position of implant being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Reimbursement may be available when there is implant coverage (a rider to the insurance contract) and the need for the procedure is appropriately supported.
2. If D6101 is performed less than a year after the implant has been placed, it is unlikely that the service would be considered for reimbursement. However, it should be reported.

NARRATIVES

The reporting of D6101 should be supported by a narrative and documentation that includes:

1. Diagnosis and pretreatment radiographic images of the service area.
2. Photos of the service area after the flap has been laid and before the debridement begins.
3. Photos after the debridement have been provided.
4. Description of the procedure and prognosis.

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

CDT 2025

Note: While out of numerical order, D6102 is correctly listed here under the Surgical Services subcategory.



WATCH

D6102 requires osseous contouring of the peri-implant defect. If no osseous contouring of the peri-implant defect area is provided, report D6101.

COMMENTS

1. D6102 reports the debridement and *osseous contouring* of the area around an existing single implant where a bony defect has developed.
2. D6102 includes the cleaning of the exposed implant surfaces to eliminate bacterial pathogens. D6102 includes reflecting a surgical flap for access to the area of the defect as well as the closure of the surgical flap once the debridement and osseous contouring has been completed.
3. If a bone graft is placed to repair the peri-implant defect as part of procedure D6102, report D6103 separately.
4. Report D6106 or D6107 for barrier membrane placement (GTR) and D4265 for biologic materials placement separately.

5. D6081 reports the 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. There is *not* a bony defect.
6. Enter the tooth number representing the position of implant being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Reimbursement may be available when there is implant coverage (a rider to the insurance contract) and the need for the procedure is appropriately supported.
2. If D6102 is performed less than a year after the implant has been placed, it is unlikely that the service would be considered for reimbursement. However, it should be reported.

NARRATIVES

The reporting of D6102 should be supported by a brief narrative and documentation that includes:

1. Diagnosis and pretreatment radiographic images of the service area.
2. Photos of the service area after the flap has been laid and before the debridement and osseous contouring begins.
3. Photos after the debridement and osseous contouring has been provided and before the flap closure.
4. Description of the procedure and prognosis.

D6103 BONE GRAFT FOR REPAIR OF PERI-IMPLANT DEFECT - DOES NOT INCLUDE FLAP ENTRY AND CLOSURE

CDT 2025

Placement of a barrier membrane or biologic materials to aid in osseous regeneration are reported separately.

Note: While out of numerical order, D6103 is correctly listed here under the Surgical Services subcategory.

COMMENTS

1. D6103 reports the placement of a bone graft in the area around an existing implant where a bony defect exists. D6102 would report the debridement and osseous contouring of a peri-implant defect, while D6103 reports the placement of the bone graft.
2. D6103 does not include the placement of a barrier membrane. See D6106 or D6107 to describe the guided tissue regeneration (GTR) barrier membrane, per site, which is reported separately.
3. D4265 reports the use of biologic materials to aid in soft and osseous tissue regeneration, which is reported separate and apart from D6103, D6106 or D6107.
4. Enter the tooth number or range of teeth representing the position of implants being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Reimbursement may be available when there is implant coverage (a rider to the insurance contract) and the need for the procedure is appropriately supported.
2. If D6103 is performed less than a year after the implant has been placed, it is unlikely that the service would be considered for reimbursement. However, it should be reported.

NARRATIVES

The reporting of D6103 should be supported by a brief narrative and documentation that includes:

3. Diagnosis and pretreatment radiographic images of the service area.
4. Photos of the service area after the flap has been laid, bone contoured and before bone graft placement.
5. Photos after the bone graft for repair of peri-implant defect has been placed, but before the flap has been replaced.
6. Description of the procedures and prognosis.

D6104 BONE GRAFT AT TIME OF IMPLANT PLACEMENT

CDT 2025

Placement of a barrier membrane, or biologic materials to aid in osseous regeneration are reported separately.

Note: While out of numerical order, D6104 is correctly listed here under the Surgical Services subcategory.

COMMENTS

1. D6104 is used to describe the placement of a bone graft at the same time as implant placement. Report the surgical placement of the implant body separately, D6010.
2. D6104 does not include the placement of a guided tissue regeneration barrier membrane. See D6106 or D6107 to describe a guided tissue regeneration barrier membrane, per site. It is inappropriate to report placement of a collagen plug or collagen tape as a barrier membrane. Placement of a collagen plug or collagen tape is considered inclusive to the procedure performed and should not be reported separately.
3. D6104 does not include the use of biologic materials to aid in soft and osseous regeneration. See D4265 to report the use of biologic materials to aid in soft and osseous tissue regeneration.
4. Enter the tooth number or range of teeth representing the position of implants being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

Reimbursement may be available when there is implant coverage (a rider to the insurance contract) and the need for the procedure is appropriately supported.

NARRATIVES

The reporting of D6104 should be supported by a narrative and documentation that includes:

1. Diagnosis and pretreatment radiographic images of the service area.
2. Photos of the service area prior to implant placement.
3. Photos after the implant and graft have been placed, but before the flap has been replaced.
4. Description of the procedures and prognosis.

D6105 REMOVAL OF IMPLANT BODY NOT REQUIRING BONE REMOVAL OR FLAP ELEVATION — CDT 2025

Note: While out of numerical order, D6105 is correctly listed here under the Surgical Services subcategory.



WARNING

Do not use D6105 to report the surgical removal of an implant body. For surgical removal (more complicated), see D6100.

COMMENTS

1. This procedure reports removing an implant body using a "non-surgical" technique that does not require bone removal nor flap elevation. D6105 may also be considered a "simple" removal of an implant body.
2. Report bone grafting (D7953) and barrier membrane (D7956/D7957) separately, if applicable.
3. See D6100 for surgical removal of implant body.
4. Enter the tooth number representing the position of implant being removed in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

Removal of implant body not requiring bone removal or flap elevation (D6105) is typically not reimbursed.

NARRATIVES

A brief narrative should identify the arch/location of the implant body removed and include a description of the procedure performed. Include the original delivery date of the implant to be removed in the narrative. Mention the requirement of bone grafting and membrane (which is reported separately), if applicable.

D6106 GUIDED TISSUE REGENERATION - RESORBABLE BARRIER, PER IMPLANT — CDT 2025

This procedure does not include flap entry and closure, or, when indicated, wound debridement, osseous contouring, bone replacement grafts, and placement of biologic materials to aid in osseous regeneration. This procedure is used for peri-implant defects and during implant placement.

Note: While out of numerical order, D6106 is correctly listed here under the Surgical Services subcategory.



WARNING

1. It is inappropriate to report placement of a collagen plug or collagen tape by reporting D6106. For placement of a collagen plug or collagen tape, see D7922.
2. Do not report D6106 for a resorbable GTR for natural teeth. See D4266.
3. Do not report D6106 for a resorbable GTR for an endentulous area. See D7956.

WATCH

This procedure reports placing a *resorbable* barrier membrane for bone regeneration around an implant that has osseous defects due to peri-implantitis. It may also be used in instances where an implant is placed and bone grafting must be done that requires a resorbable membrane being placed.



MATCH

For guided tissue regeneration around an implant using a *non*-resorbable barrier, see D6107.

COMMENTS

1. This type of resorbable barrier membrane does not require a second surgery for removal.
2. A bone graft is not always required when a resorbable barrier membrane is used. Some regeneration techniques encourage bone regrowth without the need for a bone graft.
3. D6106 includes any follow up associated with this procedure.
4. Other procedures may be performed with D6106 and should be reported separately using their unique codes. These may include D4265, D6103, and D6104.
5. Enter the tooth number or range of teeth representing the position of implants being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Resorbable barrier membranes should be reported separately when placed in concert with biologic materials (D4265) or implant related bone grafts (D6103 or D6104). Some contracts stipulate that only one regenerative procedure will be paid per infrabony defect. For example, a bone graft (D6104) may be paid following implant surgery but the biologic materials (D4265) denied.
2. There typically is a 24-to-36-month exclusion period for the delivery of the same procedure to treat the same area of the mouth.

D6107 GUIDED TISSUE REGENERATION - NON-RESORBABLE BARRIER, PER IMPLANT CDT 2025

This procedure does not include flap entry and closure, or, when indicated, wound debridement, osseous contouring, bone replacement grafts, and placement of biologic materials to aid in osseous regeneration. This procedure is used for peri-implant defects and during implant placement.

Note: While out of numerical order, D6107 is correctly listed here under the Surgical Services subcategory.



WARNING

1. It is inappropriate to report placement of a collagen plug or collagen tape by reporting D6107. For placement of a collagen plug or collagen tape, see D7922.
2. Do not report D6107 for a non-resorbable GTR for natural teeth. See D4267.
3. Do not report D6107 for a non-resorbable GTR for an endentulous area. See D7957.

WATCH

This procedure reports placing a *non-resorbable* barrier membrane for bone regeneration around an implant that has osseous defects due to peri-implantitis. It may also be used in instances where an implant is placed and bone grafting must be done that requires a non-resorbable membrane being placed.



MATCH

1. For guided tissue regeneration around an implant using a resorbable barrier, see D6106.
2. For the removal of the non-resorbable barrier, see D4286.

COMMENTS

1. The non-resorbable barrier membrane requires a second surgery for removal. See D4286 removal of non-resorbable barrier for further comments and limitations.
2. A bone graft is not always required when a barrier membrane is used. Some regeneration techniques encourage bone regrowth without the need for a bone graft.
3. Other procedures may be performed with D6107 and should be reported separately using their unique codes. These may include D4265, D6103, and D6104.
4. Enter the tooth number or range of teeth representing the position of implants being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Barrier membranes should be reported separately when placed in concert with biologic materials (D4265) or implant related bone grafts (D6103 or D6104). Some contracts stipulate that only one regenerative procedure will be paid per infrabony defect. For example, a bone graft (D6104) may be paid following implant surgery but the biologic materials (D4265) denied.
2. There typically is a 24-to-36-month exclusion period for the delivery of the same procedure to treat the same area of the mouth.

IMPLANT SUPPORTED PROSTHETICS — CDT 2025

SUPPORTING STRUCTURES — CDT 2025

D6055 CONNECTING BAR - IMPLANT SUPPORTED OR ABUTMENT SUPPORTED — CDT 2025

Utilized to stabilize and anchor a prosthesis.

While out of numerical order, D6055 is correctly listed here under the Supporting Structures subcategory.

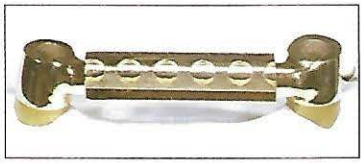
COMMENTS

1. Another option for stabilizing an implant removable overdenture is to use a connector bar (e.g., Hader® bar). The connector bar (D6055) attaches to implant abutments or to the implants themselves. The implant overdenture is fabricated to clip onto the connector bar. This attachment restricts movement of the prosthesis and makes the overdenture more secure. Each female implant attachment is reported separately as D6192.
2. Each of the implant components of the implant system are reported separately.
3. The connector bar may also be directly attached to the implants.
4. The connector bar should be reported just once, regardless of the number of abutments/implants to which it is attached. (Report D6920 when a connector bar is attached to fixed partial denture retainer crown or coping instead of being attached directly to the implants/abutments).
5. D6192 reports each female attachment "clips" embedded within the removable overdenture.
6. Indicate the range of teeth numbers to identify the location of the abutments/implants supporting the bar in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

D6055 is not typically a covered benefit.

PHOTO



This is an example of a dental implant supported connecting bar - Dolder® type.



This is an example of a dental implant supported connecting bar - Hader® type.

Courtesy Drake Dental Lab

D6056 PREFABRICATED ABUTMENT - INCLUDES MODIFICATION AND PLACEMENT CDT 2025

Modification of a prefabricated abutment may be necessary.

Note: While out of numerical order, D6056 is correctly listed here under the Supporting Structures subcategory.

WARNING

1. Do not report D6056 in conjunction with an abutment supported removable overdenture (D6110/D6111/D6112/D6113). See D6191 for semi-precision abutment (locator) and D6192 for placement of female attachment keeper assembly (locator) in the removable implant overdenture.
2. Report both D6191 and D6192 when separate abutment and locator assemblies are used with removable implant overdenture.
3. Separate abutments are not reported when using implant supported crowns or implant supported retainer crowns. The abutment is considered an integral part of this type of implant supported crown. See the General Comments at the beginning of the implant section for more information.

WATCH

1. Charge *separately* for a prefabricated implant abutment (D6056) when associated with an abutment supported implant crown. *Never* include the individual components of the implant "system" into the global implant crown fee. Reporting the components separately will correctly assign the fee for each component to the implant restoration. The implants are not a covered benefit under most contracts and reimbursement may be expected from the patient. Note, the PPO contract may dictate the fee charged for the implant and its components, even though it is not a covered benefit. The fee dictated depends on either state law or if it is a self-funded plan, federal law will apply.
2. Do not report the prefabricated (manufactured) abutment (D6056), when a custom (cast or milled) abutment (D6057) is used. The custom abutment has a higher UCR fee assigned.
3. D6051 reports an *interim* abutment which will generally be replaced by a custom abutment, D6057. See D6051 for details.

MATCH

D6056 reports an abutment that is *prefabricated* or "manufactured" (may be used "out of the box"). See D6058-D6064 and D6094/D6097 that report the various associated abutment supported *single* crowns. See D6068-D6074 and D6194/D6195 that report the various associated abutment supported implant retainer crowns for fixed partial dentures (bridges).

COMMENTS

1. A prefabricated abutment (D6056) comes from the implant manufacturer and connects the abutment supported crown restoration to the surgically placed dental implant body (D6010).
2. D6051 reports an interim abutment. See D6051 for details.
3. D6057 reports a custom abutment. See D6057 for details.
4. A prefabricated abutment is generally reported with All-on-4 or All-on-6 restorations.
5. Enter the tooth number representing the position of implant being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

Only the implant surgeon or restorative dentist who *places the prefabricated abutment* may report this code. If the implant surgeon *provides* the abutment to the restorative dentist, the surgeon should not report D6056 since he/she did not place it. The implant surgeon could only report D6199, unspecified implant procedure.

PHOTO



This is an example of a prefabricated abutment which is manufactured.

Courtesy Drake Dental Lab

D6057 CUSTOM FABRICATED ABUTMENT - INCLUDES PLACEMENT CDT 2025

Created by a laboratory process, specific for an individual application.

Note: While out of numerical order, D6057 is correctly listed here under the Supporting Structures subcategory.

WARNING

1. Do not report custom fabricated abutment (D6057) in conjunction with an abutment or implant supported overdenture (D6110/D6111/D6112/D6113). See D6191 for semi precision abutment locator and D6192 for placement of a female attachment keeper assembly (locator) in the removable implant overdenture.
2. Report both D6191 and D6192 when a separate abutment and locator assembly is used with the removable implant overdenture.
3. Separate abutments are not reported when using implant supported crowns or implant supported retainer crowns. The abutment is considered an integral part of this type of implant supported crown.See the General Comments at the beginning of the implant section for more information.

WATCH

Charge *separately* for the custom abutment (D6057) when associated with an abutment supported crown. *Never* include the individual components of the implant "system" into the global implant crown fee. Reporting the components separately will correctly assign the fee for each component to the global implant restoration. Implants are not a covered benefit under most contracts and reimbursement may be expected from the patient. Note, the PPO contract may dictate the fee charged for the implant and its abutment components, even though it is not a covered benefit. The fee dictated depends on either state law or if it is a self-funded plan, federal law will apply.

MATCH

D6057 reports a *custom* abutment (cast or milled). See D6058-D6064 and D6094/D6097 that report the various *associated* abutment supported *single* crowns. See D6068-D6074 and D6194/D6195 which report the various *associated* abutment supported retainer *crowns* for fixed partial dentures (bridges).

COMMENTS

1. A casting or milling process is used to create a *custom* abutment (D6057) specific to an individual application.
2. D6051 reports an interim abutment. See D6051 for details.
3. D6056 reports a prefabricated abutment. D6056 for details.
4. A custom abutment, if applicable, can be reported with an All-on-4 or All-on-6 restoration.
5. Enter the tooth number representing the position of implant being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

Only the implant surgeon or restorative dentist who actually *places* the custom abutment may report this code. If the implant surgeon *provides* a custom abutment to the restorative dentist, then the surgeon would report D6199 to describe this unspecified implant procedure scenario.

PHOTO



This is an example of several custom abutments. Report as D6057.

Courtesy Drake Dental Lab

D6051 EDITORIAL REVISION PLACEMENT OF INTERIM IMPLANT ABUTMENT CDT 2025

A healing cap is not an interim abutment.

Note: While out of numerical order, D6051 is correctly listed here under the Supporting Structures subcategory.

WATCH

Charge *separately* for an interim implant abutment placement (D6051). *Never* include the individual components of the implant "system" in the global implant crown fee. Reporting the components more accurately will correctly assign the fee and separate the charge for each component to the implant restoration. The implants are not a covered benefit under most contracts and reimbursement may be collected from the patient. Note, the PPO contract may dictate the fee charged for the implant and its components, even though it is not a covered benefit. The patient's responsibility to pay the non-covered amount depends on the state law or if it is a self-funded plan, federal law will apply.

COMMENTS

1. The interim implant abutment placement D6051 and interim implant crown D6085 would be placed while awaiting definitive treatment. They would be replaced by either a prefabricated abutment D6056, or custom abutment D6057, and then an abutment supported crown is cemented. This is typically an anterior abutment supported implant restoration.
2. D6198 reports the removal of the interim abutment. See D6198. Most payors consider the removal in the global fee.
3. Enter the tooth number representing the position of implant being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

The implant surgeon or restorative dentist who *places the interim implant abutment placement* may report this code. If the implant surgeon *provides* the interim implant abutment placement D6051 or the prefabricated abutment, D6056, to the restorative dentist, the surgeon should not report the abutment since he/she did not place it. The implant surgeon could only report D6199, unspecified implant procedure if the interim implant abutment or prefabricated abutment is furnished to the restoring dentist.

D6052 PREVIOUSLY DELETED CODE SEMI-PRECISION ATTACHMENT ABUTMENT

This is a previously deleted code. See D6191 and D6192 for further details.

Note: While out of numerical order, D6191 and D6192 are correctly listed here under the Supporting Structures subcategory.

D6191 SEMI-PRECISION ABUTMENT - PLACEMENT CDT 2025

This procedure is the initial placement, or replacement, of a semi-precision abutment on the implant body.

WARNING

D6052 semi-precision attachment abutment is a deleted code replaced by D6191 and D6192, commonly called locators.

WATCH

If the patient has a complete maxillary or a complete mandibular *natural tooth* overdenture (D5863 or D5865), see D5862 to report a precision attachment (e.g., a locator).

COMMENTS

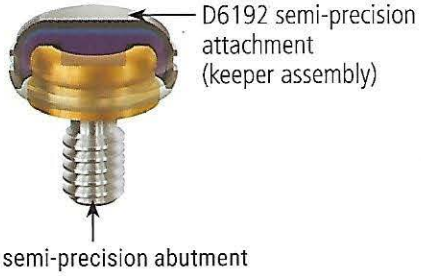
1. D6191 describes the initial placement, or replacement of a semi-precision abutment (locator) on the implant body. This is the male piece of a locator. D6192 reports the female keeper assembly (attachment) locator within the removable prosthesis.
2. Report D6191 and D6192 both for each locator set in conjunction with the abutment supported removable overdenture (D6110/D6111/D6112/D6113) when using full size implants (D6010). If using mini implants (D6013), only report D6192.
3. If modifying an existing removable prosthesis following implant surgery to be used as an interim or definitive prosthesis, report D5875 in addition to any semi-precision attachments (D6192) added to the prosthesis.
4. Enter the tooth number representing the position of implant being treated in Box 27 of the 2024 ADA Dental Claim Form.

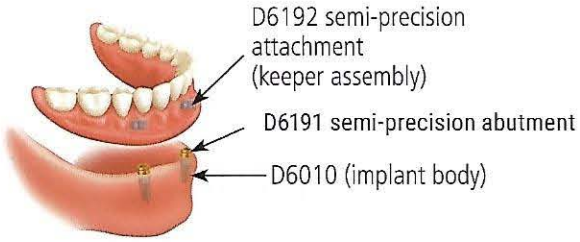
LIMITATIONS

Semi-precision abutments (D6191) may be reimbursed if the patient has implant coverage and there is sufficient justification for the use of the semi-precision abutment.

NARRATIVES The narrative should establish the need for the semi-precision abutment by describing how the abutment was inserted into the implant body along with appropriate radiographs and/or pictures.

PHOTO





D6192 SEMI-PRECISION ATTACHMENT - PLACEMENT CDT 2025

This procedure involves the luting of the initial, or replacement, semi-precision attachment to the removable prosthesis.

WARNING

D6052 semi-precision attachement is a deleted code replaced by D6191 and D6192, commonly called locators.

WATCH

If the patient has a complete maxillary or a complete mandibular *natural tooth* overdenture (D5863 or D5865), see D5862 to report a precision attachment (e.g., a locator).

COMMENTS

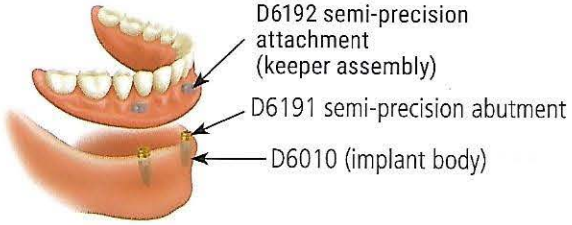
1. D6192 describes the placement, or replacement, of each female semi-precision attachment (keeper assembly) embedded within the removable implant prosthesis. D6191 describes the inital placement, or replacement, of a semi-precision abutment (locator)on the implant body.
2. D6192 reports the female keeper assembly/housing (locator) placement or replacement by either the dentist or lab.
3. If replacing only the plastic or rubber insert, O-ring, or gasket held by the semi-precision attachment, report D6091. See D6091.
4. D6192 also reports the attachment "clips" embedded in an overdenture used to affix a prosthesis to an implant supported connector bar (D6055) or natural tooth connector bar (D6920).
5. If modifying an existing removable prosthesis following implant surgery to be used as an interim or definitive prosthesis, report D5875 in addition to any semi-precision attachments (D6192) added to the prosthesis.
6. Enter the tooth number representing the position of implant being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS Semi-precision attachments (D6192) may be reimbursed if the patient has implant coverage and there is sufficient justification for the use of the semi-precision attachment.

NARRATIVES The narrative should establish the need for the semi-precision attachment by describing how the keeper assembly was attached to the removable prosthesis along with appropriate radiographs and/or pictures.

PHOTO





IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURES — CDT 2025

D6053 — PREVIOUSLY DELETED CODE IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR COMPLETELY EDENTULOUS ARCH

This is a previously deleted code. See D6110 and D6111 for further details.

D6054 — PREVIOUSLY DELETED CODE IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH

This is a previously deleted code. See D6112 and D6113 for further details.

D6110 — IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS ARCH - MAXILLARY — CDT 2025

Note: While out of numerical order, D6110 is correctly listed here under the Implant/Abutment Supported Removable Dentures subcategory.

WARNING

1. D6110 reports an *implant or abutment supported* maxillary removable overdenture for the *edentulous* arch.
2. The *natural* tooth supported maxillary overdenture - complete (D5863) is often erroneously reported when the *implant supported* removable denture for edentulous maxillary arch (D6110) is the correct code to describe the implant overdenture prosthesis. Use the correct *implant/abutment supported* removable overdenture code, D6110, to describe the maxillary prosthesis supported by an implant/abutment. For a natural tooth supported maxillary removable overdenture, see D5863.
3. Report semi-precision abutment D6191 plus semi-precision attachment D6192 (two pieces) as locators in conjunction with D6110. D6191 is the male abutment in the implant and D6192 is the female attachment in the overdenture.

COMMENTS

1. For a maxillary implant overdenture (D6110), report a semi-precision attachment female locator D6192. To report this sequence properly, there must be a separate attachment abutment, a female "keeper assembly" in the overdenture. Semi-precision attachment (D6192) now reports the placement of the keeper assembly in the implant overdenture in addition to the separate abutment (D6191), placed in the implant.
2. When a single piece mini-implant (D6013) is used, D6192 reports the "cap" that is embedded in the overdenture. Thus, report D6013 plus D6192. Do not report D6191 associated with mini implants.
3. D9932 may be reported to describe the cleaning and inspection of a removable implant/abutment supported denture (D6110).
4. If adding a metal substructure to the new overdenture, report D5876 separately in addition to the overdenture.
5. If modifying an existing removable prosthesis following implant surgery to be used as an interim or definitive prosthesis, report D5875 in addition to any semi-precision attachments (D6192) added to the prosthesis.

LIMITATIONS

Reimbursement for the implant or abutment supported removable overdenture is typically subject to the five to 10-year prosthetic replacement rule. An alternate benefit of a maxillary complete denture (D5110) may be reimbursed if no other denture (including immediate) has been reported within the period. Any adjustments done within the first six months are included in the global fee.

NARRATIVES

Use D6110 to describe a complete removable maxillary overdenture supported by implants. The claim should indicate if the prosthesis is the initial appliance or a replacement appliance and dates of the most recent extractions if this is the initial placement for the implant overdenture.

D6111 IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS ARCH - MANDIBULAR

CDT 2025

Note: While out of numerical order, D6111 is correctly listed here under the Implant/Abutment Supported Removable Dentures subcategory.



WARNING

1. D6111 reports an *implant or abutment supported* mandibular removable overdenture for the *edentulous* arch.
2. The *natural* tooth supported mandibular overdenture - complete (D5865) is often erroneously reported when the *implant supported* removable denture for completely edentulous mandibular arch (D6111) is the correct code to describe the implant overdenture prosthesis. Use the correct *implant/abutment supported* removable overdenture code, D6111, to describe the mandibular prosthesis supported by an implant/abutment. For a natural tooth supported mandibular overdenture, see D5865.
3. Report semi-precision abutment (D6191) abutment plus D6192 attachment (two pieces) as locators in conjunction with D6111. D6191 is the male abutment locator in the implant and D6192 is the female attachment locator placed in the overdenture.

COMMENTS

1. For a mandibular implant overdenture (D6111), report a semi-precision attachment female locator D6192. To report this sequence properly, there must be a separate female attachment ("keeper assembly") in the overdenture. Semi-precision attachment (D6192) now reports the placement of the keeper assembly in the implant overdenture in addition to the separate abutment (D6191), placed in the implant.
2. When a single piece mini-implant (D6013) is used, D6192 reports the "cap" attachment that is embedded in the implant overdenture. Thus, report D6013 plus D6192. Do not report D6191 associated with mini implants.
3. D9933 may be reported to describe the cleaning and inspection of a removable implant/abutment supported denture (D6111).
4. If adding a metal substructure to the new overdenture, report D5876 separately in addition to the overdenture.
5. If modifying an existing removable prosthesis following implant surgery to be used as an interim or definitive prosthesis, report D5875 in addition to any semi-precision attachments (D6192) added to the prosthesis.

LIMITATIONS

Reimbursement for the implant or abutment supported removable overdenture is typically subject to the five to 10-year prosthetic replacement limitation. An alternate benefit of a mandibular complete denture D5120 may be reimbursed if no other denture (including immediate) has been reported within the period. Any adjustments done within the first six months are included in the global fee.

NARRATIVES

Use D6111 to describe a complete removable mandibular overdenture supported by implants. The claim should indicate if the prosthesis is the initial appliance or a replacement appliance and dates of the most recent extractions if this is the initial placement for the implant overdenture.

D6112 IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH - MAXILLARY

CDT 2025

Note: While out of numerical order, D6112 is correctly listed here under the Implant/Abutment Supported Removable Denture subcategory.



WARNING

1. The *natural* tooth overdenture - maxillary partial (D5864) should not be used to describe *implant/abutment* supported removable denture for *partially edentulous* maxillary arch (D6112). If implants or abutments support the removable partial maxillary overdenture, then report a maxillary partially edentulous arch overdenture, (D6112).

2. Report semi-precision abutment D6191 plus semi-precision attachment D6192 (two pieces) as locators in conjunction with D6112. D6191 is the male abutment locator in the implant and D6192 is the female attachment locator placed in the overdenture.

COMMENTS

1. D6112 reports an *implant or abutment supported* removable overdenture for the partially edentulous maxillary arch. If the partially edentulous arch overdenture is supported/retained by *natural teeth*, see D5864.
2. For a maxillary implant overdenture (D6112), report a semi-precision attachment female locator D6192. To report this sequence properly, there must be a separate female attachment ("keeper assembly") in the removable overdenture. Semi-precision attachment (D6192) now reports the placement of the keeper assembly in the implant overdenture in addition to the separate abutment (D6191), placed in the implant.
3. When a single piece mini-implant (D6013) is used, D6192 reports the "cap" that is embedded in the overdenture. Thus, report D6013 plus D6192. See D6192. Do not report D6191 associated with mini implants.
4. D9934 may be reported to describe the cleaning and inspection of a removable implant/abutment supported denture (D6112), placed in the implant.
5. If modifying an existing removable prosthesis following implant surgery to be used as an interim or definitive prosthesis, report D5875 in addition to any semi-precision attachments (D6192) added to the prosthesis.

LIMITATIONS

An alternate benefit of D5213 (maxillary partial denture) may be reimbursed if a partial denture has not been reported within five years (seven to 10 years for some dental plans). Any adjustments done within the first six months are included in the global fee.

NARRATIVES

The claim should indicate, if the removable prosthesis is the initial appliance or a replacement appliance, and dates of most recent extractions if this is the initial placement for the overdenture.

D6113 IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH - MANDIBULAR CDT 2025

Note: While out of numerical order, D6113 is correctly listed here under the Implant/Abutment Supported Removable Denture subcategory.



WARNING

1. The *natural* tooth overdenture - mandibular partial (D5866) should not be used to describe *implant/abutment* supported removable denture for *partially edentulous* mandibular arch (D6113). If implants or abutments support the removable partial mandibular overdenture, then report a mandibular partially edentulous arch overdenture, (D6113).
2. Report the semi-precision female attachment locator (D6192) plus the semi-precision abutment D6191 (two pieces) as locators in conjunction with D6113. D6191 is the male abutment in the implant and D6192 is the female attachment placed in the overdenture.

COMMENTS

1. D6113 reports an *implant or abutment supported* removable overdenture for the partially edentulous mandibular arch. If the partially edentulous arch overdenture is supported/retained by *natural teeth*, see D5866.
2. For a mandibular implant overdenture (D6113), report a semi-precision attachment female locator D6192. To report this sequence properly, there must be a separate female attachment ("keeper assembly") in the overdenture. Semi-precision attachment (D6192) now reports the placement of the keeper assembly in the implant overdenture in addition to the separate abutment D6191, placed in the implant.
3. When a single piece mini-implant (D6013) is used, D6192 reports the "cap" that is embedded in the overdenture. Thus, report D6013 plus D6192. See D6192. Do not report D6191 associated with mini implants.
4. D9935 may be reported to describe the cleaning and inspection of a removable implant/abutment supported denture (D6113).
5. If modifying an existing removable prosthesis following implant surgery to be used as an interim or definitive prosthesis, report D5875 in addition to any semi-precision attachments (D6192) added to the prosthesis.

LIMITATIONS

An alternate benefit of D5214 (mandibular partial denture) may be reimbursed if a partial denture has not been reported within five years (seven to 10 years for some dental plans). Any adjustments done within the first six months are included in the global fee.

NARRATIVES

The claim should indicate if the removable prosthesis is the initial appliance or a replacement appliance, and dates of most recent extractions if this is the initial placement for the overdenture.

D6078 PREVIOUSLY DELETED CODE IMPLANT/ABUTMENT SUPPORTED FIXED DENTURE FOR COMPLETELY EDENTULOUS ARCH

This is a previously deleted code. See D6114 and D6115 for further details

D6079 PREVIOUSLY DELETED CODE IMPLANT/ABUTMENT SUPPORTED FIXED DENTURE FOR PARTIALLY EDENTULOUS ARCH

This is a previously deleted code. See D6116 and D6117 for further details.

D6114 IMPLANT/ABUTMENT SUPPORTED FIXED DENTURE FOR EDENTULOUS ARCH - MAXILLARY CDT 2025

Note: While out of numerical order, D6114 is correctly listed here under the Implant/Abutment supported fixed dentures (Hybrid Prosthesis) subcategory.

COMMENTS

The maxillary "hybrid prosthesis" (D6114) completely replaces *all* the missing teeth via the use of a hybrid fixed denture. The implants do not necessarily have relative tooth positions. There may be implants any place in the alveolar ridge, wherever the restorative dentist deems necessary to place the implants. This horseshoe shaped substructure may have prosthetic teeth bonded to the framework via acrylic. There may be as few as four implants or as many as eight. This maxillary fixed hybrid prosthesis is for the edentulous arch. Also commonly referred to as an All-on-X restoration, the fixed hybrid is typically connected with prefabricated abutments (D6056) attached to the implant bodies.

LIMITATIONS

1. D6114 is typically not reimbursed.
2. An implant/abutment supported fixed denture is subject to the five to 10 year replacement limitation.

NARRATIVES

1. D6114 is used to report a fixed hybrid prosthesis in the maxillary arch. Specify if this is an initial fixed denture or a replacement. If it is a replacement, list the date that the initial denture was placed.
2. Request an alternate benefit of a maxillary complete denture (D5110) or a maxillary implant/abutment supported *removable* denture (D6110) when providing an implant/abutment supported fixed maxillary denture (D6114).

D6115 IMPLANT/ABUTMENT SUPPORTED FIXED DENTURE FOR EDENTULOUS ARCH - MANDIBULAR CDT 2025

Note: While out of numerical order, D6115 is correctly listed here under the Implant/Abutment supported fixed dentures (Hybrid Prosthesis) subcategory.

COMMENTS

The mandibular "hybrid prosthesis" (D6115) completely replaces *all* the missing teeth via the use of a fixed denture. The implants do not necessarily have relative tooth positions. There may be implants any place in the alveolar ridge, wherever the restorative dentist deems necessary to place the implants. This horseshoe shaped substructure may have prosthetic teeth bonded to the framework via acrylic. There may be as few as four implants or as many as eight. This mandibular fixed hybrid prosthesis is for the edentulous arch. Also commonly referred to as an All-on-X restoration, the fixed hybrid is typically connected with prefabricated abutments (D6056) attached to the implant bodies.

LIMITATIONS

1. D6115 is typically not reimbursed.
2. An implant/abutment supported fixed denture is subject to the five to 10-year replacement limitation.

NARRATIVES

1. D6115 is used to report a hybrid fixed prosthesis in the mandibular arch. Specify if this is an initial fixed denture or a replacement. If it is a replacement, list the date that the initial denture was placed.
2. Request an alternate benefit of a mandibular complete denture (D5120) or a mandibular implant/abutment supported *removable* denture (D6111) when providing an implant/abutment supported fixed mandibular denture (D6115).

D6116 IMPLANT/ABUTMENT SUPPORTED FIXED DENTURE FOR PARTIALLY EDENTULOUS ARCH - MAXILLARY

CDT 2025

Note: While out of numerical order, D6116 is correctly listed here under the Implant/Abutment supported fixed dentures (Hybrid Prosthesis) subcategory.

COMMENTS

The maxillary "hybrid prosthesis" (D6116) replaces some missing teeth via the use of a fixed partial denture. The implants do not necessarily have relative tooth positions, i.e., there may or may not be any implant in tooth #6 position. However, there may be implants any place in the alveolar ridge, wherever the restorative dentist deems necessary to place the implants. This substructure may have prosthetic teeth bonded to the framework via acrylic. This maxillary fixed hybrid prosthesis is for the partially edentulous arch. The fixed hybrid prosthesis is typically connected with prefabricated abutments (D6056) attached to the implant bodies.

LIMITATIONS

1. D6116 is typically not reimbursed.
2. An implant/abutment supported fixed hybrid partial denture is subject to the five to 10-year replacement limitation.

NARRATIVES

1. D6116 is used to report a fixed hybrid prosthesis in the partially edentulous maxillary arch. Specify if this is an initial fixed denture or a replacement. If it is a replacement, list the date that the initial denture was placed.
2. Request an alternate benefit of a cast metal maxillary partial denture (D5213) or a maxillary implant/abutment supported *removable* partial denture (D6112) when providing an implant/abutment supported maxillary fixed partial denture for a partially edentulous maxillary arch (D6116).

D6117 IMPLANT/ABUTMENT SUPPORTED FIXED DENTURE FOR PARTIALLY EDENTULOUS ARCH - MANDIBULAR

CDT 2025

Note: While out of numerical order, D6117 is correctly listed here under the Implant/Abutment supported fixed dentures (Hybrid Prosthesis) subcategory.

COMMENTS

The mandibular "hybrid prosthesis" (D6117) replaces some missing teeth via the use of a fixed partial denture. The implants do not necessarily have relative tooth positions, i.e., there may or may not be any implant in tooth #6 position. However, there may be implants any place in the alveolar ridge, wherever the restorative dentist deems necessary to place the implants. This substructure may have prosthetic teeth bonded to the framework via acrylic. This mandibular hybrid fixed prosthesis is for the partially edentulous arch. The fixed hybrid prosthesis is typically connected with prefabricated abutments (D6056) attached to the implant bodies.

LIMITATIONS

1. D6117 is typically not reimbursed.
2. An implant/abutment supported fixed hybrid partial denture is subject to the five to 10-year replacement limitation.

NARRATIVES

1. D6117 is used to report a fixed hybrid prosthesis in the partially edentulous mandibular arch. Specify if this is an initial fixed denture or a replacement. If it is a replacement, list the date that the initial denture was placed.
2. Request an alternate benefit of a cast metal mandibular partial denture (D5214) or a mandibular implant/abutment supported *removable* partial denture (D6113) when providing an implant/abutment supported mandibular fixed partial denture for a partially edentulous arch.

D6118 IMPLANT/ABUTMENT SUPPORTED INTERIM FIXED DENTURE FOR EDENTULOUS ARCH - MANDIBULAR

CDT 2025

Used when a period of healing is necessary prior to fabrication and placement of a permanent prosthetic.

Note: While out of numerical order, D6118 is correctly listed here under the Implant/Abutment supported fixed dentures (Hybrid Prosthesis) subcategory.



WATCH

An interim implant/abutment supported fixed denture for edentulous arch - mandibular (D6118) may be provided during the rehabilitation of the edentulous mandible where implants support the interim fixed complete denture while the tissues adapt to the treatment(s) provided. The interim prosthesis is intended to function for a limited period of time while the tissues are healing/adapting. The mandibular interim complete implant/abutment supported denture is intended to function until the treatment to the mandibular arch is stable and a definitive implant/abutment supported prosthesis is fabricated.



MATCH

1. For a definitive implant/abutment supported fixed denture for edentulous arch - mandibular, see D6115
2. For an *adjustment* of an interim mandibular complete denture (typically six months after delivery), see D5411.
3. For a *repair* of an interim mandibular complete denture base, see D5511.
4. For a *replacement of missing or broken teeth* (each tooth), see D5520.
5. If modifying an existing removable prosthesis following implant surgery to be used as an interim or definitive prosthesis, report D5875.

NOTE: Many of these procedures would not generally be associated with an interim mandibular implant/complete denture.

COMMENTS

1. D6118 reports a mandibular implant/abutment supported interim fixed denture following implant placement. The interim mandibular denture is to be replaced by a long term definitive fixed implant/abutment supported denture. Reporting this interim prosthesis may impact the reimbursement of the final definitive overdenture. Many PPO contracts require all procedures to be billed (even non-covered procedures). The amount reimbursed for the interim complete abutment/implant supported denture will, in most cases, be deducted from the final denture reimbursement. In some cases, reimbursement for the interim complete implant/abutment supported denture will subject the subsequent replacement denture to the 5 year limitation period for dentures.
2. When a mandibular implant/abutment supported interim complete denture is billed, it is commonly not reimbursed. If reimbursed, any amount paid by the payor may be deducted from the permanent (final) denture reimbursement. Interim dentures in service 12 months or longer are often viewed as permanent dentures by many payors. Thus, reimbursement for the permanent implant/abutment supported fixed denture may be denied. Inform the patient of this possible limitation. It is important to verify plan limitations prior to providing this treatment.

LIMITATIONS

1. D6118 is typically not reimbursed.
2. An implant/abutment supported interim fixed denture for edentulous arch - mandibular is subject to the 5 to 10 year replacement limitation.

NARRATIVES

1. D6118 is used to report an interim fixed prosthesis in the mandibular arch. Specify if this is an initial interim fixed denture or a replacement. If it is a replacement, list the date that the initial mandibular denture was placed.
2. Request an alternate benefit of a mandibular complete denture (D5120) when providing this service.

D6119 IMPLANT/ABUTMENT SUPPORTED INTERIM FIXED DENTURE FOR EDENTULOUS ARCH - MAXILLARY

CDT 2025

Used when a period of healing is necessary prior to fabrication and placement of a permanent prosthetic.

Note: While out of numerical order, D6119 is correctly listed here under the Implant/Abutment supported fixed dentures (Hybrid Prosthesis) subcategory.

WATCH

An interim implant/abutment supported fixed denture for edentulous arch - maxillary (D6119) may be provided during the rehabilitation of the edentulous maxilla where implants support the interim fixed complete denture while the tissues adapt to the treatment(s) provided. The interim prosthesis is intended to function for a limited period of time while the tissues are healing/adapting. The maxillary interim complete implant/abutment supported denture is intended to function until the treatment to the maxillary arch is stable and a definitive implant/abutment supported prosthesis is fabricated.

MATCH

1. For a definitive implant/abutment supported fixed denture for edentulous arch - maxillary, see D6114.
2. For an *adjustment* of an interim maxillary complete denture (typically after six months), see D5410.
3. For a *repair* of an interim maxillary complete denture base, see D5512.
4. For a *replacement of missing or broken teeth* (each tooth), see D5520.
5. If modifying an existing removable prosthesis following implant surgery to be used as an interim or definitive prosthesis, report D5875.

NOTE: Many of these procedures would not generally be associated with an interim maxillary implant/complete denture.

COMMENTS

1. D6119 reports a maxillary implant/abutment supported interim fixed denture following implant placement. The interim maxillary denture is to be replaced by a long term definitive fixed implant/abutment supported denture. Reporting this interim prosthesis may impact the reimbursement of the final definitive denture. Many PPO contracts require all procedures to be billed (even non-covered procedures). The amount reimbursed for the interim complete abutment/implant supported denture will, in most cases, be deducted from the final denture reimbursement. In some cases, reimbursement for the interim complete implant/abutment supported denture will subject the subsequent replacement denture to the 5 year limitation period for dentures.
2. When a maxillary implant/abutment supported interim complete denture is billed, it is commonly not reimbursed. If reimbursed, any amount paid by the payor may be deducted from the permanent (final) denture reimbursement. Interim dentures in service 12 months or longer are often viewed as permanent dentures by many payors. Thus, reimbursement for the permanent implant/abutment supported fixed denture may be denied. Inform the patient of this possible limitation. It is important to verify plan limitations prior to providing this treatment.

LIMITATIONS

1. D6119 is typically not reimbursed.
2. An implant/abutment supported interim fixed denture for edentulous arch - maxillary is subject to the 5 to 10 year replacement limitation.

NARRATIVES

1. D6119 is used to report an interim fixed prosthesis in the maxillary arch. Specify if this is an initial interim fixed denture or a replacement. If it is a replacement, list the date that the initial maxillary denture was placed.
2. Request an alternate benefit of a maxillary complete denture (D5110) when providing this service.

SINGLE CROWNS, ABUTMENT SUPPORTED — CDT 2025

D6058 ABUTMENT SUPPORTED PORCELAIN/CERAMIC CROWN — CDT 2025

A single crown restoration that is retained, supported and stabilized by an abutment on an implant.

WARNING

1. It is misleading to report "implant type" crowns (D60xx) as "routine" individual crowns (D27xx) for natural teeth, solely to increase reimbursement. This may be considered a fraudulent act. Report exactly **what you do** rather than what may gain a higher reimbursement.
2. It is an error to report an "abutment supported" crown code for a screw retained crown that attaches directly to the implant body. See General Comments for Implant Services and photos at the beginning of this section.

MATCH

D6058 reports a porcelain/ceramic crown anchored to an implant abutment. This code describes an "abutment supported" crown anchored over either a prefabricated (D6056) or custom abutment (D6057). D6058 is not attached directly to the implant body but is instead attached to a separate abutment.

COMMENTS

1. 3D printed crowns may be reported as porcelain/ceramic provided the material is greater than 50% inorganic fillers.
2. Enter the tooth number representing the position of implant being restored in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. If an alternate benefit is provided or if covered by an implant policy rider, then reimbursement for "implant type" crowns is typically subject to the five to 10-year limitation period.
2. Age, waiting periods, missing tooth clauses, or other limitations may also apply.

NARRATIVES

Ask for the alternate benefit of a similar material type crown if there is no implant coverage.

D6059 ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (HIGH NOBLE METAL) CDT 2025

A single metal-ceramic crown restoration that is retained, supported and stabilized by an abutment on an implant.



WARNING

1. It is misleading to report "implant type" crowns (D60xx) as "routine" individual crowns (D27xx) for natural teeth, solely to increase reimbursement. This may be considered a fraudulent act. Report exactly **what you do** rather than what may gain a higher reimbursement.
2. It is an error to report an "abutment supported" crown code for a screw retained crown that attaches directly to the implant body. See General Comments for Implant Services and photos at the beginning of this section.



MATCH

D6059 reports a porcelain fused to high noble metal crown anchored to an implant abutment. This code describes an "abutment supported" crown anchored over either a prefabricated (D6056) or custom abutment (D6057). D6059 is not attached directly to the implant body but is instead attached to a separate abutment.

COMMENTS

Enter the tooth number representing the position of implant being restored in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. If an alternate benefit is provided or if covered by an implant policy rider, then reimbursement for "implant type" crowns is typically subject to a five to 10-year limitation period.
2. Age, waiting periods, missing tooth clause, or other limitations may also apply.

NARRATIVES

Ask for the alternate benefit of a similar material type crown if there is no implant coverage.

D6060 ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (PREDOMINANTLY BASE METAL) CDT 2025

A single metal-ceramic crown restoration that is retained, supported and stabilized by an abutment on an implant.



WARNING

1. It is misleading to report "implant type" crowns (D60xx) as "routine" individual crowns (D27xx) for natural teeth, solely to increase reimbursement. This may be considered a fraudulent act. Report exactly **what you do** rather than what may gain a higher reimbursement.
2. It is an error to report an "abutment supported" crown code for a screw retained crown that attaches directly to the implant body. See General Comments for Implant Services and photos at the beginning of this section.



MATCH

D6060 reports a PFM base metal crown anchored to an implant abutment. This code describes an "abutment supported" crown anchored over either a prefabricated (D6056) or custom abutment (D6057). D6060 is not attached directly to the implant body but is instead attached to a separate abutment.

COMMENTS

Enter the tooth number representing the position of implant being restored in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. If an alternate benefit is provided or if covered by an implant policy rider, then reimbursement for "implant type" crowns is typically subject to a five to 10-year limitation period.
2. Age, waiting periods, missing tooth clause, or other limitations may also apply.

NARRATIVES Ask for the alternate benefit of a similar material type crown if there is no implant coverage.

D6061 ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (NOBLE METAL) CDT 2025

A single metal-ceramic crown restoration that is retained, supported and stabilized by an abutment on an implant.



WARNING

1. It is misleading to report "implant type" crowns (D60xx) as "routine" individual crowns (D27xx) for natural teeth, solely to increase reimbursement. This may be considered a fraudulent act. Report exactly **what you do** rather than what may gain a higher reimbursement.
2. It is an error to report an "abutment supported" crown code for a screw retained crown that attaches directly to the implant body. See General Comments for Implant Services and photos at the beginning of this section.



MATCH

D6061 reports a PFM noble metal crown anchored to an implant abutment. This code describes an "abutment supported" crown anchored over either a prefabricated (D6056) or custom abutment (D6057). D6061 is not attached directly to the implant body but is instead attached to a separate abutment.

COMMENTS Enter the tooth number representing the position of implant being restored in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. If an alternate benefit is provided or if covered by an implant policy rider, then reimbursement for "implant type" crowns is typically subject to a five to 10-year limitation period.
2. Age, waiting periods, missing tooth clause, or other limitations may also apply.

NARRATIVES Ask for the alternate benefit of a similar material type crown if there is no implant coverage.

D6062 ABUTMENT SUPPORTED CAST METAL CROWN (HIGH NOBLE METAL) CDT 2025

A single cast metal crown restoration that is retained, supported and stabilized by an abutment on an implant.



WARNING

1. It is misleading to report "implant type" crowns (D60xx) as "routine" individual crowns (D27xx) for natural teeth, solely to increase reimbursement. This may be considered a fraudulent act. Report exactly **what you do** rather than what may gain a higher reimbursement.
2. It is an error to report an "abutment supported" crown code for a screw retained crown that attaches directly to the implant body. See General Comments for Implant Services and photos at the beginning of this section.



MATCH

D6062 reports a high noble metal crown anchored to an implant abutment. This code describes an "abutment supported" crown anchored over either a prefabricated (D6056) or custom abutment (D6057). D6062 is not attached directly to the implant body but is instead attached to a separate abutment.

COMMENTS Enter the tooth number representing the position of implant being restored in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. If an alternate benefit is provided or if covered by an implant policy rider, then reimbursement for "implant type" crowns is typically subject to a five to 10-year limitation period.
2. Age, waiting periods, missing tooth clause, or other limitations may also apply.

NARRATIVES Ask for the alternate benefit of a similar material type crown if there is no implant coverage.

D6063 ABUTMENT SUPPORTED CAST METAL CROWN (PREDOMINANTLY BASE METAL) CDT 2025

A single cast metal crown restoration that is retained, supported and stabilized by an abutment on an implant.



WARNING

1. It is misleading to report "implant type" crowns (D60xx) as "routine" individual crowns (D27xx) for natural teeth, solely to increase reimbursement. This may be considered a fraudulent act. Report exactly **what you do** rather than what may gain a higher reimbursement.
2. It is an error to report an "abutment supported" crown code for a screw retained crown that attaches directly to the implant body. See General Comments for Implant Services and photos at the beginning of this section.



MATCH

D6063 reports a base metal crown anchored to an implant abutment. This code describes an "abutment supported" crown anchored over either a prefabricated (D6056) or custom abutment (D6057). D6063 is not attached directly to the implant body but is instead attached to a separate abutment.

COMMENTS Enter the tooth number representing the position of implant being restored in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. If an alternate benefit is provided or if covered by an implant policy rider, then reimbursement for "implant type" crowns is typically subject to a five to 10-year limitation period.
2. Age, waiting periods, missing tooth clause, or other limitations may also apply.

NARRATIVES Ask for the alternate benefit of a similar material type crown if there is no implant coverage.

D6064 ABUTMENT SUPPORTED CAST METAL CROWN (NOBLE METAL) CDT 2025

A single cast metal crown restoration that is retained, supported and stabilized by an abutment on an implant.



WARNING

1. It is misleading to report "implant type" crowns (D60xx) as "routine" individual crowns (D27xx) for natural teeth, solely to increase reimbursement. This may be considered a fraudulent act. Report exactly **what you do** rather than what may gain a higher reimbursement.
2. It is an error to report an "abutment supported" crown code for a screw retained crown that attaches directly to the implant body. See General Comments for Implant Services and photos at the beginning of this section.



MATCH

D6064 reports a noble cast metal crown anchored to an implant abutment. This code describes an "abutment supported" crown anchored over either a prefabricated (D6056) or custom abutment (D6057). D6064 is not attached directly to the implant body but is instead attached to a separate abutment.

COMMENTS Enter the tooth number representing the position of implant being restored in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. If an alternate benefit is provided or if covered by an implant policy rider, then reimbursement for "implant type" crowns is typically subject to a five to 10-year limitation period.
2. Age, waiting periods, missing tooth clause, or other limitations may also apply.

NARRATIVES Ask for the alternate benefit of a similar material type crown if there is no implant coverage.

D6094 ABUTMENT SUPPORTED CROWN - TITANIUM AND TITANIUM ALLOYS CDT 2025

A single crown restoration that is retained, supported and stabilized by an abutment on an implant.

Note: While out of numerical order, D6094 is correctly listed here under the Single Crowns, Abutment Supported subcategory.



WARNING

1. It is misleading to report "implant type" titanium crowns (D60xx) as "routine" single crowns (D27xx) for natural teeth, solely to increase reimbursement. This may be considered a fraudulent act. Report exactly **what you do** rather than what may gain a higher reimbursement.
2. It is an error to report an "abutment supported" crown code for a screw retained crown that attaches directly to the implant body. See General Comments for Implant Services and photos at the beginning of this section.



MATCH

D6094 reports an "abutment supported" titanium and titanium alloys implant crown supported by either a prefabricated (D6056) or custom abutment (D6057). D6094 is not attached directly to the implant body but is instead attached to a separate abutment.

COMMENTS Enter the tooth number representing the position of implant being restored in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. If an alternate benefit is provided or if covered by an implant policy rider, reimbursement for "implant type" crowns is typically subject to a five to 10-year limitation period.
2. Age, waiting periods, missing tooth clause, or other limitations may also apply.

NARRATIVES Request the alternate benefit of a titanium crown (D2794) if there is no implant coverage.

D6097 ABUTMENT SUPPORTED CROWN - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS CDT 2025

A single metal-ceramic crown restoration that is retained, supported, and stabilized by an abutment on an implant.



WARNING

1. It is misleading to report "implant type" crowns (D60xx) as "routine" individual crowns (D27xx) for natural teeth, solely to increase reimbursement. This may be considered a fraudulent act. Report exactly **what you do** rather than what may gain a higher reimbursement.
2. It is an error to report an "abutment supported" crown code for a screw retained crown that attaches directly to the implant body. See General Comments for Implant Services and photos at the beginning of this section.



MATCH

D6097 reports a porcelain fused to titanium and titanium alloys crown affixed directly to an abutment on an implant. This code describes an "abutment supported" crown affixed over either a prefabricated (D6056) or custom abutment (D6057). D6097 is not attached directly to the implant body but is instead attached to a separate abutment.

COMMENTS

1. Reporting the incorrect type of metal (titanium, high noble, noble, base, etc.) used in fabricating the crown is a common coding error. Be careful to report the correct code based on the material classification.
2. Document the correct metal used in the crown on the claim form as represented in the treatment plan, the lab prescription, and the documentation from the lab. Following this protocol should eliminate reporting errors.
3. Enter the tooth number representing the position of implant being restored in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. If an alternate benefit is provided or if covered by an implant policy rider, then reimbursement for "implant type" crowns is typically subject to a five to ten year limitation period.
2. Age, waiting periods, missing tooth clause, or other limitations may also apply.

NARRATIVES Ask for the alternate benefit of a similar material type natural tooth crown if there is no implant coverage.

D6065 IMPLANT SUPPORTED PORCELAIN/CERAMIC CROWN CDT 2025

A single crown restoration that is retained, supported and stabilized by an implant.



WARNING

It is misleading to report "implant type" crowns (D60xx) as "routine" individual crowns (D27xx) for natural teeth, solely to increase reimbursement. This may be considered a fraudulent act. Always report exactly **what you do**, rather than what may gain a higher reimbursement.

WATCH

1. D6065 is an "*implant supported*" one piece porcelain/ceramic crown. It is an error to report the "*abutment* supported" code when in fact the restoration attaches directly to the implant body and does not have an abutment that separately connects to the implant body.
2. It is inappropriate to report an abutment along with an implant supported crown, as the crown is affixed directly to the implant body as one piece. See General Comments for Implant Services and photos at the beginning of this section.



MATCH

D6065 reports an implant supported one piece porcelain/ceramic crown screwed *directly to the implant*. This system is not as widely used as the *abutment supported* implant crown system. This type of crown is sometimes called a UCLA type crown.

COMMENTS

1. 3D printed crowns may be reported as porcelain/ceramic provided the material is greater than 50% inorganic fillers.
2. Enter the tooth number representing the position of implant being restored in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. If an alternate benefit is provided or if covered by an implant policy rider, then reimbursement for "implant type" crowns is typically subject to a five to 10-year limitation period.
2. Age, waiting periods, missing tooth clause, or other limitations may also apply.
3. See photo of one piece crown in General Comments at the beginning of the Implant section.

NARRATIVES

Ask for the alternate benefit of a similar material type crown if there is no implant coverage.

D6065

D6066 IMPLANT SUPPORTED CROWN PORCELAIN FUSED TO HIGH NOBLE ALLOYS CDT 2025

A single metal-ceramic crown restoration that is retained, supported and stabilized by an implant.



WARNING

It is misleading to report "implant type" crowns (D60xx) as "routine" individual crowns (D27xx) for natural teeth, solely to increase reimbursement. This can be considered a fraudulent act. Report exactly **what you do** rather than what may gain a higher reimbursement.

WATCH

1. D6066 is a one piece "*implant supported*" porcelain fused to high noble crown. It is an error to report the "*abutment supported*" code when in fact the restoration attaches directly to the implant body and does not have an abutment that separately connects to the implant body.
2. It is inappropriate to report an abutment along with an implant supported crown, as the crown is affixed directly to the implant body as one piece. See General Comments for Implant Services and photos at the beginning of this section.



MATCH

D6066 reports a one piece metal-ceramic crown (high noble metal) retained by a screw placed *directly into the implant*. This system is not as widely used as the *abutment supported* implant crown system. This type of crown is sometimes called a UCLA type crown.

COMMENTS Enter the tooth number representing the position of implant being restored in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. If an alternate benefit is provided or if covered by an implant policy rider, then reimbursement for "implant type" crowns is typically subject to a five to 10-year limitation period.
2. Age, waiting periods, missing tooth clause, or other limitations may also apply.
3. See photo of one piece crown in Gerneral Comments at the beginning of the Implant section.

NARRATIVES Ask for the alternate benefit of a similar material type crown if there is no implant coverage.

D6067 IMPLANT SUPPORTED CROWN - HIGH NOBLE ALLOYS CDT 2025

A single metal crown restoration that is retained, supported and stabilized by an implant.



WARNING It is misleading to report "implant type" crowns (D60xx) as "routine" individual crowns (D27xx) for natural teeth, solely to increase reimbursement. This can be considered a fraudulent act. Report exactly **what you do** rather than what may gain a higher reimbursement.

WATCH

1. D6067 is a one piece "*implant supported*" high noble all metal crown. It is an error to report the "*abutment supported*" code when in fact the restoration attaches directly to the implant body and does not have an abutment that separately connects to the implant body.
2. It is inappropriate to report an abutment along with an implant supported crown, as the crown is affixed directly to the implant body as one piece. See General Comments for Implant Services and photos at the beginning os this section.



MATCH D6067 reports a one piece cast or milled metal crown (high noble metal) screwed *directly into the implant*. This system is not as widely used as the *abutment supported* implant crown system. This type of crown is sometimes called a UCLA type crown.

COMMENTS Enter the tooth number representing the position of implant being restored in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. If an alternate benefit is provided or if covered by an implant policy rider, then reimbursement for "implant type" crowns is typically subject to a five to 10-year limitation period.
2. Age, waiting periods, missing tooth clause, or other limitations may also apply.
3. See photo of one piece crown in General Comments at the beginning of the Implant section.

NARRATIVES Ask for the alternate benefit of a similar material type crown if there is no implant coverage.

D6082 IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE ALLOYS CDT 2025

A single metal-ceramic crown restoration that is retained, supported and stabilized by an implant.



WARNING It is misleading to report "implant type" crowns (D60xx) as "routine" individual crowns (D27xx) for natural teeth, solely to increase reimbursement. This can be considered a fraudulent act. Report exactly **what you do** rather than what may gain a higher reimbursement.

WATCH

1. D6082 is an "implant supported" porcelain fused to predominantly base alloys. It is an error to report the "abutment supported" code when in fact the restoration attaches directly to the implant body and does not have an abutment that separately connects to the implant body.

2. It is inappropriate to report an abutment along with an implant supported crown, as the crown is affixed directly to the implant body as one piece. See General Comments for Implant Services and photos at the beginning os this section.

MATCH

D6082 reports a metal-ceramic crown (porcelain fused to predominantly base alloys) typically retained by a screw placed directly into the implant. This type of crown is sometimes called a UCLA type crown.

COMMENTS

1. Reporting the incorrect type of metal (high noble, noble, base, etc.) used in fabricating the crown is a common coding error. Be careful to report the correct code based on the material classification.
2. Document the correct metal used in the crown on the 2024 ADA Dental Claim Form as represented in the treatment plan, the lab prescription, and the documentation from the lab. Following this protocol should eliminate reporting errors.
3. See photo of one piece crown in General Comments at the beginning of the Implant section.
4. Enter the tooth number representing the position of implant being restored in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. If an alternate benefit is provided or if covered by an implant policy rider, then reimbursement for "implant type" crowns is typically subject to a five to ten year limitation period.
2. Age, waiting periods, missing tooth clause, or other limitations may also apply.

NARRATIVES

Ask for the alternate benefit of a similar material type natural tooth crown if there is no implant coverage.

D6083 IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO NOBLE ALLOYS CDT 2025

A single metal-ceramic crown restoration that is retained, supported and stabilized by an implant.

WARNING

It is misleading to report "implant type" crowns (D60xx) as "routine" individual crowns (D27xx) for natural teeth, solely to increase reimbursement. This can be considered a fraudulent act. Report exactly **what you do** rather than what may gain a higher reimbursement.

WATCH

1. D6083 is an "implant supported" porcelain fused to noble alloys. It is an error to report the "abutment supported" code when in fact the restoration attaches directly to the implant body and does not have an abutment that separately connects to the implant body.
2. It is inappropriate to report an abutment along with an implant supported crown, as the crown is affixed directly to the implant body as one piece. See General Comments for Implant Services and photos at the beginning of this section.

MATCH

D6083 reports a metal-ceramic crown (porcelain fused to noble alloys) typically retained by a screw placed directly into the implant. This type of crown is sometimes called a UCLA type crown.

COMMENTS

1. Reporting the incorrect type of metal (high noble, noble, base, etc.) used in fabricating the crown is a common coding error. Be careful to report the correct code based on the material classification.
2. Document the correct metal used in the crown on the 2024 ADA Dental Claim Form as represented in the treatment plan, the lab prescription, and the documentation from the lab. Following this protocol should eliminate reporting errors.
3. See photo of one piece crown in General Comments at the beginning of the Implant section.
4. Enter the tooth number representing the position of implant being restored in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. If an alternate benefit is provided or if covered by an implant policy rider, then reimbursement for "implant type" crowns is typically subject to a five to ten year limitation period.
2. Age, waiting periods, missing tooth clause, or other limitations may also apply.

NARRATIVES

Ask for the alternate benefit of a similar material type natural tooth crown if there is no implant coverage.

D6084 IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS CDT 2025

A single metal-ceramic crown restoration that is retained, supported and stabilized by an implant.



WARNING

It is misleading to report "implant type" crowns (D60xx) as "routine" individual crowns (D27xx) for natural teeth, solely to increase reimbursement. This can be considered a fraudulent act. Report exactly **what you do** rather than what may gain a higher reimbursement.



WATCH

1. D6084 is an "implant supported" porcelain fused to titanium and titanium alloys. It is an error to report the "abutment supported" code when in fact the restoration attaches directly to the implant body and does not have an abutment that separately connects to the implant body.
2. It is inappropriate to report an abutment along with an implant supported crown, as the crown is affixed directly to the implant body as one piece. See General Comments for Implant Services and photos at the beginning of this section.



MATCH

D6084 reports a metal-ceramic crown (porcelain fused to titanium and titanium alloys) typically retained by a screw placed directly into the implant. This type of crown is sometimes called a UCLA type crown.

COMMENTS

1. Reporting the incorrect type of metal (titanium, high noble, noble, base, etc.) used in fabricating the crown is a common coding error. Be careful to report the correct code based on the material classification.
2. Document the correct metal used in the crown on the 2024 ADA Dental Claim Form as represented in the treatment plan, the lab prescription, and the documentation from the lab. Following this protocol should eliminate reporting errors.
3. See photo of one piece crown in General Comments at the beginning of the Implant section.
4. Enter the tooth number representing the position of implant being restored in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. If an alternate benefit is provided or if covered by an implant policy rider, then reimbursement for "implant type" crowns is typically subject to a five to ten year limitation period.
2. Age, waiting periods, missing tooth clause, or other limitations may also apply.

NARRATIVES

Ask for the alternate benefit of a similar material type natural tooth crown if there is no implant coverage.

D6086 IMPLANT SUPPORTED CROWN - PREDOMINANTLY BASE ALLOYS CDT 2025

A single metal crown restoration that is retained, supported and stabilized by an implant.



WARNING

It is misleading to report "implant type" crowns (D60xx) as "routine" individual crowns (D27xx) for natural teeth, solely to increase reimbursement. This can be considered a fraudulent act. Report exactly **what you do** rather than what may gain a higher reimbursement.

WATCH

1. D6086 is an "implant supported" crown - predominantly base alloys. It is an error to report the "abutment supported" code when in fact the restoration attaches directly to the implant body and does not have an abutment that separately connects to the implant body.
2. It is inappropriate to report an abutment along with an implant supported crown, as the crown is affixed directly to the implant body as one piece. See General Comments for Implant Services and photos at the beginning of this section.

MATCH

D6086 reports a metal crown (predominantly base alloys) typically retained by a screw placed directly into the implant. This type of crown is sometimes called a UCLA type crown.

COMMENTS

1. Reporting the incorrect type of metal (high noble, noble, base, etc.) used in fabricating the crown is a common coding error. Be careful to report the correct code based on the material classification.
2. Document the correct metal used in the crown on the 2024 ADA Dental Claim Form as represented in the treatment plan, the lab prescription, and the documentation from the lab. Following this protocol should eliminate reporting errors.
3. See photo of one piece crown in General Comments at the beginning of the Implant section.
4. Enter the tooth number representing the position of implant being restored in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. If an alternate benefit is provided or if covered by an implant policy rider, then reimbursement for "implant type" crowns is typically subject to a five to ten year limitation period.
2. Age, waiting periods, missing tooth clause, or other limitations may also apply.

NARRATIVES

Ask for the alternate benefit of a similar material type natural tooth crown if there is no implant coverage.

D6087 IMPLANT SUPPORTED CROWN - NOBLE ALLOYS CDT 2025

A single metal crown restoration that is retained, supported and stabilized by an implant.

WARNING

It is misleading to report "implant type" crowns (D60xx) as "routine" individual crowns (D27xx) for natural teeth, solely to increase reimbursement. This can be considered a fraudulent act. Report exactly **what you do** rather than what may gain a higher reimbursement.

WATCH

1. D6087 is an "implant supported" crown - noble alloys. It is an error to report the "abutment supported" code when in fact the restoration attaches directly to the implant body and does not have an abutment that separately connects to the implant body.
2. It is inappropriate to report an abutment along with an implant supported crown, as the crown is affixed directly to the implant body as one piece. See General Comments for Implant Services and photos at the beginning of this section.

MATCH

D6087 reports a metal crown (noble alloys) typically retained by a screw placed directly into the implant. This type of crown is sometimes called a UCLA type crown.

COMMENTS

1. Reporting the incorrect type of metal (high noble, noble, base, etc.) used in fabricating the crown is a common coding error. Be careful to report the correct code based on the material classification.
2. Document the correct metal used in the crown on the 2024 ADA Dental Claim Form as represented in the treatment plan, the lab prescription, and the documentation from the lab. Following this protocol should eliminate reporting errors.
3. See photo of one piece crown in General Comments at the beginning of the Implant section.
4. Enter the tooth number representing the position of implant being restored in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. If an alternate benefit is provided or if covered by an implant policy rider, then reimbursement for "implant type" crowns is typically subject to a five to ten year limitation period.
2. Age, waiting periods, missing tooth clause, or other limitations may also apply.

NARRATIVES

Ask for the alternate benefit of a similar material type natural tooth crown if there is no implant coverage.

D6088 IMPLANT SUPPORTED CROWN - TITANIUM AND TITANIUM ALLOYS CDT 2025

A single metal crown restoration that is retained, supported and stabilized by an implant.



WARNING

It is misleading to report "implant type" crowns (D60xx) as "routine" individual crowns (D27xx) for natural teeth, solely to increase reimbursement. This can be considered a fraudulent act. Report exactly **what you do** rather than what may gain a higher reimbursement.



WATCH

1. D6088 is an "implant supported" crown - titanium and titanium alloys. It is an error to report the "abutment supported" code when in fact the restoration attaches directly to the implant body and does not have an abutment that separately connects to the implant body.
2. It is inappropriate to report an abutment along with an implant supported crown, as the crown is affixed directly to the implant body as one piece. See General Comments for Implant Services and photos at the beginning of this section.



MATCH

D6088 reports a metal crown (titanium and titanium alloys) typically retained by a screw placed directly into the implant. This type of crown is sometimes called a UCLA type crown.

COMMENTS

1. Reporting the incorrect type of metal (titanium, high noble, noble, base, etc.) used in fabricating the crown is a common coding error. Be careful to report the correct code based on the material classification.
2. Document the correct metal used in the crown on the 2024 ADA Dental Claim Form as represented in the treatment plan, the lab prescription, and the documentation from the lab. Following this protocol should eliminate reporting errors.
3. See photo of one piece crown in General Comments at the beginning of the Implant section.
4. Enter the tooth number representing the position of implant being restored in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. If an alternate benefit is provided or if covered by an implant policy rider, then reimbursement for "implant type" crowns is typically subject to a five to ten year limitation period.
2. Age, waiting periods, missing tooth clause, or other limitations may also apply.

NARRATIVES

Ask for the alternate benefit of a similar material type natural tooth crown if there is no implant coverage.

FIXED PARTIAL DENTURE RETAINER, ABUTMENT SUPPORTED CDT 2025

D6068 ABUTMENT SUPPORTED RETAINER FOR PORCELAIN/CERAMIC FPD CDT 2025

A ceramic retainer for a fixed partial denture that gains retention, support and stability from an abutment on an implant.



WARNING

1. It is misleading to report "implant type" retainer crowns (D60xx) as "routine" retainer crowns (D67xx) attached to natural teeth, solely to increase reimbursement. This can be considered a fraudulent act. Report exactly **what you do** rather than what may gain a higher reimbursement.

2. When providing a retainer crown (reimbursed at 50% of the payor's fee) it could be considered fraud to intentionally report the retainer crown as a single crown (sometimes reimbursed at 80% of the payor's fee) to gain a higher reimbursement. This could be considered upcoding, a fraudulent act.
3. It is an error to report an "abutment supported" crown code for a screw retained crown that attaches directly to the implant body. See General Comments for Implant Services and photos at the beginning of this section.

MATCH

1. See the *regular* fixed partial denture (bridge) pontic codes that *match* the abutment supported retainer crown. See D6245 to report the correct pontic type for this abutment supported retainer, D6068.
2. D6068 reports the abutment supported (porcelain/ceramic) *retainer crown* for an "implant type" fixed partial denture (bridge) that is supported by either a prefabricated (D6056) or custom abutment (D6057).

COMMENTS

1. 3D printed crowns may be reported as porcelain/ceramic provided the material is greater than 50% inorganic fillers.
2. Enter the tooth number representing the position of implant being restored in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. If an alternate benefit is provided or if covered by an implant policy rider is provided, then reimbursement for "implant type" crowns is typically subject to a five to 10-year limitation period.
2. Age, waiting periods, missing tooth clause, or other limitations may also apply.

NARRATIVES

Ask for the alternate benefit of a similar material type retainer crown if there is no implant coverage.

D6069 ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (HIGH NOBLE METAL) CDT 2025

A metal-ceramic retainer for a fixed partial denture that gains retention, support and stability from an abutment on an implant.

WARNING

1. It is an error to report "implant type" retainer crowns (D60xx) as "routine" retainer crowns (D67xx) attached to natural teeth, solely to increase reimbursement. This can be considered a fraudulent act. Always report exactly **what you do** not what may gain a higher reimbursement.
2. When providing a retainer crown (reimbursed at 50% of the payor's fee) it could be considered fraud to intentionally report the retainer crown as a single crown (sometimes reimbursed at 80% of the payor's fee) to gain a higher reimbursement. This could be considered upcoding, a fraudulent act.
3. It is an error to report an "abutment supported" crown code for a screw retained crown that attaches directly to the implant body. See General Comments for Implant Services and photos at the beginning of this section.

MATCH

1. See the *regular* fixed partial denture (bridge) pontic codes that *match* the abutment supported retainer crown. See D6240 to report the correct pontic type for this abutment supported retainer, D6069.
2. D6069 reports the abutment supported (porcelain fused to high noble metal) *retainer crown* for an "implant type" fixed partial denture (bridge) that is supported by either a prefabricated (D6056) or custom abutment (D6057).

COMMENTS

Enter the tooth number representing the position of implant being restored in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. If an alternate benefit is provided or if covered by an implant policy rider, then reimbursement for "implant type" crowns is typically subject to a five to 10-year limitation period.
2. Age, waiting periods, missing tooth clause, or other limitations may also apply.

NARRATIVES

Ask for the alternate benefit of a similar material type retainer crown if there is no implant coverage.

D6070 ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (PREDOMINANTLY BASE METAL) CDT 2025

A metal-ceramic retainer for a fixed partial denture that gains retention, support and stability from an abutment on an implant.

WARNING

1. It is misleading to report "implant type" retainer crowns (D60xx) as "routine" retainer crowns (D67xx) attached to natural teeth, solely to increase reimbursement. This can be considered a fraudulent act. Always report exactly **what you do** rather than what may gain a higher reimbursement.
2. When providing a retainer crown (reimbursed at 50% of the payor's fee) it could be considered fraud to intentionally report the retainer crown as a single crown (sometimes reimbursed at 80% of the payor's fee) to gain a higher reimbursement. This could be considered upcoding, a fraudulent act.
3. It is an error to report an "abutment supported" crown code for a screw retained crown that attaches directly to the implant body. See General Comments for Implant Services and photos at the beginning of this section.

MATCH

1. See the *regular* fixed partial denture (bridge) pontic codes that *match* the abutment supported retainer crown. See D6241 to report the correct pontic type for this PFM base metal *abutment supported* retainer crown, D6070.
2. D6070 reports the abutment supported (porcelain fused to predominantly base metal) retainer crown for an "implant type" fixed partial denture (bridge) that is supported by either a prefabricated (D6056) or custom abutment (D6057).

COMMENTS Enter the tooth number representing the position of implant being restored in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. If an alternate benefit is provided or if covered by an implant policy rider, then reimbursement for "implant type" crowns is typically subject to a five to 10-year limitation period.
2. Age, waiting periods, missing tooth clause, or other limitations may also apply.

NARRATIVES Ask for the alternate benefit of a similar material type retainer crown if there is no implant coverage.

D6071 ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (NOBLE METAL) CDT 2025

A metal-ceramic retainer for a fixed partial denture that gains retention, support and stability from an abutment on an implant.

WARNING

1. It is misleading to report "implant type" retainer crowns (D60xx) as "routine" retainer crowns (D67xx) attached to natural teeth, solely to gain reimbursement. Always report exactly **what you do** rather than what is reimbursed.
2. When providing a retainer crown (reimbursed at 50% of the payor's fee) it could be considered fraud to intentionally report the retainer crown as a single crown (reimbursed at 80% of the payor's fee) to gain a higher reimbursement. This could be considered upcoding, a fraudulent act.
3. It is an error to report an "abutment supported" crown code for a screw retained crown that attaches directly to the implant body. See General Comments for Implant Services and photos at the beginning of this section.

MATCH

1. See the *regular* fixed partial denture (bridge) pontic codes that *match* the abutment supported retainer crown. See D6242 to report the correct pontic type for this PFM noble metal *abutment supported* retainer crown, D6071.
2. D6071 reports the abutment-supported (porcelain fused to noble metal) retainer *crown* for an "implant type" fixed partial denture (bridge) that is supported by either a prefabricated (D6056) or custom abutment (D6057).

COMMENTS Enter the tooth number representing the position of implant being restored in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. If an alternate benefit is provided or if covered by an implant policy rider, then reimbursement for "implant type" crowns is typically subject to a five to 10-year limitation period.
2. Age, waiting periods, missing tooth clause, or other limitations may also apply.

NARRATIVES

Ask for the alternate benefit of a similar material type retainer crown if there is no implant coverage.

D6072 ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (HIGH NOBLE METAL) CDT 2025

A cast metal retainer for a fixed partial denture that gains retention, support and stability from an abutment on an implant.



WARNING

1. It is misleading to report "implant type" retainer crowns (D60xx) as "routine" retainer crowns (D67xx) attached to natural teeth, solely to increase reimbursement. Always "report exactly **what you do** rather than what is reimbursed.
2. When providing a retainer crown (reimbursed at 50% of the payor's fee) it could be considered fraud to intentionally report the retainer crown as a single crown (reimbursed at 80% of the payor's fee) to gain a higher reimbursement. This could be considered upcoding, a fraudulent act.
3. It is an error to report an "abutment supported" crown code for a screw retained crown that attaches directly to the implant body. See General Comments for Implant Services and photos at the beginning of this section.



MATCH

1. See the *regular fixed partial denture* (bridge) pontic codes that *match* the abutment supported retainer crown. See D6210 to report the correct pontic type for this high noble metal *abutment supported* retainer crown, D6072.
2. D6072 reports the abutment supported (high noble metal) retainer *crown* for an "implant type" fixed partial denture (bridge) that is supported by either a prefabricated (D6056) or custom abutment (D6057).

COMMENTS

Enter the tooth number representing the position of implant being restored in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. If reimbursed as an alternate benefit or as an implant when covered by an implant policy rider, reimbursement for "implant type" crowns is typically subject to a five to 10-year limitation period.
2. Age, waiting periods, missing tooth clause, or other limitations may also apply.

NARRATIVES

Ask for the alternate benefit of a similar material type retainer crown if there is no implant coverage.

D6073 ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (PREDOMINANTLY BASE METAL) CDT 2025

A cast metal retainer for a fixed partial denture that gains retention, support and stability from an abutment on an implant.



WARNING

1. It is misleading to report "implant type" retainer crowns (D60xx) as "routine" retainer crowns (D67xx) attached to natural teeth, solely to increase reimbursement. Always report exactly **what you do** rather than what is reimbursed.
2. When providing a retainer crown (reimbursed at 50% of the payor's fee) it could be considered fraud to intentionally report the retainer crown as a single crown (reimbursed at 80% of the payor's fee) to gain a higher reimbursement. This could be considered upcoding, a fraudulent act.
3. It is an error to report an "abutment supported" crown code for a screw retained crown that attaches directly to the implant body. See General Comments for Implant Services and photos at the beginning of this section.

MATCH

1. See the *regular fixed partial denture* (bridge) pontic codes that *match* the abutment supported retainer crown. See D6211 to report the correct pontic type for this base metal *abutment supported* retainer crown, D6073.
2. D6073 reports the abutment-supported (predominantly base metal) retainer *crown* for an "implant type" fixed partial denture (bridge) that is supported by either a prefabricated (D6056) or custom abutment (D6057).

COMMENTS Enter the tooth number representing the position of implant being restored in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. If an alternate benefit is provided or if covered by an implant policy rider, then reimbursement for "implant type" crowns is typically subject to a five to 10-year limitation period.
2. Age, waiting periods, missing tooth clause, or other limitations may also apply.

NARRATIVES Ask for the alternate benefit of a similar material type retainer crown if there is no implant coverage.

D6074 ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (NOBLE METAL) CDT 2025

A cast metal retainer for a fixed partial denture that gains retention, support and stability from an abutment on an implant.

WARNING

1. It is misleading to report "implant type" retainer crowns (D60xx) as "routine" retainer crowns (D67xx) attached to natural teeth, solely to increase reimbursement. Always report exactly **what you do** rather than what is reimbursed.
2. When providing a retainer crown (reimbursed at 50% of the payor's fee) it could be considered fraud to intentionally report the retainer crown as a single crown (reimbursed at 80% of the payor's fee) to gain a higher reimbursement. This could be considered upcoding, a fraudulent act.
3. It is an error to report an "abutment supported" crown code for a screw retained crown that attaches directly to the implant body. See General Comments for Implant Services and photos at the beginning of this section.

MATCH

1. See the *regular fixed partial denture* (bridge) pontic codes that *match* the abutment supported retainer crown. See D6212 to report the correct pontic type for this noble metal *abutment supported* retainer crown, D6074.
2. D6074 reports the abutment supported (noble metal) retainer *crown* for an "implant type" fixed partial denture (bridge) that is supported by either a prefabricated (D6056) or custom abutment (D6057).

COMMENTS Enter the tooth number representing the position of implant being restored in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. If an alternate benefit is provided or if covered by an implant policy rider, then reimbursement for "implant type" crowns is typically subject to a five to 10-year limitation period.
2. Age, waiting periods, missing tooth clause, or other limitations may also apply.

NARRATIVES Ask for the alternate benefit of a similar material type retainer crown if there is no implant coverage.

D6194 ABUTMENT SUPPORTED RETAINER CROWN FOR FPD - TITANIUM AND TITANIUM ALLOYS CDT 2025

A retainer for a fixed partial denture that gains retention, support and stability from an abutment on an implant.

Note: While out of numerical order, D6194 is correctly listed here under the Fixed Partial Denture, Abutment Supported subcategory.

WARNING

1. It is misleading to report "implant type" retainer crowns (D60xx) as "routine" retainer crowns (D67xx) for *natural* teeth, solely to gain reimbursement. This can be considered a fraudulent act. Always report exactly what you do rather than what is reimbursed.

2. Single crowns may be reimbursed at 50-80% of the payor's fee. Retainer crowns may be reimbursed at a 50% payor's fee. It could be considered fraud to intentionally report retainer crowns as single crowns to increase the reimbursement rate for the service. This could be considered upcoding, a fraudulent act.
3. It is an error to report an "abutment supported" crown code for a screw retained crown that attaches directly to the implant body. See General Comments for Implant Services and photos at the beginning of this section.

MATCH

1. See the *regular fixed partial denture* (bridge) pontic codes that *match* the abutment supported retainer crown. See D6214 to report the *matching* titanium pontic for this titanium and titanium alloys retainer crown, D6194.
2. D6194 reports the abutment supported titanium and titanium alloys retainer crown for an "implant type" fixed partial denture (bridge) that is supported by either a prefabricated abutment (D6056) or custom abutment (D6057).

COMMENTS

Enter the tooth number representing the position of implant being restored in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. If an alternate benefit is provided or if covered by an implant policy rider, then reimbursement for "implant type" crowns is typically subject to a five to 10-year limitation period.
2. Age, waiting periods, missing tooth clause, or other limitations may also apply.

NARRATIVES

Request the alternate benefit of a similar type retainer crown material if there is no implant coverage.

D6195 ABUTMENT SUPPORTED RETAINER - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS

CDT 2025

A metal-ceramic retainer for a fixed partial denture that gains retention, support, and stability from an abutment on an implant.

WARNING

1. It is misleading to report "implant type" retainer crowns (D60xx) as "routine" retainer crowns (D67xx) attached to natural teeth, solely to increase reimbursement. This can be considered a fraudulent act. Report exactly **what you do** rather than what may gain a higher reimbursement.
2. When providing a retainer crown (reimbursed at 50% of the payor's fee) it could be considered fraud to intentionally report the retainer crown as a single crown (sometimes reimbursed at 80% of the payor's fee) to gain a higher reimbursement. This could be considered upcoding, a fraudulent act.
3. It is an error to report an "abutment supported" crown code for a screw retained crown that attaches directly to the implant body. See General Comments for Implant Services and photos at the beginning of this section.

MATCH

1. See the regular fixed partial denture (bridge) pontic codes that match the abutment supported retainer crown. See D6243 to report the correct pontic type for this abutment supported retainer, D6195.
2. D6195 reports the abutment supported (porcelain fused to titanium and titanium alloys) retainer crown for an "implant type" fixed partial denture (bridge) that is supported by either a prefabricated (D6056) or custom abutment (D6057).

COMMENTS

1. Reporting the incorrect type of material (ceramic, titanium, high noble, noble, base, etc.) used in fabricating the retainer crown is a common coding error. Be careful to report the correct code based on the material classification.
2. Document the correct material used in the crown retainer on the claim form as represented in the treatment plan, the lab prescription, and the documentation from the lab. Following this protocol should eliminate reporting errors.
3. Enter the tooth number representing the position of implant being restored in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. If an alternate benefit is provided or if covered by an implant policy rider is provided, then reimbursement for "implant type" crowns is typically subject to a five to ten year limitation period.
2. Age, waiting periods, missing tooth clause, or other limitations may also apply.

NARRATIVES Ask for the alternate benefit of a similar material type natural tooth retainer crown if there is no implant coverage.

FIXED PARTIAL DENTURE RETAINER, IMPLANT SUPPORTED — CDT 2025

D6075 IMPLANT SUPPORTED RETAINER FOR CERAMIC FPD — CDT 2025

A ceramic retainer for a fixed partial denture that gains retention, support and stability from an implant.



WARNING

1. It is misleading to report "implant type" retainer crowns (D60xx) as "routine" retainer crowns (D67xx) attached to natural teeth, solely to increase reimbursement. Always report exactly **what you do** rather than what is reimbursed.
2. When providing a retainer crown (reimbursed at 50% of the payor's fee) it could be considered fraud to intentionally report the retainer crown as a single crown (reimbursed at 80% of the payor's fee) to gain a higher reimbursement. This could be considered upcoding, a fraudulent act.

WATCH

1. D6075 reports an "implant supported" ceramic retainer *crown*. It is an error to report the prosthesis as an "implant supported" retainer crown when the fixed partial denture (bridge) is supported by an abutment that separately connects to the implant body.
2. It is inappropriate to report an abutment along with an implant supported crown, as the crown is affixed directly to the implant body as one piece. See General Comments for Implant Services and photos at the beginning of this section.



MATCH

See the *regular fixed partial denture* (bridge) pontic codes that correctly *match* the *implant supported* ceramic retainer crown. See D6245 to report the *matching* ceramic pontic for this *implant supported* ceramic retainer crown (D6075).

COMMENTS

1. D6075 reports the "implant supported" (ceramic) retain*er crown* for an "implant type" fixed partial denture (bridge). The ceramic retainer crown attaches directly (cemented or screw retained) to the implant body. There is no associated abutment used to support the retainer crown.
2. See General Comments at the beginning of the Implant section for photo of implant - supported ceramic crown.
3. 3D printed crowns may be reported as porcelain/ceramic provided the material is greater than 50% inorganic fillers.
4. Enter the tooth number representing the position of implant being restored in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. If an alternate benefit is provided or if covered by an implant policy rider, then reimbursement for "implant type" crowns is typically subject to a five to 10-year limitation period.
2. Age, waiting periods, missing tooth clause, or other limitations may also apply.

NARRATIVES Ask for the alternate benefit of a similar material type retainer crown if there is no implant coverage.

D6076 IMPLANT SUPPORTED RETAINER FOR FPD - PORCELAIN FUSED TO HIGH NOBLE ALLOYS — CDT 2025

A metal-ceramic retainer for a fixed partial denture that gains retention, support and stability from an implant.



WARNING

1. It is misleading to report "implant type" retainer crowns (D60xx) as "routine" retainer crowns (D67xx) attached to natural teeth, solely to increase reimbursement. Always report exactly **what you do** rather than what is reimbursed.
2. When providing a retainer crown (reimbursed at 50% of the payor's fee) it could be considered fraud to intentionally report the retainer crown as a single crown (reimbursed at 80% of the payor's fee) to gain a higher reimbursement. This could be considered upcoding, a fraudulent act.



WATCH

1. D6076 reports an "implant supported" porcelain fused to high noble alloys retainer *crown*. It is an error to report the prosthesis as an "implant supported" retainer crown when the fixed partial denture (bridge) is supported by an abutment that separately connects to the implant body.
2. It is inappropriate to report an abutment along with an implant supported crown, as the crown is affixed directly to the implant body as one piece. See General Comments for Implant Services and photos at the beginning of this section.



MATCH

See the *regular* fixed partial denture (bridge) pontic codes that correctly *match* the *implant supported* PFM retainer crown. See the PFM high noble (D6240) code to report the *matching* pontic for this type of porcelain fused to metal *implant supported* retainer crown, D6076.

COMMENTS

1. D6076 reports the "implant-supported" (PFM high-noble) retainer *crown* for an "implant-type" bridge. The retainer crown attaches directly (cemented or screw-retained) to the implant body. There is no associated abutment used to support the retainer crown.
2. See General Comments at the beginning of the Implant section for photo of implant - supported crown.
3. Enter the tooth number representing the position of implant being restored in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. If an alternate benefit is provided or if covered by an implant policy rider, then reimbursement for "implant type" crowns is typically subject to a five to 10-year limitation period.
2. Age, waiting periods, missing tooth clause, or other limitations may also apply.

NARRATIVES

Ask for the alternate benefit of a similar material type retainer crown if there is no implant coverage.

D6077 IMPLANT SUPPORTED RETAINER FOR METAL FPD - HIGH NOBLE ALLOYS CDT 2025

A metal retainer for a fixed partial denture that gains retention, support and stability from an implant.



WARNING

1. It is misleading to report "implant type" retainer crowns (D60xx) as "routine" retainer crowns (D67xx) attached to natural teeth, solely to increase reimbursement. Always report exactly **what you do** rather than what is reimbursed.
2. When providing a retainer crown (reimbursed at 50% of the payor's fee) it could be considered fraud to intentionally report the retainer crown as a single crown (reimbursed at 50% of the payor's fee) to gain a higher reimbursement. This is considered upcoding, a fraudulent act.



WATCH

1. D6077 reports an "implant supported" high noble metal retainer *crown*. It is an error to report the prosthesis as an "implant supported" retainer crown when the fixed partial denture (bridge) is supported by an abutment that separately connects to the implant body.
2. It is inappropriate to report an abutment along with an implant supported crown, as the crown is affixed directly to the implant body as one piece. See General Comments for Implant Services and photos at the beginning of this section.



MATCH

See the *regular fixed partial denture* (bridge) pontic codes that *match* the *implant supported* metal retainer crown. See the cast high noble metal (D6210) code to report the *matching* pontic for this type of metal *implant supported* retainer crown, D6077.

COMMENTS

1. D6077 reports the "implant supported" metal (high noble) retainer *crown* for an "implant type" fixed partial denture (bridge). The high noble metal retainer crown attaches directly (cemented or screw retained) to the implant body. There is no associated abutment used to support the retainer crown.
2. Enter the tooth number representing the position of implant being restored in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. If reimbursed as an alternate benefit or as an implant when covered by an implant policy rider, reimbursement for "implant type" crowns is typically subject to a five to 10-year limitation period.
2. Age, waiting periods, missing tooth clause, or other limitations may also apply.

NARRATIVES Ask for the alternate benefit of a similar material type retainer crown if there is no implant coverage.

D6098 IMPLANT SUPPORTED RETAINER - PORCELAIN FUSED TO PREDOMINANTLY BASE ALLOYS

CDT 2025

A metal-ceramic retainer for a fixed partial denture that gains retention, support, and stability from an implant.



WARNING

1. It is misleading to report "implant type" retainer crowns (D60xx) as "routine" retainer crowns (D67xx) attached to natural teeth, solely to increase reimbursement. Always report exactly **what you do** rather than what is reimbursed.
2. When providing a retainer crown (reimbursed at 50% of the payor's fee), it could be considered fraud to intentionally report the retainer crown as a single crown (reimbursed at 80% of the payor's fee) to gain a higher reimbursement. This could be considered upcoding, a fraudulent act.



WATCH

1. D6098 reports an "implant supported" porcelain fused to predominantly base alloys retainer crown. It is an error to report the prosthesis as an "implant supported" retainer crown when the fixed partial denture (bridge) is supported by an abutment that separately connects to the implant body.
2. It is inappropriate to report an abutment along with an implant supported crown, as the crown is affixed directly to the implant body as one piece. See General Comments for Implant Services and photos at the beginning of this section.



MATCH

See the regular fixed partial denture (bridge) pontic codes that correctly match the implant supported PFM retainer crown. See the appropriate PFM predominantly base alloys (D6241) code to report the matching pontic for this type of metal in the implant supported base metal retainer crown, D6098.

COMMENTS

1. D6098 reports the "implant supported" (PFM predominantly base alloys) retainer crown for an "implant type" fixed partial denture (bridge). The crown retainer attaches directly (cemented or screw retained) to the implant body. There is no associated separate abutment used to support the crown retainer.
2. Reporting the incorrect type of metal (titanium, titanium alloy, or high noble metal, etc.) used in fabricating the crown retainer is a common coding error. Be careful to report the correct code based on the material classification.
3. Document the correct metal used in the crown retainer on the claim form as represented in the treatment plan, the lab prescription, and the documentation from the lab. Following this protocol should eliminate reporting errors.
4. See General Comments at the beginning of the Implant section for photo of implant - supported crown.
5. Enter the tooth number representing the position of implant being restored in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. If an alternate benefit is provided or if covered by an implant policy rider, then reimbursement for "implant type" crowns is typically subject to a five to ten year limitation period.
2. Age, waiting periods, missing tooth clause, or other limitations may also apply.

NARRATIVES Ask for the alternate benefit of a similar material type natural tooth retainer crown if there is no implant coverage.

D6099 IMPLANT SUPPORTED RETAINER FOR FPD - PORCELAIN FUSED TO NOBLE ALLOYS

CDT 2025

A metal-ceramic retainer for a fixed partial denture that gains retention, support, and stability from an implant.



WARNING

1. It is misleading to report "implant type" retainer crowns (D60xx) as "routine" retainer crowns (D67xx) attached to natural teeth, solely to increase reimbursement. Always report exactly **what you do** rather than what is reimbursed.
2. When providing a retainer crown (reimbursed at 50% of the payor's fee), it could be considered fraud to intentionally report the retainer crown as a single crown (reimbursed at 80% of the payor's fee) to gain a higher reimbursement. This could be considered upcoding, a fraudulent act.

WATCH

1. D6099 reports an "implant supported" porcelain fused to noble alloys retainer crown. It is an error to report the prosthesis as an "implant supported" retainer crown when the fixed partial denture (bridge) is supported by an abutment that separately connects to the implant body.
2. It is inappropriate to report an abutment along with an implant supported crown, as the crown is affixed directly to the implant body as one piece. See General Comments for Implant Services and photos at the beginning of this section.

MATCH

See the regular fixed partial denture (bridge) pontic codes that correctly match the implant supported PFM noble retainer crown. See the appropriate PFM noble alloys (D6242) code to report the matching pontic for this type of metal in the implant supported PFM noble retainer crown, D6099.

COMMENTS

1. D6099 reports the "implant supported" (PFM noble alloys) retainer crown for an "implant type" fixed partial denture (bridge). The crown retainer attaches directly (cemented or screw retained) to the implant body. There is no associated separate abutment used to support the crown retainer.
2. Reporting the incorrect type of metal (titanium, titanium alloy, or high noble metal, etc.) used in fabricating the crown retainer is a common coding error. Be careful to report the correct code based on the material classification.
3. Document the correct metal used in the crown retainer on the claim form as represented in the treatment plan, the lab prescription, and the documentation from the lab. Following this protocol should eliminate reporting errors.
4. See General Comments at the beginning of the Implant section for photo of implant supported crown.
5. Enter the tooth number representing the position of implant being restored in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. If an alternate benefit is provided or if covered by an implant policy rider, then reimbursement for "implant type" crowns is typically subject to a five to ten year limitation period.
2. Age, waiting periods, missing tooth clause, or other limitations may also apply.

NARRATIVES

Ask for the alternate benefit of a similar material type natural tooth retainer crown if there is no implant coverage.

D6120 IMPLANT SUPPORTED RETAINER - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS CDT 2025

A metal-ceramic retainer for a fixed partial denture that gains retention, support, and stability from an implant.

WARNING

1. It is misleading to report "implant type" retainer crowns (D60xx) as "routine" retainer crowns (D67xx) attached to natural teeth, solely to increase reimbursement. Always report exactly **what you do** rather than what is reimbursed.
2. When providing a retainer crown (reimbursed at 50% of the payor's fee), it could be considered fraud to intentionally report the retainer crown as a single crown (reimbursed at 80% of the payor's fee) to gain a higher reimbursement. This could be considered upcoding, a fraudulent act.

WATCH

1. D6120 reports an "implant supported" porcelain fused to titanium and titanium alloys retainer crown. It is an error to report the prosthesis as an "implant supported" retainer crown when the fixed partial denture (bridge) is supported by an abutment that separately connects to the implant body.
2. It is inappropriate to report an abutment along with an implant supported crown, as the crown is affixed directly to the implant body as one piece. See General Comments for Implant Services and photos at the beginning of this section.

MATCH

See the regular fixed partial denture (bridge) pontic codes that correctly match the implant supported PFM retainer crown. See the appropriate PFM titanium and titanium alloys (D6243) code to report the matching pontic for this type of metal in the implant supported retainer crown, D6120.

COMMENTS

1. D6120 reports the "implant supported" (PFM titanium and titanium alloys) retainer crown for an "implant type" fixed partial denture (bridge). The crown retainer attaches directly (cemented or screw retained) to the implant body. There is no associated separate abutment used to support the crown retainer.
2. Reporting the incorrect type of metal (noble or high noble metal, etc.) used in fabricating the crown retainer is a common coding error. Be careful to report the correct code based on the material classification.
3. Document the correct metal used in the crown retainer on the 2024 ADA Dental Claim Form as represented in the treatment plan, the lab prescription, and the documentation from the lab. Following this protocol should eliminate reporting errors.
4. See General Comments at the beginning of the Implant section for photo of implant supported crown.
5. Enter the tooth number representing the position of implant being restored in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. If an alternate benefit is provided or if covered by an implant policy rider, then reimbursement for "implant type" crowns is typically subject to a five to ten year limitation period.
2. Age, waiting periods, missing tooth clause, or other limitations may also apply.

NARRATIVES

Ask for the alternate benefit of a similar material type natural tooth retainer crown if there is no implant coverage.

D6121 IMPLANT SUPPORTED RETAINER FOR METAL FPD - PREDOMINANTLY BASE ALLOYS

CDT 2025

A metal retainer for a fixed partial denture that gains retention, support, and stability from an implant.



WARNING

1. It is misleading to report "implant type" retainer crowns (D60xx) as "routine" retainer crowns (D67xx) attached to natural teeth, solely to increase reimbursement. Always report exactly **what you do** rather than what is reimbursed.
2. When providing a retainer crown (reimbursed at 50% of the payor's fee), it could be considered fraud to intentionally report the retainer crown as a single crown (reimbursed at 80% of the payor's fee) to gain a higher reimbursement. This could be considered upcoding, a fraudulent act.

WATCH

1. D6121 reports an "implant supported" predominantly base alloys metal retainer crown. It is an error to report the prosthesis as an "implant supported" retainer crown when the fixed partial denture (bridge) is supported by an abutment that separately connects to the implant body.
2. It is inappropriate to report an abutment along with an implant supported crown, as the crown is affixed directly to the implant body as one piece. See General Comments for Implant Services and photos at the beginning of this section.



MATCH

See the regular fixed partial denture (bridge) pontic codes that correctly match the implant supported PFM retainer crown. See the appropriate predominantly base alloy pontic (D6211) code to report the matching pontic for this type of metal implant supported retainer crown, D6121.

COMMENTS

1. D6121 reports the "implant supported" (metal predominantly base alloys) retainer crown for an "implant type" fixed partial denture (bridge). The crown retainer attaches directly (cemented or screw retained) to the implant body. There is no associated separate abutment used to support the crown retainer.
2. Reporting the incorrect type of metal (noble or high noble metal, etc.) used in fabricating the crown retainer is a common coding error. Be careful to report the correct code based on the material classification.
3. Document the correct metal used in the crown retainer on the 2024 ADA Dental Claim Form as represented in the treatment plan, the lab prescription, and the documentation from the lab. Following this protocol should eliminate reporting errors.
4. See General Comments at the beginning of the Implant section for photo of implant supported crown.
5. Enter the tooth number representing the position of implant being restored in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. If an alternate benefit is provided or if covered by an implant policy rider, then reimbursement for "implant type" crowns is typically subject to a five to ten year limitation period.

2. Age, waiting periods, missing tooth clause, or other limitations may also apply.

NARRATIVES Ask for the alternate benefit of a similar material type natural tooth retainer crown if there is no implant coverage.

D6122 IMPLANT SUPPORTED RETAINER FOR METAL FPD - NOBLE ALLOYS CDT 2025

A metal retainer for a fixed partial denture that gains retention, support, and stability from an implant.



WARNING

1. It is misleading to report "implant type" retainer crowns (D60xx) as "routine" retainer crowns (D67xx) attached to natural teeth, solely to increase reimbursement. Always report exactly **what you do** rather than what is reimbursed.
2. When providing a retainer crown (reimbursed at 50% of the payor's fee), it could be considered fraud to intentionally report the retainer crown as a single crown (reimbursed at 80% of the payor's fee) to gain a higher reimbursement. This could be considered upcoding, a fraudulent act.



WATCH

1. D6122 reports an "implant supported" noble alloys metal retainer crown. It is an error to report the prosthesis as an "implant supported" retainer crown when the fixed partial denture (bridge) is supported by an abutment that separately connects to the implant body.
2. It is inappropriate to report an abutment along with an implant supported crown, as the crown is affixed directly to the implant body as one piece. See General Comments for Implant Services and photos at the beginning of this section.



MATCH

See the regular fixed partial denture (bridge) pontic codes that correctly match the implant supported PFM retainer crown. See the appropriate noble alloy pontic (D6212) code to report the matching pontic for this type of noble metal implant supported retainer crown, D6122.

COMMENTS

1. D6122 reports the "implant supported" (metal noble alloys) retainer crown for an "implant type" fixed partial denture (bridge). The crown retainer attaches directly (cemented or screw retained) to the implant body. There is no associated separate abutment used to support the crown retainer.
2. Reporting the incorrect type of metal (titanium, titanium, or high noble metal, etc.) used in fabricating the crown retainer is a common coding error. Be careful to report the correct code based on the material classification.
3. Document the correct metal used in the crown retainer on the 2024 ADA Dental Claim Form as represented in the treatment plan, the lab prescription, and the documentation from the lab. Following this protocol should eliminate reporting errors.
4. See General Comments at the beginning of the Implant section for photo of implant supported crown.
5. Enter the tooth number representing the position of implant being restored in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. If an alternate benefit is provided or if covered by an implant policy rider, then reimbursement for "implant type" crowns is typically subject to a five to ten year limitation period.
2. Age, waiting periods, missing tooth clause, or other limitations may also apply.

NARRATIVES Ask for the alternate benefit of a similar material type natural tooth retainer crown if there is no implant coverage.

D6123 IMPLANT SUPPORTED RETAINER FOR METAL FPD - TITANIUM AND TITANIUM ALLOYS CDT 2025

A metal retainer for a fixed partial denture that gains retention, support, and stability from an implant.



WARNING

1. It is misleading to report "implant type" retainer crowns (D60xx) as "routine" retainer crowns (D67xx) attached to natural teeth, solely to increase reimbursement. Always report exactly **what you do** rather than what is reimbursed.

2. When providing a retainer crown (reimbursed at 50% of the payor's fee), it could be considered fraud to intentionally report the retainer crown as a single crown (reimbursed at 80% of the payor's fee) to gain a higher reimbursement. This could be considered upcoding, a fraudulent act.

WATCH

1. D6123 reports an "implant supported" titanium and titanium alloys metal retainer crown. It is an error to report the prosthesis as an "implant supported" retainer crown when the fixed partial denture (bridge) is supported by an abutment that separately connects to the implant body.
2. It is inappropriate to report an abutment along with an implant supported crown, as the crown is affixed directly to the implant body as one piece. See General Comments for Implant Services and photos at the beginning of this section.



MATCH

See the regular fixed partial denture (bridge) pontic codes that correctly match the implant supported titanium and titanium alloys retainer crown. See the appropriate titanium alloy pontic (D6214) code to report the matching pontic for this type of metal implant supported retainer crown, D6123.

COMMENTS

1. D6123 reports the "implant supported" (titanium metal alloys) retainer crown for an "implant type" fixed partial denture (bridge). The crown retainer attaches directly (cemented or screw retained) to the implant body. There is no associated separate abutment used to support the crown retainer.
2. Reporting the incorrect type of metal (titanium, titanium, or high noble metal, etc.) used in fabricating the crown retainer is a common coding error. Be careful to report the correct code based on the material classification.
3. Document the correct metal used in the crown retainer on the 2024 ADA Dental Claim Form as represented in the treatment plan, the lab prescription, and the documentation from the lab. Following this protocol should eliminate reporting errors.
4. Enter the tooth number representing the position of implant being restored in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. If an alternate benefit is provided or if covered by an implant policy rider, then reimbursement for "implant type" crowns is typically subject to a five to ten year limitation period.
2. Age, waiting periods, missing tooth clause, or other limitations may also apply.

NARRATIVES

Ask for the alternate benefit of a similar material type natural tooth retainer crown if there is no implant coverage.

OTHER IMPLANT SERVICES — CDT 2025

D6080 REVISED IMPLANT MAINTENANCE PROCEDURES WHEN A FULL ARCH FIXED HYBRID PROSTHESIS IS REMOVED AND REINSERTED, INCLUDING CLEANSING OF PROSTHESIS AND ABUTMENTS — CDT 2025

This procedure includes active debriding of the implant(s) and examination of all aspects of the implant system, including the occlusion and stability of the superstructure. The patient is also instructed in thorough daily cleansing of the implant(s).

REVISIONS

IMPLANT MAINTENANCE PROCEDURES WHEN A FULL ARCH FIXED HYBRID PROSTHESIS IS ~~PROSTHESES ARE~~ REMOVED AND REINSERTED, INCLUDING CLEANSING OF PROSTHESIS ~~PROSTHESES~~ AND ABUTMENTS.

This procedure includes active debriding of the implant~~(s)~~ and examination of all aspects of the implant system(s), including the occlusion and stability of the superstructure. The patient is also instructed in thorough daily cleansing of the implant(s). ~~This is not a per implant code, and is indicated for implant supported fixed prostheses.~~



WARNING

1. Do not report D6080 when removing, cleansing, and inspecting implant or abutment supported fixed bridges or crowns or partial arch restorations. D6080/D6180 only reports implant maintenance of a full arch fixed hybrid prosthesis.
2. Do not report D6080 if the full arch fixed hybrid restoration is cleansed in place but not removed. See D6180.

WATCH

1. If cleaning and performing maintenance on a full arch fixed hybrid restoration without removal, see D6180.
2. If removing, cleansing, and reinserting implant or abutment supported crowns, bridges, or partial arch restorations, there is no specific code. Report D6199 unspecified implant procedure by report.
3. Note that D1110 prophylaxis includes removal of plaque calculus and stains on implants and implant restorations but does not include removal of a prosthesis.

COMMENTS

1. D6080 only applies to the removal, cleansing, and reinsertion of an implant supported fixed hybrid prosthesis.
2. Implant maintenance procedure (D6080/D6180) on a full arch fixed hybrid restoration includes the active debridement of all the implant(s) and abutments. D6080/D6180 also includes hygiene instruction given to the patient on the importance of thorough daily cleansing of the prosthesis and abutments.
3. Diagnostic radiographic images, periodic oral evaluation (D0120), and prophylaxis (D1110) or periodontal maintenance (D4910) of natural teeth and implant crowns in the opposing arch are not a part of the D6080/D6180 procedure and should be reported separately.
4. D6081 describes scaling and debridement of a single implant in the presence of mucositis, including inflammation, bleeding upon probing and increased pocket depths; includes cleaning of the implant surfaces, without flap entry and closure. This may be done in conjunction with D6080/D6180, and is reported per implant.
5. Replacement of the restorative material in the screw access holes following D6080 may be reported using D6197. See D6197.
6. Enter the arch being treated in the appropriate box of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. When no implant benefits are available, there are no benefits available for implant maintenance procedures (D6080/D6180).
2. Note: Many payors require documentation and additional information when reporting D6080/D6180. Reimbursement is subject to plan limitations and exclusions.
3. D6080/D6180 could be reported in addition to prophylaxis (D1110) or periodontal maintenance (D4910) of teeth or implants on the opposing arch. However, if one of the implants required D6081, it cannot be performed along with D1110 or D4910 on the same date of service..
4. The implant maintenance procedure (D6080/D6180) may be considered a part of the global prophylaxis (D1110) or periodontal maintenance (D4910) service.

NARRATIVES

1. Ask for the alternate benefit of prophylaxis (D1110) and include a narrative if D6080/D6180 is not reimbursed.
2. The narrative should describe the service provided and that the fixed prosthesis was removed, inspected, cleaned, and reinserted. Describe that the implant(s) were actively debrided.

D6081 REVISED SCALING AND DEBRIDEMENT OF A SINGLE IMPLANT IN THE PRESENCE OF MUCOSITIS, INCLUDING INFLAMMATION, BLEEDING UPON PROBING AND INCREASED POCKET DEPTHS; INCLUDES CLEANING OF THE IMPLANT SURFACES, WITHOUT FLAP ENTRY AND CLOSURE — CDT 2025

This procedure is not performed in conjunction with D1110, D4910, or D4346.

REVISIONS

SCALING AND DEBRIDEMENT OF A SINGLE IMPLANT IN THE PRESENCE OF ~~INFLAMMATION OR~~ MUCOSITIS, INCLUDING INFLAMMATION, BLEEDING UPON PROBING AND INCREASED POCKET DEPTHS ~~OF A SINGLE IMPLANT, INCLUDING~~; INCLUDES CLEANING OF THE IMPLANT SURFACES, WITHOUT FLAP ENTRY AND CLOSURE

This procedure is not performed in conjunction with D1110, D4910, or D4346.

WATCH

1. Report D6101, D6102, and D6103 if a flap entry and other treatment are utilized to treat a peri-implant defect(s).
2. Note that inflammation alone is not sufficient to report D6081. Mucositis with inflammation, bleeding upon probing, and increased pocket depths must be present.

MATCH

When there is mucositis associated with a single implant, D6081 reports the scaling and debridement of the affected single implant when a flap is not utilized.

COMMENTS

1. D1110, D4910, and D4346 report the treatment to, and around, natural teeth and are not to be reported with D6081 on the same service date. Note that prophylaxis (D1110/D1120) and periodontal maintenance (D4910) now include implant crowns.
2. D6081 reports scaling and debridement in the presence of mucositis of a single implant (recognized by the presence of inflammation, bleeding on probing, and increased pocket depths), including cleaning of the implant surfaces, without flap entry and closure.
3. Enter the tooth number representing the position of implant being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

Reimbursement for this procedure is greatly limited and is generally restricted to patients with implant coverage, if any.

TIPS

1. D6081 is a per implant code. If more than one existing implant is treated, submit D6081 for each of the single implants scaled and debrided which have mucositis. This procedure cannot be reported in conjunction with D1110, D4910, or D4346 on the same service date.
2. D6081 and implant maintenance procedures (D6080/D6180) may be reported on the same service date as long as D1110, D4910, or D4346 are not performed.

NARRATIVES

A narrative should always be provided to support the submission of D6081 for each implant that describes inflammation and/or mucositis treatment. Provide probing depths, bleeding points, radiographs, and photographs to support the need for D6081 treatment.

D6085 INTERIM IMPLANT CROWN

CDT 2025

Placed when a period of healing is necessary prior to fabrication and placement of the definitive prosthesis.



WARNING

Do not report an interim implant crown (D6085) as a temporary placed in association with the routine fabrication of an implant supported or abutment supported crown.

WATCH

1. D6085 reports a single unit interim implant crown.
2. Interim implant crowns (D6085) may be used while the implant continues to osseointegrate, healing around the abutment, or when the prognosis of the implant body is in question.



MATCH

D6085 reports an interim implant crown when an undetermined period of healing is necessary prior to the fabrication and placement of the permanent implant supported or abutment supported crown. An interim abutment (D6051) typically may be associated with the interim implant crown (D6085) - typically an anterior area.

COMMENTS

1. An interim implant crown (D6085) may be necessary when a period of healing for the implant body and/or abutment is necessary for the surrounding tissue prior to the fabrication and placement of the long-term implant supported or abutment supported crown, particularly for an anterior restoration. Most dental plans exclude coverage of interim procedures.
2. D6198 reports the removal of any interim implant component, including interim implant crown. However, most payors consider the removal in the global D6085 fee.
3. Enter the tooth number representing the position of implant being restored in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

The submission of D6085 may impact payment of the final prosthesis. If the interim implant crown (D6085) is reimbursed, this may prevent reimbursement for the permanent definitive restoration due to any frequency limitations of the plan document.

NARRATIVES

1. The narrative should establish the need for the interim implant restoration (i.e., healing, integration, unknown prognosis, etc.).
2. Estimate how long the interim implant crown will be utilized as an interim restoration (should be less than 12 months).

D6089 ACCESSING AND RETORQUING LOOSE IMPLANT SCREW - PER SCREW

CDT 2025



WARNING

Do not report D6089 when an implant screw is fully replaced. See D6193..

WATCH

1. If an implant screw must be replaced, see D6193.
2. To document removing a broken implant screw, see D6096.
3. To report replacing the restorative material in an implant access hole not associated with initial placement or maintenance, see D6197.



MATCH

D6089 documents simply accessing and retorquing a screw within an implant prosthesis. This can include but is not limited to an implant-supported crown or bridge, an abutment-supported restoration, or intermediary abutment screws.

COMMENTS

1. D6089 documents accessing and retorquing a screw within an implant prosthesis. This allows for accurate record keeping of where the screw is located and how many times a screw has been retorqued, so this can be considered when deciding if it can be tightened again or if it needs to be replaced.
2. Previously, this procedure could only be reported using D6199 unspecified implant procedure, by report.
3. Enter the tooth number representing the position of implant being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. For D6089 to be benefited, the policy must benefit implant procedures.
2. For an emergency situation with discomfort, see D9110 palliative treatment of dental pain, per visit.

TIPS

Most always, D6089 will be followed by D6197 replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant.

D6090 REVISED REPAIR OF IMPLANT/ABUTMENT SUPPORTED PROSTHESIS

CDT 2025

REVISIONS

REPAIR OF IMPLANT/ABUTMENT SUPPORTED PROSTHESIS, ~~BY REPORT~~

~~This procedure involves the repair or replacement of any part of the implant supported prosthesis.~~

COMMENTS

1. Repair of implant/abutment supported prosthesis (D6090) is used to report the repair of any part of any type of implant supported prosthesis, including crowns, bridges, fixed or removable restorations.
2. For replacement of a semi-precision attachment (keeper assembly), see D6192.
3. For replacement of a normally replaceable component of a semi-precision or precision attachment, see D6091.
4. To report a reline/rebase of an implant supported prosthesis see the 5000 section for these procedures.
5. For replacement of an implant screw, see D6193.
6. For tightening an implant screw without replacement, see D6089 followed by D6197.
7. Enter the tooth number representing the position of implant being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. If a contract has no implant benefits there would be no benefit for the repair of an implant supported prosthesis.
2. D6090 may reset the five to 10-year exclusion period limitation for the implant supported prosthesis, if reimbursed.

NARRATIVES

While no longer a "by report" code, it is still recommended to include a brief narrative when reporting D6090. The narrative should identify the original date of placement, and a description of the repair to the implant supported prosthesis is provided.

D6091 REPLACEMENT OF REPLACEABLE PART OF SEMI-PRECISION OR PRECISION ATTACHMENT OF IMPLANT/ABUTMENT SUPPORTED PROSTHESIS, PER ATTACHMENT

CDT 2025



WATCH

When the replacement part of a semi-precision or precision attachment is associated with a *removable (natural* tooth) partial denture, report D5867. Do not report D6091 in any circumstances involving natural teeth.



MATCH

Use code D6091 to report the replacement of replaceable part of a semi-precision or precision attachment component of an associated implant/abutment supported prosthesis removable overdenture (D6110/D6111) or partial removable overdenture (D6112/D6113).

COMMENTS

1. Normally replaceable parts include o-rings, clips, plastic, vinyl, or metal parts of locators that are expected to be replaced, and are reported as D6091. However, replacing a screw of an implant supported crown or a fixed hybrid (All-on-X) restoration (this is not a normally replaceable part) would be reported as D6193.
2. If the entire female attachment locator ("keeper assembly") is replaced in the overdenture, report D6192.
3. If the entire male semi-precision abutment is replaced on the implant body, report D6191.
4. Enter the tooth number representing the position of implant being treated in Box 27 of the 2024 ADA Dental Claim Form.

NARRATIVES

Identify the attachment type and delivery date of the original semi precision or precision attachment. D6091 is not typically reimbursed unless the replacement is due to damage. Reimbursement for replacement is not typically made for attachments worn out by normal wear and tear. When replacement is necessary due to damage request an alternate benefit of a repair (D6090).

D6092 RE-CEMENT OR RE-BOND IMPLANT/ABUTMENT SUPPORTED CROWN

CDT 2025

COMMENTS

1. Re-cement or re-bond implant/abutment supported crown (D6092) reports re-cementing or re-bonding both implant and abutment supported *single* crowns.
2. Enter the tooth number representing the position of implant being recemented in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. The exclusion period for re-cementation or re-bonding of an implant/abutment supported crown is typically six to 12 months following the initial placement of the restoration.
2. If re-cementation or re-bonding of the implant/abutment supported crown is performed in a different office within the exclusion period, the six to 12-month limitation period may not apply.

NARRATIVES

Include a brief narrative that alerts the payor when the implant crown was originally seated. If re-cementation or re-bonding occurs in an office, by a dentist, that did not originally deliver the crown, note this in a brief narrative.

D6093 RE-CEMENT OR RE-BOND IMPLANT/ABUTMENT SUPPORTED FIXED PARTIAL DENTURE

CDT 2025

COMMENTS

1. Re-cement or re-bond implant/abutment supported fixed partial denture (D6093) reports re-cementing or re-bonding both implant and abutment supported fixed partial dentures (bridges).
2. Enter the tooth numbers or range representing the position of the implant restoration being recemented in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. The typical exclusion period for re-cementation or re-bonding of an implant/abutment supported fixed partial denture (bridge) is six to 12 months following initial placement of the fixed restoration.
2. If re-cementation or re-bonding of the implant/abutment supported fixed partial denture (bridge) is performed in a different office within the exclusion period, the six to 12-month limitation period may not apply.

NARRATIVES Include a brief narrative that alerts the payor when the implant/abutment supported fixed partial denture (bridge) was originally seated. If re-cementation or re-bonding occurs in an office, by a dentist, that did not originally deliver the fixed bridge, note this in a brief narrative.

D6095 DELETED REPAIR IMPLANT ABUTMENT, BY REPORT CDT 2025

This is a deleted code. See D6090 for further details.

D6096 REMOVE BROKEN IMPLANT RETAINING SCREW CDT 2025



WARNING D6096 does not describe the *routine* removal, replacement, or re-tightening of an intact screw. D6096 specifies that the implant retaining screw is broken and it is assumed that the remaining screw fragment could not be removed using standard and conventional techniques.



MATCH D6096 is used to describe the removal of the broken implant retaining screw when the screw cannot be accessed and removed without extraordinary or unusual techniques. This code applies to the removal of a broken screw that retains an abutment or an implant crown.

COMMENTS

1. D6096 would only be considered for reimbursement if there is implant coverage included in the plan document.
2. For tightening an implant screw without replacement, see D6089 followed by D6197.
3. Enter the tooth number representing the position of implant being treated in Box 27 of the 2024 ADA Dental Claim Form.

TIPS Most always, D6096 will be followed by D6193 replacement of an implant screw and D6197 replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant.

NARRATIVES A narrative should be included that establishes and describes the unconventional techniques used to remove the broken implant retaining screw. Photo(s) of the fractured screw are recommended.

Note: D6110-D6117 codes are located under the Implant/Abutment supported removable dentures and Implant/Abutment supported fixed dentures (hybrid prosthesis) subcategories earlier in this section of the book. Many of the codes in this section are not in numerical order, but under various subcategory sections.

D6180 NEW PROCEDURE IMPLANT MAINTENANCE PROCEDURES WHEN A FULL ARCH FIXED HYBRID PROSTHESIS IS NOT REMOVED, INCLUDING CLEANSING OF PROSTHESIS AND ABUTMENTS CDT 2025

This procedure includes active debriding of the implant(s) and prosthesis. The patient is also instructed in thorough daily cleansing of the implant(s).



WARNING

1. Do not report D6080/D6180 when cleaning and inspecting implant or abutment supported fixed bridges or crowns or partial arch restorations. D6080/D6180 only reports implant maintenance of a full arch fixed hybrid prosthesis.
2. Do not report D6180 for implant maintenance if the full arch fixed hybrid restoration is removed. See D6080.

WATCH

1. If cleaning and performing maintenance on a full arch fixed hybrid restoration with removal of the prosthesis, see D6080.
2. If removing, cleansing, and reinserting implant or abutment supported crowns, bridges, or partial arch restorations, there is no specific code. Report D6199 unspecified implant procedure by report.
3. Note that D1110 prophylaxis includes removal of plaque calculus and stains on implants and implant restorations as a preventive service. D6180 is a theraputic service and is more appropriate to report for fixed hybrid restorations cleaned without removal as long as all parts of the code and descriptor are met.

COMMENTS

1. The American College of Prosthodontics states that the removal of a fixed, screw-retained implant prosthesis for evaluation is not needed unless there are signs of peri-implantitis, a demonstrated inability to maintain adequate oral hygiene, or there are mechanical complications that require removal. This is a therapeutic procedure and could not be considered a D1110/D1120 prophylaxis, which are considered preventive procedures.
2. D6180 only applies to the cleansing and maintenance of a full arch fixed hybrid prosthesis when the prosthesis is not removed.
3. Implant maintenance procedures (D6080/D6180) on a full arch fixed hybrid prosthesis includes the active debridement of all the implant(s) and abutments. D6080/D6180 must also include hygiene instruction given to the patient on the importance of thorough daily cleansing of the prosthesis and abutments. This should be noted in the clinical record.
4. Diagnostic radiographic images, periodic oral evaluation (D0120), and prophylaxis (D1110) or periodontal maintenance (D4910) of natural teeth and implant crowns in the opposing arch are not a part of the D6080/D6180 procedure and should be reported separately.
5. D6081 describes scaling and debridement of a single implant in the presence of mucositis, including inflammation, bleeding upon probing and increased pocket depths; includes cleaning of the implant surfaces, without flap entry and closure. This may be done in conjunction with D6080/D6180, and is reported per implant.
6. Enter the arch being treated in the appropriate box of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. When no implant benefits are available, there are no benefits available for implant maintenance procedures (D6080/D6180).
2. Note: Many payors require documentation and additional information when reporting D6080/D6180. Reimbursement is subject to plan limitations and exclusions.
3. D6080/D6180 could be reported in addition to prophylaxis (D1110) or periodontal maintenance (D4910) of teeth or implants on the opposing arch. However, if one of the implants required D6081, it cannot be performed along with D1110 or D4910 on the same date of service..
4. The implant maintenance procedure (D6080/D6180) may be considered a part of the global prophylaxis (D1110) or periodontal maintenance (D4910) service.

NARRATIVES

1. Ask for the alternate benefit of prophylaxis (D1110) and include a narrative if D6080/D6180 is not reimbursed.
2. The narrative should describe the service provided and that the fixed prosthesis was inspected and cleansed without removal. Describe that the implant(s) were actively debrided.

D6190 RADIOGRAPHIC/SURGICAL IMPLANT INDEX, BY REPORT CDT 2025

An appliance, designed to relate osteotomy or fixture position to existing anatomic structures, to be utilized during radiographic exposure for treatment planning and/or during osteotomy creation for fixture installation.

Note: This code appears here in numerical order but it is properly situated at the start of the Implant Services, under the Pre-Surgical Services subcategory.

WATCH

1. It is an error to report either a surgical stent (D5982) or surgical splint (D5988) when providing a surgical implant index. D6190 is the correct code to report when a radiographic/surgical implant index (D6190) is provided to guide in the surgical placement of implants. Also use D6190 to report radiographic implant mapping or the implant template guide.
2. For indexing for osteotomy using dynamic robotic assisted or dynamic navigation, see D7939.

COMMENTS

1. D6190 is used to describe a radiographic index or a surgical guide used to assist in surgical implant placement. The index is inserted in the patient's mouth while the radiograph is taken. The index is designed in such a manner that it can also be used during implant placement to guide the positioning of the implant. If this is the case, the radiographic index is also the surgical index.
2. When a surgical index is not also a radiographic index, the index may not be radiopaque. If the index is only a surgical index, it is used as a guide to the osteotomy or for ideal fixture positioning. In some cases, a radiographic index is sufficient. In other cases only the surgical index is needed. Some, more complex cases may require both.

3. A surgical index can be a suck down, acrylic guide, 3D printed, or CAD/CAM fabricated (very expensive). The fee for the implant index varies depending upon the laboratory fee, and generally not marked much above the lab fee for the guide.
4. The patient fee for the implant index varies depending on the laboratory fee, and generally is not much above the lab fee.
5. Enter the arch or quadrant being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Payors may require two or more implants to benefit D6190.
2. Typically, D6190 is not reimbursed unless the patient has a policy with an implant rider. This service is subject to any exclusions, limitations, or maximum reimbursements outlined in the plan.

TIPS

1. The surgeon may request the restorative dentist to make this radiographic/surgical index. The general practitioner might charge $150 to $500 for this procedure, depending on the lab cost.
2. It is suggested that the surgical implant index (D6190) be billed as a separate component of the implant service. Many times the implant procedures are not a covered benefit (unless there is a rider). The index will generally be billable to, and the responsibility of the patient. Separately billing the index is not unbundling.
3. It is not unbundling to allocate and report D6190 separately. This can make a difference if a PPO is fee capping for non covered procedures.

NARRATIVES

A brief narrative should be provided when reporting D6190. The service will not be reimbursed unless there is an implant rider in the contract. Should the patient be covered by a policy with an implant rider, this procedure may be considered diagnostic and integral for the implant fee.

PHOTO



This is an example of a radiograph/surgical implant index to guide the surgeon to the proper site to place the implant.

Courtesy Drake Dental Lab

D6193 NEW PROCEDURE REPLACEMENT OF AN IMPLANT SCREW CDT 2025

WATCH

1. D6193 reports the replacement of an implant screw for implant supported restorations or abutments.
2. If accessing and retorquing a loose implant screw without replacement, see D6089 followed by D6197. Do not report D6193 if the screw is not replaced.
3. If removing a broken implant retaining screw, report D6096 in addition to D6193 and D6197.

COMMENTS

1. D6193 replacement of an implant screw will most often be followed by D6197 replacement of restorative material. See D6197.
2. Enter the tooth number representing the position of implant being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

D6193 may not be reimbursed unless the patient has a policy with an implant rider. This service is subject to any exclusions, limitations, or maximum reimbursements outlined in the plan.

D6197 REPLACEMENT OF RESTORATIVE MATERIAL USED TO CLOSE AN ACCESS OPENING OF A SCREW-RETAINED IMPLANT SUPPORTED PROSTHESIS, PER IMPLANT

CDT 2025



WARNING

1. This procedure is specific to screw-retained implant supported prostheses and is not to be reported with endodontic access closure.
2. Do not report D2330 or D2391 for screw-retained implant prosthesis access closure.
3. Do not report D6197 for the inital placement of restorative material at time of restoration insertion. The initial placement of restorative material to close the access opening is included in the global procedure code of the implant supported restoration and should not be reported separately.



MATCH

D6197 reports the replacement of the restorative material used to close the access opening of a screw retained implant supported prosthesis, per implant.

COMMENTS

1. This procedure was previously reported by some offices using a one surface resin or amalgam restoration code, but those codes should now be reserved for natural tooth restorations or endodontic access hole closure. The fee for D6197 could approximate that of the appropriate one surface restoration.
2. This procedure involves the removal of any remaining restorative materials in the screw-retained implant access opening. Placement of retentive aspects could be added as part of this procedure. Composite restorative material is placed, shaped, and cured, based on material directions. The composite restorative material is then polished.
3. D6197 may be reported for the replacement of restorative material on each screw access hole following D6080 implant maintenance but this may not be reimbursed by payors.
4. Enter the tooth number representing the position of implant being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

D6197 will likely be denied by payors but could typically be considered a patient out of pocket expense.

TIPS

D6197 should normally follow D6089 accessing and retorquing loose implant screw – per screw or D6193 replacement of an implant screw.

D6198 REMOVE INTERIM IMPLANT COMPONENT

CDT 2025

Removal of implant component (e.g., interim abutment; provisional implant crown) originally placed for a specific clinical purpose and period of time determined by the dentist.

WATCH

1. D6198 describes the removal of an interim implant component, not the removal of the implant itself.
2. D6100 describes the surgical removal of the implant body, not any components of the implant system.
3. D6105 describes the non-surgical removal of the implant body, not any components of the implant system.



MATCH

D6198 describes the removal of any of the interim implant component(s). Those components could include, but not be limited to a healing cap, an interim abutment, an interim implant crown, and an interim implant retainer.

COMMENTS

1. An interim component is placed for a specific clinical purpose and period of time determined by the dentist, not intended to be a permanent treatment. An interim abutment, crown, or retainer is not intended to provide a permanent definitive treatment but to be used for a limited period where further treatment or completion of diagnosis is necessary prior to the delivery of the definitive (permanent) prosthesis.
2. Each component (interim abutment or interim crown) should be reported separately when they are removed using D6198.
3. Enter the tooth number representing the position of implant being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS While D6198 does report a separate service, many payors will consider the removal of any interim implant component is an integral part of the global placement fee for reimbursement purposes. Also, if there is no implant coverage, this service will not be reimbursed.

NARRATIVES The narrative should include pretreatment radiographic images of the area, a description of the component being removed as well as a description of the procedure should be included.

D6199 UNSPECIFIED IMPLANT PROCEDURE, BY REPORT CDT 2025

Use for procedure that is not adequately described by a code. Describe procedure.

COMMENTS

1. Before you report D6199, look throughout this section and the **implant index** page (page 287) for the procedure you are looking for. A multitude of the implant services codes are not in numerical order.
2. D6199 may be used to report the application of Cervitec® Gel, when applied to treat peri-implantitis.

NARRATIVES This is a by report code. Therefore, a brief narrative is always required when this code is submitted.

GENERAL COMMENTS FOR FIXED PARTIAL DENTURE (BRIDGEWORK) SERVICES

AUTHOR'S COMMENTS

WATCH

1. Be careful that the bridge pontic material-type matches the corresponding retainer material-type. Always use the matching code, according to its material classification.
2. Reporting the incorrect type of material (high noble, noble, base, resin, etc.) used in fabricating the pontic is a common coding error. Be careful to report the correct code based on the material classification. Document the correct material used in the pontic on the claim form as represented in the treatment plan, the lab prescription, and the documentation from the lab. Following this protocol should eliminate reporting errors.
3. Cantilever bridges:
   a. A cantilever bridge is only supported by one pontic and is attached to a single retainer crown. A cantilever bridge may be the treatment of choice when an implant is not an option and the conservation of the tooth structure on an adjacent tooth is a priority. A cantilever bridge may be preferable in periodontal cases as a cantilever bridge is easier to clean than a conventional bridge.
   b. To report a cantilever bridge, use the appropriate FPD (bridge) retainer code plus pontic code. The narrative provided with the claim should identify when the missing tooth was extracted and that the prosthesis is a "cantilever" in the remarks section of the claim form. Include a radiograph of the entire arch. Be aware that there may be waiting periods or other exclusions associated with these procedures.



MATCH

Watch for any MATCH legends that relate to the corresponding fixed partial denture (bridgework) procedure.

LIMITATIONS

1. Payors may exclude reimbursement for Captek fixed partial dentures (bridges), due to the materials makeup.
2. Payors may exclude reimbursement for fixed partial dentures for patients under age sixteen.
3. Some plans have a six to 12-month waiting period for basic services. Longer limitations (12 to 36 months) may apply for major (fixed prosthetic) services. Plan limitations are highly variable as to what is considered basic or major coverage.
4. Some plans limit reimbursement of anterior fixed partial dentures (bridges) to three units (e.g., retainer crown, pontic, and retainer crown).
5. Age, waiting periods, missing tooth, or other limitations may also apply.
6. If there are edentulous spaces in different quadrants in the same arch, alternate benefits of a partial denture may apply.
7. The payor may reimburse a retainer crown if the supporting abutment retainer (on its own) qualifies for a crown.

TIPS

1. Consider:
   a. The "missing tooth" clause may apply to the initial retainer crown placement; however, it may not apply to a replacement retainer crown or fixed partial denture (bridge). The "missing tooth" clause applies to teeth extracted (but not replaced) prior to the plan's current coverage.
   b. Some contracts have waiting periods. The placement of an original fixed partial denture (bridge) may be reimbursed after the current contract is in effect for one to three years.
   c. Benefits may apply if an additional tooth is extracted adjacent to the edentulous space while the contract is in place.
2. When there is more than one edentulous space in the arch, an alternate benefit of a removable partial denture is often applied. If, however, a fixed partial denture(s) has (have) been provided that restores all previous missing teeth in that arch, the narrative should communicate that the existing fixed partial denture(s) exist and the proposed fixed partial denture be reimbursed.

NARRATIVES

1. When submitting a crown claim, it is essential that appropriate documentation including a brief narrative be included to avoid delays and/or claim denials.
2. If treating cracked tooth syndrome, indicate that the diagnosis for the full coverage crown was made by using a Tooth Slooth®, transillumination or seeing the crack into dentin.

3. The narrative should address the existence of caries or other pathology, condition and size of prior restoration, and the condition of the remaining tooth structure. Make note of any undermined, fractured or missing cusps and any symptoms the patient may be experiencing with the affected tooth.
4. "See attached radiographic image" (if tooth has RCT, send PA radiographic image).
5. List any missing cusps.
6. Estimate and state percentage of healthy tooth structure left after fracture, caries and/or any previous restoration is removed. If diagnosis is cracked tooth syndrome, state method of diagnosis, e.g., Tooth Slooth® positive on MF cusp.
7. State if tooth has existing or planned RCT (root canal therapy).
8. State if tooth has circumferential decay and amount of it, e.g., circumferential decay on M, L and D encompassing 270 degrees of tooth.
9. State endodontic and periodontal prognosis for tooth.
10. If this is a replacement crown, state date that the previous crown was seated.
11. If replacing an existing crown, state reason for replacement, e.g., tooth has caries, margins are open, porcelain is fractured off, poor contacts are causing food impactions, etc.
12. Preoperative intraoral images demonstrating decay, cracks, large failing restorations, or missing tooth structure are crucial to supporting the medical necessity of full coverage restorations.

PROSTHODONTICS, FIXED — CDT 2025

Each retainer and each pontic constitutes a unit in a fixed partial denture.

Local anesthesia is usually considered to be a part of Fixed Prosthodontic procedures.

The term "fixed partial denture" or FPD is synonymous with fixed bridge or bridgework.

Fixed partial denture prosthetic procedures include routine temporary prosthetics. When indicated, interim or provisional codes should be reported separately.

CLASSIFICATION OF MATERIALS — CDT 2025

Classification of Metals (Source: ADA Council on Scientific Affairs - online at ADA.org/2190.aspx**)**

The noble metal classification system has been adopted as a more precise method of reporting various alloys used in dentistry. The alloys are defined on the basis of the percentage of metal content:

high noble alloys - noble metal content >= 60% (gold+platinum group) and gold >= 40%;

titanium and titanium alloys - Titanium >= 85%;

noble alloys - noble metal content >= 25% (gold+platinum group);

predominantly base alloys - noble metal content < 25% (gold+platinum group);

*metals of the platinum group are platinum,palladium, rhodium, iridium, osmium and ruthenium.

Porcelain/ceramic - Refers to materials containing predominantly inorganic refractory compounds including porcelains, glasses, ceramics and glass-ceramics.

Resin - Refers to any resin-based composite, including fiber or ceramic reinforced polymer compounds, and glass ionomers.

Editor's Comments: Porcelain/ceramic is now defined as materials containing predominantly inorganic refractory compounds including porcelains, glasses, ceramics and glass-ceramics. This means 3D printed restorations using materials containing more than 50% inorganic filler may now be classified as porcelain/ceramic.

D6205 PONTIC - INDIRECT RESIN BASED COMPOSITE CDT 2025

Not to be used as a temporary or provisional prosthesis.

WATCH

1. Be careful that the fixed partial (bridge) *pontic* material type matches the corresponding *retainer* crown material type. Always use the matching code, according to its material classification.
2. Pontic - indirect resin based composite (D6205) reports a permanent fixed partial denture indirect resin (bridge) pontic. It is an error to report D6205 for a *provisional* prosthesis. D6253 should be reported for a *provisional* pontic.



MATCH

When reporting D6205, pontic-indirect resin based composite, be careful that this code *matches* the corresponding permanent indirect resin based composite retainer crown, D6710.

COMMENTS

1. D6205 describes Artglass®, Cristobel®, Belleglass®, etc., type resin based materials.
2. The pontic of a bonded Hugger bridge is reported as D6205. The associated resin retainers would be reported as D6549.
3. 3D printed resin pontics may be reported using D6205 as long as the appropriate resin material is used. Claim Form.
4. Enter the teeth number(s) or range of teeth being restored in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Reimbursement for the replacement of a fixed partial denture (bridge) is typically subject to a five to 10-year limitation.
2. Age, waiting periods, missing tooth clause or other limitations may also apply to the placement of a fixed partial denture (bridge).
3. The permanent indirect resin fixed partial denture (bridge) pontic (D6205) may be reimbursed as, and subject to, the same exclusions/limitations as a cast fixed partial denture pontic.

NARRATIVES

Resin bridges may not be reimbursed. If reimbursement for D6205 is denied, appeal the denial and ask for an alternate benefit. It is recommended that the policy be reviewed to determine the contract language that identifies this exclusion. If reimbursed, this type of pontic might be paid at the D6251 payor's level.

D6210 PONTIC - CAST HIGH NOBLE METAL CDT 2025



MATCH

1. When reporting pontic-cast high noble metal (D6210), be careful that the materials reported to describe the pontic *match* the corresponding (cast high noble metal) retainer crown (D6790).
2. D6210 may also report the fixed partial denture (bridge) pontic to *match* the corresponding *abutment supported* implant retainer crown (D6072). D6210 may also report the fixed partial denture pontic that is a *match* to the corresponding *implant supported* high noble metal retainer crown (D6077).

COMMENTS

Enter the teeth number(s) or range of teeth being restored in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Reimbursement for a fixed partial denture (bridge) is typically subject to a five to 10-year limitation.
2. Age, waiting periods, missing tooth clause or other limitations may also apply to the placement of a fixed partial denture (bridge).

D6211 PONTIC - CAST PREDOMINANTLY BASE METAL CDT 2025



MATCH

1. When reporting pontic-cast predominantly base metal (D6211), be careful that the materials reported to describe the pontic *match* the corresponding (cast base metal) retainer crown (D6791).
2. D6211 may also report the base metal bridge pontic that is supported by an *abutment supported* implant retainer crown (D6073).
3. D6211 bridge pontic *does have a matching implant supported* base metal retainer crown. Report D6121 with narrative to describe the *matching* (cast base metal) *implant supported* retainer crown.

COMMENTS Enter the teeth number(s) or range of teeth being restored in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Reimbursement for a fixed partial denture is typically subject to a five to 10-year limitation.
2. Age, waiting periods, missing tooth clause, or other limitations may apply to the placement of a fixed partial denture.

D6212 PONTIC - CAST NOBLE METAL CDT 2025



MATCH

1. When reporting pontic-cast noble metal (D6212), be careful that the materials reported to describe the pontic *match* the corresponding (cast base metal) (D6792).
2. D6212 may also report the noble metal fixed partial denture (bridge) pontic that is supported by an *abutment supported* implant noble metal retainer crown (D6074).
3. D6212 bridge pontic *does have a matching implant supported* noble metal retainer crown. Report D6122 with narrative to describe the *matching* (cast noble metal) *implant supported* retainer crown.

COMMENTS Enter the teeth number(s) or range of teeth being restored in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Reimbursement for a fixed partial denture is typically subject to a five to 10-year limitation.
2. Age, waiting periods, missing tooth clause, or other limitations may apply to the placement of a fixed partial denture.

D6214 PONTIC - TITANIUM AND TITANIUM ALLOYS CDT 2025



MATCH

1. When reporting a titanium and titanium alloys pontic (D6214), be careful that the materials reported to describe the pontic match the corresponding titanium and titanium alloys crown retainer (D6794).
2. D6214 may also report the titanium and titanium alloy fixed partial denture (bridge) pontic that is supported by an abutment supported implant titanium metal retainer crown (D6194).
3. D6214 does have a matching implant supported titanium metal retainer crown. Report D6123 with narrative to describe the matching (titanium) implant supported retainer crown.

COMMENTS Enter the teeth number(s) or range of teeth being restored in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Reimbursement for a fixed partial denture is typically subject to a five to 10-year limitation.
2. Age, waiting periods, missing tooth clause, or other limitations may apply to the placement of a fixed partial denture.

TIPS The nomenclature for pontic - titanium (D6214) reports a titanium pontic.

D6240 PONTIC - PORCELAIN FUSED TO HIGH NOBLE METAL CDT 2025

MATCH

1. When reporting pontic - porcelain fused to high noble metal (D6240), be careful to ensure this code *matches* the corresponding (PFM high noble metal) retainer crown (D6750).
2. D6240 may also be used to report the fixed partial denture (bridge) pontic that is a *match* to the corresponding *abutment supported* (PFM high noble metal) retainer crown, (D6069).
3. D6240 may also be used to report the fixed partial denture pontic that *matches* the corresponding *implant supported* (PFM high noble metal) retainer crown, (D6076).

COMMENTS Enter the teeth number(s) or range of teeth being restored in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Reimbursement for a fixed partial denture is typically subject to a five to 10-year limitation.
2. Age, waiting periods, missing tooth clause, or other limitations may apply to the placement of a fixed partial denture.

D6241 PONTIC - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL CDT 2025

MATCH

1. When reporting pontic - porcelain fused to predominantly base metal (D6241), be careful to ensure this code used to describe the pontic *matches* the corresponding (PFM base metal) retainer crown (D6751).
2. D6241 may also be used to report the fixed partial denture (bridge) pontic that *matches* the corresponding *abutment supported* (PFM base metal) retainer crown, (D6070).
3. D6241 *does have a matching implant supported* (PFM base metal) retainer crown code. Report D6120 to report the corresponding implant supported (PFM base metal) retainer crown.

COMMENTS Enter the teeth number(s) or range of teeth being restored in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Reimbursement for a fixed partial denture is typically subject to a five to 10-year limitation.
2. Age, waiting periods, missing tooth clause, or other limitations may apply to the placement of a fixed partial denture.

D6242 PONTIC - PORCELAIN FUSED TO NOBLE METAL CDT 2025

MATCH

1. When reporting pontic - porcelain fused to noble metal (D6242), be careful to ensure that this code *matches* the corresponding (PFM noble metal) retainer crown (D6752).
2. D6242 may also be used to report the fixed partial denture (bridge) pontic that *matches* the corresponding *abutment supported* (PFM noble metal) retainer crown (D6071).
3. D6242 *does have a matching* "implant supported" (PFM noble metal) retainer crown code. Report D6099, with a brief narrative, to report the corresponding *implant supported* (PFM noble metal) retainer crown.

COMMENTS Enter the teeth number(s) or range of teeth being restored in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Reimbursement for a fixed partial denture is typically subject to a five to 10-year limitation.
2. Age, waiting periods, missing tooth clause, or other limitations may apply to the placement of a fixed partial denture.

D6243 PONTIC - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS

CDT 2025

MATCH

1. When reporting pontic - porcelain fused to titanium and titanium alloys (D6243), be careful to ensure this code matches the corresponding (PFM titanium and titanium alloys) retainer crown, (D6753).
2. D6243 may also be used to report the fixed partial denture (bridge) pontic that is a match to the corresponding abutment supported (PFM titanium and titanium alloys) retainer crown, (D6195).
3. D6243 may also be used to report the fixed partial denture pontic that matches the corresponding implant supported retainer crown, porcelain fused to titanium and titanium alloys (D6120).

COMMENTS

Enter the teeth number(s) or range of teeth being restored in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Reimbursement for a fixed partial denture is typically subject to a five to ten year limitation.
2. Age, waiting periods, missing tooth clause, or other limitations may apply to the placement of a fixed partial denture.

D6245 PONTIC - PORCELAIN/CERAMIC

CDT 2025

MATCH

1. When reporting pontic - porcelain/ceramic (D6245), be careful to ensure that this code *matches* the corresponding (porcelain/ceramic) retainer crown (D6740).
2. D6245 may also be used to report the fixed partial denture (bridge) pontic that *matches* the corresponding *abutment supported* porcelain retainer crown (D6068).
3. D6245 may also be used to report the bridge pontic that *matches* the corresponding *implant supported* porcelain retainer crown (D6075).

LIMITATIONS

1. Reimbursement for a fixed partial denture is typically subject to a five to 10-year limitation.
2. Age, waiting periods, missing tooth clause, or other limitations may apply to the placement of a fixed partial denture.

COMMENTS

1. Porcelain/ceramic is now defined as materials containing predominantly inorganic refractory compounds including porcelains, glasses, ceramics and glass-ceramics. This means 3D printed restorations using materials containing more than 50% inorganic filler may now be classified as porcelain/ceramic.
2. Enter the teeth number(s) or range of teeth being restored in the appropriate boxes of the 2024 ADA Dental Claim Form.

NARRATIVES

All porcelain ceramic (non-metallic) fixed partial dentures (bridges) may be excluded from reimbursement. When reporting D6245, some payors may not reimburse an alternate benefit. However, always appeal if reimbursement for D6245 is initially denied, because the alternate benefit may be reimbursed. Ask the patient to obtain a copy of the full dental coverage contract from their Human Resources department. Review the policy to determine if there is a specific limitation. If all porcelain/ceramic pontics are excluded, ask for an alternate benefit.

PHOTO



The image depicts a three unit porcelain/ceramic bridge. The bridge is made up of the pontic (D6245) and two retainer crowns (D6740).

Courtesy of Keller Dental Lab

D6250 PONTIC - RESIN WITH HIGH NOBLE METAL

CDT 2025



MATCH

1. When reporting pontic - resin with high noble metal (D6250), be careful to ensure that this code *matches* the corresponding resin with high noble metal used in fabricating the retainer crown (D6720).
2. There are *no matching abutment supported* or *implant supported* resin with high noble metal retainer codes to report with high noble metal retainer crowns. Report D6199 with a brief narrative to describe this type of retainer crown.

COMMENTS Enter the teeth number(s) or range of teeth being restored in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Reimbursement for a fixed partial denture (bridge) is typically subject to a five to 10-year limitation.
2. Age, waiting periods, missing tooth clause, or other limitations may apply to the placement of a fixed partial denture.

D6251 PONTIC - RESIN WITH PREDOMINANTLY BASE METAL

CDT 2025



MATCH

1. When reporting pontic - resin with predominantly base metal (D6251), be careful to ensure this code *matches* the corresponding resin with base metal retainer crown (D6721).
2. There are *no matching abutment supported* or *implant supported* resin with base metal codes used to report resin with predominantly base metal retainer crowns. Report D6199 with a brief narrative to describe these retainer crowns.

COMMENTS Enter the teeth number(s) or range of teeth being restored in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Reimbursement for a fixed partial denture (bridge) is typically subject to a five to 10-year limitation.
2. Age, waiting periods, missing tooth clause, or other limitations may apply to the placement of a fixed partial denture.

D6252 PONTIC - RESIN WITH NOBLE METAL

CDT 2025



MATCH

1. When reporting a pontic - resin with noble metal (D6252), be careful to ensure this code *matches* the corresponding resin with noble metal retainer crown (D6722).
2. There are *no matching abutment supported* or *implant supported* resin with noble metal retainer crown codes. Report D6199 to describe this type of retainer with a brief narrative.

COMMENTS Enter the teeth number(s) or range of teeth being restored in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Reimbursement for a replacement fixed partial denture (bridge) is typically subject to a five to 10-year limitation.
2. Age, waiting periods, missing tooth clause, or other limitations may apply to the placement of a fixed partial denture.

D6253 INTERIM PONTIC - FURTHER TREATMENT OR COMPLETION OF DIAGNOSIS NECESSARY PRIOR TO FINAL IMPRESSION

CDT 2025

Not to be used as a temporary pontic for a routine prosthetic restoration.



WARNING

1. Do not report an interim pontic (D6253) as a temporary pontic for *routine* fixed partial denture (bridge) fabrication.
2. D6253 reports *an interim* pontic to be in place for a limited period of time. For instance, during extended periodontal treatment. The length of time can vary and is not specified. A definitive (final) restoration would be placed later.

WATCH

The corresponding interim retainer crown code is D6793.

COMMENTS

1. D6253 reports an interim pontic. This type of interim restoration allows time for healing, diagnosis, or completion of other procedures, prior to the fabrication of the final definitive restoration.
2. Interim restorations may be used to change the vertical dimension, complete periodontal therapy, diagnose cracked tooth syndrome, etc.
3. An interim pontic (D6253) is often used on an immediate bridge to replace the extracted tooth while the socket heals prior to final prep and impression.
4. An interim pontic (D6253) may be attached to an interim retainer crown on a fractured tooth to see if symptoms subside with full coverage or if endodontic therapy will be necessary.
5. D6793 does not specify the material or fabrication method. It may be made chairside, laboratory fabricated, prefabricated, milled, or 3D printed.
6. Enter the tooth number being restored in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

Very few payors will reimburse D6253 and then, only if the interim fixed partial denture is part of *a multistaged* treatment plan and anticipated to be in place for a period of time.

NARRATIVES

1. "Interim pontic will be utilized as interim restoration."
2. "Final impression has not been made."
3. State reason for interim use - e.g. allow time for periodontal healing.

D6254 PREVIOUSLY DELETED CODE INTERIM PONTIC

This is a previously deleted code. See Interim Pontic D6253 for further details.

FIXED PARTIAL DENTURE RETAINERS - INLAYS/ONLAYS CDT 2025

D6545 RETAINER - CAST METAL FOR RESIN BONDED FIXED PROSTHESIS CDT 2025

WATCH

1. Be careful that the *pontic* material type matches the corresponding wing *retainer* material type. Always use the matching code, according to its material classification.
2. Report each retainer as a seperate unit.

MATCH

1. D6545 describes a "Maryland" type fixed partial denture (bridge) "wing" retainer. A "Maryland" fixed partial denture consists of one or two cast metal retainers (wings) which are resin bonded to retainer teeth *plus* the appropriate *matching* pontic(s). Report each retainer seperately.
2. For a "Maryland" type fixed partial denture with ceramic "wing" retainer crowns, see D6548.
3. If the retainer "wings" are resin, see D6549.
4. When the abutment tooth is prepared to receive an *inlay* instead of a conservative bonded "wing" retainer crown, report the appropriate *inlay* retainer code. If an inlay retainer code *does not exist that matches* the pontic, report D6999, by report.

COMMENTS

1. When reporting D6545, be careful to ensure this retainer code *matches* the corresponding material type pontic.
2. For re-cementing a Maryland bridge, report D6930.
3. Enter the tooth number to which the retainer will be attached in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Age, waiting periods, missing tooth clause, or other limitations may apply to this service. Additionally, a Maryland type fixed partial denture is often *excluded* from reimbursement.
2. Most *payors* will not reimburse a "Maryland" or other fixed partial denture used to replace congenitally missing teeth (typically maxillary lateral incisors).
3. Reimbursement for replacement of fixed partial denture is typically subject to a five to 10-year limitation.
4. D6545 may not qualify as a fixed partial denture retainer with certain payors.

TIPS

Retainer - cast metal for resin bonded fixed prosthesis (D6545) describes the cast metal "wing" retainer of a Maryland type fixed partial denture. This type of fixed partial denture is used to conserve tooth structure of the retainers. The fee for *each* winged retainer is often equal to one-half to three-quarters of the pontic fee. The *total fee* for a Maryland type fixed partial denture is typically two to two and one-half times the pontic fee. Reimbursement for the "wings" of a Maryland fixed partial denture varies widely. Some plans do not cover Maryland type fixed partial dentures.

NARRATIVES

If the payor denies reimbursement for D6545, appeal the denial and request an alternate benefit of a conventional bridge. Ask the patient to obtain a copy of the plan document from Human Resources. Review the policy to determine if there is a specific limitation applicable to a Maryland bridge.

ADDITIONAL INFORMATION

Reporting the incorrect *type* of material (high noble, noble, base, ceramic, etc.) used in fabricating the wing retainer is a common coding error. Be careful to report the correct code based on the material classification. Document the correct material used in the pontic on the claim form as represented in the treatment plan, the lab prescription, and the documentation from the lab. Following this protocol should eliminate reporting errors.

D6548 RETAINER - PORCELAIN/CERAMIC FOR RESIN BONDED FIXED PROSTHESIS

CDT 2025

WATCH

1. Be careful that the *pontic* material type matches the corresponding wing *retainer* material type. Always use the matching code, according to its material classification.
2. Report each retainer as a seperate unit.



MATCH

1. One or two ceramic "wing retainers" (D6548) that are resin bonded to retainer teeth, *plus* a matching ceramic pontic (D6245) reports a Maryland type fixed partial denture (bridge). Report each retainer seperately.
2. For cast metal "wing" retainers of a Maryland type fixed partial denture, see D6545.
3. If the retainer "wings" are made of resin or composite, report D6549. Do not report D6548 for fixed partial dentures that utilize resin or composite "wings."
4. If the tooth retainer is affixed into a prepared *inlay* prep instead of to a conservative bonded "wing" retainer, the retainer would be reported using inlay - porcelain/ceramic, two surfaces (D6600).

COMMENTS

1. When reporting D6548, be careful to ensure this retainer code *matches* the corresponding porcelain pontic (D6245).
2. For re-cementing a Maryland fixed partial denture, report D6930.
3. Porcelain/ceramic is now defined as materials containing predominantly inorganic refractory compounds including porcelains, glasses, ceramics and glass-ceramics. This means 3D printed restorations using materials containing more than 50% inorganic filler may now be classified as porcelain/ceramic.
4. Enter the tooth number to which the retainer will be attached in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Age, waiting periods, missing tooth clause, or other limitations may apply to this service. Additionally, a "Maryland" type fixed partial denture is often *excluded* from reimbursement.
2. Most payors will *not* reimburse a "Maryland" or other fixed partial denture used to replace congenitally missing teeth (typically maxillary lateral incisors).
3. Reimbursement for a bridge is typically subject to a five to 10-year limitation.
4. D6548 may not qualify as a fixed partial denture retainer with certain payors.

TIPS

Retainer - porcelain/ceramic for resin bonded fixed prosthesis (D6548) is the porcelain/ceramic "wing retainer" of a Maryland type fixed partial denture. The Maryland type fixed partial denture is used in an effort to conserve the tooth structure of the tooth retainers. The fee for *each* winged retainer is often equal to one-half to three-quarters of the pontic fee. The *total fee* for a Maryland type fixed partial denture is typically two to two and one-half times the pontic fee. Reimbursement for the "wings" of a Maryland fixed partial denture varies widely. Some plans do not cover Maryland fixed partial dentures.

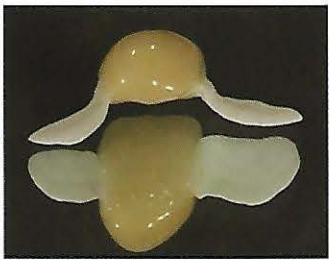
NARRATIVES

If the payor denies reimbursement for D6548, appeal the denial and request an alternate benefit of a conventional bridge. Ask the patient to obtain a copy of the full dental contract from Human Resources. Review the policy to determine if there is a specific limitation applicable to a Maryland bridge.

ADDITIONAL INFORMATION

Reporting the incorrect *type* of material (high noble, noble, base, ceramic, etc.) used in fabricating the wing retainer is a common coding error. Be careful to report the correct code based on the material classification. Document the correct material used in the pontic on the claim form as represented in the treatment plan, the lab prescription, and the documentation from the lab. Following this protocol should eliminate reporting errors.

PHOTO



1. This is an example of a porcelain/ceramic Maryland fixed partial denture (bridge).
2. Each retainer tooth "wing" is reported as D6548 and the pontic is reported as D6245.

Courtesy Drake Dental Lab

D6549 RESIN RETAINER - FOR RESIN BONDED FIXED PROSTHESIS CDT 2025

WATCH

1. Be careful that the *pontic* material type matches the corresponding wing *retainer* material type. Always use the matching code, according to its material classification.
2. Report each retainer as a seperate unit.

MATCH

1. One or two resin "wing retainers" (D6549) that are resin bonded to retainer teeth, *plus* a matching resin pontic (D6205) reports a bonded Hugger bridge or a Maryland type fixed partial denture (bridge). Report each retainer seperately.
2. For cast metal "wing" retainers of a Maryland type fixed partial denture, see D6545.
3. If the retainer "wings" are made of porcelain or ceramic, report (D6548). Do *not* report D6548 for fixed partial dentures that utilize resin or composite "wings."
4. If the tooth retainer is affixed into a prepared *inlay* prep instead of to a conservative bonded "wing" retainer, the wing retainer would be reported using indirectly fabricated resin retainer inlay, two surfaces (D6999, with narrative).

D6549

COMMENTS

1. When reporting D6549, be careful that this resin retainer code *matches* the corresponding resin pontic (D6205).
2. For recementing a Maryland fixed partial denture, report D6930.
3. 3D printed resin retainers may be reported using D6549 as long as the appropriate materials are used in fabrication.
4. Enter the tooth number to which the retainer will be attached in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Age, waiting periods, missing tooth clause, or other limitations may apply to this service. Additionally, a "Maryland" type fixed partial denture is often *excluded* from reimbursement.
2. Most payors will *not* reimburse a "Maryland" or fixed partial denture used to replace congenitally missing teeth (typically maxillary lateral incisors).
3. Reimbursement for a bridge is typically subject to a five to 10-year limitation.
4. D6549 may not qualify as a fixed partial denture retainer with certain payors.

TIPS

Resin retainer - for resin bonded fixed prosthesis (D6549) is the resin "wing retainer" portion of a Maryland type fixed partial denture. The Maryland type fixed partial denture is used in an effort to conserve the tooth structure of the tooth retainers. The fee for *each* winged retainer is often equal to one-half to three-quarters of the pontic fee. The *total fee* for a Maryland type fixed partial denture is typically two to two and one-half times the pontic fee. Reimbursement for the "wings" of a Maryland fixed partial denture varies widely. Some plans do not cover Maryland fixed partial dentures.

NARRATIVES

If the payor denies reimbursement for D6549, appeal the denial and request an alternate benefit of a conventional fixed partial denture. Ask the patient to obtain a copy of the full dental contract from their Human Resources department. Review the policy to determine if there is a specific limitation applicable to a Maryland fixed partial denture.

ADDITIONAL INFORMATION

Reporting the incorrect *type* of material (high noble, noble, base, ceramic, etc.) used in fabricating the wing retainer is a common coding error. Be careful to report the correct code based on the material classification. Document the correct material used in the pontic on the claim form as represented in the treatment plan, the lab prescription, and the documentation from the lab. Following this protocol should eliminate reporting errors.

D6600 RETAINER INLAY - PORCELAIN/CERAMIC, TWO SURFACES CDT 2025



MATCH

When reporting inlay - porcelain/ceramic, two surfaces (D6600), be careful to ensure the inlay material reported *matches* the corresponding porcelain/ceramic type pontic (D6245).

COMMENTS

1. Porcelain/ceramic is now defined as materials containing predominantly inorganic refractory compounds including porcelains, glasses, ceramics and glass-ceramics. This means 3D printed restorations using materials containing more than 50% inorganic filler may now be classified as porcelain/ceramic.
2. Enter the tooth number and surfaces being restored in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Age, waiting periods, missing tooth, or other limitations may apply.
2. Reimbursement for a fixed partial denture (bridge) is typically subject to a five to 10-year limitation period.
3. D6600, which is a porcelain/ceramic retainer inlay, may not qualify as a fixed partial denture retainer with certain payors while an onlay could.

NARRATIVES

1. Porcelain/ceramic or resin bridges may be denied. Appeal the denial and request an alternate benefit of a conventional bridge. Ask the patient to obtain a copy of the full dental contract from Human Resources. Review the policy to determine if there is a specific limitation applicable either to a Maryland bridge or other inlay retainer-based bridge.
2. Inlay *retainer* claims may be considered for reimbursement if accompanied with full documentation (proper narrative, pretreatment diagnostic radiographic image/photograph and photograph of the final preparation) to justify the need.

D6601 RETAINER INLAY - PORCELAIN/CERAMIC, THREE OR MORE SURFACES CDT 2025



MATCH

When reporting inlay - porcelain/ceramic, three or more surfaces (D6601), be careful to ensure that this code *matches* the corresponding porcelain/ceramic pontic (D6245).

COMMENTS

1. Porcelain/ceramic is now defined as materials containing predominantly inorganic refractory compounds including porcelains, glasses, ceramics and glass-ceramics. This means 3D printed restorations using materials containing more than 50% inorganic filler may now be classified as porcelain/ceramic.
2. Enter the tooth number and surfaces being restored in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Age, waiting periods, missing tooth, or other limitations may apply.
2. Reimbursement for replacement of a fixed partial denture bridge is typically subject to a five to 10-year limitation period.
3. D6601, which is a porcelain/ceramic retainer inlay, may not qualify as a fixed partial denture retainer with certain payors while an onlay could.
4. To receive reimbursement for an onlay retainer on a separate, stand-alone basis, the tooth must meet the same criterion that justifies the placement of a crown (missing a cusp, fractured cusp, extensive breakdown and/or decay).

NARRATIVES

1. Porcelain/ceramic or resin bridges may be denied. Appeal the denial and request an alternate benefit of a conventional bridge. Ask the patient to obtain a copy of the full dental contract from Human Resources. Review the policy to determine if there is a specific limitation applicable either to a Maryland bridge or any other inlay-retained bridge.
2. Inlay *retainer* claims may be considered for reimbursement if accompanied with full documentation (proper narrative, pretreatment diagnostic radiographic image/photograph and photograph of the final preparation) to justify the need.

D6602 RETAINER INLAY - CAST HIGH NOBLE METAL, TWO SURFACES CDT 2025



MATCH

When reporting inlay - cast high noble metal, two surfaces (D6602), be careful to ensure the inlay material *matches* the corresponding cast high noble metal pontic (D6210).

COMMENTS

Enter the teeth number(s) or range of teeth being restored in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Age, waiting periods, missing tooth, or other limitations may also apply.
2. Reimbursement for replacement of a fixed partial denture (bridge) is typically subject to a five to 10-year limitation period.
3. An inlay (D6602) might not qualify as a retainer, while an onlay could.
4. To receive reimbursement for an onlay retainer on a separate, stand-alone basis, the tooth must meet the same criterion that justifies the placement of a crown (missing a cusp, fractured cusp, extensive breakdown and/or decay).

NARRATIVES

Inlay *retainer* claims may be considered for reimbursement if accompanied with full documentation (proper narrative, pretreatment diagnostic radiographic image/photograph and photograph of the final preparation) to justify the need.

D6603 RETAINER INLAY - CAST HIGH NOBLE METAL, THREE OR MORE SURFACES CDT 2025



MATCH

When reporting inlay - cast high noble metal, three or more surfaces (D6603), be careful to ensure the inlay material *matches* the corresponding cast high noble metal pontic (D6210).

COMMENTS

Enter the teeth number(s) or range of teeth being restored in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Age, waiting periods, missing tooth, or other limitations may apply.
2. Reimbursement for replacement of a fixed partial denture (bridge) is typically subject to a five to 10-year limitation period.
3. An inlay (D6603) might not qualify for reimbursement as a retainer, while an onlay could.
4. To receive reimbursement for an onlay retainer on a separate, stand-alone basis, the tooth must meet the same criterion that justifies the placement of a crown (missing a cusp, fractured cusp, fracture, extensive breakdown and/or decay).

NARRATIVES Inlay *retainer* claims may be considered for reimbursement if accompanied with full documentation (proper narrative, pretreatment diagnostic radiographic image/photograph and photograph of the final preparation) to justify the need.

D6604 RETAINER INLAY - CAST PREDOMINANTLY BASE METAL, TWO SURFACES CDT 2025



MATCH

When reporting inlay - cast predominantly base metal, two surfaces (D6604), be careful that the inlay material *matches* the corresponding cast base metal type of pontic (D6211).

COMMENTS Enter the teeth number(s) or range of teeth being restored in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Age, waiting periods, missing tooth, or other limitations may also apply.
2. Reimbursement for replacement of fixed partial denture (bridges) is typically subject to a five to 10-year limitation period.
3. An inlay (D6604) might not qualify for reimbursement as a retainer, while an onlay could.
4. To receive reimbursement for an onlay retainer on a separate, stand-alone basis, the tooth must meet the same criterion that justifies the placement of a crown (missing a cusp, fractured cusp, fracture, extensive breakdown and/or decay).

NARRATIVES Inlay *retainer* claims may be considered for reimbursement if accompanied with full documentation (proper narrative, pretreatment diagnostic radiographic image/photograph and photograph of the final preparation) that justifies its placement.

D6605 RETAINER INLAY - CAST PREDOMINANTLY BASE METAL, THREE OR MORE SURFACES CDT 2025



MATCH

When reporting inlay - cast predominantly base metal, three or more surfaces (D6605), be careful to ensure this code *matches* the corresponding cast base metal pontic (D6211).

COMMENTS Enter the teeth number(s) or range of teeth being restored in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Age, waiting periods, missing tooth, or other limitations may apply.
2. Reimbursement for replacement of fixed partial dentures (bridges) is typically subject to a five to 10-year limitation period.
3. An inlay (D6605) might not qualify for reimbursement as a retainer, while an onlay could.
4. To receive reimbursement for an onlay retainer on a separate, stand-alone basis, the tooth must meet the same criterion that justifies the placement of a crown (missing a cusp, fractured cusp, extensive breakdown and/or decay).

NARRATIVES Inlay *retainer* claims may be considered for reimbursement if accompanied with full documentation (proper narrative, pretreatment diagnostic radiographic image/photograph and photograph of the final preparation) that justifies its placement.

D6606 RETAINER INLAY - CAST NOBLE METAL, TWO SURFACES CDT 2025



MATCH

When reporting inlay - cast noble metal, two surfaces (D6606), be careful to ensure this code *matches* the corresponding cast noble metal pontic (D6212).

COMMENTS Enter the teeth number(s) or range of teeth being restored in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Age, waiting periods, missing tooth, or other limitations may apply.
2. Reimbursement for replacement of fixed partial dentures (bridges) is typically subject to a five to 10-year limitation period.
3. An inlay (D6606) might not qualify for reimbursement as a retainer while an onlay could. To receive reimbursement for an onlay retainer, the tooth must meet the same criterion that justifies the placement of a crown (missing a cusp, fractured cusp, extensive breakdown and/or decay).

NARRATIVES Inlay *retainer* claims may be considered for reimbursement if accompanied with full documentation (proper narrative, pretreatment diagnostic radiographic image/photograph and photograph of the final preparation) that justifies the service.

D6607 RETAINER INLAY - CAST NOBLE METAL, THREE OR MORE SURFACES CDT 2025



MATCH

When reporting inlay - cast noble metal, three or more surfaces (D6607), be careful to ensure that this code *matches* the corresponding cast noble metal pontic, D6212.

COMMENTS Enter the teeth number(s) or range of teeth being restored in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Age, waiting periods, missing tooth, or other limitations may apply.
2. Reimbursement for replacement of bridges is typically subject to a five to 10-year limitation period.
3. An inlay (D6607) might not qualify for reimbursement as a retainer while an onlay could. To receive reimbursement for an onlay retainer, the tooth must meet the same criterion that justifies the placement of a crown (missing a cusp, fractured cusp, extensive breakdown and/or decay).

NARRATIVES Inlay retainer claims may be considered for reimbursement if accompanied with full documentation (a brief narrative, pretreatment diagnostic radiographic image/photograph and photograph of the final preparation) that justifies the service.

D6624 RETAINER INLAY - TITANIUM CDT 2025

Note: While out of numerical order, D6624 is correctly listed here in the Fixed Partial Denture Retainers - inlays/onlays subcategory.



MATCH

When reporting inlay - titanium (D6624), be careful to ensure that this code *matches* the corresponding titanium pontic (D6214).

COMMENTS Enter the teeth number(s) or range of teeth being restored in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. If age limitations, waiting periods, missing tooth clause, least expensive alternate treatment (LEAT) clause, or prosthetic replacement clause does not apply, most dental plans will provide a benefit for inlay or onlay fixed partial denture (bridge) retainers as long as the supporting teeth are sound. Some plans provide an alternate base metal benefit when titanium inlay retainers are used.
2. Age, waiting periods, missing tooth, or other limitations may apply.
3. Reimbursement for replacement of fixed partial dentures is typically subject to a five to 10-year limitation period.

TIPS

1. The nomenclature used to describe inlay titanium restorations (D6624) is very broad. The titanium inlay code reports *all types of titanium inlays*, either metal, or coated with ceramic or resin. The titanium inlay code is used to report all surface classifications.
2. Inlay retainer claims may be considered for reimbursement if accompanied with full documentation (a brief narrative, pretreatment diagnostic radiographic image/photograph and photograph of the final preparation) that justifies the service.

D6608 RETAINER ONLAY - PORCELAIN/CERAMIC, TWO SURFACES CDT 2025

WARNING

Onlays must "cap" or "shoe" at least one cusp. If the onlay retainer restoration does not "cap" or "shoe" a cusp, reporting onlay porcelain/ceramic, two surfaces (D6608) is an error. The ADA Glossary of dental terms, when describing an onlay states: "Going up the incline more than one half of the distance from fossa to cusp tip *is not* an onlay." It further states that, "A restoration that restores one or more cusps and adjoining occlusal surfaces or the entire occlusal surface and is retained by mechanical or adhesive means." The Journal of Prosthodontic Dentistry, The Glossary of Prosthodontic Terms, July 2005, pg. 57).

MATCH

When reporting onlay porcelain/ceramic, two surfaces (D6608), be careful to ensure this code *matches* the corresponding porcelain/ceramic pontic (D6245).

COMMENTS

1. It is important that at least one *buccal* or *lingual* surface be a part of the onlay restoration and reported on the claim form for reimbursement of an onlay retainer to be considered. An MO does not describe an onlay. An MOF, MOL, DOF, DOL, MODL, MODF or MODFL describes an onlay.
2. Porcelain/ceramic is now defined as materials containing predominantly inorganic refractory compounds including porcelains, glasses, ceramics and glass-ceramics. This means 3D printed restorations using materials containing more than 50% inorganic filler may now be classified as porcelain/ceramic.
3. Enter the tooth number and surfaces being restored in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. If age limitations, waiting periods, missing tooth clause, least expensive alternate treatment (LEAT) clause, or prosthetic replacement clause does not apply, most dental plans will provide a benefit for onlay bridge retainers as long as the supporting teeth are sound. Some plans provide an alternate base metal benefit when porcelain/ceramic onlay retainers are used.
2. Age, waiting periods, missing tooth, or other limitations may apply.
3. Reimbursement for replacement of fixed partial dentures (bridges) is typically subject to a five to 10-year limitation period.

NARRATIVES

Onlay claims are typically reimbursed if accompanied with full documentation (a brief narrative, pretreatment diagnostic radiographic image/photograph and photograph of the final preparation). To receive reimbursement for an onlay, the tooth must meet the same criterion that justifies the placement of a crown (missing a cusp, fractured cusp, extensive breakdown and/or decay). A narrative should be provided when reporting an onlay, stating that the onlay is a conservative option to a full crown.

D6609 RETAINER ONLAY - PORCELAIN/CERAMIC, THREE OR MORE SURFACES CDT 2025

WARNING

Onlays must "cap" or "shoe" at least one cusp. If the onlay retainer restoration does not "cap" or "shoe" a cusp, reporting onlay porcelain/ceramic, three or more surfaces (D6609) is an error. The ADA Glossary of dental terms, when describing an onlay states: "Going up the incline more than one half of the distance from fossa to cusp tip *is not* an onlay." It further states that, "A restoration that restores one or more cusps and adjoining occlusal surfaces or the entire occlusal surface and is retained by mechanical or adhesive means." The Journal of Prosthodontic Dentistry, The Glossary of Prosthodontic Terms, July 2005, pg. 57).

MATCH

When reporting onlay - porcelain/ceramic, three or more surfaces (D6609), be careful to ensure that the onlay retainer code *matches* the corresponding porcelain/ceramic pontic (D6245).

COMMENTS

1. It is important that at least one *buccal* and/or *lingual* surface be a part of the onlay restoration (capping one or more cusps) for reimbursement of an onlay retainer to be considered. An MOD does not describe an onlay. An MOF, MOL, DOF, DOL, MODL, MODF or MODFL describes an onlay.
2. Porcelain/ceramic is now defined as materials containing predominantly inorganic refractory compounds including porcelains, glasses, ceramics and glass-ceramics. This means 3D printed restorations using materials containing more than 50% inorganic filler may now be classified as porcelain/ceramic.
3. Enter the tooth number and surfaces being restored in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. If age limitations, waiting periods, missing tooth clause, least expensive alternate treatment (LEAT) clause, or prosthetic replacement clause does not apply, most dental plans will provide a benefit for onlay bridge retainers as long as the supporting teeth are sound. Some plans provide an alternate base metal benefit when porcelain/ceramic onlay retainers are used.
2. Age, waiting periods, missing tooth, or other limitations may apply.
3. Reimbursement for replacement of fixed partial dentures is typically subject to a five to 10-year limitation period.

NARRATIVES

Onlay claims are typically reimbursed if accompanied with full documentation (a brief narrative, pretreatment diagnostic radiographic image/photograph and photograph of the final preparation). To receive reimbursement for an onlay, the tooth must meet the same criterion that justifies the placement of a crown (missing a cusp, fractured cusp, extensive breakdown and/or decay). A narrative should be provided when reporting an onlay, stating that the onlay is a conservative option to a full crown.

D6610 RETAINER ONLAY - CAST HIGH NOBLE METAL, TWO SURFACES CDT 2025



WARNING

Onlays must "cap" or "shoe" at least one cusp. If the onlay retainer restoration does not "cap" or "shoe" a cusp, reporting onlay - cast high noble metal, two surfaces (D6610) is an error. The ADA Glossary of dental terms, when describing an onlay states: "Going up the incline more than one half of the distance from fossa to cusp tip *is not* an onlay." It further states that, "A restoration that restores one or more cusps and adjoining occlusal surfaces or the entire occlusal surface and is retained by mechanical or adhesive means." The Journal of Prosthodontic Dentistry, The Glossary of Prosthodontic Terms, July 2005, pg. 57).



MATCH

When reporting an onlay - cast high noble metal, two surfaces (D6610), be careful to ensure that the onlay retainer code *matches* the corresponding high noble metal pontic (D6210).

COMMENTS

1. It is important that at least one *buccal* and/or *lingual* surface be a part of the onlay restoration (capping one or more cusps) for reimbursement of an onlay retainer to be considered. An MOD does not describe an onlay. An MOF, MOL, DOF, DOL, MODL, MODF or MODFL describes an onlay.
2. Enter the tooth number and surfaces being restored in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. If age limitations, waiting periods, missing tooth clause, least expensive alternate treatment (LEAT) clause, or prosthetic replacement clause does not apply, most dental plans will provide a benefit for onlay bridge retainers as long as the supporting teeth are sound. Some plans provide an alternate base metal benefit when onlay retainers are used.
2. Age, waiting periods, missing tooth, or other limitations may apply.
3. Reimbursement for replacement of fixed partial dentures (bridges) is typically subject to a five to 10-year limitation period.

NARRATIVES

Onlay claims are typically reimbursed if accompanied with full documentation (a brief narrative, pretreatment diagnostic radiographic image/photograph and photograph of the final preparation). To receive reimbursement for an onlay, the tooth must meet the same criteria that justifies the placement of a crown (missing a cusp, fractured cusp, extensive breakdown and/or decay) . A narrative should be provided when reporting an onlay, stating that the onlay is a conservative option to a full crown.

D6611 RETAINER ONLAY - CAST HIGH NOBLE METAL, THREE OR MORE SURFACES CDT 2025



WARNING

Onlays must "cap" or "shoe" at least one cusp. If the onlay retainer restoration does not "cap" or "shoe" a cusp, reporting onlay - cast high noble metal, three or more surfaces (D6611) is an error. The ADA Glossary of dental terms, when describing an onlay states: "Going up the incline more than one half of the distance from fossa to cusp tip *is not* an onlay." It further states that, "A restoration that restores one or more cusps and adjoining occlusal surfaces or the entire occlusal surface and is retained by mechanical or adhesive means." The Journal of Prosthodontic Dentistry, The Glossary of Prosthodontic Terms, July 2005, pg. 57).

MATCH

When reporting an onlay - cast high noble metal, three or more surfaces (D6611), be careful to ensure that the onlay retainer code *matches* the corresponding cast high noble metal pontic (D6210).

COMMENTS

1. It is important that at least one *buccal* and/or *lingual* surface be a part of the onlay restoration (capping one or more cusps) for reimbursement of an onlay retainer to be considered. An MOD does not describe an onlay. An MOF, MOL, DOF, DOL, MODL, MODF or MODFL describes an onlay.
2. Enter the tooth number and surfaces being restored in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. If age limitations, waiting periods, missing tooth clause, least expensive alternate treatment (LEAT) clause, or prosthetic replacement clause does not apply, most dental plans will provide a benefit for onlay bridge retainers as long as the supporting teeth are sound. Some plans provide an alternate base metal benefit when onlay retainers are used.
2. Age, waiting periods, missing tooth, or other limitations may apply.
3. Reimbursement for replacement of fixed partial dentures (bridges) is typically subject to a five to 10-year limitation period.

NARRATIVES

Onlay retainers are usually reimbursed when reported with full documentation (a brief narrative, beginning diagnostic radiographic image/photograph and photograph of preparation). To receive reimbursement for an onlay retainer, the tooth must meet the same criteria for a crown (missing a cusp, fractured cusp and breakdown), necessitated by fracture or decay. A brief narrative should be used when reporting an onlay retainer, stating that the onlay is a conservative option to a full crown.

D6612 RETAINER ONLAY - CAST PREDOMINANTLY BASE METAL, TWO SURFACES CDT 2025

WARNING

Onlays must "cap" or "shoe" at least one cusp. If the onlay retainer restoration does not "cap" or "shoe" a cusp, reporting onlay - cast predominantly base metal, two surfaces (D6612) is an error. The ADA Glossary of dental terms, when describing an onlay states: "Going up the incline more than one half of the distance from fossa to cusp tip *is not* an onlay." It further states that, "A restoration that restores one or more cusps and adjoining occlusal surfaces or the entire occlusal surface and is retained by mechanical or adhesive means." The Journal of Prosthodontic Dentistry, The Glossary of Prosthodontic Terms, July 2005, pg. 57).

MATCH

When reporting an onlay - cast predominantly base metal, two surfaces (D6612), be careful to ensure that the onlay retainer code *matches* the corresponding cast base metal type of pontic (D6211).

COMMENTS

1. It is important that at least one *buccal* and/or *lingual* surface be a part of the onlay restoration (capping one or more cusps) for reimbursement of an onlay retainer to be considered. An MOD does not describe an onlay. An MOF, MOL, DOF, DOL, MODL, MODF or MODFL describes an onlay.
2. Enter the tooth number and surfaces being restored in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. If age limitations, waiting periods, missing tooth clause, least expensive alternate treatment (LEAT) clause, or prosthetic replacement clause does not apply, most dental plans will provide a benefit for onlay bridge retainers as long as the supporting teeth are sound. Some plans provide an alternate base metal benefit when onlay retainers are used.
2. Age, waiting periods, missing tooth, or other limitations may apply.
3. Reimbursement for replacement of bridges is typically subject to a five-to-10-year limitation period.

NARRATIVES

Onlay retainers are usually reimbursed when reported with full documentation (a brief narrative, beginning diagnostic radiographic image/photograph and photograph of preparation). To receive reimbursement for an onlay retainer, the tooth must meet the same criteria for a crown (missing a cusp, fractured cusp and breakdown), necessitated by fracture or decay. A brief narrative should be used when reporting an onlay retainer, stating that the onlay is a conservative option to a full crown.

D6613 RETAINER ONLAY - CAST PREDOMINANTLY BASE METAL, THREE OR MORE SURFACES

CDT 2025



WARNING

Onlays must "cap" or "shoe" at least one cusp. If the onlay retainer restoration does not "cap" or "shoe" a cusp, reporting onlay - cast predominantly base metal, three or more surfaces (D6613) is an error. The ADA Glossary of dental terms, when describing an onlay states: "Going up the incline more than one half of the distance from fossa to cusp tip *is not* an onlay." It further states that, "A restoration that restores one or more cusps and adjoining occlusal surfaces or the entire occlusal surface and is retained by mechanical or adhesive means." The Journal of Prosthodontic Dentistry, The Glossary of Prosthodontic Terms, July 2005, pg. 57).



MATCH

When reporting an onlay - cast predominantly base metal, three or more surfaces (D6613), be careful to ensure that the onlay retainer code *matches* the corresponding cast base metal type of pontic (D6211).

COMMENTS

1. It is important that at least one *buccal* and/or *lingual* surface be a part of the onlay restoration (capping one or more cusps) for reimbursement of an onlay retainer to be considered. An MOD does not describe an onlay. An MOF, MOL, DOF, DOL, MODL, MODF or MODFL describes an onlay.
2. Enter the tooth number and surfaces being restored in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. If age limitations, waiting periods, missing tooth clause, least expensive alternate treatment (LEAT) clause, or prosthetic replacement clause does not apply, most dental plans will provide a benefit for onlay bridge retainers as long as the supporting teeth are sound. Some plans provide an alternate base metal benefit when onlay retainers are used.
2. Age, waiting periods, missing tooth, or other limitations may apply.
3. Reimbursement for replacement of fixed partial dentures (bridges) is typically subject to a five to 10-year limitation period.

NARRATIVES

Onlay retainers are usually reimbursed when reported with full documentation (a brief narrative, beginning diagnostic radiographic image/photograph and photograph of preparation). To receive reimbursement for an onlay retainer, the tooth must meet the same criteria for a crown (missing a cusp, undermined cusp, fractured cusp and breakdown), necessitated by fracture or decay. A brief narrative should be used when reporting an onlay retainer, stating that the onlay is a conservative option to a full crown.

D6614 RETAINER ONLAY - CAST NOBLE METAL, TWO SURFACES

CDT 2025



WARNING

Onlays must "cap" or "shoe" at least one cusp. If the onlay retainer restoration does not "cap" or "shoe" a cusp, reporting onlay porcelain/ceramic, two surfaces (D6614) is an error. The ADA Glossary of dental terms, when describing an onlay states: "Going up the incline more than one half of the distance from fossa to cusp tip *is not* an onlay." It further states that, "A restoration that restores one or more cusps and adjoining occlusal surfaces or the entire occlusal surface and is retained by mechanical or adhesive means." The Journal of Prosthodontic Dentistry, The Glossary of Prosthodontic Terms, July 2005, pg. 57).



MATCH

When reporting an onlay - cast noble metal, two surfaces, (D6614), be careful to ensure that the onlay code *matches* the corresponding cast noble metal type of pontic (D6212).

COMMENTS

1. It is important that at least one *buccal* and/or *lingual* surface be a part of the onlay restoration (capping one or more cusps) for reimbursement of an onlay retainer to be considered. An MOD does not describe an onlay. An MOF, MOL, DOF, DOL, MODL, MODF, or MODFL describes an onlay.
2. Enter the tooth number and surfaces being restored in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. If age limitations, waiting periods, missing tooth clause, least expensive alternate treatment (LEAT) clause, or prosthetic replacement clause does not apply, most dental plans will provide a benefit for onlay bridge retainers as long as the supporting teeth are sound. Some plans provide an alternate base metal benefit when onlay retainers are used.

2. Age, waiting periods, missing tooth, or other limitations may apply.
3. Reimbursement for replacement of fixed partial dentures (bridges) is typically subject to a five to 10-year limitation period.

NARRATIVES

Onlay retainers are usually reimbursed when reported with full documentation (a brief narrative, beginning diagnostic radiographic image/photograph and photograph of preparation). To receive reimbursement for an onlay retainer, the tooth must meet the same criteria for a crown (missing a cusp, undermined cusp, fractured cusp and breakdown), necessitated by fracture or decay. A narrative should be used when reporting an onlay retainer, stating that the onlay is a conservative option to a full crown.

D6615 RETAINER ONLAY - CAST NOBLE METAL, THREE OR MORE SURFACES CDT 2025



WARNING

Onlays must "cap" or "shoe" at least one cusp. If the restoration does not "cap" or "shoe" a cusp, reporting onlay - cast noble metal, three or more surfaces (D6615) is an error. The ADA Glossary of dental terms, when describing an onlay states: "Going up the incline more than one half of the distance from fossa to cusp tip *is not* an onlay." It further states that, "A restoration that restores one or more cusps and adjoining occlusal surfaces or the entire occlusal surface and is retained by mechanical or adhesive means." (The Journal of Prosthodontic Dentistry, The Glossary of Prosthodontic Terms, July 2005, pg. 57).



MATCH

When reporting onlay - cast noble metal, three or more surfaces (D6615), be careful to ensure that this code *matches* the corresponding cast noble metal pontic D6212.

COMMENTS

1. It is important that at least one *buccal* and/or *lingual* surface be a part of the onlay restoration (capping one or more cusps) for reimbursement of an onlay to be considered. An MOD does not describe an onlay. An MOF, MOL, DOF, DOL, MODL, MODF or MODFL describes an onlay.
2. Enter the tooth number and surfaces being restored in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. If age limitations, waiting periods, missing tooth clause, least expensive alternate treatment (LEAT) clause, or prosthetic replacement clause does not apply, most dental plans will provide a benefit for inlay or onlay bridge retainers as long as the supporting teeth are sound.
2. Age, waiting periods, missing tooth, or other limitations may apply.
3. Reimbursement for replacement of fixed partial denture (bridges) is typically subject to a five to 10- limitation period.

NARRATIVES

Onlay retainers are usually reimbursed when reported with full documentation (a brief narrative, beginning diagnostic radiographic image/photograph and photograph of preparation). To receive reimbursement for an onlay retainer, the tooth must meet the same criteria for a crown (missing a cusp, fractured cusp and breakdown), necessitated by fracture or decay. A narrative should be used when reporting an onlay retainer, stating that the onlay is a conservative option to a full crown.

D6624 RETAINER INLAY - TITANIUM CDT 2025

Note: D6624 appears here in numerical order. Its true location is after D6607 but the information for this code is printed in this location in its entirety.



MATCH

When reporting inlay - titanium (D6624), be careful to ensure that this code *matches* the corresponding titanium pontic (D6214).

COMMENTS

Enter the teeth number(s) or range of teeth being restored in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. If age limitations, waiting periods, missing tooth clause, least expensive alternate treatment (LEAT) clause, or prosthetic replacement clause does not apply, most dental plans will provide a benefit for inlay or onlay fixed partial denture (bridge) retainers as long as the supporting teeth are sound. Some plans provide an alternate base metal benefit when titanium inlay retainers are used.
2. Age, waiting periods, missing tooth, or other limitations may apply.
3. Reimbursement for replacement of fixed partial dentures is typically subject to a five to 10-year limitation period.
4. An inlay (D6624) might not qualify for reimbursement as a retainer while an onlay could. To receive reimbursement for an onlay retainer on a separate, stand-alone basis, the tooth must meet the same criterion that justifies the placement of a crown (missing a cusp, fractured cusp, extensive breakdown and/or decay).

TIPS

1. The nomenclature used to describe inlay titanium restorations (D6624) is very broad. The titanium inlay code reports *all types of titanium inlays*, either metal, or coated with ceramic or resin. The titanium inlay code is used to report all surface classifications.
2. Inlay retainer claims may be considered for reimbursement if accompanied with full documentation (a brief narrative, pretreatment diagnostic radiographic image/photograph and photograph of the final preparation) that justifies the service.

D6634 RETAINER ONLAY - TITANIUM CDT 2025



WARNING

Onlays must "cap" or "shoe" at least one cusp. If the restoration does not "cap" or "shoe" a cusp, reporting onlay - titanium (D6634) is an error. The ADA Glossary of dental terms, when describing an onlay states: "Going up the incline more than one half of the distance from fossa to cusp tip *is not* an onlay." It further states that, "A restoration that restores one or more cusps and adjoining occlusal surfaces or the entire occlusal surface and is retained by mechanical or adhesive means." (The Journal of Prosthodontic Dentistry, The Glossary of Prosthodontic Terms, July 2005, pg. 57).



MATCH

When reporting onlay - titanium (D6634), be careful to insure that this code *matches* the corresponding titanium pontic, D6214.

COMMENTS

1. It is important that at least one *buccal* and/or *lingual* surface be a part of the onlay restoration (capping one or more cusps) for reimbursement of an onlay to be considered. An MOD does not describe an onlay. An MOF, MOL, DOF, DOL, MODL, MODF or MODFL describes an onlay.
2. Enter the tooth number and surfaces being restored in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. If age limitations, waiting periods, missing tooth clause, least expensive alternate treatment (LEAT) clause, or prosthetic replacement clause does not apply, most dental plans will provide a benefit for inlay or onlay bridge retainers as long as the supporting teeth are sound.
2. Age, waiting periods, missing tooth, or other limitations may apply.
3. Reimbursement for replacement of fixed partial dentures (bridges) is typically subject to a five to 10-year limitation period.

TIPS

The nomenclature used to describe the titanium only restorations (D6634) is very broad. The titanium onlay code reports *all types of titanium onlay*, either metal, or coated with ceramic or resin. The titanium onlay code is used to report all surface classifications, i.e., whether it is two, three or more surfaces.

NARRATIVES

Onlays are usually reimbursed when reported with full documentation (a brief narrative, beginning diagnostic radiographic image/photograph and photograph of preparation). To receive reimbursement for an onlay, the tooth must meet the same criteria for a crown (missing a cusp, undermined cusp, fractured cusp and breakdown), necessitated by fracture or decay. A narrative should be used when reporting an onlay, stating that the onlay is a conservative option to a full crown.

D6710 RETAINER CROWN - INDIRECT RESIN BASED COMPOSITE CDT 2025

Not to be used as a temporary or provisional prosthesis.



WARNING

This code is not intended to describe a temporary or provisional prosthesis.

WATCH

Crown - indirect resin based composite (D6710) reports a permanent indirect retainer crown (resin based composite). It is an error to use D6710 to describe a *provisional* prosthesis. D6793 may be used to report a *provisional* retainer crown.



MATCH

When reporting crown - indirect resin based composite (D6710), be careful to ensure that this retainer crown code *matches* the corresponding indirect resin based composite pontic (D6205).

COMMENTS

1. When reporting the supporting retainer crowns of a fixed partial denture (bridge), note that the term used in current CDT is "fixed partial denture retainer crowns." While many dental practices still use the term "abutment" to identify the retainer crown units of a fixed partial denture (bridge), the use of the term retainer can be confusing. The term "abutment" refers to the connection piece that attaches a prosthetic device to a root form implant (see D6056/ D6057). To avoid billing errors, the components of a three unit fixed partial denture should be identified as retainer-pontic-retainer, rather than abutment-pontic-abutment.
2. D6710 is used to describe resin based retainer crowns made of Artglass®, Belleglass®, Cristobel®, etc. type materials.
3. 3D printed resin retainer crowns may be reported using D6710 as long as the appropriate materials are used in fabrication.
4. Enter the tooth number being restored in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Age restrictions, waiting periods, missing tooth clause, or other limitations may apply to the reimbursement for this service.
2. Reimbursement for replacement of fixed partial dentures is typically subject to a five to 10-year limitation period.
3. D6710 may be reimbursed according to the same exclusions/limitations as a cast fixed partial denture retainer crown.

NARRATIVES

Resin bridges may be denied. Appeal the denial of the indirect resin based composite fixed partial denture and request an alternate benefit of a conventional fixed partial denture. Ask the patient to obtain a copy of the full dental coverage contract from their Human Resources department. Review the policy to determine if there is a specific limitation applicable to an indirect resin based composite fixed partial denture and appeal appropriately. If reimbursed, this service may be paid at the D6721 payor's fee level.

D6720 RETAINER CROWN - RESIN WITH HIGH NOBLE METAL CDT 2025



MATCH

When reporting crown - resin with high noble (D6720), be careful to ensure that this retainer crown code *matches* the corresponding resin with high noble metal pontic (D6250).

COMMENTS

1. When reporting the supporting retainer crowns of a fixed partial denture bridge, note that the term used in current CDT is "fixed partial denture retainer crowns." While many dental practices still use the term "abutment" to identify the retainer crown units of a fixed partial denture, the use of the term retainer can be confusing. The term "abutment" refers to the connection piece that attaches a prosthetic device to a root form implant (see D6056/D6057). To avoid billing errors, the components of a three unit fixed partial denture should be identified as retainer-pontic-retainer, rather than abutment-pontic-abutment.
2. Enter the tooth number being restored in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Age restrictions, waiting periods, missing tooth clause, or other limitations may apply to the reimbursement for this service.
2. Reimbursement for replacement of fixed partial dentures is typically subject to a five to 10-year limitation period.

D6721 RETAINER CROWN - RESIN WITH PREDOMINANTLY BASE METAL CDT 2025



MATCH

When reporting crown - resin with predominantly base metal (D6721), be careful to ensure that this retainer crown code *matches* the corresponding resin with base metal pontic (D6251).

COMMENTS

1. When reporting the supporting retainer crown of a fixed partial denture (bridge), note that the term used in current CDT is "fixed partial denture retainer crowns." While many dental practices still use the term "abutment" to identify the retainer crown units of a fixed partial denture, the use of the term retainer can be confusing. The term "abutment" refers to the connection piece that attaches a prosthetic device to a root form implant (see D6056/D6057). To avoid billing errors, the bridge components of a three-unit fixed partial denture should be identified as retainer-pontic-retainer, rather than abutment-pontic-abutment.
2. Enter the tooth number being restored in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Age restrictions, waiting periods, missing tooth clause, or other limitations may apply to the reimbursement for this service.
2. Reimbursement for replacement of fixed partial dentures is typically subject to a five to 10-year limitation period.

D6722 RETAINER CROWN - RESIN WITH NOBLE METAL CDT 2025



MATCH

When reporting crown - resin with noble metal (D6722), be careful to ensure that the retainer crown code *matches* the corresponding resin with noble metal pontic (D6252).

COMMENTS

1. When reporting the supporting retainer crown of a fixed partial denture (bridge), note that the term used in current CDT is "fixed partial denture retainer crowns." While many dental practices still use the term "abutment" to identify the retainer crown units of a fixed partial denture, the use of the term retainer can be confusing. The term "abutment" refers to the connection piece that attaches a prosthetic device to a root form implant (see D6056/D6057). To avoid billing errors, the components of a three-unit fixed partial denture should be identified as retainer-pontic-retainer, rather than abutment-pontic-abutment.
2. Enter the tooth number being restored in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Age restrictions, waiting periods, missing tooth clause, or other limitations may apply to the reimbursement for this service.
2. Reimbursement for replacement of fixed partial dentures is typically subject to a five to 10-year limitation period.

D6740 RETAINER CROWN - PORCELAIN/CERAMIC CDT 2025

MATCH

When reporting crown - porcelain/ceramic (D6740), be careful to ensure that this retainer crown code *matches* the corresponding porcelain/ceramic pontic (D6245).

COMMENTS

1. When reporting the supporting retainer crown of a fixed partial denture (bridge), note that the term used in current CDT is "fixed partial denture retainer crowns." While many dental practices still use the term "abutment" to identify the retainer crown units of a fixed partial denture, the use of the term retainer can be confusing. The term "abutment" refers to the connection piece that attaches a prosthetic device to a root form implant (see D6056/D6057). To avoid billing errors, the components of a three-unit fixed partial denture should be identified as retainer-pontic-retainer, rather than abutment-pontic-abutment.
2. Porcelain/ceramic is now defined as materials containing predominantly inorganic refractory compounds including porcelains, glasses, ceramics and glass-ceramics. This means 3D printed restorations using materials containing more than 50% inorganic filler may now be classified as porcelain/ceramic.
3. Enter the tooth number being restored in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Age restrictions, waiting periods, missing tooth clause, or other limitations may apply to the reimbursement for this service.
2. Reimbursement for replacement of fixed partial dentures is typically subject to a five-to-10-year limitation period.
3. D6740 is used to report fixed partial denture retainers made of materials such as Procera®, Empress® and LavaUltimate®.

PHOTO



The image depicts a three unit porcelain/ceramic bridge. The bridge is made up of the pontic (D6245) and two retainer crowns (D6740).

Courtesy of Keller Dental Lab

D6750 RETAINER CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL CDT 2025

MATCH

When reporting crown - porcelain fused to high noble metal (D6750), be careful to ensure that the retainer crown code *matches* the corresponding PFM high noble metal pontic (D6240).

COMMENTS

1. When reporting the supporting retainer crowns of a fixed partial denture (bridge), note that the term used in current CDT is "fixed partial denture retainer crowns." While many dental practices still use the term "abutment" to identify the retainer crown units of a fixed partial denture, the use of the term retainer can be confusing. The term "abutment" refers to the connection piece that attaches a prosthetic device to a root form implant (see D6056/D6057). To avoid billing errors, the components of a three unit fixed partial retainer should be identified as retainer-pontic-retainer, rather than abutment-pontic-abutment.
2. Enter the tooth number being restored in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Age restrictions, waiting periods, missing tooth clause, or other limitations may apply to the reimbursement for this service.
2. Reimbursement for replacement of fixed partial dentures is typically subject to a five to 10-year limitation period.

D6751 RETAINER CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL CDT 2025

MATCH

When reporting crown - porcelain fused to predominantly base metal (D6751), be careful to ensure that the retainer crown code *matches* the corresponding PFM base metal pontic (D6241).

COMMENTS

1. When reporting the supporting retainer crowns of a fixed partial denture (bridge), note that the term used in current CDT is "fixed partial denture retainer crowns." While many dental practices still use the term "abutment" to identify the retainer crown units of a fixed partial denture, the use of the term retainer can be confusing. The term "abutment" refers to the connection piece that attaches a prosthetic device to a root form implant (see D6056/D6057). To avoid billing errors, the components of a three unit fixed partial denture should be identified as retainer-pontic-retainer, rather than abutment-pontic-abutment.
2. Enter the tooth number being restored in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Age restrictions, waiting periods, missing tooth clause, or other limitations may apply to the reimbursement for this service.
2. Reimbursement for replacement of fixed partial dentures is typically subject to a five to 10-year limitation period.

D6752 RETAINER CROWN - PORCELAIN FUSED TO NOBLE METAL CDT 2025

MATCH

When reporting crown - porcelain fused to noble metal (D6752), be careful to ensure that this code *matches* the corresponding PFM noble metal pontic (D6242).

COMMENTS

1. When reporting the supporting retainer crowns of a fixed partial denture (bridge), note that the term used in current CDT is "fixed partial denture retainer crowns." While many dental practices still use the term "abutment" to identify the retainer crown units of a fixed partial denture, the use of the term retainer can be confusing. The term "abutment" refers to the connection piece that attaches a prosthetic device to a root form implant (see D6056/D6057). To avoid billing errors, the components of a three unit fixed partial denture should be identified as retainer-pontic-retainer, rather than abutment-pontic-abutment.
2. Enter the tooth number being restored in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Age restrictions, waiting periods, missing tooth clause, or other limitations may apply to the reimbursement for this service.
2. Reimbursement for replacement of fixed partial dentures is typically subject to a five to 10-year limitation period.

D6753 RETAINER CROWN - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS CDT 2025

MATCH

When reporting retainer crown - porcelain fused to titanium and titanium alloys (D6753), be careful to ensure that the retainer crown code matches the corresponding PFM titanium and titanium alloy pontic (D6243).

COMMENTS

1. When reporting the supporting retainer crowns of a fixed partial denture (bridge), note that the term used in current CDT is "fixed partial denture retainer crowns." While many dental practices still use the term "abutment" to identify the retainer crown units of a fixed partial denture, the use of the term retainer can be confusing. The term "abutment" refers to the connection piece that attaches a prosthetic device to a root form implant (see D6056/D6057). To avoid billing errors, the components of a three unit fixed partial denture (FPD) retainer should be identified as retainer-pontic-retainer, rather than abutment-pontic-abutment.

2. Be careful that the bridge pontic material-type matches the corresponding crown retainer material-type. Always use the matching code, according to its material classification.
3. Reporting the incorrect type of material used in fabricating the crown retainer is a common coding error. Be careful to report the correct code based on the material classification. Document the correct material used in the pontic on the claim form as represented in the treatment plan, the lab prescription, and the documentation from the lab. Following this protocol should eliminate reporting errors.
4. Enter the tooth number being restored in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Age restrictions, waiting periods, missing tooth clause, or other limitations may apply to the reimbursement for this service.
2. Reimbursement for replacement of fixed partial dentures is typically subject to a five to ten year limitation period.

D6780 RETAINER CROWN - 3/4 CAST HIGH NOBLE METAL CDT 2025



MATCH

When reporting crown - ¾ cast high noble metal (D6780), be careful to ensure that the code reported for the retainer *matches* the corresponding cast high noble metal pontic (D6210).

COMMENTS

1. When reporting the retainer crowns of a fixed partial denture (bridge), note that the term used in current CDT is "fixed partial denture retainer crowns." While many dental practices still use the term "abutment" to identify the retainer crown units of a fixed partial denture, the use of the term retainer can be confusing. The term "abutment" refers to the connection piece that attaches a prosthetic device to a root form implant (see D6056/D6057). To avoid billing errors, the components of a three unit fixed partial denture should be identified as retainer-pontic-retainer, rather than abutment-pontic-abutment.
2. ¾ crowns are most often placed on first molars with the mesio-buccal surfaces left intact for esthetics.
3. Enter the tooth number being restored in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Age restrictions, waiting periods, missing tooth clause, or other limitations may apply to the reimbursement for this service.
2. Reimbursement for replacement of fixed partial dentures is typically subject to a five to 10-year limitation period.

TIPS

A ¾ crown covers the occlusal surface in addition to three of the four remaining sides of the tooth.

D6781 RETAINER CROWN - 3/4 CAST PREDOMINANTLY BASE METAL CDT 2025



MATCH

When reporting crown - ¾ cast predominantly base metal (D6781), be careful to ensure that this code *matches* the corresponding cast base metal pontic (D6211).

COMMENTS

1. When reporting the retainer crowns of a fixed partial denture (bridge), note that the term used in current CDT is "fixed partial denture retainer crowns." While many dental practices still use the term "abutment" to identify the retainer crown units of a fixed partial denture, the use of the term retainer can be confusing. The term "abutment" refers to the connection piece that attaches a prosthetic device to a root form implant (see D6056/D6057). To avoid billing errors, the components of a three unit fixed partial denture should be identified as retainer-pontic-retainer, rather than abutment-pontic-abutment.
2. ¾ crowns are most often placed on first molars with the mesio-buccal surfaces left intact for esthetics.
3. Enter the tooth number being restored in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Age restrictions, waiting periods, missing tooth clause, or other limitations may apply to the reimbursement for this service.
2. Reimbursement for replacement of fixed partial dentures is typically subject to a five to 10-year limitation period.

TIPS

A ¾ crown covers the occlusal surface in addition to three of the four remaining sides of the tooth.

D6782 RETAINER CROWN - 3/4 CAST NOBLE METAL CDT 2025



MATCH

When reporting crown - ¾ cast noble metal (D6782), be careful to ensure that this code *matches* the corresponding cast noble metal pontic (D6212).

COMMENTS

1. When reporting the retainer crowns of a fixed partial denture (bridge), note that the term used in current CDT is "fixed partial denture retainer crowns." While many dental practices still use the term "abutment" to identify the retainer crown units of a fixed partial denture, the use of the term retainer can be confusing. The term "abutment" refers to the connection piece that attaches a prosthetic device to a root form implant (see D6056/D6057). To avoid billing errors, the components of a three unit fixed partial denture should be identified as retainer-pontic-retainer, rather than abutment-pontic-abutment.
2. ¾ crowns are most often placed on first molars with the mesio-buccal surfaces left intact for esthetics.
3. Enter the tooth number being restored in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Age restrictions, waiting periods, missing tooth clause, or other limitations may apply to the reimbursement for this service.
2. Reimbursement for replacement of fixed partial dentures is typically subject to a five to 10-year limitation period.

TIPS

A ¾ crown covers the occlusal surface in addition to three of the four remaining sides of the tooth.

D6783 RETAINER CROWN - 3/4 PORCELAIN/CERAMIC CDT 2025



MATCH

When reporting crown - ¾ porcelain/ceramic (D6783), be careful that the corresponding porcelain/ceramic pontic (D6245) material matches the retainer crown.

COMMENTS

1. When reporting the retainer crowns of a fixed partial denture (bridge), note that the term used in current CDT is "fixed partial denture retainer crowns." While many dental practices still use the term "abutment" to identify the retainer crown units of a fixed partial denture, the use of the term retainer can be confusing. The term "abutment" refers to the connection piece that attaches a prosthetic device to a root form implant (see D6056/D6057). To avoid billing errors, the components of a three unit fixed partial denture should be identified as retainer-pontic-retainer, rather than abutment-pontic-abutment.
2. ¾ crowns are most often placed on first molars with the mesio-buccal surfaces left intact or anterior teeth for esthetics.
3. D6783 is used to report ¾ crowns fabricated of materials such as Empress® and Procera® and includes Lava Ultimate®.
4. Porcelain/ceramic is now defined as materials containing predominantly inorganic refractory compounds including porcelains, glasses, ceramics and glass-ceramics. This means 3D printed restorations using materials containing more than 50% inorganic filler may now be classified as porcelain/ceramic.
5. Enter the tooth number being restored in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Age restrictions, waiting periods, missing tooth clause, or other limitations may apply to the reimbursement for this service.
2. Reimbursement for replacement of fixed partial dentures is typically subject to a five to 10-year limitation period.

TIPS

1. A ¾ crown covers the occlusal surface in addition to three of the four remaining sides of the tooth.
2. D6783 is used to report a restoration placed on an anterior tooth with the lingual or the facial surface of enamel intact.

D6784 RETAINER CROWN 3/4 - TITANIUM AND TITANIUM ALLOYS CDT 2025

MATCH

When reporting crown - ¾ cast titanium and titanium (D6784), be careful to ensure that the code reported for the retainer matches the corresponding cast titanium metal pontic (D6214).

COMMENTS

1. When reporting the retainer crowns of a fixed partial denture (bridge), note that the term used in current CDT is "fixed partial denture retainer crowns." While many dental practices still use the term "abutment" to identify the retainer crown units of a fixed partial denture, the use of the term retainer can be confusing. The term "abutment" refers to the connection piece that attaches a prosthetic device to a root form implant (see D6056/D6057). To avoid billing errors, the components of a three unit fixed partial denture should be identified as retainer-pontic-retainer, rather than abutment-pontic-abutment.
2. ¾ crowns are most often placed on first molars with the mesio-buccal surfaces left intact for esthetics.
3. Be careful that the bridge pontic metal matches the corresponding retainer metal-type. Always use the matching code, according to its material classification.
4. Reporting the incorrect type of material used in fabricating the retainer is a common coding error. Be careful to report the correct code based on the material classification. Document the correct material used in the pontic on the claim form as represented in the treatment plan, the lab prescription, and the documentation from the lab. Following this protocol should eliminate reporting errors.
5. Enter the tooth number being restored in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Age restrictions, waiting periods, missing tooth clause, or other limitations may apply to the reimbursement for this service.
2. Reimbursement for replacement of fixed partial dentures is typically subject to a five to ten year limitation period.

TIPS

A ¾ crown covers the occlusal surface in addition to three of the four remaining sides of the tooth.

D6790 RETAINER CROWN - FULL CAST HIGH NOBLE METAL CDT 2025

MATCH

When reporting crown - full cast high noble metal (D6790), report the corresponding cast high noble pontic (D6210).

COMMENTS

1. When reporting the retainer crowns of a fixed partial denture (bridge), note that the term used in current CDT is "fixed partial denture retainer crowns." While many dental practices still use the term "abutment" to identify the retainer crown units of a fixed partial denture, the use of the term retainer can be confusing. The term "abutment" refers to the connection piece that attaches a prosthetic device to a root form implant (see D6056/D6057). To avoid billing errors, the components of a three unit fixed partial denture should be identified as retainer-pontic-retainer, rather than abutment-pontic-abutment.
2. Enter the tooth number being restored in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Age restrictions, waiting periods, missing tooth clause, or other limitations may be applied to the reimbursement for this service.
2. Reimbursement for replacement of fixed partial dentures is typically subject to a five to 10-year limitation period.

D6791 RETAINER CROWN - FULL CAST PREDOMINANTLY BASE METAL CDT 2025

MATCH

When reporting crown - full cast predominantly base metal (D6791), be careful to ensure that the code *matches* the corresponding cast base metal pontic (D6211).

COMMENTS

1. When reporting the retainer crowns of a fixed partial denture (bridge), note that the term used in current CDT is "fixed partial denture retainer crowns." While many dental practices still use the term "abutment" to identify the retainer crown units of a fixed partial denture, the use of the term retainer can be confusing. The term "abutment" refers to the connection piece that attaches a prosthetic device to a root form implant (see D6056/D6057). To avoid billing errors, the components of a three unit fixed partial denture should be identified as retainer-pontic-retainer, rather than abutment-pontic-abutment.
2. Enter the tooth number being restored in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Age restrictions, waiting periods, missing tooth clause, or other limitations may be applied to the reimbursement for this service.
2. Reimbursement for replacement of fixed partial dentures is typically subject to a five to 10-year limitation period.

D6792 RETAINER CROWN - FULL CAST NOBLE METAL CDT 2025

MATCH

When reporting crown - full cast noble metal (D6792), be careful to ensure that the code *matches* the corresponding cast noble metal pontic (D6212).

COMMENTS

1. When reporting the retainer crowns of a fixed partial denture (bridge), note that the term used in current CDT is "fixed partial denture retainer crowns." While many dental practices still use the term "abutment" to identify the retainer crown units of a fixed partial denture, the use of the term retainer can be confusing. The term "abutment" refers to the connection piece that attaches a prosthetic device to a root form implant (see D6056/D6057). To avoid billing errors, the components of a three unit fixed partial denture should be identified as retainer-pontic-retainer, rather than abutment-pontic-abutment.
2. Enter the tooth number being restored in Box 27 of the 2024 ADA Dental Claim Form.

D6791

LIMITATIONS

1. Age restrictions, waiting periods, missing tooth clause, or other limitations may be applied to the reimbursement for this service.
2. Reimbursement for replacement of fixed partial dentures is typically subject to a five to 10-year limitation period.

D6794 RETAINER CROWN - TITANIUM AND TITANIUM ALLOYS CDT 2025

Note: While out of numerical order, this code is correctly listed here within the Fixed Partial Denture Retainers-Crowns subcategory.

MATCH

When reporting D6794, the retainer crown (titanium and titanium alloys) code should *match* the corresponding titanium and titanium alloys pontic (D6214).

COMMENTS

1. When reporting the retainer crowns of a fixed partial denture (bridge), note that the term used in current CDT is "fixed partial denture retainer crowns." While many dental practices still use the term "abutment" to identify the retainer crown units of a fixed partial denture, the use of the term retainer can be confusing. The term "abutment" refers to the connection piece that attaches a prosthetic device to a root form implant (see D6056/D6057). To avoid billing errors, the components of a three unit fixed partial denture should be identified as retainer-pontic-retainer, rather than abutment-pontic-abutment.
2. Enter the tooth number being restored in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Age restrictions, waiting periods, missing tooth clause, or other limitations may be applied to the reimbursement of fixed partial dentures.
2. Reimbursement for the replacement of a fixed partial denture is typically subject to a five to 10-year limitation.

D6793 INTERIM RETAINER CROWN - FURTHER TREATMENT OR COMPLETION OF DIAGNOSIS NECESSARY PRIOR TO FINAL IMPRESSION

CDT 2025

Not to be used as a temporary retainer crown for a routine prosthetic restoration.



WARNING

1. Do not report an interim retainer crown (D6793) as an interim retainer crown for routine fixed partial denture (bridge) fabrication procedures.
2. Crown - indirect resin based composite (D6710) reports a permanent indirect retainer (resin based composite). It is an error to report D6710 for an *interim* prosthesis. D6793 should be reported for an *interim* retainer crown. Do not report D6710 to describe an *interim* retainer crown.



MATCH

When reporting an *interim* retainer crown (D6793), *match* the corresponding interim pontic (D6253) with the *interim* retainer crown.

COMMENTS

1. D6793 reports an interim retainer crown. This type of interim restoration allows time for healing, diagnosis, or completion of other procedures, prior to the fabrication of the final definitive restoration.
2. Interim restorations may be used to change the vertical dimension, complete periodontal therapy, diagnose cracked tooth syndrome, etc.
3. An interim retainer crown (D6794) is often used with an immediate bridge, while the associated pontic replaces the extracted tooth during healing of the extraction site and prior to final prep and impression.
4. An interim retainer crown (D6793) can be placed on a fractured tooth to see if symptoms subside with full coverage or if endodontic therapy will be necessary.
5. D6793 does not specify the material or fabrication method. It may be made chairside, laboratory fabricated, prefabricated, milled, or 3D printed.
6. Enter the tooth number being restored in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

Very few payors will reimburse D6793 and then, only if the interim fixed partial denture is part of a *multistaged* treatment plan and anticipated to be in place for awhile.

NARRATIVES

1. "Interim retainer crown will be utilized as extended time interim restoration."
2. "Final impression has not been made."
3. State reason for interim use - e.g. allow time for periodontal healing.

D6794 RETAINER CROWN - TITANIUM AND TITANIUM ALLOYS CDT 2025

Note: D6794 appears here in numerical order. Its true location is after D6792 but the information for this code is printed in this location in its entirety.



MATCH

When reporting D6794, the retainer crown (titanium and titanium alloys) code should *match* the corresponding titanium and titanium alloys pontic (D6214).

COMMENTS

1. When reporting the retainer crowns of a fixed partial denture, note that the term used in current CDT is "fixed partial denture retainer crowns." While many dental practices still use the term "abutment" to identify the retainer crown units of a fixed partial denture, the use of the term retainer can be confusing. The term "abutment" refers to the connection piece that attaches a prosthetic device to a root form implant (see D6056/D6057). To avoid billing errors, the components of a three unit fixed partial denture should be identified as retainer-pontic-retainer, rather than abutment-pontic-abutment.
2. Enter the tooth number being restored in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Age restrictions, waiting periods, missing tooth clause, or other limitations may be applied to the reimbursement of fixed partial dentures.
2. Reimbursement for the replacement of a fixed partial denture is typically subject to a five to 10-year limitation.

D6795 PREVIOUSLY DELETED CODE INTERIM RETAINER CROWN

This is a previously deleted code. See D6793 for further details.

OTHER FIXED PARTIAL DENTURE SERVICES CDT 2025

D6920 CONNECTOR BAR CDT 2025

A device attached to fixed partial denture retainer or coping which serves to stabilize and anchor a removable overdenture prosthesis.



WARNING

Do not report D6920 for an implant supported connector bar (D6055). D6920 reports a connector bar supported by natural tooth retainer crowns or copings. See D6055.

COMMENTS

1. D6920 reports a "connector bar," such as Hader® bar or Dolder® bar, that connects the fixed partial denture crown retainers or copings together and supports and anchors a removable natural-tooth overdenture.
2. The bar connects to each abutment coping (D2975) or directly to each fixed partial denture retainer crown. A removable overdenture "snaps" over the connector bar (D6920). This attachment restricts movement of the prosthesis and makes the overdenture more secure. Each female "clip" attachment is reported separately as D6192.
3. Fees for the connector bar vary with the length/size/complexity of the bar.
4. The connector bar should be reported just once, regardless of the number of retainer crowns or copings to which it is attached.
5. Natural tooth overdentures should be reported using codes from the removable prosthodontics category of service (5000s), not the implant category of service. These codes range from D5863-D5866, as appropriate.
6. Report the arch, quadrant, or range of teeth on the prosthesis that is supported by the bar, as applicable, in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS D6920 is seldom reimbursed and if reimbursed the coverage is highly variable among payors.

D6930 RE-CEMENT OR RE-BOND FIXED PARTIAL DENTURE CDT 2025



WATCH

1. For re-cementing or re-bonding a *single* unit natural tooth restoration, see D2910 and D2920.
2. For re-cementing or re-bonding a *single* unit *abutment* or *implant supported* restoration, see D6092.
3. D6093 describes the re-cementation or re-bonding of an *abutment* or *implant supported* fixed partial denture (bridge).

COMMENTS

1. D6930 is used to report the re-cementation or re-bonding of a conventional fixed partial denture (bridge) and includes Maryland bridges.
2. Enter the tooth numbers or range of teeth associated with the fixed partial denture in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Some payors will not reimburse a re-cementation or re-bonding provided by the same provider within six to 12 months of delivery. If re-cementation or re-bonding is necessary within six to 12 months of delivery, the service is considered a part of the initial procedure.
2. Some payors reimburse the re-cementation or re-bonding of a bridge once per lifetime.
3. The re-cementation or re-bonding of a bridge may not be subject to the typical limitation period if re-cemented or re-bonded by a different dentist in a different office.
4. The reimbursement for re-cementing or re-bonding a bridge is typically higher than the re-cementation or re-bonding of a single crown unit.

NARRATIVES

Include a brief narrative that alerts the payor when the fixed partial denture (bridge) was originally seated. If re-cementation or re-bonding occurs in an office, by a dentist that did not originally deliver the bridge, note this in a brief narrative.

D6940 STRESS BREAKER CDT 2025

A non-rigid connector.

COMMENTS

1. D6940 is used to report a "stress breaker" for a fixed partial denture (bridge), such as a "keyway." The purpose of a stress breaker is to relieve harmful stresses on the crown retainer teeth. It is a non-rigid connector.
2. Enter the tooth numbers and surfaces involved in the stress breaker in the appropriate boxes of the 2024 ADA Dental Claim Form. The tooth numbers or range of teeth involved in the full fixed partial denture itself will be reported seperately with that restoration.

LIMITATIONS

D6940 is not typically reimbursed. Reimbursement is highly variable among payors.

NARRATIVES

Submit D6940 with a narrative that explains why the stress breaker is necessary.

D6950 PRECISION ATTACHMENT CDT 2025

A pair of components constitutes one precision attachment that is separate from the prosthesis.

COMMENTS

1. D6950 may be used to document a precision attachment within a fixed bridge to allow for placement when path of draw issues exist.
2. This type of precision attachment (D6950) is also used to report each set of male and female components of a "precision" partial connected to a fixed retainer crown of a bridge.
3. For semi-precision locators related to an implant overdenture, see D6191/D6192.
4. Each precision attachment (male/female pair) is reported separately.

5. Enter the tooth number involved in the precision attachment for a precision partial on the 2024 ADA Dental Claim Form. Enter the tooth numbers and surfaces involved in each precision attachment placed within a fixed partial denture to correct for path of draw issues. The tooth numbers or range of teeth involved in the full fixed partial denture itself will be reported separately with that restoration.

LIMITATIONS D6950 is typically not reimbursed. Reimbursement is highly variable among payors.

NARRATIVES Submit D6950 with a narrative that explains why the precision attachment is necessary. If the precision attachment is used for cosmetic reasons, the service will not be reimbursed.

D6970 PREVIOUSLY DELETED CODE POST AND CORE IN ADDITION TO FIXED PARTIAL DENTURE RETAINER, INDIRECTLY FABRICATED

This is a previously deleted code. See D2952 to report an indirectly fabricated post and core for a crown or retainer crown.

D6971 PREVIOUSLY DELETED CODE CAST POST AS PART OF FIXED PARTIAL DENTURE RETAINER

This is a previously deleted code. See D6999 to report this procedure.

D6972 PREVIOUSLY DELETED CODE PREFABRICATED POST AND CORE IN ADDITION TO FIXED PARTIAL DENTURE RETAINER

This is a previously deleted code. See D2954 to report prefabricated post and core for a crown or retainer crown.

D6973 PREVIOUSLY DELETED CODE CORE BUILD UP FOR RETAINER, INCLUDING ANY PINS

This is a previously deleted code. See D2950 to report a core buildup for a crown or retainer crown.

D6975 PREVIOUSLY DELETED CODE COPING

This is a previously deleted code. See D2975 for further details.

D6976 PREVIOUSLY DELETED CODE EACH ADDITIONAL INDIRECTLY FABRICATED POST - SAME TOOTH

This is a previously deleted code. See D2953 for further details.

D6977 PREVIOUSLY DELETED CODE EACH ADDITIONAL PREFABRICATED POST - SAME TOOTH

This is a previously deleted code. See D2957 for further details.

D6980 FIXED PARTIAL DENTURE REPAIR, NECESSITATED BY RESTORATIVE MATERIAL FAILURE

CDT 2025

COMMENTS

1. Fixed partial denture repair (D6980) requires a restorative material failure (fracture).
2. Do not report D6980 for a composite or amalgam placed below the margin of a retainer crown due to decay. Report a composite or amalgam code depending on the type of restoration done. A narrative might say "A facial composite was placed in an area of decay below the margin of the retainer crown."
3. Also report D6980 to describe the repair of a interim fixed partial denture (bridge).
4. For endodontic access closure (through an existing cemented or bonded bridge) consider a single surface composite (D2391) or single surface amalgam (D2140) to report this type of service, typically paid at 80% of the payor's fee. A narrative could state, "An occlusal composite was placed for endodontic access hole closure." Do not report D6980 for endodontic access closure although some plans still benefit D6980 for this usage.

LIMITATIONS

Some payors limit the reimbursement for the repair to no more than one half of the fee allowed for a new fixed partial denture (bridge) and if paid, is 50% of the UCR fee. Note, a repair may "reset" the exclusion period of five, seven or 10 years for the reimbursement of the replacement of the old prosthesis with a new fixed prosthesis.

NARRATIVES

The narrative should describe the prosthesis being repaired (including tooth numbers or range of teeth), the procedure performed, and original placement date. The narrative should indicate the time involved in the repair and a copy of the laboratory bill should be included.

D6985 PEDIATRIC PARTIAL DENTURE, FIXED

CDT 2025

This prosthesis is used primarily for aesthetic purposes.



WARNING

1. It is misleading to report a pediatric partial denture, fixed (D6985) situation, which is really utilized for aesthetic purposes (pediatric partial), when replacing the central and lateral incisors and canines as a space maintainer. The narrative should disclose the true nature of the fixed partial denture prosthesis which is aesthetic, not a space maintainer.
2. Payors typically indicate that a space maintainer is not considered dentally necessary when only replacing central and/or lateral incisors and/or canines. Generally a first or second primary molar must be missing.

COMMENTS

1. Pediatric partial denture, fixed (D6985), reports a fixed partial prosthesis that may replace either primary or permanent teeth. This aesthetic service is generally provided as a result of the parent's insistence.
2. 3D printed pediatric partial dentures may be reported using D6985.
3. Enter the arch, quadrant, and/or teeth being replaced in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. The code descriptor states that D6985 is used "primarily for aesthetic purposes." Most payors will not reimburse D6985 since is it considered cosmetic in nature. If the primary canines have been lost, the payor might reimburse a space maintainer as an alternate benefit.
2. Most payors require the loss of a primary first or second molar for reimbursement of D6985. Plan limitations and reimbursement is highly variable.

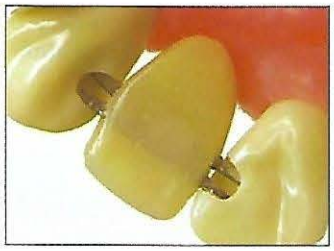
D6999 UNSPECIFIED FIXED PROSTHODONTIC PROCEDURE, BY REPORT CDT 2025

Used for procedure that is not adequately described by a code. Describe procedure.

COMMENTS

1. Report unspecified fixed prosthodontic procedure, by report (D6999) for fixed prosthodontic related procedures. This list is not exhaustive. There may be other unspecified fixed prosthodontic procedures not included in this list:
   a. The cast post as part of a fixed partial denture retainer (D6791) has been previously deleted. Use D6999, by report, to file this procedure.
   b. Describing a fixed partial denture retainer crown material for which there is no code.
   c. Use D6999, by report, to describe surveying a *new* retainer crown (as extra charge in addition to crown) to receive a clasp assembly of a *new* partial denture framework.
   d. Use D6999 to report *each* wing type retainer of a Hugger® bridge.
   e. Use D6999 to report *each* "Talon" retainer of a Monodont® bridge.
   f. Custom staining of a bridge with the patient presenting to an outside laboratory for a color and characterization evaluation, report the fee for custom staining separately as D6999.
2. For recementing a Maryland type fixed partial denture (bridge), see D6930.
3. For sectioning a fixed bridge and retaining a portion of it, intact and serviceable in the mouth, see D9120.

PHOTO



1. This is an example of a Monodont® bridge.
2. Each retainer wing (Talon) is reported as D6999 and the pontic as D6251.

Courtesy Drake Dental Lab

Local anesthesia is usually considered to be part of Oral and Maxillofacial Surgical procedures.

For dental benefit reporting purposes a quadrant is defined as four or more contiguous teeth and/or teeth spaces distal to the midline.

EXTRACTIONS (INCLUDES LOCAL ANESTHESIA, SUTURING, IF NEEDED, AND ROUTINE POSTOPERATIVE CARE) CDT 2025

D7111 EXTRACTION, CORONAL REMNANTS - PRIMARY TOOTH CDT 2025

Removal of soft tissue-retained coronal remnants.



WARNING

It is a common coding error to report extraction, *coronal remnants* - primary tooth (D7111), for *"routine"* primary (baby) tooth extractions. If any primary *root* structures remain, report the extraction as (D7140) for a primary tooth, which typically has a higher fee. See D7140 for further details.

COMMENTS

1. A coronal remnant's removal is reported using D7111. *Be careful* to bill primary tooth extractions using code D7140 if the crown is intact and a portion of the root remains. Most payors reimburse D7140 for a primary tooth extraction at a higher rate than for extraction of coronal remnants (D7111). Most dental plans provide the same reimbursement for primary and permanent extractions. Note: Some dentists charge a lower fee for primary tooth extractions than for permanent tooth extractions, but this is not required at all. What if the child cries? What is the fee?
2. Report extraction, coronal remnants - primary tooth (D7111), for primary teeth that are held in by soft-tissue, *without roots*. Only the primary crown (or fragments of it) remains.
3. Therefore, primary tooth extractions with intact crown and some root structure present, should be reported as D7140.
4. D7250 may be reported for extraction of *residual* roots of a primary tooth if removal requires a cutting procedure (soft tissue and bone). The residual roots would not be "exposed".
5. Enter the tooth number being extracted in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. The reimbursement for D7111 is typically lower than D7140.
2. Some payors have an exclusion for reimbursement of D7111 if an extraction is performed in conjunction with other surgery performed at the same site on the same day. For instance, when primary coronal remnants and an underlying permanent premolar are extracted (for orthodontic reasons) on the same service date, some payors would reimburse the underlying permanent premolar tooth only, but not the primary tooth coronal remnant.
3. If the extraction is for orthodontics, answer the question, "Is this for orthodontics?" on the claim form, "yes." If orthodontic benefits are available, orthodontic extractions for orthodontic reasons are generally reimbursed at 50% of the payor's fee, subject to the typical $1,500 lifetime orthodontic benefit. Sometimes an "orthodontic extraction" is reimbursed from the general dental benefits. If this is the case, reimbursement is usually made at 80% of the payor's fee. A deductible and other plan limitations may apply. Plan limitations are variable.

TIPS

1. Extraction, coronal remnants - primary tooth (D7111) could be used to report a child's emergency visit, when the primary tooth remnant is "hanging." The fee for extraction of a coronal remnant (D7111) may represent an "office visit" type fee to remove the coronal remnant and consult with the parent.
2. When extracting several primary teeth on the same service date where some are classified as D7111 and others as D7140, (if you choose to "discount" the fee in these situations) report each extraction at a discounted fee. Do not charge the full fee for some of the extractions and not report other teeth that were extracted. Always report "what you do." This approach will work much better for PPO contracted providers.

D7140 EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT (ELEVATION AND/OR FORCEPS REMOVAL) CDT 2025

Includes removal of tooth structure, minor smoothing of socket bone, and closure, as necessary.



WARNING

Elevation of a mucoperiosteal flap or suture placement alone do not warrant reporting of D7210. D7140 includes soft tissue management and minor smoothing of socket bone.

WATCH

1. It is a common coding error to report extraction, coronal remnants - primary tooth (D7111), for primary (baby) tooth extractions. If some primary root structures and the crown remains, report the extraction (D7140) for a primary tooth. See D7111 for further details regarding extraction of soft tissue retained coronal remnants.
2. D7140 is used also to describe an "exposed root" removal, where the coronal portion of the tooth has broken or decayed off at or near the gum line. If the exposed root remnant can be accessed and extracted without laying a flap, removing bone, or sectioning the root, report D7140.
3. If bone is removed and/or the exposed tooth root is sectioned for removal, see extraction, erupted tooth (D7210). D7210 is a more complicated procedure than D7140 and is reimbursed at a higher UCR fee. D7210 in the past was called a "surgical" extraction.
4. See removal of residual (not exposed root) tooth roots (D7250) to describe procedures which includes cutting of soft tissue and bone removal of tooth structure, and closure.
5. If the extraction is a part of orthodontic treatment, answer the question, "Is this for orthodontics?" on the claim form, "yes." If orthodontic benefits are available, extractions for orthodontic reasons are generally reimbursed at 50% of the payor's fee, subject to the lifetime orthodontic benefit. Sometimes an "orthodontic extraction" is reimbursed from the general dental benefits. If this is the case, reimbursement is usually made at 80% of the payor's fee. A deductible and other plan limitations may apply.
6. Do not report removal of *residual* tooth roots (D7250) for the extraction of *exposed* roots of an erupted tooth (D7140). See D7250 to report removal of residual tooth roots (a cutting procedure) involving a root left from a prior extraction).

COMMENTS

1. D7140 is often called a "simple" extraction. Reimbursement for the extraction of an erupted tooth (D7140) is generally considered a "basic service" and paid at 80% of payor's fee.
2. D7140 is used to describe the removal of an erupted tooth (both primary *and* permanent) or *exposed roots* of an erupted tooth. Since this code is used to report "multiple extractions" on the same service date, the D7140 code may be used to report each *additional* tooth or exposed root extraction extracted on the same date of service.
3. Payors typically reimburse the *same* payor's fee for a primary *or* permanent tooth extraction.
4. For removal of an erupted tooth, requiring *removal of bone* and/or *sectioning of the tooth*, see D7210. To report D7210, laying a flap or placing a suture is not required and is optional.
5. Enter the tooth number being extracted in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Most payors consider alveoloplasty in *conjunction* with extractions to be a part of the *global* extraction fee. The description of D7140 indicates some *minor* removal/smoothing of bone is included. This minor removal/smoothing of bone should not be reported as an alveoloplasty in addition to the extraction. If significant bony recontouring is required and involves *multiple adjacent* extraction sites, see alveoloplasty in conjunction with extractions (D7310/D7311).
2. Suture removal, minor smoothing of bone, closure, and follow up is included in the global fee for an erupted tooth extraction. The treatment of infection after extractions can be reported. See treatment of complications (post surgical) - unusual circumstances (D9930). This code may be used to report treatment of a dry socket or removal of a bony sequestrum. However, most payors consider D9930 (by the same office) to be a part of the global D7140 extraction fee. See D9930 for common limitations.

TIPS

Some doctors, for multiple extractions, will charge for *fewer* extractions than were actually performed, when some extractions may have been "easy," and they want to reduce the patient's overall expense. By reducing the true extraction count and then charging the full fee for fewer extractions than were actually done, the overall reimbursement will be *less* when participating in a low PPO fee plan. For better reimbursement, charge a lower fee for *each* extraction, rather than reduce the true extraction count. The total fee charged is the same with either approach, but if the patient has a low PPO fee plan, charging a fee on each extraction performed and reporting all the extractions will result in a higher reimbursement. Always report the exact number of teeth extracted and the actual fee charged for each extraction. There is no rule that requires every extraction to be charged at the same fee.

D7210 EXTRACTION, ERUPTED TOOTH REQUIRING REMOVAL OF BONE AND/OR SECTIONING OF TOOTH, AND INCLUDING ELEVATION OF MUCOPERIOSTEAL FLAP IF INDICATED — CDT 2025

Includes related cutting of gingiva and bone, removal of tooth structure, minor smoothing of socket bone and closure.



WARNING

1. It is misleading to report D7210 for extraction of an erupted tooth when an *erupted* tooth is extracted without removal of bone and/or sectioning of the tooth and only a suture is placed. D7210 requires removal of bone and/or sectioning of the tooth. When bone is not removed and/or the tooth is not sectioned, *do not* report D7210. Placing suture(s) does not elevate the extraction to the level of an extraction of an erupted tooth (D7210). The removal of bone and/or "sectioning of tooth" are required to report D7210. Sectioning the tooth does elevate the service to that described by D7210. The elevation of a mucoperiosteal flap is included as part of D7210, if indicated. Note: the elevation of a mucoperiosteal flap is no longer required to report D7210.
2. Reporting D7210 is considered "upcoding" which may be considered a fraudulent act when actually performing extraction (D7140) where the tooth was only elevated for removal, even if a flap was laid.

COMMENTS

1. If the extraction of an erupted tooth requires the removal of bone and/or sectioning of the tooth, report D7210, not D7140. D7210 is often referred to as a "surgical" extraction. Sectioning may be performed by surgical handpiece, chisel and mallet, or other tool. D7210 is typically reimbursed at a level of 150-180% higher than D7140. The increased fee/reimbursement is justified by the fact that the removal procedure requires increased time and because of the increased difficulty of the procedure. Some general practitioners do not utilize the extraction code, D7210, when justified. The procedure counts for D7210 generally make up a *fraction* of the "routine" extraction (D7140) counts in a general dental office.
2. Be certain to document the elements of the procedure that made it surgical vs. a simple extraction, such as what bone was removed or how the tooth was sectioned. This justifies the reporting of D7210.
3. Enter the tooth number being extracted in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Suture placement and removal, minor smoothing of bone, closure, and routine follow up is included in the global fee for D7210. Treatment for *extensive* infection after tooth removal could be a reimbursable service (see D9930 treatment of complications (post surgical) - unusual circumstances, by report). Alveoloplasty in conjunction with an extraction is generally considered a part of the extraction when performed on the same service date. Incidental bone removal during a single extraction (D7210) is not considered a separate billable alveoloplasty service. If multiple adjacent extractions are performed or if significant bony recontouring is required, see alveoloplasty in conjunction with extractions (D7310/D7311).
2. D7210 is used to report an extraction. Some payors require that the more complicated D7210 procedure be submitted to the patient's medical payor before reimbursement is considered under the dental plan. If the claim has been submitted to the medical payor, attach the medical explanation of benefits to the dental claim form. See our *Medical Dental Cross Coding With Confidence* manual at www.practicebooster.com/store.
3. The descriptor for D7210 indicates that either "removal of bone" *or* "sectioning of the tooth" is justification for reporting D7210. Note: Some payors may require *both* removal of bone and sectioning of the tooth to qualify for reimbursement. Some payors require that laying a mucoperiosteal flap be done to be considered for reimbursement even though the elevation of a mucoperiosteal flap is no longer required to report D7210, according to the code's descriptor.
4. See D9930 to report treatment of complicated (post-surgical) situations such as extensive infection. However, most payors consider D9930 (by the same office) to be a part of the global extraction fee.

NARRATIVES

1. D7210 should not be overutilized. Accurately describe the procedure in the clinical notes. A typical note might read: "elevated flap (if applicable) and removed bone and/or sectioned tooth. These procedures were necessary to extract the tooth." An intra-oral camera photo of the sectioned tooth is recommended as proof that the procedure was provided and the procedure qualifies as a D7210 extraction.
2. State if bone was removed during the extraction and why it was necessary, e.g., tooth was fractured off below bone level. "See attached image."
3. State if tooth was sectioned during extraction and why, e.g., tooth had curved roots, sectioning was necessary to remove tooth as atraumatically as possible. "See attached image."
4. A current diagnostic radiographic image should be sent as part of the documentation and any supporting photographs.

D7220 REMOVAL OF IMPACTED TOOTH - SOFT TISSUE CDT 2025

Occlusal surface of tooth covered by soft tissue; requires mucoperiosteal flap elevation.

COMMENTS

1. Suture removal and follow up is considered a part of the global surgical fee for removal of an impacted tooth - soft tissue (D7220).
2. Extensive infection after an impacted tooth removal, can be reported separately on a subsequent service date. See D9930 to report treatment of complicated (post-surgical) situations. However, most payors consider D9930 (by the same office) to be a part of the global extraction fee.
3. Enter the tooth number being removed in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Reimbursement of D7220 is typically based on the payor's assessment of the narrative and the anatomical position of the impacted tooth from submitted diagnostic radiographic images. The surgical technique necessary for removal is not considered. This procedure requires the elevation of a mucoperiosteal flap for access as the tooth is located beneath occlusal soft tissue. When reporting D7220, the coronal portion of the tooth is not submerged in bone.
2. Some payors require that the medical plan be billed *before* consideration of the service under the dental plan. If medical billing is required, attach the medical explanation of benefits to the subsequent dental claim form. See our *Medical Dental Cross Coding With Confidence* manual at *www.practicebooster.com/store*.
3. Sectioning the tooth is not a requirement to submit this procedure (D7220) for payment, but it does require mucoperiosteal flap elevation.
4. In some cases, D7220 may be subject to age limitations. Some plans limit coverage to patients who are 15 to 30 years of age.

NARRATIVES

1. A brief narrative should describe the anatomical position of the tooth and should indicate that the occlusal surface of the tooth was covered by soft tissue.
2. The narrative should explain that a mucoperiosteal flap was elevated.
3. A current diagnostic radiographic image of the pretreatment area should be sent as part of the documentation. "See attached radiographic images(s) and operative notes." A pretreatment photograph of the surgical area may also be sent.

D7230 REMOVAL OF IMPACTED TOOTH - PARTIALLY BONY CDT 2025

Part of crown covered by bone; requires mucoperiosteal flap elevation and bone removal.

COMMENTS

1. Suture removal and follow up is considered a part of the global surgical fee for removal of an impacted tooth - partially bony (D7230).
2. Extensive infection after an impacted tooth removal can be reported separately. See D9930 to report treatment of complicated (post-surgical) situations. However, most payors consider D9930 (by the same office) to be a part of the global extraction fee.

3. Enter the tooth number being removed in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. D7230 reports removal of impacted tooth - partially bony where "part of" the crown is covered by bone. "Part of" the crown covered by bone implies that less than 50% of the crown is covered by bone. The surgical technique necessary for removal is not considered for reimbursement. This code requires that both a mucoperiosteal flap be elevated and that pericoronal bone be removed in order to access the tooth for extraction.
2. Some payors require that the medical plan be billed *before* consideration of the service under the dental plan. If medical billing is required, attach the medical explanation of benefits to the subsequent dental claim form. See our *Medical Dental Cross Coding With Confidence* manual at *www.practicebooster.com/store*.
3. Sectioning the tooth is not a requirement to submit this procedure (D7230) for payment, but it does require a mucoperiosteal flap elevation and pericoronal bone removal to access the tooth.
4. In some cases, D7230 may be subject to age limitations. Some plans limit coverage to patients who are 15 to 30 years of age.

NARRATIVES

1. A brief narrative should describe the anatomical position of the tooth and should indicate that a portion of the crown was covered by soft tissue and bone and that there was some bone removed to allow access for the extraction.
2. The narrative should explain that a mucoperiosteal flap was elevated and that pericoronal bone was removed.
3. A current diagnostic radiographic image of the pretreatment area should be sent as part of the documentation. "See attached image(s) and operative notes."

D7240 REMOVAL OF IMPACTED TOOTH - COMPLETELY BONY CDT 2025

Most or all of crown covered by bone; requires mucoperiosteal flap elevation and bone removal.

COMMENTS

1. Suture removal and follow up is considered a part of the global surgical fee for removal of an impacted tooth - completely bony (D7240).
2. Extensive infection after an impacted tooth removal can be reported separately on a subsequent service date. See D9930 to report treatment of complicated (post-surgical) situations. However, most payors consider D9930 (by the same office) to be a part of the global extraction fee.
3. Enter the tooth number being removed in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. D7240 reports removal of impacted tooth - completely bony where the descriptor indicates "most *or* all" of the crown is covered by bone. "Most" of the crown covered by bone implies that more than 50% of the crown is covered by bone. The surgical technique necessary for removal is not considered for reimbursement. This code requires that both a mucoperiosteal flap be elevated and that pericoronal bone be removed in order to access the tooth for extraction.
2. Some payors require that the medical plan be billed *before* consideration of the service under the dental plan. If medical billing is required, attach the medical explanation of benefits to the subsequent dental claim form. See our *Medical Dental Cross Coding With Confidence* manual at *www.practicebooster.com/store*.
3. Sectioning the tooth is not a requirement to submit this procedure (D7240) for payment, but it does require a mucoperiosteal flap elevation and pericoronal bone removal to access the tooth.
4. In some cases, D7240 may be subject to age limitations. Some plans limit coverage to patients who are 15 to 30 years of age.

NARRATIVES

1. A brief narrative should describe the anatomical position of the tooth and should indicate that a portion of the crown was covered by soft tissue and that more than 50% of the crown was covered by bone.
2. The narrative should explain that a mucoperiosteal flap was elevated and that pericoronal bone was removed.
3. A current diagnostic radiograph of the pretreatment area should be sent as part of the documentation. "See attached image(s) and operative notes."

D7241 REMOVAL OF IMPACTED TOOTH - COMPLETELY BONY, WITH UNUSUAL SURGICAL COMPLICATIONS — CDT 2025

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

COMMENTS

1. This code is used to describe the removal of a completely bony impaction which is "unusually difficult or complicated." Factors that may justify the use of this code are: Nerve dissection required, separate closure of maxillary sinus, or difficult access due to aberrant tooth position." The reimbursement for this service is higher than for a "routine" completely bony impaction. This code is used infrequently and is designed to describe particularly exceptional circumstances.
2. Suture removal and follow up is considered a part of the global surgical fee for removal of an impacted tooth - completely bony with unusual surgical complication (D7241).
3. Extensive infection after an impacted tooth removal, could be reported separately. See D9930 to report treatment of complicated (post-surgical) situations. However, most payors consider D9930 (by the same office) to be a part of the global extraction fee.
4. Report nerve dissection (D7259) or primary closure of a sinus perforation (D7261) separately.
5. Enter the tooth number being removed in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. D7241 reports removal of impacted tooth - completely bony, with unusual surgical complications where "most *or* all" of the crown is covered by bone and the procedure was unusually complicated. "Most" is defined as more than 50% of the crown is covered by bone. The surgical technique necessary for removal is not considered for reimbursement. This code requires that both a mucoperiosteal flap be elevated and that bone be removed in order to access the tooth for extraction.
2. Some payors require that the medical plan be billed *before* consideration of the service under the dental plan. If medical billing is required, attach the medical explanation of benefits to the subsequent dental claim form. See our *Medical Dental Cross Coding With Confidence* manual at *www.practicebooster.com/store*.
3. Sectioning the tooth is not a requirement to submit this procedure (D7241) for payment.
4. In some cases, D7241 may be subject to age limitations. Some plans limit coverage to patients who are 15 to 30 years of age.

NARRATIVES

1. A brief narrative should describe the anatomical position of the tooth and should indicate that most or all of the crown was covered by bone and specific surgical complications were involved (name them).
2. The narrative should explain that a mucoperiosteal flap was elevated and that bone was removed and how the procedure was unusually complicated. Mention nerve dissection, separate closure of maxillary sinus required, or aberrant tooth position as may apply.
3. A current diagnostic radiograph of the pretreatment area should be sent as part of the documentation. "See attached image(s) and operative notes."

D7250 REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING PROCEDURE) — CDT 2025

Includes cutting of soft tissue and bone, removal of tooth structure, and closure.



WATCH

1. D7250, removal of residual tooth roots (cutting procedure) does not describe "difficult" extractions of an erupted tooth (D7140) or the removal of the exposed root (D7140). If removing bone or sectioning the erupted tooth or exposed root is required to extract the erupted tooth/root, report D7210.
2. "Residual tooth roots" refers to roots left from a prior extraction procedure or remains after the fracture of the crown portion of the tooth. D7250 should not be used to describe the removal of a root fractured at the extraction appointment, same visit. D7250 does describe the removal of a root at a subsequent appointment, on a different treatment date, or by a different provider. The initial extraction occurred for a portion of the tooth crown sometime before removal of the *residual* root. In this case, reporting D7250 might evoke the "missing tooth" clause. The tooth was "extracted" (although partially) at an earlier date. The missing tooth clause might limit the reimbursement for a new bridge, implant or partial if the initial extraction was done before the patient was covered under the existing dental plan. D7250 applies to permanent or primary residual root removal.

3. If a tooth root remains after an attempted extraction, report D7999 unspecified oral surgery procedure, by report for the partial (incomplete) tooth extraction to not create issues with reimbursement of future procedures.
4. If a retained root is *exposed* (visible in the mouth), then the removal of the exposed root should be reported as extraction of *exposed root*, D7140. If the exposed root requires removal of bone or sectioning for removal, report D7210.

COMMENTS

Enter the tooth number of the root being removed in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. The D7250 descriptor describes the "cutting of the soft tissue and *bone*, removal of tooth structure, and closure." This code is appropriate to use when removing *residual* root fragments remaining in the bone left from a previous *incomplete* extraction or the fracturing off of the crown of the tooth. Some payors require a diagnostic image to confirm that the *residual* root is completely embedded in bone.
2. D7250 would be used to describe the situation where a general practitioner attempts the extraction of a tooth, cannot remove all the root structure and refers the patient for completion of the procedure, removal of the residual tooth root(s) to an oral surgeon. The oral surgeon would report D7250 to describe the procedure. The GP could only report a partial (incomplete) extraction, D7999, by report.
3. Suture removal and follow up is included in the global fee for D7250. Treatment of extensive infection after this procedure would be reported separately. See D9930 to report treatment of complications (post-surgical) - unusual circumstances. However, most payors consider D9930 to be in the global extraction fee.
4. Reporting the removal of residual tooth roots (D7250) may invoke the "missing tooth" limitation. Clearly explain the circumstances in a brief narrative and appeal the denial.
5. Some payors require that the medical plan be billed *before* consideration of this service under the dental plan. If medical billing is required, attach the medical explanation of benefits to the subsequent dental claim form submission. See our *Medical Dental Cross Coding With Confidence* manual at www.practicebooster.com/store.

NARRATIVES

A brief narrative should describe the position of the *residual* tooth roots, including cutting of soft tissue and bone, removal of the tooth structure, and closure. A current diagnostic radiographic image of the residual roots should also be included with the claim.

D7251 CORONECTOMY - INTENTIONAL PARTIAL TOOTH REMOVAL, IMPACTED TEETH ONLY

CDT 2025

Intentional partial tooth removal is performed when a neurovascular complication is likely if the entire impacted tooth is removed.



WARNING

1. D7251 reports an *intended* partial removal of an impacted tooth crown leaving residual tooth structure on purpose.
2. Do not use D7251 to report an unintended, incomplete extraction of an erupted tooth leaving residual root structures. See unspecified oral procedure, by report (D7999), to report an incomplete extraction of a tooth.
3. Do not use D7251 for a decoronation or submergence of an erupted tooth. See D3921.

COMMENTS

1. D7251 reports a procedure where the coronal portion of the impacted tooth is removed while some residual tooth structure is intentionally left.
2. This intentional procedure (D7251) should have the pretreatment consent of the patient.
3. The residual tooth structures are not disturbed in this procedure and remain.
4. For the decoronation or submergence of an *erupted* tooth, see D3921.
5. Enter the tooth number being partially removed in Box 27 of the 2024 ADA Dental Claim Form.

NARRATIVES

1. A brief narrative should reflect that a neurovascular complication is likely if the entire impacted tooth is removed.
2. "Intentionally removed only part of tooth due to proximity of neurovascular bundle. See attached radiographic images(s) and operative notes."
3. A current diagnostic radiographic image of the impacted tooth should be included with the claim.

D7252 NEW PROCEDURE PARTIAL EXTRACTION FOR IMMEDIATE IMPLANT PLACEMENT

CDT 2025

Sectioning the root of a tooth vertically, then extracting the palatal portion of the root. The buccal section of the root is retained in order to stabilize the buccal plate prior to immediate implant placement. Also known as the Socket Shield Technique.

WARNING

Do not report D7252 for an intentional partial extraction of an erupted tooth (D3921), partial removal of an impacted tooth (D7251), or hemisection (D3920).

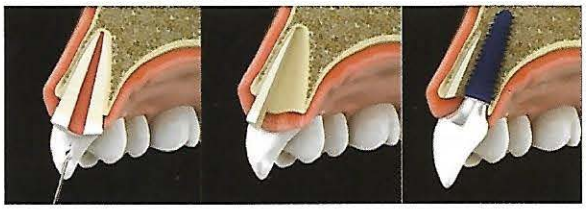
COMMENTS

1. This procedure is often called the Partial Extraction Technique or Socket Shield Technique.
2. D7252 reports the removal of the palatal half of a tooth root while intentionally leaving the buccal portion in place to aid in bone stabilization before immediate implant placement. This procedure is used in specific circumstances when the buccal/facial bone is thin and has a high risk of fracturing or collapsing during tooth extraction. This would result in loss of vertical height of the alveolar bone, which decreases options for immediate implant placement, including successful integration of the implant with sufficient buccal or facial bone height.
3. When the facial bone is thin and there is a high risk of fracture of the buccal plate with resulting bone loss creating a loss in vertical height, a partial extraction procedure is the best option for maintaining maximum bone on the facial which will stabilize the buccal plate and enhance the longevity of the implant. The tooth is sectioned mesiodistally and the palatal portion is removed. The remaining buccal tooth structure is reduced in thickness to assume a concave shape similar to the profile and height of the bone crest. An immediate implant is then placed with a bone graft between the implant and the remaining tooth structure.
4. Report the implant (D6010), bone graft at time of implant placement (D6104), biologic materials (D4265), and/or implant membranes (D6106/D6107) in addition to D7252.
5. Enter the tooth number being sectioned and partially removed in Box 27 of the 2024 ADA Dental Claim Form.

NARRATIVES

A brief narrative should reflect that the buccal/facial bone is thin and at risk of fracture or collapse. Report the sectioning and reshaping of the remaining tooth root to protect the buccal plate and allow for immediate implant placement.

PHOTO



Courtesy of Prof. Howard Gluckman and MegaGen America

D7259 NEW PROCEDURE NERVE DISSECTION CDT 2025

Involves the separation or isolation of a nerve from surrounding tissues. Performed to gain access to and protect nerves during surgical procedures.

COMMENTS

1. D7259 reports the process of incision in the soft tissue followed by careful dissection through layers of tissue to expose the nerve. The nerve is identified and then carefully mobilized to prevent stretching, compression, or excessive movement during the performance of another dental service. This is typically performed to gain access to and protect important nerves during the removal of impacted teeth with intimate anatomical relation to the nerve, dental implant placement, orthognathic surgery, or treatment of nerve-related conditions like trigeminal neuralgia.
2. D7259 may frequently be reported in conjunction with D7241 removal of impacted tooth - completely bony, with unusual surgical complications, but is not limited to this situation. It may be performed during any appropriate surgical procedure where a nerve requires isolation and protection.
3. Report the quadrant, tooth number, or range of teeth numbers involved in the surgical procedure as applicable in the appropriate boxes of the 2024 ADA Dental Claim Form.

NARRATIVES

A brief narrative should describe the procedure performed and the reason for needing to isolate or protect the dissected nerve.

D7260 OROANTRAL FISTULA CLOSURE CDT 2025

Excision of fistulous tract between maxillary sinus and oral cavity and closure by advancement flap.

COMMENTS

Report the quadrant treated in the appropriate box of the 2024 ADA Dental Claim Form.

NARRATIVES

A detailed narrative is often required for consultant review before this procedure will be considered for reimbursement.

D7261 PRIMARY CLOSURE OF A SINUS PERFORATION CDT 2025

Subsequent to surgical removal of tooth, exposure of sinus requiring repair, or immediate closure of oroantral or oralnasal communication in absence of fistulous tract.

COMMENTS

Report the quadrant treated in the appropriate box of the 2024 ADA Dental Claim Form.

NARRATIVES

A detailed narrative is often required for consultant review before this procedure will be considered for reimbursement.

D7270 TOOTH REIMPLANTATION AND/OR STABILIZATION OF ACCIDENTALLY EVULSED OR DISPLACED TOOTH CDT 2025

Includes splinting and/or stabilization.



WATCH

1. D7270 reports reimplanting and/or stabilization of an accidentally *evulsed* or *displaced* tooth. D7270 is a *trauma related* code. In some cases, the tooth (teeth) is (are) stabilized with a bonded wire to anchor the teeth (splinted).
2. If the alveolus is fractured, see alveolus-closed reduction (D7670).
3. Do not report intra-oral placement of a fixation device (D7998) in addition to D7270. A fixation device would be -considered integral with tooth reimplantation and/or stabilization (D7270).

4. For splinting/stabilizing of mobile, periodontally involved teeth, see splint-intracoronal (D4322) and splint-extracoronal (D4323).

COMMENTS

1. Any adjustments, removal of splint, or follow up visits, are included in the initial global fee. These procedures should be considered in the overall treatment fee.
2. Report the tooth number or range of teeth treated in the appropriate box of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. This procedure may also be reimbursed under medical or accident insurance. Most payors process medical claims for accident and trauma and consider the medical plan as primary for reimbursement purposes. See our *Medical Dental Cross Coding With Confidence* manual at *www.practicebooster.com/store*.
2. Attach the medical explanation of benefits to the dental claim form. Some dental payors have a six to 12-month filing limitation.
3. File a dental claim form (with all pertinent information) within this limitation period, even if medical has not responded within the established period. This locks up the initial filing limitation.

NARRATIVES

1. Write a detailed narrative and include radiographs and the tooth numbers involved.
2. The fee should be adjusted to commensurate with the complexity of the treatment.

D7272 TOOTH TRANSPLANTATION (INCLUDES REIMPLANTATION FROM ONE SITE TO ANOTHER AND SPLINTING AND/OR STABILIZATION) CDT 2025



WATCH

1. D7272, tooth *transplantation* does not describe a tooth *reimplantation* related to an accident. D7272 is *not* accident related. D7272 is an intentional tooth transplantation.
2. See tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth (D7270) or alveolus-closed reduction (D7670) to report situations regarding trauma.
3. It is an error to report D7272 as an intentional reimplantation (D3470), which is an endodontic related procedure. See D3470 for further details.
4. Do not report intra-oral placement of a fixation device (D7998) in addition to reporting D7272. A fixation device would be considered integral with the tooth transplantation (D7272).

COMMENTS

Tooth transplantation (D7272) describes the intentional transplanting (extracting and moving) of a tooth from one site to another site. An example of this procedure is transplanting a third molar to a second molar socket. *(This is not a common procedure.)*

LIMITATIONS

Tooth transplantation (D7272) is not generally reimbursed. If tooth transplantation is reimbursed, the associated extraction may be considered in the global fee for D7272.

NARRATIVES

Include the tooth number of the transplanted tooth and name the location of the receiving site.

D7280 EXPOSURE OF AN UNERUPTED TOOTH CDT 2025

An incision is made and the tissue is reflected and bone removed as necessary to expose the crown of an impacted tooth not intended to be extracted.



WARNING

Exposure of an unerupted tooth to expose the crown is often orthodontically related. The ADA claim form has a question, "Is this for orthodontics?" Most software programs, by default, answer this "no." It is an error to answer "no" if the service is in fact related to orthodontic treatment. Reimbursement for D7280, when performed with orthodontic treatment, may be applied toward the "lifetime orthodontic benefit" which is typically a $1,500 lifetime benefit.



MATCH

1. D7280 describes the exposure of an impacted/unerupted crown of an impacted tooth. Note: If placing an attachment (button, ectopic pin, band or, bracket) report this procedure *separately.*
2. See D7283 for further details regarding the placement of a *device* to facilitate eruption of an impacted tooth.

COMMENTS

1. D7283 is often reported in association with the "uncovering" of an unerupted/impacted tooth for placement of an orthodontic "button," band, ectopic pin or bracket placement. See D7283 for further details regarding the placement of a *device* to facilitate eruption of an impacted tooth.
2. D7280 is *not* limited to use with patients undergoing orthodontic treatment. For instance, D7280 could report uncovering bone for a second molar to erupt.
3. A pedicle graft (D4270) or a free soft tissue graft (D4277) may also be required as a separate procedure. See D4270 and D4277 for further details.
4. Report the tooth number treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. D7280 will generally require an orthodontic rider for reimbursement. The claim form question, "Is this for orthodontics?" usually must be answered "yes" for D7280 to be considered for reimbursement.
2. If the procedure is not related to orthodontics, state the reason for the procedure.

NARRATIVES

1. A brief narrative should describe the tooth number and location of the unerupted tooth.
2. Describe that an incision was made, tissue reflected, and any bone that was removed to expose the crown of the impacted tooth.

D7281 PREVIOUSLY DELETED CODE SURGICAL EXPOSURE OF IMPACTED OR UNERUPTED TOOTH TO AID ERUPTION

This is a previously deleted code. See D7280 for further details.

D7282 MOBILIZATION OF ERUPTED OR MALPOSITIONED TOOTH TO AID ERUPTION

CDT 2025

To move/luxate teeth to eliminate ankylosis; not in conjunction with an extraction.

COMMENTS

1. D7280 reports the mobilization of an erupted or malpositioned tooth to aid in its eruption.
2. The purpose of the mobilization procedure is to eliminate ankylosis (the union of the root of the tooth to the surrounding bone). By "breaking loose" or "mobilizing" the tooth from the bone, the tooth is free to erupt normally.
3. D7282 is not associated with an extraction or exposure. The tooth must be moved/luxated.
4. Report the tooth number treated in Box 27 of the 2024 ADA Dental Claim Form.

D7283 PLACEMENT OF DEVICE TO FACILITATE ERUPTION OF IMPACTED TOOTH

CDT 2025

Placement of an attachment on an unerupted tooth, after its exposure, to aid in its eruption.
Report the surgical exposure separately using D7280.



WARNING

Placement of device to facilitate eruption of impacted tooth (D7283) may be orthodontically related. The ADA claim form has a related question, "Is this for orthodontics?" Most software programs, by default, answer this "no." It is an error to answer "no", if the procedure is an *orthodontic related* procedure. Reimbursement for D7283 may be applied to the "lifetime orthodontic benefit" (typically $1,500) and be reimbursed at 50% of the UCR fee.



MATCH

Placement of a bracket or device to facilitate eruption of impacted tooth (D7283) reports placing a "button," bracket, ectopic pin, or band on an unerupted tooth, after the surgical exposure of the crown of the tooth (D7280). Thus, D7283 is associated with exposure of an unerupted tooth (D7280) and is reported separately. The procedure may, or may not be specifically related to an orthodontic case.

COMMENTS

Report the tooth number treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. D7283 may be eligible for reimbursement *if* exposure of an unerupted tooth (D7280) procedure is also reimbursed. See D7280.
2. D7283 will generally require an orthodontic rider for reimbursement if related to orthodontics. The claim form question, "Is this for orthodontics?" usually must be answered "yes" for D7283 to be considered for reimbursement.

NARRATIVES

Briefly describe the placement of a device (orthodontic bracket, pin, band or other device) on an unerupted tooth, after the tooth has been surgically exposed. Describe the device and its purpose.

D7284 EXCISIONAL BIOPSY OF MINOR SALIVARY GLANDS CDT 2025



WARNING

1. Do not report D7284 for the excision of benign or malignant soft tissue lesions. See D7410-D7415.
2. Do not report D7284 for incisional biopsy of soft tissue. See D7286.

COMMENTS

1. Labial minor salivary gland biopsy is part of the diagnostic workup for suspected Sjögren's syndrome. D7284 reports a labial minor salivary gland biopsy which requires the excision of architecturally intact salivary gland organs through an incision.
1. Report the area of the oral cavity treated in the appropriate box of the 2024 ADA Dental Claim Form.

NARRATIVES

Write a narrative outlining the medical necessity of this procedure.

D7285 INCISIONAL BIOPSY OF ORAL TISSUE - HARD (BONE, TOOTH) CDT 2025

For partial removal of specimen only. This procedure involves biopsy of osseous lesions and is not used for apicoectomy/periradicular surgery. This procedure does not entail an excision.



WATCH

1. D7285, incisional biopsy of oral tissue - hard (bone, tooth) is used to describe an incisional biopsy of oral *osseous* or *bone* tissue. A biopsy is the surgical removal of a partial *specimen* of tissue for histologic evaluation. The microscopic examination is a separate procedure.
2. For incisional biopsy of oral tissue - soft, see D7286.

COMMENTS

1. A biopsy describes the *removal* of a specimen, not the entire lesion, and not the *microscopic examination* of the submitted specimen. This code does not report the total excision of a hard tissue lesion.
2. Report the area of the oral cavity treated in the appropriate box of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. D7285, biopsy of oral tissue - hard (bone, tooth) is not typically reimbursed without an accompanying pathology report.
2. Biopsies may be considered a part of other associated procedures performed in the same area, on the same service date when processed for reimbursement. D7285 should not be reported in conjunction with apicoectomy or periradicular surgery.
3. For medical insurance reimbursement, a "referral" may be required from the patient's primary care physician. See our *Medical Dental Cross Coding With Confidence* manual at *www.practicebooster.com/store*.

TIPS

If the *entire* lesion is excised, report the appropriate lesion code (D7410-D7415), not D7285.

NARRATIVES

1. Remit the hard tissue biopsy specimen for analysis. After receiving the pathology report prepare the dental claim form. Make a copy of the pathology report and attach the pathology report to the dental claim form. Unless the pathology report accompanies the dental claim form, D7285 will probably not be reimbursed by dental insurance. The narrative should describe the location of the lesion, procedures used for the *hard* tissue removal, and a differential diagnosis.
2. "See attached copy of pathology report."

D7286 INCISIONAL BIOPSY OF ORAL TISSUE - SOFT CDT 2025

For partial removal of an architecturally intact specimen only. This procedure is not used at the same time as codes for apicoectomy/periradicular curettage. This procedure does not entail an excision.

WATCH

1. An incisional biopsy consists of removing part of the lesion (specimen) for histologic evaluation.
2. Biopsy of oral tissue - soft (D7286) should not be used to describe the "OralCDx® brush biopsy" procedure. Report the brush biopsy as: transepithelial sample collection (D7288), for the OralCDx® brush biopsy.
3. For incisional biopsy of oral tissue - hard, see D7285.

COMMENTS

1. Report D7286 for an incisional soft-tissue biopsy. An incisional biopsy consists of removing part of the lesion for a histologic evaluation. By definition the specimen is architecturally intact. Architecturally intact refers to the fact that the sample is three dimensional.
2. A biopsy describes the *removal* of a specimen, not the microscopic examination of the specimen. This code *does not* report the total removal of the soft tissue lesion.
3. A soft tissue laser could be used as an adjunct to perform this procedure provided the specimen removed is architecturally intact.
4. Report the area of the oral cavity treated in the appropriate box of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. The soft tissue biopsy will not typically be reimbursed by dental insurance without an accompanying pathology report.
2. A biopsy may be considered to be a part of other associated procedures performed in the same area, on the same service date. D7286 should not to be reported in conjunction with apicoectomy or periradicular curettage.
3. For medical reimbursement, see our *Medical Dental Cross Coding With Confidence* manual at *www.practicebooster.com/store*.

TIPS

1. If the *entire* lesion is excised, report the appropriate lesion code (D7410-D7415), not D7286.
2. Report D7284 for excisional biopsy of minor salivary glands.

NARRATIVES

1. Send the soft tissue biopsy specimen to a pathologist for analysis. After receiving the pathology report, prepare the dental claim form. Make a copy of the pathology report and attach it to the dental claim form. Unless the pathology report accompanies the dental claim form, D7286 will probably not be reimbursed by the payor. A brief narrative should describe the location of the lesion, procedures used for the *soft* tissue removal, and a differential diagnosis.
2. "See attached copy of pathology report."

D7287 EXFOLIATIVE CYTOLOGICAL SAMPLE COLLECTION CDT 2025

For collection of non-transepithelial cytology sample via mild scraping of the oral mucosa.

WATCH

Do not report exfoliative cytological sample collection (D7287) for a "OralCDx® brush biopsy." For the OralCDx® brush biopsy, report brush biopsy - transepithelial sample collection (D7288).

COMMENTS

1. Report D7287 for a non-transepithelial cytology sample, or smear. A smear often involves swabbing an area with a cotton swab and submitting the cells that have adhered to the swab for microscopic evaluation.
2. Report the area of the oral cavity treated in the appropriate box of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. D7287 will not typically be reimbursed without an accompanying pathology report attached to the dental claim form.
2. Biopsies may be considered a part of associated procedures performed in the same area, on the same service date.

NARRATIVES

1. Send the exfoliative cytological sample to a pathologist for analysis. After receiving the pathology report prepare the dental claim form. Make a copy of the pathology report and attach it to the dental claim form. Unless the pathology report accompanies the dental claim form, D7287 will probably not be reimbursed by the payor.
2. A brief narrative should describe the location of the lesion, procedures used for the sample removal, and a differential diagnosis.
3. "See attached copy of pathology report."

D7288 BRUSH BIOPSY - TRANSEPITHELIAL SAMPLE COLLECTION CDT 2025

For collection of oral disaggregated transepithelial cells via rotational brushing of the oral mucosa.



WATCH

Use brush biopsy - transepithelial sample collection (D7288) to report the OralCDx® brush biopsy. Do *not* report biopsy of oral tissue - soft (D7286) or exfoliative cytological sample collection (D7287) for the OralCDx® transepithelial sample collection.

COMMENTS

1. The brush biopsy (D7288) sample includes more cell layers than an exfoliative cytological sample (D7287). A brush biopsy scrapes the mucosa exposing the subcutaneous layer and creates bleeding. A cytology sample does not puncture the mucosa. A brush biopsy is like *scraping* into the floor, whereas a cytology sample (D7287) is more like *sweeping* the floor.
2. See D0486 for the associated oral pathology laboratory procedure.
3. A biopsy describes the removal of the sample, not the microscopic examination of the sample.
4. Report the area of the oral cavity treated in the appropriate box of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. D7288 will not typically be reimbursed without including a copy of the pathology report with the claim form.
2. D7288 reports the "sample collection" of transepithelial cells. The OralCDx® laboratory fee is reported *separately* through medical insurance.

NARRATIVES

1. Send the brush biopsy specimen to a pathologist for analysis. After receiving the pathology report prepare the dental claim form. Make a copy of the pathology report and attach it to the dental claim form. Unless the pathology report accompanies the dental claim form, D7288 will probably not be reimbursed by the payor.
2. A brief narrative should describe the location of the lesion, procedures used for the transepithelial sample removal, and a differential diagnosis.

D7290 SURGICAL REPOSITIONING OF TEETH CDT 2025

Grafting procedure(s) is/are additional.

COMMENTS

D7290, surgical repositioning of teeth is not limited to orthodontic treatment.

LIMITATIONS

1. Surgical repositioning of teeth (D7290) may be reimbursed and subject to the orthodontic lifetime maximum limitation when associated with orthodontic treatment. Reimbursement for D7290 is highly variable among payors.
2. The ADA claim form has a question, "Is this for orthodontics?" Most software programs, by default, answer this "no." It is an error to answer "no" if the service is in fact related to the orthodontic treatment. Reimbursement for D7290, when performed with the orthodontics, may be applied toward the "lifetime orthodontic benefit," which typically ranges anywhere from $1,000-$2,000.

NARRATIVES

A brief narrative should identify the tooth number (or letter) and include pre-operative radiographs. Explain why the procedure was necessary, the technique used and include radiographic image and pre-operative photographs.

D7291 TRANSSEPTAL FIBEROTOMY/SUPRA CRESTAL FIBEROTOMY, BY REPORT CDT 2025

The supraosseous connective tissue attachment is surgically severed around the involved teeth. Where there are adjacent teeth, the transseptal fiberotomy of a single tooth will involve a minimum of three teeth. Since the incisions are within the gingival sulcus and tissue and the root surface is not instrumented, this procedure heals by the reunion of connective tissue with the root surface on which viable periodontal tissue is present (reattachment).

MATCH

Transseptal fiberotomy/supra crestal fiberotomy (D7291) is typically associated with orthodontic treatment and at its completion after the active tooth movement phase is complete.

COMMENTS

Report each target tooth number (not adjacent teeth) involved for each transseptal fiberotomy/supra crestal fiberotomy.

LIMITATIONS

1. Reimbursement for D7291 is subject to the plan document's limitations and may be limited to the anterior permanent teeth and premolar.
2. The ADA claim form has a question, "Is this for orthodontics?" If the procedure is associated with orthodontic treatment, answer "yes" to the question on the ADA form "Is this for orthodontics?" Most software programs, by default, answer this "no." It is an error to answer "no" if the service is in fact related to the orthodontic treatment. Reimbursement for D7291, when performed with the orthodontics, may be applied toward the "lifetime orthodontic benefit," which typically ranges anywhere from $1,000-$2,000.

NARRATIVES

Identify each target tooth number (not adjacent teeth) in the narrative.

D7292 PLACEMENT OF TEMPORARY ANCHORAGE DEVICE [SCREW RETAINED PLATE] REQUIRING FLAP CDT 2025

COMMENTS

1. Temporary skeletal anchorage devices are used in orthodontics. They are devices temporarily fixed in bone to provide a stationary anchorage point to attach appliances to orthodontically move teeth. They may be used to intrude or extrude teeth, to treat anterior cross bites or open bites, to move teeth distally or mesially, etc. These devices may be also used as part of orthognathic treatment. Because D7292 may be used with orthognathics, the codes have been listed in the oral and maxillofacial surgery category of codes. These anchorage devices are not intended to be permanent. In most instances, the device (plate/screw) is placed underneath the alveolar mucosa.
2. D7292 reports the placement of a temporary anchorage device which requires a flap. Its purpose is for temporary skeletal anchorage. D7292 is used to specifically report a *screw retained plate*. This may be an orthodontic related procedure.
3. Removal of the temporary anchorage device is included in the global fee for D7292 by most payors. Report D7298 for removal of the TAD device.
4. See also D7293 and D7294 for placement of other types of temporary anchorage devices.
5. Report the quadrant treated in the appropriate box of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. D7292 is generally not a reimbursed procedure.
2. The ADA claim form has a question, "Is this for orthodontics?" If the procedure is associated with orthodontic treatment, answer "yes" to the question on the ADA form "Is this for orthodontics?" Most software programs, by default, answer this "no." It is an error to answer "no" when the service is in fact related to the orthodontic treatment. Reimbursement for D7292, when performed in conjunction with orthodontics, may be applied toward the "lifetime orthodontic benefit," which typically ranges anywhere from $1,000-$2,000.

D7293 PLACEMENT OF TEMPORARY ANCHORAGE DEVICE REQUIRING FLAP CDT 2025

COMMENTS

1. Temporary skeletal anchorage devices are used in orthodontics. They are devices temporarily fixed in bone to provide a stationary anchorage point to attach appliances to orthodontically move teeth. They may be used to intrude or extrude teeth, to treat anterior cross bites or open bites, to move teeth distally or mesially, etc. These devices are also used as part of orthognathic treatment. Because D7293 have been used with orthognathics, the codes have been listed in the oral and maxillofacial surgery category of codes. These anchorage devices are not intended to be permanent. In most instances, the device is placed underneath the alveolar mucosa making the long term integration of the device unlikely.
2. D7293 reports the placement of a temporary anchorage device (excluding a screw retained plate) which *requires* a flap. Its purpose is for temporary skeletal anchorage. This may be an orthodontic related procedure.
3. Removal of the temporary anchorage device is included in the global fee for D7293 by most payors. Report D7299 for removal of the TAD device.
4. See also D7292 and D7294 for placement of other types of temporary anchorage devices.
5. Report the quadrant treated in the appropriate box of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. D7293 is generally not a reimbursed procedure.
2. The ADA claim form has a question, "Is this for orthodontics?" If the procedure is associated with orthodontic treatment, answer "yes" to the question on the ADA form "Is this for orthodontics?" Most software programs, by default, answer this "no." It is an error to answer "no" when the service is in fact related to the orthodontic treatment. Reimbursement for D7293, when performed in conjunction with orthodontics, may be applied toward the "lifetime orthodontic benefit," which typically ranges anywhere from $1,000-$2,000.

D7294 PLACEMENT OF TEMPORARY ANCHORAGE DEVICE WITHOUT FLAP CDT 2025

COMMENTS

1. Temporary skeletal anchorage devices are used in orthodontics. They are devices temporarily fixed in bone to provide a stationary anchorage point to attach appliances to orthodontically move teeth. They may be used to intrude or extrude teeth, to treat anterior cross bites or open bites, to move teeth distally or mesially, etc. These devices are also used as part of orthognathic treatment. Because D7294 has been used with orthognathics, the codes have been listed in the oral and maxillofacial surgery category of codes. These anchorage devices are not intended to be permanent. In most instances, the device is placed underneath the alveolar mucosa making the long term integration of the device unlikely.
2. D7294 reports the placement of a temporary anchorage device which does *not* require a flap. Its purpose is for temporary skeletal anchorage. This may be an orthodontic related procedure.
3. Removal of the temporary anchorage device is included in the global fee for D7294 by most payors. Report D7300 for removal of the TAD device.
4. See also D7292 and D7293 for placement of other types of temporary anchorage devices.
5. Report the quadrant treated in the appropriate box of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. D7294 is generally not a reimbursed procedure.
2. The ADA claim form has a question, "Is this for orthodontics?" If the procedure is associated with orthodontic treatment, answer "yes" to the question on the ADA form "Is this for orthodontics?" Most software programs, by default, answer this "no." It is an error to answer "no" when the service is in fact related to the orthodontic treatment. Reimbursement for D7294, when performed in conjunction with orthodontics, may be applied toward the "lifetime orthodontic benefit," which typically ranges anywhere from $1,000-$2,000.

D7295 HARVEST OF BONE FOR USE IN AUTOGENOUS GRAFTING PROCEDURE CDT 2025

Reported in addition to those autogenous graft placement procedures that do not include harvesting of bone.

WARNING

D7295 may not be reported with D7950 (osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report) or D7951/D7952 (sinus augmentations). The descriptors for these graft procedures specify that obtaining the bone is included in their procedure codes.

WATCH

1. D7295 reports the harvesting of the patient's bone for use in *autogenous* grafting procedures. The donor site could be located in, but does not have to be limited to, the ramus, iliac crest, or symphysis. The donor site could be located in the mandible or maxilla.
2. Bone socket graft (D7953) and repair of maxillofacial soft and/or hard tissue defect (D7955) are procedures that *do not* include the harvesting of bone. D7295 reports the bone harvesting separately from the autogenous grafting procedure.

COMMENTS

1. Existing bone graft procedures described by D7953 and D7955 *do not* include harvesting the bone. D7295 can be reported in addition to D7953 when harvesting a patient's bone (autogenous) for a ridge preservation graft or when repairing a maxillofacial hard tissue defect (D7955).
2. D7295 may involve harvesting bone from the mandible or maxilla or from a distant site such as the iliac crest. The surgeon makes an incision over the donor site, elevates a flap, harvests bone for grafting, and then closes the wound.
3. Report the quadrant treated in the appropriate box of the 2024 ADA Dental Claim Form.

D7296 CORTICOTOMY - ONE TO THREE TEETH OR TOOTH SPACES, PER QUADRANT CDT 2025

This procedure involves creating multiple cuts, perforations, or removal of cortical, alveolar or basal bone of the jaw for the purpose of facilitating orthodontic repositioning of the dentition. This procedure includes flap entry and closure. Graft material and membrane, if used, should be reported separately.

WARNING

When reporting D7296, corticotomy for the purpose of accelerating tooth movement for orthodontics, be sure to answer in Box 40 on the claim form "Is this for orthodontics?" "yes".

WATCH

Graft material (D7295) and membranes (D4266/D4267), if used, should be reported separately. This procedure includes flap entry and closure as provided during the corticotomy procedure.

MATCH

D7296 describes creating multiple cuts, perforations, or removal of cortical, alveolar or basal bone of the jaw for the purpose of facilitating orthodontic repositioning of the dentition involving one to three teeth or tooth spaces, per quadrant.

COMMENTS

1. A corticotomy involves a cutting of the cortical bone that does not necessarily split the bone into two pieces (bone fracture) but involves the cortical bone only, which leaves intact the medullary vessels and periosteum. Corticotomy enhances more rapid orthodontic movement. D7296 describes the treatment of one to three teeth or tooth spaces, per quadrant. Each quadrant treated is reported separately.
2. Report the quadrant and tooth or range of teeth treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

When this service is provided to expedite orthodontic treatment, if reimbursed, it will be subject to the plan's lifetime orthodontic limitations and exclusions. If there is no orthodontic coverage, it would be unlikely that this service would be reimbursed.

NARRATIVES A narrative should be included that describes the specifics for the service, what was done, and the extent and location of the procedure. Photos that document the procedure would be helpful.

D7297 CORTICOTOMY - FOUR OR MORE TEETH OR TOOTH SPACES, PER QUADRANT

CDT 2025

This procedure involves creating multiple cuts, perforations, or removal of cortical, alveolar or basal bone of the jaw for the purpose of facilitating orthodontic repositioning of the dentition. This procedure includes flap entry and closure. Graft material and membrane, if used, should be reported separately.



WARNING

When reporting D7297, corticotomy for the purpose of accelerating tooth movement for orthodontics, be sure to answer in Box 40 on the claim form, "Is this for orthodontics?", "yes".



WATCH

Graft material (D7295) and membranes (D4266/D4267), if used, should be reported separately. This procedure includes flap entry and closure as provided during the corticotomy procedure.



MATCH

D7297 describes creating multiple cuts, perforations, or removal of cortical, alveolar or basal bone of the jaw for the purpose of facilitating orthodontic repositioning of the dentition involving four or more teeth or tooth spaces, per quadrant.

COMMENTS

1. A corticotomy involves a cutting of the cortical bone that does not necessarily split the bone into two pieces (bone fracture) but involves the cortical bone only, which leaves intact the medullary vessels and periosteum. Corticotomy enhances more rapid orthodontic movement. D7297 describes the treatment of four or more teeth or tooth spaces, per quadrant. Each quadrant treated is reported separately.
2. Report the quadrant and range of teeth treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS When this service is provided to expedite orthodontic treatment, if reimbursed, it will be subject to the plan's lifetime orthodontic limitations and exclusions. If there is no orthodontic coverage, it would be unlikely that this service would be reimbursed.

NARRATIVES A narrative should be included that describes the specifics for the service, what was done, and the extent and location of the procedure. Photos that document the procedure would be helpful.

D7298 REMOVAL OF TEMPORARY ANCHORAGE DEVICE [SCREW RETAINED PLATE], REQUIRING FLAP

CDT 2025

COMMENTS

1. Often with severe alveolar fractures, osteotomies, Lefort procedures, etc., stabilization is difficult to obtain without some type of fixation device. Plates that are held in place by screws are often utilized to stabilize the bony structures as a part of these surgical procedures to aid in maintaining proper alignment of the bone segments until the bone has healed. Once healed, these plates and screws often need to be removed so that they, being a source of inflammation, will not cause subsequent complications. To place and to access these plates and screws initially and at the time of removal, flap procedures are utilized to access the area of treatment. D7298 reports the surgical removal of the temporary anchorage device (screw retained plate) that requires a flap.
2. See D7299 to report the removal of a temporary anchorage device that does not involve a plate but does require a flap.
3. See D7300 to report the removal of temporary anchorage device when a flap is not needed to complete the removal of the device.
4. Report the quadrant treated in the appropriate box of the 2024 ADA Dental Claim Form.

LIMITATIONS The removal of a temporary anchorage device is generally not covered by dental payors; however, there could be reimbursment by medical payors. The claim for this procedure should be submitted to the medical payor for primary coverage and then to dental once having received the medical EOB.

NARRATIVES The narrative should provide pre-removal radiographic images, the reason for the removal, a description of the procedure used that includes the need and use of a flap procedure to access the plate and remove the screws and the expected outcome of the service.

D7299 REMOVAL OF TEMPORARY ANCHORAGE DEVICE, REQUIRING FLAP CDT 2025

COMMENTS

1. D7299 reports the removal of the temporary anchorage device, requiring flap but should not be used when the temporary anchorage device is a screw retained plate. Report D7299 for the removal of a temporary anchorage device that does *not* involve a plate but does require a flap.
2. Use D7298 to describe the removal of a temporary anchorage device that consists of a plate and screws requiring a flap.
3. See D7300 to report the removal of any temporary anchorage device, that does not require a flap to access the anchorage device.
4. Report the quadrant treated in the appropriate box of the 2024 ADA Dental Claim Form.

LIMITATIONS The removal of a temporary anchorage device is generally *not* covered by dental payors; however, there could be reimbursment by medical payors. The claim for this procedure should be submitted to the medical payor for primary coverage and then to dental once having received the medical EOB.

NARRATIVES The narrative should provide pre-removal radiographic images, the reason for the removal, a description of the procedure used to include the need and use for a flap procedure and the expected outcome of the service.

D7300 REMOVAL OF TEMPORARY ANCHORAGE DEVICE WITHOUT FLAP CDT 2025

COMMENTS

1. Use D7300 to report the removal of any temporary anchorage device that does not require a flap to access the anchorage device.
2. Use 7298 to describe the removal of a temporary anchorage screw retained plate that requires a flap to access the device and screws.
3. D7299 reports the removal of the temporary anchorage device, requiring flap.
4. Report the quadrant treated in the appropriate box of the 2024 ADA Dental Claim Form.

LIMITATIONS The removal of a temporary anchorage device is generally not covered by dental payors; however, there could be reimbursment by medical payors. The claim for this procedure should be submitted to the medical payor for primary coverage and then to dental once having received the medical EOB.

NARRATIVES The narrative should provide appliance pre-removal radiographic images, photographic images, the reason for the removal, a description of the procedure used not requiring a flap and the expected outcome of the service.

D7310 ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS - FOUR OR MORE TEETH OR TOOTH SPACES, PER QUADRANT CDT 2025

The alveoloplasty is distinct (separate procedure) from extractions. Usually in preparation for a prosthesis or other treatments such as radiation therapy and transplant surgery.



WATCH

1. It is improper to report an alveoloplasty as a routine part of the extraction procedure. It is only appropriate to report an alveoloplasty for reimbursement when substantial reshaping of alveolar bone has occurred. The clinical record should clearly detail the service provided. Typically an alveoloplasty would be performed with *multiple* adjacent extractions only.
2. D7310 reports recontouring alveolar structures after extractions, usually in preparation for a fixed or removable prosthesis.
3. For an alveoloplasty *not* in conjunction with extractions, four or more teeth or tooth spaces, see D7320.

COMMENTS

1. Alveoloplasty is indicated when there is a need to surgically correct anatomical irregularities. These irregularities may be caused by trauma, unusual growth patterns, or an irregular alveolar ridge after multiple extractions.
2. This procedure is reported "per quadrant" (four or more teeth or tooth spaces).
3. Report D5982 for an alveoloplasty guide, when applicable.
4. Report the quadrant and teeth or range of teeth treated in the appropriate box of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Many payors exclude the reimbursement for alveoloplasty if performed on the same service date as extractions. The alveoloplasty is often considered a part of an extraction (D7140) or an extraction requiring sectioning and/or bone removal (D7210), and is not reimbursed separately. If four adjacent teeth (or more) are extracted on the same service date, then there may be reimbursement for this alveoloplasty (D7310). The reimbursement for this procedure is highly variable.
2. If an alveoloplasty is reimbursed, a frenectomy (D7961/D7962) procedure may be considered a part of the alveoloplasty if performed in the same area, on the same service date, and therefore the frenectomy may not be reimbursed.
1. The erupted tooth (D7140/D7210) extraction codes now include in the descriptor "minor smoothing of socket bone." Consequently, many payors decline reimbursement for an "alveoloplasty in *conjunction* with extractions." For possible reimbursement of D7310, the dentist must clearly document and support the fact that much more was involved in the bony recontouring procedure than the "minor smoothing of socket bone" and that four or more teeth or tooth spaces was involved.
2. The erupted tooth (D7140/D7210) extraction codes now include in the descriptor "minor smoothing of socket bone." Consequently, many payors decline reimbursement for an "alveoloplasty in *conjunction* with extractions." For possible reimbursement of D7310, the dentist must clearly document and support the fact that much more was involved in the bony recontouring procedure than the "minor smoothing of socket bone" and that four or more teeth or tooth spaces was involved.

NARRATIVES

Always submit a brief narrative with photos of the treatment area before, during, and after the procedure and a pretreatment radiographic image. An irregular alveolar process or intermittent extractions done over the course of several years, or extraction of multiple adjacent teeth, may be bona fide factors for justifying the need for an alveoloplasty. Typically, suturing and significant socket recontouring would be a part of the (D7310) procedure and the fact that they were done should be reported in a brief narrative.

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

CDT 2025

The alveoloplasty is distinct (separate procedure) from extractions. Usually in preparation for a prosthesis or other treatments such as radiation therapy and transplant surgery.



WATCH

1. It is improper to report an alveoloplasty as a routine part of the extraction procedure. It is only appropriate to report an alveoloplasty for reimbursement when substantial reshaping of alveolar bone has occurred. The clinical record should clearly detail the service provided. Typically an alveoloplasty would be performed with *multiple* adjacent extractions only.
2. D7311 reports recontouring alveolar structures after one to three extractions, usually in preparation for a fixed or removable prosthesis.
3. For an alveoloplasty *not* in conjunction with extractions, one to three teeth or tooth spaces, per quadrant, see D7321.

COMMENTS

1. Alveoloplasty is indicated when there is a need to surgically correct anatomical irregularities. These irregularities may be caused by trauma, unusual growth patterns, or an irregular alveolar ridge after extractions.
2. This procedure is reported "per quadrant" (one to three teeth or tooth spaces).
3. Report D5982 for an alveoloplasty guide, when applicable for multiple teeth.
4. Report the quadrant and teeth or range of teeth treated in the appropriate box of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Many payors exclude the reimbursement for alveoloplasty if performed on the same service date as extractions. The alveoloplasty is often considered a part of an extraction (D7140) or an extraction requiring sectioning and/or bone removal (D7210), and is not reimbursed separately. If three adjacent teeth (or more) are extracted on the same service date, then there may be reimbursement for the alveoloplasty. The reimbursement for this procedure is highly variable.
2. If an alveoloplasty is reimbursed, a frenectomy (D7961/D7962) procedure may be considered a part of the alveoloplasty if performed in the same area, on the same service date, and therefore the frenectomy may not be reimbursed.
3. The erupted tooth (D7140/D7210) extraction codes now include in the descriptor "minor smoothing of socket bone." Consequently, many payors decline reimbursement for an "alveoloplasty in *conjunction* with extractions." For possible reimbursement of D7311, the dentist must clearly document and support the fact that much more was involved in the bony recontouring procedure than the "minor smoothing of socket bone."

NARRATIVES

Always submit a brief narrative with photos of the treatment area before, during, and after the procedure and a pretreatment radiographic image. An irregular alveolar process or intermittent extractions done over the course of several years, or extraction of multiple adjacent teeth, may be bona fide factors for justifying the need for an alveoloplasty. Typically, suturing and significant socket recontouring would be a part of the D7311 procedure and the fact that they were done should be reported in a brief narrative.

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

CDT 2025

No extractions performed in an edentulous area. See D7310 if teeth are being extracted concurrently with the alveoloplasty. Usually in preparation for a prosthesis or other treatments such as radiation therapy and transplant surgery.

COMMENTS

1. Alveoloplasty is indicated when there is a need to surgically correct anatomical irregularities. These irregularities may be caused by trauma, unusual growth patterns, or an irregular alveolar ridge after multiple extractions.
2. This procedure is reported "per quadrant" (four or more teeth or tooth spaces).
3. D7320 is used to report recontouring the alveolus *not* in conjunction with extractions, usually in preparation for a fixed or removable prosthesis. D7320 may be associated with radiation therapy and transplant surgery.
4. Report D7320 for an alveoloplasty (four or more teeth or tooth spaces per quadrant) *not in conjunction* with extractions. D7320 is provided on a service date after the date of extractions.
5. Report the quadrant and teeth or range of teeth treated in the appropriate box of the 2024 ADA Dental Claim Form.

LIMITATIONS

If D7320 is reimbursed, a frenectomy (D7961/D7962) procedure may be considered a part of the alveoloplasty if performed in the same area, on the same service date and therefore, the frenectomy may not be reimbursed.

NARRATIVES

Always submit a brief narrative with photos of the treatment area before, during, and after the procedure and a pretreatment radiographic image. An irregular alveolar process or intermittent extractions done over the course of several years, or extraction of multiple adjacent teeth in the past may be bona fide factors for justifying the need for an alveoloplasty. Typically, suturing and significant socket recontouring would be a part of the procedure and the fact that they were done should be reported. Submit a brief narrative emphasizing why the procedure was necessary, the area involved, and the procedures performed.

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

CDT 2025

No extractions performed in an edentulous area. See D7311 if teeth are being extracted concurrently with the alveoloplasty. Usually in preparation for a prosthesis or other treatments such as radiation therapy and transplant surgery.

COMMENTS

1. Alveoloplasty is indicated when there is a need to surgically correct anatomical irregularities. These irregularities may be caused by trauma, unusual growth patterns, or an irregular alveolar ridge after extractions.
2. This procedure is reported "per quadrant" (one to three teeth or tooth spaces).
3. D7321 is used to report recontouring the alveolus *not* in conjunction with extractions, usually in preparation for a fixed or removable prosthesis. D7321 may be associated with radiation therapy and transplant surgery.
4. Report D7321 for an alveoloplasty (one to three teeth or tooth spaces per quadrant) *not in conjunction* with extractions. D7321 is provided on a service date after the date of extractions. Three teeth or tooth spaces may be required for reimbursement.
5. Report the quadrant and teeth or range of teeth treated in the appropriate box of the 2024 ADA Dental Claim Form.

LIMITATIONS

If D7321 is reimbursed, a frenectomy (D7961/D7962) procedure may be considered a part of the alveoloplasty if performed in the same area, on the same service date, and therefore, the frenectomy may not be reimbursed.

NARRATIVES

Always submit a brief narrative with photos of the treatment area before, during and after the procedure and a pretreatment radiographic image. An irregular alveolar process or intermittent extractions done over the course of several years, or extraction of multiple adjacent teeth in the past, may be bona fide factors for justifying the need for an alveoloplasty. Typically, suturing and significant socket recontouring would be a part of the procedure and the fact that they were done should be reported. Submit a brief narrative emphasizing why the procedure was necessary, the area involved, and the procedures performed.

VESTIBULOPLASTY

CDT 2025

Any series of surgical procedures designed to increase relative alveolar ridge height

D7340 VESTIBULOPLASTY - RIDGE EXTENSION (SECONDARY EPITHELIALIZATION)

CDT 2025

COMMENTS

Report the quadrant treated in the appropriate box of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Vestibuloplasty (D7340) is typically excluded if performed in, or associated with, an implant procedure.
2. If D7340 is reimbursed, the payor may consider frenectomy (D7961/D7962) *a part of* the vestibuloplasty, if performed in same area on same service date, and therefore, the frenectomy might not be reimbursed.
3. Reimbursement is generally limited to a ridge extension procedure.

D7350 VESTIBULOPLASTY - RIDGE EXTENSION (INCLUDING SOFT TISSUE GRAFTS, MUSCLE REATTACHMENT, REVISION OF SOFT TISSUE ATTACHMENT AND MANAGEMENT OF HYPERTROPHIED AND HYPERPLASTIC TISSUE) CDT 2025

COMMENTS

Report the quadrant treated in the appropriate box of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Vestibuloplasty (D7350) is typically excluded if performed in, or associated with, an implant procedure.
2. If D7350 is reimbursed, the payor may consider frenectomy (D7961/D7962) a part of the vestibuloplasty procedure if performed in same area on same service date, and therefore, the frenectomy may not be reimbursed.
3. Reimbursement is generally limited to a ridge extension procedure.

EXCISION OF SOFT TISSUE LESIONS CDT 2025

Includes non-odontogenic cysts.

D7410 EXCISION OF BENIGN LESION UP TO 1.25 CM CDT 2025

COMMENTS

1. Report D7284 for excisional biopsy of minor salivary glands.
2. Report the arch treated in the appropriate box of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Excision of benign lesion up to 1.25 cm (D7410) may be excluded from consideration for reimbursement if associated with another surgical procedure or biopsy procedure performed at the same site, on the same service date.
2. When D7410 is reported as a stand-alone procedure of the excision of a *complete* lesion, a pathology report describing the lesion as benign should be attached and submitted for dental reimbursement.
3. If the lesion is not benign, report D7413.
4. D7410 may, or may not be, a covered dental benefit; however, the procedure may be considered for reimbursement through medical insurance. See our *Medical Dental Cross Coding With Confidence* manual at *www.practicebooster.com/store*.

NARRATIVES

1. A brief narrative is generally required when reporting D7410. The narrative should describe the location of the lesion, procedures used for the tissue removal, and a differential diagnosis.
2. "See attached copy of pathology report."

D7411 EXCISION OF BENIGN LESION GREATER THAN 1.25 CM CDT 2025

COMMENTS

1. Report D7284 for excisional biopsy of minor salivary glands.
2. Report the arch treated in the appropriate box of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Excision of benign lesion greater than 1.25 cm (D7411) may be excluded from consideration for reimbursement if associated with another surgical procedure or biopsy procedure performed at the same site, on the same service date.
2. When D7411 is reported as a stand-alone procedure of the excision of a complete lesion, a pathology report describing the lesion as benign should be attached and submitted for dental reimbursement.
3. If the lesion is not benign, report D7414.
4. D7411 may not be a covered dental benefit; however, the procedure may be considered for reimbursement through medical insurance. See our *Medical Dental Cross Coding With Confidence* manual at *www.practicebooster.com/store*.

NARRATIVES

1. A brief narrative is generally required when reporting D7411. The narrative should describe the location of the lesion, procedures used for the tissue removal, and a differential diagnosis.
2. "See attached copy of pathology report."

D7412 EXCISION OF BENIGN LESION, COMPLICATED — CDT 2025

Requires extensive undermining with advancement or rotational flap closure.

COMMENTS

1. Report D7284 for excisional biopsy of minor salivary glands.
2. Report the arch treated in the appropriate box of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Excision of benign lesion, complicated (D7412) may be excluded from consideration for reimbursement if associated with another surgical procedure or biopsy procedure performed at the same site, on the same service date.
2. When D7412 is reported as a stand-alone procedure of the excision of a complete lesion, a pathology report describing the lesion as benign should be attached and submitted for dental reimbursement.
3. If the lesion is not benign, report D7415.
4. D7412 may not be a covered dental benefit; however, the procedure may be considered for reimbursement through medical insurance. See our *Medical Dental Cross Coding With Confidence* manual at *www.practicebooster.com/store*.

NARRATIVES

1. A brief narrative is generally required when reporting D7412. The narrative should describe the location of the lesion, procedures used for the tissue removal, a differential diagnosis, and identify that extensive undermining with advancement or a rotational flap closure was performed as part of the procedure.
2. "See attached copy of pathology report."

D7413 EXCISION OF MALIGNANT LESION UP TO 1.25 CM — CDT 2025

COMMENTS

1. Report D7284 for excisional biopsy of minor salivary glands.
2. Report the arch treated in the appropriate box of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Excision of malignant lesion up to 1.25 cm (D7413) may be excluded from consideration for reimbursement if associated with another surgical procedure or biopsy procedure performed at the same site, on the same service date.
2. When D7413 is reported as a stand-alone procedure of the excision of a complete lesion, a pathology report describing the lesion as malignant should be attached and submitted for dental reimbursement.
3. If the lesion is not malignant, report D7410.
4. D7413 may not be a covered dental benefit; however, the procedure may be considered for reimbursement through medical insurance. See our *Medical Dental Cross Coding With Confidence* manual at *www.practicebooster.com/store*.

NARRATIVES

1. A brief narrative and pathology report is required when reporting this code. After receiving the pathology report, prepare the dental claim form. Make a copy of the pathology report and attach it to a dental claim form. Unless the pathology report accompanies the dental claim form, this code may not be reimbursed by the payor. The narrative should describe the location of the lesion, procedures used for the tissue removal, and a differential diagnosis of the lesion.
2. "See attached copy of pathology report."

D7414 EXCISION OF MALIGNANT LESION GREATER THAN 1.25 CM — CDT 2025

COMMENTS

1. Report D7284 for excisional biopsy of minor salivary glands.
2. Report the arch treated in the appropriate box of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Excision of malignant lesion greater than 1.25 cm (D7414) may be excluded from consideration for reimbursement if associated with another surgical procedure or biopsy procedure performed at the same site, on the same service date.
2. When D7414 is reported as a stand-alone procedure of the excision of a complete lesion, a pathology report describing the lesion as malignant should be attached and submitted for dental reimbursement.
3. If the lesion is not malignant, report D7411.
4. D7414 may not be a covered dental benefit; however, the procedure may be considered for reimbursement through medical insurance. See our *Medical Dental Cross Coding With Confidence* manual at *www.practicebooster.com/store*.

NARRATIVES

1. A brief narrative and pathology report is required when reporting D7414. After receiving the pathology report, prepare the dental claim form. Make a copy of the pathology report and attach it to a dental claim form. Unless the pathology report accompanies the dental claim form, this code may not be reimbursed by the payor. The narrative should describe the location of the lesion, procedures used for the tissue removal, and a differential diagnosis of the lesion.
2. "See attached copy of pathology report."

D7415 EXCISION OF MALIGNANT LESION, COMPLICATED — CDT 2025

Requires extensive undermining with advancement or rotational flap closure.

COMMENTS

1. Report D7284 for excisional biopsy of minor salivary glands.
2. Report the arch treated in the appropriate box of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Excision of malignant lesion, complicated (D7415) may be excluded from consideration for reimbursement if associated with another surgical procedure or biopsy procedure performed at the same site, on the same service date.
2. When D7415 is reported as a stand-alone procedure of the excision of a complete lesion, a pathology report describing the lesion as malignant should be attached and submitted for dental reimbursement.
3. If the lesion is not malignant, report D7412.
4. D7415 may or may not be a covered dental benefit; however, the procedure may be considered for reimbursement through medical insurance. See our *Medical Dental Cross Coding With Confidence* manual at *www.practicebooster.com/store*.

NARRATIVES

1. A brief narrative and pathology report is required generally when reporting D7415. After receiving the pathology report, prepare the dental claim form. Make a copy of the pathology report and attach it to the dental claim form. Unless the pathology report accompanies the dental claim form, D7415 will probably not be reimbursed by the payor. The narrative should describe the location of the lesion, procedures used for the tissue removal, a differential diagnosis, and should explain that extensive undermining with advancement or a rotational flap closure was performed as part of the procedure.
2. "See attached copy of pathology report."

D7465 DESTRUCTION OF LESION(S) BY PHYSICAL OR CHEMICAL METHOD, BY REPORT — CDT 2025

Examples include using cryo, laser or electro surgery.

Note: While out of numerical order, D7465 is correctly listed here under the excision of soft tissue lesions category.

COMMENTS

1. The descriptor of destruction of lesion(s) by physical or chemical method (D7465) gives examples of specific technologies (cryo, laser, electro surgery) to perform this procedure.
2. This is the *only* descriptor that specifically mentions a laser. Keep in mind that insurance payors reimburse for the procedure being performed rather than for the device or technology used to perform it.

3. The technology used to perform a procedure provides increased efficiency by reducing procedure time and clinical benefits such as faster healing time, better results, etc. The technology used does not increase the reimbursement for the procedure performed.
4. D7465 reports apthous ulcer destruction performed with a laser, cryosurgery, electrosurgery, or by chemical means, such as Debacterol®. It does not inlcude the treatment of oral lesions with corticosteroid, antibiotic, antiviral, anesthetic, or other medications.
5. Report the arch treated in the appropriate box of the 2024 ADA Dental Claim Form.

NARRATIVES This is a "by report" code and a brief narrative is required. Indicate the arch. Describe the lesion and the method used to obliterate the lesion.

EXCISION OF INTRA-OSSEOUS LESIONS — CDT 2025

D7440 EXCISION OF MALIGNANT TUMOR - LESION DIAMETER UP TO 1.25 CM — CDT 2025

COMMENTS Report the arch treated in the appropriate box of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Excision of malignant tumor - lesion diameter up to 1.25 cm (D7440) may be excluded from consideration for reimbursement if associated with another surgical procedure or biopsy procedure performed at the same site, on the same service date.
2. When D7440 is reported as a stand-alone procedure of the excision of a tumor, a pathology report describing the tumor as malignant should be attached and submitted for dental reimbursement.
3. D7440 may not be a covered dental benefit; however, the procedure may be considered for reimbursement through medical insurance. See our *Medical Dental Cross Coding With Confidence* manual at *www.practicebooster.com/store*.

NARRATIVES

1. A brief narrative and copy of the pathology report is highly recommended when reporting D7440. Send the tissue biopsy specimen for analysis. After receiving the pathology report, prepare the dental claim form. Make a copy of the pathology report and attach it to the dental claim form. Unless the pathology report accompanies the dental claim form, D7440 will probably not be reimbursed by the payor. The brief narrative should describe the location of the lesion, procedures used for the tissue removal, and a differential diagnosis.
2. "See attached copy of pathology report."

D7441 EXCISION OF MALIGNANT TUMOR - LESION DIAMETER GREATER THAN 1.25 CM — CDT 2025

COMMENTS Report the arch treated in the appropriate box of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Excision of malignant tumor - lesion diameter greater than 1.25 cm (D7441) may be excluded from consideration for reimbursement if associated with another surgical procedure or biopsy procedure performed at the same site, on the same service date.
2. When D7441 is reported as a stand-alone procedure of the excision of a tumor, a pathology report describing the tumor as malignant should be attached and submitted for dental reimbursement.
3. D7441 may, or may not be a covered dental benefit; however, the procedure may be considered for reimbursement through medical insurance. See our *Medical Dental Cross Coding With Confidence* manual at *www.practicebooster.com/store*.

NARRATIVES

1. A brief narrative and copy of the pathology report is highly recommended when reporting D7441. Send the tissue biopsy specimen for analysis. After receiving the pathology report, prepare the dental claim form. Make a copy of the pathology report and attach it to a dental claim form. Unless the pathology report accompanies the dental claim form, D7441 will probably not be reimbursed by the payor. The brief narrative should describe the location of the lesion, procedures used for the tissue removal, and a differential diagnosis.
2. "See attached copy of pathology report."

D7450 REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR - LESION DIAMETER UP TO 1.25 CM

CDT 2025

COMMENTS

Report the arch treated in the appropriate box of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm (D7450) may be excluded from consideration for reimbursement if associated with another surgical procedure or biopsy procedure performed at the same site, on the same service date.
2. When D7450 is reported as a stand-alone procedure, a pathology report should be attached describing the cyst or tumor as benign and submitted for dental reimbursement.
3. D7450 may not be a covered dental benefit; however, the procedure may be considered for reimbursement through medical insurance. See our *Medical Dental Cross Coding With Confidence* manual at *www.practicebooster.com/store*.

NARRATIVES

1. A brief narrative and copy of the pathology report is highly recommended when reporting D7450. Send the tissue biopsy specimen for analysis. After receiving the pathology report, prepare the dental claim form. Make a copy of the pathology report and attach it to the dental claim form. Unless the pathology report accompanies the dental claim form, D7450 will probably not be reimbursed by the payor. The brief narrative should describe the location of the lesion, procedures used for the tissue removal, and a differential diagnosis.
2. "See attached copy of pathology report."

D7451 REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR - LESION DIAMETER GREATER THAN 1.25 CM

CDT 2025

COMMENTS

1. If the ondontogenic cyst requires marsupialization, report D7509.
2. Report the arch treated in the appropriate box of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm (D7451) may be excluded from consideration for reimbursement if associated with another surgical procedure or biopsy procedure performed at the same site, on the same service date.
2. When D7451 is reported as a stand-alone procedure, a pathology report should be attached describing the cyst or tumor as benign and submitted for dental reimbursement.
3. D7451 may not be a covered dental benefit; however, the procedure may be considered for reimbursement through medical insurance. See our *Medical Dental Cross Coding With Confidence* manual at *www.practicebooster.com/store*.

NARRATIVES

1. A brief narrative and copy of the pathology report is highly recommended when reporting D7451. After receiving the pathology report prepare the dental claim form. Make a copy of the pathology report and attach it to the dental claim form. Unless the pathology report accompanies the dental claim form, D7451 will probably not be reimbursed by the payor. The brief narrative should describe the location of the lesion, procedures used for the tissue removal, and a differential diagnosis.
2. "See attached copy of pathology report."

D7460 REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR - LESION DIAMETER UP TO 1.25 CM

CDT 2025

COMMENTS

Report the arch treated in the appropriate box of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm (D7460) may be excluded from consideration for reimbursement if associated with another surgical procedure or biopsy procedure performed at the same site, on the same service date.
2. When D7460 is reported as a stand-alone procedure, a pathology report should be attached describing the cyst or tumor as benign and submitted for dental reimbursement.

3. D7460 may not be a covered dental benefit; however, the procedure may be considered for reimbursement through medical insurance. See our *Medical Dental Cross Coding With Confidence* manual at www.practicebooster.com/store.

NARRATIVES

1. A brief narrative and copy of the pathology report is highly recommended when reporting D7460. After receiving the pathology report, prepare the dental claim form. Make a copy of the pathology report and attach it to the dental claim form. Unless the pathology report accompanies the dental claim form, D7460 will probably not be reimbursed by the payor. The brief narrative should describe the location of the lesion, procedures used for the tissue removal, and a differential diagnosis.
2. "See attached copy of pathology report."

D7461 REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR - LESION DIAMETER GREATER THAN 1.25 CM

CDT 2025

COMMENTS

Report the arch treated in the appropriate box of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm (D7461) may be excluded from consideration for reimbursement if associated with another surgical procedure or biopsy procedure performed at the same site, on the same service date.
2. When D7461 is reported as a stand-alone procedure, a pathology report should be attached describing the cyst or tumor as benign and submitted for dental reimbursement.
3. The technology used to perform a procedure provides increased efficiency by reducing procedure time and clinical benefits such as faster healing time, better results, etc. The technology used does not increase the reimbursement for the procedure performed.
4. D7465 reports aphthous ulcer treatment performed with a laser.

NARRATIVES

1. A brief narrative and copy of the pathology report is highly recommended when reporting D7461. After receiving the pathology report prepare the dental claim form. Make a copy of the pathology report and attach it to the dental claim form. Unless the pathology report accompanies the dental claim form, D7461 will probably not be reimbursed by the payor. The brief narrative should describe the location of the lesion, procedures used for the tissue removal, and a differential diagnosis.
2. "See attached copy of pathology report."

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

CDT 2025

Examples include using cryo, laser or electro surgery.

This code's position is in numerical order here. But, it actually follows D7415. However, D7465 is printed here in its entirety.

COMMENTS

1. The descriptor of destruction of lesion(s) by physical or chemical method (D7465) gives examples of specific technologies (cryo, laser, electro surgery) to perform this procedure.
2. This is the *only* descriptor that specifically mentions a laser. Keep in mind that insurance payors reimburse for the procedure being performed rather than for the device or technology used to perform it.
3. The technology used to perform a procedure provides increased efficiency by reducing procedure time and clinical benefits such as faster healing time, better results, etc. The technology used does not increase the reimbursement for the procedure performed.
4. D7465 reports aphthous ulcer destruction performed with a laser, cryosurgery, electrosurgery, or by chemical means, such as Debacterol®. It does not inlcude the treatment of oral lesions with corticosteroid, antibiotic, antiviral, anesthetic, or other medications.
5. Report the arch treated in the appropriate box of the 2024 ADA Dental Claim Form.

NARRATIVES

This is a "by report" code and a brief narrative is required. Indicate the arch. Describe the lesion and the method used to obliterate the lesion.

D7471 REMOVAL OF LATERAL EXOSTOSIS (MAXILLA OR MANDIBLE) CDT 2025

COMMENTS

1. A lateral exostosis is a bony growth on the cheek facing side of the maxilla or cheek facing side of the mandible.
2. Report the arch treated in the appropriate box of the 2024 ADA Dental Claim Form.

LIMITATIONS

Although this is a *per site* code used for the removal of tori, osseous tuberosities, or any other bony protuberances, some payors pay only once per arch per lifetime. When submitting a claim, identify the arch treated and include current pre-operative radiographs of the area. It can also be helpful to send a pretreatment photograph. Be aware that reimbursement for removal of lateral exostosis is unlikely if performed on the same day as osseous periodontal surgery.

NARRATIVES

1. A brief narrative is required when reporting D7471. Report if the procedure is done in conjunction with the reline or construction of a removable prosthesis. Photos and/or models may be required.
2. Claims for the services should indicate the site treated of the maxilla or mandible. If multiple sites are involved, use separate lines to report each site. Benefits are often limited to one treatment per arch per lifetime.
3. Some dental plans require that the patient's medical payor be billed first before considering payment under dental. Include the EOB from the medical payor with the claim to the dental payor as documentation that the medical plan was billed first. See our *Medical Dental Cross Coding With Confidence* manual at *www.practicebooster.com/store*.

D7472 REMOVAL OF TORUS PALATINUS CDT 2025

COMMENTS

A torus palatinus is a bony growth which develops on the midline of the roof of the mouth, and is slow-growing.

LIMITATIONS

Removal of torus palatinus (D7472), if a covered benefit, is often reimbursed only once per lifetime.

NARRATIVES

1. A brief narrative is required when reporting D7472. Report if the procedure is done in conjunction with the reline or construction of a removable prosthesis. Photos and/or models may be required.
2. Claims for the service should indicate the site treated. If multiple sites are involved, use separate lines to report each site. Benefits are often limited to one per lifetime.
3. Some dental plans require that the patient's medical payor be billed first before considering payment under dental. Include the EOB from the medical payor with the claim to the dental payor as documentation that the medical plan was billed first.

D7473 REMOVAL OF TORUS MANDIBULARIS CDT 2025

COMMENTS

1. A torus mandibularis is a bony growth which develops on the lingual of the mandible, and is slow-growing.
2. Report the quadrant treated in the appropriate box of the 2024 ADA Dental Claim Form.

LIMITATIONS

Removal of torus mandibularis (D7473), if a covered benefit, is often reimbursed only once per arch, per lifetime.

NARRATIVES

1. A brief narrative is required when reporting D7473. Report if the procedure is done in conjunction with the reline or construction of a removable prosthesis. Photos and/or models may be required.
2. Claims for the services should indicate the site treated. If multiple sites are involved, use separate lines to report each site. Benefits are often limited to one arch per lifetime.
3. Some dental plans require that the patient's medical payor be billed first before considering payment under dental. Include the EOB from the medical payor with the claim to the dental payor as documentation that the medical plan was billed first. See our *Medical Dental Cross Coding With Confidence* manual at *www.practicebooster.com/store*.

D7485 REDUCTION OF OSSEOUS TUBEROSITY — CDT 2025

COMMENTS

Report the quadrant treated in the appropriate box of the 2024 ADA Dental Claim Form.

LIMITATIONS

Reduction of osseous tuberosity (D7485), if a covered benefit, is often reimbursed only once per arch, per lifetime.

NARRATIVES

1. A narrative is required when reporting D7485. Note: If the procedure is done in conjunction with the reline or construction of a removable prosthesis, photos and/or models may be required.
2. Claims for the services should indicate the site treated. If multiple sites are involved, use separate lines to report each site. Benefits are often limited to one per arch per lifetime.
3. Some dental plans require that the patient's medical payor be billed before considering payment under dental. Include the EOB from the medical payor with the claim to the dental payor as documentation that the medical plan was billed first. See our *Medical Dental Cross Coding With Confidence* manual at www.practicebooster.com/store.

D7490 RADICAL RESECTION OF MAXILLA OR MANDIBLE — CDT 2025

Partial resection of maxilla or mandible; removal of lesion and defect with margin of normal appearing bone. Reconstruction and bone grafts should be reported separately.

COMMENTS

1. Reconstruction procedures and bone grafts should be reported separately.
2. Report the arch treated in the appropriate box of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Radical resection of maxilla or mandible (D7490) is not typically reimbursed by dental insurance.
2. Specify the arch.
3. This is typically considered for reimbursement through medical insurance. See our *Medical Dental Cross Coding With Confidence* manual at www.practicebooster.com/store..

SURGICAL INCISION — CDT 2025

D7509 MARSUPIALIZATION OF ODONTOGENIC CYST — CDT 2025

Surgical decompression of a large cystic lesion by creating a long-term open pocket or pouch.



WARNING

It is inappropriate to report D7509 for an incision and drainage of an abscess (see D7510/D7511/D7520/D7521).

COMMENTS

1. This procedure involves an incision into a large maxillary or mandibular cystic lesion and making a window; typically removing a portion of the cyst for biopsy and creating a longer-term opening from the outside similar to a pouch, allowing for decompression or drainage.
2. After the ondontogenic cyst has decompressed from the initial procedure, it is most often followed by a second stage surgery for complete removal.
3. If marsupialization of odontogenic cyst is not required, report D7450 or D7451.
4. Report the quadrant and tooth number associated with the cyst in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

Removing tissue to create a window is in effect taking a tissue sample for biopsy, therefore payors may not pay for both D7509 and the soft-tissue biopsy (D7286) on the same service date.

NARRATIVES

Specify the location of the cyst.

D7510 INCISION AND DRAINAGE OF ABSCESS - INTRA-ORAL SOFT TISSUE CDT 2025

Involves incision through mucosa, including periodontal origins.

COMMENTS

1. The incision and drainage of abscess (D7510) may also be accomplished through an incision in the gingival sulcus.
2. Incision and drainage of abscess - intra-oral soft tissue (D7510) includes the incision and drainage through the mucosa of a periodontal abscess.
3. Report the quadrant and tooth number(s) treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Payors will consider post-operative visits a part of the incise and drainage global fee.
2. Payors may consider D7510 to be a global component of an extraction, apicoectomy, excision of foreign body, or other procedure on the same service date.
3. If the intra-oral abscess extends beyond the alveolus, D7510 may not be reimbursed by the dental plan. However, the procedure may be considered for reimbursement through the medical plan. See our *Medical Dental Cross Coding With Confidence* manual at *www.practicebooster.com/store*.

TIPS

1. Incision and drainage of abscess - intra-oral soft tissue (D7510) is often reimbursed.
2. If the "incision and drainage" is accomplished during a *single* appointment, consider charging a *lower* fee. If *two* visits are required, i.e., procedure is more complicated and/or a rubber dam drain is placed, then consider a *higher* fee for D7510 and note that the treatment required multiple appointments.

NARRATIVES

1. While D7510 is not by report, you are encouraged to identify the quadrant and include a brief clinical description for the dental consultant's review. D7510 is often disallowed if done on the same date and by the same provider who performed endodontics, extractions, or other treatment. A pretreatment photograph and radiographic image of the area can be helpful in documenting the need for the procedure.
2. Note if the treatment required multiple appointments, if applicable.

D7511 INCISION AND DRAINAGE OF ABSCESS - INTRA-ORAL SOFT TISSUE - COMPLICATED (INCLUDES DRAINAGE OF MULTIPLE FASCIAL SPACES) CDT 2025

Incision is made intra-orally and dissection is extended into adjacent fascial space(s) to provide adequate drainage of abscess/cellulitis.

COMMENTS

1. This incision and drainage procedure is associated with an acute abscess with facial swelling. D7511 is used to describe the situation where the infection has spread into adjacent fascial spaces and treatment requires intra-oral drainage of one or more fascial spaces.
2. Report the quadrant and tooth number(s) treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Payors will consider post-operative visits a part of the incise and drain global fee.
2. If the intra-oral abscess extends beyond the alveolus, then D7511 may be excluded by dental insurance, but reimbursed through a medical insurance plan. See our *Medical Dental Cross Coding With Confidence* manual at *www.practicebooster.com/store*.

NARRATIVES

While D7511 is not by report, you are encouraged to include a brief narrative and should be very specific as to the appearance of the area treated, procedures used to accomplish the drainage, and the fascial spaces involved. A pretreatment photograph and radiographic image of the area can be helpful in documenting the need for the procedure.

D7520 INCISION AND DRAINAGE OF ABSCESS - EXTRA-ORAL SOFT TISSUE

CDT 2025

Involves incision through skin.

WATCH

Report D7520 for the incision and draining of an abscess through an *external* access opening. That is, the access to the abscess is made *extra-orally* (not in the mouth but somewhere on the face) and through soft tissue. For incision and drainage *intra-oral* soft tissue, report D7510.

COMMENTS

1. D7520 is used to describe a procedure performed in an acute situation of facial swelling. The spread of infection into adjacent fascial spaces requires drainage and is most appropriately accessed from an area outside the oral cavity. It requires additional expertise and time. D7520 is more likely a covered benefit under a medical plan. See our *Medical Dental Cross Coding With Confidence* manual at *www.practicebooster.com/store*.
2. Report the arch treated in the appropriate box of the 2024 ADA Dental Claim Form.

LIMITATIONS

Typically not a covered dental benefit; possibly considered for reimbursement through medical insurance. See our *Medical Dental Cross Coding With Confidence* manual at *www.practicebooster.com/store*.

NARRATIVES

While D7520 is not by report, you are encouraged to include a brief narrative and should be very specific as to the appearance of the area treated, procedures used to accomplish the drainage, and the fascial spaces involved. Pretreatment photographs and possibly radiographic images can be helpful in documenting the need for this procedure.

D7521 INCISION AND DRAINAGE OF ABSCESS - EXTRA-ORAL SOFT TISSUE - COMPLICATED (INCLUDES DRAINAGE OF MULTIPLE FASCIAL SPACES)

CDT 2025

Incision is made extra-orally and dissection is extended into adjacent fascial space(s) to provide adequate drainage of abscess/cellulitis.

WATCH

Report D7521 for the incision and draining of an abscess through an *external access* opening. That is, the access to the abscess is made *extra-orally* (not in the mouth but somewhere on the face) and through soft tissue. For incision and drainage - *intra-oral* soft tissue, report D7510.

COMMENTS

1. D7521 is used to describe a complicated procedure performed in medically acute situations of facial swelling. The spread of infection into adjacent fascial spaces requires drainage and is most appropriately accessed from an area outside the oral cavity. It requires additional expertise and time. D7521 is more likely a covered benefit under a medical plan. See our *Medical Dental Cross Coding With Confidence* manual at *www.practicebooster.com/store*.
2. Report the arch treated in the appropriate box of the 2024 ADA Dental Claim Form.

LIMITATIONS

Typically not a covered dental benefit; could possibly be considered for reimbursement through medical insurance.

NARRATIVES

While D7521 is not by report, you are encouraged to include a brief narrative and should be very specific as to the appearance of the area treated, procedures used to accomplish the drainage, and the fascial spaces involved. Pretreatment photographs and possibly radiographic images can be helpful in documenting the need for this procedure.

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

CDT 2025

COMMENTS

1. D7530 could include the removal of splinters (foreign body) embedded in soft tissue.
2. If the foreign body is embedded in muscle and/or bone, report D7540.

LIMITATIONS

Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue (D7530) may be reimbursed under dental insurance. If not, D7530 could possibly be considered for reimbursement through medical insurance. See our *Medical Dental Cross Coding With Confidence* manual at *www.practicebooster.com/store*.

NARRATIVES While D7530 is not by report, you are encouraged to include a brief narrative and should be very specific as to the location of the foreign body. Pretreatment photographs and possibly radiographic images can be helpful in documenting the need for this procedure.

D7540 REMOVAL OF REACTION PRODUCING FOREIGN BODIES, MUSCULOSKELETAL SYSTEM

CDT 2025

May include, but is not limited to, removal of splinters, pieces of wire, etc., from muscle and/or bone.

COMMENTS

1. D7540 includes removal of splinters, wire, etc. from muscle and/or bone.
2. For removal of a foreign body from soft tissue, report D7530.

LIMITATIONS Removal of reaction producing foreign bodies, musculoskeletal system (D7540) may be reimbursed under dental insurance. If not, D7540 could possibly be considered for reimbursement through medical insurance. See our *Medical Dental Cross Coding With Confidence* manual at www.practicebooster.com/store.

NARRATIVES While D7540 is not by report, you are encouraged to include a brief narrative and should be very specific as to the location of the foreign body. Pretreatment photographs and possibly radiographic images can be helpful in documenting the need for this procedure.

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

CDT 2025

Removal of loose or sloughed-off dead bone caused by infection or reduced blood supply.

COMMENTS

1. Partial ostectomy/sequestrectomy for removal of non-vital bone (D7550) reports the removal of loose or denuded (sloughed off) non-vital bone from surrounding healthy bone caused by infection or reduced blood supply, not just small slivers or bone chips remaining as a routine consequence of a recent extraction.
2. For the *simplest* removal of a very small sliver of loose or denuded non-vital bone at a visit with pain/discomfort as reported by the patient at the doctor's discretion, consider reporting a palliative procedure (D9110). See D9110 for details.
3. To report removal of small slivers or chips of bone subsequent to a recent extraction, see D0171 re-evaluation - post-operative (if at no charge) or D9930 treatment of complications (post-surgical) - unusual circumstances, by report (if more significant and a charge is made).
4. Report the arch treated in the appropriate box of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. If D7550 is used to describe a follow up procedure provided by the *same* provider, many payors may consider this procedure a part of the *global* extraction fee. The payor may deny reimbursement for D7550. If a *different* office (other than the office performing the initial procedure) performs this procedure, D7550 may be reimbursed.
2. Some payors may "remap" D7550 to palliative (D9110) for reimbursement. See D9110 for further details.

NARRATIVES Include a brief narrative with the claim that describes the location and includes a description of the partial ostectomy.

D7560 MAXILLARY SINUSOTOMY FOR REMOVAL OF TOOTH FRAGMENT OR FOREIGN BODY

CDT 2025

LIMITATIONS This is typically considered for reimbursement through medical insurance.

D7610 MAXILLA - OPEN REDUCTION (TEETH IMMOBILIZED, IF PRESENT) CDT 2025

Teeth may be wired, banded or splinted together to prevent movement. Incision required for interosseous fixation.

LIMITATIONS This is typically considered for reimbursement through medical insurance.

D7620 MAXILLA - CLOSED REDUCTION (TEETH IMMOBILIZED, IF PRESENT) CDT 2025

No incision required to reduce fracture. See D7610 if interosseous fixation is applied.

LIMITATIONS This is typically considered for reimbursement through medical insurance.

D7630 MANDIBLE - OPEN REDUCTION (TEETH IMMOBILIZED, IF PRESENT) CDT 2025

Teeth may be wired, banded or splinted together to prevent movement. Incision required to reduce fracture.

LIMITATIONS This is typically considered for reimbursement through medical insurance.

D7640 MANDIBLE - CLOSED REDUCTION (TEETH IMMOBILIZED, IF PRESENT) CDT 2025

No incision required to reduce fracture. See D7630 if interosseous fixation is applied.

LIMITATIONS This is typically considered for reimbursement through medical insurance.

D7650 MALAR AND/OR ZYGOMATIC ARCH - OPEN REDUCTION CDT 2025

LIMITATIONS This is typically considered for reimbursement through medical insurance.

D7660 MALAR AND/OR ZYGOMATIC ARCH - CLOSED REDUCTION CDT 2025

LIMITATIONS This is typically considered for reimbursement through medical insurance.

D7670 ALVEOLUS - CLOSED REDUCTION, MAY INCLUDE STABILIZATION OF TEETH CDT 2025

Teeth may be wired, banded, or splinted together to prevent movement.

LIMITATIONS This is typically considered for reimbursement through medical insurance.

D7671 ALVEOLUS - OPEN REDUCTION, MAY INCLUDE STABILIZATION OF TEETH CDT 2025

Teeth may be wired, banded or splinted together to prevent movement.

LIMITATIONS This is typically considered for reimbursement through medical insurance.

D7680 FACIAL BONES - COMPLICATED REDUCTION WITH FIXATION AND MULTIPLE SURGICAL APPROACHES

CDT 2025

Facial bones include upper and lower jaw, cheek, and bones around eyes, nose, and ears.

LIMITATIONS

1. This is typically considered for reimbursement through medical insurance.
2. If covered by a dental plan, some payors may require an operative report for consultant review of the services provided.
3. Many dental plans require that the patient's medical payor be billed first before considering payment under dental. Include the EOB from the medical payor with the claim to the dental payor as documentation that the medical plan was billed first.

TREATMENT OF OPEN FRACTURES

CDT 2025

D7710 MAXILLA - OPEN REDUCTION

CDT 2025

Incision required to reduce fracture.

LIMITATIONS This is typically considered for reimbursement through medical insurance.

D7720 MAXILLA - CLOSED REDUCTION

CDT 2025

LIMITATIONS This is typically considered for reimbursement through medical insurance.

D7730 MANDIBLE - OPEN REDUCTION

CDT 2025

Incision required to reduce fracture.

LIMITATIONS This is typically considered for reimbursement through medical insurance.

D7740 MANDIBLE - CLOSED REDUCTION

CDT 2025

LIMITATIONS This is typically considered for reimbursement through medical insurance.

D7750 MALAR AND/OR ZYGOMATIC ARCH - OPEN REDUCTION

CDT 2025

Incision required to reduce fracture.

LIMITATIONS This is typically considered for reimbursement through medical insurance.

D7760 MALAR AND/OR ZYGOMATIC ARCH - CLOSED REDUCTION

CDT 2025

LIMITATIONS This is typically considered for reimbursement through medical insurance.

D7770 ALVEOLUS - OPEN REDUCTION STABILIZATION OF TEETH

CDT 2025

Fractured bone(s) are exposed to mouth or outside the face. Incision required to reduce fracture.

LIMITATIONS This is typically considered for reimbursement through medical insurance.

D7771 ALVEOLUS, CLOSED REDUCTION STABILIZATION OF TEETH CDT 2025

Fractured bone(s) are exposed to mouth or outside the face.

LIMITATIONS This is typically considered for reimbursement through medical insurance.

D7780 FACIAL BONES - COMPLICATED REDUCTION WITH FIXATION AND MULTIPLE APPROACHES CDT 2025

Incision required to reduce fracture. Facial bones include upper and lower jaw, cheek, and bones around eyes, nose, and ears.

LIMITATIONS This is typically considered for reimbursement through medical insurance.

REDUCTION OF DISLOCATION AND MANAGEMENT OF OTHER TEMPOROMANDIBULAR JOINT DYSFUNCTIONS CDT 2025

Procedures that are an integral part of a primary procedure should not be reported separately.

D7810 OPEN REDUCTION OF DISLOCATION CDT 2025

Access to TMJ via surgical opening.

LIMITATIONS This is typically considered for reimbursement through medical insurance.

D7820 CLOSED REDUCTION OF DISLOCATION CDT 2025

Joint manipulated into place; no surgical exposure.

LIMITATIONS This is typically considered for reimbursement through medical insurance.

D7830 MANIPULATION UNDER ANESTHESIA CDT 2025

Usually done under general anesthesia or intravenous sedation.

LIMITATIONS This is typically considered for reimbursement through medical insurance.

D7840 CONDYLECTOMY CDT 2025

Removal of all or portion of the mandibular condyle (separate procedure).

LIMITATIONS This is typically considered for reimbursement through medical insurance.

D7850 SURGICAL DISCECTOMY, WITH/WITHOUT IMPLANT CDT 2025

Excision of the intra-articular disc of a joint.

LIMITATIONS This is typically considered for reimbursement through medical insurance.

D7852 DISC REPAIR

CDT 2025

Repositioning and/or sculpting of disc; repair of perforated posterior attachment.

LIMITATIONS This is typically considered for reimbursement through medical insurance.

D7854 SYNOVECTOMY

CDT 2025

Excision of a portion or all of the synovial membrane of a joint.

LIMITATIONS This is typically considered for reimbursement through medical insurance.

D7856 MYOTOMY

CDT 2025

Cutting of muscle for therapeutic purposes (separate procedure).

LIMITATIONS This is typically considered for reimbursement through medical insurance.

D7858 JOINT RECONSTRUCTION

CDT 2025

Reconstruction of osseous components including or excluding soft tissues of the joint with autogenous, homologous, or alloplastic materials.

LIMITATIONS This is typically considered for reimbursement through medical insurance.

D7860 ARTHROTOMY

CDT 2025

Cutting into joint (separate procedure).

LIMITATIONS This is typically considered for reimbursement through medical insurance.

D7865 ARTHROPLASTY

CDT 2025

Reduction of osseous components of the joint to create a pseudoarthrosis or eliminate an irregular remodeling pattern (osteophytes).

LIMITATIONS This is typically considered for reimbursement through medical insurance.

D7870 ARTHROCENTESIS

CDT 2025

Withdrawal of fluid from a joint space by aspiration.

LIMITATIONS This is typically considered for reimbursement through medical insurance.

D7871 NON-ARTHROSCOPIC LYSIS AND LAVAGE

CDT 2025

Inflow and outflow catheters are placed into the joint space. The joint is lavaged and manipulated as indicated in an effort to release minor adhesions and synovial vacuum phenomenon as well as to remove inflammation products from the joint space.

COMMENTS Non-arthroscopic lysis and lavage is typically used to describe the debridement and irrigation for removal of inflammatory products (scar tissue) from the joint space.

LIMITATIONS D7871 is usually reported to the medical payor and will require an operative report.

D7872 ARTHROSCOPY - DIAGNOSIS, WITH OR WITHOUT BIOPSY

CDT 2025

LIMITATIONS This is typically considered for reimbursement through medical insurance.

D7873 ARTHROSCOPY: LAVAGE AND LYSIS OF ADHESIONS

CDT 2025

Removal of adhesions using the arthroscope and lavage of the joint cavities.

LIMITATIONS This is typically considered for reimbursement through medical insurance.

D7874 ARTHROSCOPY: DISC REPOSITIONING AND STABILIZATION

CDT 2025

Repositioning and stabilization of disc using arthroscopic techniques.

LIMITATIONS This is typically considered for reimbursement through medical insurance.

D7875 ARTHROSCOPY: SYNOVECTOMY

CDT 2025

Removal of inflamed and hyperplastic synovium (partial/complete) via an arthroscopic technique.

LIMITATIONS This is typically considered for reimbursement through medical insurance.

D7876 ARTHROSCOPY: DISCECTOMY

CDT 2025

Removal of disc and remodeled posterior attachment via the arthroscope.

LIMITATIONS This is typically considered for reimbursement through medical insurance.

D7877 ARTHROSCOPY: DEBRIDEMENT

CDT 2025

Removal of pathologic hard and/or soft tissue using the arthroscope.

LIMITATIONS This is typically considered for reimbursement through medical insurance.

D7880 OCCLUSAL ORTHOTIC DEVICE, BY REPORT

Presently includes splints provided for treatment of temporomandibular joint dysfunction.

WARNING

Occlusal orthotic device (D7880) does not describe tooth whitening trays (D9972) or an occlusal guard (D9944, D9945, and D9946). D7880 describes splints used for the treatment of temporomandibular joint disfunction.

WATCH

1. Do not report an occlusal orthotic device (D7880) as an occlusal guard (D9944, D9945, and D9946). D7880 reports a device to alleviate pain/clicking in the jaw joint(s) associated with TMJ dysfunction and typically involves multiple follow up treatment visits. D9944, D9945, and D9946 report an occlusal guard which minimizes the effects of bruxism (grinding) and other occlusal factors.
2. See D9947 for custom sleep apnea appliance fabrication and placement.

COMMENTS

1. D7880 is used to report a TMJ dysfunction treatment device. The majority of general dental plans exclude all diagnostic and treatment of TMJ dysfunction related services.
2. An occlusal splint is considered an "occlusal orthotic device." D7880 is not typically a covered dental benefit. The procedure may be considered for reimbursement through the medical insurance plan. See our *Medical Dental Cross Coding With Confidence* manual at *www.practicebooster.com/store*.
3. An Aqualizer® is a specific type of appliance that can be described using D7880 for the patient that has a documented issue with TMJ.
4. For occlusal orthotic device adjustment see D7881. This could be required if a restoration is placed requiring a subsequent adjustment to the orthotic device or it becomes ill-fitting.
5. For temporomandibular joint dysfunction - non-invasive physical therapies, see D9130.
6. For unspecified TMD therapy, by report, see D7899.

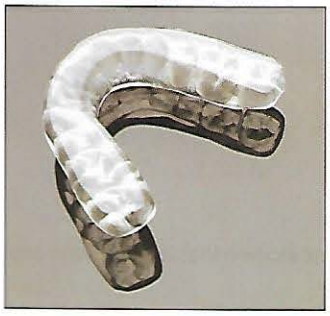
LIMITATIONS

1. Some payors require preauthorization *prior* to treatment of TMJ dysfunction.
2. Some payors maintain that the global fee for occlusal orthotic device (D7880) includes multiple visits and all occlusal adjustments, no matter how many follow up visits are required. Others maintain that six months follow up is in the global fee.
3. If the patient's dental plan includes a separate TMJ rider, D7880 may be reimbursed. The TMJ rider may also cover a complete occlusal adjustment and a removable hard acrylic splint. The TMJ rider may include coverage for an occlusal guard (D9944, D9945, and D9946). If D7880 is a covered benefit through the TMJ rider, reimbursement may have a lifetime maximum and/ or be subject to a deductible. Call the payor to verify specific coverage. Reimbursement is highly variable.

NARRATIVES

1. The narrative should include a description of the signs, symptoms, prognosis of treatment, estimated treatment duration, and type of orthotic device and materials used.
2. The narrative should include the diagnosis i.e., temporomandibular joint dysfunction, and a brief description of the patient's symptoms. "See attached radiographic image(s) and TMJ workup notes and diagnosis."

PHOTO



The appliances used to treat TMJ dysfunction (D7880) and bruxism (D9944, D9945, and D9946) can appear to be similar. The occlusal orthotic device treatment (D7880) would involve a series of occlusal adjustments.

Courtesy Keller Dental Laboratory



This is an example of a device/appliance/splint which could possibly treat temporomandibular joint dysfunction (NTI-tss).

Courtesy Keller Dental Laboratory

D7881 OCCLUSAL ORTHOTIC DEVICE ADJUSTMENT — CDT 2025

WATCH

D7881 does not report adjustments made to the occlusal orthotic device at delivery. Adjustments made within six months of delivery are included in the *global* fee for the occlusal orthotic device, by report (D7880).

COMMENTS

1. D7880/D7881 reports TMJ related treatment and is typically not reimbursed by dental payors. These procedures may be considered for reimbursement through a medical insurance plan. See our *Medical Dental Cross Coding With Confidence* manual at www.practicebooster.com/store.
2. An adjustment to an orthotic device could be required after a new restoration is placed in the mouth for proper fit.

LIMITATIONS

1. Occlusal orthotic device (D7880) reports the delivery of a device to alleviate pain/clicking in the jaw/joint(s) due to TMJ dysfunction. It typically involves multiple follow up visits as part of the overall treatment. Most payors maintain that the global fee for the occlusal orthotic device includes multiple visits and *all* occlusal adjustments, no matter how many follow up visits are required. Some payors have a limitation period of six months following the initial delivery of the device when adjustments are included in the global fee.
2. Reimbursement for TMJ related treatment such as occlusal orthotic device, by report (D7880) and occlusal orthotic device adjustment (D7881) may be available when a dental plan includes a separate TMJ rider, which is not a common rider. If there is a TMJ rider, benefits for the device and any adjustments may have a separate lifetime maximum and/or may be subject to a deductible.

NARRATIVES

1. While D7881 is not a by report procedure, it is suggested to note the initial delivery date of the occlusal orthotic device (D7880) on claims submitted for adjustments.
2. Indicate why the occlusal orthotic device adjustment was necessary.

D7899 UNSPECIFIED TMD THERAPY, BY REPORT — CDT 2025

Used for procedure that is not adequately described by a code. Describe procedure.

REPAIR OF TRAUMATIC WOUNDS — CDT 2025

Excludes closure of surgical incisions.

D7910 SUTURE OF RECENT SMALL WOUNDS UP TO 5 CM — CDT 2025

WATCH

It is improper to use D7910 to report the routine closure of a surgical incision that is *inclusive* in another procedure.

COMMENTS

This code is typically used to describe the repair of a laceration (trauma) and should be reported when closing a wound.

LIMITATIONS

1. Suture of small wounds up to 5 cm (D7910) may be covered under dental benefits, limited to the repair of oral related structures.
2. Suture of recent small wounds may be covered under medical insurance. See our Medical Dental Cross Coding With Confidence manual at www.practicebooster.com/store.

COMPLICATED SUTURING (RECONSTRUCTION REQUIRING DELICATE HANDLING OF TISSUES AND WIDE UNDERMINING FOR METICULOUS CLOSURE) CDT 2025

Excludes closure of surgical incisions.

D7911 COMPLICATED SUTURE - UP TO 5 CM CDT 2025

COMMENTS

This code reports complicated suturing, typically in an emergency setting. This procedure is more complicated than the routine suture of recent small wounds up to 5 cm (D7910). It requires delicate handling and meticulous closure of tissues.

LIMITATIONS

This is typically considered for reimbursement through medical insurance. See our Medical Dental Cross Coding With Confidence manual at www.practicebooster.com/store.

D7912 COMPLICATED SUTURE - GREATER THAN 5 CM CDT 2025

COMMENTS

This code is used to describe complicated suturing, typically in an emergency setting. This procedure is more complicated than either D7910 or D7911. It requires delicate handling and meticulous closure of tissues.

LIMITATIONS

This is typically considered for reimbursement through medical insurance. See our Medical Dental Cross Coding With Confidence manual at www.practicebooster.com/store.

OTHER REPAIR PROCEDURES CDT 2025

D7920 SKIN GRAFT (IDENTIFY DEFECT COVERED, LOCATION AND TYPE OF GRAFT) CDT 2025

LIMITATIONS

This is typically considered for reimbursement through medical insurance. See our Medical Dental Cross Coding With Confidence manual at www.practicebooster.com/store.

D7921 COLLECTION AND APPLICATION OF AUTOLOGOUS BLOOD CONCENTRATE PRODUCT CDT 2025

COMMENTS

1. D7921 reports the utilization of platelet rich plasma (PRP) or platelet rich fibrin (PRF) to enhance the success of sinus grafting, ridge augmentation, osseous integration of implants, some endodontic procedures and some periodontal procedures. It can improve wound healing, tissue regeneration and can help augment bone graft procedures.
2. The patient's blood is drawn and centrifuged to separate and highly concentrate the red blood cells and platelets with growth factors.
3. The autologous blood concentrate product is derived from the patient's own blood, reducing the risk of disease transmission.
4. The time needed to prepare and place platelet rich plasma (PRP) adds only a little additional time to the overall bone graft procedure. Platelet rich fibrin (PRF) membranes are a derivative of platelet rich plasma (PRP).
5. Platelet rich plasma (PRP) and platelet rich fibrin (PRF) are considered specific biologic materials that are considered a specific biologic material and is best reported using D7921. See also D4265 biologic materials to aid in soft and osseous tissue regeneration, per site.

LIMITATIONS

1. D7921 is not generally reimbursed.
2. Some policies with an implant rider may reimburse D7921.

D7922 PLACEMENT OF INTRA-SOCKET BIOLOGICAL DRESSING TO AID IN HEMOSTASIS OR CLOT STABILIZATION, PER SITE

CDT 2025

This procedure can be performed at time and/or after extraction to aid in hemostasis. The socket is packed with a hemostatic agent to aid in hemostasis and/or clot stabilization.

COMMENTS

1. D7922 documents and reports the placement of a hemostatic agent (i.e., collagen plug, strips, Gelfoam®, etc.). The hemostatic agent may be placed at the time of extraction or post extraction following extraction of a natural tooth or implant removal. If the material is used for some other reason besides as a hemostatic (I.e. collagen as a barrier membrane), report the code appropriate for that procedure (I.e. resorbable GTR codes D4266, D6106, or D7956).
2. D7922 is reported per site. The appropriate related tooth/site number is entered in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Do not expect reimbursement from dental plans as a payor will consider this *inclusive* to the global fee for the extraction or implant removal.
2. A PPO contract will most likely *disallow* this charge considering this charge inclusive to the global fee for the extraction. Refer to your PPO processing policy manual for this type of contract provision.
3. A dental plan may consider reimbursement if the dentist or billing entity placing the hemostatic agent is not the dentist or billing entity who performed the original extraction.

TIPS

While D7922 is not a by report procedure, it is suggested to include a narrative describing the patient's chief complaint (reason for the visit) and the procedure performed. Include that a different dentist or billing entity placed the hemostatic agent than the dentist or billing entity who performed the extraction, if applicable.

NARRATIVES

1. Include a narrative indicating the reason for the hemostatic agent and date of extraction of natural tooth or implant removal.
2. The narrative should indicate that a different dentist or billing entity placed the hemostatic agent than the dentist or billing entity who originally performed the extraction.

D7939 INDEXING FOR OSTEOTOMY USING DYNAMIC ROBOTIC ASSISTED OR DYNAMIC NAVIGATION

CDT 2025

A guide is stabilized to the teeth and/or the bone to allow for virtual guidance of osteotomy.



WARNING

Do not report D7939 when performing implant placement that is not robotic assisted or dynamic navigated. See D6190 radiographic/surgical implant index, by report for specifics.



MATCH

D7939 describes the placement of a guide to allow for robotic-assisted or dynamic navigation-guided surgery, including osteotomy and implant placement.

COMMENTS

1. The guide is normally fixed on the arch in an area other than the area receiving the surgery.
2. This type of surgery is considered dynamic, not static, as when performing traditional implant placement through a prefabricated guide or stent.
3. Yomi® is the first FDA cleared robot assisted surgery system.
4. Enter the tooth number(s) or range of teeth where implants are being placed in the appropriate boxes of the 2024 ADA Dental Claim Form.

NARRATIVES Describe the area receiving the surgery and the area of the guide's placement.

D7940 OSTEOPLASTY - FOR ORTHOGNATHIC DEFORMITIES CDT 2025

Reconstruction of jaws for correction of congenital, developmental or acquired traumatic or surgical deformity.

LIMITATIONS This is typically considered for reimbursement through medical insurance. See our *Medical Dental Cross Coding With Confidence* manual at *www.practicebooster.com/store*.

D7941 OSTEOTOMY - MANDIBULAR RAMI CDT 2025

LIMITATIONS This is typically considered for reimbursement through medical insurance. See our *Medical Dental Cross Coding With Confidence* manual at *www.practicebooster.com/store*.

D7943 OSTEOTOMY - MANDIBULAR RAMI WITH BONE GRAFT; INCLUDES OBTAINING THE GRAFT CDT 2025

LIMITATIONS This is typically considered for reimbursement through medical insurance. See our *Medical Dental Cross Coding With Confidence* manual at *www.practicebooster.com/store*.

D7944 OSTEOTOMY - SEGMENTED OR SUBAPICAL CDT 2025

Report by range of tooth numbers within segment.

COMMENTS

1. An osteotomy involves the surgical sectioning of bone. A segmental osteotomy is used to correct skeletal dental malocclusions that would otherwise be unmanageable with conventional orthodontic care.
2. Enter the tooth number(s) or range of teeth being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS This is typically considered for reimbursement through medical insurance. See our *Medical Dental Cross Coding With Confidence* manual at *www.practicebooster.com/store*.

NARRATIVES Report the range of tooth numbers within the segment sectioned.

D7945 OSTEOTOMY - BODY OF MANDIBLE CDT 2025

Sectioning of lower jaw. This includes exposure, bone cut, fixation, routine wound closure and normal post-operative follow-up care.

LIMITATIONS This is typically considered for reimbursement through medical insurance. See our *Medical Dental Cross Coding With Confidence* manual at *www.practicebooster.com/store*.

D7946 LEFORT I (MAXILLA - TOTAL) CDT 2025

Sectioning of the upper jaw. This includes exposure, bone cuts, downfracture, repositioning, fixation, routine wound closure and normal post-operative follow-up care.

LIMITATIONS This is typically considered for reimbursement through medical insurance. See our *Medical Dental Cross Coding With Confidence* manual at *www.practicebooster.com/store*.

D7947 LEFORT I (MAXILLA - SEGMENTED) CDT 2025

When reporting a surgically assisted palatal expansion without downfracture, this code would entail a reduced service and should be "by report."

LIMITATIONS This is typically considered for reimbursement through medical insurance. See our *Medical Dental Cross Coding With Confidence* manual at www.practicebooster.com/store.

D7948 LEFORT II OR LEFORT III (OSTEOPLASTY OF FACIAL BONES FOR MIDFACE HYPOPLASIA OR RETRUSION) - WITHOUT BONE GRAFT CDT 2025

Sectioning of upper jaw. This includes exposure, bone cuts, downfracture, segmentation of maxilla, repositioning, fixation, routine wound closure and normal post-operative follow-up care.

LIMITATIONS This is typically considered for reimbursement through medical insurance. See our *Medical Dental Cross Coding With Confidence* manual at www.practicebooster.com/store.

D7949 LEFORT II OR LEFORT III - WITH BONE GRAFT CDT 2025

Includes obtaining autografts.

LIMITATIONS This is typically considered for reimbursement through medical insurance. See our *Medical Dental Cross Coding With Confidence* manual at www.practicebooster.com/store.

D7950 OSSEOUS, OSTEOPERIOSTEAL, OR CARTILAGE GRAFT OF THE MANDIBLE OR MAXILLA - AUTOGENOUS OR NONAUTOGENOUS, BY REPORT CDT 2025

This procedure is for ridge augmentation or reconstruction to increase height, width and/or volume of residual alveolar ridge. It includes obtaining graft material. Placement of a barrier membrane, if used, should be reported separately.



WARNING

1. This graft procedure *includes* the harvesting of the graft material. Do not report the harvest of bone (D7295) in conjunction with this graft procedure.
2. D7950 does *not* report grafting procedures related to *periodontal* or other *disease conditions*. See D4263/D4264 to describe periodontal grafting procedures associated with periodontally related osseous surgery procedures (tooth related).

WATCH

1. It is an error to report D7950 to describe a "socket graft" in conjunction with an extraction or implant removal. D7950 does not involve an extraction site. The maxillary or mandibular area is edentulous (not a fresh extraction site). See D7953 for further details regarding a routine bone "socket graft" associated with an extraction of a tooth or implant removal for ridge preservation.
2. If there is an extraction, and an implant is immediately placed with a bone graft on the same service date, report the bone graft at time of implant placement (D6104) separately.



MATCH

Placement of a barrier membrane (in addition to the graft procedure) should be reported as a separate procedure. See the guided tissue regeneration codes (D7956/D7957) for further details on reporting the placement of a barrier membrane in conjunction with a graft. It is inappropriate to report placement of a collagen plug or collagen tape as a barrier membrane. Placement of a collagen plug or collagen tape should be documented and reported using D7922.

COMMENTS

1. The goal for D7950 is to increase the height, width and/or volume of the existing alveolar ridge. D7950 reports a ridge augmentation with a bone graft not associated with an extraction or implant removal performed on the same service date.

2. D7950 is used to report a block graft as well as a particulate graft in an edentulous area of the maxilla or mandible.
3. D7950 is also used to report a ridge split or ridge flip graft in an edentulous area of the maxilla or mandible.
4. Enter the arch being treated in the appropriate box of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. If implant related, this procedure is not a covered dental benefit, unless the policy has an implant rider. Reimbursement is subject to plan limitations.
2. The flap is a part of the ridge augmentation (D7950) procedure and should not be billed separately.

TIPS

Terms you should know:

Allogenic graft - usually freeze dried cells transferred from another human being that are used to repair a defect or supplement a deficiency. Demineralized bone graft products are an example of this (allograft bone material).

Alloplastic - refers to inorganic bone substitute materials used for tissue grafting and augmentation. Hydroxyapatite bone graft is an example of this type of graft (e.g., OsteoGraft®, Bio-oss®, PepGen®, etc.).

Autogenous - a graft taken from one part of a patient's body and transferred to another. Chin, hip, and rib grafts would be examples of an autogenous graft.

Guided tissue regeneration - used to enhance and promote bone growth by placing a barrier membrane D7956/D7957 e.g., Gore-tex®, BioMend®, etc.

NARRATIVES

1. D7950 may possibly be reimbursed for a graft placed in the anterior area to provide support for the pontic of an anterior bridge.
2. It is recommended that a brief narrative be provided to justify the bone graft service associated with the fabrication of an anterior tooth-related bridge.
3. Indicate the arch.

D7951 SINUS AUGMENTATION WITH BONE OR BONE SUBSTITUTES VIA A LATERAL OPEN APPROACH

CDT 2025

The augmentation of the sinus cavity to increase alveolar height for reconstruction of edentulous portions of the maxilla. This procedure is performed via a lateral open approach. This includes obtaining the bone or bone substitutes. Placement of a barrier membrane, if used, should be reported separately.



WARNING

1. This D7951 procedure describes a "sinus lift" via a lateral open approach which *includes* the harvesting of the autograft or obtaining the allograft material. Do not report harvest of bone for use in autogenous grafting procedure (D7295) in conjunction with D7951.
2. An alternate "sinus lift" procedure is achieved via a "vertical approach." D7952 reports the other sinus lift technique which utilizes the vertical approach, also referred to as "punch method" or "bump".



WATCH

1. It is improper to report D7951 for a bone "socket graft" in conjunction with an extraction. D7951 is *not* associated with the preservation of bone after an extraction. A bone socket graft (associated with the extraction) for ridge preservation is reported by D7953.
2. D7951 should not be used to report grafting related to periodontally involved teeth. See D4263 or D4264 to report periodontally related grafting procedures, associated with natural tooth periodontal osseous surgery (D4260 or D4261).



MATCH

Placement of a barrier membrane used in conjunction with sinus augmentation (D7951) should be reported separately. See the guided tissue regeneration codes (D7956/D7957) for further details on reporting the placement of a resorbable or non-resorbable membrane as a separate procedure.

COMMENTS

1. Sinus augmentations (lifts) are used to enhance alveolar height for implant placement within edentulous portions of the maxilla. The procedure includes the harvesting of the bone graft material but does not include a barrier membrane. D7951 reports a sinus augmentation (lift) utilizing a lateral open approach ("window") technique. The flap is included and is not billed separately.
2. The global fee for D7951 includes obtaining the bone (from the patient) or the use of bone substitutes.

TIPS

The sinus augmentation via a lateral open approach procedure is usually not a covered dental benefit unless covered by an implant rider. Reimbursement is limited by the plan's deductibles and annual maximums.

D7952 SINUS AUGMENTATION VIA A VERTICAL APPROACH — CDT 2025

The augmentation of the sinus to increase alveolar height by vertical access through the ridge crest by raising the floor of the sinus and grafting as necessary. This includes obtaining the bone or bone substitutes.



WARNING

1. This D7952 procedure describes a "punch method", "sinus lift", or "bump" via a vertical approach and *includes* the harvesting of the autograft or obtaining the allograft material. Do not report harvest of bone for use in autogenous grafting procedure (D7295) in conjunction with D7952.
2. An alternate "sinus lift" procedure is achieved via a lateral open "window." D7951 reports this technique utilizing a lateral open approach.



WATCH

1. It is wrong to report D7952 for a bone "socket graft" in conjunction with an extraction. D7952 is *not* associated with the preservation of bone after an extraction. A bone socket graft (associated with the extraction) for ridge preservation is described by D7953.
2. D7952 should not be used to report grafting related to periodontally involved teeth. See D4263 or D4264 to report periodontally related grafting procedures associated with periodontal osseous surgery (D4260 or D4261).



MATCH

Placement of a barrier membrane used in conjunction with sinus augmentation (D7952) should be reported separately. See the guided tissue regeneration codes (D7956/D7957) for further details on reporting the placement of a resorbable or non-resorbable barrier membrane as a separate procedure.

COMMENTS

1. Sinus augmentations (lifts) are used to enhance alveolar height for implant placement within edentulous portions of the maxilla. The procedure includes the harvesting of the bone graft material but does not include a barrier membrane (D7956/D7957). D7952 reports a sinus augmentation (lift) utilizing a vertical approach osteotome technique. The flap is included and is not billed separately.
2. The global fee for D7952 includes obtaining the bone (from the patient) or the use of bone substitutes.

TIPS

The sinus augmentation via a vertical approach procedure is usually not a covered dental benefit unless covered by an implant rider. Reimbursement is limited by the plan's deductibles and annual maximums.

D7953 BONE REPLACEMENT GRAFT FOR RIDGE PRESERVATION - PER SITE — CDT 2025

Graft is placed in an extraction or implant removal site at the time of the extraction or removal to preserve ridge integrity (e.g., clinically indicated in preparation for implant reconstruction or where alveolar contour is critical to planned prosthetic reconstruction). Does not include obtaining graft material. Membrane, if used, should be reported separately.



WATCH

1. Bone replacement graft (D7953) is used to describe any type of bone graft placed in a "fresh" *extraction* site or *implant removal site* where there will be healing prior to implant placement on a later service date. *Do not* use periodontal osseous surgery bone replacement grafts codes (D4263 or D4264) to report a bone replacement graft for an *extraction* or *implant removal site*. D4263 or D4264 reports periodontal osseous surgery related bone replacement grafts to stimulate periodontal (around a tooth) regeneration when the disease process has led to a deformity of the bone.

2. D7950 reports the ridge augmentation of an *existing* edentulous ridge (not at a fresh extraction site). A ridge augmentation (D7950) does not describe a bone replacement graft (D7953), which is placed in the fresh socket after an extraction or implant removal.
3. D6104 reports the bone graft placed at the same time as implant placement.
4. This code does not report bone grafting after a third molar removal.
5. Enter the arch and each site being grafted in the appropriate boxes of the 2024 ADA Dental Claim Form.

MATCH

If a membrane is placed, the membrane would be reported separately with a guided tissue regeneration code (D7956/D7957). It is inappropriate to report placement of a collagen plug or collagen tape as a barrier membrane. Placement of a collagen plug or collagen tape should be documented and reported using D7922.

COMMENTS

1. The extraction of a tooth often results in loss of alveolar ridge volume. Significant bone loss can hinder and complicate the placement of an implant and/or compromise the function and esthetics of a fixed partial denture. A bone graft for ridge preservation preserves the ideal anatomy of the extraction site. D7953 is reported when performing a socket preservation graft at the time of the extraction or implant removal. D7953 does not include obtaining graft material. Guided tissue regeneration barriers (D7956) or (D7957) or biologic materials (D4265), when placed are reported separately.
2. If an implant rider *is* available, a bone replacement graft may be reimbursed for anterior *or* posterior teeth. Reimbursement is subject to the need and benefit availability. Reimbursement for this procedure is inconsistent. Some payors may require the bone graft be done on the same service date as the implant placement. It is recommended that the payor be contacted for specific coverage information/limitations prior to providing this treatment for the patient.

LIMITATIONS

1. The procedure is not typically reimbursed unless an implant rider is available. The reimbursement is subject to the plan's limitations.
2. If no implant rider is available, D7953 will usually not be reimbursed for a bone replacement graft for *posterior* teeth as it is associated with an implant.
3. For anterior teeth, a benefit may be reimbursed as the procedure may benefit a conventional bridge. If so, a brief narrative should be included documenting the necessity of the bone graft. Pre-operative photos and radiographic images should also be included.

TIPS

1. The material cost of grafts varies widely. The fee charged should be the actual material cost of the graft plus a "labor" charge to place the graft.
2. Terms you should know:

   Allogenic graft - usually freeze dried cells from another human being that are used to repair a defect or supplement a deficiency. Demineralized bone graft products are an example of this (allograft bone material).

   Alloplastic - refers to inorganic bone substitute materials used for tissue grafting and augmentation. Hydroxyapatite bone graft is an example of this type of graft (e.g., OsteoGraft®, Bio-oss®, PepGen®, etc.).

   Autogenous - a graft taken from one part of a patient's body and transferred to another. Chin, hip, and rib grafts would be examples of an autogenous graft.

   Guided tissue regeneration - used to enhance and promote bone growth by placing a barrier membrane D7956/D7957, e.g., Gore-tex®, BioMend®, etc.

D7955 REPAIR OF MAXILLOFACIAL SOFT AND/OR HARD TISSUE DEFECT — CDT 2025

Reconstruction of surgical, traumatic, or congenital defects of the facial bones, including the mandible, may utilize graft materials in conjunction with soft tissue procedures to repair and restore the facial bones to form and function. This does not include obtaining the graft and these procedures may require multiple surgical approaches. This procedure does not include edentulous maxilla and mandibular reconstruction for prosthetic considerations.

WARNING

Do not use this code to describe the reconstruction and grafting of the edentulous maxilla and mandible for prosthetic reasons. See D7950

WATCH

1. Do not report the repair of maxillofacial soft and/or hard tissue defect (D7955) for a bone "socket graft" in conjunction with an *extraction* for ridge preservation. D7955 *does not* pertain to a fresh extraction site. See bone replacement graft for ridge preservation - per site (D7953) for further details.
2. D7955 *does not* describe ridge augmentation. For ridge augmentation in an edentulous area to increase height, width and/or volume, see D7950.
3. Any type of bone graft may be used for D7955. The global fee for D7955 does not include obtaining the graft. The harvesting of bone (D7295) would be reported separately, in addition to D7955.

COMMENTS

1. The descriptor clarifies that D7955 should not be used to report ridge augmentation in preparation for an implant or prosthesis. D7955 is typically billed to the patient's medical plan and is used to describe the repair of residual defects resulting from resection of tumors, defects related to traumatic injuries, or congenital defects that limit the form or function of the facial bones. This procedure may be used to describe situations where the repair involves the treatment of a defect found anywhere in the facial bones. See our *Medical Dental Cross Coding With Confidence* manual at www.practicebooster.com/store.
2. Enter the arch being treated in the appropriate box of the 2024 ADA Dental Claim Form.

D7956 GUIDED TISSUE REGENERATION, EDENTULOUS AREA - RESORBABLE BARRIER, PER SITE

CDT 2025

This procedure does not include flap entry and closure, or, when indicated, wound debridement, osseous contouring, bone replacement grafts, and placement of biologic materials to aid in osseous regeneration. This procedure may be used for ridge augmentation, sinus lift procedures, and after tooth extraction.

WARNING

It is inappropriate to report placement of a collagen plug or collagen tape by reporting D7956. For placement of a collagen plug or collagen tape, see D7922.

WATCH

This procedure reports placing a resorbable barrier membrane for bone regeneration in edentulous areas, including surgical procedures such as ridge augmentation or sinus lifts which require barrier membranes. The resorbable barrier membrane could also be used when a tooth is extracted and bone socket grafting is necessary for ridge preservation.

MATCH

1. For guided tissue regeneration in an edentulous area using a non-resorbable barrier, see D7957.
2. For guided tissue generation around an implant using a resorbable barrier, see D6106.
3. For guided tissue regeneration around a natural tooth using a resorbable membrane, see D4266.

COMMENTS

1. This type of barrier membrane is resorbable and does not require a second surgery for removal.
2. A bone graft is not always required when a barrier membrane is used. Some regeneration techniques encourage bone regrowth without the need for a bone graft.
3. D7956 globally includes any follow up associated with this procedure.
4. Other procedures may be performed with D7956 and should be reported separately using their unique codes. These may include D4265, D7950, D7951, D7952, and D7953.
5. Enter the tooth number(s) or range of teeth where the membrane is being placed in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Resorbable barrier membranes should be reported separately when placed in concert with biologic materials (D4265) or bone grafts (D7950, D7951, D7952, and D7953). Some contracts stipulate that only one regenerative procedure will be paid per infrabony defect. For example, a bone graft may be paid following implant related surgery but the biologic materials (D4265) denied.
2. D7956, when provided in conjunction with sinus augmentation (D7951 or D7952), ridge augmentation (D7950) or bone replacement graft for ridge preservation (D7953) may not be reimbursed when associated with an implant.
3. There typically is a 24-to-36-month exclusion period for the delivery of the same procedure to treat the same area of the mouth.

D7957 GUIDED TISSUE REGENERATION, EDENTULOUS AREA - NON-RESORBABLE BARRIER, PER SITE

CDT 2025

This procedure does not include flap entry and closure, or, when indicated, wound debridement, osseous contouring, bone replacement grafts, and placement of biologic materials to aid in osseous regeneration. This procedure may be used for ridge augmentation, sinus lift procedures, and after tooth extraction.



WARNING

It is inappropriate to report placement of a collagen plug or collagen tape by reporting D7957. Placement of a collagen plug or collagen tape, see D7922.



WATCH

This procedure reports placing a *non-resorbable* barrier membrane for bone regeneration in *edentulous* areas, including when surgical procedures such as ridge augmentation or sinus lifts require barrier membranes. The non-resorbable barrier membrane could also be used when a tooth is extracted and bone grafting is necessary for ridge preservation.



MATCH

1. For guided tissue regeneration around an *implant* using a non-resorbable barrier, see D6107.
2. For guided tissue generation around a natural tooth with non-resorbable barrier (osseous surgery), see D4267.
3. For guided tissue regeneration, endentulous area - resorbable barrier, see D7956.
4. For the removal of the non-resorbable barrier, see D4286.

COMMENTS

1. The non-resorbable barrier membrane requires a second-stage surgery for removal (see D4286).
2. A bone graft is not always required when a barrier membrane is used. Some regeneration techniques encourage bone regrowth without the need for a bone graft.
3. Other procedures may be performed with D7957 and should be reported separately using their unique codes. These may include D4265, D7950, D7951, D7952, and D7953.
4. Enter the tooth number(s) or range of teeth where the membrane is being placed in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Non-resorbable barrier membranes should be reported separately when placed in concert with biologic materials (D4265) or bone grafts (D7950, D7951, D7952, and D7953). Some contracts stipulate that only one regenerative procedure will be paid per infrabony defect. For example, a bone graft may be paid following osseous surgery but the biologic materials (D4265) denied.
2. D7957, when provided in conjunction with sinus augmentation (D7951 or D7952), ridge augmentation (D7950) or bone replacement graft for ridge preservation (D7953) may not be reimbursed when associated with an implant.
3. There typically is a 24-to-36-month exclusion period for the delivery of the same procedure to treat the same area of the mouth.

D7960 PREVIOUSLY DELETED CODE FRENULECTOMY - ALSO KNOWN AS FRENECTOMY OR FRENOTOMY - SEPARATE PROCEDURE NOT INCIDENTAL TO ANOTHER PROCEDURE

This is a previously deleted code. See D7961 and D7962 for further details.

D7961 BUCCAL / LABIAL FRENECTOMY (FRENULECTOMY) CDT 2025

COMMENTS

1. D7961 can be used to report the excision of a frenum that *restricts the ability to function normally.* D7961 has no age restriction and may be performed using any of several techniques. The frenulum labii inferioris (between the lower lip and gum), and frenulum labii superiorus (between upper gum and lip), may be involved. Sutures may or may not be placed during the frenectomy procedure.
2. Frenectomy, (D7961), may be used to prevent the progression of gingival recession, eliminate large diastemas between teeth, or eliminate interference with a prosthetic appliance. An unusually strong frenum can affect speech and mastication.
3. Enter the arch being treated in the appropriate box of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Frenulectomy (frenectomy or frenotomy) D7961, may be a contract benefit as a stand-alone procedure.
2. Many payors deny D7961 when performed on the same day at the same site as other surgical procedures, such as a gingivectomy, soft tissue graft, periodontal osseous surgery, alveoloplasty, or vestibuloplasty. They consider a frenectomy integral to any of these procedures. Documentation supporting the fact that the doctor performed this separate service, that it required significant effort, and that the procedure was a separate service from any of the above listed surgeries should be contained in the patient's record.

TIPS

D7961 (buccal/labial) often has a lower fee than frenuloplasty (D7963). Frenuloplasty (D7963) is a more complicated procedure with "repositioning of aberrant muscle and z-plasty or other local flap closure." It's not a "clip and snip."

NARRATIVES

While D7961 is not a by report code, it is recommended that a brief narrative should describe arch and the frenum location and the pathological condition it caused which interferes with proper oral development or function. If the frenectomy was associated with another procedure requiring significant effort, so state it.

D7962 LINGUAL FRENECTOMY (FRENULECTOMY) CDT 2025

COMMENTS

1. D7962 can be used to report the excision of a frenum that *restricts the ability to function normally.* D7960 has no age restriction and may be performed using any of several techniques. The frenulum linguae (below the tongue) is involved. Sutures may or may not be placed during the frenectomy procedure.
2. Frenectomy, (D7962), may be used to prevent the progression of gingival recession, eliminate large diastemas between teeth, or eliminate interference with a prosthetic appliance. An unusually strong frenum can affect speech and mastication.
3. Enter the arch being treated in the appropriate box of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Frenulectomy (frenectomy or frenotomy) D7962, may be a contract benefit as a stand-alone procedure.
2. Many payors deny D7962 when performed on the same day at the same site as other surgical procedures, such as a gingivectomy, soft tissue graft, periodontal osseous surgery, alveoloplasty, or vestibuloplasty. They consider a frenectomy integral to any of these procedures. Documentation supporting the fact that the doctor performed this separate service, that it required significant effort, and that the procedure was a separate service from any of the above listed surgeries should be contained in the patient's record.

TIPS

D7962 (lingual) often has a lower payor's fee than frenuloplasty (D7963). Frenuloplasty (D7963) is a more complicated procedure with "repositioning of aberrant muscle and z-plasty or other local flap closure." It's not a "clip and snip."

NARRATIVES

While D7962 is not a by report code, it is recommended that a brief narrative should describe the frenum location and the pathological condition it caused which interferes with proper oral development or function. If the frenectomy was associated with another procedure requiring significant effort, so state it.

D7963 FRENULOPLASTY — CDT 2025

Excision of frenum with accompanying excision or repositioning of aberrant muscle and z-plasty or other local flap closure.

COMMENTS

1. Frenuloplasty (D7963), also known as "Z-plasty," is a more complex procedure than D7961 and D7962. The "Z-plasty" is named as a result of the "Z" shaped incision associated with a frenuloplasty. The frenum is released from the underlying muscle and sutured. A "Z" shaped closure is made. This type of surgical approach is often used in cosmetic surgery and reconstructive surgery. It allows greater flexibility of the skin and underlying structure during the healing process.
2. Enter the arch being treated in the appropriate box of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. It should also be noted that many payors deny frenuloplasty (D7963) when performed on the same day in the same site area as other surgical procedures, such as a gingivectomy, soft tissue graft, periodontal osseous surgery, alveoloplasty, or vestibuloplasty. Documentation supporting the fact that the doctor performed these services, that they required significant effort, and that the procedure was a separate service should be contained in the patient's record.
2. D7963 is reported as a per site procedure.

TIPS

Frenuloplasty (D7963) may have a higher payor's fee than buccal/labial frenulectomy (D7961) or lingual frenulectomy (D7962). Frenuloplasty (D7963) is a more complicated procedure with "repositioning of aberrant muscle and z-plasty or other local flap closure."

NARRATIVES

While D7963 is not a by report code, it is recommended that a brief narrative should describe the frenum location, the necessity of the excision and repositioning of the aberrant muscle, and local flap closure. If the frenuloplasty was associated with another procedure requiring significant effort, state this in the narrative.

D7970 EXCISION OF HYPERPLASTIC TISSUE - PER ARCH — CDT 2025

COMMENTS

1. D7970 is used to describe the removal of an epulis. An epulis is typically caused by an ill-fitting denture. The denture irritates the underlying tissue causing the hyperplasia. The area may be asymptomatic and the size of the epulis and resulting symptoms can increase significantly if not treated. This hyperplastic tissue may affect the fit of the denture. D7970 is used to report the excision of this "flabby" tissue.
2. Hyperplastic gingival tissue may result from orthodontic treatment. D7970 reports the excision of the overgrowth of hyperplastic gingival tissue around the teeth and orthodontic appliances. This hyperplastic tissue may be excised before or after the removal of the orthodontic appliances. The claim form question, "Is this for orthodontics?" must be answered "yes."
3. Hyperplastic gingival tissue may result from medication.
4. Hyperplastic gingival tissue may be a symptom of poor oral hygiene.
5. Enter the arch being treated in the appropriate box of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Excision of hyperplastic tissue (D7970) may be a covered benefit and subject to policy limitations.
2. D7970 may not be reimbursed if other surgical procedures are performed at the same site on the same service date.

TIPS

In cases of drug related hyperplastic tissue, (such as with Dilantin®, etc.) submit a narrative. Identify the arch. If drug related, the procedure may be reimbursed under the patient's medical insurance. See our *Medical Dental Cross Coding With Confidence* manual at *www.practicebooster.com/store*.

NARRATIVES

While D7970 is not a by report code, the narrative should identify the specific arch when reporting D7970. This procedure is reported on a "per arch" basis. Identify if the procedure is due to an ill-fitting denture, orthodontic treatment, medication, or other reasons.

D7971 EXCISION OF PERICORONAL GINGIVA

CDT 2025

Removal of inflammatory or hypertrophied tissues surrounding partially erupted/impacted teeth.



WARNING

1. D7971 is only reported in association with *partially* erupted or impacted teeth. Generally D7971 is used to describe the excision of pericoronal gingiva in the child or young adult cutting a first, second, or third molar. In addition, D7971 could report cutting a "facial window" on erupting central or lateral incisors in a young child.
2. Do not report D7971 for routine soft tissue management of a fully erupted tooth associated with an amalgam or composite restorations or crown preparation. See gingivectomy to allow for restorative access (D4212) for further details.

WATCH

Do not report a gingivectomy (D4210 or D4211) when excising periocoronal gingiva (D7971) of a partially erupted tooth. Gingivectomy is associated with a fully *erupted tooth* and periodontal issues while excision of pericoronal gingiva is associated with *partially erupted/impacted tooth*. Also, do not report D4212 which is a gingivectomy or gingivoplasty to allow access for a restorative procedure per tooth. This procedure (D7971) is performed on a fully erupted tooth. Gingivectomy (D4210 or D4211) is a *periodontal* procedure (removing pockets) associated with a fully erupted tooth, while D4212 is for restorative access.

COMMENTS

1. Report D7971 for "removing inflamed or thickened tissue" around a partially erupted or impacted primary or permanent tooth. D7971 may also report an operculectomy (removal of a mucosal flap that partially or completely covers a partially erupted/impacted tooth).
2. For exposure of an unerupted tooth that is impacted, see D7280.
3. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

A partially erupted tooth with surrounding inflamed or hypertrophied tissue may require access for a restoration (sealant/composite/amalgam). If performed on the same service date as the restoration, D7971 may be considered a part of the restoration and not reimbursed.

TIPS

The excision of pericoronal gingiva (D7971) on previous service date with the restorative procedure on a subsequent restorative service date will improve reimbursement odds.

NARRATIVES

While D7971 is not a by report code, it is recommended that a brief narrative should identify the tooth number and explain why the procedure was necessary.

D7972 SURGICAL REDUCTION OF FIBROUS TUBEROSITY

CDT 2025

COMMENTS

1. D7972 is used to describe pre-prosthetic surgery where fibrous tissue creates an unstable base to support a removable complete denture or a removable partial denture or where the tuberosity is so large that there is inadequate space between the tuberosity and the opposing arch for the prosthesis.
2. Enter the quadrant being treated in the appropriate box of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. Surgical reduction of fibrous tuberosity (D7972) may be reimbursed if necessary for the success of the prosthetic appliance. If reimbursed, the procedure is subject to a once per lifetime limitation for the same treatment location.
2. D7972 may be considered a part of a gingivectomy (D4210 or D4211) or periodontal osseous surgery (D4260 or D4261) when performed in the same area on the same date.

NARRATIVES

While D7972 is not a by report code, it is recommended that a narrative should identify the quadrant and explain the necessity of the pre-prosthetic surgery. Describe how the fibrous tuberosity is creating an unstable base or how it may interfere with the delivery of a removable complete denture or a removable partial denture.

D7979 NON - SURGICAL SIALOLITHOTOMY CDT 2025

A sialolith is removed from the gland or ductal portion of the gland without surgical incision into the gland or the duct of the gland; for example via manual manipulation, ductal dilation, or any other non-surgical method.



WATCH

For a *surgical* sialolithotomy, see D7980.

COMMENTS

1. D7979 describes the non-surgical removal of a salivary calculus.
2. The non-surgical removal of a salivary calculus is generally accomplished by "milking" the sialolith out of the occluded duct via manual manipulation.

LIMITATIONS This is typically considered for reimbursement through medical insurance.

NARRATIVES Photos of the area and a short description of the service as well as a description of the patient's symptoms are recommended.

D7980 SURGICAL SIALOLITHOTOMY CDT 2025

Procedure by which a stone within a salivary gland or its duct is removed, either intra-orally or extra-orally.

COMMENTS For a *non-surgical* sialolithotomy, see D7979.

LIMITATIONS This is typically considered for reimbursement through medical insurance. See our *Medical Dental Cross Coding With Confidence* manual at *www.practicebooster.com/store*.

D7981 EXCISION OF SALIVARY GLAND, BY REPORT CDT 2025

LIMITATIONS This is typically considered for reimbursement through medical insurance. See our *Medical Dental Cross Coding With Confidence* manual at *www.practicebooster.com/store*.

D7982 SIALODOCHOPLASTY CDT 2025

Procedure for the repair of a defect and/or restoration of a portion of a salivary gland duct.

LIMITATIONS This is typically considered for reimbursement through medical insurance. See our *Medical Dental Cross Coding With Confidence* manual at *www.practicebooster.com/store*.

D7983 CLOSURE OF SALIVARY FISTULA CDT 2025

Closure of an opening between a salivary duct and/or gland and the cutaneous surface, or an opening into the oral cavity through other than the normal anatomic pathway.

LIMITATIONS This is typically considered for reimbursement through medical insurance. See our *Medical Dental Cross Coding With Confidence* manual at *www.practicebooster.com/store*.

D7990 EMERGENCY TRACHEOTOMY — CDT 2025

Formation of a tracheal opening usually below the cricoid cartilage to allow for respiratory exchange.

LIMITATIONS This is typically considered for reimbursement through medical insurance. See our *Medical Dental Cross Coding With Confidence* manual at *www.practicebooster.com/store*.

D7991 CORONOIDECTOMY — CDT 2025

Removal of the coronoid process of the mandible.

LIMITATIONS This is typically considered for reimbursement through medical insurance. See our *Medical Dental Cross Coding With Confidence* manual at *www.practicebooster.com/store*.

D7993 SURGICAL PLACEMENT OF CRANIOFACIAL IMPLANT- EXTRA ORAL — CDT 2025

Surgical placement of a craniofacial implant to aid in retention of an auricular, nasal, or orbital prosthesis.



WATCH For placement of an intra-oral endosteal implant, see D6010.

COMMENTS

1. D7993 is a surgical placement of a craniofacial implant extraorally to retain an extra oral prosthesis. Extra oral craniofacial implants are often placed in patients with extra oral defects from head and neck cancer, head and neck trauma or congenital disorder. This procedure as part of the total rehabilitation helps patients return to a more normal life.
2. The guide for impalnt placement may be reported separately with D6190, when applicable.

LIMITATIONS A dental plan may exclude reimbursement for D7993 but may be submitted to the patient's medical plan for reimbursement consideration, in some cases.

D7994 SURGICAL PLACEMENT: ZYGOMATIC IMPLANT — CDT 2025

An implant placed in the zygomatic bone and exiting through the maxillary mucosal tissue providing support and attachment of a maxillary dental prosthesis.

COMMENTS

1. Patients with severe atrophy of the maxilla may require placement of two implants into the zygomatic bone and two endosteal implants placed in the anterior region of the maxilla. The zygomatic implants would be reported using D7994 and the endosteal implants would be reported using D6010.
2. An implant guide/index may be reported separately with D6190, when applicable.

LIMITATIONS D7994 may be considered for reimbursement when the plan includes an implant rider. Other limitations may apply, when implants are a covered benefit.

TIPS D7994 reports surgical placement of a single zygomatic implant; therefore in instances where more than one implant of the same type is placed, the procedure code is appropriately entered once in Box 29 with the appropriate quantity entered in Box 29b of the 2024 ADA Dental Claim Form. The fee for placement of multiple zygomatic implants during the same encounter, is the total of fees for each zygomatic implant placement.

NARRATIVES While D7994 is not a by report code, it is recommended that a clinical note should include the amount of atrophy necessitating D7994.

D7995 SYNTHETIC GRAFT - MANDIBLE OR FACIAL BONES, BY REPORT — CDT 2025

Includes allogenic material.

LIMITATIONS This is typically considered for reimbursement through medical insurance. See our *Medical Dental Cross Coding With Confidence* manual at *www.practicebooster.com/store*.

D7996 IMPLANT-MANDIBLE FOR AUGMENTATION PURPOSES (EXCLUDING ALVEOLAR RIDGE), BY REPORT — CDT 2025

LIMITATIONS This is typically considered for reimbursement through medical insurance. See our *Medical Dental Cross Coding With Confidence* manual at *www.practicebooster.com/store*.

D7997 APPLIANCE REMOVAL (NOT BY DENTIST WHO PLACED APPLIANCE), INCLUDES REMOVAL OF ARCH BAR — CDT 2025



WATCH

1. D7997 appliance removal (not by dentist who placed appliance) reports the removal of an arch bar or other appliances, which were placed as a part of a surgical procedure.
2. D7997 *does not* describe the removal of active *orthodontic appliances*. Report D8695 for the removal of fixed orthodontic appliances for reasons other than completion of treatment.

COMMENTS

1. D7997 reports the removal of surgical stabilization devices by providers other than the one that placed the device. While it states that this includes removal of arch bar, it is not limited to arch bar removal. It would be appropriate to report in other cases, for example the removal of a splint placed for trauma related subluxation of teeth (not orthodontic retention or periodontal splinting).
2. Removal of appliances by the same dentist who placed them is considered an integral part of the original procedure and is not reported separately.
3. Enter the arch being treated in the appropriate box of the 2024 ADA Dental Claim Form.

LIMITATIONS Do not expect reimbursement.

D7998 INTRA-ORAL PLACEMENT OF A FIXATION DEVICE NOT IN CONJUNCTION WITH A FRACTURE — CDT 2025

The placement of intermaxillary fixation appliance for documented medically accepted treatments not in association with fractures.

COMMENTS

1. D7998 reports the intra-oral placement of a fixation device not in conjunction with the treatment of a fracture.
2. Do not use this code to describe tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth (D7270) or tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization) (D7272). Any fixation provided with D7998 is considered to be a part of the procedure.
3. D7998 includes a device used for stabilization of the TMJ during a CT scan.

LIMITATIONS This may be considered for reimbursement through medical insurance. See our *Medical Dental Cross Coding With Confidence* manual at *www.practicebooster.com/store*.

D7999 UNSPECIFIED ORAL SURGERY PROCEDURE, BY REPORT CDT 2025

Used for procedure that is not adequately described by a code. Describe procedure.



WATCH

1. D7999 may be used to describe the *unintended* partial extraction of a tooth, with referral to oral surgeon for removal of the remaining root fragment and may be reported as D7999.
2. Biopsy in conjunction with apicoectomy or periradicular surgery procedures should be reported as D7999. The biopsy descriptors for D7285 and D7286 prohibit its use with procedures reported for apicoectomy.
3. See D7251 for an *intentional* partial removal of an impacted tooth's crown or coronectomy. D7251 applies to situations where when a neurovascular complication is likely if the entire *impacted* tooth is removed.

It is important to have a clear understanding of orthodontic coding requirements to minimize coding errors. Comprehensive orthodontics includes a coordinated diagnosis, which could include, but not be limited to, a cephalometric radiographic image with analysis, photographs, and diagnostic casts.

Additionally, comprehensive orthodontics includes treatment of the entire mouth that leads to the improvement of a patient's craniofacial dysfunction and/or dentofacial deformity which may include anatomical, functional and/or esthetic relationships. The treatment should result in a functional and ideal occlusion to create a class I molar/canine relationship. If the orthodontic treatment being provided does not meet this goal of comprehensive orthodontics from both the diagnostic and treatment aspects, consider reporting limited orthodontic treatment.

D8040 reports limited orthodontic treatment of the adult dentition. Limited treatment might include the treatment of one arch and/or segments of both arches, closing open spaces, crossbite correction or uprighting a tooth for a fixed partial denture, etc. D8030 or D8040 may be used to report a case where the treatment is limited in scope or where the entire dentition may not be engaged. Because limited orthodontic treatment does not involve the entire dentition, PPO fees are typically less than fees offered for treatment of a comprehensive case. Refer to page 436 for additional information regarding adult comprehensive orthodontic treatment (D8090).

Receiving payment for orthodontic claims can be challenging because each insurance payor has its own way of structuring payments. With orthodontic claims in particular, it is essential to contact the payor directly to find out its payment schedule, limitations, and restrictions. Some make monthly payments while others pay quarterly. Some will not pay unless monthly claims are submitted, while others automatically remit monthly or quarterly payments once they approve the initial claim. Once the patient's dental plan describes how they structure their orthodontic payments, create a spreadsheet or a tickler file to keep track of how each plan pays claims.

As an example, one plan will pay 50% of its allowable fee when orthodontic treatment begins, another 25% five months later, and the remaining 25% as a final payment six months later. Regardless of how many months the patient will be in treatment, this plan pays off its portion within 12 months. This is just an example of how one major payor structures its orthodontic payments. There are as many variations as there are payors, which is why it is so important to know up front how each patient's plan is structured before initiating treatment.

Submitting each component of orthodontic records (e.g., D0330, D0340, D0350, D0470) (separately) up-front can not only increase the cash flow for your practice, it may also act as an early indication to the provider on exactly how the case will be paid. Some payors will reimburse records in addition to the typical lifetime maximum orthodontic benefits. Others consider the records payment to be part of the lifetime orthodontic benefit.

Note: the question arises - how do I code Invisalign® type cases when treating both arches? The CDT 2025 Coding Companion Training Guide for the Dental Team answers this question on page 348, question and answer# 3.

"3. What code should be used to report treatment using clear aligners?

> Treatments using clear aligner therapy would be the same codes that would be used for a treatment utilizing orthodontic brackets. Code selection is dependent on the nature of the treatment (limited or comprehensive) and the stage of dental development, rather than the type of appliance used."
>
> Source CDT 2025 Coding Companion Training Guide for the Dental Team, page 348.
>
> Therefore, according to the 2025 Coding Companion, D8090 would be reported for an adult case where the entire dentition is being addressed and treated.

Is This for Orthodontics?"

The 2024 ADA Dental Claim Form Box 40 must be checked "yes" when reporting any orthodontic related treatment related to orthodontics. Box 40 contains the question, "Is this for orthodontics?" Most software programs, by default, answer this "no" for routine claims. It is an error to answer "no" if the service is in fact orthodontic related treatment. For example, an orthodontist may send a treatment request to the general dentist requesting a routine procedure be performed as it relates to the orthodontic treatment plan.

This applies to all orthodontic codes contained in this section of CDT (D8000 - D8999) and any other treatment performed related to orthodontics. Some common examples of related treatment are but not limited to ortho records procedures such as panoramic radiographs (D0330), study models (D0470), photos (D0350) and 2D Cephalometric radiographic image (D0340), extraction of first permanent premolars, discing, frenectomy, etc.

Reimbursement for any service when performed related to orthodontics, may be applied toward the "lifetime orthodontic benefit," which typically ranges anywhere from $1,000 to $2,000. However, this is plan specific and can vary greatly. Some plans may consider reimbursement for routine dental procedures related to the orthodontic treatment under the general dental benefits, while some do not. It is improper to not disclose to the payor that the treatment provided is for orthodontic procedures as this could result in inappropriate reimbursement of benefits. The treating doctor is responsible for all information submitted on the claim form and is held accountable.

DENTITION CDT 2025

All of the following orthodontic treatment codes 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.

Primary Dentition: Teeth developed and erupted first in order of time.

Transitional Dentition: The final phase of the transition from primary to adult teeth, in which the deciduous molars and canines are in the process of shedding and the permanent successors are emerging.

Adolescent Dentition: The dentition that is present after the normal loss of primary teeth and prior to cessation of growth that would affect orthodontic treatment.

Adult Dentition: The dentition that is present after the cessation of growth that would affect orthodontic treatment.

LIMITED ORTHODONTIC TREATMENT CDT 2025

Orthodontic treatment with a limited objective utilizing any therapeutic modality with a limited objective or scale of treatment. Treatment may occur in any stage of dental development or dentition.

The objective may be limited by:

- not involving the entire dentition.
- not attempting to address the full scope of the existing or developing orthodontic problem.
- mitigating an aspect of a greater malocclusion (i.e. crossbite, overjet, overbite, arch length, anterior alignment, one phase of multi-phase treatment, treatment prior to the permanent dentition, etc.).
- a decision to defer or forego comprehensive treatment.

D8010 LIMITED ORTHODONTIC TREATMENT OF THE PRIMARY DENTITION CDT 2025

IMPORTANT: See general orthodontic comments located prior to D8000.

When reporting any orthodontic procedure, be sure to check Box 40 of the 2024 ADA Dental Claim Form, "Is this for orthodontics?", as "yes." See author's comments at the beginning of this section.

COMMENTS

1. D8010 reports "limited orthodontic treatment of the primary dentition." Limited treatment might include the treatment of one arch, closing open spaces, correction of a localized crossbite, or uprighting a tooth. It may be directed at the only existing problem, or only one aspect of a larger problem when a decision is made to defer or forego more comprehensive therapy.
2. Note that D8050 - Interceptive orthodontic treatment for the primary dentition is DELETED. Report D8010 going forward.
3. For space maintenance (holding space, no active movement and no prior history of orthodontics), see fixed space maintainers (D1510, D1516, D1517 or D1575) and removable space maintainers (D1520 or D1526/D1527).
4. For retention placed immediately after the conclusion of active treatment, see D8680, if applicable.
5. Report the quadrant and/or arch treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

This procedure is typically reimbursed if there are orthodontic benefits available.

TIPS

Do not "save" the orthodontic lifetime benefits. Bill what you do. Many times the dental insurance benefits change if the parent's employment changes. The change in employment and coverage may reset the lifetime maximum. That new maximum can be applied to subsequent orthodontic treatment.

D8020 LIMITED ORTHODONTIC TREATMENT OF THE TRANSITIONAL DENTITION CDT 2025

IMPORTANT: See general orthodontic comments located prior to D8000.

When reporting any orthodontic procedure, be sure to check Box 40 of the 2024 ADA Dental Claim Form, "Is this for orthodontics?", as "yes." See author's comments at the beginning of this section.

COMMENTS

1. D8020 reports "limited orthodontic treatment of the transitional dentition." Limited treatment might include the treatment of one arch, closing open spaces, correction of a localized crossbite, or uprighting a tooth. It may be directed at the only existing problem, or only one aspect of a larger problem about which a decision is made to defer or forego more comprehensive therapy.
2. Transitional dentition is a term used to describe the final phase of the transition from primary to permanent teeth in which most primary teeth have been lost or are in the process of shedding and permanent successors are not yet in function (Mosby's Dental Dictionary, © 2008). In other words, the patient has both primary and permanent teeth.
3. Note that D8060 - Interceptive orthodontic treatment of the transitional dentition is DELETED. Report D8020 going forward.
4. For space maintenance (holding space, no active movement and no prior history of orthodontics), see fixed space maintainers (D1510, D1516, D1517 or D1575) and removable space maintainers (D1520 or D1526/D1527).
5. For retention placed immediately after the conclusion of active treatment, see D8680, if applicable.
6. Report the quadrant and/or arch treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

This procedure is typically reimbursed if there are orthodontic benefits available.

TIPS

Do not "save" the orthodontic lifetime benefits. Bill what you do. Many times the dental insurance benefits change if the parent's employment changes. The change in employment and coverage may reset the lifetime maximum. That new maximum (if available) can be applied to subsequent orthodontic treatment.

D8030 LIMITED ORTHODONTIC TREATMENT OF THE ADOLESCENT DENTITION CDT 2025

IMPORTANT: See general orthodontic comments located prior to D8000.

When reporting any orthodontic procedure, be sure to check Box 40 of the 2024 ADA Dental Claim Form, "Is this for orthodontics?", as "yes." See author's comments at the beginning of this section.



MATCH

D8030 may be used to report a Reveal®, ClearCorrect®, SLX Clear Aligners®, SureSmile®,3M Clarity, Six Month Smiles®, Smart Moves®, Inman Aligner™, ClearControl® or Invisalign® case where the treatment is limited in scope.

COMMENTS

1. D8030 reports "limited orthodontic treatment of the adolescent dentition." Limited treatment might include the treatment of one arch or an arch segment, closing open spaces, correction of a localized crossbite, or uprighting a tooth. It may be directed at the only existing problem, or only one aspect of a larger problem about which a decision is made to defer or forego more comprehensive therapy.
2. With the adolescent dentition (all permanent teeth erupted or erupting after the normal loss of primary teeth), the mandible and maxilla are still growing such that it would affect orthodontic treatment.
3. For space maintenance (holding space, no active movement and no prior history of orthodontics), see fixed space maintainers (D1510, D1516, D1517 or D1575) and removable space maintainers (D1520 or D1526/D1527).
4. For retention placed immediately after the conclusion of active treatment, see D8680, if applicable.
5. For clear aligners, if the entire adolescent dentition is addressed, report D8080.
6. Report the quadrant and/or arch treated in the appropriate boxes of the 2024 ADA Dental Claim Form

LIMITATIONS

This procedure is typically reimbursed if there are orthodontic benefits available.

TIPS

Do not "save" the orthodontic lifetime benefit. Many times the dental insurance benefits change if the parent's employment changes. The change in employment and coverage may reset the lifetime maximum. That new maximum can be applied to subsequent orthodontic treatment.

PHOTO



This is an example of a clear aligner.

D8040 LIMITED ORTHODONTIC TREATMENT OF THE ADULT DENTITION CDT 2025

IMPORTANT: See general orthodontic comments located prior to D8000.

When reporting any orthodontic procedure, be sure to check Box 40 of the 2024 ADA Dental Claim Form, "Is this for orthodontics?", as "yes." See author's comments at the beginning of this section.

MATCH

D8040 may be used to report a Reveal®, ClearCorrect®, SLX Clear Aligners®, SureSmile®,3M Clarity, Six Month Smiles®, Smart Moves®, Inman Aligner™, Clear Control® or Invisalign® case or one that is limited in scope.

COMMENTS

1. D8040 reports "limited orthodontic treatment of the adult dentition." Limited treatment might include the treatment of one or two arches or an arch segment, closing open spaces, correction of a localized crossbite, or uprighting a tooth for a (fixed partial denture). It may be directed at the only existing problem, or only one aspect of a larger problem about which a decision is made to defer or forego more comprehensive therapy.
2. With the adult dentition, all maxillary and mandibular teeth are fully erupted and all growth has ceased that would affect orthodontic treatment.
3. For space maintenance (holding space, no active movement and no prior history of orthodontics), see fixed space maintainers (D1510, D1516, D1517 or D1575) and removable space maintainers (D1520 or D1526/D1527).
4. For retention placed immediately after the conclusion of active treatment, see D8680, if applicable.
5. PPO fees are considerably lower for D8040 versus D8090.
6. For clear aligners, if the entire adult dentition is addressed, see D8090.
7. Report the quadrant and/or arch treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

This procedure is typically reimbursed if there are orthodontic benefits available.

TIPS

Do not "save" the orthodontic lifetime benefit. Many times the dental insurance benefits change if the adult's employment changes. The change in employment and coverage may reset the lifetime maximum. That new maximum (if available) can be applied to subsequent orthodontic treatment.

PHOTO



This is an example of a clear aligner.

PREVIOUSLY DELETED INTERCEPTIVE ORTHODONTIC TREATMENT - SUBCATEGORY

D8050 PREVIOUSLY DELETED CODE INTERCEPTIVE ORTHODONTIC TREATMENT OF THE PRIMARY DENTITION

This is a previously deleted code. See D8010 for further details. Also read the revised Limited Orthodontic Treatment subcategory.

D8060 PREVIOUSLY DELETED CODE INTERCEPTIVE ORTHODONTIC TREATMENT OF THE TRANSITIONAL DENTITION

This is a previously deleted code. See D8020 for further details. Also read the revised Limited Orthodontic Treatment subcategory.

COMPREHENSIVE ORTHODONTIC TREATMENT CDT 2025

Comprehensive orthodontic care includes a coordinated diagnosis and treatment leading to the improvement of a patient's craniofacial dysfunction and/or dentofacial deformity which may include anatomical, functional and/or esthetic relationships.

Treatment may utilize fixed and/or removable orthodontic appliances and may also include functional and/or orthopedic appliances in growing and non-growing patients.

Adjunctive procedures to facilitate care may be required. Comprehensive orthodontics may incorporate treatment phases focusing on specific objectives at various stages of dentofacial development.

D8070 COMPREHENSIVE ORTHODONTIC TREATMENT OF THE TRANSITIONAL DENTITION CDT 2025

IMPORTANT: See general orthodontic comments located prior to D8000.

When reporting any orthodontic procedure, be sure to check Box 40 of the 2024 ADA Dental Claim Form, "Is this for orthodontics?", as "yes." See author's comments at the beginning of this section.

COMMENTS

1. D8070 reports "comprehensive orthodontic treatment of the transitional dentition." It may be considered "Phase I" of continuing comprehensive treatment. Basically, comprehensive orthodontic treatment is often started with the transitional dentition if the treatment plan is comprehensive.
2. The ADA Glossary of Dental Clinical Terms states that transitional dentition "Refers to a mixed dentition; begins with the appearance of the permanent first molars and ends with the exfoliation of the deciduous teeth." (ADA.org) In other words, the patient has both primary and permanent teeth.
3. Comprehensive orthodontic treatment always involves both the upper and lower arches. But, all teeth do not necessarily need to be banded for a case to be considered comprehensive. For example, the second molars may not need to be banded, but the end result of a comprehensive case involves the proper alignment and function of all teeth in both arches.
4. None of CDT's orthodontic treatment codes specify that orthodontic brackets or bands are required. In other words, orthodontic cases using traditional orthodontic brackets and wires are coded the same as orthodontic cases using a series of removable appliances. D8070 may be used to report treatment with clear aligners.
5. There is no standard that establishes how long active treatment must last for a case to be considered comprehensive. More complex cases typically take longer than simpler cases. Typically, the cost of orthodontic treatment varies depending on the complexity of the case and the length of active treatment. Likewise, most third party payors adjust their payments based on the provider's anticipated length of active treatment, prior to retention.

LIMITATIONS

This procedure is typically reimbursed if there are orthodontic benefits available.

TIPS

Do not "save" the orthodontic lifetime benefits. Many times the dental insurance benefits change if the parent's employment changes. The change in employment and coverage may reset the lifetime maximum. That new maximum (if available) can be applied to subsequent orthodontic treatment.

NARRATIVES

The initial claim should include an identification of the occlusion type (I, II, III), overall charge, banding fee (typically 1/3-1/2 of the total fee), the estimated number of months in treatment, and the remaining monthly charge.

D8080 COMPREHENSIVE ORTHODONTIC TREATMENT OF THE ADOLESCENT DENTITION

CDT 2025

IMPORTANT: See general orthodontic comments located prior to D8000.

When reporting any orthodontic procedure, be sure to check Box 40 of the 2024 ADA Dental Claim Form, "Is this for orthodontics?", as "yes." See author's comments at the beginning of this section.

COMMENTS

1. D8080 reports "comprehensive orthodontic treatment of the adolescent dentition." It may be considered "Phase I" of continuing comprehensive treatment. Basically, comprehensive orthodontic treatment is often started with the adolescent dentition if the treatment plan is comprehensive.
2. With the adolescent dentition (all permanent teeth erupted with the normal loss of all primary teeth), the mandible and maxilla are still growing and growth that would affect orthodontic treatment is not complete.
3. Comprehensive orthodontic treatment always involves both the upper and lower arches. But, all teeth do not necessarily need to be banded ultimately for a case to be considered comprehensive. For example, the second molars may not need to be banded, but the end result of a comprehensive case involves the proper alignment and function of all teeth in both arches. For clear aligners, if the entire adolescent dentition is addressed, report D8080.
4. None of CDT's orthodontic treatment codes specify that orthodontic brackets or bands are required. In other words, orthodontic cases using traditional orthodontic brackets and wires are coded the same as orthodontic cases using a series of removable appliances.
5. There is no standard that establishes how long active treatment must last for a case to be considered comprehensive. More complex cases typically take longer than simpler cases. Typically, the cost of orthodontic treatment varies depending on the complexity of the case and the length of active treatment. Likewise, most third party payors adjust their payments based on the provider's anticipated length of active treatment, prior to retention.
6. If clear aligner therapy addresses the enitre adolescent dentition, then report D8080, see the general orthodontic comments located prior to D8000.

LIMITATIONS

This procedure is typically reimbursed if there are orthodontic benefits available.

TIPS

Do not "save" the orthodontic lifetime benefit. Many times the dental insurance benefits change if the parent's employment changes. The change in employment and coverage may reset the lifetime maximum. That new maximum (if available) can be applied to subsequent orthodontic treatment.

NARRATIVES

The initial claim should include an identification of the occlusion type (I, II, III), overall charge, banding fee (typically 1/3-1/2 of the total fee), the estimated number of months in treatment, and the remaining monthly charge.

D8090 COMPREHENSIVE ORTHODONTIC TREATMENT OF THE ADULT DENTITION

CDT 2025

IMPORTANT: See general orthodontic comments located prior to D8000.

When reporting any orthodontic procedure, be sure to check Box 40 of the 2024 ADA Dental Claim Form, "Is this for orthodontics?", as "yes." See author's comments at the beginning of this section.

COMMENTS

1. Comprehensive orthodontic treatment always involves both the upper and lower arches. But, all teeth do not necessarily need to be banded ultimately for a case to be considered comprehensive. For example, the second molars may not need to be banded, but the end result of a comprehensive case involves the proper alignment and function of all teeth in both arches. For clear aligners, if the entire adult dentition is addressed, report D8090.

2. When reporting treatment for the adult dentition, the maxillary and mandibular growth is complete before treatment is started.
3. None of CDT's orthodontic treatment codes specify that orthodontic brackets or bands are required. In other words, orthodontic cases using traditional orthodontic brackets and wires are coded the same as orthodontic cases using a series of removable devices.
4. There is no standard that establishes how long active treatment must last for a case to be considered comprehensive. More complex cases typically take longer than simpler cases. Typically, the cost of orthodontic treatment varies depending on the complexity of the case and the length of active treatment. Likewise, most third party payors adjust their payments based on the provider's anticipated length of active treatment, prior to retention.
5. If clear aligner therapy addresses the entire adult dentition, then report D8090. See the general orthodontic comments located prior to D8000.

LIMITATIONS This procedure is typically reimbursed if there are orthodontic benefits available.

TIPS Do not "save" the orthodontic lifetime benefit. Many times the dental insurance benefits change if the adult's employment changes. The change in employment and coverage could possibly reset the lifetime maximum. That new maximum (if available) can be applied to subsequent orthodontic treatment.

NARRATIVES The initial claim should include an identification of the occlusion type (I, II, III), overall charge, banding fee (typically 1/3-1/2 of the total fee), the estimated number of months in treatment, and the remaining monthly charge.

D8091 NEW PROCEDURE COMPREHENSIVE ORTHODONTIC TREATMENT WITH ORTHOGNATHIC SURGERY CDT 2025

Treatment of craniofacial syndromes or orthopedic discrepancies that require multiple phases of orthodontic treatment including monitoring growth and development between active phases of treatment.

IMPORTANT: See general orthodontic comments located prior to D8000.

When reporting any orthodontic procedure, be sure to check Box 40 of the 2024 ADA Dental Claim Form, "Is this for orthodontics?", as "yes." See author's comments at the beginning of this section.

COMMENTS

1. D8091 documents and reports multi-phased comprehensive orthodontic treatment of patients that have craniofacial syndromes. Banding may be necessary pre and post surgery, as well as at varying stages of development.
2. Report D8091 to differentiate various syndromes with a significant craniofacial component requiring multiple phases of orthodontic treatment pre and post-surgery and at varying stages of skeletal and dental development. In the past, treatment of these syndromes were not identified or differentiated by codes D8070/D8080/D8090. Reporting D8091 allows for consideration of the long-term implications of pre and post-surgical cases.
3. To report a periodic orthodontic treatment visit associated with orthognathic surgery, see D8691.

LIMITATIONS Complex orthodontic treatments associated with craniofacial syndromes may best be covered by medical insurance. See our *Medical Dental Cross Coding With Confidence* manual at *www.practicebooster.com/store*.

D8210 REMOVABLE APPLIANCE THERAPY CDT 2025

Removable indicates patient can remove; includes appliances for thumb sucking and tongue thrusting.

IMPORTANT: See general orthodontic comments located prior to D8000.

When reporting any orthodontic procedure, be sure to check Box 40 of the 2024 ADA Dental Claim Form, "Is this for orthodontics?", as "yes." See author's comments at the beginning of this section.

WATCH

1. It is an error to report removable appliance therapy (D8210) for active minor tooth movement using Hawley/springs to correct a crossbite for a child. D8010 and D8020 reports limited treatment. D8210 is used to report removable appliances used to control harmful habits. Habit appliances are not intended to move teeth, but to break a harmful habit.
2. D8210 could report a removable appliance designed to prevent a growth and development related condition created by a harmful habit.
3. D8210 should not be used to report an occlusal guard, occlusal orthotic device, periodontal guard, bite guard, or occlusal splint. See occlusal guard (bruxism) appliance (D9944, D9945, and D9946) and occlusal orthotic device (D7880) regarding a TMJ dysfunction appliance.

COMMENTS

1. Removable appliance therapy (D8210) reports "removable" appliances designed to treat harmful habits such as thumb sucking and tongue thrusting. However, D8210 (removable appliance therapy) is seldom used to treat a thumb sucking habit as the child can remove it.
2. If the appliance does not treat a "harmful habit," consider reporting the appropriate "limited orthodontic treatment" procedures to describe the procedure based on the patient's dentition.
3. Report the quadrant and/or arch treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. This procedure may be reimbursed if there are orthodontic benefits available. The reimbursement is generally made at 50% of the payor's fee and is applied to the orthodontic lifetime maximum (typically ranges anywhere from $1,000-$2,000).
2. Harmful habit appliances may not be covered by some plans with orthodontic coverage.

TIPS

Do not "save" the orthodontic lifetime benefits. Many times the dental insurance benefits change if the parent's employment changes. The change in employment and coverage may reset the lifetime maximum. That new maximum can be applied to subsequent orthodontic treatment.

NARRATIVES

A brief narrative should describe the "harmful habit."

D8220 FIXED APPLIANCE THERAPY CDT 2025

Fixed indicates patient cannot remove appliance; includes appliances for thumb sucking and tongue thrusting.

IMPORTANT: See general orthodontic comments located prior to D8000.

When reporting any orthodontic procedure, be sure to check Box 40 of the 2024 ADA Dental Claim Form, "Is this for orthodontics?", as "yes." See author's comments at the beginning of this section.

WATCH

1. It is an error to report fixed appliance therapy (D8220) for active minor tooth movement. D8220 is used to report a fixed (cemented/bonded) appliance provided to control harmful habits, such as thumb sucking and tongue thrusting. Habit appliances are not intended to move teeth but to break a harmful habit.
2. D8220 reports a fixed appliance designed to prevent a growth and development related condition created by a harmful habit.
3. D8220 should not be used to report an occlusal guard, occlusal orthotic device, periodontal guard, bite guard, or occlusal splint. See occlusal guard (D9944, D9945, and D9946) regarding a bruxism appliance and occlusal orthotic device (D7880) regarding a TMJ dysfunction appliance.

COMMENTS

1. Fixed appliance therapy (D8220) is used to describe a fixed "harmful habit" appliance, i.e., for thumb sucking, tongue thrusting, etc.
2. If the appliance does not treat the "harmful habit," but is an active appliance, consider reporting the appropriate "limited orthodontic treatment" procedure based on the patient's dentition.
3. Report the quadrant and/or arch treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. This procedure is typically reimbursed if there are orthodontic benefits available. The reimbursement is generally made at 50% of the payor's fee and is applied to the orthodontic lifetime maximum (typically ranges anywhere from $1,000-$2,000).
2. Harmful habit appliances may not be covered by some plans with orthodontic coverage.

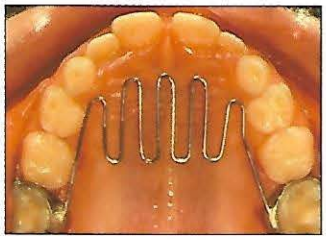
TIPS

Do not "save" the orthodontic lifetime benefits. Many times the dental insurance benefits change if the parent's employment changes. The change in employment and coverage may reset the lifetime maximum. That new maximum (if available) can be applied to subsequent orthodontic treatment.

NARRATIVES

A brief narrative should describe the "harmful habit."

PHOTO



This is a maxillary fixed appliance to control harmful habits.

Courtesy Drake Dental Lab

OTHER ORTHODONTIC SERVICES — CDT 2025

D8660 PRE-ORTHODONTIC TREATMENT EXAMINATION TO MONITOR GROWTH AND DEVELOPMENT — CDT 2025

Periodic observation of patient dentition, at intervals established by the dentist, to determine when orthodontic treatment should begin. Diagnostic procedures are documented separately.

IMPORTANT: When reporting any orthodontic procedure, be sure to check Box 40 of the 2024 ADA Dental Claim Form, "Is this for orthodontics?", as "yes." See author's comments at the beginning of this section.

COMMENTS

1. Pre-orthodontic treatment examination to monitor growth and development (D8660) may be used to report a visit (prior to initiation of active orthodontic treatment) where growth and development of the patient is monitored to determine when active treatment should begin.
2. Case presentation (D9450) could also be reported for presenting an orthodontic case on a subsequent date after a periodic oral evaluation (D0120) or comprehensive oral evaluation (D0150) visit. Typically, there is no charge or reimbursement for D9450.
3. D8660 does not include orthodontic records (D0330, D0340, D0350 and D0470). These records should be reported separately from the case, upfront, before the case begins.

LIMITATIONS

1. Pre-orthodontic treatment examination to monitor growth and development (D8660) is seldom charged to the patient and the courtesy is used as an incentive to treat the case later. The pre-orthodontic treatment examination, if reimbursed, is typically re-mapped to one of the oral evaluation codes and is subject to either the "one evaluation per year" or "two evaluations per year" limitation. Some payors will reimburse a more liberal "three evaluations per year" if an evaluation is done at a different provider's or specialist's office. D8660 may be re-mapped by some payors to some type of oral evaluation (such as D0150 or D0140).
2. The consultation-diagnostic service provided by dentist or physician other than the requesting dentist or physician (D9310) may possibly be reimbursed. To report D9310, there must be a requesting dentist or physician. See D9310 for details.

D8670 PERIODIC ORTHODONTIC TREATMENT VISIT

CDT 2025

IMPORTANT: When reporting any orthodontic procedure, be sure to check Box 40 of the 2024 ADA Dental Claim Form, "Is this for orthodontics?", as "yes." See author's comments at the beginning of this section.

COMMENTS

1. Periodic orthodontic treatment visit (D8670) reports monthly or quarterly active orthodontic treatment adjustments and/or visits. Some payors require the submission of monthly or quarterly claims to disburse payments for ongoing active treatment. Other payors automatically make monthly or quarterly payments.
2. Periodic orthodontic treatment visits (D8670) are often part of the global (case) treatment fee paid by the payor during the course of active orthodontic treatment and are subject to the contract limitations.
3. With clear aligner therapy, D8670 may report progress evaluations and delivery of additional trays.

D8671 NEW PROCEDURE PERIODIC ORTHODONTIC TREATMENT VISIT ASSOCIATED WITH ORTHOGNATHIC SURGERY

CDT 2025

IMPORTANT: See general orthodontic comments located prior to D8000.

When reporting any orthodontic procedure, be sure to check Box 40 of the 2024 ADA Dental Claim Form, "Is this for orthodontics?", as "yes." See author's comments at the beginning of this section.

COMMENTS

1. D8671 documents and reports multi-phased comprehensive orthodontic treatment of patients that have craniofacial syndromes. Banding may be necessary pre and post surgery, as well as at varying stages of development.
2. Code D8671 documents and reports periodic orthodontic treatment visits to evaluate treatment progress, update wires, and evaluate for varying phases of orthodontics in coordination with surgical treatment. In the past, D8670 was used for all periodic orthodontic treatment visits. However, there was no opportunity to distinguish between traditional orthodontic cases and complex craniofacial cases that require surgery. This code allows for identification and differentiation, allowing additional treatment for patients with craniofacial syndromes that require much more complex multi-phase and multi-disciplinary coordination.
3. To report comprehensive orthodontic treatment with orthognathic surgery, see D8091.

LIMITATIONS

Complex orthodontic treatments associated with craniofacial syndromes may best be covered by medical insurance. See our *Medical Dental Cross Coding With Confidence* manual at *www.practicebooster.com/store*.

D8680 ORTHODONTIC RETENTION (REMOVAL OF APPLIANCES, CONSTRUCTION AND PLACEMENT OF RETAINER(S))

CDT 2025

IMPORTANT: When reporting any orthodontic procedure, be sure to check Box 40 of the 2024 ADA Dental Claim Form, "Is this for orthodontics?", as "yes." See author's comments at the beginning of this section.



WATCH

1. D8680 is used to describe orthodontic retention appliances (retainers) delivered immediately after the active orthodontic phase of treatment has been completed. D8680 reports both arches, if applicable.
2. It is an error to report (D7997) for removal of orthodontic appliances. D7997 includes the surgical removal of an arch bar and is an oral surgery code.
3. For the replacement of a lost or broken orthodontic-related retainer previously placed, see D8703, D8704 maxillary/mandibular, respectively.

COMMENTS

1. If a different provider other than the provider who placed the active appliances removes the active appliances, report D8680 and submit a brief narrative describing the retainers placed. D8680 might be reimbursed if the orthodontic lifetime benefits have not been exhausted.
2. D8680 is reported on the claim form once whether retention is placed in one arch or both arches. Indicate the arch(es) treated in Box 25 of the 2024 ADA Dental Claim Form designated by the appropriate two-digit code (e.g., both arches [00], upper arch [01], or lower arch [02]).

LIMITATIONS Orthodontic retention (D8680) is used to describe: Removing braces or other active appliances as well as the fabrication and delivery of removable or fixed orthodontic retainers, or a combination. Most payors consider retention a part of the global orthodontic case fee. Even so, retention may be separately reported.

TIPS If a different provider other than the provider who placed active appliances removes the active appliances, report D8680 and submit a brief narrative describing the retainers placed. D8680 might be reimbursed if the orthodontic lifetime benefits have not been exhausted.

NARRATIVES Indicate that the active orthodontic phase of treatment has been completed. Note the type of retainers placed.

D8681 REMOVABLE ORTHODONTIC RETAINER ADJUSTMENT CDT 2025

IMPORTANT: When reporting any orthodontic procedure, be sure to check Box 40 of the 2024 ADA Dental Claim Form, "Is this for orthodontics?", as "yes." See author's comments at the beginning of this section.

WATCH

D8681 does not report the adjustment of an appliance for a patient currently in active removable appliance therapy. An appliance adjustment for a patient in active removable appliance therapy is typically included in the global fee of the active therapy.

COMMENTS D8681 typically reports the adjustment of an existing removable retainer placed after active treatment is complete and retention placed.

LIMITATIONS D8681 is not typically reimbursed.

TIPS D8681 may be reimbursed if the orthodontic lifetime benefits have not been exhausted or the patient has a new insurance plan with orthodontic benefits.

NARRATIVES If the provider adjusting the retainer did not place the retainer, indicate as such.

D8690 PREVIOUSLY DELETED CODE ORTHODONTIC TREATMENT (ALTERNATIVE BILLING TO A CONTRACT FEE)

This is a previously deleted code. It has not been replaced by a new code.

D8691 PREVIOUSLY DELETED CODE REPAIR OF ORTHODONTIC APPLIANCE

This is a previously deleted code. See D8696 and D8697 for further details.

D8692 PREVIOUSLY DELETED CODE REPLACEMENT OF LOST OR BROKEN RETAINER

This is a previously deleted code. See D8703 and D8704 for further details.

D8693 PREVIOUSLY DELETED CODE RE-CEMENT OR RE-BOND FIXED RETAINER

This is a previously deleted code. See D8698 and D8699 for further details.

D8694 PREVIOUSLY DELETED CODE REPAIR OF FIXED RETAINERS, INCLUDES REATTACHMENT

This is a previously deleted code. See D8701 and D8702 for further details .

D8695 REMOVAL OF FIXED ORTHODONIC APPLIANCES FOR REASONS OTHER THAN COMPLETION OF TREATMENT

CDT 2025

IMPORTANT: When reporting any orthodontic procedure, be sure to check Box 40 of the 2024 ADA Dental Claim Form, "Is this for orthodontics?", as "yes." See author's comments at the beginning of this section.



WARNING

D8695, removal of fixed orthodontic appliances for reasons other than completion of treatment, should not be reported by the current treating dentist when the removal of the oral appliances is a part of the "normal" sequence of treatment or when the appliances are removed at the completion of treatment.



WATCH

D8695, removal of fixed orthodontic appliances for reasons other than completion of treatment, may be reported by a dentist that removes the orthodontic appliances prematurely, other than at the completion of treatment and could be by the dentist who did not provide the orthodontic care. On the other hand, the treating dentist could report D8695 and remove the orthodontic appliances prior to treatment completion.



MATCH

1. D8695, removal of fixed orthodontic appliances for reasons other than completion of treatment, would be reported when a patient has elected to have the appliances removed by a dentist who has provided orthodontic treatment. For instance, going to a special event such as a wedding. A separate fee might be charged.
2. D8695 may also report when a patient discontinues treatment at one provider and goes to another provider to have appliances removed.

LIMITATIONS If the patient has orthodontic coverage and the lifetime plan maximums have not been reached, the removal of the orthodontic appliances may be reimbursed if the appliances are removed by a dentist other than the dentist who provided the orthodontic treatment.

NARRATIVES The narrative should establish the reason for the premature removal of the appliances and indicate that the dentist who removed the appliances is not the dentist that directed treatment. Photos may be helpful in receiving reimbursement.

D8696 REPAIR OF ORTHODONTIC APPLIANCE - MAXILLARY

CDT 2025

Does not include bracket and standard fixed orthodontic appliances. It does include functional appliances and palatal expanders.

IMPORTANT: When reporting any orthodontic procedure, be sure to check Box 40 of the 2024 ADA Dental Claim Form, "Is this for orthodontics?", as "yes." See author's comments at the beginning of this section.

COMMENTS

1. Repair of orthodontic appliance - maxillary (D8696) would include repair of functional appliances and palatal expanders.
2. D8696 does not include the repair of brackets and standard fixed orthodontic appliances.
3. See D8698 for re-bond or re-cement fixed orthodontic retainer - maxillary.
4. See D8701 for repair of fixed retainer, includes reattachment - maxillary.

LIMITATIONS

1. D8696 is not typically reimbursed.
2. Any repair of any appliance during active treatment is generally included in the global orthodontic case fee.

D8697 REPAIR OF ORTHODONTIC APPLIANCE - MANDIBULAR CDT 2025

Does not include bracket and standard fixed orthodontic appliances. It does include functional appliances and palatal expanders.

IMPORTANT: When reporting any orthodontic procedure, be sure to check Box 40 of the 2024 ADA Dental Claim Form, "Is this for orthodontics?", as "yes." See author's comments at the beginning of this section.

COMMENTS

1. Repair of orthodontic appliance - mandibular (D8697) would include repair of functional appliances and palatal expanders.
2. D8697 does not include the repair of brackets and standard fixed orthodontic appliances.
3. See D8699 for re-bond or re-cement fixed orthodontic retainer - mandibular.
4. See D8702 for repair of fixed retainer, includes reattachment - mandibular.

LIMITATIONS

1. D8697 is not typically reimbursed.
2. Any repair of any appliance during active treatment is generally included in the global orthodontic case fee.

D8698 RE-CEMENT OR RE-BOND FIXED RETAINER - MAXILLARY CDT 2025

IMPORTANT: When reporting any orthodontic procedure, be sure to check Box 40 of the 2024 ADA Dental Claim Form, "Is this for orthodontics?", as "yes." See author's comments at the beginning of this section.

COMMENTS

1. D8698 may be used to report the re-cement or re-bond of a fixed maxillary orthodontic retainer, not requiring repair.
2. The fixed retainer (placed after the completion of active orthodontic treatment) may become loose. An example of a fixed retainer is one that connects to the upper permanent canines. A button is cemented to the lingual of each upper canine with a connecting heavy wire that provides retention for the upper anterior teeth position.
3. D8696 is reported when repairing a removable maxillary orthodontic appliance, including retainers. See D8696 for details.
4. D8701 may be reported when repairing a fixed maxillary orthodontic retainer, including reattachment. See D8701 for details.

LIMITATIONS

D8698 is not reimbursed when the lifetime orthodontic maximums have been exhausted and/or if orthodontic coverage is not available.

NARRATIVES

1. Write a brief narrative identifying what was done and why the treatment was necessary.
2. If a different dentist or office, other than the original treating dentist, re-cements or re-bonds the retainer, include this in the narrative.

D8699 RE-CEMENT OR RE-BOND FIXED RETAINER - MANDIBULAR CDT 2025

IMPORTANT: When reporting any orthodontic procedure, be sure to check Box 40 of the 2024 ADA Dental Claim Form, "Is this for orthodontics?", as "yes." See author's comments at the beginning of this section.

COMMENTS

1. D8699 may be used to report the re-cement or re-bond of a fixed mandibular orthodontic retainer, not requiring repair.
2. The fixed retainer (placed after the completion of active orthodontic treatment) may become loose. An example of a fixed retainer is one that connects to the lower permanent canines. A button is cemented to the lingual of each lower canine with a connecting heavy wire that provides retention for the lower anterior teeth position.
3. D8697 is reported when repairing a removable mandibular orthodontic appliance, including retainers. See D8697 for details.
4. D8702 may be reported when repairing a fixed mandibular orthodontic retainer, including reattachment. See D8702 for details

LIMITATIONS

D8699 is not reimbursed when the lifetime orthodontic maximums have been exhausted and/or if orthodontic coverage is not available.

NARRATIVES

1. Write a brief narrative identifying what was done and why the treatment was necessary.
2. If a different dentist or office, other than the original treating dentist, re-cements or re-bonds the retainer, include this in the narrative.

D8701 REPAIR OF FIXED RETAINER, INCLUDES REATTACHMENT - MAXILLARY CDT 2025

IMPORTANT: When reporting any orthodontic procedure, be sure to check Box 40 of the 2024 ADA Dental Claim Form, "Is this for orthodontics?", as "yes." See author's comments at the beginning of this section.

COMMENTS

1. Repair of fixed orthodontic retainer - maxillary (D8701) includes the reattachment/recementation of the repaired maxillary fixed retainer into proper position.
2. The fixed retainer (placed after the completion of active orthodontic treatment for retention) may become broken or damaged. An example of a fixed maxillary retainer is one that connects to the lingual of the upper permanent canines. A bar or wire is cemented to the lingual of the upper six anterior teeth.
3. D8696 may be reported when repairing a removable maxillary orthodontic appliance, including retainers. See D8696 for details.
4. For re-cement or re-bond of a fixed maxillary retainer not requiring a repair, see D8698.

LIMITATIONS

1. D8701 is not typically reimbursed unless there is an orthodontic rider. D8701 is not reimbursed when the lifetime orthodontic maximums have been exhausted and/or if orthodontic coverage is not available.
2. Any repair of an appliance during active treatment is generally included in the global orthodontic case fee.
3. If the maxillary fixed (retention) retainer breaks while the patient is still covered by orthodontic insurance but the lifetime maximum has not been exhausted, then the repair might be reimbursed.

D8702 REPAIR OF FIXED RETAINER, INCLUDES REATTACHMENT - MANDIBULAR CDT 2025

IMPORTANT: When reporting any orthodontic procedure, be sure to check Box 40 of the 2024 ADA Dental Claim Form, "Is this for orthodontics?", as "yes." See author's comments at the beginning of this section.

COMMENTS

1. Repair of fixed orthodontic retainer - mandibular (D8702) includes the reattachment/recementation of the repaired fixed mandibular retainer into proper position.
2. The fixed retainer (placed after the completion of active orthodontic treatment for retention) may become broken or damaged. An example of a fixed mandibular retainer is one that connects to the lingual of the lower permanent canines. A bar or wire is cemented to the lingual of the lower six anterior teeth.
3. D8697 may be reported when repairing a removable mandibular orthodontic appliance, including retainers. See D8697 for details.
4. For re-cement or re-bond of a fixed mandibular retainer not requiring a repair, see D8699.

LIMITATIONS

1. D8702 is not typically reimbursed unless there is an orthodontic rider. D8702 is not reimbursed when the lifetime orthodontic maximums have been exhausted and/or if orthodontic coverage is not available.
2. Any repair of an appliance during active treatment is generally included in the global orthodontic case fee.
3. If the mandibular fixed (retention) retainer breaks while the patient is still covered by orthodontic insurance but the lifetime maximum has not been exhausted, then the repair might be reimbursed.

D8703 REPLACEMENT OF LOST OR BROKEN RETAINER - MAXILLARY CDT 2025

IMPORTANT: When reporting any orthodontic procedure, be sure to check Box 40 of the 2024 ADA Dental Claim Form, "Is this for orthodontics?", as "yes." See author's comments at the beginning of this section.

COMMENTS

1. D8703 is used to describe the "replacement of lost or broken maxillary retainer," previously placed - post-orthodontics. The maxillary retainer replaced can be fixed or removable.
2. The common scenario for reporting D8703 is when the patient has completed orthodontic treatment, had retainers placed, but has lost subsequent contact with the treating orthodontist. Consequently, a general practitioner or another orthodontist subsequently replaces the lost or broken maxillary retainer.
3. For re-bond or re-cement of a fixed maxillary retainer, see D8698.
4. D8681 is used to describe an adjustment made to an existing orthodontic retainer, which is performed after the delivery date of the retainer.

LIMITATIONS

1. D8703 is not typically reimbursed unless part of the lifetime orthodontic maximum remains and the patient still has orthodontic coverage.
2. Reimbursement for lost or broken retainers (fixed or removable) is often excluded under most orthodontic riders.

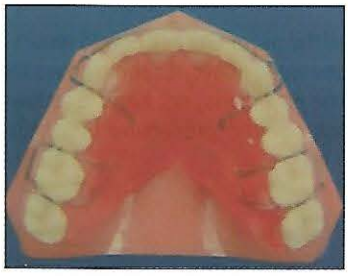
TIPS

The removal of the first retainer and the delivery of the second retainer would not generally be reimbursed unless orthodontic benefits are available when the retainer is removed and the new retainer delivered.

NARRATIVES

Write a brief narrative explaining the reason the retainer was replaced.

PHOTO



This is a replacement appliance (Hawley) for a broken retainer (placed post orthodontics).

Courtesy Space Maintainers Lab

D8704 REPLACEMENT OF LOST OR BROKEN RETAINER - MANDIBULAR CDT 2025

IMPORTANT: When reporting any orthodontic procedure, be sure to check Box 40 of the 2024 ADA Dental Claim Form, "Is this for orthodontics?", as "yes." See author's comments at the beginning of this section.

COMMENTS

1. D8704 is used to describe the "replacement of lost or broken mandibular retainer," previously placed - post-orthodontics. The mandibular retainer replaced can be fixed or removable.
2. The common scenario for reporting D8704 is when the patient has completed orthodontic treatment, had retainers placed, but has lost subsequent contact with the treating orthodontist. Consequently, a general practitioner or another orthodontist subsequently replaces the lost or broken mandibular retainer.
3. For re-bond or re-cement of a fixed mandibular retainer, see D8699.
4. D8681 is used to describe an adjustment made to an existing orthodontic retainer, which is performed after the delivery date of the retainer.

LIMITATIONS

1. D8704 is not typically reimbursed unless part of the lifetime orthodontic maximum remains and the patient still has orthodontic coverage.
2. Reimbursement for lost or broken retainers (fixed or removable) is often excluded under most orthodontic riders.

TIPS

The removal of the first retainer and the delivery of the second retainer would not generally be reimbursed unless orthodontic benefits are available when the retainer is removed and the new retainer delivered.

NARRATIVES

Write a brief narrative explaining the reason the retainer was replaced.

D8999 UNSPECIFIED ORTHODONTIC PROCEDURE, BY REPORT CDT 2025

Used for procedure that is not adequately described by a code. Describe procedure.

IMPORTANT: When reporting any orthodontic procedure, be sure to check Box 40 of the 2024 ADA Dental Claim Form, "Is this for orthodontics?", as "yes." See author's comments at the beginning of this section.

COMMENTS

1. D8999 is used to report a procedure not adequately described by an existing orthodontic code.
2. Unspecified orthodontic procedure, by report (D8999) may be used to describe the following orthodontic related procedures:
   a. Removal of residual bonding "flash" after the debanding appointment. D8999 would be reported as an additional procedure in addition to the prophylaxis by the general practitioner, typically at a recall visit subsequent to orthodontic debanding. See prophylaxis - adult (D1110) for details.
   b. If used, ceramic brackets may be a separate and additional fee.
   c. If used, Reveal®, Invisalign®, or other clear aligners may be a separate and additional fee.
   d. If used, lingual brackets may be a separate and additional fee.

Note: PPO contracts control the fee of an orthodontic case. Call the payor and ask how to report and charge (with the patient's written consent) the "extra fee" for the optional services listed above. In some cases the PPO Processing Policy Manual may give guidance as to "optional services." Some payors may not allow (disallow) the surcharge. PPO contracts generally require ALL services be submitted, even "non-covered" procedures for which there is a charge.

D9110 PALLIATIVE TREATMENT OF DENTAL PAIN - PER VISIT CDT 2025

Treatment that relieves pain but is not curative; services provided do not have distinct procedure codes.

Author's Comments:

It is important to always report "what you do" using the CDT code that best describes the procedure performed. At the emergency or routine visit, there could be several coding options available if the patient reports pain or discomfort. As always, the dentist should determine the current CDT code that best describes overall the context of the procedure and the patient's record must support the D9110 procedure performed and reported.

The information below discusses some procedures that may be performed to alleviate the patient's pain/discomfort at a visit as reported by palliative, D9110. The key concepts of the palliative treatment are that it must:

1. Alleviate a patient's pain or discomfort.
2. Must be initiated by the patient.
3. Not be curative in nature.
4. Not be a definitive procedure that would be more appropriately reported with its own code, as determined by the treating dentist.
5. May or may not be an emergency visit.

Again, it is the dentist who determines the appropriate code to document the service provided. Circumstances and the procedure's extent should be considered when deciding whether to report D9110 or a more definitive procedure code. The patient's record should contain information that supports reporting a definitive v. palliative procedure. As long as the patient's record states the issues of the patient's complaint or discomfort, describes what steps were performed to alleviate the pain/discomfort, and meets the conditions above, then D9110 may be reported at the dentist's discretion.

The insurance industry considers certain procedures "integral" to the procedure and those procedures reported as separate codes may not be reimbursed (re-bonding of an appliance while under active treatment, desensitizing, adjustments, follow-up, treatment of dry socket by the same practitioner, etc.). For instance, desensitizing at the SRP visit or at recall may not be reimbursed, while desensitizing a single "hot tooth" with discomfort at an unrelated area of the mouth may be reimbursed. This may be performed at a routine or emergency visit. Therefore, always provide a truthful narrative with the reporting of D9110. Thus, the payor makes the ultimate reimbursement decision.



WARNING

D9110 is not reported when only writing a prescription. D9110 is reported when the patient is provided treatment in some way to alleviate discomfort. There is no CDT code for writing a prescription. D9999 would be a means to document this action or it may be an integral part of an oral evaluation which is reported separately.

WATCH

1. D9110 is reported on a "per visit" basis *regardless* of the number of palliative procedures rendered on the same service date.
2. Historically, D9110 was only appropriate on an emergency visit and payors typically required no other care be delivered. With the removal of "emergency" in the descriptor, D9110 may now be reported on either an emergency visit or in conjunction with a regularly scheduled appointment provided the patient reports pain or discomfort. It is unknown how payors will treat this change.
3. The palliative (D9110) code is used to report treatment performed to alleviate acute symptoms of pain/discomfort as always requested by the patient at the time of treatment and that is not curative.

4. Palliative (D9110) should not be used to describe an appointed root canal visit with the start of a root canal when measuring length using an apex locator and then starting instrumentation of the canal(s). Opening the tooth and debriding a *portion* of the pulpal tissue (to relieve pain) may be reported by D9110. Report the chief complaint and the treatment provided at the visit in a brief narrative.

   Note: Palliative should not be reported if the procedure delivered could be fully and accurately described using an existing CDT code. It should only be reported if the procedure delivered varies in some way from the distinct CDT codes available or is not described by an existing code. It is at the provider's clinical opinion as to if palliative or a different distinct procedure code should be reported.

COMMENTS

1. Palliative (D9110) should not be used to describe *definitive* treatment (extractions, endodontics, crowns, restorations, surgery, etc.) or procedures that have distinct CDT codes. Palliative could mean to ease symptoms without necessarily curing the underlying disease. But, sometimes a palliative treatment eliminates the problem. For instance, smoothing the edge of a chipped tooth might not require any subsequent treatment at the time. Palliative treatment describes a treatment performed to alleviate the patient's *acute* and/or *spontaneous* complaint/problem that is not curative. The service may be performed at either an emergency visit or any other appointment.
2. The descriptor of the code does not prohibit reporting D9110, palliative treatment, with other treatment, a problem focused oral evaluation (D0140), or other evaluations performed on the same service date. D9110 may be performed on the same date of service as separate, definitive care as long as the services are not related. That said, if current processing polices remain in place, many payors may exclude reimbursement for palliative procedures when other, definitive treatment procedures are reported on the same service date.
3. D9110 is an *underutilized* code. The reporting of D9110 is appropriate for non-definitive procedures that reduce discomfort and/or sensitivity, or relief of acute and/or spontaneous pain. D9110 is appropriate when the *patient* complains of spontaneous discomfort and requests aid.
4. Palliative (D9110) can be reported in *conjunction* with an office visit – after regularly scheduled hours (D9440). The patient would generally be responsible for payment of the after hours visit (D9440) out-of-pocket.
5. Enter the teeth number(s) or range of teeth being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. A problem focused oral evaluation (D0140) is an "evaluation or exam" while palliative (D9110) is "performing" a treatment procedure to alleviate pain/discomfort. Palliative treatment is always *initiated* by the patient whether at an emergency visit or any other visit. The problem focused oral evaluation (D0140) or any other evaluation is generally limited by the "one evaluation per six months" or "two evaluations per year" exclusion. Oral evaluations are *stand-alone* and may be reported in conjunction with D9110. However, some payors will not reimburse an oral evaluation in conjunction with D9110 if performed on the same service date. The payment of an oral evaluation would generally be subject to frequency limitations.
2. Some payors will reimburse palliative (D9110), the problem focused oral evaluation (D0140), and diagnostic pulp tests, i.e., pulp vitality test (D0460) performed on the same service date. However, this is rare.
3. Reimbursement is variable. Palliative (D9110) may be classified as preventive and reimbursed at 100% of the payor's fee or palliative may be considered a basic service and reimbursed at 80% of the payor's fee. In some cases palliative (D9110) may have a deductible applied before reimbursement is forthcoming, but this is uncommon.
4. Palliative (D9110) *should not* be reported *in conjunction* with an office visit for observation (during regularly scheduled hours), D9430. The descriptor of D9430 stipulates that no other services are performed on the same service date.

TIPS

1. Palliative (D9110) and one or two periapical diagnostic radiographic image(s) could be reported for the patient of record who presents with acute pain/discomfort where a non-definitive service is performed. The fee reported for palliative treatment could vary according to the time spent and the complexity of the procedure. The fee charged should be consistent for both non-insured and insured patients under similar circumstances. Local anesthesia related palliative (D9110) procedures could be reported with a higher fee than shorter procedures performed with no anesthesia. However, the payor's fee for palliative is usually a single fixed allowable fee, regardless of the time related to the service.
2. *Periapical radiographic images are often taken in conjunction with the palliative procedure and both codes are generally reimbursed.* Two or three periapical radiographic images may be reimbursed at an emergency visit or in conjunction with a regular, appointed visit if the acute condition is separate from the appointed care. If a single bitewing is reported at the emergency visit, it may affect bitewing reimbursement at the subsequent *recall visit*. Bitewings may be limited to "once a year." *One* bitewing may be subject to the bitewing limitation with some payors. *Periapicals, taken at emergency visits, typically are not associated with the bitewing limitation.* However, periapicals may be subject to a deductible and may be paid at 80% of the payor's fee in some situations.

3. Note that there is no CDT code for only writing a prescription; D9999 would be a means to document this action.
4. *Periapical radiographic images are often taken in conjunction with the palliative procedure and both codes are generally reimbursed.* Two or three periapical radiographic images may be reimbursed at an emergency visit or in conjunction with a regular, appointed visit if the acute condition is separate from the appointed care. If a single bitewing is reported at the emergency visit, it may affect bitewing reimbursement at the subsequent *recall visit*. Bitewings may be limited to "once a year." *One* bitewing may be subject to the bitewing limitation with some payors. *Periapicals, taken at emergency visits, typically are not associated with the bitewing limitation.* However, periapicals may be subject to a deductible and may be paid at 80% of the payor's fee in some situations.
5. Note that there is no CDT code for only writing a prescription; D9999 would be a means to document this action.

NARRATIVES

1. Palliative (D9110) always *requires* a brief narrative in order to receive consistent reimbursement, even though it is not a "by report" code. *Always* submit a narrative, reporting "what you do," with full disclosure regarding the reporting of D9110. *Always* mention the tooth number or area of mouth, if applicable. The narrative, if applicable, should state "patient will return for more definitive treatment." This indicates *definitive* treatment was not performed during the palliative visit. Remember that narratives on the electronic claim should not include more than 80 characters, including punctuation and spaces, to guarantee that the full narrative is received by the payor.
2. Palliative (D9110) must not be a definitive treatment (extraction, restoration, etc.), however, the descriptor of D9110 itself *does not* restrict the delivery of other services performed on the same service date. That said, many plans may exclude reimbursement for palliative procedures when other, definitive treatment procedures are reported on the same service date.
3. The following are possible *palliative* procedures provided to relieve acute and spontaneous pain, discomfort, or sensitivity. These procedures are *initiated* by a complaint from the patient, not at the suggestion of the provider. Note: Palliative should not be reported if the procedure delivered could be fully and accurately described using an existing CDT code. It should only be reported if the procedure delivered varies in some way from the distinct CDT codes available or is not described by an existing code. It is at the provider's clinical opinion as to if palliative or a different distinct procedure code should be reported. Identify the tooth number, if one was treated. Note: Electronic claims software may limit narratives to 80 characters in the "remarks" section of the claim form. If so, shorten the narratives listed below or file with an electronic attachment:
   a. Fractured tooth: "Mesio-buccal cusp of tooth #3 was fractured. The specific area was smoothed for patient comfort." Add "To be followed by subsequent visit," if the situation requires a subsequent visit.
   b. Sensitive tooth: "Gluma was applied to mesio-buccal cusp area to relieve discomfort, tooth #19." Add "To be followed by subsequent visit," if the situation requires a subsequent visit.
   c. Open tooth for relief of pain only, no endo instrumentation sequence initiated: "Acute pain with tooth #3. #3 was opened only to the extent (partial pulpal debridement) for drainage and patient relief. To be followed by subsequent RCT." Full endodontic benefits (when initiated subsequently) typically will remain under this scenario. See pulpal debridement (D3221) for comments regarding referral to an endodontist (another billing office), when a complete pulpal debridement is reported. D3221 may have a higher reimbursement fee than palliative (D9110), however some payors consider D3221 to be a "take back" code if the same office performs the subsequent endodontic treatment.
   d. Temporary placement of IRM for discomfort associated with heat and/or cold: "Patient had sensitivity with tooth #3. Caries was hand excavated (partially) and IRM placed. To be followed by subsequent visit for further evaluation/treatment."
   e. Sensitive individual tooth upon biting: "#6 was adjusted slightly out of occlusion for relief of pain/sensitivity upon biting. To be followed by subsequent visit if applicable." This is not considered by most dentists and payors to be a limited occlusal adjustment since only one tooth was involved with discomfort.
   f. Examine/write prescription in conjunction with minor treatment to relieve discomfort and pain: "Upon biting, tooth #3 was painful. Tooth #3 was adjusted out of occlusion for patient's comfort/relieve bite. Patient will return for further evaluation/treatment." A prescription is written and the patient is to be seen later in the GP office or the patient is referred to a specialist for evaluation/treatment. However, note that D9110 is not to be reported just for writing a prescription. Some type of treatment must actually be performed before D9110 can be reported.
   g. Discomfort with inflammation, heavy calculus buildup, debris: "Patient presented with heavy calculus, debris, and generalized gingival inflammation. Calculus and debris removed from a selected area (partial debridement) for patient comfort, relief, and healing. To be followed by subsequent visit for D4355." If sufficient time is available, consider full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit (D4355). See D4355.

h. Diagnosis at emergency visit: "Patient has previously been seen for pain and diagnosis of tooth #3. Patient was again in pain upon biting, with a tentative diagnosis of cracked tooth syndrome. Tooth taken out of occlusion for diagnostic purposes; to be followed by subsequent visit for a crown if symptoms do not resolve."

i. Anesthetic for acute pain relief: "Patient was in severe pain and long lasting anesthetic was administered for temporary relief. Patient was referred to endodontist for further treatment later in the day."

j. Irrigation or removal of irritants: "Patient was in discomfort due to food impaction in the erupting tooth #18. Area was irrigated to relieve discomfort."

D9120 FIXED PARTIAL DENTURE SECTIONING — CDT 2025

Separation of one or more connections between abutments and/or pontics when some portion of a fixed prosthesis is to remain intact and serviceable following sectioning and extraction or other treatment. Includes all recontouring and polishing of retained portions.

COMMENTS

1. D9120 is used to report the sectioning of a fixed bridge (natural tooth or abutment/implant supported) between the retainer crown (abutment crown) and/or pontic(s). Some portion of the existing fixed bridge is retained.
2. The procedure includes all recontouring and polishing of the remaining retainer crown.
3. An extraction, if done, would be reported *separately* and apart from the D9120 procedure.
4. Enter the teeth number(s) or range of teeth being restored in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. If the sectioning of the fixed bridge is part of a transitional/provisional procedure, D9120 may be considered a part of the global fee for the definitive treatment, and therefore not reimbursed.
2. Some payors include the sectioning of the bridge as part of the extraction fee for a failed retainer crown, if done on the same date of service as the extraction and by the same provider.

NARRATIVES

1. "See attached pre-operative radiographic image."
2. State which part(s) of bridge were removed and which part(s) remained intact, e.g., "removed retainer crown #30 due to caries and pontics #28 and #29. Retainer crown on #27 remains."

D9130 TEMPOROMANDIBULAR JOINT DYSFUNCTION - NON-INVASIVE PHYSICAL THERAPIES — CDT 2025

Therapy including but not limited to massage, diathermy, ultrasound, or cold application to provide relief from muscle spasms, inflammation or pain, intending to improve freedom of motion and joint function. This should be reported on a per session basis.



WARNING

D9130 describes treatment of TMD with non-invasive *physical* therapies. D9130 excludes any treatment that is pharmacological.



MATCH

1. D9130 describes the treatment of temporomandibular joint dysfunction by non-invasive physical therapy modalities.
2. The service is reported on a per session basis.

COMMENTS

The non-invasive treatment of temporomandibular joint disorders may include various modalities of physical therapy, the outcomes of which are pain management and muscle relaxation of the temporomandibular joint and its supporting structures. Examples of modalities used to perform this procedure may include but are not limited to transcutaneous electrical nerve stimulation (e.g., TENS unit) application of cold gel pack, infrared (e.g., treatment using laser technology), manipulation (e.g., chiropractic manipulation for anterior displacement of a disc), etc. While D9130 is broad in terms of how the procedure is performed, this code is selected based on the procedure performed.

LIMITATIONS D9130 generally is not covered by dental plans; however, this type of physical therapy may be covered by the patient's medical carrier. Delivery by a licensed Physical Therapist may be a requirement for reimbursement.

TIPS D9130 would describe scenarios where a patient presents with limited jaw movement and says they are experiencing pain when moving the jaw. The doctor performs an oral evaluation (e.g., D0140 limited oral evaluation - problem focused) and diagnoses that the patient is suffering from temporomandibular joint dysfunction. The doctor presents a conservative treatment plan, starting with non-invasive therapy (e.g., physical manipulation). If non-invasive therapy is not successful, oral appliance or surgical treatment options may be considered.

NARRATIVES The narrative would include a diagnosis of TMD, a description of the non-invasive physical therapy provided, and any images that help to support the diagnosis and treatment of TMD.

ANESTHESIA — CDT 2025

D9210 LOCAL ANESTHESIA NOT IN CONJUNCTION WITH OPERATIVE OR SURGICAL PROCEDURES — CDT 2025

COMMENTS For reversal agent (such as Oraverse®) of local anesthesia, report D9999.

LIMITATIONS

1. Local anesthesia is not generally reimbursed separately from a clinical procedure. See D9215.
2. Local anesthesia may be administered to aid with a definitive *diagnosis* (to identify a pain source). Local anesthesia not in conjunction with operative or surgical procedures (D9210) may be reported for this diagnostic procedure at a regularly scheduled visit.
3. D9210 may be reported in conjunction with a limited oral evaluation - problem focused (D0140) or palliative treatment of dental pain (D9110). Note: There may be frequency limitations applied to D0140. See D0140 and D9110.
4. The administration of a long-lasting anesthesia for pain/discomfort may be reimbursed in certain circumstances. For instance, a GP could administer a long-lasting anesthetic to temporarily relieve pain so an endodontist could see the patient later in the day. See D9110 for particular details.
5. If D9210 is reported, a participating PPO provider may be contractually obligated to write off the additional costs. Most payors include local anesthesia in the global procedure fee of all the procedures where it is normally used.

NARRATIVES

1. If a patient requests local anesthesia in conjunction with a routine prophylaxis, consider reporting D9210 (with narrative) when an extra fee is charged. The anesthesia may be denied, and becomes the patient's responsibility, depending on the PPO provider contract. For non-contracted dentists, D9210 would be the patient's responsibility, if denied. If disallowed by the contracted PPO, then the fee for the procedure must be written off.
2. D9210 may be used to report Oraqix® used prior to prophylaxis (D1110) or SRP (D4341/D4342). However, D9999 is recommended. When using Oraqix®, report D9999 and include a brief note, "Patient requested needle free Oraqix®." If D9210 is reported, EOBs may instruct contracted providers to write off the additional costs. Payors may maintain that any local anesthesia administered is a part of the global fee for the definitive procedure.

D9211 REGIONAL BLOCK ANESTHESIA — CDT 2025

COMMENTS For reversal agent (such as Oraverse®) of local anesthesia, report D9999.

LIMITATIONS Regional block anesthesia (D9211) may be used to report local anesthesia administered to aid in making a diagnosis during a problem focused oral evaluation (D0140) or during a recall evaluation (D0120). Generally, local anesthesia is not reimbursed, but may be reimbursed when necessary to determine a definitive *diagnosis*.

TIPS See palliative D9110 for treatment/diagnosis of acute and spontaneous dental pain as reported by the patient at a visit. Palliative (D9110) is treatment, not an evaluation. See D9110 for particular details.

NARRATIVES Include a brief narrative that indicates the procedure was performed to diagnose the trigger area for spontaneous/acute pain as reported by the patient at a visit.

D9212 TRIGEMINAL DIVISION BLOCK ANESTHESIA

CDT 2025

COMMENTS

For reversal agent (such as Oraverse®) of local anesthesia, report D9999.

LIMITATIONS

Trigeminal division block anesthesia (D9212) may be used to report the local anesthesia administered to aid in making a diagnosis during a problem focused oral evaluation (D0140) or during a recall evaluation (D0120). Generally, local anesthesia is not reimbursed but may be reimbursed when necessary to determine a definitive diagnosis.

TIPS

See palliative (D9110) for treatment/diagnosis of acute and spontaneous dental pain as reported by the patient at a visit. Palliative (D9110) is treatment, not an evaluation. See D9110 for particular details.

NARRATIVES

Include a brief narrative to explain that the procedure was necessary to diagnose the trigger area for spontaneous/acute pain as reported by the patient at a visit.

D9215 LOCAL ANESTHESIA IN CONJUNCTION WITH OPERATIVE OR SURGICAL PROCEDURES

CDT 2025

COMMENTS

For reversal agent (such as Oraverse®) of local anesthesia, report D9999.

LIMITATIONS

Most payors consider local anesthesia (D9215) to be a part of the procedure fee. Note: The descriptors for various operative, endodontic and surgical procedures use the word "usually" as it applies to local anesthesia. These descriptors state that "local anesthesia is usually considered to be a part of the various clinical procedures." Local anesthesia *may* be reported *separately* from the clinical procedure; however, most payors consider local anesthesia an integral part of the *global* procedure." D9215 is rarely reimbursed.

If D9215 is reported, the contracted PPO provider may be obligated to write off the additional costs. Most payors hold that local anesthesia is included in the *global* procedure fee.

TIPS

1. Do not routinely charge a separate fee for local anesthesia.
2. See palliative (D9110) for treatment/diagnosis of acute and spontaneous dental pain at a visit. Treatment must be rendered. See D9110 for particular details.
3. If a patient requests local anesthesia in conjunction with a routine prophylaxis or SRP, consider reporting D9210 (with narrative) if an extra fee is charged. D9210 reports local anesthesia not in conjunction with operative or surgical procedures. The anesthesia may be the patient's responsibility or the provider may be in a contractually obligated PPO to write off the additional costs. See D9210.

D9219 EVALUATION FOR MODERATE SEDATION, DEEP SEDATION OR GENERAL ANESTHESIA

CDT 2025



WARNING

D9219 consists of a review of the patient's current medical history and medication use and NPO status. However, patients with significant medical considerations (e.g., ASA III or IV) may require consultation with their primary care physician or consulting medical specialist. The same guidelines define the term "must" as "indicates an imperative need and/or duty; an essential or indispensable item."

WATCH

Although some payors argue that the pre-anesthesia evaluation is part of the deep sedation/general anesthesia (D9222) procedure, the descriptor for D9222 states that anesthesia begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in continuous attendance of the patient. D9222 does not refer to any evaluation that occurs prior to the administration of the anesthetic. Because of this, the Code Maintenance Committee (CMC) considers this stand-alone evaluation to be separate from the existing deep sedation/general anesthesia procedure codes (D9222/D9223).

COMMENTS

If the anesthesiologist is an independent provider, he/she may not have an established relationship with the patient and would need to spend additional time before the procedure to review the patient's chart and medical history.

LIMITATIONS

Reimbursement for (D9219) will likely be poor.

D9220 PREVIOUSLY DELETED CODE DEEP SEDATION/GENERAL ANESTHESIA - FIRST 30 MINUTES

This is a previously deleted code. See D9222 for further details.

D9221 PREVIOUSLY DELETED CODE DEEP SEDATION/GENERAL ANESTHESIA - EACH ADDITIONAL 15 MINUTES

This is a previously deleted code. See D9223 for further details.

D9222 DEEP SEDATION/GENERAL ANESTHESIA - FIRST 15 MINUTES CDT 2025

Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients or duties.

The level of anesthesia is determined by the anesthesia provider's documentation of the anesthetic effects upon the central nervous system and not dependent upon the route of administration.

WATCH

Report D9222 for the first 15 minutes of deep sedation/general anesthesia. Report D9223 for each subsequent 15 minute increment of deep sedation/general anesthesia. Confirm with the payor and PPO contract/processing policies prior to reporting any increment of less than 15 minutes. Reimbursement for increments of time less than 15 minutes can vary greatly among payors.

COMMENTS

1. The period of anesthesia starts when the doctor begins to administer the anesthetic agent and ends when the doctor may safely leave the room; thus leaving the patient with trained personnel to be monitored during the recovery period.
2. Additional 15 minute increments of deep sedation/general anesthesia should be described using D9223, deep sedation/general anesthesia - each subsequent 15 minute increment.

LIMITATIONS

1. Deep sedation/general anesthesia - first 15 minutes (D9222) may be reimbursed in connection with qualified oral surgery, endodontic, or periodontal surgical procedures. Dental and medical plan limitations relating to sedation vary widely.
2. Payors may require billing the patient's medical plan before submitting the claim to the dental plan.
3. It is common for payors to limit reimbursements to a maximum of 2 hours of general anesthesia.

TIPS

General anesthesia is typically only covered when provided in conjunction with a qualified oral surgery procedure and is medically necessary, not as an elective procedure to make the patient comfortable or the procedure easier for the dentist. Anesthesia records and an anesthesia permit number are typically required.

NARRATIVES

1. Describe the necessity for deep sedation/general anesthesia. A report is required that establishes medical necessity for deep sedation/general anesthesia. Deep sedation, general anesthesia, is reimbursed only when deemed medically necessary. Documentation of medical necessity may include the fact that the patient is handicapped, uncontrollable, or has other qualifying medical or dental conditions, such as:
   a. The removal of bony impacted third molars.
   b. Six or more teeth in various quadrants extracted on the same date of service.
   c. Patients allergic to local anesthetic.
   d. High risk medical patients requiring surgical or multiple extractions.
   e. Patients with cerebral palsy, epilepsy, Down Syndrome, hyperactivity, etc.
   f. Patients under six years of age who require multiple extractions and/or restorations.
   g. Infection causing local anesthesia to be ineffective.
   h. Three or more surgical flaps reflected in a single appointment.

2. Include the general anesthesia permit number on the claim form in the remarks section. Some payors require the permit number.
3. The time for recovery and monitoring by trained personnel, after the doctor has left the room, should not be billed as deep sedation/general anesthesia time.
4. See D9219 to report evaluation for moderate sedation, deep sedation, or general anesthesia.

D9223 DEEP SEDATION/GENERAL ANESTHESIA - EACH SUBSEQUENT 15 MINUTE INCREMENT

CDT 2025



WATCH

D9223 is measured in subsequent 15 minute increments. Confirm with the payor and PPO contract/processing policies prior to reporting any increment of less than 15 minutes. Reimbursement for increments of time less than 15 minutes can vary greatly among payors.

COMMENTS

The period of anesthesia starts when the doctor begins to administer the anesthetic agent and ends when the doctor may safely leave the room, leaving the patient with trained personnel to be monitored during the recovery period.

LIMITATIONS

1. Deep sedation/general anesthesia - each subsequent 15 minute increment (D9223) may be reimbursed in connection with qualified oral surgery, endodontic, or periodontal *surgical* procedures. Dental and medical plan limitations relating to sedation vary widely.
2. Payors may require the patient's medical plan to be billed before submitting the claim to the dental plan
3. It is common for payors to limit reimbursements to two hours of general anesthesia.

TIPS

General anesthesia is typically only covered when provided in conjunction with a qualified oral surgery procedure and is medically necessary, not as an elective procedure to make the patient comfortable or the procedure easier for the dentist. Anesthesia records and an anesthesia permit number are typically required.

NARRATIVES

1. Describe the necessity for deep sedation/general anesthesia. A report is required that establishes medical necessity for deep sedation/general anesthesia. Deep sedation, general anesthesia, is reimbursed only when deemed medically necessary. Documentation of medical necessity may include the fact that the patient is handicapped, uncontrollable, or has other qualifying medical or dental conditions, such as:
   a. The removal of bony impacted third molars.
   b. Six or more teeth in various quadrants extracted on the same date of service.
   c. Patients allergic to local anesthetic.
   d. High risk medical patients requiring surgical or multiple extractions.
   e. Patients with cerebral palsy, epilepsy, Down Syndrome, hyperactivity, etc.
   f. Patients under six years of age who require multiple extractions and/or restorations.
   g. Infection causing local anesthesia to be ineffective.
   h. Three or more surgical flaps reflected in a single appointment.
2. Include the general anesthesia permit number on the claim form in the remarks section. Some payors require the permit number.
3. The time for recovery and monitoring by trained personnel, after the doctor has left the room, should not be billed as deep sedation/general anesthesia time.
4. See D9219 to report evaluation for deep sedation or general anesthesia, separate and apart.

D9230 INHALATION OF NITROUS OXIDE/ANALGESIA, ANXIOLYSIS

CDT 2025

COMMENTS

1. D9230 is used to report the administration of N_2O without regard to the length of administration.
2. Report behavior management in 15 minute increments (D9920) when provided in *addition* to D9230.

LIMITATIONS

1. Nitrous oxide (N_2O) is reported as inhalation of nitrous oxide/analgesia, anxiolysis (D9230). A fee should be charged for N_2O. The fee level could vary according to the length of administration. Nitrous oxide is typically a non-covered service.
2. Some Medicaid plans and a few other programs reimburse nitrous oxide or reimburse behavior management (D9920) as an alternate benefit. Special consideration may be given for more complex treatment visits or for young or phobic patients. Consult your state Medicaid provider manual for details.
3. Most payors will not pay for the administration of nitrous oxide. If administered under an emergency trauma related scenario, request special consideration for management of anxiety.
4. Plan limitations and reimbursement, if any, for D9230 are highly variable.

NARRATIVES

While nitrous oxide may not be a covered benefit, submitting a brief narrative that outlines the extra time for the procedure may result in a higher fee reimbursement for the procedure itself. If administered as part of an operative procedure, submit a brief narrative to support the medical necessity stating, "The patient's level of anxiety and the patient's ability to cooperate made extra time and the administration of N_2O necessary to complete the three surface MOD composite procedure, #J. Please consider reimbursement at a higher fee than for the normal pediatric related procedure." Be sure the clinical notes reflect the medical necessity of the nitrous oxide.

D9239 INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANALGESIA - FIRST 15 MINUTES

CDT 2025

Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients or duties.

The level of anesthesia is determined by the anesthesia provider's documentation of the anesthetic effects upon the central nervous system and not dependent upon the route of administration.



WATCH

IV sedation is measured in 15 minute increments. Report D9239 for the first 15 minutes of intravenous moderate (conscious) sedation/analgesia. Report D9243 for each subsequent 15 minute increment of intravenous moderate (conscious) sedation/analgesia. Confirm with the payor and PPO contract/processing policies prior to reporting any increment of less than 15 minutes. Reimbursement for increments of time less than 15 minutes can vary greatly among payors.

COMMENTS

1. The period of anesthesia starts when the doctor begins to administer the anesthetic agent and ends when the doctor may safely leave the room, leaving the patient with trained personnel to be monitored during the recovery period.
2. Some payors provide reimbursement only for general anesthesia, but not IV sedation. If reimbursed, anesthesia records and an anesthesia permit number are typically required and must be noted on the claim, in the remarks section, to qualify for reimbursement of D9239/D9243.
3. Report D9239 for the first 15 minutes of IV sedation and D9243 for each subsequent 15 minute increment. Confirm with the payor and PPO contract/processing policies prior to reporting any increment of less than 15 minutes. Reimbursement for increments of time less than 15 minutes can vary greatly among payors.

LIMITATIONS

1. Intravenous moderate (conscious) sedation/analgesia - first 15 minutes (D9239) may be reimbursed when provided with certain oral surgery, endodontic, or periodontal surgery procedures. Dental and medical plan limitations related to IV sedation are highly variable.
2. Payors may require billing the patient's medical plan before submitting the claim to the dental plan. See our *Medical Dental Cross Coding With Confidence* manual at *www.practicebooster.com/store*..

TIPS

While some plans consider reimbursement for IV sedation in conjunction with qualifying oral surgery procedures, coverage for IV sedation varies widely among dental plans. Plans may reimburse D9239 and D9243 if two or more teeth are extracted at a single visit. Other plans may require the extraction of eight or more teeth at a single visit before IV sedation will be considered for reimbursement. D9239 and D9243 may be reimbursed for periodontal surgery procedures under some dental plans.

Although IV sedation is not a "by report" procedure, it may be helpful to note if the patient is allergic to local anesthesia, has a severe infection, is less than 6 years old, or is medically impaired or compromised. An anesthesia report should be included. If reimbursement is not available under the dental plan, IV sedation may be covered by the patient's medical plan, in some circumstances. If the dental procedure being performed is a covered benefit of the medical plan, then IV sedation may be covered by the medical plan. In addition, if the patient's medical condition meets the criteria necessitating IV sedation, then a benefit may be available. For example, a child with severe intellectual disabilities, etc. may receive benefit for IV sedation from the medical plan. Always verify coverage with the medical payor prior to treatment. A medical preauthorization may be required for reimbursement. Medical benefits are always primary to any dental benefits.

NARRATIVES

1. Describe the need for intravenous moderate (conscious) sedation/analgesia. Deep sedation, general anesthesia, and intravenous moderate (conscious) sedation are reimbursed only when deemed medically necessary. Documentation of need may include the fact that the patient is handicapped, uncontrollable, or has other qualifying medical or dental conditions, such as:
   a. The removal of bony impacted third molars.
   b. Six or more teeth in various quadrants extracted on the same date of service.
   c. Patients allergic to local anesthetic.
   d. High risk medical patients requiring surgical or multiple extractions.
   e. Patients with cerebral palsy, epilepsy, Down Syndrome, hyperactivity, etc.
   f. Patients under 6 years of age who require multiple extractions and/or restorations.
   g. Infection causing local anesthesia to be ineffective.
   h. Three or more surgical flaps reflected in a single appointment.
2. Include the anesthesia permit number on the claim form in the remarks section. Some payors require the permit number.
3. The time for recovery and monitoring after the doctor has left the room by trained personnel should not be billed as IV sedation.

D9241 PREVIOUSLY DELETED CODE INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANALGESIA - FIRST 30 MINUTES

This is a previously deleted code. See D9239 for further details.

D9242 PREVIOUSLY DELETED CODE INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANALGESIA - EACH ADDITIONAL 15 MINUTES

This is a previously deleted code. See D9243 for further details.

D9243 INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANALGESIA EACH SUBSEQUENT 15 MINUTE INCREMENT

CDT 2025

WATCH

IV sedation is measured in subsequent 15 minute increments. Confirm with the payor and PPO contract/processing policies prior to reporting any increment of less than 15 minutes. Reimbursement for increments of time less than 15 minutes can vary greatly among payors.

COMMENTS

1. The period of anesthesia starts when the doctor begins to administer the anesthetic agent and ends when the doctor may safely leave the room; thus leaving the patient with trained personnel to be monitored during the recovery period.
2. Some payors provide reimbursement only for general anesthesia, but not IV sedation. If reimbursed, anesthesia records and an anesthesia permit number are typically required and must be noted on the claim in the remarks section, to qualify for reimbursement of D9239/D9243.

3. Report D9243 for each subsequent 15 minute increment. Confirm with the payor and PPO contract/processing policies prior to reporting any increment of less than 15 minutes. Reimbursement for increments of time less than 15 minutes can vary greatly among payors.

LIMITATIONS

1. Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment (D9243) may be reimbursed when provided with certain oral surgery, endodontic, or periodontal surgery procedures. Dental and medical plan limitations related to sedation are highly variable.
2. Payors may require that the patient's medical plan be billed before submitting the claim to the dental plan. See our *Medical Dental Cross Coding With Confidence* manual at *www.practicebooster.com/store*.

NARRATIVES

1. *Describe* the need for intravenous moderate (conscious) sedation/analgesia. Deep sedation, general anesthesia, and intravenous moderate (conscious) sedation are reimbursed only when deemed medically necessary. Documentation of need may include the fact that the patient is handicapped, uncontrollable, or has other qualifying medical or dental conditions, such as:
   a. The removal of bony impacted third molars.
   b. Six or more teeth in various quadrants extracted on the same date of service.
   c. Patients allergic to local anesthetic.
   d. High risk medical patients requiring surgical or multiple extractions.
   e. Patients with cerebral palsy, epilepsy, Down Syndrome, hyperactivity, etc.
   f. Patients under six years of age who require multiple extractions and/or restorations.
   g. Infection causing local anesthesia to be ineffective.
   h. Three or more surgical flaps reflected in a single appointment.
2. Include the anesthesia permit number on the claim form in the remarks section. Some payors require the permit number.
3. The time for recovery and monitoring after the doctor has left the room by trained personnel should not be billed as IV sedation.

ADDITIONAL INFORMATION

While some plans consider reimbursement for IV sedation in conjunction with qualifying oral surgery procedures, coverage for IV sedation varies widely among dental plans. Plans may reimburse D9243 if two or more teeth are extracted at a single visit. Other plans may require the extraction of eight or more teeth at a single visit before IV sedation will be considered for reimbursement. D9243 may be reimbursed for periodontal surgery procedures under some dental plans.

Although D9243 is not a "by report" procedure, it may be helpful to note if the patient is allergic to local anesthesia, has a severe infection, is less than six years old, or is medically impaired or compromised. An anesthesia report should be included. If reimbursement is not available under the dental plan, IV sedation may be covered by the patient's medical plan, in some circumstances. If the dental procedure being performed is a covered benefit of the medical plan then IV sedation may be covered by the medical plan. In addition, if the patient's medical condition meets the criteria necessitating IV sedation then a benefit may be available. For example, a child with severe intellectual disabilities, etc. may receive benefit for IV sedation from the medical plan. Always verify coverage with the medical payor prior to treatment. A medical preauthorization may be required for reimbursement. Medical benefits are always primary to any dental benefits.

D9248 NON-INTRAVENOUS CONSCIOUS SEDATION CDT 2025

This includes non-IV minimal and moderate sedation.

A medically controlled state of depressed consciousness while maintaining the patient's airway, protective reflexes and the ability to respond to stimulation or verbal commands. It includes non-intravenous administration of sedative and/or analgesic agent(s) and appropriate monitoring.

The level of anesthesia is determined by the anesthesia provider's documentation of the anesthetic's effects upon the central nervous system and not dependent upon the route of administration.

COMMENTS

1. D9248 is reported when performing non-intravenous conscious sedation (D9248). This includes non-IV minimal and moderate sedation. The duration of sedation does not affect billing. D9248 is billed per treatment session, just like nitrous oxide ($N_2$0).
2. Non-intravenous conscious sedation (oral and by injection) reports administration and *monitoring* of sedation with agents such as Valium®, Ativan®, Halcion®, and chloral hydrate. Thus, it can include liquid, tablets and intramuscular injection of sedative (e.g., Ketamine®).

LIMITATIONS

1. D9248 may occasionally be reimbursed when administered with qualifying oral surgery, endodontic, or periodontal *surgical* procedures. Dental and medical plan limitations for D9248 are highly variable. Dental plans may require a medical claim be submitted prior to a dental claim. See our *Medical Dental Cross Coding With Confidence* manual at *www.practicebooster.com/store*..
2. Non-intravenous conscious sedation (D9248) is typically a non-covered service. Certain Medicaid or other programs may reimburse D9248 or reimburse behavior management (D9920) as an alternate benefit. Consult the state's Medicaid Processing Policy manual for details. Reimbursement for D9248 is highly variable.

NARRATIVES

1. A report is required that outlines the reasons why non-intravenous conscious sedation is necessary. Reasons that may justify the administration of non-intravenous conscious sedation might include the treatment of a handicapped patient, or one that has mitigating medical problems, has multiple impactions, is less than six years old, etc. A brief narrative should include a copy of the doctor's conscious sedation certificate with the claim.
2. While non-intravenous conscious sedation may not be a covered benefit, writing a narrative that outlines the extra time and effort expended to provide the procedure may result in a higher reimbursement for the procedure. Submit a narrative that describes why the extra time for the procedure was needed. The request may result in a higher fee reimbursement for the procedure itself. Submit a narrative with the restorative procedure stating, "The patient's level of anxiety and the patient's ability to cooperate made extra time and the administration of non-intravenous conscious sedation was necessary to complete the three surface MOD composite procedure, #J. Please consider reimbursement at a higher fee than for the normal pediatric related procedure."

PROFESSIONAL CONSULTATION — CDT 2025

D9310 CONSULTATION - DIAGNOSTIC SERVICE PROVIDED BY DENTIST OR PHYSICIAN OTHER THAN REQUESTING DENTIST OR PHYSICIAN — CDT 2025

A patient encounter with a practitioner whose opinion or advice regarding evaluation and/or management of a specific problem; may be requested by another practitioner or appropriate source. The consultation includes an oral evaluation. The consulted practitioner may initiate diagnostic and/or therapeutic services.



WATCH

1. It is an error to report a consultation (D9310) for treatment plan presentations. Report case presentation (D9450) to describe a treatment plan presentation given subsequently after the comprehensive oral evaluation (D0150/D0180). See D9450.
2. D9310 would be reported by a consulting doctor, when rendering an opinion, to whom the patient has been referred. D9310 requires a requesting dentist, physician, or other appropriate medical source. The doctor who renders the second opinion may or may not provide the clinical treatment. The consulting dentist (often a specialist but not required) may initiate *diagnostic* and/or *therapeutic services. D9310 includes an oral evaluation.* Any dentist can report D9310 under the required circumstances.
3. The general practitioner should consider reporting D0140 or D0150/D0180 when the patient (not a physician or dentist) requests a self-referred second opinion. The general practitioner may report a problem focused evaluation (D0140) or comprehensive evaluation (D0150/D0180) for the patient who requested a second opinion depending on the elements of the evaluation.

COMMENTS

1. D9310 should only be reported if the doctor is giving an *opinion or advice* for a patient specifically referred by a physician, dentist, or other appropriate medical source. The consulting dentist may initiate *diagnostic* and/or *therapeutic* services under D9310. This code always includes an oral evaluation related to the specific request for the opinion or advice. The specialist should consider reporting the consultation (D9310) code for second opinions. The doctor providing the consultation should send (and maintain a copy of) written communication to the referring dentist or physician about his/her findings during the consultation.

2. A general practitioner who has a self-referred *new* patient presenting for a second opinion with a *complete treatment plan* from a previous dentist should report a comprehensive oral evaluation (D0150/D0180). If the *new* patient requests a consultation regarding a *single* or limited service (example: evaluating a front tooth for a crown), the general practitioner should consider reporting a limited oral evaluation - problem focused (D0140).

LIMITATIONS

1. D9310 may not be reimbursed by certain payors. The reimbursement for D9310, if paid, is typically higher than the comprehensive oral evaluation (D0150/D0180).
2. Some payors consider the consultation an *alternate b*enefit to an oral evaluation and will reimburse the consultation subject to the typical "one evaluation per year" or "two evaluations per year" limitation. Some payors reimburse a "third" evaluation performed in a different office if the third evaluation is performed by a specialist. Coverage is plan specific.
3. If the consultation (D9310) is directed toward a non-covered procedure (for instance, TMJ dysfunction or implants), the consultation may not be reimbursed.
4. D9310 is not reimbursed on the same service date with the same provider in conjunction with a comprehensive oral evaluation (exam) (D0150/D0180). The consultation code (D9310) *includes* an oral evaluation.
5. If D9310 is denied as a non-covered benefit, then submit an appeal and ask for an alternate benefit of D0120, D0150, D0160, or D0180 as may apply.

TIPS

1. If the purpose of the visit is for a case presentation subsequent to the comprehensive evaluation (D0150/D0180), report case presentation (D9450), not consultation (D9310).
2. If the purpose of the visit is to give a second opinion, at the patient's request - not at the request of a dentist or physician, report oral evaluation, problem focused D0140 for a particular patient complaint or report D0150/D0180 (comprehensive evaluation) for a general second opinion. The *self-referred* patient is classified as a new patient and the appropriate comprehensive oral evaluation is reported, *not a* consultation (D9310) which specifically requires a referral from a dentist, physician, or another appropriate source.

D9311 CONSULTATION WITH A MEDICAL HEALTH CARE PROFESSIONAL CDT 2025

Treating dentist consults with a medical health care professional concerning medical issues that may affect patient's planned dental treatment.

WATCH

Consultation (D9310) reports a diagnostic service provided by a dentist or physician upon request of a physician or dentist. The consulted practitioner may initiate diagnostic and/or therapeutic services regarding treatment.



MATCH

D9311 describes the exchange of health information (initiated by the treating dentist) that might affect the patient's planned dental treatment. This information may be exchanged in writing, verbally, or electronically.

COMMENTS

A dentist often confers with another healthcare professional about proposed or active treatment for patients with contributory health conditions to ensure appropriate care is provided, while being mindful of other potentially dangerous medical conditions. D9311 may be used to report this type of consult requested by the treating dentist when additional information regarding the patient is obtained. The patient would not need to be physically present during the consultation or a part of this exchange of information.

LIMITATIONS

D9311 generally will not be reimbursed, as it may be considered either a part of the global oral evaluation (D0150/D0180) or the consultation (D9310) process.

D9410 HOUSE/EXTENDED CARE FACILITY CALL CDT 2025

Includes visits to nursing homes, long-term care facilities, hospice sites, institutions, etc. Report in addition to reporting appropriate code numbers for actual services performed.

COMMENTS

1. Report D9410 for each and every patient visited, if applicable. Ethically, the provider should charge an appropriate fee in high patient count situations. Reimbursement may be limited to one service per facility per service date.
2. The dental claim form should indicate both the billing entity (dental office address) and the address of the place of service (house/extended care facility address). The appropriate place of service code should be entered on the claim. The place of service code should be entered in Box 38 of the 2024 ADA Dental Claim Form.

LIMITATIONS

House/extended care facility call (D9410) is not typically reimbursed.

D9420 HOSPITAL OR AMBULATORY SURGICAL CENTER CALL CDT 2025

Care provided outside the dentist's office to a patient who is in a hospital or ambulatory surgical center. Services delivered to the patient on the date of service are documented separately using the applicable procedure codes.

COMMENTS

1. Hospital or ambulatory surgical center call (D9420) is used to report an *additional* fee for providing a clinical procedure in a hospital or ambulatory surgical center setting.
2. D9420 may be reported for *each* patient seen in the hospital or ambulatory surgical call center.
3. The dental claim form should indicate the billing entity (dental office address) and the address of the place of service (hospital or ambulatory surgical center address). The appropriate place of service code should be entered on the claim. The place of service code should be entered in Box 38 of the 2024 ADA Dental Claim Form.

LIMITATIONS

D9420 is typically a non-covered service. Some medical plans may provide reimbursement.

TIPS

It is suggested that prepayment for hospital or ambulatory surgical center call (D9420) be obtained from the patient or parent *before* scheduling hospital time for the operating room. In lieu of that, at a minimum, a predetermination of benefits for the proposed treatment should be obtained from the dental or medical insurance payor.

D9430 OFFICE VISIT FOR OBSERVATION (DURING REGULARLY SCHEDULED HOURS) - NO OTHER SERVICES PERFORMED CDT 2025

WATCH

1. Office visit for observation (during regular scheduled hours) - no other services performed (D9430) is not typically reimbursed. No other services are performed, other than the observation.
2. Follow up observation appointments (after specific treatment) are typically included in the *global* fee for the procedure performed. D9430 is not typically reimbursed. D0171 is now available to report a re-evaluation - post-operative visit, which is generally not reported or reimbursed but may be used to record the visit.
3. The oral re-evaluation (D0170) is *inappropriate* if it follows a specific treatment. D0170 is a follow-up monitoring of continuing pain or soft tissue lesion. Generally a fee would be charged for D0170 and it would "burn up" an oral evaluation benefit. See D0170.

COMMENTS

1. D9430 may be reported for *observing* the patient during regular hours, *without performing any clinical services.* Office visit for observation (D9430) is not generally reimbursed. If the office visit for observation is reimbursed the benefit will generally be classified as an "oral evaluation" and subject to the "one evaluation per six months" or "two evaluations per year" limitation. If the observation visit is a follow up to a problem focused (emergency) oral evaluation (D0140), then D0170 or D0171 may apply. See D0170 and D0171 for further details.

2. If a non-definitive procedure is actually performed at the office as a result of the patient's reporting of discomfort/sensitivity/pain, then palliative (D9110) may apply. Report any radiographic images taken in addition to the palliative treatment provided. See palliative D9110, for further details.

TIPS

D9430 is often used to report a "no charge" office visit. Some offices use this code internally for "work in progress" visits (such as multiple visits for constructing a partial denture). Under this scenario, the D9430 code is not charged or filed for reimbursement. For internal office codes such as work in progress, crown delivery, broken appointment, etc., assign codes in the D0000-D0119 range to prevent confusion or improper billing/coding. However, now that D0171 is available, D0171 probably applies better than the reporting of D9430 under most circumstances.

D9440 OFFICE VISIT - AFTER REGULARLY SCHEDULED HOURS

CDT 2025



WARNING

1. Do not report D9440 to stay beyond 5pm on a regular treatment day to see an emergency patient.
2. Do not report D9440 for a *series* of emergency patient visits on a day not regularly worked.

COMMENTS

The fee charged for an office visit - after regularly scheduled hours (D9440) is typically in a range of $150-$250 *plus* the treatment fee for the specific services rendered.

TIPS

If the doctor and team leave the office on Friday at noon and are called back Friday afternoon for an emergency, D9440 would apply since the office is reopened.

NARRATIVES

D9440 is typically a non-covered service. Always submit a brief narrative when reporting D9440 as it may be reimbursed by some payors, but is a long shot. Some Medicaid programs reimburse the doctor for the D9440 visit. The narrative should identify the time of day, day of the week, and circumstances necessitating an office visit after regularly scheduled hours.

D9450 CASE PRESENTATION, SUBSEQUENT TO DETAILED AND EXTENSIVE TREATMENT PLANNING

CDT 2025



WARNING

Many practices err by reporting a consultation (D9310) for a treatment plan case presentation. Report D9450 for the case presentation. See consultation (D9310) for further details on proper use of the consultation code, which requires a patient referral specifically from a physician or dentist.

COMMENTS

1. Report case presentation (D9450) for a case presentation performed subsequently to the comprehensive oral evaluation (D0150), comprehensive periodontal evaluation (D0180), or detailed and extensive oral evaluation (D0160). D9450 is not typically reimbursed but may be used to "track" the office's formal case presentations. Generally there is no charge or reimbursement. However, if a lab bill is incurred, usually there is a charge.
2. Once an orthodontic workup is completed then the patient can return for a case presentation (D9450).
3. The case presentation is done when you have gathered the information and spent some time determining what is the most appropriate course of treatment: such as a complete diagnosis and treatment plan encompassing a myriad of issues. While the presentation may be given on another day, it doesn't have to be, as long as you studied the information sufficiently to establish a reasoned treatment plan and presented it subsequent to gathering the data.

LIMITATIONS

If the case presentation (D9450) is reimbursed on a rare occasion as an alternative benefit, the payors generally treat the D9450 as a periodic oral evaluation (D0120) or comprehensive oral evaluation (D0150 or D0180) and make the case presentation (D9450) subject to the "one evaluation per six months" or "two evaluations per 12 months" frequency limitation.

TIPS

A fee is not generally charged for the case presentation (D9450); however, if the doctor incurs a fee (typically a laboratory fee) related to the case presentation, it would be appropriate to assign a fee to D9450. Some offices will credit all or a part of any related case presentation fee toward the total case fee, if treatment is accepted and completed. The credit is extended toward the final payment amount.

D9610 THERAPEUTIC PARENTERAL DRUG, SINGLE ADMINISTRATION CDT 2025

Includes single administration of antibiotics, steroids, anti-inflammatory drugs, or other therapeutic medications. This code should not be used to report administration of sedative, anesthetic or reversal agents.

WARNING

1. Do not use D9610 to report the administration of sedatives, anesthetic or reversal agents. For deep sedation/general anesthesia, see D9222 and D9223; for intravenous moderate (conscious) sedation/analgesia, see D9239 and D9243. For non-intravenous conscious sedation, including tablets, liquids and intramuscular injections, see D9248. For nitrous oxide, see D9230.
2. Do not use D9610 to report gingival irrigation. D4921 reports gingival irrigation - per quadrant.

COMMENTS

1. Therapeutic parenteral drug administration (D9610) includes a *single* drug administered (subcutaneous, intramuscular, or intravenous). These drugs are generally administered for the treatment of infection or anti-inflammatory therapeutic purposes.
2. Sedative agents should be reported as D9222, D9223, D9230, D9239, D9243 or D9248.
3. D9610 reports the administration of a single therapeutic parenteral drug. When two or more different medications are administered, report D9612.

LIMITATIONS Therapeutic parenteral drug (D9610) is not typically a covered benefit.

NARRATIVES A brief narrative should identify the drug name, dosage, type of administration (subcutaneous, intramuscular or intravenous), and the therapeutic purpose of the drug administered.

D9612 THERAPEUTIC PARENTERAL DRUGS, TWO OR MORE ADMINISTRATIONS, DIFFERENT MEDICATIONS CDT 2025

Includes multiple administrations of antibiotics, steroids, anti-inflammatory drugs or other therapeutic medications. This code should not be used to report administration of sedatives, anesthetic or reversal agents.

WARNING

1. Do not report D9612 to describe the administration of sedatives, anesthetic or reversal agents. For deep sedation/general anesthesia, see D9222 and D9223; for intravenous moderate (conscious) sedation/analgesia, see D9239 and D9243; and for non-intravencus conscious sedation, including tablets, liquids, and intramuscular injections, see D9248. For nitrous oxide, see D9230.
2. Do not use D9612 to report gingival irrigation. D4921 reports gingival irrigation - per quadrant.

COMMENTS

1. Therapeutic parenteral drug administration (D9612) describes the administration of *two or more* injected drugs (subcutaneous, intramuscular, or intravenous). These drugs are typically administered for the treatment of infection or for anti-inflammatory therapeutic purposes.
2. Sedative agents should be reported as D9222, D9223, D9230, D9239, D9243 or D9248.
3. D9612 reports the administration of two or more therapeutic parenteral drugs. When a single therapeutic drug is administered, report D9610.

LIMITATIONS Therapeutic parenteral drugs (D9612) are not typically a covered benefit.

NARRATIVES A brief narrative should identify the drug name, dosage, type of administration (subcutaneous, intramuscular or intravenous), and the therapeutic purpose of the drug administered.

D9613 INFILTRATION OF SUSTAINED RELEASE THERAPEUTIC DRUG, PER QUADRANT

CDT 2025

Infiltration of a sustained release pharmacologic agent for long acting surgical site pain control. Not for local anesthesia purposes.

WARNING

Do not report D9613 when a conventional local anesthesia is injected adjacent to the surgical site for anesthesia.

WATCH

The pharmacological agent injected should be considered long-acting and should not be reported for the use of a conventional local anesthesia.

COMMENTS

1. D9613 describes the infiltration of a sustained release pharmacologic agent for long acting surgical site pain control.
2. Enter the quadrant being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

COMMENTS

According to U.S. Department of Health and Human Services, opioid overdose accounted for more than 42,000 deaths in 2016, more than any previous year on record, with an estimated 40% of opioid overdose deaths involving a prescription opioid. With the increased media focus on the opioid epidemic and the use and problems associated opioids, patients are seeking non-narcotic options for post-operative pain management. To decrease the use of narcotic pain medications in pain management protocols, some dentists are now using a long-lasting release pharmacologic agent to infiltrate the surgical site. This type of non-opioid therapeutic sustained release drug injected around the surgical site following a procedure has proven successful in decreasing or eliminating the need for post-operative opioids for pain control.

LIMITATIONS

At this time, a few plans do recognize and consider reimbursement for this service.

TIPS

Analgesic "cocktails" like: 400 mg of 0.75% ropivacaine (53.33 mL), 0.6 mg of 1-mg/mL epinephrine (0.6 mL), 5 mg of 0.5-mg/mL morphine sulfate (10 mL), and 36.07 mL of 0.9% sodium chloride solution (Exparel®), for example, have been found effective in controlling surgical site post-operative pain. D9613 describes the use of sustained release analgesic cocktails of this type. This code could describe the scenarios where the patient has had the extractions of impacted teeth (#1, 16, 17, and 32) and an analgesic cocktail was administered to reduce/control pain without the use of opioids or other addictive medications.

NARRATIVES

The narrative should establish the date and nature of the surgical service as well as the doctor's attempt to reduce or eliminate the need for an oral analgesic using a long acting sustained release pharmacological drug, reducing the risk of addiction or dependency on a narcotic.

D9630 DRUGS OR MEDICAMENTS DISPENSED IN THE OFFICE FOR HOME USE

CDT 2025

Includes, but is not limited to oral antibiotics, oral analgesics, and topical fluoride; does not include writing prescriptions.

WATCH

1. This code should not be used to report the writing of prescriptions. See problem focused evaluation (D0140) or pulp vitality test (D0460) for use of these codes at the emergency visit when writing prescriptions.
2. Do not report D9630 for chlorhexidine or Peridex® used in clinical treatment in the office. See gingival irrigation - per quadrant (D4921) to report the clinical use of chlorhexidine and/or Peridex® as a gingival irrigant.

COMMENTS

1. For internal office use, an alternative approach is to assign tooth whitening refills or other take home products/ drugs a numerical code *less* than D0120 (since the official CDT code range starts with D0120).
2. See gingival irrigation - per quadrant (D4921) for further details in reporting medicaments such as chlorhexidine or Peridex® used as an irrigant in conjunction with scaling and root planing clinical services.

3. There is not a specific code for in office use of MI Paste™ or MI Paste Plus.™ For in office use as a preventive treatment of white spots during orthodontic treatment or afterwards in the general practice, report unspecified preventive procedure, by report (D1999). Report D2990 for treatment of orthodontic white spots with a resin infiltrant (Icon).
4. See D1999, by report for reporting non-prescription fluoride toothpaste, xylitol products and floss. Also report D1999 for cleaning devices such as toothbrushes, inter-dental cleaners, and floss threaders.
5. Use D9630 if dispensed in the office for *home* use of MI type pastes.
6. See D9985 to document/report sales tax.
7. If antibiotics are dispensed for immediate use in office, such as premedication, report D9999 unspecified adjunctive procedure, by report.

TIPS

D9630 may be used to report prescription strength products dispensed in the office for *at home* use. For tracking purposes, consider assigning subcategories to this code, such as D9630A, D9630B, D9630C, etc., to account for the various drugs and/or medicaments. Typical *take home* products include, but are not limited to, prescription strength topical fluoride, chlorhexidine rinses, oral antibiotics, oral analgesics, remineralization products, MI Paste™, MI Paste Plus™, PreviDent®, Fluoridex®, gel refill for Perio Protect Trays® etc.

LIMITATIONS

D9630 is not typically reimbursed.

NARRATIVES

1. Include a brief narrative to document the need for the take home drug and/or medicament and the quantity dispensed. This code is "by report." Reimbursement is poor.
2. Home use of medicaments may be indicated for moderate or high caries risk patient. A caries risk assessment form must be included in the clinical documentation to support the diagnosis of moderate or high caries risk. Report D0602 caries risk assessment and documentation, with a finding of moderate risk typically with a zero fee on the claim. Report D0603 caries risk assessment and documentation, with a finding of high risk typically with a zero fee on the claim form.

ADDITIONAL INFORMATION

Dental practices should use D9630 to report a variety of products dispensed for home use, including oral antibiotics, oral analgesics, chlorhexidine rinses, prescription strength topical fluorides, and remineralization products. Here are some examples of the type of products that may be reported using D9630:

Oral antibiotics Instead of writing a prescription, some dentists dispense oral antibiotics in the office for certain patients (e.g., to prevent infective endocarditis, for patients who have had total joint replacement, or for patients with an oral infection requiring antibiotic therapy, etc.). Justification for this protocol may be when emergency treatment is being rendered during hours in which pharmacies are closed, there is no pharmacy nearby, or when the dentist wants to confirm that the patient actually took the medication.

Oral analgesics Oral analgesics are medications that block pain or raise the patient's pain tolerance. The more familiar analgesics are aspirin, acetaminophen, codeine, etc. Debacterol® is a medication that is also considered to be an oral analgesic in that it is used to treat and relieve the pain associated with aphthous stomatitis (canker sores).

Chlorhexidine rinses Chlorhexidine rinses are often used in the dental office to irrigate inflamed and bleeding gums when curetting a periodontal abscess or performing a prophylaxis, full mouth debridement, periodontal scaling and root planing (SRP), etc. Some dental plans now provide a benefit for antimicrobial rinses such as Peridex®, PerioGard®, PerioRx®, etc., when initially administered at the time of SRP and dispensed for patients to use at home. D9630 should only be reported for chlorhexidine rinses that are dispensed for use at home. In office gingival irrigation with a chlorhexidine rinse should be reported as D4921.

Topical home fluoride gels/rinses D9630, by report, can also be used to report prescription strength topical fluoride gels, prescription strength fluoride rinses, etc., when dispensed for use by the patient at home. Some dental plans now provide coverage for products such as PreviDent®, Fluoridex®, etc., for patients who have an increased risk of developing root caries following gingival recession. When fluoride is used to treat root sensitivity in the office, D9910 should be billed on a "per visit" basis, and when fluoride varnish is used in the office therapeutically to prevent caries, D1206 should be billed. Topical fluoride applied as a preventive protocol that is not fluoride varnish (whether gel, foam, or swish) should be reported using D1208. See D1206 and D1208 for details on in office fluoride application.

Note: For non-prescription fluoride toothpaste, xylitol products and floss, toothbrushes, inter-dental cleaners, and floss threaders, report D1999, by report.

MRS. SMITH NEEDS HOME TOPICAL FLUORIDE "Mrs. Smith, you have a high risk of developing caries, and we do not have fluoridated water here in our community. This is a fluoride gel for you to use daily after brushing and flossing to help prevent cavities. Be sure to spit out the excess after brushing. Please remember that this is a prescription strength medication, not toothpaste, and must be kept out of reach of young children."

Remineralization products Decalcified "white spots" (typically seen in moderate to high caries risk patients, such as those with orthodontic appliances, high sugar diet, heavy plaque buildup, etc.) are caused when acid producing bacteria attack tooth enamel. When this occurs, the goal is to remineralize the tooth before a cavity develops. MI Paste™, MI Paste Plus™, and ReNew Remineralizing Paste® are examples of remineralization products that may be applied in the office with a prophy cup or dispensed for home use (e.g., custom tray application or Q-tip application). When dispensed for home use, remineralization products can be reported using D9630. When fluoride varnish is used for remineralization (in office) for caries risk patients, report D1206. See D1206 and D1208 for distinction in reporting.

For a caries preventive medicament application - per tooth applied in-office for primary prevention or remineralization, see D1355.

For resin infiltration of incipient smooth surface lesions, see D2990.

For application of hydroxyapatite regeneration medicament - per tooth, see D2991.

MISCELLANEOUS SERVICES — CDT 2025

D9910 APPLICATION OF DESENSITIZING MEDICAMENT — CDT 2025

Includes in-office treatment for root sensitivity. Typically reported on a "per visit" basis for application of topical fluoride. This code is not to be used for bases, liners or adhesives used under restorations.

WATCH

1. It is an error to report the application of a desensitizing medicament (D9910) in office for *caries related, preventive* fluoride application. Report D1206 or D1208 for *caries reduction related fluoride application*, not D9910.
2. Do not report D9910 in conjunction with routine crown delivery to reduce subsequent sensitivity. The desensitizing fluoride application under this scenario is considered *integral to* the crown procedure. In this scenario D9910 should not be reported *separately*. D9910 should not be used to report the routine use of a base, liner, or adhesive applied under restorations. The D9910 descriptor states "this code is not to be used for bases, liners or adhesives used under restorations." The restorative codes are *inclusive* of all bases, liners, adhesives, desensitizers, and etching.
3. Desensitizing *resins* are not to be reported as D9910. Desensitizing resins are reported separately as D9911, on a "per tooth" basis. The objective is to apply a resin to the cervical and/or root surface to desensitize the tooth. See D9911.

COMMENTS

1. Report application of desensitizing medicament (D9910) at checkups and *regularly* scheduled clinical visits when treating tooth sensitivity with a desensitizing medicament. D9910 is reported on a "per visit" basis and may be applied to one tooth, some teeth, or all of the teeth in the mouth.
2. D9910 may be used to report the application of a desensitizing medicament as an *adjunct* to prophylaxis or periodontal treatment. D9910 may be reported in conjunction with osseous surgery, SRP or at a periodontal maintenance (D4910) visit. D9910 is *not* generally reimbursed. The patient may be billed and is expected to pay out of pocket if the procedure is not reimbursed. An exception will apply for contracted PPO dentists who are prohibited from charging a separate fee for the application of a desensitizing medicament.
3. D9910 is not limited to fluoride application as a desensitizing medicament, however topical fluoride is commonly used.
4. D9910 can be reported when the Silver Diamine application objective is to treat sensitivity. Although D9910 is not a "by report" code, a narrative is suggested describing the patient's sensitivity. The narrative would be specific to the patient's documented diagnosis of sensitivity.
5. D1355 reports caries preventive medicament application - per tooth. This procedure is for prevention or remineralization medicaments not including topical fluorides. For instance, D1355 can report a Silver Diamine application for remineralization, per tooth.
6. Curodont Repair, if used as a desensitizer, could be reported as D9910.
7. Enter the teeth number(s) or range of teeth being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS D9910 is often limited by dental plans. Also, see D9110, palliative treatment.

TIPS

1. Consider charging a *lower* fee for a desensitizing treatment (D9910) if reported in connection with a recall visit. A higher fee should be considered for desensitizing treatment provided at a *stand-alone* appointment, due to operatory setup time and performance of OSHA procedures.
2. Also refer to palliative (D9110), which may report treatment at any visit when there is discomfort/pain of a limited nature reported by the patient. See D9110 for particular details.

NARRATIVES Although D9910 is not a "by report" code, a brief narrative citing the details of the patient's sensitivity is suggested. The narrative would be specific to the patient's documented diagnosis of sensitivity.

ADDITIONAL INFORMATION How can different CDT codes be reported to describe essentially the same procedure? When reporting the application of fluoride varnish or other medicament (e.g., Duraflor®, Duraphat®, CavityShield™, Cervitec® Gel etc.), the patient's diagnosis determines the code. Why was fluoride varnish used? Was it used to remineralize incipient carious lesions, or was it used to treat root sensitivity at a regularly scheduled or emergency visit?

1. D1206 is used to report the application of fluoride varnish to reduce caries risk (generally at recall) - either child or adult.
2. D1208 is used to report the administration of topical fluoride preparations (other than fluoride varnish) to reduce caries risk - child or adult.
3. If fluoride varnish is used to treat tooth sensitivity, report D9910. D9910 (application of desensitizing medicament) is billed "per visit." The treatment could be done on one tooth or the whole mouth. Also see D9110.
4. D9910 may be used to report the application of Cervitec® Gel if it is applied to treat a documented diagnosis of tooth sensitivity.

D9911 APPLICATION OF DESENSITIZING RESIN FOR CERVICAL AND/OR ROOT SURFACE, PER TOOTH

CDT 2025

Typically reported on a "per tooth" basis for application of adhesive resins. This code is not to be used for bases, liners, or adhesives used under restorations.



WATCH

1. It is an error to report D9911 for bases, liners, or adhesives when applied under a restoration. The D9911 descriptor prohibits the reporting of the use of desensitizing resins for restorations. Restorative procedure codes *include* all bases, liners, etchings, desensitizers, and adhesives with the procedure.
2. If *caries* is involved and the preparation extends into the *dentin* (or fracture is involved), report an anterior or a posterior resin/composite direct restoration that includes any bases, liners, or adhesives placed. DO NOT report D9911 as a separate procedure when placing an amalgam, composite, or crown restoration.

COMMENTS Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS Application of desensitizing resin (D9911) is used to report the application of adhesive resins to desensitize the "cervical and/or root surface" of a tooth and is reported "per tooth." *D9911 may or may not be reimbursed.*

TIPS

1. Some payors will re-map D9911 as a resin-based composite - one surface, anterior (D2330), or to a resin-based composite - one surface, posterior (D2391). In some cases it may be re-mapped to palliative, D9110. Report D9911 even though a payor may re-map this code to an alternative code. Always "**report what you do**." Let the payor remap to an alternative code according to the dental plan's language. Always appeal if not paid.
2. Also refer to palliative (D9110). See D9110 for particular details.

NARRATIVES The key word is a desensitizing "resin." D9911 would be used for those patients presenting with root sensitivity at a recall or other visit. Narratives should emphasize the pain/sensitivity reported by the patient.

D9912 PRE-VISIT PATIENT SCREENING — CDT 2025

Capture and 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 is to be treated within the dental practice.

WATCH

1. D9912 reports a health status screening, not a dental assessment or dental screening. This service is to determine the health condition of the patient as it relates to their health and about any conditions that could lead to disease transmission from the patient to the dental team or other patients. This could include bacterial, viral, or any other conditions that could be transmitted subsequently in the dental environment.
2. D9912 does not report the completion and review of a health history or questionnaire completed after the patient has presented for an appointment. D9912 does describe the documentation and evaluation of the patient's health status prior to, or on the scheduled date of service and before the decision to start treatment.
3. D0190, screening of a patient and D0191 assessment of a patient are associated with dental conditions, not health status conditions. Although knowing about the patient's health conditions is important, especially as those health conditions relate to the patient's dental condition and treatment, D9912 reports the screening of a patient to determine if there is a risk of infectious disease transmission specifically, prior to dental treatment.

MATCH

1. D9912 reports the screening of a patient to determine if there is a risk of infectious disease transmission specifically, prior to dental treatment.
2. This screening can be accomplished via many platforms from a phone call the day of the patient's visit, a teledentistry encounter, or a screening and evaluation outside the practice or in the waiting area. The intent of the D9912, pre-visit patient screening, is to identify any conditions the patient may have that need to be addressed prior to dental treatment and to determine if the subsequent treatment visit should occur.

COMMENTS

1. D9912 reports pre-visit patient screening to determine if the patient can be seen without presenting a health risk to the team and other patients.
2. This is an administrative protocol where the patient's health status is determined before the patient is moved to the treatment area.
3. The screening may consist of a temperature check, a health questionnaire, an assessment of the patient's potential exposure and a determination of the patient's vaccination status.
4. Findings of the screening will help determine whether the patient is treated or rescheduled for later treatment when the health risk has abated.

LIMITATIONS

Administrative codes of this type would not generally be reimbursed by a payor as it is an administrative in nature and not a treatment code.

D9913 NEW PROCEDURE ADMINISTRATION OF NEUROMODULATORS — CDT 2025

COMMENTS

1. D9913 documents and reports the use of neuromodulators such as Botox® in dentistry.
2. Neuromodulators are being used therapeutically to treat muscle-generated dental diseases like TMJ disorders, mandibular muscle spasms, masseter hypertrophy and pathologic clenching, and bruxism.
3. D9913 also reports neuromodulators being used cosmetically to treat dental conditions such as deep nasolabial folds, radial lip lines, high lip lines, and lip deformities.
4. In the past, neuromodulators might be reported using D7899 unspecified TMD therapy, by report, D9610 therapeutic parenteral drug, single administration, or D9999 unspecified adjunctive procedure, by report, depending on the intended use.
5. For the administration of dermal fillers, see D9914.

LIMITATIONS

1. Reporting these codes allows for documentation and billing, but these codes are unlikely to be reimbursed under dental insurance.
2. You may receive coverage by billing medical insurance. See our *Medical Dental Cross Coding With Confidence* manual at www.practicebooster.com/store.

D9914 NEW PROCEDURE ADMINISTRATION OF DERMAL FILLERS — CDT 2025

COMMENTS

1. D9914 documents and reports the use of dermal fillers in dentistry.
2. Dermal fillers are used to treat orofacial conditions such as deep nasolabial folds, radial lip lines, high lip lines, lip deformities, smile lines, and to increase the volume of the papilla (treating black triangles between teeth).
3. In the past, dermal fillers might be reported using D9999 unspecified adjunctive procedure, by report, depending on the intended use.
4. For administration of neuromodulators, see D9913.

LIMITATIONS

1. Reporting these codes allows for documentation and billing, but these codes are unlikely to be reimbursed under dental insurance.
2. You may receive coverage by billing medical insurance. See our *Medical Dental Cross Coding With Confidence* manual at www.practicebooster.com/store.

D9920 BEHAVIOR MANAGEMENT, BY REPORT — CDT 2025

May be reported in addition to treatment provided. Should be reported in 15-minute increments.

COMMENTS

1. The use of a papoose board would be a form of behavior management. Other types of behavior management may also be reported with this code.
2. D9920 behavior management is billed separately in 15 minute increments. Additional treatment may include N_2O (D9230) and/or non-intravenous conscious sedation (D9248).
3. D9920 can be reported when other procedures cannot. For example, the dentist spends a considerable amount of time trying to get the child to cooperate, however no procedure was able to be performed.
4. Behavior management is reported in 15 minute increments. For instance, an hour of behavior management would be a quantity of "4" entered in block 29b of the 2024 ADA claim form.
5. All additional services delivered during the appointment should be separately reported (I.e., prophy, pulpotomy, restorations, pharmacologic agents, SSCs, etc.

LIMITATIONS

Behavior management (D9920) is not typically reimbursed, except through certain government funded programs.

NARRATIVES

1. When reporting D9920, note the extra time taken to complete the procedure (in addition to the normal procedure time) and describe the necessity for behavior management. Outline the nature of the patient's behavior (young unruly child, etc.). The ADA's 2025 Companion states "the supporting narrative should note the duration of the behavior management procedure (e.g., number of minutes) and the specific techniques used. These techniques include use or non-use of pharmacologic agents, the use of calming strategies, the use of medical protective stabilization, the use of additional staff, etc. " There should be a description of the use or non-use of pharmacologic agents, the use of calming strategies, the use of restraints, the use of additional staff, etc." Consult with the payor regarding the reporting of D9920. Determine the applicability of the service to the individual situation and the coverages available. Plan limitations are highly variable.
2. In some cases, a narrative may yield a higher reimbursement for the procedure. Submit a narrative with the restorative procedure stating "extra time required for three surface MOD composite, #J. Please consider a higher fee for the pediatric restorative procedure." Plan limitations are highly variable.

D9930 TREATMENT OF COMPLICATIONS (POST-SURGICAL) - UNUSUAL CIRCUMSTANCES, BY REPORT — CDT 2025

For example, treatment of a dry socket following extraction or removal of bony sequestrum.

LIMITATIONS

Treatment of complications (post-surgical), D9930 may not be reimbursed when performed by the *same* office that provided the original surgical service. A thirty day follow up is typically considered *a part of the original* surgical service and not reimbursed separately by most payors. Most surgical codes indicate that "routine post-operative care" is included. Checking healing and suture removal *would be considered* routine under this scenario. Treatment of a dry socket or removal of a bony sequestrum is considered by many payors as *routine* post-surgical care and a part of the global fee.

TIPS

If a *different* billing office treats a dry socket, removes a bony sequestrum, or controls bleeding post-treatment, D9930 may be reimbursed under that scenario.

NARRATIVES

1. Include a brief narrative that explains the circumstances of the office visit and who originally provided the surgical treatment. If the extraction was performed by a different provider, be sure to indicate that in the narrative.
2. "See attached copy of operative notes."

D9931 PREVIOUSLY DELETED CODE CLEANING AND INSPECTION OF A REMOVABLE APPLIANCE

This is a previously deleted code. See D9932, D9933, D9934, and D9935 for further details.

D9932 CLEANING AND INSPECTION OF REMOVABLE COMPLETE DENTURE, MAXILLARY

CDT 2025

This procedure does not include any adjustments.

WATCH

Adjustment of removable prosthesis is reported as adjust complete denture - maxillary (D5410).

COMMENTS

1. D9932 is used to report the cleaning and inspection (by the dentist) of a removable maxillary complete denture. Dentures that have accumulated calculus and other foreign materials require professional cleaning and inspection. For example, a patient presents with hardened calculus on his/her denture, which is removed by an ultrasonic cleaner and/or dental hand instrument.
2. Report each complete denture for cleaning and inspection, per arch, separately. Any team member may clean the denture, but the inspection must be performed by the dentist.
3. D9932 may also report the cleaning and inspection of a removable implant/abutment supported maxillary overdenture (D6110).
4. Prophylaxis (D1110/D1120) and periodontal recall maintenance (D4910) includes scaling and polishing implant crowns.

LIMITATIONS

1. Payors may require verification that an inspection is performed by a dentist (i.e., inspection by a dentist) rather than a dental team member who puts the appliance in an ultrasonic cleaner.
2. Document that the dentist inspected the removable prosthesis and recommended that D9932 be performed. The clinical notes of the dentist should describe the inspection by the dentist and the cleaning of the denture.

D9933 CLEANING AND INSPECTION OF REMOVABLE COMPLETE DENTURE, MANDIBULAR

CDT 2025

This procedure does not include any adjustments.

WATCH

Adjustment of removable prosthesis is reported as adjust complete denture - mandibular (D5411).

COMMENTS

1. D9933 is used to report the cleaning and inspection (by the dentist) of a removable mandibular complete denture. Dentures that have accumulated calculus and other foreign materials require professional cleaning and inspection. For example, a patient presents with hardened calculus on his/her denture, which is removed by an ultrasonic cleaner and/or dental hand instrument.

2. Report each complete denture for cleaning and inspection, per arch, separately. Any team member may clean the denture, but the inspection must be performed by the dentist.
3. D9933 may also report the cleaning and inspection of a removable implant/abutment supported mandibular overdenture (D6111).
4. Prophylaxis (D1110/D1120) and periodontal recall maintenance (D4910) includes scaling and polishing implant crowns.

LIMITATIONS

1. Payors may require verification that an inspection is performed by a dentist (i.e., inspection by a dentist) rather than a dental team member who puts the appliance in an ultrasonic cleaner.
2. Document that the dentist inspected the removable prosthesis and recommended that D9933 be performed. The clinical notes of the dentist should describe the inspection by the dentist and the cleaning of the denture.

D9934 CLEANING AND INSPECTION OF REMOVABLE PARTIAL DENTURE, MAXILLARY

CDT 2025

This procedure does not include any adjustments.

WATCH

Adjustment of removable partial prosthesis is reported as adjust partial denture - maxillary (D5421).

COMMENTS

1. D9934 is used to report the cleaning and inspection (by the dentist) of a maxillary removable partial denture. Dentures that have accumulated calculus and other foreign materials require professional cleaning and inspection. For example, a patient presents with hardened calculus on his/her partial denture, which is removed by an ultrasonic cleaner and/or dental hand instrument.
2. Report each partial denture for cleaning and inspection, per arch, separately. Any team member may clean the denture, but the inspection must be performed by the dentist.
3. D9934 may also report the cleaning and inspection of a removable implant/abutment supported maxillary partial overdenture (D6112).
4. Prophylaxis (D1110/D1120) and periodontal recall maintenance (D4910) includes scaling and polishing implant crowns.

LIMITATIONS

1. Payors may require verification that an inspection is performed by a dentist (i.e., inspection by a dentist) rather than a dental team member who puts the appliance in an ultrasonic cleaner.
2. Document that the dentist inspected the removable prosthesis and recommended that D9934 be performed. The clinical notes of the dentist should describe the inspection by the dentist and the cleaning of the partial denture.

D9935 CLEANING AND INSPECTION OF REMOVABLE PARTIAL DENTURE, MANDIBULAR

CDT 2025

This procedure does not include any adjustments.



WATCH

Adjustment of removable partial prosthesis is reported adjust partial denture - mandibular (D5422).

COMMENTS

1. D9935 is used to report the cleaning and inspection (by the dentist) of a mandibular removable partial denture. Dentures that have accumulated calculus and other foreign materials require professional cleaning and inspection. For example, a patient presents with hardened calculus on his/her partial denture, which is removed by an ultrasonic cleaner and/or dental hand instrument.

2. Report each partial denture for cleaning and inspection, per arch, separately. Any team member may clean the denture, but the inspection must be performed by the dentist.
3. D9935 may also report the cleaning and inspection of a removable implant/abutment supported mandibular partial overdenture (D6113).
4. Prophylaxis (D1110/D1120) and periodontal recall maintenance (D4910) includes scaling and polishing implant crowns.

LIMITATIONS

1. Payors may require verification that an inspection is performed by a dentist (i.e., inspection by a dentist) rather than a dental team member who puts the removable prosthesis in an ultrasonic cleaner.
2. Document that the dentist inspected the removable prosthesis and recommended that D9935 be performed. The clinical notes of the dentist should describe the inspection by the dentist and the cleaning performed of the partial denture.

D9938 FABRICATION OF A CUSTOM REMOVABLE CLEAR PLASTIC TEMPORARY AESTHETIC APPLIANCE

CDT 2025



WARNING

Do not report D9938 for fabrication of clear plastic appliances other than as temporary aesthetic appliances.



WATCH

1. For the placement of a custom removable clear plastic temporary aesthetic appliance, see D9939.
2. For use of clear plastic appliances for orthodontic retention, see D8680.
3. For use of clear plastic appliances for space maintenance, see D1526 (maxillary) and D1527 (mandibular).
4. For use of clear plastic appliances for an interim partial denture, see D5820 and D5821.



MATCH

D9938 describes the fabrication of a clear plastic appliance, often referred to as an "Essix" appliance, used for temporary esthetic preservation.

COMMENTS

1. This fabrication may be done via vacuum forming or by 3D printing.
2. D9938 documents the fabrication of a clear plastic aesthetic appliance separate from its placement, however the D9938 will likely be seen as an integral part of the placement procedure by payors and not be reimbursed separately.
3. Enter the arch being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. D9938 is for the fabrication of the clear plastic appliance only. The code can be used to document the procedure, but D9938 will likely not be reimbursed.
2. See D9939 for the placement of a custom removable clear plastic temporary aesthetic appliance. Payors are unlikely to reimburse both D9938 and D9939. Of the two, D9939 has the highest likelihood of reimbursement.
3. As with all new codes, it may take several years for payors to recognize D9938 for reimbursement purposes.

D9939 PLACEMENT OF A CUSTOM REMOVABLE CLEAR PLASTIC TEMPORARY AESTHETIC APPLIANCE

CDT 2025



WARNING

Do not report D9939 for placement of clear plastic appliances other than as temporary aesthetic appliances.



WATCH

1. For the fabrication of a custom removable clear plastic temporary aesthetic appliance, see D9938.
2. For use of clear plastic appliances for orthodontic retention, see D8680.
3. For use of clear plastic appliances for space maintenance, see D1526 (maxillary) and D1527 (mandibular).
4. For the use of clear plastic appliances for an interim partial denture, see D5820 and D5821.

MATCH

D9939 describes the placement of a clear plastic appliance, often referred to as an "Essix" appliance, for use as a temporary esthetic appliance.

COMMENTS

1. D9939 is reported separately from the fabrication of the clear plastic appliance.
2. D9938 is for the fabrication of the clear plastic appliance only. The code can be used to document the procedure, but D9938 will likely not be reimbursed.
3. Enter the arch being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. As with all new codes, it may take several years for payors to recognize D9939 for reimbursement purposes.
2. Payors are unlikely to reimburse both D9938 and D9939. D9939 is more likely to be reimbursed if benefited. Payors are unlikely to reimburse both D9938 and D9939. Of the two, D9939 has the highest likelihood of reimbursement.
3. As with all new codes, it may take several years for payors to recognize D9939 for reimbursement purposes.

D9940 PREVIOUSLY DELETED CODE OCCLUSAL GUARD, BY REPORT

This is a previously deleted code. See D9944, D9945, and D9946 for further details.

D9941 FABRICATION OF ATHLETIC MOUTHGUARD CDT 2025

WARNING

It is misleading to report diagnostic casts (D0470), fluoride gel carrier (D5986), occlusal orthotic device (TMJ dysfunction appliance) (D7880), or occlusal guard (D9944, D9945, and D9946) solely to gain reimbursement for fabrication of an athletic mouthguard. This reporting is improper and may be considered fraud if intentional.

COMMENTS

Enter the arch being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. D9941 reports fabrication of an athletic mouthguard.
2. Fabrication of athletic mouthguard (D9941) is not generally reimbursed.
3. Always submit a claim for D9941. While not routine, some payors may reimburse this service.

D9942 REPAIR AND/OR RELINE OF OCCLUSAL GUARD CDT 2025

WATCH

It is inappropriate and misleading to report repair and/or reline of occlusal guard (D9942) for *adjusting* an occlusal guard. After delivery, six months of follow up adjustments are generally considered by payors to be a part of the *global fee* for the occlusal guard (D9944, D9945, and D9946). See D9943, for an adjustment to an occlusal guard.

COMMENTS

1. Occlusal guards may break or no longer fit after long term use. They may be relined or repaired at less expense to the patient than a replacement. The occlusal guard that is repaired and/or relined is reported as D9942.
2. For *adjusting* an occlusal guard after delivery, see D9943. Payors may require a waitng period after delivery, such as six months, before the adjustment would be reimbursed.
3. Enter the arch being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. When benefits are available, the fee reimbursed for a repair or reline may be limited to less than 50% of a new occlusal guard fee. In some cases the reimbursement of the repair/reline may "reset" the five year limitation period.
2. In certain cases, the repair/reline may be reimbursed if the fabrication of the occlusal guard is reimbursed. Reimbursement for the repair and/or reline of an occlusal guard is highly variable among payors.

NARRATIVES Include the date of the original delivery of the occlusal guard and the reason for the repair and/or reline of the occlusal guard.

D9943 OCCLUSAL GUARD ADJUSTMENT CDT 2025

WATCH

D9943 does not report occlusal guard adjustments at the delivery. Adjustments made on the date of the delivery are included in the global fee for the occlusal guard.

COMMENTS

1. After delivery, six months of follow up adjustments are generally considered to be part of the global fee by payor's for the occlusal guard (D9944, D9945, and D9946).
2. Enter the arch being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS This code will not be benefitted by most plans.

NARRATIVES Although D9943 is not a by report code, it is recommended to document the original delivery date of the occlusal guard on the claim.

D9944 OCCLUSAL GUARD - HARD APPLIANCE, FULL ARCH CDT 2025

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.



WARNING

It is misleading to report the delivery of an occlusal guard - hard appliance, full arch (D9944) to describe tooth whitening trays (D9975) or for TMJ treatment to receive reimbursement. Tooth whitening trays are provided for cosmetic purposes and are not generally a covered service.



WATCH

1. The hard occlusal guard (D9944) and the occlusal orthotic device (D7880) are often confused. Report D9944 to describe a hard or hard/soft occlusal guard for minimizing the effects of "bruxism" and "clenching of teeth." Report D7880 to describe an appliance provided to treat TMJ dysfunction, which typically includes multiple visits or D5999 to report a snoring appliance Snoring is considered a social, not medical, condition.
2. Report D9947 only for the fabrication and placement of a custom sleep apnea appliance.

COMMENTS

1. Bruxism is the parafunctional or habitual "clinching" or "grinding" of teeth.
2. There are three basic, broad types of bruxism appliances:
   - Laboratory made hard acrylic appliance with or without soft liner (D9944) as long as occlusal is hard.
   - Soft (generally suck down) appliance (D9945), typically fabricated in the dental office.
   - The NTI-tss, an anterior partial hard arch appliance, generally worn at night (D9946).

   The hard occlusal guard fee might vary from $550 to $750, depending on the type of appliance. Factors such as the laboratory bill, the clinical technique used, and the total number of visits for impressions, delivery and follow up may affect the overall fee charged. Occlusal guards usually require a few visits to deliver the appliance.
3. See D9943 to report an adjustment of an occlusal guard. A waiting period (up to six months) may be required.
4. Report D9942 for the repair and/or reline of an occlusal guard. A waiting period (up to six months) may be required.
5. Enter the arch being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. If the hard occlusal guard (D9944), also known as a night guard, perio guard, or bite guard is reimbursed, it is generally reimbursed under dental, not medical insurance.
2. Reimbursement for an occlusal guard (D9944) may be subject to an age exclusion, for instance, children 12 years of age or younger.

3. Some payors only reimburse for bruxism; others require periodontal treatment (SRP or in some cases osseous surgery) to justify reimbursement.
4. Occlusal guards may be reimbursed under "preventive," "basic," or "major" classifications. Classification is highly variable. Waiting periods may apply for basic and major coverage.
5. After delivery of the occlusal appliance, six months of follow up care (including adjustments) is typically considered integral in the global occlusal guard fee by payors. For an occlusal guard adjustment, see D9943. Adjusting an occlusal guard is generally not reimbursed.
6. Although the occlusal orthotic device, by report (D7880) is generally considered to be for TMJ dysfunction, a few payors will reimburse the occlusal guard (for bruxism) as an alternate benefit of the TMJ dysfunction appliance code D7880. This is not typical.
7. Pretreatment authorization may be required for D9944.

Note: D9944 does not report a TMJ dysfunction appliance or active TMJ dysfunction treatment. TMJ dysfunction is not typically a covered dental benefit without a TMJ dysfunction rider; however, TMJ dysfunction may be reimbursed through medical insurance. TMJ dysfunction treatment (for pain, symptoms) involves a splint, multiple visits, and typically occlusal adjustments. The dental code for an appliance used to treat TMJ dysfunction is occlusal orthotic device (D7880). See D7880 for further details.

TIPS

If a patient requires a hard occlusal nightguard covering the entire arch because of night grinding or has advancing periodontal mobility due to occlusal factors, the appliance is reported as D9944. If bruxism is the problem, a simple narrative indicating the patient is a bruxer should be all that is necessary. However, if periodontal mobility is the problem after treatment, then the narrative should include a periodontal diagnosis along with a comprehensive periodontal charting and mouth images.

If the patient is experiencing temporomandibular joint dysfunction (TMD), the occlusal orthotic should be reported using code D7880. A narrative should describe the TMD diagnosis and symptoms, e.g., joint pain, popping, clicking, crepitus, migraines, deviated opening, etc.

Some plans cover appliances for bruxism, mobility, and/or some for TMD, but few cover all three. Know the clinical problem, (i.e., there is a diagnosis) before you check for benefits.

NARRATIVES

1. To determine if a splint or occlusal guard is covered by a patient's dental plan, one must first determine the purpose of the appliance. Is it needed to minimize the effects of bruxism? Is periodontal mobility due to occlusal factors a part of the diagnosis, or is the patient experiencing headaches and pain in the temporomandibular joint area?
2. Although D9944 is not a by report code, it is recommended to include a narrative and documentation as indicated below:
   - If the diagnosis is bruxism, state "Diagnosis = Bruxism." An occlusal guard is necessary to minimize the effects of bruxism and clenching of teeth." For occlusal guards, keep the narrative short.
   - If there is a *history* of scaling and root planing (D4341/D4342) or periodontal osseous surgery (D4260/D4261), note this in the narrative when reporting an occlusal guard. The narrative might state "This patient has undergone periodontal therapy on (date). Include a description of the case type." Coverage for D9944 may vary based on whether the policy includes a supplemental "periodontal rider." The rider could make a difference in coverage if there is a supplemental "periodontal rider" in the contract. Even so, some payors make a distinction between case types and will only reimburse for the more advanced osseous surgery. SRP (D4341/D4342) treatment may not suffice. Some plans require the occlusal guard be placed within six months of active periodontal treatment. If D9944 is reimbursed under a periodontal rider, the benefit may be available only once every five years or be limited to a lifetime maximum. The annual maximum will generally apply. Reimbursement is highly variable.
   - Some plans require the occlusal guard be placed within six months of the active periodontal treatment (SRP or osseous surgery). If the occlusal guard is required to address periodontal mobility, include a periodontal diagnosis, current periodontal charting, and radiographs.

PHOTO



This is an example of a hard acrylic occlusal guard (D9944).

Courtesy Drake Dental Lab

D9945 OCCLUSAL GUARD - SOFT APPLIANCE, FULL ARCH CDT 2025

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.



WARNING

It is misleading to report the delivery of an occlusal guard- soft appliance, full arch (D9945) to describe tooth whitening trays (D9975). Tooth whitening trays are provided for cosmetic purposes and are not generally a covered service.

WATCH

1. The soft occlusal guard (D9945) and the occlusal orthotic device (D7880) can be confused. Report D9945 to describe a soft occlusal guard for minimizing the effects of "bruxism" and "clenching of teeth." Report D7880 to describe an appliance provided to treat TMJ dysfunction, which typically includes multiple visits or D5999 to report a snoring appliance. Snoring is considered a social, not medical condition.
2. Report D9947 only for the fabrication and placement of a custom sleep apnea appliance.

COMMENTS

1. Bruxism is the parafunctional or habitual "clinching" or "grinding" of teeth.
2. There are three basic, broad types of bruxism appliances:
   - Soft (generally suck down) appliance (D9945), typically fabricated in the dental office.
   - Laboratory made hard acrylic appliance with or without soft liner (D9944).
   - The NTI-tss, an anterior partial hard arch appliance, generally worn at night (D9946).

   The soft occlusal guard fee might vary from $250 to $450, depending on the type of appliance. Factors such as the laboratory bill, the clinical technique used, and the total number of visits for impressions, delivery and follow up may affect the overall fee charged. Occlusal guards usually require a few visits to deliver the appliance.
3. See D9943 to report an adjustment of an occlusal guard. A waiting period (up to six months) may be required.
4. Report D9942 for the repair and/or reline of an occlusal guard. A waiting period (up to six months) may be required.
5. Enter the arch being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. If the soft occlusal guard (D9945), also known as a night guard, perio guard, or bite guard is reimbursed, it is generally reimbursed under dental, not medical insurance.
2. Reimbursement for an occlusal guard (D9945) may be subject to an age exclusion, for instance, children 12 years of age or younger.
3. Some payors only reimburse for bruxism; others require periodontal treatment (SRP or in some cases osseous surgery) to justify reimbursement.
4. Occlusal guards may be reimbursed under "preventive," "basic," or "major" classifications. Classification is highly variable. Waiting periods may apply for basic and major coverage.
5. After delivery of the occlusal appliance, six months of follow up care (including adjustments) is typically considered integral in the global occlusal guard fee by payors. For an occlusal guard adjustment, see D9943. Adjusting an occlusal guard is usually not reimbursed.
6. Although the occlusal orthotic device, by report (D7880) is generally considered to be for TMJ dysfunction, a few payors will reimburse the occlusal guard (for bruxism) as an alternate benefit of the TMJ dysfunction appliance code D7880. This is not typical.
7. Pretreatment authorization may be required for D9945.

Note: D9945 does not report a TMJ dysfunction appliance or active TMJ dysfunction treatment. TMJ dysfunction is not typically a covered dental benefit without a TMJ dysfunction rider; however, TMJ dysfunction may be reimbursed through medical insurance. TMJ dysfunction treatment (for pain, symptoms) involves a splint, multiple visits, and typically occlusal adjustments. The dental code for an appliance used to treat TMJ dysfunction is occlusal orthotic device (D7880). See D7880 for further details.

TIPS

If a patient requires a soft occlusal nightguard covering the entire arch because of night grinding or has advancing periodontal mobility due to occlusal factors, the appliance is reported using code D9945. If bruxism is the problem, a simple narrative indicating the patient is a bruxer should be all that is necessary. However, if periodontal mobility is the problem, then the narrative should include a periodontal diagnosis along with a comprehensive periodontal charting and mouth images.

If the patient is experiencing temporomandibular joint dysfunction (TMD), the occlusal orthotic should be reported using code D7880. A narrative should describe the TMD diagnosis and symptoms, e.g., joint pain, popping, clicking, crepitus, migraines, deviated opening, etc.

Some plans cover appliances for bruxism, mobility, and/or some for TMD, but few cover all three. Know the clinical problem, (i.e., there is a diagnosis) before you check for benefits.

NARRATIVES

1. To determine if a splint or occlusal guard is covered by a patient's dental plan, one must first determine the purpose of the appliance. Is it needed to minimize the effects of bruxism? Is periodontal mobility due to occlusal factors a part of the diagnosis, or is the patient experiencing headaches and pain in the temporomandibular joint area?
2. Although D9945 is not a by report code, it is recommended to include a narrative and documentation as indicated below:
   - If the diagnosis is bruxism, state "Diagnosis = Bruxism." An occlusal guard is necessary to minimize the effects of bruxism and clenching of teeth." For occlusal guards, keep the narrative short.
   - If there is a *history* of scaling and root planing (D4341/D4342) or periodontal osseous surgery (D4260/D4261), note this in the narrative when reporting an occlusal guard. The narrative might state "This patient has undergone periodontal therapy on (date). Include a description of the case type." Coverage for D9945 may vary based on whether the policy includes a supplemental "periodontal rider." The rider could make a difference in coverage if there is a supplemental "periodontal rider" in the contract. Even so, some payors make a distinction between case types and will only reimburse for the more advanced osseous surgery. SRP (D4341/D4342) treatment may not suffice. Some plans require the occlusal guard be placed within six months of active periodontal treatment. If D9945 is reimbursed under a periodontal rider, the benefit may be available only once every five years or be limited to a lifetime maximum. The annual maximum will generally apply. Reimbursement is highly variable.
   - Some plans require the occlusal guard be placed within six months of the active periodontal treatment (SRP or osseous surgery). If the occlusal guard is required to address periodontal mobility, include a periodontal diagnosis, current periodontal charting, and radiographs.

D9946 OCCLUSAL GUARD - HARD APPLIANCE, PARTIAL ARCH CDT 2025

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.



WARNING

It is misleading to report the delivery of an occlusal guard- hard appliance, partial arch (D9946) to describe tooth whitening trays (D9975) to receive reimbursement. Tooth whitening trays are provided for cosmetic purposes and are not generally a covered service.



WATCH

1. The occlusal guard - hard appliance, partial arch (D9946) and the occlusal orthotic device (D7880) are often confused. Report D9946 to describe a hard occlusal guard, partial arch for minimizing the effects of "bruxism" and "clenching of teeth." Report D7880 to describe an appliance provided to treat TMJ dysfunction, which typically includes multiple visits or D5999 to report a snoring appliance. Snoring is considered a social, not medical, condition.
2. Report D9947 for the fabrication and placement of a custom sleep apnea appliance.

COMMENTS

1. Bruxism is the parafunctional or habitual "clinching" or "grinding" of teeth.
2. There are three basic, broad types of bruxism appliances:
   - The NTI-tss, an anterior partial arch hard appliance, generally worn at night (D9946).
   - Soft (generally suck down) appliance (D9945), typically fabricated in the dental office.
   - Laboratory made hard acrylic appliance with or without soft liner (D9944).

The NTI occlusal guard fee might vary from $250 to $650, depending on the type of appliance. Factors such as the laboratory bill, the clinical technique used, and the total number of visits for impressions, delivery and follow up may affect the overall fee charged. Occlusal guards usually require a few visits to deliver the appliance.

3. See D9943 to report an adjustment of an occlusal guard. A waiting period (up to six months) may be required.
4. Report D9942 for the repair and/or reline of an occlusal guard. A waiting period (up to six months) may be required.
5. Enter the arch being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

1. If the hard occlusal guard, partial arch (D9946), also known as a night guard or anterior deprogrammer, or bite guard is reimbursed, it is generally reimbursed under dental, not medical insurance.
2. Reimbursement for an occlusal guard (D9946) may be subject to an age exclusion, for instance, children 12 years of age or younger.
3. Some payors only reimburse for bruxism; others require periodontal treatment (SRP or in some cases osseous surgery) to justify reimbursement.
4. Occlusal guards may be reimbursed under "preventive," "basic," or "major" classifications. Classification is highly variable. Waiting periods may apply for basic and major coverage.
5. After delivery of the occlusal appliance, six months of follow up care (including adjustments) is typically considered integral in the global occlusal guard fee by payors. For an occlusal guard adjustment, see D9943. Adjusting an occlusal guard is usually not reimbursed.
6. Although the occlusal orthotic device, by report (D7880) is generally considered to be for TMJ dysfunction, a few payors will reimburse the occlusal guard (for bruxism) as an alternate benefit of the TMJ dysfunction appliance code D7880. This is not typical.
7. Pretreatment authorization may be required for D9946.

Note: D9946 does not report a TMJ dysfunction appliance or active TMJ dysfunction treatment. TMJ dysfunction is not typically a covered dental benefit without a TMJ dysfunction rider; however, TMJ dysfunction may be reimbursed through medical insurance. TMJ dysfunction treatment (for pain, symptoms) involves a splint, multiple visits, and typically occlusal adjustments. The dental code for an appliance used to treat TMJ dysfunction is occlusal orthotic device (D7880). See D7880 for further details.

TIPS

If a patient requires a hard nightguard covering part of the arch because of night grinding or pain in the anterior due to occlusal factors, the appliance is billed using code D9946. If bruxism is the problem, a simple narrative indicating the patient is a bruxer should be all that is necessary.

If the patient is experiencing temporomandibular joint dysfunction (TMD), the occlusal orthotic should be billed using code D7880. A narrative should describe the (TMD) diagnosis and symptoms, e.g., joint pain, popping, clicking, crepitus, migraines, deviated opening, etc.

Some plans cover appliances for bruxism, mobility, and/or some for TMD, but few cover all three. Know the clinical problem, (i.e., there is a diagnosis) before you check for benefits.

NARRATIVES

1. To determine if a splint or occlusal guard is covered by a patient's dental plan, one must first determine the purpose of the appliance. Is it needed to minimize the effects of bruxism? Is periodontal mobility a part of the diagnosis, or is the patient experiencing headaches and pain in the temporomandibular joint area?
2. Describe the pain/bruxism diagnosis and the necessity of the hard appliance, partial arch.
3. See Narrative #2 for D9945 as outlined above. Repairs to sleep apnea appliances are typically not reimbursed under dental.

PHOTO



This is an example of a device/appliance/splint (NTI-tss).

Courtesy Keller Dental Laboratory

D9950 OCCLUSION ANALYSIS - MOUNTED CASE

CDT 2025

Includes, but is not limited to, facebow, interocclusal records tracings, and diagnostic wax-up; for diagnostic casts, see D0470.

COMMENTS

1. D9950 is a mounted case and the diagnostic casts (D0470) would be reported separately.
2. D9950 includes a diagnostic wax-up.

LIMITATIONS

Occlusion analysis - mounted case (D9950) is not generally reimbursed.

TIPS

Some offices choose to credit the occlusal analysis - mounted case plus diagnostic cast fees by 50-100% toward the overall case fee, particularly if it's associated with a preliminary wax-up prior to treatment.

D9951 OCCLUSAL ADJUSTMENT - LIMITED

CDT 2025

May also be known as equilibration; reshaping the occlusal surfaces of teeth to create harmonious contact relationships between the maxillary and mandibular teeth. Presently includes discing/odontoplasty/enamoplasty. Typically reported on a "per visit" basis. This should not be reported when the procedure only involves bite adjustment in the routine post-delivery care for a direct/indirect restoration or fixed/removable prosthodontics.

WATCH

D9951 "should not be reported when the procedure involves minor bite adjustments in the routine post-delivery care for a direct/indirect restoration or fixed/removable prosthodontics."

COMMENTS

1. If an occlusal adjustment is required within a short period of completion of a restorative procedure, it is considered a part of the global restorative procedure and D9951 should not be reported.
2. Occlusal adjustment - limited (D9951) is typically reported on a "per visit" basis. This procedure is not generally reimbursed.
3. If the adjustment of a single tooth is deemed necessary at a visit for the treatment of discomfort or acute pain as reported by the patient, see palliative (D9110). Although D9110 is not a by report code, it is recommended to provide an appropriate narrative to justify the submission of the D9110 code. See D9110 for details.
4. A fissurotomy is a mechanical *component* of a sealant placement. See sealant (D1351), which includes fissurotomy.
5. For removal of enamel projections or odontoplasty per tooth, see D9971. This would typically not be related to an occlusal adjustment for equilibration of teeth.

LIMITATIONS

1. Certain dental policies include a "periodontal rider," which may reimburse occlusal adjustments. The occlusal adjustment may be considered an "adjunct" to periodontal therapy (SRP) or osseous surgery. Occlusal adjustment may improve the prognosis of the periodontal treatment. However, a periodontal surgical case may be required for reimbursement. Reimbursement, if available, may be limited to treatment within six months of the periodontal treatment.
2. Some payors consider a "limited" occlusal adjustment as *less* than eight teeth and reimburse this procedure once per 12 months. Others will reimburse a series of limited adjustment visits (highly variable among payors).
3. D9951 could possibly be reported as an adjunct to orthodontic treatment, but it is considered to be incidental and a part of the global orthodontic case. However, often the orthodontic lifetime maximum is depleted unless there was a change in employment, "resetting" additional, lifetime orthodontic benefits. Be sure to answer "Yes" to this claim form question, "Is treatment for orthodontics?" to be considered for reimbursement of an occlusal adjustment.
4. D9951 may possibly be covered for TMJ dysfunction treatment if the dental policy has a "TMJ rider." Plan limitations are highly variable.

TIPS

1. A *series* of occlusal adjustment-limited (D9951) visits provided on different service dates may be reimbursed at an overall higher rate than a *one time* billed complete occlusal adjustment (D9952) which includes multiple visits.

2. D9951 reports "discing" primary canines for proper occlusal eruption of permanent lower anterior incisors, along with odontoplasty, and enameloplasty. Always use a brief narrative. Occasionally, discing primary canines is reimbursed.

NARRATIVES

Although D9951 is not a by report code, it is recommended that a narrative be submitted, which should:

1. State diagnosis and which specific teeth were adjusted.
2. If applicable, submit a brief narrative indicating that the patient has undergone periodontal therapy: "The patient underwent osseous surgery (or SRP) on mm/dd/yy." Note the type of periodontal case.

D9952 OCCLUSAL ADJUSTMENT - COMPLETE

CDT 2025

Occlusal adjustment may require several appointments of varying length, and sedation may be necessary to attain adequate relaxation of the musculature. Study casts mounted on an articulating instrument may be utilized for analysis of occlusal disharmony. It is designed to achieve functional relationships and masticatory efficiency in conjunction with restorative treatment, orthodontics, orthognathic surgery, or jaw trauma when indicated. Occlusal adjustment enhances the healing potential of tissues affected by the lesions of occlusal trauma.

COMMENTS

Occlusal adjustment - complete (D9952) is not generally reimbursed. Exception: Certain dental policies include a "periodontal rider," which provides reimbursement for a *complete* occlusal adjustment. The occlusal adjustment may be considered an "adjunct" to periodontal surgery. Occlusal adjustments may improve the prognosis of periodontal treatment. A surgical periodontal case (D4240/D4241/D4260/D4261) may be required for reimbursement. SRP (D4341/D4342) treatment may not be enough to qualify the patient for D9952 reimbursement.

LIMITATIONS

1. If the complete occlusal adjustment is reimbursed, D9952 may be limited to once per lifetime.
2. Some payors require eight or more teeth to be present to consider a complete occlusal adjustment for reimbursement. For fewer teeth, consider limited occlusal adjustment (D9951).
3. D9952 may be reimbursed if the policy has a "TMJ dysfunction treatment rider." Plan limitations are highly variable.
4. Payor's consider an occlusal adjustment incidental to the completion of an orthodontic case and is not separately reimbursed.

TIPS

1. Occlusal adjustment-complete (D9952) is provided to improve the prognosis of periodontal, orthodontic, and TMJ dysfunction treatment.
2. D9952 reports a comprehensive *series* of visits, not a *single* visit. Reporting occlusal adjustment-limited (D9951) on a visit by visit basis may result in a higher reimbursement than D9952, if reimbursed. D9952, when reimbursed, may be subject to a once in a lifetime limitation. See D9951.

NARRATIVES

1. Although D9952 is not a by report code, it is recommended that a brief narrative should indicate that the patient has undergone periodontal therapy: "The patient underwent osseous surgery (or SRP) on mm/dd/yy." A surgical periodontal case (D4240/D4241/D4260/D4261) may be a prerequisite for reimbursement of this procedure. SRP (D4341/D4342) treatment may not qualify the patient for D9952.
2. To state the diagnosis and if treatment was done in conjunction with restorative treatment, orthodontics, orthognathic surgery, jaw trauma or TMJ dysfunction treatment.

D9961 DUPLICATE / COPY PATIENT'S RECORDS

CDT 2025

Note: This code is placed here in numerical order but resides correctly in the non-clinical section.



WARNING

Patients are entitled to a copy of their clinical records, regardless of the status of their account. It would be improper under HIPAA to deny the patient a copy of their clinical record for any reason.



WATCH

It is advised to obtain a written release (from the patient) before providing a copy of the patient's records to any entity. When the practice receives a signed records transfer request from a patient, using the appropriate form as defined by HIPAA, the clinical record should be duplicated and sent to the entity identified on the records transfer request form. If emailed, the record should be sent via a secure email system that meets HIPAA standards to ensure compliance with the HIPAA mandate. This administrative task is documented using D9961.



MATCH

D9961 describes the duplication or copying of the patient's records. Original records should be retained and only a copy provided.

COMMENTS

Copying or duplicating patient records is a very common and often-performed non-clinical task in most practices. D9961 would be used to document the act of duplicating a patient's records. The reasons for the duplication of records may include a patient moving or switching practices, requesting a copy of their records for personal use, or when a specialist requests a copy for information about a shared patient, etc. Duplication or copying refers to preparing the record for transfer electronically (placement on a disc or flash drive) or manually (copying paper records). The practice may generally charge a reasonable fee for duplication of records.

LIMITATIONS

Payors do not typically pay for the duplication of patient records.

TIPS

HIPAA indicates that a practice can only charge the actual cost of labor and materials for copying records. Some states may have a "no charge" requirement for the first copy of records. Contact your State Board of Dentistry to determine your state regulations.

D9970 ENAMEL MICROABRASION

CDT 2025

The removal of discolored surface enamel defects resulting from altered mineralization or decalcification of the superficial enamel layer. Submit per treatment visit.



WARNING

Enamel microabrasion (D9970) should not be confused with "preventive" resins. If the caries and preparation extends into the dentin, then the restoration is an amalgam or composite. Report using the corresponding restorative code. A preventive resin restoration (D1352) is a *conservative* restoration (with the doctor's cavity preparation) of a cavitated lesion in enamel that *does not* extend into the dentin. On the other hand, if the mechanically and/or chemically prepared enamel surface is sealed to prevent decay, report sealant (D1351).

COMMENTS

1. Enamel microabrasion (D9970) may be provided for anterior teeth. Microabrasion is generally considered a cosmetic procedure. It often involves applying an acid and "buffing" out the enamel defect and it may include air abrasion
2. D9970 is used to describe enamel microabrasion by treatment *visit*, not *per tooth*. The procedure would include the treatment of *all* teeth with enamel microabrasion on the same service date.
3. The global fee for D9970 should be reported and reflect the time spent for the enamel microabrasion of one or more teeth on the same service date.
4. Enter the teeth number(s), range of teeth, and/or surfaces being treated, as applicable, in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

Because the microabrasion procedure is considered cosmetic, this code is not generally reimbursed.

D9971 ODONTOPLASTY - PER TOOTH

CDT 2025

Removal/reshaping of enamel surfaces or projections.

COMMENTS

1. D9971 reports odontoplasty per tooth. In instances of multiple teeth, the procedure code is appropriately entered once in Box 29 with the appropriate quantity entered in Box 29b of the 2024 ADA Dental Claim Form. The fee for multiple teeth treated is the total of fees for each tooth.
2. Also read occlusal adjustment - limited (D9951) for additional information. D9951 reports discing, odontoplasty, and enameloplasty *as a part of* a limited occlusal adjustment.

3. A fissurotomy is a *component* of a sealant placement, see sealant (D1351), which includes fissurotomy.
4. Enter the teeth number(s), range of teeth, and/or surfaces being treated, as applicable, in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

D9971 is typically not reimbursed.

TIPS

D9971 is reported for adjusting each tooth. If three teeth are treated, D9971 would be reported three times. While payors often deny D9971 as cosmetic, payment may be provided in certain situations (typically accident related scenarios). With discomfort as reported by a patient at any visit, limited odontoplasty (e.g., smoothing the sharp edge of a tooth) could possibly be reimbursed under palliative (D9110). See D9110 for more details.

D9972 EXTERNAL BLEACHING - PER ARCH - PERFORMED IN OFFICE CDT 2025



WARNING

1. It is misleading to report diagnostic casts (D0470), fluoride gel carrier (D5986), occlusal orthotic device (TMJ dysfunction treatment appliance) (D7880), or occlusal guard (D9944, D9945, and D9946) when providing external bleaching for tooth whitening in the dental office to gain reimbursement.
2. Many PPO contracts require reporting all procedures performed, even if it is a non-covered procedure. Contracted PPO offices may have tooth whitening procedure fees controlled when submitted yet pay no reimbursement. To not submit a tooth whitening procedure (if charged) is typically a violation of the PPO contract.



WATCH

1. D9972 External bleaching reports in office bleaching only, **per arch**. Take home trays would be included.
2. For take home bleaching treatments on a standalone basis e.g., (trays or strips), report D9975 **per arch**.

COMMENTS

1. D9972 is used to describe external bleaching performed in office only.
2. Diagnostic casts D0470 are considered integral to the in office tooth whitening service code, D9972 and should not be reported separately.
3. D9972 is reported on a *per arch* basis. If treating the whole mouth, cut in half the total whitening fee and report it for each arch reporting D9972. Correctly reporting external bleaching per arch (at one-half fee per arch) may limit a PPO's fee controls for non-covered procedures. If an insured plan that is written in a state without non-covered legislation or if the plan is self-funded under ERISA then this approach could be beneficial by improving the allowable fee in some cases. Refer to Dental Administration with Confidence to learn more about fee-capping for non-covered services.
4. Enter the arch being treated in the appropriate boxes of the 2024 ADA Dental Claim Form.

LIMITATIONS

As a general rule, tooth whitening (bleaching) is not reimbursed. Some payors may offer "cosmetic riders," which cover the bleaching of severe tetracycline staining or severe fluorosis of anterior permanent teeth. The benefit, if available, may be subject to frequency or lifetime maximums.

TIPS

1. For in office "power bleaching" D9972, consider a total fee of $395 to $695 per arch. For the KöR bleaching technique, the fee could be much higher. In office bleaching D9972 is generally $100 to $300 greater than the fee for take home application bleaching tray systems (D9975). The bleaching fee for most offices typically *includes* the at home trays to enhance whitening effects, or for "touch up," after the in office bleaching has been performed. Split the total bleaching fee in *half* and report the upper and lower arch separately as D9972.
2. Consider this illustration of tooth whitening pricing:

   (D9972A) In-Office Bleaching - Whitening (upper arch) - $195 and up.

   (D9972B) In-Office Bleaching - Whitening (lower arch) - $195 and up.

   Compare fees in your local area and consider the cost of the time and materials required to perform this procedure in your office before establishing your office fee. Some offices greatly discount tooth whitening for marketing purposes.

D9973 EXTERNAL BLEACHING - PER TOOTH CDT 2025



WARNING

1. It is misleading to report diagnostic casts (D0470), fluoride gel carrier (D5986), occlusal orthotic device (TMJ dysfunction treatment appliance) (D7880), or occlusal guard (D9944, D9945, and D9946) when providing external bleaching for tooth whitening in the dental office to gain reimbursement.
2. Many PPO contracts require reporting all procedures performed, even if it is a non-covered procedure. Contracted PPO offices may have tooth whitening procedure fees controlled when submitted yet pay no reimbursement. To not submit a procedure to the PPO payor (if charged) is typically a violation of the contract.

COMMENTS

1. D9973 is used to describe external bleaching on a per tooth basis and is performed in the office.
2. Diagnostic casts D0470 are considered a part of the tooth whitening service code, D9973, and should not be reported separately.
3. See D9972 for external bleaching-per arch in office. See D9975 for take home bleaching trays and strips.
4. See D9974 for internal bleaching-per tooth (bleaching an endodontically treated tooth).
5. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

As a general rule, tooth whitening (bleaching) is not reimbursed. Some payors may offer "cosmetic riders," which cover the bleaching of severe tetracycline staining or severe fluorosis of anterior permanent teeth. The benefit, if available, may be subject to frequency or lifetime maximums.

D9974 INTERNAL BLEACHING - PER TOOTH CDT 2025



WARNING

1. For endodontic access closure after internal bleaching of a natural tooth, it is improper to report a core buildup (D2950). A core buildup is specifically for securing the retention of a crown on a fully prepared tooth. See D2950 for specific reporting requirements of a core buildup.
2. Report an amalgam or composite lingual or occlusal restoration to report an endodontic access hole closure after the internal bleaching of a tooth.



WATCH

1. It is an error to report D3960 to describe internal bleaching of an endodontically treated tooth. D3960 is a previously deleted code. Report the current code, internal bleaching - per tooth (D9974).
2. It is an error to report *external* bleaching (D9972, D9973 or D9975) as internal bleaching of an endodontically treated tooth.

COMMENTS

1. Internal bleaching - per tooth (D9974) is used to describe the internal bleaching (whitening) of an endodontically treated single tooth that has not been crowned, typically an anterior tooth. D9974 reports a series of treatment visits to bleach a tooth from the inside after endodontic treatment. Two or more treatment visits may be required to complete the bleaching process.
2. D9974 *does not* include the closure of the endodontic access opening. Reporting a single surface anterior (D2330) or posterior resin composite (D2391) would be appropriate for reporting the endodontic access closure performed on a *natural* tooth, after the internal bleaching treatment is completed. D9974 is typically performed on anterior teeth.
3. Enter the tooth number being treated in Box 27 of the 2024 ADA Dental Claim Form.

LIMITATIONS

If reimbursement is available, it may be subject to a three year or five year limitation. Generally internal bleaching (D9974) is a patient expense.

TIPS

The fee quoted should be for completion of the service, generally for the first two or three treatments. Communicate to the patient that there may be additional visits required to gain desired results. Additional visits may result in additional fees per visit. However, a dental plan will not reimburse additional visit fees and a PPO will typically disallow.

NARRATIVES

Although D9974 is not a by report code, it is recommended that a narrative be submitted. D9974 may occasionally be reimbursed. Submit a photograph and a brief narrative describing the initial endodontic treatment date, with a before and final diagnostic image demonstrating the completed internal bleaching procedure.

D9975 EXTERNAL BLEACHING FOR HOME APPLICATION, PER ARCH; INCLUDES MATERIALS AND FABRICATION OF CUSTOM TRAYS — CDT 2025

WARNING

1. It is misleading to report diagnostic casts (D0470), fluoride gel carrier (D5986), occlusal orthotic device (TMJ dysfunctional treatment appliance) (D7880), or occlusal guard (D9944, D9945, and D9946) when providing external bleaching for tooth whitening, to gain reimbursement.
2. Many PPO contracts require reporting all procedures performed, even if it is a non-covered procedure. Contracted PPO offices may have tooth whitening procedure fees controlled when submitted. To not submit a procedure (if charged) is typically a violation of the PPO contract.

WATCH

1. For in office bleaching report D9972, on a per arch basis. D9972 includes take home trays.
2. For whitening refills only, report D9999. If sales tax is required, see D9985.

COMMENTS

1. D9975, external bleaching reports home bleaching only. The home bleaching application can be accomplished using custom trays or strips.
2. Diagnostic casts D0470 are considered inclusive of the home application tooth whitening service code, D9975, and should not be reported separately.
3. D9975 is reported on a per arch basis. If treating the whole mouth, report each upper and lower arch separately, at one-half of the full fee. Reporting external bleaching-per arch (at one-half of the full fee per arch) may be important, if an insured plan that is written in a state without non-covered legislation or if the plan is self-funded under ERISA then this could be beneficial by improving the allowable fee in some cases.

LIMITATIONS

As a general rule, tooth whitening (bleaching) is not reimbursed. Some payors may offer "cosmetic riders," which cover the bleaching of severe tetracycline staining or severe fluorosis of anterior permanent teeth. The benefit, if available, may be subject to frequency or lifetime maximums.

TIPS

1. $99 "tooth whitening for life" has gained some popularity as a marketing tool. This is a program that includes free bleaching refills as an incentive if the patient keeps timely recall appointments.
2. Consider this illustration of pricing:

   (D9975A) Home Application Whitening, first arch - upper - $100 or higher.

   (D9975B) Home Application Whitening, second arch - lower - $100 or higher.

   (D9975C) Whitening Strips (Crest White Strips®/Ultradent's Tres White®) - $65 to $95 or higher.

   Compare fees in your local area and consider the cost of the time and materials required to perform this procedure before establishing your fee. Some offices greatly discount take home tooth whitening for marketing purposes.

NON-CLINICAL PROCEDURES — CDT 2025

D9961 DUPLICATE / COPY PATIENT'S RECORDS — CDT 2025

Note: This code is not placed in numerical order but resides correctly here in the non-clinical procedures section.

WARNING

Patients are entitled to a copy of their clinical records, regardless of the status of their account. It would be improper to deny the patient a copy of their clinical record for any reason.

WATCH

It is advised to obtain a written release (from the patient) before providing a copy of the patient's records to any entity. When the practice receives a signed records transfer request from a patient, using the appropriate form as defined by HIPAA, the clinical record should be duplicated and sent to the entity identified on the records transfer request form. If emailed, the record should be sent via a secure email system that meets HIPAA standards to ensure compliance with the HIPAA mandate. This administrative task is documented using D9961.

MATCH

D9961 describes the duplication or copying of the patient's records. Original records should be retained and only a copy provided.

COMMENTS

Copying or duplicating patient records is a very common and often-performed non-clinical task in most practices. D9961 would be used to document the act of duplicating a patient's records. The reasons for the duplication of records may include a patient moving or switching practices, requesting a copy of their records for personal use, or when a specialist requests a copy for information about a shared patient, etc. Duplication or copying refers to preparing the record for transfer electronically (placement on a disc or flash drive) or manually (copying paper records). The practice may generally charge a reasonable fee for duplication of records.

LIMITATIONS

Payors do not typically pay for the duplication of patient records.

TIPS

HIPAA indicates that a practice can only charge the actual cost of labor and materials for copying records. Some states may have a "no charge" requirement for the first copy of records. Contact your State Board of Dentistry to determine your state regulations.

D9985 SALES TAX CDT 2025



WARNING

Sales and use tax is NOT a Medical Device Tax. A medical device tax is a federal tax. Only sales tax should be reported with D9985.

COMMENTS

1. With the eventual conversion to the HIPAA standard electronic claim form in the future, it is essential that this be made easier. Creating a code for Sales Tax (D9985) will alleviate some of these reporting problems.
2. Sales tax is reported with Sales Tax (D9985) and describes the application of sales tax to dental services and/or products provided to the patient. The sales tax amount, if any, is directed by local and state law.
3. The majority of states have a sales and use tax on products separately sold by dentists, but only a few states have a tax on dental services. For instance, a toothbrush included in a prophylaxis appointment could be included in the dental service fee, and would be exempt from product sales tax, as it is not separately sold/collected in most states. But, if the patient wanted to buy extra toothbrushes for the family, there would be sales tax on the tooth brush purchase. There are some states that have a sales tax on dental services, and several others are considering legislation. Sometimes, just cosmetic procedures are taxed such as cosmetic dentistry and tooth whitening trays. Without this sales tax code, it may appear a provider's charges for certain procedures are higher than intended and thus artificially inflate fee rates and potential tax liability.
4. A sales/service/product tax code is necessary to properly record transactions in the patient record and invoicing. Consult your CPA as to the specifics of your state law.
5. ADA Dental Claim Form Special Completion Instructions may be found at https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/publications/cdt/special_instructions_d9985_sales_tax.pdf
6. For more information, see the Dental Administration with Confidence manual, which may be found at www.practicebooster.com/store.

LIMITATIONS

Sales Tax (D9985) is not reimbursed by dental payors and must be paid by the patient (or the practice can pay the sales tax).

D9986 MISSED APPOINTMENT CDT 2025

COMMENTS

1. Centers for Medicare and Medicaid Services (CMS) (by statute) indicate no charge may be assessed to the patient for missed appointments (and those cancelled without sufficient notice), but dentists could benefit from having a way to electronically document (and track) patient missed appointments. According to the National Association of Dental Plans' CDT Workgroup, a missed appointment code is needed for compliance with certain state and federally funded programs and to allow the electronic health record to accurately reflect patient behavior related to dental care.

2. It is common knowledge that a patient who does not arrive for scheduled care adds to the cost of dental care because both administrative and clinical team members must prepare for the delivery of the patient's scheduled services and the loss of productive time. Patients who miss their appointments undermine both the efficiency and productivity of the entire dental practice.
3. Previously, there was no specific CDT code for reporting a missed appointment, whether a provider intends to charge a fee or not.
4. D9986 allows a provider to document and more easily track his/her inability to provide serviceswhen a patient fails to attend a scheduled appointment.

LIMITATIONS

1. There will be no reimbursement by payors for a missed appointment.
2. For private pay patients, with a prior written agreement, missed appointments and those cancelled (without sufficient notice) might be charged.
3. For patients of government programs, such as Medicaid/Medicare, the Centers for Medicare and Medicaid Services (CMS) state that no charge can be assessed to the patient for missed appointments.

ADDITIONAL INFORMATION

A typical coding scenario involves a patient who does not show up for a scheduled appointment to be treated by the dentist, hygienist, or other professional. There is no record of the patient's intent to cancel or reschedule the appointment. The unanticipated void in the schedule disrupts the practice workflow and requires adjustment to the schedule for delivery of services to other patients who arrive on time. D9986 documents and reports this missed appointment.

D9987 CANCELLED APPOINTMENT — CDT 2025

COMMENTS

1. D9987 may be used to document a patient who cancels a previously scheduled appointment without adequate notice (creating an unanticipated void in the provider's schedule), to track a patient who cancels an appointment without rescheduling, or to simply document in the patient's electronic record that he/she cancelled an appointment.
2. Tracking cancelled appointments is important to document continuity of care in the patient's electronic health record. The administrative code D9987 will be particularly helpful for identifying and tracking patients who frequently cancel appointments.
3. Although traditional dental plans do not provide a benefit for broken appointments or cancellations without adequate notice, having the ability to codify/document a broken, cancelled, or late appointment on a patient's billing statement may improve compliance, even when no fee is assessed.
4. This may also help providers track patients who have not yet rescheduled their appointment following a cancellation.

LIMITATIONS

1. There will be no reimbursement by payors for a cancelled appointment.
2. For private pay patients, with a prior written agreement, a cancelled appointment (without sufficient notice) might incur a fee.
3. For patients of government programs, such as Medicaid/Medicare, the Centers for Medicare and Medicaid Services (CMS) state that no charge can be assessed to the patient for cancelled appointments.

ADDITIONAL INFORMATION

It was the National Association of Dental Plans' CDT Workgroup that requested this administrative based code stating that it is needed for compliance with certain state and federally funded programs and to allow for the electronic health record to accurately reflect patient behavior related to dental care. D9987 allows a provider to document that they were unable to provide services because the patient cancelled his/her scheduled appointment.

D9990 CERTIFIED TRANSLATION OR SIGN-LANGUAGE SERVICES - PER VISIT — CDT 2025



WARNING

D9990 does not describe providing translation service or sign-language interpretation services by the patient's family member, uncertified person or uncertified team member.

WATCH

Be careful to obtain a copy of the translator's certification to document their qualifications.



MATCH

D9990 describes a scenario when a person, who is a certified translator or sign-language communicator, is provided by the practice to communicate with the patient.

COMMENTS

There is a requirement under the Affordable Care Act, Section 1557 that requires covered entities to provide free language services to patients whose primary language is not English. Section 1557 of the Affordable Care Act provision, effective July 18, 2016, prohibits discrimination on the basis of race, color, national origin, sex, or disability in healthcare programs that receive federal financial assistance. Compliance for this regulation includes, but is not limited to, providing qualified interpreters and translators. To improve efficiencies in benefit determination it was determined by the Code Maintenance Committee that translation services warranted its own code. D9990, a specific code for translation, enhances processing efficiencies and allows benefit determination without requests for additional documentation.

Section 1557 regulation requires translation services to the non-English speaking patient or their authorized representatives on issues involving their medical condition and treatment, including dental conditions and treatment. The practice has the option to provide language assistance through various methods, including the use of competent bilingual team members, interpreters, contracts or formal arrangements with local organizations providing interpretation or translation services, or technology and telephonic interpretation services. There are many cost-effective translation services available to dentists. The American Dental Association has endorsed CyraCom® as a provider for phone and video interpretation, enabling dentists to communicate with their non-English speaking patients in seconds. Visit interpret.cyracom.com for more information regarding this valuable service.

The non-English speaking patient has the right to make an informed decision. Without the use of outside certified translation services, this right is taken away from the patient. Dentists should be aware that Google translation is not reliable as is the use of non-qualified individuals such as the child of a patient, etc.

LIMITATIONS

Most payors do not reimburse for this service even though it may be a required service. Some payors may provide a low or no-cost translation service.

TIPS

This service may be needed when a patient presents for treatment whose primary language is not English. It is the treating doctor's responsibility to ensure meaningful, effective communication with all patients; therefore, the practice schedules a translator to communicate with the patient. The translator assists the patient in completing all vital documents, including but not limited to, waivers of rights, appointment scheduling, administrative processes and policies, financial policies, and insurance benefit forms. The translator will also assist in communicating all treatment recommendations during the doctor consultation, as well as the consent to treatment forms.

NARRATIVES

While D9990 is no a "by report" code, it is suggested that the narrative should identify the type of disability or communication challenge (e.g., patient doesn't speak English), who provided the translating service, and a copy of the translator's credentials.

D9991 DENTAL CASE MANAGEMENT - ADDRESSING APPOINTMENT COMPLIANCE BARRIERS

CDT 2025

Individualized efforts to assist a patient to maintain scheduled appointments by solving transportation challenges or other barriers.



WATCH

This code should not be used to report the "normal" interaction the practice has with a patient or caregiver to maintain appointment compliance and discussion regarding transportation issues.



MATCH

D9991 is used to report the additional and individualized efforts expended to aid a patient who may not have transportation for dental appointments or that may have other barriers that prevent appointment compliance. D9991 reports situations where the office arranges a "Medicaid cab" provider to provide transportation for the patient and caregiver to and from the dental appointment to ensure continuing care and treatment compliance.

COMMENTS The American Association of Pediatric Dentistry (AAPD) requested case management codes to provide a method of quantifying case management efforts. The government has begun a Medicaid Dental Transformation Initiative and the adoption of these case management codes is intended to help the dentist report efforts in fulfilling the initiative requirements. California Medicaid provides incentives for dental health management efforts. D9991 will also help describe and document these efforts.

LIMITATIONS Administrative codes, like this code, are intended to be used to track varying behaviors of patients and healthcare providers. It is very unlikely that these codes will be reimbursed.

NARRATIVES While D9991 is not a "by report" it is suggested that if this code is submitted, describe the administrative action and efforts made in association with the provision of this administrative service. A description of the individualized efforts should be noted.

D9992 DENTAL CASE MANAGEMENT - CARE COORDINATION CDT 2025

Assisting in a patient's decisions regarding the coordination of oral health care services across multiple providers, provider types, specialty areas of treatment, health care settings, health care organizations and payment systems. This is the additional time and resources expended to provide experience or expertise beyond that possessed by the patient.

WATCH This code should not be used to report the "normal" efforts the practice makes when referring a patient to another healthcare professional or coordinating treatment.



MATCH D9992 reports the extraordinary effort the practice exerts when helping a patient to accomplish their chosen treatment and helping to direct the coordination of oral healthcare services across multiple providers, provider types, specialty areas of treatment, healthcare settings, healthcare organizations, and payment systems. D9992 reports the additional time and resources expended to provide experience or expertise beyond that possessed by the patient.

COMMENTS The American Association of Pediatric Dentistry (AAPD) requested case management codes to provide a method of quantifying case management efforts. The government has begun a Medicaid Dental Transformation Initiative and the adoption of these case management codes is intended to help the dentist report efforts in fulfilling the initiative requirements. California Medicaid provides incentives for dental health management efforts. D9992 will also help describe and document these efforts.

LIMITATIONS Administrative codes, like this code, are intended to be used to track varying behaviors of patients and healthcare providers. It is very unlikely that these codes will be reimbursed.

NARRATIVES While D9992 is not a "by report" code, it is suggested that if this code is submitted, describe the administrative action and efforts made in association with the provision of this administrative service. A description of the individualized efforts should be noted.

D9993 DENTAL CASE MANAGEMENT - MOTIVATIONAL INTERVIEWING CDT 2025

Patient-centered, personalized counseling using methods such as Motivational Interviewing (MI) to identify and modify behaviors interfering with positive oral health outcomes. This is a separate service from traditional nutritional or tobacco counseling.



WATCH D9993 should not be used to report the "normal" efforts the practice makes to identify and modify preventive behaviors interfering with positive oral outcomes. This service goes over and above traditional nutritional or tobacco counseling. Recognized patient-centered, personalized counseling should be used, such as Motivational Interviewing (MI) in the process to justify the submission of this procedure code.

MATCH

D9993 reports the use of patient-centered, personalized counseling methods, such as Motivational Interviewing (MI) to identify and modify behaviors interfering with positive health outcomes. The counseling method used when reporting this service should conform to an existing recognized and professionally acceptable method intended to identify and modify behaviors interfering with positive oral health outcomes. D9993 is intended to report the extraordinary effort the practice exerts when attempting to identify and modify behaviors that interfere with positive oral health outcomes. D9993 describes the additional time, method and resources expended to provide counseling over and above nutritional or tobacco counseling.

COMMENTS

The American Association of Pediatric Dentistry (AAPD) requested case management codes to provide a method of quantifying case management efforts. The government has begun a Medicaid Dental Transformation Initiative and the adoption of these case management codes is intended to help the dentist report efforts in fulfilling the initiative requirements. California Medicaid provides incentives for dental health management efforts. D9993 will also help describe and document these efforts.

LIMITATIONS

Administrative codes, like this code, are intended to be used to track varying behaviors of patients and healthcare providers. It is very unlikely that these codes will be reimbursed.

NARRATIVES

While D9993 is not a "by report" code, it is suggested that if this code is submitted, describe the administrative action and efforts made in association with the provision of this administrative service. A specific reference to the type of Motivational Interviewing used is recommended.

D9994 DENTAL CASE MANAGEMENT - PATIENT EDUCATION TO IMPROVE ORAL HEALTH LITERACY

CDT 2025

Individual, customized communication of information to assist the patient in making appropriate health decisions designed to improve oral health literacy, explained in a manner acknowledging economic circumstances and different cultural beliefs, values, attitudes, traditions and language preferences, and adopting information and services to these differences, which requires the expenditure of time and resources beyond that of an oral evaluation or case presentation.

WATCH

D9994 should not be used to report the "normal" efforts the practice makes to provide individual, customized communication of information to assist the patient in making appropriate health decisions designed to improve oral health literacy explained in a manner acknowledging economic circumstances and different cultural beliefs, values, attitudes, traditions, and language preferences, and adopting information and services to these differences. D9994 should not be used to describe a simple oral evaluation or case presentation.

MATCH

D9994 is used to report the individual, customized communication of information to assist the patient in making appropriate health decisions designed to improve oral health literacy explained in a manner acknowledging economic circumstances and different cultural beliefs, values, attitudes, traditions, and language preferences, and adopting information and services to these differences.

COMMENTS

The American Association of Pediatric Dentistry (AAPD) requested case management codes to provide a method of quantifying case management efforts. The government has begun a Medicaid Dental Transformation Initiative and the adoption of these case management codes is intended to help the dentist report efforts in fulfilling the initiative requirements. California Medicaid provides incentives for dental health management efforts. D9994 will also help describe and document these efforts.

LIMITATIONS

Administrative codes, like this code, are intended to be used to track varying behaviors of patients and healthcare providers. It is very unlikely that these codes will be reimbursed.

NARRATIVES

While D9994 is not a "by report" code, it is suggested that if this code is submitted, describe the administrative action and efforts made in association with the provision of this administrative service. The specific case management actions taken to educate the patient and improve oral health literacy should be noted.

D9995 TELEDENTISTRY - SYNCHRONOUS; REAL-TIME ENCOUNTER CDT 2025

Reported in addition to other procedures (e.g., diagnostic) delivered to the patient on the date of service.

WATCH

D9995, Teledentistry - synchronous; real-time encounter does not describe a "regular" phone consult or video consult with another healthcare professional but would include instances where both professionals "interact" with one another and/or with the patient during the encounter.



MATCH

1. D9995, Teledentistry - synchronous, can be defined as the real-time remote provision of dental care, advice, or treatment through the medium of information technology, rather than through direct personal contact with any patient(s) involved.
2. For information that is stored and forwarded to a dentist for subsequent review, see D9996 teledentistry - asynchronous.

COMMENTS

1. D9995 is reported in addition to any other procedure performed on the date of service (e.g., diagnostic services, prophylaxis, fluoride application, etc.)
2. When reporting teledentistry (D9995), the place of service code 02 should be entered in Box 38 of the 2024 ADA Dental Claim Form for the teledentistry claim.
3. In addition, when reporting teledentistry (D9995), the treating dentist and treatment location must be reported in Box 56 of the 2024 ADA Dental Claim Form. The location is reported according to the physical location of the patient receiving teledentistry services. This address may differ from the location of the treating dentist providing the teledentistry services.
4. The patient's clinical record should reflect the type of teledentistry provided, all services provided and findings by all healthcare providers involved in the encounter. Some government funded programs, such as Medicaid may have specific documentation guidelines. Refer to the state Medicaid Provider Manual for clarification.

LIMITATIONS

1. Reimbursement for teledentistry is expected to vary a great deal among commercial plans and government funded plans.
2. Some medical plans and government funded plans may consider reimbursement for teledentistry under specific conditions.

TIPS

1. The provider who oversees the teledentistry encounter completes the limited oral evaluation, provides a diagnosis and treatment plan, and is responsible for documenting and reporting the teledentistry encounter (D9995) should report the code. It is advisable to confirm any state regulations that may exist regarding who reports the teledentistry encounter.
2. The provider (e.g., hygienist, supervising dentist, etc.) who is practicing within their state licensure reports the additional procedures performed such as a prophylaxis, diagnostic images, and fluoride application. It is advisable to confirm with the state dental practice act regarding who is responsible for reporting all procedures performed.

D9996 TELEDENTISTRY - ASYNCHRONOUS; INFORMATION STORED AND FORWARDED TO DENTIST FOR SUBSEQUENT REVIEW CDT 2025

Reported in addition to other procedures (e.g., diagnostic) delivered to the patient on the date of service.

WATCH

D9996, Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review does not describe a "regular" phone consult or video consult with another healthcare professional but would include instances where the subsequent professional would have access to and could review the patient's information at a remote location after the initial encounter.



MATCH

1. D9996, Teledentistry - asynchronous, can be defined as the storage and subsequent review of the dental care, and to provide advice or treatment recommendations through the medium of information technology, rather than through direct personal contact with any patient(s) involved.

2. For teledentistry - synchronous, where the information is passed in real time, see D9995.

COMMENTS

1. D9996 is reported in addition to any other procedure performed on the date of service (e.g., diagnostic services, prophylaxis, fluoride application, etc.)
2. When reporting teledentistry (D9996), the place of service code 02 should be entered in Box 38 of the 2024 ADA Dental Claim Form for the teledentistry claim.
3. In addition, when reporting teledentistry (D9996), the treating dentist and treatment location must be reported in Box 56 of the 2024 ADA Dental Claim Form. The location is reported according to the physical location of the patient receiving teledentistry services. This address may differ from the location of the treating dentist providing the teledentistry services.
4. The patient's clinical record should reflect the type of teledentistry provided, all services provided and findings by all healthcare providers involved in the encounter. Some government funded programs, such as Medicaid may have specific documentation guidelines. Refer to the state Medicaid Provider Manual for clarification.

LIMITATIONS

1. Reimbursement for teledentistry is expected to vary a great deal among commercial plans and government funded plans.
2. Some medical plans and government funded plans may consider reimbursement for teledentistry under specific conditions.

TIPS

1. The provider who oversees the teledentistry encounter completes the limited oral evaluation, provides a diagnosis and treatment plan, and is responsible for documenting and reporting the teledentistry encounter (D9996) should report the code. It is advisable to confirm any state regulations that may exist regarding who reports the teledentistry encounter.
2. The provider (e.g., hygienist, supervising dentist, etc.) who is practicing within their state licensure reports the additional procedures performed, such as a prophylaxis, diagnostic images, and fluoride application. It is advisable to confirm with the state dental practice act regarding who is responsible for reporting all procedures performed.

D9997 DENTAL CASE MANAGEMENT - PATIENTS WITH SPECIAL HEALTH CARE NEEDS

CDT 2025

Special treatment considerations for 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 healthcare services.

COMMENTS

1. D9997 documents and reports various types of modifications made to the delivery of treatment for patient with special needs to ensure customized or comprehensive care is provided.
2. Report D9997 when provided in states such as Wisconsin that have passed legislation for payors to consider a higher reimbursement for the actual dental services provided to Medicaid patients with special needs, requiring modifications to receive customized or comprehensive dental care. A charge may not be allowed for D9997 but documenting D9997 on the 2024 ADA Dental Claim Form may increase reimbursement for the associated dental services provided.
3. Clinical documentation should include a description of the modifications made to the delivery of dental treatment and why the modifications were necessary.

LIMITATIONS

A PPO contract may disallow a charge for D9997 considering the modifications inclusive to the global fee of the dental service(s). Refer to your PPO processing policy manual regarding this type of contract provision.

TIPS

Examples of modified care may include but not limited to additional auxiliary team members (i.e., needed in the operatory during treatment, extra time needed to complete the treatment, rearrangement of the operatory for any physical conditions, etc.

NARRATIVES

While D9997 is not a "by report" code, it is suggested to include a narrative describing the modifications made for the delivery of treatment to patients with special health care needs.

D9999 UNSPECIFIED ADJUNCTIVE PROCEDURE, BY REPORT CDT 2025

Used for procedure that is not adequately described by a code. Describe procedure.

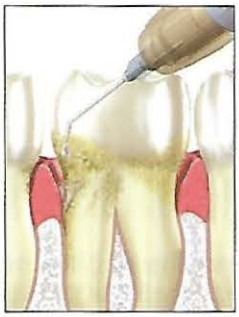
COMMENTS

1. D9999 reports a procedure not adequately described by an existing code in any other category.
2. Unspecified adjunctive procedure, by report (D9999) may be used to describe the following procedures. The list is not exhaustive and D9999 may be used to report any type of unspecified adjunctive procedure, by report.
   a. For reporting Oraqix®, consider D9999. Having a needle free option for anesthesia removes a major obstacle to initial periodontal therapy for patients fearful of injections. Oraqix®, an FDA approved local anesthetic gel, was developed for adults requiring local anesthesia during scaling and root planing. Hygienists love its quick 30 second onset, and patients like the fact that they are only numb for 20 minutes instead of two to three hours following treatment. Since Oraqix® anesthetizes only the nerves in the gingival margin and periodontal pockets where it is applied, dentists have also found it useful for other procedures such as gingivectomies, packing cord, etc. Oraqix® is more expensive than conventional anesthesia. Based on the current descriptor, D9210 can be used to report Oraqix®. D9210 does not indicate that local anesthesia must be injected. However, only a few dental plans pay for local anesthesia separately. Most include anesthesia in their allowable fee for root planing and scaling. Unfortunately, most PPO contracts often instruct contracted providers to write off the additional costs. To avoid this, consider billing D9999 with a brief note: "Patient requested needle free Oraqix®." While it is not likely to be paid by the dental plan, some plans consider Oraqix® an optional service and this will allow contracted providers to charge their patients. Be sure the patient agrees to the charge in writing. Refer to your PPO Processing Policy Manual regarding optional services.
   b. Report D9999 to describe the in office treatment using MI Paste® or MI Paste Plus® to treat white spots after orthodontic treatment. This is typically not reimbursed. This treatment may involve multiple visits and some practices may charge one fee ($150 - $200) for up to x number of visits. For Icon® treatment of white spots, see D2990. For Curodont Repair treatment of white spots, see D2991.
   c. Report D9999 for the dispensing of teeth whitening refills. See D9985 to document and report sales tax collected.

NARRATIVES

As with all codes that include "by report" in the nomenclature, include a narrative describing the procedure performed.

PHOTO



Oraqix® is applied to the gingiva to relieve the discomfort of SRP treatment.

Courtesy DENTSPLY Pharmaceutical

D9947 CUSTOM SLEEP APNEA APPLIANCE FABRICATION AND PLACEMENT CDT 2025



WATCH

1. D9947 reports an appliance fabricated specifically to treat sleep apnea and should meet current approved criterion for sleep apnea appliances.
2. D9947 specifies that the appliance is a custom appliance that is unique to, and specifically fabricated for the patient being treated.
3. See D7880 to report an appliance to treat TMJ/TMD.
4. See D9944, D9945, and D9946 to report various occlusal guards intended to treat clenching and grinding without a TMD diagnosis.

COMMENTS

1. D9947 reports the fabrication and placement of a custom sleep apnea appliance.
2. Diagnosis of sleep apnea is outside the scope of dental practice in many states; therefore, a licensed sleep specialist should make the diagnosis of sleep apnea.
3. A referral from a sleep specialist should be obtained before providing sleep apnea appliances to dental patients.
4. For adjustment of a sleep apnea appliance, see D9948.
5. For repair of sleep apnea appliance, see D9949.
6. For a snoring appliance, see D5999. Snoring is considered a social, not medical, condition.

LIMITATIONS

1. Sleep apnea is a medical condition and treatment for it is seldom reimbursed by a dental plan. Because medical coverage is considered primary to dental coverage, claims for a sleep apnea appliance should be submitted to the patient's medical payor and an EOB obtained prior to submitting to the dental plan(s).
2. Any adjustments of sleep apnea appliances are generally included in the first 6 months of wear after delivery by payors. Adjustments are generally not reimbursed under dental.

NARRATIVES

Although D9947 is not a by report code, it is recommended that a narrative for a sleep apnea appliance should include documentation of the patient's sleep apnea condition from a sleep specialist, documentation of the patient's inability to tolerate a CPAP apparatus, a description of the appliance and the expected outcome.

D9948 ADJUSTMENT OF CUSTOM SLEEP APNEA APPLIANCE CDT 2025



WATCH

D9948 reports the necessary adjustment of a custom sleep apnea appliance after the date of delivery. Adjustments made to the custom sleep apnea appliance on the delivery date is included in the fee for the custom sleep apnea appliance and should not be billed separately.



MATCH

The D9948 describes the necessary adjustment(s) made after the delivery of the custom sleep apnea appliance.

COMMENTS

1. Because of the nature of the sleep apnea appliance and the tendency for wear, these appliances need adjustment from time to time.
2. For the fabrication and placement of a custom sleep apnea appliance, see D9947.
3. For the repair of a sleep apnea appliance, see D9949.

LIMITATIONS

1. Sleep apnea is a medical condition and treatment for it and adjustments is seldom reimbursed by a dental plan. Because medical coverage is considered primary to dental coverage, claims for sleep apnea appliance should be submitted to the patient's medical payor and an EOB obtained prior to submitting to the dental plan(s).

2. Any adjustments of sleep apnea appliances are generally included in the first 6 months of wear after delivery by payors.
3. The fee for an adjustment of a sleep apnea appliance is the patient's responsibility unless disallowed (patient cannot be charged) by the contracted PPO dental payor.
4. Adjustments of a sleep apnea appliance may be possibly payable from that patient's medical plan if there is medical coverage for fabrication of sleep apnea appliances. Adjustments to sleep apnea appliances are typically not reimbursed under dental.

NARRATIVES

Although D9948 is not a by report code, it is recommended that a narrative should include the patient's chief complaint regarding the need to adjust the custom sleep apnea appliance, a photographic image that substantiates the need for the adjustment, a description of why the adjustment is necessary, a description of the adjustment made to the appliance and the patient's reaction to the result of the adjustment.

D9949 REPAIR OF CUSTOM SLEEP APNEA APPLIANCE

CDT 2025



MATCH

D9948 reports the necessary repair of a custom sleep apnea appliance made after delivery.

COMMENTS

1. Because of the nature of the sleep apnea appliance and the tendency for the wearer to stress the appliance, these appliances need repairs from time to time.
2. For the adjustment of a sleep apnea appliance, see D9948.
3. For the fabrication and placement of a custom sleep apnea appliance, see D9947.

LIMITATIONS

1. Sleep apnea is a medical condition and treatment for it is seldom reimbursed by a dental plan. Because medical coverage is considered primary to dental coverage, claims for sleep apnea appliance and repairs should be submitted to the patient's medical payor and an EOB obtained prior to submitting to the dental plan(s).
2. Any repair of a sleep apnea appliance is typically included in the first six months of wear after delivery by payors.
3. The repair of a sleep apnea appliance is the patient's responsibility unless disallowed (patient cannot be charged) by the contracted PPO dental payor.
4. The fee for an adjustment of a sleep apnea appliance is the patient's responsibility unless disallowed.
5. Repairs of a sleep apnea appliance may be payable from that patient's medical plan if there is medical coverage for fabrication of sleep apnea appliances. Repairs to sleep apnea appliances are typically not reimbursed under dental.

NARRATIVES

Although D9949 is not a by report code, it is recommended that a narrative should include the patient's chief complaint regarding the damaged custom sleep apnea appliance, a photographic image that substantiates the need for the repair, an explanation of why the repair is necessary, a description of the repair made to the appliance and the patient's reaction to the result of the repair.

D9953 RELINE CUSTOM SLEEP APNEA APPLIANCE (INDIRECT)

CDT 2025

Resurface dentition side of appliance with new soft or hard base material as required to restore original form and function.



WARNING

Do not report D9953 for the reline of a custom snore appliance, occlusal guard, complete denture, partial denture, or other removable restoration other than a custom sleep apnea appliance.

WATCH

1. This procedure reports the indirect reline of an appliance fabricated specifically to treat sleep apnea and should meet current approved criterion for sleep apnea appliances.
2. The sleep apnea appliance must be a custom appliance that is unique to, and specifically fabricated for the patient being treated.

3. The indirect reline is a laboratory (not chairside) procedure that may take place within the dental practice or in a separate lab location.



MATCH

1. For the fabrication of sleep apnea appliances, see D9947.
2. For the adjustment of sleep apnea appliances, see D9948.
3. For the repair of sleep apnea appliances, see D9949.
4. For the fabrication of a *snore* guard appliance, see D5999. Snoring is a social, not medical, condition.
5. For unspecified removable prosthodontic procedures, see D5899.

COMMENTS

1. This procedure is appropriate when a patient presents with complaint that the previously placed custom sleep apnea appliance is no longer comfortable while being worn. Upon inspection, the dentist observes that retention is not adequate and that the base material requires relining so that retention is maintained.
2. All existing sleep apnea appliance base material is removed in accordance with the product recommendations (e.g., mechanical; chemical) and replaced with equivalent new material. The relined appliance is test-fitted to ensure appropriate material placement and patient comfort.

LIMITATIONS

Dental coverage often excludes sleep apnea appliances, therefore a reline of a sleep apnea appliance will likely not be benefitted by dental insurance but may possibly be covered under medical policies.

NARRATIVES

Although D9953 is not a by report code, it is recommended that a narrative be submitted. The narrative should include the patient's chief complaint regarding the need to reline the custom sleep apnea appliance, a photographic image that substantiates the need for the reline, a description of why the reline is necessary, a description of the reline made to the appliance, and the patient's reaction to the result of the reline.

D9954 FABRICATION AND DELIVERY OF ORAL APPLIANCE THERAPY (OAT) MORNING REPOSITIONING DEVICE

CDT 2025

Device for use immediately after removing a mandibular advancement device to aid in relieving muscle/jaw pain and occlusal changes.



WARNING

Do not report D9954 for the fabrication and delivery of a custom sleep apnea appliance. See D9947.

WATCH

1. For the fabrication of a sleep apnea oral appliance, see D9947.
2. For the adjustment of the sleep apnea appliance, see D9948.
3. For repairs to the sleep apnea appliance, see D9949.
4. For relines of a sleep apnea appliance, see D9953.
5. For a routine titration visit of a sleep apnea appliance, see D9955.



MATCH

D9954 documents the fabrication and delivery of a morning repositioning device commonly used as a part of sleep apnea oral appliance therapy.

COMMENTS

A morning repositioning device may aid in relieving muscle/jaw pain and occlusal changes created by wearing mandibular advancement appliances overnight.

LIMITATIONS

Some payors may maintain that D9954 is a part of the global fee of a custom sleep apnea appliance, D9947.

D9955 ORAL APPLIANCE THERAPY (OAT) TITRATION VISIT

CDT 2025

Post-delivery visit for titration of a mandibular advancement device and to subsequently evaluate the patient's response to treatment, integrity of the device, and management of side effects.



WARNING

Do not report D9955 for the fabrication, adjustment, repair, or reline of a sleep apnea oral appliance. See below.

WATCH

For the fabrication of a sleep apnea oral appliance, see D9947. For the adjustment of the appliance, see D9948. For repairs to the appliance, see D9949. For relines of a sleep apnea appliance, see D9953. For the fabrication of a morning repositioning device, see D9954.



MATCH

D9955 describes a routine post-delivery visit for titration of a mandibular advancement device and to subsequently evaluate the patient's response to treatment, integrity of the device, and management of side effects. This is documented separately from any needed adjustments or repairs.

D9956 ADMINISTRATION OF HOME SLEEP APNEA TEST

CDT 2025

Sleep apnea test, for patients who are at risk for sleep related breathing disorders and appropriate candidates, as allowed by applicable laws. Also, to help the dentist in defining the optimal position of the mandible.



WARNING

Do not report D9956 for in office screening for sleep related breathing disorders. See D9957.



MATCH

D9956 documents the ordering or dispensing of home sleep apnea testing (HSAT) devices.

COMMENTS

HSAT may be done in order to gather objective data to be used along with clinical findings for a physician diagnosis, to help the dentist determine the therapeutic position of the mandible for optimal treatment, or to gather objective data to help the treating physician determine treatment efficacy.

LIMITATIONS

State law may prohibit home testing by dentists. Check your state board statutes.

D9957 SCREENING FOR SLEEP RELATED BREATHING DISORDERS — CDT 2025

Screening activities, performed alone or in conjunction with another evaluation, to identify signs and symptoms of sleep-related breathing disorders.



WARNING

Do not report D9957 for the administration of home sleep apnea tests. See D9956.



MATCH

D9957 documents the screening for sleep related breathing disorders.

COMMENTS

1. Screening for sleep related breathing disorders (SRBD) includes the use of validated screening tools as well as key physical features and the patient's medical history and clinical findings related to obstructive sleep apnea and snoring.
2. D9957 may include the administration of validated questionnaires, recording baselines for BMI, blood pressure, and neck circumference, elicitation of history of sleep problems such as witnessed apneas and hypersomnolence, HPI, medication history, and clinical oral findings that may be indicative of sleep problems.

LIMITATIONS

Many payors will consider D9957 to be a part of a global dental evaluation if done in conjunction with D0150/D0180.

D9959 NEW PROCEDURE UNSPECIFIED SLEEP APNEA SERVICES PROCEDURE, BY REPORT — CDT 2025

COMMENTS

D9959 is used to report a procedure not adequately described by an existing sleep apnea code.

NARRATIVES

As with all codes that include "by report" in the nomenclature, include a narrative describing the procedure performed.

Glossary

A

AAE - American Academy of Endodontics.

AAO - American Academy of Orthodontics.

AAOMS - American Association of Oral Maxillofacial Surgeons.

AAP - American Academy of Periodontology.

AAPD - American Academy of Pediatric Dentistry.

AGD - Academy of General Dentistry.

Abutment - An abutment supports a prosthesis; a component of an implant system that is used to affix the crown to the implant.

Adjudication - Refers to the processing of a claim.

Adjunct/Adjunctive - Describes a treatment that is performed following the primary treatment.

Allowable Charge - The maximum amount of benefit allowed for a dental procedure per the indemnity or the PPO plan contract.

Alternate Benefit - A provision of a dental plan allowing the payor to provide a less expensive benefit, or an alternate benefit for a non-covered procedure, such as molar composite restorations. An alternate benefit of an amalgam may be applied for a composite restoration performed on a molar.

Asynchronous Teledentistry - Health information transmitted via the use of secure electronic means to a provider who will evaluate a health condition or render a service outside of real time interaction with the patient.

Auto Adjudication - The payor automatically processes the claim without review.

B

By Report - A brief narrative describing the dental procedure performed, required when reporting certain procedures.

C

CAL - Clinical Attachment Loss - involves the loss of alveolar bone support and gingival attachment as the periodontal fibers migrate apically from the CEJ due to periodontal toxins in plaque.

CBCT - Cone Beam CT imaging technology (3D radiographic image).

CEJ - Cementoenamel junction - the area of the tooth where the enamel covering the crown of the tooth and the cementum that covers the root of the tooth meet.

Claim - A written request to an insurance plan for benefit payment. A claim form may be submitted by the patient or the provider to the payor.

Claim Form - The paper form or electronic format used to submit the claim. These forms are specific to dental and medical claims and the appropriate form must be used. The 2024 ADA Dental Claim Form is the current claim form version.

Clinical - Refers to direct patient care (i.e., the diagnosis and treatment of the patient).

Connective Tissue Grafts (CT) - Donor tissue is taken usually from the patient and is placed in the area of gingival recession to obtain root coverage. Sometimes the tissue is from a donor other than the patient. Materials such as Allograft® may be used.

Current Dental Terminology (CDT) - A code set defined by the American Dental Association that the dentist is required to report for services rendered, as outlined in the summary plan description and the plan document.

D

Debridement - The gross removal of supra and subgingival calculus.

Dental Benefits Consultant - The dentist who reviews dental claims for insurance companies in order to determine benefits per the established criteria of the dental plan document.

Diastema - A space between two adjacent teeth, usually a large space between anterior teeth.

Digital Imaging and Communication in Medicine (DICOM-) - refers to the set of rules followed when exchanging a digital image to other providers.

Discing Teeth - A term used to describe an orthodontic procedure where a disc is used to remove a small amount of enamel from primary teeth to create adequate space for the eruption of the permanent teeth. Discing is also performed to make space for orthodontic aligners for permanent tooth movement.

Downcoding - The practice by payors to change a procedure from the one reported for benefit determination only. Typically, this results in a less expensive benefit allowed for, than the actual procedure performed, as stated in the plan document.

E

ECC - Early Childhood Caries.

EOB - Explanation of benefits - explains the plan's benefit and how it is calculated.

Epulis - An oral tumor typically benign often caused by ill-fitting dentures.

Exposed Roots - The crown of the tooth is missing and the exposed root is above or at the gum line.

F

Fixed Partial Denture (FPD) (also known as a bridge) - May consist of retainer crowns and a pontic(s) to replace a missing tooth and is permanently affixed to the teeth on either side of the missing tooth, usually with the retainer affixed with a dental cement or bonding material. The FPD may be supported by natural teeth or implants.

Flipper - Common term used to describe an interim removable partial denture. It is used typically for a short time period such as during the healing phase after implant placement.

Fraud - A benefit received when a false claim, inflated claim or billing of services not actually performed has taken place (determined by a court of law).

Furcation - The area of a multi rooted tooth where the roots separate from one another.

G

General Practitioner (GP) - General dentist.

Gingivectomy - The surgical removal of gingiva (soft tissue) from around a fully erupted tooth.

Gingivoplasty - A surgical procedure that reshapes the gingiva (soft tissue) around a tooth.

Global Fee - The fee for a procedure that includes all necessary procedures prior to, during, and following the procedure (e.g., bases, liners, and etching are considered part of the global fee for an operative procedure).

Guided Tissue Regeneration (GTR) - Also known as a barrier membrane - placed under the tissue and over the bone to aid in the regeneration of new bone.

H

Hugger Bridge - A type of bridge that consists of two resin retainer "wings" that are bonded and one pontic (Maryland Bridge).

I

Iatrogenic - Trauma or condition created by the dentist's treatment.

Incision and Drainage (I&D) - The surgical incision in order to drain an area of infection.

Indirect Restoration - A restoration fabricated outside of the mouth, i.e., a lab fabricated or CAD/CAM made crown or onlay.

Interim - Short-term use - typically refers to a denture or other appliance used during the healing phase of treatment or to allow further needed treatment to be completed.

IRM- Intermediate Restorative Material - A medicative material typically used after removing extensive decay and remains until the patient returns for a definitive treatment.

ITR - Interim Therapeutic Restoration - A medicative restoration placed until a definitive restorative can be placed. This procedure is typically performed on primary teeth with decay and may last the lifetime of the primary tooth.

L

LDA/LDAA - Local Delivery Antimicrobial Agents - such as Atridox®, Arestin®, PerioChip®, etc.

Least Expensive Alternative Treatment (LEAT) - A clause within a dental plan that allows the payor to pay a benefit for the least expensive treatment option when multiple options of treatment are available (e.g., benefits of a removable partial denture in lieu of a benefit for implants or fixed partial dentures when multiple teeth are missing throughout the arch being restored).

M

Mandible - The lower jaw.

Maryland Bridge - Refers to a resin bonded bridge fabricated to replace a missing tooth and consists of two retainer wings bonded to the lingual of the teeth adjacent to the missing tooth and attached to the pontic replacing the missing tooth. This bridge is named for the University of Maryland, where it was developed.

Maxilla - The upper jaw.

Maximum Plan Allowance (MPA) - A benefit allowance for a procedure.

Mineral Trioxide Aggregate (MTA) - Describes a filling material that creates a plug for the apex of a tooth as part of repairing a perforated root, treatment for apexogenesis, or is used to treat internal root resorption.

MRI - Magnetic Resonance Imaging - A technique used in dentistry for the purpose of diagnosing and evaluating soft tissue.

Multi-Slice Computer Tomography (MSCT) - A scan that captures an image of a specific part of the body.

N

Narrative - A written report describing the dental procedure performed with the goal of proving medical/dental necessity.

O

Occlusal - The biting surface of posterior teeth, i.e., premolars and molars.

Occlusal Guard - A removable appliance placed to protect against bruxism, and clinching or grinding of teeth.

Occupational Health and Safety Administration (OSHA) - A set of federal laws and regulations enforced by OSHA to ensure safety and health in the workplace.

P

Payor (carrier) - A third party company who administers plan benefits.

Plan Document (Insurance Contract) - The 150/200 page document used by the payor to pay claims.

Porcelain Fused to Metal (PFM) - A crown fabricated with porcelain fused to a metal coping (various metals) resulting in a tooth colored restoration.

PPO - Preferred Provider Organization - A plan that allows the patient to seek treatment from the dentist of his/her choice. If the chosen provider participates with the patient's PPO network then the patient's out-of-pocket expense is less. The participating provider agrees to only charge the patient the lowest contracted amount.

PRP - Platelet Rich Plasma - The process of spinning the patient's blood and using the growth factors when performing bone graft procedures in order to boost bone growth.

PRR - Preventive Resin Restoration - Restoration of an active carious lesion in a pit and fissure (enamel) where the preparation does not extend into the dentin.

Pulp - Blood vessels and tissue inside the pulp cavity of a tooth.

R

Re-mapping or Downcoding - A practice by payors whereby the benefit has been provided for a less expensive alternate treatment (LEAT).

Residual Tooth Roots - Root tips remaining after the extraction or loss of the crown of a tooth. A surgical procedure is required to remove residual tooth roots.

Rider - An amendment within a dental plan that can add or delete benefits and/or limitations of the plan (e.g., implant rider).

Root Canal Therapy (RCT) - Treatment that consists of removing the damaged or diseased pulp from the root of the tooth, obturating the canals, and sealing the canals with a non-resorbable material.

S

Scaling and Root Planing (SRP) - Treatment procedure for periodontal disease. The removal of plague and calculus from around the teeth and the root surfaces where pocketing has occurred due to the loss of bone. It also involves the smoothing of the root.

Snap-on-Smile - A custom-made set of teeth that fit over the existing teeth of the arch. It is made of a thin material and looks like natural teeth. In addition to using this appliance as a cosmetic appliance, it can be used to stabilize mobile teeth, act as an interim partial, or as a retainer after the completion of active orthodontics such as to maintain space until an implant can be placed.

Stainless Steel Crown (SSC) - A type of crown fabricated using nickel chrome commonly used as a restoration for primary teeth with a large amount of decay and not enough tooth structure for a conventional (filling) restoration. An SSC can also be used for permanent tooth restorations in some situations.

Stayplate - Sometimes, referred to as a "flipper" - A temporary appliance that replaces a missing tooth or multiple missing teeth and functions until a definitive procedure can be performed. Typically fabricated out of acrylic and may not have clasps.

Surgical Splint - A splint which assists in the stabilization and immobilization of broken bones during healing.

Surgical Stent - A custom made clear mold of the arch that has been modified to be used as a guide for the dentist to know where to adjust bone after extractions.

Synchronous Teledentistry - Real time interaction between a patient and provider to render a service via audiovisual technologies.

T

Take Back Code - Used to describe when a payor reduces the benefit of a definitive procedure after paying a benefit for another procedure previously done at a different date of service. This is usually when both procedures are performed by the same billing office.

Teledentistry - The use of telehealth systems in dentistry to include patient care and education using various forms of technology.

Temporomandibular Disorder (TMD) - A disorder of the joint often caused by bruxism, clenching and grinding of the teeth.

Temporomandibular Joint (TMJ) - The hinge part of the jawbone which connects the jaw to the skull.

Third-Party - Also known as the payor, carrier, or the insurer. The third party is responsible for the collection of premium payments, determines benefits and processes the benefit payments for claims. For insured plans, the third party assumes financial risks and for self-funded plans the third party only performs administration services on behalf of the self-funded plan, and provides a provider network.

TMJ Dysfunction - A syndrome affecting the joint most often caused by bruxism, clenching and grinding of the teeth.

Torus/Tori - Protrusion of bone.

U

Upcoding - The reporting of a more complex procedure than actually performed with a higher fee (i.e., a surgical extraction).

Usual, Customary, and Reasonable (UCR) Fees - A method used by payors to set average fees based upon the fee submission of dentists in a defined zip code area.

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