United Concordia Dental Clinical Policy

Disclaimer

I acknowledge the following information:

1. This document was developed to assist United Concordia in administering standard plan benefits and do not constitute a description of plan benefits. If you are a United Concordia member, please review and discuss any questions regarding clinical policies with your treating provider and refer to your specific benefit plan for the terms, conditions, limitations, and exclusions of your coverage. The benefit plan will define which supplies and services are covered, excluded and/or subject to limitations and may differ from this document.
2. Information contained in this document does not constitute an offer or a guarantee of payment. Please note that if there is a conflict between this document and a member's benefit plan, the terms of the benefit plan will govern and will supersede this document.
3. Clinical policies do not constitute dental treatment advice, nor are they intended to govern the practice of dental treatment. They are intended to reflect United Concordia's reimbursement and coverage guidelines. Treating providers are solely responsible for dental treatment advice and related treatment of members. Coverage for services may vary for individual members based on the terms of their specific benefit plan and the specific facts of a particular situation.
4. United Concordia retains the right to review and revise its Dental Clinical Policy at its sole discretion at any time without prior notice. United Concordia Dental Clinical Policy is the proprietary information of United Concordia. Any sale, copying or dissemination of United Concordia Dental Clinical Policy is prohibited; however, limited copying of United Concordia Dental Clinical Policy is permitted for individual use.

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*Please note that this document outlines the benefit exclusions and limitations for a standard (generic) United Concordia Dental PPO plan. For plan-specific information, please refer to the **MyDental**Benefits (Member) or **MyPatients'**Benefits (Provider) tools available at www.unitedconcordia.com.*

INTRODUCTION

ABOUT UNITED CONCORDIA DENTAL CLAIMS PAYMENT POLICIES

United Concordia Dental Clinical Policy reflects implementation of contract exclusions and limitations and are developed by four different Dental Directors licensed in multiple states and representing different clients/plans and regional areas of dental practice and the Chief Dental Officer. United Concordia's Dental Directors develop Dental Clinical Policy that is based on continuous review of the American Dental Association Current Dental Terminology (CDT) (updated annually), published peer-reviewed clinical evidence, and input from other sources including the United Concordia Dental National Advisory Committee that consists of a variety of actively practicing dental clinicians from different areas and different types of practices. Any dentist, regardless of network status, is always welcome to send any white papers for review to the Dental Advisor Unit at P.O. Box 69420, Harrisburg, PA 17106, where it will be forwarded to our Dental Directors for review and consideration in future policy discussions.

Dental Clinical Policy is reviewed annually, at a minimum, and modified as applicable, based on annual updates to the American Dental Association Current Dental Terminology Codebook, which often includes introduction of new codes that represent a new or emerging treatment, new or updated dental literature and published peer-reviewed scientific evidence, mandates by regulatory agencies, and requests from clinical expert(s) to enhance clarity and readability or update the supportive scientific evidence.

Any related department-specific guidelines derived from the United Concordia Dental Clinical Policy that are utilized in coverage decision-making are routinely monitored through claims auditing, claims data analysis, and inter-rater reliability testing of staff to ensure consistent application. Utilization Management staff and Dentist Advisors are trained in the use of the criteria. A Dentist Advisor is a licensed active practicing dentist, or retired former practitioner, contracted by United Concordia to determine dental benefits in accordance with contract exclusions and limitations for dental services where manual clinical review is part of the adjudication process. Clinical criteria use in coverage decision-making is monitored to ensure the consistent application by all through inter-rater reliability testing and routine auditing.

NON-DISCRIMINATION STATEMENT

In compliance with applicable Federal Civil Rights Laws, United Concordia Dental Clinical Policies do not discriminate on the basis of race, color, national origin, sex, age, disability, sex assigned at birth, gender identity or recorded gender. Furthermore, UCD will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. UCD will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual.

UNITED CONCORDIA DENTAL CLAIMS PAYMENT POLICY CHANGES

Dental services on payment claims, predeterminations, and prior-authorizations will be processed in accordance with the policy in effect at the time the claim, predetermination, or prior-authorization is received. This is applicable to both claim forms received by mail and electronic claim submission reporting dental service(s).

CONTRACT CHANGES

Any change in a Member's dental contract between the date any dental service or procedure was predetermined or prior-authorized and the date the dental service or procedure is performed (completed) may result in a difference in the amounts approved. If the Member's dental contract changes between the date the dental service was predetermined or prior-authorized and the date the dental service was performed (completed), payment will be based on the Member's coverage in effect on the date the procedures were performed (completed). This applies to coinsurance, maximums and deductibles.

REPORTING DENTAL SERVICES OR PROCEDURES

Dental services or procedures should be reported using the American Dental Association's current dental terminology procedure codes. The American Dental Association annual publication (updated January each year) of Current Dental Terminology is designated by the federal government as the national terminology for reporting dental services on claims submitted to third-party payers, in accordance with authority granted by the Health Insurance Portability and Accountability Act of 1996 (HIPPA). Each procedure in the CDT Code has a Procedure Code (a five-character alphanumeric code beginning with the letter "D" that identifies a specific procedure), Nomenclature (the written title of a Procedure Code), and Descriptor (a written narrative that further defines the nature and intended use of a single Procedure Code, or group of such codes).

CHANGING REPORTED CDT CODES

In the process of administering United Concordia dental policies, there are certain circumstances when the reported procedure code may be changed for the purposes of benefit determination.

- If the procedure code does not match the reported description of service, it is United Concordia's policy to process claims based upon the description of service when the procedure code and description reported do not agree. If a description is reported in the absence of a valid CDT code, the code D9999 will be used for processing purposes.
- If the submitted code is not consistent with the descriptor of the current CDT code based on the diagnostic materials submitted, claims history, and/or information submitted with the claim and the procedure may be translated to a valid CDT procedure code.
- Codes specifically defined as "first site" or "additional site" or "first 15 minutes" or "additional 15 minutes" may be recoded as appropriate to be accurate to the CDT descriptor when multiple codes are submitted (ex: Bone graft D4263/D4264, soft tissue graft D4273/D4283, D4275/D4285, D4277/D4278, deep sedation/general anesthesia D9222/D9223, intravenous moderate (conscious) sedation/analgesia D9239/D9243).
- Codes may be changed in the administration of claims payment policy.
    - The code for routine prophylaxis is based on the age of the patient and under UCD claims payment policy, children are considered those 12 and younger, and adults are those 13 and older. If an office submits a claim reporting an adult prophylaxis (code D1110) for a person who is six years old, the code is changed to the child prophylaxis code (D1120) for processing.
    - The appropriate code for closure of an endodontic access cavity through an existing crown or bridge abutment under UCD claims payment policy is a direct restoration (D2330 L for an anterior tooth and D2391 O for a posterior tooth). If an office submits a claim reporting a core buildup (D2950) or crown or bridge repair (D2980 or D6980) for closure of an endodontic access cavity through an existing crown or bridge abutment, the code is changed to a 1-surface direct restoration (D2330 L or D2391 O) for processing.
    - An Extraction/Impaction code (D7140-D7251) may be benefitted according to the CDT code descriptor the submitted diagnostic materials supports was completed during Manual Clinical Review by a Dental Advisor.
- The Alternate Benefit Provision (ABP) limitation in some contracts limit United Concordia Dental's payment to the allowance for a professionally acceptable, but less costly method of treatment. In these situations, the reported procedure code(s) will be changed to the code allowed under the contract's Alternate Benefit Provision (ABP) limitation. For example, United Concordia Dental's payment for an inlay may be limited to the allowance for amalgam restoration. The inlay code will be changed to the corresponding code for amalgam restoration. Payment will be based on the allowance for the amalgam restoration. In such cases, United Concordia Dental is not recommending which treatment should be provided. Should the dentist and member elect to proceed with the original (more costly) service; the

member will be financially responsible for the difference between the dentist's charge for the service provided and United Concordia Dental's payment for the service allowed under the contract's Alternate Benefit Provision (ABP) limitation. Alternate Benefit Provision is plan-specific and may apply to the following codes: Intraoral tomosynthesis (D0372-D0374), Posterior resin-based composite restorations (D2391-D2394), Inlay (D2510-D2530, D2610-D2630, D2650-D2652), 2-Surface Onlay (D2542, D2642, D2662), Prefabricated crown (D2932-D2934), Prefabricated post and core (D2954), Fixed partial denture (D6205-D6794).

- CDT coding and nomenclature are the copyright of the American Dental Association; all rights reserved.

DIAGNOSTIC MATERIAL REQUIREMENTS AND MANUAL CLINICAL REVIEW

Services on dental claims are benefitted in accordance with the plan's contract Exclusions & Limitations. Many Exclusions & Limitations can be evaluated by logic in the United Concordia Dental claims processing system (ex: a frequency limitation), but some Exclusions & Limitations can only be evaluated by a person utilizing diagnostic materials submitted with the claim and that part of the process is referred to as Manual Clinical Review (ex: a dental service that was Misreported (a dental service other than the dental service for the CDT code reported), a dental service that is related to an Implant or TMD (in the absence of a rider), a dental service related to alteration of vertical dimension, or a dental service that is not Dentally/Medically Necessary or does not meet generally accepted standards of dental treatment as defined by United Concordia Dental). Diagnostic materials are dental chart-based documentation such as x-rays, periodontal charting, and chart/progress/treatment notes utilized during diagnosis and treatment. Diagnostic materials are required whenever Manual Clinical Review is necessary as part of benefit determination of a dental service.

MINIMUM REQUIREMENTS FOR DIAGNOSTIC MATERIALS FOR MANUAL CLINICAL REVIEW

CHART = Patient-specific chart-based documentation regarding the patient's condition and/or services planned or completed is REQUIRED when reporting the service. A copy of the patient's medical/dental history and applicable progress/treatment notes is ideal and preferred, but any type of patient-specific documentation such as narratives and clinical summaries, may be submitted to meet this requirement.

X-RAY = Pre-treatment, diagnostic x-ray(s) of the reported tooth/quadrant is REQUIRED when reporting the service. In addition to the required pre-treatment, diagnostic x-ray(s), any other patient-specific chart-based documentation regarding the patient's condition and/or services planned or completed (a copy of the patient's medical/dental history and applicable progress/treatment notes is notes is ideal and preferred, but any type of patient-specific documentation such as narratives and clinical summaries may be optionally submitted.

*Submission of additional x-rays (outside of required), written documentation (chart notes/narratives/periodontal charting/specialist letters/etc.) when not specifically required, photographs, and other diagnostic materials outside of required diagnostic materials listed is optional and should corroborate with evidence presented in required materials.

Dental Service Descriptor (CDT Code)	CHART	X-RAY
Detailed and extensive oral evaluation - problem focused, by report (D0160)	**X**	
Unspecified diagnostic Procedure, by report (D0999)	**X**	
Unspecified preventive procedure, by report (D1999)	**X**	
Inlay (D2510 - D2530, D2610 - D2630, D2650 - D2652) * when plan does not have Alternate Benefit Provision		**X***
Onlay (D2542 - D2544, D2642 - D2644, D2662 - D2664)		**X**
Crown (D2710 - D2794)		**X**

Core buildup, including any pins when required (D2950)		**X**
Post and Core (D2952, D2954) *A post-endodontic treatment, diagnostic x-ray ***IN ADDITION*** to a pre-treatment diagnostic x-ray of the tooth.		**X***
Unspecified restorative procedure, by report (D2999)	**X**	
Internal root repair of perforation defects (D3333)	**X**	**X**
Hemisection (including any root removal), not including root canal therapy (D3920)	**X**	**X**
Decoronation or submergence of an erupted tooth (D3921)	**X**	**X**
Unspecified endodontic procedure, by report (D3999)	**X**	
Gingivectomy or gingivoplasty (D4210, D4211)	***PERIO CHART**	**X**
Gingival flap procedure, including root planing (D4240, D4241)	***PERIO CHART**	**X**
Clinical crown lengthening - hard tissue (D4249)	***PERIO CHART**	**X**
Osseous surgery (D4260, D4261)	***PERIO CHART**	**X**
Bone replacement graft – retained natural tooth (D4263, D4264)	***PERIO CHART**	**X**
Mesial/distal wedge procedure, single tooth (D4274)	***PERIO CHART**	**X**
Periodontal scaling and root planing (D4341, D4342)		**X**
Unspecified periodontal procedure, by report (D4999)	**X**	
Unspecified removable prosthodontic procedure, by report (D5899)	**X**	
Abutment/implant supported crown (D6058-D6067, D6082-D6084, D6086- D6088, D6094, D6097)		**X**
Abutment/implant supported fixed partial denture (D6068- D6077, D6098, D6099, D6120- D6123, D6194-D6195) *when a covered benefit by plan		**X***
Implant/abutment supported removable denture(D6110-D6113) *when benefit is covered by specific plan		**X***
Implant/abutment supported fixed denture (D6114-D6117) *when benefit is covered by specific plan		**X***
Debridement of peri-implant defect (D6101/D6102) *when benefit is covered by specific plan	**X***	**X***
Fixed partial denture (Bridge) (D6205 - D6794)		**X**
Unspecified fixed prosthodontic procedure, by report (D6999)	**X**	
Removal of impacted tooth - completely bony, with unusual surgical complications (D7241)		**X**
Coronectomy - intentional partial tooth removal, impacted teeth only (D7251)	**X**	**X**
Incision and drainage of abscess - intraoral soft tissue (D7510, D7511)	**X**	
Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report (D7950), Bone replacement graft for ridge preservation - per site (D7953), Repair of maxillofacial soft and/or hard tissue defect (D7955), Synthetic graft - mandible or facial bones, by report (D7995)	**X**	**X**
Nerve Dissection (D7259)	**X**	**X**
Unspecified oral surgery procedure, by report (D7999)	**X**	

Administration of nitrous oxide (D9230), In-office administration of minimal sedation – single drug – enteral (D9244), Administration of moderation sedation – enteral (D9245)	**SEE BELOW**	
Administration of moderation sedation – intravenous (D9239, D9243), Administration of moderation sedation – non-intravenous parenteral (D9246, D9247), Administration of deep sedation/general anesthesia (D9222, D9223)	**SEE BELOW**	
Administration of general anesthesia with advanced airway (D9224, D9925)	**SEE BELOW**	
Unspecified adjunctive procedure, by report (D9999)	**X**	

Diagnostic Requirements when reporting Anesthesia services

- **Administration of nitrous oxide (D9230), In-office administration of minimal sedation – single drug – enteral (D9244), Administration of moderation sedation – enteral (D9245)** does not routinely require submission of any diagnostic materials when the Member is age 12 or younger and/or if the anesthesia is reported in conjunction with a dental service that requires extensive time and/or manipulation (Implant Placement (D6010, D6012, D6040, D6050), Extraction/Impaction (D7210, D7220, D7230, D7240, D7241, D7251), Other Surgical Procedures (D7260, D7261, D7280), Vestibuloplasty (D7340, D7350), Excision of Bone Tissue (D7471, D7472, D7473, D7485), Surgical incision (D7560), Treatment of Closed Fractures (D7610-D7680), Treatment of Open Fractures (D7710-D7780), Reduction of Dislocation and Management of Other Temporomandibular Joint Dysfunctions (D7810-D7877), Other Repair Procedures (D7920, D7940-D7952, D7980-D7991, D7994, D7996). Diagnostic materials are required when the patient is age 13 or older or anesthesia is not being provided in conjunction with a listed service, and the anesthesia is being recommended by the provider because of specific complex medical issues and/or specific treatment needs.
- **Administration of moderation sedation – intravenous (D9239, D9243), Administration of moderation sedation – non-intravenous parenteral (D9246, D9247), Administration of deep sedation/general anesthesia (D9222, D9223)** does not require submission of documentation when the anesthesia is reported with a service that requires extensive time and/or manipulation (Implant Placement (D6010, D6012, D6040, D6050), Extraction/Impaction (D7210, D7220, D7230, D7240, D7241, D7251), Other Surgical Procedures (D7260, D7261, D7280), Vestibuloplasty (D7340, D7350), Excision of Bone Tissue (D7471, D7472, D7473, D7485), Surgical incision (D7560), Treatment of Closed Fractures (D7610-D7680), Treatment of Open Fractures (D7710-D7780), Reduction of Dislocation and Management of Other Temporomandibular Joint Dysfunctions (D7810-D7877), Other Repair Procedures (D7920, D7940-D7952, D7980-D7991, D7994, D7996). Diagnostic materials are required when anesthesia is not being provided in conjunction with a listed service, and the anesthesia is being recommended by the provider because of specific complex medical issues and/or treatment needs.
- **Administration of general anesthesia with advanced airway (D9224, D9925)** always requires submission of patient-specific chart-based documentation regarding the patient's condition and/or services planned or completed. A copy of the patient's medical/dental history and applicable progress/treatment notes is ideal and preferred, but any type of patient-specific documentation such as narratives and clinical summaries, may be submitted to meet this requirement.

DIAGNOSTIC SERVICES (D0120-D0999)

- Dental services that are routinely provided in conjunction with or as part of another procedure in accordance with accepted standards of dental practice are defined as integral by United Concordia Dental and excluded from coverage. Some dental services may be denied as integral when reported in the absence of another dental service (for example: local anesthesia) or denied as integral only when another more comprehensive dental service has been benefitted. Participating dentists may not bill a patient for a service denied as integral. Any benefit for any Diagnostic service per CDT code descriptor as

reported is inclusive of all charges for work, materials, and supplies related to the service, and if reported separately, these services may be denied as integral.

- Dental services that are reported in a treatment sequence that is not appropriate in accordance with accepted standards of dental practice are defined as integral by United Concordia Dental and excluded from coverage (for example: a crown reported on a date following an extraction benefitted on the same tooth). Participating dentists may not bill a patient for a service denied because it is reported in an inappropriate treatment sequence.
- Dental services that are misreported or that represent a procedure other than the one reported are excluded from coverage. Dental services should be reported in accordance with the nomenclature and descriptors defined in the current year American Dental Association's Current Dental Terminology (CDT) codebook. Participating dentists may not bill a patient for a service denied because it is misreported.
- Dental services must be dentally/medically necessary and meet accepted standards of dental practice, as defined by United Concordia, which requires any tooth or teeth to have acceptable prognosis and meet United Concordia's definition of dental/medical necessity for the reported code as defined by the current ADA Current Dental Terminology codebook. Dental services determined not to meet United Concordia's definition of dental/medical necessity are not billable to the patient by a participating dentist unless the dentist notifies the patient of his or her potential financial liability prior to treatment and the patient chooses to receive the treatment (financial agreement). Participating dentists should document such notification specifically (with the date, tooth number, service, potential financial liability, and signature of the patient) in the patient's record.
- Any services utilized for the treatment of temporomandibular joint disorders (TMD/TMJ) or for implant placement, restoration, or maintenance is excluded from coverage and denied as not covered unless benefits are specifically provided for under a TMD or Implant rider.

PERIODIC ORAL EVALUATION - ESTABLISHED PATIENT (D0120)
Limited to 2 of Periodic Oral Evaluation (D0120), Oral evaluation for a patient under three years of age and counseling with primary caregiver (D0145), Comprehensive evaluation (D0150), or Comprehensive periodontal evaluation (D0180) per calendar year.
Denied as INTEGRAL when provided by the same Dentist, on the same date as a Consultation (D9310).
LIMITED ORAL EVALUATION - PROBLEM FOCUSED (D0140)
Limited to 1 of Limited Evaluation Problem Focused (D0140) or Consultation (D9310) per 12-month period per billing provider (TIN).
Denied as INTEGRAL when provided by the same Dentist, on the same date as a Consultation (D9310), or another Examination/Evaluation (D0120, D0140, D0150, D0160, D0170, D0180).
ORAL EVALUATION FOR A PATIENT UNDER THREE YEARS OF AGE AND COUNSELING WITH PRIMARY CAREGIVER (D0145)
Limited to 2 of Periodic Oral Evaluation (D0120), Oral evaluation for a patient under three years of age and counseling with primary caregiver (D0145), Comprehensive evaluation (D0150), or Comprehensive periodontal evaluation (D0180) per calendar year.
Denied as INTEGRAL when provided by the same Dentist, on the same date as a Consultation (D9310).
COMPREHENSIVE ORAL EVALUATION - NEW OR ESTABLISHED PATIENT (D0150)
Limited to 2 of Periodic Oral Evaluation (D0120), Oral evaluation for a patient under three years of age and counseling with primary caregiver (D0145), Comprehensive evaluation (D0150), or Comprehensive periodontal evaluation (D0180) per calendar year.
Denied as INTEGRAL when provided by the same Dentist, on the same date as a Consultation (D9310) or Comprehensive periodontal evaluation (D0180).
DETAILED AND EXTENSIVE ORAL EVALUATION - PROBLEM FOCUSED, BY REPORT (D0160)
Limited to 1 of Detailed and extensive oral evaluation (D0160) per dentist per billing provider (TIN) per eligible diagnosis.

TMD RIDER ONLY: Limited to 1 of Detailed and extensive oral evaluation (D0160) for TMD/CMD dental services per 12-month period in addition to routine oral evaluations.
Denied as INTEGRAL when provided by the same Dentist, on the same date as a Consultation (D9310), or another Examination/Evaluation (D0120, D0140, D0150, D0160, D0170, D0180).
REQUIRED DIAGNOSTIC MATERIALS: Patient-specific chart-based documentation regarding the patient's condition and/or services planned or completed is REQUIRED when reporting the service. A copy of the patient's medical/dental history and applicable progress/treatment notes is ideal and preferred, but any type of patient-specific documentation such as narratives and clinical summaries, may be submitted to meet this requirement. Other chart materials such as chart notes and photographs may optionally be submitted and should corroborate clinically with the submitted x-rays for consideration during manual clinical review.
Denied as TMD RELATED when related to the excluded condition of temporomandibular dysfunction (TMD) **unless plan has specific coverage for TMD services.*
Denied as MISREPORTED if a Dental Advisor determines that the written documentation does not support that the service planned (pre-estimation) or was completed (claim) meets the current CDT Current Dental Terminology descriptor of the code reported.
RE-EVALUATION - POST-OPERATIVE OFFICE VISIT (D0171)
Denied as INTEGRAL when reported alone or in conjunction with any other service.
COMPREHENSIVE PERIODONTAL EVALUATION - NEW OR ESTABLISHED PATIENT (D0180)
Limited to 2 of Periodic Oral Evaluation (D0120), Oral evaluation for a patient under three years of age and counseling with primary caregiver (D0145), Comprehensive evaluation (D0150), or Comprehensive periodontal evaluation (D0180) per calendar year.
Denied as INTEGRAL when provided by the same Dentist, on the same date as a Consultation (D9310).
INTRAORAL - COMPREHENSIVE SERIES OF RADIOGRAPHIC IMAGES (D0210)
Limited to 1 of Intraoral – comprehensive series (D0210) or Panoramic film (D0330) per 5-year period. **Situational approval may apply when the Intraoral – comprehensive series (D0210) is reported by a General Dentist or Periodontist, and a Panoramic film (D0330) was paid to a different Provider within the 5-year period**
Denied as NOT STANDARD OF DENTAL TREATMENT when provided for a Member Age 4 and under. **Situational approval may apply upon Second Review/Appeal by a Dental Advisor with documentation of extenuating circumstances.**
INTRAORAL - PERIAPICAL FIRST RADIOGRAPHIC IMAGE (D0220)
INTRAORAL - PERIAPICAL EACH ADDITIONAL RADIOGRAPHIC IMAGE (D0230)
Limited to 4 of Intraoral – periapical radiographic image (D0220, D0230) per 12-month period.
Multiple Periapical Radiograph first radiographic image (D0220) reported on the same date of service by same provider will process as one Periapical radiograph first radiographic image (D0220) and replace all remaining periapical radiographic with the additional periapical code (D0230).
Denied as INTEGRAL when reported by the same Dentist, on the same date of service as an Intraoral – comprehensive series (D0210).
Denied as INTEGRAL when reported as part of restorative treatment and not diagnostic purposes, which includes any periapical radiograph image (D0220, D0230) reported by the same Dentist, on the same date as an Inlay (D2510-D2530, D2610-D2630, D2650-D2652), Onlay (D2542-D2544, D2642-D2644, D2662-D2664), Crown (D2710–D2799), or Fixed Partial Denture (Bridge) (D6205–D6253, D6545–D6634, D6710–D6794). **Situational approval may apply when the office indicates the specific teeth imaged on the x-ray are different than the tooth endodontically treated (the x-ray is in a different area of the mouth than the restorative service completed).**
Denied as INTEGRAL when reported as part of endodontic treatment ("working length" and "final fill" x-rays) and not diagnostic purposes, which includes any periapical radiograph image (D0230) reported by the same Dentist, on the same date as a Pulpotomy (D3220-D3222), Endodontic therapy (D3230-D3333), Endodontic Retreatment (D3346-D3348), Apexification/Recalcification (D3351-D3353), Pulpal Regeneration (D3355-D3357), Apicoectomy/Periradicular Services (D3410-D3503), Hemisection (D3920), or Decoronation (D3921). **Situational approval may apply when the office indicates the specific teeth imaged on the x-ray are**

different than the tooth endodontically treated (the x-ray is in a different area of the mouth than the endodontic service completed).
INTRAORAL - OCCLUSAL RADIOGRAPHIC IMAGE (D0240)
Limited to 2 of Intraoral- occlusal radiographic image (D0240) per 24 month period.
Denied as NOT STANDARD OF DENTAL TREATMENT when reported on a Member Age 8 and older. **Situational approval may apply upon Second Review/Appeal by a Dental Advisor with documentation of extenuating circumstances.**
BITEWING - SINGLE RADIOGRAPHIC IMAGE (D0270)
BITEWINGS - TWO RADIOGRAPHIC IMAGES (D0272)
BITEWINGS - THREE RADIOGRAPHIC IMAGES (D0273)
BITEWINGS - FOUR RADIOGRAPHIC IMAGES (D0274)
VERTICAL BITEWINGS - 7 TO 8 RADIOGRAPHIC IMAGES (D0277)
Limited to 1 occurrence per 12-month period for Members under age 19 and 1 occurrence per 18 month period for Member age 19 and older. An occurrence is counted when more than a single bitewing is reported on the same date of service by the same dentist. If only one bitewing was taken it will not be counted as an occurrence. (For purposes of calculating bitewing eligibility, an intraoral complete series (D0210, D0372) counts as an occurrence of bitewings.)
The appropriate CDT code for the number of bitewings reported on the same date of service will be processed if the incorrect code is reported (single bitewing x-ray taken on a date of service (D0270), two bitewing x-rays taken on the same date of service (D0272), three bitewing x-rays taken on the same date of service (D0273), four bitewing x-rays taken on the same date of service (D0274), 7-8 vertical bitewing x-rays taken on the same date of service (D0277).
A maximum of Bitewings – 2 radiographic images (D0272) would be appropriate according to this definition when reporting bitewing x-rays for a member Age 5 and under, as the number of posterior teeth erupted (present in the mouth) at that age is three or less permanent and deciduous molar/ premolar teeth per quadrant. Bitewings - three radiographic images (D0273), bitewings - four radiographic images (D0274), vertical bitewings - 7 to 8 radiographic images (D0277) are processed as Bitewings – 2 radiographic images (D0272) when reported for a Member Age 5 and under for NOT STANDARD OF DENTAL TREATMENT. **Situational approval may apply on Second Review/Appeal by a Dental Advisor with documentation of extenuating circumstances.**
Denied as INTEGRAL when reported by the same Dentist, on the same date of service as an Intraoral – comprehensive series (D0210).
Denied as INTEGRAL when reported as part of restorative treatment and not diagnostic purposes, which includes any periapical radiograph image (D0220, D0230) reported by the same Dentist, on the same date as an Inlay (D2510-D2530, D2610-D2630, D2650-D2652), Onlay (D2542-D2544, D2642-D2644, D2662-D2664), Crown (D2710–D2799), or Fixed Partial Denture (Bridge) (D6205–D6253, D6545–D6634, D6710–D6794). **Situational approval may apply when the office indicates the specific teeth imaged on the x-ray are different than the tooth endodontically treated (the x-ray is in a different area of the mouth than the restorative service completed).**
TEMPOROMANDIBULAR JOINT ARTHROGRAM, INCLUDING INJECTION (D0320)
OTHER TEMPOROMANDIBULAR JOINT RADIOGRAPHIC IMAGES, BY REPORT (D0321)
TOMOGRAPHIC SURVEY (D0322)
TMD RIDER ONY: No frequency limitation.
PANORAMIC RADIOGRAPHIC IMAGE (D0330)
Limited to 1 of Intraoral – comprehensive series (D0210) or Panoramic film (D0330) per 5-year period. **Situational approval may apply when a Panoramic film (D0330) is reported by an Oral Surgeon or Periodontist and the Intraoral – comprehensive series (D0210) was previously reported by a different Provider within the 5-year period.**
Panoramic radiographic image (D0330) is denied for NOT STANDARD OF DENTAL TREATMENT when reported for a Member Age 4 and under. **Situational approval may apply on Second Review/Appeal by a Dental Advisor with documentation of extenuating circumstances.**

2D CEPHALOMETRIC RADIOGRAPHIC IMAGE - ACQUISITION, MEASUREMENT AND ANALYSIS (D0340)
Limited to 1 of Cephalometric radiographic image (D0340) per lifetime. **Situational approval may apply on Second Review/Appeal by a Dental Advisor with documentation of extenuating circumstances.**
CONE BEAM CT CAPTURE AND INTERPRETATION WITH LIMITED FIELD OF VIEW - LESS THAN ONE WHOLE JAW (D0364)
CONE BEAM CT CAPTURE AND INTERPRETATION WITH FIELD OF VIEW OF ONE FULL DENTAL ARCH – MANDIBLE (D0365)
CONE BEAM CT CAPTURE AND INTERPRETATION WITH FIELD OF VIEW OF ONE FULL DENTAL ARCH - MAXILLA, WITH OR WITHOUT CRANIUM (D0366)
CONE BEAM CT CAPTURE AND INTERPRETATION WITH FIELD OF VIEW OF BOTH JAWS; WITH OR WITHOUT CRANIUM (D0367)
IMPLANT RIDER ONLY: Limited to 1 of Cone beam CT (D0364, D0365, D0366 or D0367) per tooth per lifetime for Member Age 18 and older.
INTRAORAL TOMOSYNTHESIS -COMPREHENSIVE SERIES OF RADIOGRAPHIC IMAGES (D0372)
INTRAORAL TOMOSYNTHESIS – BITEWING RADIOGRAPHIC IMAGE (D0373)
INTRAORAL TOMOSYNTHESIS – PERIAPICAL RADIOGRAPHIC IMAGE (D0374)
Alternate Benefit Provision applies (per contract). Intraoral tomosynthesis – comprehensive series (D0372) will be processed as Intraoral – Comprehensive series (D0210), Intraoral tomosynthesis – bitewing (D0373) will be processed as Bitewing radiograph (D0270), Intraoral tomosynthesis – periapical (D0374) will be processed as Intraoral - Periapical radiograph (D0220). Refer to D0210/D0270/D0220 for applicable Exclusions & Limitations.
3D PRINTING OF A 3D DENTAL SURFACE SCAN (D0396)
Denied as INTEGRAL when reported alone or in conjunction with any other service.
COLLECTION, PREPARATION AND ANALYSIS OF SALIVA SAMPLE - POINT-OF-CARE (D0426)
Limited to 1 of Collection and analysis of saliva sample - point-of-care (D0426) per 5 year period.
PULP VITALITY TESTS (D0460)
Denied as INTEGRAL when reported alone or in conjunction with any other service.
TESTING FOR CRACKED TOOTH (D0461)
Denied as INTEGRAL when reported alone or in conjunction with any other service.
DIAGNOSTIC CAST (D0470)
Denied as INTEGRAL when reported alone or in conjunction with any other service.
CARIES RISK ASSESSMENT AND DOCUMENTATION, WITH A FINDING OF LOW RISK (D0601)
CARIES RISK ASSESSMENT AND DOCUMENTATION, WITH A FINDING OF MODERATE RISK (D0602)
CARIES RISK ASSESSMENT AND DOCUMENTATION, WITH A FINDING OF HIGH RISK (D0603)
Denied as INTEGRAL when reported alone or in conjunction with any other service.
UNSPECIFIED DIAGNOSTIC PROCEDURE, BY REPORT (D0999)
No frequency limitation.
REQUIRED DIAGNOSTIC MATERIALS: Patient-specific chart-based documentation regarding the patient's condition and/or services planned or completed is REQUIRED when reporting the service. A copy of the patient's medical/dental history and applicable progress/treatment notes is ideal and preferred, but any type of patient-specific documentation such as narratives and clinical summaries, may be submitted to meet this requirement. Other chart materials such as chart notes and photographs may optionally be submitted and should corroborate clinically with the submitted x-rays for consideration during manual clinical review.
Denied as MISREPORTED (GENERIC) when the service described has a specific and valid CDT code.
Denied as INTEGRAL (GENERIC) when the service described has no specific and valid code because it is part of the Standard of Dental Treatment for another principal service (includes multi-step processes and individual dentist choices for what products and/or techniques that may be used). Examples: Description of impressions, infection control, isolation techniques (including gel barrier, Isolite®, and rubber dam placement), temperature (hot/cold) testing, tooth sleuth testing, transillumination.

Denied as MISREPORTED AND INTEGRAL when the service described has a specific and valid code because it is part of the Standard of Dental Treatment for another principal service (includes multi-step processes and individual dentist choices for what products and/or techniques that may be used).
Denied as NOT COVERED (GENERIC) when the service described has no specific and valid code and describes a service that is not covered.
Denied as MISREPORTED AND NOT COVERED when the service described has a specific and valid code and describes a service that is not covered.

PREVENTIVE SERVICES (D1110-D1999)

- Dental services that are routinely provided in conjunction with or as part of another procedure in accordance with accepted standards of dental practice are defined as integral by United Concordia Dental and excluded from coverage. Some dental services may be denied as integral when reported in the absence of another dental service (for example: local anesthesia) or denied as integral only when another more comprehensive dental service has been benefitted. Any benefit for any Diagnostic service per CDT code descriptor as reported is inclusive of all charges for work, materials, and supplies related to the procedure, and if reported separately, these services may be denied as integral. Participating dentists may not bill a patient for a service denied as integral.
- Dental services that are reported in a treatment sequence that is not appropriate in accordance with accepted standards of dental practice are defined as integral by United Concordia Dental and excluded from coverage (for example: a crown reported on a date following an extraction benefitted on the same tooth). Participating dentists may not bill a patient for a service denied because it is reported in an inappropriate treatment sequence.
- Dental services that are misreported or that represent a procedure other than the one reported are excluded from coverage. Dental services should be reported in accordance with the nomenclature and descriptors defined in the current year American Dental Association's Current Dental Terminology (CDT) codebook. Participating dentists may not bill a patient for a service denied because it is misreported.
- Dental services must be dentally/medically necessary and meet accepted standards of dental practice, as defined by United Concordia, which requires any tooth or teeth to have acceptable prognosis and meet United Concordia's definition of dental/medical necessity for the reported code as defined by the current ADA Current Dental Terminology codebook. Dental services determined not to meet United Concordia's definition of dental/medical necessity are not billable to the patient by a participating dentist unless the dentist notifies the patient of his or her potential financial liability prior to treatment and the patient chooses to receive the treatment (financial agreement). Participating dentists should document such notification specifically (with the date, tooth number, service, potential financial liability, and signature of the patient) in the patient's record.
- Any services utilized for the treatment of temporomandibular joint disorders (TMD/TMJ) or for implant placement, restoration, or maintenance is excluded from coverage and denied as not covered unless benefits are specifically provided for under a TMD or Implant rider.

PROPHYLAXIS – ADULT (D1110)
PROPHYLAXIS – CHILD (D1120)
Limited to 2 of Prophylaxis (Adult D1110 or Child D1120) per calendar year and the combination of 1 Scaling in the presence of inflammation (D4346) and 2 of Prophylaxis (Adult D1110 or Child D1120) per calendar year. Optional benefit: *Smile for Health®-Wellness and Pregnancy Benefit provides one additional Prophylaxis (D1110) or Periodontal maintenance (D4910) for members with diabetes, lupus, rheumatoid arthritis, heart disease, oral cancer and members that have had a stroke or an organ transplant or are pregnant. Members with a qualifying chronic health condition must be registered prior to receiving services and can register at www.unitedconcordia.com under MyDentalBenefits.

Adult Prophylaxis (D1110) is defined by the CDT code as a service for the permanent and transitional dentition. An Adult prophylaxis (D1110) reported for a Member Age 12 and under will be processed as Child Prophylaxis (D1120).
Denied as INTEGRAL when reported on the same day, by the same Dentist as Periodontal maintenance (D4910)
Denied as INAPPROPRIATE TREATMENT SEQUENCE when reported on the same day, as a surgical periodontal service (D4210- D4285), Full mouth debridement (D4355), or Scaling in the presence of inflammation (D4346).
TOPICAL APPLICATION OF FLUORIDE VARNISH (D1206)
TOPICAL APPLICATION OF FLUORIDE - EXCLUDING VARNISH (D1208)
Limited to 1 of Topical application of fluoride (D1206 or D1208) per calendar year for a Member Age 13 and under.
IMMUNIZATION COUNSELING (D1301)
Denied as INTEGRAL when reported alone or in conjunction with other services.
SEALANT - PER TOOTH (D1351)
Limited to 1 of Sealant (D1351) per permanent molar tooth (#2,3,14,15,18,19,30,31) per 3-year period for Member Age 15 and under. **Situational approval may apply upon Second Review/Appeal by a Dental Advisor for an age limitation with documentation of extenuating circumstances, such as delayed eruption.**
Denied as NOT STANDARD OF DENTAL TREATMENT when reported by the same Dentist, on the same tooth and surface within 12 months of initial placement of sealant (D1351).
Denied as INTEGRAL when reported by the same Dentist, on the same date, same tooth, and same surface as Preventive Resin Restoration (D1352). Situational approval may apply for upon Second Review/Appeal by a Dental Advisor with documentation of extenuating circumstances.
Denied as INTEGRAL when reported by the same Dentist, on the same tooth, and same surface, as an Amalgam or Resin-Based Composite Restoration (D2140-D2394). **Situational approval may apply for upon Second Review/Appeal by a Dental Advisor with documentation of extenuating circumstances.**
APPLICATION OF CARIES ARRESTING MEDICAMENT - PER TOOTH (D1354)
Limited to 2 of Application of caries arresting medicament (D1354) per tooth per 12-month period for Member Age 1-6 and 1 per tooth per 12-month period for Member Age 7-12.
Denied as MISREPORTED when reported for anything other than Silver Diamine Fluoride (SDF).
SPACE MAINTAINER - FIXED, UNILATERAL - PER QUADRANT (D1510)
SPACE MAINTAINER - FIXED - BILATERAL, MAXILLARY (D1516)
SPACE MAINTAINER - FIXED - BILATERAL, MANDIBULAR (D1517)
SPACE MAINTAINER - REMOVABLE, UNILATERAL - PER QUADRANT (D1520)
SPACE MAINTAINER - REMOVABLE - BILATERAL, MAXILLARY (D1526)
SPACE MAINTAINER - REMOVABLE - BILATERAL, MANDIBULAR (D1527)
DISTAL SHOE SPACE MAINTAINER - FIXED, UNILATERAL - PER QUADRANT (D1575)
Unilateral Space Maintainers (D1510, D1520, D1575): Limited to 1 per quadrant to replace prematurely lost primary molar/permanent molar. Bilateral Space Maintainers (D1516, D1517, D1526, D1527): Limited to 1 per arch to replace one or more prematurely lost primary molar/permanent molar(s) for a Member Age 13 and under.
RE-CEMENT OR RE-BOND BILATERAL SPACE MAINTAINER – MAXILLARY (D1551)
RE-CEMENT OR RE-BOND BILATERAL SPACE MAINTAINER – MANDIBULAR (D1552)
RE-CEMENT OR RE-BOND UNILATERAL SPACE MAINTAINER - PER QUADRANT (D1553)
Limited to 1 of Re-cement or re-bond space maintainer (D1551, D1552, D1553) per 3-year period for a Member Age 13 and under.
Denied as INTEGRAL when reported by the same Dentist, in the same quadrant/arch within 6 months of insertion/placement a Space Maintainer (D1510, D1516, D1517, D1520, D1526, D1527, D1575).
REMOVAL OF FIXED UNILATERAL SPACE MAINTAINER - PER QUADRANT (D1556)
REMOVAL OF FIXED BILATERAL SPACE MAINTAINER – MAXILLARY (D1557)

REMOVAL OF FIXED BILATERAL SPACE MAINTAINER – MANDIBULAR (D1558)
No frequency limitation.
Denied as INTEGRAL when reported by the same Dentist, in the same quadrant/arch as a Space Maintainer (D1510, D1516, D1517, D1520, D1526, D1527, D1575) in the same quadrant/arch by the same Dentist.
UNSPECIFIED PREVENTIVE PROCEDURE, BY REPORT (D1999)
No frequency limitation.
REQUIRED DIAGNOSTIC MATERIALS: Patient-specific chart-based documentation regarding the patient's condition and/or services planned or completed is REQUIRED when reporting the service. A copy of the patient's medical/dental history and applicable progress/treatment notes is ideal and preferred, but any type of patient-specific documentation such as narratives and clinical summaries, may be submitted to meet this requirement. Other chart materials such as chart notes and photographs may optionally be submitted and should corroborate clinically with the submitted x-rays for consideration during manual clinical review.
Denied as MISREPORTED (GENERIC) when the service described has a specific and valid CDT code.
Denied as INTEGRAL (GENERIC) when the service described has no specific and valid code because it is part of the Standard of Dental Treatment for another principal service (includes multi-step processes and individual dentist choices for what products and/or techniques that may be used). Examples: Bacterial decontamination®/Laser Bacterial Reduction (LBR)®, Ozone therapy, Ultrasonic instrumentation (Prophyjet®, Ultrasonic ®, Cavitron®), Prophy paste (with or without fluoride)
Denied as MISREPORTED + INTEGRAL when the service described has a specific and valid code because it is part of the Standard of Dental Treatment for another principal service (includes multi-step processes and individual dentist choices for what products and/or techniques that may be used). Example: Oral hygiene instruction.
Denied as NOT COVERED (GENERIC) when the service described has no specific and valid code and describes a service that is not covered.
Denied as MISREPORTED + NOT COVERED when the service described has a specific and valid code and describes a service that is not covered.

RESTORATIVE SERVICES (D2140-D2999)

- Dental services that are routinely provided in conjunction with or as part of another procedure in accordance with accepted standards of dental practice are defined as integral by United Concordia Dental and excluded from coverage. Some dental services may be denied as integral when reported in the absence of another dental service (for example: local anesthesia) or denied as integral only when another more comprehensive dental service has been benefitted. Participating dentists may not bill a patient for a service denied as integral. Any benefit for any Restorative service per CDT code descriptor as reported is inclusive of all charges for work, materials, and supplies related to the procedure, and if reported separately, these services may be denied as integral.
- Dental services that are reported in a treatment sequence that is not appropriate in accordance with accepted standards of dental practice are defined as integral by United Concordia Dental and excluded from coverage (for example: a crown reported on a date following an extraction benefitted on the same tooth). Participating dentists may not bill a patient for a service denied because it is reported in an inappropriate treatment sequence.
- Dental services that are misreported or that represent a procedure other than the one reported are excluded from coverage. Dental services should be reported in accordance with the nomenclature and descriptors defined in the current year American Dental Association's Current Dental Terminology (CDT) codebook. Participating dentists may not bill a patient for a service denied because it is misreported.
- Dental services must be dentally/medically necessary and meet accepted standards of dental practice, as defined by United Concordia, which requires any tooth or teeth to have acceptable prognosis and meet United Concordia's definition of dental/medical necessity for the reported code as defined by the current

ADA Current Dental Terminology codebook. Dental services determined not to meet United Concordia's definition of dental/medical necessity are not billable to the patient by a participating dentist unless the dentist notifies the patient of his or her potential financial liability prior to treatment and the patient chooses to receive the treatment (financial agreement). Participating dentists should document such notification specifically (with the date, tooth number, service, potential financial liability, and signature of the patient) in the patient's record.

- Any services utilized for the treatment of temporomandibular joint disorders (TMD/TMJ) or for implant placement, restoration, or maintenance is excluded from coverage and denied as not covered unless benefits are specifically provided for under a TMD or Implant rider.
- For reporting and benefit purposes, the billing/completion date for any Indirect restoration (any Inlay, Onlay, Crown, Indirectly fabricated Post and Core, Implant Abutment, Implant/Abutment Supported Crown or Fixed Partial Denture (Bridge), Labial Veneer, or Fixed Partial Denture (Bridge) or Indirectly fabricated Prosthesis (any Complete or Partial Denture, including Immediate, Interim, and Implant/Abutment Supported, or any Indirect Denture Rebase, Reline, and/or Repair) is the cementation or final placement date. Any Indirect restoration or Prosthesis begun prior to the effective date of coverage or cemented after the cancellation date of coverage is not eligible for payment. A 30-90 day extension may apply, please verify for specific Member plan/contract. Please resubmit the claim along with the corrected date.

AMALGAM - ONE SURFACE, PRIMARY OR PERMANENT (D2140)
AMALGAM - TWO SURFACES, PRIMARY OR PERMANENT (D2150)
AMALGAM - THREE SURFACES, PRIMARY OR PERMANENT (D2160)
AMALGAM - FOUR OR MORE SURFACES, PRIMARY OR PERMANENT (D2161)
RESIN-BASED COMPOSITE - ONE SURFACE, ANTERIOR (D2330)
RESIN-BASED COMPOSITE - TWO SURFACES, ANTERIOR (D2331)
RESIN-BASED COMPOSITE - THREE SURFACES, ANTERIOR (D2332)
RESIN-BASED COMPOSITE - FOUR OR MORE SURFACES OR INVOLVING INCISAL ANGLE (ANTERIOR) (D2335)
RESIN-BASED COMPOSITE - ONE SURFACE, POSTERIOR (D2391)
RESIN-BASED COMPOSITE - TWO SURFACES, POSTERIOR (D2392)
RESIN-BASED COMPOSITE - THREE SURFACES, POSTERIOR (D2393)
RESIN-BASED COMPOSITE - FOUR OR MORE SURFACES, POSTERIOR (D2394)
Limited to 1 of Amalgam Restoration (D2140, D2150, D2160, D2161) or Resin-based composite Restoration (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per surface per tooth per billing provider (TIN) per 24-month period. Replacement of an existing restoration is limited to only when they are not, and cannot be made, serviceable. For any non-standard plan that chooses to apply an ALTERNATE BENEFIT PROVISION, when Resin-based composite, posterior (D2391-D2394) is reported, payment will be made for a comparable Amalgam restoration (D2140-D2161) on bicuspids and molars (teeth 1-5, 12-21, 28-32). A participating dentist may bill the member the difference between the allowance for the alternate benefit and the dentist's charge for the service completed. ***Situational approval may apply when a one-surface restoration (D2140, D2330, D2391) is reported within frequency limitation of a previous basic restoration on the occlusal (O) or lingual surface (L) specifically for access closure following endodontic treatment (D3230, D3240, D3310, D3320, D3330, D3346, D3347, D3348, D3351, D3352, D3353, D3355, D3356, D3357). *Situational approval may apply in an Appeal with Dental Advisor review for placement of a separate restoration on a surface that has been restored in the past 12 months with documentation of extenuating circumstances.**
Multiple Amalgam Restorations (D2140, D2150, D2160, D2161) or multiple Resin-based composite Restorations (D2391, D2392, D2393, D2394) reported by the same Dentist, on the same posterior tooth, and on the same day that involve multiple surfaces with at least one common surface, or contiguous surfaces may be processed as a single restoration reflecting the number of different surfaces involved.
Amalgam Restorations (D2140, D2150, D2160, D2161) or multiple Resin-based composite Restorations (D2391, D2392, D2393, D2394) reported where number of surfaces do not match the reported procedure code may be processed in accordance with the number of surfaces reported.

Amalgam or Resin-based composite two surface restorations (D2150, D2331 or D2392) denied as MISREPORTED when reported with non-touching surfaces (MD or FL).
Multiple Amalgam Restorations (D2140, D2150, D2160, D2161) or multiple Resin-based composite Restorations (D2391, D2392, D2393, D2394) reported on the same day, by the same Dentist, on the same posterior tooth involving multiple surfaces with at least one common surface or contiguous surfaces may be processed as a single restoration reflecting the number of different surfaces involved. • Example: Multiple restorations reported same date, same dentist, same tooth, same material on the same surface is paid as one restoration. One restoration per surface may be allowed. 15 O/A D2140 and 15 O/A D2140 = 15 O/A D2140 • Example: Multiple restorations reported same date, same dentist, same tooth, same material, and at least one common surface on a POSTERIOR tooth: 13 MO/R D2392 and 13 DO/R D2392 = 13 MOD/R D2393 • Example: Multiple restorations reported same date, same dentist, same tooth, same material, contiguous (touching) surfaces on a POSTERIOR tooth: 13 MO/A D2150 and 13 D/A D2140 = 13 MOD/A D2160 • Example: Multiple restorations reported same date, same dentist, same tooth, DIFFERENT materials will NOT be combined = 13 MO/A D2150 and 13 B/R D2391 = 13 MO/A D2150 and 13 B/R D2391
Denied for INTEGRAL when reported by the same Dentist, on the same tooth, and on the same date as a Prefabricated post and core (D2954), Indirectly fabricated post and core (D2952), Core buildup (D2950).
Any multi-surface restoration is denied for INAPPROPRIATE TREATMENT SEQUENCE when reported by the same Dentist, on the same tooth, on the same date or following any allowed benefit for a Crown (D2710-D2799), Inlay/Onlay (D2510-D2664), Prefabricated crown (D2928 -D2934), Fixed partial denture (D6545-D6549, D6600-D6615, D6624, D6634, D6710-D6794. ***Situational approval may apply for upon Second Review/Appeal by a Dental Advisor with documentation of extenuating circumstances.**
RESIN BASED COMPOSITE CROWN (D2390)
Limited to 1 of Amalgam Restoration (D2140, D2150, D2160, D2161) or Resin-based composite Restoration (D2330, D2331, D2332, D2335, D2390) per anterior tooth per billing provider (TIN) per 24-month period. Replacement of an existing restoration is limited to only when they are not, and cannot be made, serviceable.
INLAY - METALLIC - ONE SURFACE (D2510)
INLAY - METALLIC - TWO SURFACES (D2520)
INLAY - METALLIC - THREE OR MORE SURFACES (D2530)
INLAY - PORCELAIN/CERAMIC - ONE SURFACE (D2610)
INLAY - PORCELAIN/CERAMIC - TWO SURFACES (D2620)
INLAY - PORCELAIN/CERAMIC - THREE OR MORE SURFACES (D2630)
INLAY - RESIN-BASED COMPOSITE - ONE SURFACE (D2650)
INLAY - RESIN-BASED COMPOSITE - TWO SURFACES (D2651)
INLAY - RESIN-BASED COMPOSITE - THREE OR MORE SURFACES (D2652)
Limited to 1 of Inlay (D2510-D2530, D2610-D2630, D2650-D2652), Onlay (D2542-D2544, D2642-D2644, D2662-D2664), or Crown (D2710-D2794) per tooth per 5 years. Replacement of an existing restoration is limited to only when they are not, and cannot be made, serviceable. For any plan that chooses to apply an ALTERNATE BENEFIT PROVISION, when Inlay (D2510-D2652) is reported, payment will be made for a comparable Amalgam or Resin-based Composite restoration. Refer to Amalgam and Resin-based Composite restoration (D2140-D2394) Exclusion & Limitations. A participating dentist may bill the member the difference between the allowance for the alternate benefit and the dentist's charge for the service completed. ***Situational approval may be allowed upon Second Review/Appeal if a Veneer (D2960-D2962) was paid in history. *Situational approval may be allowed upon Second Review/Appeal with Dental Advisor Review for an inlay or onlay benefitted under ALTERNATE BENEFIT PROVISION with documentation of extenuating circumstances.**
Denied as NOT STANDARD OF DENTAL TREATMENT when reported on a Member Age 13 and younger. ***Situational approval may be allowed upon Second Review/Appeal with Dental Advisor Review with documentation of extenuating circumstances.**
Denied as INAPPROPRIATE TREATMENT SEQUENCE when reported on the same date as an Onlay (D2542-D2544, D2642-D2644, D2662-D2664), or Crown (D2710-D2794) on the same tooth, and by the same Dentist.

DIAGNOSTIC MATERIAL REQUIREMENT: Submission of a pre-treatment, diagnostic x-ray must accompany the EDI/ADA Claim Form when reporting this service. Other chart materials may optionally be submitted and should corroborate clinically with the submitted x-rays for consideration during manual clinical review. **If specific rationale is provided explaining why x-ray(s) are not available (patient is pregnant, special needs, medical complication, etc.), the service may be referred to manual clinical review (Dental Advisor) in the absence of required materials.** Denied/Developed (If the plan situs is a state that requires it, an attempt will be made to contact the office to obtain the diagnostic materials required for manual clinical review (in a process referred to as "development") prior to denial in accordance with state regulations) if the attachment(s) do not contain the diagnostic materials specifically required for the service and if there is not a claim/predetermination submitted in history within 12 months for the same patient, for the same service type (e.g., crown), for the same tooth/site by the same provider that has the requirement diagnostic materials.
Denied as MISREPORTED if a Dental Advisor determines that the diagnostic materials do not show that the service planned (predetermination) or was completed (claim) meets the current CDT Current Dental Terminology descriptor of the code reported.
Denied for REPLACEMENT if a Dental Advisor determines that the diagnostic materials show that the tooth has an existing inlay that does not have a non-repairable fracture and/or periodontal pathology resultant from an issue with the existing restoration and/or the tooth does not have new decay or missing tooth structure.
Denied for NOT DENTALLY/MEDICALLY NECESSARY if a Dental Advisor determines that the diagnostic materials show that the tooth has acceptable periodontal, endodontic, and restorative prognosis and does not have decay and/or missing tooth structure that cannot be restored with a direct restoration (amalgam or resin-based composite material).
ONLAY - METALLIC - TWO SURFACES (D2542)
ONLAY - METALLIC - THREE SURFACES (D2543)
ONLAY - METALLIC - FOUR OR MORE SURFACES (D2544)
ONLAY - PORCELAIN/CERAMIC - TWO SURFACES (D2642)
ONLAY - PORCELAIN/CERAMIC - THREE SURFACES (D2643)
ONLAY - PORCELAIN/CERAMIC - FOUR OR MORE SURFACES (D2644)
ONLAY - RESIN-BASED COMPOSITE - TWO SURFACES (D2662)
ONLAY - RESIN-BASED COMPOSITE - THREE SURFACES (D2663)
ONLAY - RESIN-BASED COMPOSITE - FOUR OR MORE SURFACES (D2664)
Limited to 1 of Inlay (D2510-D2530, D2610-D2630, D2650-D2652), Onlay (D2542-D2544, D2642-D2644, D2662-D2664), Crown (D2710-D2794) per tooth per 5 years. Replacement of an existing restoration is limited to only when they are not, and cannot be made, serviceable. For any plan that chooses to apply an ALTERNATE BENEFIT PROVISION, when Onlay two-surface restoration (D2542, D2642, D2662) is reported, payment will be made for a comparable Amalgam restoration (D2150). Refer to Amalgam restoration (D2140, D2150, D2160) Exclusion & Limitations. A participating dentist may bill the member the difference between the allowance for the alternate benefit and the dentist's charge for the service completed. ***Situational approval may be allowed upon Second Review/Appeal if a Veneer (D2960-D2962) was paid in history.**
Denied as NOT STANDARD OF DENTAL TREATMENT when reported on a Member Age 13 and younger. ***Situational approval may be allowed upon Second Review/Appeal with Dental Advisor Review with documentation of extenuating circumstances.**
Denied as MISREPORTED when reported without a facial or lingual surface.
Denied as INAPPROPRIATE TREATMENT SEQUENCE when reported on the same date as an Onlay (D2542-D2544, D2642-D2644, D2662-D2664), or Crown (D2710-D2794) on the same tooth, and by the same Dentist.
DIAGNOSTIC MATERIAL REQUIREMENT: Submission of a pre-treatment, diagnostic x-ray must accompany the EDI/ADA Claim Form when reporting this service. Other chart materials may optionally be submitted and should corroborate clinically with the submitted x-rays for consideration during manual clinical review. **If specific rationale is provided explaining why x-ray(s) are not available (patient is pregnant, special needs, medical complication, etc.), the service may be referred to manual clinical review (Dental Advisor) in the absence of required materials.** Denied/Developed (If the plan situs is a state that requires it, an attempt will be

made to contact the office to obtain the diagnostic materials required for manual clinical review (in a process referred to as "development") prior to denial in accordance with state regulations) if the attachment(s) do not contain the diagnostic materials specifically required for the service and if there is not a claim/predetermination submitted in history within 12 months for the same patient, for the same service type (e.g., crown), for the same tooth/site by the same provider that has the requirement diagnostic materials.
Denied as MISREPORTED if a Dental Advisor determines that the diagnostic materials do not show that the service planned (predetermination) or was completed (claim) meets the current CDT Current Dental Terminology descriptor of the code reported.
Denied as NOT STANDARD OF DENTAL TREATMENT POOR PERIODONTAL PROGNOSIS if a Dental Advisor determines that diagnostic materials shows that the tooth has a poor or hopeless prognosis.
Denied as NOT STANDARD OF DENTAL TREATMENT POOR RESTORATIVE PROGNOSIS if a Dental Advisor determines that diagnostic materials shows that the tooth has a poor or hopeless prognosis.
Denied as NOT STANDARD OF DENTAL TREATMENT POOR ENDODONTIC PROGNOSIS – ROOT FRACTURE if a Dental Advisor determines that diagnostic materials shows that the tooth has a poor or hopeless prognosis.
Denied for VERTICAL DIMENSION if a Dental Advisor determines that diagnostic materials shows that the restoration is associated with alteration of vertical dimension.
Denied for REPLACEMENT NOT DENTALLY/MEDICALLY NECESSARY if a Dental Advisor determines that the diagnostic materials shows that a tooth with an existing onlay, crown, or bridge abutment does not have a non-repairable fracture and/or periodontal pathology resultant from an issue with the existing restoration and/or the tooth does not have new decay or missing tooth structure.
Denied for NOT DENTALLY/MEDICALLY NECESSARY if a Dental Advisor determines that the diagnostic materials do not show a tooth with decay and/or missing tooth structure involving three or more tooth surfaces that cannot be restored with a direct restoration (generally when decay and/or missing tooth structure with any existing restorations comprises >50% of a cusp/incisal edge or tooth overall).
CROWN - RESIN-BASED COMPOSITE (INDIRECT) (D2710)
RESIN - 3/4 RESIN-BASED COMPOSITE (INDIRECT) (D2712)
CROWN - RESIN WITH HIGH NOBLE METAL (D2720)
CROWN - RESIN WITH PREDOMINANTLY BASE METAL (D2721)
CROWN - RESIN WITH NOBLE METAL (D2722)
CROWN - PORCELAIN/CERAMIC (D2740)
CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL (D2750)
CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL (D2751)
CROWN - PORCELAIN FUSED TO NOBLE METAL (D2752)
CROWN - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS (D2753)
CROWN - 3/4 CAST HIGH NOBLE METAL (D2780)
CROWN - 3/4 CAST PREDOMINANTLY BASE METAL (D2781)
CROWN - 3/4 CAST NOBLE METAL (D2782)
3/4 PORCELAIN/CERAMIC (D2783)
CROWN - FULL CAST HIGH NOBLE METAL (D2790)
CROWN - FULL CAST PREDOMINANTLY BASE METAL (D2791)
CROWN - FULL CAST NOBLE METAL (D2792)
CROWN - TITANIUM AND TITANIUM ALLOYS (D2794)
Limited to 1 of Inlay (D2510-D2530, D2610-D2630, D2650-D2652), Onlay (D2542-D2544, D2642-D2644, D2662-D2664), Crown (D2710-D2794), or Veneer (D2960-D2962) per tooth per 5 years. Replacement of an existing restoration is limited to only when they are not, and cannot be made, serviceable. ***Situational approval may be allowed upon Second Review/Appeal if a Veneer (D2960-D2962) was paid in history.**

Denied as NOT STANDARD OF DENTAL TREATMENT when reported on a Member Age 13 and younger. ***Situational approval may be allowed upon Second Review/Appeal with Dental Advisor Review with documentation of extenuating circumstances.**
Denied as INAPPROPRIATE TREATMENT SEQUENCE when reported on the same date as an Onlay (D2542-D2544, D2642-D2644, D2662-D2664), or Crown (D2710-D2794) on the same tooth, and by the same Dentist.
DIAGNOSTIC MATERIAL REQUIREMENT: Submission of a pre-treatment, diagnostic x-ray must accompany the EDI/ADA Claim Form when reporting this service. Other chart materials may optionally be submitted and should corroborate clinically with the submitted x-rays for consideration during manual clinical review. **If specific rationale is provided explaining why x-ray(s) are not available (patient is pregnant, special needs, medical complication, etc.), the service may be referred to manual clinical review (Dental Advisor) in the absence of required materials.**
Denied as MISREPORTED/SPLINTING if CDT Code for "single tooth crown" reported but diagnostic materials show a Bridge/FPD (multiple connected retainer crowns with NO pontic).
Denied as MISREPORTED if CDT Code for "single tooth crown" reported but documentation diagnostic materials show a Bridge/FPD (multiple retainer crowns with at least one pontic).
Denied as MISREPORTED if a Dental Advisor determines that the diagnostic materials do not show that the service planned (predetermination) or was completed (claim) meets the current CDT Current Dental Terminology descriptor of the code reported.
Denied as NOT STANDARD OF DENTAL TREATMENT POOR PERIODONTAL PROGNOSIS if a Dental Advisor determines that diagnostic materials show that the tooth has a poor or hopeless prognosis.
Denied as NOT STANDARD OF DENTAL TREATMENT POOR RESTORATIVE PROGNOSIS if a Dental Advisor determines that diagnostic materials show that the tooth has a poor or hopeless prognosis.
Denied as NOT STANDARD OF DENTAL TREATMENT POOR ENDODONTIC PROGNOSIS – ROOT FRACTURE if a Dental Advisor determines that diagnostic materials show that the tooth has a poor or hopeless prognosis.
Denied for VERTICAL DIMENSION if a Dental Advisor determines that diagnostic materials show that the restoration is associated with alteration of vertical dimension.
Denied for REPLACEMENT NOT DENTALLY/MEDICALLY NECESSARY if a Dental Advisor determines that diagnostic materials show that the tooth with an existing onlay, crown, or bridge abutment does not have a non-repairable fracture and/or periodontal pathology resultant from an issue with the existing restoration and/or the tooth does not have new decay or missing tooth structure.
Denied for NOT DENTALLY/MEDICALLY NECESSARY if a Dental Advisor determines that the diagnostic materials show a tooth with no planned/completed root canal treatment that does not have decay and/or missing tooth structure involving three or more tooth surfaces that cannot be restored with a direct restoration (generally when decay and/or missing tooth structure with any existing restorations comprises >50% of a cusp/incisal edge or tooth overall) or does not show confirmation of a specific clinical diagnosis of Cracked Tooth Syndrome.
RE-CEMENT OR RE-BOND INLAY, ONLAY, VENEER OR PARTIAL COVERAGE RESTORATION (D2910)
RE-CEMENT OR RE-BOND INDIRECTLY FABRICATED OR PREFABRICATED POST AND CORE (D2915)
RE-CEMENT OR RE-BOND CROWN (D2920)
Limited to 1 of Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration (D2910), 1 of Re-cement or re-bond indirectly fabricated or prefabricated post and core (D2915), and 1 of Re-cement or re-bond crown (D2920) per tooth per 3-year period.
Denied as INTEGRAL when reported on the same tooth and the same date of service, by the same Dentist as any Crown, Inlay, or Onlay.
Denied as INTEGRAL when reported for the same tooth within by the same Dentist within the initial 12 months post insertion of the same Inlay, Onlay, Veneer, Partial coverage restoration, Indirectly fabricated or Prefabricated post and core, or Crown. ***Situational approval may be allowed upon Second Review/Appeal with documentation that Recementation was necessary following root canal treatment or because of an accidental injury. Situational approval may be allowed upon Second Review/Appeal with Dental Advisor Review with documentation of extenuating circumstances.**
PREFABRICATED STAINLESS STEEL CROWN - PRIMARY TOOTH (D2930)

PREFABRICATED STAINLESS STEEL CROWN - PERMANENT TOOTH (D2931)
PREFABRICATED RESIN CROWN (D2932)
PREFABRICATED STAINLESS STEEL CROWN WITH RESIN WINDOW (D2933)
PREFABRICATED ESTHETIC COATED STAINLESS STEEL CROWN - PRIMARY TOOTH (D2934)
Limited to 1 of Prefabricated crown (D2930, D2932, D2933, or D2934) per primary tooth per lifetime for Member under Age 14 and 1 of Prefabricated crown (D2931, D2932, D2933) per permanent tooth per lifetime for Member under Age 14. For any plan that chooses to apply an ALTERNATE BENEFIT PROVISION, when Prefabricated crown (D2932, D2933, D2934) is reported on a posterior tooth (A, B, I, L, S, T or 1-5,12-16,17-21,28-32), payment will be made for a comparable Prefabricated Crown (D2930, D2931). A participating dentist may bill the member the difference between the allowance for the alternate benefit and the dentist's charge for the service completed.
Denied as NOT STANDARD OF DENTAL TREATMENT when reported on a Member Age 14 and older. ***Situational approval may be allowed for PREFABRICATED STAINLESS STEEL CROWN - PRIMARY TOOTH (D2930) on a primary tooth for Member Age 14 and older upon Second Review/Appeal with Dental Advisor Review with documentation of extenuating circumstances.**
Any multi-surface restoration is denied for INAPPROPRIATE TREATMENT SEQUENCE when reported by the same Dentist, on the same tooth, on the same date or following any allowed benefit for a Crown (D2710-D2799), Inlay/Onlay (D2510-D2664), Prefabricated crown (D2928-D2934), Fixed partial denture (D6545-D6549, D6600-D6615, D6624, D6634, D6710-D6794.
RESTORATIVE FOUNDATION FOR AN INDIRECT RESTORATION (D2949)
Denied as INTEGRAL when reported alone or in conjunction with other services.
CORE BUILDUP, INCLUDING ANY PINS WHEN REQUIRED (D2950)
Limited to 1 of Core buildup (D2950), Post and core in addition to crown, indirectly fabricated (D2952), or Prefabricated post and core in addition to crown (D2954) per tooth per 5-year period.
Denied as NOT STANDARD OF DENTAL TREATMENT when reported on a Member Age 13 and younger. ***Situational approval may be allowed upon Second Review/Appeal with Dental Advisor Review with documentation of extenuating circumstances**.
Denied as NOT STANDARD OF DENTAL TREATMENT when reported on a primary tooth. ***Situational approval may be allowed upon Second Review/Appeal with Dental Advisor Review for a Core buildup denied for primary tooth with documentation of extenuating circumstances.**
Denied as MISREPORTED when reported on the same date or prior to an Inlay (D2510-D2530, D2610-D2630, D2650-D2652), Onlay (D2542-D2544, D2642-D2644, D2662-D2664), Veneer (D2960-D2962), 3/4 crown (D2780-D2783), Prefabricated crown (D2928-D2934), Pontic (D6205-D6299), or Implant/Abutment supported crown (D6058-D6067, D6082-D6084, D6086-D6088, D6094, D6097) on the same tooth.
A Core buildup (D2950), Post and core in addition to crown, indirectly fabricated (D2952), Prefabricated post and core in addition to crown (D2954) reported on a tooth with an existing Crown or Fixed partial denture abutment (Bridge abutment) and indication that Root canal treatment was or will be completed on the tooth through the existing crown (RCT access closure) will be processed as single surface Resin-based composite restoration (Anterior D2330 L or Posterior D2391 O).
DIAGNOSTIC MATERIAL REQUIREMENT: Submission of a pre-treatment, diagnostic x-ray must accompany the EDI/ADA Claim Form when reporting this service. Other chart materials may optionally be submitted and should corroborate clinically with the submitted x-rays for consideration during manual clinical review. **If specific rationale is provided explaining why x-ray(s) are not available (patient is pregnant, special needs, medical complication, etc.), the service may be referred to manual clinical review (Dental Advisor) in the absence of required materials.**
Denied as NOT STANDARD OF DENTAL TREATMENT POOR PERIODONTAL PROGNOSIS if a Dental Advisor determines that submitted diagnostic materials shows that the tooth has a poor or hopeless prognosis.
Denied as NOT STANDARD OF DENTAL TREATMENT POOR RESTORATIVE PROGNOSIS if a Dental Advisor determines that submitted diagnostic materials shows that the tooth has a poor or hopeless prognosis.

Denied as NOT STANDARD OF DENTAL TREATMENT POOR ENDODONTIC PROGNOSIS – ROOT FRACTURE if a Dental Advisor determines that submitted diagnostic materials shows that the tooth has a poor or hopeless prognosis.
Denied for VERTICAL DIMENSION if a Dental Advisor determines that submitted diagnostic materials shows that the restoration is associated with alteration of vertical dimension.
Denied for REPLACEMENT NOT DENTALLY/MEDICALLY NECESSARY if a Dental Advisor determines that the submitted diagnostic materials shows that the tooth with an existing onlay, crown, or bridge abutment does not have a non-repairable fracture and/or periodontal pathology resultant from an issue with the existing restoration and/or the tooth does not have new decay or missing tooth structure.
Denied as MISREPORTED (UPCODING) if a Dental Advisor determines that the submitted diagnostic materials shows that the procedure planned or completed is/was placement of restorative material to yield a more ideal form, including elimination of undercuts (which meets the definition of Restorative foundation (D2949) which is INTEGRAL, rather than a Core Buildup (D2950), which is defined as the *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*.
PIN RETENTION - PER TOOTH, IN ADDITION TO RESTORATION (D2951)
No frequency limitation.
Denied as STANDARD OF DENTAL TREATMENT when reported without a restoration on the same date, on the same tooth, and by the same Dentist.
Multiple instances of Pin retention (D2951) reported by the same Dentist, on the same tooth and on the same date of service, are processed as a single Pin retention (D2951) per tooth for STANDARD OF DENTAL TREATMENT
POST AND CORE IN ADDITION TO CROWN, INDIRECTLY FABRICATED (D2952)
PREFABRICATED POST AND CORE IN ADDITION TO CROWN (D2954)
Limited to 1 of Core buildup (D2950), Post and core in addition to crown, indirectly fabricated (D2952), or Prefabricated post and core in addition to crown (D2954) per tooth per 5-year period. For any plan that chooses to apply an ALTERNATE BENEFIT PROVISION, when Post and core, indirectly fabricated (D2952) is reported, payment will be made for comparable Prefabricated post and core in addition to crown (D2954). A participating dentist may bill the member the difference between the allowance for the alternate benefit and the dentist's charge for the service completed. ***Situational approval may be allowed upon Second Review/Appeal with Dental Advisor Review for a Post and core, indirectly fabricated (D2952) benefitted as a Prefabricated post and core (D2954) under ALTERNATE BENEFIT PROVISION with documentation of extenuating circumstances.**
Denied as NOT STANDARD OF DENTAL TREATMENT when reported on a Member Age 13 and younger. ***Situational approval may be allowed upon Second Review/Appeal with Dental Advisor Review with documentation of extenuating circumstances.**
Denied as NOT STANDARD OF DENTAL TREATMENT when reported on a primary tooth. ***Situational approval may be allowed upon Second Review/Appeal with Dental Advisor Review for a Core buildup denied for primary tooth with documentation of extenuating circumstances.**
Denied as MISREPORTED when reported on the same date or prior to an Inlay (D2510-D2530, D2610-D2630, D2650-D2652), Onlay (D2542-D2544, D2642-D2644, D2662-D2664), Veneer (D2960-D2962), 3/4 crown (D2780-D2783), Prefabricated crown (D2928-D2984), Pontic (D6205-D6299), or Implant/Abutment supported crown (D6058-D6067, D6082-D6084, D6086-D6088, D6094, D6097) on the same tooth.
A Core buildup (D2950), Post and core in addition to crown, indirectly fabricated (D2952) or Prefabricated post and core in addition to crown (D2954) reported on a tooth with an existing Crown or Fixed partial denture abutment (Bridge abutment) and indication that Root canal treatment was or will be completed on the tooth through the existing crown (RCT access closure) will be processed as a single surface Resin-based composite restoration (Anterior D2330 L or Posterior D2391 O).
DIAGNOSTIC MATERIALS REQUIRED: Submission of a pre-treatment, diagnostic x-ray showing evidence of RCT (or written documentation/claim history of RCT) must accompany the EDI/ADA Claim Form when reporting this service. Other chart materials may optionally be submitted and should corroborate clinically with the submitted x-rays for consideration during manual clinical review.

If specific rationale is provided explaining why x-ray(s) are not available (patient is pregnant, special needs, medical complication, etc.), the service may be referred to manual clinical review (Dental Advisor) in the absence of required materials
Denied as NOT STANDARD OF DENTAL TREATMENT POOR PERIODONTAL PROGNOSIS if a Dental Advisor determines that diagnostic materials show that the tooth has a poor or hopeless prognosis.
Denied as NOT STANDARD OF DENTAL TREATMENT POOR RESTORATIVE PROGNOSIS if a Dental Advisor determines that diagnostic materials show that the tooth has a poor or hopeless prognosis.
Denied as NOT STANDARD OF DENTAL TREATMENT POOR ENDODONTIC PROGNOSIS – ROOT FRACTURE if a Dental Advisor determines that diagnostic materials show that the tooth has a poor or hopeless prognosis.
Denied for VERTICAL DIMENSION if a Dental Advisor determines that diagnostic materials show that the restoration is associated with alteration of vertical dimension.
Denied for REPLACEMENT NOT DENTALLY/MEDICALLY NECESSARY if a Dental Advisor determines that diagnostic materials show that the tooth with an existing onlay, crown, or bridge abutment does not have a non-repairable fracture and/or periodontal pathology resultant from an issue with the existing restoration and/or the tooth does not have new decay or missing tooth structure.
Denied as MISREPORTED (UPCODING) if a Dental Advisor determines that the diagnostic materials show that the procedure planned or completed is/was placement of restorative material to yield a more ideal form, including elimination of undercuts, box forms, and concave irregularities (which meets the CDT descriptor of Restorative foundation (D2949) that is considered INTEGRAL to the Crown by United Concordia), rather than a Core Buildup (D2950), which is defined as the building up of coronal structure when there is insufficient retention for a separate extracoronal restorative procedure.
EACH ADDITIONAL INDIRECTLY FABRICATED POST - SAME TOOTH (D2953)
EACH ADDITIONAL PREFABRICATED POST - SAME TOOTH (D2957)
Denied as INTEGRAL when reported alone or in conjunction with other services.
REMOVAL OF AN INDIRECT RESTORATION ON A NATURAL TOOTH (D2956)
Denied as INTEGRAL when reported alone or in conjunction with other services.
ADDITIONAL PROCEDURES TO CUSTOMIZE A CROWN TO FIT UNDER AN EXISTING PARTIAL DENTURE FRAMEWORK (D2971)
Limited to 1 of Additional procedures to customize a crown (D2971) per tooth per 5 years.
CROWN REPAIR NECESSITATED BY RESTORATIVE MATERIAL FAILURE (D2980)
INLAY REPAIR NECESSITATED BY RESTORATIVE MATERIAL FAILURE (D2981)
ONLAY REPAIR NECESSITATED BY RESTORATIVE MATERIAL FAILURE (D2982)
Limited to 1 of Crown Repair (D2980), Inlay Repair (D2981), and Onlay Repair (D2982) per tooth per 36-month period following the initial 5 years post insertion of the Crown, Inlay, or Onlay.
Denied as INTEGRAL when reported for the same tooth, by the same Dentist within the initial 5 years post insertion of the Crown, Inlay, or Onlay.
APPLICATION OF HYDROXYAPATITE REGENERATION MEDICAMENT – PER TOOTH (D2991)
Limited to 2 of Application of caries arresting medicament (D1354) per tooth per 12-month period for Member Age 1-6 and 1 per tooth per 12-month period for Member Age 7-12.
Denied as MISREPORTED when reported for anything other than Curodont ® (Curodont Repair Fluoride Plus®) or CrystLCare®.
UNSPECIFIED RESTORATIVE PROCEDURE, BY REPORT (D2999)
No frequency limitation.
Denied as MISREPORTED (GENERIC) when the service described has a specific and valid CDT code. Example: Interim restorations (“provisional or temporary”) (if NOT associated with Crown D2710-D2794 or Bridge D6205-D6792) (D2799, D6793, D6253), Protective restoration (Sedative or temporary restoration or filling, IRM ®, FUGI ®) (D2940), Regeneration medicament (Curodont®) (D2991)
Denied as INTEGRAL (GENERIC) when the service described has no specific and valid code because it is part of the Standard of Dental Treatment for another principal service (includes multi-step processes and individual dentist choices for what products and/or techniques that may be used). Examples: Abrasion/Microabrasion/Sandblasting, Acid etch (Phosphoric acid – Ultra-Etch®, Etch-Rite®), Bases or Liners

((Glass ionomer – Dycal®, HydroxTM®, Life®, VLC Dycal®, Calcium hydroxide – Lime-lite®, Vitrebond®, Ionoseal®, Calcimol®, ACTIVA®, Fugi®, Multi-Cal®, Alrox®, Cavitec®, Copalite®, IRM®), Bite block, Bite Registration, Bonding agents (Peak Universal Bond®, Optibond®, All Bond®, Scotchbond®, Clearfil SE®, Futurabond®, Adhese Viva®, G Bond®), Caries detecting agents (Caries Detector®, Caries Indicator®, Snoop®), Cavity varnish (Copal – Cavity VarnishTM®, Copalite®), Cementation (Inlay/Onlay/Crown/Veneer/Fixed Partial Denture (Bridge)), Hemostatic gel/solution (Astringedent®, Viscostat®, Expasyl®) (”preparation of gingival tissue”), Impressions, Interim restorations (“provisional or temporary”) (if associated with Crown D2710-D2794 or Bridge D6205-D6792), Isolation techniques (including gel barrier, Isolite®, and rubber dam placement), Lab fees, Light/LED curing, Matrix bands (Pro-Matrix®, Palodent®, Automatrix®, Composi-Tight®), Preparation of tooth (“Prep” for Inlay/Onlay/Crown/Veneer/Fixed Partial Denture (Bridge)), Removal of existing restorations (including removal of existing crowns/bridges), Upgrades for Metal or Materials (including Porcelain margin, Captek®, Lumineer ®, Empress ®, Zirconia®, Additional Porcelain, Denture teeth and material upgrades like Ivoclar ®, Val-plast ®, Flexite® etc). ***Situational approval may be allowed for Specialized procedures/characterizations upon Second Review/Appeal with Dental Advisor. Must have lab slip documenting specific associated costs associated with custom restorative/prosthetic work like gemstones and engravings (outside of required name label in dentures/partials) in restorative and prosthetic work and specific signed Member financial agreement.**
Denied as MISREPORTED + INTEGRAL when the service described has a specific and valid code because it is part of the Standard of Dental Treatment for another principal service (includes multi-step processes and individual dentist choices for what products and/or techniques that may be used). Example: Diagnostic casts (“study or lab models”) (**D0470**), Local anesthetic (Lidocaine®, Bupivacaine®, Marcaine®, Septocaine®) and modalities for administration (Viajet®) (**D9210-D9215**), Restorative foundation for indirect restoration (“blocking undercuts/irregularities”)(**D2949**), Topical anesthestic (Oraquix, Hurricaine, Tetracaine®) (**D9210-D9215**)
Denied as NOT COVERED (GENERIC) when the service described has no specific and valid code and describes a service that is not covered.
Denied as MISREPORTED + NOT COVERED when the service described has a specific and valid code and describes a service that is not covered.

ENDODONTIC SERVICES (D3110-D3999)

- Dental services that are routinely provided in conjunction with or as part of another procedure in accordance with accepted standards of dental practice are defined as integral by United Concordia Dental and excluded from coverage. Some dental services may be denied as integral when reported in the absence of another dental service (for example: local anesthesia) or denied as integral only when another more comprehensive dental service has been benefitted. Any benefit for any Endodontic service per CDT code descriptor as reported is inclusive of all charges for work, materials, and supplies related to the procedure, and if reported separately, these services may be denied as integral. Participating dentists may not bill a patient for a service denied as integral.
- Dental services that are reported in a treatment sequence that is not appropriate in accordance with accepted standards of dental practice are defined as integral by United Concordia Dental and excluded from coverage (for example: a crown reported on a date following an extraction benefitted on the same tooth). Participating dentists may not bill a patient for a service denied because it is reported in an inappropriate treatment sequence.
- Dental services that are misreported or that represent a procedure other than the one reported are excluded from coverage. Dental services should be reported in accordance with the nomenclature and descriptors defined in the current year American Dental Association’s Current Dental Terminology (CDT) codebook. Participating dentists may not bill a patient for a service denied because it is misreported.
- Dental services must be dentally/medically necessary and meet accepted standards of dental practice, as defined by United Concordia, which requires any tooth or teeth to have acceptable prognosis and meet United Concordia’s definition of dental/medical necessity for the reported code as defined by the current ADA Current Dental Terminology codebook. Dental services determined not to meet United Concordia’s

definition of dental/medical necessity are not billable to the patient by a participating dentist unless the dentist notifies the patient of his or her potential financial liability prior to treatment and the patient chooses to receive the treatment (financial agreement). Participating dentists should document such notification specifically (with the date, tooth number, service, potential financial liability, and signature of the patient) in the patient's record. • For reporting and benefit purposes, the billing/completion date for any endodontic service (except for apexification/recalcification and pulpal regeneration services that have specific codes for initial, interim, and completion) is the completion (final fill) date. Any endodontic service begun prior to the effective date of coverage or completed after the cancellation date of coverage is not eligible for payment. A 30-90 day extension may apply, please verify for specific Member plan/contract.
PULP CAP - DIRECT (EXCLUDING FINAL RESTORATION) (D3110)
PULP CAP - INDIRECT (EXCLUDING FINAL RESTORATION) (D3120)
Denied as INTEGRAL when reported alone or in conjunction with another service.
THERAPEUTIC PULPOTOMY (EXCLUDING FINAL RESTORATION) - REMOVAL OF PULP CORONAL TO THE DENTINOCEMENTAL JUNCTION AND APPLICATION AND MEDICAMENT (D3220)
No frequency limitation.
Denied for NOT STANDARD OF DENTAL TREATMENT when reported on a permanent tooth. ***Situational approval for permanent tooth may be allowed upon Second Review/Appeal with Dental Advisor Review with documentation of extenuating circumstances.**
Denied as INTEGRAL when reported by the same Dentist, on the same primary tooth, on the same date or within 6 months prior to Pulpal debridement (D3221) or Pulpal Therapy on Primary Teeth (D3230-D3240)
Denied as INAPPROPRIATE TREATMENT SEQUENCE when reported on the same primary tooth following Pulpal debridement (D3221), Partial pulpotomy for apexogenesis (D3222), or Pulpal therapy (D3230-D3240).
PULPAL DEBRIDEMENT, PRIMARY AND PERMANENT TEETH (D3221)
Limited to 2 of Palliative treatment (D9110) per 12 month period in combination with Pulpal Debridement (D3221).
Denied as INTEGRAL when reported by the same Dentist, on the same tooth, on the same date as Pulpal Therapy on Primary Teeth (D3230-D3240), Endodontic therapy (D3310-D3330), Root canal retreatment (D3346-D3348), Apexification/Recalcification (D3351-D3353) or Pulpal regeneration (D3355-D3357) or Palliative treatment (D9110).
PARTIAL PULPOTOMY FOR APEXOGENESIS - PERMANENT TOOTH WITH INCOMPLETE ROOT DEVELOPMENT (D3222)
Limited to 1 of Partial pulpotomy (D3222) per permanent tooth per lifetime
Denied for INTEGRAL when reported by the same Dentist, on the same tooth for the same date or within 6 months prior to Pulpal Debridement (D3221), Endodontic therapy (D3310-D3333), Treatment of RCT Obstruction (D3331), Incomplete RCT (D3332), Internal Root Repair (D333), Endodontic Retreatment (D3346-D3348), Apexification/Recalcification (D3351-D3353), or Pulpal regeneration (D3355-D3357).
Denied for INAPPROPRIATE TREATMENT SEQUENCE when reported on the same tooth following Pulpal Debridement (D3221), Endodontic therapy (D3310-D3333), Treatment of RCT Obstruction (D3331), Incomplete RCT (D3332), Internal Root Repair (D3333), Endodontic Retreatment (D3346-D3348), Apexification/Recalcification (D3351-D3353), or Pulpal regeneration (D3355-D3357).
PULPAL THERAPY (RESORBABLE FILLING) - ANTERIOR, PRIMARY TOOTH (EXCLUDING FINAL RESTORATION) (D3230)
PULPAL THERAPY (RESTORABLE FILLING) - POSTERIOR, PRIMARY TOOTH (EXCLUDING FINAL RESTORATION) (D3240)
Limited to 1 of Pulpal Therapy – Anterior (D3230) per Anterior tooth (C, D, E, F, G, H, M, N, O, P, Q, R) per lifetime and 1 of Pulpal Therapy – Posterior (D3240) per Posterior tooth (A, B, I, J, K, L, S, T) tooth per lifetime.
Pulpal therapy (D3230, D3240) reported on a permanent tooth will be denied for MISREPORTED.

ENDODONTIC THERAPY, ANTERIOR TOOTH (EXCLUDING FINAL RESTORATION) (D3310)
ENDODONTIC THERAPY, PREMOLAR TOOTH (EXCLUDING FINAL RESTORATION) (D3320)
ENDODONTIC THERAPY, MOLAR TOOTH (EXCLUDING FINAL RESTORATION) (D3330)
Limited to 1 of Endodontic Therapy – Anterior (D3310) per Anterior tooth (6-11, 22-27) per lifetime and 1 of Endodontic Therapy – Premolar (D3320) per Premolar tooth (4, 5, 12, 13, 20, 21, 28, 29) per lifetime and 1 of Endodontic Therapy – Molar (D3330) per Molar tooth (1, 2, 3, 14, 15, 16, 17, 18, 19, 30, 31, 32) per lifetime.
Denied for INTEGRAL when reported on the same tooth, by the same provider on the same date or following Apexification (D3351-D3353).
TREATMENT OF ROOT CANAL OBSTRUCTION; NON-SURGICAL ACCESS (D3331)
Denied as INTEGRAL when reported alone or in conjunction with another service. ***Situational approval may be allowed upon Second Review/Appeal with Dental Advisor Review with documentation of extenuating circumstances and only when reported by a different provider than previously reported endodontic services on the same tooth.**
INTERNAL ROOT REPAIR OF PERFORATION DEFECTS (D3333)
No frequency limitation.
DIAGNOSTIC MATERIALS REQUIRED: Submission of a pre-treatment, diagnostic x-ray and written documentation must accompany the EDI/ADA Claim Form when reporting this service. Other chart materials may optionally be submitted and should corroborate clinically with the submitted x-rays for consideration during manual clinical review. **If specific rationale is provided explaining why x-ray(s) are not available (patient is pregnant, special needs, medical complication, etc.), the service may be referred to manual clinical review (Dental Advisor) in the absence of required materials.**
Denied for NOT STANDARD OF DENTAL TREATMENT when reported for repair of an intragenic injury (same dentist doing the primary procedure).
Denied for INCOMPLETE TREATMENT when documentation indicates that the Member did not return to complete initiated endodontic treatment.
Denied for MISREPORTED if a Dental Advisor determines that the submitted documentation does not support that the service planned (pre-estimation) or was completed (claim) meets the current CDT Current Dental Terminology descriptor of the code reported.
Denied for NOT STANDARD OF DENTAL TREATMENT POOR PERIODONTAL PROGNOSIS if a Dental Advisor determines that submitted documentation supports that the tooth has a poor or hopeless prognosis.
Denied for NOT STANDARD OF DENTAL TREATMENT POOR RESTORATIVE PROGNOSIS if a Dental Advisor determines that submitted documentation supports that the tooth has a poor or hopeless prognosis.
RETREATMENT OF PREVIOUS ROOT CANAL THERAPY – ANTERIOR (D3346)
RETREATMENT OF PREVIOUS ROOT CANAL THERAPY – PREMOLAR (D3347)
RETREATMENT OF PREVIOUS ROOT CANAL THERAPY – MOLAR (D3348)
Limited to 1 of Retreatment of Previous Root Canal Therapy – Anterior (D3346) per Anterior tooth (6-11, 22-27) per lifetime and 1 of Retreatment of Previous Root Canal Therapy – Premolar (D3347) per Premolar tooth (4, 5, 12, 13, 20, 21, 28, 29) per lifetime and 1 of Retreatment of Previous Root Canal Therapy – Molar (D3348) per Molar tooth (1, 2, 3, 14, 15, 16, 17, 18, 19, 30, 31, 32) per lifetime.
Denied for NOT STANDARD OF DENTAL TREATMENT when reported on the same tooth, by the same Provider, within 30 days of Endodontic Therapy (D3310, D3320, D3330). ***Situational approval may be allowed upon Second Review/Appeal with Dental Advisor Review with documentation of extenuating circumstances.**
Denied for SPECIALIZED PROCEDURES AND TECHNIQUES EXCLUSION when reported in the same arch as an Overdenture (D5863, D5864, D5865, D5866).
APEXIFICATION/RECALCIFICATION - INITIAL VISIT (APICAL CLOSURE/CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, ETC.) (D3351)
APEXIFICATION/RECALCIFICATION - INTERIM MEDICATION REPLACEMENT (D3352)
APEXIFICATION/RECALCIFICATION - FINAL VISIT (INCLUDES COMPLETED ROOT CANAL THERAPY - APICAL CLOSURE/CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, ETC.) (D3353)
No frequency limitation.

Denied as MISREPORTED when reported by the same Dentist, on the same tooth, on the same date or following Endodontic Treatment (D3310-D3330).
Denied for STANDARD OF DENTAL TREATMENT when reported on a primary (deciduous) tooth or on a permanent tooth on a Member Age 15 and older.
PULPAL REGENERATION - INITIAL VISIT (D3355)
PULPAL REGENERATION - INTERIM MEDICATION REPLACEMENT (D3356)
No frequency limitation.
Denied for STANDARD OF DENTAL TREATMENT when reported on a primary (deciduous) tooth or on a permanent tooth on a Member Age 15 and older.
PULPAL REGENERATION - COMPLETION OF TREATMENT (D3357)
Limited to 1 of Initial Visit (D3355) per tooth per lifetime.
Denied for STANDARD OF DENTAL TREATMENT when reported on a primary (deciduous) tooth or on a permanent tooth on a Member Age 15 and older.
APICOECTOMY – ANTERIOR (D3410)
APICOECTOMY - PREMOLAR (FIRST ROOT) (D3421)
APICOECTOMY - MOLAR (FIRST ROOT) (D3425)
No frequency limitation.
APICOECTOMY - (EACH ADDITIONAL ROOT) (D3426)
Limited to 1 of Each Additional Root (D3426) per Premolar tooth (4, 5, 12, 13, 20, 21, 28, 29) and 3 of Each Additional Root (D3426) per Molar (1, 2, 3, 14, 15, 16, 17, 18, 19, 30, 31, 32) per lifetime.
RETROGRADE FILLING - PER ROOT (D3430)
Limited to 1 of Retrograde filling-per root (D3430) per Anterior tooth (6-11, 22-27), 2 of Retrograde filling-per root (D3430) per Premolar tooth (4, 5, 12, 13, 20, 21, 28, 29) and 3 of Retrograde filling-per root (D3430) per Molar tooth (1, 2, 3, 14, 15, 16, 17, 18, 19, 30, 31, 32) per lifetime.
ROOT AMPUTATION - PER ROOT (D3450)
No frequency limitation.
SURGICAL REPAIR OF ROOT RESORPTION – ANTERIOR (D3471)
SURGICAL REPAIR OF ROOT RESORPTION – PREMOLAR (D3472)
SURGICAL REPAIR OF ROOT RESORPTION – MOLAR (D3473)
No frequency limitation.
Denied for INTEGRAL when reported on the same tooth, by the same Provider on the same date of service or after Apicoectomy (D3410-D3426), Surgical Repair of root resorption (D3471 – D3473 or surgical exposure (D3427, D3501 – D3503). ***Situational approval may be allowed upon Second Review/Appeal with Dental Advisor Review with documentation of extenuating circumstances.**
SURGICAL EXPOSURE OF ROOT SURFACE WITHOUT APICOECOMTY OR REPAIR OF ROOT RESORPTION – ANTERIOR (D3501)
SURGICAL EXPOSURE OF ROOT SURFACE WITHOUT APICOECTOMY OR REPAIR OF ROOT RESORPTION – PREMOLAR (D3502)
SURGICAL EXPOSURE OF ROOT SURFACE WITHOUT APICOECTOMY OR REPAIR OF ROOT RESORPTION – MOLAR (D3503)
No frequency limitation.
Denied for INTEGRAL when reported on the same tooth, by the same Provider on the same date of service or after Apicoectomy (D3410-D3426), Surgical Repair of root resorption (D3471 – D3473 or surgical exposure (D3427, D3501 – D3503). ***Situational approval may be allowed upon Second Review/Appeal with Dental Advisor Review with documentation of extenuating circumstances.**
HEMISECTION (INCLUDING ANY ROOT REMOVAL), NOT INCLUDING ROOT CANAL THERAPY (D3920)
No frequency limitation.
DIAGNOSTIC MATERIALS REQUIRED: Submission of a pre-treatment, diagnostic x-ray and written documentation must accompany the EDI/ADA Claim Form when reporting this service. Other chart materials may optionally be

submitted and should corroborate clinically with the submitted x-rays for consideration during manual clinical review. **If specific rationale is provided explaining why x-ray(s) are not available (patient is pregnant, special needs, medical complication, etc.), the service may be referred to manual clinical review (Dental Advisor) in the absence of required materials.**
Denied as MISREPORTED if a Dental Advisor determines that the submitted documentation does not support that the service planned (pre-estimation) or was completed (claim) meets the current CDT Current Dental Terminology descriptor of the code reported.
Denied as NOT STANDARD OF DENTAL TREATMENT POOR PERIODONTAL PROGNOSIS if a Dental Advisor determines that submitted documentation supports that the tooth has a poor or hopeless prognosis.
Denied as NOT STANDARD OF DENTAL TREATMENT POOR RESTORATIVE PROGNOSIS if a Dental Advisor determines that submitted documentation supports that the tooth has a poor or hopeless prognosis.
Denied as NOT STANDARD OF DENTAL TREATMENT POOR ENDODONTIC PROGNOSIS – ROOT FRACTURE if a Dental Advisor determines that submitted documentation supports that the tooth has a poor or hopeless prognosis.
DECORONATION OR SUBMERGENCE OF AN ERUPTED TOOTH (D3921)
No frequency limitation.
DIUANGOSTIC MATERIALS REQUIRED: Submission of a pre-treatment, diagnostic x-ray and written documentation must accompany the EDI/ADA Claim Form when reporting this service. Other chart materials may optionally be submitted and should corroborate clinically with the submitted x-rays for consideration during manual clinical review. **If specific rationale is provided explaining why x-ray(s) are not available (patient is pregnant, special needs, medical complication, etc.), the service may be referred to manual clinical review (Dental Advisor) in the absence of required materials.**
Denied as MISREPORTED if a Dental Advisor determines that the submitted documentation does not support that the service planned (pre-estimation) or was completed (claim) meets the current CDT Current Dental Terminology descriptor of the code reported.
Denied as NOT STANDARD OF DENTAL TREATMENT POOR PERIODONTAL PROGNOSIS if a Dental Advisor determines that submitted documentation supports that the tooth has a poor or hopeless prognosis.
Denied as NOT STANDARD OF DENTAL TREATMENT POOR RESTORATIVE PROGNOSIS if a Dental Advisor determines that submitted documentation supports that the tooth has a poor or hopeless prognosis.
Denied as NOT STANDARD OF DENTAL TREATMENT POOR ENDODONTIC PROGNOSIS – ROOT FRACTURE if a Dental Advisor determines that submitted documentation supports that the tooth has a poor or hopeless prognosis.
UNSPECIFIED ENDODONTIC PROCEDURE, BY REPORT (D3999)
No frequency limitation.
Denied as MISREPORTED (GENERIC) when the service described has a specific and valid CDT code. Example: Cyst/Granuloma Removal/Excision (may involve a laser) (**D7410, D7471**), Post removal (if NOT associated with Endodontic retreatment **D3346**-**D3348**) (**D2955**)
Denied as INTEGRAL (GENERIC) when the service described has no specific and valid code because it is part of the Standard of Dental Treatment for another principal service (includes multi-step processes and individual dentist choices for what products and/or techniques that may be used). Examples: Bite block, Isolation techniques (including gel barrier, Isolite®, and rubber dam placement),
Denied as MISREPORTED + INTEGRAL when the service described has a specific and valid code because it is part of the Standard of Dental Treatment for another principal service (includes multi-step processes and individual dentist choices for what products and/or techniques that may be used). Example: Root canal therapy materials or techniques (GentleWave®, Biopure®, SoftCore®, Thermafil®), Post removal (if associated with Endodontic retreatment **D3346**-**D3348**) (**D2955**), Local anesthetic (Lidocaine®, Bupivacaine®, Marcaine®, Septocaine®) and modalities for administration (Viajet®) (**D9210-D9215**) Topical anesthestic (Oraquix, Hurricaine, Tetracaine®) (**D9210-D9215**), Treatment of root canal obstruction (“removal of pulp stones” “retrieval of broken/separated files” (**D3331**)
Denied as NOT COVERED (GENERIC) when the service described has no specific and valid code and describes a service that is not covered.

Denied as MISREPORTED + NOT COVERED when the service described has a specific and valid code and describes a service that is not covered. Example: Pulp testing/Pulp vitality test (**D0470**) *SPECIFIC PLANS MAY COVER

PERIODONTAL SERVICES (D4210-D4999)

- Dental services that are routinely provided in conjunction with or as part of another procedure in accordance with accepted standards of dental practice are defined as integral by United Concordia Dental and excluded from coverage. Some dental services may be denied as integral when reported in the absence of another dental service (for example: local anesthesia) or denied as integral only when another more comprehensive dental service has been benefitted. Any benefit for any Periodontal service per CDT code descriptor as reported is inclusive of all charges for work, materials, and supplies related to the procedure, and if reported separately, these services may be denied as integral. Participating dentists may not bill a patient for a service denied as integral.
- Dental services that are reported in a treatment sequence that is not appropriate in accordance with accepted standards of dental practice are defined as integral by United Concordia Dental and excluded from coverage (for example: a crown reported on a date following an extraction benefitted on the same tooth). Participating dentists may not bill a patient for a service denied because it is reported in an inappropriate treatment sequence.
- Dental services that are misreported or that represent a procedure other than the one reported are excluded from coverage. Dental services should be reported in accordance with the nomenclature and descriptors defined in the current year American Dental Association's Current Dental Terminology (CDT) codebook. Participating dentists may not bill a patient for a service denied because it is misreported.
- Dental services must be dentally/medically necessary and meet accepted standards of dental practice, as defined by United Concordia, which requires any tooth or teeth to have acceptable prognosis and meet United Concordia's definition of dental/medical necessity for the reported code as defined by the current ADA Current Dental Terminology codebook. Dental services determined not to meet United Concordia's definition of dental/medical necessity are not billable to the patient by a participating dentist unless the dentist notifies the patient of his or her potential financial liability prior to treatment and the patient chooses to receive the treatment (financial agreement). Participating dentists should document such notification specifically (with the date, tooth number, service, potential financial liability, and signature of the patient) in the patient's record.
- Any services utilized for the treatment of temporomandibular joint disorders (TMD/TMJ) or for implant placement, restoration, or maintenance is excluded from coverage and denied as not covered unless benefits are specifically provided for under a TMD or Implant rider.

GINGIVECTOMY OR GINGIVOPLASTY - FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT (D4210)

GINGIVECTOMY OR GINGIVOPLASTY - ONE TO THREE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT (D4211)

Limited to 1 of Gingivectomy (D4210, D4211), Gingival flap procedure (D4240, D4241), Osseous surgery (D4260, D4261), Periodontal bone graft (D4263, D4264), Guided Tissue Regeneration (D4266, D4267), Mesial distal wedge procedure (D4274), or Soft tissue graft (D4270, D4273, D4275, D4276, D4277, D4278, D4283, D4285) per area of the mouth per 36 month period. ***Situational approval may apply on Second Review/Appeal. Please provide diagnostic materials demonstrating the presence of extenuating circumstances for Dental Advisor Review.**

Denied as INTEGRAL when reported by the same Dentist, on the same tooth, on the same date as an Amalgam or Resin-based composite restoration (D2140-D2394), Inlay (D2510-D2530, D2610-D2630, D2650-D2652), Onlay (D2542-D2544, D2642-D2644, D2662-D2664), Crown (D2710-D2799), Core buildup/Post & Core (D2950, D2952, D2954), Veneer (D2960-D2962), Implant crown (D6058-D6067, D6082-D6088, D6094, D6097), Fixed Partial Denture (Bridge) (D6600-D6615, D6634, D6710-D6740, D6750, D6751-D6753, D6780, D6781), Implant Fixed Partial Denture (D6068-D6077, D6098, D6099, D6120- D6123, D6194, D6114-D6119) or Extraction (D7111- D7251).

Denied as INTEGRAL when reported by the same Dentist, for the same area of the mouth, on the same date as Gingivectomy (D4211), Gingival flap (D4240, D4241), or Osseous Surgery (D4260, D4261).
Denied as INAPPROPRIATE TREATMENT SEQUENCE when reported for the same area of the mouth, on the same date as Scaling and Root Planing (D4341, D4342).
REQUIRED DIAGNOSTIC MATERIALS: Submission of a pre-treatment, diagnostic x-ray and periodontal charting must accompany the EDI/ADA Claim Form when reporting this service. Other chart materials may optionally be submitted and should corroborate clinically with the submitted x-rays for consideration during manual clinical review. ***Situational approval may apply on Second Review/Appeal. Please provide specific rationale explaining why x-ray(s) are not available (patient is pregnant, special needs, medical complication, etc.).for Dental Advisor Review.**
Denied for MISREPORTED when documentation indicates that the Member does not have the minimum number of natural teeth present for the code reported.
Denied for MISREPORTED if a Dental Advisor determines that the submitted documentation does not support that the service planned (pre-estimation) or was completed (claim) meets the current CDT Current Dental Terminology descriptor of the code reported and the procedure that is planned/was performed is to allow access for a restorative procedure and/or procedure is planned/was performed on ONE tooth.
Denied for MISREPORTED if a Dental Advisor determines that the submitted documentation does not support that the service planned (pre-estimation) or was completed (claim) meets the current CDT Current Dental Terminology descriptor of the code reported and the teeth in the indicated quadrant have periodontal disease.
Denied for NOT DENTALLY/MEDICALLY NECESSARY if a Dental Advisor determines that the submitted documentation does not support that the service planned (pre-estimation) or was completed (claim) meets the current CDT Current Dental Terminology descriptor of the code reported and the teeth in the indicated quadrant do not have confirmed medication-induced or pathologic (non-cosmetic) gingival hyperplasia/hypertrophy. Treatment for pocket reduction, altered passive eruption, and cosmetics do not qualify as a dentally necessary condition for this procedure.
GINGIVECTOMY OR GINGIVOPLASTY TO ALLOW ACCESS FOR RESTORATIVE PROCEDURE, PER TOOTH (D4212)
INTEGRAL when reported alone or in conjunction with other services.
GINGIVAL FLAP PROCEDURE, INCLUDING ROOT PLANING - FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT (D4240)
GINGIVAL FLAP PROCEDURE, INCLUDING ROOT PLANING - ONE TO THREE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT (D4241)
Limited to 1 of Gingivectomy (D4210, D4211), Gingival flap procedure (D4240, D4241), Osseous surgery (D4260, D4261), Periodontal bone graft (D4263, D4264), Guided Tissue Regeneration (D4266, D4267), Mesial distal wedge procedure (D4274), or Soft tissue graft (D4270, D4273, D4274, D4275, D4276, D4277, D4278, D4283, D4285) per area of the mouth per 36 month period. Exception: Gingival Flap (D4240, D4241) and Periodontal Bone Graft (D4263, D4264) and/or Periodontal Guided Tissue Regeneration (D4266, D4267) may be allowed when reported on the same date, same tooth/teeth, by the same Dentist. **Optional benefit:** *Smile for Health®-Wellness and Pregnancy Benefit provide one (1) of Gingival flap procedure (D4240, D4241) or Osseous surgery (D4260, D4261) per area of the mouth covered at 100% for members with diabetes, lupus, rheumatoid arthritis, heart disease, oral cancer and members that have had a stroke or an organ transplant or are pregnant. Members with a qualifying chronic health condition must be registered prior to receiving services and can register at www.unitedconcordia.com under MyDentalBenefits.
Denied for INTEGRAL when reported by the same Dentist, for the same area of the mouth, on the same date, as any surgical endodontic (D3410-D3426, D3430, D3450, D3460, D3470, D3910, D3920), surgical periodontal (D4249, D4260-D4261, D4270-D4278, D4283, D4385, D4341, D4342, D4286), or oral surgery service (D7000-D7999).
Denied for INAPPROPRIATE TREATMENT SEQUENCE when reported for the same area of the mouth, on the same date as Scaling and Root Planing (D4341, D4342).
REQUIRED DIAGNOSTIC MATERIALS: Submission of a pre-treatment, diagnostic x-ray and periodontal charting must accompany the EDI/ADA Claim Form when reporting this service. Other chart materials may optionally be submitted and should corroborate clinically with the submitted x-rays for consideration during manual clinical review. ***Situational approval may apply on Second Review/Appeal. Please provide specific rationale explaining why x-ray(s) are not available (patient is pregnant, special needs, medical complication, etc.).for Dental Advisor Review.**
Denied for MISREPORTED when documentation indicates that the Member does not have the minimum number of natural teeth present for the code reported.

Denied for MISREPORTED if a Dental Advisor determines that the submitted documentation does not support that the service planned (pre-estimation) or was completed (claim) meets the current CDT Current Dental Terminology descriptor of the code reported and the procedure that is planned/was performed is to allow access for a restorative procedure and/or procedure is planned/was performed on ONE tooth.
Denied for MISREPORTED if a Dental Advisor determines that the submitted documentation does not support that the service planned (pre-estimation) or was completed (claim) meets the current CDT Current Dental Terminology descriptor of the code reported, meaning that the teeth in the reported quadrant do not show the presence of periodontal disease with moderate-deep pocket depths necessitating a gingival flap to gain access to the root surface of the tooth for debridement of the root surface and removal of granulation tissue (as evidenced by radiographic bone loss, which is necessary to physically complete the procedure as defined).
APICALLY POSITIONED FLAP (D4245)
INTEGRAL when reported alone or in conjunction with other services.
CLINICAL CROWN LENGTHENING - HARD TISSUE (D4249)
Limited to 1 of Clinical crown lengthening (D4249) per tooth per lifetime.
Denied as INTEGRAL when reported in the same area of the mouth, on the same date, to the same Dentist by any allowed benefit for Osseous surgery (D4260, D4261).
Denied as INAPPROPRIATE TREATMENT SEQUENCE when reported on the same tooth, on the same day as Bone graft (D4263, D4264).
Denied for INAPPROPRIATE TREATMENT SEQUENCE when reported for the same area of the mouth, on the same date as Scaling and Root Planing (D4341, D4342).
REQUIRED DIAGNOSTIC MATERIALS: Submission of a pre-treatment, diagnostic x-ray and periodontal charting must accompany the EDI/ADA Claim Form when reporting this service. Other chart materials may optionally be submitted and should corroborate clinically with the submitted x-rays for consideration during manual clinical review. ***Situational approval may apply on Second Review/Appeal. Please provide specific rationale explaining why x-ray(s) are not available (patient is pregnant, special needs, medical complication, etc.).for Dental Advisor Review.**
Denied for MISREPORTED if a Dental Advisor determines that the submitted documentation shows that the service planned (pre-estimation) or was completed (claim) to allow access for a restorative procedure (D4212) and/or procedure is planned/was performed on ONE tooth (D4212).
Denied for MISREPORTED (INAPPROPRIATE FOR CONDITION) if a Dental Advisor determines that the submitted documentation shows that the tooth has periodontal disease.
Denied for VERTICAL DIMENSION if a Dental Advisor determines that the submitted documentation shows the procedure planned/performed is to alter vertical dimension/restore tooth structure lost from attrition/erosion/abrasion.
Denied for NOT DENTALLY/MEDICALLY NECESSARY if a Dental Advisor determines that the submitted documentation shows that the procedure planned/performed meets CDT nomenclature and descriptor for code reported and the tooth has adequate healthy tooth structure remaining above the level of bone for restoration retention and preservation of biologic width.
OSSEOUS SURGERY (INCLUDING ELEVATION OF A FULL THICKNESS FLAP AND CLOSURE) - FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT (D4260)
OSSEOUS SURGERY (INCLUDING ELEVATION OF A FULL THICKNESS FLAP AND CLOSURE) - ONE TO THREE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT (D4261)
Limited to 1 of Gingivectomy (D4210, D4211), Gingival flap procedure (D4240, D4241), Osseous surgery (D4260, D4261), Periodontal bone graft (D4263, D4264), Guided Tissue Regeneration (D4266, D4267), Mesial distal wedge procedure (D4274), or Soft tissue graft (D4270, D4273, D4274, D4275, D4276, D4277, D4278, D4283, D4285) per area of the mouth per 36 month period. Exception: Osseous Surgery (D4260, D4261) and Periodontal Bone Graft (D4263, D4264) and/or Periodontal Guided Tissue Regeneration (D4266, D4267) may be allowed when reported on the same date, same tooth/teeth, by the same Dentist. **Optional benefit:** *Smile for Health®-Wellness and Pregnancy Benefit provide one (1) of Gingival flap procedure (D4240, D4241) or Osseous surgery (D4260, D4261) per area of the mouth covered at 100% for members with diabetes, lupus, rheumatoid arthritis, heart disease, oral cancer and members that have had a stroke or an organ transplant or are pregnant. Members with a qualifying chronic health condition must be registered prior to receiving services and can register at www.unitedconcordia.com under MyDentalBenefits.

Denied for INAPPROPRIATE TREATMENT SEQUENCE when reported for the same area of the mouth, on the same date as Scaling and Root Planing (D4341, D4342).
REQUIRED DIAGNOSTIC MATERIALS: Submission of a pre-treatment, diagnostic x-ray and periodontal charting must accompany the EDI/ADA Claim Form when reporting this service. Other chart materials may optionally be submitted and should corroborate clinically with the submitted x-rays for consideration during manual clinical review. ***Situational approval may apply on Second Review/Appeal. Please provide specific rationale explaining why x-ray(s) are not available (patient is pregnant, special needs, medical complication, etc.).for Dental Advisor Review.**
Denied for MISREPORTED when documentation indicates that the Member does not have the minimum number of natural teeth present for the code reported.
Denied for NOT STANDARD OF DENTAL TREATMENT - POOR PERIODONTAL PROGNOSIS if a Dental Advisor determines that the submitted documentation show that all indicated teeth have significant loss of attachment (evidenced by total bone loss of 75% or more and/or Class 3 furcation involvement and/or Class 3+ mobility).
Denied for MISREPORTED if a Dental Advisor determines that the submitted documentation does not support that the service planned (pre-estimation) or was completed (claim) meets the current CDT Current Dental Terminology descriptor of the code reported, meaning that the teeth in the reported quadrant do not show the presence of periodontal disease with moderate-deep pocket depths necessitating reshaping of the alveolar process (as evidenced by radiographic bone loss, which is necessary to physically complete the procedure as defined).
BONE REPLACEMENT GRAFT - RETAINED NATURAL TOOTH - FIRST SITE IN QUADRANT (D4263)
BONE REPLACEMENT GRAFT - RETAINED NATURAL TOOTH - EACH ADDITIONAL SITE IN QUADRANT (D4264)
Limited to 1 of Gingivectomy (D4210, D4211), Gingival flap procedure (D4240, D4241), Osseous surgery (D4260, D4261), Periodontal bone graft (D4263, D4264), Guided Tissue Regeneration (D4266, D4267), Mesial distal wedge procedure (D4274), or Soft tissue graft (D4270, D4273, D4274, D4275, D4276, D4277, D4278, D4283, D4285) per area of the mouth per 36 month period. Exception: Gingival Flap (D4240, D4241) or Osseous Surgery (D4260, D4261) and Periodontal Bone Graft (D4263, D4264) and/or Periodontal Guided Tissue Regeneration (D4266, D4267) may be allowed when reported on the same date, same tooth/teeth, by the same Dentist.
Denied for INAPPROPRIATE TREATMENT SEQUENCE when reported for the same area of the mouth, on the same date as Scaling and Root Planing (D4341, D4342).
Denied as MISREPORTED when reported on the same tooth as an Implant (D3460, D6010-D6199).
Denied as INAPPROPRIATE TREATMENT SEQUENCE when reported by the same Dentist, on the same tooth, on the same day as Clinical Crown lengthening (D4249).
REQUIRED DIAGNOSTIC MATERIALS: Submission of a pre-treatment, diagnostic x-ray and periodontal charting must accompany the EDI/ADA Claim Form when reporting this service. Other chart materials may optionally be submitted and should corroborate clinically with the submitted x-rays for consideration during manual clinical review. ***Situational approval may apply on Second Review/Appeal. Please provide specific rationale explaining why x-ray(s) are not available (patient is pregnant, special needs, medical complication, etc.).for Dental Advisor Review.**
Bone replacement graft – retained natural tooth (D4263, D4264) may be updated as necessary to meet the appropriate CDT Code per descriptor (first site in quadrant vs. each additional site in quadrant).
Denied for MISREPORTED AND IMPLANT RELATED if a Dental Advisor determines that the submitted documentation does not show that the service planned (pre-estimation) or was completed (claim) meets the current CDT Current Dental Terminology descriptor of the code reported and evidence shows that the service is associated with an implant.
Denied for MISREPORTED AND NOT IMPLANT RELATED if a Dental Advisor determines that the submitted documentation does not show that the service planned (pre-estimation) or was completed (claim) meets the current CDT Current Dental Terminology descriptor of the code reported and evidence does NOT show that the service is associated with an implant.
Denied for IMPLANT RELATED if a Dental Advisor determines that the submitted documentation shows that the service planned (pre-estimation) or was completed (claim) meets the current CDT Current Dental Terminology descriptor of the code reported and evidence shows that the service is associated with an implant.
Denied for NOT STANDARD OF DENTAL TREATMENT – POOR PERIODONTAL PROGNOSIS if a Dental Advisor determines that the submitted documentation show that all indicated teeth have significant loss of attachment (evidenced by total bone loss of 75% or more and/or Class 3 furcation involvement and/or Class 3+ mobility).

Denied for NOT DENTALLY/MEDICALLY NECESSARY if a Dental Advisor determines that the submitted documentation shows that the service planned (pre-estimation) or was completed (claim) for a tooth that does not have a deformity of the bone caused by periodontal disease.
GUIDED TISSUE REGENERATION, NATURAL TEETH - RESORBABLE BARRIER, PER SITE (D4266)
GUIDED TISSUE REGENERATION, NATURAL TEETH- NON-RESORBABLE BARRIER, PER SITE (INCLUDES MEMBRANE REMOVAL) (D4267)
Limited to 1 of Guided tissue regeneration (D4266 or D4267) per tooth per lifetime and 1 of Gingivectomy (D4210, D4211), Gingival flap procedure (D4240, D4241), Osseous surgery (D4260, D4261), Mesial distal wedge procedure, Periodontal bone graft (D4263, D4264), Guided tissue regeneration (D4266, D4267) or Soft tissue grafts (D4270, D4273, D4274, D4275, D4276, D4277, D4278, D4283, D4285) per area of the mouth per 36 month period.
Denied for INAPPROPRIATE TREATMENT SEQUENCE when reported for the same area of the mouth, on the same date as Scaling and Root Planing (D4341, D4342).
Denied for NOT STANDARD OF DENTAL TREATMENT when not reported on the same tooth, on the same date, by the same Provider as Osseous surgery (D4260, D4261) or Periodontal Bone Graft (D4263, D4264). **Situational approval may apply on Second Review/Appeal by a Dental Advisor with documentation of extenuating circumstances.**
Denied for MISREPORTED when reported by the same Dentist, on the same tooth, on the same date or after an Apicoectomy (D3410, D3421, D3425, D3426, D3430), Root amputation (D3450), Hemisection (D3920), Surgical exposure of root surface (D3501, D3502, D3503), Surgical repair of root resorption (D3471, D3472, D3473), or Extraction (D7111, D7140, D7210, D7220, D7230,D7240, D7241, D7250), or Coronectomy (D7251).
Denied for MISREPORTED AND IMPLANT RELATED if a Dental Advisor determines that the submitted documentation does not show that the service planned (pre-estimation) or was completed (claim) meets the current CDT Current Dental Terminology descriptor of the code reported and evidence shows that the service is associated with an implant.
Denied for MISREPORTED AND NOT IMPLANT RELATED if a Dental Advisor determines that the submitted documentation does not show that the service planned (pre-estimation) or was completed (claim) meets the current CDT Current Dental Terminology descriptor of the code reported and evidence does NOT show that the service is associated with an implant.
Denied for IMPLANT RELATED if a Dental Advisor determines that the submitted documentation shows that the service planned (pre-estimation) or was completed (claim) meets the current CDT Current Dental Terminology descriptor of the code reported and evidence shows that the service is associated with an implant.
Denied for NOT STANDARD OF DENTAL TREATMENT – POOR PERIODONTAL PROGNOSIS if a Dental Advisor determines that the submitted documentation show that all indicated teeth have significant loss of attachment (evidenced by total bone loss of 75% or more and/or Class 3 furcation involvement and/or Class 3+ mobility).
Denied for NOT DENTALLY/MEDICALLY NECESSARY if a Dental Advisor determines that the submitted documentation shows that the service planned (pre-estimation) or was completed (claim) for a tooth not in association with an approved periodontal bone graft.
PEDICLE SOFT TISSUE GRAFT PROCEDURE (D4270)
AUTOGENOUS CONNECTIVE TISSUE GRAFT PROCEDURE (INCLUDING DONOR AND RECIPIENT SURGICAL SITES) FIRST TOOTH/, IMPLANT OR EDENTULOUS TOOTH POSITION IN GRAFT (D4273)
NON-AUTOGENOUS CONNECTIVE TISSUE GRAFT (INCLUDING RECIPIENT SITE AND DONOR MATERIAL) FIRST TOOTH, IMPLANT, OR EDENTULOUS TOOTH POSITION IN GRAFT (D4275)
COMBINED CONNECTIVE TISSUE AND PEDICLE GRAFT, PER TOOTH (D4276)
FREE SOFT TISSUE GRAFT PROCEDURE (INCLUDING RECIPIENT AND DONOR SURGICAL SITES) FIRST TOOTH, IMPLANT, OR EDENTULOUS TOOTH POSITION IN GRAFT (D4277)
FREE SOFT TISSUE GRAFT PROCEDURE (INCLUDING RECIPIENT AND DONOR SURGICAL SITES) EACH ADDITIONAL TOOTH, IMPLANT, OR EDENTULOUS TOOTH POSITION IN GRAFT (D4278)
AUTOGENOUS CONNECTIVE TISSUE GRAFT PROCEDURE (INCLUDING DONOR AND RECIPIENT SURGICAL SITES) EACH ADDITIONAL TOOTH, IMPLANT OR EDENTULOUS TOOTH POSITION IN GRAFT (D4283)
NON-AUTOGENOUS CONNECTIVE TISSUE GRAFT (INCLUDING RECIPIENT SITE AND DONOR MATERIAL) FEACH ADDITIONAL TOOTH, IMPLANT, OR EDENTULOUS TOOTH POSITION IN GRAFT (D4285)
Limited to 1 of Gingivectomy (D4210, D4211), Gingival flap procedure (D4240, D4241), Osseous surgery (D4260, D4261), Periodontal bone graft (D4263, D4264), Guided Tissue Regeneration (D4266, D4267), Mesial distal wedge

procedure (D4274), or Soft tissue graft (D4270, D4273, D4275, D4276, D4277, D4278, D4283, D4285) per area of the mouth per 36 month period.
Denied for INAPPROPRIATE TREATMENT SEQUENCE when reported for the same area of the mouth, on the same date as Scaling and Root Planing (D4341, D4342), Osseous surgery (D4260, D4261), Gingivectomy (D4210, D4211), Gingival flap (D4240, D4241), Crown lengthening (D4249), or Mesial distal wedge (D4274).
Denied for MISREPORTED when reported by the same Dentist, on the same tooth, on the same date or after an Apicoectomy (D3410, D3421, D3425, D3426, D3430), Root amputation (D3450), Hemisection (D3920), Surgical exposure of root surface (D3501, D3502, D3503), Surgical repair of root resorption (D3471, D3472, D3473), or Extraction (D7111, D7140, D7210, D7220, D7230,D7240, D7241, D7250), or Coronectomy (D7251).
Soft tissue graft (D4270, D4273, D4275, D4276, D4277, D4278, D4283, D4285) may be updated as necessary to meet the appropriate CDT Code per descriptor (first tooth, implant, or edentulous tooth position in graft vs. each additional tooth, implant, or edentulous tooth position in graft).
MESIAL/DISTAL WEDGE PROCEDURE (D4274)
Limited to 1 of Gingivectomy (D4210, D4211), Gingival flap procedure (D4240, D4241), Osseous surgery (D4260, D4261), Periodontal bone graft (D4263, D4264), Guided Tissue Regeneration (D4266, D4267), Mesial distal wedge procedure (D4274), or Soft tissue graft (D4270, D4273, D4274, D4275, D4276, D4277, D4278, D4283, D4285) per area of the mouth per 36 month period.
Denied for INAPPROPRIATE TREATMENT SEQUENCE when reported for the same area of the mouth, on the same date as Scaling and Root Planing (D4341, D4342).
REQUIRED DIAGNOSTIC MATERIALS: Submission of a pre-treatment, diagnostic x-ray and periodontal charting must accompany the EDI/ADA Claim Form when reporting this service. Other chart materials may optionally be submitted and should corroborate clinically with the submitted x-rays for consideration during manual clinical review. ***Situational approval may apply on Second Review/Appeal. Please provide specific rationale explaining why x-ray(s) are not available (patient is pregnant, special needs, medical complication, etc.).for Dental Advisor Review.**
Denied for MISREPORTED if a Dental Advisor determines that the submitted documentation does not support that the service planned (pre-estimation) or was completed (claim) meets the current CDT Current Dental Terminology descriptor of the code reported and the procedure that is planned/was performed is to allow access for a restorative procedure and/or procedure is planned/was performed on ONE tooth.
Denied for MISREPORTED if a Dental Advisor determines that the submitted documentation does not support that the service planned (pre-estimation) or was completed (claim) meets the current CDT Current Dental Terminology descriptor of the code reported, meaning that the teeth in the reported quadrant do not show the presence of periodontal disease with moderate-deep pocket depths necessitating a gingival flap to gain access to the root surface of the tooth for debridement of the root surface and removal of granulation tissue (as evidenced by radiographic bone loss, which is necessary to physically complete the procedure as defined).
REMOVAL OF NON-RESORBABLE BARRIER (D4286)
INTEGRAL when reported alone or in conjunction with other services.
PERIODONTAL SCALING AND ROOT PLANING - FOUR OR MORE TEETH PER QUADRANT (D4341)
PERIODONTAL SCALING AND ROOT PLANING - ONE TO THREE TEETH PER QUADRANT (D4342)
Limited to 1 of Scaling and root planing (D4341 or D4342) per quadrant per 36 months. **Optional benefit:** *Smile for Health®-Wellness and Pregnancy Benefit provide one (1) of Scaling and root planing (D4341 or D4342) per area of the mouth covered at 100% for members with diabetes, lupus, rheumatoid arthritis, heart disease, oral cancer and members that have had a stroke or an organ transplant or are pregnant. Members with a qualifying chronic health condition must be registered prior to receiving services and can register at www.unitedconcordia.com under MyDentalBenefits.
Scaling and Root planing, one to three teeth per quadrant (D4342) is denied for INTEGRAL when reported within FREQUENCY for Scaling and Root planing, four or more teeth per quadrant (D4341).
Denied for INAPPROPRIATE TREATMENT SEQUENCE when reported for the same area of the mouth, same date, as any allowed benefit for a surgical periodontal service (D4210-D4285).
REQUIRED DIAGNOSTIC MATERIALS: Submission of a pre-treatment, diagnostic x-ray and periodontal charting must accompany the EDI/ADA Claim Form when reporting this service. Other chart materials may optionally be submitted and should corroborate clinically with the submitted x-rays for consideration during manual clinical review.

***Situational approval may apply on Second Review/Appeal. Please provide specific rationale explaining why x-ray(s) are not available (patient is pregnant, special needs, medical complication, etc.).for Dental Advisor Review.**
Denied for MISREPORTED if a Dental Advisor determines that the submitted documentation does not show that the service planned (pre-estimation) or was completed (claim) meets the current CDT Current Dental Terminology descriptor of the code reported, specifically that the teeth in the reported quadrant do not show the presence of periodontal disease necessitating instrument of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces (as evidenced by radiographic bone loss, which is necessary to physically complete the procedure as defined).
SCALING IN PRESENCE OF GENERALIZED MODERATE OR SEVERE GINGIVAL INFLAMMATION - FULL MOUTH, AFTER ORAL EVALUATION (D4346)
Limited to 1 of Scaling in the presence of inflammation (D4346) per 36 months and the combination of Prophylaxis (D1110)/Scaling in presence of generalized moderate or severe gingival inflammation (D4346) may not exceed 2 per calendar year.
Scaling in the presence of inflammation (D4346) is denied for NOT STANDARD OF DENTAL TREATMENT when reported on a Member under Age 16. ***Situational approval may apply on Second Review/Appeal. Please provide diagnostic materials demonstrating the presence of extenuating circumstances for Dental Advisor Review.**
Denied as INAPPROPRIATE TREATMENT SEQUENCE when reported on the same date, by the same Dentist as a surgical periodontal service (D4210-D4285).
Denied for INAPPROPRIATE TREATMENT SEQUENCE when reported on the same date, by the same Dentist as Full mouth debridement (D4355), Scaling and Root planing (D4341, D4342), or Periodontal Maintenance (D4910), or Prophylaxis (D1110).
FULL MOUTH DEBRIDEMENT TO ENABLE A COMPREHENSIVE PERIODONTAL EVALUATION AND DIAGNOSIS ON A SUBSEQUENT VISIT (D4355)
Limited to 1 of Full mouth debridement (D4355) per lifetime.
Denied as INTEGRAL when reported by the same Dentist, on the same date as Scaling and Root Planing (D4341, D4342).
Denied as INAPPROPRIATE TREATMENT SEQUENCE when reported on the same date as Periodontal maintenance (D4910).
PERIODONTAL MAINTENANCE (D4910)
Limited to 2 of Periodontal maintenance (D4910) per calendar year. **Optional benefit:** *Smile for Health®-Wellness and Pregnancy Benefit provides one additional Prophylaxis (D1110) or Periodontal maintenance (D4910) for members with diabetes, lupus, rheumatoid arthritis, heart disease, oral cancer and members that have had a stroke or an organ transplant or are pregnant. Members with a qualifying chronic health condition must be registered prior to receiving services and can register at www.unitedconcordia.com under MyDentalBenefits.
Denied as INTEGRAL when reported by the same Dentist, on the same date as Periodontal surgery (D4210-D4285) or Scaling and Root Planing (D4341, D4342).
GINGIVAL IRRIGATION (D4921)
INTEGRAL when reported alone or in conjunction with other services.
UNSPECIFIED PERIODONTAL PROCEDURE (D4999)
No frequency limitation.
REQUIRED DIAGNOSTIC MATERIALS: Submission of written documentation must accompany the EDI/ADA Claim Form when reporting this service. Other chart materials may optionally be submitted and should corroborate clinically with the submitted written documentation for consideration during manual clinical review.
Denied as MISREPORTED (GENERIC) when the service described has a specific and valid CDT code.
Denied as INTEGRAL (GENERIC) when the service described has no specific and valid code because it is part of the Standard of Dental Treatment for another principal service (includes multi-step processes and individual dentist choices for what products and/or techniques that may be used).
Denied as MISREPORTED + INTEGRAL when the service described has a specific and valid code because it is part of the Standard of Dental Treatment for another principal service (includes multi-step processes and individual dentist choices for what products and/or techniques that may be used).

Denied as NOT COVERED (GENERIC) when the service described has no specific and valid code and describes a service that is not covered.
Denied as MISREPORTED + NOT COVERED when the service described has a specific and valid code and describes a service that is not covered.
Denied as MISREPORTED + IMPLANT RELATED (NO RIDER) when the service described has a specific and valid code and describes a service that is related to an implant.

PROSTHODONTICS, REMOVEABLE (D5110-D5999)

- Dental services that are routinely provided in conjunction with or as part of another procedure in accordance with accepted standards of dental practice are defined as integral by United Concordia Dental and excluded from coverage. Some dental services may be denied as integral when reported in the absence of another dental service (for example: local anesthesia) or denied as integral only when another more comprehensive dental service has been benefitted. Any benefit for any Removeable Prosthodontic service per CDT code descriptor as reported is inclusive of all charges for work, materials, and supplies related to the procedure, and if reported separately, these services may be denied as integral. Participating dentists may not bill a patient for a service denied as integral.
- Dental services that are reported in a treatment sequence that is not appropriate in accordance with accepted standards of dental practice are defined as integral by United Concordia Dental and excluded from coverage (for example: a crown reported on a date following an extraction benefitted on the same tooth). Participating dentists may not bill a patient for a service denied because it is reported in an inappropriate treatment sequence.
- Dental services that are misreported or that represent a procedure other than the one reported are excluded from coverage. Dental services should be reported in accordance with the nomenclature and descriptors defined in the current year American Dental Association's Current Dental Terminology (CDT) codebook. Participating dentists may not bill a patient for a service denied because it is misreported.
- Dental services must be dentally/medically necessary and meet accepted standards of dental practice, as defined by United Concordia, which requires any tooth or teeth to have acceptable prognosis and meet United Concordia's definition of dental/medical necessity for the reported code as defined by the current ADA Current Dental Terminology codebook. Dental services determined not to meet United Concordia's definition of dental/medical necessity are not billable to the patient by a participating dentist unless the dentist notifies the patient of his or her potential financial liability prior to treatment and the patient chooses to receive the treatment (financial agreement). Participating dentists should document such notification specifically (with the date, tooth number, service, potential financial liability, and signature of the patient) in the patient's record.
- Any services utilized for the treatment of temporomandibular joint disorders (TMD/TMJ) or for implant placement, restoration, or maintenance is excluded from coverage and denied as not covered unless benefits are specifically provided for under a TMD or Implant rider.
- For reporting and benefit purposes, the billing/completion date for any Indirect restoration (any Inlay, Onlay, Crown, Indirectly fabricated Post and Core, Implant Abutment, Implant/Abutment Supported Crown or Fixed Partial Denture (Bridge), Labial Veneer, or Fixed Partial Denture (Bridge)) or Indirectly fabricated Prosthesis (any Complete or Partial Denture, including Immediate, Interim, and Implant/Abutment Supported, or any Indirect Denture Rebase, Reline, and/or Repair) is the cementation or final placement date. Any Indirect restoration or Prosthesis begun prior to the effective date of coverage or cemented after the cancellation date of coverage is not eligible for payment. A 30-90 day extension may apply, please verify for specific Member plan/contract. Please resubmit the claim along with the corrected date.

COMPLETE DENTURE – MAXILLARY (D5110)
COMPLETE DENTURE – MANDIBULAR (D5120)
IMMEDIATE DENTURE – MAXILLARY (D5130)

IMMEDIATE DENTURE – MANDIBULAR (D5140)
Limited to 1 of Complete or immediate denture (D5110/D5120, D5130/D5140), Complete overdenture (D5863/D5865), Partial or immediate partial denture (D5211/D5212, D5213/D5214, D5221/D5222, D5223/D5224, D5225/D5226, D5227/D5228, D5282/D5283/ D5284/D5286) or partial overdenture (D5864/D5865), or Fixed Partial Denture/Bridge (D6205-D6252, D6545-D6792, D6794) per arch per 5 year period for replacement of natural tooth/teeth in an arch.
Denied for NOT STANDARD OF DENTAL TREATMENT when reported for a Member under age 17. ***Situational approval may apply on Second Review/Appeal. Please provide diagnostic materials demonstrating the presence of extenuating circumstances for Dental Advisor Review.**
MAXILLARY PARTIAL DENTURE - RESIN BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH) (D5211)
MANDIBULAR PARTIAL DENTURE - RESIN BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH) (D5212)
MAXILLARY PARTIAL DENTURE -CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH) (D5213)
MANDIBULAR PARTIAL DENTURE - CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH) (D5214)
IMMEDIATE MAXILLARY PARTIAL DENTURE -RESIN BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH) (D5221)
IMMEDIATE MANDIBULAR PARTIAL DENTURE -RESIN BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH) (D5222)
IMMEDIATE MAXILLARY PARTIAL DENTURE - CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH) (D5223)
IMMEDIATE MANDIBULAR PARTIAL DENTURE - CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH) (D5224)
MAXILLARY PARTIAL DENTURE -FLEXIBLE BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH) (D5225)
MANDIBULAR PARTIAL DENTURE - FLEXIBLE BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH) (D5226)
IMMEDIATE MAXILLARY PARTIAL DENTURE - FLEXIBLE BASE (INCLUDING ANY CLASPS, RESTS AND TEETH) (D5227)
Limited to 1 of Complete or immediate denture (D5110/D5120, D5130/D5140), Complete overdenture (D5863/D5865), Partial or immediate partial denture (D5211/D5212, D5213/D5214, D5221/D5222, D5223/D5224, D5225/D5226, D5227/D5228, D5282/D5283/ D5284/D5286) or partial overdenture (D5864/D5865), or Fixed Partial Denture/Bridge (D6205-D6252, D6545-D6792, D6794) per arch per 5 year period for replacement of natural tooth/teeth in an arch.
Denied for NOT STANDARD OF DENTAL TREATMENT when reported for a Member under age 17. ***Situational approval may apply on Second Review/Appeal. Please provide diagnostic materials demonstrating the presence of extenuating circumstances for Dental Advisor Review.**
REMOVEABLE UNILATERAL PARTIAL DENTURE - ONE PIECE CAST METAL (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH), MAXILLARY (D5282)
REMOVEABLE UNILATERAL PARTIAL DENTURE - ONE PIECE CAST METAL (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH), MANDIBULAR (D5283)
REMOVEABLE UNILATERAL PARTIAL DENTURE - ONE PIECE FLEXIBLE BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH), PER QUADRANT (D5284)
REMOVEABLE UNILATERAL PARTIAL DENTURE - ONE PIECE RESIN (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH), PER QUADRANT (D5286)
Limited to 1 of Complete or immediate denture (D5110/D5120, D5130/D5140), Complete overdenture (D5863/D5865), Partial or immediate partial denture (D5211/D5212, D5213/D5214, D5221/D5222, D5223/D5224, D5225/D5226, D5227/D5228, D5282/D5283/ D5284/D5286) or partial overdenture (D5864/D5865), or Fixed Partial

Denture/Bridge (D6205-D6252, D6545-D6792, D6794) per arch per 5 year period for replacement of natural tooth/teeth in an arch.
Denied for NOT STANDARD OF DENTAL TREATMENT when reported for a Member under age 17. ***Situational approval may apply on Second Review/Appeal. Please provide diagnostic materials demonstrating the presence of extenuating circumstances for Dental Advisor Review.**
Denied if there are no missing natural permanent tooth/teeth requiring replacement (space for tooth movement/"drifting") does not meet contract terms.
Denied as MISREPORTED if a Dental Advisor determines that the diagnostic materials do not show that the service planned (predetermination) or was completed (claim) meets the current CDT Current Dental Terminology descriptor of the code reported.
ADJUST COMPLETE DENTURE – MAXILLARY (D5410)
ADJUST COMPLETE DENTURE – MANDIBULAR (D5411)
ADJUST PARTIAL DENTURE – MAXILLARY (D5421)
ADJUST PARTIAL DENTURE – MANDIBULAR (D5422)
No frequency limitation.
Denied as INTEGRAL when reported by the same Dentist within initial 6 months following insertion of any complete or partial denture (D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5227, D5228, D5282, D5284, D5286).
REPAIR BROKEN COMPLETE DENTURE BASE, MANDIBULAR (D5511)
REPAIR BROKEN COMPLETE DENTURE BASE, MAXILLARY (D5512)
Limited to 1 of Repair broken complete denture base, mandibular (D5511) and 1 of Repair broken complete denture base, maxillary (D5512) per 36 month period.
REPLACE MISSING OR BROKEN TEETH – COMPLETE DENTURE (EACH TOOTH) (D5520)
Limited to 1 of Replace missing or broken teeth (D5520) or Replace broken teeth (D5640) or add tooth to existing partial denture (D5650) per maxillary arch per 36 month period.
REPAIR RESIN PARTIAL DENTURE BASE, MANDIBULAR (D5611)
REPAIR RESIN PARTIAL DENTURE BASE, MAXILLARY (D5612)
Limited to 1 of Repair broken complete denture base, mandibular (D5611) and 1 of Repair resin partial base, maxillary (D5612) per 36 month period.
REPAIR CAST PARTIAL FRAMEWORK, MANDIBULAR (D5621)
REPAIR CAST PARTIAL FRAMEWORK, MAXILLARY (D5622)
Limited to 1 of Repair cast framework mandibular (D5621) and 1 of Repair cast partial framework, maxillary (D5622) per 36 month period.
REPAIR OR REPLACE BROKEN RETENTIVE/CLASPING MATERIALS – PER TOOTH (D5630)
Limited to 1 of Repair or replace broken retentive/clasping materials – per tooth (D5630) per 36 month period.
REPLACE BROKEN TEETH - PER TOOTH (D5640)
Limited to 1 of Replace missing or broken teeth (D5520) or Replace broken teeth (D5640) or add tooth to existing partial denture (D5650) per maxillary arch per 36 month period.
ADD TOOTH TO EXISTING PARTIAL DENTURE (D5650)
Limited to 1 of Add tooth to existing partial denture (D5650) or Replace broken teeth (D5640) or add tooth to existing partial denture (D5650) per 36 month period.
ADD CLASP TO EXISTING PARTIAL DENTURE – PER TOOTH (D5660)
Limited to 1 of Add clasp to existing partial denture – per tooth (D5660) per 36 month period.
REPLACE ALL TEETH AND ACRYLIC ON CAST METAL FRAMEWORK (MAXILLARY) (D5670)
REPLACE ALL TEETH AND ACRYLIC ON CAST METAL FRAMEWORK (MANDIBULAR) (D5671)

Limited to 1 of Replace all teeth and acrylic on cast metal framework (maxillary) (D5670) and 1 of Replace all teeth and acrylic on cast metal framework (mandibular) (D5671) per 5 years.
REBASE COMPLETE MAXILLARY DENTURE (D5710)
REBASE COMPLETE MANDIBULAR DENTURE (D5711)
REBASE MAXILLARY PARTIAL DENTURE (D5720)
REBASE MANDIBULAR PARTIAL DENTURE (D5721)
REBASE HYBRID PROSTHESIS (D5725)
RELINE COMPLETE MAXILLARY DENTURE (DIRECT) (D5730)
RELINE COMPLETE MANDIBULAR DENTURE (DIRECT) (D5731)
RELINE MAXILLARY PARTIAL DENTURE (DIRECT) (D5740)
RELINE MANDIBULAR PARTIAL DENTURE (DIRECT) (D5741)
RELINE COMPLETE MAXILLARY DENTURE (INDIRECT) (D5750)
RELINE COMPLETE MANDIBULAR DENTURE (INDIRECT) (D5751)
RELINE MAXILLARY PARTIAL DENTURE (INDIRECT) (D5760)
RELINE MANDIBULAR PARTIAL DENTURE (INDIRECT) (D5761)
SOFT LINER FOR COMPLETE OR PARTIAL REMOVABLE DENTURE – INDIRECT (D5765)
Limited to 1 of Rebase (D5710, D5711, D5720, D5721, D5725) or Reline (D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761) or Liner (D5765) per 3 years.
Denied as INTEGRAL when reported within six months following insertion of the complete or partial denture by the same Dentist.
Reline (D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761) on in process claim, reported same date of service, same provider as a Rebase (D5710, D5711, D5720, D5721, D5725), will deny for INTEGRAL to the Rebase.
OVERDENTURE - COMPLETE MAXILLARY (D5863)
OVERDENTURE - COMPLETE MANDIBULAR (D5865)
OVERDENTURE - PARTIAL MAXILLARY (D5864)
OVERDENTURE - PARTIAL MANDIBULAR (D5866)
Limited to 1 of Complete Denture (D5110/D5120, D5130/D5140, D5863/D5865), Partial Denture (D5211/D5212, D5213/D5214, D5221/D5222, D5223/D5224, D5225/D5226, D5227/D5228, D5282/D5283/ D5284/D5286, D5864/D5865), or Fixed Partial Denture/Bridge (D6205-D6794) per arch per 5 year period for replacement of natural tooth/teeth in an arch.
Denied for NOT STANDARD OF DENTAL TREATMENT when reported for a Member under age 17. ***Situational approval may apply on Second Review/Appeal. Please provide diagnostic materials demonstrating the presence of extenuating circumstances for Dental Advisor Review.**
Specialized procedures used in preparation for an Overdenture are not covered and include such procedures as but not limited to preparing teeth to serve as abutments (tooth modification and reduction), copings (“thimbles”), intentional root canal therapy, amalgam plug, intentional post and core, precision attachments.
UNSPECIFIED REMOVABLE PROSTHODONTIC SERVICE, BY REPORT (D5899)
No frequency limitation.
REQUIRED DIAGNOSTIC MATERIALS: Submission of written documentation must accompany the EDI/ADA Claim Form when reporting this service. Other chart materials may optionally be submitted and should corroborate clinically with the submitted written documentation for consideration during manual clinical review.
Denied as MISREPORTED (GENERIC) when the service described has a specific and valid CDT code.
Denied as INTEGRAL (GENERIC) when the service described has no specific and valid code because it is part of the Standard of Dental Treatment for another principal service (includes multi-step processes and individual dentist choices for what products and/or techniques that may be used).

Denied as MISREPORTED + INTEGRAL when the service described has a specific and valid code because it is part of the Standard of Dental Treatment for another principal service (includes multi-step processes and individual dentist choices for what products and/or techniques that may be used).
Denied as MISREPORTED + IMPLANT RELATED (NO RIDER) when the service described has a specific and valid code and describes a service that is related to an implant. Denied as MISREPORTED + NOT COVERED when the service described has a specific and valid code and describes a service that is not covered.
Denied as NOT COVERED (GENERIC) when the service described has no specific and valid code and describes a service that is not covered.

IMPLANT SERVICES (D6010-D6197)

- Dental services that are routinely provided in conjunction with or as part of another procedure in accordance with accepted standards of dental practice are defined as integral by United Concordia Dental and excluded from coverage. Some dental services may be denied as integral when reported in the absence of another dental service (for example: local anesthesia) or denied as integral only when another more comprehensive dental service has been benefitted. Any benefit for any Implant service per CDT code descriptor as reported is inclusive of all charges for work, materials, and supplies related to the procedure, and if reported separately, these services may be denied as integral. Participating dentists may not bill a patient for a service denied as integral.
- Dental services that are reported in a treatment sequence that is not appropriate in accordance with accepted standards of dental practice are defined as integral by United Concordia Dental and excluded from coverage (for example: a crown reported on a date following an extraction benefitted on the same tooth). Participating dentists may not bill a patient for a service denied because it is reported in an inappropriate treatment sequence.
- Dental services that are misreported or that represent a procedure other than the one reported are excluded from coverage. Dental services should be reported in accordance with the nomenclature and descriptors defined in the current year American Dental Association's Current Dental Terminology (CDT) codebook. Participating dentists may not bill a patient for a service denied because it is misreported.
- Dental services must be dentally/medically necessary and meet accepted standards of dental practice, as defined by United Concordia, which requires any tooth or teeth to have acceptable prognosis and meet United Concordia's definition of dental/medical necessity for the reported code as defined by the current ADA Current Dental Terminology codebook. Dental services determined not to meet United Concordia's definition of dental/medical necessity are not billable to the patient by a participating dentist unless the dentist notifies the patient of his or her potential financial liability prior to treatment and the patient chooses to receive the treatment (financial agreement). Participating dentists should document such notification specifically (with the date, tooth number, service, potential financial liability, and signature of the patient) in the patient's record.
- Any services utilized for the treatment of temporomandibular joint disorders (TMD/TMJ) or for implant placement, restoration, or maintenance is excluded from coverage and denied as not covered unless benefits are specifically provided for under a TMD or Implant rider.
- For reporting and benefit purposes, the billing/completion date for any Indirect restoration (any Inlay, Onlay, Crown, Indirectly fabricated Post and Core, Implant Abutment, Implant/Abutment Supported Crown or Fixed Partial Denture (Bridge), Labial Veneer, or Fixed Partial Denture (Bridge)) or Indirectly fabricated Prosthesis (any Complete or Partial Denture, including Immediate, Interim, and Implant/Abutment Supported, or any Indirect Denture Rebase, Reline, and/or Repair) is the cementation or final placement date. Any Indirect restoration or Prosthesis begun prior to the effective date of coverage or cemented after the cancellation date of coverage is not eligible for payment. A 30-90 day extension may apply, please verify for specific Member plan/contract. Please resubmit the claim along with the corrected date.

ENDOSTEAL IMPLANT (D6010)
SURGICAL PLACEMENT: EPOSTEAL IMPLANT (D6040)

SURGICAL PLACEMENT: TRANSOSTEAL IMPLANT (D6050)
IMPLANT RIDER ONY: Limited to 1 of Surgical placement of implant body; endosteal implant (D6010), Surgical placement mini implant (D6013), Surgical placement: eposteal implant (D6040), or Surgical placement: transosteal implant (D6050) per lifetime.
Denied as NOT STANDARD OF DENTAL TREATMENT when reported for a Member Age 18 and younger. ***Situational approval may be allowed upon Second Review/Appeal with Dental Advisor Review with documentation of extenuating circumstances.**
SECOND STAGE IMPLANT SURGERY (D6011)
IMPLANT RIDER ONY: Limited to 1 of Second stage implant surgery (D6011) per site per lifetime.
Denied as NOT STANDARD OF DENTAL TREATMENT when reported for a Member Age 18 and younger. ***Situational approval may be allowed upon Second Review/Appeal with Dental Advisor Review with documentation of extenuating circumstances.**
SURGICAL PLACEMENT MINI IMPLANT (D6013)
IMPLANT RIDER ONY: Limited to 1 of Surgical placement of implant body; endosteal implant (D6010), Surgical placement mini implant (D6013), Surgical placement: eposteal implant (D6040), or Surgical placement: transosteal implant (D6050) per site per lifetime.
Denied as NOT STANDARD OF DENTAL TREATMENT when reported for a Member Age 18 and younger. ***Situational approval may be allowed upon Second Review/Appeal with Dental Advisor Review with documentation of extenuating circumstances.**
SCALING AND DEBRIDEMENT OF A SINGLE IMPLANT IN THE PRESENCE OF PERI-IMPLANTITIS INFLAMMATION, BLEEDING UPON PROBING AND INCREASED POCKET DEPTHS, INCLUDING CLEANING OF THE IMPLANT SURFACES WITHOUT FLAP ENTRY AND CLOSURE (D6049)
IMPLANT RIDER ONLY: Limited to 2 of Implant maintenance (D6049, D6080, D6081, D6180, D6280) per calendar year.
Denied as NOT STANDARD OF DENTAL TREATMENT when reported for a Member Age 18 and younger. ***Situational approval may be allowed upon Second Review/Appeal with Dental Advisor Review with documentation of extenuating circumstances.**
Denied as MISREPORTED when reported by the same Dentist on the same date as Prophy (D1110), Periodontal Maintenance (D4910), or Scaling in the presence of inflammation (D4346).
CONNECTING BAR (D6055)
IMPLANT RIDER ONY: Limited to 1 of Connecting bar (D6055) per lifetime.
Denied as NOT STANDARD OF DENTAL TREATMENT when reported for a Member Age 18 and younger. ***Situational approval may be allowed upon Second Review/Appeal with Dental Advisor Review with documentation of extenuating circumstances.**
PREFABRICATED ABUTMENT (D6056)
CUSTOM FABRICATED ABUTMENT (D6057)
IMPLANT RIDER ONY: Limited to 1 of Prefabricated abutment (D6056) or Custom fabricated abutment (D6057) per tooth per 5 years.
Denied as NOT STANDARD OF DENTAL TREATMENT when reported for a Member Age 18 and younger. *Situational approval may be allowed upon Second Review/Appeal with Dental Advisor Review with documentation of extenuating circumstances.
ABUTMENT SUPPORTED PORCELAIN/CERAMIC CROWN (D6058)
ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (HIGH NOBLE METAL) (D6059)
ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (PREDOMINANTLY BASE METAL) (D6060)
ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (NOBLE METAL) (D6061)
ABUTMENT SUPPORTED CAST METAL CROWN (HIGH NOBLE METAL) (D6062)
ABUTMENT SUPPORTED CAST METAL CROWN (PREDOMINANTLY BASE METAL) (D6063)
ABUTMENT SUPPORTED CAST METAL CROWN (NOBLE METAL) (D6064)

IMPLANT SUPPORTED PORCELAIN/CERAMIC CROWN (D6065)
IMPLANT SUPPORTED PORCELAIN FUSED TO METAL CROWN (HIGH NOBLE METAL) (D6066)
IMPLANT SUPPORTED CROWN - HIGH NOBLE ALLOYS (D6067)
IMPLANT SUPPORTED PORCELAIN FUSED TO METAL CROWN (PREDOMINANTLY BASE METAL) (D6082)
IMPLANT SUPPORTED PORCELAIN FUSED TO METAL CROWN (NOBLE METAL) (D6083)
IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO TITANIUM OR TITANIUM ALLOYS (D6084)
IMPLANT SUPPORTED CROWN - PREDOMINANTLY BASE ALLOYS (D6086)
IMPLANT SUPPORTED CROWN - NOBLE ALLOYS (D6087)
IMPLANT SUPPORTED CROWN - TITANIUM AND TITANIUM ALLOYS (D6088)
ABUTMENT SUPPORTED CROWN - TITANIUM AND TITANIUM ALLOYS (D6094)
ABUTMENT SUPPORTED CROWN - PORCELAIN FUSED TO TITANIUM OR TITANIUM ALLOYS (D6097)
Limited to 1 of Inlay (D2510-D2530, D2610-D2630, D2650-D2652), Onlay (D2542-D2544, D2642-D2644, D2662-D2664), Crown (D2710-D2794), or Implant/Abutment supported crown (D6058-D6067, D6082-D6084, D6086-D6088, D6094, D6097) per tooth per 5 years. Replacement of an existing restoration is limited to only when they are not, and cannot be made, serviceable.
Denied as MISREPORTED when reported by the same Dentist, on the same date, and in the same arch and associated with pontic codes (D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6253).
IMPLANT MAINTENANCE (D6080)
IMPLANT RIDER ONLY: Limited to 2 of Implant maintenance (D6049, D6080, D6081, D6180, D6280) per calendar year.
Denied as NOT STANDARD OF DENTAL TREATMENT when reported for a Member Age 18 and younger. ***Situational approval may be allowed upon Second Review/Appeal with Dental Advisor Review with documentation of extenuating circumstances.**
SCALING & DEBRIDEMENT IMPLANT (D6081)
IMPLANT RIDER ONLY: Limited to 2 of Implant maintenance (D6049, D6080, D6081, D6180, D6280) per calendar year.
Denied as NOT STANDARD OF DENTAL TREATMENT when reported for a Member Age 18 and younger. ***Situational approval may be allowed upon Second Review/Appeal with Dental Advisor Review with documentation of extenuating circumstances.**
Denied as MISREPORTED when reported by the same Dentist on the same date as Prophy (D1110), Periodontal Maintenance (D4910), or Scaling in the presence of inflammation (D4346).
ACCESSING AND RETORQUING LOOSE IMPLANT SCREW – PER SCREW (D6089)
Limited to 1 of Accessing and retorquing loose implant screw – per screw (D6089) per tooth per 3 year period.
Denied as INTEGRAL when reported on the same tooth, by the same Dentist within 12 months of cementation of an abutment or implant supported crown or retainer or implant/abutment supported fixed denture (D6057-D6077, D6082-D6084, D6086, D6088, D6094, D6097, D6098, D6099, D6184, D6195) or previous recementation (D6092, D6093).
REPAIR IMPLANT SUPPORTED PROSTHESIS, BY REPORT (D6090)
IMPLANT RIDER ONLY: Limited to 1 of Repair implant supported prosthesis (D6090) per tooth and 1 of Repair implant abutment (D6095) per tooth per lifetime.
Denied as NOT STANDARD OF DENTAL TREATMENT when reported for a Member Age 18 and younger. ***Situational approval may be allowed upon Second Review/Appeal with Dental Advisor Review with documentation of extenuating circumstances.**
Denied as INTEGRAL when reported on the same tooth, by the same Dentist within 5 years of cementation/placement of an abutment or implant supported crown or retainer or implant/abutment supported fixed denture (D6057-D6077, D6082-D6088, D6094, D6097-D6099, D6114-D6123, D6110-D6123, D6194, D6195).

Denied as MISREPORTED if a Dental Advisor determines that the submitted documentation does not support that the service planned (pre-estimation) or was completed (claim) meets the current CDT Current Dental Terminology descriptor of the code reported.
Denied as NOT STANDARD OF DENTAL TREATMENT POOR PERIODONTAL PROGNOSIS if a Dental Advisor determines that submitted documentation supports that the implant has a poor or hopeless prognosis.
RE-CEMENT OR RE-BOND IMPLANT/ABUTMENT SUPPORTED CROWN (D6092)
RE-CEMENT OR RE-BOND IMPLANT/ABUTMENT SUPPORTED FIXED PARTIAL DENTURE (D6093)
1 of Re-cement or re-bond implant/abutment supported crown (D6092) per tooth per 3 years and 1 of Re-cement or re-bond implant/abutment supported fixed partial denture (D6093) per tooth per 3 years.
Denied as INTEGRAL when reported on the same tooth, by the same Dentist within 12 months of cementation of an abutment or implant supported crown or retainer or implant/abutment supported fixed denture (D6057-D6077, D6082-D6084, D6086, D6088, D6094, D6097, D6098, D6099, D6184, D6195) or previous recementation (D6092, D6093).
REMOVE BROKEN IMPLANT RETAINING SCREW (D6096)
IMPLANT RIDER ONLY: No frequency limitation.
Denied as NOT STANDARD OF DENTAL TREATMENT when reported for a Member Age 18 and younger. ***Situational approval may be allowed upon Second Review/Appeal with Dental Advisor Review with documentation of extenuating circumstances.**
Denied as INTEGRAL when reported on the same tooth by the same Dentist as within 12 months of placement of the initial prosthetic and maintenance service screw-retained abutment or implant supported crown or retainer or implant/abutment supported fixed denture (D6051-D6199 D6051, D6056-D6067, D6082-D6088, D6094, D6097, D6114-D6117).
SURGICAL REMOVAL OF IMPLANT BODY (D6100)
REMOVAL OF IMPLANT BODY NOT REQUIRING BONE REMOVAL NOR FLAP ELEVATION (D6105)
IMPLANT RIDER ONLY: Limited to 1 of Surgical removal of implant body (D6100) and Removal of implant body not requiring bone removal nor flap elevation (D6105) per tooth per lifetime.
Denied as NOT STANDARD OF DENTAL TREATMENT when reported for a Member Age 18 and younger. ***Situational approval may be allowed upon Second Review/Appeal with Dental Advisor Review with documentation of extenuating circumstances.**
DEBRIDEMENT OF A PERI-IMPLANT DEFECT (D6101)
DEBRIDEMENT AND OSSEOUS CONTOURING OF A PERI-IMPLANT DEFECT (D6102)
IMPLANT RIDER ONLY: Limited to 1 of Debridement of a peri-implant defect (D6101) and 1 of Debridement of osseous contouring of a peri-implant defect (D6102) per lifetime.
Denied as NOT STANDARD OF DENTAL TREATMENT when reported for a Member Age 18 and younger. ***Situational approval may be allowed upon Second Review/Appeal with Dental Advisor Review with documentation of extenuating circumstances.**
DIAGNOSTIC MATERIALS REQUIRED: Submission of a pre-treatment, diagnostic x-ray must accompany the EDI/ADA Claim Form when reporting this service. Other chart materials such as written documentation (narrative, progress notes, or other written information regarding details of the service planned or provided) and photographs may optionally be submitted and should corroborate clinically with the submitted x-rays for consideration during manual clinical review. **If specific rationale is provided explaining why x-ray(s) are not available (patient is pregnant, special needs, medical complication, etc.), the service may be referred to manual clinical review (Dental Advisor) in the absence of required materials**.
Denied as MISREPORTED if a Dental Advisor determines that the submitted documentation does not support that the service planned (pre-estimation) or was completed (claim) meets the current CDT Current Dental Terminology descriptor of the code reported.
Denied as NOT STANDARD OF DENTAL TREATMENT POOR PERIODONTAL PROGNOSIS if a Dental Advisor determines that submitted documentation supports that the implant has a poor or hopeless prognosis.

BONE GRAFT AT TIME OF IMPLANT PLACEMENT (D6104)
IMPLANT RIDER ONLY: Limited to 1 of Bone graft at time of implant placement (D6104) per lifetime.
Denied as NOT STANDARD OF DENTAL TREATMENT when reported for a Member Age 18 and younger. ***Situational approval may be allowed upon Second Review/Appeal with Dental Advisor Review with documentation of extenuating circumstances.**
REMOVABLE DENTURE FOR EDENTULOUS ARCH – MAXILLARY (D6110)
REMOVABLE DENTURE FOR EDENTULOUS ARCH – MANDIBULAR (D6111)
REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH – MAXILLARY (D6112)
REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH – MANDIBULAR (D6113)
FIXED DENTURE FOR EDENTULOUS ARCH – MAXILLARY (D6114)
FIXED DENTURE FOR EDENTULOUS ARCH – MANDIBULAR (D6115)
FIXED DENTURE FOR PARTIALLY EDENTULOUS ARCH – MAXILLARY (D6116)
FIXED DENTURE FOR PARTIALLY EDENTULOUS ARCH – MANDIBULAR (D6117)
IMPLANT RIDER ONLY: Limited to 1 of Implant supported fixed partial denture (D6068-D6077, D6098, D6099, D6120-D6123, D6194, D6195, D6205-D6252), or Implant supported removable denture (D6110-D6113), or Implant supported fixed denture (D6114-D6117) per arch per 5 years.
Denied as NOT STANDARD OF DENTAL TREATMENT when reported for a Member Age 18 and younger. ***Situational approval may be allowed upon Second Review/Appeal with Dental Advisor Review with documentation of extenuating circumstances.**
IMPLANT MAINTENANCE PROCEDURES WHEN A FULL ARCH FIXED HYBRID PROSTHESIS IS NOT REMOVED, INCLUDING CLEANSING OF PROSTHESIS AND ABUTMENTS (D6180)
IMPLANT RIDER ONLY: Limited to 2 of Implant maintenance (D6049, D6080, D6081, D6180, D6280) per calendar year.
Denied as NOT STANDARD OF DENTAL TREATMENT when reported for a Member Age 18 and younger. ***Situational approval may be allowed upon Second Review/Appeal with Dental Advisor Review with documentation of extenuating circumstances.**
REPLACEMENT OF AN IMPLANT SCREW (D6193)
Limited to 1 of Replacement of an implant screw (D6193) per tooth per 3 year period.
Denied as INTEGRAL when reported on the same tooth by the same Dentist as within 12 months of placement of the initial prosthetic and maintenance service screw-retained abutment or implant supported crown or retainer or implant/abutment supported fixed denture (D6051, D6056-D6067, D6082-D6088, D6094, D6097, D6114-D6117).
REPLACEMENT OF RESTORATIVE MATERIAL USED TO CLOSE AN ACCESS OPENING OF A SCREW-RETAINED IMPLANT SUPPORTED PROSTHESIS, PER IMPLANT (D6197)
IMPLANT RIDER ONLY: Limited to 1 of Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant (D6197) per tooth per lifetime.
Denied as NOT STANDARD OF DENTAL TREATMENT when reported for a Member Age 18 and younger. *Situational approval may be allowed upon Second Review/Appeal with Dental Advisor Review with documentation of extenuating circumstances.
REMOVE INTERIM IMPLANT COMPONENT (D6198)
IMPLANT RIDER ONLY: No frequency limitation
Denied as NOT STANDARD OF DENTAL TREATMENT when reported for a Member Age 18 and younger. ***Situational approval may be allowed upon Second Review/Appeal with Dental Advisor Review with documentation of extenuating circumstances.**

PROSTHODONTICS, FIXED (D6205-D6999)

- Dental services that are routinely provided in conjunction with or as part of another procedure in accordance with accepted standards of dental practice are defined as integral by United Concordia Dental and excluded from coverage. Some dental services may be denied as integral when reported in the absence of another dental service (for example: local anesthesia) or denied as integral only when another more comprehensive dental service has been benefitted. Any benefit for any fixed prosthodontic service per CDT code descriptor as reported is inclusive of all charges for work, materials, and supplies related to the procedure, and if reported separately, these services may be denied as integral. Participating dentists may not bill a patient for a service denied as integral.
- Dental services that are reported in a treatment sequence that is not appropriate in accordance with accepted standards of dental practice are defined as integral by United Concordia Dental and excluded from coverage (for example: a crown reported on a date following an extraction benefitted on the same tooth). Participating dentists may not bill a patient for a service denied because it is reported in an inappropriate treatment sequence.
- Dental services that are misreported or that represent a procedure other than the one reported are excluded from coverage. Dental services should be reported in accordance with the nomenclature and descriptors defined in the current year American Dental Association's Current Dental Terminology (CDT) codebook. Participating dentists may not bill a patient for a service denied because it is misreported.
- Dental services must be dentally/medically necessary and meet accepted standards of dental practice, as defined by United Concordia, which requires any tooth or teeth to have acceptable prognosis and meet United Concordia's definition of dental/medical necessity for the reported code as defined by the current ADA Current Dental Terminology codebook. Dental services determined not to meet United Concordia's definition of dental/medical necessity are not billable to the patient by a participating dentist unless the dentist notifies the patient of his or her potential financial liability prior to treatment and the patient chooses to receive the treatment (financial agreement). Participating dentists should document such notification specifically (with the date, tooth number, service, potential financial liability, and signature of the patient) in the patient's record.
- Any services utilized for the treatment of temporomandibular joint disorders (TMD/TMJ) or for implant placement, restoration, or maintenance is excluded from coverage and denied as not covered unless benefits are specifically provided for under a TMD or Implant rider.
- For reporting and benefit purposes, the billing/completion date for any Indirect restoration (any Inlay, Onlay, Crown, Indirectly fabricated Post and Core, Implant Abutment, Implant/Abutment Supported Crown or Fixed Partial Denture (Bridge), Labial Veneer, or Fixed Partial Denture (Bridge)) or Indirectly fabricated Prosthesis (any Complete or Partial Denture, including Immediate, Interim, and Implant/Abutment Supported, or any Indirect Denture Rebase, Reline, and/or Repair) is the cementation or final placement date. Any Indirect restoration or Prosthesis begun prior to the effective date of coverage or cemented after the cancellation date of coverage is not eligible for payment. A 30-90 day extension may apply, please verify for specific Member plan/contract. Please resubmit the claim along with the corrected date.

PONTIC - INDIRECT RESIN BASED COMPOSITE (D6205)
PONTIC - CAST HIGH NOBLE METAL (D6210)
PONTIC - CAST PREDOMINANTLY BASE METAL (D6211)
PONTIC - CAST NOBLE METAL (D6212)
PONTIC - TITANIUM AND TATANIUM ALLOYS (D6214)
PONTIC - PORCELAIN FUSED TO HIGH NOBLE METAL (D6240)
PONTIC - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL (D6241)
PONTIC - PORCELAIN FUSED TO NOBLE METAL (D6242)
PONTIC - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS (D6243)
PONTIC - PORCELAIN/CERAMIC (D6245)

PONTIC - RESIN WITH HIGH NOBLE METAL (D6250)
PONTIC - RESIN WITH PREDOMINANTLY BASE METAL (D6251)
PONTIC - RESIN WITH NOBLE METAL (D6252)
INTERIM PONTIC - FURTHER TREATMENT OR COMPLETION OF DIAGNOSIS NECESSARY PRIOR TO FINAL IMPRESSION (D6253)
RETAINER - CAST METAL FOR RESIN BONDED FIXED PROSTHESIS (D6545)
RETAINER - PORCELAIN/CERAMIC FOR RESIN BONDED FIXED PROSTHESIS (D6548)
RESIN RETAINER - FOR RESIN BONDED FIXED PROSTHESIS (D6549)
RETAINER INLAY - PORCELAIN CERAMIC, TWO SURFACES (D6600)
RETAINER INLAY - PORCELAIN/CERAMIC, THREE OR MORE SURFACES (D6601)
RETAINER INLAY - CAST HIGH NOBLE METAL, TWO SURFACES (D6602)
RETAINER INLAY - CAST HIGH NOBLE METAL, THREE OR MORE SURFACES (D6603)
RETAINER INLAY - CAST PREDOMINANTLY BASE METAL, TWO SURFACES (D6604)
RETAINER INLAY - CAST PREDOMINANTLY BASE METAL, THREE OR MORE SURFACES (D6605)
RETAINER INLAY - CAST NOBLE METAL, TWO SURFACES (D6606)
RETAINER INLAY - CAST NOBLE METAL, THREE OR MORE SURFACES (D6607)
RETAINER ONLAY - PORCELAIN/CERAMIC, TWO SURFACES (D6608)
RETAINER ONLAY - PORCELAIN/CERAMIC, THREE OR MORE SURFACES (D6609)
RETAINER ONLAY - CAST HIGH NOBLE METAL, TWO SURFACES (D6610)
RETAINER ONLAY - CAST HIGH NOBLE METAL, THREE OR MORE SURFACES (D6611)
RETAINER ONLAY - CAST PREDOMINANTLY BASE METAL, TWO SURFACES (D6612)
RETAINER ONLAY - CAST PREDOMINANTLY BASE METAL, THREE OR MORE SURFACES (D6613)
RETAINER ONLAY - CAST NOBLE METAL, TWO SURFACES (D6614)
RETAINER ONLAY - CAST NOBLE METAL, THREE OR MORE SURFACES (D6615)
RETAINER INLAY – TITANIUM (D6624)
RETAINER ONLAY – TITANIUM (D6634)
RETAINER CROWN - INDIRECT RESIN BASED COMPOSITE (D6710)
RETAINER CROWN - RESIN WITH HIGH NOBLE METAL (D6720)
RETAINER CROWN - RESIN WITH PREDOMINANTLY BASE METAL (D6721)
RETAINER CROWN - RESIN WITH NOBLE METAL (D6722)
RETAINER CROWN - PORCELAIN/CERAMIC (D6740)
RETAINER CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL (D6750)
RETAINER CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL (D6751)
RETAINER CROWN - PORCELAIN FUSED TO NOBLE METAL (D6752)
RETAINER CROWN - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS (D6753)
RETAINER CROWN - 3/4 CAST HIGH NOBLE METAL (D6780)
RETAINER CROWN - 3/4 CAST PREDOMINANTLY BASE METAL (D6781)
RETAINER CROWN - 3/4 CAST NOBLE METAL (D6782)
RETAINER CROWN - 3/4 PORCELAIN/CERAMIC (D6783)
RETAINER CROWN 3/4 - TITANIUM AND TITANIUM ALLOYS (D6784)
RETAINER CROWN - FULL CAST HIGH NOBLE METAL (D6790)
RETAINER CROWN - FULL CAST PREDOMINANTLY BASE METAL (D6791)
RETAINER CROWN - FULL CAST NOBLE METAL (D6792)
RETAINER CROWN - TITANIUM AND TITANIUM ALLOYS (D6794)
Limited to 1 of Complete or immediate denture (D5110/D5120, D5130/D5140), Complete overdenture (D5863/D5865), Partial or immediate partial denture (D5211/D5212, D5213/D5214, D5221/D5222, D5223/D5224, D5225/D5226, D5227/D5228, D5282/D5283/ D5284/D5286) or partial overdenture (D5864/D5865), or Fixed Partial Denture/Bridge (D6205-D6252, D6545-D6792, D6794) per arch per 5 year period for replacement of natural

tooth/teeth in an arch. For any plan that chooses to apply an ALTERNATE BENEFIT PROVISION, when a Fixed Partial Denture (Bridge) (D6209-D6794) is reported, if there are two or more bilaterally missing teeth or when there are three or more adjacent missing teeth in the arch, payment will be made for a comparable Removeable Partial Denture (D5213, D5214). Refer to Removeable Partial Denture (D5213, D5214) Exclusion & Limitations. A participating dentist may bill the member the difference between the allowance for the alternate benefit and the dentist's charge for the service completed. ***Situational approval may be allowed upon Second Review/Appeal with Dental Advisor Review for a Fixed partial denture (Bridge) (D6209-D6794) benefitted as a Removeable Partial Denture (D5213, D5214) under ALTERNATE BENEFIT PROVISION with documentation of extenuating circumstances.**
Denied for NOT STANDARD OF DENTAL TREATMENT when reported on a Member Age 13 and under (excludes Resin-Bonded Fixed Partial Denture (Maryland Bridge) D6545, D6548, D6549). ***Situational approval may be allowed upon Second Review/Appeal with Dental Advisor Review with documentation of extenuating circumstances.**
DIAGNOSTIC MATERIAL REQUIREMENT: Submission of a pre-treatment, diagnostic x-ray must accompany the EDI/ADA Claim Form when reporting this service. Only for a plan that chooses to apply an ALTERNATE BENEFIT PROVISION, x-ray(s) showing all teeth present in the arch are required when reporting this service. Other chart materials may optionally be submitted and should corroborate clinically with the submitted x-rays for consideration during manual clinical review. **If specific rationale is provided explaining why x-ray(s) are not available (patient is pregnant, special needs, medical complication, etc.), the service may be referred to manual clinical review (Dental Advisor) in the absence of required materials.**
Any Denture (D5110-D5140), Partial Denture (D5211-D5286), or Fixed Partial Denture/Bridge (D6205- D6792, D6794) is only a potential benefit per contract for replacement of a natural tooth/teeth in an arch. Any Partial Denture (D5211-D5286), or Fixed Partial Denture/Bridge (D6205- D6792, D6794) not intended to replace a missing natural tooth/teeth and intended to close spacing resultant from drifted or misaligned teeth is denied as NOT COVERED. Denied as MISREPORTED (SPLINTING) if no missing tooth/teeth on x-ray/noted on claim and no extraction on the same claim or in history (bridge not replacing a missing tooth)
Denied as MISREPORTED when SINGLE CROWN CODES are reported for teeth adjacent to missing tooth/teeth spaces (instead of RETAINER CODES) or missing tooth/teeth spaces (instead of PONTIC CODES)
Denied as MISREPORTED when RETAINER CODES are incorrectly reported for missing tooth/teeth spaces (instead of PONTIC CODES) and/or PONTIC codes are incorrectly reported for teeth adjacent to missing tooth/teeth spaces (instead of RETAINER CODES)
Denied as NOT STANDARD OF DENTAL TREATMENT when there are BOTH IMPLANT AND NATURAL TEETH RETAINER CODES reported + PONTIC CODE(S) as part of the same bridge
Denied as IMPLANT RELATED when one or more pontic code(s) reported with an implant retainer (when Member does not have Implant Rider).
Denied as MISREPORTED if a Dental Advisor determines that the diagnostic materials do not show that the service planned (predetermination) or was completed (claim) meets the current CDT Current Dental Terminology descriptor of the code reported.
Denied as NOT STANDARD OF DENTAL TREATMENT POOR PERIODONTAL PROGNOSIS if a Dental Advisor determines that diagnostic materials show that the tooth has a poor or hopeless prognosis.
Denied as NOT STANDARD OF DENTAL TREATMENT POOR RESTORATIVE PROGNOSIS if a Dental Advisor determines that diagnostic materials show that the tooth has a poor or hopeless prognosis.
Denied as NOT STANDARD OF DENTAL TREATMENT POOR ENDODONTIC PROGNOSIS – ROOT FRACTURE if a Dental Advisor determines that diagnostic materials show that the tooth has a poor or hopeless prognosis.
Denied for VERTICAL DIMENSION if a Dental Advisor determines that diagnostic materials show that the restoration is associated with alteration of vertical dimension.
Denied for REPLACEMENT NOT DENTALLY/MEDICALLY NECESSARY if a Dental Advisor determines that diagnostic materials show that the tooth with an existing onlay, crown, or bridge abutment does not have a non-repairable fracture and/or periodontal pathology resultant from an issue with the existing restoration and/or the tooth does not have new decay or missing tooth structure.
RE-CEMENT OR RE-BOND FIXED PARTIAL DENTURE (D6930)
Limited to 1 of Re-cement or re-bond fixed partial denture (D6930) per 3 year period.

Denied as INTEGRAL when reported for the same tooth within by the same Dentist within the initial 12 months post insertion of the same Fixed Partial Denture. Situational approval may be allowed upon Second Review/Appeal with documentation that Recementation was necessary following root canal treatment or because of an accidental injury. Situational approval may be allowed upon Second Review/Appeal with Dental Advisor Review with documentation of extenuating circumstances.
FIXED PARTIAL DENTURE REPAIR NECESSITATED BY RESTORATIVE MATERIAL FAILURE (D6980)
No frequency limitation.
Denied as INTEGRAL when reported for the same tooth, by the same Dentist within the initial 5 years post insertion of the same Fixed partial denture.
UNSPECIFIED FIXED PROSTHODONTIC PROCEDURE, BY REPORT (D6999)
No frequency limitation.
Denied as MISREPORTED (GENERIC) when the service described has a specific and valid CDT code. Example: Interim restorations (“provisional or temporary”) (if NOT associated with Crown D2710-D2794 or Bridge D6205-D6792) (D2799, D6793, D6253), Protective restoration (Sedative or temporary restoration or filling, IRM ®, FUGI ®) (D2940), Regeneration medicament (Curodont®) (D2991)
Denied as INTEGRAL (GENERIC) when the service described has no specific and valid code because it is part of the Standard of Dental Treatment for another principal service (includes multi-step processes and individual dentist choices for what products and/or techniques that may be used). Examples: Abrasion/Microabrasion/Sandblasting, Acid etch (Phosphoric acid – Ultra-Etch®, Etch-Rite®), Bases or Liners ((Glass ionomer – Dycal®, HydroxTM®, Life®, VLC Dycal®, Calcium hydroxide – Lime-lite®, Vitrebond®, Ionoseal®, Calcimol®, ACTIVA®, Fugi®, Multi-Cal®, Alrox®, Cavitec®, Copalite®, IRM®), Bite block, Bite Registration, Bonding agents (Peak Universal Bond®, Optibond®, All Bond®, Scotchbond®, Clearfil SE®, Futurabond®, Adhese Viva®, G Bond®), Caries detecting agents (Caries Detector®, Caries Indicator®, Snoop®), Cavity varnish (Copal – Cavity VarnishTM®, Copalite®), Cementation (Inlay/Onlay/Crown/Veneer/Fixed Partial Denture (Bridge)), Hemostatic gel/solution (Astringedent®, Viscostat®, Expasyl®) (”preparation of gingival tissue”), Impressions, Interim restorations (“provisional or temporary”) (if associated with Crown D2710-D2794 or Bridge D6205-D6792), Isolation techniques (including gel barrier, Isolite®, and rubber dam placement), Lab fees, Light/LED curing, Matrix bands (Pro-Matrix®, Palodent®, Automatrix®, Composi-Tight®), Preparation of tooth (“Prep” for Inlay/Onlay/Crown/Veneer/Fixed Partial Denture (Bridge)), Removal of existing restorations (including removal of existing crowns/bridges), Upgrades for Metal or Materials (including Porcelain margin, Captek®, Lumineer ®, Empress ®, Zirconia®, Additional Porcelain, Denture teeth and material upgrades like Ivoclar ®, Val-plast ®, Flexite® etc). ***Situational approval may be allowed for Specialized procedures/characterizations upon Second Review/Appeal with Dental Advisor. Must have lab slip documenting specific associated costs associated with custom restorative/prosthetic work like gemstones and engravings (outside of required name label in dentures/partials) in restorative and prosthetic work and specific signed Member financial agreement.**
Denied as MISREPORTED + INTEGRAL when the service described has a specific and valid code because it is part of the Standard of Dental Treatment for another principal service (includes multi-step processes and individual dentist choices for what products and/or techniques that may be used). Example: Diagnostic casts (“study or lab models”) (**D0470**), Local anesthetic (Lidocaine®, Bupivacaine®, Marcaine®, Septocaine®) and modalities for administration (Viajet®) (**D9210-D9215**), Restorative foundation for indirect restoration (“blocking undercuts/irregularities”)(**D2949**), Topical anesthestic (Oraquix, Hurricaine, Tetracaine®) (**D9210-D9215**)
Denied as NOT COVERED (GENERIC) when the service described has no specific and valid code and describes a service that is not covered.

ORAL & MAXILLOFACIAL SURGERY (D7111-D7999)

• Dental services that are routinely provided in conjunction with or as part of another procedure in accordance with accepted standards of dental practice are defined as integral by United Concordia Dental and excluded from coverage. Some dental services may be denied as integral when reported in the absence of another dental service (for example: local anesthesia) or denied as integral only when another more comprehensive dental

service has been benefitted. Any benefit for any Oral & Maxillofacial surgery service per CDT code descriptor as reported is inclusive of all charges for work, materials, and supplies related to the procedure, and if reported separately, these services may be denied as integral. Participating dentists may not bill a patient for a service denied as integral.

- Dental services that are reported in a treatment sequence that is not appropriate in accordance with accepted standards of dental practice are defined as integral by United Concordia Dental and excluded from coverage (for example: a crown reported on a date following an extraction benefitted on the same tooth). Participating dentists may not bill a patient for a service denied because it is reported in an inappropriate treatment sequence.
- Dental services that are misreported or that represent a procedure other than the one reported are excluded from coverage. Dental services should be reported in accordance with the nomenclature and descriptors defined in the current year American Dental Association's Current Dental Terminology (CDT) codebook. Participating dentists may not bill a patient for a service denied because it is misreported.
- Dental services must be dentally/medically necessary and meet accepted standards of dental practice, as defined by United Concordia, which requires any tooth or teeth to have acceptable prognosis and meet United Concordia's definition of dental/medical necessity for the reported code as defined by the current ADA Current Dental Terminology codebook. Dental services determined not to meet United Concordia's definition of dental/medical necessity are not billable to the patient by a participating dentist unless the dentist notifies the patient of his or her potential financial liability prior to treatment and the patient chooses to receive the treatment (financial agreement). Participating dentists should document such notification specifically (with the date, tooth number, service, potential financial liability, and signature of the patient) in the patient's record.
- Any services utilized for the treatment of temporomandibular joint disorders (TMD/TMJ) or for implant placement, restoration, or maintenance is excluded from coverage and denied as not covered unless benefits are specifically provided for under a TMD or Implant rider.

EXTRACTION, CORONAL REMNANTS - PRIMARY TOOTH (D7111)

Limited to 1 of Extraction, Coronal Remnants (D7111) per primary tooth per lifetime.

Denied as INTEGRAL when reported by the same Dentist, for the same tooth number as another type of extraction or impaction (D7140, D7210, D7220, D7230, D7240, D7241, D7250, D7251).

EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT (ELEVATION AND/OR FORCEPS REMOVAL) (D7140)

Limited to 1 of Extraction, erupted tooth (D7140) or Extraction, erupted tooth requiring removal of bone (D7210), or Removal of Impacted Tooth - Soft Tissue (D7220), or Removal of Impacted Tooth - Partially Bony (D7230), or Removal of Impacted Tooth - Completely Bony (D7240), or Removal of Impacted Tooth - Completely Bony, With Unusual Surgical Complications (D7241) per permanent tooth and per primary tooth per lifetime.

EXTRACTION, ERUPTED TOOTH REQUIRING REMOVAL OF BONE AND/OR SECTIONING OF TOOTH, AND INCLUDING ELEVATION OF MUCOPERIOSTEAL FLAP IF INDICATED (D7210)

Limited to 1 of Extraction, erupted tooth (D7140) or Extraction, erupted tooth requiring removal of bone (D7210), or Removal of Impacted Tooth - Soft Tissue (D7220), or Removal of Impacted Tooth - Partially Bony (D7230), or Removal of Impacted Tooth - Completely Bony (D7240), or Removal of Impacted Tooth - Completely Bony, With Unusual Surgical Complications (D7241) per permanent tooth and per primary tooth per lifetime.

REMOVAL OF IMPACTED TOOTH - SOFT TISSUE (D7220)

REMOVAL OF IMPACTED TOOTH - PARTIALLY BONY (D7230)

REMOVAL OF IMPACTED TOOTH - COMPLETELY BONY (D7240)

Limited to 1 of Extraction, erupted tooth (D7140) or Extraction, erupted tooth requiring removal of bone (D7210), or Removal of Impacted Tooth - Soft Tissue (D7220), or Removal of Impacted Tooth - Partially Bony (D7230), or Removal of Impacted Tooth - Completely Bony (D7240), or Removal of Impacted Tooth - Completely Bony, With Unusual Surgical Complications (D7241) per permanent tooth and per primary tooth per lifetime.

Benefitted as Extraction, Coronal Remnants - Primary Tooth (D7111) as MISREPORTED if a Dental Advisor determines that the submitted documentation supports that removal of soft tissue-retained coronal remnants of a primary tooth is planned or completed.

Benefitted as Extraction, Erupted Tooth Or Exposed Root (Elevation and/or Forceps Removal) (D7140) if a Dental Advisor determines that the submitted documentation supports that removal of tooth structure, minor smoothing of socket bone, and closure, as necessary, is planned or completed.
Benefitted as Extraction, Erupted Tooth Requiring Removal Of Bone and/or Sectioning Of Tooth, and Including Elevation Of Mucoperiosteal Flap if Indicated (D7210) as MISREPORTED if a Dental Advisor determines that the submitted documentation supports that related cutting of gingiva and bone (bone removal required), removal of tooth structure, and minor smoothing of socket bone and closure, is planned or completed.
Benefitted as Removal Of Impacted Tooth - Soft Tissue (D7220) as MISREPORTED if a Dental Advisor determines that the submitted documentation supports that removal of a tooth where the occlusal surface is covered by soft tissue (>50%); requires mucoperiosteal flap elevation, is planned or completed.
Benefitted as Removal Of Impacted Tooth - Partially Bony (D7230) as MISREPORTED if a Dental Advisor determines that the submitted documentation supports that removal of a tooth where part of the crown is covered by bone (>50% anatomical crown); requires mucoperiosteal flap elevation and bone removal. Bone removal required. is planned or completed.
Benefitted as Removal Of Impacted Tooth - Completely Bony (D7240) as MISREPORTED if a Dental Advisor determines that the submitted documentation supports that removal of a tooth where most or all of the crown covered by bone (>75% anatomical crown); requires mucoperiosteal flap elevation and bone removal. Bone removal required. is planned or completed.
REMOVAL OF IMPACTED TOOTH - COMPLETELY BONY, WITH UNUSUAL SURGICAL COMPLICATIONS (D7241)
Limited to 1 of Extraction, erupted tooth (D7140) or Extraction, erupted tooth requiring removal of bone (D7210), or Removal of Impacted Tooth - Soft Tissue (D7220), or Removal of Impacted Tooth - Partially Bony (D7230), or Removal of Impacted Tooth - Completely Bony (D7240), or Removal of Impacted Tooth - Completely Bony, With Unusual Surgical Complications (D7241) per permanent tooth and per primary tooth per lifetime.
DIAGNOSTIC MATERIALS REQUIRED: Submission of a pre-treatment, diagnostic x-ray must accompany the EDI/ADA Claim Form when reporting this service. Other chart materials may optionally be submitted and should corroborate clinically with the submitted x-rays for consideration during manual clinical review. **If specific rationale is provided explaining why x-ray(s) are not available (patient is pregnant, special needs, medical complication, etc.), the service may be referred to manual clinical review (Dental Advisor) in the absence of required materials.**
Benefitted as Extraction, Coronal Remnants - Primary Tooth (D7111) as MISREPORTED if a Dental Advisor determines that the submitted documentation supports that removal of soft tissue-retained coronal remnants of a primary tooth is planned or completed.
Benefitted as Extraction, Erupted Tooth Or Exposed Root (Elevation and/or Forceps Removal) (D7140) if a Dental Advisor determines that the submitted documentation supports that removal of tooth structure, minor smoothing of socket bone, and closure, as necessary, is planned or completed.
Benefitted as Extraction, Erupted Tooth Requiring Removal Of Bone and/or Sectioning Of Tooth, and Including Elevation Of Mucoperiosteal Flap if Indicated (D7210) as MISREPORTED if a Dental Advisor determines that the submitted documentation supports that related cutting of gingiva and bone (bone removal required), removal of tooth structure, and minor smoothing of socket bone and closure, is planned or completed.
Benefitted as Removal Of Impacted Tooth - Soft Tissue (D7220) as MISREPORTED if a Dental Advisor determines that the submitted documentation supports that removal of a tooth where the occlusal surface is covered by soft tissue (>50%); requires mucoperiosteal flap elevation, is planned or completed.
Benefitted as Removal Of Impacted Tooth - Partially Bony (D7230) as MISREPORTED if a Dental Advisor determines that the submitted documentation supports that removal of a tooth where part of the crown is covered by bone (>50% anatomical crown); requires mucoperiosteal flap elevation and bone removal. Bone removal required. is planned or completed.
Benefitted as Removal Of Impacted Tooth - Completely Bony (D7240) as MISREPORTED if a Dental Advisor determines that the submitted documentation supports that removal of a tooth where most or all of the crown covered by bone (>75% anatomical crown); requires mucoperiosteal flap elevation and bone removal. Bone removal required. is planned or completed.
REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING PROCEDURE) (D7250)

Limited to 1 of Removal of residual tooth roots (D7250) per permanent tooth and per primary tooth per lifetime per lifetime.
Denied as INTEGRAL when reported by the same Dentist, for the same tooth number as an Extraction or Impaction (D7111, D7140, D7210, D7220, D7230, D7240, D7241).
Denied as INTEGRAL when reported by the same Dentist, for the same tooth number as Hemisection (D3920)
CORONECTOMY - INTENTIONAL PARTIAL TOOTH REMOVAL, IMPACTED TEETH ONLY (D7251)
Limited to 1 of Coronectomy (D7251) per permanent tooth and per primary tooth per lifetime per lifetime.
DIAGNOSTIC MATERIAL REQUIRED: Submission of a pre-treatment, diagnostic x-ray and written documentation must accompany the EDI/ADA Claim Form when reporting this service. Other chart materials may optionally be submitted and should corroborate clinically with the submitted x-rays for consideration during manual clinical review. **If specific rationale is provided explaining why x-ray(s) are not available (patient is pregnant, special needs, medical complication, etc.), the service may be referred to manual clinical review (Dental Advisor) in the absence of required materials.**
Denied as MISREPORTED if a Dental Advisor determines that the diagnostic materials do not show that the service planned (predetermination) or was completed (claim) meets the current CDT Current Dental Terminology descriptor of the code reported.
Denied as NOT DENTALLY/MEDICALLY NECESSARY If a Dental Advisor determines that the submitted documentation does not support that the impacted tooth is symptomatic (requiring removal) and that neurovascular complication is likely if the entire impacted tooth is removed.
PARTIAL EXTRACTION FOR IMMEDIATE IMPLANT PLACEMENT (D7252)
IMPLANT RIDER ONLY: Limited to 1 of Partial extraction for immediate implant placement per permanent maxillary anterior tooth (#6, 7, 8, 9, 10, 11) per lifetime.
NERVE DISSECTION (D7259) *NEW CODE CDT2025
Limited to 1 of Nerve dissection (D7259) per permanent tooth per lifetime
Denied as INTEGRAL when reported on the same tooth, on the same date, and by the same Dentist as a Removal of impacted tooth - completely bony, with unusual surgical complications (D7241).
DIAGNOSTIC MATERIAL REQUIRED: Submission of a pre-treatment, diagnostic x-ray and written documentation must accompany the EDI/ADA Claim Form when reporting this service. Other chart materials may optionally be submitted and should corroborate clinically with the submitted x-rays for consideration during manual clinical review. **If specific rationale is provided explaining why x-ray(s) are not available (patient is pregnant, special needs, medical complication, etc.), the service may be referred to manual clinical review (Dental Advisor) in the absence of required materials.**
Denied as MISREPORTED if a Dental Advisor determines that the diagnostic materials do not show that the service planned (predetermination) or was completed (claim) meets the current CDT Current Dental Terminology descriptor of the code reported.
Denied as NOT DENTALLY/MEDICALLY NECESSARY If a Dental Advisor determines that the submitted documentation does not support that the impacted tooth is symptomatic (requiring removal) and that neurovascular complication is likely if the entire impacted tooth is removed.
TOOTH RE-IMPLANTATION AND/OR STABILIZATION OF ACCIDENTALLY AVULSED OR DISPLACED TOOTH (D7270)
No frequency limitation
EXPOSURE OF AN UNERUPTED TOOTH (D7280)
Limited to 1 of Exposure of an unerupted tooth (D7280) per permanent tooth and per primary tooth per lifetime per lifetime.
Denied as MISREPORTED when reported by the same Dentist on the same date, on the same tooth as an extraction of impaction (D7111, D7210, D7220, D7230, D7240, D7241).
PLACEMENT OF DEVICE TO FACILITATE ERUPTION OF IMPACTED TOOTH (D7283)
Limited to 1 of Placement of device to facilitate eruption of impacted tooth (D7283) per permanent tooth and per primary tooth per lifetime per lifetime.
EXCISIONAL BIOPSY OF MINOR SALIVARY GLANDS (D7284)
No frequency limitation.

Denied as INTEGRAL when reported by the same Dentist in the same tooth/site and on the same date of service as an Extraction, Removal of an impacted tooth, Apicoectomy or Periradicular surgery. ***Situational approval may be allowed upon Second Review/Appeal with Dental Advisor Review with documentation of extenuating circumstances.**
TRANSSEPTAL FIBEROTOMY/SUPRA CRESTAL FIBEROTOMY, BY REPORT (D7291)
Limited to 1 of Transseptal fiberotomy (D7291) per permanent premolar tooth (#5-12, 21-28) per lifetime.
ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS - FOUR OR MORE TEETH OR TOOTH SPACES, PER QUADRANT (D7310)
No frequency limitation.
ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS - ONE TO THREE TEETH OR TOOTH SPACES, PER QUADRANT (D7311
Denied as INTEGRAL when reported alone or in conjunction with other services.
ALVEOLOPLASTY NOT IN CONJUNCTION WITH EXTRACTIONS - FOUR OR MORE TEETH OR TOOTH SPACES, PER QUADRANT (D7320)
ALVEOLOPLASTY NOT IN CONJUNCTION WITH EXTRACTIONS - ONE TO THREE TEETH OR TOOTH SPACES, PER QUADRANT (D7321)
No frequency limitation.
Denied as MISREPORTED INTEGRAL reported on the same day, same provider and same area as extractions (D7140, D7210, D7220, D7230, D7240, D7241, D7250).
VESTIBULOPLASTY - RIDGE EXTENSION (SECONDARY EPITHELIALIZATION) (D7340)
VESTIBULOPLASTY - RIDGE EXTENSION (INCLUDING SOFT TISSUE GRAFTS, MUSCLE REATTACHMENT, REVISION OF SOFT TISSUE ATTACHMENT AND MANAGEMENT OF HYPERTROPHIED AND HYPERPLASTIC TISSUE) (D7350)
No frequency limitation.
Denied as INTEGRAL when reported by the same Dentist on the same day, and same area as any periodontal surgical service (D4210-D4285)
EXCISION OF MALIGNANT TUMOR - LESION DIAMETER GREATER THAN 1.25 CM (D7450)
REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR - LESION DIAMETER UP TO 1.25 CM (D7451)
No frequency limitation.
Denied as INTEGRAL when reported by the same Dentist in the same tooth/site and on the same date of service as an Extraction, Removal of an impacted tooth, Apicoectomy or Periradicular surgery. ***Situational approval may be allowed upon Second Review/Appeal with Dental Advisor Review with documentation of extenuating circumstances.**
REMOVAL OF LATERAL EXOSTOSIS (MAXILLA OR MANDIBLE) (D7471)
REMOVAL OF TORUS PALATINUS (D7472)
REMOVAL OF TORUS MANDIBULARIS (D7473)
REDUCTION OF OSSEOUS TUBEROSITY (D7485)
No frequency limitation.
Denied as INTEGRAL when reported by the same Dentist in the same tooth/site and on the same date of service as an Osteoplasty - for orthognathic deformities (D7940), Osteotomy - mandibular rami (D7941), Osteotomy - mandibular rami with bone graft; includes obtaining the graft (D7943), Osteotomy - segmented or subapical (D7944), Osteotomy - body of mandible (D7945), Lefort i (maxilla - total) (D7946), Lefort I (maxilla - segmented) (D7947), Lefort II or Lefort III (osteoplasty of facial bones for midface hypoplasia or retrusion) - without bone graft (D7948), Lefort II or Lefort III - with bone graft (D7949).
MARSUPIALIZATION OF ODONTOGENIC CYST (D7509)
No frequency limitation
INCISION AND DRAINAGE OF ABSCESS - INTRAORAL SOFT TISSUE (D7510)
INCISION AND DRAINAGE OF ABSCESS – INTRAORAL SOFT TISSUE – COMPLICATED (INCLUDES DRAINAGE OF MULTIPLE FASCIAL SPACES) (D7511)

No frequency limitation
Denied as INTEGRAL when reported by the same Dentist on the same date, and the same area as any definitive Service (D1110 – D9999). ***Situational approval may be allowed upon Second Review/Appeal with Dental Advisor Review with documentation of extenuating circumstances.**
DIAGNOSTIC MATERIAL REQUIRED: Submission of written documentation must accompany the EDI/ADA Claim Form when reporting this service. Other chart materials may optionally be submitted and should corroborate clinically with the submitted x-rays for consideration during manual clinical review. **If specific rationale is provided explaining why x-ray(s) are not available (patient is pregnant, special needs, medical complication, etc.), the service may be referred to manual clinical review (Dental Advisor) in the absence of required materials.**
Denied as MISREPORTED if a Dental Advisor determines that the diagnostic materials do not show that the service planned (predetermination) or was completed (claim) meets the current CDT Current Dental Terminology descriptor of the code reported.
ALVEOLUS - CLOSED REDUCTION, MAY INCLUDE STABILIZATION OF TEETH (D7670)
ALVEOLUS - OPEN REDUCTION, MAY INCLUDE STABILIZATION OF TEETH (D7671)
ALVEOLUS - OPEN REDUCTION STABILIZATION OF TEETH (D7770)
ALVEOLUS, CLOSED REDUCTION STABILIZATION OF TEETH (D7771)
No frequency limitation
OCCLUSAL ORTHOTIC DEVICE, BY REPORT (D7880)
TMD RIDER ONLY: No frequency limitation.
PLACEMENT OF INTRA-SOCKET BIOLOGICAL DRESSING TO AID IN HEMOSTASIS OR CLOT STABILIZATION, PER SITE (D7922)
Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site (D7922) is commonly referred to as “treatment of “dry socket”” and common brand names for materials utilized includes Eugenol ®, GelFoam ®, SurgiCel ®, and BenaCel ®]
Denied as INTEGRAL when reported alone or in conjunction with other services.
OSSEOUS, OSTEOPERIOSTEAL, OR CARTILAGE GRAFT OF THE MANDIBLE OR MAXILLA - AUTOGENOUS OR NONAUTOGENOUS, BY REPORT (D7950)
No frequency limitation.
IMPLANT RIDER ONLY: Limited to 1 of Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla (D7950) and 1 of Bone graft at time of implant placement (D7953) per tooth/site per lifetime.
IMPLANT RIDER ONLY: Denied as NOT STANDARD OF DENTAL TREATMENT when reported for a Member Age 18 and younger. ***Situational approval may be allowed upon Second Review/Appeal with Dental Advisor Review with documentation of extenuating circumstances.**
DIAGNOSTIC MATERIALS REQUIRED: Submission of a pre-treatment, diagnostic x-ray and written documentation must accompany the EDI/ADA Claim Form when reporting this service. Written documentation must reasonably corroborate clinically with the submitted x-rays for consideration during manual clinical review. Other chart materials may optionally be submitted and should corroborate clinically with the submitted x-rays for consideration during manual clinical review. **If specific rationale is provided explaining why x-ray(s) are not available (patient is pregnant, special needs, medical complication, etc.), the service may be referred to manual clinical review (Dental Advisor) in the absence of required materials.**
Denied as MISREPORTED if a Dental Advisor determines that the submitted documentation does not support that the service planned (pre-estimation) or was completed (claim) meets the current CDT Current Dental Terminology descriptor of the code reported.
Denied as NOT STANDARD OF DENTAL TREATMENT when reported for replacement of a primary tooth (A-T) or third molar (1, 16, 17, 32).
SINUS AUGMENTATION WITH BONE OR BONE SUBSTITUTES VIA A LATERAL OPEN APPROACH (D7951)
SINUS AUGMENTATION VIA A VERTICAL APPROACH (D7952)

IMPLANT RIDER ONLY: Limited to 1 of Sinus augmentation (D7951 or D7952) per lifetime.
IMPLANT RIDER ONLY: Denied as NOT STANDARD OF DENTAL TREATMENT when reported for a Member Age 18 and younger. ***Situational approval may be allowed upon Second Review/Appeal with Dental Advisor Review with documentation of extenuating circumstances.**
BONE REPLACEMENT GRAFT FOR RIDGE PRESERVATION - PER SITE (D7953)
IMPLANT RIDER ONLY: Limited to 1 of Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla (D7950) and 1 of Bone graft at time of implant placement (D7953) per tooth/site per lifetime.
IMPLANT RIDER ONLY: Denied as NOT STANDARD OF DENTAL TREATMENT when reported for a Member Age 18 and younger. ***Situational approval may be allowed upon Second Review/Appeal with Dental Advisor Review with documentation of extenuating circumstances.**
DIAGNOSTIC MATERIALS REQUIRED: Submission of a pre-treatment, diagnostic x-ray and written documentation must accompany the EDI/ADA Claim Form when reporting this service. Written documentation must reasonably corroborate clinically with the submitted x-rays for consideration during manual clinical review. Other chart materials may optionally be submitted and should corroborate clinically with the submitted x-rays for consideration during manual clinical review. **If specific rationale is provided explaining why x-ray(s) are not available (patient is pregnant, special needs, medical complication, etc.), the service may be referred to manual clinical review (Dental Advisor) in the absence of required materials.**
Denied as MISREPORTED if a Dental Advisor determines that the submitted documentation does not support that the service planned (pre-estimation) or was completed (claim) meets the current CDT Current Dental Terminology descriptor of the code reported.
Denied as NOT STANDARD OF DENTAL TREATMENT when reported for replacement of a primary tooth (A-T) or third molar (1, 16, 17, 32).
BUCCAL/LABIAL FRENECTOMY (FRENULECTOMY) (D7961)
LINGUAL FRENECTOMY (FRENULECTOMY) (D7962)
FRENULOPLASTY (D7963)
No frequency limitation.
Denied as INTEGRAL when reported by the same Dentist, on the same tooth/site any periodontal surgical service (D4210-D4285). ***Situational approval may apply when the Frenulectomy/Frenuloplasty (D7961-D7963) is confirmed to be completed in a different area that the periodontal surgical service**
Frenuloplasty (D7963) denied as INTEGRAL when reported by the same Dentist on the same date of service and on the same site as Frenulectomy (D7951, D7962). ***Situational approval may apply when the Frenuloplasty (D7963) is confirmed to be completed in a different area that the Frenulectomy (D7961-D7962).**
EXCISION OF PERICORONAL GINGIVA (D7971)
No frequency limitation.
Denied as INTEGRAL when reported on the same date, by the same Dentist, on the same tooth/site as a restorative, endodontic, surgical periodontal, or oral surgery service (D2140-D2999, D3110-D3999, D4210-D4276, D7000-D7999). ***Situational approval may be allowed upon Second Review/Appeal with Dental Advisor Review with documentation of extenuating circumstances.**
SURGICAL REDUCTION OF FIBROUS TUBEROSITY (D7972)
No frequency limitation.
SURGICAL PLACEMENT: ZYGOMATIC IMPLANT (D7994)
IMPLANT RIDER ONLY: Limited to 1 of Surgical placement: Zygomatic implant (D7994) per site per lifetime.
IMPLANT RIDER ONLY: Denied as NOT STANDARD OF DENTAL TREATMENT when reported for a Member Age 18 and younger. ***Situational approval may be allowed upon Second Review/Appeal with Dental Advisor Review with documentation of extenuating circumstances.**
SYNTHETIC GRAFT - MANDIBLE OR FACIAL BONES, BY REPORT (D7995)
No frequency limitation.
DIAGNOSTIC MATERIALS REQUIRED: Submission of a pre-treatment, diagnostic x-ray and written documentation must accompany the EDI/ADA Claim Form when reporting this service. Written documentation must reasonably

corroborate clinically with the submitted x-rays for consideration during manual clinical review. Other chart materials may optionally be submitted and should corroborate clinically with the submitted x-rays for consideration during manual clinical review. **If specific rationale is provided explaining why x-ray(s) are not available (patient is pregnant, special needs, medical complication, etc.), the service may be referred to manual clinical review (Dental Advisor) in the absence of required materials.**
Denied as MISREPORTED if a Dental Advisor determines that the submitted documentation does not support that the service planned (pre-estimation) or was completed (claim) meets the current CDT Current Dental Terminology descriptor of the code reported.
Denied as NOT STANDARD OF DENTAL TREATMENT when reported for replacement of a primary tooth (A-T) or third molar (1, 16, 17, 32).
UNSPECIFIED ORAL SURGERY PROCEDURE, BY REPORT (D7999)
No frequency limitation.
Denied as MISREPORTED (GENERIC) when the service described has a specific and valid CDT code. Example:
Denied as INTEGRAL (GENERIC) when the service described has no specific and valid code because it is part of the Standard of Dental Treatment for another principal service (includes multi-step processes and individual dentist choices for what products and/or techniques that may be used). Examples: Aspiration of a cyst reported with another service, Bite block, Infection control (sterilization) - (including but not limited to all OSHA standard requirements), Phlebotomy/Venipuncture/Intravenous (IV) Access, Personal Protective Equipment (PPE), Supplies and materials (including but not limited to all disposables – Bibs, drapes, Cotton rolls, cotton pellets, Dri-Tips®, Dri-Aid®, Dri-Angle®,sponge/gauze squares, applicators, covers, etc.), Topical anesthestic (Oraquix, Hurricaine, Tetracaine®) (**D9210-D9215**)
Denied as MISREPORTED + INTEGRAL when the service described has a specific and valid code because it is part of the Standard of Dental Treatment for another principal service (includes multi-step processes and individual dentist choices for what products and/or techniques that may be used). Example: “Socket smoothing” or “bone removal” associated with extraction of 1-3 teeth (D7311), Cyst/Granuloma Removal/Excision (may involve a laser) (D7410, D7471), Collection and application of autologous blood concentrate product (Platelet rich plasma (PRP) or Plasma rich fibrin (PRF)) (D7921), Local anesthetic (Lidocaine®, Bupivacaine®, Marcaine®, Septocaine®) and modalities for administration (Viajet®) (**D9210-D9215**), Placement of intra-socket biological dressing (Treatment of “dry socket”) (Gelfoam®, Surgicel®, Collagen Plug) (**D7922**)
Denied as NOT COVERED (GENERIC) when the service described has no specific and valid code and describes a service that is not covered. Example: Aspiration of a cyst reported alone.
Denied as MISREPORTED + NOT COVERED when the service described has a specific and valid code and describes a service that is not covered.
Denied as MISREPORTED + IMPLANT RELATED (NO RIDER) when the service described has a specific and valid code and describes a service that is related to an implant.

ORTHODONTICS (D8010-D8999)

- Dental services that are routinely provided in conjunction with or as part of another procedure in accordance with accepted standards of dental practice are defined as integral by United Concordia Dental and excluded from coverage. Some dental services may be denied as integral when reported in the absence of another dental service (for example: local anesthesia) or denied as integral only when another more comprehensive dental service has been benefitted. Any benefit for any Orthodontic service per CDT code descriptor as reported is inclusive of all charges for work, materials, and supplies related to the procedure, and if reported separately, these services may be denied as integral. Participating dentists may not bill a patient for a service denied as integral.
- Dental services that are reported in a treatment sequence that is not appropriate in accordance with accepted standards of dental practice are defined as integral by United Concordia Dental and excluded from coverage (for

example: a crown reported on a date following an extraction benefitted on the same tooth). Participating dentists may not bill a patient for a service denied because it is reported in an inappropriate treatment sequence.

- Dental services that are misreported or that represent a procedure other than the one reported are excluded from coverage. Dental services should be reported in accordance with the nomenclature and descriptors defined in the current year American Dental Association's Current Dental Terminology (CDT) codebook. Participating dentists may not bill a patient for a service denied because it is misreported.
- Dental services must be dentally/medically necessary and meet accepted standards of dental practice, as defined by United Concordia, which requires any tooth or teeth to have acceptable prognosis and meet United Concordia's definition of dental/medical necessity for the reported code as defined by the current ADA Current Dental Terminology codebook. Dental services determined not to meet United Concordia's definition of dental/medical necessity are not billable to the patient by a participating dentist unless the dentist notifies the patient of his or her potential financial liability prior to treatment and the patient chooses to receive the treatment (financial agreement). Participating dentists should document such notification specifically (with the date, tooth number, service, potential financial liability, and signature of the patient) in the patient's record.
- Any services utilized for the treatment of temporomandibular joint disorders (TMD/TMJ) or for implant placement, restoration, or maintenance is excluded from coverage and denied as not covered unless benefits are specifically provided for under a TMD or Implant rider.

LIMITED ORTHODONTIC TREATMENT OF THE PRIMARY DENTITION (D8010)
LIMITED ORTHODONTIC TREATMENT OF THE TRANSITIONAL DENTITION (D8020)
LIMITED ORTHODONTIC TREATMENT OF THE ADOLESCENT DENTITION (D8030)
LIMITED ORTHODONTIC TREATMENT OF THE ADULT DENTITION (D8040)
No frequency limitation. Limited to dependent children under Age 19.
Benefit offset as INTEGRAL when reported by the same Dentist, as any allowed benefit paid for Removable appliance therapy (D8210), Fixed appliance therapy (D8220), or Orthodontic retention (D8680).
DIAGNOSTIC MATERIALS REQUIRED: Submission of the total treatment plan and total case fee, excluding diagnostics (this fee should include retention and case finishing procedures that should not be listed or billed separately), starting date of treatment ("banding" or placement of appliances date), and total length of anticipated treatment in months must accompany the EDI/ADA Claim Form when reporting this service.
COMPREHENSIVE ORTHODONTIC TREATMENT OF THE TRANSITIONAL DENTITION (D8070)
COMPREHENSIVE ORTHODONTIC TREATMENT OF THE ADOLESCENT DENTITION (D8080)
COMPREHENSIVE ORTHODONTIC TREATMENT OF THE ADULT DENTITION (D8090)
COMPREHENSIVE ORTHODONTIC TREATMENT ASSOCIATED WITH ORTHOGNATHIC SURGERY WHEN ADDITIONAL SURGICAL INTERVENTION IS PLANNED (D8091)
No frequency limitation. Limited to dependent children under Age 19.
Benefit offset as INTEGRAL when reported by the same Dentist, as any allowed benefit paid for Removable appliance therapy (D8210), Fixed appliance therapy (D8220), or Orthodontic retention (D8680).
DIAGNOSTIC MATERIALS REQUIRED: Submission of the total treatment plan and total case fee, excluding diagnostics (this fee should include retention and case finishing procedures that should not be listed or billed separately), starting date of treatment ("banding" or placement of appliances date), and total length of anticipated treatment in months must accompany the EDI/ADA Claim Form when reporting this service.
PERIODIC ORTHODONTIC TREATMENT VISIT (D8670)
PERIODIC ORTHODONTIC TREATMENT VISIT FOR COMPREHENSIVE TREATMENT ASSOCAITED WITH ORTHOGNATHIC SURGERY (D8671)
UTILIZED FOR MONTHLY OR QUARTERLY PAYMENTS FOR LIMITED/COMPREHENSIVE ORTHODONTIC TREATMENT BY UNITED CONCORDIA DENTAL
ORTHODONTIC RETENTION (REMOVAL OF APPLIANCES, CONSTRUCTION AND PLACEMENT OF RETAINER(S)) (D8680)
No frequency limitation. Limited to dependent children under Age 19.

Benefit denied as INTEGRAL when reported by the same Dentist, as any allowed benefit paid for Limited orthodontic treatment (D8010-D8040) or Comprehensive orthodontic treatment (D8070-D8091).

ADJUNCTIVE GENERAL SERVICE (D9110-D9999)

- Dental services that are routinely provided in conjunction with or as part of another procedure in accordance with accepted standards of dental practice are defined as integral by United Concordia Dental and excluded from coverage. Some dental services may be denied as integral when reported in the absence of another dental service (for example: local anesthesia) or denied as integral only when another more comprehensive dental service has been benefitted. Any benefit for any Adjunctive general service per CDT code descriptor as reported is inclusive of all charges for work, materials, and supplies related to the procedure, and if reported separately, these services may be denied as integral. Participating dentists may not bill a patient for a service denied as integral.
- Dental services that are reported in a treatment sequence that is not appropriate in accordance with accepted standards of dental practice are defined as integral by United Concordia Dental and excluded from coverage (for example: a crown reported on a date following an extraction benefitted on the same tooth). Participating dentists may not bill a patient for a service denied because it is reported in an inappropriate treatment sequence.
- Dental services that are misreported or that represent a procedure other than the one reported are excluded from coverage. Dental services should be reported in accordance with the nomenclature and descriptors defined in the current year American Dental Association's Current Dental Terminology (CDT) codebook. Participating dentists may not bill a patient for a service denied because it is misreported.
- Dental services must be dentally/medically necessary and meet accepted standards of dental practice, as defined by United Concordia, which requires any tooth or teeth to have acceptable prognosis and meet United Concordia's definition of dental/medical necessity for the reported code as defined by the current ADA Current Dental Terminology codebook. Dental services determined not to meet United Concordia's definition of dental/medical necessity are not billable to the patient by a participating dentist unless the dentist notifies the patient of his or her potential financial liability prior to treatment and the patient chooses to receive the treatment (financial agreement). Participating dentists should document such notification specifically (with the date, tooth number, service, potential financial liability, and signature of the patient) in the patient's record.
- Any services utilized for the treatment of temporomandibular joint disorders (TMD/TMJ) or for implant placement, restoration, or maintenance is excluded from coverage and denied as not covered unless benefits are specifically provided for under a TMD or Implant rider.

PALLIATIVE TREATMENT OF DENTAL PAIN - PER VISIT (D9110)
Limited to 2 of Palliative treatment (D9110) and/or Pulpal debridement (D3221) per 12 month period and 1 of Palliative treatment (D9110) or Pulpal debridement (D3221) per day.
Denied as MISREPORTED when reported by the same Dentist, on the same date of service as a definitive service (D1110-D1205, D1351-D3220, D3230-D8998, D9111-D9230, D9610, D9910, D9930-D9998)
Denied as MISREPORTED when reported by the same Dentist more than 1 per day.
LOCAL ANESTHESIA NOT IN CONJUNCTION WITH OPERATIVE OR SURGICAL PROCEDURES (D9210)
REGIONAL BLOCK ANESTHESIA (D9211)
TRIGEMINAL BLOCK (D9212)
Denied as INTEGRAL when reported alone or in conjunction with other services.
EVALUATION FOR MODERATE SEDATION, DEEP SEDATION OR GENERAL ANESTHESIA (D9219)
Denied as INTEGRAL when reported alone or in conjunction with other services.
ADMINISTRATION OF NITROUS OXIDE (D9230)
IN-OFFICE ADMINISTRATION OF MINIMAL SEDATION – SINGLE DRUG – ENTERAL (D9244)

AMINISTRATION OF DEEP SEDATION/GENERAL ANESTHESIA - FIRST 15 MINUTE INCREMENT, OR ANY PORTION THEREOF (D9222)
ADMINISTRATION OF DEEP SEDATION/GENERAL ANESTHESIA - EACH SUBSEQUENT 15 MINUTE INCREMENT OR ANY PORTION THEREOF (D9223)
ADMINISTRATION OF GENERAL ANESTHESIA WITH ADVANCED AIRWAY – FIRST 15 MINUTE INCREMENT, OR ANY PORTION THEREOF (D9224)
ADMINISTRATION OF GENERAL ANESTHESIA WITH ADVANCED AIRWAY – EACH SUBSEQUENT 15 MINUTE INCREMENT, OR ANY PORTION THEREOF (D9225)
ADMINISTRATION OF MODERATE SEDATION – INTRAVENOUS - FIRST 15 MINUTE INCREMENT OR ANY PORTION THEREOF (D9239)
ADMINISTRATION OF MODERATE SEDATION – INTRAVENOUS - EACH SUBSEQUENT 15 MINUTE INCREMENT OR ANY PORTION THEREOF (D9243)
ADMINISTRATION OF MODERATE SEDATION – ENTERAL (D9245)
ADMINISTRATION OF MODERATE SEDATION – NON-INTRAVENOUS PARENTERAL – FIRST 15 MINUTE INCREMENT, OR ANY PORTION THEREOF (D9246)
ADMINISTRATION OF MODERATE SEDATION – NON-INTRAVENOUS PARENTERAL – EACH SUBSEQUENT 15 MINUTE INCREMENT, OR ANY PORTION THEREOF (D9247)
Limited to 60 minutes of Deep sedation/General anesthesia (D9222/D9223) or Intravenous moderate (conscious) sedation/analgesia (D9239/D9243) per date of service.
Administration of deep sedation/general anesthesia or Administration of Moderate sedation – intravenous or Administration of general anesthesia with advanced airway - first 15 minute increment, or any portion thereof (D9222, D9239, D9224) may be updated to Administration of deep sedation/general anesthesia or Administration of Moderate sedation - intravenous or Administration of general anesthesia with advanced airway - each subsequent 15 minute increment, or any portion thereof (D9223, D9243, D9225) as necessary to meet the appropriate CDT Code per descriptor.
Administration of nitrous oxide (D9230) is denied as INTEGRAL when reported by the same Dentist on the same date as In-office administration of minimal sedation – single drug – enteral (D9244), Administration of moderate sedation – enteral (D9245), Administration of moderate sedation – non-intravenous parenteral (D9246, D9247), Administration of moderate sedation - intravenous (D9239, D9243), Administration of deep sedation/general anesthesia (D9222, D9223), or Administration of general anesthesia with advanced airway (D9224, D9225).
In-office administration of minimal sedation – single drug – enteral (D9244) is denied as INTEGRAL when reported by the same Dentist on the same date as Administration of moderate sedation – enteral (D9245), Administration of moderate sedation – non-intravenous parenteral (D9246, D9247), Administration of moderate sedation - intravenous (D9239, D9243), Administration of deep sedation/general anesthesia (D9222, D9223), or Administration of general anesthesia with advanced airway (D9224, D9225).
Administration of moderate sedation – enteral (D9245) is denied as INTEGRAL when reported by the same Dentist on the same date as Administration of moderate sedation – non-intravenous parenteral (D9246, D9247), Administration of moderate sedation - intravenous (D9239, D9243), Administration of deep sedation/general anesthesia (D9222, D9223), or Administration of general anesthesia with advanced airway (D9224, D9225).
Administration of moderate sedation – non-intravenous parenteral (D9246, D9247) is denied as INTEGRAL when reported by the same Dentist on the same date as Administration of moderate sedation - intravenous (D9239, D9243), Administration of deep sedation/general anesthesia (D9222, D9223), or Administration of general anesthesia with advanced airway (D9224, D9225).
Administration of moderate sedation - intravenous (D9239, D9243) is denied as INTEGRAL when reported by the same Dentist on the same date as Administration of deep sedation/general anesthesia (D9222, D9223), or Administration of general anesthesia with advanced airway (D9224, D9225).
Administration of deep sedation/general anesthesia (D9222, D9223) is denied as INTEGRAL when reported by the same Dentist on the same date as or Administration of general anesthesia with advanced airway (D9224, D9225).
Administration of nitrous oxide (D9230) and In-office administration of minimal sedation – single drug – enteral (D9244) are denied as NOT STANDARD OF DENTAL TREATMENT if the diagnostic materials do NOT show any indication that:

- The member is a pediatric patient (Member 12 years old or younger).
- The member (any age) has any type of intellectual disability, developmental delay, neuroatypical condition (Autism Spectrum Disorder, Sensory Sensitivity, and/or Behavioral Challenges - especially if agitation, aggression, or self-harm behaviors are noted).
- The member (any age) has any type of physical disability or limitation that impacts cooperation and safety for both the member and the dental team during planned/performed dental treatment.

Administration of moderate sedation – non-intravenous parenteral (D9245, D9246), Administration of deep sedation/General anesthesia (D9222, D9223), or Administration of moderate sedation - intravenous (D9239, D9243), or Administration of general anesthesia with advanced airway (D9224, D9225) are denied as NOT STANDARD OF DENTAL TREATMENT if the diagnostic materials do NOT show any indication that:

- The member is a pediatric patient (Member 12 years old or younger) with extensive dental treatment planned/performed for/on the same date of service: for example, 6+ teeth or at least one tooth in each quadrant requiring restorations (fillings, crowns), endodontic services (pulpectomy, root canal treatment), and/or oral surgery.
- The member (any age) has any type of intellectual disability, developmental delay, neuroatypical condition (Autism Spectrum Disorder, Sensory Sensitivity, and/or Behavioral Challenges - especially if agitation, aggression, or self-harm behaviors are noted).
- The member (any age) has any type of physical disability or limitation that impacts cooperation and safety for both the member and the dental team during planned/performed dental treatment.

Denied as MISREPORTED if a Dental Advisor determines that the diagnostic materials do not show that the service planned (predetermination) or was completed (claim) meets the current CDT Current Dental Terminology descriptor of the code reported.

Denied as NOT DENTALLY/MEDICALLY NECESSARY if a Dental Advisor determines that the diagnostic materials do NOT show any indication that:

- The patient (any age) has any type of intellectual disabilities, developmental delays, neuroatypical conditions (Autism Spectrum Disorder, Sensory Sensitivities, and/or Behavioral Challenges - especially if associated with agitation, aggression, or self-harm behaviors), or any Physical disability or limitation that impacts cooperation and safety for both the member and the dental team during planned/performed dental treatment.
- The patient (any age) has dental needs that Requiring Extensive Time and/or Manipulation planned/performed: These services may include: Implant Placement (D6010, D6012, D6040, D6050), Extraction/Impaction (D7210, D7220, D7230, D7240, D7241, D7251), Other Surgical Procedures (D7260, D7261, D7280), Vestibuloplasty (D7340, D7350), Excision of Bone Tissue (D7471, D7472, D7473, D7485), Surgical incision (D7560), Treatment of Closed Fractures (D7610-D7680), Treatment of Open Fractures (D7710-D7780), Reduction of Dislocation and Management of Other Temporomandibular Joint Dysfunctions (D7810-D7877), Other Repair Procedures (D7920, D7940-D7952, D7980-D7991, D7994, D7996) or other extensive treatment needs outside of treatment being completed in one visit exclusively for patient convenience (example: full mouth edentulation vs. 4 quads of scaling and root planing).
- Administration of nitrous oxide (D9230) and In-office administration of minimal sedation – single drug – enteral (D9244): The member is a pediatric patient (Member 12 years old or younger) with mild to moderate anxiety, phobia, any type of behavioral concerns that may impact cooperation or safety for both the member and the dental team, or extensive dental treatment planned/performed for/on the same date of service: for example, 6+ teeth or at least one tooth in each quadrant requiring restorations (fillings, crowns), endodontic services (pulpectomy, root canal treatment), and/or oral surgery.
- The patient is a pediatric patient (Member 12 years old or younger) with extensive dental treatment planned/performed: for example, 6+ teeth or at least one tooth in each quadrant requiring restorations (fillings, crowns), endodontic services (pulpectomy, root canal treatment), and/or oral surgery.
- The patient (any age) has any type of Neurological Conditions with Impaired Neurological Function: Patients with severe cerebral palsy, severe multiple sclerosis, or other neurological conditions that impact movement control, ability to cooperate, and potential for aspiration
- The patient (any age) has any type of Medical conditions limiting tolerance for procedures: Patients with heart conditions, respiratory problems, uncontrolled epilepsy or seizure disorders, uncontrolled bleeding disorders, or

other health issues might require GA/IV Sedation to minimize the stress on their bodies during long or complex procedures. There have been failed attempts at dental treatment with local anesthesia and/or Inhalation of Nitrous oxide-and/or Minimal or Moderate sedation.
CONSULTATION - DIAGNOSTIC SERVICE PROVIDED BY DENTIST OR PHYSICIAN OTHER THAN REQUESTING DENTIST OR PHYSICIAN (D9310)
Limited to 1 of Limited Evaluation Problem Focused (D0140) or Consultation (D9310) per 12-month period per billing provider (TIN).
CLEANING AND INSPECTION OF REMOVABLE COMPLETE DENTURE, MAXILLARY (D9932)
CLEANING AND INSPECTION OF REMOVABLE COMPLETE DENTURE, MANDIBULAR (D9933)
CLEANING AND INSPECTION OF REMOVABLE PARTIAL DENTURE, MAXILLARY (D9934)
CLEANING AND INSPECTION OF REMOVABLE PARTIAL DENTURE, MANDIBULAR (D9935)
Denied as INTEGRAL when reported alone or in conjunction with other services.
OCCLUSAL GUARD - HARD APPLIANCE, FULL ARCH (D9944)
OCCLUSAL GUARD - SOFT APPLIANCE, FULL ARCH (D9945)
OCCLUSAL GUARD - HARD APPLIANCE, PARTIAL ARCH (D9946)
OCCLUSAL GUARD RIDER ONLY: Limited to 1 of Occlusal guard (D9944, D9945, D9946) per 60 months for Members Age 22 and older.
TMD RIDER ONLY: No frequency limitation.
OCCLUSION ANALYSIS - MOUNTED CASE (D9950)
TMD RIDER ONLY: No frequency limitation.
OCCLUSAL ADJUSTMENT – LIMITED (D9951)
OCCLUSAL ADJUSTMENT – COMPLETE (D9952)
TMD RIDER ONLY: No frequency limitation.
Denied as INTEGRAL when reported by the same Dentist, on the same date of service as an Amalgam or Resin-based composite restoration (D2140-D2394) or Root canal treatment (D3230, D3240, D3310-D3330).
UNSPECIFIED ADJUNCTIVE PROCEDURE, BY REPORT D9999)
No frequency limitation
Denied as MISREPORTED (GENERIC) when the service described has a specific and valid CDT code. Example:
Denied as INTEGRAL (GENERIC) when the service described has no specific and valid code because it is part of the Standard of Dental Treatment for another principal service (includes multi-step processes and individual dentist choices for what products and/or techniques that may be used). Examples: Aspiration of a cyst reported with another service, Bite block, Infection control (sterilization) - (including but not limited to all OSHA standard requirements), Phlebotomy/Venipuncture/Intravenous (IV) Access, Personal Protective Equipment (PPE), Supplies and materials (including but not limited to all disposables – Bibs, drapes, Cotton rolls, cotton pellets, Dri-Tips®, Dri-Aid®, Dri-Angle®,sponge/gauze squares, applicators, covers, etc.), Topical anesthetic (Oraquix, Hurricaine, Tetracaine®) (D9210-D9215)
Denied as MISREPORTED + INTEGRAL when the service described has a specific and valid code because it is part of the Standard of Dental Treatment for another principal service (includes multi-step processes and individual dentist choices for what products and/or techniques that may be used). Example: “Socket smoothing” or “bone removal” associated with extraction of 1-3 teeth (D7311), Cyst/Granuloma Removal/Excision (may involve a laser) (D7410, D7471), Collection and application of autologous blood concentrate product (Platelet rich plasma (PRP) or Plasma rich fibrin (PRF)) (D7921), Local anesthetic (Lidocaine®, Bupivacaine®, Marcaine®, Septocaine®) and modalities for administration (Viajet®) (D9210-D9215), Placement of intra-socket biological dressing (Treatment of “dry socket”) (Gelfoam®, Surgicel®, Collagen Plug) (D7922)
Denied as NOT COVERED (GENERIC) when the service described has no specific and valid code and describes a service that is not covered. Example: Aspiration of a cyst reported alone.
Denied as MISREPORTED + NOT COVERED when the service described has a specific and valid code and describes a service that is not covered.
Denied as MISREPORTED + IMPLANT RELATED (NO RIDER) when the service described has a specific and valid code and describes a service that is related to an implant.