CareFirst
Family of health care plans

Part 12: Adjunctive General Services

Comprehensive Dental Reference Guide

Please use the Comprehensive Dental Reference Guide when preparing your claims and pre-treatment estimates for CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc., (collectively, "CareFirst"), CareFirst BlueCross BlueShield Medicare Advantage, The Dental Network, and the Federal Employee Program®.

- **CDT code descriptions**
- **Utilization review perspectives on clinical presentations appropriate for benefit allowance**
- **CareFirst-required documentation to allow for processing**
- **Identification of codes that require a clinical review by our staff of licensed dentists**

Selecting the most appropriate code to describe treatment rendered and providing required documentation streamlines the claims submission process.

These descriptions and directions are based on standard plan designs. Individual patient plans may vary. Verify benefits and eligibility for each patient before the appointment.

Current Dental Terminology (CDT) © American Dental Association (ADA). All rights reserved. There are important differences between CareFirst Dental's Processing Policies and Procedures and dental plan benefits and the processing policies and descriptors found in CDT.

CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. CareFirst BlueCross BlueShield Medicare Advantage is the shared business name of CareFirst Advantage, Inc. and CareFirst Advantage PPO, Inc. In the District of Columbia and Maryland, CareFirst MedPlus is the business name of First Care, Inc. In Virginia, CareFirst MedPlus is the business name of First Care, Inc. of Maryland (used in VA by: First Care, Inc.). CareFirst of Maryland, Inc., Group Hospitalization and Medical Services, Inc., CareFirst Advantage, Inc., CareFirst Advantage PPO, Inc., CareFirst BlueChoice, Inc., First Care, Inc., and The Dental Network, Inc. are independent licensees of the Blue Cross and Blue Shield Association. BLUE CROSS®, BLUE SHIELD®, the Cross and Shield Symbols, and Federal Employee Program® are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

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Adjunctive General: D9000–D9999

The information provided is based on general clinical policy and can vary for each patient's plan. Verify benefits and eligibility for each patient before the appointment, as there are differences among plans. The following information gives generalized clinical requirements and guidance for each CDT code.

Adjunctive General			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D9110	Palliative treatment of dental pain—minor procedure	This service is typically covered once per service date only, but there is no limit to the frequency of this service on different dates. This service is to treat dental pain and is a minor procedure not aligned with any other CDT code. The palliative treatment benefits will not be allowed if definitive services are performed on the same tooth on the same service date. However, this procedure is allowed on the same date as an exam, radiographs and preventive care.	No documentation is required.
D9120	Fixed partial denture sectioning	This procedure is for sectioning of one or more connections between pontics and/or abutments; some portion of the fixed prosthesis must remain intact and serviceable following sectioning; usually, extraction of an abutment tooth is involved, includes recontouring and polishing of the retained potions; teeth must be in functional occlusion; abutment teeth must have adequate bone support.	**Requires clinical review; pre-treatment estimate recommended.** Full-mouth series or panoramic and periapical radiograph; rationale or statement of medical necessity; tooth to be extracted or retained.
D9128	Photobiomodulation therapy—first 15 minute increment, or any portion thereof	Typically not covered.	n/a
D9129	Photobiomodulation therapy—each subsequent 15 minute increment, or any portion thereof	Typically not covered.	n/a

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Adjunctive General			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D9130	Temporomandibular joint dysfunction—non-invasive physical therapies	Typically not covered.	n/a
D9210	Local anesthesia not in conjunction with operative or surgical procedures	This procedure is considered inclusive to any operative or surgical procedures and cannot be billed separately.	n/a
D9211	Regional block anesthesia	This procedure is considered inclusive to any operative or surgical procedures and cannot be billed separately.	n/a
D9212	Trigeminal division block anesthesia	This procedure is considered inclusive to any operative or surgical procedures and cannot be billed separately.	n/a
D9215	Local anesthesia in conjunction with operative or surgical procedures	This procedure is considered inclusive to any operative or surgical procedures and cannot be billed separately.	n/a
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	Benefits for this service are typically allowed up to two per benefit period in addition to the two exams allowed per benefit period, but not on the same service date as the evaluation.	No documentation is required.
D9222	Administration of deep sedation/general anesthesia—first 15 minute increment, or any portion thereof	Deep sedation or general anesthesia is covered along with the following services and is billed in increments of 15 minutes. Endo: 3410, D3421, D3425, D3426, D3450, D3920 Perio: D4260, D4261, D4263, D4264, D4270, D4271, D4273, D4277, D4278 Implant surgery: D6010, D6100, D6103 Oral surgery: D7220, D7230, D7240, D7241, D7250, D7260, D7261, D7280, D7282, D7283, D7290, D7310, D7320, D7311, D7321, D7340, D7350, D7440, D7441, D7450, D7451, D7460, D7461, D746, D7471, D7472, D7473, D7485, D7490, D7510, D7520, D7511, D74=521, D7953, D7970, D7971, D7972 D7210 is covered if there are multiple surgical extractions. It requires a statement of medical necessity along with that claim.	**Requires clinical review; pre-treatment estimate recommended.** For multiple D7210 procedures on the same service date ONLY, submit a narrative with the rationale and description of medical necessity. All other allowed services do not require the submission of additional information.

*Check patient eligibility including age and frequency limitations for each service.

Adjunctive General			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D9223	Administration of deep sedation/general anesthesia—each subsequent 15 minute increment, or any portion thereof	Deep sedation or general anesthesia is covered along with the following services and is billed in increments of 15 minutes. Endo: 3410, D3421, D3425, D3426, D3450, D3920 Perio: D4260, D4261, D4263, D4264, D4270, D4271, D4273, D4277, D4278 Implant surgery: D6010, D6100, D6103 Oral surgery: D7220, D7230, D7240, D7241, D7250, D7260, D7261, D7280, D7282, D7283, D7290, D7310, D7320, D7311, D7321, D7340, D7350, D7440, D7441, D7450, D7451, D7460, D7461, D746, D7471, D7472, D7473, D7485, D7490, D7510, D7520, D7511, D74=521, D7953, D7970, D7971, D7972 D7210 is covered if there are multiple surgical extractions. It requires a statement of medical necessity along with that claim.	**Requires clinical review; pre-treatment estimate recommended.** For multiple D7210 procedures on the same service date ONLY, submit a narrative with the rationale and description of medical necessity. All other allowed services do not require the submission of additional information.
D9224	Administration of general anesthesia with advanced airway—first 15 minute increment, or any portion thereof	Typically not covered.	n/a
D9225	Administration of general anesthesia with advanced airway—each subsequent 15 minute increment, or any portion thereof	Typically not covered.	n/a
D9230	Administration of nitrous oxide	Typically not covered.	n/a
D9239	Administration of moderate sedation - intravenous—first 15 minute increment, or any portion thereof	Intravenous moderate (conscious) sedation or analgesia is covered along with the following services and is billed in increments of 15 minutes. Endo: 3410, D3421, D3425, D3426, D3450, D3920 Perio: D4260, D4261, D4263, D4264, D4270, D4271, D4273, D4277, D4278 Implant surgery: D6010, D6100, D6103 Oral surgery: D7220, D7230, D7240, D7241, D7250, D7260, D7261, D7280, D7282, D7283, D7290, D7310, D7320, D7311, D7321, D7340, D7350, D7440, D7441, D7450, D7451, D7460, D7461, D746, D7471, D7472, D7473, D7485, D7490, D7510, D7520, D7511, D74521, D7953, D7970, D7971, D7972 D7210 is covered if there are multiple surgical extractions and requires a statement of medical necessity along with that claim.	**Requires clinical review; pre-treatment estimate recommended.** For multiple D7210 procedures on the same service date ONLY, submit a narrative with the rationale and description of medical necessity. All other allowed services do not require the submission of additional information.

*Check patient eligibility including age and frequency limitations for each service.

Adjunctive General			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D9243	Administration of moderate sedation - intravenous—each subsequent 15 minute increment, or any portion thereof	Intravenous moderate (conscious) sedation or analgesia is covered along with the following services and is billed in increments of 15 minutes. Endo: 3410, D3421, D3425, D3426, D3450, D3920 Perio: D4260, D4261, D4263, D4264, D4270, D4271, D4273, D4277, D4278 Implant surgery: D6010, D6100, D6103 Oral surgery: D7220, D7230, D7240, D7241, D7250, D7260, D7261, D7280, D7282, D7283, D7290, D7310, D7320, D7311, D7321, D7340, D7350, D7440, D7441, D7450, D7451, D7460, D7461, D746, D7471, D7472, D7473, D7485, D7490, D7510, D7520, D7511, D74521, D7953, D7970, D7971, D7972 D7210 is covered if there are multiple surgical extractions and requires a statement of medical necessity along with that claim.	**Requires clinical review; pre-treatment estimate recommended.** For multiple D7210 procedures on the same service date ONLY, submit a narrative with the rationale and description of medical necessity. All other allowed services do not require the submission of additional information.
D9244	In-office administration of minimal sedation—single drug—enteral	Typically not covered.	n/a
D9245	Administration of moderate sedation—enteral	Typically not covered.	n/a
D9246	Administration of moderate sedation—non-intravenous parenteral—first 15 minute increment, or any portion thereof	Typically not covered.	n/a
D9247	Administration of moderate sedation - non-intravenous parenteral—each subsequent 15 minute increment, or any portion thereof	Typically not covered.	n/a
D9310	Consultation—diagnostic service provided by a dentist or physician other than requesting a dentist or physician	The benefit for consultation is limited to one consultation per dentist per condition. Benefit allowed if billed by a specialist. If being billed by a general dentist, a narrative is required.	**Requires clinical review; pre-treatment estimate recommended.** For general dentists, submit a statement of medical necessity and a description of the condition evaluated.
D9311	Consultation with a medical healthcare professional	This service is considered inclusive to the diagnostic evaluation or exam performed by the dentist who submits the claim.	n/a
D9420	Hospital or ambulatory surgical center call	Benefits are available for children up to age 19 when billed by a Pediatric Dentist, for all other providers and with a statement of medical necessity attached.	**Requires clinical review; pre-treatment estimate recommended.** For dentists other than pediatric dentists, submit a statement of medical necessity.

*Check patient eligibility including age and frequency limitations for each service.

Adjunctive General			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D9430	Office visit for observation (during regularly scheduled hours)—no other services performed	This procedure is considered inclusive to the other services performed for which the follow-up observation was completed.	n/a
D9440	Office visit—after regularly scheduled hours	Typically not covered.	n/a
D9450	Case presentation, detailed and extensive treatment planning	This procedure is considered inclusive to the definitive services performed.	n/a
D9610	Therapeutic parenteral drug, single administration	Typically not covered.	n/a
D9612	Therapeutic parenteral drugs, two or more administrations, different medications	Typically not covered.	n/a
D9613	Infiltration of sustained-release therapeutic drug—single or multiple sites	This procedure is only allowed for long-acting local anesthetics and D7230, D7240 and D7241. Other general anesthesia and conscious sedation procedures can be performed on the same service date (D9222, D9223, D9230, D9239, D9242 and D9248).	No documentation is required.
D9630	Drugs or medicaments dispensed in the office for home use	Typically not covered.	n/a
D9910	Application of desensitizing medicament	Typically not covered.	n/a
D9911	Application of desensitizing resin for cervical and/or root surface, per tooth	This benefit is typically allowed as required but not if billed with a fluoride treatment, other composite restorations or definitive services on the same tooth.	No documentation is required.
D9912	Pre-visit patient screening	This procedure is considered inclusive to the other services performed.	n/a
D9913	Administration of neuromodulators	This procedure is typically not covered under the dental benefit plan.	n/a
D9914	Administration of dermal fillers	This procedure is typically not covered under the dental benefit plan.	n/a
D9920	Behavior management, by report	Benefits for this procedure are available for children over the age of 24 months and under the age of 13. The submission requires a statement of medical necessity. If anesthesia services are performed, then this service will be considered inclusive.	**Requires clinical review; pre-treatment estimate recommended.** Submit a statement of medical necessity detailing the actions that need to be taken to manage the patient.
D9930	Treatment of complications (post-surgical)—unusual circumstances, by report	Benefits for this procedure are typically considered inclusive to the surgical procedures performed that day; if this is billed on a separate service date, a narrative describing the complications and treatment plan is required.	**Requires clinical review; pre-treatment estimate recommended.** Submit a statement of medical necessity detailing the issues surrounding the complication and the treatment that was required to manage the case.

*Check patient eligibility including age and frequency limitations for each service.

Adjunctive General			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D9932	Cleaning and inspection of removable complete denture, maxillary	Benefits are typically limited to two per benefit period. This procedure only applies to patients who are fully edentulous in the mandibular arch.	No documentation is required.
D9933	Cleaning and inspection of removable complete denture, mandibular	Benefits are typically limited to two per benefit period. This procedure only applies to patients who are fully edentulous in the mandibular arch.	No documentation is required.
D9934	Cleaning and inspection of removable partial denture, maxillary	Benefits are typically limited to two per benefit period. This procedure only applies to patients who are partially edentulous in the maxillary arch.	No documentation is required.
D9935	Cleaning and inspection of removable partial denture, mandibular	Benefits are typically limited to two per benefit period; this procedure only applies to patients who are partially edentulous in the mandibular arch.	No documentation is required.
D9936	Cleaning and inspection of occlusal guard—per appliance	Typically not covered.	n/a
D9938	Fabrication of a custom removable clear plastic temporary aesthetic appliance	Benefits are not typically available as this service is considered inclusive to the primary prosthodontic service.	n/a
D9939	Placement of a custom removable clear plastic temporary aesthetic appliance	This service is not typically covered.	n/a
D9941	Fabrication of athletic mouthguard	Benefits are typically not covered but are dependent upon the patient's contract.	n/a
D9942	Repair and/or reline of an occlusal guard	Benefits are typically not covered but are dependent upon the patient's contract.	n/a
D9943	Occlusal guard adjustment	Benefits are typically not covered but are dependent upon the patient's contract, and if covered, they are not available until six months after the appliance was delivered.	n/a
D9944	Occlusal guard—hard appliance, full arch	Benefits are typically not covered but are dependent upon the patient's contract.	n/a.
D9945	Occlusal guard—soft appliance, full arch	Benefits are typically not covered but are dependent upon the patient's contract.	n/a
D9946	Occlusal guard—hard appliance, partial arch	Benefits are typically not covered but are dependent upon the patient's contract.	n/a.
D9947	Custom sleep apnea appliance fabrication and placement	Custom sleep apnea appliance fabrication and placement is considered a medical service. It may be billed under the patient's medical plan. It may or may not be covered.	n/a
D9948	Adjustment of custom sleep apnea appliance	Adjustment of custom sleep apnea appliances is considered a medical service. It may be billed under the patient's medical plan. It may or may not be covered.	**n/a**

*Check patient eligibility including age and frequency limitations for each service.

Adjunctive General			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D9949	Repair of custom sleep apnea appliance	Repair of custom sleep apnea appliances is considered a medical service. It may be billed under the patient's medical plan. It may or may not be covered.	n/a
D9950	Occlusion analysis—mounted case	Typically not covered.	n/a
D9951	Occlusal adjustment—limited	This benefit is typically limited to once every five years and covered in conjunction with periodontal treatment. It should be billed on a "per visit" basis rather than "per tooth." It will only be paid once, even if billed on the same service date with multiple teeth. If submitted with endodontic or restorative or fixed prosthodontic procedures, it is considered inclusive to the primary treatment.	**Requires clinical review; pre-treatment estimate recommended.** Submit a Full-mouth series or panoramic radiographs, occlusal analysis, perio charting and history, and (for non-ACA policies) a letter of medical necessity.
D9952	Occlusal adjustment—complete	This benefit is typically limited to once every five years and covered in conjunction with periodontal treatment. It should be billed on a "per visit" basis rather than "per tooth." It will only be paid once, even if billed on the same service date with multiple teeth. If submitted with endodontic or restorative or fixed prosthodontic procedures, it is considered inclusive to the primary treatment.	**Requires clinical review; pre-treatment estimate recommended.** Submit a Full-mouth series or panoramic radiographs, occlusal analysis, perio charting and history, and (for non-ACA policies) a letter of medical necessity.
D9953	Reline custom sleep apnea appliance (indirect)	Relining a custom sleep apnea appliance is considered a medical service. It may be billed under the patient's medical plan. It may or may not be covered.	n/a
D9954	Fabrication and delivery of oral appliance therapy (OAT) morning repositioning device	Fabrication and delivery of OAT morning repositioning devices is considered a medical service. It may be billed under the patient's medical plan. It may or may not be covered.	n/a
D9955	Oral appliance therapy (OAT) titration visit	OAT titration visit is considered a medical service. It may be billed under the patient's medical plan. It may or may not be covered.	n/a
D9956	Administration of home sleep apnea test	Administration of a home sleep apnea test is considered a medical service. It may be billed under the patient's medical plan. It may or may not be covered.	n/a
D9957	Screening for sleep-related breathing disorders	Screening for sleep-related breathing disorders is considered a medical service. It may be billed under the patient's medical plan. It may or may not be covered.	n/a
D9959	Unspecified sleep apnea services procedure, by report	Benefits are typically not covered under the dental benefit but may be covered under the medical plan.	n/a
D9961	Duplicate/copy patient records	Typically not covered.	n/a
D9970	Enamel microabrasion	Typically not covered.	n/a
D9971	Odontoplasty 1-2 teeth, includes removal of enamel projections	Typically not covered.	n/a

*Check patient eligibility including age and frequency limitations for each service.

Adjunctive General			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D9972	External bleaching—per arch—performed in the office	Typically not covered.	n/a
D9973	External bleaching-per tooth	Typically not covered.	n/a
D9974	Internal bleaching-per tooth	Typically not covered.	n/a
D9975	External bleaching for home application, per arch, includes materials and fabrication of custom trays.	Typically not covered.	n/a
D9985	Sales Tax	Typically not covered.	n/a
D9986	Missed appointment	Typically not covered.	n/a
D9987	Cancelled appointment	Typically not covered.	n/a
D9990	Certified translation or sign-language services—per visit	Typically not covered.	n/a
D9991	Dental case management-addressing appointment compliance barriers	Typically not covered.	n/a
D9992	Dental case management—care coordination	This procedure is considered inclusive to the examination.	n/a
D9993	Dental case management—motivational interviewing	This procedure is considered inclusive to the examination.	n/a
D9994	Dental case management—patient education to improve oral health literacy	Typically not covered.	n/a
D9995	Teledentistry—synchronous; real-time encounter	This service can be submitted only with a D0140 or D0170 on the same service date to allow for remote, real-time, video or audio examination of a problem-focused issue. There is no additional fee other than that for the examination, but this code allows for tracking the remote teledentistry visit.	n/a
D9996	Teledentistry—asynchronous; information stored and forwarded to a dentist for subsequent review	Examinations with an asynchronous relay of information are not covered benefits.	n/a
D9997	Dental Case Management—Patients with special healthcare needs	Typically not covered.	n/a
D9999	Unspecified procedure, by report	Treatment that is not accurately described by an existing procedure code can be submitted with D9999, along with the details of the procedure performed.	**Requires clinical review; pre-treatment estimate recommended.** A detailed narrative that describes the treatment provided, the rationale for the treatment, and any appropriate imaging or treatment notes are needed to review for benefits.

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