Thank You
For Being A
Delta Dental Participating Dentist

Delta Dental of Iowa is pleased to present you with this Dentist Office Manual. We hope it is a useful source of information for you and your office staff. Please take the opportunity to review the Manual in its entirety. We look forward to serving you in the future and continuing our mutually supportive relationship.
# Table of Contents

## SECTION 1: INTRODUCTION

- Manual Overview .................................................................................................................................1-1
- History of Delta Dental .................................................................................................................................1-2
- Delta Dental of Iowa Overview ....................................................................................................................1-3
- Delta Dental of Iowa Mission and Value Statement ...............................................................................1-3
- Delta Dental of Iowa Foundation .............................................................................................................1-4
- Delta Dental of Iowa Roles and Responsibilities .........................................................................................1-5
- Important Definitions ......................................................................................................................................1-8

## SECTION 2: PROGRAMS AND PARTICIPATION

- Delta Dental Programs ...............................................................................................................................2-1
- Delta Dental Premier* ..................................................................................................................................2-1
- Delta Dental PPOsm .......................................................................................................................................2-2
- DeltaCare .......................................................................................................................................................2-3
- DeltaUSA .........................................................................................................................................................2-3
- hawk-i Dental Program .................................................................................................................................2-3
- Federal Government Programs (FGP) .............................................................................................................2-4
- Dentist Participation .......................................................................................................................................2-5
- Credentialing ...................................................................................................................................................2-8
- Locum Tenens ..................................................................................................................................................2-9
- Dentist Terminates Participating Agreement .................................................................................................2-10
- Delta Dental of Iowa Terminates Participating Agreement ............................................................................2-10
- Appealing a Termination Notice .....................................................................................................................2-11

## SECTION 3: VALUE-ADDED SERVICES

- Value-Added Services Program .......................................................................................................................3-1
- Direct Deposit ................................................................................................................................................3-1
- Electronic Attachments .................................................................................................................................3-2
- Dendalytics .....................................................................................................................................................3-2
- Brighter Scheduler .........................................................................................................................................3-2
- Delta Dental Vision Discount ..........................................................................................................................3-3
- Language Translation Services ..........................................................................................................................3-3
# Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life Interpretation, Inc.</td>
<td>3-4</td>
</tr>
<tr>
<td>Medix Dental®</td>
<td>3-5</td>
</tr>
<tr>
<td>Automated External Defibrillators (AED)</td>
<td>3-5</td>
</tr>
<tr>
<td>Professional Solutions</td>
<td>3-6</td>
</tr>
<tr>
<td>Emergency Kits and Products</td>
<td>3-7</td>
</tr>
<tr>
<td>Dental Publications</td>
<td>3-8</td>
</tr>
<tr>
<td>Electronic Remittance Advice (ERA)</td>
<td>3-8</td>
</tr>
<tr>
<td>Stepping Stones to Success</td>
<td>3-9</td>
</tr>
<tr>
<td>Xylitol Products</td>
<td>3-9</td>
</tr>
<tr>
<td>Spore Testing</td>
<td>3-9</td>
</tr>
<tr>
<td>Smart Smiles</td>
<td>3-10</td>
</tr>
<tr>
<td>Individual Dental Product Brochures</td>
<td>3-10</td>
</tr>
<tr>
<td>Additional Value-Added Services</td>
<td>3-10</td>
</tr>
<tr>
<td><strong>SECTION 4: HIPAA</strong></td>
<td></td>
</tr>
<tr>
<td>HIPAA</td>
<td>4-1</td>
</tr>
<tr>
<td>HIPAA Questions and Answers</td>
<td>4-5</td>
</tr>
<tr>
<td>HIPAA Informational Web Sites</td>
<td>4-6</td>
</tr>
<tr>
<td><strong>SECTION 5: SERVICE CONTACTS</strong></td>
<td></td>
</tr>
<tr>
<td>Customer Service</td>
<td>5-1</td>
</tr>
<tr>
<td>Fax-Back Feature</td>
<td>5-2</td>
</tr>
<tr>
<td>Eligibility and Claim Status</td>
<td>5-2</td>
</tr>
<tr>
<td>Delta Dental of Iowa Web Site</td>
<td>5-2</td>
</tr>
<tr>
<td>Delta Dental National Web Site</td>
<td>5-3</td>
</tr>
<tr>
<td>Paper Claims Mailing Address</td>
<td>5-4</td>
</tr>
<tr>
<td>Written Inquiries</td>
<td>5-4</td>
</tr>
<tr>
<td>Request a Review or Appeal of a Denied Claim or Pre-Treatment Estimate</td>
<td>5-5</td>
</tr>
<tr>
<td>Professional Relations Staff</td>
<td>5-5</td>
</tr>
<tr>
<td>Other Delta Dental Member Companies</td>
<td>5-6</td>
</tr>
</tbody>
</table>
## SECTION 6: CLAIM FILING

- Claim Filing: 6-1
- Electronic Claims Submissions: 6-1
- Remarks on Claims: 6-2
- Fax-In Claims: 6-2
- Real-Time Claims and Predeterminations/Prior Authorizations: 6-3
- Recoupment of Overpayment: 6-3
- Radiograph Return Policy: 6-3
- Electronic Attachments: 6-4
- Direct Deposit: 6-4
- Electronic Remittance Advice (ERA): 6-5
- Claim Filing Procedures: 6-5
- Dentist Connection Claim Filing Features: 6-6
- Request a Review or Appeal of a Denied Claim or Pre-Treatment Estimate: 6-7
- Filing a Dental Claim: 6-7
- Subscriber / Patient Information: 6-8
- Record of Services Provided: 6-9
- Predetermination/Prior Authorization: 6-11
- Dentist Information: 6-12
- Ancillary Claim/Treatment Information: 6-12
- Orthodontic Services: 6-13
- Orthodontic Predetermination/Prior Authorization: 6-14
- *Hawk/-Orthodontic Services*: 6-16
- Duplicate Claims: 6-16
- Infection Control: 6-16
- Claim Filing Tips: 6-16
- Fraud: 6-18

## SECTION 7: ELIGIBILITY AND BENEFITS

- Eligibility: 7-1
- Work in Progress: 7-1
- Benefits: 7-1
- Benefit Coverage Descriptions and Designs: 7-2
- Evidence-Based Dentistry: 7-3
## Table of Contents

Small Group Businesses and Individual Policies ......................................................... 7-4

*hawk-i* Program ........................................................................................................... 7-6

### SECTION 8: COORDINATION OF BENEFITS

Coordination of Benefits ............................................................................................... 8-1
Primary Coverage ............................................................................................................ 8-1
Divorce or Separation .................................................................................................... 8-2
Remarriage - If No Divorce Decree ............................................................................... 8-2
General COB Rules ........................................................................................................ 8-2
Dual Delta Dental ............................................................................................................ 8-3
COB and the Maximum Plan Allowance ...................................................................... 8-3
Non-Duplication of Benefits ......................................................................................... 8-4
Medicaid ....................................................................................................................... 8-4

*hawk-i* Dental Program ............................................................................................. 8-4
Dental Wellness Plan (DWP) ......................................................................................... 8-5
Help Determining Order of Benefits ........................................................................... 8-5

### SECTION 9: PROCEDURES AND PROCESSING POLICIES

Procedures and Processing Policies ............................................................................. 9-1
Delta Dental of Iowa’s Responsibility ........................................................................... 9-1
In-Office Audit ................................................................................................................ 9-1
Dental Necessity and Appropriateness ......................................................................... 9-1
Patient Record Keeping ................................................................................................ 9-2
Request a Review or Appeal of a Denied Claim or Pre-Treatment Estimate .................. 9-4
Delta Dental Processing Policies ................................................................................ 9-8
Dentist Handbook Preamble ........................................................................................ 9-9
Dentist Handbook ........................................................................................................ 9-10

### SECTION 10: MISCELLANEOUS

Miscellaneous Section .................................................................................................. 10-1
Introduction

Manual Overview
This Manual is a reference guide for dental offices contracting with Delta Dental of Iowa (DDIA). The Manual is divided into the following sections:

- Introduction -- summary of Delta Dental’s history and an overview of DDIA’s mission and values, along with DDIA’s public benefit efforts and a list of terms and definitions;

- Programs and Participation -- overview of Delta Dental’s programs and dentist’s network participation;

- Value-Added Services -- details about DDIA’s Value-Added Services Program for Participating Dentists;

- HIPAA -- information regarding the Health Insurance Portability and Accountability Act of 1996, including questions and answers;

- Service Contacts -- a guide for accessing customer service assistance from Delta Dental of Iowa and other Delta Dental member companies;

- Claim Filing -- a general explanation of claim filing guidelines, including claim and attachment submission options, radiograph return policy and claim filing tips;

- Eligibility and Benefits -- information about Covered Person’s eligibility and dental coverage;

- Coordination of Benefits -- an overview of coordination of benefits and determination of primary payer for Covered Persons with more than one dental benefits plan;

- Procedures and Processing Policies -- a handbook of standardized processing policies used by all Delta Dental member companies;

- Miscellaneous -- a section for dental offices to keep important DDIA correspondence.
Delta Dental Makes Dental Care Available and Affordable

History of Delta Dental
Delta Dental of Iowa is one of 39 independent dental service organizations (Delta Dental member companies) that conduct business in all 50 states, the District of Columbia and Puerto Rico. These service organizations are all members of Delta Dental Plans Association (DDPA); whose mission is to help improve the overall oral health of the nation by making dental care more available and affordable to the public through the expansion of dental benefits programs. This mission is accomplished through Delta Dental member companies’ partnerships with their dentists and customers, resulting in real solutions to oral health care, with a focus on prevention.

Delta Dental is the Nation's Largest Dental Benefits Carrier
Delta Dental is the nation's largest, most experienced dental benefits company. Made up of independent, affiliated member companies, Delta Dental is a not-for-profit organization. We offer a nationwide dental benefits program for a wide range of groups and individuals. Delta Dental member companies administer programs that provide enrollees with quality, cost-effective dental benefits.

Today, Delta Dental serves more than 129,000 groups nationwide with dental insurance and provides dental coverage to over 73 million* people.

The Delta Dental Premier® panel of dentists is the country’s most extensive dentist network and contracts with over 152,000* dentists practicing in more than 356,000 dentist locations.

Delta Dental PPOsm (Preferred Provider Organization) has over 102,000* contracted dentists practicing in more than 282,000 dentist locations.

*DDPA Fact Sheet - September 2016

Delta Dental is a Not-for-Profit Dental Service Corporation
Delta Dental of Iowa Overview
Delta Dental of Iowa (DDIA) is a not-for-profit dental service corporation that administers prepaid dental benefit programs for employer groups and individuals. DDIA was sponsored and supported by the Iowa Dental Association (IDA) in 1970 to provide professional dental benefits coverage.

DDIA is the largest and most experienced provider of dental benefits in the state of Iowa and has focused on dental benefits for over 45 years.

Through hard work, excellent service, cost controls, community involvement and an overall commitment in delivering affordable oral health care to Iowans, Delta Dental is recognized as the dental coverage leader in Iowa.

Delta Dental of Iowa Mission and Value Statement

MISSION
We are dedicated to improving the health and smiles of the people we serve.

VALUE STATEMENT

**Improve Lives:** We improve people’s lives with our products and services. We give back to our communities. We believe in making a difference.

**One Team:** We are one team. We value collaboration and respect diverse perspectives to find the best outcome for the entire organization and our customers.

**Embrace Change:** We embrace change with a spirit of curiosity and adaptability to identify opportunities. We are willing to take appropriate risks. We learn from our experiences, find solutions and achieve results.

**Exceptional Quality Service:** We create exceptional customer experiences by continually focusing on delivering high quality service.

**Leadership at All Levels:** We are empowered to take initiative and make decisions that serve our customers. We take pride and ownership in our work, showing leadership in our daily activities and contributions.

**Bring Smiles:** We bring smiles to our co-workers, customers, business partners and providers by building long-lasting relationships as well as bringing a spirit of fun to our work.
Introduction

**Delta Dental of Iowa Foundation**

In 2008, Delta Dental of Iowa (DDIA) established the Delta Dental of Iowa Foundation. The Foundation consists of thirteen board members and is a non-profit 501 (c)(3) supporting organization. The Foundation works with a variety of statewide oral health stakeholders to invest in public benefit programs that improve access to care, prevention, education and research to support the Foundation’s 2020 strategic goals:

Every Iowa child age 0-12, living in a household with an income below 300 percent of the federal poverty level, will be cavity-free.

Every Iowa nursing home resident and homebound elderly person will have access to oral health care.

**FIND (Fulfilling Iowa’s Need for Dentists) Project**

**Loan Repayment Award** - The loan repayment award provides $50,000 over a three-year period, or up to $100,000 over a five-year period, for the repayment of educational debt for dentists who agree to practice in a designated dental shortage area and devote at least 35 percent of their practice to Medicaid, Dental Wellness Plan, elderly, disabled, and other underserved patients. More information about the FIND project can be found at www.iowafindproject.com.

**Free Dental Care Provided**

**Iowa Mission of Mercy** - Delta Dental of Iowa Foundation is a major sponsor of the Iowa Mission of Mercy (IMOM) event. IMOM is a two-day event that serves patients seeking dental care at no cost. Throughout the two-day event, hundreds of dentists, hygienists and other volunteers, including Delta Dental of Iowa employees, come together to assist Iowans in need.

**Dentist Recruitment to Rural, Underserved communities**

**The University of Iowa College of Dentistry** - A collaboration between the DDIA Foundation and The University of Iowa College of Dentistry has resulted in the Iowa Practice Opportunities Coordinator position. This position manages recruitment of dentists to rural, underserved communities throughout the state and help match Iowa’s dental graduates with open practice sites. The coordinator
works with local and statewide organizations to identify communities seeking a
dentist and facilitate placement.

Educational Oral Health Kits for Children

Smart Smiles - The Smart Smiles kit includes an educator’s guide and curriculum
which includes a tooth model with floss and large toothbrush, a DVD, CD and age
appropriate books about oral health. The kits assist in educating children about the
importance of their teeth and the value of good oral health. These kits are available
for loan or purchase as well as through multiple community-based organizations. To
borrow or buy a kit, contact Delta Dental of Iowa’s Public Benefit Program at 515-261-
5500 or 800-544-0718.

Grant Funding Programs

Grants for Oral Health Projects - The Delta Dental of Iowa Foundation mission is to
support and improve the oral health of Iowans. The Foundation supports projects by
funding:

• Oral health education and prevention
• Community water fluoridation
• Access to care for underserved children
• Access to care for the homebound elderly and nursing home residents

Funding is provided to 501(c)3 organizations across Iowa.

Additional Funding

General Contributions - The Delta Dental of Iowa Foundation reviews grant requests
for larger, long-term projects on an ongoing basis throughout the year. Funded
projects are intended to be larger in scope (regional or statewide) and broader in
reach in order to improve the oral health care of all Iowans.

Delta Dental of Iowa Roles and Responsibilities

DDIA Board of Directors - DDIA is governed by a Board of Directors. Iowa
Participating Dentists make up one-third of the Board. The other two-thirds of the
Board of Directors are public representatives.
Dental Director - The Dental Director is an Iowa licensed dentist and is responsible for dental policies and programs, new product design and development, marketing, professional claim review and all relations with Iowa dentists.

Director of Professional Relations - The Director of Professional Relations leads Delta Dental's professional relations team, which incorporates provider contracting, office visits, communication, education, credentialing, provider operations and provider data management.

Professional Relations Representatives - The Professional Relations Representatives are responsible for maintaining ongoing network development and relationship building with dentists. The Professional Relations Representatives help manage various network initiatives, in addition to the training of dental office staff about Delta Dental. If you would like to schedule an office visit with the Professional Relations Representative, please call Professional Relations at 515-261-5500 or 800-544-0718 or e-mail provrelations@deltadentalia.com.

Utilization Review Coordinator - The Utilization Review Coordinator manages activities regarding focused review of claims to ensure dental necessity and appropriateness and prevention of fraud and abuse. The Utilization Review Coordinator performs dental office audits and educates dental offices of proper code reporting. The Coordinator also maintains and ensures compliance with processing policies.

Professional Relations Coordinators - Professional Relations Coordinators are responsible for DDIA’s dentist network contracting, credentialing processes and provider data management. They respond to participation inquiries and are accountable for communicating important information to Participating Dentists. In addition, Professional Relations Coordinators assist offices with tax identification changes, address changes, claim filing questions and acts as a liaison between the participating dentist and other Delta Dental member companies.

Customer Service Representatives - Customer Service Representatives answer phone inquiries, process claims and respond to written correspondence. Their role is to assist dental offices and customers who need help with a variety of issues such as checking eligibility, benefits and claim status. All Customer Service
Representatives participate in extensive training before they answer phone calls. Many of the representatives have prior dental background and are trained in dental terminology, insurance terminology and customer service skills. Phone calls are monitored to ensure Customer Service Representatives are providing superior service to customers.

**Claim Review Specialists** - The Claim Review Specialists work closely with Dentist Consultants and the Dental Director to ensure claims are processed according to the Covered Person’s dental benefits and claim procedures and processing policies. They answer questions which arise regarding claims review and processing.

**DDIA Professional Advisory Group** - DDIA has a Professional Advisory Group that meets periodically to discuss items of interest to Iowa dentists. The committee includes dentist representatives from all disciplines of dentistry and dental office staff. This group meets with the Dental Director and DDIA staff.

The Professional Advisory Group provides a unique opportunity for dentists to have direct input to DDIA. If you would like additional information or would like a specific topic discussed by the group, contact Professional Relations at 515-261-5500 or 800-544-0718 or e-mail provrelations@deltadentalia.com.

**Provider Appeals Committee** - The Provider Appeals Committee is appointed by the Delta Dental of Iowa Chair of the Board of Directors with the approval of the Board of Directors, as referenced in the Uniform Regulations, to act as a provider review body to Delta Dental of Iowa on matters concerning the participation status of Participating Dentists as defined in the Delta Dental of Iowa Uniform Regulations (Section 23). The Provider Appeals Committee provides prompt, fair, and impartial hearings to Participating Dentists in many different kinds of disputes of participation status regarding, but not limited to, credentialing, utilization review, and quality management matters. The primary function of the Provider Appeals Committee is to hear appeals from Participating Dentists whose contracts with Delta Dental of Iowa have been served with a Notice of Termination for Cause.
Please note this Committee does not review claim processing appeals. For more information about Notice of Terminations, please refer to the Programs and Participation section of this Manual. For directions on how to file an appeal on a denied claim, refer to the Procedures and Processing Policies section of this manual.

**Important Terms and Definitions**

The following are a list of frequently used terms and definitions to assist you in understanding the information provided in this Manual and to better understand a Covered Person’s dental benefits when corresponding with DDIA.

**Allowance/Allowed Amount**
The total dollar amount allowed for a specific dental service or procedure, including the amounts payable by the Covered Person (i.e., Deductibles, Copayments and Coinsurance), under the payment arrangement stipulated by the specific dental plan or discount program of the Covered Person, determined as specified in the Agreement signed by the Participating Dentist.

**Alternate/Alternative Benefit**
When there are alternative or optional methods of treatment that are equally effective, benefits will be provided for the less complex and/or less expensive professionally accepted procedure that restores and maintains the teeth and supporting structures. An Alternate Benefit determination is not intended to reflect negatively on the dentist’s treatment plan or to recommend which treatment should be provided. The dentist and Covered Person should discuss and decide the course of treatment. If the Alternate Benefit procedure allowance and the Maximum Plan Allowance (MPA), or the PPO Fee Schedule as the case may be, of the treatment performed is billable to the Covered Person.

**Approved Amount**
The total fee a participating dentist agrees to accept as payment in full for a procedure. It includes both the Delta Dental allowance and the patient responsibility. Participating dentists agree not to collect from the patient any difference between the approved amount and their actual fee for the procedure.
Benefits Certificate
A document that contains a general explanation of the benefits and related provisions of the dental benefit program. Also known as a Summary Plan Description (SPD).

Benefit Period
The Benefit Period is either a calendar year or a fiscal year. A calendar year begins on January 1 and ends on December 31. A fiscal year begins on a specific date and ends 12 months later.

Billed Charge
The Billed Charge is the amount the dentist bills for a specific dental service or procedure.

Copayment
A Copayment is a specified amount, rather than a percentage, that a Covered Person pays. It may be applicable after a Deductible or in lieu of a Deductible.

Coinsurance
Coinsurance is the percentage of expenses the Covered Person pays for Covered Services after the Deductible is met, if applicable.

Contractholder
A Contractholder is an individual, sole proprietorship, partnership, limited liability company, corporation, association, group or other legal entity that has contracted with Delta Dental for a dental insurance plan or the administration of a dental plan.

Contract Maximum
Most DDIA contracts with Contractholders have a maximum limit on the amount of benefits payable in a Benefit Period.

Covered Charge
The Covered Charge is a charge for a dental procedure that is a covered benefit under the Covered Person’s policy.
**Covered Person**
A Covered Person is any dental patient eligible for dental benefits under a dental program that is insured or administered by Delta Dental (or by a Delta Dental Member Company).

**Covered Services**
Covered services are dental services to which a Covered Person is eligible as a result of being insured by, or included under a dental plan administered by, Delta Dental (or by a Delta Dental Member Company).

**Deductible**
A Deductible is the fixed amount the Covered Person pays for Covered Services before payment of benefits begin. The Deductible usually applies each Benefit Period unless it is a lifetime Deductible.

**Delta Dental Member Company**
Delta Dental Member Company is a company that is an active member or affiliate member of Delta Dental Plans Association, as defined in the Delta Dental Plans Association Bylaws.

**Denied/Deny**
If the fee for a procedure or service is denied, the procedure or service is not a benefit of the patient’s coverage and the approved amount is collectible from the patient.

**Dependents**
Family members covered under the Subscriber’s contract are referred to as Dependents.

**Disallow/Disallowed**
If the fee for a service is disallowed, reimbursement for the service was either included as part of a payment of a more global service provided or paid as an alternative benefit by Delta Dental; and / or the service is still within the time frame for which it should be warranted by the Participating Dentist. Disallowed fees are not collectible from the patient by a participating dentist.
Lifetime Maximum
Some DDIA contracts have a lifetime maximum in addition to the regular Benefit Period contract Maximum. The most common Lifetime Maximum is for orthodontic services.

Maximum Plan Allowance
Delta Dental Premier® Participating Dentists agree to accept as payment in full the lesser of the Maximum Plan Allowance (MPA) or the Billed Charge for Covered Services rendered. The MPA is the amount which Delta Dental establishes as its maximum allowable fee under the Delta Dental Premier® program.

Non-Participating Dentist
A Non-Participating Dentist is a dentist who has not entered into an Agreement with Delta Dental.

Maximum Out-Of-Pocket
Maximum Out-Of-Pocket is the maximum amount the plan member pays per Benefit Period for certain Covered Services for Deductible and Member Coinsurance.

Participating Dentist
A Participating Dentist is a dentist who holds a current license to practice dentistry under Chapter 153, Code of Iowa, with an office located in the State of Iowa, who has entered into an Agreement with Delta Dental.

PPO Fee Schedule
Delta Dental PPOsm Participating Dentists agree to accept as payment in full the lesser of the PPO Fee Schedule or the Billed Charge for Covered Services rendered. The Delta Dental PPO Fee Schedule is the maximum allowable fee under the Delta Dental PPO program.

Subscriber
The Subscriber is the Covered Person whose name the coverage is written in.

Summary Plan Description (SPD)
A document that contains a general explanation of the benefits and related provisions of the dental benefit program. Also known as a Benefits Certificate.
Waiting Period
The Waiting Period is the amount of time a Covered Person must wait before certain benefits are available for dental benefits coverage.
Delta Dental Programs
The success of Delta Dental of Iowa (DDIA) is tied to our supportive relationship with the dentists of Iowa. More than ninety percent of Iowa dentists participate in the Delta Dental Premier® network. This relationship enables us to successfully market DDIA and the network of Participating Dentists as part of an individual’s or employer’s health care package.

Dentists interested in participating with DDIA or with questions regarding participation should contact Professional Relations at 515-261-5500 or 800-544-0718 or e-mail provrelations@deltadentalia.com.

There are three types of dental benefit programs provided by Delta Dental. They are:

- **Delta Dental Premier®** - traditional fee-for-service
- **Delta Dental PPOsm** - preferred provider organization
- **DeltaCare** - dental health maintenance organization

Traditional Fee-For Service Network

Delta Dental Premier®
Delta Dental Premier® is Delta Dental’s traditional fee-for-service program in which dentists agree to participate by signing a Participating Dentist’s agreement. In Iowa, the traditional fee-for-service program represents the majority of DDIA’s business. However, in response to demand in the marketplace, the PPO program is becoming more prevalent in Iowa. A dentist who participates in his or her local Delta Dental member company Delta Dental Premier® network automatically participates in the Delta Dental Premier® network with DeltaUSA of other Delta Dental member companies (e.g. Delta Dental of California, Delta Dental of Minnesota, etc.). See DeltaUSA coverage later in this section.

Delta Dental Premier® Participating Dentists are held to the lesser of the Billed Charge or the Delta Dental Maximum Plan Allowance (MPA) for Covered Services. Participating Dentists receive payment directly from Delta Dental and are listed in the Delta Dental Premier® local and national Participating Dentist directories. For
self-funded plans, the Covered Person is responsible for any applicable Copayment, Coinsurance, Deductible, Non-Covered Services and amounts not payable due to excess of the Contract Maximum, Waiting Periods, frequency limitations and deductibles up to the Premier allowed amount. For insured plans, the Covered Person is responsible for any applicable Copayment, Coinsurance, Deductible, Non-Covered Services and amounts not payable due to excess of the Contract Maximum, Waiting Periods and frequency limitations.

**Preferred provider Organization Network**

**Delta Dental PPO™**
Delta Dental PPO™ is Delta Dental’s preferred provider organization program. A Delta Dental Premier® Participating Dentist has the option of also participating in the PPO network. Participation in the Delta Dental Premier® network is not affected by participation or non-participation with PPO. Dentists interested in joining the PPO network sign a supplemental agreement. A Participating Dentist who participates in his or her local Delta Dental member company Delta Dental PPO™ network automatically participates in the Delta Dental PPO™ network with DeltaUSA of other Delta Dental member companies (e.g. Delta Dental of California, Delta Dental of Minnesota, etc.). See Delta Dental national coverage later in this section.

When a Covered Person has PPO coverage and visits a PPO Participating Dentist, the dentist is held to the lesser of the Billed Charge or the PPO fee for Covered Services. Dentists who sign this supplemental agreement are listed in the PPO local and national Participating Dentist directories. Covered Persons with PPO coverage may go to a dentist of their choice, but may have a larger out-of-pocket expense if they go to a Non-Participating PPO dentist. For self-funded plans, the Covered Person is responsible for any applicable PPO Copayment, Coinsurance, Deductible, Non-Covered Services and amounts not payable due to excess of the Contract Maximum, Waiting Periods, frequency limitations and deductibles up to the PPO Allowed Amount. For insured plans, the Covered Person is responsible for any applicable PPO Copayment, Coinsurance, Deductible, Non-Covered Services and amounts not payable due to excess of the Contract Maximum, Waiting Periods and frequency limitations.
DeltaCare
DeltaCare is Delta Dental’s dental health maintenance organization (DHMO) program.

National Delta Dental Coverage

DeltaUSA
DeltaUSA (also known as Delta Dental national coverage) is a Delta Dental Plans Association national accounts program. It is designed to provide quality, uniform dental benefits to employers with employees located in more than one state who desire claims administration and services from a single site. DeltaUSA programs allow Covered Persons to receive the full value of a dentist’s participation with Delta Dental, even if their employer group is headquartered in another state.

For Covered Persons who have DeltaUSA, complete the claim form and submit it directly to the Delta Dental member company administering that particular group. The reimbursement for this national business is the same as you receive for your local Delta Dental of Iowa business.

Delta Dental member companies deliver three types of dental benefit programs (described previously in this section) on a national basis through DeltaUSA. They are Delta Dental Premier®, Delta Dental PPOsm and DeltaCare USA. As previously mentioned, dentists who participate in their local Delta Dental networks also participate with DeltaUSA of other Delta Dental member companies (e.g. Delta Dental of California, Delta Dental of Minnesota, etc.).

Iowa CHIP Program

hawk-i Dental Program
The Healthy and Well Kids in Iowa (hawk-i) program is the government subsidized CHIP program of Iowa and utilizes the Delta Dental Premier® network and reimbursement methodology for dental services except for orthodontic services.

There is a separate non-branded Delta Dental hawk-i orthodontic network created to provide treatment to hawk-i Covered persons for medically necessary orthodontic cases. All orthodontic services requires a predetermination/prior authorization before treatment begins. Although you may participate in the Delta
Dental Premier® network, you must sign a separate hawk-i Orthodontic Services Agreement if you wish to participate in the hawk-i orthodontic provider panel. More information regarding the hawk-i Program can be found in the Eligibility and Benefits section of this manual. Please contact Professional Relations at 800-544-0718 if you would like additional information regarding participation in the hawk-i orthodontic network.

There is no dental benefit coverage if a hawk-i Covered Person receives services from a Non-Participating Dentist.

Delta Dental of California administers the Federal Government Programs

Federal Government Programs (FGP)
The Federal Government Programs, which is a division of Delta Dental of California, administers four different Federal Programs. The five different programs are outlined below:

Delta Dental Legion/TRDP Network
The TRICARE Retiree Dental Program (TRDP) will end December 31, 2018. Dental coverage for military retirees and their families will be offered under the Federal Employees Dental and Vision Insurance Program (FEDVIP).

Federal Employees Dental and Vision Program (FEDVIP)
Federal employees and annuitants (retirees) are eligible for the FEDVIP program. Delta Dental offers coverage in the FEDVIP with two plan options available for your patients. Delta Dental Premier Providers are considered out-of-network for FEDVIP. Both our Delta Dental Legion and PPO networks are considered in-network. To become a Legion provider, please send a Legion contract request to FSPS@delta.org. If you are interested in becoming a PPO provider, please contact your local Delta Dental plan to inquire and make changes to your information/status.

Veterans Affairs Dental Insurance Program (VADIP)
The Veterans Affairs Dental Insurance Program (VADIP) is a program established under the US Department of Veterans Affairs. There are an estimated 7.4 million eligible for the program. Delta Dental of California is one of two carriers that
enrollees can choose from and is a voluntary program. The VADIP utilizes the Delta Dental PPO network and there are three tiers of coverage plans that enrollees can select - the Standard Plan, the Enhanced Plan or the Comprehensive Plan. For more information, contact Federal Services at Delta Dental of California at 888-838-8737 or access the web site at www.deltadentalvadip.org.

Public Health Services Active Duty Dental Program (PHS ADDP)
The PHS ADDP is a federally funded dental program for the active duty officers of the Commissioned Corps of the U.S. Public Health Service. Commissioned Corps officers are highly trained public health professionals who work in one of several health fields. Dependents of these officers are not included under this program. The PHS ADDP program utilizes the Delta Dental Premier® network. For more information, contact Federal Services at Delta Dental of California at 888-838-8737.

Office of the Comptroller of Currency (OCC)
Delta Dental of California’s Federal Government programs administers the dental benefits for the Office of Comptroller of Currency (OCC) for active and retired employees of the OCC and the Office of Financial Research (OFR) and their families. They have two coverage options which is Delta Dental PPO or DeltaCare USA. For more information, contact Federal Services at Delta Dental of California at 888-838-8737.

Responsibilities of Participating Dentists

**Dentist Participation**
When a dentist signs the Delta Dental Participating Dentist’s Agreement, he or she agrees to:

- abide by Delta Dental’s rules, regulations, Uniform Regulations and this Dentist Office Manual, including Delta Dental’s incorrect payment policy of deducting from future payments as outlined in Section 7 of the Uniform Regulations;
- not require Delta Dental Covered Persons to prepay any portion of Covered Services except the Copayment, Coinsurance and Deductible;
- accept from Delta Dental (or from a Delta Dental member company, as the case may be) as payment in full for Covered Services rendered to Covered Persons the lesser of: (i) the Delta Dental Maximum Plan Allowance (MPA) (or Delta Dental PPOsm Fee), or (ii) Participating Dentist’s fees for such Covered Services;
• not bill the Covered Persons for the balance, if any, between Participating Dentist’s fees for such Covered Services and the Maximum Plan Allowance (MPA) (or Delta Dental PPOsm Fee); provided, however, that the Participating Dentist may bill the Covered Person for Covered Services: (i) up to the MPA (or Delta Dental PPOsm Fee) for amounts not payable due to excess of the Contract Maximum, Waiting Periods, frequency limitations or Deductibles for Covered Persons receiving dental benefits under a self-funded dental plan administered by Delta Dental or any other Delta Dental Member Company; and (ii) for any Copayment, Coinsurance or Deductibles, all in accordance with the Delta Dental Uniform Regulations and other rules and regulations;

• furnish Delta Dental of Iowa credentialing information by completing a Professional Application and Credentialing Form when requested;

• file claims for completed services to Delta Dental within 365 days of the date-of-service and include all documents necessary to review, process and finalize the claim. Documentation includes, but is not limited to, clinical rationale/narrative, radiographs, periodontal chart, patient’s treatment record, coordination of benefits information, as applicable. If the claim is not received and finalized within this time period, the claim may be disallowed as the Participating Dentist’s responsibility and not billable to the Covered Person;

• follow Delta Dental’s processing policies and claim filing guidelines;

• when required, provide information and patient office records for the purpose of conducting reviews and/or in-office audits;

• furnish services that meet Delta Dental’s criteria for dental necessity and dental appropriateness of care as defined in the Delta Dental of Iowa Uniform Regulations;

• comply with Occupational Safety and Health Administration (OSHA) requirements and Centers for Disease Control (CDC) infection control guidelines;

• conduct business in accordance with the principles and ethics of the American Dental Association (ADA) and Iowa Dental Board (IDB);

• comply with all applicable state and federal laws and regulations (e.g. Health Insurance Portability and Accountability Act (HIPAA)).

• Check the program exclusion status of individuals and entities prior to entering into employment or contractual relationships. Provider agrees to check the HHS-OIG website (http://exclusions.oig.hhs.gov/ or https://oig.hhs.gov/exclusions/index.asp) by the name of any individual or entity for their exclusion status before the Provider hires or enters into any contractual relationship with the person or entity. In addition, Provider agrees to check the
HHS-OIG website monthly to capture exclusions and reinstatements that have occurred since the last search. Provider must report to Delta Dental of Iowa any exclusion information discovered through such service.

Delta Dental is generally prohibited from paying for any items or services furnished, ordered, or prescribed by excluded individuals or entities. This payment ban applies to any items or services reimbursable under the government program that are furnished by an excluded individual or entity, and extends to (1) all methods of reimbursement, whether payment results from itemized claims, cost reports, fee schedules, or a prospective payment system, (2) payment for administrative or management services not directly related to patient care, but that are a necessary component of providing items and services to government program members, when those payments are reported on a cost report or are otherwise payable by the government program; and (3) payment to cover an excluded individual’s salary, expenses or fringe benefits, regardless of whether they provide direct patient care, when those payments are reported on a cost report or are otherwise payable by government program. In addition, no government payments can be made for any items or services directed or prescribed by an excluded physician or other authorized person when the individual or entity furnishing the services either knew or should have known of the exclusion. This prohibition applies even when the government payment itself is made to another provider, practitioner or supplier that is not excluded. See 42 C.F.R. § 1001.1901(b).

Benefits of Participation

The following are benefits of being a Delta Dental Participating Dentist:

- Delta Dental pays you directly, reducing collection problems;
- includes network participation in Delta Dental national coverage;
- increase and maintain your patient base by publishing your name in Participating Dentist directories;
- access to the Value-Added Services Program for Participating Dentists (refer to the Value-Added Services section for additional information);
- partnership with the largest, most experienced and recognized dental benefits carrier in Iowa;
• access to Delta Dental’s Professional Relations Representative for in-office visits to assist in answering questions regarding dentist participation, claims processing policies, attachment requirements, coding issues and other areas of concern;
• invitation to attend educational seminars hosted by Delta Dental of Iowa
• receive informational and educational communications regularly, including Participating Dentist newsletters.

Credentialing is a Requirement of Participation

Credentialing
Participating Dentists need to complete a credentialing form at least every three years. This is a requirement of participation in the Delta Dental networks.

Only aggregate information is provided to groups regarding the credentialing process. All individual responses are strictly confidential.

DDIA Participating Dentists agree to the following credentialing elements:

• accurately and thoroughly complete the Professional Application & Credentialing Form as requested;
• have an active state issued dental license;
• provide the Federal DEA license, if applicable;
• have adequate malpractice liability coverage and provide a copy of the liability declaration page;
• disclose any licensing board actions, malpractice claims and other adverse personal background information;
• comply with Centers for Disease Control (CDC) infection control guidelines.
• provide a copy of certification of specialty training or education, if applicable;
• provide a professional work history or curriculum vitae with explanation for any gaps in work history; complete and provide the federally mandated ownership control form from the owner of the business; complete and provide W-9 form with the business name and tax identification number.

DDIA will only backdate network participation 30 days prior to the date that all required credentialing and signed contract information is received.
Notify Professional Relations immediately of any changes in your credentialing elements at 515-261-5500 or 800-544-0718 or e-mail provrelations@deltadentalia.com.

Temporary Practicing Dentists

Locum Tenens
Locum tenens is a term used to describe a person who temporarily fulfills the duties of another. If you utilize a locum tenens dentist and they treat Delta Dental Covered Person’s, it is imperative the temporary dentist completes a Professional Application and Credentialing form and signs a Delta Dental Participating Dentist’s Agreement. If the temporary dentist chooses not to participate with Delta Dental, the payment will be sent to the Subscriber and the Covered Person’s benefits may be lesser for seeing a Non-Participating Dentist. It is misrepresentation and a form of fraud to submit claims of a treating locum tenens dentist under the name of another dentist.

Please contact Professional Relations at 515-261-5500 or 800-544-0718 or e-mail provrelations@deltadentalia.com for participating information for a locum tenens dentist practicing in your office.

Terminating Participating Agreement

Dentist Terminates Participating Agreement
In order to terminate from any of the Delta Dental networks, it is necessary to send your notice in writing.

Delta Dental Premier®
A dentist may terminate the Delta Dental Premier® Participating Dentist’s Agreement by giving at least sixty (60) days written notice to Delta Dental by certified mail, return receipt requested. DDIA will send a letter of acknowledgment to the dentist confirming the termination effective date. DDIA may notify Covered Persons of the dentist’s network termination. The dentist should also inform Covered Persons when there is a termination of the Delta Dental Premier® Participating Dentist’s Agreement.
Delta Dental PPO℠
A dentist may terminate participation in the Delta Dental PPO℠ network without affecting participation in the Delta Dental Premier® network, by giving at least sixty (60) days written notice to Delta Dental by certified mail, return receipt requested. DDIA will send a letter of acknowledgment to the dentist confirming the termination effective date. DDIA may notify Delta Dental Covered Persons with PPO coverage of the dentist’s network termination. The dentist should also inform PPO Covered Persons when there is a termination of the Delta Dental PPO℠ Agreement.

DDIA Terminates Participating Agreement
Notices of Termination; Other Notices
Any notice of termination (“Notice of Termination”) required or permitted to be given to a Participating Dentist under the Uniform Regulations shall be in writing and shall be deemed given when delivered personally, placed in the U.S. mail (postage prepaid) and sent certified or registered, return receipt requested, or delivered to a recognized overnight courier service for next day delivery (delivery charges prepaid), and addressed to the Participating Dentist at the address set forth on the Participating Dentist’s Agreement, or to such other address for Notices of Termination as provided in writing to Delta Dental by the Participating Dentist. Any other notices to Participating Dentist under the Uniform Regulations shall be effective as of the date set forth in such notice upon placing the notice in the U.S. mail (postage prepaid) addressed to the Participating Dentist at the address set forth on the Participating Dentist’s Agreement, or to such other address for such notices as provided in writing to Delta Dental by the Participating Dentist.

Termination without Cause
Delta Dental may terminate a Participating Dentist’s Delta Dental Premier® and/or Delta Dental PPO℠ Agreement without cause at any time by sending a Notice of Termination, which termination will be effective sixty (60) days or more after the date of such Notice of Termination, as designated in the Notice of Termination.

Termination For Cause
Delta Dental may terminate a Participating Dentist’s Agreement if Participating Dentist breaches or violates any of the provisions of the Participating Dentist’s Agreement or these Uniform Regulations, Participating Dentist’s license to practice dentistry issued by the IDB is suspended or terminated, other sanctions issued by the IDB, lack of adherence to published national clinical dental standards, or Participating
Dentist’s conduct is determined by Delta Dental to be unprofessional and/or such conduct could be detrimental to Delta Dental, its Contract holders, or Covered Persons.

Any such termination shall be effective on the date designated by Delta Dental in the Notice of Termination (which may be immediate), as determined by Delta Dental. The Notice of Termination will state the reasons for such termination and that the Participating Dentist has a right to request a hearing on the termination.

Appealing a Termination Notice
A Participating Dentist may appeal a termination of participation for cause as set forth in the Uniform Regulations.
Value-Added Services Program
Delta Dental of Iowa (DDIA) recognizes the value of Participating Dentists. In appreciation, DDIA has developed a Value-Added Services Program that includes exclusive product discounts, educational materials and other valuable business services. The following pages outline some of the Value-Added Services available to Participating Dentists.

Automatic Deposits in Your Bank Account

Direct Deposit
DDIA can automatically deposit your claim payments directly into your designated bank account - whether you file paper or electronic claims. Choosing Direct Deposit will avoid the hassle of paper check processing and mail time of paper checks.

You can choose to receive an e-mail which prompts you to access the secure Dentist Connection on DDIA’s web site to retrieve your Remittance Advices (RAs).

DDIA is offering a $50 bonus for Iowa participating network dental offices that sign up for Direct Deposit. The incentive is per office and/or Tax Identification Number (TIN) and must be the first time the office has signed up for Direct Deposit.

Sign up for Direct Deposit is quick and easy. You may sign-up online for Direct Deposit on the Dentist Connection of DDIA’s web site at www.deltadentalia.com. You may also contact Professional Relations for additional information at 515-261-5500 or 800-544-0718 or e-mail provrelations@deltadentalia.com.

Additionally, at the time of Direct Deposit sign-up, you can also opt to receive Delta Dental National EFT/ERA. By selecting this option, you are enrolling to receive direct deposits from all Delta Dental member companies and retrieve your RAs from a single site without needing to fill out duplicate paperwork with each Delta Dental.

To receive the $50 incentive, you must complete the Direct Deposit bonus form. The form can be found on the Value-Added Services section on the Dentist Connection of DDIA’s web site. Upon verification of Direct Deposit usage, a check
will be mailed to your office. Please note you may terminate direct deposit anytime if you are dissatisfied. However, you are only eligible once for the $50 bonus if you decide to re-enroll at a later date.

**NEA FastAttach™ Savings**

**Electronic Attachments**
If you do not currently have the capability of sending scanned radiographs or other electronic attachments and would like information about National Electronic Attachment Inc.’s (NEA) FastAttach™ software, please contact NEA at 800-782-5150 ext. 2 or visit www.welcometonea.com to learn more about how this software provides dental offices the capability of sending digitized radiographs and attachments in support of electronic claims. NEA’s Payer ID number is 080001. DDIA and NEA have partnered to offer Participating Dentists special savings. Contact NEA directly for current discount information.

**Web-based Tool to Improve Oral Health Outcomes**

**Dentalytics**
Dentalytics is a web-based tool that Delta Dental developed in association with WhiteCloud Analytics. This service is free and available for all Iowa participating network dentists to identify potential improvements in the quality of care patients. Dentalytics is used in conjunction with office patient management systems to identify high-risk patients and ensure they receive recommended preventive dental care to improve oral health outcomes. For more information or to sign up for Dentalytics, contact Professional Relations at 800-544-0718 or e-mail provrelations@deltadentalia.com.

**Patients Schedule Online Appointments**

**Brighter Scheduler**
Brighter Scheduler is a free service that connects patients and participating network dentists through Delta Dental’s online dentist directory. By signing up with Brighter Scheduler, patients can easily request appointments 24/7 online. Additionally, participating dentists are two times likely of being selected by new patients, there is
a decrease of no-shows and last minute cancellations and reduced marketing and administrative expenses for you and your office. For more information, call Brighter at 888-300-4742 or visit brighter.com/deltadental.

Vision Discount Program

Delta Dental Vision Discount
DDIA now offers a discount program through EyeMed Vision Care for your family, office staff and their immediate family at no cost. To receive these discounts, simply present the vision discount card that can be printed from DDIA’s website at www.deltadentalia.com. In addition, DDIA offers fully-insured vision plans with coverage for frames, lenses and annual eye exams. If you are interested in offering the fully-insured vision plan with richer benefits to your employees, please contact Marketing at 877-423-3582 ext. 15522.

Language Translation Service

TransPerfect Translation Services
DDIA provides a language translation service to all DDIA Participating Dentists at no cost. Charges are billed directly to DDIA. If you have a language barrier with a patient, TransPerfect translation services will provide translation. For the most efficient use of these services, please provide a series of questions to your patient at the beginning and end of the exam. Non-verbal cues (such as a thumbs up or down, or green/yellow/red cards) can be utilized throughout the exam for patient interaction. To learn more about TransPerfect translation services go to www.transperfectconnect.com.

Follow these steps when using TransPerfect:

1. Dial 855-886-2901
2. Enter Seven-digit code: 8186159
3. Enter Pin: 6476
4. Select Language
5. Connect. Brief the Interpreter: Summarize what you wish to accomplish and provide any special instructions.
Hearing Impaired Translation Service

**Life Interpretation, Inc.**

Participating Dentists can receive free sign language interpreting services from Life Interpretation, Inc. This service helps communication with deaf and hearing impaired patients. To learn more about Life Interpretation, Inc. go to www.lifeinterpreter.com.

**Follow these steps when using Life Interpretation, Inc.:**

1. Contact Life Interpretation, Inc. at 515-265-5433 to schedule an interpreter. Be sure to contact them as soon as possible to schedule an appointment.
2. Identify yourself as a Delta Dental Participating Dentist to schedule an interpreter at no cost.
3. Provide Life Interpretation, Inc. with the following information:
   - Date, time and duration of the patient’s appointment
   - Address of dentist’s office
   - Name of the deaf or hearing impaired patient
   - Dentist’s name, phone number and name of office contact
4. If you need to cancel, please contact Life Interpretation, Inc. at least 24 hours before the appointment.
5. You will receive confirmation from Life Interpretation, Inc. for the interpreter.

**Please note:** *Offices filing claims or claim attachments electronically or use the Internet to verify eligibility or claim status are considered a covered entity under the HIPAA Privacy and Security Rules.

If you are a covered entity and are also using Language Line Services (LLS) or Life Interpretation, Inc., DDIA recommends that you secure a Business Associate agreement with them due to the extent of possible protected Patient Health Information (PHI) being exchanged. For more information regarding HIPAA, refer to the HIPAA section of this Manual.

Send Business Associate Agreements with TransPerfect to:

**Email**

Eric Walano, ewalano@transperfect.com
or

**Mail**
TransPerfect Global HQ  
3 Park Avenue  
39th Floor  
New York NY 10016

Send Business Associate Agreements with Life Interpretation, Inc to:

Life Interpretation, Inc.  
PO Box 5002  
Des Moines, IA  50305-5002

*This information is for instructional and educational purposes only. It does not constitute legal advice. Recipients are strongly urged to contact their legal counsel for advice with respect to the interpretation of HIPAA and its applicability and the facts and circumstances of the situation at hand.

**Free Technology Assessment**

**Medix Dental**
Medix Dental is Delta Dental of Iowa’s latest value-added services partner. Medix Dental offers this convenient IT “checkup” as part of our value-added services. Medix Dental can identify where your office technology security is vulnerable so you can take corrective action and avoid costly HIPAA violations.

To request your complimentary assessment, please visit medixdental.com/ddia1 or call Luara at 877-885-1010.

**Discounted Defibrillators**

**Automated External Defibrillators (AED)**
AED Professionals™ and DDIA have come together to offer Participating Dentists discounts on Automated External Defibrillators (AEDs) and accessories. Access
www.aedprofessionals.com to choose the AED for your office. Contact AED Professionals at 888-541-2337 to order. Be sure to mention you are a Delta Dental Participating Dentist to receive a discount.

Reduced Costs on Malpractice Insurance

Professional Solutions
Malpractice Insurance - DDIA and Professional Solutions Insurance Company work together to offer Participating Dentists comprehensive malpractice insurance at a reduced cost. As part of an exclusive agreement with Professional Solutions, Participating Dentists can receive a 10% premium discount on malpractice insurance.

Contact Professional Solutions at 800-864-8026 ext. 4716 to receive a complimentary malpractice and business insurance review.

Lower Rates for Credit Card Processing

Credit Card Processing - DDIA and Professional Solutions Financial Services partner to offer Participating Dentists the lowest overall price on credit card processing. Professional Solutions will compare your current program to their low rates and reduced fees.

For more information, contact Professional Solutions at 800-970-5060 ext. 5960 or visit www.profsolutions.com.

Special Credit Card Offer

MilesAway® MasterCard® - Professional Solutions Financial Services offer Participating Dentists a MilesAway MasterCard. Take advantage of a 0% introductory APR on all purchases for a full six months and 7,500 bonus points when signing up for a Professional Solutions MilesAway Card. Redeem points for a $75 gift card to major national retailers right away. Or, save and accumulate more points toward other great rewards. This business card has no annual fee and earns up to 120,000 points.

Request your MilesAway MasterCard by visiting www.profsolutions.com and fill out a short Express Request Form.
Equipment Financing Available

**Equipment Financing** - Participating Dentists can also take advantage of Professional Solutions’ equipment financing program. The following are benefits of the program:

- No pre-payment penalties
- Fast approval/funding, usually within one business day or faster
- No down payments, no hidden fees or undisclosed service charges
- No middleman - negotiate the equipment price with the supplier, and Professional Solutions will finance it
- No obligation review of your current contract compared to Professional Solutions

To find out more, call 800-970-5060 ext. 5990 or visit www.profsolutions.com.

Discounted Emergency Kits and Products

**Emergency Kits and Products**
HealthFirst Corporation offers Participating Dentists a 15% discount on all emergency kits and a 10% discount on all other products excluding DVD sets, miscellaneous drugs, automated refill service program and AEDs.

For a list of emergency kits and products, access the HealthFirst web site at www.healthfirstcorp.com. Please note the prices on the web site do not reflect the Delta Dental discount.

To order, call HealthFirst Corporation at 425-771-5733 or 800-331-1984. Be sure to mention that you are a Delta Dental Participating Dentist and would like the discount rate. Reduced prices are valid for new orders only and do not apply to previously purchased items.

Dental Handbook Discounts
Dental Publications

A special discount is offered to Participating Dentists for three dental publications through Lexi-Comp, Inc. The available books are:
- *Drug Information Handbook for Dentistry*
- *Dental Office Medical Emergencies*
- *Oral Soft Tissue Diseases*

Special discounts are available for one, two or all three books. Contact Professional Relations at 515-261-5500 or 800-544-0718 or e-mail provrelations@deltadentalia.com for prices and ordering details.

Electronic Payment Information

**Electronic Remittance Advice (ERA)**
Electronic Remittance Advice is an electronic communication containing claims payment information delivered from the insurance carrier. It replaces your paper Remittance Advices (RAs). The ERA provides quicker payment information than a mailed paper RA.

ERA facilitates automatic posting of payments in your dental software. This auto posting eliminates the time consuming need for manual entry and reduces data entry errors. An ERA allows quicker processing of patient billing and faster payment of accounts receivables.

Only participating network dentists that receive Direct Deposits can sign-up for ERA. Contact your practice management software to confirm if your current software has the ERA transaction capabilities. If so, and Change Healthcare is your clearinghouse, please work with them directly to sign up for this service.
**Value-Added Services**

**Patient Forms and Record Keeping Course Discounts**

**Stepping Stones to Success**
Stepping Stones to Success offers Participating Dentists discounts on patient charts, patient education brochures, informed consent forms and CDT-Dental Insurance Coding Handbook.

Stepping Stones to Success also offers its most comprehensive study course, Record Keeping Basics, to Delta Dental Participating Dentists at a significant savings. It demonstrates what constitutes a complete record and details step-by-step what should be recorded. The course includes instruction manual, sample forms and guidelines to prevent malpractice problems.
For more information contact Stepping Stones to Success at 800-548-2164 or visit www.steppingstonestosuccess.com.

**Xylitol Gum, Mints, Mouthwash, Toothpaste Discounts**

**Xylitol Products**
Xylitol is a natural sweetener that disrupts the bacteria that feed off of the sugars in the foods we eat which cause cavities. Xylitol gum or mints are available at a 15% discount off wholesale price through Epic Dental. Visit www.epicdental.com to select the products you would like and call Epic at 800-494-3742 to order. Be sure to tell them you are a participating Delta Dental network dentist to receive a discount.

**Sterilizer Monitoring Discount**

**Spore Testing**
Participating network dentists can receive significant discounts for spore testing kits through Steri-Check Systems, Inc.

Contact Professional Relations at 515-261-5500 or 800-544-0718 or e-mail provrelations@deltadentalia.com for additional information or ordering details.

**Educational Oral Health Kits for Children**
Value-Added Services

Smart Smiles
The Smart Smiles kit includes an educator’s guide and curriculum which includes a tooth model with floss and large toothbrush, a DVD, CD and age appropriate books about oral health. The kits assist in educating children about the importance of their teeth and the value of good oral health. These kits are available for loan or purchase as well as through multiple community-based organizations. To borrow or buy a kit, contact Delta Dental of Iowa’s Public Benefit Program at 515-261-5500 or 800-544-0718.

Dental Product Brochures

Individual Dental Product Brochures
Delta Dental sells individual dental coverage and is available to all permanent residents of Iowa. For patients asking to purchase dental benefits, DDIA provides a supply of free Individual Dental Product brochures and applications for your dental office waiting room. To order a supply, contact Marketing at 888-423-3582 or e-mail individualproduct@deltadentalia.com.

Contact Information

Additional Value-Added Services
Please note that Value-Added Services can change or end at any time. For a list of current offers, access the Value-Added Services section on the Dentist Connection of DDIA’s web site at www.deltadentalia.com. Watch for additional discounts and offerings in future publications of the Delta Dental Dialogue. For more information or ordering details about any of the aforementioned Value-Added Services, contact Professional Relations at 515-261-5500 or 800-544-0718 or e-mail provrelations@deltadentalia.com.

Delta Dental of Iowa (“DDIA”) has arranged with (“Vendors”) to offer goods and/or services to DDIA’s Providers on terms and conditions that may vary from Vendor’s offer of such goods and/or services to others. DDIA has made such arrangements with Vendor solely to benefit DDIA’s Providers. DDIA is not the offerer or seller of such goods and/or services. Each Provider should make its own investigation and analysis of the goods and/or services offered by Vendor. DDIA MAKES NO WARRANTIES OR GUARANTEES WHATSOEVER CONCERNING VENDOR’S GOODS AND/OR SERVICES.”
Health Insurance Portability and Accountability Act (HIPPA)

HIPAA
The Health Insurance Portability and Accountability Act (HIPAA) of 1996 (and implementing regulations) is a federal law intended to provide better access to health insurance, limit fraud and abuse and reduce administrative costs. Since electronic transactions are significantly more cost effective than paper for providers, patients and health plans, HIPAA includes a major provision (Administrative Simplification) that is designed to encourage the use of electronic transactions, while safeguarding patient privacy.

To do so, HIPAA created a universal language or standard for electronic transmissions used in the health care industry. It also established standards governing the privacy/security of health information, which is an extremely important issue for consumers today. Specific requirements are detailed in rules issued by the federal Department of Health and Human Services (DHHS). Please refer to end of this section for important HIPAA web sites.

Covered Entities

All health plans, health care clearinghouses and health care providers who maintain or transmit protected health information in electronic form standardized by DHHS are referred to as “Covered Entities”. If you file electronic claims, submit electronic attachments or use the Internet to check benefits, eligibility or claims status, you are considered a covered entity.

Health Information

“Health Information” is any information, whether oral or recorded in any form or medium, that:

• Is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university or health care clearinghouse; and
• Relates to the past, present or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual.

**Individually Identifiable Health Information**

“**Individually Identifiable Health Information (IIHI)**” is information that is a subset of Health Information, including demographic information collected from an individual, and;

- Is created or received by a health care provider, health plan, employer, or health care clearinghouse;
- Relates to the past, present or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual;
- Identifies the individual, or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

**Protected Health Information**

“**Protected Health Information (PHI)**” is Individually Identifiable Health Information maintained or transmitted by electronic media or transmitted or maintained in any other form or medium by a covered entity.

**Business Associate**

A **“Business Associate”** is defined as a person or organization that performs a function or activity on behalf of a Covered Entity and has access to PHI, but is not part of the Covered Entity’s work force.

Covered Entities must comply with the HIPAA Transactions and Code Sets Standards. To comply with these standards, you need to ensure that the format you are using for submitting claims electronically is HIPAA compliant. Covered Entities transferring data electronically have to adopt the use of the Current Dental
Terminology (CDT), which is periodically updated by the American Dental Association.

Privacy Standards

The Privacy Standards are intended to streamline the flow of information integral to the operation of the health care system while protecting confidential health information from inappropriate access, disclosure and use.

Security Standards

The Security Standards are intended to provide safeguards for data storage, protection of information transmission systems and the establishment of chain-of-trust agreements between Covered Entities and their business partners.

National Provider Identifier

Dentists who are Covered Entities are required by law to obtain a National Provider Identifier (NPI) number and use NPIs on electronic transactions.

All dentists are eligible for an NPI. Delta Dental strongly encourages all dentists to obtain and use an NPI to submit all claims - paper or electronic. This will enable you to maintain a unique identifier for use with all payers.

The NPI is a ten digit unique identifier for health care providers and organizations. There are two basic types of NPIs available; individual and organizational. Individual NPIs, also known as Type 1 NPIs, are for health care providers, such as dentists. Organizational, or Type 2 NPIs are for use by incorporated businesses, such as group practices and clinics.
Applying for NPI

NPI Application Process:

2. Complete the application and follow instructions to submit either online or by mail. Faxes are not accepted.
3. After confirmation of the receipt of your application, you should receive your NPI via e-mail within one to five business days if you submitted the application online. Mailed applications may require up to 20 days to process.

Be sure to notify Delta Dental of your NPI number(s) by contacting Professional Relations at 515-261-5500 or 800-544-0718 or e-mail provrelations@deltadentalia.com.

HITECH Act

The HITECH Act amends HIPAA and is a part of the American Recovery and Reinvestment Act (Federal Stimulus Package). The HITECH Act required the Department of Health and Human Services (HHS) to issue regulations for breach notification by Covered Entities and their Business Associates subject to HIPAA. HITECH rules require Covered Entities (and their Business Associates) to notify affected individuals, the media and the Secretary of HHS following a breach of unsecured PHI. Consequently, Covered Entities must implement security breach detection and notification programs (or alternatively, ensure that PHI is “secured” in accordance with the guidance.)
HIPAA Questions and Answers

Do dental offices need a Business Associate agreement with Delta Dental?

No. Business Associate agreements are not necessary between Covered Entities for the purpose of treatment, payment and health care operations (TPO).

Is a fax transmission considered an electronic transmission under HIPAA standards?

No. DHHS has not adopted a transaction standard for fax transmissions. However, if you are a Covered Entity, you are subject to the Privacy and Security Standards. You need to take appropriate steps to ensure the fax machine is located in a private and secure location to protect PHI that may be on incoming or outgoing documents.

Can I give DDIA fees over the phone for procedures I have performed?

Yes. Fees are necessary for treatment, payment and health care operations (TPO) and are not considered PHI.

What can dental offices expect when calling DDIA for patient eligibility, benefits and claims status?

DDIA authenticates callers to ensure that customers’ privacy rights are protected under HIPAA. It is necessary for the dental office to provide the following information when requesting disclosure of a patient’s Protected Health Information:

- Caller name
- Dentist or office name
- Dentist tax identification number (TIN)
- Subscriber identification number
- Covered Person name
- Covered Person date of birth
This information becomes part of DDIA’s call log and is necessary for tracking uses and disclosures of Protected Health Information (PHI) under HIPAA.

**Do I need an NPI if I file paper claims?**

You are not required by HIPAA to obtain an NPI if you are not considered a Covered Entity. However, DDIA is strongly encouraging all dentists to obtain and use an NPI on paper claims as well.

**Does it cost to apply for an NPI?**

No. There is no cost to apply for an NPI.

**Am I subject to HIPAA requirements if I access Delta Dental’s web site to check benefits, eligibility and check status of claims?**

Yes. If you use the Internet to check patient’s benefits, eligibility and check status of claims, as a Covered Entity, you are required to follow HIPAA provisions, including obtaining an NPI. Be sure to notify DDIA of your NPI so it can be added to the provider records. You will be denied access to the Dentist Connection on DDIA’s web site if your NPI is not on file.

*This information is for instructional and educational purposes only. It does not constitute legal advice. Recipients are strongly urged to contact their legal counsel for advice with respect to the interpretation of HIPAA and its applicability to the recipient and the facts and circumstances of the situation at hand.*

**HIPAA Informational Web Sites**

Visit the official HIPAA web site at:  
www.hhs.gov/hipaa/index.html

Access the Office for Civil Rights web site at:  
www.hhs.gov/ocr
Customer Service
Delta Dental of Iowa (DDIA) Customer Service is available from 7:30 a.m. to 5 p.m. Monday through Friday.

Customer Service Phone Numbers

To contact a Customer Service Representative for Group and Individual patients, use the following phone number:

800-544-0718 (Option 5)

To contact a Customer Service Representative for hawk-i patients, use the following phone number:

800-544-0718 (Option 3)

You will be asked to enter your National Provider Identifier (NPI) after you have selected the appropriate phone option outlined above.

Authenticating Phone Calls

All calls disclosing Protected Health Information are authenticated. When calling DDIA, please be prepared to provide the Customer Service Representative with your name, the dentist or office name, the dentist tax identification number, the Covered Person’s identification number, name and date of birth. For more information regarding HIPAA, refer to the HIPAA Section of this Manual.

Contact Customer Service for information regarding:

- filing claims
- claim status
- eligibility
- benefits
- claim processing
Obtain Patient Benefits and Eligibility by Fax

Fax-Back Feature
DDIA has an interactive phone system which provides many features. One beneficial feature is a Fax-Back option which allows you to obtain patient benefits and eligibility faxed to your office. This option is available 24 hours a day 7 days a week through our toll free phone number 800-544-0718.

Check Eligibility and Claim Status by Phone

Eligibility and Claim Status
Another element of DDIA’s phone system is a voice response feature that allows you to check patient eligibility and status of a claim by selecting the appropriate menu option and simply entering the requested Covered Person’s information.

Access Web Site for Patient Information and Claim Status

Delta Dental of Iowa Web Site
Confirm patient eligibility, benefits and claim status 24 hours a day 7 days a week on the secure Dentist Connection on DDIA’s web site at www.deltadentalia.com. Additionally, claims and predeterminations/prior authorizations can be completed and submitted to DDIA for processing at no cost through the Dentist Connection.

To register on the Dentist Connection, follow the steps below:

1. Go to www.deltadentalia.com
2. Select “Dentist” on the right side of the Home Page which is the area of the web site that you want to register
3. Then click on “New User? Sign up” to the right of the Log in button
4. Follow the prompts and enter the following information:
   a. Person’s Name Registering for Access
   b. Business Tax ID Number (nine-digit; no dashes)
   c. Business City
   d. Business Zip
   e. Provider First Name
   f. Provider Last Name
   g. License ID (four digit state license number; no preceding zero)
h. License State

Please note: the information entered must match what DDIA has on file. The most common mismatched information is the dentist’s license number. DDIA uses the dentist’s four digit state issued license number; do not use the zero preceding the license number.

You will then be prompted to select your User ID and Password.

For security purposes, each person in your office using the Dentist Connection should register with their own User ID and Password. Please inform DDIA when office staff with access to the Dentist Connection are no longer employed by you so their web site login can be inactivated. This will ensure they no longer have access to Covered Person’s benefits, eligibility and claims information.

National Web site

Delta Dental National Web Site
Delta Dental Plans Association (DDPA) offers a national Delta Dental web site that you may access if you need to check benefits, eligibility and claim status for a patient that has coverage with Delta Dental of another state (e.g. Delta Dental of California, Delta Dental of Minnesota, etc.). The web address for the national Delta Dental web site is www.deltadental.com.

The Delta Dental User ID and Password login that you select for the Delta Dental of Iowa specific web site is the same for the National Portal web site.

Please use the Iowa specific web site when checking Iowa Covered Persons’ eligibility and claim status. The Iowa web site provides more specific benefits details for Iowa Covered Persons than the National Portal web site.
DDIA Paper Claims Mailing Address

Paper Claims Mailing Address

Mail all completed paper claim forms to:

Delta Dental of Iowa
PO Box 9000
Johnston, IA  50131-9000

Written Inquiries

Mail claim corrections, other carrier payment information, additional claim review documentation and other written inquiries, along with a copy of the Remittance Advice (RA) provided by DDIA to:

Written Inquiry Addresses

For Group and Individual patients:

ATTN:  CLAIMS REVIEW DEPARTMENT
Delta Dental of Iowa
9000 Northpark Dr
Johnston, IA  50131

For hawk-i patients:

ATTN:  CLAIMS REVIEW DEPARTMENT
Delta Dental of Iowa
PO Box 9030
Johnston, IA  50131

When mailing written inquiries, please include a copy of the RA, a brief explanation, attach any applicable supporting documents or attachments and include the following details:

- Covered Person’s name
- Subscriber name (if different from the Covered Person)
• Subscriber identification number
• Date of service
• Claim number, if available

**Do not resubmit claims for reconsideration or review to PO Box 9000, Johnston, IA 50131 claims address.** Otherwise it will be entered as a new claim and will systematically deny as a duplicate claim instead of being reconsidered or reviewed by the Claims Review Department.

**Request a Review or Appeal of a Denied Claim or Pre-Treatment Estimate**
For additional details regarding the Review and/or Appeal of a claim or pre-treatment estimate that was denied in whole or in part, please refer to the Procedures and Processing Policies section of this Manual.

**Contact Professional Relations**

**Professional Relations Staff**
Certain questions or information should be directed to the Professional Relations staff. Please contact Professional Relations at 515-261-5500 or 800-544-0718 or e-mail provrelations@deltadentalia.com if you:

• change your office address or phone number;
• have a change in your credentialing information;
• are a new dentist opening an office or have a new associate or locum tenens dentist joining your practice;
• are leaving a practice due to retirement, relocation, etc.;
• change your tax identification number (TIN);
• have questions about your Participating Dentist’s Agreement(s), credentialing, processing policies;
• would like to schedule an office visit with DDIA’s Professional Relations Representative regarding office training needs, network participation, claims processing guidelines, attachment requirements or any other area of concern;
• need information regarding your participation with Delta Dental;
• have an unresolved issue with another Delta Dental Member Company;
• have questions about the Dentist Connection on DDIA’s web site or are having trouble registering;
• need information about DDIA’s Value-Added Services Program for Participating Dentists.

**DeltaUSA**

**Other Delta Dental Member Companies**

DeltaUSA (also known as Delta Dental national coverage) is a national dental benefit program that all Delta Dental member companies offer. It is designed to meet the needs of employers with employees located in more than one state who desire claims administration and services from a single site. A dentist who participates with their local Delta Dental also participates with DeltaUSA coverage programs administered by other Delta Dental member companies (e.g. Delta Dental of California, Delta Dental of Minnesota, etc.).

For patients who have DeltaUSA, complete a claim form and submit it directly to the Delta Dental member company administering that particular group, also known as the Control Plan. The fee reimbursement for national business is the same as you receive for your Delta Dental of Iowa business.

Please refer to the Programs and Participation section of this Manual for more information about Delta Dental's networks and dental programs.

Use the following Delta Dental claim mailing addresses and Customer Service numbers on the following pages for Covered Persons with Delta Dental national coverage of another state. The Payer ID Numbers are also listed for filing electronic claims. For questions about a Covered Person’s eligibility or benefits, please contact the Delta Dental member company listed on the Covered Person’s identification card. You may also access the Delta Dental National web site at www.deltadental.com or the Delta Dental member company specific web site listed on the following pages.
Alabama
Delta Dental Insurance Company (DDIC)
PO Box 1809
Alpharetta, GA  30023-1809
800-521-2651
www.deltadentalins.com
Payer #94276

Alaska
Delta Dental of Oregon (Alaska)
601 SW 2nd Ave
Portland, OR  97204
888-374-8906
www.modahealth.com
Payer #CDOR1

Arizona
Delta Dental of Arizona
PO Box 43026
Phoenix, AZ  85080
800-352-6132
www.deltadentalaz.com
Payer #86027

Arkansas
Delta Dental of Arkansas
PO Box 15965
North Little Rock, AR  72231-5965
800-462-5410
www.deltadentalar.com
Payer #CDAR1

California
Delta Dental of California
PO Box 997330
Sacramento, CA  95899-7330
888-335-8227
www.deltadentalca.org
Payer #77777

Colorado
Delta Dental of Colorado
PO Box 173803
Denver, CO  80217-3803
800-610-0201
www.deltadentalco.com
Payer #84056

Connecticut
Delta Dental of New Jersey
PO Box 222
Parsippany, NJ  07054
800-452-9310
www.deltadentalnj.com
Payer #22189

Delaware
Delta Dental of Pennsylvania
PO Box 2105
Mechanicsburg, PA  17055
800-932-0783
www.deltadentalins.com
Payer #51022

District of Columbia
Delta Dental of Pennsylvania
PO Box 2105
Mechanicsburg, PA  17055
800-932-0783
www.deltadentalins.com
Payer #52147
Service Contacts

Florida
Delta Dental Insurance Company (DDIC)
PO Box 1809
Alpharetta, GA  30023-1809
800-521-2651
www.deltadentalins.com
Payer #94276

Georgia
Delta Dental Insurance Company (DDIC)
PO Box 1809
Alpharetta, GA  30023-1809
800-521-2651
www.deltadentalins.com
Payer #94276

Guam
Hawaii Dental Service
700 Bishop Street, Suite 700
Honolulu, HI  96813
800-232-2533
www.deltadentalhi.org

Hawaii
Hawaii Dental Service
700 Bishop Street, Suite 700
Honolulu, HI  96813
800-232-2533
www.hawaiidentalservice.com
Payer #DEHI1

Idaho
Delta Dental of Idaho
PO Box 2870
Boise, ID  83701
800-356-7586
www.deltadentalid.com
Payer #82029

Illinois
Delta Dental of Illinois
PO Box 5402
Lisle, IL  60532
800-323-1743
www.deltadentalil.com
Payer #05030 (group plans)
Payer #IDIND (IL individual plans only)

Indiana
Delta Dental of Indiana
PO Box 9085
Farmington Hills, MI  48333-9085
800-524-0149
www.deltadentalin.com
Payer #DDPIN

Kansas
Delta Dental of Kansas
1619 N Waterfront Pkwy
PO Box 789769
Wichita, KS  67278-9769
800-234-3375
www.deltadentalks.com
Payer #E3960

Kentucky
Delta Dental of Kentucky
PO Box 242810
Louisville, KY  40224-2810
800-955-2030

January 2019
www.deltadentalky.com
Payer #CDKY1

**Louisiana**
Delta Dental Insurance Company (DDIC)
PO Box 1809
Alpharetta, GA 30023-1809
800-521-2651
www.deltadentalins.com
Payer #94276

**Maine**
Northeast Delta Dental
PO Box 2002
Concord, NH 03302-2002
800-832-5700
www.nedelta.com
Payer #02027

**Maryland**
Delta Dental of Pennsylvania
PO Box 2105
Mechanicsburg, PA 17055
800-932-0783
www.deltadentalins.com
Payer #23166

**Massachusetts**
Delta Dental of Massachusetts
PO Box 2907
Milwaukee, WI 53201
800-872-0500
www.deltadentalma.com
Payer #04614

**Michigan**
Delta Dental of Michigan
PO Box 9085
Farmington Hills, MI 48333-9085
800-524-0149
www.deltadentalmi.com
Payer #DDPMI

**Minnesota**
Delta Dental of Minnesota
PO Box 59238
Minneapolis, MN 55459-0238
800-448-3815
www.deltadentalmn.org
Payer #26004 or 07000

**Mississippi**
Delta Dental Insurance Company (DDIC)
PO Box 1809
Alpharetta, GA 30023-1809
800-521-2651
www.deltadentalins.com
Payer #94276

**Missouri**
Delta Dental of Missouri
PO Box 8690
St. Louis, MO 63126-0690
800-335-8266
www.deltadentalmo.com
Payer #43090

**Montana**
Delta Dental Insurance Company (DDIC)
PO Box 1809
Service Contacts

Alpharetta, GA  30023-1809
800-521-2651
www.deltadentalins.com
Payer #94276

**Nebraska**
Delta Dental of Nebraska
PO Box 245
Minneapolis, MN  55440-0245
866-827-3319
www.deltadentalne.org
Payer #07027

**Nevada**
Delta Dental Insurance Company (DDIC)
PO Box 1809
Alpharetta, GA  30023-1809
800-521-2651
www.deltadentalins.com
Payer #94276

**New Hampshire**
Northeast Delta Dental
PO Box 2002
Concord, NH  03302-2002
800-832-5700
www.nedelta.com
Payer #02027

**New Jersey**
Delta Dental of New Jersey
PO Box 222
Parsippany, NJ  07054
800-452-9310
www.deltadentalnj.com
Payer #22189

**New Mexico**
Delta Dental of New Mexico
2500 Louisiana Blvd NE, Suite 600
Albuquerque, NM  87110
800-999-0963
www.deltadentalnm.com
Payer #85022

**New York**
Delta Dental of Pennsylvania
PO Box 2105
Mechanicsburg, PA  17055
800-932-0783
www.deltadentalins.com
Payer #11198

**North Carolina**
Delta Dental of North Carolina
PO Box 9085
Farmington Hills, MI  48333-9085
800-662-8856
www.deltadentalnc.org
Payer #56101

**North Dakota**
Delta Dental of North Dakota
PO Box 59238
Minneapolis, MN  55459-0238
800-448-3815
www.deltadentalmn.org
Payer #26004

**Northeast Delta Dental**
PO Box 2002
Concord, NH  03302-2002
800-832-5700
Service Contacts

www.nedelta.com
Payer #02027

Ohio
Delta Dental of Ohio
PO Box 9085
Farmington Hills, MI 48333-9085
800-524-0149
www.deltadentaloh.com
Payer #DDPOH

Oklahoma
Delta Dental of Oklahoma
PO Box 548809
Oklahoma City, OK 73154-8809
800-522-0188
www.deltadentalok.org
Payer #22229 and CDOK1

Oregon
Delta Dental of Oregon
601 SW 2nd Ave
Portland, OR 97204
800-452-1058
www.modahealth.com
Payer #CDOR1

Pennsylvania
Delta Dental of Pennsylvania
PO Box 2105
Mechanicsburg, PA 17055
800-932-0783
www.deltadentalins.com
Payer #23166

Puerto Rico
Delta Dental of Puerto Rico

PO Box 9020992
San Juan, PR 00902-0992
866-622-6120
www.deltadentalpr.com
Payer #680652604

Rhode Island
Delta Dental of Rhode Island
PO Box 1517
Providence, RI 02901-1517
800-843-3582
www.deltadentalri.com
Payer #05029

South Carolina
Delta Dental of Missouri
PO Box 8690
St. Louis, MO 63126
800-335-8266
www.deltadentalsc.com
Payer #43091

South Dakota
Delta Dental of South Dakota
PO Box 1157
Pierre, SD 57501
877-841-1478
www.deltadentalsd.com
Payer #54097

Tennessee
Delta Dental of Tennessee
240 Venture Circle
Nashville, TN 37228-1699
800-223-3104
www.deltadentaltn.com
Payer #CDTN1
Texas
Delta Dental Insurance Company (DDIC)
PO Box 1809
Alpharetta, GA  30023-1809
800-521-2651
www.deltadentalins.com
Payer #94276

Utah
Delta Dental Insurance Company (DDIC)
PO Box 1809
Alpharetta, GA  30023-1809
800-521-2651
www.deltadentalins.com
Payer #94276

Vermont
Northeast Delta Dental
PO Box 2002
Concord, NH  03302-2002
800-832-5700
www.nedelta.com
Payer #02027

Virginia
Delta Dental of Virginia
4818 Starkey Rd
Roanoke, VA  24018
800-237-6060
www.deltadentalva.com
Payer #54084

Washington
Delta Dental of Washington
PO Box 75983
Seattle, WA  98175
800-554-1907
www.deltadentalwa.com
Payer #91062

West Virginia
Delta Dental of Pennsylvania
PO Box 2105
Mechanicsburg, PA  17055
800-932-0783
www.deltadentalins.com
Payer #31096

Wisconsin
Delta Dental of Wisconsin
PO Box 828
Stevens Point, WI  54481-0828
800-236-3712
www.deltadentalwi.com
Payer #39069

Wyoming
Delta Dental of Wyoming
PO Box 29
Cheyenne, WY  82003-0029
800-735-3379
www.deltadentalwy.org
Payer #CDWY1
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Participating Dentists Agree to File Claims

Claim Filing
The Delta Dental of Iowa (DDIA) Participating Dentist’s Agreement requires Participating Dentists to file claims on behalf of all Delta Dental Covered Persons. This applies whether Delta Dental is the primary dental benefits company or the secondary dental benefits company. In addition, Participating Dentists agree to follow Delta Dental’s billing instructions, processing policies and submission requirements and recommendations for specific procedures. This section of the Manual provides information on filing paper and electronic claims, services beneficial to your office, predeterminations/prior authorizations and claim filing tips. Refer to the Dentist Handbook in tab 9 in this Manual for a list of all Current Dental Terminology (CDT) procedure codes and processing policies.

Electronic Claims

Electronic Claims Submissions
Electronic claims submission is the quickest way to enter a claim into DDIA’s claims processing system. There are many benefits to filing claims electronically. The following are some of the advantages:

- Claims enter directly into DDIA’s claims system to begin processing; no claims entry necessary by claims staff.
- Faster payment turnaround time which results in improved cash flow.
- Less paperwork and simpler claims filing.
- Less chance of a processing error.
- Reduced mail costs and mail time.
- More efficient and better for the environment.
- Minimal start-up investment and maximizes your computer’s capability.

Please contact Professional Relations at 515-261-5500 or 800-544-0718 for a list of clearinghouses, questions regarding electronic claims or electronic claims submission problems.
DDIA’s Payer ID Number
Some practice management systems require a “payer identification number”. The payer ID number for DDIA Group and Individual member claims is **CDIA1**. The payer ID number for **hawk-i** member claims is **CDIAM**. If your system requests a Delta Dental “provider number”, use the dentist’s state issued license number. DDIA does not issue provider numbers.

If there is additional information that will assist DDIA in processing the claim, please send as an electronic attachment. DDIA and NEA have partnered to offer Participating Dentists special savings. Please refer to the Value-Added Services section of this manual for additional information regarding discounts with National Electronic Attachments, Inc.

Remarks Section of Claim

Remarks on Claims
Narratives or remarks included on your claims submission will be added to the claim content and used for claim situations which require review. Please be concise with what claim comments/remarks are included in this section of the claim. Remarks such as Please Rush, Second Submission or Duplicate Claim will only slow down the processing time of your claim.

Fax One-Page Claims to DDIA

Fax-In Claims
DDIA offers offices a Fax-In claims service at no cost. The Fax-In service is for single page claims only with no cover sheets. This feature cannot be used for predeterminations/prior authorizations or orthodontic claims. Using this claims filing option will save your office postage costs and will eliminate mail time which means faster claims processing for you. Faxed claims are prepped for entry. The toll free fax number is 866-269-9118.
Immediate Processing of Claims and Predeterminations/Prior Authorizations

Real-Time Claims and Predeterminations/Prior Authorizations
Real-time claims is a web application used to submit claims. The application shows what a patient’s benefits are and allows the same day adjudication of a claim. A remittance advice (RA) will print while the patient is still in your office. The patient will know their financial responsibility immediately which will reduce accounts receivable. The payment will post on the next weekly payment cycle.

Real-time predeterminations/prior authorizations can assist your office in helping the patient make informed decisions regarding proposed treatment and making financial arrangements. It also helps in quicker scheduling of your patient’s next appointment. If additional information is necessary, the predetermination/prior authorization will indicate that additional information is needed for review.

Contact your practice management software team to determine if they offer this timely and efficient claims filing option.

Auto-Recoupment of Incorrect Payment

Recoupment of Overpayment
In the event Delta Dental makes payments and payments are later determined to have been made in error, or were for dental services not Covered Services because they were cosmetic, elective, not dentally necessary or dentally appropriate, or because of dentist’s error, Delta Dental’s error, overpayment by Delta Dental or a patient’s ineligibility for coverage, Delta Dental will deduct from future payments due to the dentist amounts equal to the amount of the incorrect payments.

Do Not Send Original Radiographs

Radiograph Return Policy
Delta Dental of Iowa will not return radiographs or other attachments unless accompanied with a self-addressed, stamped envelope. When radiographs are needed, please send duplicates only - no originals. Be sure to properly identify and date the copy of the image.
Please follow DDIA’s attachment guidelines unless DDIA individually instructs you otherwise. You will find a current, quick reference list of attachment guidelines under the Resources tab in the Forms section of the Dentist Connection on DDIA’s web site at www.deltadentalia.com or you may contact Professional Relations at 515-261-5500 or 800-544-0718 or e-mail provrelations@deltadentalia.com for a copy.

Delta Dental retains the right to request radiographs and/or other documentation for any procedure when necessary to process a claim.

**Sending Electronic Attachments**

**Electronic Attachments**
If you do not currently have the capability of sending scanned radiographs or other electronic attachments and would like information about National Electronic Attachment Inc.’s (NEA) FastAttach™ software, please contact NEA at 800-782-5150 ext.2 or visit www.welcometonea.com to learn more about how this software provides dental offices the capability of sending digitized radiographs and attachments in support of their electronic claims. NEA’s Payer ID number is 080001.

DDIA and NEA have partnered to offer Participating Dentists special savings. Please refer to the Value-Added Services section of this manual for additional information regarding discounts with National Electronic Attachments, Inc.

**Automatic Deposits in Your Bank Account**

**Direct Deposit**
DDIA can automatically deposit your claim payments directly into your designated bank account - whether you file paper or electronic claims. Choosing Direct Deposit (aka electronic funds transfer (EFT) will avoid the hassle of paper check processing and mail time of paper checks.

You can choose to receive an e-mail which prompts you to access the secure Dentist Connection on DDIA’s web site to retrieve your Remittance Advices (RAs).

Sign-up for Direct Deposit is quick and easy. You may sign-up online for Direct Deposit on the Dentist Connection of DDIA’s web site at www.deltadentalia.com.
You may also contact Professional Relations for additional information at 515-261-5500 or 800-544-0718 or e-mail provrelations@deltadentalia.com.

Additionally, at the time of Direct Deposit sign-up, you can also opt to receive Delta Dental National EFT/ERA. By selecting this option, you are enrolling to receive direct deposits from all Delta Dental member companies and retrieve your RAs from a single site without needing to fill out duplicate paperwork with each Delta Dental.

DDIA is offering a $50 bonus for Iowa participating network dental offices that sign up for Direct Deposit. Refer to the Value-Added Services section of this manual for more information.

Electronic Payment Information

Electronic Remittance Advice (ERA)
Electronic Remittance Advice is an electronic communication containing claims payment information delivered from the insurance carrier. It replaces your paper Remittance Advice (RA). The ERA provides quicker payment information than a mailed RA.

ERA facilitates automatic posting of payments in your dental software. This auto posting eliminates the time consuming need for manual entry and reduces data entry errors. An ERA allows quicker processing of patient billing and faster payment of accounts receivables.

Only participating network dentists that receive Direct Deposits can sign-up for ERA. Contact your practice management software to confirm if your current software has the ERA transaction capabilities. If so, and Change Healthcare is your clearinghouse, please work with them directly to sign up for this service.

Timely Filing Guidelines

Claim Filing Procedures
File claims as soon as the service is completed. Claims must be received within 365 days of the service completion date and include all documents and attachments necessary to review, process and finalize the claim. Documentation includes, but is not limited to, clinical rationale/narrative, radiographs, periodontal chart, patient’s
treatment record, coordination of benefits information as applicable. If the claim is not received and finalized within this time period, the claim may be disallowed as the Participating Dentist’s responsibility and not billable to the patient.

Paper Claims Mailing Address

DDIA’s paper claims address is:

Delta Dental of Iowa
PO Box 9000
Johnston, IA  50131-9000

Delta Dental Member Companies

Other state Delta Dental member company mailing addresses, web sites and phone numbers are listed in the Service Contacts section of this Manual. Refer to the Covered Person’s identification card to confirm the Delta Dental member company that they have their coverage through. For questions regarding eligibility or benefits for a patient who has coverage with another Delta Dental member company, call that company directly or access the Delta Dental National Portal web site at www.deltadental.com or their direct web site listed in the Service Contacts section of this Manual. The Delta Dental User ID and Password that you select for the Dentist Connection on DDIA’s web site is the same when logging on to the National Portal web site.

DDIA accepts all universal claim forms, including the American Dental Association (ADA) claim form, as long as all important information is included to process the claim. Please refrain from using superbills. Superbills are easily detached from the claim and delay the claim preparation and processing.

Claim Filing on the Dentist Connection

Dentist Connection Claim Filing Features
Claims may be completed and submitted by to DDIA for processing at no cost through the secured Dentist Connection on DDIA’s web site at www.deltadentalia.com. Please refer to the Service Contacts section of this Manual for more information about registering on the web site.
Submit claims for processing - Submit claims for processing for services that have been completed. Once entered, claims are adjudicated real time with an immediate response to you on processing.

Submit predeterminations/prior authorizations - Predeterminations/prior authorizations may be completed and submitted to DDIA for processing. The prior authorization is not a guarantee of payment. It is subject to the terms and limitations of the Subscriber's benefits and processing policies in effect at the time services are provided.

Request a benefit estimate - A benefit estimate is different from a predetermination/prior authorization. Dentists can use the Benefit Estimate tool on the Dentist Connection to quickly determine how a planned service may be adjudicated. Similar to a predetermination/prior authorization, services submitted using the Benefit Estimate will be checked for frequency limitations, age limitations and processing policies.

Unlike a predetermination/prior authorization, services submitted using the Benefit Estimate tool assumes any clinical criteria required to be submitted and reviewed when submitting an actual claim for services is met. The Benefit Estimate tool provides immediate, real time results but is not a guarantee of payment.

Request a Review or Appeal of a Denied Claim or Pre-Treatment Estimate
For additional details regarding the Review and/or Appeal of a claim or pre-treatment estimate that was denied in whole are in part, please refer to the Procedures and Processing Policies section of this Manual.

Filing a Dental Claim
All sections of the claim form must be completed to avoid a delay in processing. If you need assistance filling out a form, contact a DDIA Customer Service Representative at 515-261-5500 or 800-544-0718. Use the following guidelines when completing sections of a claim form.
Complete a claim when filing for a predetermination/prior authorization for future services or for a statement of actual services performed. Please check the applicable box usually found at the top of the claim form.

Identify the Subscriber and Patient

Subscriber/ Patient Information
Please use the following guidelines when completing the subscriber / patient section of a claim form:

• Use the patient’s full name. **Do not** submit nicknames.
• Be sure to mark the box that reflects the patient’s relationship to the Subscriber and the patient’s gender.
• It is **extremely** important to enter the patient’s correct date of birth.
• Be sure to indicate the Subscriber’s name and identification number which is listed on the Delta Dental identification card. Please note that several employer groups have asked DDIA to remove the Subscriber’s name and/or social security number from identification cards. This is an effort to prevent identity theft. These cards should be treated as valid identification cards. Please request the Subscriber’s social security number from the patient.
• Include the Subscriber’s address on the form.

A group number is not required to file a claim. If your practice management system requires a group number, you can find group numbers on the secure Dentist Connection.

• If there is other dental coverage, please provide the name and address of the other carrier. If DDIA is the secondary carrier, a copy of the primary carrier’s claim payment is required in order to coordinate benefits. Refer to the Coordination of Benefit (COB) section of this manual for more information regarding COB.
• Have the patient, parent or guardian or Subscriber sign and date the claim form. If it is kept on file, please note “signature on file”.

Record the Treatment Performed

Record of Services Provided
This section of the claim form provides detailed information about the services provided.

Please use the following guidelines when completing the record of services section of a claim form:

• Delta Dental uses the standard numbering system. Use letters to identify primary teeth and numbers to identify permanent teeth. Supernumerary teeth in the permanent dentition are identified by the numbers 51 through 82, beginning with the area of the upper right third molar, following around the upper arch and continuing on the lower arch to the area of the lower right third molar. Supernumerary teeth in the primary dentition are identified by placing an “S” following the tooth letter the supernumerary is adjacent to. Refer to the Current Dental Terminology (CDT) Manual for a tooth chart.

• Tooth numbers are required on procedures involving specific teeth. Generalized procedures, such as prophylaxis, fluoride treatments, radiographs, evaluations are excluded from the tooth number requirement.

• The mouth is divided into four quadrants: upper right (UR), upper left (UL), lower right (LR) and lower left (LL). When filing periodontal services, note the tooth number(s) or the quadrant to identify the teeth/area being treated.

• Identify the tooth surfaces when submitting a restoration. The following single letter codes are used to identify surfaces:

<table>
<thead>
<tr>
<th>Surface</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buccal</td>
<td>B</td>
</tr>
<tr>
<td>Distal</td>
<td>D</td>
</tr>
<tr>
<td>Facial</td>
<td>F</td>
</tr>
<tr>
<td>Incisal</td>
<td>I</td>
</tr>
</tbody>
</table>
• Give a complete written description of the service performed.

• When submitting a claim for payment, record the date each procedure was completed. Delta Dental does not pay for incomplete procedures. Do not list a date of service if a predetermination/prior authorization request is being submitted.

• When listing procedure codes, use the most recent version of the American Dental Association’s (ADA) Current Dental Terminology (CDT) manual.

• Enter the billed charge for each completed service. Procedures and charges must be listed individually; they cannot be combined. Please verify the total fee reflect the correct sum of the billed charges.

For example, billing $2,700 for a bridge on tooth numbers 29, 30 and 31 is insufficient. Instead, bill in the following manner:

D6750 #29 $900 (porcelain fused to high noble metal retainer crown)
D6240 #30 $900 (porcelain fused to high noble metal pontic)
D6750 #31 $900 (porcelain fused to high noble metal retainer crown)

• Be sure to complete the Other Coverage section of the claim form if the patient has other dental benefits coverage. If a payment has been received from a government program or another dental benefits company, indicate the amount received in the box that indicates “other fees”. A copy of the primary carrier’s claim payment is needed in order to coordinate benefits. Refer to the Coordination of Benefit (COB) section of this manual for more information regarding COB.

If a pre-treatment estimate has been received, date it once the services have been performed and send it in for processing.
Predetermination/Prior Authorization
When the predetermination/prior authorization box is checked at the top of a claim form, a pre-treatment estimate is being requested.

Estimate for Future Services

It is strongly recommended to submit a predetermination/prior authorization request for treatment plans over $250 or those containing onlays, crowns, fixed prosthetics, implants and periodontal surgery. Follow these steps when filing for a predetermination/prior authorization request:

1) Use a dental claim form and check the box at the top marked predetermination/prior authorization. If this is not an option on the claim form being used, write “predetermination or prior authorization” at the top of the form.

2) Complete the claim form in the normal manner with the exception of the date of service column; since services have not been provided, leave the dates of service column blank.

3) Submit the form to DDIA to process.

When a predetermination/prior authorization request is processed, a pre-treatment estimate is generated informing the Covered Person and the dentist the amount DDIA will pay if services are provided. DDIA’s response to a predetermination/prior authorization request provides:

- a verification of the Covered Person’s eligibility at the time the request was submitted and processed;
- a description of the Covered Person’s benefits at the time the request was submitted and processed;
- an opportunity for the Covered Person to make proper financial arrangements with the dentist before the treatment begins;
- information on the terms and limitations of the Subscriber’s current plan language.
Limitations of Pre-Treatment Estimate

The pre-treatment estimate is not a guarantee of payment. As noted above, it is subject to the terms and limitations of the Subscriber’s benefits and processing policies in effect at the time services are provided. For example, if a predetermination/prior authorization is submitted and the Subscriber’s coverage changes before the services are provided, the services will be processed based on the benefits in effect on the completion date of service. Keep in mind that the remaining balance of a Covered Person’s contract maximum will be altered if claims are processed and paid after the prior authorization.

When treatment is completed, enter the dates of service on the pre-treatment estimate and return it to DDIA with the dentist’s and Covered Person’s signature. If any information needs to be corrected, make the changes on the computerized copy. Cross out the wrong information and replace it with the correct data.

Identify the Billing Entity and Treating Dentist

Dentist Information

The dentist sections of the claim form identifies the billing entity and treating dentist.

Please use the following guidelines when completing the dentist information of a claim form:

• Please list the billing entity or billing dentist’s name, address and phone number.

• Include the billing entity or dentist’s tax identification number (TIN). The number entered should be the TIN recorded with the Internal Revenue Service (IRS). Please contact the dentist’s accountant if you are unsure of the correct TIN.

• Enter the National Provider Identifier (NPI) number. (Please see HIPAA Section of this Manual for more information regarding the NPI number.)

• It is important to input the state issued license number of the dentist who performed the services.
• The treating dentist who performed the services needs to be listed in the treating section of the claim form. He/she must also sign and date the claim. Be sure to enter the treating dentist’s license number and National Provider Identifier (NPI) number in this section as well.

Other Important Claim Information

Ancillary Claim/Treatment Information
This area of the claim includes other important information about treatment location and enclosures attached, along with whether treatment is result of an occupational injury or an accident. It is also the section that provides more detail if services were for orthodontic treatment or prosthesis placement. Include the appropriate code of where the treatment was performed.

Be sure to indicate if radiographs or other review documents are included with the claim.

• If services are for orthodontic services, indicate the date the appliances were placed and the months of treatment.

• If services include placement of a prosthesis, please indicate if it is the initial placement or if it is a replacement. If it is a replacement, include the date of previous placement, if known, and the reason for the replacement.

• Be sure to check the appropriate box if treatment is a result of occupational injury, auto accident or other accident. If yes, provide a brief description of the injury and the injury date and include a copy of the medical carrier’s claim payment report, if applicable.

Orthodontic Treatment

Orthodontic Services
Please use the filing details outlined previously to complete the subscriber, patient, ancillary/treatment information and the dentist areas of the claim form. Do not submit regular dental services and orthodontic services on the same claim form. Use the following instructions in completing the record of services section when filing for orthodontic services.
• If a Covered Person is having limited orthodontic treatment with no monthly adjustment charges, record the date the appliances were placed and the total fee with the applicable orthodontic code. If no date is listed, the claim will be processed as a predetermination/prior authorization.

• Be sure to submit the total treatment fee including the retention fee.

• DDIA processes 25% of the total orthodontic treatment fee.

• List the initial placement fee for the appliances with the applicable orthodontic code. Document the date the appliances were placed. If no date is listed, the claim will be processed as a predetermination/prior authorization.

• The monthly fee is determined by subtracting the initial down payment from the total fee of the therapy (including the retention fee) and divide the remaining amount by the number of anticipated monthly treatments. Please submit the total fee for the monthly visits, along with the number of months estimated.

• Use the actual date of service if billing an evaluation, impressions, cephalometric x-ray, etc. List the date and fee for these services with the applicable code.

• Verify that the total fee reflects the sum of the billed charges on the claim.

• If payment is received from another dental benefits company, please include a copy of the primary carrier’s claim payment in order to coordinate benefits.

Once the monthly orthodontic treatment information is received, DDIA will automatically process the monthly treatments. There is no need to continue filing claims for the monthly visits.

DDIA will pay the monthly treatments every three-months based on the banding date.

**Orthodontic Predetermination/Prior Authorization**
Orthodontists may submit a predetermination/prior authorization request before beginning actual work. Follow the previously outlined claim submission guidelines
but mark the claim form as a predetermination/prior authorization and do not enter dates of service.

When the orthodontic predetermination/prior authorization request is processed, a pre-treatment estimate is generated informing the Covered Person and the orthodontist the amount DDIA will pay if services are provided. If actual orthodontic services and a predetermination/prior authorization is being submitted on the same claim, make sure the dates are clearly marked for the actual services performed.

To file the claim for payment, return the pre-treatment estimate and clearly indicate the date the appliances were placed and the number of months of treatment. Include the appropriate signatures and the automatic monthly payments will be initiated. No further paperwork is required unless the treatment plan changes. DDIA will pay the monthly treatments every three-months based on the banding date.

**Terminated Orthodontic Treatment**

If orthodontic treatment terminates before it is completed, please send a written notice of the last date of service and indicate if there was a change in the total orthodontic treatment fee. Send this information to:

ATTN: CLAIMS REVIEW DEPARTMENT  
Delta Dental of Iowa  
9000 Northpark Dr.  
Johnston, IA  50131

**Transferred Orthodontic Patient**

If a Delta Dental Covered Person who has begun orthodontic treatment transfers to your office, please indicate this on the claim form. Include the first date of treatment with your office, the amount billed for the monthly treatments and the number of estimated treatments remaining.
hawk-i Orthodontic Claims

hawk-i Orthodontic Services
The hawk-i program offers a medically necessary orthodontic benefit to hawk-i members. All orthodontic treatment requires a predetermination/prior authorization before treatment begins. For more information regarding hawk-i orthodontic services, please refer to the Eligibility and Benefits section of this manual.

Duplicate Claims Cost Money

Duplicate Claims
Each duplicate claim filed results in additional handling fees for your office and costs DDIA to process the unnecessary claim. If you currently file claims electronically, check your electronic submissions to ensure you're not including claims sent previously. Duplicate filings occur in some dental office practice management systems when claims at the end of a transmission are not deleted and are subsequently resubmitted.

If you are unsure whether the claim has been filed, please access the Dentist Connection on DDIA’s web site at www.deltadentalia.com or use the voice response feature on DDIA’s interactive phone system to check the status of the claim before refiling.

Infection Control Should Not be Billed Separately

Infection Control
DDIA understands that costs are incurred by the dentist to comply with Centers for Disease Control (CDC) recommended infection control guidelines. However, infection control is not a unique element of a dental procedure but is a dentist's professional responsibility. These costs are part of the day-to-day operations and office overhead and should not be billed separately. Participating Dentists may not bill the Covered Person or Delta Dental separately for these charges.

Claim Filing Tips
Review the following filing tips to ensure quick and accurate claims processing:
• Verify the print quality and legibility of your claims.

• Predeterminations/prior authorizations are strongly recommended for treatment plans over $250 or those containing onlays, crowns, fixed prosthetics, implants and periodontal surgery.

• It is very important to submit claims with the Covered Person’s correct date of birth.

• When sending photos or radiographs, indicate the date of the image and identify teeth by labeling “right” (R) or “left” (L). **Do not send original radiographs.** DDIA will not return radiographs unless the office includes a self-addressed, stamped envelope with the submission. Be sure to include sufficient postage.

• The dentist performing the services should sign and date the claim form.

• Submit crowns, onlays, inlays, veneers, bridges and dentures with the seat date, not the preparation date.

• File root canal therapy (RCT) with the completion or fill date.

• When you file periodontal services (i.e. root planing and scaling, osseous surgery, grafting, gingivectomy), include the tooth number or the quadrant (UR, UL, LL, LR) to identify the teeth/area being treated. Be sure to include the necessary submission requirements for these procedures. (Please refer to the Procedures and Processing Policies section of this Manual for additional details.)

• Be sure to include the tooth number when filing a claim for recementing a restoration. List tooth numbers for fillings, inlays, onlays, crowns, bridge retainer crowns and pontics.
Report Suspected Fraud

Fraud

Fraud is a knowing misrepresentation of a fact to obtain benefits whether or not successful. Fraud is a crime of deception usually for material gain. Iowa is a mandatory reporting state for fraud. This means that all suspected fraud must be filed with the Iowa Insurance Division by DDIA. If fraud is suspected, report it to DDIA’s Utilization Review Coordinator at 515-261-5500 or 800-544-0718. The following are examples of fraud:

- Billing for a service not performed;
- Billing for a more expensive service than the one actually provided;
- Performing and billing unnecessary services with intentional false representation that the services were necessary;
- Office staff files a claim or a patient requests the claim be filed with an incorrect date of service or procedure code in an attempt to receive a service or better benefit;
- Waiver of the patient’s co-payment or coinsurance;
- Office falsifying patient name and identifying information or a patient providing a false name and identifying information, such as a social security number, date of birth or residential address;
- Office or patient deliberately failing to report the existence of additional dental benefits coverage and billing two or more carriers for the full amount;
- Patients who misrepresent themselves as another person with dental benefits coverage;
- Patient trying to obtain benefits under a former spouse’s plan.
Check Eligibility by Phone, Fax or Web site

Eligibility
Eligibility can vary from plan to plan so be sure to verify before assuming eligibility. Confirm eligibility using DDIA's interactive voice response phone system by simply entering the requested Covered Person’s information. You also have the option of selecting the Fax-Back feature through the interactive phone system to obtain patient benefits and eligibility faxed to your office. Eligibility can also be confirmed by accessing the Dentist Connection on DDIA’s web site at www.deltadentalia.com. All of these options are available 24 hours a day 7 days a week.

Services must be Completed

Work in Progress
Generally, dental care benefits cease on the date the Covered Person loses coverage. This applies to any Covered Service completed after the termination date. Multiple visit procedures begun but not completed before the Covered Person loses benefits are not payable. If DDIA makes payment and the Covered Person is determined to be ineligible, the claim will be reprocessed to recover the amount paid in error.

Check Benefits by Fax or Web site

Benefits
Like eligibility, benefits can vary from plan to plan. A Covered Person’s benefits can be verified by using DDIA’s interactive phone system and selecting the Fax-Back feature to obtain patient benefits and eligibility faxed to your office. Benefits can also be verified by accessing the Dentist Connection on DDIA’s web site at www.deltadentalia.com. Both options are available 24 hours a day 7 days a week.

DDIA offers dental benefits to Contractholders which cover dental procedures that are both dentally necessary and dentally appropriate. Employer groups purchase dental coverage for employees which causes variations in dental benefits from group to group. DDIA also offers individual dental benefits and voluntary dental benefits which can vary as well. Therefore, some contracts exclude procedures that other contracts may cover. There are also variations of dental benefits in the Deductible amounts, Coinsurance or Copayment amounts, annual Contract Maximums and Lifetime Maximums.
Eligibility and Benefits

Benefit Coverage Descriptions and Designs
To better understand a Covered Person’s dental benefits, the following are some benefit coverage descriptions and designs that may be helpful in understanding the different types of dental benefits offered by DDIA. As mentioned previously, benefits can vary from plan to plan so be sure to verify a patient’s benefits by using DDIA’s interactive phone system and selecting the Fax-Back feature to obtain patient benefits and eligibility faxed to your office. Benefits can also be verified by accessing the Dentist Connection on DDIA’s web site at www.deltadentalia.com.

CheckUp Plus - CheckUp Plus is a DDIA plan design that Contractholders can choose that waives diagnostic and preventive dental service costs from applying to a Covered Person’s Contract Maximum.

Differential Reimbursement - Some Contractholders may choose a contract that has Differential Reimbursement. A patient with this kind of contract may visit any dentist; however, reimbursement will be different depending if a dentist is a Participating Dentist or a Non-Participating Dentist. Reimbursement for Participating Dentists is the Billed Charge or the Maximum Plan Allowance (MPA), whichever is less. Reimbursement for Non-Participating Dentists may be at a lesser amount.

If a Covered Person chooses to seek services from a Non-Participating Dentist, the Covered Person is liable for the difference between the dentist’s Billed Charge and the lesser reimbursement level. This contract design encourages Covered Persons to seek services from Participating Dentists to reduce their out-of-pocket expense.

Enhanced Benefits Program - Enhanced Benefits Program is an additional benefit option that Contractholders can add to their dental coverage. Enhanced Benefits Program integrates medical and dental care. This benefit is customized at the individual level by offering additional benefits to persons who have specific dental or medical conditions (i.e. diabetes, pregnancy, serious periodontal condition, high-risk cardiac condition, suppressed immune system, kidney failure or dialysis and cancer with chemotherapy and/or radiation) that can be positively affected by additional care. Not all groups offer the Enhanced Benefits Program. For those that do, Covered Persons must be signed up to receive the extra benefits. The Covered Person or dentist can enroll the Covered Person in the Program by accessing the Dentist Connection on the DDIA web site at www.deltadentalia.com and selecting “Add Health Condition”.
Step Coinsurance - Step Coinsurance is designed to encourage Covered Persons to receive routine preventive services by offering coinsurance incentives.

An example of step coinsurance is during the first year of coverage, coinsurance will be at the highest level (e.g. 30%). During the second and third years of coverage, providing the Covered Person visited the dentist for preventive services at least once during the benefit period, the coinsurance obligation decreases (e.g. 20%, 10%). If the Covered Person did not visit the dentist for preventive services during a Benefit Period, the highest coinsurance level can apply in the following Benefit Period.

To Go™ Maximum Carry Over - DDIA has an optional benefit for some dental plans called To Go™. This optional benefit allows Covered Persons to roll the unused Contract Maximum amount from one Benefit Period to the next and is subject to certain applicable criteria.

Evidence-Based Dentistry
Delta Dental recognizes both policy development and clinical uses of the available evidence to define Evidence-Based Dentistry:

*Evidence-Based Dentistry* is a set of principals and methods intended to ensure that to the greatest extent possible, clinical decisions, guidelines, and other types of policies are based on and consistent with good evidence of effectiveness and benefit.

“Policy Development” includes areas such as benefit coverage. While the Delta Dental definition is similar to that of the American Dental Association (ADA) in terms of its clinical approach, Delta Dental, as a leader in the dental benefits industry, has the responsibility of balancing evidence-based dental practices with sound benefit policy guidelines.

Evidence-Based Dentistry offers a promising new direction for the future of dentistry and dental benefits. As science confirms that the use of innovative or more or less aggressive dental interventions does help improve health outcomes, Delta Dental will be at the forefront of innovative ways to promote those interventions through changes in benefit design, enrollee education and communication, and by working
closely with Delta Dental Member Companies and health plans to integrate and make optimal use of patient data.

**Affordable Care Act (ACA)**

**Small Group Businesses and Individual Policies**
Delta Dental offers dental benefits coverage to small employer group businesses, 1 to 50 employees, and individuals. They have the option of purchasing dental benefits that are also compliant with the Patient Protection and Affordable Care Act (ACA) provisions which is effective October 1, 2016. This coverage includes the 10 essential health benefits (EHB), which includes pediatric dental services up to age 19. However, Delta Dental will provide pediatric coverage until age 21. Benefits for adults and children on the same policy may now be different. Please note that not all small group and individual coverages offered by Delta Dental include all ACA defined pediatric dental benefits.

Pediatric dental services, as defined by the State of Iowa, offer expanded coverage with annual out-of-pocket limits not to exceed $350 per child or $700 for all children in a family. There is no annual or lifetime maximum on benefits, and plans include coverage for medically necessary orthodontia.

Medically necessary orthodontic services help correct severe handicapping malocclusions caused by cranio-facial orthopedic deformities involving the teeth. Examples of congenital defects or anomalies that affect the face and possibly the dentoalveolar arches, or their relationships to each other and may be medically necessary depending on the functional impairment conditions causing such deformities include:

**Medical Conditions Considered Medically Necessary**

- Cleft palate isolated
- Lateral or oblique facial clefting
- Cleft mandible
- Klippel-Fiel Syndrome
- Pierre Robin Syndrome
- Trisomies 18, 21, 13 - 15
- Chondroectodermal dysplasia (Ellis-van Creveld Syndrome)
Eligibility and Benefits

- Bird headed dwarfism (Nanocephalic or primordial dwarfism)
- Turner's Syndrome (X-0 Syndrome)
- Klinefelter’s Syndrome
- Craniofacial dysostosis (Crouzon’s Syndrome)
- Occuloauriculovertebral dysplasia (Goldenhar’s Syndrome)
- Occulamandibulofacial Syndrome (Hallerman Striff Syndrome, Ullrich et al Syndrome)
- Treacher Collins Syndrome
- Hemifacial microsomia
- Hemifacial hyperplasia.

Such conditions often require a combined pre- or post-orthognathic surgery/orthodontic treatment approach.

All orthodontic treatment requires a predetermination/prior authorization before the treatment begins. Please include the following information with the predetermination/prior authorization:

Statement from Covered Person’s physician (MD/DO) re-affirming medical diagnosis. Covered Person’s Physician’s (MD/DO) name and contact information.

Individual dental coverage is available through Delta Dental of Iowa to all permanent residents of Iowa. If you have patients that are interested in purchasing individual dental coverage, they may call 877-423-3582 or e-mail individualproduct@deltadentalia.com.

If you have additional questions regarding the new small group and individual dental benefit plan coverage, please contact Customer Service at 515-261-5500 or 800-544-0718.
Important Reminders for Iowa CHIP Program

**hawk-i Program**
Delta Dental of Iowa is the sole carrier for the *hawk-i* program that utilizes Delta Dental’s Premier network. However, there is a separate non-branded Delta Dental *hawk-i* orthodontic network for medically necessary orthodontic services.

Below are a few reminders on the *hawk-i* program.

**hawk-i Caries Risk Assessment** - Under the *hawk-i* program, your *hawk-i* patient may be eligible for additional benefits. *hawk-i* members who are at high risk for caries may be eligible for additional fluoride treatments and bitewing radiographs. A Caries Risk Assessment Tool for *hawk-i* patients **must be** completed each year and submitted by the treating dentist to document the caries risk status. This form is available on the Delta Dental Dentist Connection at www.deltadentalia.com by selecting Forms in the Resources tab.

The completed *hawk-i* Caries Risk Assessment can be faxed to 888-264-0195 or e-mailed to hawki@deltadentalia.com. **Due to PHI please send secure.**

**hawk-i Emergency Services that need Prior Authorization**

**hawk-i Emergency Services** - The *hawk-i* program also covers emergency services even if the patient has met their annual benefit maximum. The services are intended to address urgent clinical problems to allow a member to return to normal, pain- and infection-free oral functioning. Emergency services are limited and do not provide for definitive dental treatment.

Effective July 1, 2015, Delta Dental of Iowa’s agreement with the Department of Human Services for The Healthy and Well Kids in Iowa (*hawk-i*) program requires that dentists obtain a predetermination/prior authorization for specific Emergency Services.

Emergency service codes that are included in this predetermination/prior authorization process include:
D2940 Protective Restoration
D4320 Provisional Splinting - Intracoronal
D4321 Provisional Splinting - Extracoronal
D5810 Interim Complete Denture (Max)
D5811 Interim Complete Denture (Man)
D5820 Interim Partial Denture (Max)
D5821 Interim Partial Denture (Man)
D7510 Incision & Drainage of Abscess
D7910 Suture of recent small wound up to 5 cm
D7911 Complicated Sutures – up to 5 cm
D7912 Complicated Sutures – greater than 5 cm

Other procedures may be performed but do not require predetermination/prior authorization.

To complete the Predetermination/Prior Authorization process please follow these steps:

Complete the predetermination/prior authorization form with narrative. This form can be found on the Delta Dental of Iowa Dentist Connection website by selecting Forms in the Resources Tab.

Please email the form with appropriate documents (including radiographs) to Delta Dental at: hawki@preauth@deltadentalia.com. Due to PHI please send secure.

Delta Dental will monitor this e-mail address throughout each business day. Once reviewed a response will be provided to the senders email address. Any requests provided after 4:30 will be responded to on the next business day.

If you submit a claim that includes these Emergency Service CDT codes and a predetermination/prior authorization was not completed, the claim will drop for review and may require additional information to determine emergency condition and appropriate processing.
Emergency Services Criteria

Covered services must meet one or more of the following emergent/urgent criteria:

- services related to the relief of significant pain or to eliminate acute infection
- services to treat traumatic clinical conditions
- services that allow a patient to attain the basic human functions (i.e., eating, speaking, etc.)
- services that prevent a condition from seriously jeopardizing one’s health/functioning or deteriorating in an imminent time-frame to a more serious and costly dental problem

A narrative must be submitted for the services to be considered for emergency coverage. If you are submitting your claim electronically, please be sure to submit your narrative through an electronic attachment stating the claim is for emergency services. Supporting documentation such as radiographs and photographs are not required, but can expedite the claim process when the documentation clearly demonstrates the emergent condition. Treatment beyond addressing the emergency need may be denied.

Emergency services are available from any dentist regardless of the dentists’ participation in the Delta Dental Premier network. Patients should use a network dentist as follow-up care for the emergency may only be obtained from a Delta Dental Premier provider.

**NOTE:** The aforementioned emergency criteria and risk assessment processes are for the hawk-i program only and may be different than other programs administered by Delta Dental of Iowa.

**hawk-i Orthodontic Claim Reporting** - The hawk-i program offers a medically necessary orthodontic benefit to hawk-i members. Dentists must sign a separate hawk-i Orthodontic Services Agreement to participate in the hawk-i orthodontic provider panel. If the orthodontic treatment is reviewed and approved as medically necessary, reimbursement is based on the hawk-i orthodontic fee schedule.
Eligibility and Benefits

All Orthodontic Treatment Require Predetermination/Prior Authorization

All orthodontic services require a predetermination/prior authorization before treatment begins. Below are a few reminders when filing **hawk-i** orthodontic claims:

- Procedure codes D8020 limited orthodontic treatment of the transitional dentition and D8060 interceptive orthodontic treatment of the transitional dentition should only be reported when initial appliance therapy is in conjunction with comprehensive treatment (D8070/D8080).
- Report procedure codes D8210/D8220 only for harmful habits that intend to address a deformative action on the teeth and jaw(s).
- Clearly label all radiographs, photographs and diagnostic casts with the patient’s name, the dentist’s name and the date.
- Diagnostic casts should be neatly trimmed.
- Be sure to carefully package diagnostic casts to ensure they arrive in good condition.

Please refer to the **hawk-i** Orthodontic Program Administrative Guide for complete claim requirements.

**hawk-i** orthodontic claims and attachments should be mailed to:
Delta Dental of Iowa, Attention: **hawk-i**, 9000 Northpark Dr., Johnston, IA 50131
Coordination of Benefits

Coordination of Benefits (COB) applies when a Covered Person is covered by two or more dental benefits plans. Determining which insurance company is primary (the first to pay) and which company is secondary (the second to pay) can be complicated. The rules governing coordination of benefits are established by the National Association of Insurance Commissioners (NAIC).

The COB provision allows the secondary carrier to reduce the amount of its benefits by the amount paid by the primary plan. A Covered Person with two or more dental benefits plans may collect up to, but never more than, 100% of charges for Covered Services.

Complete the Other Carrier Section of the Claim

It is very important that the other insurance portion of the claim form is filled out completely, so that DDIA can research the information to determine the order of benefits. Be sure to include a copy of the primary plan’s claims report when submitting a claim to DDIA as the secondary carrier. Clearly note the amount the primary plan paid in the third party payment box on the claim form.

Determining Primary Payer

Primary Coverage

NAIC guidelines help plans avoid claim payment delays and incorrect benefit denials by establishing nationally accepted guidelines that determine primary and secondary payers. Generally, if both spouses have family or two-person coverage, use these NAIC guidelines to determine whose contract is primary.

• If the Covered Person is the Subscriber, they are primary on their own contract; the spouse’s contract is secondary.

• The spouse whose birthday falls first (month and day) in the calendar year holds primary coverage for dependent children; the other spouse’s contract is secondary. This is called the Birthday Rule.
Divorce Decree

Divorce or Separation
If the Covered Person is a dependent child of parents who are legally separated or divorced, there may be a court decree stating which parent is responsible for the child's health care expenses.

- If a court decree states that one parent is responsible for the child’s health care expenses, that plan is primary.
- If a court decree gives custody to one parent, but does not state responsibility for health care, the plan of the parent with custody is primary.
- If a court decree states that parents have joint custody and/or joint responsibility for health care, primary and secondary status is determined by the Birthday Rule.

Order of Benefits

Remarriage - If No Divorce Decree
If a child’s parents are remarried, and the child is also covered under the step-parent’s plan, the order is as follows:

1. The plan of the natural parent with custody.
2. The plan of the step-parent with custody.
3. The plan of the natural parent without custody.
4. The plan of the step-parent without custody.

General COB Rules
There are general COB rules that will always apply. These include:

- If an individual is covered as a retired employee under one plan and as an active employee under another plan, the active employee plan is always primary.
• If an individual works two jobs and therefore is an active employee under two plans, the plan which has the earliest effective date of coverage is primary.

Two DDIA Policies

Dual Delta Dental
When a Covered Person is covered under two different DDIA plans, it is called Dual Delta Dental. Once Dual Delta Dental is known, a secondary claim will not need to be filed. Instead, DDIA will automatically create a claim and process it under the secondary coverage and coordinate benefits. A secondary claim will not need to be submitted.

To notify DDIA of Dual Delta Dental, note the following information when submitting the primary claim:

• Name of the Subscriber who has the secondary DDIA coverage.
• Identification number of the secondary Subscriber.
• Birthday information (or divorce information, if applicable).

Amounts Over the MPA or PPO Fee Schedule

COB and the Maximum Plan Allowance
As a Delta Dental Participating Dentist, a secondary payer may be billed for any unpaid balance. When Delta Dental is primary, it is possible for the claim to be paid in full between the two plans. If another carrier pays the difference between the Billed Charge and the Delta Dental Maximum Plan Allowance (MPA) (in the case of a Delta Dental Premier Participating Dentist) or the Delta Dental PPOsm Fee Schedule (in the case of a PPO Participating Dentist), the MPA or PPO fee reduction is not applicable. However, if this difference is not covered by the other dental benefits plan, the amount over the MPA or the PPO fee is the Participating Dentist’s responsibility and cannot be billed to the Covered Person. When Delta Dental is secondary, Delta Dental will not pay any amount over the Delta Dental Maximum Plan Allowance (MPA) (in the case of a Delta Dental Premier Participating Dentist) or the Delta Dental PPOsm Fee Schedule (in the case of a PPO Participating Dentist).
Special Contract Provision

Non-Duplication of Benefits
Non-duplication of benefits is a contract provision relieving the secondary payer of liability if the services performed are covered under another dental benefits plan. It is distinct from the COB provision in that reimbursement is limited to the level allowed by one of the two plans, rather than a total of 100% of covered charges.

For example, both the primary plan and the secondary plan pays 80% for a covered procedure. If the secondary coverage has a non-duplication of benefits provision, then no additional amount is due because the primary plan already paid what the secondary would have paid.

Medicaid
By law, the Medicaid program is the payor of last resort. Therefore, if you have patients that are covered by both Medicaid and a third-party carrier, such as Delta Dental of Iowa, you must file the claim to the third-party carrier first. Once payment information is received from the primary carrier, a claim should be submitted to Medicaid. Don't forget to include the amount paid by the primary carrier in the appropriate section on the Medicaid claim form.

hawk-i Dental Program
Coordination of Benefits involving Healthy and Well Kids in Iowa (hawk-i) program is the same as Medicaid and is the payor of last resort. If you have patients that are covered by both hawk-i and a third-party carrier, you must first file the claim to the third-party carrier. Once payment is received from the third-party carrier, a claim should be filed to Delta Dental of Iowa under the hawk-i coverage. Don't forget to include the amount paid by the primary carrier in the appropriate section of the claim form and include a copy of the primary carrier's explanation of payment. In cases where a patient has Delta Dental of Iowa through hawk-i and also Delta Dental of Iowa through a group or individual policy, submit the claim under the group or individual Delta Dental policy identification number first. When filing the primary claim, be sure to indicate there is additional coverage through hawk-i by completing the other coverage information on the claim form. Once this is noted on the primary
claim, we will automatically process the claim under the *hawk-i* secondary coverage so you will not need to submit another claim.

**Dental Wellness Plan (DWP)**
Coordination of Benefits involving the Dental Wellness Plan (DWP) program is the same as Medicaid and is the payor of last resort. If you have patients that are covered by both DWP and a third-party carrier, such as Delta Dental of Iowa, you must file the claim to the third-party carrier first. Once payment information is received from the primary carrier, a claim should be submitted to DWP. Don’t forget to include the amount paid by the primary carrier in the appropriate section on the claim form.

**Contact Customer Service**

**Help Determining Order of Benefits**
For help in determining primary and secondary coverage, contact Customer Service at 515-261-5500 or 800-544-0718.
Procedures and Processing Policies
This section provides in depth details about Delta Dental’s standardized processing policies used by all Delta Dental Member Companies.

Utilization Review

Delta Dental of Iowa’s Responsibility
It is Delta Dental of Iowa’s responsibility to Contractholders who purchase dental benefits to oversee utilization and billing patterns of the Participating Dentist network. Utilization review is performed to determine if a dentist’s practice patterns are beyond the Iowa norm of like dentists with similar education and practice experience. If unusual patterns are detected, DDIA will review all factors that could establish reasons why a dentist would demonstrate differing results than peers.

Review of Dental Records

In-Office Audit
As indicated in the DDIA Uniform Regulations, DDIA may make periodic examinations of dentist’s offices to examine and review patient dental records during regular office hours to determine that charges to DDIA Subscribers and Covered Persons are no greater than to other patients and to determine that services are dentally necessary and appropriate.

Dental Necessity and Appropriateness
As outlined in the DDIA Uniform Regulations, Participating Dentists shall furnish and will receive payment for Covered Services that meet Delta Dental’s criteria for dental necessity and dental appropriateness and as defined in the applicable Covered Person’s benefit certificate and in the Uniform Regulations. Interpretation of these contract provisions by Delta Dental will determine if the service is dentally necessary, dentally appropriate and eligible for payment.

Dental Necessity
The following must be true for a procedure, service or supply to be considered dentally necessary:

• The diagnosis is proper; and
• The treatment is necessary to preserve or restore the basic form and the function of the teeth and the health of the gums, bone and other tissues, which support the teeth.

Dentally Appropriate

Each of the following must be true for a procedure, service or supply to be considered dentally appropriate:

• It is the most appropriate procedure for the Covered Person’s individual circumstances; and
• It is consistent with and meets professionally recognized standards of dental care and complies with criteria adopted by Delta Dental.

Accurate and Legible Records are Important

Patient Record Keeping
At times it may be necessary for DDIA to request a copy of a Covered Person’s treatment notes, tooth chart and/or ledger for further clarification of a claim. It is important that the Covered Person’s records are complete and legible. The following lists patient record keeping requirements as outlined by the Iowa Dental Board (IDB):

650 - 27.11 (153,272C) Record keeping. Dentists shall maintain patient records in a manner consistent with the protection of the welfare of the patient. Records shall be permanent, timely, accurate, legible, and easily understandable.

27.11 (1) Dental records. Dentists shall maintain dental records for each patient. The records shall contain all of the following:

a. Personal data.

(1) Name, date of birth, address and, if a minor, name of parent or guardian.
(2) Name and telephone number of person to contact in case of emergency.
b. **Dental and medical history.** Dental records shall include information from the patient or the patient’s parent or guardian regarding the patient’s dental and medical history. The information shall include sufficient data to support the recommended treatment plan.

c. **Patient’s reason for visit.** When a patient presents with a chief complaint, dental records shall include the patient’s stated oral health care reasons for visiting the dentist.

d. **Clinical examination progress notes.** Dental records shall include chronological dates and descriptions of the following:

   (1) Clinical examination findings, tests conducted, and a summary of all pertinent diagnoses;
   (2) Plan of intended treatment and treatment sequence;
   (3) Services rendered and any treatment complications;
   (4) All radiographs, study models, and periodontal charting, if applicable;
   (5) Name, quantity, and strength of all drugs dispensed, administered, or prescribed; and
   (6) Name of dentist, dental hygienist, or any other auxiliary, who performs any treatment or service or who may have contact with a patient regarding the patient’s dental health.

e. **Informed consent.** Dental records shall include, at a minimum, documentation of informed consent that includes discussion of procedure(s), treatment options, potential complications and known risks, and patient’s consent to proceed with treatment.

27.11 (2) **Retention of records.** A dentist shall maintain a patient’s dental record for a minimum of six years after the date of last examination, prescription, or treatment. Records for minors shall be maintained for a minimum of either (a) one year after the patient reaches the age of majority (18), or (b) six years, whichever is longer. Study models and casts shall be maintained for six years after the date of completion of treatment. Alternatively, one year after completion of treatment, study models and
casts may be provided to the patient for retention. Proper safeguards shall be maintained to ensure safety of records from destructive elements.

27.11 (3) **Electronic record keeping.** The requirements of this rule apply to electronic records as well as to records kept by any other means. When electronic records are kept, a dentist shall keep either a duplicate hard copy record or use an unalterable electronic record.

27.11 (4) **Correction of records.** Notations shall be legible, written in ink, and contain no erasures or white outs. If incorrect information is placed in the record, it must be crossed out with a single nondeleting line and be initialed by a dental health care worker.

27.11 (5) **Confidentiality and transfer of records.** Dentists shall preserve the confidentiality of patient records in a manner consistent with the protection of the welfare of the patient. Upon request of the patient or patient’s legal guardian, the dentist shall furnish the dental records or copies or summaries of the records, including dental radiographs or copies of the radiographs that are of diagnostic quality, as will be beneficial for the future treatment of that patient. The dentist may charge a nominal fee for duplication of records, but may not refuse to transfer records for nonpayment of any fees.

*(IDB Code 650, Chapter 27 - Standards of Practice and Principles of Professional Ethics)*

**Request a Review or Appeal of a Denied Claim or Pre-Treatment Estimate**

If Delta Dental of Iowa does not pay all or part of a patient’s claim and the patient or the patient’s representative thinks the service should be covered, they can ask for a full and fair review of that claim.

DDIA’s process includes 2 steps. Please follow step 1 (Review of a Denied Claim or Pre-Treatment Estimate) before proceeding to step 2 (Appeal a Denied Claim or Pre-Treatment Estimate). If you skip step 1 and proceed to step 2, it will be the only review and/or appeal of the claim.
Request a Review

**Step 1 - Request a Review of a Denied Claim or Pre-Treatment Estimate**

To request a Review of a claim or Pre-Treatment Estimate on behalf of your patient, a dentist must:

- Send a letter requesting review of the denied claim or pre-treatment estimate.
- Provide all appropriate review documentation (e.g. narrative, patient treatment record, radiographs, etc.).
- Include your name, patient's name and the patient identification number on all documents.

This information will be reviewed by the dental consultant and a determination will be provided to you within 30 days.

You may send the Review and supporting documents via the following:

**For Group or Individual patients:**

Fax Number: 888-264-1440

Email Address: claims@deltadentalia.com *(Be sure to secure the email since Patient Health Information (PHI) is included.)*

Mailing Address:

ATTN: CLAIMS REVIEW DEPARTMENT  
Delta Dental of Iowa  
9000 Northpark Dr  
Johnston, IA  50131
For **hawk-i** patients:

Fax Number: 888-264-0195

Email Address: **hawk{i}@deltadentalia.com** *(Be sure to secure the email since Patient HealthInformation (PHI) is included.)*

Mailing Address: ATTN: CLAIMS REVIEW DEPARTMENT
Delta Dental of Iowa
PO Box 9030
Johnston, IA 50131-9040

If you are dissatisfied with the outcome of Step 1 (Review of a denied claim or pre-treatment estimate, you may proceed to Step 2.

**Request an Appeal**

**Step 2 - Request an Appeal a Denied Claim or Pre-Treatment Estimate**

To request an Appeal of a denied claim or pre-treatment estimate on behalf of your patient, a dentist must:

- Submit a completed Appeal Request Form including the reason you disagree with the claim decision, all new documents, records, and any other information related to the claim. There is no need to resend documents previously provided with the original claim or the step 1 Review of the claim. The Appeal Request Form can be found on the Dentist Connection on the Delta Dental web site (www.deltadentalia.com/dentist) in the Resource section under Forms.

- Include your name, patient’s name and the patient identification number on all documents.

- Submit the completed Appeal Request Form within 180 calendar days from the date of the original adverse benefit determination from Delta Dental of Iowa. Any
Appeal Request Form sent after 180 days will not be reviewed and the processing will stand.

You may not initiate an appeal if the plan member or their authorized representative has already filed an appeal pertaining to the same service.

**Appeal Committee Decisions are Final**

All Appeals will be reviewed by an Appeals Committee and will be the final decision for the claim or pre-treatment estimate. For this reason be sure all information is provided with the Appeal Request Form because there will not be an opportunity for any additional appeal or review by DDIA.

**Delta Dental’s Appeal Decision**

Within 30 days of receiving the completed Appeal Request Form, Delta Dental of Iowa will send a written decision and indicate any action that has been taken. However, when special circumstances arise, Delta Dental of Iowa may require 60 days. Delta Dental of Iowa will notify you within the original 30 day timeframe in the event we require additional days.

You may send the completed Appeal Request Form and supporting documents via the following:

**For Group or Individual patients:**

Fax Number: 888-264-1440

Email Address: claims@deltadentalia.com *(Be sure to secure the email since Patient Health Information (PHI) is included.)*

Mailing Address:

ATTN: APPEALS  
Delta Dental of Iowa  
PO Box 9010  
Johnston, IA  50131-9010
For hawk-i patients:

Fax Number:  888-264-0195

Email Address:  hawki@deltadentalia.com (Be sure to secure the email since Patient Health Information (PHI) is included.)

Mailing Address:  ATTN:  APPEALS
Delta Dental of Iowa
PO Box 9040
Johnston, IA  50131-9040

HIPPA Code Set Requirements

Delta Dental Processing Policies
Delta Dental's processing policies reflect the data code set requirements set forth under the Administrative Simplification Provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and related regulations. It is the policy of the Delta Dental Plans Association to comply with all such requirements, as well as to require all Delta Dental Member Companies and their Participating Dentists to comply with such requirements.

However, consistent with HIPAA, Delta Dental exercises its right to determine claims reimbursement procedures and requires the processing of such codes in accordance with the following policies, unless prohibited under other applicable law or specific group contract provisions.

Notwithstanding treatment of procedures under Delta Dental’s processing policies, dentists are required to utilize those procedure codes reflective of services rendered and in accordance with HIPAA. Amounts charged under any procedure shall not be inflated or manipulated in light of Delta Dental's processing policies. Please refer to the HIPAA section of this Manual for further information regarding HIPAA.
Dentist Handbook Preamble
The following handbook provides Delta Dental’s standard processing policies for all CDT codes and is used by all Delta Dental Member Companies. Please note that there may be variations to the standard processing policies depending on the specific contract provisions. Therefore, the following information should not be interpreted as comprehensive and encompassing of all possible limitations and exclusions. These policies are standards of payment and should not be misconstrued as standards of care.
Dentist Handbook
National Processing Policies

Introductory Note

These national processing policies have been revised to reflect data code set requirements set forth under the Administrative Simplification Provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and related regulations. It is the policy of Delta Dental to comply with all such requirements as well as to require all Delta Dental member companies and their participating dentists to comply with such requirements. However, consistent with HIPAA, Delta Dental exercises its right to determine claims reimbursement procedures and requires the processing of such codes in accordance with the following policies, unless prohibited under other applicable law or specific group/individual contract provisions (described below). Notwithstanding, treatment of procedures under the national processing policies, dentists are required to utilize those procedure codes reflective of services rendered and in accordance with HIPAA. Amounts charged under any procedure shall not be inflated or manipulated in light of the processing policies. Delta Dental member companies shall ensure that their application of these processing policies is consistent with their contractual obligations to groups and enrollees.

General Policies

General policies (GP) related to each category of procedure codes precede the category code listing. Policies for specific procedure codes are listed in each category after the codes and nomenclature.

Terms of group/individual contracts vary. Policies in this Handbook that address benefits, limitations and exclusions are “model” policies that have not been tailored to reflect the specific terms of applicable group/individual contracts. This Handbook may not fully or accurately reflect the terms of applicable group/individual contracts, and may be inconsistent with such terms. In all cases, the terms of group/individual contracts take precedence over Dentist Handbook policies. Please contact the member company listed on the patient’s identification card for the specific terms of a group/individual contract.

For the purposes of this manual, the following definitions apply:

Allowance: The amount of Delta Dental’s payment for the procedure benefitted.

Approved Amount: The total fee a participating dentist agrees to accept as payment in full for a procedure. It includes both the Delta Dental allowance and the patient responsibility. Participating dentists agree not to collect from the patient any difference between the approved amount and their actual fee for the procedure.

Denied/Deny: If the benefit for a procedure or service is denied, the procedure or service is not a benefit of the patient’s coverage and the approved amount is collectable from the patient. Specific group/individual contract provisions take precedence over processing policies. It is recommended that the dental office contact the appropriate member company for the group/individual account to determine the specific benefits, limitations and exclusions.

Disallowed: If the fee for a procedure or service is disallowed, it is not benefitted by Delta Dental or collectable from the patient by a participating dentist.
**Alternative Benefit:** In cases where alternative methods of treatment exist, benefits are provided for the least costly, professionally acceptable treatment. This determination is not to recommend which treatment should be provided. It is a determination of benefits under terms of the patient’s coverage. The dentist and patient should decide the course of treatment. If the treatment rendered is other than the one benefitted, the difference between Delta Dental’s allowance and the approved amount for the actual treatment rendered is collectable from the patient.

**In Conjunction With:** In conjunction with means as part of another procedure or course of treatment including, but not limited to, being rendered on the same day.

**Processed as:** When a procedure is processed as a different procedure, participating dentists agree to accept all the limitations, processing policies, and approved amounts that apply to the procedure Delta Dental benefits.

All services provided to Delta Dental members are subject to the following general policies:

- Documentation of extraordinary circumstances can be submitted for review by report.
- Individual consideration may be given if additional supporting documentation is provided (e.g. diagnostic quality radiographs, clinical notes, charting, etc.)
- Fees for completion of claim forms and submission of documentation to Delta Dental to enable benefit determination are not benefits. They are not collectable from the patient by a participating dentist.
- Infection control and OSHA compliance are included in the fee for the dental services provided. Separate fees are disallowed and not collectable separately from the patient by a participating dentist.
- Multistage procedures are reported and benefitted upon completion. The completion date is the date of insertion for removable prosthetic appliances. The completion date for immediate dentures is the date that the remaining teeth are removed and the denture is inserted. The completion date for fixed partial dentures and crowns, onlays and inlays is the cementation date of the final restoration regardless of the type of cement utilized. The completion date for endodontic treatment is the date the canals are permanently filled.
- Charges for procedures determined not to be necessary or not meeting generally accepted standards of care may be denied or disallowed. Many of the processing policies that follow, describe payment procedures that are based on the timing and sequence of inter-related procedures. However, the timing and sequencing of treatment is the responsibility of the dentist rendering care and should always be determined by the treating dentist based on the patient’s needs.
- When a procedure is by report and subject to coverage under medical, it should be submitted to the patient’s medical carrier first. When submitting to Delta Dental, a copy of the explanation of payment or payment voucher from the medical carrier should be included with the claim, plus a narrative describing the procedure performed, reasons for performing the procedure, pathology report if appropriate, and any other information deemed pertinent. In the absence of such information, Delta Dental will not benefit the procedure.
- The term specialized procedure describes a dental service or procedure that is used when unusual or extraordinary circumstances exist, and is not generally used when conventional methods are adequate.
- Additional supporting documentation may be requested in order to make a benefit determination.
- Narratives as documentation are not considered legal entities nor are they contemporaneous in nature. The patient record/clinical notes are considered a legal document and are contemporaneous. The only acceptable legal written documentation for utilization review are the contemporaneous treatment notes.
- For payment purposes, local anesthesia is an integral part of the procedure being performed and additional fees are disallowed.
Terms of group/individual contracts vary. Policies in this Handbook that address benefits, limitations and exclusions are "model" policies that have not been tailored to reflect the specific terms of applicable group/individual contracts. This Handbook may not fully or accurately reflect the terms of applicable group/individual contracts, and may be inconsistent with such terms. In all cases, the terms of group/individual contracts take precedence over Dentist Handbook policies. Please contact the member company listed on the patient's identification card for the specific terms of a group/individual contract.

Clinical Oral Evaluations

- **D0100 - D0999**

  The number and type of evaluations available for benefits are based on group/individual contract.

- **D0120** Periodic oral evaluation – established patient

  The fees for consultation, diagnosis, and routine treatment planning are disallowed as components of the oral evaluation, by the same dentist/dental office.

- **D0140** Limited oral evaluation - problem focused

- **D0145** Oral evaluation for a patient under three years of age and counseling with primary caregiver

  Oral evaluation includes any caries susceptibility tests (D0425) or oral hygiene instructions (D1330) provided on the same date. When performed on the same date, any fees for D0425 and D1330 are disallowed.

  For patients under the age of three, any other comprehensive evaluation code submitted is benefited as D0145. Any fees in excess of D0145 are disallowed.

- **D0150** Comprehensive oral evaluation – new or established patient

  A comprehensive oral evaluation is payable once per patient per dentist/dental office. Additional comprehensive evaluations of any type when billed by the same dentist/dental office are processed as periodic evaluations, and any fee charged in excess of the approved amount for the periodic evaluation is disallowed.

  The fees for consultation, diagnosis, and routine treatment planning are disallowed as components of the oral evaluation, by the same dentist/dental office.

  If the patient has not received any services for three years from the same dentist/dental office, a comprehensive evaluation may be benefitted.

- **D0160** Detailed and extensive oral evaluation-problem focused, by report

  Any fees in excess of the approved amount for a comprehensive oral evaluation (D0150) or periodic oral evaluation (D0120) are disallowed.
If the patient has not received any services for three years from the same dentist/dental office, a comprehensive evaluation may be benefitted.

D0170 Re-evaluation-limited, problem focused (established patient, not post-op visit)

The fees for re-evaluation are disallowed in conjunction with any other procedure by the same dentist/dental office.

D0171 Re-evaluation – post operative office visit

The fees for re-evaluation are disallowed when submitted by the same dentist/dental office that performed the original procedure.

D0180 Comprehensive periodontal evaluation - new or established patient

A comprehensive periodontal evaluation is payable once per patient, per dentist/dental office. Additional comprehensive evaluations of any type when billed by the same dentist/dental office are processed as periodic evaluations, and any fee charged in excess for the approved amount for the periodic evaluation is disallowed.

This evaluation should not be reported in addition to a comprehensive oral evaluation (D0150) by the same dentist/dental office in the same treatment series. This procedure is not intended for use as a separate code for periodontal charting.

If a D0180 is submitted with D4910 by the same dentist/dental office it is benefitted as a D0120 and the difference in the approved amount is disallowed unless the D0180 is the initial evaluation by the dentist rendering the D4910.

Pre-Diagnostic Services

GP Benefits are determined by group/individual contract. D0190

Screening of a patient

When reported in conjunction with an evaluation, the fee for screening of a patient is disallowed.

D0191 Assessment of a patient

When reported in conjunction with an evaluation, the fee for the assessment of a patient is disallowed.

Diagnostic Imaging

GP Fees for duplication (copying) of diagnostic images for insurance purposes are disallowed.

GP Benefits for diagnostic imaging, tests and examinations are determined by group/individual contract.

GP Images must be of diagnostic quality; properly oriented if submitted for document purposes, and with the date of exposure and a patient identifier indicated on all images. Images not of diagnostic quality are disallowed.

GP Individually listed intraoral radiographic images by the same dentist/dental office are considered a complete series if the fee for individual radiographic images equals or exceeds the fee for a complete series. Any amount charged in excess of the allowance for a complete series (D0210) is disallowed.

GP When image capture only procedures are submitted with capture and interpretation procedures, the fee for the image capture only procedure will be disallowed.
When interpretation of a diagnostic image procedure (D0391) is submitted with the capture and interpretation procedures, the fee for the interpretation of a diagnostic image (D0391) will be disallowed.

Limit two bitewing images for patients under age 10. A D0273 or D0274 submitted for a patient under age 10 may be processed as D0272 and the excess fees of D0272 are disallowed.

Diagnostic imaging codes (D0210 - D0371) include image capture and interpretation. The fee for interpretation of a diagnostic image by a practitioner not associated with the capture of the image is processed according to contract. In all other instances, the fees for interpretation are disallowed.

The FDA/ADA 2012 document Selection of Patients for Radiographic Examinations provides guidance for when the prescription of a full mouth series of radiographs is appropriate. These guidelines state that radiographs are to be prescribed by dentists only after reviewing the patient’s health history and completing a clinical examination. Once a decision to obtain radiographs is made, it is the dentist’s responsibility to follow the ALARA Principle (As Low as Reasonably Achievable) to minimize the patient’s exposure to radiation. For most new patient encounters in dentate adults, and children or adolescents with transitional or permanent dentition, an individualized radiographic exam is appropriate, usually consisting of selected periapical images, posterior bitewings and a panoramic exam. A full mouth intraoral radiographic exam is usually performed when the patient has clinical evidence of generalized dental disease or history of extensive dental treatment.

http://www.fda.gov/Radiation-EmittingProducts/RadiationEmittingProductsandProcedures/MedicalImaging/Medical X-Rays/ucm116504.htm Table 1. from these guidelines is provided here:
<table>
<thead>
<tr>
<th>Patient Age and Dental Developmental Stage</th>
<th>New Patient* being evaluated for oral diseases</th>
<th>Recall Patient* with clinical caries or at increased risk for caries**</th>
<th>Recall Patient* with no clinical caries and not at increased risk for caries**</th>
<th>Recall Patient* with periodontal disease</th>
<th>Patient (New and Recall) for monitoring of dentofacial growth and development, and/or assessment of dental/skeletal relationships</th>
<th>Patient with other circumstances including, but not limited to, proposed or existing implants, other dental and craniofacial pathoses, restorative/endodontic needs, treated periodontal disease and caries remineralization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child with Primary Dentition (prior to eruption of first permanent tooth)</td>
<td>Individualized radiographic exam consisting of selected periapical/occlusal views and/or posterior bitewings if proximal surfaces cannot be visualized or probed. Patients without evidence of disease and with open proximal contacts</td>
<td>Posterior bitewing exam at 6-12 month intervals if proximal surfaces cannot be examined visually or with a probe</td>
<td>Posterior bitewing exam at 12-24 month intervals if proximal surfaces cannot be examined visually or with a probe</td>
<td>Clinical judgment as to the need for and type of radiographic images for the evaluation of periodontal disease. Imaging may consist of, but is not limited to, selected bitewing and/or periapical images of areas where periodontal disease (other than nonspecific gingivitis) can be demonstrated clinically.</td>
<td>Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring of dentofacial growth and development, or assessment of dental and skeletal relationships. Panoramic or periapical</td>
<td>Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring of these conditions</td>
</tr>
<tr>
<td>Child with Transitional Dentition (after eruption of first primary tooth)</td>
<td>Individualized radiographic exam consisting of posterior bitewings with selected periapical images.</td>
<td>Posterior bitewing exam at 6-12 month intervals if proximal surfaces cannot be examined visually or with a probe</td>
<td>Posterior bitewing exam at 12-24 month intervals if proximal surfaces cannot be examined visually or with a probe</td>
<td>Clinical judgment as to the need for and type of radiographic images for evaluation and/or monitoring of dentofacial growth and development, or assessment of dental and skeletal relationships. Panoramic or periapical</td>
<td>Usually not indicated for monitoring of growth and development. Clinical judgment as to the need for and type of radiographic image for evaluation of dental and skeletal relationships.</td>
<td>Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring of these conditions</td>
</tr>
<tr>
<td>Adolescent with Permanent Dentition (prior to eruption of first permanent tooth)</td>
<td>Individualized radiographic exam consisting of posterior bitewings with panoramic exam or posterior bitewings and selected periapical images. A full mouth intraoral radiographic exam is preferred when the patient has clinical evidence of generalized oral disease or a history of extensive disease.</td>
<td>Posterior bitewing exam at 6-18 month intervals if proximal surfaces cannot be examined visually or with a probe</td>
<td>Posterior bitewing exam at 18-36 month intervals if proximal surfaces cannot be examined visually or with a probe</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Adult, Dentate or Partially Edentulous</td>
<td>Individualized radiographic exam, based on clinical signs and symptoms.</td>
<td>Posterior bitewing exam at 6-18 month intervals if proximal surfaces cannot be examined visually or with a probe</td>
<td>Posterior bitewing exam at 24-36 month intervals if proximal surfaces cannot be examined visually or with a probe</td>
<td>Not applicable</td>
<td>Usually not indicated for monitoring of growth and development. Clinical judgment as to the need for and type of radiographic image for evaluation of dental and skeletal relationships.</td>
<td>Usually not indicated for monitoring of growth and development. Clinical judgment as to the need for and type of radiographic image for evaluation of these conditions</td>
</tr>
</tbody>
</table>

* New Patient
** Recalled Patient
Image Capture with Interpretation

D0210 Intraoral-complete series radiographic images.

The fee for any type of bitewings submitted with an intraoral-complete series are considered part of the full mouth series for payment and benefit purposes. Any fee in excess of a full mouth series is disallowed.

In the absence of contract language for bitewing frequency limitation, bitewings, of any type, are disallowed within 12 months of an intraoral-complete series.

A separate fee for a panoramic radiographic image (D0330) in conjunction with D0210 by the same dentist/dental office is disallowed as a component part of D0210.

When bitewings are processed as part of an intraoral complete series, a separate benefit for bitewings will not be allowed if the full mouth time limitation has been met within the benefit period.

D0220 Intraoral-periapical-first radiographic image

D0230 Intraoral-periapical-each additional radiographic image

Routine working and final treatment radiographic images taken by the same dentist/dental office for endodontic therapy are considered a component of the complete treatment procedure. Separate fees for these images are disallowed.

D0240 Intraoral-occlusal radiographic image

D0250 Extraoral-2-D projection radiographic image created using a stationary radiation source and detector

Extraoral posterior radiographic image is denied unless covered by group/individual contract.

D0251 Extraoral posterior dental radiographic image

Extraoral posterior radiographic image is denied unless covered by group/individual contract.

D0270 Bitewing-single radiographic image

D0272 Bitewings-two radiographic images

D0273 Bitewings-three radiographic images D0274

Bitewings-four radiographic images Limit two bitewing images for patients under age 10. A D0273 or D0274 submitted for a patient under age 10 may be processed as D0272 and the excess fees of D0272 are disallowed.

D0277 Vertical bitewings - 7 to 8 radiographic images

Vertical bitewings are considered bitewings for benefit purposes. If the fee for the vertical bitewings with or without additional radiographic images equals or exceeds the fee for a complete series, it would be considered a complete series for payment, benefit, and time limitation purposes. The fee in excess of the fee for a complete series of radiographic images is disallowed.
D0310  Sialography

D0320  Temporomandibular joint arthrogram including injection  D0321
Other temporomandibular joint radiographic images, by report

D0322  Tomographic survey

D0330  Panoramic radiographic image

A panoramic radiographic image, with or without supplemental radiographic images (such as periapicals, bitewings, and/or occlusal radiographic images) is considered a complete series for time limitation purposes and any fee charged in excess of the allowance for a complete series (D0210) is disallowed.

Benefits for subsequent panoramic radiographic images taken within the contractual time limitation for an intraoral complete series are denied and the approved amount is collectable from the patient.

Benefits for panoramic image is limited to individuals age six and older.

D0340  2-D Cephalometric radiographic image – acquisition, measurement and analysis

A cephalometric radiographic image is payable only in conjunction with orthodontic benefits. The fee for a cephalometric radiographic image taken in conjunction with services other than orthodontic treatment is denied and the approved amount is collectable from the patient.

D0350  2D oral/facial photographic images obtained intraorally or extraorally

Oral/facial images are benefitted only once per case in conjunction with orthodontic services.

Benefits for oral/facial images taken in conjunction with any other procedure are denied, and the approved amount is collectable from the patient.

D0351  3D photographic image

3D photographic image is denied as a specialized technique, and the approved amount is collectable from the patient.

D0364  Cone beam CT capture and interpretation with limited field of view – less than one whole jaw

The fee for the cone beam CT capture and interpretation with limited field of view – less than one whole jaw is denied.

D0365  Cone beam CT capture and interpretation with field of view of one full dental arch – mandible

The fee for cone beam CT capture and interpretation with field of view of one full dental arch – mandible is denied.

D0366  Cone beam CT capture and interpretation with field of view of one full dental arch – maxilla with or without cranium

The fee for cone beam CT capture and interpretation with field of view of one full dental arch – maxilla with or without cranium is denied.
D0367  Cone beam CT capture and interpretation with field of view of both jaws, with and without cranium

The fee for cone beam CT capture and interpretation with field of view of both jaws, with and without cranium is denied.

D0368  Cone beam CT capture and interpretation for TMJ series including two or more exposures.

The fee for cone beam CT capture and interpretation for TMJ series including two or more exposures is denied.

D0369  Maxillofacial MRI capture and interpretation

The fee for maxillofacial MRI capture and interpretation is denied.

D0370  Maxillofacial ultrasound capture and interpretation

The fee for maxillofacial ultrasound, capture and interpretation is denied.

D0371  Sialoendoscopy capture and interpretation

The fee for sialoendoscopy capture and interpretation is denied.

**Diagnostic Imaging – Image Capture Only**

GP  When image capture only procedures are submitted with capture and interpretation procedures, the fee for the image capture only procedure will be disallowed.

D0380  Cone beam CT image capture with limited field of view – less than one whole jaw

The fee for cone beam CT image capture with limited field of view – less than one whole jaw is denied.

D0381  Cone beam CT image capture with field of view one full dental arch – mandible

The fee for cone beam CT image capture with field of view one full dental arch – mandible is denied.

D0382  Cone beam CT image capture with field of view one full dental arch – maxilla, with and without cranium

The fee for cone beam CT image capture with field of view one full dental arch – maxilla, with and without cranium is denied.

D0383  Cone beam CT image capture field of view both jaws, with or without cranium

The fee for cone beam CT image capture field of view both jaws, with or without cranium is denied.

D0384  Cone beam CT image capture for TMJ series including two or more exposures

The fee for cone beam CT image capture for TMJ series including two or more exposures is denied.

D0385  Maxillofacial MRI image capture

The fee for maxillofacial MRI image capture is denied.
D0386 Maxillofacial ultrasound image capture

The fee for maxillofacial ultrasound image capture is denied.

**Interpretation and Report Only**

D0391 Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report

Benefits for interpretation of diagnostic image by a practitioner not associated with capture of the image, including report are denied.

**Post Processing of Image or Image Sets**

D0393 Treatment simulation using 3-D image volume

Treatment simulation using 3-D image volume is denied as a specialized technique.

D0394 Digital subtraction of two or more images or image volumes of the same modality

Digital subtraction of two or more images or image volumes is denied as a specialized technique.

D0395 Fusion of one two or more 3-D image volumes of the same modality

Fusion of two or more 3-D image volumes from the same modality is denied as specialized technique.

**Tests and Examinations**

D0411 HbA1c in-office point of service testing

Benefits for HbA1c in-office point of service testing are denied unless covered by group/individual contract.

When D0411 is submitted on the same date/same dentist/dental office as D0412, D0412 is disallowed.

D0412 Blood glucose level test: in office using a glucose meter

Benefits for blood glucose level test are denied unless covered by group/individual contract.

Fees for D0412 are disallowed on the same date/same dentist/dental office as D0411. D0414

Laboratory processing of microbial specimen to include culture and sensitivity studies, preparation and transmission of written report

Benefits for laboratory processing of microbial specimen are denied unless covered by group/individual contract.

D0415 Collection of microorganisms for culture and sensitivity

Benefits for bacteriologic studies for determination of sensitivity of pathologic agents to antibiotics are denied and the approved amount is collectable from the patient.

D0416 Viral culture
Studies for determining pathologic agents are specialized procedures and the benefits are denied.

D0417 Collection and preparation of saliva sample for laboratory diagnostic testing

Benefits for the collection and preparation of a saliva sample are denied and the approved amount is collectable from the patient.

D0418 Analysis of saliva sample

Benefits for the analysis of a saliva sample are denied and the approved amount is collectable from the patient.

D0422 Collection and preparation of genetic sample material for laboratory analysis and report

Genetic tests for susceptibility to periodontal diseases are denied unless covered by group/individual contract.

D0423 Genetic test for susceptibility to diseases - specimen analysis

Genetic tests for susceptibility to periodontal diseases are denied unless covered by group/individual contract.

D0425 Caries susceptibility tests

Benefits for caries susceptibility tests are denied and the approved amount is collectable from the patient.

D0431 Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures

Adjunctive pre-diagnostic tests that aid in the detection of mucosal abnormalities are considered investigational and fees are denied.

D0460 Pulp vitality tests

Pulp vitality tests are payable per visit, not per tooth, and only for the diagnosis of emergency conditions. Fees for pulp tests are disallowed when performed on the same date by the same dentist/dental office as any other definitive procedure except radiographic images, limited oral evaluation – problem focused (D0140), protective restoration (D2940), palliative treatment (D9110), radiographic images (D0210 - D0391), and consultation (D9310).

D0470 Diagnostic casts

Diagnostic casts are a benefit once when performed in conjunction with orthodontic services. The fees for additional casts taken during or after orthodontic treatment by the same dentist/dental office are included in the fee for orthodontics and are disallowed.

The fees for cast restorations and prosthetic procedures include diagnostic casts. Any fees charged for diagnostic casts in excess of the approved amount for these procedures by the same dentist/dental office are disallowed. Benefits for diagnostic casts taken in conjunction with any other procedure are denied and the approved amount is collectable from the patient.

Oral Pathology Laboratory

GP All oral pathology procedures must be accompanied by a pathology report to be considered
The fee for an oral pathology procedure not accompanied by a pathology report is disallowed.

The benefits for pathology reports submitted by anyone other than a licensed dentist are denied, and the approved amount is collectable from the patient.

When more than two procedures are performed on the same area of the mouth on the same day, benefits are based upon, but not limited to, the most inclusive procedure.

Fees for the included procedures are disallowed and not billable to the patient by a participating dentist. These inter-related procedures include, but are not limited to, the following hierarchy:

Most inclusive  D0474
D0473
D0472
D0480

All oral pathology procedures are by report and subject to medical coverage. Pathology reports, procedures D0472, D0473, and D0474 include preparation of tissue (sectioning, staining, etc.) and gross and microscopic examination. The fees for D0475, D0480, D0482 and D0483 are disallowed as being a component of the pathology procedures.

D0472 Accession of tissue, gross examination, preparation and transmission of written report

D0473 Accession of tissue, gross and microscopic examination, preparation and transmission of written report

D0474 Accession of tissue, gross and microscopic examination including assessment of surgical margins for presence of disease, preparation and transmission of written report

D0475 Decalcification procedure

D0476 Special stains for microorganisms

D0477 Special stains, not for microorganisms

D0478 Immunohistochemical stains

D0479 Tissue in-site hybridization, including interpretation

D0480 Accession of exfoliative cytologic smears, microscopic examination, preparation and transmission of written report

D0481 Electron microscopy

D0482 Direct immunofluorescence

D0483 Indirect immunofluorescence

D0484 Consultation on slides prepared elsewhere

Consultation on slides prepared elsewhere is benefitted as D9310 – Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment).

D0485 Consultation, including preparation of slides from biopsy material supplied by referring source

D0486 Laboratory accession of transepithelial cytologic sample, microscopic examination,
preparation and transmission of written report

D0502 Other oral pathology procedures, by report

Benefits for other oral pathology procedures for routine surgical procedures are denied and the approved amount is collectable from the patient.

D0600 Non-ionizing diagnostic procedure capable of quantifying, monitoring and recording changes in structure of enamel, dentin, and cementum

The fees for D0600 are disallowed when submitted with an evaluation.

D0601 Caries risk assessment and documentation, with a finding of low risk

The fee for caries risk assessment is disallowed for children under age three.

The fee for caries risk assessment is disallowed when submitted with other risk assessment codes on the same date of service by the same dentist/dental office.

D0602 Caries risk assessment and documentation, with a finding of moderate risk

The fee for caries risk assessment is disallowed for children under age three.

The fee for caries risk assessment is disallowed when submitted with other risk assessment codes on the same date of service by the same dentist/dental office.

D0603 Caries risk assessment and documentation, with a finding of high risk

The fee for caries risk assessment is disallowed for children under age three.

The fee for caries risk assessment is disallowed when submitted with other risk assessment codes on the same date of service by the same dentist/dental office.

D0999 Unspecified diagnostic procedure, by report

Benefits for medical procedures such as but not limited to urine analysis, blood studies and skin tests are denied and the approved amount is collectable from the patient.

PREVENTIVE D1000 - D1999

Terms of group/individual contracts vary. Policies in this Handbook that address benefits, limitations and exclusions are "model" policies that have not been tailored to reflect the specific terms of applicable group/individual contracts. This Handbook may not fully or accurately reflect the terms of applicable group/individual contracts and may be inconsistent with such terms. In all cases, the terms of group/individual contracts take precedence over Dentist Handbook policies. Please contact the member company listed on the patient’s identification card for the specific terms of a group/individual contract.

GP A fee for a prophylaxis done during the same episode of treatment by the same dentist/dental office as a periodontal maintenance, scaling in the presence of generalized moderate or severe gingival inflammation, scaling and root planing or periodontal surgery is considered to be part of those procedures and is disallowed.

GP Periodontal maintenance (D4910) is counted toward the contract limitation for prophylaxis and full mouth debridement (D4355).

Dental Prophylaxis

GP For payment purposes, the distinction between the adult and child dentition may be
determined by contract. In the absence of group/individual contract language regarding age, a person age 14 and older is considered an adult for benefit determination purposes of a prophylaxis-adult. Any fee, for persons less than age 14 in excess of the approved amount for D1120 is disallowed and not chargeable to the patient.

**D1110** Prophylaxis-adult

When submitted with D4346, the fees for D1110 are disallowed by the same dentist/dental office.

**D1120** Prophylaxis-child

When submitted with D4346, the fees for D1120 are disallowed by the same dentist/dental office.

Fees for toothbrush prophylaxis are disallowed.

**Topical Fluoride Treatment (office procedure)**

**GP** Using prophylaxis paste containing fluoride, a fluoride rinse, or fluoride swish in conjunction with a prophylaxis is considered a prophylaxis only and a separate fee for this type of topical fluoride application is disallowed on the same date of service and by the same dentist/dental office as the prophylaxis.

**GP** The age limitation for topical fluoride gel or varnish treatments determined by group/individual contract.

**GP** Fluoride gels, rinses, tablets, or other preparations intended for home applications are denied and the approved amount is collectable from the patient.

**D1206** Topical fluoride varnish

The application of topical fluoride varnish, delivered on a single visit and involving the entire oral cavity. Benefits for topical fluoride varnish when used for desensitization or as cavity liner are denied.

**D1208** Topical application of fluoride - excluding varnish

**Other Preventive Services**

**D1310** Nutritional counseling for the control of dental disease

The benefit for nutritional counseling is denied and the approved amount is collectable from the patient.

**D1320** Tobacco counseling for the control and prevention of oral disease

The benefit for tobacco counseling is denied unless covered by group/individual contract.

**D1330** Oral hygiene instructions

The benefit for oral hygiene instruction is denied and the approved amount is collectable from the patient.

**D1351** Sealant-per tooth

Sealants are payable once per tooth on the occlusal surface of permanent first and second molars for patients through age 15. The teeth must be free from overt dentinal caries (incipient caries sealing is preferred) or restorations on the occlusal surface.
Special consideration for late eruption can be given by report.
A separate fee for sealant done on the same date of service and on the same surface as a restoration by the same dentist/dental office is considered a component of the restoration and is disallowed.

Benefits for sealants are denied and the approved amount is collectable from the patient when submitted documentation or the patient’s claim history indicates an existing restoration on the occlusal surface of the same tooth.

The fee for repair or replacement of a sealant or preventive resin restoration by the same dentist/dental office within 24 months of initial placement is included in the fee for the initial placement and is disallowed. The benefit for repair or replacement of a sealant by a different dentist/dental office within 24 months of initial placement is denied and the approved amount is collectable from the patient.

Benefits for repair or replacement of sealants requested after 24 months have elapsed since initial placement are denied and the approved amount is collectable from the patient.

**D1352 Preventive resin restoration in a moderate to high caries risk patient – permanent tooth**

When covered by group/individual contract fees for preventive resin restoration completed on the same date of service and on the same surface as a restoration by the same dentist/dental office are disallowed as a component of the restoration.

Fees for replacement of preventive resin restoration are disallowed if performed within 24 months of initial placement of preventive resin restoration and/sealant by the same dentist/dental office.

**D1353 Sealant repair – per tooth**

Fees for repairing sealants completed on the same date of service and on the same surface as a restoration by the same dentist/dental office are disallowed as a component of the restoration.

Benefits to repair sealants are denied when submitted documentation or the patient’s claims history indicates a restoration on the occlusal surface of the same tooth.

Fees for repair or replacement of a sealant are disallowed if performed within 24 months of initial placement by the same dentist/dental office.

Benefits for repairing sealants requested 24 months or more following the initial placement are denied or covered based on group/individual contract.

**D1354 Interim caries arresting medicament application- per tooth**

Benefits are limited to two applications per tooth per benefit year.

Benefits for more than two applications per tooth per benefit year are denied.

Fees for D1354 are disallowed when done on the same date of service as a restoration.

Benefits for restorations placed within three month of interim caries arresting medicament application are reduced by that amount.

**Space Maintenance (passive appliances)**
GP The benefits for repair or replacement of a space maintainer are denied and the approved amount is collectable from the patient.

GP Only one space maintainer is provided for a space per quadrant per lifetime. Additional appliances are denied and the approved amount is collectable from the patient.

GP Space maintainers for missing primary anterior teeth, missing permanent teeth, or for persons age 14 or over are denied and the approved amount is collectable from the patient.

GP Space maintainer fees include all teeth, clasps and rests. Any fee charged in excess of the approved amount for the appliance by the same dentist/dental office is disallowed.

D1510 Space maintainer-fixed unilateral

D1516 space maintainer – fixed – bilateral, maxillary D1517

space maintainer – fixed – bilateral, mandibular

D1520 Space maintainer-removable unilateral

D1526 Space maintainer – removable - bilateral, maxillary D1527

Space maintainer – removable - bilateral, mandibular

D1550 Re-cement or rebond space maintainer

One recementation or rebonding is allowed per space maintainer. Benefits for subsequent requests for recementation or rebonding by the same office are denied and the approved amount is collectable from the patient.

D1555 Removal of fixed space maintainer

The fee for removal of a fixed space maintainer by the same dentist/dental office who placed the appliance is disallowed.

The fee for removal of a fixed maintainer is disallowed when submitted with recementation.

D1575 Distal shoe space maintainer - fixed – unilateral

Limited to children 8 and younger.

Fees for repairs and adjustments by same dentist/dental office are disallowed.

D1999 Unspecified preventive procedure, by report

**RESTORATIVE D2000 - D2999**

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GP The fee for a restoration includes services such as, but not limited to, adhesives, etching, liners, bases, direct and indirect pulp caps, local anesthesia, polishing, occlusal adjustment, caries removal, and gingivectomy done on the same date of service as the restoration. A
A fee for the replacement of amalgam or composite restorations, same tooth and same surface(s), is disallowed if done by the same dentist/dental office within 24 months of the initial restoration. Benefits may be denied and the approved amount for the restoration collectable from the patient if done by a different dentist/dental office.

When multiple restorations involving the proximal and occlusal surfaces of the same tooth are requested or performed, the allowance is limited to that of a multi-surface restoration. Any fee charged in excess of the allowance for the multi-surface restoration by the same dentist/dental office is disallowed. A separate benefit may be allowed for a noncontiguous restoration on the buccal or lingual surface(s) of the same tooth.

Any restoration involving two or more contiguous surfaces should be reported using the appropriate multiple surface restoration code.

When restorations not involving the occlusal surface are requested or performed on posterior teeth, the allowance is limited to that of a one surface restoration. Any fee charged in excess of the allowance for the one-surface restoration is disallowed.

Benefits are allowed only once per surface in a 24 month interval, irrespective of the number or combination of procedures requested or performed. A fee for restoration of a surface within 24 months of previous treatment is disallowed if done by the same dentist/dental office. Benefits are denied and the approved amount is collectable from the patient if done by a different dentist/dental office.

Multistage procedures are reported and benefitted upon completion. The completion date is the date of insertion for removable prosthetic appliances. The completion date for fixed partial dentures and crowns, onlays, and inlays is the cementation date regardless of the type of cement utilized.

If an indirectly fabricated restoration is performed by the same dentist/dental office within 24 months of the placement of an amalgam or composite restoration the Delta Dental payment and patient co-payment allowance for the amalgam or composite restorations will be deducted from the indirectly fabricated restoration benefit.

Tooth preparation, temporary restorations, cement bases, impressions, laboratory fees and material, occlusal adjustment, gingivectomies (on the same date of service), and local anesthesia are considered to be included in the fee for all restorations, and a separate fee for any of these procedures by the same dentist/dental office is disallowed. Fees for buildups, not required for retention are disallowed.

Benefits for restorations for altering occlusion, involving vertical dimension, replacing tooth structure lost by attrition, erosion, abrasion, abfraction, corrosion, TMD or periodontal, orthodontic, or other splinting are denied and the approved amount is collectable from the patient.

Biomimetic restorations (e.g. Biodentine) are denied as investigational.

**Definitions**

**Attrition**

1. The frictional wearing of the teeth over time. Severe attrition, due to bruxing may be evident. (Treatment Planning in Dentistry; Mosby 2006).


**Abrasion**

1. Wearing away or notching of the teeth by a mechanical means, such as tooth
brushing. (Treatment Planning in Dentistry; Mosby 2006).
2. The grinding or wearing away of tooth substance by mastication, incorrect brushing methods, bruxism or similar causes. (Mosby's Dental Dictionary).
3. The abnormal wearing away of a substance or tissue by a mechanical process. (Mosby's Dental Dictionary).
4. The loss of tooth structure from the mechanical rubbing of teeth by some object or objects (no source).
5. The act or result of the grinding or wearing away of a substance, such as a tooth worn by mastication, bruxing or tooth brushing. (The Glossary of Operative Dentistry Terms).

**Erosion**
1. The wasting away or loss of substance of a tooth by a chemical process that does not involve known bacterial action. (Treatment Planning in Dentistry; Mosby 2006).
2. The process and the results of loss of dental hard tissue that is chemically etched away from the tooth surface, by acid and/or chelation, without bacterial involvement. (ten Cate & Imfeld, Eur J Oral Sci 1996; 104:241).

**Abfraction**
Pathological loss of tooth structure owing to biomechanical forces (flexion, compression, or tension) or chemical degradation; it is most visible as V-shaped notches in the cervical area of a tooth. (Mosby's Medical Dictionary, 9th edition; Elsevier)

**Amalgam Restorations (including polishing)**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D2140</td>
<td>Amalgam - one surface, primary or permanent</td>
</tr>
<tr>
<td>D2150</td>
<td>Amalgam - two surfaces, primary or permanent</td>
</tr>
<tr>
<td>D2160</td>
<td>Amalgam - three surfaces, primary or permanent</td>
</tr>
<tr>
<td>D2161</td>
<td>Amalgam - four or more surfaces, primary or permanent</td>
</tr>
</tbody>
</table>

**Resin-Based Composite Restorations-Direct**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP</td>
<td>In the event an anterior proximal restoration involves a significant portion of the labial or lingual surface, it may be reported as D2331 or D2332, as appropriate.</td>
</tr>
<tr>
<td>D2330</td>
<td>Resin-based composite - one surface, anterior</td>
</tr>
<tr>
<td>D2331</td>
<td>Resin-based composite - two surfaces, anterior</td>
</tr>
<tr>
<td>D2332</td>
<td>Resin-based composite - three surfaces, anterior</td>
</tr>
<tr>
<td>D2335</td>
<td>Resin-based composite - four or more surfaces or involving the incisal angle (anterior)</td>
</tr>
<tr>
<td>D2390</td>
<td>Resin-based composite crown, anterior</td>
</tr>
<tr>
<td>GP</td>
<td>Benefits for resin based composite restorations on posterior teeth are determined by group/individual contract.</td>
</tr>
<tr>
<td>D2391</td>
<td>Resin - based composite - one surface, posterior</td>
</tr>
<tr>
<td>D2392</td>
<td>Resin - based composite - two surfaces, posterior</td>
</tr>
<tr>
<td>D2393</td>
<td>Resin - based composite - three or more surfaces, posterior</td>
</tr>
</tbody>
</table>
D2394  Resin - based composite - four or more surfaces, posterior  Gold

**Foil Restorations**

**GP**  An alternate benefit allowance is made for an amalgam or resin restoration, according to the policies for amalgam or resin restorations. The difference between the allowance for the amalgam or resin restoration and the approved amount for the gold foil restoration is denied and collectable from the patient.

D2410  Gold foil - one surface
D2420  Gold foil - two surfaces
D2430  Gold foil - three surfaces

**Inlay/Onlay Restorations**

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

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

**GP**  When the retentive quality of a tooth qualifies for an onlay, benefits are based on the submitted procedure. If an alternate benefit allowance is applied, the difference between the allowance for the alternative benefit and the approved amount for the inlay/onlay restoration is denied and collectable from the patient.

**GP**  For inlay restorations, an alternate benefit allowance is made for an amalgam or resin restoration, according to the policies for amalgam and resin restorations. The difference between the allowance for the amalgam or resin restoration and the approved amount for the inlay restoration is denied and collectable from the patient.

**GP**  Crowns and indirectly fabricated restorations are optional benefits unless the tooth is damaged by decay or fracture to the point it cannot be restored by an amalgam or resin restoration. If the fee for a crown or indirectly fabricated restoration is not allowed, an alternate benefit allowance for an amalgam or resin restoration is made according to the policies for those restorations and the difference between the allowance for the amalgam or resin restoration and the approved amount for the crown or indirectly fabricated restoration is denied and collectable from the patient.

**GP**  Benefits for crowns and onlays are denied and the approved amount is collectable from the patient for children under 12 years of age.

**GP**  Onlays are considered to cover one or more cusps and include the inlay. Onlays are only benefitted when the tooth would otherwise qualify for a crown based on degree of breakdown.

D2510  Inlay - metallic - one surface
D2520  Inlay - metallic - two surfaces
D2530  Inlay - metallic - three or more surfaces
D2542  Onlay - metallic - two surfaces
D2543  Onlay - metallic - three surfaces
D2544  Onlay - metallic - four or more surfaces
Porcelain/ceramic inlays/onlays include all indirect ceramic and porcelain type inlays/onlays.

D2610 Inlay - porcelain/ceramic - one surface
D2620 Inlay - porcelain/ceramic - two surfaces
D2630 Inlay - porcelain/ceramic - three or more surfaces
D2642 Onlay - porcelain/ceramic - two surfaces
D2643 Onlay - porcelain/ceramic - three surfaces
D2644 Onlay - porcelain/ceramic - four or more surfaces

Resin-based composite inlays/onlays must utilize indirect technique.

D2650 Inlay - resin - based composite - one surface
D2651 Inlay - resin - based composite - two surfaces
D2652 Inlay - resin - based composite - three or more surfaces
D2662 Onlay - resin - based composite - two surfaces
D2663 Onlay - resin - based composite - three surfaces
D2664 Onlay - resin - based composite - four or more surfaces

Crowns - Single Restorations Only

GP Crowns and indirectly fabricated restorations are optional benefits unless the tooth is damaged by decay or fracture to the point it cannot be restored by an amalgam or resin restoration. If the fee for a crown or indirectly fabricated restoration is not allowed, an alternate benefit allowance for an amalgam or resin restoration is made according to the policies for those restorations and the difference between the allowance for the amalgam or resin restoration and the approved amount for the crown or indirectly fabricated restoration is denied and collectable from the patient.

GP Benefits for crowns and onlays are denied and the approved amount is collectable from the patient for children under 12 years of age.

Requests for crowns are considered as stated below:

Crowns / Veneers For Anterior Teeth

- Moderate peripheral tooth structure loss with $\frac{1}{2}$ or more of the incisal edge structure lost, (including at least one incisal angle).
- Severe damage to the peripheral tooth structure where both the mesial and distal proximal area structure loss extends beyond 3mm from the outer tooth surface.
- Severe damage affecting more than 50% of central tooth structure.

Crowns / Veneers For Anterior Teeth Are Not Benefited When:

- There is minimal damage to the peripheral tooth structure with small proximal or Class V lesions.
• Moderate damage to peripheral tooth structure with one incisal angle involved and less than 1/2 of the incisal edge structure is lost.
• The tooth is treated endodontically and the access is conservative and there are small proximal lesions.
• The primary purpose is: cosmetic, alteration of tooth color, alteration of tooth shape and size, or closure of diastema spacing.

Crowns / Veneers For Anterior Teeth Are Not Benefited When:
• There is minimal damage to the peripheral tooth structure with small proximal or Class V lesions.
• Moderate damage to peripheral tooth structure with one incisal angle involved and less than 1/2 of the incisal edge structure is lost.
• The tooth is treated endodontically and the access is conservative and there are small proximal lesions.
• The primary purpose is: cosmetic, alteration of tooth color, alteration of tooth shape and size, or closure of diastema spacing.

Crowns / Onlays For Posterior Teeth Are Not Benefited When:
• Minimal damage with small occlusal, proximal and / or facial lesions, or combined occlusal and proximal lesions
• Moderate damage where occlusal or proximal lesions extend 1mm past the dentino-enamel junction.
• Periodontally compromised teeth with poor prognosis or for molars with significant furcation involvement.

Crowns, Onlays, Veneers
• Crowns / Onlays / Veneers are not benefited that are preventative in nature (i.e., to prevent unpredictable or possible anticipated future fractures or to eliminate crack or craze lines in the absence of pathology).
• Crowns / Onlays / Veneers are not benefited for primarily cosmetic purposes.
• Crowns / Onlays / Veneers are not benefited when the primary purpose is for splinting
• Crowns / Onlays / Veneers are not benefited to replace tooth structure lost due to wear, attrition, abfraction, abrasion, or erosion.


D2720 Crown - resin with high noble metal

D2721 Crown - resin with predominantly base metal

D2722 Crown - resin with noble metal
D2740  Crown - porcelain/ceramic
D2750  Crown - porcelain fused to high noble metal
D2751  Crown - porcelain fused to predominantly base metal
D2752  Crown - porcelain fused to noble metal
D2780  Crown - ¾ cast high noble metal
D2781  Crown - ¾ cast predominantly base metal
D2782  Crown - ¾ cast noble metal
D2783  Crown - ¾ porcelain/ceramic
D2790  Crown - full cast high noble metal
D2791  Crown - full cast predominantly base metal
D2792  Crown - full cast noble metal
D2794  Crown - titanium
D2799  Provisional crown

The fee for a provisional crown by the same dentist/dental office is disallowed as a component of the fee for a permanent crown.

When a temporary or provisional crown is billed as a therapeutic measure for a fractured tooth, it may be benefitted subject to individual consideration.

Other Restorative Services

GP    Delta Dental considers the cementation date to be that date upon which the completed or indirectly fabricated post, prefabricated post and core, inlay, onlay, crown, or fixed partial denture is first delivered to the mouth. The type of cement used is not a determining factor (whether permanent or temporary).

GP    Fees for recementation or rebonding of indirectly fabricated or prefabricated post and cores, inlays, onlays, crowns, and fixed partial dentures are disallowed if done within six months of the initial seating date by the same dentist or dental office.

GP    Benefits may be paid for one recementation or rebonding after six months have elapsed since initial placement. Subsequent requests for recementation or rebonding by the same provider are denied and the approved amount is collectable from the patient. Benefits may be paid when billed by a provider other than the one who seated the bridge or performed the previous recementation or rebonding.

GP    Post recement or rebond (D2915) and crown recement or rebond (D2920) are not allowed on the same tooth on the same day by the same dentist/dental office. The allowance will be made only for D2920 when D2915 and D2920 are submitted together. The fee for D2915 will be disallowed.

GP    Fees for crown, inlay, onlay and veneer repairs are disallowed within 24 months of the original restoration.
D2910 Recement or rebond inlay, onlay, veneer or partial coverage restoration

D2915 Recement or rebond indirectly fabricated or prefabricated post and core

D2920 Recement or rebond crown

D2921 Reattachment of tooth fragment, incisal edge or cusp

Fees for the replacement of amalgam or composite restorations or attachment of tooth fragment within 24 months are disallowed if done by the same dentist/dental office. Benefits may be allowed if done by a different dentist.

D2929 Prefabricated porcelain/ceramic crown - primary tooth

A fee for replacement of a prefabricated porcelain/ceramic crown by the same dentist/dental office within 24 months is included in the initial crown placement and is disallowed.

D2930 Prefabricated stainless steel crown - primary tooth

A fee for replacement of a stainless steel crown on a primary tooth by the same dentist/dental office within 24 months is included in the initial crown placement and is disallowed.

D2931 Prefabricated stainless steel crown - permanent tooth

A fee for replacement of a stainless steel crown on a permanent tooth by the same dentist/dental office within 24 months is included in the initial crown placement and is disallowed.

D2932 Prefabricated resin crown

A prefabricated resin crown is a benefit only on anterior primary teeth. If submitted for a posterior primary tooth or for a permanent tooth, an alternate benefit allowance for D2930 or D2931 is made. The difference between the allowance for the D2930 or D2931 and the approved amount for the D2932 is denied and collectable from the patient.

D2933 Prefabricated stainless steel crown with resin window

A prefabricated stainless steel crown with resin window is a benefit only on anterior primary teeth. If submitted for a posterior primary tooth or for a permanent tooth, an alternate benefit allowance for D2930 or D2931 is made. The difference between the allowance for the D2930 or D2931 and the approved amount for the D2933 is denied and collectable from the patient.

A fee for replacement of a stainless steel crown on a primary or permanent tooth by the same dentist/dental office within 24 months is included in the initial crown placement and is disallowed.

D2934 Prefabricated esthetic coated stainless steel crown – primary tooth

A prefabricated esthetic coated stainless steel crown is a benefit only on anterior primary teeth. If submitted for a posterior primary tooth or for a permanent tooth, an alternate benefit allowance for D2930 or D2931 is made. The difference between the allowance for the D2930 or D2931 and the approved amount for the D2934 is denied and collectable from the patient.

A fee for replacement of a stainless steel crown on a primary or permanent tooth by the same dentist/dental office within 24 months is included in the initial crown placement and is disallowed.
Benefits may be allowed with the same processing policies and edits as a D2933 if performed on permanent teeth and subject to individual consideration.

D2940 Protective restoration

Protective restorations are a benefit for emergency relief of pain.

A separate fee for protective restoration is disallowed when performed in conjunction with a definitive restoration or endodontic access closure by the same dentist/dental office on the same date of service.

D2941 Interim therapeutic restoration – primary dentition

Interim therapeutic restoration is disallowed in conjunction with definitive restoration within 24 months.

D2949 Restorative foundation for an indirect restoration

This procedure is a component of the definitive indirect restoration. Fees are disallowed.

02950 Core buildup, including any pins when required

Substructures are a benefit only when necessary to retain an indirectly fabricated restoration due to extensive loss of tooth structure from caries or fracture. The procedure should not be reported when the procedure only involves a filler to eliminate any undercut, box form, or concave irregularity in the preparation. Fees for buildups not required for retention are disallowed.

A separate fee for a buildup is disallowed when radiographs indicate sufficient tooth structure remains to support an indirectly fabricated restoration.

D2951 Pin retention-per tooth, in addition to restoration

Pin retention is a benefit once per tooth when necessary on a permanent tooth and when completed at the same appointment. Fees for additional pins on the same tooth by the same dentist/dental office are disallowed as a component of the initial pin placement.

A fee for pin retention when billed in conjunction with a buildup by the same dentist/dental office is disallowed as a component of the buildup procedure.

D2952 Post and core in addition to crown, indirectly fabricated

An indirectly fabricated post and core in addition to crown is a benefit only on an endodontically treated tooth. The fee for an indirectly fabricated post and core is disallowed when radiographs indicate an absence of endodontic treatment and incompletely filled canal space. Unresolved radiolucencies may be a reason to disallow, but will be evaluated based on the time since the completion of the endodontic service and co-joint signs and symptoms.

An indirectly fabricated post and core in anterior teeth is a benefit only when there is insufficient tooth structure to support a cast restoration.

When radiographs indicate more than half of the coronal tooth structure remains, the benefits for post and core are denied.

D2953 Each additional indirectly fabricated post- same tooth

D2954 Prefabricated post and core in addition to crown
A prefabricated post and core in addition to crown is a benefit only on an endodontically treated tooth. The fee for a prefabricated post and core is disallowed when radiographs indicate an absence of endodontic treatment and incompletely filled canal space.

A prefabricated post and core in anterior teeth is a benefit only when there is insufficient tooth structure to support a cast restoration.

When radiographs indicate more than half of the coronal tooth structure remains, the benefits for post and core are denied.

D2955 Post removal

The fee for post removal when the procedure is submitted by the same dentist/office rendering retreatment is disallowed as a component of the fee for the retreatment.

D2957 Each additional prefabricated post in the same tooth

D2960 Labial veneer (resin laminate) – chairside

D2961 Labial veneer (resin laminate) - laboratory  D2962 Labial veneer (porcelain laminate) – laboratory

Benefit are determined by group/individual contract.

A veneer could be a benefit in cases where the criteria for a crown is met. In such a case the policies for indirectly fabricated restorations apply.

D2971 Additional procedures to construct new crown under existing partial denture framework

D2975 Coping

Copings are considered an integral part of the final restoration. Additional fees are denied.

D2980 Crown repair, necessitated by restorative material failure

Fees for a crown repair completed on the same date of service as a new crown are disallowed.

Fees for repairs are disallowed within 24 months of the original restoration by the same dentist/dental office. Benefits are denied if done by a different dentist/dental office.

D2981 Inlay repair, necessitated by restorative material failure

Fees for inlay repairs completed on the same date of service as a new inlay are disallowed.

D2982 Onlay repair, necessitated by restorative material failure

Fees for onlay repairs completed on the same date of service as a new onlay are disallowed.

Fees for repairs are disallowed within 24 months of the original restoration by the same dentist/dental office. Benefits are denied if done by a different dentist/dental office.

D2983 Veneer repair, necessitated by restorative material failure

Fees for veneer repairs completed on the same date of service as a new veneer are disallowed.
Fees for repairs are disallowed within 24 months of the original restoration by the same dentist/dental office. Benefits are denied if done by a different dentist/dental office.

D2990  Resin infiltration of incipient smooth surface lesions

Benefits for resin infiltration of incipient smooth surface lesions are denied as investigational.

D2999  Unspecified restorative procedure, by report

**ENDODONTICS  D3000 - D3999**

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**GP**  Endodontic retreatment may include the removal of a post, pin(s), old root canal filling material, and the procedures necessary to prepare the canals and place the canal filling. This includes complete root canal therapy. Separate fees for these procedures by the same dentist/dental office are disallowed as included in the fees for the retreatment.

**Pulp Capping**

**GP**  Fees for direct or indirect pulp caps are disallowed when provided by the same dentist/dental office in conjunction with the final restoration for the same tooth.

**GP**  Benefits for root canal therapy done in conjunction with an overdenture are denied and the approved amount is collectable from the patient.

**D3110**  Pulp cap-direct (excluding final restoration)

Fees for the pulp cap performed with a restoration by the same dentist/dental offices are disallowed.

**D3120**  Pulp cap-indirect (excluding final restoration)

**Pulpotomy**

**D3220**  Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament.

The benefit for a pulpotomy provided on a permanent tooth is processed as palliative treatment (D9110) and the fees in excess of the palliative treatment are disallowed.

Fee for therapeutic pulpotomy are disallowed in conjunction with a root canal procedure.

**D3221**  Pulpal debridement, primary and permanent teeth

The fee for gross pulpal debridement is disallowed when endodontic treatment is completed on the same tooth on the same day by the same dentist/dental office. Unusual cases may be referred for individual consideration.

Fees for palliative treatment are disallowed when submitted by the same dentist/dental office.
D3222 Partial pulpotomy for apexogenesis – permanent tooth with incomplete root development

Fees for Partial pulpotomy for apexogenesis are disallowed when performed within 30 days/same tooth/same dentist/same dental office as root canal therapy or codes D3351-D3353.

Endodontic Therapy on Primary Teeth

D3230 Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)

D3240 Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)

Benefits for a root canal are denied when a pulpectomy or pulpotomy are billed and radiographs reveal insufficient root structure, internal resorption, furcal perforation or extensive periapical pathosis.

Endodontic Therapy (including treatment plan, clinical procedures and follow-up care)

GP The fee for a root canal includes all radiographic images during treatment and temporary restorations. Any additional fees by the same dentist/dental office are disallowed.

GP When a radiographic image indicates obturation of an endodontically treated tooth has been performed without the use of a biologically acceptable nonresorbable semisolid or solid core material, fees for the endodontic therapy and/or restoration of the tooth are disallowed.

GP The completion date for endodontic therapy is the date that the canals are permanently filled.

GP Difficult removal of broken instrument or posts by a different dentist/dental office is subject to individual consideration.

D3310 Endodontic therapy - anterior tooth (excluding final restoration)

D3320 Endodontic therapy - premolar tooth (excluding final restoration)

A separate fee for palliative treatment is disallowed when done in conjunction with root canal therapy by the same dentist/dental office on the same date of service.

Incompletely filled root canals are not a benefit and the fee for the endodontic therapy is disallowed.

D3330 Endodontic therapy – molar tooth (excluding final restoration)

A separate fee for palliative treatment is disallowed when done in conjunction with root canal therapy by the same dentist/dental office on the same date of service.

Incompletely filled root canals are not a benefit and the fee for the endodontic therapy is disallowed.

D3331 Treatment of root canal obstruction; non-surgical access

D3331 is considered a component of a root canal. The fee for the procedure by the same dentist/dental office is disallowed.

The fee for D2955, post removal, is not included in this procedure.
D3332 Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth

is subject to individual consideration, by report.

D3333 Internal root repair of perforation defects

Internal root repair is considered apexification/recalcification – initial visit (D3351) for benefit purposes. It is subject to the same processing policies as apexification/recalcification – initial visit.

The fee for internal root repair of perforation defects is disallowed when done in conjunction with an apicoectomy and/or retrograde filling by the same dentist/dental office.

The benefit for D3333 is denied if reported on a primary tooth.

The fee for internal root repair of perforation defects is disallowed on the same date of service as apicoectomy.

The fee for internal root repair of perforation defects is disallowed if perforation is iatrogenic by the same dentist/dentist office.

Endodontic Retreatment

GP Endodontic retreatment may include the removal of a post, pin(s), old root canal filling material, and the procedures necessary to prepare the canals and place the canal filling. This includes complete root canal therapy. Separate fees for these procedures by the same dentist/dental office are disallowed as included in the fees for the retreatment.

GP The fee for retreatment of root canal therapy or retreatment of apical surgery by the same dentist/dental office within 24 months of initial treatment is disallowed as a component of the fee for the original procedure. Benefits by another dentist/dental office are denied.

D3346 Retreatment of previous root canal therapy – anterior

D3347 Retreatment of previous root canal therapy – premolar

D3348 Retreatment of previous root canal therapy – molar

Apexification/Recalcification

D3351 Apexification/recalcification- initial visit (apical closure/calcific repair of perforations, root resorption, etc.)

Apexification is eligible for benefits on permanent teeth with incomplete root development or for repair of a perforation.

D3352 Apexification/recalcification - interim medication replacement

D3353 Apexification/recalcification - final visit (includes completed root canal therapy- apical closure/calcific repair of perforations, root resorption, etc.)

Apexification/recalcification - final visit benefits are administered as the same processing policies as D3310, D3320, or D3330 (depending on tooth type) and any fee charged in excess of the approved amount for the D3310, D3320, or D3330 (depending on the tooth type) is disallowed.

Pulpal Regeneration

D3355 Pulpal Regeneration - initial visit

This procedure is considered experimental and benefits are denied and the approved
amount is collectable from the patient.

D3356  Pulpal regeneration - interim medication replacement

This procedure is considered experimental and benefits are denied and the approved amount is collectable from the patient.

D3357  Pulpal regeneration - completion of treatment

This procedure is considered experimental and benefits are denied and the approved amount is collectable from the patient.

**Apicoectomy/Periradicular Services**

GP  The fee for biopsy of oral tissue is disallowed as included in the fee for a surgical procedure (e.g. apicoectomy) when performed in the same location and on the same date of service by the same dentist/dental office.

D3410  Apicoectomy - anterior

D3421  Apicoectomy - premolar (first root)

D3425  Apicoectomy - molar (first root)

D3426  Apicoectomy (each additional root)

D3427  Periradicular surgery without apicoectomy

Disallow when performed on the same tooth by the same dentist/dental office on the same date as apicoectomy (D3410-D3426), retrograde filling (D3430), and root amputation (D3450).

D3428  Bone graft in conjunction with periradicular surgery - per tooth; first surgical site

Benefits for these procedures when billed in conjunction with periradicular surgery are denied as specialized technique.

D3429  Bone graft in conjunction with periradicular surgery - each additional contiguous tooth in same surgical site.

Benefits for these procedures when billed in conjunction with periradicular surgery are denied as specialized technique.

D3430  Retrograde filling - per root

Retrograde filling includes all retrograde procedures per root. Any fee charged in excess of the allowance for a retrograde filling by the same dentist/dental office is disallowed.

D3431  Biologic materials to aid in soft and osseous tissue regeneration in conjunction with periradicular surgery

Benefits are available only when billed for natural teeth. Benefits for these procedures when billed in conjunction with periradicular surgery, etc. are denied as a specialized technique.

D3432  Guided tissue regeneration, resorbable barrier, per site in conjunction with periradicular surgery

Benefits are available only when billed for natural teeth. Benefits for these procedures when billed in conjunction with periradicular surgery are denied as a specialized technique.
D3450  Root amputation - per root

A separate fee for root amputation is disallowed when performed in conjunction with an apicoectomy by the same dentist/dental office.

D3460  Endodontic endosseous implant

D3470  Intentional reimplantation (including necessary splinting)

Intentional reimplantation is considered a specialized procedure. Benefits are denied and the approved amount is collectable from the patient.

Other Endodontic Procedures

D3910  Surgical procedure for isolation of tooth with rubber dam

A separate fee for isolation of a tooth with a rubber dam by the same dentist/dental office is disallowed as a component of the fee for the procedure performed.

D3920  Hemisection (including any root removal), not including root canal therapy

D3950  Canal preparation and fitting of preformed dowel or post

A separate fee for canal preparation and fitting of preformed dowel or post by the same dentist/dental office is disallowed as a component of the fee for the post or root canal therapy.

D3999  Unspecified endodontic procedure, by report

PERIODONTICS  D4000 - D4999

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GP  When more than one surgical procedure is provided on the same teeth on the same day, benefits are based upon, but not limited to, the most inclusive procedure.

GP  The fee for the following services: D1110, D1120, D4346, D4355, and/or D4910 may be disallowed if the services are rendered by the same dentist/dental office within 30 days after the most recent scaling and root planing (D4341, D4342) or other periodontal therapy.

GP  Fees for the included procedures are disallowed and not billable to the patient by a participating dentist/dental office. These inter-related services include but are not limited to the following hierarchy:

D4260 (most inclusive), D4261, D6103, D4249, D4245, D4268, D4240, D4241, D6102, D4274, D4210, D4211, D4212, D4341, D4342, D4346, D4355, D4910, D1110, D1120 (least inclusive)

GP  Periodontal services are only benefitted when performed on natural teeth for treatment of periodontal disease. Unless otherwise specified by contract, benefits for these procedures when billed in conjunction with implants, ridge augmentation, extraction sites and/or
periradicular surgery are denied and the approved amount is collectable from the patient.

GP The fee for biopsy (D7285, D7286), frenulectomy (D7960) and excision of hard and soft tissue lesions (D7410, D7411, D7450, D7451) are disallowed when the procedures are by the same dentist/ dental office performed on the same date, same surgical site/area, and any other surgical procedure. Request for individual consideration can always be submitted, by report, for the dental consultant for review.

GP Laser disinfection is a technique, not a procedure. Fees for laser disinfection are disallowed. If done as a standalone procedure, the benefit for laser disinfection is denied and the approved amount is collectable from the patient.

GP The fees for low level laser therapy when performed as part of another procedure are disallowed. When billed as a standalone procedure, benefits for low level laser therapy are denied as investigational.

GP Benefits for laser biostimulation as a standalone procedure are denied as investigational.

GP Periodontal charting is considered as part of the oral evaluation (D0120, D0150, D0160, D0180). If periodontal evaluation and oral evaluation are billed on the same date of service, the fee for the oral evaluation (D0120, D0150, D0160) is a benefit and the fee for the periodontal evaluation is disallowed.

GP When periodontal charting is requested for surgical and non-surgical procedures it must be submitted with a periodontal chart dated no more than 12 months prior to the date of service.

GP Perioscopy is a technique not a procedure. The fees for perioscopy are disallowed.

The following categorizes procedures for reporting and adjudicating by quadrant, site or individual tooth in order to enhance standard benefits determination and expedite claims processing.

Radiographs must show loss of alveolar crest height beyond the normal 1-1.5 millimeter distance to the cemento-enamel junction (CEJ). Note: panoramic radiographs per American Academy of Periodontology have limited value in the diagnosis of periodontal disease.

In the case of procedure codes D4341 and D4342 there must be radiographic documentation of bone loss or loss of clinical attachment on the diseased teeth/periodontium involved. In the absence of bone loss or loss of clinical attachment, a benefit allowance for a prophylaxis (D1110) or scaling in the presence of moderate to severe gingival inflammation (D4346) is made and any fee in excess of the approved amount for D1110 is chargeable to the patient.

Prior to periodontal surgery, a waiting period of a minimum of four weeks should typically follow periodontal scaling and root planing to allow for healing and re-evaluation and to assess tissue response.

Quadrant: D4210, D4260, D4240 D4341

Site: a site is defined by the current ADA CDT manual.

Sites: D4249, D4263, D4264, D4265, D4266, D4267, D4268, D4270, D4273, D4275, D4276, D4277, D4278, D4283, D4285, D4320, D4321, D6081, D6101, D6102 and D6103

One to three diseased teeth/periodontium per quadrant: D4211, D4231 D4241, D4261, D4342

Per tooth: D4212, D4268, D4273, D4276, D4277, D4278, D4283, D4285, D6081, D6101, D6102, D6103

Per implant: D6101, D6102, D6103

Surgical Services (including usual postoperative care)
A separate fee for all necessary postoperative care, finishing procedures (D1110, D1120, D4341, D4342, D4355, D4910), evaluations, or other surgical procedures on the same date of service or for three months following the initial periodontal surgery in relation to both natural teeth and implants by the same dentist/dental office is disallowed. In the absence of documentation of extraordinary circumstances, the fee for additional surgery or for any surgical re-entry by the same dentist/dental office for 36 months is disallowed.

If extraordinary circumstances are present the benefits will be denied and are the patient's responsibility up to the approved amount for the surgery.

If periodontal surgery is performed less than four weeks after scaling and root planing, the fee for the surgical procedure or the scaling and root planing may be disallowed following consultant review.

Periodontally involved teeth which would qualify for surgical pocket reduction benefits under these procedure codes (D4210, D4211, D4240, D4241, D4260, D4261) must be documented to have at least 5 mm pocket depths and bone loss beyond 1-1.5 millimeters. If pocket depths are under 5 mm, then benefits are denied.

Benefits for periodontal surgical services are available only when billed for natural teeth. Benefits for these procedures when billed in conjunction with implants, ridge augmentation, extraction sites, periradicular surgery, etc. are denied as a specialized or elective procedure.

Providing more than two, D4265, D4266, D4267, D4270, D4273, D4275, D4276, D4277, D4278, D4283, D4285, D6101, D6102, or osseous grafts (D4263, D4264, D6103) within any given quadrant should be highly unusual and additional submissions will only be considered on a by report basis. When documentation of exceptional circumstances is submitted, benefits may be denied, unless covered, dependent on group/individual contract language.

Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant

Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant

A separate fee for gingivectomy or gingivoplasty - per tooth is disallowed when performed in conjunction with the preparation of a crown or other restoration by the same dentist/dental office.

Only diseased teeth/periodontium are eligible for benefit consideration. Bounded tooth spaces are not counted as the procedure does not require a flap extension.

Gingivectomy or gingivoplasty – to allow access for restorative procedures – per tooth

A separate fee for any gingivectomy or gingivoplasty procedure - per tooth is disallowed when performed in conjunction with the preparation of a crown or other restoration by the same dentist/dental office.

Anatomical crown exposure – four or more contiguous teeth or tooth bounded spaces teeth per quadrant

Anatomical crown exposure is considered cosmetic in nature and therefore denied by group/individual contracts that exclude cosmetic services.

Anatomical crown exposure – one to three teeth or tooth bounded spaces per
Anatomical crown exposure is considered cosmetic in nature and therefore denied by group/individual contracts that exclude cosmetic services.

**D4240** Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant

**D4241** Gingival flap procedure, including root planing - one to three contiguous teeth, or tooth bounded spaces per quadrant

Benefits are based upon, but not limited to, the most inclusive procedure. A tooth bounded space counts as one space irrespective of the number of teeth that would normally exist in the space. Only diseased natural teeth/periodontium are eligible for benefit consideration.

**D4245** Apically positioned flap

Benefits are based upon, but not limited to, the most inclusive procedure.

**D4249** Clinical crown lengthening - hard tissue

A separate fee for crown lengthening is disallowed when performed in conjunction with osseous surgery on the same teeth by the same dentist/dental office.

Crown lengthening is a benefit per site, not per tooth, when adjacent teeth are included. This procedure is carried out to expose sound tooth structure by removal of bone before restorative or prosthodontic procedures. It is not generally provided in the presence of periodontal disease. This is only a benefit when bone is removed and sufficient time is allowed for healing.

The fees for crown lengthening are disallowed when performed on the same date as the final restoration placement.

**D4260** Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant.

**D4261** Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth, or tooth bounded spaces per quadrant.

No more than two quadrants of osseous surgery on the same date of service are benefitted, in the absence of a narrative explaining exceptional circumstance.

For benefit purposes, the fee for osseous surgery includes crown lengthening, osseous contouring, distal or proximal wedge surgery, scaling and root planing, gingivectomy, frenectomy, frenuloplasty, debridements, periodontal maintenance, prophylaxis, anatomical crown exposure, surgical drainage and flap procedures. A separate fee for any of these procedures done on the same date, in the same surgical area by the same dentist/dental office, as D4260 is disallowed. A separate benefit may be available for soft tissue grafts, bone replacement grafts, guided tissue regeneration, biologic materials with demonstrated efficacy in aiding periodontal tissue regeneration, exostosis removal, hemisection, extraction, apicoectomy, root amputations.

For dental benefit reporting purposes a quadrant is defined as four or more contiguous teeth and tooth bounded spaces per quadrant. A tooth bounded space counts as one space irrespective of the number of teeth that would normally exist in the space. Only diseased natural teeth/periodontium are eligible for benefit consideration.

**D4263** Bone replacement graft - retained natural tooth first site in quadrant

Up to two teeth per quadrant may be benefitted.
Bone replacement grafts are denied when submitted with apicoectomy sites, implants, mucogingival/soft tissue grafts, periradicular surgery, ridge augmentation or preservation procedures, sinus elevation, defects from cyst removal, hemisections or with extractions.

D4264 Bone replacement graft – retained natural tooth, each additional site in quadrant  Up to two teeth per quadrant may be benefitted.

Bone replacement grafts are denied when submitted with apicoectomy sites, implants, mucogingival/soft tissue grafts, periradicular surgery, ridge augmentation or preservation procedures, sinus elevation, defects from cyst removal, hemisections or with extractions.

D4265 Biologic materials to aid in soft and osseous tissue regeneration

Biologic materials may be eligible for stand-alone benefits when reported with periodontal flap surgery (D4240, D4241, D4245, D4260 and D4261)

Benefits are available only when billed for natural teeth.

When submitted with a D4263, D4264, D4266, D4267, D4270, D4273, D4275, D4276, D4277, D4278, D4283, D4285, D4341, or D4342 in the same surgical site, the fee for the D4265 is denied.

Benefits for D4265 when billed in conjunction with implants or other oral surgical procedures are denied as a specialized procedure.

D4266 Guided tissue regeneration - resorbable barrier, per site

Benefits for GTR are denied in conjunction with soft tissue grafts in the same surgical area.

Benefits for these procedures when billed in conjunction with implants, ridge augmentation, extraction sites, periradicular surgery, etc., are denied and the approved amount collectible from the patient.

D4267 Guided tissue regeneration - nonresorbable barrier, per site (includes membrane removal)

Benefits for GTR are denied in conjunction with soft tissue grafts in the same surgical area.

Benefits for these procedures when billed in conjunction with implants, ridge augmentation, extraction sites, periradicular surgery, etc., are denied and the approved amount collectible from the patient.

D4268 Surgical revision procedure, per tooth

The fee for D4268 is considered a component of the surgical procedure and is disallowed.

If D4268 is performed by the same dentist/dental office within 36 months of previous periodontal surgery, the fee for the procedure is disallowed. It may be eligible for consideration under dentist consultant review.

If D4268 is performed within the specified time limits by a different office/dentist, the contractual time limits would apply and the fee is denied and the approved amount is collectable from the patient.

D4270 Pedicle soft tissue graft procedure

When multiple grafts are provided within a single quadrant, benefits are limited up to two teeth or soft tissue grafts per quadrant.
D4273  Autogenous connective tissue graft procedures, (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft

Benefits for GTR, in conjunction with soft tissue grafts in the same surgical area, are denied.

Benefits are limited to up to two teeth or soft tissue grafts per quadrant.

D4274  Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)

D4275  Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft

D4275 may be eligible for benefit consideration in lieu of D4265, D4266, D4267, D4270, D4273, D4276, D4277 and D4278.

When multiple sites are provided within a single quadrant benefits are limited to up to two teeth or soft tissue grafts per quadrant.

Benefits for frenulectomy (D7960) or frenuloplasty (D7963) are disallowed when performed in conjunction with D4275, D4276 or D4285.

Benefits are limited to up to two teeth or soft tissue grafts per quadrant D4276

Combined connective tissue and double pedicle graft per tooth

This procedure may be eligible for consideration in lieu of D4265, D4266, D4267, D4270, D4273, D4275, D4277, or D4278 under dentist consultant review based upon documentation of clinical conditions (Miller Class III).

When multiple teeth are grafted within a single quadrant, a maximum of two natural teeth or soft tissue grafts are benefitted unless extraordinary circumstances are documented.

Benefits for frenulectomy (D7960) or frenuloplasty (D7963) are disallowed when performed in conjunction with D4270, D4273, D4275, D4276, D4277, D4278, D4283 or D4285.

D4277  Free soft tissue graft procedure (including recipient and donor surgical sites) - first tooth, implant or edentulous tooth site in graft

When multiple grafts are provided within a single quadrant, a maximum of two teeth or soft tissue grafts are benefitted unless extraordinary circumstances are documented.

Benefits for GTR and or bone grafts, in conjunction with soft tissue grafts in the same surgical area, are denied.

Fees for a frenulectomy D7960 or frenuloplasty D7963 are disallowed when performed in conjunction with soft tissue grafts contiguous tooth position in same graft site).

D4278  Free soft tissue graft procedure (including recipient and donor sites) – each additional contiguous tooth position in same graft site

Allow up to two teeth per quadrant.

Benefits for GTR and or bone grafts, in conjunction with soft tissue grafts in the same surgical area, are denied.

Fees for a frenulectomy D7960 or frenuloplasty D7963 are disallowed when performed in conjunction with soft tissue grafts contiguous tooth position in same graft site).

D4283  Autogenous connective tissue graft procedure (including donor and recipient surgical sites)
– each additional contiguous tooth, implant or edentulous tooth position in same graft site

A maximum of two teeth or soft tissue grafts per quadrant are benefitted.

Benefits for GTR and or bone grafts, in conjunction with soft tissue grafts in the same surgical area, are denied.

Fees for a frenulectomy D7960 or frenoplasty D7963 are disallowed when performed in conjunction with soft tissue grafts contiguous tooth position in same graft site).

D4285 Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site

A maximum of two teeth or soft tissue grafts per quadrant are benefitted.

Benefits for GTR and or bone grafts, in conjunction with soft tissue grafts in the same surgical area, are denied.

Fees for a frenulectomy D7960 or frenoplasty D7963 are disallowed when performed in conjunction with soft tissue grafts contiguous tooth position in same graft site).

**Non-surgical periodontal services**

D4320 Provisional splinting – intracoronal

Benefits for splinting are denied.

D4321 Provisional splinting - extracoronal

The benefit for splinting is denied and the approved amount is collectable from the patient.

D4341 Periodontal scaling and root planing - four or more teeth or spaces per quadrant

In absence of radiographic documentation of bone loss and clinical attachment loss fees are disallowed. Benefits of a prophylaxis or scaling in the presence of generalized moderate or severe gingival inflammation may be given.

Adult prophylaxis procedures (D1110), full mouth scaling (D4346) or debridement (D4355) are considered a component when submitted on the same date of service as D4341 and the fees are disallowed.

Fees for D4341, when billed in conjunction with periodontal surgery procedures by the same dentist/dental office are disallowed as a component of the surgical procedure.

In the absence of a contractual time limitation on frequency of benefits for D4341, any fee for retreatment performed by the same dentist within 24 months of initial therapy is disallowed.

No more than two full quadrants of scaling and root planing will be benefitted on the same date of service. The fees for more than two quadrants of D4341 are disallowed in the absence of supporting documentation (diagnostic quality radiographs (demonstrating alveolar bone loss), periodontal probing depths with at least 4mm pockets, proof of clinical attachment loss, and may also include evidence of length of the appointment in which the procedures were provided, information related to local anesthetic used, and/or a copy of the clinical progress notes).

D4342 Periodontal scaling and root planing - one to three teeth, per quadrant

In absence of radiographic documentation of bone loss and clinical attachment loss fees are
Benefits of a prophylaxis or scaling in the presence of generalized moderate or severe gingival inflammation may be given.

Adult prophylaxis procedures (D1110), full mouth scaling (D4346) or debridement (D4355) are considered a component when submitted on the same date of service as D4342 and the fees are disallowed.

Fees for D4342, when billed in conjunction with periodontal surgery procedures by the same dentist/dental office are disallowed as a component of the surgical procedure.

In the absence of a contractual time limitation on frequency of benefits for D4341, any fee for retreatment performed by the same dentist within 24 months of initial therapy is disallowed. Retreatment done by a different dentist within 24 months is denied and the approved amount is collectable from the patient.

**D4346** Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation

Benefits for D4346 include prophylaxis, fees for D1110, D1120 or D4355 are disallowed when submitted with D4346 by the same dentist/dental office.

Fees for D4346 are disallowed when submitted with D4910 by the same dentist/dental office.

**D4355** Full mouth debridement to enable comprehensive oral evaluation and diagnosis on a subsequent visit

In absence of group/individual contract language, the procedure is benefitted once in a lifetime. A D4355 may be benefitted in order to do a proper evaluation and diagnosis if the patient has not been to the dentist in several years, and the dentist is unable to accomplish an effective prophylaxis under normal conditions.

Fees for full mouth debridement are disallowed on the same date of service as D0150, D0160 or D0180.

**D4381** Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth

Localized delivery of chemotherapeutic agents is denied and the approved amount is collectable from the patient. A D4381 may be a contractual benefit for refractory cases by individual consideration.

When covered contractually, D4381 is subject to the following processing policies:

1. A D4381 may be benefitted, subject to dental consultant review if the following conditions exist:
   a. It is being performed six weeks to six months following initial therapy (scaling and root planning or periodontal surgery).
   b. It is being performed for a patient of record on periodontal maintenance following initial therapy (scaling and root planning or periodontal surgery).
   c. If either 1 or 2 are met, it involves no more than two refractory sites (teeth) per quadrant with pocket depths of at least 5mm and less than 10 mm.

2. If different teeth are treated in the quadrant, within twelve months, benefits are denied and the approved amount is collectable from the patient.

3. If the same teeth are re-treated within 24 months, benefits are denied and the approved amount is collectable from the patient.
4. Teeth must have 5mm – 10 mm pocketing to be eligible for benefits. If less than 5 mm pocketing, benefits are denied and the approved amount is collectable from the patient.

5. Benefits are provided for up to two teeth per quadrant. If three or more teeth are submitted, the entire case is denied and the approved amount is collectable from the patient.

6. When submissions are requested outside time parameters, benefits are denied and the approved amount is collectable from the patient.

Other Periodontal Services

D4910 Periodontal maintenance

Benefits for D4910 include prophylaxis and scaling and root planing procedures. Separate fees for these procedures by the same dentist/dental office are disallowed when billed in conjunction with periodontal maintenance (D4910).

If a D0180 is submitted with a D4910 it is benefitted as a D0120 and the difference in the approved amount between the D0120 and the D0180 is disallowed unless the D0180 is the initial evaluation by the dentist rendering the D4910.

Fees for D4910 when billed within 30 days of periodontal therapy by the same dentist/dental office are disallowed.

D4920 Unscheduled dressing change (by someone other than the treating dentist)

The definition of the same dentist includes dentists and staff in the same dental office. A fee for dressing change performed by the same dentist or staff in the same dental office is disallowed within 30 days following the surgical procedure.

D4921 Gingival irrigation – per quadrant

Medicaments and solutions used for gingival irrigation are not covered benefits and the benefits are denied.

Fees for gingival irrigation are disallowed when performed with any periodontal service.

D4999 Unspecified periodontal procedure, by report

PROSTHODONTICS (REMOVABLE) D5000 - D5899

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GP Characterizations, staining, overdentures, or metal bases are considered specialized techniques or procedures. An alternate benefit allowance is made for a conventional denture. Any fee charged in excess of the allowance for conventional denture is denied and the difference between the allowance for the conventional denture and the approved amount for the procedure performed is collectable from the patient.

GP The fees for full or partial dentures include any reline/rebase, adjustment or repair required within six months of delivery by the same dentist/dental office, except in the case of...
immediate dentures. Except in the case of immediate dentures, the fees for these services by the same dentist/dental office are disallowed.

GP Benefits may be denied and the approved amount is collectable from the patient if repair or replacement within contractual time limitations is the patient’s fault.

GP The benefits for restorations for altering occlusion, involving vertical dimension, treating TMD, replacing tooth structure lost by attrition, erosion, abrasion (wear), abfraction, corrosion or for periodontal, orthodontic or other splinting are denied and the approved amount is collectable from the patient.

GP The fees for cast or indirectly fabricated restorations and prosthetic procedures include all models, temporaries and other associated procedures. Any fees charged for these procedures in excess of the approved amounts for the cast or indirectly fabricated restorations or prosthetic procedures by the same dentist/dental office are disallowed.

GP Multistage procedures are reported and benefitted upon completion. The completion date is the date of insertion for removable prosthetic appliances. The completion date for immediate dentures is the date that the remaining teeth are removed and the denture is inserted. The completion date for fixed partial dentures and crowns, onlays, and inlays is the cementation date regardless of the type of cement utilized.

**Complete Dentures (including routine post-delivery care)**

**D5110** Complete denture, maxillary

**D5120** Complete denture, mandibular

**D5130** Immediate denture, maxillary

**D5140** Immediate denture, mandibular

**Partial Dentures (including routine post-delivery care)**

GP A posterior fixed bridge and a removable partial denture are not a benefit in the same arch within a five year period. An allowance for a removable partial denture is made and any fee charged in excess of the allowance is denied and the approved amount is collectable from the patient.

GP The fees for fixed bridges or removable cast partials are denied and the approved amount is collectable from the patient, for patients under age 16.

**D5211** Maxillary partial denture-resin base (including retentive/clasping materials, rests, and teeth)

**D5212** Mandibular partial denture-resin base (including retentive/clasping materials, rests, and teeth)

**D5213** Maxillary partial denture-cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)

**D5214** Mandibular partial denture-cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)

**D5221** Immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)

**D5222** Immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)
D5223 Immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)

D5224 Immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)

D5225 Maxillary partial denture – flexible base (including any clasps, rests, and teeth) D5226 Mandibular partial denture – flexible base (including any clasps, rests, and teeth)

D5282 Removable unilateral partial denture – one piece cast metal (including clasps and teeth), maxillary

D5283 Removable unilateral partial denture – one piece cast metal (including clasps and teeth), mandibular

**Adjustments to Dentures**

GP The fees for full or partial dentures include any adjustments or repairs required within six months of delivery, except in the case of immediate dentures. If performed by the same dentist/dental office within six months of initial placement, fees for adjustments or repairs are disallowed.

GP The fees for adjustments to complete or partial dentures are limited to two adjustments per denture per twelve months (after six months has elapsed since initial placement). More frequent adjustments are denied and the approved amount is collectable from the patient.

D5410 Adjust complete denture - maxillary D5411 Adjust complete denture - mandibular

D5421 Adjust partial denture - maxillary D5422 Adjust partial denture - mandibular

**Repairs to Complete Dentures**

GP The fee for the repair of a complete denture cannot exceed one-half of the fee for a new appliance, and any excess fee by the same dentist/dental office is disallowed.

GP The fees for full or partial dentures include any adjustments or repairs required within six months of delivery, except in the case of immediate dentures. If performed by the same dentist/dental office within six months of initial placement, fees for adjustments or repairs are disallowed.

D5511 Repair broken complete denture base, mandibular

Fees for repairs of complete dentures, if performed within six months of initial placement by the same dentist/dental office are disallowed.

D5512 Repair broken complete denture base, maxillary

Fees for repairs of complete dentures, if performed within six months of initial placement by the same dentist/dental office are disallowed.

D5520 Replace missing or broken teeth-complete denture (each tooth)

**Repairs to Partial Dentures**

GP The fee for the repair of a partial denture cannot exceed one-half of the fee for a new
appliance, and any excess fee by the same dentist/dental office is disallowed.

**GP**  
The fees for full or partial dentures include any adjustments or repairs required within six months of delivery, except in the case of immediate dentures. If performed by the same dentist/dental office within six months of initial placement, fees for the adjustments or repairs are disallowed.

**D5611** Repair resin partial denture base, mandibular  
Fees for repairs of resin partial dentures, if performed within six months of initial placement by the same dentist/dental office are disallowed.

**D5612** Repair resin partial denture base, maxillary  
Fees for repairs of resin partial dentures, if performed within six months of initial placement by the same dentist/dental office are disallowed.

**D5621** Repair cast framework, mandibular  
Fees for repairs of cast partial dentures, if performed within six months of initial placement by the same dentist/dental office are disallowed.

**D5622** Repair cast partial framework, maxillary  
Fees for repairs of cast partial dentures, if performed within six months of initial placement by the same dentist/dental office are disallowed.

**D5630** Repair or replace broken retentive clasping materials - per tooth

**D5640** Replace broken teeth-per tooth

**D5650** Add tooth to existing partial denture

**D5660** Add clasp to existing partial denture – per tooth

**D5670** Replace all teeth and acrylic on cast metal framework (maxillary)  
Replace all teeth and acrylic on cast metal framework (mandibular)

The fee for a D5670 or D5671 cannot exceed one-half of the fee for a new appliance, and any excess fee by the same dentist/dental office is disallowed.

**Denture Rebase Procedures**

**GP**  
The fee for the rebase includes the fee for relining. When the fee for a reline performed in conjunction with rebase (within six months of) by the same dentist/dental office the fee for the reline is disallowed.

**GP**  
The fee for a rebase includes adjustments required within six months of delivery. A fee for an adjustment performed within six months of a reline or rebase by the same dentist/dental office is disallowed.

**D5710** Rebase complete maxillary denture  
Rebase complete mandibular denture

**D5720** Rebase maxillary partial denture  
Rebase mandibular partial denture
**Denture Reline Procedures**

GP The fee for a reline includes adjustments required within six months of delivery. A fee for an adjustment billed within six months of a reline by the same dentist/dental office is disallowed.

GP The fee for the rebase includes the fee for relining. The fee for a reline performed in conjunction with (within six months of) a rebase by the same dentist/dental office is disallowed.

D5730 Reline complete maxillary denture (chairside) D5731
Reline complete mandibular denture (chairside)

D5740 Reline maxillary partial denture (chairside) D5741
Reline mandibular partial denture (chairside) D5750
Reline complete maxillary denture (laboratory) D5751
Reline complete mandibular denture (laboratory)

D5760 Reline maxillary partial denture (laboratory)
D5761 Reline mandibular partial denture (laboratory)

**Interim Prosthesis**

D5810 Interim complete denture (maxillary) D5811
Interim complete denture (mandibular)

The benefits for interim complete dentures are denied and the approved amount is collectable from the patient.

D5820 Interim partial denture (maxillary) D5821
Interim partial denture (mandibular)

An interim partial denture is a benefit only in children age 16 or under for missing anterior permanent teeth. If submitted for any other reasons, the fees for D5820 and D5821 are denied and the approved amount is collectable from the patient.

**Other Removable Prosthetic Services**

D5850 Tissue conditioning, maxillary

D5851 Tissue conditioning, mandibular

A separate fee for tissue conditioning is disallowed if performed by the same dentist/dental office on the same day the denture is delivered or a reline/rebase is provided.

Tissue conditioning is not a benefit more than twice per denture unit per 36 months, and the benefit for tissue conditioning is denied and the approved amount is collectable from the patient if done more frequently.

D5862 Precision attachment, by report
The benefit for a precision attachment is denied and the approved amount is collectable from the patient.

D5863 Overdenture – complete maxillary

Complete and partial overdentures are considered specialized techniques and the benefit for an overdenture procedure is denied. An allowance will be made for a conventional denture, and any excess fee is chargeable to the patient.

D5864 Overdenture – partial maxillary

Complete and partial overdentures are considered specialized techniques and the benefit for an overdenture procedure is denied. An allowance will be made for a conventional denture, and any excess fee is chargeable to the patient.

D5865 Overdenture - complete mandibular

Complete and partial overdentures are considered specialized techniques and the benefit for an overdenture procedure is denied. An allowance will be made for a conventional denture, and any excess fee is chargeable to the patient.

D5866 Overdenture – partial mandibular

Complete and partial overdentures are considered specialized techniques and the benefit for an overdenture procedure is denied. An allowance will be made for a conventional denture, and any excess fee is chargeable to the patient.

D5867 Replacement of replaceable part of semi-precision or precision attachment (male or female component)

The benefit for this procedure (D5867) is denied, and the approved amount is collectable from the patient.

D5875 Modification of a removable prosthesis following implant surgery

The benefits for implant services are denied and the approved amount is collectable from the patient unless contract specifies that implants are a benefit.

D5876 add metal substructure to acrylic full denture (per arch)

The benefits are denied as a specialized technique.

D5899 Unspecified removable prosthodontic procedure, by report

MAXILLOFACIAL PROSTHETICS D5900 - D5999

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GP The benefits for maxillofacial prosthetics are denied and the approved amount is collectable from the patient.

D5911 Facial moulage (sectional) D5912
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>D5913</td>
<td>Facial moulage (complete)</td>
</tr>
<tr>
<td>D5914</td>
<td>Nasal prosthesis</td>
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<tr>
<td>D5915</td>
<td>Auricular prosthesis</td>
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<tr>
<td>D5916</td>
<td>Orbital prosthesis</td>
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<tr>
<td>D5917</td>
<td>Ocular prosthesis</td>
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<tr>
<td>D5918</td>
<td>Facial prosthesis</td>
</tr>
<tr>
<td>D5919</td>
<td>Nasal septal prosthesis</td>
</tr>
<tr>
<td>D5920</td>
<td>Ocular prosthesis, interim</td>
</tr>
<tr>
<td>D5921</td>
<td>Cranial prosthesis</td>
</tr>
<tr>
<td>D5922</td>
<td>Facial augmentation implant prosthesis</td>
</tr>
<tr>
<td>D5923</td>
<td>Nasal prosthesis, replacement</td>
</tr>
<tr>
<td>D5924</td>
<td>Auricular prosthesis, replacement</td>
</tr>
<tr>
<td>D5925</td>
<td>Orbital prosthesis, replacement</td>
</tr>
<tr>
<td>D5926</td>
<td>Facial prosthesis, replacement</td>
</tr>
<tr>
<td>D5927</td>
<td>Obturator prosthesis, surgical</td>
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<td>D5928</td>
<td>Obturator prosthesis, definitive</td>
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<tr>
<td>D5929</td>
<td>Obturator prosthesis, modification</td>
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<tr>
<td>D5930</td>
<td>Mandibular resection prosthesis with guide flange</td>
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<tr>
<td>D5931</td>
<td>Mandibular resection prosthesis without guide flange</td>
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<tr>
<td>D5932</td>
<td>Obturator prosthesis, interim</td>
</tr>
<tr>
<td>D5933</td>
<td>Trismus appliance (not for TMD treatment)</td>
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<tr>
<td>D5934</td>
<td>Feeding aid</td>
</tr>
<tr>
<td>D5935</td>
<td>Speech aid prosthesis, pediatric</td>
</tr>
<tr>
<td>D5936</td>
<td>Speech aid prosthesis, adult</td>
</tr>
<tr>
<td>D5937</td>
<td>Palatal augmentation prosthesis</td>
</tr>
<tr>
<td>D5938</td>
<td>Palatal lift prosthesis, definitive</td>
</tr>
<tr>
<td>D5939</td>
<td>Palatal lift prosthesis, interim</td>
</tr>
<tr>
<td>D5940</td>
<td>Palatal lift prosthesis, modification</td>
</tr>
<tr>
<td>D5941</td>
<td>Speech aid prosthesis, modification</td>
</tr>
</tbody>
</table>
D5982 Surgical stent
D5984 Radiation shield
D5985 Radiation cone locator
D5987 Commissure splint D5988 Surgical splint
D5992 Adjust maxillofacial prosthetic appliance, by report
D5993 Maintenance and cleaning of a maxillofacial prosthesis (extra or intraoral) other than required adjustments, by report

**Carriers**

D5983 Radiation carrier
D5986 Fluoride gel carrier
D5991 Vesiculobullous disease medicament carrier

Benefits are denied unless the group/individual contract specifies that maxillofacial prosthetics are a benefit.

D5992 Adjust maxillofacial prosthetic appliance, by report
D5993 Maintenance and cleaning of a maxillofacial prosthesis (extra- or intra-oral) other than required adjustments, by report

Benefits are denied unless the group/individual contract specifies that maxillofacial prosthetics are a benefit.

D5994 Periodontal medicament carrier with peripheral seal – laboratory processed

Benefits are DENIED unless the group/individual contract specifies that maxillofacial prosthetics are a benefit.

D5999 Unspecified maxillofacial prosthesis, by report

**IMPLANT SERVICES**  D6000 - D6199 IMPLANT SERVICES

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**GP** Unless the group/individual contract specifies implants are covered, the benefits for implant services are denied and the approved amount is collectable.

**GP** When benefitted, implant time limitations are established by contract.

**GP** Benefits for implants are denied for patients under the age of 19 and the approved amount is collectable from the patient.
Fixed partial denture prosthetic procedures include the routine use of temporary prosthetics during the time for normal laboratory fabrication of the completed prosthesis. Interim or provisional appliances are disallowed when reported less than six months.

**Dental Procedures**

**D6010** Surgical placement of implant body: endosteal implant

**D6011** Second stage implant surgery

**D6012** Surgical placements of interim implant body for transitional prosthesis: endosteal implant

Benefits are denied and the approved amount is collectible from the patient. This procedure is considered part of the transitional prosthesis, which is not a covered benefit.

**D6013** Surgical placement of mini implant

**D6040** Surgical placement: eposteal implant

**D6050** Surgical placement: transosteal implant

**Implant Supported Prosthetics**

Where benefitted by contract, benefits for the placement of an implant to natural tooth bridge are denied. Special consideration may be given by report particularly where there is documentation of semi-ridged fixation between the tooth and implant and where other risk factors are not present.

**D6051** Interim abutment

**D6052** Semi-precision attachment abutment

Benefits are denied and the approved amount is collective from the patient unless the contract specifies this is a benefit.

**D6055** Connecting bar – implant supported or abutment supported

**D6056** Prefabricated abutment – includes modification and placement

**D6057** Custom fabricated abutment - includes placement

**D6058** Abutment supported porcelain/ceramic crown

**D6059** Abutment supported porcelain fused to metal crown (high noble metal)

**D6060** Abutment supported porcelain fused to metal crown (predominantly base metal)  
**D6061** Abutment supported porcelain fused to metal crown (noble metal)

**D6062** Abutment supported cast metal crown (high noble metal)

**D6063** Abutment supported cast metal crown (predominantly base metal)

**D6064** Abutment supported cast metal crown (noble metal)

**D6094** Abutment supported crown (titanium)

**D6065** Implant supported porcelain/ceramic crown

**D6066** Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)
D6067  Implant supported metal crown (titanium, titanium alloy, high noble metal)  D6068  
Abutment supported retainer for porcelain/ceramic FPD

D6069  Abutment supported retainer for porcelain fused to metal FPD (high noble metal)

D6070  Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)

D6071  Abutment supported retainer for porcelain fused to metal FPD (noble metal)

D6072  Abutment supported retainer for cast metal FPD (high noble metal)

D6073  Abutment supported retainer for cast metal FPD (predominantly base metal)

D6074  Abutment supported retainer for cast metal FPD (noble metal)

D6194  Abutment supported retainer for cast metal FPD (titanium)

D6075  Implant supported retainer for ceramic FPD

D6076  Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy or high noble metal)

D6077  Implant supported retainer for cast metal FPD (titanium, titanium alloy or high noble metal)

**Other Implant Services**

D6080  Implant maintenance procedures, including: removal of prosthesis, cleansing of prosthesis and abutments, reinsertion of prosthesis

Benefits are denied unless covered by group/individual contract.

D6081  Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure

When covered by group/individual contract, fees for D6081 are disallowed when performed in the same quadrant by the same dentist/dental office as D4341/D4342 or D4240/4241, D4260/D4264 or D6101/D6102.

Fees for retreatment by the same dentist/dental office within 24 months of initial therapy are disallowed.

Fees for D6081 are disallowed when performed within 12 months of restoration (D6058-D6077, D6085, D6094, D6118, D6119, D6194) placement by same dentist/dental office.

Fees for D6081 are disallowed when performed in conjunction with D1110, D4346 or D4910.

D6085  Provisional implant crown

Benefits are denied unless covered by group/individual contract.

D6090  Repair implant supported prosthesis, by report

D6091  Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment.
Benefits are denied as a specialized procedure unless the contract specifies that implant procedures are covered benefits.

**D6092 Recement or rebond implant/abutment supported crown**

Fee for the recementation or rebonding of crowns are disallowed if done within six months of the initial seating date by the same dentist/dental office.

Benefits may be paid for one recementation or rebonding after six months have elapsed since the initial placement. Subsequent requests for recementation or rebond by the same dentist/dental office are denied. Benefits may be paid when billed by a dentist/dental office other than the one who seated the crown or performed the previous recementation or rebond.

**D6093 Recement or rebond implant/abutment supported fixed partial denture**

Fee for recementation or rebonding for fixed partial dentures are disallowed if done within six months of the initial seating date by the same dentist/dental office.

Benefits may be paid for one recementation or rebonding after six months have elapsed since the initial placement. Subsequent requests for recementation or rebond by the same dentist/dental office are denied. Benefits may be paid when billed by a dentist other than the one who seated the crown or performed the previous recementation or rebond.

**D6095 Repair implant abutment, by report D6096**

Remove broken implant retaining screw

Benefits are denied, unless implants are covered by group/individual contract.

**D6100 Implant removal, by report**

**D6101 Debridement of a periimplant defect or defects surrounding a single implant and surface cleaning of exposed implant surfaces, including flap entry and closure**

Benefits are denied unless covered by group/individual contract.

Fees for D6101 are disallowed in conjunction with osseous surgery (D4260 or DD4261)

Fees for D6101 are disallowed when performed in the same surgical site by the same dentist/dental office on the same date of service as D6102.

**D6102 Debridement and osseous contouring of a periimplant defect or defects surrounding a single implant and includes surface cleaning of the exposed implant surfaces and includes flap entry and closure**

Benefits are denied unless covered by group/individual contract.

Fees for D6102 are disallowed in conjunction with osseous surgery (D4260 or DD4261) Fees for other procedures done on the same date as D6102 are disallowed.

**D6103 Bone graft for repair of periimplant defect – does not include flap entry and closure. Placement of a barrier membrane or biologic materials to aid in osseous regeneration are reported separately.**
Benefits for D6103 when billed in conjunction with implants, implant removal, ridge augmentation or preservation, in extraction site, periradicular surgery, etc. are DENIED.

D6104 Bone graft at time of implant placement

Benefits for D6104 when billed in conjunction with implants, implant removal, ridge augmentation or preservation, in extraction site, periradicular surgery, etc. are DENIED.

D6110 Implant /abutment supported removable denture for edentulous arch – maxillary

Benefits are determined by group/individual contract. An alternate benefit of the conventional complete denture may be given.

D6111 Implant /abutment supported removable denture for edentulous arch – mandibular

Benefits are determined by group/individual contract. An alternate benefit of the conventional complete denture may be given.

D6112 Implant /abutment supported removable denture for partially edentulous arch – maxillary

Benefits are determined by group/individual contract. An alternate benefit of the conventional partial denture may be given.

D6113 Implant /abutment supported removable denture for partially edentulous arch – mandibular

Benefits are determined by group/individual contract. An alternate benefit of the conventional partial denture may be given.

D6114 Implant /abutment supported fixed denture for edentulous arch – maxillary

Benefits are determined by group/individual contract. An alternate benefit of the conventional complete denture may be given.

D6115 Implant /abutment supported fixed denture for edentulous arch – mandibular

Benefits are determined by group/individual contract. An alternate benefit of the conventional complete denture may be given.

D6116 Implant /abutment supported fixed denture for partially edentulous arch – maxillary

Benefits are determined by group/individual contract. An alternate benefit of the conventional partial denture may be given.

D6117 Implant /abutment supported fixed denture for partially edentulous arch – mandibular

Benefits are determined by group/individual contract. An alternate benefit of the conventional partial denture may be given.

D6118 Implant/abutment supported interim fixed denture for edentulous arch – mandibular

Benefits for implant abutment supported fixed denture are denied.

D6119 implant/abutment supported interim fixed denture for edentulous arch – maxillary

Benefits for implant abutment supported fixed denture are denied.

D6190 Radiographic/surgical implant index, by report
Benefits for implant index are denied as a specialized procedure.

D6199 Unspecified implant procedure, by report

**PROSTHODONTICS, FIXED D6200 - D6999**

Terms of group/individual contracts vary. Policies in this Handbook that address benefits, limitations and exclusions are "model" policies that have not been tailored to reflect the specific terms of applicable group/individual contracts. This Handbook may not fully or accurately reflect the terms of applicable group/individual contracts, and may be inconsistent with such terms. In all cases, the terms of group/individual contracts take precedence over Dentist Handbook policies. Please contact the member company listed on the patient’s identification card for the specific terms of a group/individual contract.

GP Fixed prosthodontics are subject to contractual time limits.

GP Benefits will be based on the number of pontics necessary for the space, not to exceed the normal complement of teeth.

GP A posterior fixed bridge and a removable partial denture are not benefits in the same arch within the frequency limitations. An allowance for a removable partial denture is made and any fee charged in excess of the allowance is denied and the approved amount is collectable from the patient.

GP The fees for cast or indirectly fabricated restorations and prosthetic procedures include all models, temporaries, laboratory charges and materials, and other associated procedures. Any fees charged for these procedures by the same dentist/dental office in excess of the approved amounts for the cast or indirectly fabricated restorations or prosthetic procedures are disallowed.

GP The fees for fixed prosthodontics are denied and the approved amount is collectable from the patient for children under 16 years of age.

GP Cementation date is the delivery date. The type of cement used is not a determining factor (whether permanent or temporary).

GP The fees for restorations for altering occlusion, involving vertical dimension, treating TMD, replacing tooth structure lost by attrition, erosion, abrasion (wear), abfraction, corrosion or for periodontal, orthodontic or other splinting are denied and the approved amount is collectable from the patient.

GP Multistage procedures are reported and benefitted upon completion. The completion date is the date of insertion for removable prosthetic appliances. The completion date for immediate dentures is the date that the remaining teeth are removed and the denture is inserted. The completion date for fixed partial dentures and crowns, onlays, and inlays is the cementation date regardless of the type of cement utilized.

GP An allowance of a conventional fixed prosthesis is provided for porcelain/ceramic or resin bridges. The difference between the allowance for the conventional fixed prosthesis and the approved amount for the porcelain/ceramic or resin bridge is collectable from the patient.

GP Fixed partial denture prosthetic procedures include the routine use of temporary prosthetics during the time for normal laboratory fabrication of the completed prosthesis. Interim or provisional appliances are disallow when reported less than six months.

GP Benefits for cantilevered second molar pontics are denied unless unusual
circumstances exist.

**Fixed Partial Denture Pontics**

- D6205 Pontic-indirect resin-based composite
- D6210 Pontic-cast high noble metal
- D6211 Pontic-cast predominantly base metal
- D6212 Pontic-cast noble metal
- D6214 Pontic-titanium
- D6240 Pontic-porcelain fused to high noble metal
- D6241 Pontic-porcelain fused to predominantly base metal
- D6242 Pontic-porcelain fused to noble metal
- D6245 Pontic-porcelain/ceramic
- D6250 Pontic-resin with high noble metal
- D6251 Pontic-resin with predominantly base metal
- D6252 Pontic-resin with noble metal
- D6253 Provisional pontic

Temporary and provisional fixed prostheses are not separate benefits and are included in the fee for the permanent prostheses. The fees for the temporary fixed prostheses by the same dentist/dental office are disallowed.

**Fixed Partial Denture Retainers – Inlays/Onlays**

- D6545 Retainer-cast metal for resin bonded fixed prosthesis
- D6548 Retainer- porcelain/ceramic for resin bonded fixed prosthesis

Benefits will be considered for a conventional fixed prosthesis. The difference between the allowance for the conventional prosthesis and the approved amount for the D6548 is denied and collectable from the patient.

- D6549 Resin retainer – for resin bonded fixed prosthesis
- D6600 Retainer inlay - porcelain/ceramic, two surfaces

Benefits will be considered for a conventional fixed prosthesis. The difference between the allowance for the conventional prosthesis and the approved amount for the D6600 is denied and collectable from the patient.

- D6601 Retainer inlay - porcelain/ceramic, three or more surfaces

Benefits will be considered for a conventional fixed prosthesis. The difference between the allowance for the conventional prosthesis and the approved amount for the D6601 is denied and collectable from the patient.
D6602  Retainer inlay - cast high noble metal, two surfaces
D6603  Retainer inlay - cast high noble metal, three or more surfaces
D6604  Retainer inlay - cast predominantly base metal, two surfaces
D6605  Retainer inlay - cast predominantly base metal, three or more surfaces
D6606  Retainer inlay - cast noble metal, two surfaces
D6607  Retainer inlay - cast noble metal, three or more surfaces
D6608  Retainer onlay - porcelain/ceramic, two surfaces

Benefits will be considered for a conventional fixed prosthesis. The difference between the allowance for the conventional prosthesis and the approved amount for the D6608 is denied and collectable from the patient.

D6609  Retainer onlay - porcelain/ceramic, three or more surfaces

Benefits will be considered for a conventional fixed prosthesis. The difference between the allowance for the conventional prosthesis and the approved amount for the D6609 is denied and collectable from the patient.

D6610  Retainer onlay - cast high noble metal, two surfaces
D6611  Retainer onlay - cast high noble metal, three or more surfaces
D6612  Retainer onlay - cast predominantly base metal, two surfaces
D6613  Retainer onlay - cast predominantly base metal, three or more surfaces
D6614  Retainer onlay - cast noble metal, two surfaces
D6615  Retainer onlay - cast noble metal, three or more surfaces
D6624  Retainer inlay - titanium
D6634  Retainer onlay - titanium

**Fixed Partial Denture Retainers-Crowns**

D6710  Retainer crown – indirect resin based composite

Benefits will be considered for a conventional fixed prosthesis. The difference between the allowance for the conventional prosthesis and the approved amount for the D6710 is denied and collectable from the patient.

D6720  Retainer crown - resin with high noble metal
D6721  Retainer crown - resin with predominantly base metal
D6722  Retainer crown - resin with noble metal
D6740  Retainer crown- porcelain/ceramic
D6750  Retainer crown-porcelain fused to high noble metal
D6751 Retainer crown-porcelain fused to predominantly base metal
D6752 Retainer crown-porcelain fused to noble metal
D6780 Retainer crown-¾ cast high noble metal
D6781 Retainer crown- ¾ cast predominantly base metal
D6782 Retainer crown- ¾ cast noble metal
D6783 Retainer crown- ¾ porcelain/ceramic
D6790 Retainer crown-full cast high noble metal
D6791 Retainer crown-full cast predominantly base metal
D6792 Retainer crown-full cast noble metal
D6793 Provisional retainer crown

Temporary fixed prostheses are not separate benefits and are included in the fee for the permanent prostheses. The fees for the temporary fixed prostheses by the same dentist/dental office are disallowed.

D6794 Retainer crown-titanium Other

Fixed Partial Denture Services D6920

Connector bar

The fee for a connector bar is denied and the approved amount is collectable from the patient.

D6930 Recement or rebond fixed partial denture

Delta Dental considers the cementation date to be that date upon which the completed bridge is first delivered to the mouth. The type of cement used is not a determining factor (whether permanent or temporary).

Fees for recementation or rebonding of inlays, onlays, crowns, and fixed partial dentures are disallowed if done within six months of the initial seating date by the same dentist/dental office.

Benefits may be paid for one recementation or rebonding after six months have elapsed since initial placement. Subsequent requests for recementation or rebond by the same dentist/dental office are denied and the approved amount is collectable from the patient.

Benefits may be paid when billed by a provider other than the one who seated the bridge or performed the previous recementation or rebonding.

D6940 Stress breaker

The benefit for a stress breaker is denied and the approved amount is collectable from the patient.

D6950 Precision attachment

The benefit for a precision attachment is denied and the approved amount is collectable from the patient.
D6980  Fixed partial denture repair necessitated by restorative material failure

The fee for the repair of a fixed partial denture cannot exceed one-half of the fee for a new appliance, and any fee charged in excess of the allowance by the same dentist/dental office is disallowed.

D6985  Pediatric partial denture, fixed

The fee for a pediatric partial denture, fixed is denied and the approved amount is collectable from the patient.

D6999  Unspecified fixed prosthodontic procedure, by report

**ORAL AND MAXILLOFACIAL SURGERY**  D7000 - D7999

Terms of group/individual contracts vary. Policies in this Handbook that address benefits, limitations and exclusions are "model" policies that have not been tailored to reflect the specific terms of applicable group/individual contracts. This Handbook may not fully or accurately reflect the terms of applicable group/individual contracts, and may be inconsistent with such terms. In all cases, the terms of group/individual contracts take precedence over Dentist Handbook policies. Please contact the member company listed on the patient's identification card for the specific terms of a group/individual contract.

**GP**  The fee for all oral and maxillofacial surgery includes local anesthesia, suturing if needed, and routine postoperative care, including treatment of dry sockets. Separate fees for these procedures when performed in conjunction with oral and maxillofacial surgery are disallowed. If performed by another dentist these procedures are denied and the approved amount is collectable from the patient.

**GP**  Fees for exploratory surgery or unsuccessful attempts at extractions are disallowed.

**GP**  Impaction codes are based on the anatomical position of the tooth, rather than the surgical procedure necessary for removal.

**GP**  The fees for biopsy (D7285, D7286), frenulectomy (D7960), frenuloplasty (D7963) and excision of hard and soft tissue lesions (D7411, D7450, D7451) are disallowed when the procedure is performed on the same day, same surgical site/area, by the same dentist/dental office and any other surgical procedure. Requests for individual consideration can always be submitted by report for dental consultant review.

**Extractions (includes local anesthesia, suturing if needed, and routine postoperative care)**

**D7111**  Extraction, coronal remnants - primary tooth

D7111 is considered part of any other primary surgery in the same surgical area on the same date and the fee is disallowed if performed by the same dentist/dental office.

**D7140**  Extraction, erupted tooth or exposed root (elevation and/or forceps removal)

**Surgical Extractions-(includes local anesthesia, suturing if needed, and routine postoperative care)**

**D7210**  Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth and including elevation of mucoperiosteal flap if indicated.

**D7220**  Removal of impacted tooth - soft tissue

**D7230**  Removal of impacted tooth - partially bony  D7240
Removal of impacted tooth - completely bony

D7241  Removal of impacted tooth - completely bony, with unusual surgical complications

D7250  Removal of residual tooth roots (cutting procedure)

The fee for root recovery is disallowed if submitted in conjunction with a surgical extraction (in the same surgical area) by the same dentist/dental office.

D7251  Coronectomy – intentional partial tooth removal

Depending on the group/individual coverage, coronectomy may be benefitted under individual consideration and only for documented probable neurovascular complications as proximity to mental foramen, inferior alveolar nerve, sinus, etc.

Other Surgical Procedures

D7260  Oroantral fistula closure

D7261  Primary closure of a sinus perforation

When submitted with D7241, the fees for D7261 are disallowed.

D7270  Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth

D7270 includes anesthesia, suturing, postoperative care and removal of the splint by the same dentist/dental office.

D7272  Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization)

The benefit for tooth transplantation is denied and the approved amount is collectable from the patient.

D7280  Exposure of an unerupted tooth

D7280 may be considered under orthodontic benefits. Benefits are denied in the absence of orthodontic benefits.

D7282  Mobilization of erupted or malpositioned teeth to aid eruption

The fee for D7282 is disallowed when performed by the same dentist/dental office in conjunction with other surgery in immediate area.

D7283  Placement of device to facilitate eruption of impacted tooth

Benefits are determined by group/individual contract. Benefits are denied in absence of orthodontic benefits.

D7285  Incisional biopsy of oral tissue - hard (bone, tooth)

D7286  Incisional biopsy of oral tissue - soft (all others)

A fee for biopsy of oral tissue is disallowed if not submitted with a pathology report. The fee for biopsy of oral tissue is disallowed as included in the fee for a surgical procedure (e.g. apicoectomy, extraction, etc.) when performed by the same dentist/dental office in the same surgical area and on the same date of service.
Biopsy of oral tissue is only benefitted for oral structures.

D7287 Exfoliative cytological sample collection
By report and subject to coverage under the medical plan.

D7288 Brush biopsy – transepithelial sample collection
By report and subject to coverage under the medical plan. If covered under dental a pathology report must be included.

D7290 Surgical repositioning of teeth

D7291 Transseptal fiberotomy, supra crestal fiberotomy by report. Benefits are denied unless covered by group/individual contract.

D7292 Placement of temporary anchorage device [screw retained plate] requiring flap, includes device removal

D7293 Placement of temporary anchorage device requiring flap, includes device removal

D7294 Placement: temporary anchorage device without surgical flap
Benefits are denied and the fee is chargeable to the patient. D7292, D7293 and D7294 are considered specialized procedures and not covered benefits.

If the group/individual contract includes orthognathic surgery, these procedures are included in the surgery.

D7295 Harvest of bone for use in autogenous grafting procedure
D7296 Corticotomy – one to three teeth or tooth spaces, per quadrant
Benefits for corticotomy are denied.

D7297 Corticotomy – four or more teeth or tooth spaces, per quadrant
Benefits for corticotomy are denied.

Alveoloplasty—Preparation of Ridge for Dentures

GP A quadrant for oral surgery purposes is defined as four or more continuous teeth and/or teeth spaces distal to the midline.

D7310 Alveoloplasty in conjunction with extractions- four or more teeth or tooth spaces per quadrant
The fee for D7310 performed by the same dentist/dental office in the same surgical area on the same date of service as extractions (D7140, D7210-D7250) is disallowed.

D7311 Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces per quadrant
The fee for D7311 performed by the same dentist/dental office in the same surgical area on the same date of service as extractions (D7140, D7210-D7250) is disallowed.
D7320  Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces per quadrant

D7321  Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces per quadrant

Count tooth bounded spaces for D7321 partial quadrant code.

A tooth bounded space counts as one space irrespective of the number of teeth that would normally exist in the space.

**Vestibuloplasty**

GP  All procedures are by report and subject to coverage under the medical plan.

D7340  Vestibuloplasty - ridge extension (secondary epithelialization)

D7350  Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)

**Excision of Soft Tissue Lesions**

GP  All procedures are by report and subject to coverage under the medical plan.

GP  The fee for D7410 and D7411 is disallowed as included in the fee for another surgery performed in the same area of the mouth on the same day by the same dentist/dental office.

GP  Pathology laboratory report is required. If no report is submitted, the fee for the procedure is disallowed.

D7410  Excision of benign lesion up to 1.25 cm

D7411  Excision of benign lesion greater than 1.25 cm

D7412  Excision of benign lesion, complicated

D7413  Excision of malignant lesion up to 1.25 cm

D7414  Excision of malignant lesion greater than 1.25 cm

D7415  Excision of malignant lesion, complicated

D7465  Destruction of lesion(s) by physical or chemical method, by report

**Excision of Intra-Osseous Lesions**

GP  All procedures are by report and subject to coverage under the medical plan.

GP  Pathology laboratory report is required. If no report is submitted, the fee for the procedure is disallowed.

GP  The fee for D7450 and D7451 is disallowed as included in the fee for another surgery performed in the same area of the mouth on the same day by the same dentist/dental office.

D7440  Excision of malignant tumor - lesion diameter up to 1.25 cm

D7441  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  Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm

D7460  Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm

D7461  Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm

**Excision of Bone Tissue**

**GP**  All procedures are by report and subject to coverage under the medical plan. Individual consideration may be available by report.

D7471  Removal of lateral exostosis (maxilla or mandible)

D7472  Removal of torus palatinus

D7473  Removal of torus mandibularis

D7485  Reduction of osseous tuberosity

D7490  Radical resection of maxilla or mandible

If considered under dental, the fee for D7490 is disallowed unless pathology laboratory report is submitted.

**Surgical Incision**

**GP**  All procedures are by report and are subject to coverage under the medical plan. If not covered under medical, Procedures D7530-D7560 require a pathology report.

D7510  Incision and drainage of abscess - intraoral soft tissue

The fee for surgical incision is disallowed when done on the same date (in the same operative area) and by the same dentist/dental office as endodontics (D3000-D3999), oral surgery (D7000-D7999), palliative treatment and surgical periodontal procedures (D4210-D4278).

D7511  Incision and drainage of abscess-intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)

The fee for surgical incision is disallowed when done on the same date (in the same operative area) and by the same dentist/dental office as endodontics, extractions, palliative treatment or other definitive service.

D7520  Incision and drainage of abscess-extraoral soft tissue

D7521  Incision and drainage of abscess-extraoral soft tissue – complicated (includes drainage of multiple fascial spaces)

Incision and drainage of abscess - extraoral soft tissue is a benefit only if a dentally related infection is present. If it is not related to a dental infection, the benefit for treatment is denied and the approved amount is collectable from the patient.

D7530  Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue

D7540  Removal of reaction producing foreign bodies, musculoskeletal system
D7550  Partial ostectomy/sequestrectomy for removal of non-vital bone
D7560  Maxillary sinusotomy for removal of tooth fragment or foreign body

**Treatment of Closed Fractures**

**GP**
All procedures are by report and are subject to coverage under the medical plan.

**GP**
A separate fee for splinting, wiring or banding is disallowed when performed by the same dentist/dental office rendering the primary procedure.

D7610  Maxilla - open reduction (teeth immobilized if present)
D7620  Maxilla - closed reduction (teeth immobilized if present)  D7630  Mandible - open reduction (teeth immobilized if present)
D7640  Mandible - closed reduction (teeth immobilized if present)
D7650  Malar and/or zygomatic arch - open reduction
D7660  Malar and/or zygomatic arch - closed reduction
D7670  Alveolus - closed reduction, may include stabilization of teeth
D7671  Alveolus - open reduction, may include stabilization of teeth
D7680  Facial bones - complicated reduction with fixation and multiple surgical approaches

**Treatment of Open Fractures**

**GP**
All procedures are by report and are subject to coverage under the medical plan.

**GP**
A separate fee for splinting, wiring or banding is disallowed when performed by the same dentist/dental office rendering the primary procedure.

D7710  Maxilla - open reduction  D7720  Maxilla - closed reduction
D7730  Mandible - open reduction
D7740  Mandible - closed reduction
D7750  Malar and/or zygomatic arch - open reduction
D7760  Malar and/or zygomatic arch - closed reduction
D7770  Alveolus - open reduction stabilization of teeth
D7771  Alveolus, closed reduction stabilization of teeth
D7780  Facial bones - complicated reduction with fixation and multiple approaches

**Reduction of Dislocation and Management of Other Temporomandibular Joint Dysfunctions**

**GP**
All procedures are denied and the approved amount is collectable from the patient unless
covered by the subscriber's group/individual contact and are subject to coverage under the medical plan.

GP  When covered by the group/individual contract all procedures are by report and subject to coverage under the medical plan. The fees for procedures that are an integral part of a primary procedure should not be reported separately and are disallowed.

D7810  Open reduction of dislocation
D7820  Closed reduction of dislocation
D7830  Manipulation under anesthesia
D7840  Condylectomy
D7850  Surgical discectomy, with/without implant
D7852  Disc repair
D7854  Synovectomy
D7856  Myotomy
D7858  Joint reconstruction
D7860  Arthrotomy
D7865  Arthroplasty
D7870  Arthrocentesis
D7871  Non - arthroscopic lysis and lavage

Benefits are denied unless related TMJ services are covered by group/individual contract.

D7872  Arthroscopy - diagnosis, with or without biopsy
D7873  Arthroscopy - lavage and lysis of adhesions
D7874  Arthroscopy - disc repositioning and stabilization
D7875  Arthroscopy - synovectomy
D7876  Arthroscopy - discectomy
D7877  Arthroscopy - debridement
D7880  Occlusal orthotic device, by report
D7881  Occlusal orthotic device adjustment

Benefits for occlusal orthotic devise adjustments are denied unless covered by group/individual contract.

When covered by contract, all adjustments within 6 months from initial placement are disallowed.

Allow one per year following six months from initial placement.
D7899  Unspecified TMD therapy, by report

**Repair of Traumatic Wounds**

GP  Repair of traumatic wounds is limited to oral structures.

D7910  Suture of recent small wounds up to 5 cm

**Complicated Suturing (reconstruction requiring delicate handling of tissues and wide undermining for meticulous closure)**

GP  Complicated suturing is limited to oral structures.

D7911  Complicated suture - up to 5 cm

D7912  Complicated suture - greater than 5 cm

**Other Repair Procedures**

GP  All procedures except D7960, D7970, and D7971 are by report and subject to coverage under medical plan.

D7920  Skin grafts (identify defect covered, location and type of graft)  D7921

Collection and application of autologous blood concentrate product

The benefit for collection and application of autologous blood concentrate product is DENIED as investigational and is not a covered benefit.

D7940  Osteoplasty - for orthognathic deformities

D7941  Ostectomy - mandibular rami

D7943  Ostectomy - mandibular rami with bone graft; includes obtaining the graft

D7944  Ostectomy - segmented or subapical - per sextant or quadrant

D7945  Ostectomy - body of mandible

D7946  LeFort I (maxilla - total)

D7947  LeFort I (maxilla - segmented)

D7948  LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retusion) - without bone graft

D7949  LeFort II or LeFort III - with bone graft

D7950  Osseous, osteoperiosteal, or cartilage graft of the mandible - autogenous or nonautogenous, by report

Benefits for D7950 when billed in conjunction with implants, implant removal, ridge augmentation, extraction sites, periradicular surgery etc. are denied as a specialized procedure.

D7951  Sinus augmentation with bone or bone substitutes via lateral open approach

Benefits for D7951 when billed in conjunction with implants, implant removal, ridge augmentation, extraction sites, periradicular surgery etc. are denied as a specialized procedure.
procedure.

D7952 Sinus augmentation via vertical approach

Benefits for D7951 when billed in conjunction with implants, implant removal, ridge augmentation, extraction sites, periradicular surgery etc. are denied as a specialized procedure.

D7953 Bone replacement graft for ridge preservation – per site

Benefits for osseous autografts and/or osseous allografts are available only when billed for natural teeth for periodontal purposes using periodontal procedure codes (D4263-D4264). Benefits for these procedures when billed in conjunction with implants, implant removal, ridge augmentation, extraction sites, periradicular surgery etc. are denied as an investigational procedure. If the contract covers dental implants this procedure may be a benefit at the time of extraction.

D7955 Repair of maxillofacial soft and hard tissue defect

D7960 Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure

A separate fee for frenulectomy is disallowed when billed in conjunction with any other surgical procedure(s) in the same surgical area, by the same dentist/dental office.

D7963 Frenuloplasty

Fees for frenuloplasty are disallowed when billed in conjunction with any other surgical procedure(s) in the same surgical area by the same dentist/dental office.

D7970 Excision of hyperplastic tissue - per arch

The fee for excision of hyperplastic tissue is disallowed when billed in conjunction with other surgical procedure(s) in the same surgical area by the same dentist/dental office.

D7971 Excision of pericoronal gingiva

The fee for excision of pericoronal gingiva is disallowed when billed in conjunction with other surgical procedure(s) in the same surgical area by the same dentist/dental office.

D7972 Surgical reduction of fibrous tuberosity

D7979 Non-surgical sialolithotomy

D7980 Surgical Sialolithotomy

D7981 Excision of salivary gland, by report

D7982 Sialodochoplasty

D7983 Closure of salivary fistula

D7990 Emergency tracheotomy

D7991 Coronoidectomy

D7995 Synthetic graft-mandible or facial bones, by report

D7996 Implant-mandible for augmentation purposes (excluding alveolar ridge), by report
Appliance removal (not by dentist who placed appliance), includes removal of archbar

The benefit for appliance removal is denied as a non-covered procedure unless the contract specifies that the related oral surgery services are a benefit. If covered, disallow 45 days following appliance placement.

D7998 Intraoral placement of a fixation devise not in conjunction with fracture

This procedure is by report and subject to coverage under the medical plan.

This procedure is disallowed by the same dentist/dental office when billed in conjunction with any surgical procedure not in conjunction with fractures for which splinting, wiring or banding is considered part of the complete procedure (e.g., D7270, D7272).

D7999 Unspecified oral surgery procedure, by report

ORTHODONTICS D8000 - D8999

Terms of group/individual contracts vary. Policies in this Handbook that address benefits, limitations and exclusions are “model” policies that have not been tailored to reflect the specific terms of applicable group/individual contracts. This Handbook may not fully or accurately reflect the terms of applicable group/individual contracts, and may be inconsistent with such terms. In all cases, the terms of group/individual contracts take precedence over Dentist Handbook policies. Please contact the member company listed on the patient's identification card for the specific terms of a group/individual contract.

GP Surgical procedures should be reported separately under the appropriate procedure codes.

GP Delta Dental does not consider mail away and other do-it-yourself aligner kits to be a covered benefit.

Limited orthodontic treatment should be used with:

Orthodontic treatment with a limited objective, not necessarily involving the entire dentition. It may be directed at the only existing problem, or at only one aspect of a larger problem in which a decision is made to defer or forego more comprehensive therapy.

Interceptive orthodontic treatment should be used with:

Interceptive orthodontics is an extension of preventive orthodontics includes localized tooth movement. Such treatment may occur in the primary or transitional dentition and may include such procedures as the redirection of ectopically erupting teeth, correction of dental crossbite, or recovery of space loss where overall space is adequate. When initiated during the incipient stages of a developing problem interceptive orthodontics may reduce the severity of the malformation and mitigate its cause. Complicating factors such as skeletal disharmonies, overall space deficiency, or other conditions may require subsequent comprehensive therapy.

Comprehensive orthodontic treatment should be used with:

Comprehensive orthodontic care includes a coordinated diagnosis and treatment leading to the improvement of the patient's craniofacial dysfunction and/or dentofacial deformity which may include anatomical, functional and/or aesthetic relationships. Treatment may utilize fixed and/or removable orthodontic appliances and may also include functional and/or orthopedic appliances in growing and non-growing patients. Adjunctive procedures, to facilitate care may be required.

Comprehensive orthodontics may incorporate several phases focusing on specific objectives at various stages of dentofacial development.
Limited Orthodontic Treatment

D8010 Limited orthodontic treatment of the primary dentition
D8020 Limited orthodontic treatment of the transitional dentition
D8030 Limited orthodontic treatment of the adolescent dentition
D8040 Limited orthodontic treatment of the adult dentition

Interceptive Orthodontic Treatment

D8050 Interceptive orthodontic treatment of the primary dentition
D8060 Interceptive orthodontic treatment of the transitional dentition

Comprehensive Orthodontic Treatment

D8070 Comprehensive orthodontic treatment of the transitional dentition
D8080 Comprehensive orthodontic treatment of the adolescent dentition
D8090 Comprehensive orthodontic treatment of the adult dentition

Minor Treatment to Control Harmful Habits

D8210 Removable appliance therapy
D8220 Fixed appliance therapy

Other Orthodontic Services

D8660 Pre-orthodontic treatment examination to monitor growth and development  Fees for D8660 are disallowed with any other evaluation.

Fees for D8660 are disallowed when submitted with D8070, D8080 or D8090.

D8670 Periodic orthodontic treatment visit

D8680 Orthodontic retention (removal of appliances, construction and placement of retainer(s))

A separate fee for orthodontic retention is disallowed within 24 months of placement by the same dentist/dental office.

Benefits for D8680 are denied if performed by a different dentist/dental office.

D8681 Removable orthodontic retainer adjustment

Fees for removable orthodontic retainer adjustments are disallowed if performed by the same dentist/dental office providing orthodontic treatment. Benefits are denied if performed by a different dentist/dental office.

D8690 Orthodontic treatment
D8691 Repair of orthodontic appliance

The benefit for repair of an orthodontic appliance is denied, and the approved amount is collectable from the patient.

D8692 Replacement of lost or broken retainer

The benefit for replacement of a lost or broken retainer is denied, and the approved amount is collectable from the patient.

D8693 Rebond or recement fixed retainer

A separate fee for rebonding or recementing, and/or repair, as required of fixed retainers is disallowed unless performed by a different dentist/dental office.

D8694 Repair of fixed retainers, includes reattachment

This procedure is included in the orthodontic case fee. Fees for D8694 are disallowed within 24 months following placement of the fixed retainer by the same dentist/dental office.

Benefits for D8694 performed after 24 months are denied.

D8695 Removal of fixed orthodontic appliances for reasons other than completion of treatment

Benefits for removal of fixed orthodontic appliances for reasons other than completion of treatment are denied.

D8999 Unspecified Orthodontic procedure, by report

ADJUNCTIVE GENERAL SERVICES D9000 - D9999

Terms of group/individual contracts vary. Policies in this Handbook that address benefits, limitations and exclusions are "model" policies that have not been tailored to reflect the specific terms of applicable group/individual contracts. This Handbook may not fully or accurately reflect the terms of applicable group/individual contracts, and may be inconsistent with such terms. In all cases, the terms of group/individual contracts take precedence over Dentist Handbook policies. Please contact the member company listed on the patient's identification card for the specific terms of a group/individual contract.

Unclassified Treatment

D9110 Palliative (emergency) treatment of dental pain-minor procedures

The fee for palliative treatment is disallowed when any other definitive treatment is performed on the same date by the same dentist/dental office.

Limited radiographic images (D0210-D0391) and tests necessary to diagnose the emergency condition are considered separately.

Palliative treatment is a benefit on a per visit basis, once on the same date, and includes all procedures necessary for the relief of pain. Evaluation is not considered as the relief of pain.

A separate fee for palliative treatment is disallowed when billed on the same date as root canal therapy by the same dentist/dental office.

The fee for D9110 is disallowed in conjunction with pupal debridement (D3221) by the same dentist/dental office.
D9120 Fixed partial denture sectioning

This procedure is only a benefit if a portion of the fixed prosthesis is to remain intact and serviceable following sectioning and extraction or other treatment.

If this code is part of the process or removing and replacing a fixed prosthesis, it is considered integral to the fabrication of the fixed prosthesis and a separate fee for this code is disallowed.

Polishing and recontouring are considered an integral part of the fixed partial denture sectioning. Additional fees are disallowed.

D9130 Temporomandibular joint dysfunction – non-invasive physical therapies

Benefits for temporomandibular joint dysfunction physical therapies are denied unless covered by group contract.

Anesthesia

D9210 Local anesthesia not in conjunction with operative or surgical procedures  D9211 Regional block anesthesia

D9212 Trigeminal division block anesthesia

D9215 Local anesthesia in conjunction with operative or surgical procedures

A separate fee for local anesthesia is disallowed whether stand alone or in conjunction with any other procedure.

D9219 Evaluation for moderate sedation, deep sedation or general anesthesia

A separate fee for evaluation for moderate sedation, deep sedation or general anesthesia is disallowed with moderate sedation, deep sedation, or general anesthesia.

D9222 Deep sedation/general anesthesia – first 15 minutes

Deep sedation/general anesthesia is a benefit only when administered;
(1) with appropriate monitoring by a properly licensed provider who is acting in compliance with applicable State rules and regulations, and
(2) In conjunction with oral surgical procedures (D7000-D7999) when covered, or when necessary due to concurrent medical conditions. Otherwise, the benefit for deep sedation/general anesthesia is denied.

The benefit for deep sedation/general anesthesia is denied when billed by anyone other than an appropriately licensed and qualified provider.

D9223 Deep sedation/general anesthesia – each subsequent 15 minute increment  Deep

sedation/general anesthesia is a benefit only when administered;
(1) with appropriate monitoring by a properly licensed provider who is acting in compliance with applicable State rules and regulations, and
(2) In conjunction with oral surgical procedures (D7000-D7999) when covered, or when necessary due to concurrent medical conditions. Otherwise, the benefit for deep sedation/general anesthesia is denied.
The benefit for deep sedation/general anesthesia is denied when billed by anyone other than an appropriately licensed and qualified provider.

Providing more than one hour of deep sedation or general anesthesia for routine dental procedures is unusual. When documentation of exceptional circumstances is submitted, benefits may be approved, dependent on group/individual contract.

D9230 Inhalation of nitrous oxide/anxiolysis, analgesia

The benefit for analgesia is denied and the approved amount is collectable from the patient.

When covered by group contract inhalation of nitrous oxide/anxiolysis, analgesia is disallowed when submitted more than once on the same date, and/or in conjunction with IV sedation and general anesthesia.

D9239 Intravenous moderate (conscious) sedation/analgesia - first 15 minutes

Intravenous moderate (conscious) sedation/analgesia is a benefit only when administered;
(1) In a dental office with appropriate monitoring by an appropriately licensed and qualified dentist who is acting in compliance with applicable rules and regulations, and
(2) In conjunction with oral surgical procedures (D7000-D7999) when covered, or when necessary due to concurrent medical conditions. Otherwise, the benefit for intravenous moderate (conscious) sedation/analgesia is denied.

D9243 Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment

Intravenous moderate (conscious) sedation/analgesia is a benefit only when administered
(1) In a dental office with appropriate monitoring by an appropriately licensed and qualified dentist who is acting in compliance with applicable rules and regulations, and
(2) In conjunction with oral surgical procedures (D7000-D7999) when covered, or when necessary due to concurrent medical conditions. Otherwise, the benefit for intravenous moderate (conscious) sedation/analgesia is denied.

The benefit for intravenous moderate (conscious) sedation/analgesia is denied when billed by anyone other than an appropriately licensed and qualified dentist.

D9248 Non-intravenous conscious sedation

The benefit for non-intravenous conscious sedation is denied, and the approved amount is collectable from the patient.

Professional Consultation

D9310 Consultation (diagnostic service provided by dentist or physician other than requesting dentist or physician.)

A separate fee for a consultation is disallowed when billed in conjunction with an examination/evaluation by the same dentist/dental office.

The benefit for a consultation in connection with non-covered services is denied and the approved amount is collectable from the patient.

Consultation (D9310) may be benefitted when the service is provided by a dentist whose opinion or advice regarding an evaluation and/or management of a specific problem may

Dentist Handbook with CDT-2019
January 2019 67
be requested by another dentist, physician or appropriate service. The dentist performing the consultation may initiate diagnostic or therapeutic services.

When covered, the consultation is subject to the same frequency limitations and processing policies as a comprehensive evaluation (D0150).

D9311 Consultation with medical health care professional

The fees for the consultation with a health care professional concerning medical issues is disallowed as part of the overall patient management.

Professional Visits

D9410 House/extended care facility call
D9420 Hospital or ambulatory surgical center call
D9430 Office visit for observation (during regularly scheduled hours) - no other services performed
   Fees for an office visit for observation are disallowed when billed with other procedures.
D9440 Office visit - after regularly scheduled hours
D9450 Case presentation, detailed and extensive treatment planning

The benefit for detailed and extensive treatment planning is denied and the approved amount is collectable from the patient.

The fee for extensive treatment planning may be benefitted for complex treatment planning cases involving multiple treatment disciplines and multiple providers of care.

When covered, the D9450 is subject to the same frequency limitations and processing policies as a comprehensive evaluation (D0150).

Drugs

GP The benefits for drugs are denied and the approved amount is collectable from the patient.

D9610 Therapeutic drug injection, by report
D9612 Therapeutic parenteral drugs, two or more administrations, different medications
D9613 Infiltration of sustained release therapeutic drug – single or multiple sites

Benefits for infiltration of sustained release therapeutic drug are denied as a specialized technique unless covered by group/individual contract. When covered, it is only a benefit when submitted with surgical extractions.

D9630 Drugs or medicaments dispensed in the office for home use

Miscellaneous Services

D9910 Application of desensitizing medicament

The benefit for application of desensitizing medicaments is denied and the approved amount is collectable from the patient.

D9911 Application of desensitizing resin for cervical and/or root surface, per tooth
The benefit for application of a desensitizing resin is denied, and the approved amount is collectable from the patient.

D9920 Behavior management, by report
The benefit for behavior management is denied and the approved amount is collectable from the patient.

D9930 Treatment of complications (postsurgical)-unusual circumstances, by report
The fee for treatment of routine postsurgical complications is disallowed when done by the first treating dentist.

Benefits for dry socket are disallowed and are included in the fee for the extraction by the same dentist/dental office.

D9932 Cleaning and inspection of removable complete denture, maxillary
Fees for cleaning and inspection of a removable complete denture are disallowed when done with a reline or rebase procedure unless covered by group/individual contract. In all other instances, benefits for cleaning and inspection of a removable complete denture are denied.

D9933 Cleaning and inspection of removable complete denture, mandibular
Fees for cleaning and inspection of a removable complete denture are disallowed when done with a reline or rebase procedure unless covered by group/individual contract. In all other instances, benefits for cleaning and inspection of a removable complete denture are denied.

D9934 Cleaning and inspection of removable partial denture, maxillary
Fees for cleaning and inspection of a removable partial denture are disallowed when done with a reline or rebase procedure. In all other instances, benefits for cleaning and inspection of a removable partial denture are denied.

D9935 Cleaning and inspection of removable partial denture, mandibular
Fees for cleaning and inspection of a removable partial denture are disallowed when done with a reline or rebase procedure. In all other instances, benefits for cleaning and inspection of a removable partial denture are denied.

D9941 Fabrication of athletic mouthguard
Fabrication of athletic mouthguard is denied unless covered by group/individual contract.

D9942 Repair or reline of occlusal guard
Benefits to repair or reline of an occlusal guard are denied and the approved amount collectible from the patient unless it is covered by the group/individual contract.

If covered, the fee for the occlusal guard includes any adjustment or repair required with six months of delivery. Fees for the adjustment or repair of the occlusal guard are disallowed if performed by the same dentist/dental office within six months of initial placement.

If covered contractually, the fee for repair of an occlusal guard cannot exceed one-half of the fee for a new appliance, and any excess fee is disallowed.
Benefits for occlusal guard adjustments are denied unless covered by group/individual contract.

When covered by contract all adjustments within 6 months are disallowed. Allow one per year following six months from initial placement.

D9944 occlusal guard – hard appliance, full arch
Benefits for occlusal guards are denied unless covered by group/individual contract.

D9945 occlusal guard – soft appliance, full arch
Benefits for occlusal guards are denied unless covered by group/individual contract.

D9946 occlusal guard – hard appliance, partial arch
Benefits for occlusal guards are denied unless covered by group/individual contract.

D9950 Occlusion analysis - mounted case
D9951 Occlusal adjustment - limited D9952
Occlusal adjustment – complete

D9961 duplicate/copy patient’s records
Benefits for duplicate/copy patient’s records is denied.

D9970 Enamel microabrasion
The benefits for enamel microabrasion are denied and the approved amount is collectable from the patient.

D9971 Odontoplasty 1-2 teeth includes removal of enamel projections
The benefit for odontoplasty is denied and is the approved amount is collectable from the patient.

D9972 External bleaching per arch – performed in office
The benefit for bleaching is denied, and the approved amount is collectable from the patient.

D9973 External bleaching per tooth
The benefit for bleaching is denied, and the approved amount is collectable from the patient.

D9974 Internal bleaching per tooth
The benefit for bleaching is denied, and the approved amount is collectable from the patient.

D9975 External bleaching for home application, per arch - includes materials and fabrication of custom tray
D9985  Sales tax
Sales/service fee are denied and the approved amount is collectable from the patient.

D9986  Missed appointment
Missed appointments are denied and the approved amount is collectable from the patient.

D9987  Cancelled appointment
Cancelled appointments are denied and the approved amount is collectable from the patient.

D9990 certified translation or sign-language services – per visit
The fees for translation services are considered inclusive in overall patient management and are disallowed.

D9991 Dental case management – addressing appointment compliance barriers
The fees for addressing appointment compliance barriers are considered inclusive in overall patient management and are disallowed.

D9992 Dental case management – care coordination
The fees for care coordination are considered inclusive in overall patient management and are disallowed.

D9993 Dental case management – motivational interviewing
Fees for motivational interviewing are disallowed when submitted on same date of service as D1310, D1320, D1330.

D9994 Dental case management – patient education to improve oral health literacy
Fees for patient education to improve oral health literacy are DISALLOWED when submitted on same date of service as D1310, D1320, D1330.

D9995 Teledentistry – synchronous; real-time encounter
The fees for teledentistry are considered inclusive in overall patient management and are disallowed.

D9996 Teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review
The fees for teledentistry are considered inclusive in overall patient management and are disallowed.

D9999 Unspecified adjunctive procedure, by report
Miscellaneous Section
Please use this section to retain important Delta Dental of Iowa (DDIA) communications for easy reference, including Delta Dental Dialogue dentist newsletters that are published at least two times a year.