ORAL AND MAXILLOFACIAL SURGERY D7000 - D7999

Local anesthesia is usually considered to be part of Oral and Maxillofacial Surgical procedures.
For dental benefit reporting purposes, a quadrant is defined as four or more contiguous teeth and/or teeth spaces distal to the midline.

General Guidelines

1. The fee for all oral and maxillofacial surgery includes local anesthesia, suturing if needed, debridement and curettage of granulation tissue and postoperative care 30 days following surgery (e.g., dry socket, bleeding). Separate fees for these procedures when performed in conjunction with oral and maxillofacial surgery are not billable to the patient when done by the same dentist/dental office and are denied and the approved amount is collectable from the patient when done by another dentist/dental office.

2. When a medical carrier statement is required, the procedure should be submitted to the patient's medical carrier first. When submitting to HDS, a copy of the explanation of benefits (EOB) or payment voucher from the medical carrier should be included with the claim, pathology report if appropriate, and any other pertinent information. In the absence of such information, the procedure will not be benefited by HDS.

3. Medical carrier statement of payment is not required for HMO. Indicate the HMO name in a narrative.

4. Impaction codes are based on the anatomical position of the tooth, rather than the surgical procedure necessary for removal.

5. Exploratory surgery is denied.

6. Benefits are not billable to the patient for incomplete or unsuccessful attempts at extractions.

7. When submitting for surgical extraction (D7210) and the tooth is not cariously broken down, fractured, or otherwise compromised, the provider should submit a narrative that states the clinical reason(s) which prevented removal of the tooth via customary elevation and forceps.

8. When a "narrative" is required, the corresponding guidelines may state what is expected in the narrative. When "narrative" expectations are not specifically stated in the guidelines, the narrative must include:

    a. Diagnosis
    Example: Acute periapical abscess #30 with fluctuant swelling on buccal.

    b. Determination of Treatment (Brief description of the procedure performed)
    Example: I & D of Acute periapical abscess.

    c. Procedure or Treatment Performed (Steps of surgical procedure, to include location and instrument used)
    Example: Incision on buccal of #30 with #15 scalpel, drain placed and secured with one 3-0 black silk suture.

9. Oral surgery benefits do not apply to Implant surgical services.

10. General Guidelines are subject to the group contract. Specific government programs (e.g., Supplemental Medicaid) have defined limits for the number of restorative and extraction procedures. Verify the benefit eligibility in advance of patient treatment.

Code & Nomenclature	Submission Requirements	Valid Tooth/ Quad/Arch/ Surface

Extractions (Includes local anesthesia, suturing, if needed, and routine postoperative care) D7111 - D7140

General Guidelines

1. Upon request, the clinical necessity for an extraction may be required. The benefit criteria for extraction may include but are not limited to:

   - Non-restorable caries or fracture
   - Recurrent infection / Pericoronitis / cellulitis / abscess / osteomyelitis
   - Associated cysts/tumors
   - Resorption/damage to adjacent teeth
   - Damage/destruction of bone
   - Non-treatable pulpal / periapical pathology
   - Internal/ external resorption of third molar
   - Ectopic position or eruption of third molar

2. Specific government programs (e.g., Supplemental Medicaid) have defined limits for the number of restorative and extraction procedures. Verify the benefit eligibility in advance of patient treatment.

D7111 — A - T

extraction, coronal remnants – primary tooth

Removal of soft tissue-retained coronal remnants.

1. Includes soft tissue-retained coronal remnants.

2. D7111 is considered part of any other primary surgery in the same surgical area on the same date and the fee is not billable to the patient if performed by the same dentist/dental office.

D7140 — A - T, 1 - 32

extraction, erupted tooth or exposed root (elevation and/or forceps removal)

Includes removal of tooth structure, minor smoothing of socket bone and closure, as necessary.

Code & Nomenclature	Submission Requirements	Valid Tooth/ Quad/Arch/ Surface

Surgical Extractions (Includes local anesthesia, suturing, if needed, and routine postoperative care) D7210 - D7251

General Guidelines

1. The fee for surgical extraction includes local anesthesia, suturing if needed, and postoperative care 30 days following surgery (e.g., dry socket, bleeding).

2. When the x-ray or other submitted documentation does not support the procedure code D7210, the procedure code will be processed as D7140.

3. Upon request, the clinical necessity for an extraction may be required. The benefit criteria for extraction may include but are not limited to:

   - Non-restorable caries or fracture
   - Recurrent infection / Pericoronitis / cellulitis / abscess / osteomyelitis
   - Associated cysts/tumors
   - Resorption/damage to adjacent teeth
   - Damage/destruction of bone
   - Non-treatable pulpal / periapical pathology
   - Internal/ external resorption of third molar
   - Ectopic position or eruption of third molar

4. Specific government programs (e.g., Supplemental Medicaid) limit the number and type of extractions to non-emergent services only. Refer to specific group benefit contracts where this exception applies.

D7210 Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	X-ray	A - T, 1 - 32

Includes cutting of gingiva and bone, removal of tooth structure, minor smoothing of socket bone and closure.

1. When extracting a tooth that is not significantly broken down due to caries or fracture, the provider should submit a narrative which details the reason(s) that prevented non-complicated removal via elevator/forceps.

2. Incisional biopsy of oral tissue – soft (D7286) and removal of benign odontogenic cyst or tumor up to 1.25 cm (D7450) are subject to dental consultant review and may not be billable to the patient in conjunction with this procedure.

D7220 removal of impacted tooth – soft tissue	X-ray	A - T, 1 - 32

Occlusal surface of tooth covered by soft tissue; requires mucoperiosteal flap elevation.

Code & Nomenclature	Submission Requirements	Valid Tooth/ Quad/Arch/ Surface
D7230 removal of impacted tooth – partially bony	X-ray	A - T, 1 - 32
Part of crown covered by bone; requires mucoperiosteal flap elevation and bone removal.		
D7240 removal of impacted tooth – completely bony	X-ray	A - T, 1 - 32
Most or all of crown covered by bone; requires mucoperiosteal flap elevation and bone removal. 1. For benefit purposes, completely bony is considered as 90% of the crown covered by bone.		
D7241 removal of impacted tooth – completely bony, with unusual surgical complications	X-ray, Operative Report	A - T, 1 - 32
Most or all of crown covered by bone; unusually difficult or complicated due to factors such as nerve dissection required, separate closure of maxillary sinus required or aberrant tooth position. 1. Operative report **must** clearly indicate the specific complication/s incurred during the course of the surgical procedure. 2. When the operative report does not indicate the complication or difficulty incurred during the course of the surgical procedure, this service will be processed as D7240 or the appropriate procedure code.		
D7250 removal of residual tooth roots (cutting procedure)	X-ray	A - T, 1 - 32
Includes cutting of soft tissue and bone, removal of tooth structure, and closure. 1. This benefit applies only to retained sub-osseous root tips. 2. This benefit is not billable to the patient if submitted in conjunction with a surgical extraction on the same tooth by the same dentist/dental office. 3. When the submitted X-ray image or other documentation does not support the HDS clinical criteria for D7250, the procedure may be processed as noted below: • When the residual root is not fully encased in bone (sub-osseous), the procedure will be processed as either D7210 (surgical removal of erupted tooth) or D7140 (extraction, erupted tooth or exposed root) based on the clinical circumstances and submitted documentation.		

Code & Nomenclature	Submission Requirements	Valid Tooth/ Quad/Arch/ Surface
D7251 coronectomy – intentional partial tooth removal, impacted teeth only	Pre-op X-ray, Narrative	17, 32

Intentional partial tooth removal is performed when a neurovascular complication is likely if the entire impacted tooth is removed.

1. Benefited under individual consideration and only for documented probable neurovascular complications such as proximity to the inferior alveolar nerve.

2. This procedure code is not to be submitted for incomplete or failed extractions.

Other Surgical Procedures D7260 - D7291

D7260 oroantral fistula closure	Operative Report	1 - 16, UL, UR

Excision of fistulous tract between maxillary sinus and oral cavity and closure by advancement flap.

D7261 primary closure of a sinus perforation	Operative Report	1 - 16, UL, UR

Subsequent to surgical removal of tooth, exposure of sinus requiring repair, or immediate closure of oroantral or oralnasal communication in absence of fistulous tract.

1. Procedure is by report. D7261 is not billable to the patient when submitted with D7241 (removal of impacted tooth, completely bony, with unusual complications).

D7270 tooth reimplantation and/ or stabilization of accidentally evulsed or displaced tooth	X-ray, Narrative	A - T, 1 - 32

Includes splinting and/or stabilization.

1. Includes postoperative care for and removal of splint by the same dentist/dental office.

2. Narrative should indicate all teeth involved and describe the method of stabilization.

D7280 Exposure of an unerupted tooth	X-ray	A - T, 1 - 32

An incision is made and the tissue is reflected and bone removed as necessary to expose the crown of an impacted tooth not intended to be extracted.

Code & Nomenclature	Submission Requirements	Valid Tooth/ Quad/Arch/ Surface
D7282 mobilization of erupted or malpositioned tooth to aid eruption	X-ray	A - T, 1 - 32

To move/luxate teeth.

D7283 Placement of device to facilitate eruption of impacted tooth	X-ray	A - T, 1 - 32

Placement of an attachment on an unerupted tooth, after its exposure, to aid in its eruption. Report the surgical exposure separately using D7280.

1. Coverage for this procedure is limited to members who have Orthodontic plan benefits.

2. Services listed with the description of “limited to members who have Orthodontic plan benefits” are only covered under those plans that have Orthodontic coverage and are payable as part of the diagnostic or basic benefits.

D7285 incisional biopsy of oral tissue-hard (bone, tooth)	Pathology Report	1 - 32 UA, LA, UL, UR, LL, LR

For partial removal of specimen only. This procedure involves biopsy of osseous lesions and is not used for apicoectomy/periradicular surgery. This procedure does not entail an excision.

1. This service is not billable to the patient when performed in conjunction with an apicoectomy (D3410, D3421, D3425 or D3426), or surgical extraction (D7210), by the same dentist/dental office in the same surgical area and on the same date of service.

2. In the absence of the pathology report, this service is not billable to the patient.

D7286 incisional biopsy of oral tissue-soft	Pathology Report	1 - 32 UA, LA, UL, UR, LL, LR

For partial removal of an architecturally intact specimen only. This procedure is not used at the same time as codes for apicoectomy/periradicular curettage. This procedure does not entail an excision.

1. This service is not billable to the patient when performed in conjunction with an apicoectomy (D3410, D3421, D3425 or D3426). Procedure code D7286 performed in conjunction with extractions in the same surgical area on the same date of service are subject to dental consultant review and may not be billable to the patient.

2. In absence of the pathology report, this service is not billable to the patient.

Code & Nomenclature	Submission Requirements	Valid Tooth/ Quad/Arch/ Surface
D7290 surgical repositioning of teeth	X-ray	1 - 32 A - T

Grafting procedure(s) is/are additional.

1. Coverage for this procedure is limited to members who have Orthodontic plan benefits.
2. Services listed with the description of “limited to members who have Orthodontic plan Benefits” are only covered under those plans that have Orthodontic coverage and are payable as part of the diagnostic or basic benefits.

D7291 transseptal fiberotomy/supra crestal fiberotomy, by report	Operative Report	1 - 32 A - T

The supraosseous connective tissue attachment is surgically severed around the involved teeth. Where there are adjacent teeth, the transseptal fiberotomy of a single tooth will involve a minimum of three teeth. Since the incisions are within the gingival sulcus and tissue and the root surface is not instrumented, this procedure heals by the reunion of connective tissue with the root surface on which viable periodontal tissue is present (reattachment).

1. Coverage for this procedure is limited to members who have Orthodontic plan benefits.
2. Services listed with the description of “limited to members who have Orthodontic plan benefits” are only covered under those plans that have Orthodontic coverage and are payable as part of the diagnostic or basic benefits.
3. Upon review of documentation, the appropriate benefit allowance will be applied.

Alveoloplasty – Preparation of Ridge D7310 - D7321

D7310 alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	UR, UL LR, LL

The alveoloplasty is distinct (separate procedure) from extractions. Usually in preparation for a prosthesis or other treatments such as radiation therapy and transplant surgery.

1. Alveoloplasty is included in the fee for surgical extractions (D7210-D7250), and is not billable to the patient if performed by the same dentist/dental office in the same surgical area on the same date of service.
2. Allowed with multiple D7140 (extraction, erupted tooth or exposed root) in the same quadrant, when periodontal disease is present.

Code & Nomenclature	Submission Requirements	Valid Tooth/ Quad/Arch/ Surface
D7311 alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant		1 - 32

The alveoloplasty is distinct (separate procedure) from extractions. Usually in preparation for a prosthesis or other treatments such as radiation therapy and transplant surgery.

1. Alveoloplasty is included in the fee for surgical extractions and is not billable to the patient if performed by the same dentist/dental office in the same surgical area on the same date of service as surgical extraction(s) (D7210-7250).

2. Allowed with D7140 in the same quadrant when periodontal disease is present.

3. If more than one tooth, indicate additional teeth numbers in narrative.

D7320 alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant		UR, UL, LR, LL

No extractions performed in an edentulous area. See D7310 if teeth are being extracted concurrently with the alveoloplasty. Usually in preparation for a prosthesis or other treatments such as radiation therapy and transplant surgery.

D7321 alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant		1 - 32

No extractions performed in an edentulous area. See D7311 if teeth are being extracted concurrently with the alveoloplasty. Usually in preparation for a prosthesis or other treatments such as radiation therapy and transplant surgery.

1. If more than one tooth, indicate additional teeth numbers in narrative.

Code & Nomenclature	Submission Requirements	Valid Tooth/ Quad/Arch/ Surface

Excision of Soft Tissue Lesions D7410 - D7415, D7465

General Guidelines

1. Pathology Report should include site and size of growth.

D7410 excision of benign lesion up to 1.25 cm **D7411** excision of benign lesion greater than 1.25 cm	Medical Carrier Statement, Pathology Report	1 - 32, UA, LA, UR, UL LR, LL

1. The benefit for D7410/D7411 is subject to the review of the pathology report and may be included in the benefit for another surgery when performed on the same date of service.

2. This service is not billable to the patient if not submitted with a pathology report.

D7413 excision of malignant lesion up to 1.25 cm **D7414** excision of malignant lesion greater than 1.25 cm	Medical Carrier Statement, Pathology Report	1 - 32, UA, LA, UR, UL LR, LL

1. This service is not billable to the patient if not submitted with a pathology report.

2. Excision of malignant lesion is not billable to the patient as included in the fee for another surgery in the same area of the mouth on the same date of service by the same dentist/dental office.

D7465 destruction of lesion(s), by physical or chemical method, by report	Narrative	1 - 32, UA, LA, UR, UL LR, LL

Examples include using cryo, laser or electro surgery.

1. Narrative should describe lesion and method of destruction.

Code & Nomenclature	Submission Requirements	Valid Tooth/ Quad/Arch/ Surface

Excision of Intra-Osseous Lesions D7440 - D7461

1. All procedures are subject to coverage under medical.
2. Pathology Report should include site and size of growth.

D7440 excision of malignant tumor – lesion diameter up to 1.25 cm **D7441** excision of malignant tumor — lesion diameter greater than 1.25 cm	Medical Carrier Statement, Pathology Report	1 - 32, UR, UL, LR, LL, UA, LA
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	Medical Carrier Statement, Pathology Report	1 - 32, UR, UL, LR, LL, UA, LA

Odontogenic Cyst – Cyst derived from the epithelium of odontogenic tissue (developmental, primordial).

1. The benefit for D7450 / D7451 is subject to the review of the pathology report and may be included in the benefit for another surgery when performed in the same area of the mouth on the same date of service by the same dentist/dental office.
2. This service is not billable to the patient if not submitted with a pathology report.

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	Medical Carrier Statement, Pathology Report	1 - 32, UR, UL, LR, LL, UA, LA

1. This service is not billable to the patient if not submitted with a pathology report.

Code & Nomenclature	Submission Requirements	Valid Tooth/ Quad/Arch/ Surface
Excision of Bone Tissue D7471 – D7490		
D7471 removal of lateral exostosis (maxilla or mandible)	Operative Report	1 - 32, UL, UR, LL, LR, UA, LA
D7472 removal of torus palatinus	Operative Report	UA
D7473 removal of torus mandibularis	Operative Report	LL, LR
D7485 reduction of osseous tuberosity	Operative Report	UL, UR

Code & Nomenclature	Submission Requirements	Valid Tooth/ Quad/Arch/ Surface
D7490 radical resection of maxilla or mandible	Medical Carrier Statement, Operative Report, Pathology Report	UL, UR, LL, LR

Partial resection of maxilla or mandible; removal of lesion and defect with margin of normal appearing bone. Reconstruction and bone grafts should be reported separately.

1. This service is not billable to the patient if not submitted with a pathology report.

Surgical Incision D7510 - D7560

D7510 incision and drainage of abscess – intraoral soft tissue	Operative Report	A - T, 1 - 32

Involves incision through mucosa, including periodontal origins.

1. The benefit for D7510 is subject to the review of the operative report and may be included in the benefit for another procedure when performed on the same date of service by the same dentist/dentist office.
2. For benefit purposes, the Operative Report must include a clinical diagnosis, site of incision and instrument used.
3. This is not an appropriate code when performing endodontic access opening and drainage.

D7511 incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)	Medical Carrier Statement, Operative Report	A - T 1 - 32

Incision is made intraorally and dissection is extended into adjacent fascial space(s) to provide adequate drainage of abscess/cellulitis.

1. The benefit for D7511 is subject to the review of the operative report and may be included in the benefit for another procedure when performed on the same date of service by the same dentist/dentist office.

D7520 incision and drainage of abscess – extraoral soft tissue	Operative Report	LL, LR, UL, UR, LA, UA

Involves incision through skin.

1. Incision and drainage of abscess - extraoral soft tissue is a benefit only if dental related infection is present.
2. The benefit is denied if not related to a dental infection.

Code & Nomenclature	Submission Requirements	Valid Tooth/ Quad/Arch/ Surface
D7521 incision and drainage of abscess – extraoral soft tissue – complicated (includes drainage of multiple fascial spaces)	Medical Carrier Statement, Operative Report	LL, LR UL, UR LA, UA
Incision is made extraorally and dissection is extended into adjacent fascial space(s) to provide adequate drainage of abscess/cellulitis. 1. This procedure is subject to coverage under medical. 2. Incision and drainage of abscess-extraoral soft tissue is a benefit only if an odontogenic related infection is present. 3. Upon review of documentation, the appropriate benefit allowance will be applied.		
D7530 removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	Medical Carrier Statement, Operative Report	A - T, 1 - 32
D7540 removal of reaction producing foreign bodies, musculoskeletal system	Operative Report	A - T, 1 - 32
May include, but is not limited to, removal of splinters, pieces of wire, etc., from muscle and/or bone.		
D7550 partial ostectomy/ sequestrectomy for removal of non-vital bone	Operative Report	A - T, 1 - 32
Removal of loose or sloughed-off dead bone caused by infection or reduced blood supply.		
D7560 maxillary sinusotomy for removal of tooth fragment or foreign body	Operative Report	A - T, 1 - 32

Code & Nomenclature	Submission Requirements	Valid Tooth/ Quad/Arch/ Surface

Treatment of Closed Fractures - D7610 - D7680

General Guidelines

1. All procedures are subject to coverage under medical.

2. A separate fee for splinting, wiring or banding is not billable to the patient when performed by the same dentist/dental office rendering the primary procedure.

D7610 maxilla – open reduction (teeth immobilized, if present)	Medical Carrier Statement, Operative Report	
Teeth may be wired, banded or splinted together to prevent movement. Incision required for interosseous fixation.		
D7620 maxilla – closed reduction (teeth immobilized, if present)	Medical Carrier Statement, Operative Report	
No incision required to reduce fracture. See D7610 if interosseous fixation is applied.		
D7630 mandible – open reduction (teeth immobilized, if present)	Medical Carrier Statement, Operative Report	
Teeth may be wired, banded or splinted together to prevent movement. Incision required to reduce fracture.		
D7640 mandible – closed reduction (teeth immobilized, if present)	Medical Carrier Statement, Operative Report	
No incision required to reduce fracture. See D7630 if interosseous fixation is applied.		
D7650 malar and /or zygomatic arch – open reduction	Medical Carrier Statement, Operative Report	
D7660 malar and /or zygomatic arch – closed reduction	Medical Carrier Statement, Operative Report	
D7670 alveolus – closed reduction, may include stabilization of teeth **D7671** alveolus – open reduction, may include stabilization of teeth	Medical Carrier Statement, Operative Report, X-ray	

Code & Nomenclature	Submission Requirements	Valid Tooth/ Quad/Arch/ Surface

Treatment of Open Fractures - D7710 - D7771

D7710 maxilla – open reduction	Medical Carrier Statement, Operative Report	
Incision required to reduce fracture.		
D7720 maxilla – closed reduction	Medical Carrier Statement, Operative Report	
D7730 mandible – open reduction	Medical Carrier Statement, Operative Report	
Incision required to reduce fracture.		
D7740 mandible – closed reduction	Medical Carrier Statement, Operative Report	
D7750 malar and/or zygomatic arch – open reduction	Medical Carrier Statement, Operative Report	
Incision required to reduce fracture.		
D7760 malar and/or zygomatic arch – closed reduction	Medical Carrier Statement, Operative Report	
D7770 alveolus – open reduction stabilization of teeth	Medical Carrier Statement, Operative Report	
Fractured bone(s) are exposed to mouth or outside the face. Incision required to reduce fracture.		
D7771 alveolus, closed reduction stabilization of teeth	Medical Carrier Statement, Operative Report	
Fractured bone(s) are exposed to mouth or outside the face.		

Code & Nomenclature	Submission Requirements	Valid Tooth/ Quad/Arch/ Surface

Reduction of Dislocation and Management of Other Temporomandibular Joint Dysfunctions D7810 - D7830

D7810
open reduction of dislocation

Medical Carrier Statement,
Operative Report

Access to TMJ via surgical opening

1. Coverage is limited to members who have TMJ benefits

D7820
closed reduction of dislocation

Medical Carrier Statement,
Operative Report

Joint manipulated into place; no surgical exposure.

1. Coverage is limited to members who have TMJ benefits.

D7830
manipulation under anesthesia

Medical Carrier Statement,
Operative Report

1. Coverage is limited to members who have TMJ benefits.

Repair of Traumatic Wounds D7910

Excludes closure of surgical incisions.

D7910
suture of recent small wounds up to 5 cm

Medical Carrier Statement,
Operative Report

Complicated Suturing (Reconstruction Requiring Delicate Handling of Tissues and Wide Undermining for Meticulous Closure)

1. Specify site in operative report.
2. Repair of traumatic wounds is limited to oral structures.
3. Operative report should include diagnosis and treatment.

Code & Nomenclature	Submission Requirements	Valid Tooth/ Quad/Arch/ Surface

Other Repair Procedures D7920 - D7999

D7953 1 - 32
bone replacement graft for ridge preservation – per site

Graft is placed in an extraction or implant removal site at the time of the extraction or removal to preserve ridge integrity (e.g., clinically indicated in preparation for implant reconstruction or where alveolar contour is critical to plan prosthetic reconstruction). Does not include obtaining graft material. Membrane, if used should be reported separately.

1. Bone replacement graft for ridge preservation – per site is denied and the approved amount is collectable from the patient unless it is a group contract specific benefit.

2. Benefit is limited to once in a 24-month period.

D7956 Narrative 1 - 5, 12 - 16, 17 - 21, 28 - 32
Guided tissue regeneration, edentulous area – resorbable barrier, per site

This procedure does not include flap entry and closure, or, when indicated, wound debridement, osseous contouring, bone replacement grafts, and placement of biologic materials to aid in osseous regeneration. This procedure may be used for ridge augmentation, sinus lift procedures, and after tooth extraction.

1. Guided tissue regeneration (GTR) when billed in conjunction with implants, soft tissue grafts on implants, ridge augmentation, ridge preservation/extraction sites, periradicular surgery, apicoectomy sites, hemisections etc. are denied as a specialized procedure.

D7957 Narrative 1 - 5, 12 - 16, 17 - 21, 28 - 32
Guided tissue regeneration, edentulous area – nonresorbable barrier, per site

This procedure does not include flap entry and closure, or, when indicated wound debridement, osseous contouring, bone replacement grafts, and placement of biologic materials to aid in osseous regeneration. This procedure may be used for ridge augmentation, sinus lift procedures, and after tooth extraction.

1. Guided tissue regeneration (GTR) when billed in conjunction with implants, soft tissue grafts on implants, ridge augmentation, ridge preservation/extraction sites, periradicular surgery, apicoectomy sites, hemisections etc. are denied as a specialized procedure.

Code & Nomenclature	Submission Requirements	Valid Tooth/ Quad/Arch/ Surface
D7961 buccal/labial frenectomy (frenulectomy)	Operative Report	UA, LA, 1 - 32

1. Operative report should include diagnosis and clinical reason(s) for the procedure.
2. The fee for frenectomy is not billable to the patient when billed on the same date as any other surgical procedure(s) in the same surgical area by the same dentist/dental office.
3. This code should not be submitted for ankyloglossia (tongue-tie).

D7962 lingual frenectomy (frenulectomy)	Operative Report	UA, LA, 1 - 32

1. Operative report should include diagnosis and clinical reason(s) for the procedure.
2. The fee for frenectomy is not billable to the patient when billed on the same date as any other surgical procedure(s) in the same surgical area by the same dentist/dental office.

D7963 frenuloplasty	Operative Report	UA, LA, 6 -11, 22 - 27

Excision of the frenum with accompanying excision or repositioning of aberrant muscle and z-plasty or other local flap closure.

1. Operative report should include diagnosis and clinical reason(s) for the procedure.
2. The fee for frenectomy is not billable to the patient when billed on the same date as any other surgical procedure(s) in the same surgical area by the same dentist/dental office.

D7970 excision of hyperplastic tissue – per arch	Narrative	UA, LA

1. The benefit for excision of hyperplastic tissue is not billable to the patient when billed in conjunction with other surgical procedure(s) in the same surgical area by the same dentist/dental office.
2. Limited to edentulous areas.

Code & Nomenclature	Submission Requirements	Valid Tooth/ Quad/Arch/ Surface
D7971 excision of pericoronal gingiva	Narrative	1 - 2, 15 - 16, 17 - 18, 31 – 32

Removal of inflammatory or hypertrophied tissues surrounding partially erupted/impacted teeth.

1. The benefit for excision of pericoronal gingiva is not billable to the patient when billed in conjunction with other surgical procedure(s) in the same surgical area by the same dentist/dental office.

2. This procedure is applicable only to the excision of gingival tissue (operculum) distal to the 2nd or 3rd molars.

D7972 surgical reduction of fibrous tuberosity	Medical Carrier Statement, Operative Report	UA, UR, UL

1. The benefit for surgical reduction of fibrous tuberosity is not billable to the patient when billed in conjunction with other surgical procedure(s) in the same surgical area by the same dentist/dental office.

D7979 non-surgical sialolithotomy	Narrative	LA, LL, LR

A sialolith is removed from the gland or ductal portion of the gland without surgical incision into the gland or the duct of the gland, for example via manual manipulation, ductal dilation, or any other non-surgical method.

D7980 surgical sialolithotomy	Medical Carrier Statement, Operative Report	LA, LL, LR

Surgical procedure by which a stone within a salivary gland or its duct is removed either intraorally or extraorally.

D7983 closure of salivary fistula	Medical Carrier Statement, Operative Report	UA, UR, UL, LA, LL, LR

Closure of an opening between a salivary duct and/or gland and the cutaneous surface or an opening into the oral cavity through other than the normal anatomic pathway.

D7999 unspecified oral surgery procedure, by report	Operative Report	

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

1. Documentation should include a clinical diagnosis, materials used, tooth number, arch, quadrant, or area of the mouth, chair time, intraoral photographic images when available, X-ray images or additional supporting information.

2. Upon review of documentation, the appropriate benefit allowance will be applied.