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

DIAGNOSTIC D0100 - D0999

Clinical Oral Evaluations D0120 - D0180

The codes in this section have been revised to recognize the cognitive skills necessary for patient evaluation. The collection and recording of some data and components of the dental examination may be delegated; however, the evaluation, diagnosis and treatment planning are the responsibility of the dentist. As with all ADA procedure codes, there is no distinction made between the evaluations provided by general practitioners and specialists. Report additional diagnostic and/or definitive procedures separately.

General Guidelines

1. The number and type of evaluations available for a patient are based on group contract. Any fees in excess of the approved fees are not billable to the patient.

2. Comprehensive and periodic evaluations include, but are not limited to, evaluations of all hard and soft tissue of the oral cavity, periodontal charting and oral cancer examination.

3. Multiple oral evaluations by the same dentist/dental office on the same day are not billable to the patient.

D0120
periodic oral evaluation – established patient

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

1. This procedure is applied to the patient's annual exam benefit.

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

D0140
limited oral evaluation – problem focused

An evaluation limited to a specific oral health problem or complaint. This may require interpretation of information acquired through additional diagnostic procedures. Report additional diagnostic procedures separately. Definitive procedures may be required on the same date as the evaluation. Typically, patients receiving this type of evaluation present with a specific problem and/or dental emergencies, trauma, acute infections, etc.

1. This is a benefit once per patient per dentist/dental office, per 12-month period. If this limit is exceeded, the benefit will be denied, and the patient is responsible to the Maximum Plan Allowance.

2. This procedure is not applied to the patient's annual exam benefit.

3. The benefit for this evaluation is not billable to the patient when performed in conjunction with a consultation by the same dentist/dental office.

4. Specific government programs (e.g., Supplemental Medicaid, Medicare) have a 1 per calendar year frequency limit for D0140. Verify if frequency limits apply per dental office in advance of patient treatment.

D0145
oral evaluation for a patient under three years of age and counseling with primary caregiver

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

1. D0145 includes any caries susceptibility tests (D0425) or oral hygiene instructions (D1330) on the same date. When performed on the same date as D0145, any fees for D0425 and D1330 are not billable to the patient.

2. When performed on a patient who is three years of age and older, D0145 is not billable to the patient. The correct evaluation code is required.

3. A comprehensive oral evaluation (D0150) submitted for a patient under three years of age will be processed as a D0145.

4. This procedure is applied to the patient's annual exam benefit.

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

D0150
comprehensive oral evaluation – new or established patient

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

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

1. This procedure is applied to the patient's annual exam benefit.

2. This procedure is a benefit once per 10 years per patient per dentist/dental office. However, if the patient has not received any services for 3 years from the same office, a comprehensive evaluation may be benefited. In all other cases, if the procedure is performed by the same dentist/dental office in less than 10 years, the benefit is limited to the allowance of a D0120 and processed to the limitations of a D0120.

3. Benefits for consultation, diagnosis and routine treatment planning are not billable to the patient as components of the benefits for this evaluation by the same dentist/dental office.

4. If the D0150 is done within 6 months of a D0180, the benefit is limited to the allowance of a D0120 and processed to the limitations of a D0120.

5. A comprehensive oral evaluation (D0150) submitted for a patient under three years of age will be processed as a D0145.

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

D0160
detailed and extensive oral evaluation – problem focused, by report

A detailed and extensive problem focused evaluation entails extensive diagnostic and cognitive modalities based on the findings of a comprehensive oral evaluation. Integration of more extensive diagnostic modalities to develop a treatment plan for a specific problem is required. The condition requiring this type of evaluation should be described and documented. Examples of conditions requiring this type of evaluation may include dentofacial anomalies, complicated perio-prosthetic conditions, complex temporomandibular dysfunction, facial pain of unknown origin, conditions requiring multi-disciplinary consultation, etc.

1. The alternate benefit of D0140 is applied, refer to D0140 guidelines for benefit and time limitations.

D0170
re-evaluation – limited, problem focused (established patient; not post-operative visit)

Assessing the status of a previously existing condition. For example:

- a traumatic injury where no treatment was rendered but patient needs follow-up monitoring;
- evaluation for undiagnosed continuing pain;
- soft tissue lesion requiring follow-up evaluation.

1. The alternate benefit of D0140 is applied, refer to D0140 guidelines for benefit and time limitations.

2. By definition, this procedure code is not to be used for a post operative visit and for follow up to “nonsurgical” definitive care such as root canal treatment or seating of a crown. It is also included as part of definitive care that might follow or have preceded the evaluation.

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

D0180
comprehensive periodontal evaluation – new or established patient

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

1. This procedure is applied to the patient's annual exam benefit.

2. This procedure is a benefit once per 10 years per patient per dentist/dental office. However, if the patient has not received any services for 3 years from the same office, a periodontal evaluation may be benefited. In all other cases, if the procedure is performed by the same dentist/dental office in less than 10 years, the benefit is limited to the allowance of a D0120 and processed to the limitations of a D0120.

3. This procedure should be used primarily by a periodontist for a referred patient from a general dentist and should not be reported in addition to a D0150 by the same dentist/dental office in the same treatment series.

4. Benefits for consultation, diagnosis and routine treatment planning are not billable to the patient as a component of the benefit for this evaluation by the same dentist/dental office.

5. If the D0180 is done within 6 months of a D0150 by the same dentist/dental office, the benefit is limited to the allowance of a D0120 and processed to the limitations of D0120.

6. This procedure is not intended for use as a separate code for periodontal charting.

7. A comprehensive periodontal evaluation (D0180) submitted for a patient under three years of age will be processed as a D0145.

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

Diagnostic Imaging D0210 - D0350

Images should be taken only for clinical reasons as determined by the patient's dentist. They should be of diagnostic quality and properly identified and dated. Images are a part of the patient's clinical record and the original images should be retained by the dentist. Originals should not be used to fulfill requests made by patients or third-parties for copies of records.

General Guidelines

1. Must be of diagnostic quality, properly oriented (tooth number, R, L), identified and dated.

2. Diagnostic services such as radiographic images must be necessary for clinical reasons. Radiographic images are adjunctive to diagnostic services and should be prescribed in accordance with the guidelines of the American Dental Association. The ADA white paper dictates that these services only be rendered in cases where they will provide additional information to the dentist/dental office and as such must be prescriptive rather than routine. (Reference ADA, FDA Dental Radiographic Examinations: Recommendations for Patient Selection and Limiting Radiation Exposure, https://www.ada.org/~/media/ADA/Publications/ADA%20News/Files/Dental_Radiographic_Examinations_2012.pdf?la=en)

3. A panoramic radiographic image D0330 or a panoramic radiographic image with associated periapicals (D0220/D0230) or bitewings (D0272/D0274) should not be submitted for payment as procedure code D0210 **intra-oral complete series.**

4. Any combination of intraoral radiographic images (periapical, occlusal, bitewing) and/or panoramic images taken by the same dentist/dental office on the same date of service are processed administratively as a complete series (D0210) when the total cumulative fees equal or exceeds the fee for a complete series (D0210). These images will be considered the equivalent of a complete series (D0210). Time and frequency limitations will be applied as determined by the group contract.

5. For oral surgeons and orthodontists, additional radiographic images may be allowed for diagnosis of specific conditions, pathology, or injury.

6. Radiographic, photographic, and diagnostic images are a part of the patient’s clinical record and the original images should be retained by the dentist.

7. Charges for duplication (copying) of radiographic images for insurance purposes are not billable to the patient.

8. Radiographic images used to verify crown seatings are considered a component of the primary procedure and are not billable to the patient.

9. Poor quality or non-diagnostic radiographic images are not billable to HDS or the patient.

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

Image Capture with Interpretation D0210 - D0350

D0210
intraoral – comprehensive series of radiographic images

A radiographic survey of the whole mouth, usually consisting of 14-22 periapical and posterior bitewing images intended to display the crowns and roots of all teeth, periapical areas and alveolar bone.

1. Time and frequency limitations for this procedure are determined by the group contract and are counted per dentist/dental office. The D0210 will be denied if contract imitations are exceeded.

D0220
intraoral – periapical first radiographic image

D0230
intraoral – periapical each additional radiographic image

1. For endodontic treatment, one pre-operative diagnostic radiograph is benefited.

2. Working and post-operative radiographic images by the same dentist/dental office are considered a component of the complete treatment procedure and separate benefits are not billable to the patient.

3. Specific government programs (e.g., Supplemental Medicaid) have a frequency limit of 2 per calendar year combined for D0220 and D0230 and is not subject to processing as a complete series. Verify frequency limits in advance of patient treatment.

D0240
intraoral – occlusal radiographic image

1. Occlusal radiographic images taken by the same dentist/ dental office, on the same day as periapical, panoramic or bitewing radiographic images are processed as a complete series if the total fee equals or exceeds the complete series D0210 fee. Any fee in excess of a full mouth series is not billable to the patient. D0210 time and frequency limitations apply.

2. Specific government programs (e.g., Medicare) have a frequency limit of 4 per calendar year for D0240 and may not be subject to processing as a complete series. Verify frequency limits in advance of patient treatment.

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

D0250
extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector

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

1. Specific government programs (e.g., Medicare) have a frequency limit of 5 per date of service for D0250. Verify frequency limits in advance of patient treatment.

D0270
bitewing – single radiographic image

1. Bitewing radiographic images taken by the same dentist/ dental office, on the same day as periapical, panoramic, or occlusal radiographic images are processed as a complete series if the total fee equals or exceeds the complete series D0210 fee. Any fee in excess of a full mouth series is not billable to the patient. D0210 time and frequency limitations apply.

2. Each D0270, D0272, D0273, D0274, D0277 when performed, are applied to the patient's annual bitewing benefit.

3. Specific government programs (e.g., Medicare) have a frequency limit of 1 per date of service for D0270 and does not count toward the annual bitewing benefit. Verify frequency limits in advance of patient treatment.

4. A claim consisting of only a bitewing - single radiographic image (D0270) with no other services are not billable to the patient.

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

D0272
bitewings – two radiographic images

D0273
bitewings – three radiographic images

D0274
bitewings – four radiographic images

1. Bitewing radiographic images taken by the same dentist/ dental office, on the same day as periapical, panoramic, or occlusal radiographic images are processed as a complete series if the total fee equals or exceeds the complete series D0210 fee. Any fee in excess of a full mouth series is not billable to the patient. D0210 time and frequency limitations apply.
2. Each D0270, D0272, D0273, D0274, D0277 when performed, is applied to the patient's annual bitewing benefit.
3. D0273 or D0274 performed on a patient under age 10 is processed as a D0272; fees in excess of a D0272 are not billable to the patient.

D0277
vertical bitewings – 7 to 8 radiographic images

This does not constitute a full mouth intraoral radiographic series.

1. Each D0270, D0272, D0273, D0274, D0277 when performed, is applied to the patient's annual bitewing benefit.

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

D0330
panoramic radiographic image

1. A panoramic radiographic image (D0330) is considered as an intraoral complete series for benefit, time and frequency limitations. Time and frequency limitations are determined by the group contract and the D0330 will be denied when the limitations are exceeded.

2. An additional panoramic radiographic image is allowed by an Oral Surgeon or Orthodontist for diagnosis of specific disease or injury. Specific government programs (e.g., Supplemental Medicaid) have limitations on the additional panoramic radiographic image performed by an Oral Surgeon or Orthodontist. Verify limits in advance of patient treatment.

3. Panoramic radiographic images taken by the same dentist/ dental office, on the same day as periapical, bitewing or occlusal radiographic images are processed as a complete series if the total fee equals or exceeds the complete series D0210 fee.

D0340
2D cephalometric radiographic image – acquisition,
measurement and analysis

1. Coverage for this procedure is limited to members who have Orthodontic Plan Benefits.

2. Benefits for a cephalometric radiographic image taken in conjunction with services other than orthodontic treatment are denied.

D0350
2D oral/facial photographic image obtained intra-orally
or extra-orally

This includes photographic images, including those obtained by intraoral and extraoral cameras, excluding radiographic images. These photographic images should be a part of the patient's clinical record.

1. Coverage for this procedure is limited to members who have Orthodontic Plan Benefits.

2. Benefits for photographic images taken in conjunction with services other than orthodontic treatment are denied.

3. Benefit is limited to once per Orthodontic case.

Code & Nomenclature	Submission Requirements	Valid Tooth/ Quad/Arch/ Surface
D0372 Intraoral tomosynthesis – comprehensive series of radiographic images	A radiographic survey of the whole mouth intended to display the crowns and roots of all teeth, periapical areas, interproximal areas and alveolar bone including edentulous areas. 1. Intraoral tomosynthesis comprehensive series is processed as the alternate benefit of a D0210. D0210 time and frequency limitations apply. 2. When billed with intraoral – complete series of radiographic images (D0210) by the same dentist/dental office, the fee for D0210 is not billable to the patient. 3. When billed with intraoral tomosynthesis – comprehensive series – capture only (D0387) by the same dentist/dental office, the fee for D0387 is not billable to the patient. 4. When billed with intraoral – complete series of radiographic images – image capture only (D0709) by the same dentist/dental office, the fee for D0709 is not billable to the patient.	
D0373 Intraoral tomosynthesis - bitewing – radiographic image	1. Tomosynthesis bitewing image is processed as the alternate benefit of a D0270. Bitewing time and frequency limitations apply. 2. When billed with bitewings (D0270, D0272,D0273, D0274, D0277) by the same dentist/dental office, the fees for D0270,D0272, D0273, D0274, and D0277 are not billable to the patient. 3. When billed with intraoral tomosynthesis bitewing – radiographic image - capture only (D0388) by the same dentist/dental office, the fee for D0388 is not billable to the patient. 4. When billed with intraoral – bitewing radiographic image – image capture only (D0708) by the same dentist/dental office, the fee for D0708 is not billable to the patient.	

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

D0374
Intraoral tomosynthesis - periapical radiographic image

1. Tomosynthesis periapical image is processed as the alternate benefit of a D0220. Refer to D0220 procedure code guidelines.
2. When billed with intraoral – periapical first radiograph image (D0220) and intraoral periapical each additional radiographic image (D0230) by the same dentist/dental office, the fees for D0220 and D0230 are not billable to the patient.
3. When billed When billed with intraoral tomosynthesis - periapical radiographic image – capture only(D0389) by the same dentist/dental office, the fee for D0389 is not billable to the patient.
4. When billed with intraoral – periapical radiographic image – image capture only
5. (D0707) by the same dentist/dental office, the fee for D0707 is not billable to the patient.

Tests and Examinations D0419 - D0470

D0419
assessment of salivary flow by measurement

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

1. The benefit for assessment of salivary flow may be phased in as employer group contracts renew. Patient benefits should be verified.
2. Limited to one assessment every three years. Subsequent submissions are not billable to the patient within 12 months and denied between 12 and 36 months.

D0460
pulp vitality tests

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

1. Pulp tests are payable per visit not per tooth and only for the diagnosis of emergency conditions.
2. Benefits for pulp tests are not billable to the patient as part of any other definitive procedure on the same day, by the same dentist/dental office except X-rays (D0210-D340), limited oral evaluation-problem focused (D0140), palliative treatment (D9110), pulpal debridement (D3221) and protective restoration (D2940). The exception also applies to consultation (D9310) for Individual Dental Plans (IDP).

Code & Nomenclature	Submission Requirements	Valid Tooth/ Quad/Arch/ Surface
D0470 diagnostic casts	Narrative	

Also known as diagnostic models or study models.

1. Coverage for this procedure is limited to members who have Orthodontic Plan benefits.
2. Diagnostic casts are payable only once per case in conjunction with orthodontic services. Additional casts taken by the same dentist/dental office during or after orthodontic treatment are included in the fee for orthodontics and separate benefits are not billable to the patient.
3. Diagnostic casts are included in the fee for restorations and prosthetic procedures and therefore are not billable to the patient.
4. Narrative must indicate the purpose for the diagnostic casts.

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

Oral Pathology Laboratory D0472 - D0485

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

General Guidelines

1. If more than one of these procedures is billed on the same day, same site by the same dentist/dental office, payment is allowed for the most inclusive procedure and the less inclusive procedure is not billable to the patient.

2. By definition these procedures include the preparation and transmission of a report.

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

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

1. Benefits are limited to one D0472, D0473 or D0474 per site on the same date of service by the same dental office

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

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

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

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

D0484
consultation on slides prepared elsewhere

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

1. This benefit is not billable to the patient when billed in conjunction with an evaluation by the same dentist/dental office.

2. D0484 is benefited as D9310 (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

Pathology Report

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

D0999
unspecified diagnostic procedure, by report

Narrative

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

1. Provide complete description of services/treatment to allow determination of appropriate benefit allowance.

2. The narrative should include clinical diagnosis, tooth number, quadrant or arch, intraoral photographic image when available and X-ray image where appropriate.