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

ADJUNCTIVE GENERAL SERVICES D9000 - D9999

Unclassified Treatment D9110 - D9120

D9110 palliative treatment of dental pain – per visit	Narrative	A - T, 1 - 32, LL, LR, UL, UR, UA, LA

Treatment that relieves pain but is not curative; services provided do not have distinct procedure codes.

1. Allowance is made for one palliative treatment per visit. (This service is payable per visit, not per tooth.) An additional palliative treatment is not billable to the patient, if performed on the same date, by the same dentist/dental office.

2. All procedures necessary for the relief of pain are included in the allowance for D9110.

3. The narrative must include the diagnosis and treatment performed to relieve pain. When a specific procedure has been performed, it will be processed as that specific procedure.

4. This code should not be submitted when a pulpectomy/pulpal debridement (D3221) or placement of a temporary/protective restoration (D2940) is performed.

5. Palliative treatment may be a benefit when performed on the same date as definitive care if the treatment sites are different.

6. Periodic (D0120), problem focused (D0140) or comprehensive (D0150/ D0180) evaluations and prophylaxis (D1110 or D1120) are allowed if performed on the same date as palliative treatment.

7. This code should not be submitted for endodontic interim treatment by the same dentist as the fee for endodontic therapy includes all appointments necessary to complete treatment.

8. Office Visits (D9430) are not billable to the patient if performed on the same date as palliative treatment, by the same dentist/dental office.

9. When the submitted narrative only indicates that a referral to a specialist or a prescription for antibiotics and/or pain medication was provided, the palliative treatment will be processed as a D0140 (limited examination – problem focused) and submitted charges in excess of a D0140 are not billable to the patient.

Code & Nomenclature	Submission Requirements	Valid Tooth/ Quad/Arch/ Surface
D9120 fixed partial denture sectioning		A - T, 1 - 32

Separation of one or more connections between abutments and/or pontics when some portion of a fixed prosthesis is to remain intact and serviceable following sectioning and extraction or other treatment. Includes all recontouring and polishing of retained portions.

1. The removal and replacement of an existing fixed partial denture is considered a component of a new fixed partial denture. A separate fee for this procedure is not billable to the patient.

2. This procedure is limited to once per fixed partial denture.

3. This procedure is covered under the Prosthodontics benefit category.

D9130
temporomandibular joint dysfunction – non-invasive physical therapies

1. Temporomandibular joint dysfunction-non-invasive physical therapies are denied and the approved amount is collectable from the patient unless it is a group contract specific benefit.

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

Unclassified Treatment D9210 - D9248

D9222
deep sedation/general anesthesia – first 15 minutes

D9223
deep sedation/general anesthesia – each subsequent 15-minute increment

Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients or duties. The level of anesthesia is determined by the anesthesia provider's documentation of the anesthetics effects upon the central nervous system and not dependent upon the route of administration.

1. Deep sedation/general anesthesia is a benefit only when provided in conjunction with implant placement (D6010) or covered endodontic (D3410-D3426), periodontal (D4210-D4275) and oral surgical procedures. When provided otherwise, the fee for deep sedation/general anesthesia is denied and the approved amount is collectable from the patient.

2. General anesthesia is a benefit for up to four 15-minute increments or as specified in the group contract. Additional increments are not billable to the patient unless clinical documentation supports more than one hour was necessary. When documentation of exceptional circumstances is submitted, benefits may be approved dependent on group/individual contract.

3. The benefit for deep sedation/general anesthesia is not billable to the patient when performed by anyone other than an appropriately licensed qualified provider certified to administer deep sedation/general anesthesia.

4. The evaluation for moderate, deep sedation or general anesthesia (D9219) is considered part of this procedure and is not billable to the patient.

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

D9230
inhalation of nitrous oxide / analgesia, anxiolysis

1. For patients covered by an Enhanced ACA Pediatric Benefit Plan, Inhalation of nitrous oxide / analgesia, anxiolysis (D9230) is a benefit only on a patient under age 13 in conjunction with operative dentistry or oral surgery. D9230 is denied when performed on a patient age 13 through 18 and the patient is responsible for the Maximum Plan Allowance.
2. For all patients not covered by an Enhanced ACA Pediatric Benefit Plan, D9230 is denied and the patient is responsible for the submitted charge amount.
3. Multiple submissions of D9230 by the same dentist/dental office on the same date of service are not billable to the patient.
4. D9230 is not billable to the patient when performed on the same date as IV sedation (D9239, D9243) and general anesthesia (D9222 and D9223).

D9239
intravenous moderate (conscious) sedation/analgesia-
first 15 minutes

D9243
Intravenous moderate (conscious)sedation/analgesia-
each subsequent 15-minute increment

Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients or duties.

The level of anesthesia is determined by the anesthesia provider's documentation of the anesthetics effects upon the central nervous system and not dependent upon the route of administration.

1. Intravenous moderate (conscious) sedation is a benefit only when provided in conjunction with implant placement (D6010) or covered endodontic (D3410-D3426), periodontal (D4210-D4275) a oral surgical procedures. When provided otherwise, the fee for intravenous moderate (conscious) sedation/analgesia is denied and the approved amount is collectable from the patient.
2. Intravenous moderate (conscious) sedation/analgesia is a benefit for up to four 15-minute increments or as specified in the group contract. Additional increments are not billable to the patient unless clinical documentation supports more than one hour was necessary. When documentation of exceptional circumstances is submitted, benefits may be approved dependent on group/individual contract.
3. The benefit for intravenous moderate conscious sedation/anesthesia is not billable to the patient when performed by anyone other than an appropriately licensed qualified provider certified to administer intravenous sedation.

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

Professional Consultation D9310

D9310 consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	Narrative	A – T, 1 – 32, LL, LR, UL, UR, UA, LA

A patient encounter with a practitioner whose opinion or advice regarding evaluation and/or management of a specific problem; may be requested by another practitioner or appropriate source. The consultation includes an oral evaluation. The consulted practitioner may initiate diagnostic and/or therapeutic services.

1. The benefit for consultation is not billable to the patient when performed in conjunction with an examination/evaluation by the same dentist/dental office.
2. This code is not applicable and is not covered when a patient is self-referred for consultation.
3. This procedure is benefited once per patient per dentist per twelve-month period.
4. Narrative must indicate the referring dentist's full name and the reason for consultation.

Professional Visits D9410 - D9450

D9420 hospital or ambulatory surgical center call	Narrative	A - T, 1 - 32

Care provided outside the dentist's office to a patient who is in a hospital or ambulatory surgical center. Services delivered to the patient on the date of service are documented separately using the applicable procedure codes.

1. Hospital or ambulatory surgical center call (D9420) is a benefit only where Enhanced ACA Pediatric Benefits apply and only where it is specified by the group contract.
2. Hospital or ambulatory surgical center call (D9420) performed not in conjunction with operative dentistry or oral surgery is denied.
3. Benefit is limited to one visit per patient per day.
4. Narrative must include the hospital name and the nature / purpose for the hospital call.
5. Submitting dentist must be a licensed, credentialed provider at the specific hospital or ambulatory surgical center.

Code & Nomenclature	Submission Requirements	Valid Tooth/ Quad/Arch/ Surface
D9430 office visit for observation (during regularly scheduled hours) – no other services performed	Narrative	A - T, 1 - 32

1. This is not an evaluation procedure. It is allowable only when the visit is for observing injuries and no other services are provided.
2. This procedure is not billable to the patient when related to a prior service that has a post-operative period.
3. Office visits for reasons other than injury/trauma will be denied. The patient will be responsible up to the allowed amount.
4. An office visit performed in conjunction with a procedure (other than X-ray images), is not billable to the patient as included in the allowance for the procedure.
5. Narrative must include the diagnosis and the cause of the injury/trauma.

D9440 office visit – after regularly scheduled hours	Narrative	A - T, 1 - 32

1. The narrative must include the time and nature of the office visit and include a statement of normal working hours.
2. This is a benefit only when the office is closed and the dentist has physically left the office and must return to provide services outside of normal working hours.

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

Drugs D9610, D9612

D9610
therapeutic parenteral drug, single administration

Includes single administration of antibiotics, steroids, anti-inflammatory drugs, or other therapeutic medications. This code should not be used to report administration of sedative, anesthetic or reversal agents.

1. Therapeutic parenteral drug, single administration is denied and the approved amount is collectable from the patient unless it is a group contract specific benefit.

D9612
therapeutic parenteral drugs, two or more administrations, different medications

Includes multiple administrations of antibiotics, steroids, anti-inflammatory drugs or other therapeutic medications. This code should not be used to report administration of sedatives, anesthetic or reversal agents. This code should be reported when two or more different medications are necessary and should not be reported in addition to code D9610 on the same date.

1. Therapeutic parenteral drugs, two or more administrations, different medications are denied and the approved amount is collectable from the patient unless it is a group contract specific benefit.

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

Miscellaneous Services D9910 - D9999

D9930
treatment of complications (post-surgical) – unusual circumstances, by report

Narrative

A - T, 1 - 32, LL, LR, UL, UR, UA, LA

1. Covered only if performed by a dentist other than the treating dentist/dental office.
2. Narrative must detail the complication and treatment rendered.
3. Benefit is limited to once per dentist/dental office.

D9941
fabrication of athletic mouthguard

1. Fabrication of athletic mouthguard benefit may be phased in as employer group contracts renew. Patient benefits should be verified.
2. Benefit is limited for patients age 18 and younger, allowed once in a 24-month period.

D9944
occlusal guard – hard appliance, full arch

Removable dental appliance designed to minimize the effects of bruxism or other occlusal factors. Not to be reported for any type of sleep apnea, snoring or TMD appliances.

1. Occlusal guard is denied and the approved amount is collectable from the patient unless it is a group contract specific benefit or the group contract includes TMD coverage.
2. Benefit is limited to one occlusal guard in a 5-year period.

D9945
occlusal guard – soft appliance, full arch

Removable dental appliance designed to minimize the effects of bruxism or other occlusal factors. Not to be reported for any type of sleep apnea, snoring or TMD appliances.

1. Occlusal guard is denied and the approved amount is collectable from the patient unless it is a group contract specific benefit or the group contract includes TMD coverage.
2. Benefit is limited to one occlusal guard in a 5-year period.

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

D9946
occlusal guard – hard appliance, partial arch

Removable dental appliance designed to minimize the effects of bruxism or other occlusal factors. Provides only partial occlusal coverage such as anterior deprogrammer. Not to be reported for any type of sleep apnea, snoring or TMD appliances.

1. Occlusal guard is denied and the approved amount is collectable from the patient unless it is a group contract specific benefit or the group contract includes TMD coverage.

2. Benefit is limited to one occlusal guard in a 5-year period.

D9974
internal bleaching – per tooth

X-ray

6 -11, 22 - 27

1. Only a benefit for discolored non-vital teeth.

2. Benefit allowance is limited to once every 12 months per tooth.

3. This procedure is covered under the Endodontics benefit category.

D9985
General sales tax

1. Charges for Hawaii General Excise Tax are not covered benefits **unless** the group contract specifies GET coverage.

2. For specific government programs (e.g., Supplemental Medicaid, Medicare), Hawaii General Excise Tax is not billable to the patient and not payable by HDS.

D9997
Dental case management-patients with special health care needs

Special treatment considerations for patients/individuals with physical, medical, developmental or cognitive conditions resulting in substantial functional limitations or incapacitation, which require that modifications be made to delivery of treatment to provide customized or comprehensive oral health care services.

1. The fees for patients with special health care needs are considered administrative and used to identify services provided to a particular type of patient and are not billable to the patient.

Code & Nomenclature	Submission Requirements	Valid Tooth/ Quad/Arch/ Surface
D9999 unspecified adjunctive 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. Narrative should include a clinical diagnosis, restorative materials used, tooth number, arch, quadrant, or area of the mouth and chair time. Intraoral photographic images when available, X-ray images, lab invoices or additional supporting information may be requested.