Unclassified Treatment D9110 - D9120

D9110
palliative (emergency) treatment of dental pain – minor procedure

Narrative

This is typically reported on a “per visit” basis for emergency treatment of dental pain.

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

2. 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.

3. Office Visits (D9430) are disallowed if performed on the same date as palliative treatment, by the same dentist/dental office.

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

5. Allowance is made for one palliative treatment per visit. (This service is payable per visit, not per tooth.) An additional palliative treatment will be disallowed, if performed on the same date, by the same dentist/dental office.

6. The narrative must include the diagnosis and treatment performed to relieve pain.

7. When the narrative indicates a specific procedure has been performed, the service will be processed as that specific procedure.

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

9. 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.

10. 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 disallowed.
### Code & Nomenclature

<table>
<thead>
<tr>
<th>Code</th>
<th>Submission Requirements</th>
<th>Valid Tooth/ Quad/Arch/Surface</th>
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</thead>
<tbody>
<tr>
<td>D9120</td>
<td>Narrative</td>
<td>A - T, 1 - 32</td>
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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. If this code is reported for the process of 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.

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

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

4. Narrative must include treatment plan and specify the tooth to be extracted.

### Anesthesia D9210 - D9248

<table>
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<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>D9223</td>
<td>deep sedation/general anesthesia – each 15 minute increment</td>
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</tbody>
</table>

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 two 15 minute increments. Additional increments are denied and the approved amount is collectable from the patient.

3. The benefit for deep sedation/general anesthesia is disallowed when performed by anyone other than a dentist/anesthesiologist certified to administer deep sedation/general anesthesia.

4. The evaluation for deep sedation or general anesthesia (D9219) is considered part of this procedure and is disallowed.
HDS PROCEDURE CODE GUIDELINES

ADJUNCTIVE GENERAL SERVICES

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 disallowed.

4. D9230 is disallowed when performed on the same date as D9223, D9243.

**D9243**
intravenous moderate (conscious) sedation/analgesia – each 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) and 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 two 15 minute increments. Additional increments are denied and are the patient’s responsibility up to the approved amount.

3. The benefit for intravenous moderate conscious sedation/analgesia is disallowed when performed by anyone other than a dentist/ anesthesiologist certified to administer intravenous sedation.
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 disallowed when performed in conjunction with an examination / evaluation by the same dentist/dental office.

2. This procedure is benefited once per patient per dentist per twelve month period.

3. 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.
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<td><strong>D9430</strong></td>
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<tr>
<td>Office visit for observation (during regularly scheduled hours)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>– no other services performed</td>
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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 will be disallowed 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 disallowed as included in the allowance for the procedure.

5. Narrative must include the diagnosis and the cause of the injury/trauma.

| **D9440** | Narrative | A - T, 1 - 32 |
| Office visit – after regularly scheduled hours | | |

1. The narrative must include the time and nature of the after hours visit and a documentation of regular scheduled office 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 after regularly scheduled hours.

### Miscellaneous Services D9910 - D9999

| **D9930** | Narrative | A - T, 1 - 32, LL, LR, UL, UR, UA, LA |
| Treatment of complications (post-surgical) – unusual circumstances, by report | | |

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.
### Code & Nomenclature | Submission Requirements | Valid Tooth/ Quad/Arch/ Surface
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**D9940**

occlusal guard, by report

Removable dental appliances, which are designed to minimize the effects of bruxism (grinding) and other occlusal factors.

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 once in a 5 year period.

**D9941**

fabrication of athletic mouthguard

1. Fabrication of athletic mouthguard 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 12 month 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.

**D9985**

general sales tax

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

**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.