BlueCross BlueShield Arizona
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Health Choice

BLUE CROSS BLUE SHIELD OF ARIZONA HEALTH CHOICE 2026 DENTAL BENEFITS FOR MEMBERS 21 AND OLDER

OVERVIEW:

AHCCCS allows for coverage of medical and surgical dental services furnished by a dentist only to the extent such services may be performed under state law either by a physician or by a dentist (A.A.C.R9-22-207). The following is based on Blue Cross Blue Shield of Arizona Health Choice interpretation of these covered services when it considers the services as medically/dentally necessary. AHCCCS covers the following dental services provided by a licensed dentist for members who are 21 years of age or older.

EMERGENCY DENTAL SERVICES COVERAGE FOR PERSONS AGE 21 YEARS AND OLDER:

Dental Criteria:

Medically necessary emergency dental care is covered for members age 21 years and older who meet the criteria for a dental emergency. A dental emergency is an acute disorder of oral health resulting in severe pain and/or infection as a result of pathology of trauma. Emergency dental services are allowed up to $1000 per member contract year (October 1st to September 30th). Follow up procedures necessary to stabilize teeth as a result of the emergency service are covered and subject to the $1000 limit. ***AI/AN members who receive dental treatment at an I.H.S/638 Tribal facility are not subject to this $1000 per member contract year limit. For AI/AN members, services outside IHS/638 Tribal facilities (i.e., by Blue Cross Blue Shield of Arizona Health Choice contracted providers) are subject to the $1000 Emergency Dental Benefit limit.**

The following services and procedures are covered as emergency dental services:

1. Emergency oral diagnostic examination (limited oral examination – problem focused),
2. Radiographs and laboratory services, limited to the symptomatic teeth,
3. Composite resin due to recent tooth fracture for anterior teeth,
4. Prefabricated crowns, to eliminate pain due to recent tooth fracture only,
5. Re-cementation of clinically sound inlays, onlays, crowns, and fixed bridges,
6. Pulp cap, direct or indirect plus filling, limited to the symptomatic teeth,
7. Root canals and vital pulpotomies when indicted for the treatment of acute infection or to eliminate pain,
8. Apicoectomy performed as a separate procedure, for treatment of acute infection or to eliminate pain, with favorable prognosis,
9. Immediate and palliative procedures, including extractions if medically necessary, for relief of pain associated with an oral or maxillofacial condition,
10. Tooth reimplantation of accidentally avulsed or displaced anterior tooth, with favorable prognosis.
11. Temporary restoration which provided palliative/sedative care (limited to the tooth receiving emergency treatment).
12. Initial treatment for acute infection, including, but not limited to, periapical and periodontal infections and abscesses by appropriate methods,
13. Preoperative procedures and anesthesia appropriate for optimal patient management, and
14. Cast crowns limited to the restoration of recent emergency root canal treated teeth only.

LIMITATIONS FOR ADULT EMERGENCY DENTAL SERVICES FOR PERSONS AGE 21 YEARS AND OLDER

1. Maxillofacial dental services provided by a dentist are not covered except to the extent prescribed for the reduction of trauma, including reconstruction of regions of the maxilla and mandible.
2. Diagnosis and treatment of temporomandibular joint dysfunction are not covered except for the reduction of trauma.
3. Routine restorative procedures and routine root canal therapy are not emergency dental services.
4. Treatment for the prevention of pulpal death and imminent tooth loss is limited to non-cast fillings, crowns constructed from pre-formed stainless steel,

pulp caps, and pulpotomies only for the tooth causing pain or in the presence of active infection.

5. Fixed bridgework and dentures to replace missing teeth are not covered.

NOTIFICATION REQUIREMENTS FOR CHARGES TO MEMBERS

In order for a provider to bill the member for emergency dental services exceeding the $1000 limit, the provider must first inform the member in a way she/he understands, that the requested dental service exceeds the $1000 limit and is not covered by AHCCCS. Before providing the dental services that will be billed to the member, the provider must furnish the member with a document to be signed in advance of the service, stating that the member understands that the dental service will not be fully paid by AHCCCS and that the member agrees to pay for the amount exceeding the $1000 emergency dental services limit, as well as services not covered by AHCCCS. The member must sign the document before receiving the service in order for the provider to bill the member. It is expected that the document contains information describing the type of service to be provided and the charge for the service.

FACILITY AND ANESTHESIA CHARGES

AHCCCS expects that in **rare** instances a member may have an underlying medical condition which necessitates that services provided under the emergency dental benefit be provided in an Ambulatory Service Center or an Outpatient Hospital and may require anesthesia as part of the emergency service. In those instances, the facility and anesthesia charges are subject to the $1000 emergency dental limit.

Dentists performing General Anesthesia (GA) on members will bill using dental codes and the cost will count towards the $1000 emergency dental limit.
Physicians performing GA on members for a dental procedure will bill medical codes and the cost will count towards the $1000 emergency dental limit.

INFORMED CONSENT

Informed consent is a process by which the provider advises the member/guardian/designated representative of the diagnosis, proposed treatment and alternate treatment methods with associated risks and benefits of each, as well as the associated risks and benefits of not receiving treatment.

1. Informed consents for oral health treatment include:
   a. A written consent for examination and/or any treatment measure, which does not include an irreversible procedure, as mentioned below. This consent is completed at the time of initial examination and is updated at each subsequent six-month follow-up appointment.
   b. A separate written consent for any irreversible, invasive procedure, including but not limited to dental fillings, pulpotomy, etc. In addition, a written treatment plan must be reviewed and signed by both parties, as described below, with the member/guardian/ designated representative receiving a copy of the complete treatment plan.
2. All providers shall complete the appropriate informed consents and treatment plans for AHCCCS members as listed above, in order to provide quality and consistent care, in a manner that protects and is easily understood by the member/guardian/designated representative. This requirement extends to all Contractor mobile unit providers. Consents and treatment plans shall be in writing and signed/dated by both the provider and the patient, or patient's representative, if under the 18 years of age or is 18 years of age or older and considered an incapacitated adult. Completed consents and treatment plans must be maintained in the members' chart and are subject to audit.

MEDICAL EXCEPTIONS NOT SUBJECT TO THE $1000 ADULT EMERGENCY DENTAL LIMIT:

1. Services related to the treatment of a medical condition such as acute pain infection, or fracture of the jaw excluding Temporomandibular Joint Dysfunction (TMJ) pain. Diagnosis and treatment of TMJ is not covered except for reduction of trauma. Covered services include:
   a. limited problem focused examination of the oral cavity
   b. required radiographs
   c. treatment of maxillofacial fractures
   d. administration of an appropriate anesthesia
   e. prescription of pain medication and antibiotics

2. Exception for Transplant Cases
   For members who require medically necessary dental services as a pre- requisite to AHCCCS covered organ or tissue transplantation. AHCCCS covers these services only after a transplant evaluation determines that the member is an appropriate candidate for organ or tissue transplantation. Covered dental services are limited to the elimination of oral infections and the treatment of oral disease. These services are not subject to the $1000 adult emergency dental limit.

Covered services include:

a. limited problem focused examination of the oral cavity
b. dental cleanings, treatment of periodontal disease
c. medically necessary extractions
d. simple restorations are covered and include silver amalgam or composite resin fillings, stainless steel crowns, and preformed crowns. Permanent crowns may be approved if deemed necessary by the dental director.
e. least expensive professionally acceptable alternative treatment (LEPAAT) may be invoked in certain cases.

These services are only covered after a transplant evaluation confirms the member is a suitable candidate for organ or tissue transplantation.

3. Exception for Cancer Cases

   Prophylactic tooth extractions in preparation for radiation treatment of **jaw, neck, or head cancer** are covered and not subject to the $1,000 adult emergency dental limit. Covered services include:

   a. Oral examination
   b. Necessary dental x-rays (if extractions are planned)
   c. Prophylactic extractions related to radiation treatment

   When requesting these services, providers must ensure medical documentation is submitted for review. If criteria are met, the dental exam and x-rays may be approved. A treatment plan with supporting documentation must then be submitted for further review.

4. Exception of Ventilator Cases
   Dental cleanings are covered for members in inpatient hospital settings who are on ventilators or physically unable to perform oral hygiene. These cleanings must be performed by a hygienist under a physician's supervision and are not subject to the $1,000 adult emergency dental limit.

DIAGNOSTIC					
CODE	**DESCRIPTION**	**TEETH COVERED**	**AUTHORIZATION REQUIRED**	**BENEFIT LIMITATIONS**	**DOCUMENTATION REQUIRED**
D0140	Limited oral evaluation-problem focused (Emergency Dental Services only)		No		
D0191	Assessment of a patient		No		
D0220	Intraoral – periapical first radiographic image		No	One per day	
D0230	intraoral –periapical each additional radiographic image		No	Five per day	
D0270	bitewing – single radiographic image		No	Two of (D0270, D0272, D0273, D0274) per year	
D0272	Bitewings – two radiographic images		No	Two of (D0270, D0272, D0273, D0274) per year	
D0273	Bitewings – three radiographic images		No	Two of (D0270, D0272, D0273, D0274) per year	
D0374	Bitewings – four radiographic images		No	Two of (D0270, D0272, D0273, D0274) per year	
D0277	Vertical bitewings – 7 to 8 films		No	One of 6 months	
D0330	Panoramic radiographic image		No	One of (D0330) per 36 months. Three of (D0330) per lifetime.	
D0364	Cone beam CT capture and interpretation with limited field of view- less than one whole jaw		Yes	Four per year	Treatment notes required to determine dental emergency. Limited to symptomatic tooth.

CODE	DESCRIPTION	TEETH COVERED	AUTHORIZATION REQUIRED	BENEFIT LIMITATIONS	DOCUMENTATION REQUIRED
D0373	Intraoral tomosynthesis-bitewing radiographic image		No	Two per one year	
D0374	Intraoral tomosynthesis-periapical radiograph image		No	Five per day	
D0388	Tomosynthesis-bitewing radiographic image- Image capture only		No	Two per one year	
D0389	Intraoral tomosynthesis-periapical radiograph image- Image capture only		No	Five per one day.	
D0461	**Testing for cracked teeth**		**No**	**One per day per tooth.**	
D0604	Antigen testing for a public health related pathogen, including coronavirus		No		
D0605	Antibody testing for a public health related pathogen, including coronavirus		No		
D0701	Panoramic radiographic image-capture only		No		
D0707	Intraoral-periapical radiographic image-image capture only		No		
D0708	Intraoral-bitewing radiographic image-image capture only.		No		

RESTORATIVE					
CODE	DESCRIPTION	TEETH COVERED	AUTHORIZATION REQUIRED	BENEFIT LIMITATIONS	REQUIRED DOCUMENTATION
D2330	Resin-based composite - one surface, anterior	6-11, 22-27	No	One (D2330) per 2 years per tooth per surface by the same provider or group	
D2331	Resin-based composite - two surfaces, anterior	6-11, 22-27	No	One of (D2331) per 2 years per tooth per surface by the same provider or group	
D2332	D2332 Resin-based composite - three surfaces, anterior	6-11, 22-27	No	One (D2332) per 2 years per tooth per surface by the same provider or group	
D2335	D2335 Resin-based composite-four or more surfaces (anterior)	6-11, 22-27	No	One (D2335) per 2 years per tooth per surface by the same provider or group	
D2390	Resin-based composite crown, anterior	6-11, 22-27	No	One per 2 years	
D2740	Crown-porcelain/ceramic substrate	2-15, 18-31 Reimbursement for a third molar will be considered only if it is functioning as a second molar.	No	One per 5 years per tooth. Endodontically treated teeth only. Pe-operative radiographs of adjacent and opposing teeth	
D2750	Crown - porcelain fused to high noble metal	2-15, 18-31 Reimbursement for a third molar will be considered only if it is functioning as a second molar.	No	One per 5 years per tooth. Endodontically treated teeth only. Pe-operative radiographs of adjacent and opposing teeth	
D2751	Crown- porcelain fused to predominantly base metal	2-15, 18-31 Reimbursement for a third molar will be considered only if it is functioning as a second molar.	No	One per 5 years per tooth. Endodontically treated teeth only. Pe-operative radiographs of adjacent and opposing teeth	
D2752	Crown - porcelain fused to noble metal	2-15, 18-31 Reimbursement for a third molar will be considered only if it is functioning as a second molar.	No	One per 5 years per tooth. Endodontically treated teeth only. Pe-operative radiographs of adjacent and opposing teeth.	
D2753	Crown – porcelain fused to titanium and titanium alloys	2-15, 18-31 Reimbursement for a third molar will be considered only if it is functioning as a second molar.	No	One per 5 years per tooth. Endodontically treated teeth only. Pe-operative radiographs of adjacent and opposing teeth	

CODE	DESCRIPTION	TEETH COVERED	AUTHORIZATION REQUIRED	BENEFIT LIMITATIONS	REQUIRED DOCUMENTATION
D2790	Crown- full cast high noble metal	2-15, 18-31 Reimbursement for a third molar will be considered only if it is functioning as a second molar.	No	One per 5 years per tooth. Endodontically treated teeth only. Pe-operative radiographs of adjacent and opposing teeth.	
D2791	Crown - full cast predominantly base metal	2-15, 18-31 Reimbursement for a third molar will be considered only if it is functioning as a second molar.	No	One per 5 years per tooth. Endodontically treated teeth only. Pe-operative radiographs of adjacent and opposing teeth.	
D2792	Crown - Full cast noble metal	2-15, 18-31 Reimbursement for a third molar will be considered only if it is functioning as a second molar.	No	One per 5 years per tooth. Endodontically treated teeth only. Pe-operative radiographs of adjacent and opposing teeth.	
D2794	Crown - titanium	2-15, 18-31 Reimbursement for a third molar will be considered only if it is functioning as a second molar.	No	One per 5 years per tooth. Endodontically treated teeth only. Pe-operative radiographs of adjacent and opposing teeth.	
D2910	Re-cement or re- bond inlay, only, veneer or partially coverage restoration	2-15, 18-31	No		
D2915	Re-cement cast or prefabricated post and core	2-15, 18-31	No		
D2920	Re-cement or re- bond crown	2-15, 18-31	No	Maximum of four per day.	
D2928	Prefabricated porcelain/ceramic crown-permanent tooth		**Yes**	.	Treatment notes, pre- operative x- ray(s) of adjacent and opposing teeth. Post- operative x-ray for reimbursement (BW and PA)

CODE	DESCRIPTION	TEETH COVERED	AUTHORIZATION REQUIRED	BENEFIT LIMITATIONS	DOCUMENTATION REQUIRED
D2931	Prefabricated stainless steel crown – permanent tooth	2-15, 18-31	No	One per 3 years by same provider or group.	
D2932	Prefabricated resin crown	6- 11, 22- 27	No	One per 3 years by same provider or group.	
D2933	Prefabricated stainless steel crown with resin window	6 - 11, 22 - 27	No	One per 3 years by same provider or group.	
D2940	Protective restoration BR on fee schedule	1 - 32	No	Not reimbursed on same day as, root canals, or permanent restorations.	
D2950	Core buildup, including any pins when required	2-15, 18-31 .	No		
D2952	Cast post and core in addition to crown	2-15, 18-31	No	Endodontically treated teeth only.	
D2954	Prefabricated post and core in addition to crown	2-15, 18-31	No	Endodontically treated teeth only.	

ENDODONTICS					
CODE	DESCRIPTION	TEETH COVERED	AUTHORIZATION REQUIRED	BENEFIT LIMITATIONS	DOCUMENTATION REQUIRED
D3110	Pulp cap - direct (excluding final restoration, when related to pain)	2-15, 18-31 Reimbursement for a third molar will be considered only if it	No	One of (D3110) per lifetime per patient per tooth	
D3120	Pulp cap - indirect (excluding final restoration, when related to pain)	2-15, 18-31 Reimbursement for a third molar will be considered only if it is functioning as a second molar	No	One of (D3120) per lifetime per patient per tooth	
D3220	Therapeutic pulpotomy (excluding final restoration), primary and permanent teeth		No	One of (D3220) per lifetime per tooth.	
D3221	Pulpal debridement, permanent teeth only	2-15, 18-31 Reimbursement for a third molar will be considered only if it is functioning as a second molar	No		
D3310	Endodontic therapy, anterior teeth (excluding final restoration)	6 - 11, 22 -27	No	One of (D3310) per lifetime per tooth (for treatment of acute infection or to eliminate pain with favorable prognosis). Maximum of four per day.	
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	4, 5, 12, 13, 20, 21, 28, 29	No	One of (D3320) per tooth (for treatment of acute infection or to eliminate pain with favorable prognosis). Maximum of three per day.	
D3330	Endodontic therapy, molar (excluding final restoration)	2, 3, 14, 15,18, 19, 30, 31	No	One of (D3330) per tooth (for treatment of acute infection or to eliminate pain with favorable prognosis). Maximum of four per day.	
D3331	Treatment of root canal obstruction, non-surgical access	2-15,18-31 reimbursement for a third molar will be considered only if it is functioning as a second molar	No		
D3346	Retreatment of previous root canal therapy-anterior	6-11, 22-27	No	Refer to Endodontist for retreatment	

CODE	DESCRIPTION	TEETH COVERED	AUTHORIZATION REQUIRED	BENEFIT LIMITATIONS	DOCUMENTATION REQUIRED
D3347	Retreatment of previous root canal Therapy- bicuspid	4, 5, 12, 13, 20,21, 28, 29	No	(Refer to Endodontist for retreatment)	
D3348	Retreatment of previous root canal therapy-molar (refer to Endodontist for retreatment)	2,3, 14, 15, 18, 19, 30,31	No	(Refer to Endodontist for retreatment)	
D3410	Apicoectomy- anterior	6 - 11, 22-27	No		
D3421	Apicoectomy – bicuspid (first root)	4, 5,12, 13, 20, 21, 28, 29	No		
D3425	Apicoectomy-molar (first root)	2, 3, 14, 15, 18,19, 30, 31	No	One per lifetime (for treatment of acute infection or to eliminate pain with favorable prognosis)	
D3426	Apicoectomy (each additional root)	2-15, 18-31	No	One per lifetime (for treatment of acute infection or to eliminate pain with favorable prognosis)	
D3430	Retrograde filling - per root	2-15, 18-31	No	One per lifetime (for treatment of acute infection or to eliminate pain with favorable prognosis)	
D3471	Surgical repair of root resorption- anterior	6-11, 22-27	**Yes**	Does not include placement of restoration.	Treatment plan, Treatment notes, preoperative x- ray(s)
D3472	Surgical repair of root resorption- premolar	4, 5,12, 13, 20, 21, 28, 29	**Yes**	Does not include placement of restoration.	Treatment plan, Treatment notes, preoperative x- ray(s)
D3473	Surgical repair of root resorption- molar	2,3,14,15,18,19,30 ,31	**Yes**	Does not include placement of restoration.	Treatment plan, treatment notes, preoperative x- ray(s)
D3501	Surgical exposure of root surface without apicoectomy, or repair of root resorption- anterior	6-11, 22- 27	Yes	Not to be used in conjunction with apicoectomy or repair of root resorption.	Treatment plan, treatment notes, preoperative x- ray(s)
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption- premolar	4, 5,12,13, 20, 21, 28, 29	Yes	Not to be used in conjunction with apicoectomy or repair of root resorption.	Treatment plan, treatment notes, preoperative x- ray(s)

CODE	DESCRIPTION	TEETH COVERED	AUTHORIZATION REQUIRED	BENEFIT LIMITATIONS	DOCUMENTATION REQUIRED
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption- molar	2, 3, 14, 15, 18, 19, 30, 31	Yes	Not to be used in conjunction with apicoectomy or repair of root resorption.	Treatment plan, treatment notes, preoperative x- ray(s)
D3921	Decoronation or submergence of an erupted tooth	2-15, 18- 31	Yes		Treatment plan, treatment notes, preoperative x- ray(s)

PERIODONTICS

CODE	DESCRIPTION	TEETH COVERED	AUTHORIZATION REQUIRED	BENEFIT LIMITATIONS	DOCUMENTATION REQUIRED
D4286	Removal of non-resorbable barrier		Yes	Frequency limit is 4 per day.	X-rays and clinical notes/narrative required

PROSTHODONTICS

CODE	DESCRIPTION	TEETH COVERED	AUTHORIZATION REQUIRED	BENEFIT LIMITATIONS	DOCUMENTATION REQUIRED
D6089	Accessing and retorquing loose implant screw-per screw		Yes	One per tooth per day.	X-rays and clinical notes/narrative required
D6105	Removal of implant body not requiring bone removal or flap elevation		Yes	One per lifetime per patient per tooth (if medically necessary for relief of pain associated with a maxillofacial condition	X-rays and clinical notes/narrative required
D6193	Replacement of an implant screw		Yes	One per day per tooth	X-rays and clinical notes/narrative required
D6197	Replacement of restorative material used to close and access opening for screw retained implant supported prosthesis, per implant.		Yes	One per 24 month(s) per patient per tooth per provider or group.	X-rays and clinical notes/narrative required

ORAL SURGERY					
CODE	**DESCRIPTION**	**TEETH COVERED**	**AUTHORIZATION REQUIRED**	**BENEFIT LIMITATIONS**	**DOCUMENTATION REQUIRED**
D7111	Extraction, coronal remnants - primary tooth	A-T	No	One per lifetime per tooth. Extractions for orthodontic purposes, asymptomatic teeth, or teeth without clinical pathology are not covered..	
D7140	Extraction - single tooth - erupted tooth or exposed root (elevation and/or forceps removal)	1-32, A -T	No	One per lifetime per tooth. Extractions for orthodontic purposes, asymptomatic teeth, or teeth without clinical pathology are not covered.	
D7210	Removal of erupted tooth	1-32, A -T	No	One per lifetime per tooth. Maximum of ten per day. Extractions for orthodontic purposes, asymptomatic teeth, or teeth without clinical pathology are not covered.	
D7220	Removal of impacted tooth - soft tissue	1-32, A -T	No	One per lifetime per tooth. Maximum of five per day. Extractions for orthodontic purposes, asymptomatic teeth, or teeth without clinical pathology are not covered.	
D7230	Removal of impacted tooth – partially bony	1-32, A -T	No	One per lifetime per tooth. Extractions for orthodontic purposes, asymptomatic teeth, or teeth without clinical pathology are not covered. Maximum of five per day	
D7240	Removal of impacted tooth- completely bony	1-32, A -T	No	One per lifetime per tooth. Maximum of five per day. Extractions for orthodontic purposes, asymptomatic teeth, or teeth without clinical pathology are not covered.	
D7241	Removal of impacted tooth- completely bony, with unusual surgical complications	1-32, A -T	No	One per lifetime per tooth. Maximum of five per day. Extractions for orthodontic purposes, asymptomatic teeth, or teeth without clinical pathology are not covered.	

CODE	DESCRIPTION	TEETH COVERED	AUTHORIZATION REQUIRED	BENEFIT LIMITATIONS	DOCUMENTATION REQUIRED
D7250	Surgical removal of residual tooth roots (cutting procedure)	1-32, A -T	No	One per lifetime per tooth. Maximum of ten per day. Extractions for orthodontic purposes, asymptomatic teeth, or teeth without clinical pathology are not covered.	
D7251	Coronectomy- intentional partial tooth removal is performed when a neurovascular complication is likely if the entire impacted tooth is removed	1-32, A -T	No	Maximum of four per day.	
D7259	Nerve dissection		Yes	One per day per tooth or per quadrant	Treatment notes, narrative of medical necessity, preoperative x- ray(s)
D7260	Oroantral fistula closure		No		
D7261	Primary closure of a sinus perforation		No	Not payable on the same date of service as the extraction	
D7270	Tooth reimplantation and/or stabilization of accidentally avulsed, or displaced tooth	Teeth 6-11, 22-27 (Anterior teeth only)	No	Includes splinting and/or stabilization. (With favorable prognosis)	
D7284	Excisional biopsy of minor salivary glands		Yes		Treatment notes, narrative of medical necessity, preoperative x- ray(s)
D7285	Incisional biopsy of oral tissue-hard (bone, tooth)		No		
D7286	Incisional biopsy of oral tissue-soft		No		
D7310	Alveoloplasty in conjunction with extraction- per quadrant	Per quadrant (10,20,30,40)			
D7311	Alveoloplasty in conjunction with extractions- one to three teeth or tooth spaces, per quadrant.	Per quadrant (10, 20, 30,40)	No		
D07320	Alveoloplasty not in conjunction with extractions- four or more teeth or tooth spaces per quadrant	Per quadrant (10, 20, 30,40)	No		
D7321	Alveoloplasty not in conjunction with extractions- one to three teeth or tooth spaces per quadrant	Per quadrant (10, 20, 30,40)	No		
D7410	Radical excision - lesion diameter up to 1.25cm		No	Pathology report in record.	

CODE	DESCRIPTION	TEETH COVERED	AUTHORIZATION REQUIRED	BENEFIT LIMITATIONS	DOCUMENTATION REQUIRED
D7411	Excision of benign lesion greater than 1.25 cm		No	Pathology report in record.	
D7415	Excision of malignant lesion, complicated		No	Pathology report in record.	
D7440	Excision of malignant tumor- lesion diameter up to 1.25cm		No	Pathology report in record.	
D7441	Excision of malignant tumor - lesion diameter greater than 1.25cm		No		
D7450	Removal of odontogenic cyst or tumor - lesion diameter up to 1.25 cm		No	Pathology report	
D7451	Removal of odontogenic cyst or tumor – lesion greater than 1.25cm		No	Pathology report in record	
D7460	Removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25cm		No	Pathology report in record	
D7461	Removal of nonodontogenic cyst or tumor - lesion greater than 1.25cm		No	Pathology report in	
D7465	Destruction of lesion(s) by physical or chemical method, by report		No		
D7509	Marsupialization of odontogenic cyst		Yes		Treatment notes, narrative of medical necessity, preoperative x- ray(s)
D7510	Incision and drainage of abscess – intraoral soft tissue	Teeth 1-32, A -T	No		
D7511	Incision and drainage of abscess– intraoral soft tissue complicated (includes drainage of multiple fascial spaces)	Teeth 1-32, A -T	No		
D7520	Incision and drainage of abscess – extraoral soft tissue	Teeth 1-32, A -T	No		
D7521	Incision and drainage of abscess- extraoral soft tissue- complicated (includes drainage of multiple facial spaces)	Teeth 1-32, A -T	No		
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue		No		
D7540	Removal of reaction-producing foreign bodies, musculoskeletal system		No		
D7550	Partial ostectomy/ sequestrectomy for removal of non-vital bone	Per Quadrant (10, 20, 30, 40)	No		

CODE	DESCRIPTION	TEETH COVERED	AUTHORIZATION REQUIRED	BENEFIT LIMITATIONS	DOCUMENTATION REQUIRED
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body		No		
D7939	Indexing for osteotomy using dynamic robotic assisted or dynamic navigation.		Yes		Treatment notes, narrative of medical necessity, preoperative x- ray(s)
D7956	Guided tissue regeneration, edentulous area- resorbable barrier, per site.		Yes		Treatment notes, narrative of medical necessity, preoperative x-ray(s)
D7957	Guided tissue regeneration, edentulous are- non resorbable barrier per site		Yes		Treatment notes, narrative of medical necessity, preoperative x-ray(s)
D7960	Max sinusotomy for removal of tooth fragment		Yes		Treatment notes, narrative of medical necessity, preoperative x-ray(s)
D7970	Excision of hyperplastic gingiva		No		
D7971	Excision of pericoronal gingiva	Teeth 1 - 32	No		
D7972	Surgical reduction of fibrous tuberosity		No		
D7979	Non-surgical sialolithotomy		Yes		Treatment plan, treatment notes, Narrative of medical necessity
D7980	Sialolithotomy		No		
D7981	Excision of salivary gland, by report		No		
D7982	Sialodochoplasty		No		
D7983	Closure of salivary fistula		No		
D7999	Unspecified oral surgery procedure, by report		No	Narrative describing service with claim.	

ADJUNCTIVE SERVICES					
CODE	**DESCRIPTION**	**TEETH COVERED**	**AUTHORIZATION REQUIRED**	**BENEFIT LIMITATIONS**	**DOCUMENTATION REQUIRED**
D9222	Deep sedation/ general anesthesia – first 15 minutes		Yes	One of (D9222) per 1 Day(s) Per patient.	Complete treatment plan, health history, narrative describing necessity for sedation, x-rays when available, sedation records
D9223	Deep sedation/ general anesthesia – each additional 15 minutes		Yes	Maximum of 11 of (D9223) per 1 Day(s) Per patient.	Complete treatment plan, health history, narrative describing necessity for sedation, x-rays when available, sedation records
D9224	**Administration of general anesthesia with advanced airway-first 15-minute increment, or any portion of thereof**		**Yes**	**One of (D9224) per 1 Day(s) Per patient.**	Complete treatment plan, health history, narrative describing necessity for sedation, x-rays when available, sedation records
D9225	**Administration of general anesthesia with advanced airway-each subsequent 15-minute increment, or any portion thereof**		**Yes**	**Maximum of 11 of (D9225) per 1 Day(s) Per patient.**	Complete treatment plan, health history, narrative describing necessity for sedation, x-rays when available, sedation records
D9230	Inhalation of nitrous oxide/ analgesia		No		
D9239	Intravenous moderate (conscious) sedation/analgesia – first 15 minutes		Yes	One of (D9239) per treatment plan per patient. Not allowed on same day with D9230, D9223 or D9248	Complete treatment plan, health history, narrative describing necessity for sedation, x-rays when available, sedation records
D9243	Intravenous moderate (conscious) sedation/analgesia – each additional 15 minutes		Yes	Maximum of 11 of (D9243) per day per patient.	Complete treatment plan, health history, narrative describing necessity for sedation, x-rays when available, sedation records
D9244	**In-office administration of minimal sedation-single drug-enteral**		**Yes**	**One of (D9244) per day.**	**Complete treatment plan, health history, narrative describing necessity for sedation, x-rays when available, sedation records**
D9245	**In-office administration of minimal sedation-single drug-enteral**		**Yes**	**One of (D9245) per day.**	**Complete treatment plan, health history, narrative describing necessity for sedation, x-rays when available, sedation records**

CODE	DESCRIPTION	TEETH COVERED	AUTHORIZATION REQUIRED	BENEFIT LIMITATIONS	DOCUMENTATION REQUIRED
D9246	**Administration of moderate sedation-non-intravenous parenteral-first 15-minute increment, or any portion thereof**		**Yes**	**One of (D9246) per day.**	**Complete treatment plan, health history, narrative describing necessity for sedation, x-rays when available, sedation records**
D9247	**Administration of moderate sedation-non-intravenous parenteral-each subsequent 15-minute increment, or any portion thereof**		**Yes**	**Maximum of 11 of (D9247) per day, per patient.**	**Complete treatment plan, health history, narrative describing necessity for sedation, x-rays when available, sedation records**
D9995	Teledentistry-synchronous		No		
D9996	Teledentistry-asynchronous		No		

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