Notice of CDT 2016
Update to Exhibit A, Per Section 31 and in VA Exhibit G, Dental Program Claims Processing Guidelines
Effective January 1, 2016

The American Dental Association (ADA) has revised the Common Dental Terminology (CDT) for 2016. We recommend you obtain a current copy of the CDT Code from the ADA, and encourage all dentists to review specific code information and make note of new codes as well as deletions and revisions. We are revising the Dental Programs Claims Processing Guidelines issued in 2011 to incorporate these changes, as indicated below. Please note your Network Fee Schedule contains the most commonly utilized procedures and may not contain all ADA codes that may be considered Covered Services. If you need the Network Fee Schedule Allowable Amount for a specific CDT 2016 code, or if you have questions, please contact Professional Services at 1-866-947-9398. This notice of CDT 2016 should be used in conjunction with your 100/200/300 participation agreement, your Network Fee Schedule and the Dental Program's Claims Processing Guidelines.

The following definitions are contained in the Dental Program's Claims Processing Guidelines for the 100/200/300 participating agreement but are repeated here for ease of cross referencing the CDT changes.

ALLOWABLE: The amount used to calculate the appropriate benefit allowance consistent with "Maximum Allowed Amount."

ALTERNATE BENEFIT: In cases where alternative methods of treatment exist, benefits are provided for the least costly professionally accepted treatment. This determination is not intended to reflect negatively on the dentist's treatment plan or to recommend which treatment should be provided. It is a determination of benefits under terms of the **Patient's** coverage. The dentist and **Patient** should decide the course of treatment. If the treatment rendered is other than the one **Benefited** the difference between allowance and the dentist charge for the actual treatment rendered is collectible from the **Patient**.

BENEFITED: Processed for payment subject to the Patient's dental benefit contract stipulations including but not limited to copayments, deductibles, maximums, determination of the **Allowable** amount, etc.

BY REPORT AND SUBJECT TO COVERAGE UNDER MEDICAL: When a procedure is **By Report and Subject To Coverage Under Medical**, it should be submitted to the **Patient**'s medical carrier first. When submitting, include a copy of the explanation of payment or payment voucher from the medical carrier with the claim, plus a narrative describing the procedure performed, reasons for performing the procedure, pathology report if appropriate, and any other information deemed pertinent. In the absence of such information the procedure will not be **Benefited**.

DENIED: If the fee for a procedure is **Denied**, the fee charged is not payable and is chargeable to the **Patient**.

DISALLOW/DISALLOWED: If the fee for a procedure is **Disallowed**, it is not **Benefited** and is not collectible from the **Patient** by a contracting dentist.

IN CONJUNCTION WITH: A service which is considered part of another procedure or episode of treatment, including but not limited to services being rendered on the same day.

PROCESSED AS: When a procedure is **Processed As** a different procedure, contracting dentists agree to accept all the limitations, claims guidelines, and **Allowable** amounts that apply to the procedure that is **Benefited** by the Patient's dental benefit contract.

Deleted Codes

D0260	extra-oral – each additional radiographic image
D0421	genetic test for susceptibility to oral disease
D2970	temporary crown (fractured tooth)s
D9220	deep sedation/general anesthesia – first 30 minutes
D9221	deep sedation/general anesthesia – each additional 15 minutes
D9241	intravenous moderate (conscious) sedation analgesia – first 30 minutes
D9242	intravenous moderate (conscious) sedation analgesia – each additional 15 minutes
D9931	cleaning and inspection of a removable appliance

New CDT Codes[1]

Please refer to your Claim Processing Guidelines for all Guidelines (G) related to coding categories of service and subcategories of service for the codes listed below, as those Guidelines (G) have not changed. It is highly recommended that network dentists be aware of new, deleted and revised codes. Subject to the member's contract, benefits for a service may be Alternated.

D0251	extra-oral posterior dental radiographic image - image limited to exposure of complete posterior teeth in both dental arches. This is a unique image that is not derived from another image. – processed the same as D0250
D0422	collection and preparation of genetic sample material for laboratory analysis and report – same as D0421
D0423	genetic test for susceptibility to diseases – specimen analysis - Certified laboratory analysis to detect specific genetic variations associated with increased susceptibility for diseases. – same as D0421
D1354	interim caries arresting medicament application - conservative treatment of an active, non-symptomatic carious lesion by topical application of a caries arresting or inhibiting medicament and without mechanical removal of sound tooth structure. – not covered
D4283	autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site – used in conjunction with D4273 – local anesthesia is usually considered a component part of periodontal procedures, but dependent upon the plan will allow up to 50% of D4273 – allow up to a maximum of 3 teeth per quadrant
D4285	non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site - local anesthesia is usually considered a component part of periodontal procedures, but dependent upon the plan will allow up to 50% of D4278 – allow up to a maximum of 3 teeth per quadrant
D5221	immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth) – includes limited follow-up care only; does not include future rebasing / relining procedure(s). – same as D5211
D5222	immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth) – includes limited follow-up care only; does not include future rebasing / relining procedure(s). – same as D5212
D5223	immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) - includes limited follow-up care only; does not include future rebasing / relining procedure(s). – same as D5213
D5224	immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) - includes limited follow-up care only; does not include future rebasing / relining procedure(s). – same as D5214
D7881	occlusal orthotic device adjustment NC - considered in the cost for the occlusal orthotic for first 6 months D8681 removable orthodontic retainer adjustment – same as D8210
D8681	Removable orthodontic retainer adjustment – same as D8210
D9223	deep sedation/general anesthesia – 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. – dental plans are not able to benefit anesthesia the same as can medical plans, therefore the benefit is derived from the division of a total of 1 hour of anesthesia divided by 4 – each fifteen minute time unit is ¼ of the total for 1 hour (prior 1 D9220 plus 2 D9221 time units)
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. – dental plans are not able to benefit anesthesia the same as can medical plans, therefore the benefit is derived from the division of a total of 1 hour of anesthesia divided by 4 – each fifteen minute time unit is ¼ of the total for 1 hour (prior 1 D9241 plus 2 D9242 time units)
D9932	Cleaning and inspection of removable complete denture, maxillary - this procedure does not include any adjustments. – processed the same as D9331
D9933	Cleaning and inspection of removable complete denture, mandibular - this procedure does not include any adjustments.- processed the same as D9331
D9934	Cleaning and inspection of removable partial denture, maxillary - this procedure does not include any adjustments. – processed

	the same as D9331
D9935	Cleaning and inspection of removable partial denture, mandibular- this procedure does not include any adjustments. – processed the same as D9931
D9943	Occlusal guard adjustment –- NC for first 6 months post insertion of D9940 - adjustments included in fee for occlusal guard

Specific member contract provisions, state or federal laws or requirements, limitations and exclusions take precedence over the Claims Processing Guidelines. Since certain contractual items (e.g. time limits, frequency of procedures, age limits, etc.) can vary among members, they have not all been listed with their associated procedure codes. Therefore this document should not be interpreted as comprehensive and encompassing all possible limitations and exclusions. Dental offices should contact Customer Service on the member's identification card to determine covered services, and the applicable limitations and exclusions.

[1]The CDT code descriptions are provided for your convenience and may be abbreviated in this document. For the complete description for each code refer to the current ADA 2016 CDT code book.