



CDT 2020

*Code on Dental Procedures and
Nomenclature*

Arkansas Procedure Guidelines Analysis



Arkansas
BlueCross BlueShield

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Diagnostic Services

CDT Code	Description of Service	Procedure Guidelines	Submission Requirements: Participating Providers
CLINICAL ORAL EVALUATIONS: One evaluation code may be billed per dentist per date of service. Evaluations, including diagnosis and treatment planning, are the responsibility of the dentist. A dentist must complete all evaluations.			
D0120	Periodic oral evaluation	Twice per calendar year	None
D0140	Limited oral evaluation: problem-focused	Once per calendar year, per patient, per dentist	None
D0145	Oral evaluation for a patient less than 3 years of age and counseling with primary caregiver	Twice per calendar year	None
D0150	Comprehensive oral evaluation, new or established patient	Once in a 24 month period, per patient, per dentist. Additional exams by the same dentist within the twenty four month period, change code to D0120 which is subject to the frequency limit for D0120.	None
D0160	Detailed, extensive oral evaluation: problem-focused, by report	Once per calendar year, per patient, per dentist	None
D0170	Re-evaluation: limited, problem focused (established patient, not post-operative visit)	Not a covered benefit	None
D0171	Re-evaluation-post operative visit	Not a covered benefit	None
D0180	Comprehensive periodontal evaluation: new or established patient	Once per patient per dentist per calendar year; Not covered in individual plans	None
PRE-DIAGNOSTIC SERVICES			
D0190	Screening of a patient: A screening, including state or federally mandated screenings, to determine an individual's need to be seen by a dentist for diagnosis	Not a covered benefit	None
D0191	Assessment of a patient: A limited clinical inspection that is performed to identify possible signs of oral or systemic disease, malformation, or injury, and the potential need for referral for diagnosis and treatment	Not a covered benefit	None

CDT Code	Description of Service	Procedure Guidelines	Submission Requirements: Participating Providers
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CDT: Diagnostic Services

DIAGNOSTIC IMAGING: Image Capture With Interpretation; Should be taken only for clinical reasons as determined by the patient's dentist. Should be of diagnostic quality and properly identified and dated. Is 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.

D0210	Intraoral complete series intraoral - complete series of radiographic images	Once in a 5 year period	None
D0220	Intraoral periapical – first radiographic image.	No limit; panoramic radiograph (D0330) reported with non-itemized charges for the same provider and same DOS as periapical radiograph will merge to the panoramic radiograph	None
D0230	Intraoral periapical – each additional radiographic image	No limit; panoramic radiograph (D0330) reported with non-itemized charges for the same provider and same DOS as periapical radiograph will merge to the panoramic radiograph	None
D0240	Intraoral occlusal radiographic image	No limitation	Arch identification
D0250	Extraoral, 2D radiographic image	No limitation	None
D0251	Extra-oral posterior dental radiographic image	Not covered	None
D0270	Bitewing – single radiographic image	No limitation	None
D0272	Bitewings – two radiographic images	Once per calendar year, except twice per calendar year for dependent child through age 18	None
D0273	Bitewings – three radiographic images	One occurrence of D0272, D0273, D0274 or D0277 in a calendar year over the age of 18	None
D0274	Bitewings – four radiographic images	One occurrence of D0272, D0273, D0274 or D0277 in a calendar year over the age of 18	None
D0277	Vertical bitewings – 7 to 8 radiographic images	One occurrence of D0272, D0273, D0274 or D0277 in a calendar year over the age of 18	None
D0310	Sialography	Not a covered benefit	None
D0320	Temporomandibular joint arthrogram, including injection	Not a covered benefit	None

CDT Code	Description of Service	Procedure Guidelines	Submission Requirements: Participating Providers
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CDT: Diagnostic Services

D0321	Other temporomandibular joint radiographic image, by report	Not a covered benefit	None
D0322	Tomographic survey	Not a covered benefit	None
D0330	Panoramic radiographic image	Once in a 5 year period	None
D0340	Cephalometric radiographic image	Once per lifetime with orthodontic benefit	None
D0350	2D oral/facial photographic images obtained intraorally or extraorally	Not a covered benefit	None
D0351	3D photographic image	Not a covered benefit	None
D0364	Cone beam CT capture and interpretation with limited field of view – less than one whole jaw	Not a covered benefit	None
D0365	Cone beam CT capture and interpretation with field of view of one full dental arch - mandible	Not a covered benefit	None
D0366	Cone beam CT capture and interpretation with field of view of one full dental arch – maxilla, with or without cranium	Not a covered benefit	None
D0367	Cone beam CT capture and interpretation with field of view of both jaws, with or without cranium	Not a covered benefit	None
D0368	Cone beam CT capture and interpretation for TMJ series including two or more exposures	Not a covered benefit	None
D0369	Maxillofacial MRI capture and interpretation	Not a covered benefit	None
D0370	Maxillofacial ultrasound capture and interpretation	Not a covered benefit	None
D0371	Sialoendoscopy capture and interpretation	Not a covered benefit	None
IMAGE CAPTURE ONLY: Capture by a Practitioner Not Associated with Interpretation and Report			
D0380	Cone beam CT image capture with limited field of view – less than one whole jaw	Not a covered benefit	None

CDT Code	Description of Service	Procedure Guidelines	Submission Requirements: Participating Providers
CDT: Diagnostic Services			
D0381	Cone beam CT capture and interpretation with field of view of one full dental arch - mandible	Not a covered benefit	None
D0382	Cone beam CT capture and interpretation with full dental arch – maxilla, with or without cranium	Not a covered benefit	None
D0383	Cone beam CT capture and interpretation with field of view of both jaws, with or without cranium	Not a covered benefit	None
D0384	Cone beam CT capture and interpretation for TMJ series including two or more exposures	Not a covered benefit	None
D0385	Maxillofacial MRI capture and interpretation	Not a covered benefit	None
D0386	Maxillofacial ultrasound capture and interpretation	Not a covered benefit	None
INTERPRETATION AND REPORT ONLY: Interpretation and Report by Practitioner not Associated with Image Capture.			
D0391	Interpretation of diagnostic image by practitioner not associated with capture of image, including report	Not a covered benefit	None
D0393	Treatment simulation using 3D image volume	Not a covered benefit	None
D0394	Digital subtraction of two or more images or image volumes of the same modality	Not a covered benefit	None
D0395	Fusion of two or more 3D image volumes of one or more modalities	Not a covered benefit	None
TESTS AND EXAMINATIONS			
D0411	HbA1c in-office point of service testing	Not a covered benefit	None
D0412	Blood glucose level test—in-office using a glucose meter	Not a covered benefit	None
D0414	Laboratory processing of microbial specimen to include culture and sensitivity studies, preparation, and transmission of written report	Not a covered benefit	None
D0415	Collection of microorganisms for culture and sensitivity	Not a covered benefit	None

CDT Code	Description of Service	Procedure Guidelines	Submission Requirements: Participating Providers
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CDT: Diagnostic Services

D0416	Viral Culture	Not a covered benefit	None
D0417	Collection and preparation of saliva sample for laboratory diagnostic testing	Not a covered benefit	None
D0418	Analysis of saliva sample	Not a covered benefit	None
D0419	Assessment of salivary flow by measurement	Not a covered benefit	None
D0422	Collection and preparation of genetic sample material for laboratory analysis and report	Not a covered benefit	None
D0423	Genetic test for susceptibility to diseases – specimen analysis	Not a covered benefit	None
D0425	Caries susceptibility tests	Not a covered benefit	None
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions; does not include cytology or biopsy procedures	Not a covered benefit	None
D0460	Pulp vitality tests	Once per visit	None
D0470	Diagnostic casts	Not a covered benefit	None

ORAL PATHOLOGY LABORATORY

D0472	Accession of tissue, gross examination, including preparation and transmission of written report	Not a covered benefit	None
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	Not a covered benefit	None
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	Not a covered benefit	None
D0475	Decalcification procedure	Not a covered benefit	None

Preventive Services

CDT Code	Description of Service	Procedure Guidelines	Submission Requirements: Participating Providers
DENTAL PROPHYLAXIS			
D1110	Prophylaxis – adult age 14+	Twice per calendar year	None
D1120	Prophylaxis – child through age 13 (up to 14 th birthday)	Twice per calendar year	None
TOPICAL FLUORIDE TREATMENT OFFICE PROCEDURE			
D1206	Topical application of fluoride varnish	Twice per calendar year through age 18. Benefit will be in place of D1203, D1204.	None
D1208	Topical application of fluoride – excluding varnish	Twice per calendar year through age 18	None
OTHER PREVENTIVE SERVICES			
D1310	Nutritional counseling for control of dental disease	Not a covered benefit	None
D1320	Tobacco counseling for control and prevention of oral disease	Not a covered benefit	None
D1330	Oral hygiene instructions	Not a covered benefit	None
D1351	Sealant – per tooth	Once in 3 years for dependents through age 15 on permanent first and second molars	Tooth identification
D1352	Preventive resin restoration in a moderate to high cariesrisk patient; permanent tooth	Once in 3 years for permanent teeth only	Tooth identification
D1353	Sealant repair-per tooth	Once in 3 years for permanent teeth only	Tooth identification
D1354	Interim caries arresting medicament application – per tooth	Not a covered benefit	None

SPACE MAINTENANCE (PASSIVE APPLIANCES): Designed to prevent tooth movement			
D1510	Space maintainer – fixed, unilateral – per quadrant	Dependents through the age of 18 for premature loss of primary molars and permanent first molars, or those that have not/will not develop	Per Quadrant
D1516	Space maintainer – fixed – bilateral, maxillary	Dependents through the age of 18 for premature loss of primary molars and permanent first molars, or those that have not/will not develop	Tooth identification
D1517	Space maintainer – fixed – bilateral, mandibular	Dependents through the age of 18 for premature loss of primary molars and permanent first molars, or those that have not/will not develop	Tooth identification
D1520	Space maintainer – removable – bilateral	Not a covered benefit	Tooth identification
D1526	Space maintainer – removable – bilateral, maxillary	Not a covered benefit	Tooth identification
D1527	Space maintainer – removable – bilateral, mandibular	Not a covered benefit	Tooth identification
D1551	Re-cement or re-bond bilateral space maintainer – maxillary	Once in a 6-month period, but not within six months of insertion by same dentist	Arch identification
D1552	Re-cement or re-bond bilateral space maintainer – mandibular	Once in a 6-month period, but not within six months of insertion by same dentist	Arch identification
D1553	Re-cement or re-bond unilateral space maintainer – per quadrant	Once in a 6-month period, but not within six months of insertion by same dentist	Arch identification
D1555	Removal of fixed space maintainer	No limitations	Tooth identification
D1556	Removal of fixed unilateral space maintainer – per quadrant	No limitations	Arch identification
D1557	Removal of fixed bilateral space maintainer – maxillary	No limitations	Arch identification
D1558	Removal of fixed bilateral space maintainer – mandibular	No limitations	Arch identification

CDT Code	Description of Service	Procedure Guidelines	Submission Requirements: Participating Providers
CDT: Restorative Services			
D2390	Resin-based composite crown, anterior	One per tooth per lifetime; primary teeth only	Tooth identification

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D2391	Resin-based composite, 1 surface, posterior, permanent or primary	One restoration per surface per tooth per 12 months. Alternate benefit of comparable amalgam restoration. No alternate code for anterior teeth.	Tooth identification, Surface identification
D2392	Resin-based composite, 2 surfaces, posterior, permanent, or primary	One restoration per surface per tooth per 12 months. Alternate benefit of comparable amalgam restoration. No alternate code for anterior teeth.	Tooth identification, Surface identification
D2393	Resin-based composite, 3 surface, posterior, permanent, or primary	One restoration per surface per tooth per 12 months. Alternate benefit of comparable amalgam restoration. No alternate code for anterior teeth.	Tooth identification, Surface identification
D2394	Resin-based composite, 4 or more surfaces, posterior permanent, or primary	One restoration per surface per tooth per 12 months. Alternate benefit of comparable amalgam restoration. No alternate code for anterior teeth.	Tooth identification, Surface identification
GOLD FOIL RESTORATIONS			
D2410	Gold foil, 1 surface	Not a covered benefit	Tooth identification, Surface identification
D2420	Gold foil, 2 surfaces	Not a covered benefit	Tooth identification, Surface identification
D2430	Gold foil, 3 surfaces	Not a covered benefit	Tooth identification, Surface identification

CDT Code	Description of Service	Procedure Guidelines	Submission Requirements: Participating Providers
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CDT: Restorative Services

INLAY/ONLAY RESTORATIONS: inlay – an intra-coronal dental restoration, made outside the oral cavity to conform to the prepared cavity, which does not restore any cusp tips; onlay – a dental restoration made outside the oral cavity that covers one or more cusp tips and adjoining occlusal surfaces, but not the entire external surface.			
D2510	Inlay – metallic, 1 surfaces (D2140)	One per tooth per 5 years. Alternate benefit of comparable amalgam restoration.	Tooth identification, Surface identification
D2520	Inlay – metallic, 2 surfaces (D2150)	One per tooth per 5 years. Alternate benefit of comparable amalgam restoration.	Tooth identification, Surface identification
D2530	Inlay – metallic, 3 or more surfaces (D2160)	One per tooth per 5 years. Alternate benefit of comparable amalgam restoration.	Tooth identification, Surface identification
D2542	Onlay – metallic, 2 surfaces (D2150)	One per tooth per 5 years. Alternate benefit of comparable amalgam restoration.	Tooth identification Surface identification
D2543	Onlay – metallic, 3 surfaces	One per tooth per 5 years	Tooth identification, Surface identification
D2544	Onlay – metallic, 4 or more surfaces	One per tooth per 5 years	Tooth identification, Surface identification
D2610	Inlay – porcelain/ceramic, 1 surface (D2140)	One per tooth per 5 years. Alternate benefit of comparable amalgam restoration.	Tooth identification, Surface identification
D2620	Inlay – porcelain/ceramic, 2 surfaces (D2150)	One per tooth per 5 years. Alternate benefit of comparable amalgam restoration.	Tooth identification, Surface identification
D2630	Inlay – porcelain/ceramic, 3 or more surfaces (D2160)	One per tooth per 5 years. Alternate benefit of comparable amalgam restoration.	Tooth identification, Surface identification
D2642	Onlay – porcelain/ceramic, 2 surfaces (D2150)	One per tooth per 5 years. Alternate benefit of comparable amalgam restoration.	Tooth identification, Surface identification

Specific Benefit Limitations

Integral Services

The integral services below are considered part of another service. No additional allowance will be paid if they are billed as a separate service.

1. Supragingival scaling integral to a prophylaxis
2. Prophylaxis on the same day as a periodontal maintenance visit (D4910) or periodontal treatment, including surgery
3. Prophylaxis on the same day as a scaling and root planing (D4341, D4342), regardless of the number of quadrants or teeth reported
4. Sealants on the same day and same surface as a resin restoration
5. Periapical X-rays taken on the same day as a panorex (D0330)
6. Periapical X-rays and/or bitewings taken on the same day as a full series (D0210)
7. Adjunctive procedures that are integral to crowns, inlays and onlays
8. Intraoral I&D (D7510) with root canal therapy
9. A diagnostic X-ray taken the same day as the initial root canal therapy is covered.
10. Pulpotomies, in conjunction with root canal therapy by the same dentist within forty-five (45) days prior to root canal therapy completion date, are integral to root canal therapy.
11. Payment is made for the most extensive periodontal surgical procedure that includes any lesser procedures on the same date. If procedures are fragmented, the lesser procedure will be denied as integral.
12. Scaling and root planing on the same date as surgical periodontal procedures
13. Periodontal maintenance when reported with scaling and root planing on the same date regardless of the number of quadrants or teeth reported
14. Periodontal maintenance on the same day and same dentist as surgical periodontal procedures
15. Complete or partial denture adjustments within six months of insertion
16. Recementation of crowns and bridges when provided within twelve (12) months following insertion by the same dentist (unless there is an indication of root canal therapy) and then it is covered once per twelve (12) months thereafter
17. Temporary cementation of crowns or bridges
18. Frenulectomy (D7960) when provided the same date, by the same dentist, and to the same area of the mouth is integral to soft tissue grafts.
19. Apical curettage and small odontogenic cysts are denied as being integral to apicoectomies.
20. Rebasing/relining of full or partial denture within six months of insertion by the same dentist
21. Small cysts are denied as being integral to extractions and surgical procedures in the same area of the mouth by the same dentist
22. Crown lengthening on the same day by the same dentist and same area as osseous surgery. The osseous surgery will be denied as being integral to the crown lengthening.
23. Palliative emergency treatment is denied as being integral to definitive treatment when provided on the same day.
24. Myofunctional therapy involving exercise / physical therapy is integral to orthodontic treatment.
25. Isolation of tooth with rubber dam
26. Local and block anesthesia

Service Limitations

The following services are specifically limited with the following conditions:

1. Sealants (D1351) and preventive resin restorations (1352) are covered for dependent children through age fifteen (15) on permanent first and second molars, and are limited to one per three-year period (a sealant cannot replace a preventive resin restoration).

2. Cephalometric X-rays (D0340) are covered once per lifetime with all others denying as integral service. Cephalometric X-rays are not covered at all unless the member's schedule of benefits specifically indicates coverage for orthodontic services (Service Category D).
3. If the allowance for the combination of multiple periapicals, bitewings or full series of X-rays exceeds the allowance for a full series, they will be combined to a full series.
4. Vertical bitewing X-rays (seven [7] to eight [8] films, D0277) are paid with the same benefit limitations as four bitewing X-rays (D0274).
5. Sedative restorations (D2940) are allowed as palliative treatment in emergency situations, otherwise they deny as not covered.
6. An allowance is made for pins (D2951) per restoration regardless of the number used, and pins without a restoration are not covered.
7. A crown must be necessary on its own merit, not just because it will support a partial.
8. Scaling and root planing for patients under age nineteen (19) requires diagnostic material submission and a Dental Advisor review.
9. Separate restorations may be allowed on same surface for anterior teeth. Separate lines represent separate restorations. Procedures related to a restoration are not paid as separate, including repairs/replacements for twelve (12) months.
10. Multiple posterior restorations are paid as one multi-surface restoration when provided on the same day by the same dentist regardless of being reported as separate restorations.
11. Pins and/or posts reported, in addition to buildup or post and core, are combined to the buildup or post and core.
12. Buildups involving posts must be preceded by root canal therapy.
13. Incomplete endodontic therapy (Code D3332) of an inoperable or fractured tooth is covered by report.
14. Apicoectomies, in absence of root canal therapy, are denied unless the canals are calcified. Apicoectomy is not allowed within thirty (30) days of root canal therapy.
15. The final apexification visit includes root canal therapy. If billed separately, the root canal therapy will be combined to the final visit.
16. Pulpotomies are covered only on deciduous teeth, through age five (5) for teeth D – G and N- O and through age eleven (11) for teeth A-C, H-J, K-M and R-T.
17. Relining and rebasing of full or partial dentures on the same day and the same dentist merges to the rebase procedure. (D5710, D5711, D5720, D5721).
18. Surgical extractions (D7210) denied for lack of coverage remain denied if submitted as simple extractions (D7111, D7140) unless, on an inquiry basis, X-rays substantiate that it is a simple extraction.
19. Vestibuloplasty on the same day as other surgical procedures requires Dental Advisor review.
20. Periodontal maintenance is covered if:
 - a. The patient has periodontal coverage.
 - b. It follows active periodontal treatment.
 - c. A routine prophylaxis has not been allowed on the same day.
 - d. The number of periodontal maintenance and prophylaxis procedures does not exceed four per year.
21. Diagnostic X-rays are not covered if there is no documentation in the patient's records indicating why the radiographs were ordered and/or what was diagnosed by the dentist upon reviewing the prescribed films.
22. Root canal retreatment (D3346, D3347, and D3348) is allowed only if it has been three (3) years following initial root canal therapy.
23. Removable space maintainers (D1510, D1515) and maintainer repairs are limited to one (1) in a three (3) year period.

Excluded Services

The following services are specifically excluded with no coverage provided:

1. A service, procedure or supply that is not Dentally Necessary or is not listed in the Schedule of Benefits
2. A service, procedure or supply that is not prescribed or rendered by or under the general supervision of a dentist

3. Any treatment, service or supply received for any illness or accidental injury arising out of, or in the course of employment or occupation for wage, profit or gain, or for injury or illness for which the member receives any benefits from motor vehicle no-fault law, regardless of any limitations in scope or coverage amount that may apply to his benefits claim under such laws

In the event a claim is paid and subsequently the member files a claim for workers' compensation benefits as to such claim, or the member settles a workers' compensation claim with any workers' compensation carrier, or otherwise receives any amount toward payment of such a claim under the Arkansas Workers' Compensation Law, state or federal workers' compensation, employers' liability or occupational disease law, or motor vehicle no-fault law, the member agrees to reimburse monies to the full extent on such claim.

4. Conditions to which dental treatment is provided by a federal or state government agency (not including medical assistance) or are provided without cost to any member by a political subdivision or governmental authority (not including plans of insurance or other benefit plans provided by the federal or state governments to government employees and employees' dependents)
 5. Services of intentional self-inflicted injuries, including drug overdose, where act resulted from not medical condition (physical or mental)
 6. Disease contracted or injuries sustained while servicing in the military forces of any nation
 7. Any condition for which services, treatment or supplies of any kind are furnished or paid for under Title XVIII (Medicare) or the Social Security Act, as amended
 8. Services, procedures or supplies with respect to congenital mouth malformation or skeletal imbalance, including but not limited to:
 - a. Treatment related to disharmony of facial bone
 - b. Treatment related to or required as a result of orthognathic surgery
 9. Treatment, services or supplies that are cosmetic in nature or performed on an elective basis (e.g., teeth bleaching, crowns or veneers on teeth without decay or fracture which would otherwise not require a crown.)
 10. Restorative or prosthetic treatment necessitated by attrition, abrasion, or erosion.
 11. Prescription drugs
 12. Local or block anesthesia, when billed separately
 13. General anesthesia (D9220, D9221) or IV conscious sedation (D9241, D9242), for a non-covered service, as well as simple extractions, or routine chair-side procedures
 14. Any experimental or investigational services or supplies or for any condition or complication arising from or related to the use of such experimental or investigational services or supplies
- Arkansas Blue Cross shall have full discretion to determine whether a dental treatment is experimental or investigational. Any dental treatment may be deemed experimental or investigational if:
- a. Reliable evidence (as defined in the box below) shows that the majority opinion among experts, as stated in the published authoritative literature, regarding the dental treatment or procedure is that further studies or clinical trials are necessary to determine its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.
 - b. Reliable evidence shows that a majority opinion among experts, as stated in the published authoritative literature, regarding the dental treatment or procedure neither supports nor denies its use for a particular condition or disease.
 - c. Reliable evidence shows that the majority opinion among experts, as stated in the published authoritative literature, regarding the dental treatment or procedure should not be used as a first-line therapy for a particular condition or disease.

Reliable Evidence shall mean only:

- The member's dental records or other information from the treating Dentist(s) or from a consultant(s) regarding the member's dental history, treatment or condition;

- The written protocol(s) under which the treatment or procedure is provided to the member;
- Any consent document the member has executed or will be asked to execute, in order to receive the treatment or procedure;
- Published reports and articles in the authoritative dental and scientific literature, signed by or published in the name of a recognized dental expert, regarding the treatment or procedure at issue as applied to the injury, illness or condition at issue; or
- The written protocol(s) used by another facility studying substantially the same dental treatment or procedure

15. The cost to replace a lost, stolen or damaged prosthetic appliance
16. House calls (D9410) and hospital calls (D9420) for dental services
17. Services incurred prior to a member's effective date or after the termination date of coverage with Arkansas Blue Cross
18. Resorbable fillings (D3230, D3240) on endodontic treated deciduous teeth
19. Any dental or medical services performed by a physician for services covered or otherwise provided to the member by a medical-surgical plan 20. Services that the member incurs at no cost
21. Service that are necessitated by lack of patient cooperation or failure to follow a professionally prescribed treatment plan 22. Plaque control programs, oral hygiene or dietary instructions
23. Any procedure deemed by the Dental Advisor to be of questionable efficacy
24. Charges for broken appointments
25. Any dental services or supplies required as the result of any accidental or traumatic injury
26. Any dental services or supplies resulting from an injury or condition caused by another party
27. Dental procedures requiring appliances or restorations that are necessary for full mouth rehabilitation, the restoration of occlusion, or to alter vertical dimensions of occlusion (except when involving full or partial dentures)
28. Non-intravenous conscious sedation (D9248), analgesia, anxiolysis or inhalation of nitrous oxide (D9230)
29. Services by an immediate relative, defined as a spouse, parents, children, brother, sister or legal guardian of the person who received the services
30. Duplicate, interim and temporary procedures, devices and appliances (e.g., when a dentist begins a crown and places a temporary crown, and then submits charges for a permanent crown, coverage for the temporary crown will be denied.)
31. Procedures requiring the presence of a tooth will be denied if history indicates the tooth has been extracted (e.g., a crown is being reported and the tooth is listed as extracted in history).
32. Gold foil restorations (D2410, D2420, D2430)
33. If a course of treatment is performed by more than one (1) dentist, Arkansas Blue Cross will pay only the charges that would have been made by a single dentist for those services.
34. Charges for the completion of any insurance forms
35. Applications of desensitizing medicaments, sub-gingival irrigations, and the localized delivery of chemotherapeutic agents (D4381)
36. Double abutments unless there is demonstrated clinical need.
37. Post removal (not in conjunction with endodontic therapy)
38. Autogenous, allogenic or synthetic grafts placed in extraction sites
39. Periodontal provisional splinting, intra-coronal or extra-coronal
40. Any services to restore tooth structure lost in order to rebuild or maintain occlusal surfaces due to mal-aligned or mal-occluded teeth, lost from wear or for stabilizing the teeth
41. Silicate cements
42. Tissue conditioning (D5850, D5851)
43. Athletic mouth guards (D9941)

44. Precision attachments (D5862, D6950)
45. Gross debridement (D4355)
46. Fiberotomies (D7291)
47. X-ray and intraoral imaging (D0260, D0290, D0310, D0320, D0321, D0322, D0350)
48. Tests/laboratory examination (D0415, D0425, D0472, D0473, D0474, D0480, D0520)
49. Nutritional counseling (D1310)
50. Tobacco counseling (D1320)
51. Replacement of fillings due to mercury sensitivity
52. Prefabricated resin crowns, prefabricated esthetic coated crowns, stainless steel crowns or stainless steel crowns with resin windows for a primary tooth for patients age 14 or older
53. Pulpectomy on a permanent tooth
54. Extraoral I & D
55. Direct (D3110) and indirect (D3120) pulp caps
56. Procedure for isolation of tooth with rubber dam
57. Bleaching of teeth (D9972, D9973, & D9974)
58. Intentional re-implantation (D3470)
59. Dressing change (D4920)
60. Maxillofacial prosthetics
61. Precious metal for partial dentures
62. Partial dentures are not covered for patients under age 14.
63. Specialized procedures (D5862, D6920, D6940, D6950, D6975)
64. Alveoplasty involving less than 5 teeth
65. Tooth transplantation (D7272) or tooth re-implantation (D7270)
66. Excision/destruction of lesions (D7410, D741, D7412, D7413, D7414, D7415, D7440, D7441, D7450, D7451, D7460, D7461)
67. Treatment of simple and compound fractures (D7610 through D7580, D7710 through D7760, D7770, D7771, D7780)
68. Treatment and reduction of dislocation and management of TMJ/TMD (Temporomandibular Joint / Temporomandibular Joint Dysfunction) (D7810 through D7899) including diagnostic X-rays, occlusal appliance, and/or splints
69. Consultations (D9310)
70. Drugs, medicaments, and/or injections (D9610, D9630)
71. Behavior management (D9920)
72. Occlusal analysis (D9950) and occlusal adjustments (D9951, D9952)
73. Pulpotomy on permanent tooth will deny as not covered unless there is an indication of an emergency, in which case it is paid as a palliative treatment. (Not covered within 45 days of RCT)
74. Bridges for patients under age fourteen (14)
75. Replacement of teeth if there is insufficient space
76. Root recovery (D7250) not completely covered by bone, if provided by the same dentist who extracted the tooth
77. Splinted crowns not replacing teeth; abutment crown(s) can be allowed if the tooth is diseased or badly broken down
78. Gross pulpal debridement (D3221)
79. Distal or proximal wedge procedure (D4274)
80. Procedures performed prior to coverage or placed after termination of coverage

81. Palliative emergency treatment (D9110) when definitive treatment is provided by the same dentist on the same day
82. Protective restorations (D2940) Problem focused (D0170)
83. Oral surgery procedures for jaw deformities, resections, etc. (D7920, D7940, D7941, D7943, D7944, D7945, D7946, D7947, D7948, D7949, D7950, D7955, D7972, D7980, D7981, D7982, D7983, D7990, D7991, D7995, D7996, and D7997)
84. Apically positioned flap procedure (D4245)
85. Enamel microabrasion (D9970)
86. Odontoplasty (D9971)
87. Sleep apnea appliances
88. Biologic materials to aid in soft and osseous tissues regeneration (D4265)
89. Provisional pontic (D6253)
90. Provisional retainer crown (D6793)
91. Pediatric partial denture-fixed (D6785)
92. Mobilization of erupted or malpositioned tooth to aid eruption (D7282)
93. Cytology sample collection (D7287)
94. A panoramic film or panorex (D0330) is not covered for children under the age of five (5).
95. Fixed partial denture resin crowns, retainer or pontics on permanent teeth
96. Hospital facility fees for dental services
97. Biopsy of oral tissue (D7285, D7286)
98. Sutures of small wounds and complicated sutures (D7910, D7911, D7912)