**Important Contacts**

Questions Can Be Answered By: Premier Provider Relations Department (916) 920-2500 1-800-640-4466

Submit Claims To: Premier Access Insurance Company

1-800-640-4466

P. O. Box 659010

Sacramento, CA 95865-9010

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IMPORTANT NOTE

The coding and nomenclature listed in this manual is to be considered definitive. The code you select to report treatment should, in all respects, accurately reflect the procedure actually performed. It is fraud to misrepresent treatment on a paper or electronic claim by entering a code which does not accurately represent the procedure actually provided.

TIPS

1. The fact that a dental procedure appears in this manual does not mean that it is covered by an eligible patient’s Premier group program. Please refer to the patient’s Certificate of Insurance brochure for detailed coverage information, including exclusions and limitations.

2. Coverage of pedodontic care is limited to children 14 years of age and younger.

3. If you report treatment with a code number which is not listed in this section, Premier will select the closest Premier code, based on the description of service on the claim form.

4. When you cannot find a specific code in this manual, you should write a complete description of the procedure and clinical reason on the Attending Dentist’s Statement and enter the appropriate code for the category of unspecified procedure as shown below:

00999 Unspecified diagnostic procedure
01999 Unspecified preventive procedure
02999 Unspecified restorative procedure
03999 Unspecified endodontic procedure
04999 Unspecified periodontic procedure
05999 Unspecified removable prosthodontic procedure
06199 Unspecified implant procedure
06999 Unspecified fixed prosthodontic procedure
07999 Unspecified oral surgery procedure
08999 Unspecified orthodontic procedure
09999 Unspecified adjunctive procedure

The coding and nomenclature listed in this manual is to be considered definitive. The code you select to report treatment should, in all respects, accurately reflect the procedure actually performed. It is fraud to misrepresent treatment on a paper or electronic claim by entering a code which does not accurately represent the procedure actually provided.
**REQUIREDS DOCUMENTATION**

Determining What Types of Documentation to Submit:

Submitting unnecessary x-rays and other documentation can be costly and time-consuming for the dental office, and may actually delay processing of your claim. If you’re unsure whether your claim should be submitted with x-rays or charting, look for the following symbols in this handbook.

| X | X-ray documentation (mounted) must be submitted with claim. |
| P | Complete periodontal charting, including pocket depths, mobility, furcation involvements, missing teeth, gingival recession and mucogingival defects must be submitted with claim. Do not submit x-rays unless specifically requested. |

A summary of the documentation requirements is shown to the right. On occasion, a Premier Dental Consultant may deem it necessary, given the circumstances of a particular case, to request x-rays for procedures that are not on this list. X-ray documentation is requested only when absolutely necessary for determining benefits.

Submission of x-rays (X) or complete periodontal charting (P) is required for the following procedures:

### RESTORATIVE

| X | 02335 | Resin – four or more surfaces or involving incisal (anterior) |
| X | 02510-02652 | Inlays/onlays – metallic, porcelain/ceramic; composite/resin |
| X | 02710-02810 | Crowns – resin; cast |
| X | 02960-02962 | Labial veneers |

### ENDODONTICS

| X | 03000-03999 | Root canals |

### PERIODONTICS

| X | 04210-04222 | Gingivectomy or gingivoplasty/gingival curettage |
| X | 04240 | Gingival flap procedure, including root planing – per quadrant |
| P X | 04249 | Clinical crown lengthening – hard tissue |
| P | 04260 | Osseous surgery – per quadrant |
| P | 04270 | Pedicle soft tissue graft procedure |
| P | 04341 | Periodontal root planing – per quadrant |

### PROSTHODONTICS, FIXED

| X | 06520-06540 | Inlays/onlays |
| X | 06545 | Retainer – cast metal for resin bonded fixed prosthesis |
| X | 06750-06792 | Bridge retainers – crowns |

### ORAL SURGERY

| X | 07130 | Root removal – exposed roots |
| X | 07210-07250 | Surgical removal of erupted/impacted tooth, tooth roots |
| X | 07260-07281 | Other surgical procedures |
| X | 07450-07461 | Removal of odontogenic/nonodontogenic cyst or tumor |
| X | 07470-07490 | Excision of bone tissue |
| X | 07540 | Removal of foreign bodies – musculoskeletal system |
| X | 07550 | Sequestrectomy for osteomyelitis |
| X | 07560 | Maxillary sinusotomy |
| X | 07610-07680 | Simple fractures |
| X | 07710-07780 | Compound fractures |
| X | 07940-07949 | Osteoplasty/osteotomy/LeFort I, II and III |
| X | 07971 | Excision of pericoronal gingiva |
| X | 07980-07981 | Sialolithotomy/excision of salivary gland |
1. The purpose of any examination is to observe and record pertinent information, past and present, necessary to arrive at a diagnosis and treatment plan. All examinations are considered to be comprehensive in nature, and to extend to all treatment disciplines.

PROCEDURE 00110
Initial oral examination.

PROCEDURE 00120
Periodic oral evaluation.

PROCEDURE 00130
Emergency oral examination.

PROCEDURE 00140
Limited oral evaluation.

This procedure is an evaluation or re-evaluation limited to a specific oral health problem.

RADIOGRAPHS – GENERAL GUIDELINES

1. Page 2 of this handbook identifies each procedure for which x-ray documentation is requested (procedures requiring submission of x-rays are marked with an X). In general, you should submit x-rays, or copies of diagnostic quality, for review by Premier’s consultant staff only for the procedures marked in that manner. Occasionally a consultant will request submission of other films to clarify a specific case.

2. Film procedures include examination and diagnosis.

3. The fees submitted for any combination of intraoral x-rays (periapical, bitewing and panoramic films) in a single treatment series cannot exceed the accepted fee for a complete intraoral series (procedure 00210) in any twelve month period.

4. X-rays should be mounted and secured to the Attending Dentist’s Statement. The patient’s name and dentist’s license number should be indicated on the mounting.

5. X-ray films will not be returned to the dental office, unless specifically requested at the time of submission. The dental office should maintain a copy of the x-ray films in the original patient record. Premier is not responsible for lost x-ray films.

6. If you are returning a notice of prior-authorization to Premier for payment, you do not need to resubmit the x-rays unless you have made changes to, or additions to, the treatment plan.

7. Please do not send films to Premier separately from a treatment form except

   a. when specifically requested by a Premier consultant; or

   b. when you are asking for reevaluation. If you forget to enclose x-rays when you submit the attending Dentist’s Statement, please wait for Premier to request them.

PROCEDURE 00210
Intraoral – complete series (including bitewings).

1. A complete series consists of sufficient diagnostic films, including bitewings as necessary, to view the dental arches and immediate supporting structures.

2. This service is limited in most Premier programs to one complete series in a five-year period.

3. A panoramic film taken in conjunction with periapical or bitewing x-ray(s) is considered to be a complete intraoral series and should be submitted as such on the Attending Dentist’s Statement.

4. A panoramic film taken in conjunction with a complete intraoral series is not a separate benefit.

PROCEDURE 00220
Intraoral – periapical -- first film.
PROCEDURE 00230
Intraoral – periapical – each additional film.

PROCEDURE 00240
Intraoral – occlusal film.

PROCEDURE 00250
Extraoral – first film.

PROCEDURE 00260
Extraoral – each additional film.

PROCEDURE 00270
Bitewings – single film

PROCEDURE 00272
Bitewings – two films

PROCEDURE 00273
Bitewings – three films

PROCEDURE 00274
Bitewings – four films

BITEWINGS – GENERAL GUIDELINES
When bitewings are provided in conjunction with a panoramic film, all films are considered a complete intraoral series, and should be indicated as procedure 00210.

PROCEDURE 00310
Sialography.

Sialography is not a benefit of most Premier programs. The fee is the patient's responsibility.

PROCEDURE 00320
TMJ arthrogram including injection.

This service is not a benefit of most Premier programs. The fee is the patient's responsibility.

PROCEDURE 00321
Other TMJ films, by report.

This service is not a benefit of most Premier programs. The fee is the patient's responsibility.

PROCEDURE 00322
Tomographic survey.

1. This service is not a benefit of most Premier programs. The fee is the patient's responsibility.

2. CT scans and MRIs are not benefits of Premier programs. Such services should be indicated as procedure 00999.

PROCEDURE 00330
Panoramic film.

1. A panoramic film taken in conjunction with any bitewing or periapical film is considered a complete intraoral series, and should be indicated as procedure 00210.

2. A panoramic film taken in conjunction with a complete intraoral series is not a separate benefit.

PROCEDURE 00340
Cephalometric films.

If more than one cephalometric film is taken, please use a separate line of the Attending Dentist's Statement for each, and indicate a separate fee for each.

Cephalometric films are only a benefit for Premier members with orthodontic coverage.

TESTS AND LABORATORY EXAMINATIONS.

PROCEDURE 00415
Bacteriologic studies for determination of pathologic agents.

This service is not a benefit of most Premier programs.

PROCEDURE 00425
Caries susceptibility tests.

This service is not a benefit of most Premier programs.

PROCEDURE 00425
Caries susceptibility tests.

This service is not a benefit of most Premier programs.

PROCEDURE 00470
Diagnostic casts.

1. Most Premier programs provide benefits for diagnostic casts only when they are provided in conjunction with orthodontic service. When otherwise provided, their cost is the responsibility of the patient.

2. Impressions are considered part of, and included in the fee for, cast restorations and prosthetic appliances.

3. Please enter on the Attending Dentist's Statement a single, combined fee for the upper and lower casts.

4 Please do not send diagnostic casts to Premier unless they are specifically requested by a consultant.

PROCEDURE 00471
Diagnostic photographs.

When photographs are provided in connection with orthodontic services, the patient is responsible for the fee. Photographs taken in connection with services other than orthodontic procedures are considered part of, and included in the fees for, the other procedures.

PROCEDURE 00501
Histopathologic examinations.

Please attach the laboratory report to the Attending Dentist's Statement.

PROCEDURE 00999
Unspecified diagnostic procedure, by report.

Please enter a complete description of services on the Attending Dentist's Statement.
PREVENTIVE PROCEDURES (01000 – 01999)

**Procedure Codes**

**Dental prophylaxis**
- 01110 Prophylaxis - adult
- 01120 Prophylaxis - child to age 14

**Topical fluoride treatment (office procedure)**
- 01201 Topical application of fluoride (prophylaxis not included) - child to age 14
- 01203 Topical application of fluoride (prophylaxis not included) - child to age 14
- 01204 Topical application of fluoride (excluding prophylaxis) - adult
- 01205 Topical application of fluoride (including prophylaxis) - adult

**Other preventive services**
- 01310 Nutritional counseling for the control of dental disease
- 01330 Oral hygiene instruction
- 01351 Sealant - per tooth

**Space maintenance (passive appliances)**
- 01510 Space maintainer - fixed unilateral
- 01515 Space maintainer - fixed bilateral
- 01520 Space maintainer - removable unilateral
- 01525 Space maintainer - removable bilateral
- 01999 Unspecified preventive procedure, by report

**Guidelines**

**PROPHYLAXIS AND FLUORIDE TREATMENT - GENERAL GUIDELINES**

1. Prophylaxis is defined as scaling and polishing to include complete removal of calculus, soft deposits, plaque, stains and the smoothing of unattached tooth surfaces.

2. Benefits are limited to one prophylaxis and/or fluoride treatment in a 6-month period in most Premier programs. Some group purchasers have contracted for different limitations. Additional treatments are the patient’s responsibility.

3. Prophylaxis and fluoride treatment are included in procedure 04910 (periodontal maintenance procedures following active therapy/periodontal prophylaxis).

4. When topical application of fluoride is provided on the same date, or in the same treatment series as prophylaxis, it should be submitted as either procedure 01201 or 01205.

5. Fluoride rinses and other materials or appliances to be used by the patient for home care are not covered in Premier programs. They should be listed on the Attending Dentist’s Statement as procedure 01999.

6. The application of fluoride separate from prophylaxis is a benefit for caries control only.

7. The use of fluoride or other medicaments for desensitization should be listed on the Attending Dentist’s Statement as procedure 09910. Their use for microbial control should be listed as procedure 01999. These procedures are not benefits of Premier programs, and any fees are the patient’s responsibility.

**DENTAL PROPHYLAXIS**

**PROCEDURE 01110** Prophylaxis - adult

**PROCEDURE 01120** Prophylaxis - child to age 14.

**TOPICAL FLUORIDE TREATMENT (OFFICE PROCEDURE)**

**PROCEDURE 01201** Topical application of fluoride (prophylaxis not included) - child to age 14.

**PROCEDURE 01203** Topical application of fluoride (excluding prophylaxis) - child to age 14.

**PROCEDURE 01204** Topical application of fluoride (including prophylaxis) - adult.

**PROCEDURE 01205** Topical application of fluoride (including prophylaxis) - adult.

**OTHER PREVENTIVE SERVICES**

**PROCEDURE 01310** Nutritional counseling for the control of dental disease.

This procedure is not a benefit of most Premier programs.

**PROCEDURE 01330** Oral hygiene instruction.

This procedure is not a benefit of most Premier programs.

**PROCEDURE 01351** Sealant – per tooth.

1. Pit and fissure sealants are benefits of most Premier programs.

2. When sealants are covered, they are payable as Basic benefits. Programs that include sealants generally limit the benefit to permanent, non-caries, unrestored first and second molars to age 14. If otherwise provided, the patient is responsible for the fee.

3. Under some Premier group programs, there is a maximum
allowance payable per tooth, and the patient is responsible for the remainder of the allowed fees.

4. Please enter the tooth number and a separate fee for each sealant provided on individual lines of the Attending Dentist’s Statement.

5. The provision of sealants under a Premier program includes any reapplication within a three year period.

6. Special control programs such as oral hygiene instruction and nutritional counseling are not covered, and should be listed on the Attending Dentist’s Statement under code 01330 and 01310, respectively.

SPACE MAINTENANCE
(PASSIVE APPLIANCES)

PROCEDURE 01510
Space maintainer – fixed unilateral.
1. This service is defined as a unilateral space maintainer utilizing a stainless steel crown or band as the attachment for the loop or shoe.

2. The cost of the stainless steel crown or band is considered to be included in the total fee for the space maintainer.

3. Please indicate the space being maintained by identifying the quadrant in the column marked “tooth number” with an abbreviation (UR, UL, LR, LL).

PROCEDURE 01515
Space maintainer – fixed bilateral.

1. This procedure includes all necessary clasps.

2. Activating appliances are benefits only when the group program includes orthodontic coverage.

3. Please indicate the spaces being maintained by identifying the arch in the “tooth number” column with an abbreviation (UL, UR, LR, LL).

PROCEDURE 01520
Space maintainer – removable unilateral.

1. This procedure includes all necessary clasps.

2. Activating appliances are benefits only when the group program includes orthodontic coverage.

3. Please indicate the spaces being maintained by identifying the quadrant in the “tooth number” column with an abbreviation (UL, UR, LR, LL).

PROCEDURE 01525
Space maintainer – removable bilateral.

This procedure includes all necessary clasps.

1. This procedure includes all necessary clasps.

2. Activating appliances are benefits only when the group program includes orthodontic coverage.

Please indicate the spaces being maintained by identifying the arch in the “tooth number” column with an abbreviation (UL, UR, LR, LL).

PROCEDURE 01999
Unspecified preventive procedure, by report.

Please enter a complete description of the service and clinical reason on the Attending Dentist’s Statement.

– Submit x-rays only for procedures marked “X” –
### RESTORATIVE PROCEDURES (02000 – 02999)

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<td>02110 Amalgam – one surface, primary</td>
<td>1. Premier programs provide for restoration of tooth structure loss from caries. Restorations which are provided because of attrition, abrasion, erosion, wear, or for cosmetic purposes are considered optional services under most programs, and are the financial responsibility of the patient.</td>
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<td>02120 Amalgam – two surfaces, primary</td>
<td>2. When the restoration is of amalgam, silicate cement, or resin, the tooth surface(s) must be identified on the Attending Dentist’s Statement in the column marked “surfaces.” Please use the following abbreviations:</td>
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<td>B buccal</td>
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<td>02210 Silicate cement – per restoration</td>
<td>3. Allowance is made for a tooth surface once only in each episode of treatment, regardless of the number or combination of restorations placed thereon.</td>
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<td>02330 Resin – one surface, anterior</td>
<td>4. Replacement of otherwise satisfactory amalgam restorations is a benefit when allergy to mercury has been verified and documented by a medical specialist (allergist). Premier will make an allowance for corresponding amalgam restorations toward the cost of replacement when such Attending Dentist’s Statements are submitted with the required documentation.</td>
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<td>02751X Crown – porcelain fused to predominantly base metal</td>
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<td>02752X Crown – porcelain fused to noble metal</td>
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<td>02999 Unspecified restorative procedure, by report</td>
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*Submit x-rays only for procedures marked “X” –*
5. Replacement of amalgam or resin restorations in less than 12 months for patients up to age 19 and 36 months for patients 19 and over by the same dentist or by a dentist at the same location is not chargeable to Premier or to the patient except in extraordinary circumstances involving external violent and accidental means, recurrent caries or radiation therapy.

6. Fees for restorations include direct pulp capping (see procedure 03110 for additional information) and any material placed in a tooth as a base (or construed to be a base). A separate allowance for indirect pulp capping is made on for exposure or near exposure for the pulp, and only in the circumstances described in the explanation of procedure 03120.

7. Occlusal correction is considered to be part of the placing of multiple restorations involving occlusal surfaces.

8. The term “anterior” refers to the incisors and cuspid.

“Posterior” refers to bicuspids and molars.

AMALGAM RESTORATIONS (INCLUDING POLISHING)

PROCEDURE 02110
Amalgam – one surface, primary.

PROCEDURE 02120
Amalgam – two surfaces, primary.

PROCEDURE 02130
Amalgam – three surfaces, primary.

PROCEDURE 02131
Amalgam – four or more surfaces, primary.

PROCEDURE 02140
Amalgam – one surface, permanent.

PROCEDURE 02150
Amalgam – two surfaces, permanent.

PROCEDURE 02160
Amalgam – three surfaces, permanent.

PROCEDURE 02161
Amalgam – four or more surfaces, permanent.

SILICATE RESTORATIONS

PROCEDURE 02210
Silicate cement – per restoration.

FILLED OR UNFILLED RESIN RESTORATIONS

PROCEDURE 02330
Resin – anterior.

1. This procedure involves a single restoration on anterior teeth, which does not involve the incisal angle. For resin restorations on posterior teeth, please see procedures 02385 through 02387 for permanent teeth, and procedures 02380 through 02382 for primary teeth.

2. Proximal restorations in anterior teeth which do not involve the incisal angle (a DL restoration, for example) are considered single surface restorations. If the incisal angle is involved, see procedure 02335

3. Two separate restorations, such as a facial and lingual restorations on the same tooth, on the same date of service will be considered as one restoration with two or more surfaces.

4. The fee is considered to include all materials or techniques associated with placing the restoration.

PROCEDURE 02331
Resin – two surfaces, anterior.

1. This procedure involves a single restoration on anterior teeth, which does not involve the incisal angle. For resin restorations on posterior teeth, please see procedures 02385 through 02387 for permanent teeth, and procedures 02380 through 02382 for primary teeth.

2. Proximal restorations in anterior teeth which do not involve the incisal angle (a DL restoration, for example) are considered single surface restorations. If the incisal angle is involved, see procedure 02335

3. Two separate restorations, such as a facial and lingual restorations on the same tooth,
on the same date of service will be considered as one restoration with two or more surfaces.

4. The fee is considered to include all materials or techniques associated with placing the restoration.

PROCEDURE 02335 - X
Resin – four or more surfaces or involving incisal angle (anterior).

1. Please submit mounted x-ray.

2. This is a class IV restoration. The restoration replaces one or both incisal angles of an anterior tooth. When the incisal angle is not involved, use procedure 02330.

3. The fee is considered to include all materials or techniques associated with placing the restoration.

PROCEDURE 02380
Resin – one surface, posterior – primary.

PROCEDURE 02381
Resin – two surfaces, posterior – primary.

PROCEDURE 02382
Resin – three or more surfaces, posterior – primary.

PROCEDURE 02385
Resin – one surface, posterior – permanent.

PROCEDURE 02386
Resin – two surfaces, posterior – permanent.

PROCEDURE 02387
Resin – three or more surfaces, posterior – permanent.

INLAYS, ONLAYS, CROWNS – GENERAL GUIDELINES

1. Prior authorization is required for all cast unit restorations.

2. Crowns (including laminates) jackets and cast inlays and onlays are a benefit once in a five-year period in most Premier programs.

3. Tooth preparation, pulp caps, temporary restorations, cement bases, impressions, gingivectomy, gingival procedures and local anesthesia are considered components of, and included in the fee for, the complete restoration.

4. Occlusal correction is considered part of the placing of restorations involving occlusal surfaces.

5. Preparation of the gingival tissue for placing a crown is included in the fee for the crown.

6. When a crown is placed posterior to the maxillary first molar or the mandibular second bicuspid, porcelain, resin or similar materials are optional. Premier may make an allowance based on the dentist's fee for the corresponding full metal crown.

7. Premier programs provide for amalgam or resin restorations for treatment of caries. If the tooth can be restored with such material, any cast restoration, crown, partial crown, or jacket is considered optional. Premier will make an allowance for the corresponding amalgam or resin restoration. Restorations which are provided because of attrition, abrasion, erosion, wear or for cosmetic purposes are considered optional services, and are the financial responsibility of the patient.

8. Crowns on anterior teeth are not a benefit for children under 16 years of age. Premier may make an allowance for a prefabricated crown.

9. Amalgam or resin build-ups are considered part of the preparation for the complete restoration.

10. Provision of crowns includes any recementation or repair by the same dental office within twelve months.

11. Premier has adopted the system of classification and nomenclature for cast restorations set forth by the American Dental Association. The “noble metal” classification system permits a precise method of reporting various alloys used in fabricating the cast restoration, based on the percentage by weight of metals from the gold (Au) and platinum (Pt) groups.

<table>
<thead>
<tr>
<th>Noble Metal Classification and Required Percentage by Weight</th>
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| **Noble**: Noble metal content equal to or greater than 60% (gold, platinum, palladium) and gold equal to or greater than 40%.
| **High Noble**: Noble metal content equal to or greater than 25% (gold, platinum, palladium).
| **Predominantly Base**: Noble metal content less than 25% (gold, platinum, palladium). |

12. In the “date service performed” column of the Attending Dentist’s Statement, indicate the date the crown, jacket or cast inlay was permanently cemented. Impression dates should not be indicated unless specifically requested by Premier.

13. A crown is a benefit when at least four or more surfaces of the teeth have defects and at least one cusp is undermined (In case of anterior teeth, the incisal angle must be undermined).
INLAY RESTORATIONS

PROCEDURE 02510 - X
Inlay – metallic – one surface.

1. Please submit mounted x-ray.

2. Premier programs provide for amalgam, synthetic porcelain or resin restorations for treatment of caries if the tooth can be restored with such material. In such cases a metallic inlay is considered optional, and the fee is the responsibility of the patient. Premier will make an allowance for an amalgam restoration.

PROCEDURE 02520 - X
Inlay – metallic – two surfaces.

1. Please submit mounted x-ray.

2. See procedure 02510, item 2.

PROCEDURE 02530 - X
Inlay – metallic – three or more surfaces.

1. Please submit mounted x-ray.

2. This procedure is considered to involve the restoration of three or more surfaces.

3. See procedure 02510, item 2.

PROCEDURE 02540 - X
Onlay – metallic – per tooth (in addition to inlay)

1. Please submit mounted x-ray.

2. To qualify as an onlay, the preparation must extend onto the facial and/or lingual surface of the tooth.

3. On the Attending Dentist’s Statement please enter a fee for the onlay which is separate from the fee for the inlay. Enter the tooth number for the onlay.

PROCEDURE 02610 - X
Inlay – porcelain/ceramic – one surface.

1. Please submit mounted x-ray.

2. This procedure is not a benefit of Premier programs. When it is provided, an allowance may be made for the corresponding amalgam restoration or metallic inlay.

PROCEDURE 02620 - X
Inlay – porcelain/ceramic – two surfaces.

1. Please submit mounted x-ray.

2. This procedure is not a benefit of Premier programs. When it is provided, an allowance may be made for the corresponding amalgam restoration or metallic inlay.

PROCEDURE 02630 - X
Inlay – porcelain/ceramic – three or more surfaces.

1. Please submit mounted x-ray.

2. This procedure is not a benefit of Premier programs. When it is provided, an allowance may be made for the corresponding amalgam restoration or metallic inlay.

PROCEDURE 02650 - X
Inlay – composite/resin – one surface (laboratory processed)

1. Please submit mounted x-ray.

2. The procedure is considered a specialized technique and is not a benefit of Premier programs. When it is provided, an allowance may be made for the corresponding amalgam restoration or metallic inlay.

PROCEDURE 02651 - X
Inlay – composite/resin – two surfaces (laboratory processed).

1. Please submit mounted x-ray.

2. This procedure is considered a specialized technique and is not a benefit of Premier programs. When it is provided, an allowance may be made for the corresponding amalgam restoration or metallic inlay.

3. Fees for procedure 02510 are considered to incorporate any charge for onlay.

CROWNS – SINGLE RESTORATION ONLY

(See general guidelines for inlays, onlays and crowns, page 10.)

PROCEDURE 02710 - X
Crown – resin (laboratory).

1. Please submit mounted x-ray.

2. When a resin crown is used as a temporary restoration while the final restoration is being fabricated, it is not a separate benefit and should be included in the fee for the completed restoration.

3. When provided on children, “plastic” or “polycarbonate” crowns of a permanent nature,
routinely used for a fractured anterior tooth until a porcelain or other permanent restoration can be placed, should be indicated as procedure 02932.

**PROCEDURE 02740 - X**
Crown – porcelain/ceramic substrate.
1. Please submit mounted x-ray.

**PROCEDURE 02750 - X**
Crown – porcelain fused to high noble metal.
1. Please submit mounted x-ray.
2. Procedure 02750 is for a single restoration only. Please use procedure 06750 if the crown is part of a fixed prosthetic appliance.

**PROCEDURE 02751 - X**
Crown – porcelain fused to predominantly base metal.
1. Please submit mounted x-ray.
2. Procedure 02751 is for a single restoration only. Please use procedure 06751 if the crown is part of a fixed prosthetic appliance.

**PROCEDURE 02752 - X**
Crown – porcelain fused to noble metal.
1. Please submit mounted x-ray.
2. Procedure 02752 is for a single restoration only. Please use procedure 06752 if the crown is part of a fixed prosthetic appliance.

**PROCEDURE 02790 - X**
Crown – ¾ cast metallic.
1. Please submit mounted x-ray.
2. When metallic inlays and onlays are provided, see procedures 02510 through 02540.
3. Procedure 02810 is for a single restoration only. Please use procedure 06780 if the crown is part of a fixed prosthetic appliance.

**PROCEDURE 02810 - X**
Crown – ¾ cast metallic.
1. Please submit mounted x-ray.
2. Procedure 02810 is for a single restoration only. Please use procedure 06780 if the crown is part of a fixed prosthetic appliance.

**PROCEDURE 02910**
Recement inlay.
Please indicate the tooth number on the Attending Dentist’s Statement.

**PROCEDURE 02920**
Recement crown.

**PROCEDURE 02930**
Prefabricated stainless steel crown - primary tooth.

**PROCEDURE 02931**
Prefabricated stainless steel crown - permanent tooth

**PROCEDURE 02932**
Prefabricated resin crown.

**PROCEDURE 02933**
Prefabricated stainless steel crown - with resin window. This procedure is a benefit only on maxillary anterior teeth.

**PROCEDURE 02950**
Crown buildup (substructure), including any pins.
1. A build up under a crown is not a benefit. It is included in the fee for the crown.

**PROCEDURE 02951**
Pin retention - per tooth, in addition to restoration.
1. This procedure is for pin retention, per tooth, when necessary and when the final restoration is amalgam or resin.
2. Please indicate the tooth number and the fee on the Attending Dentist’s Statement on a separate line from the amalgam or resin restoration.
3. The fee is considered to apply per tooth, regardless of the number of pins placed.

**PROCEDURE 02952**
Cast post and core in addition to crown.
1. This procedure code applies to an individually fitted and specially cast post (including a core and coping) that is necessary for placement into the endodontically treated canal when the remaining tooth structure is insufficient for crown placement. Please describe the
service fully on the Attending Dentist’s Statement.

2. When the post is prefabricated, use procedure 02954.

3. As defined, the fee includes the post and any core (buildup/substructure).

**PROCEDURE 02954**
Prefabricated post and core in addition to crown.

1. This procedure code applies to commercial products such as screw posts, endo posts, Kurer anchors or crown savers, or any preformed post of any material or shape for placement into the endodontically treated canal for support.

2. As defined, the fee includes the post and any core (buildup/substructure).

**PROCEDURE 02960 - X**
Labial veneer (laminate) - chairside.

1. Please submit mounted x-ray.

   indicate the surface(s) restored.

2. The in-office application of a dental laminate with direct materials is a benefit only on permanent, anterior teeth, and is considered to be a Basic procedure, subject to all of the same limitations and exclusions as other anterior restorations.

3. By means of a contract rider, some groups may provide limited coverage for laminate veneers/partial crowns (and bleaching) for cosmetic correction of amelogenesis imperfecta, dentinogenesis imperfecta, congenitally missing anterior teeth, maxillary midline diastema, pegged lateral incisors, severe fluorosis and severe tetracycline staining. Benefits are limited to a lifetime maximum per patient.

4. Prior-authorization is required.

**PROCEDURE 02961 - X**
Labial veneer (resin laminate) - laboratory.

1. Please submit mounted x-ray.

2. Laminate/partial crowns are benefits only on permanent, anterior teeth, subject to all of the limitations and exclusions for crowns (see page 10 for Crowns - General Guidelines). In particular, laminate/partial crowns are not benefits when provided for purely cosmetic purposes, or to restore structure loss from wear, attrition or erosion.

3. Laminate/partial crowns are not benefits as abutments to acid-etch retained bridges.

4. See procedure 02960, item 3.

5. Prior-authorization is required.

**PROCEDURE 02962 - X**
Labial veneer (porcelain laminate) - laboratory.

1. Please submit mounted x-ray.

2. Laminate/partial crowns are benefits only on permanent, anterior teeth, subject to all of the limitations and exclusions for crowns (see page 10 for Crowns - General Guidelines). In particular, laminate/partial crowns are not benefits when provided for purely cosmetic purposes, or to restore structure loss from wear, attrition or erosion.

3. Laminate/partial crowns are not benefits as abutments of acid-etch retained bridges.

4. See procedure 02960, item 3.

5. Prior-authorization is required.

**PROCEDURE 02980**
Crown repair, by report.

Please write a report on the Attending Dentist's Statement of the nature of the repair. The allowance will be determined after evaluation by the Premier consultant staff.

**PROCEDURE 02999**
Unspecified restorative procedure, by report.

Please enter a complete description of service and clinical reason on the Attending Dentist’s Statement.
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<td>PROCEDURE 03110 Pulp cap - direct (excluding final restoration).</td>
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| Pulpotomy | 03220 Therapeutic pulpotomy (excluding final restoration) |

| Root canal therapy (including treatment plan, clinical procedures and follow-up care) | 03310X Root canal therapy – anterior (excluding final restoration) |
| 03320X Root canal therapy – bicuspid (excluding final restoration) | 03330X Root canal therapy – molar (excluding final restoration) |
| 03350X Apexitification/ recalcification-per treatment visit (includes apical closure/calcific repair of perforations root resorption, etc.) |

| Periapical services | 03410X Apicoectomy/periradicular surgery - anterior |
| 03421X Apicoectomy/periradicular surgery - bicuspid (first root) | 03425X Apicoectomy/periradicular surgery - molar (first root) |
| 03426 Apicoectomy/periradicular surgery (each additional root) | 03430X Retrograde filling - per root |
| 03450 Root amputation - per root | 03460P Endodontic endosseous implant |

| Other endodontic procedures | 03920 Hemisection (including any root removal), not including root canal therapy |
| 03960 Bleaching of discolored tooth | 03999 Unspecified endodontic procedure, by report |

3. The fee is considered to include all materials associated with providing the indirect pulp cap, including any temporary restoration.

**PULPOTOMY**

PROCEDURE 03220 Therapeutic pulpotomy (excluding final restoration).

This procedure is considered part of, and included in the fee for the complete endodontic treatment.

1. This is not a benefit for adults. If no other treatment is provided, this is payable as procedure 09110.

2. For children, pre-operative and post-operative x-rays are covered if required.

**ROOT CANAL THERAPY (INCLUDING TREATMENT PLAN, CLINICAL PROCEDURES, AND FOLLOW-UP CARE)**

**ROOT CANAL THERAPY-GENERAL GUIDELINES**

1. Test films taken as part of root canal therapy are considered part of, and included in the fee for, the complete endodontic procedure.

2. The initial opening into the canal and routing post-operative visits are considered part of, and included in the fee for, completed endodontic treatment.

3. Incomplete endodontic treatment is not a benefit of Premier programs. In the date of service column of the Attending Dentist’s Statement, please indicate the date that the treatment was completed.
endodontic treatment was completed.

4. When endodontic treatment is provided in conjunction with overdentures, please give full details in the description of service section of the Attending Dentist’s Statement.

5. A final x-ray must be submitted with the claim.

6. Premier and the patient are not responsible for payment toward unacceptable root canal procedures.

7. An acceptable root canal treatment is one that the final film indicates a dense filling of the apical 1/3 within 1.5 mm of the apex of each root.

PROCEDURE 03310 - X
Root canal therapy - anterior (excluding final restoration).

1. Final film required.

PROCEDURE 03320 - X
Root canal therapy - bicuspid (excluding final restoration).

1. Final film required.

PROCEDURE 03330 - X
Root canal therapy - molar (excluding final restoration).

1. Final film required.

PROCEDURE 03350 - X
Apexification/recalcification - per treatment visit (includes apical closure/calciﬁc repair of perforations, root resorption, etc.).

1. Final film required.

2. This service does not include the final root canal filling.

PERIAPICAL SERVICES

PROCEDURE 03410
Apicoectomy/periradicular surgery - anterior.

1. This service is defined as the excision of the apical portion of the root of a previously endodontically treated anterior tooth to remove diseased periapical tissue.

2. This service is considered part of, and included in the fee for, osseous surgery (procedure 04260).

3. For retrograde filling, see procedure 03430.

PROCEDURE 03421
Apicoectomy/periradicular surgery - bicuspid (first root).

1. This service is defined as the excision of the apical portion of the root of a previously endodontically treated bicuspid to remove diseased periapical tissue.

2. This service is considered part of, and included in the fee for, osseous surgery (procedure 04260).

3. For retrograde filling, see procedure 03430.

4. For additional roots, see procedure 03426.

PROCEDURE 03425
Apicoectomy/periradicular surgery - molar (first root).

1. This service is defined as the excision of the apical portion of the root of a previously endodontically treated molar to remove diseased periapical tissue.

2. This service is considered part of, and included in the fee for, osseous surgery (procedure 04260).

3. For retrograde filling, see procedure 03430.

4. For additional roots, see procedure 03426.

PROCEDURE 03426
Apicoectomy/periradicular surgery (each additional root).

1. Please submit an operative report. The consultant staff will determine Premier’s allowance.

2. When more than one additional root is involved, please use a separate line of the Attending Dentist’s Statements for each additional root, and indicate the tooth number.

PROCEDURE 03430
Retrograde filling - per root, in addition to Apicoectomy/periradicular surgery.

When more than one root is involved, please submit a mounted x-ray for review by Premier’s consultant staff, and use a separate line for the Attending Dentist’s Statement for each root.

PROCEDURE 03450
Root amputation - per root.

1. Please indicate tooth number, description of service and the fee on the appropriate line of the Attending Dentist’s Statement. Endodontic treatment, if any, should be indicated separately.

2. This service is considered part of, and included in the fee for, osseous surgery (procedure 04260).

PROCEDURE 03460 - X
Endodontic endosseous implant.

1. Please submit mounted x-rays.

2. Authorization is required. Premier will not pay for implant procedures which are provided without obtaining the required authorization.

3. See “Implants - general guidelines” in this section of the handbook, immediately preceding procedure 06030.
4. Implants are not benefits of most Premier programs

5. Procedure 03460 describes a smooth and/or threaded pin implant which extends through the root canal into periapical bone to stabilize a mobile tooth.

OTHER ENDODONTIC PROCEDURES

PROCEDURE 03920
Hemisection (including any root removal), not including root canal therapy.

1. Please indicate tooth number, description of service and the fee on one line of the Attending Dentist’s Statement. Endodontic treatment, if any, should be indicated separately.

2. This service is considered part of, and included in the fee for, osseous surgery, (procedure 04260).

PROCEDURE 03960
Bleaching of discolored tooth.

1. Bleaching is not a benefit of Premier programs, and is the financial responsibility of the patient.

PROCEDURE 03999
Unspecified endodontic procedure, by report.

Please enter a complete description of service and clinical reason on the Attending Dentist’s Statement.
### PERIODONTIC PROCEDURES (04000 – 04999)

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1. **Please submit complete periodontal charting.**
   Reporting of procedure 04210 requires the submission of a complete periodontal charting which indicate 4 isolated pockets of 5mm or more.

2. Placement or surgical repair of implants is a benefit only after 5 years.

3. These surgical procedures are directed at correction of the soft tissue around the tooth. Gingivectomy is the excision of the soft tissue wall of the periodontal pocket when the pocket is uncomplicated by extension into the underlying bone. Gingivoplasty is the procedure by which gingival deformities (particularly enlargements) are reshaped and reduced to create normal and functional form. Procedure 04210 is considered to include any frenectomy and/or distal wedge performed in the same are on the same case.

4. Root planing performed in the same quadrant as procedure 04210 must precede the surgery by at least four weeks. When the interval between the procedure is less than four weeks, the root planing is considered to be included in the fee for the surgery.

5. Procedure 04210 is considered to include three months postoperative care and any surgical re-entry for three years. Exceptional cases will be given consideration on a by report basis.

6. Please indicate the quadrant treated by abbreviation (UR, URL, LL, LR) in the column marked “tooth number” on the Attending Dentist’s Statement. Use the tooth chart on the Attending Dentist’s Statement to

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**SURGICAL SERVICES (INCLUDING USUAL POST-OPTERATIVE SERVICES)**

**PROCEDURE 04210 - P**
Gingivectomy or gingivoplasty - per quadrant.

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- Submit x-rays only for procedures marked “X” and submit full periodontal charting for procedures marked “P” –
indicate missing teeth, circling the surgical area(s). When fewer than six teeth are involved in a quadrant, the Premier consultant staff will determine the allowances based on a portion of the fee for a full quadrant. Use one line of the treatment form for each quadrant and enter a separate fee for each quadrant.

7. A quadrant is considered to include at least six teeth. When only one tooth is involved in a quadrant, see procedure 04211. When more than one tooth is involved in a quadrant, the Premier consultant staff will make an allowance based on a portion of the fee for procedure 04210. Generally, the allowance for two or three teeth will be up to one half of the full quadrant fee; up to two-thirds for four teeth; and up to five-sixths for five teeth.

PROCEDURE 04211 - P
Gingivectomy or gingivoplasty - single tooth.

1. Please submit complete periodontal charting. Reporting of procedure 04211 requires the submission of a complete periodontal charting which indicate at least 5 to 6 mm pockets, early bone loss, and a definite case type diagnosis and treatment plan. Use the tooth chart on the Attending Dentist’s Statement to indicate missing teeth, circling the surgical area(s).

2. Procedure 04211 is considered to include any frenectomy provided in the same area on the same date.

3. Procedure 04211 is considered to include three months postoperative care and any surgical re-entry for three years. Exceptional cases will be given consideration on a by report basis.

4. Gingivectomy provided in association with the preparation of a crown or other restoration is included in the fee for the restoration.

5. Procedure 04211 is for use when only one tooth is involved in a quadrant. When more than one tooth is involved in a quadrant, the gingivectomy or gingivoplasty should be submitted as procedure 04210. See procedure 04210, item 6, for information on determining allowances when fewer than six teeth are involved in a quadrant.

PROCEDURE 04220 - P
Gingival curettage, surgical - per quadrant, narrative report required.

1. Please submit complete periodontal charting. Reporting of procedure 04220 requires the submission of a complete periodontal charting which indicate at least 5 to 6 mm pockets, early bone loss, and a definitive case type diagnosis and treatment plan. Use the tooth chart on the Attending Dentist’s Statement to indicate missing teeth, circling the surgical area(s). If more than two quadrants are done in one appointment, a narrative report will be required.

2. Gingival curettage, surgical, is defined as a definitive surgical procedure involving removal of the sulcular wall (crevicular or sulcular epithelium). This service, usually performed under local anesthesia, includes the removal of dental calculus, other pocket debris, residual granulation tissue and the judicious smoothing of the cementum/dentin.

3. Please indicate the quadrant treated by abbreviation (UR, UL, LL, LR) in the column marked “tooth number” on the Attending Dentist’s Statement. Use one line of the treatment form for each quadrant and enter a separate fee for each quadrant.

4. Procedure 04220 would not be performed on the same date as procedures 01110 through 01205, periodontal root planing (procedure 04341) or periodontal maintenance procedures (procedure 04910).

5. Procedure 04220 is considered to include three months postoperative care and any surgical re-entry for three years.

6. Since surgical re-entry is included for three years, procedure 04220 would generally not be used preceding or following other surgical procedures on the same teeth. Cases involving extraordinary circumstances may be submitted by report.

7. By definition, procedure 04220 would not precede or follow non-surgical periodontal root planing, per quadrant.

PROCEDURE 04240 - P
Gingival flap procedure, including root planing - per quadrant.

1. Please submit complete periodontal charting. Reporting of procedure 04240 requires the submission of a complete periodontal charting which indicate at least case type II periodontal disease 5 to 6 mm pockets, early bone loss, and a definitive case type diagnosis and treatment plan. Use the tooth chart on the Attending Dentist’s Statement to indicate missing teeth, circling the surgical area(s). When fewer than six teeth are involved in a quadrant, the Premier consultant staff will determine the allowances based on a portion of the fee for a full quadrant.

– Submit x-rays only for procedures marked “X” and submit full periodontal charting for procedures marked “P” –
2. Similar to gingival curettage, surgical (procedure 04220), the gingival flap procedure facilitates access via resection and retraction of a soft tissue flap. When different periodontal surgical procedures are provided in any 36-month period in the same quadrant, the total approved (benefits) will be based upon the full quadrant fee for the “most inclusive procedure.”

3. Please indicate the quadrant treated by abbreviation (UR, UL, LL, LR) in the column marked “tooth number” on the Attending Dentist’s Statement. Use one line of the treatment form for each quadrant and enter a separate fee for each quadrant.

4. Procedure 04240 is considered to include any frenectomy and/or distal wedge performed in the same area on the same date.

5. Procedure 04240 would not be performed on the same date as procedures 01110 through 01205, periodontal root planing (procedure 04341) or periodontal maintenance procedures (procedure 04910).

6. Procedure 04240 is considered to include three months post-operative care and any surgical re-entry for three years.

7. Since surgical re-entry is included for three years, procedure 04240 would generally not be used preceding or following other periodontal surgical procedures on the same teeth.

8. By definition, procedure 04240 includes root planing and therefore would not precede or follow non-surgical root planing, per quadrant.

9. Periodontal root planing usually would not be performed until 36 months after surgery in the same area.

**PROCEDURE 04249 - X**
Clinical crown lengthening – hard tissue.

1. **Please submit a mounted x-ray and narrative report.** Indicate the tooth or teeth involved. The allowance will be determined following review by the Premier consultant staff.

2. **This procedure is carried out to expose sound tooth structure, facilitating restorative procedures.** It is not generally provided in the presence of periodontal disease.

3. **Preparation involving only soft tissue prior to placing a crown or other restoration is considered to be included in the fee for the restoration.**

4. **Crown lengthening for cosmetic purposes or to correct congenital or developmental defects is not a benefit of Premier programs.** The fee is the patient’s responsibility.

5. When performed in conjunction with other osseous periodontal surgery, crown lengthening is considered part of, and included in the fee for, the more inclusive surgery.

6. Procedure 04249 is considered to include any distal wedge performed in the same area on the same date.

**PROCEDURE 04250 - PX**
Mucogingival surgery - per quadrant

1. **Procedure 04250 is defined as plastic surgery to correct gingival deformities.** It is not provided in the presence of periodontal disease. It is not a benefit when performed for cosmetic purposes.

2. Please provide a narrative report indicating the rationale for this procedure. Please report indications and site(s) involved. Reporting of procedure 04250 requires the submission of a complete periodontal charting. Use the tooth chart to indicate missing teeth circling the surgical area(s). A quadrant is considered to include at least six teeth. When fewer than six teeth are involved in a quadrant, the Premier consultant staff will make an allowance based on a portion of the fee for a full quadrant. Generally, the allowance for from one to three teeth will be up to one-half of the full quadrant fee; up to two-thirds for four teeth; and up to five-sixths for five teeth.

3. **Procedure 04250 is considered to include any frenectomy and/or distal wedge performed in the same area on the same date.**

4. **Procedure 04250 does not include pedicle or free soft tissue grafts.** Refer to procedures 04270 and 04271.

5. When mucogingival procedures and osseous surgery are performed in the same quadrant and in the same treatment episode, the procedure code for the most inclusive procedure is appropriate for the quadrant.

**PROCEDURE 04260 - PX**
Osseous surgery (including flap entry, bone grafts, guided tissue regeneration and closure) - per quadrant

1. **Please submit complete periodontal charting.** Reporting of procedure 04260 requires the submission of a complete periodontal charting which indicate at least case type III periodontal disease 5 to 8 mm pockets, moderate to severe bone loss) and a definitive case type diagnosis and treatment plan.
2. The purpose of this periodontal surgery is to eliminate the pockets by means of eradication or new attachment. The implication in this procedure is that having made a flap entry, the dentist will complete all procedures necessary to achieve that purpose. Therefore, any osseous contouring, including removal of exostosis, hemisections, extractions, root amputations, frenectomy, any new attachment procedures, apicoectomies, curettage, guided tissue regeneration, root planing and grafting are considered merely the variations of treatment open to the dentist who elects to perform and report procedures under code 04260. If there is a combination of procedures in one quadrant (e.g. buccal flap procedure, gingivectomy on lingual surfaces), then the most inclusive procedure 04260 is listed. Osseous surgery of less than usual involvement should require a lesser than usual fee.

3. This procedure is considered to include three months postoperative care and any surgical re-entry for three years.

4. Root planing performed in the same quadrant as osseous surgery must precede the surgery by at least four weeks. When the interval between the procedures is less than four weeks, the root planing is considered to be included in the fee for the surgery.

5. Procedure 04260 is considered to include any osseous contouring, distal or proximal wedge surgery, frenectomy, bone grafts, guided tissue regeneration, curettage or scaling, root planing, soft tissue grafts, gingivectomy and flap procedures.

6. When mucogingival procedures and osseous surgery are performed in the same quadrant and in the same treatment episode, the procedure code for the most inclusive procedure is appropriate for the quadrant.

**PROCEDURE 04270 - P**

Pedicle soft tissue graft procedure.

1. **Please submit complete periodontal charting.** Reporting of procedure 04270 requires the submission of a complete periodontal charting.

2. **Allowances for this procedure are made by site.** A site consists of up to two adjacent diseased teeth which may cross the midline. When pedicle grafts are provided within a single quadrant, each procedure is limited to two sites per quadrant with a maximum allowance not to exceed the full quadrant allowance for osseous surgery.

3. **This procedure is considered to include three months postoperative care and any surgical re-entry for three years.**

4. Use of procedure code 04270 is appropriate only when the procedure is not performed in conjunction with any other periodontal services in the same area. When other periodontal services are involved, this service is considered to be part of, and included in the fee for, the most inclusive service.

5. Procedure 04270 is not a benefit when performed for cosmetic purposes.

6. Procedure 04270 is considered to include any frenectomy and/or distal wedge performed in the same area on the same date.

**PROCEDURE 04271 - P**

Free soft tissue graft procedure (including donor site surgery).

1. **Please submit complete periodontal charting.** This procedure includes subepithelial connective tissue grafts and is considered to include three months postoperative care and any surgical re-entry for three years. Exceptional cases will be given consideration on a by report* basis.

2. Use of procedure code 04271 is appropriate only when the procedure is not performed in conjunction with any other periodontal services in the same area. When other periodontal services are involved, this service is considered to be part of, and included in the fee for, the most inclusive service.

3. Please enter the tooth number on the Attending Dentist’s Statement and circle the treatment site(s) on the tooth chart. Also, please provide complete periodontal charting showing the areas of gingival recession and any mucogingival defects and the surgical rationale for review by Premier’s consultant staff. Premier’s allowance is made on a per tooth basis. Limited to two sites per quadrant up to full allowance for Procedure 04260. Not covered for cosmetic reasons. Benefits are provided for specific teeth which exhibit mucogingival defects.

4. Procedure 04271 is not a benefit when performed for cosmetic purposes. The fee is the responsibility of the patient.

5. Procedure 04271 is considered to include any frenectomy and/or distal wedge performed in the same area on the same date.
ADJUNCTIVE
PERIODONTAL SERVICES

PROCEDURE 04320
Provisional splinting – intracoronal.
1. Temporary tooth stabilization is not a benefit of Premier programs.

PROCEDURE 04321
Provisional splinting – extracoronal.
1. Temporary tooth stabilization is not a benefit of Premier programs.

PROCEDURE 04341 - P
Periodontal root planing – per quadrant.
1. Please submit complete periodontal charting.

Reporting of procedure 04341 requires the submission of clearly diagnostic radiographs and complete periodontal charting which indicate at least case type II periodontal disease (5 to 6 mm pockets, early bone loss) and a definitive case type diagnosis and treatment plan.

2. Periodontal root planing is defined as a definitive non-surgical periodontal treatment involving the judicious and thorough planing of the root surface.

3. This service is not prophylaxis and scaling – see procedure 01110.

4. Please indicate the quadrant treated by abbreviation (UR, UL, LL, LR) in the column marked "tooth number" on the Attending Dentist's Statement. Use the tooth chart on the Attending Dentist's Statement to indicate missing teeth, circling the surgical area(s). Use one line of the treatment form for each quadrant, and enter a separate fee for each quadrant.

5. Periodontal root planing is generally not appropriate on the same date as procedures 01110 through 01205, gingival curettage, surgical (04220), gingival flap procedure (04240) osseous surgery (04260) or periodontal maintenance procedures (04910).

6. Root planing as reported under procedure 04341 is generally not appropriate in the same area for at least 24 months following completion of the active treatment phase. It is expected that the active treatment phase will be completed within three months of beginning therapy. For any necessary follow-up root planing, see procedure 04910.

7. Periodontal root planing would generally not be used until after 36 months following active periodontal surgery in the same areas. See procedure 04910.

8. This service may precede surgical services 04210, 04211, and 04260 after sufficient time (no less than four weeks) has elapsed to evaluate the tissue response. By definition, this non-surgical procedure would not precede or follow gingival curettage, surgical (04220) or gingival flap procedures (04240).

9. Post-operative visits and treatment for the three months following root planing and all surgical periodontal services are considered part of, and included in the fee for, the root planing or surgical procedure.

10. Procedure 04341 is a benefit only when a minimum of 3 teeth which indicate case type II or greater periodontal disease are present in a quadrant. When fewer than 6 teeth in the full mouth indicate case type II or greater periodontal disease, allowance for periodontal root planing is limited to not more than one quadrant.

OTHER PERIODONTAL SERVICES

PROCEDURE 04910
Periodontal maintenance procedures following active therapy (periodontal prophylaxis). Procedure 04910 must be preceded by periodontal surgery or root planing 04341.

1. Please provide the dates, areas treated and the type of previous periodontal treatment performed on the Attending Dentist's Statement.

2. Periodontal maintenance procedures (periodontal prophylaxis) may be used in those cases in which a patient has completed active periodontal therapy, and commencing no sooner than three months thereafter. The procedure includes any examination for evaluation, curettage, root planing and/or polishing as may be necessary.

3. Post-operative visits and treatment for the three months following root planing and all surgical periodontal services are considered part of, and included in the fee for, the root planing or surgical procedure.

4. After the initial three-month post-operative period, periodontal maintenance procedures, alone or in combination with other prophylaxis and/or fluoride procedures, are subject to the same contractual limitations as with prophylaxis treatments, generally two in 12 months. Additional treatments are the responsibility of the patient.
**NOTE:** Please refer to a patient's Premier Certificate of Insurance to determine covered services and supplies, exclusions and limitations for an individual patient.

**PROCEDURE 04920**
Unscheduled dressing change (by someone other than treating dentist).

1. Unscheduled dressing changes by the same dentist, or by a dentist at the same location, are considered part of, and included in the fees for, periodontal surgery.

2. When performed by a different dentist at some other location, please provide a brief narrative report citing the circumstances.

**PROCEDURE 04999**
Unspecified periodontal procedure, by report. Please enter a complete description of services and clinical reason on the Attending Dentist's Statement.
EXAMPLES OF REPORTING OF PERIODONTAL SERVICES.

Presented here are examples of periodontal case presentation on the Attending Dentist’s Statement. For case types II, III, IV and V, a complete periodontal chart indicating missing teeth and circling treatment areas must be included. Benefits are based on the extent of the area treated.

<table>
<thead>
<tr>
<th>Case Type I</th>
<th>Case Type II</th>
<th>Case Type III</th>
<th>Case Type IV</th>
<th>Case Type V</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identification of teeth with ‘x’</td>
<td>Pocket markings attached</td>
<td>Examination and treatment plan</td>
<td>Examination and treatment plan</td>
<td>Pocket markings attached</td>
</tr>
<tr>
<td>(including x-rays, prophylaxis, materials used, etc.)</td>
<td></td>
<td>2</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td>(including x-rays, prophylaxis, materials used, etc.)</td>
<td></td>
<td>2</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td>(including x-rays, prophylaxis, materials used, etc.)</td>
<td></td>
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</tr>
<tr>
<td>Pocket markings attached</td>
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<tr>
<td>Pocket markings attached</td>
<td></td>
<td>2</td>
<td>7</td>
<td>10</td>
</tr>
</tbody>
</table>

Type I – No Periodontal Services.

Type II – Case type identified, missing teeth charted, documentation attached, quadrants listed

Type III – Case type identified, surgical areas circled and missing teeth charted, documentation attached, 09952 and 04321 not benefits of most programs.

Type IV – Case type identified, surgical areas circled and missing teeth charted, documentation and narrative report attached, 04260 minimum of four weeks following root

Type V – Case type identified, surgical areas circled and missing teeth charted, documentation and narrative report attached, 04260 minimum of four weeks following root
<table>
<thead>
<tr>
<th>CASE TYPES</th>
<th>CASE TYPE I</th>
<th>CASE TYPE II</th>
<th>CASE TYPE III</th>
<th>CASE TYPE IV</th>
<th>CASE TYPE V</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical description</td>
<td>Inflammation of the gingiva, characterized clinically by hyperplasia, edema, reactivity, gingival pocket formation, pocket depth less than 5 mm and no bone loss</td>
<td>Progression of gingival inflammation into the alveolar bone crest and early bone loss resulting in moderate pocket formation (5 to 6 mm).</td>
<td>More advanced state of previous Type, with increased destruction of periodontal structures and moderate-to-deep pockets (5 to 8 mm), moderate-to-severe bone loss and tooth mobility.</td>
<td>Further progression of periodontitis with severe destruction of the periodontal structures with increased pocket depth, usually greater than 7 to 8 mm with increased tooth mobility.</td>
<td>Continued demonstration of numerous sites of periodontitis where loss of attachment is progressing, even after traditional therapy has been completed and good home care is evident.</td>
</tr>
<tr>
<td>Generally applicable treatment procedures (exceptions considered by report with complete documentation)</td>
<td>Non-Surgical 01110 − Prophylaxis 01205 − Prophylaxis with fluoride</td>
<td>Non-Surgical 01110 − Prophylaxis 01205 − Prophylaxis with fluoride 04341 − Root planing 04910 − Periodontal maintenance procedures (periodontal prophylaxis)</td>
<td>Surgical 04210 − Gingivectomy per quadrant 04211 − Gingivectomy single tooth 04220 − Gingival curettage 04240 − Gingival flap procedure</td>
<td>Non-Surgical 01110 − Prophylaxis 01205 − Prophylaxis with fluoride 04341 − Root planing 04910 − Periodontal maintenance procedures (periodontal prophylaxis)</td>
<td>Non-Surgical 01110 − Prophylaxis 01205 − Prophylaxis with fluoride 04341 − Root planing 04910 − Periodontal maintenance procedures (periodontal prophylaxis)</td>
</tr>
<tr>
<td>Premier contractual payment limitations</td>
<td>Generally, two prophylaxes or prophylaxes with fluoride singly or in combination, in any 12 month period. Additional prophylaxes are the responsibility of the patient.</td>
<td>Generally, two prophylaxes, prophylaxes with fluoride or periodontal prophylaxes singly or in combination, in any 12 month period. (Periodontal maintenance at least 90 days after completion of active periodontal therapy.) Additional treatment is the responsibility of the patient.</td>
<td>Generally, two prophylaxes, prophylaxes with fluoride or periodontal prophylaxes singly or in combination, in any 12 month period. (Periodontal maintenance at least 90 days after completion of active periodontal therapy.) Additional treatment is the responsibility of the patient.</td>
<td>Generally, two prophylaxes, prophylaxes with fluoride or periodontal prophylaxes singly or in combination, in any 12 month period. (Periodontal maintenance at least 90 days after completion of active periodontal therapy.) Additional treatment is the responsibility of the patient.</td>
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</tr>
<tr>
<td>Additional guidelines which are generally applicable</td>
<td>Up to four quadrants of root planing during active treatment phase based on diagnosis and documentation. Any necessary root planing for 24 months thereafter is usually included under periodontal maintenance procedures (periodontal prophylaxis). Gingivectomy, gingival curettage or gingival flap procedures, as appropriate with documentation. (Surgical curettage by definition would not precede or follow non-surgical root planing, nor would it precede or follow other surgical pocket reduction procedures.)</td>
<td>Up to four quadrants of root planing during active treatment phase based on diagnosis and documentation. Any necessary root planing for 24 months thereafter is usually included under periodontal maintenance procedures (periodontal prophylaxis). Osseous surgery and guided tissue regeneration as appropriate with documentation. (Use of gingivectomy or curettage surgical procedures would be unusual in the presence of intrabony defects.)</td>
<td>Up to four quadrants of root planing during active treatment phase based on diagnosis and documentation. Any necessary root planing for 24 months thereafter is usually included under periodontal maintenance procedures (periodontal prophylaxis). Osseous surgery and guided tissue regeneration as appropriate with documentation. (Use of gingivectomy or curettage surgical procedures would be unusual in the presence of intrabony defects.)</td>
<td>Up to four quadrants of root planing during active treatment phase based on diagnosis and documentation. Any necessary root planing for 24 months thereafter is usually included under periodontal maintenance procedures (periodontal prophylaxis). Osseous surgery and guided tissue regeneration as appropriate with documentation. (Use of gingivectomy or curettage surgical procedures would be unusual in the presence of intrabony defects.)</td>
<td></td>
</tr>
<tr>
<td>Documentation requirements</td>
<td>Completion of Attending Dentist's Statement</td>
<td>A definitive periodontal case type diagnosis and treatment plan. Complete periodontal charting indicating 5 to 6 mm pockets, early bone loss. X-rays may be required.</td>
<td>A definitive periodontal case type diagnosis and treatment plan. Complete periodontal charting indicating 5 to 8 mm pockets, early bone loss. X-rays may be required.</td>
<td>A definitive periodontal case type diagnosis and treatment plan. Complete periodontal charting indicating 5 to 8 mm pockets, early bone loss. X-rays may be required.</td>
<td>A definitive periodontal case type diagnosis and treatment plan. Including factors which may be vital to the success of continued therapy, e.g., pathogens or systemic complications.</td>
</tr>
</tbody>
</table>

**CASE TYPES**

- **Clinical description**
  - Inflammation of the gingiva, characterized clinically by hyperplasia, edema, reactivity, gingival pocket formation, pocket depth less than 5 mm and no bone loss.

- **Generally applicable treatment procedures (exceptions considered by report with complete documentation)**
  - Non-Surgical 01110 − Prophylaxis 01205 − Prophylaxis with fluoride.

- **Premier contractual payment limitations**
  - Generally, two prophylaxes or prophylaxes with fluoride singly or in combination, in any 12 month period. Additional prophylaxes are the responsibility of the patient.

- **Additional guidelines which are generally applicable**
  - Up to four quadrants of root planing during active treatment phase based on diagnosis and documentation. Any necessary root planing for 24 months thereafter is usually included under periodontal maintenance procedures (periodontal prophylaxis). Gingivectomy, gingival curettage or gingival flap procedures, as appropriate with documentation. (Surgical curettage by definition would not precede or follow non-surgical root planing, nor would it precede or follow other surgical pocket reduction procedures.)

- **Documentation requirements**
  - Completion of Attending Dentist's Statement.

**CASE TYPE I**

- **Gingivitis**
  - A definitive periodontal case type diagnosis and treatment plan. Complete periodontal charting indicating 5 to 6 mm pockets, early bone loss. X-rays may be required. Completion of non-surgical root planing or surgical curettage procedures within three months of beginning active therapy.

**CASE TYPE II**

- **Early Periodontitis**
  - More advanced state of previous Type, with increased destruction of periodontal structures and moderate-to-deep pockets (5 to 8 mm), moderate-to-severe bone loss and tooth mobility.

**CASE TYPE III**

- **Moderate Periodontitis**
  - Further progression of periodontitis with severe destruction of the periodontal structures with increased pocket depth, usually greater than 7 to 8 mm with increased tooth mobility.

**CASE TYPE IV**

- **Advanced Periodontitis**
  - Continued demonstration of numerous sites of periodontitis where loss of attachment is progressing, even after traditional therapy has been completed and good home care is evident.

**CASE TYPE V**

- **Refractory Periodontitis**
  - Generally, two prophylaxes, prophylaxes with fluoride or periodontal prophylaxes singly or in combination, in any 12 month period. (Periodontal maintenance at least 90 days after completion of active periodontal therapy.) Additional treatment is the responsibility of the patient.

**Additional guidelines which are generally applicable**

- Up to four quadrants of root planing during active treatment phase based on diagnosis and documentation. Any necessary root planing for 24 months thereafter is usually included under periodontal maintenance procedures (periodontal prophylaxis). Osseous surgery and guided tissue regeneration as appropriate with documentation. (Use of gingivectomy or curettage surgical procedures would be unusual in the presence of intrabony defects.)

**Documentation requirements**

- Completion of Attending Dentist's Statement.

**A definitive periodontal case type diagnosis and treatment plan.** Complete periodontal charting indicating 5 to 8 mm pockets, early bone loss. X-rays may be required. Completion of non-surgical root planing or surgical curettage procedures within three months of beginning active therapy.

**A definitive periodontal case type diagnosis and treatment plan.** Complete periodontal charting indicating 7 to 8 mm pockets, early bone loss. X-rays may be required. Completion of non-surgical root planing or surgical curettage procedures within three months of beginning active therapy.

**A definitive periodontal case type diagnosis and treatment plan.** Including factors which may be vital to the success of continued therapy, e.g., pathogens or systemic complications.
### Prosthodontics, Removable (05000 – 05899)

#### Procedure Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>05110</td>
<td>Complete denture, upper</td>
</tr>
<tr>
<td>05120</td>
<td>Complete denture, lower</td>
</tr>
<tr>
<td>05130</td>
<td>Immediate denture, upper</td>
</tr>
<tr>
<td>05140</td>
<td>Immediate denture, lower</td>
</tr>
<tr>
<td>05111</td>
<td>Upper partial denture – resin base (including any conventional clasps, rests and teeth)</td>
</tr>
<tr>
<td>05121</td>
<td>Lower partial denture – resin base (including any conventional clasps, rests and teeth)</td>
</tr>
<tr>
<td>05131</td>
<td>Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)</td>
</tr>
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<td>05211</td>
<td>Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)</td>
</tr>
<tr>
<td>05212</td>
<td>Removable unilateral partial denture – one piece cast metal (including clasps and teeth)</td>
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<tr>
<td>05610</td>
<td>Repair broken complete denture base</td>
</tr>
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<td>05620</td>
<td>Replace missing or broken teeth – complete denture (each tooth)</td>
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<td>05630</td>
<td>Repair resin denture base</td>
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<tr>
<td>05640</td>
<td>Replace broken teeth – per tooth</td>
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<td>Add tooth to existing partial denture</td>
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<td>05660</td>
<td>Add clasp to existing partial denture</td>
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<td>05710</td>
<td>Rebase complete upper denture</td>
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<td>05720</td>
<td>Rebase upper partial denture</td>
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<td>05721</td>
<td>Rebase lower partial denture</td>
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<td>05730</td>
<td>Reline complete upper denture (chairside)</td>
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<td>05731</td>
<td>Reline complete lower denture (chairside)</td>
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<td>05740</td>
<td>Reline upper partial denture (chairside)</td>
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<td>Reline lower partial denture (chairside)</td>
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<td>05761</td>
<td>Reline lower partial denture (laboratory)</td>
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<td>05810</td>
<td>Temporary complete denture (upper)</td>
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<tr>
<td>05811</td>
<td>Temporary complete denture (lower)</td>
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<td>05820</td>
<td>Temporary partial – stayplate denture (upper)</td>
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<td>05821</td>
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<td>Tissue conditioning, mandibular</td>
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<td>Overdenture – complete, by report</td>
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<tr>
<td>05861</td>
<td>Overdenture – partial, by report</td>
</tr>
<tr>
<td>05862</td>
<td>Precision attachment, by report</td>
</tr>
<tr>
<td>05899</td>
<td>Unspecified removable prosthodontic procedure, by report</td>
</tr>
</tbody>
</table>

#### Guidelines

**Removable Prosthodontics – General Guidelines**

1. Procedures relating to dentures, immediate dentures, partial dentures and relines include adjustments for twelve months following installation.

2. Impressions are considered components of, and included in the fee for, the final appliance.

3. Premier programs provide for replacement of missing teeth with full or partial dentures using standard procedures. Treatment involving specialized techniques is considered optional and the patient is responsible for the additional fee. This includes, but is not limited to the following:
   a. precious metal, personalization or characterization;
   b. precision attachments;
   c. overdentures, overlays, and, except where specifically covered by the group contract, implants and procedures and appliances associated with them.

4. Premier programs do not provide benefits for replacement of satisfactory prosthodontic appliances.

5. Under most Premier programs, prosthetic appliances are a benefit once in a five-year period.

6. Maxillofacial prosthodontics are not benefits of any Premier program.

7. Occlusal correction is considered part of the placing of a removable prosthodontic appliance.
8. When a partial dentures and a fixed bridge are placed in the same arch, the bridge is considered optional, and Premier's allowance is based on the cost of the partial denture. When applicable, Premier may deduct from the allowance any payment already made toward the fixed bridge.

9. Procedures and appliances to correct congenital or developmental malformations are not benefits of Premier programs.

10. If the total fees for adjustments, rebase, repair and/or reline procedures on a complete or partial denture in the same sequence of treatment equal or exceed the fee for a complete or partial denture, Premier's allowance will be based on the fee for a new appliance, and be subject to the contractual limitations for the provision of dentures (usually once in five years). Any amount in excess to the approved allowance is not chargeable to the patient.

PROCEDURE 05120
Complete denture, lower

1. This procedure is subject to a maximum allowance. Premier will pay its coinsurance percentage of the maximum allowance. The patient is responsible for the remaining portion.

2. A standard denture is defined as a removable prosthetic appliance provided to replace missing natural, permanent teeth that is constructed using accepted and conventional procedures and materials.

PROCEDURE 05130
Immediate denture, upper

For determination of benefits, an upper immediate denture is considered to be equivalent to procedure 05110, full upper denture. See procedure 05110, items 1 and 2.

PROCEDURE 05140
Immediate denture, lower

For determination of benefits, a lower immediate denture is considered to be equivalent to procedure 05120, full lower denture. See procedure 05120, items 1 and 2.

PROCEDURE 05211
Upper partial denture – resin base (including any conventional clasps, rests and teeth)

1. On one line of the Attending Dentist's Statement, please indicate one fee for the entire upper partial denture. This procedure is considered to include the base and all conventional clasps, rests and teeth.

2. Please indicate on the tooth chart of the Attending Dentist's Statement the missing teeth being replaced by the partial denture.

3. This procedure is subject to a maximum allowance. Premier will pay its coinsurance percentage of the maximum allowance. The patient is responsible for the remaining portion.

4. Removable partial dentures are not a benefit for patients under age 16. Premier may make an allowance for a space maintainer or a stayplate for anterior teeth, and the patient is responsible for the additional fee.

PROCEDURE 05110
Complete denture, upper

1. This procedure is subject to a maximum allowance. Premier will pay its coinsurance percentage of the maximum allowance. The patient is responsible for the remaining portion.

2. A standard denture is defined as a removable prosthetic appliance provided to replace missing natural, permanent teeth that is constructed using accepted and conventional procedures and materials.

PROCEDURE 05210
Complete denture, lower

1. This procedure is subject to a maximum allowance. Premier will pay its coinsurance percentage of the maximum allowance. The patient is responsible for the remaining portion.

2. A standard denture is defined as a removable prosthetic appliance provided to replace missing natural, permanent teeth that is constructed using accepted and conventional procedures and materials.

PROCEDURE 05212
Lower partial denture – resin base (including any conventional clasps, rests and teeth)

1. On one line of the Attending Dentist's Statement, please indicate one fee for the entire lower partial denture. This procedure is considered to include the base and all conventional clasps, rests and teeth.

2. Please indicate on the tooth chart of the Attending Dentist's Statement the missing teeth being replaced by the partial denture.

3. This procedure is subject to a maximum allowance. Premier will pay its coinsurance percentage of the maximum allowance. The patient is responsible for the remaining portion.

4. Removable partial dentures are not a benefit for patients under age 16. Premier may make an allowance for a space maintainer or a stayplate for anterior teeth, and the patient is responsible for the additional fee.

– Submit x-rays only for procedures marked “X” –

PROSTHODONTICS-REMOVABLE (05000 – 05899)  Page 26 of 54  Revised 08-01-2000
PROCEDURE 05213
Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).

1. On one line of the Attending Dentist’s Statement, please indicate one fee for the entire upper partial denture. This procedure is considered to include the base and all conventional clasps, rests and teeth.

2. Please indicate on the tooth chart of the Attending Dentist’s Statement the missing teeth being replaced by the partial denture.

3. This procedure is subject to a maximum allowance. Premier will pay its copayment percentage of the maximum allowance. The patient is responsible for the remaining portion.

4. Removable partial dentures are not a benefit for patients under age 16. Premier may make an allowance for a space maintainer or a stayplate for anterior teeth, and the patient is responsible for the additional fee.

PROCEDURE 05281
Removable unilateral partial denture – one piece cast metal (including clasps and teeth).

1. Please use one line of the Attending Dentist’s Statement for each tooth and each clasp. Indicating the tooth number and fee for each unit. Use the tooth chart to indicate missing teeth.

2. Adjustments during the 12 month period following placement are considered to be included in the fee for the appliance.

3. Specialized techniques, precious metal or precision attachments are considered optional, and fees for such are the patient’s responsibility. The Premier allowance will be based on a standard appliance.

PROCEDURE 05411
Adjust complete denture – lower

Denture adjustments provided within 12 months of the placing of a denture are considered to be included in the fee for the denture.

PROCEDURE 05421
Adjust partial denture – upper

Denture adjustments provided within 12 months of the placing of a denture are considered to be included in the fee for the denture.

PROCEDURE 05422
Adjust partial denture – lower

Denture adjustments provided within 12 months of the placing of a denture are considered to be included in the fee for the denture.

REPAIRS TO COMPLETE DENTURES

PROCEDURE 05510
Repair broken complete denture base.

Please indicate the arch in the column marked “tooth number” with an abbreviation (U = upper, L = lower).

PROCEDURE 05520
Replace missing or broken teeth – complete denture (each tooth).

Please provide in the description of service the total number of teeth involved. Indicate the arch in the column marked “tooth number” with an abbreviation (U = upper, L = lower).

REPAIRS TO PARTIAL DENTURES

PROCEDURE 05610
Repair resin denture base.

Please indicate the arch in the column marked “tooth number”
with an abbreviation (U = upper, 
L = lower).

PROCEDURE 05620
Repair cast framework, by
report. Please provide a full
report of the extent of the repair
on the Attending Dentist's
Statement, or attach a report if
additional space is needed. The
fee will be reviewed by the
Premier consultant staff to
determine the appropriate
allowance.

PROCEDURE 05630
Repair or replace broken clasp.
1. Please indicate the arch in
the column marked "tooth
number" by abbreviation (U =
upper, L = lower).
2. Enter the fee for repair or
replacement of the clasp. If
more than one clasp is replaced
or repaired, use a separate line
of the Attending Dentist's
Statement to describe the
additional repairs.

PROCEDURE 05640
Replace broken teeth – per
tooth.
1. Please indicate the arch (U =
upper, L = lower) in the "tooth
number" column of the Attending
Dentist's Statement.
2. Enter the fee for replacement
of the first tooth. If more than
one tooth is replaced, please
use a separate line of the
Attending Dentist's Statement for
each tooth.

PROCEDURE 05650
Add tooth to existing partial
denture.
1. Please indicate the arch (U =
upper, L = lower) in the "tooth
number" column of the Attending
Dentist's Statement.
2. Enter the fee for the tooth. If
more than one tooth is added,
please use a separate line of the
Attending Dentist's Statement for
each tooth.

PROCEDURE 05660
Add clasp to existing partial
denture.
1. Please indicate the arch (U =
upper, L = lower) in the "tooth
number" column of the Attending
Dentist's Statement.
2. Enter the fee for the clasp. If
more than one clasp is added,
please use a separate line of the
Attending Dentist's Statement for
each clasp.

DENTURE REBASE
PROCEDURES
PROCEDURE 05710
Reline complete upper denture.
1. Any rebase is considered to
include a reline.
2. The allowance is considered
to include adjustments for 12
months
3. A duplicate denture (a spare
or second denture) is not a
benefit under Premier programs.
The patient is responsible for the
fee.

PROCEDURE 05711
Reline complete lower denture.
1. Any rebase is considered to
include a reline.
2. The allowance is considered
to include adjustments for 12
months
3. A duplicate denture (a spare
or second denture) is not a
benefit under Premier programs.
The patient is responsible for the
fee.

DENTURE RELINE
PROCEDURES
PROCEDURE 05730
Reline complete upper denture
(chairside).
1. Reline allowances include
adjustment for a 12 month
period following placement.
2. Relines should not be
submitted on a prior-
authorization request at the
same time as the denture.
Please submit a separate
request when you are ready to
reline the denture.

PROCEDURE 05731
Reline complete lower denture
(chairside).
1. Reline allowance include
adjustment for a 12 month
period following placement.
2. Relines should not be
submitted on a prior-
authorization request at the
same time as the denture.
Please submit a separate
request when you are ready to
reline the denture.
NOTE: PLEASE REFER TO A PATIENT’S PREMIER CERTIFICATE OF INSURANCE TO DETERMINE COVERED SERVICES AND SUPPLIES, EXCLUSIONS AND LIMITATIONS FOR AN INDIVIDUAL PATIENT.

request when you are ready to reline the denture.

PROCEDURE 05740
Reline upper partial denture (chairside).
1. Reline allowance include adjustment for a 12 month period following placement.
2. Relines should not be submitted on a prior-authorization request at the same time as the denture. Please submit a separate request when you are ready to reline the denture.

PROCEDURE 05741
Reline lower partial denture (chairside).
1. Reline allowance include adjustment for a 12 month period following placement.
2. Relines should not be submitted on a prior-authorization request at the same time as the denture. Please submit a separate request when you are ready to reline the denture.

PROCEDURE 05750
Reline complete upper denture (laboratory).
1. Reline allowance include adjustment for a 12 month period following placement.
2. Relines should not be submitted on a prior-authorization request at the same time as the denture. Please submit a separate request when you are ready to reline the denture.

PROCEDURE 05751
Reline complete lower denture (laboratory).
1. Reline allowance include adjustment for a 12 month period following placement.
2. Relines should not be submitted on a prior-authorization request at the same time as the denture. Please submit a separate request when you are ready to reline the denture.

OTHER REMOVABLE PROSTHETIC SERVICES

PROCEDURE 05810
Temporary complete denture (upper).
Temporary complete dentures are not benefits of Premier programs.

PROCEDURE 05811
Temporary complete denture (lower).
Temporary complete dentures are not benefits of Premier programs.

PROCEDURE 05820
Temporary partial – stayplate denture (upper).
1. A stayplate or other temporization service is a benefit only to replace extracted anterior teeth for adults during the healing period, and as an anterior space maintainer for children. Any other stayplates or temporization services are considered optional and are the financial responsibility of the patient.
2. On one line of the Attending Dentist’s Statement, please enter one fee for the complete appliance. Procedure 05820 includes all teeth and clasps.
3. Replacement of temporization services for adults is not a benefit.

PROCEDURE 05821
Temporary partial – stayplate denture (lower).
1. A stayplate or other temporization service is a benefit only to replace extracted anterior teeth for adults during the healing period, and as an anterior space maintainer for children. Any other stayplates or temporization services are considered optional and are the financial responsibility of the patient.
2. On one line of the Attending Dentist’s Statement, please enter one fee for the complete appliance. Procedure 05821 includes all teeth and clasps.
3. Replacement of temporization services for adults is not a benefit.

PROCEDURE 05850
Tissue conditioning, maxillary.
A maximum of one tissue conditioning may be allowed per arch in a 12 month period. The patient is responsible for additional treatments.
PROCEDURE 05851
Tissue conditioning, mandibular.

A maximum on one tissue conditionings may be allowed per arch in a 12 month period. The patient is responsible for additional treatments.

PROCEDURE 05860
Odenture – complete, by report.

Odentures are not benefits of Premier programs.

PROCEDURE 05861
Odenture – partial, by report.

Odentures are not benefits of Premier programs.

PROCEDURE 05862
Precision attachment, by report

1. Precision attachments are not benefits of Premier programs, and are the financial responsibility of the patient.

PROCEDURE 05899
Unspecified removable prosthodontic procedure, by report. Please enter a complete description of the service and clinical reason on the Attending Dentist's Statement.
### MAXILLOFACIAL PROSTHETICS (05900 – 05999)

**Procedure Codes**

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<tr>
<th>Procedure Code</th>
<th>Description</th>
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<td>05932</td>
<td>Post-surgical obturator</td>
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<td>05935</td>
<td>Mandibular resection (denture) prosthesis</td>
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<td>05951</td>
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<td>05952</td>
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<td>05956</td>
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<td>05957</td>
<td>Speech bulb</td>
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<tr>
<td>05982</td>
<td>Surgical stent</td>
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<tr>
<td>05983</td>
<td>Radiation carrier</td>
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<td>05984</td>
<td>Radiation shield</td>
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<td>Radiation cone locator</td>
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<tr>
<td>05986</td>
<td>Fluoride gel carrier</td>
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<tr>
<td>05999</td>
<td>Unspecified maxillofacial prosthesis, by report.</td>
</tr>
</tbody>
</table>

**Guidelines**

**MAXILLOFACIAL PROSTHETICS – GENERAL GUIDELINES**

Maxillofacial prosthetic procedures are not benefits of Premier programs, and are the financial responsibility of the patient.
NOTE: PLEASE REFER TO A PATIENT’S PREMIER CERTIFICATE OF INSURANCE TO DETERMINE COVERED SERVICES AND SUPPLIES, EXCLUSIONS AND LIMITATIONS FOR AN INDIVIDUAL PATIENT.

IMPLANT SERVICES (06000 – 06199)

<table>
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<th>Guidelines</th>
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<td>Surgical placement of implant body: endosteal implant</td>
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<tr>
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<td>Surgical placement: transosteal implant</td>
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<td>06055</td>
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<td>06100</td>
<td>Implant removal, by report</td>
</tr>
<tr>
<td>06199</td>
<td>Unspecified implant procedure, by report</td>
</tr>
</tbody>
</table>

Guidelines:

IMPLANT – GENERAL GUIDELINES

1. Implants, and procedures and appliances associated with them, are not benefits of Premier programs, except replacement of existing implants that are at least 5 years old and in need of replacement.
## Other fixed prosthetic services

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Guidelines</th>
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<tr>
<td><strong>Bridge pontics</strong></td>
<td><strong>FIXED PROSTHODONTICS – GENERAL GUIDELINES</strong></td>
</tr>
<tr>
<td>06210 Pontic – cast high noble metal</td>
<td>1. Under most Premier programs, prosthetic appliances are a benefit once in a five-year period.</td>
</tr>
<tr>
<td>06211 Pontic – cast predominately base metal</td>
<td>2. Tooth preparation, temporary restorations, cement bases, impressions and local anesthesia are considered components of, and included in the fee for, the completed prosthetic appliances.</td>
</tr>
<tr>
<td>06212 Pontic – cast noble metal</td>
<td>3. Occlusal correction is considered part of the placing of restorations involving occlusal surfaces.</td>
</tr>
<tr>
<td>06240 Pontic – porcelain fused to high noble metal</td>
<td>4. When a fixed bridge and a partial denture are placed in the same arch, the bridge is considered optional, and Premier’s allowance is based on the cost of the partial denture. When applicable, Premier may deduct form the allowance any payment already made toward the fixed bridge.</td>
</tr>
<tr>
<td>06241 Pontic – porcelain fused to predominately base metal</td>
<td>5. Resin-bonded bridges on primary teeth are not a benefit of Premier programs. Other fixed bridges and removable cast partials are not a benefit for patients under age 16. When provided, Premier may make an allowance for a space maintainer.</td>
</tr>
<tr>
<td>06242 Pontic – porcelain fused to noble metal</td>
<td>6. Procedures and appliances to correct congenital or developmental malformations are not benefits. Replacement of congenitally missed permanent teeth is not a benefit, regardless of the length of time the deciduous tooth is retained.</td>
</tr>
<tr>
<td>06245 Pontic – porcelain, ceramic substrate</td>
<td>7. Most Premier programs which include prosthetic benefits do not cover pre-existing conditions. Therefore, the replacement of teeth extracted before the patient became eligible under a Premier program is not generally covered.</td>
</tr>
<tr>
<td><strong>Bridge retainers - crowns</strong></td>
<td>8. Bridges which use laminates/partial crowns as abutments are not benefits. When provided, the patient is responsible for the total cost.</td>
</tr>
<tr>
<td>06530X Inlay – metallic – three or more surfaces</td>
<td>10. Prior-authorization is required.</td>
</tr>
<tr>
<td>06540X Inlay – metallic per tooth in addition to inlay</td>
<td></td>
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<tr>
<td>06545X Retainer – cast metal for resin bonded fixed prosthesis</td>
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<tr>
<td><strong>Bridge retainers - crowns</strong></td>
<td><strong>Noble Metal Classification and Required Percentage by Weight</strong></td>
</tr>
<tr>
<td>06750X Crown – porcelain fused to high noble metal</td>
<td>Noble: Noble metal content equal to or greater than 60% (gold, platinum, palladium) and gold equal to or greater than 40%.</td>
</tr>
<tr>
<td>06751X Crown – porcelain fused to noble metal</td>
<td>High Noble: Noble metal content equal to or greater than 25% (gold, platinum, palladium).</td>
</tr>
<tr>
<td>06752X Crown – porcelain fused to noble metal</td>
<td>Predominantly Base: Noble metal content less than 25% (gold, platinum, palladium).</td>
</tr>
<tr>
<td>06780X Crown – ¼ cast high noble metal</td>
<td></td>
</tr>
<tr>
<td>06790X Crown – full cast high noble metal</td>
<td></td>
</tr>
<tr>
<td>06791X Crown – full cast predominately base metal</td>
<td></td>
</tr>
<tr>
<td>06792X Crown – full cast noble metal</td>
<td></td>
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<tr>
<td><strong>Other fixed prosthetic services</strong></td>
<td><strong>BRIDGE PONTICS</strong></td>
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<tr>
<td>06930 Recement bridge</td>
<td>PROCEDURE 06210 Pontic – cast high noble metal. *</td>
</tr>
<tr>
<td>06940 Stress breaker</td>
<td>1. Please use a separate line of the Attending Dentist’s Statement for each tooth involved in the fixed bridge. Indicate a separate fee for each tooth.</td>
</tr>
<tr>
<td>06950 Precision attachment</td>
<td>2. Prior-authorization is required. Please submit mounted x-rays.</td>
</tr>
<tr>
<td>06970 Prefabricated post and core in addition to bridge retainer</td>
<td><strong>PROCEDURE 06211</strong> Pontic – cast predominately base metal</td>
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<tr>
<td>06972 Prefabricated post and core</td>
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<td>06973– Retainer crown build up (substructure) including any pins</td>
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<td>06975 Coping – metal</td>
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<td>06980 Bridge repair, by report</td>
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<tr>
<td>06999 Unspecified fixed prosthodontic procedure by report</td>
<td></td>
</tr>
</tbody>
</table>

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*Submit x-rays only for procedures marked “X”. See General Guidelines for classification of metal alloys.*
1. Please use a separate line of the Attending Dentist’s Statement for each tooth involved in the fixed bridge. Indicate a separate fee for each tooth.

2. Prior-authorization is required.

PROCEDURE 06212
Pontic – cast noble metal.

1. Please use a separate line of the Attending Dentist’s Statement for each tooth involved in the fixed bridge. Indicate a separate fee for each tooth.

2. Prior-authorization is required.

PROCEDURE 06240
Pontic – porcelain fused to high noble metal.

1. Please use a separate line of the Attending Dentist’s Statement for each tooth involved in the fixed bridge. Indicate a separate fee for each tooth.

2. Prior-authorization is required.

PROCEDURE 06241
Pontic – porcelain fused to predominately base metal.

1. Please use a separate line of the Attending Dentist’s Statement for each tooth involved in the fixed bridge. Indicate a separate fee for each tooth.

2. Prior-authorization is required.

PROCEDURE 06242
Pontic – porcelain fused to noble metal.

1. Please use a separate line of the Attending Dentist’s Statement for each tooth involved in the fixed bridge. Indicate a separate fee for each tooth.

Retailers

PROCEDURE 06540 - X
Retainer – cast metal for resin bonded fixed prosthesis.

1. Please use a separate line of the Attending Dentist’s Statement for each tooth involved in the fixed bridge. Indicate a separate fee for each pontic.

2. Acid etch retainers, associated with resin-bonded bridges, are benefits of most Premier programs, and are subject to the standard prosthodontic limitations and exclusions. Please refer to page 30 for guidelines on fixed prosthodontics.

3. The fee is considered to include any necessary rebonding or repair for the three years following placement.

4. Please use a separate line of the Attending Dentist’s Statement for each tooth involved in the resin-bonded bridge. Indicate a separate fee for each pontic.

5. Acid etch retained bridges on primary teeth are considered optional services. When provided, Premier may make an allowance for a space maintainer.

6. Prior-authorization is required.

PROCEDURE 06545 - X
Retainer – porcelain, ceramic substrate.

1. Please submit mounted x-rays.

2. Enter a fee for the onlay that is separate from the fee for the inlay.

3. This code is the prosthetic equivalent of procedure 02540. Please use procedure 02540 if onlay is not a part of a prosthetic appliance.

4. Prior-authorization is required.

– Submit x-rays only for procedures marked “X”. See General Guidelines for classification of metal alloys –
BRIDGE RETAINERS – CROWNS

PROCEDURE 06750 - X
Crown – porcelain fused to high noble metal.*
1. Please submit mounted x-rays.
   Use a separate line for each tooth involved in the fixed bridge and indicate a separate fee for each unit.
2. This code is the prosthetic equivalent of procedure 02750. Please use procedure 02750 if the crown is not a part of a prosthetic appliance.
3. Prior-authorization is required.

PROCEDURE 06751 - X
Crown – porcelain fused to predominately base metal.*
1. Please submit mounted x-rays.
   Use a separate line for each tooth involved in the fixed bridge and indicate a separate fee for each unit.
2. This code is the prosthetic equivalent of procedure 02751. Please use procedure 02751 if the crown is not a part of a prosthetic appliance.
3. Prior-authorization is required.

PROCEDURE 06752 - X
Crown – porcelain fused to noble metal.*
1. Please submit mounted x-rays.
   Use a separate line for each tooth involved in the fixed bridge and indicate a separate fee for each unit.
2. This code is the prosthetic equivalent of procedure 02752. Please use procedure 02752 if the crown is not a part of a prosthetic appliance.
3. Prior-authorization is required.

PROCEDURE 06780 - X
Crown – ¾ cast high noble metal.*
1. Please submit mounted x-rays.
   Use a separate line for each tooth involved in the fixed bridge and indicate a separate fee for each unit.
2. This code is the prosthetic equivalent of procedure 02810. Please use procedure 02810 if the crown is not a part of a prosthetic appliance.
3. Prior-authorization is required.

PROCEDURE 06790 - X
Crown – full cast high noble metal.*
1. Please submit mounted x-rays.
   Use a separate line for each tooth involved in the fixed bridge and indicate a separate fee for each unit.
2. This code is the prosthetic equivalent of procedure 02790. Please use procedure 02790 if the crown is not a part of a prosthetic appliance.
3. Prior-authorization is required.

PROCEDURE 06791 - X
Crown – full cast predominately base metal.*
1. Please submit mounted x-rays. Use a separate line for each tooth involved in the fixed bridge and indicate a separate fee for each unit.
2. This code is the prosthetic equivalent of procedure 02791. Please use procedure 02791 if the crown is not a part of a prosthetic appliance.
3. Prior-authorization is required.
4. Please enter the tooth number on the Attending Dentist's Statement. Use a separate line for each tooth involved in the fixed bridge and indicate a separate fee for each unit.

PROCEDURE 06792 - X
Crown – full cast noble metal.*
1. Please submit mounted x-rays.
2. This code is the prosthetic equivalent of procedure 02792. Please use procedure 02792 if the crown is not a part of a prosthetic appliance.
3. Prior-authorization is required.

PROCEDURE 06930
Recement bridge.
Please enter in the description of service the tooth number of each tooth included in the bridge.

PROCEDURE 06940
Stress breaker.
1. This procedure code is for a simple stress breaker such as a keyway. More complex or precision attachments are optional and are the patient's responsibility. Stress breakers are covered only in connection with fixed prosthodontics. If otherwise provided, they are considered specialized techniques which are the financial responsibility of the patient.
2. Please indicate in the "tooth number" column the arch in
which the stress breaker is placed (U = upper, L = lower).

PROCEDURE 06950
Precision attachment.
1. Precision attachments are not benefits of Premier programs and are the financial responsibility of the patient.

PROCEDURE 06970
Cast post and core in addition to bridge retainer.
1. This code is the prosthetic equivalent of procedure 02952. Please use procedure 02952 if the post and core are not part of a prosthetic appliance.
2. When the post is prefabricated as part of the bridge, use procedure 06972.
3. This code applies to an individually fitted and specially cast post (including a core and coping) that is necessary for placement into the endodontically treated canal when the remaining tooth structure is insufficient for bridge placement. Please enter the tooth number and describe the service fully on the Attending Dentist's Statement.
4. This procedure is considered to include the post and any core (buildup/substructure).

PROCEDURE 06972
Prefabricated post and core in addition to bridge retainer.
1. This code is the prosthetic equivalent of procedure 02954. Please use procedure 02954 if the post and core are not part of a prosthetic appliance.
2. This code applies to commercial products such as screw posts, endo posts, Kurer anchors and crown savers, or any preformed post of any material or shape for placement into the endodontically treated canal for support.
3. Please enter the tooth number on the Attending Dentist's Statement.
4. This procedure is considered to include the post and any core (buildup/substructure).

PROCEDURE 06973
Retainer crown buildup (substructure) including any pins.
1 Retainer crown buildup is not a benefit.

PROCEDURE 06975
Coping – metal.
This service is considered a specialized technique and is not a benefit of Premier programs. The fee is the patient's responsibility.

PROCEDURE 06980
Bridge repair, by report.
Please write a report on the Attending Dentist's Statement on the duration of treatment or repair. If additional space is needed, attach a report to the treatment form. The allowance will be determined after evaluation by the Premier consultant staff, based on time and laboratory charges.

PROCEDURE 06999
Unspecified fixed prosthodontic procedure, by report.
Please enter a complete description of service and clinical reason on the Attending Dentist's Statement.

NOTE: PLEASE REFER TO A PATIENT'S PREMIER CERTIFICATE OF INSURANCE TO DETERMINE COVERED SERVICES AND SUPPLIES, EXCLUSIONS AND LIMITATIONS FOR AN INDIVIDUAL PATIENT.

– Submit x-rays only for procedures marked “X”. See General Guidelines for classification of metal alloys –
PREMIER ACCESS
DENTAL • LIFE • DISABILITY
DENTIST HANDBOOK

NOTE: PLEASE REFER TO A PATIENT’S PREMIER CERTIFICATE OF INSURANCE TO DETERMINE COVERED SERVICES AND SUPPLIES, EXCLUSIONS AND LIMITATIONS FOR AN INDIVIDUAL PATIENT.

ORAL SURGERY (07000 – 07999)

Procedure Codes

Extractions – includes local anesthesia and routine postoperative care
07110 Single tooth
07120 Each additional tooth
07130X Root removal – exposed roots

Surgical extractions – includes local anesthesia and routine postoperative care
07210X Surgical removal of erupted tooth
07220X Removal of impacted tooth – soft tissue
07230X Removal of impacted tooth – partial bony
07240X Removal of impacted tooth – complete bony
07250X Surgical removal of residual tooth roots (cutting procedure)

Other surgical procedures
07260X Oral antral fistula closure
07270X Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth and alveolus
07272X Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization)
07280X Surgical exposure of impacted or unerupted tooth for orthodontic reasons
07281X Surgical exposure of impacted or unerupted tooth to aid eruption
07285 Biopsy of oral tissue – hard
07286 Biopsy of oral tissue – soft
07290 Surgical repositioning of teeth
07291 Transseptal fiberotomy, by report

Alveoloplasty – surgical preparation of ridge for dentures
07310 Alveoloplasty in conjunction with extractions – per quadrant
07320 Alveoloplasty not in conjunction with extractions – per quadrant

Vestibuloplasty
07340 Vestibuloplasty – ridge extension (secondary epithelialization)
07350 Vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachments, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).

Removal of tumors, cysts and neoplasms
07430 Excision of benign tumor – lesion diameter up to 1.25 cm
07431 Excision of beginning tumor – lesion diameter greater than 1.25 cm
07440 Excision of malignant tumor – lesion diameter up to 1.25 cm
07441 Excision of malignant tumor – lesion diameter greater than 1.25 cm
07450X Removal of odontogenic cyst or tumor – lesion diameter up to 1.25 cm
07451X Removal of odontogenic cyst or tumor – lesion diameter greater than 1.25 cm
07460X Removal of nonodontogenic cyst or tumor – lesion diameter up to 1.25 cm
07461X Removal of nonodontogenic cyst or tumor – lesion diameter greater than 1.25 cm
07465 Destruction of lesion(s) by physical methods, by report

Excision of bone tissue
07470X Removal of exostosis – maxilla or mandible
07480X Partial ostectomy (guttering or saucerization)
07490X Radical resection of mandible with bone graft

Surgical incision
07510 Incision and drainage of abscess – intraoral soft tissue
07520 Incision and drainage of abscess – extraoral soft tissue
07530 Removal of foreign body, skin or subcutaneous areolar tissue
07540X Removal of foreign body, musculoskeletal system
07550X Sequestrectomy for osteomyelitis
07560X Maxillary sinusotomy for removal of tooth fragment or foreign body

Treatment of fractures – simple
07610X Maxilla – open reduction (teeth immobilized if present)
07620X Maxilla – closed reduction (teeth immobilized if present)
07630X Mandible – open reduction (teeth immobilized if present)
07640X Mandible – closed reduction (teeth immobilized if present)
07650X Malar and/or zygomatic arch – open reduction
07660X Malar and/or zygomatic arch – closed reduction
07670X Alveolus – stabilization of teeth, open reduction splinting
07680X Facial bones – complicated reduction with fixation and multiple surgical approaches

Treatment of fractures – compound
07710X Maxilla – open reduction
07720X Maxilla – closed reduction
07730X Mandible – open reduction
07740X Mandible – closed reduction
07750X Malar and/or zygomatic arch – open reduction
07760X Malar and/or zygomatic arch – closed reduction
07770X Alveolus – stabilization of teeth, open reduction splinting
07780X Facial bones – complicated reduction with fixation and multiple surgical approaches

Reduction of dislocation and management of other temporomandibular joint dysfunctions
07810 Open reduction of dislocation

– Submit x-rays only for procedures marked “X” –
Guidelines

ORAL SURGERY – GENERAL GUIDELINES

1. Fees for oral surgery procedures include local anesthesia and routine postoperative visits. For general anesthesia, see procedures 09220 and 09221. For I.V. sedation, see procedure 09240.

2. All hospital costs are the responsibility of the patient. Additional fees charged by the dentist for performing procedures in the hospital are the responsibility of the patient.

3. Any charge for a stent in conjunction with oral surgery is included in the fee for the surgery.

4. Removal of asymptomatic teeth is not a benefit of Premier programs.

EXTRCTIONS

PROCEDURE 07110

Single tooth

1. This code is to be used to indicate the first uncomplicated extraction on each date of service.

2. Please indicate the tooth number or letter.

PROCEDURE 07120

Each additional tooth.

Please use one line of the Attending Dentist's Statement for each additional uncomplicated extraction. Indicate tooth number or letter and the requested fee for each extraction, as shown below.

PROCEDURE 07130 - X

Root removal - exposed roots.

Please submit a mounted x-ray or narrative report for review by Premier's consultant staff.

SURGICAL EXTRACTIONS

PROCEDURE 07210 - X

Surgical removal of erupted tooth.

1. Please submit mounted x-rays.

2. This service is defined as the reflection of a soft tissue flap and the removal of bone and/or the sectioning of the tooth.

3. When multiple surgical extractions are provided, they are considered to include any necessary alveoloplasty.

PROCEDURE 07220 - X

Removal of impacted tooth – soft tissue.

1. Please submit mounted x-ray.

2. Classification of impactions is based on the anatomical position of the tooth rather than the surgical technique employed in removal.

3. The service is considered to include the excision of associated minor cystic or inflamed soft tissue.

PROCEDURE 07230 - X

Removal of impacted tooth – partially bony.

1. Please submit mounted x-ray.

2. Classification of impactions is based on the anatomical position of the tooth rather than the surgical technique employed in removal.

3. The service is considered to include the excision of associated minor cystic or inflamed soft tissue.

PROCEDURE 07240 - X

Removal of impacted tooth – completely bony.
1. Please submit mounted x-ray.
2. Classification of impactions is based on the anatomical position of the tooth rather than the surgical technique employed in removal.
3. The service is considered to include the excision of associated minor cystic or inflamed soft tissue.

PROCEDURE 07250 - X
Surgical removal of residual tooth roots (cutting procedure).
1. Please submit mounted x-ray.

OTHER SURGICAL PROCEDURES

PROCEDURE 07260 - X
Oral antral fistula closure.
Please submit mounted x-ray, a brief history and a surgical report.

PROCEDURE 07270 - X
Tooth reimplantation and stabilization of accidentally evulsed or displaced tooth and/or alveolus.
Please submit mounted x-ray(s) and an operative report.

PROCEDURE 07272 - X
Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization).
1. Please submit mounted x-ray.
2. This procedure is considered to include the tooth extraction.

PROCEDURE 07280 - X
Surgical exposure of impacted or unerupted tooth for orthodontic reasons (including orthodontic attachments).
1. This procedure is a benefit only of group programs which have orthodontic coverage or which have specifically included it as a covered benefit. Payment will be applied toward the patient's orthodontic maximum.
2. For exposure to aid eruption, or without attachments, please use procedure 07281.
3. Please use one line of the Attending Dentist's Statement for each tooth involved. Indicate the tooth number or letter and the requested fee for each tooth.

PROCEDURE 07281 - X
Surgical exposure of impacted or unerupted tooth to aid eruption.
Please use one line of the Attending Dentist’s Statement for each tooth involved. Indicate the tooth number or letter and the requested fee for each tooth.

PROCEDURE 07285
Biopsy of oral tissue – hard.
1. Please attach a copy of the pathology report.
2. This service is considered to be included in the fee for the resection of hard tissue.

PROCEDURE 07286
Biopsy of oral tissue – soft.
1. Please attach a copy of the pathology report.
2. This service is considered to be included in the fee for the resection of tumors and excision of cysts.

PROCEDURE 07290
Surgical repositioning of teeth.
1. This procedure is a benefit only of group programs which have orthodontic coverage. Payment will be applied toward the patient’s orthodontic maximum.
2. Please include a written report on the Attending Dentist’s Statement. The allowance will be determined by Premier’s consultant staff.

PROCEDURE 07291
Transseptal fiberotomy, by report.
1. This procedure is a benefit only of group programs which have orthodontic coverage. Payment will be applied toward the patient’s orthodontic maximum.
2. Please include a written report on the Attending Dentist’s Statement. The allowance will be determined by Premier’s consultant staff.

ALVEOLOPLASTY

PROCEDURE 07340
Vestibuloplasty – ridge extension (secondary epithelialization).
1. This service is defined as the revision of the maxillary or mandibular arches by incising horizontally over the crest for the recontouring of the osseous structures and lengthening the labial and/or buccal vestibule.
2. Please provide an operative report for review by the Premier consultant staff.

PROCEDURE 07350
Vestibuloplasty – ridge extension (including soft tissue attachment and management of hypertrophied and hyperplastic tissue).
1. This service is defined as the revision of the maxillary or mandibular alveolar arches by undermining the submucosal tissues which in turn lengthens the vertical dimension of the buccal and labial vestibule.
2. This procedure is considered to include any associated frenectomy.
3. This procedure does not include hard or soft tissue or
synthetic grafts. Bone or other hard tissue or synthetic grafts used to augment the vestibuloplasty are not benefits of Premier programs. Such an additional fee should be indicated on the Attending Dentist’s Statement as a separate item. The cost is the responsibility of the patient.

4. Please provide an operative report for review by the Premier consultant staff.

**REMOVAL OF TUMORS, CYSTS AND NEOPLASMS**

**PROCEDURE 07430**
Excision of benign tumor – lesion diameter up to 1.25 cm.

Please identify area of tumor and provide the operative/pathology report.

**PROCEDURE 07431**
Excision of benign tumor – lesion diameter greater than 1.25 cm.

Please identify area of tumor and provide the operative/pathology report.

**PROCEDURE 07440**
Excision of malignant tumor – lesion diameter up to 1.25 cm.

Please identify area of tumor and provide the operative/pathology report. The allowance will be determined by Premier’s consultant staff.

**PROCEDURE 07441**
Excision of malignant tumor – lesion diameter greater than 1.25 cm.

Please identify area of tumor and provide the operative/pathology report. The allowance will be determined by Premier’s consultant staff.

**PROCEDURE 07450 - X**
Removal of odontogenic cyst or tumor – lesion diameter up to 1.25 cm.

1. Please submit mounted x-ray in the case of an osseous lesion.

2. Indicate the location of the cyst and provide a copy of the pathologist’s report.

**PROCEDURE 07451 - X**
Removal of odontogenic cyst or tumor – lesion diameter greater than 1.25 cm.

1. Please submit mounted x-ray in the case of an osseous lesion.

2. Indicate the location of the cyst and provide a copy of the pathologist’s report.

**PROCEDURE 07460 - X**
Removal of nonodontogenic cyst or tumor – lesion diameter up to 1.25 cm.

1. Please submit mounted x-ray in the case of an osseous lesion.

2. Indicate the location of the cyst and provide a copy of the pathologist’s report.

**PROCEDURE 07461 - X**
Removal of nonodontogenic cyst or tumor – lesion diameter greater than 1.25 cm.

1. Please submit mounted x-ray in the case of an osseous lesion.

2. Indicate the location of the cyst and provide a copy of the pathologist’s report.

**PROCEDURE 07465**
Destruction of lesion(s) by physical methods, by report.

Please include a written report on the Attending Dentist’s Statement. The allowance will be determined by Premier’s consultant staff.

**EXCISION OF BONE TISSUE**

**PROCEDURE 07470 - X**
Removal of exostosis – maxilla or mandible.

1. Please identify the quadrant treated by abbreviation (UR, UL, LR, LL) in the column marked “tooth number” on the Attending Dentist’s Statement. If multiple quadrants are involved, use separate lines of the treatment form and enter a separate fee for each quadrant.

2. This service is considered part of, and included in the fee for, osseous surgery (procedure 04260).

**PROCEDURE 07480 - X**
Partial ostectomy (guttering or saucерization).

Please include a written report on the Attending Dentist’s Statement. The allowance will be determined by Premier’s consultant staff.

**PROCEDURE 07490 - X**
Radical resection of mandible with bone graft.

An operative report must be provided on the Attending Dentist’s Statement or attached when more space is needed. Please enclose a copy of the pathologist’s report for review by our consultant staff to determine the allowance.

**SURGICAL INCISION**

**PROCEDURE 07510**
Incision and drainage of abscess – intraoral soft tissue.

1. This procedure involves incision and the placement of a surgical draining device.

2. Please provide brief clinical description on the Attending
NOTE: PLEASE REFER TO A PATIENT’S PREMIER CERTIFICATE OF INSURANCE TO DETERMINE COVERED SERVICES AND SUPPLIES, EXCLUSIONS AND LIMITATIONS FOR AN INDIVIDUAL PATIENT.

Please submit mounted x-ray.

PROCEDURE 07630 - X
Mandible – open reduction (teeth immobilized if present).

Please submit mounted x-ray.

PROCEDURE 07640 - X
Mandible – closed reduction (teeth immobilized if present).

Please submit mounted x-ray.

PROCEDURE 07650 - X
Malar and/or zygomatic arch – open reduction.

Please submit mounted x-ray and an operative report.

The consultant staff will determine Premier’s allowances.

PROCEDURE 07660 - X
Malar and/or zygomatic arch – closed reduction.

Please submit mounted x-ray and an operative report.

The consultant staff will determine Premier’s allowances.

PROCEDURE 07670 - X
Alveolus – stabilization of teeth, open reduction splinting.

Please submit mounted x-ray(s) and an operative report and indicate the teeth involved.

PROCEDURE 07680 - X
Facial bones – complicated reduction with fixation and multiple surgical approaches.

Please submit mounted x-ray and an operative report. The consultant staff will determine Premier’s allowance.

TREATMENT OF FRACTURES – SIMPLE

PROCEDURE 07610 - X
Maxilla – open reduction (teeth immobilized if present).

Please submit mounted x-ray.

PROCEDURE 07620 - X
Maxilla – closed reduction (teeth immobilized if present).

Please submit mounted x-ray and an operative report.

PROCEDURE 07720 - X
Maxilla – closed reduction.

Please submit mounted x-ray and an operative report.

PROCEDURE 07730 - X
Mandible – open reduction.

Please submit mounted x-ray and an operative report.

PROCEDURE 07740 - X
Mandible – closed reduction.

Please submit mounted x-ray and an operative report.

PROCEDURE 07750 – X
Malar and/or zygomatic arch – open reduction.

Please submit mounted x-ray and an operative report.

The consultant staff will determine Premier’s allowance.

PROCEDURE 07760 - X
Malar and/or zygomatic arch – closed reduction.

Please submit mounted x-ray and an operative report.

The consultant staff will determine Premier’s allowance.

PROCEDURE 07770 - X
Alveolus – stabilization of teeth, open reduction splinting.

Please submit mounted x-ray and an operative report. The consultant staff will determine Premier’s allowance.

PROCEDURE 07780 - X
Facial bones – complicated reduction with fixation and multiple surgical approaches.

Please submit mounted x-ray and an operative report. The consultant staff will determine Premier’s allowance.

REDUCTION OF DISLOCATION AND MANAGEMENT OF OTHER
TEMPOROMANDIBULAR JOINT DYSFUNCTIONS

GENERAL GUIDELINES

1. With the exception of specific procedures for reduction of fractures and dislocations, services related to TMJ dysfunctions are excluded from most Premier programs. The cost of excluded procedures is the financial responsibility of the patient.

2. Through a contract rider to the standard group contract, a few Premier groups provide limited coverage for certain TMJ services, subject to a lifetime maximum allowance:

   - 07880 Occlusal orthotic device
   - 07881 Removable metal
   - 09940 Occlusal guard
   - 09952 Occlusal adjustment – complete

3. Repair or replacement of any appliance furnished in whole or in part as TMJ benefits is not covered. The cost is the financial obligation of the patient.

4. Services which would normally be provided under medical care, including, but not limited to, psychotherapy, are not benefits.

PROCEDURE 07810
Open reduction of dislocation.

Please submit history and operative report for review by the Premier consultant staff, which will determine Premier’s allowance.

PROCEDURE 07820
Closed reduction of dislocation.

This service is defined as a single emergency repositioning of the mandible by physical manipulation.

PROCEDURE 07830
Manipulation under anesthesia.

Please submit history and operative report for review by the Premier consultant staff.

PROCEDURE 07840
Condylectomy.

This service is not a benefit of most Premier programs. The fee is the patient’s responsibility.

PROCEDURE 07850
Meniscectomy.

This service is not a benefit of most Premier programs. The fee is the patient’s responsibility.

PROCEDURE 07860
Arthroscopy, by report.

This service is not a benefit of most Premier programs. The fee is the patient’s responsibility.

PROCEDURE 07865
Arthroplasty, by report.

This service is not a benefit of most Premier programs. The fee is the patient’s responsibility.

PROCEDURE 07870
Arthrocentesis, by report.

This service is not a benefit of most Premier programs. The fee is the patient’s responsibility.

PROCEDURE 07880
Occlusal orthotic device.

1. This service is not a benefit of most Premier programs.

2. Authorization is required when the group contract provides coverage for this and other TMJ services.

PROCEDURE 07881
Removal of metal overlay stabilizing appliance.

1. This service is not a benefit of most Premier programs.

2. Authorization is required when the group contract provides coverage for this and other TMJ services.

3. Replacement or repair of a metal overlay stabilizing appliance provided under a Premier program is not covered.

PROCEDURE 07899
Unspecified TMD procedure, by report.

Please enter a complete description of service and clinical reason on the Attending Dentist’s Statement.

REPAIR OF TRAUMATIC WOUNDS

PROCEDURE 07910
Suture of recent small wounds up to 5 cm.

A report of the extent of the treatment must be submitted. Please provide a written report on the Attending Dentist’s Statement or attach a report when more space is needed. The clinical remarks will be reviewed by our consultant staff to determine the allowance.

PROCEDURE 07911
Suture of complex wounds up to 5 cm.

A report of the extent of the treatment must be submitted. Please provide a written report on the Attending Dentist’s Statement or attach a report when more space is needed. The clinical remarks will be reviewed by the Premier consultant staff to determine the allowance.
NOTE: PLEASE REFER TO A PATIENT’S PREMIER CERTIFICATE OF INSURANCE TO DETERMINE COVERED SERVICES AND SUPPLIES, EXCLUSIONS AND LIMITATIONS FOR AN INDIVIDUAL PATIENT.

PROCEDURE 07912
Suture of complex wounds greater than 5 cm.
A report of the extent of treatment must be submitted. Please provide a written report on the Attending Dentist’s Statement or attach a report when more space is needed. The clinical remarks will be reviewed by the Premier staff to determine the allowance.

PROCEDURE 07940 - X
Osteoplasty – for orthognathic deformities.

1. Please submit mounted x-ray and an operative report.
   The consultant staff will determine Premier’s allowance.

2. This service is a benefit only for groups which have orthodontic coverage. Any payment will be applied toward the individual’s orthodontic maximum.

PROCEDURE 07941 - X
Osteotomy – ramus, closed.

1. Please submit mounted x-ray and an operative report.
   The consultant staff will determine Premier’s allowance.

2. This service is a benefit only for groups which have orthodontic coverage. Any payment will be applied toward the individual’s orthodontic maximum.

PROCEDURE 07942 - X
Osteotomy – ramus, open.

1. Please submit mounted x-ray and an operative report.
   The consultant staff will determine Premier’s allowance.

2. This service is a benefit only for groups which have orthodontic coverage. Any payment will be applied toward the individual’s orthodontic maximum.

PROCEDURE 07943 - X
Osteotomy – ramus, open with bone graft.

Please submit mounted x-ray and an operative report.

2. This service is a benefit only for groups which have orthodontic coverage. Any payment will be applied toward the individual’s orthodontic maximum.

PROCEDURE 07944 - X
Osteotomy – segmented or subapical – per sextant or quadrant.

Please submit mounted x-ray and an operative report.

2. This service is a benefit only for groups which have orthodontic coverage. Any payment will be applied toward the individual’s orthodontic maximum.

PROCEDURE 07946 - X
LeFort I (maxilla – total).

Please submit mounted x-ray and an operative report.

2. This service is a benefit only for groups which have orthodontic coverage. Any payment will be applied toward the individual’s orthodontic maximum.

PROCEDURE 07948 - X
LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) – without bone graft.

Please submit mounted x-ray and an operative report.

2. This service is a benefit only for groups which have orthodontic coverage. Any payment will be applied toward the individual’s orthodontic maximum.

PROCEDURE 07949 - X
LeFort II or LeFort III with bone graft.

Please submit mounted x-ray and an operative report.

2. This service is a benefit only for groups which have orthodontic coverage. Any payment will be applied toward the individual’s orthodontic maximum.

PROCEDURE 07960
Frenulectomy (frenectomy or frenotomy) – separate procedure.
This service is considered part of and included in the fee for, alveoloplasty (procedures 07310 and 07320), gingivectomy or gingivoplasty (procedures 04210 and 04211), osseous surgery (procedure 04260), mucogingival surgery (procedure 04250) and soft tissue grafts (procedures 04270 and 04271).

PROCEDURE 07970
Excision of hyperplastic tissue – per arch.
Please identify the arch treated as either U (upper arch) or L (lower arch) in the column marked “tooth number” on the Attending Dentist’s Statement. If both arches are involved, use two lines of the treatment form and enter a separate fee for each arch.
PROCEDURE 07971-X
Excision of pericoronal gingiva

1. Applies most commonly to the removal of the operculum in the third molar region.
2. The preparation of gingival tissues for placing a crown or other restoration is included in the fee for restoration.

Please submit mounted x-ray and narrative report for exceptional circumstances.

PROCEDURE 07980 - X
Sialolithotomy

Please submit mounted x-ray and narrative report for exceptional circumstances.

PROCEDURE 07981 - X
Excision of salivary gland, by report.

Please submit mounted x-ray and detailed operative report.

The Premier consultant staff will determine Premier’s allowance.

PROCEDURE 07982
Sialodochoplasty.

Please provide clinical report documenting the need for the service for review by the Premier consulting staff.

PROCEDURE 07983
Closure of salivary fistula.

Please provide clinical history of the patient’s condition and an operative report for review by the Premier consultant staff.

PROCEDURE 07990
Emergency tracheotomy

This service is not a benefit of Premier programs. The fee is the patient’s responsibility.

PROCEDURE 07991
Coronoidectomy.

This service is not a benefit of Premier programs. The fee is the patient’s responsibility.

PROCEDURE 07999
Unspecified oral surgery procedure, by report

Please enter a complete description of service and clinical need on the Attending Dentist’s Statement.
ORTHODONTICS (08000 – 08999)

Procedure Codes

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<td>08999 Unspecified orthodontic procedure, by report</td>
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</table>

Guidelines

ORTHODONTICS – GENERAL GUIDELINES

1. To determine whether your patient has orthodontic benefits, please call (916) 920-2500.

2. Orthognathic surgery is generally a benefit of groups with orthodontic coverage.

3. Services related to orthodontic treatment are usually benefits of a patient's diagnostic or basic coverage, whether or not the program provides orthodontic coverage. Such procedures may include examination, x-rays and extractions.

4. Allowances for orthodontic procedures include all appliances, adjustments, insertion, removal and post treatment stabilization (retention).

5. Repairs or replacements of any appliances inserted under a Premier program are not covered. The fee is the patient's responsibility.

6. Premier's orthodontic coding and nomenclature classifies treatment based on two factors: the type of dentition (primary, transitional/mixed, and permanent) and the expected duration of the active phase of treatment. Time intervals are in six month increments. When submitting a claim or request for prior-authorization, please select the code that corresponds to the patient's dentition and most closely to the estimated length of treatment.

7. Cases involving minor treatment for tooth guidance and interceptive orthodontic treatment should be submitted under the codes for limited treatment (codes 08306-08112, 08706-08712).

8. Please do not submit x-rays or diagnostic casts with orthodontic claims or requests for prior-authorization unless specifically requested to do so by Premier.

MINOR TREATMENT TO CONTROL HARMFUL HABITS

PROCEDURE 08210
Appliance to control harmful habits (removable).

1. This procedure is an orthodontic service only, and is not to be confused with a night guard, bite guard or occlusal splint which are not benefits.

2. Please indicate the nature of the harmful habit, and the estimated number of months of treatment.

PROCEDURE 08220
Appliances to control harmful habits (fixed or cemented).

This procedure is not a benefit of Premier programs.

TREATMENT OF THE PRIMARY DENTITION

PROCEDURE 08306
Limited treatment (1 arch or less), 6 months

PROCEDURE 08312
Limited treatment (1 arch or less), 12 months

TREATMENT OF THE TRANSITIONAL (MIXED) DENTITION

PROCEDURE 08406
Limited treatment (1 arch or less), 6 months

– Submit x-rays only for procedures marked “X” –
**NOTE:** Please refer to a patient's Premier Certificate of Insurance to determine covered services and supplies, exclusions and limitations for an individual patient.

**PROCEDURE 08412**
Limited treatment (1 arch or less), 12 months.

**PROCEDURE 08512**
Full treatment, 12 months.

**PROCEDURE 08518**
Full treatment, 18 months.

**PROCEDURE 08524**
Full treatment, 24 months.

If the active phase of treatment is estimated to extend beyond 24 months, please use the by report procedure 08999 and include a complete description for review by the Premier orthodontic consultant staff.

**PROCEDURE 08610**
Phased treatment – Phase 1

Procedure 08610 encompasses corrective measures that start in the primary or transitional dentition, with additional treatment postponed while awaiting further development of the adult dentition.

**PROCEDURE 08620**
Phased treatment – Phase 2.

Procedure 08620 is the continuation of treatment (described under procedure 08610), usually performed on the permanent dentition.

**PROCEDURE 08706**
Limited treatment (1 arch or less), 6 months.

**PROCEDURE 08712**
Limited treatment (1 arch or less), 12 months.

**PROCEDURE 08818**
Full treatment, 18 months.

**PROCEDURE 08824**
Full treatment, 24 months.

**PROCEDURE 08830**
Full treatment, 30 months.

If the active phase of treatment is estimated to extend beyond 30 months, please use the by report procedure 08999 and include a complete description for review by the Premier orthodontic consultant staff.

**OTHER ORTHODONTIC SERVICES**

**PROCEDURE 08910**
Replacement retainer.

Repair or replacement of any appliance inserted under a Premier program is not a benefit. The fee is the patient's responsibility.

**PROCEDURE 08999**
Unspecified orthodontic procedure, by report.

Please enter a complete description of the service on the Attending Dentist's Statement for review by the Premier orthodontic consultant staff.

**TREATMENT OF THE PERMANENT DENTITION**

**PROCEDURE 08706**
Limited treatment (1 arch or less), 6 months.

**PROCEDURE 08712**
Limited treatment (1 arch or less), 12 months.

**PROCEDURE 08818**
Full treatment, 18 months.

**PROCEDURE 08824**
Full treatment, 24 months.

**PROCEDURE 08830**
Full treatment, 30 months.

-- Submit x-rays only for procedures marked “X” --
# ADJUNCTIVE GENERAL SERVICES (09000 – 09999)

**Procedure Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>09110</td>
<td>Palliative (emergency) treatment of dental pain – minor procedure</td>
</tr>
<tr>
<td>09210</td>
<td>Local anesthesia not in conjunction with operative or surgical procedures</td>
</tr>
<tr>
<td>09211</td>
<td>Regional block anesthesia</td>
</tr>
<tr>
<td>09212</td>
<td>Trigeminal division block anesthesia</td>
</tr>
<tr>
<td>09215</td>
<td>Local anesthesia</td>
</tr>
<tr>
<td>09220</td>
<td>General anesthesia – first 30 minutes</td>
</tr>
<tr>
<td>09221</td>
<td>General anesthesia – each additional 15 minutes</td>
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<tr>
<td>09230</td>
<td>Analgesia</td>
</tr>
<tr>
<td>09240</td>
<td>Intravenous sedation</td>
</tr>
<tr>
<td>09310</td>
<td>Special consultation (specialist only – separate fee only if patient not treated by consultant)</td>
</tr>
<tr>
<td>09410</td>
<td>House call</td>
</tr>
<tr>
<td>09420</td>
<td>Hospital call</td>
</tr>
<tr>
<td>09430</td>
<td>Office visit for observation (during regularly scheduled hours) – no other services performed</td>
</tr>
<tr>
<td>09440</td>
<td>Office visit – after regularly scheduled hours</td>
</tr>
<tr>
<td>09910</td>
<td>Application of desensitizing medicament</td>
</tr>
<tr>
<td>09920</td>
<td>Behavior management, by report</td>
</tr>
<tr>
<td>09930</td>
<td>Treatment of complications (post-surgical) – unusual circumstances, narrative report required</td>
</tr>
<tr>
<td>09940</td>
<td>Occlusal guard, by report</td>
</tr>
<tr>
<td>09941</td>
<td>Fabrication of athletic mouthguard, by report</td>
</tr>
<tr>
<td>09950</td>
<td>Occlusion analysis – mounted case, including all related procedures</td>
</tr>
<tr>
<td>09951</td>
<td>Occlusal adjustment – limited</td>
</tr>
<tr>
<td>09952</td>
<td>Occlusal adjustment – complete</td>
</tr>
<tr>
<td>09999</td>
<td>Unspecified adjunctive procedure, by report</td>
</tr>
</tbody>
</table>

**Guidelines**

## UNCLASSIFIED TREATMENT

**PROCEDURE 09110**

Palliative (emergency) treatment of dental pain – minor procedure.

1. This service is payable per visit, not per tooth, and the fee includes all treatment provided other than required x-rays.
2. Emergencies cannot be submitted for predetermination of cost.
3. A temporary restoration is considered a component of, and included in the fee for, the final restoration. Such temporary restorations are not considered emergency palliatives.
4. Please provide in the description of service a description of the nature of the emergency and the treatment provided.

## ANESTHESIA

**PROCEDURE 09210**

Local anesthesia not in conjunction with operative or surgical procedures.

In most instances, local anesthesia is considered to be part of, and included in the fee for, the service provided. If there are exceptional circumstances, please provide a brief narrative on the Attending Dentist's Statement for review by the Premier consultant staff.

**PROCEDURE 09211**

Regional block anesthesia.

In most instances, this procedure is considered to be part of, and included in the fee for, the services provided. If there are exceptional circumstances, please provide a brief narrative on the Attending Dentist’s Statement for review by the Premier consultant staff.

**PROCEDURE 09212**

Trigeminal division block anesthesia.

In most instances, local anesthesia is considered to be part of, and included in the fee for, the service provided. If there are exceptional circumstances, please provide a brief narrative on the Attending Dentist's Statement for review by the Premier consultant staff.

**PROCEDURE 09215**

Local anesthesia.

This procedure is considered part of, and included in the fee for, other services. A separate fee may not be charged to the patient.

**PROCEDURE 09220**

General anesthesia – first 30 minutes.

1. General anesthesia is a benefit of most Premier programs only when provided by a dentist in conjunction with covered oral surgery procedures (procedures 07000 through 07999). When otherwise provided, the patient is responsible for the fee.
2. Allowance for general anesthesia is for office administration only. Additional charges for anesthesiologists or anesthesiologists are the patient's responsibility.
3. For Premier to make an allowance for general anesthesia, the dentist’s general anesthesia permit number must be indicated on the Attending Dentist’s Statement.

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"Submit x-rays only for procedures marked ‘X’ –"
enter the permit number on or below the description of service.

4. If more than 30 minutes of general anesthesia are administered, please see procedure 09221.

PROCEDURE 09221
General anesthesia – each additional 15 minutes.

Please use one line of the Attending Dentist’s Statement for each additional 15 minutes of general anesthesia administered. Indicate a separate fee for each 15-minute period.

PROCEDURE 09230
Analgesia.

This procedure is not a benefit of most Premier programs. The fee is the patient’s responsibility.

PROCEDURE 09240
Intravenous sedation

1. IV sedation is not a benefit of most Premier programs. For those groups which provide coverage for IV sedation, the procedure is generally a benefit only when administered in conjunction with covered surgery. If otherwise provided, the fee is the patient’s responsibility.

2. When IV sedation is administered, please indicate the name of the medication(s) and the duration on the Attending Dentist’s Statement to enable the Premier consultant staff to determine the allowance.

3. Please enter the dentist’s permit number on or below the description of service line.

PROFESSIONAL VISITS

PROCEDURE 09410
House call.

This procedure is not a benefit. The fee is the patient’s responsibility.

PROCEDURE 09420
Hospital call.

This procedure is not a benefit. The fee is the patient’s responsibility.

PROCEDURE 09430
Office visit for observation (during regularly scheduled hours) – no other services performed.

1. This is not an examination procedure. It is allowable only when the visit is for the purpose of observing or treating injuries and when no other services are provided. The nature of the injury must be described on the Attending Dentist’s Statement.

2. This procedure is not payable in conjunction with hospital visits, periodontal recalls, orthodontic observation or as a routine post-operative visit.

PROCEDURE 09440
Office visit – after regularly scheduled hours.

Any additional services provided should be indicated by specific procedure codes on separate lines of the Attending Dentist’s Statement.

DRUGS

PROCEDURE 09610
Therapeutic drug injection

1. Therapeutic drug injection is not a benefit. The fee is the patient’s responsibility.

2. Local anesthesia is considered a component of, and included in the fee for, a complete procedure.

PROCEDURE 09630
Other drugs and/or medicaments, by report.

Prescription drugs, premedication and/or analgesia are not benefits of most Premier programs. The fee is the patient’s responsibility.

MISCELLANEOUS SERVICES

PROCEDURE 09910
Application of desensitizing medicament.

The application of fluoride and other medicaments for desensitizing is not a benefit. The fee is the patient’s responsibility.

PROCEDURE 09920
Behavior management, by report.

This procedure is not a benefit. The fee is the patient’s responsibility.

PROCEDURE 09930
Treatment of complications (post-surgical) – unusual circumstances, narrative report required.

1. Routine postoperative visits for irrigation, dressing change and suture removal are considered to be part of, and
included in the fee for the surgical service.

2. In the case of postoperative complications, please provide a narrative description of the complications in the description of service for review by the Premier consultant staff.

PROCEDURE 09940
Occlusal guard, by report.

1. Occlusal guards are not benefits of most Premier programs.

2. Authorization is required when the appliance is to be provided as part of covered TMJ therapy.

3. Some Premier groups may include coverage for an occlusal guard as part of their periodontal benefits. In these instances, the benefit is limited to a maximum lifetime allowance per patient.

4. Repair or replacement of an occlusal guard provided under any Premier program is not a benefit. Any fee is the patient’s responsibility.

PROCEDURE 09941
Fabrication of athletic mouthguard, by report.

This procedure is not a benefit. The fee is the patient’s responsibility.

PROCEDURE 09950
Occlusion analysis – mounted, including all related procedures.

This procedure is not a benefit. The fee is the patient’s responsibility.

PROCEDURE 09951
Occlusal adjustment – limited.

1. Limited occlusal adjustment is not a benefit of most Premier programs.

2. This service is considered a necessary part of, and included in the fee for, multiple restorations involving occlusal surfaces and prosthodontic services.

3. For groups which cover this procedure (providing limited coverage for certain TMJ services), authorization is required.

4. Please indicate the quadrant treated by abbreviation (UR, UL, LR, LL) in the column marked “tooth number” on the Attending Dentist’s Statement. Use one line of the treatment form for each quadrant and enter a separate fee for each quadrant.

PROCEDURE 09952
Occlusal adjustment – complete.

1. Complete occlusal adjustment is not a benefit of most Premier programs.

2. For groups which cover this procedure (providing limited coverage for certain TMJ services), authorization is required.

PROCEDURE 09999
Unspecified adjunctive procedure, by report.

Please provide a complete description of service and clinical reason on the Attending Dentist’s Statement.

– Submit x-rays only for procedures marked “X” –
PROCEDURE LISTING (00100 – 09999) Page 50 of 54 Revised 08-01-2000

DIAGNOSTIC (00100 – 09999)

Clinical oral examinations
00110 Initial oral examination
00120 Periodic oral evaluation
00130 Emergency oral examination
00140 Limited oral examination

Radiographs
00210 Intraoral—complete series (including bitewings)
00220 Intraoral—periapical—first film
00230 Intraoral—periapical—each additional film
00240 Intraoral—occlusal film
00250 Extraoral—first film
00260 Extraoral—each additional film
00270 Bitewings—single film
00272 Bitewings—two films
00273 Bitewings—three films
00274 Bitewings—four films
00310 Sialography
00320 TMJ arthrogram including injection
00321 Other TMJ films, by report
00322 Tomographic survey
00330 Panoramic film
00340 Cephalometric film
00415 Bacteriologic studies
00425 Caries susceptibility tests
00470 Diagnostic casts
00471 Diagnostic photographs
00501 Histopathologic exams
00999 Unspecified diagnostic procedure, by report

PREVENTIVE (01000 – 01999)

Dental prophylaxis
01110 Prophylaxis - adult
01120 Prophylaxis - child to age 14

Topical fluoride treatment (office procedure)
01201 Topical application of fluoride (prophylaxis not included)- child to age 14
01203 Topical application of fluoride (prophylaxis not included)- child to age 14

Other preventive services
01310 Nutritional counseling for the control of dental disease
01330 Oral hygiene instruction
01351 Sealant - per tooth

Space maintenance (passive appliances)
01510 Space maintainer - fixed unilateral
01515 Space maintainer - fixed bilateral
01520 Space maintainer - removable unilateral
01525 Space maintainer — removable bilateral
01999 Unspecified preventive procedure, by report

RESTORATIVE (02000 – 02999)

Amalgam restorations (including polishing)
02110 Amalgam – one surface, primary
02120 Amalgam – two surfaces, primary
02130 Amalgam – three surfaces, primary
02131 Amalgam – four or more surfaces, primary
02140 Amalgam – one surface, permanent
02150 Amalgam – two surfaces, permanent
02160 Amalgam – three surfaces, permanent
02161 Amalgam – four or more surfaces, permanent

Silicate restorations
02210 Silicate cement – per restoration
02330 Resin – anterior
02350 Resin – two surfaces, anterior
02332 Resin – three surfaces, anterior
0235X Resin – four or more surfaces or involving incisal angle (anterior)

02380 Resin – one surface, posterior – primary
02381 Resin – two surfaces, posterior – primary
02382 Resin – three or more surfaces, posterior – primary
02385 Resin – one surface, posterior – permanent
02386 Resin – two surfaces, posterior – permanent
02387 Resin – three or more surfaces, posterior – permanent

Inlay restorations
02510X Inlay – metallic – one surface
02520X Inlay – metallic – two surfaces
02530X Inlay – metallic – three or more surfaces
02540X Onlay – metallic – per tooth (in addition to inlay)
02610X Inlay – porcelain/ceramic – one surface
02620X Inlay – porcelain/ceramic – two surfaces
02630X Inlay – porcelain/ceramic – three or more surfaces
02650X Inlay – composite/resin – one surface (laboratory processed)
02651X Inlay – composite/resin – two surfaces (laboratory processed)
02652X Inlay – composite/resin – three or more surfaces (laboratory processed)

Crows-single restoration only
02710X Crown – resin (laboratory)
02740X Crown – porcelain/ceramic substrate
02750X Crown – porcelain fused to high noble metal
02751X Crown – porcelain fused to predominantly base metal
02752X Crown – porcelain fused to noble metal
02790X Crown – full cast high noble metal
02791X Crown – full cast predominantly base metal
02792X Crown – full cast noble metal
02810X Crown – ¾ cast metal

Other restorative services
02910 Recement inlay
02920 Recement crown

– Submit x-rays only for procedures marked “X” — Coverage Restrictions Discussed in Applicable Section of Handbook

NOTE: PLEASE REFER TO A PATIENT’S PREMIER CERTIFICATE OF INSURANCE TO DETERMINE COVERED SERVICES AND SUPPLIES, EXCLUSIONS AND LIMITATIONS FOR AN INDIVIDUAL PATIENT.
ENDODONTICS

02930 Prefabricated stainless steel crown – primary tooth
02931 Prefabricated stainless steel crown – permanent tooth
02932 Prefabricated resin crown
02933 Prefabricated stainless steel crown with resin window
02950 Crown buildup (substructure), including any pins
02951 Pin retention – per tooth, in addition to restoration
02952 Cast post and core in addition to crown
02954 Prefabricated post and core in addition to crown
02960 Labial veneer (laminate) – chairside
02961 Labial veneer (resin laminate) – laboratory
02962 Labial veneer (porcelain laminate) – laboratory
02980 Crown repair, by report
02999 Unspecified restorative procedure, by report

* Repair of perforations root resorption, etc.*

PERIAPICAL SERVICES

03410X Apicoectomy/periapical surgery – anterior root
03421X Apicoectomy/periapical surgery – bicuspid (first root)
03425X Apicoectomy/periapical surgery – molar (first root)
03426 Apicoectomy/periapical surgery (each additional root)
03430X Retrograde filling – per root
03450 Root amputation – per root
03460P Endodontic endosseous implant

OTHER ENDODONTIC PROCEDURES

03920 Hemisection (including any root removal), not including root canal therapy
03960 Bleaching of discolored restoration
03999 Unspecified endodontic procedure, by report

PERIODONTICS

04321 Provisional splinting – extracoronal, by report
04341P Periodontal root planing – per quadrant

Other periodontal services

04910 Periodontal maintenance procedures following active therapy (periodontal prophylaxis)
04920 Unscheduled dressing change (by someone other than treating dentist)
04999 Unspecified periodontal procedure, by report

PROSTHODONTICS – REMOVABLE

(05000 – 05899)

Complete dentures (including routine post delivery care)
05110 Complete denture, upper
05120 Complete denture, lower
05130 Immediate denture, upper
05140 Immediate denture, lower

Partial dentures (including routine post delivery care)
05211 Upper partial denture – resin base (including any conventional clasps, rests and teeth)
05212 Lower partial denture – resin base (including any conventional clasps, rests and teeth)
05213 Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)
05214 Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)
05281Removable unilateral partial denture – one piece cast metal (including clasps and teeth)

ADJUSTMENTS TO DENTURES

05410 Adjust complete denture – upper
05411 Adjust complete denture – lower
05421 Adjust partial denture – upper

Submit x-rays only for procedures marked “X” – Coverage Restrictions Discussed in Applicable Section of Handbook.
## Procedure Listing

### Other Removable Prosthetic Services

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<th>Description</th>
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<tbody>
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<td>05422</td>
<td>Adjust partial denture – lower</td>
</tr>
<tr>
<td>05510</td>
<td>Repair complete dentures</td>
</tr>
<tr>
<td>05520</td>
<td>Replace broken complete denture base</td>
</tr>
<tr>
<td>05610</td>
<td>Repair partial denture base</td>
</tr>
<tr>
<td>05620</td>
<td>Repair cast framework, by report</td>
</tr>
<tr>
<td>05630</td>
<td>Repair or replace broken clasp</td>
</tr>
<tr>
<td>05640</td>
<td>Replace broken teeth – per tooth</td>
</tr>
<tr>
<td>05650</td>
<td>Add tooth to existing partial denture</td>
</tr>
<tr>
<td>05660</td>
<td>Add clasp to existing partial denture</td>
</tr>
<tr>
<td>05710</td>
<td>Rebase complete upper denture</td>
</tr>
<tr>
<td>05711</td>
<td>Rebase complete lower denture</td>
</tr>
<tr>
<td>05720</td>
<td>Rebase upper partial denture</td>
</tr>
<tr>
<td>05721</td>
<td>Rebase lower partial denture</td>
</tr>
<tr>
<td>05730</td>
<td>Reline complete upper denture (chairside)</td>
</tr>
<tr>
<td>05731</td>
<td>Reline complete lower denture (chairside)</td>
</tr>
<tr>
<td>05740</td>
<td>Reline upper partial denture (chairside)</td>
</tr>
<tr>
<td>05741</td>
<td>Reline lower partial denture (chairside)</td>
</tr>
<tr>
<td>05750</td>
<td>Reline complete upper denture (laboratory)</td>
</tr>
<tr>
<td>05751</td>
<td>Reline complete lower denture (laboratory)</td>
</tr>
<tr>
<td>05760</td>
<td>Reline upper partial denture (laboratory)</td>
</tr>
<tr>
<td>05761</td>
<td>Reline lower partial denture (laboratory)</td>
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</tbody>
</table>

### Denture Rebase Procedures

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<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>05760</td>
<td>Reline upper partial denture (chairside)</td>
</tr>
<tr>
<td>05761</td>
<td>Reline lower partial denture (chairside)</td>
</tr>
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</table>

### Other Removable Prosthetic Services

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>05810</td>
<td>Temporary complete denture (upper)</td>
</tr>
<tr>
<td>05811</td>
<td>Temporary complete denture (lower)</td>
</tr>
<tr>
<td>05820</td>
<td>Temporary partial – stayplate denture (upper)</td>
</tr>
<tr>
<td>05821</td>
<td>Temporary partial – stayplate denture (lower)</td>
</tr>
<tr>
<td>05850</td>
<td>Tissue conditioning, maxillary</td>
</tr>
</tbody>
</table>

### Denture Reline Procedures

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>05851</td>
<td>Tissue conditioning, Mandibular</td>
</tr>
<tr>
<td>05860</td>
<td>Overdenture – complete, by report</td>
</tr>
<tr>
<td>05861</td>
<td>Overdenture – partial, by report</td>
</tr>
<tr>
<td>05862</td>
<td>Precision attachment, by report</td>
</tr>
<tr>
<td>05899</td>
<td>Unspecified removable prosthetic procedure, by report</td>
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</table>

### Denture Rebasing Procedures

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>05931</td>
<td>Surgical obturator</td>
</tr>
<tr>
<td>05932</td>
<td>Post-surgical obturator</td>
</tr>
<tr>
<td>05933</td>
<td>Refitting of obturator</td>
</tr>
<tr>
<td>05934</td>
<td>Mandibular resection (flare) prosthesis</td>
</tr>
<tr>
<td>05935</td>
<td>Mandibular resection (denture) prosthesis</td>
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</tbody>
</table>

### Denture Reline Procedures

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>05951</td>
<td>Feeding aid</td>
</tr>
<tr>
<td>05952</td>
<td>Pediatric speech aid</td>
</tr>
<tr>
<td>05953</td>
<td>Adult speech aid</td>
</tr>
<tr>
<td>05954</td>
<td>Superimposed prosthesis</td>
</tr>
<tr>
<td>05955</td>
<td>Palatal lift prosthesis</td>
</tr>
<tr>
<td>05956</td>
<td>Obturator</td>
</tr>
<tr>
<td>05957</td>
<td>Speech bulb</td>
</tr>
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</table>

### Denture Reline Procedures

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>05982</td>
<td>Surgical stent</td>
</tr>
<tr>
<td>05983</td>
<td>Radiation carrier</td>
</tr>
<tr>
<td>05984</td>
<td>Radiation shield</td>
</tr>
<tr>
<td>05985</td>
<td>Radiation cone locator</td>
</tr>
<tr>
<td>05986</td>
<td>Fluoride gel carrier</td>
</tr>
<tr>
<td>05999</td>
<td>Unspecified maxillofacial prosthesis, by report.</td>
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</tbody>
</table>

### Other Fixed Prosthetic Services

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>06010</td>
<td>Surgical placement of implant body: endosteal implant</td>
</tr>
<tr>
<td>06020</td>
<td>Abutment placement or substitution: endosteal implant</td>
</tr>
<tr>
<td>06040</td>
<td>Surgical placement: eposteal implant</td>
</tr>
<tr>
<td>06050</td>
<td>Surgical placement: tranosteal implant</td>
</tr>
<tr>
<td>06055</td>
<td>Dental implant supported connecting bar</td>
</tr>
<tr>
<td>06080</td>
<td>Implant maintenance procedures</td>
</tr>
<tr>
<td>06090</td>
<td>Repair implant supported prosthesis, by report</td>
</tr>
<tr>
<td>06095</td>
<td>Repair implant abutment, by report</td>
</tr>
<tr>
<td>06100</td>
<td>Implant removal, by report</td>
</tr>
<tr>
<td>06199</td>
<td>Unspecified implant procedure, by report</td>
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</tbody>
</table>

### Implant Services

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>06240</td>
<td>Pontic – porcelain fused to high noble metal</td>
</tr>
<tr>
<td>06242</td>
<td>Pontic – porcelain fused to noble metal</td>
</tr>
<tr>
<td>06245</td>
<td>Pontic – porcelain, ceramic substrate</td>
</tr>
</tbody>
</table>

### Bridge Retainers

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>06520X</td>
<td>Inlay – metal – two surfaces</td>
</tr>
<tr>
<td>06530</td>
<td>Inlay – metal – three or more surfaces</td>
</tr>
<tr>
<td>06540</td>
<td>Inlay – metal per tooth in addition to inlay</td>
</tr>
<tr>
<td>06545X</td>
<td>Retainer – cast metal for resin bonded fixed prosthesis</td>
</tr>
</tbody>
</table>

### Bridge Retainers - Crowns

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>06750X</td>
<td>Crown – porcelain fused to high noble metal</td>
</tr>
<tr>
<td>06751X</td>
<td>Crown – porcelain fused to noble metal</td>
</tr>
<tr>
<td>06752X</td>
<td>Crown – porcelain fused to noble metal</td>
</tr>
<tr>
<td>06780X</td>
<td>Crown – ¾ cast high noble metal</td>
</tr>
<tr>
<td>06790X</td>
<td>Crown – full cast high noble metal</td>
</tr>
<tr>
<td>06791X</td>
<td>Crown – full cast predominately base metal</td>
</tr>
<tr>
<td>06792X</td>
<td>Crown – full cast noble metal</td>
</tr>
</tbody>
</table>

### Other Fixed Prosthetic Services

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>06930</td>
<td>Recement bridge</td>
</tr>
<tr>
<td>06940</td>
<td>Stress breaker</td>
</tr>
<tr>
<td>06950</td>
<td>Precision attachment</td>
</tr>
</tbody>
</table>

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**NOTE:** Please refer to a patient’s Premier Certificate of Insurance to determine covered services and supplies, exclusions and limitations for an individual patient.

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**Premier Access Dentist Handbook**

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**Maxillofacial Prosthetics (05900 – 05999)**

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>05931</td>
<td>Surgical obturator</td>
</tr>
<tr>
<td>05932</td>
<td>Post-surgical obturator</td>
</tr>
<tr>
<td>05933</td>
<td>Refitting of obturator</td>
</tr>
<tr>
<td>05934</td>
<td>Mandibular resection (flare) prosthesis</td>
</tr>
<tr>
<td>05935</td>
<td>Mandibular resection (denture) prosthesis</td>
</tr>
</tbody>
</table>

**Prosthodontics – Fixed (06200 – 06999)**

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>06210</td>
<td>Pontic – cast high noble metal</td>
</tr>
<tr>
<td>06211</td>
<td>Pontic – cast predominately base metal</td>
</tr>
<tr>
<td>06212</td>
<td>Pontic – cast noble metal</td>
</tr>
<tr>
<td>06240</td>
<td>Pontic – porcelain fused to high noble metal</td>
</tr>
<tr>
<td>06241</td>
<td>Pontic – porcelain fused to base metal</td>
</tr>
<tr>
<td>06242</td>
<td>Pontic – porcelain fused to noble metal</td>
</tr>
<tr>
<td>06245</td>
<td>Pontic – porcelain, ceramic substrate</td>
</tr>
</tbody>
</table>

### Bridge Retainers

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>06520X</td>
<td>Inlay – metal – two surfaces</td>
</tr>
<tr>
<td>06530</td>
<td>Inlay – metal – three or more surfaces</td>
</tr>
<tr>
<td>06540</td>
<td>Inlay – metal per tooth in addition to inlay</td>
</tr>
<tr>
<td>06545X</td>
<td>Retainer – cast metal for resin bonded fixed prosthesis</td>
</tr>
</tbody>
</table>

### Bridge Retainers - Crowns

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>06750X</td>
<td>Crown – porcelain fused to high noble metal</td>
</tr>
<tr>
<td>06751X</td>
<td>Crown – porcelain fused to noble metal</td>
</tr>
<tr>
<td>06752X</td>
<td>Crown – porcelain fused to noble metal</td>
</tr>
<tr>
<td>06780X</td>
<td>Crown – ¾ cast high noble metal</td>
</tr>
<tr>
<td>06790X</td>
<td>Crown – full cast high noble metal</td>
</tr>
<tr>
<td>06791X</td>
<td>Crown – full cast predominately base metal</td>
</tr>
<tr>
<td>06792X</td>
<td>Crown – full cast noble metal</td>
</tr>
</tbody>
</table>

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**Implant Services (06000 – 06199)**

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>06010</td>
<td>Surgical placement of implant body: endosteal implant</td>
</tr>
<tr>
<td>06020</td>
<td>Abutment placement or substitution: endosteal implant</td>
</tr>
<tr>
<td>06040</td>
<td>Surgical placement: eposteal implant</td>
</tr>
<tr>
<td>06050</td>
<td>Surgical placement: tranosteal implant</td>
</tr>
</tbody>
</table>

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Other surgical procedures
06970 Prefabricated post and core in addition to bridge retainer
06972 Prefabricated post and core
06973- Retainer crown build up (substructure) including any pins
06975 Coping – metal
06980 Bridge repair, by report
06999 Unspecified fixed prosthodontic procedure by report

ORAL SURGERY (07000 – 07999)

Extractions – includes local anesthesia and routine postoperative care
07110 Single tooth
07120 Each additional tooth
07130X Root removal – exposed roots

Surgical extractions – includes local anesthesia and routine postoperative care
07210X Surgical removal of erupted tooth
07220X Removal of impacted tooth – soft tissue
07230X Removal of impacted tooth – partial bony
07240X Removal of impacted tooth – complete bony
07250X Surgical removal of residual tooth roots (cutting procedure)

Other surgical procedures
07260X Oral antral fistula closure
07270X Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth and or alveolus
07272X Tooth transplantation (includes reimplantation from one site to another and splitting and/or stabilization)
07280X Surgical exposure of impacted or unerupted tooth for orthodontic reasons
07281X Surgical exposure of impacted or unerupted tooth to aid eruption
07285 Biopsy of oral tissue – hard

07285 Biopsy of oral tissue – soft
07290 Surgical repositioning of teeth
07291 Transpalatal fibrotoomy, by report

Alveoplasty – surgical preparation of ridge for dentures
07310 Alveoplasty in conjunction with extractions – per quadrant
07320 Alveoplasty not in conjunction with extractions – per quadrant

Vestibuloplasty
07340 Vestibuloplasty – ridge extension (secondary epithelialization)
07350 Vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachments, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).

Removal of tumors, cysts and neoplasms
07430 Excision of benign tumor – lesion diameter up to 1.25 cm
07431 Excision of beginning tumor – lesion diameter greater than 1.25 cm
07440 Excision of malignant tumor – lesion diameter up to 1.25 cm
07441 Excision of malignant tumor – lesion diameter greater than 1.25 cm
07450X Removal of odontogenic cyst or tumor – lesion diameter up to 1.25 cm
07451X Removal of odontogenic cyst or tumor – lesion diameter greater than 1.25 cm
07460X Removal of nonodontogenic cyst or tumor – lesion diameter up to 1.25 cm
07461X Removal of nonodontogenic cyst or tumor – lesion diameter greater than 1.25 cm
07465 Destruction of lesion(s) by physical methods, by report

Excision of bone tissue
07470X Removal of exostosis – maxilla or mandible
07480X Partial ostectomy (guttering or saucerization)
07490X Radical resection of mandible with bone graft

Surgical incision
07510 Incision and drainage of abscess – intraoral soft tissue
07520 Incision and drainage of abscess – extraoral soft tissue
07530 Removal of foreign body, skin or subcutaneous areolar tissue
07540X Removal of foreign body, musculoskeletal system
07550X Sequestrectomy for osteomyelitis
07560X Maxillary sinusotomy for removal of tooth fragment or foreign body

Treatment of fractures – simple
07610X Maxilla – open reduction (teeth immobilized if present)
07620X maxilla – closed reduction (teeth immobilized if present)
07630X mandible – open reduction (teeth immobilized if present)
07640X mandible – closed reduction (teeth immobilized if present)
07650X Malar and/or zygomatic arch – open reduction
07660X Malar and/or zygomatic arch – closed reduction
07670X Alveolus – stabilization of teeth, open reduction splinting
07680X Facial bones – complicated reduction with fixation and multiple surgical approaches

Treatment of fractures – compound
07710X Maxilla – open reduction
07720X Maxilla – closed reduction
07730X Mandible – open reduction
07740X Mandible – closed reduction
07750X Malar and/or zygomatic arch – open reduction
07760X Malar and/or zygomatic arch – closed reduction
07770X Alveolus – stabilization of teeth, open reduction splinting

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07780X Facial bones — complicated reduction with fixation and multiple surgical approaches

Reduction of dislocation and management of other temporomandibular joint dysfunctions

07810 Open reduction of dislocation
07820 Closed reduction of dislocation
07830 Manipulation under anesthesia
07840 Condylectomy
07850 Menisectomy
07860 Arthrotomy, by report
07865 Arthroplasty, by report
07870 Arthrocentesis, by report
07880 Oclusal orthotic device
07881 Removable metal overlay stabilizing appliance
07899 Unspecified TMD procedure, by report

Repair of traumatic wounds

07910 Suture of recent small wounds up to 5 cm

Complicated suturing

07911 Suture of complex wounds up to 5 cm
07912 Suture of complex wounds greater than 5 cm

Other repair procedures

07940X Osteoplasty — for orthognathic deformities
07941X Osteotomy — ramus, closed
07942X Osteotomy — ramus, open
07943X Osteotomy — ramus, open with bone graft
07944X Osteotomy — segmented or subapical — per sextant or quadrant
07945X Osteotomy — body of mandible
07946X LeFort I (maxilla — total)
07947X LeFort I (maxilla — segmented)
07948X LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) — without bone graft
07949X LeFort II or LeFort III — with bone graft
07960 Frenulectomy (frenectomy or frenotomy) — separate procedure
07970 Excision of hyperplastic tissue — per arch

07971 Excision of pericoronal gingiva
07980X Sialolithotomy
07981X Excision of salivary gland, by report
07982 Sialodochoplasty
07983 Closure of salivary fistula
07990 Emergency tracheotomy
07991 Coronoidectomy
07999 Unspecified oral surgery procedure, by report

ORTHODONTICS (08000 — 08999)

Minor treatment to control harmful habits

08210 Appliance to control harmful habits (removable)
08220 Appliance to control harmful habits (fixed or cemented)

Treatment of the primary dentition

08306 Limited treatment (1 arch or less), 6 months
08312 Limited treatment (1 arch or less), 12 months

Treatment of the transitional (mixed) dentition

08406 Limited treatment (1 arch or less), 6 months
08412 Limited treatment (1 arch or less) 12 months
08512 Full treatment, 12 months
08518 Full treatment, 18 months
08524 Full treatment, 24 months
08610 Phased treatment — Phase 1
08620 Phased treatment — Phase 2

Treatment of the permanent dentition

08706 Limited treatment (1 arch or less), 6 months
08712 Limited treatment (1 arch or less), 12 months
08812 Full treatment, 12 months
08818 Full treatment, 18 months
08824 Full treatment, 24 months
08830 Full treatment, 30 months

Other orthodontic services

08910 Replacement retainer
08999 Unspecified orthodontic procedure, by report

ADJUNCTIVE GENERAL SERVICES (09000 — 09999)

Unclassified treatment

09110 Palliative (emergency) treatment of dental pain — minor procedure

Anesthesia

09210 Local anesthesia not in conjunction with operative or surgical procedures
09211 Regional block anesthesia
09212 Trigeminal division block anesthesia
09215 Local anesthesia
09220 General anesthesia — first 30 minutes
09221 General anesthesia — each additional 15 minutes
09230 Analgesia
09240 Intravenous sedation

Professional consultation

09310 Special consultation (specialist only — separate fee only if patient not treated by consultant)

Professional visits

09410 House call
09420 Hospital call
09430 Office visit for observation (during regularly scheduled hours) — no other services performed
09440 Office visit — after regularly scheduled hours

Drugs

09910 Application of desensitizing medicament
09920 Behavior management, by report
09930 Treatment of complications (post-surgical) — unusual circumstances, narrative report required
09940 Occlusal guard, by report
09941 Fabrication of athletic mouthguard, by report
09950 Occlusion analysis — mounted case, including all related procedures
09951 Occlusal adjustment -- limited
09952 Occlusal adjustment -- complete
09999 Unspecified adjunctive procedure, by report

NOTE: PLEASE REFER TO A PATIENT'S PREMIER CERTIFICATE OF INSURANCE TO DETERMINE COVERED SERVICES AND SUPPLIES, EXCLUSIONS AND LIMITATIONS FOR AN INDIVIDUAL PATIENT.

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