GOVERNMENT OF DUBAI

DUBAI HEALTH AUTHORITY

Dubai Standards in Healthcare

Dubai Standards of Care – 2018

(Dental Billing Rules)

Dubai Government Health Insurance Program

Acknowledgment

Dubai Health Authority (DHA) has strategic objective programs to improve the oral health outcomes and ensure that all individuals have access to high quality treatments.

Therefore, this document provides adjudication rules for Dubai government health insurance programs. This will enable the Health Funding Department to assess the dental billing performance in Dubai and to ensure safe and competent delivery of dental services.

We would like to thank **Dr. Ayesha Abdullah Alalili** on her effort of leading the team to develop The Dental billing rules in collaboration with expert Dentists working in the government and private sectors. This document may be amended from time to time at the decision of Dubai Health Authority (DHA).

Dubai standard of care
Health Funding Department
Dubai Health Authority

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Dubai Standards of Care- Dental Billing Rules

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Dubai Standards of Care- Dental Billing Rules

SCOPE

The Dental billing rules apply to all healthcare providers in all Dubai government health insurance program networks. It applies in both SAADA and ENAYA programs.

PURPOSE

DHA is the sole responsible entity for ensuring that all health facilities and healthcare professionals under Dubai government health insurance network have Standard dental billing rules to ensure best quality.

INTRODUCTION:

This document provides a comprehensive outline to assist providers in determining benefit coverage for dental procedures. When the fee for a procedure is disallowed, it is not payable by Dubai government health insurance programs and cannot be collected from the patient. All dental services are subject to prior approval. Multistage procedures should be billed upon completion. You must indicate the completion date when submitting for payment.

This document is subject to changes and updates by health funding department- Dubai health authority.

CLINICAL ORAL EVALUATIONS

Complete, comprehensive, and accurate health record must be maintained for each patient. Dental history, chief complaint, diagnosis, treatment plan and treatment done with accurate date of the treatment must be documented in patient health record within the health care provider to assure payment from health funding department.

Code	CDT Definition	Payment rules and guidance's	Submission Requirement
D0120- D0160	The codes in this section recognize the cognitive skills necessary for patient evaluation. The collection and recording of some data and components of the dental examination may be delegated; however, the evaluation, which includes diagnosis and treatment planning, is the responsibility of the dentist. As with all ADA procedure codes, there is no distinction made between the evaluations provided by general practitioners and specialists. Report additional diagnostic and/or definitive procedures separately.	Any Dental consultation/oral evaluation is covered by the same dentist within period of 3 month. Dental visits after initial consultation/evaluation consider as follow up visits and shouldn't claimed to Dubai government health insurance program or bared by patient No consultation or evaluation to be billed if the dentist does any dental procedure in same visit/day. Therefore, If provider had initiated any Dental treatment within the initial visit as treatment, service fee should include consultation charges	
D0170	re-evaluation - limited, problem focused (established patient; not post-operative visit)		➢ PA x-rays

D0180	comprehensive periodontal evaluation - new or established patient	➢ periodontal chart or bitewing x-ray or OPG

RADIOGRAPHS/DIAGNOSTIC IMAGING (INCLUDING INTERPRETATION)

code	CDT Definition	Payment rules and guidance's	Submission requirement
D0210 *D0220* *D0230* *D0240* *D0270* *D0272* *D0273* *D0274*	intraoral - complete series of radiograph image intraoral - periapical first radiograph image intraoral - periapical each additional radiograph image intraoral - occlusal radiograph image bitewing - single radiograph images bitewings - two radiograph images bitewings – three radiograph images bitewings – four radiograph images	Initial X-ray for any dental treatment can be billed separately; other x-ray taken during treatment is part of the procedure cost. Any combination of intraoral radiographs (periapical, occlusal, bitewing and/or panoramic films) taken by the same dentist/dental office on the same day with fees that equal or exceed fees for complete series will be processed as D0210. D0210 is limited to once per year.	
D0330	Panoramic film	Panoramic x-ray is covered once a year	
D0340	2D cephalometric radiographic image - acquisition, measurement and analysis	Coverage for this procedure is limited to members who have Orthodontic Plan Benefits. Benefits for cephalometric film performed with services other than orthodontic treatment are denied	

ORAL PATHOLOGY LABORATORY

Code	CDT Definition	Payment rules and guidance's	Submission requirement
D0472 - D0485	These are procedures generally performed in a pathology laboratory and do not include the removal of the tissue sample from the patient.		Pathology report
D0502 *D0999*	other oral pathology procedures, by report unspecified diagnostic procedure, by report	Any code that had the paraphrase (by report) requires submission of report for payment	Pathology report

DENTAL PROPHYLAXIS AND PREVENTIVE SERVICES

code	CDT Definition	Payment rules and guidance's	Submission requirement
D1110	prophylaxis - adult	prophylaxis performed on the same date by the same dentist/dental office as a Periodontal Maintenance (D4910) or Scaling and Root Planing (D4341/D4342) is considered to be part of those procedures and the fee is disallowed Prophylaxis is covered twice a year. Both Codes D1110 or D1120 can't be used together	
D1120	prophylaxis – child		
D1206 *D1208*	topical application of fluoride varnish topical application of fluoride-excluding varnish	Topical application of fluoride used for members up to 18 years old. It includes fluoride gel, fluoride gel Carrier or fluoride varnish application.	
D1351	sealant - per tooth	Sealant- per tooth (D1351) are payable ONCE per tooth on the occlusal surface of permanent first and second molars only. Sealant is limited to patients up to 18 years of age.	
D1510 *D1515* *D1520* *D1525*	space maintainer - fixed - unilateral space maintainer - fixed - bilateral space maintainer - removable - unilateral space maintainer - removable - bilateral	Service includes impression, space maintainer devise, lab charges &cementation.	
D1550	re-cement or re-bond space maintainer	this code cannot used by the same dentist who cement the space maintainer unless 6 months period passed from initial cementation	
D1555	removal of fixed space maintainer	Benefits for removal of fixed space maintainer by the same dentist/dental office who placed the appliance are disallowed. D1555 is disallowed when submitted with re-cementation.	
D1575 *D1999*	Distal shoe space maintainer - fixed - unilateral Unspecified preventive procedure, by report	Any code that had the paraphrase (by report) requires submission of report for payment.	

RESTORATION

- When multiple restorations for the same tooth are requested or performed, multi-surface codes should be used. It's not accepted to bill each surface separately
- Example: if a composite filling is done in buccal and occlusal surfaces. The provider should use the code: resin-based composite - two surfaces, posterior.
- All restorations (direct or indirect), should include: Tooth preparation, adhesives, etching, liners, bases, pulp capping, temporary restorations, buildups, cement, impressions, laboratory fees, filling material, polishing, occlusal adjustment, re-cement and local anesthesia
- Restoration provided for cosmetic purposes are non-payable
- The QUANTITY of fillings is limited to four fillings per claim/per day (not applied for general anesthesia cases).

Code	CDT Definition	Payment rules and guidance's	Submission requirement
D2140 ***D2150*** ***D2160*** ***D2161***	amalgam - one surface, primary or permanent amalgam - two surfaces, primary or permanent amalgam - three surfaces, primary or permanent amalgam - four or more surfaces, primary or permanent	amalgam filling is limited to one per 10 years. Tooth preparation, all adhesives (including amalgam bonding agents), liners and bases are included as part of the restoration. If pins are used, they should be reported separately (see D2951).	
D2330 ***D2331*** ***D2332*** ***D2335*** ***D2390*** ***D2391*** ***D2392*** ***D2393*** ***D2394***	resin-based composite - one surface, anterior resin-based composite - two surfaces, anterior resin-based composite - three surfaces, anterior resin-based composite - four or more surfaces or involving incisal angle (anterior) resin-based composite crown, anterior resin-based composite - one surface, posterior resin-based composite - two surfaces, posterior resin-based composite - three surfaces, posterior resin-based composite - four or more surfaces, posterior	Composite filling is limited every two years per tooth surface Resin-based composite refers to a broad category of materials including but not limited to composites. may include bonded composite, light-cured composite, etc. Tooth preparation, acid etching, adhesives (including resin bonding agents), liners and bases and curing are included as part of the restoration. Glass ionomers, when used as restorations, should be reported with these codes. If pins are used, they should be reported separately (see D2951).	

CROWNS

- Crowns are OPTIONAL benefits. They are only eligible for a permanent tooth that has finished a root canal treatment and its covered once per 10 years
- It is mandatory to submit x-ray's for approval of any fixed prosthesis. Multistage procedures are billed upon completion. The completion of crowns is the cementation date.
- The fee for a Fixed prosthesis service such as, but not limited to, tooth preparation, diagnostic wax-up, electro surgery, temporary restorations, cement bases, impressions, laboratory fees, occlusal adjustment within 6 months after the restoration, post-operative visits, local anesthesia, crown lengthening and gingivectomy on the same date of service. These procedures are disallowed when submitted as a separate charge.

code	**CDT Definition**	**Payment rules and guidance's**	**Submission requirement**
D2710	crown - resin-based composite(indirect)	Coverage for an all porcelain/resin crown (non-metal) is limited to the anterior and premolars teeth that completed root canal treatment. Provider should submit clear periapical x-ray for the approval of the crown. This codes does not include facial veneers.	PA xray
D2712	crown - ¾ resin-based composite (indirect)		
D2721	crown - resin with predominantly base metal		
D2722	Crown - resin with noble meta		
D2740	crown - porcelain/ceramic substrate		
D2751	crown - porcelain fused to predominantly base metal		
D2752	Crown - porcelain fused to noble metal		
D2781	crown - 3/4 cast predominantly base metal		
D2782	crown - 3/4 cast noble metal		
D2783	crown - 3/4 porcelain/ceramic		
D2791	crown - full cast predominantly base metal		
D2792	crown - full cast noble metal		
D2799	provisional crown- further treatment or completion of diagnosis necessary prior to final impression	Provisional crown (D2799) and temporary crown (D2970), which is fitted crown over a	

	Crown utilized as an interim restoration of at least six months duration during restorative treatment to allow adequate time for healing or completion of other procedures. This includes, but is not limited to changing vertical dimension, completing periodontal therapy or cracked-tooth syndrome. This is not to be used as a temporary crown for a routine prosthetic restoration.	damaged tooth as an immediate protective device of at least six months duration. This is not to be used as temporization during routine crown fabrication	

OTHER RESTORATIVE SERVICES

code	CDT Definition	Payment rules and guidance's	Submission requirement
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core		
D2920	Re-cement or re-bond crown	Recement crown (D2920) is billed only if is it done from different provider or in different facility than the clinic which the crown was delivered. Recemantation of crown is not covered for the provider in the same day of delivery. Its only accepted if it is needed after delivering the crown 6 month. D2920 and D2915 are not benefits on the same tooth on the same service date by the same dentist office. If submitted, D2915 will be disallowed.	
D2921	Reattachment of tooth fragment, incisal edge or cusp		
		Stain steel crown is crown that covers deciduous teeth. Other type of crown is not covered for deciduous teeth.	
D2930	prefabricated stainless steel crown - primary tooth		
D2931	prefabricated stainless steel crown - permanent tooth		
D2932	prefabricated resin crown		
D2940	protective restoration	Protective restoration is a benefit for emergency relief of pain. A separate fee for protective restoration Is NOT covered when performed in combination with restoration or endodontic access closure or as a temporary filling	

D2950	core buildup, including any pins when required	Core build up (D2950) cannot be billed with composite filling when a crown is to be placed on the tooth. Either composite filling or core build up codes is covered with the crown.	PA xray
D2951	pin retention - per tooth, in addition to restoration		
D2952	post and core in addition to crown, indirectly fabricated		
D2953	each additional indirectly fabricated post - same tooth	*Core is built around a prefabricated post. This procedure includes the core material.*	
D2954	prefabricated post and core in addition to crown	*Post removal code can utilize with submitting x-ray and only when it is complex, deep and, time-consuming* *For removal of posts (e.g., fractured posts) not to be used in conjunction with endodontic treatment or endodontic retreatment (D3346, D3347, D3348).*	PA xray PA xray
D2955	post removal		
D2957	each additional prefabricated post - same tooth (To be used with D2954)		
D2980	crown repair, necessitated by restorative material failure		PA xray
D2999	unspecified restorative procedure, by report	Any code that had the paraphrase (by report) requires submission of report for payment	

PULP CAPING AND ENDODONTIC PROCEDURE

- Local anesthesia is usually considered to be part of Endodontic procedures.
- Multistage procedures are billed upon completion. The completion of endodontic procedure is on obturation date.

Code	CDT Definition	Payment rules and guidance's	Submission Requirement
D3110	pulp cap - direct (excluding final restoration)	is procedure to protect the pulp from additional injury and to promote healing and repair via formation of secondary dentin. This code is not to be used for bases and liners when all caries has been removed	
D3120	pulp cap - indirect (excluding final restoration)		
D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	Pulpotomy includes removal of pulp, application of medicament and temporary filling. This is not to be construed as the first stage of root canal therapy	

D3221	pulpal debridement, primary and permanent teeth	The benefit for D3221 is disallowed on the same day of D3220 or root canal therapy - This benefit is allowed once per tooth per lifetime D3221 can used if patient didn't show up to complete root canal treatment.	
D3222	partial pulpotomy for apexogenesis - permanent tooth with incomplete root development		
D3230 *D3240*	pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration) pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	endodontic therapy for primary tooth includes removal of pulp, application of medicament and temporary filling. This is not to be construed as the first stage of root canal therapy	
D3310 *D3320* *D3330* *D3331* *D3332* *D3333*	endodontic therapy, anterior tooth (excluding final restoration) endodontic therapy, bicuspid tooth (excluding final restoration) endodontic therapy, molar (excluding final restoration) treatment of root canal obstruction; non-surgical access incomplete endodontic therapy; inoperable, unrestorable or fractured tooth internal root repair of perforation defects	If patient did not complete root canal treatment or patient didn't show up to complete the treatment. Provider should submit code D3221(pulpal debridement, primary and permanent teeth). If patient decide to complete the treatment and provider already submit D3221, TPA has the right to adjust the price of endodontic treatment Endodontic treatment includes local anesthesia, canal preparation, intracanal medication, temporary restorations, buildups, pulpal debridement, canal obturation, incision and drainage of abscess(D7510).	PA xray
D3346 D3347 D3348	retreatment of previous root canal therapy - anterior retreatment of previous root canal therapy - bicuspid retreatment of previous root canal therapy - molar	Retreatment codes (D3346, D3347, D3348) include removing of the post, removing all restoration, incision and drainage of abscess if required and obturation of canals Retreatment is payable once per tooth.	Pre-operative X-ray
D3999	unspecified endodontic procedure, by report	Any code that had the paraphrase (by report) requires submission of report for payment	

APEXIFICATION, APICOECTOMY AND OTHER ENDODONTIC PROCEDURES

Code	**CDT Definition**	**Payment rules and guidance's**	**Submission Requirement**
D3355 *D3356* *D3357*	pulpal regeneration – initial visit pulpal regeneration -interim medication replacement pulpal regeneration – completion of treatment		pre-procedural x-ray

D3410	apicoectomy - anterior		pre-procedural x-ray
D3421	apicoectomy - bicuspid (first root)		pre-procedural x-ray
D3425	apicoectomy - molar (first root)		
D3426	apicoectomy (each additional root)		
D3427	Periradicular surgery without apicoectomy		
	retrograde filling - per root		
D3430			

SURGICAL SERVICES

Code	CDT Definition	Payment rules and guidance's	Submission requirement
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	*Gingivectomy or gingivoplasty can't be utilized if related to member esthetic condition such as Gummy smile, or as treatment of side effects of non-covered treatment. also shouldn't use in purpose of crown lengthening. Procedure is a benefit if the pocket depth is greater than or equal to 5 mm It's limited to once per four year in one oral site for members above 12 years of age. A separate benefit for gingivectomy or gingivoplasty-per tooth is disallowed when performed in conjunction with the preparation of a crown or other restoration by the same dentist/dental office*	periodontal chart or bitewing xray or OPG
D4211	gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant		
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth		
D4230	anatomical crown exposure - four or more contiguous teeth per quadrant		
D4231	anatomical crown exposure - one to three teeth per quadrant		
D4240	gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	Provider can utilize gingival flap services (D4240, 4241 and 4245) if member has Loss attachment and periodontitis condition. Procedure is a benefit if the pocket is greater than or equal to 5 mm. Procedure D4240 includes root planing (D4341/4342) and the benefit for root planing will be disallowed when performed in conjunction with D4240/4241. Frequency limit is 5 year per tooth	OPG x-ray or bitewing x-ray
D4241	gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant		
D4245	apically positioned flap		
D4249	clinical crown lengthening - hard tissue	Crown lengthening is applied only when bone is removed and sufficient time is allowed for healing. Benefits for crown lengthening are disallowed when performed on the same day as crown preparations or restorations. A separate fee for crown lengthening is disallowed when performed in conjunction with osseous surgery on the same teeth.	

		If more than one tooth, indicate teeth numbers in the narrative. The fee for multiple crown lengthening sites within a single quadrant will not exceed the benefit for D4260.	
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	The fee for osseous surgery includes: ▪ Osseous contouring ▪ Distal or proximal wedge surgery Scaling and root planing (D4341, D4342) ▪ Gingivectomy (D4210, D4211) ▪ Flap procedures (D4240, D4241)	OPG or/and Periodontal chart
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	This procedure is a benefit if the pocket depth is greater than or equal to 5 mm. Usually only two full quadrants of osseous surgery are allowed on the same date of service. Benefits in excess of two osseous surgeries on the same date of service are denied unless a narrative is supplied to explain exceptional circumstances. - If periodontal surgery is performed less than four weeks after scaling and root planing, the benefit for the scaling and root planing will be deducted from the surgery. - For one to three teeth, when subsequent treatment of the same procedure is required within the same quadrant, the total benefit is limited to the allowance of the quadrant fee. - For D4261, if more than one tooth, indicate teeth numbers in narrative. Osseous surgery is a benefit on the same tooth once every 3 years. The following procedures may be a benefit separately on the same day: Osseous grafts (D4263, D4264) Exotosis removal (D7471) Hemisection (D3920) Extraction (D7140) Apicoectomy (D3410) Root Amputations (D3450) Guided Tissue Regeneration (D4266) Soft tissue grafts (D4271) This procedure is a benefit if the pocket depth is greater than or equal to 5 mm. Benefits for bone grafting are available only when billed for natural teeth and performed for periodontal purposes.	
D4263	Bone replacement graft - retained natural tooth - first site in quadrant Bone replacement graft - retained natural tooth - each additional site in quadrant Biologic materials to aid in soft and osseous tissue regeneration	The benefit for bone grafting is denied as a specialized or elective technique when billed in conjunction with implants, ridge augmentation, extraction sites, periradicular surgery, etc. – refer to D7950, D7951 and D7953. - This procedure must be submitted with a gingival flap (D4240/D4241) or	
D4264	Guided tissue regeneration - resorbable barrier, per site		

	Guided tissue regeneration - nonresorbable	osseous surgery (D4260/D4261)
D4265	barrier, per site (includes membrane removal)	entry procedure. - Maximum benefit for bone replacement
D4266	Surgical revision procedure, per tooth	grafts is two sites per quadrant.
	Pedicle soft tissue graft procedure	Bone graft for the second site in
D4267		the same quadrant will be processed as D4264
		Narrative should specify donor site
	Autogenous connective tissue graft	and if one of the following
D4268	procedure (including donor and recipient surgical sites) first tooth, implant or	conditions applies: Active recession
D4270	edentulous tooth position in graft	No attached gingival No keratinized gingival Mucogingiva
	Mesial/distal wedge procedure, single	defect Progressive perio disease
	tooth (when not performed in conjunction with surgical procedures in the same	Not a benefit when performed for cosmetic purposes.
D4273	anatomical area)	Benefits for guided tissue
	Combined connective tissue and double pedicle graft, per tooth	regeneration (D4266,D4267) are denied in conjunction with soft tissue grafts in the same surgical area.
D4274		Benefits for Frenulectomy (D7960) or Frenuloplasty (D7963) are disallowed in conjunction with soft tissue grafts (D4271, D4275). Extraoral grafts are not covered benefits.
D4276		Maximum benefit for free soft tissue graft is two sites per quadrant. Free soft tissue graft for more than two sites within a quadrant will be denied to the eligible fee. Provider can utilize Graft services once in a lifetime for same oral site; in which no other consideration can be given if member graft had failed for any reason

NON-SURGICAL PERIODONTAL SERVICE

Code	CDT Definition	Payment rules and guidance's	Submission requirement
D4320	Provisional splinting - intracoronal		
D4321	Provisional splinting - extracoronal	NOT covered for members less than 12 years of age. It is covered	
D4341	periodontal scaling and root planing - four or more teeth per quadrant	once per quadrant/ year Whenever scaling and root	full-mouth periodontal charting, OPG or
D4342	periodontal scaling and root planing - one to three teeth per quadrant	planning is needed (D4341 and D4342) more than 2 quadrants within a single visit, the following should be documented/ submitted upon requested: full-mouth periodontal charting, OPG or bitewing X-ray, and the	bitewing X-
D4355	full mouth debridement to enable comprehensive evaluation and diagnosis	treatment plan Prophylaxis (D1110) is disallowed	
D4381	localized delivery of antimicrobial agents via a controlled release vehicle into	if performed on the same day as D4341 or D4342.	

	diseased crevicular tissue, per tooth, by report		
D4910	periodontal maintenance	Periodontal maintenance (D4910) code used for patient with chronic periodontal disease. it can be utilized 3 months after scaling and root planning and requires submission of a periodontal chart or bitewing x-ray or OPG reflecting the disses of member. Any code that had the paraphrase (by report) requires submission of report for payment	periodontal chart or bitewing x-ray or OPG
D4999	unspecified periodontal procedure, by report		

ORAL SURGERY

code	CDT Definition	Payment rules and guidance's	Submission requirement
D7111	extraction, coronal remnants - deciduous tooth		
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	Any extraction includes local anesthesia, removal of tooth structure, incision, bone removal, tooth dissection, suturing, removal of suture, routine post-operative care. Unsuccessful attempts at extractions are disallowed. Biopsy of oral tissue – soft (D7286) and Removal of benign odontogenic cyst or tumor up to 1.25 cm (D7450) may be disallowed in conjunction with extraction procedures	pre-procedural X-ray
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated		
D7220	removal of impacted tooth - soft tissue		
D7230	removal of impacted tooth - partially bony		
D7240	removal of impacted tooth - completely bony		
D7241	removal of impacted tooth - completely bony, with unusual surgical complications		
D7250	surgical removal of residual tooth roots (cutting procedure)		
D7251	coronectomy – intentional partial tooth removal		
D7260	oroantral fistula closure		
D7261	primary closure of a sinus perforation		
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth		
D7280	Exposure of an unerupted tooth		
D7285	biopsy of oral tissue - hard (bone, tooth)	This service is disallowed when performed in conjunction with an apicoectomy (D3410, D3421, D3425 or D3426), or surgical extraction (D7210), by the same dentist/dental office in the same surgical area and on the same date of service.	Pathology report
D7286	biopsy of oral tissue – soft		

	exfoliative cytological sample collection	
D7287	brush biopsy - transepithelial sample	
D7288	collection	
D7410	excision of benign lesion up to 1.25 cm	
D7411	excision of benign lesion greater than 1.25 cm	
D7412	excision of benign lesion, complicated	
D7440	excision of malignant tumor - lesion diameter up 1.25 cm	
D7450	removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	
D7451	removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	
D7510	Incision and drainage of abscess - intraoral soft tissue.	The fee of Incision and drainage of abscess-intraoral soft tissue (D7510) is not covered when done on the same date with endodontics (D3110-D3999), oral surgery (D7111-D7999), and surgical periodontal procedures (D4210-D4276). Furthermore, It's covered once per tooth.
D7511	incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	
D7520	incision and drainage of abscess - extraoral soft tissue	
D7521	incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	
D7910	suture of recent small wounds up to 5 cm	suture is part for any surgical treatment, separate fees suture is not covered.
D9210	local anesthesia not in conjunction with operative or surgical procedures	Local anesthesia is part of any dental treatment. Separate fees for local anesthesia is not covered.
D9211	regional block anesthesia	
D9212	trigeminal division block anesthesia	
D9215	local anesthesia in conjunction with operative or surgical procedures	
D9220	deep sedation/general anesthesia - first 30 minutes	
D9221	deep sedation/general anesthesia - each additional 15 minutes	
D9230	inhalation of nitrous oxide / anxiolysis, analgesia	
D9241	intravenous conscious sedation/analgesia - first 30 minutes	
D9242	intravenous conscious sedation/analgesia - each additional 15 minutes	
D9248	non-intravenous conscious sedation	

ORTHODONTIC PROCEDURE

code	CDT Definition	Payment rules and guidance's	Submission requirement
D8010	limited orthodontic treatment of the primary dentition	Coverage for this codes is limited to members who have Orthodontic Plan Benefits.	
D8020	limited orthodontic treatment of the transitional dentition		
D8030	limited orthodontic treatment of the adolescent dentition		
D8040	limited orthodontic treatment of the adult dentition		

D8050	interceptive orthodontic treatment of the primary dentition
D8060	interceptive orthodontic treatment of the transitional dentition
D8070	comprehensive orthodontic treatment of the transitional dentition
D8080	comprehensive orthodontic treatment of the adolescent dentition
D8090	comprehensive orthodontic treatment of the adult dentition
D8210	removable appliance therapy
D8220	fixed appliance therapy
D8660	pre-orthodontic treatment examination to monitor growth and development
D8670	periodic orthodontic treatment visit
D8680	orthodontic retention (removal of appliances, construction and placement of retainer(s))
D8690	orthodontic treatment (alternative billing to a contract fee)
D8691	repair of orthodontic appliance
D8692	replacement of lost or broken retainer
D8693	Re-cement or re-bond fixed retainer
D8694	Repair of fixed retainers, includes reattachment
D8999	unspecified orthodontic procedure, by report

REFERENCES

- Health regulation department (2012), Dubai health authority, Outpatient Care Facilities Regulation2012. [Available at: https://www.dha.gov.ae/Documents/Regulations/Outpatient%20Care%20Facilities%20Regulation.pdf
- Hawai medical assurance association(2010) Dental Procedure Guidelines.[Available at: https://www.hmaa.com/wp-content/uploads/2012/11/dental_procedure_guidelines.pdf
- Delta Dental of California(2013),Federal Government Programs Division, Dentist Handbook[available at: http://www.deltadentalfeds.org/downloads/dentist-handbook.pdf
- Delta Dental of North Carolina(2014),PARTICIPATING DENTIST UNIFORM REQUIREMEN TS.[available at http://www.deltadentalnc.com/MediaLibraries/Global/documents/DDNC_DDS_UNIFORM_REQUIREMENTS.pdf
- American association of endodontist(2018) Endodontists' Guide to CDT© 2018. Available at:
- https://www.aae.org/specialty/practice-management/dental-claims-coding-submission/
- American dental association(2017),CDT-2017 CODE ON DENTAL PROCEDURES AND NOMENCLATURE Effective January 1, 2017