Notice of CDT 2025
Update to Exhibit A, Per Section 31 and in VA Exhibit G, Dental Program Claims Processing Guidelines
Effective January 1, 2025

The American Dental Association (ADA) has revised the Common Dental Terminology (CDT) for 2025. We recommend you obtain a current copy of the CDT Code from the ADA and encourage all dentists to review specific code information and make note of new codes as well as deletions and revisions. We are revising the Dental Programs Claims Processing Guidelines to incorporate these changes, as indicated below. Please note your Network Fee Schedule contains the most commonly utilized procedures and may not contain all ADA codes that may be considered Covered Services. If you need the Network Fee Schedule Allowable Amount for a specific CDT 2025 code, or if you have questions, please contact Professional Services at 1-866-947-9398. This notice of CDT 2025 should be used in conjunction with your 100/200/300/Prime/Complete participation agreement, your Network Fee Schedule and the Dental Program's Claims Processing Guidelines.

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

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

ALTERNATE BENEFIT: In cases where alternative methods of treatment exist and an alternation of benefits is made, the Plan will reimburse at the allowed amount for the alternated benefit (e.g. porcelain crown alternates to base-metal crown). When there is a maximum allowed amount on the submitted service (e.g. porcelain crown), the provider will be allowed to balance bill the **Patient** up to that allowable when alternation occurs (e.g. the difference in allowable for the metal and porcelain crown). If we do not have a maximum allowed amount on a submitted service, the provider will be allowed to balance bill the **Patient** up to usual and customary charges when alternation occurs. This determination is not intended to reflect negatively on the dentist's treatment plan or to recommend which treatment should be provided. It is a determination of benefits allowed under terms of the **Patient's** coverage. The dentist and **Patient** decide on the course of treatment.

COVERED: Processed for payment subject to the member's benefit plan stipulations including but not limited to copayments, deductibles, maximums, determination of the **Allowable** amount, etc.

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

DISALLOW/DISALLOWED: If procedure is **Disallowed**, it is not **Covered** and is not collectible from the **Patient** by a contracted dentist.

IN CONJUNCTION WITH: A service which is considered part of another procedure or episode of treatment.

PATIENT: The person who receives the treatment or service that is submitted for dental benefits.

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

COMPLEX ORAL SURGICAL PROCEDURES: Surgical procedures that involve flap development with the removal and replacement of diseased hard and soft tissues of the oral cavity.

Deleted Codes

Procedure code	Description
D2941	interim therapeutic restoration – primary dentition
D6095	repair implant abutment, by report

New CDT Codes[1]

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

Procedure code	Description
D2956	removal of an indirect restoration on a natural tooth
D6180	implant maintenance procedures when a full arch fixed hybrid prosthesis is not removed, including cleansing of prosthesis and abutments
D6193	replacement of an implant screw
D7252	partial extraction for immediate implant placement
D7259	nerve dissection
D8091	comprehensive orthodontic treatment with orthognathic surgery
D8671	periodic orthodontic treatment visit associated with orthognathic surgery
D9913	administration of neuromodulators
D9914	administration of dermal fillers
D9959	unspecified sleep apnea services procedure, by report

Revised Codes

Procedure code	Description
D0160	A detailed and extensive problem focused evaluation entails extensive diagnostic and cognitive modalities based on the findings of a comprehensive oral evaluation. Integration of more extensive diagnostic modalities to develop a treatment plan for a specific problem is required. The condition requiring this type of evaluation should be described and documented. Examples of conditions requiring this type of evaluation may include dentofacial anomalies, complicated perio-prosthetic conditions, complex temporomandibular

Procedure code	Description
	dysfunction, facial pain of unknown origin, sleep related breathing disorders, conditions requiring multi-disciplinary consultation, etc.
D0801	A surface scan of any aspect of the intraoral anatomy.
D1330	Description removed.
D2940	placement of interim direct restoration. - Direct placement of a restorative material to protect tooth and/or tissue form. This procedure may be used to relieve pain, promote healing, manage caries, create a seal for endodontic isolation, or prevent further deterioration until definitive treatment can be rendered. Not to be used for endodontic access closure, or as a base or liner under restoration.
D6011	This procedure, also known as second stage implant surgery, involves removal of tissue that covers the implant body so that a fixture of any type can be placed.
D6080	implant maintenance procedures when a full arch fixed hybrid prosthesis is removed and reinserted, including cleansing of prosthesis and abutments. - This procedure includes active debriding of the implant(s) and examination of all aspects of the implant system, including the occlusion and stability of the superstructure. The patient is also instructed in thorough daily cleansing of the implant(s).
D6081	scaling and debridement of a single implant in the presence of mucositis, including inflammation, bleeding upon probing and increased pocket depths; includes cleaning of the implant surfaces, without flap entry and closure. - This procedure is not performed in conjunction with D1110, D4910, or D4346.
D6090	repair of implant/abutment supported prosthesis

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

[1]The CDT code descriptions are provided for your convenience and may be abbreviated in this document. For the complete description for each code refer to the current ADA 2025 CDT code book.