DELTA DENTAL

Dental Office Update

2022 CDT Code and Processing Changes

On January 1, 2022, Delta Dental of Oregon (DDOR) will implement the new codes that the ADA has outlined in CDT-22. The table shows which new codes may be covered by DDOR. Any new CDT codes not listed on the chart are not covered under DDOR plans.

Please refer to the group limitations of each patient's plan in Benefit Tracker for specific benefit information as some plans may handle the new codes differently.

Also, the following codes will be deleted with CDT-22. DDOR will no longer accept deleted codes after March 2022.

- **D4320**
- **D4321**
- **D8050**
- **D8060**
- **D8690**

CDT-2022 code books can be purchased through the American Dental Association at ada.org.

New 2022 CDT codes:

Code	Nomenclature	2022 Coverage
D3911	intraorifice barrier	An intraorifice barrier is considered part of the root canal procedure (D3310-D3348) and the fees are Not Billable to the Patient.
D3921	decoronation or submergence of an erupted tooth	By Review
D5227	immediate maxillary partial denture - flexible base (including any clasps, rests and teeth)	Benefits are determined by group/individual contract
D5228	immediate mandibular partial denture - flexible base (including any clasps, rests and teeth)	Benefits are determined by group/individual contract

D5725	rebase hybrid prosthesis	Benefits are determined by group/individual contract
D5765	soft liner for complete or partial removable denture – indirect	Benefits are determined by group/individual contract
D6198	remove interim implant component	a. Fees for removal of an interim implant component by the same dentist/dental office who placed the implant component are considered part of the interim abutment placement procedure and are NOT BILLABLE TO THE PATIENT. b. Benefits for removal of an interim implant abutment by a different dentist/office than who placed the abutment are DENIED.
D9947	custom sleep apnea appliance fabrication and placement	Denied unless covered by group/individual contract
D9948	adjustment of custom sleep apnea appliance	Denied unless covered by group/individual contract
D9949	repair of custom sleep apnea appliance	Denied unless covered by group/individual contract

2022 Processing Policy Changes:

Code	Nomenclature	2022 Coverage
D1120	Prophylaxis - child	When submitted with D4346, fees for D1120 by the same dentist/dental office are NOT BILLABLE TO THE PATIENT.
D4263	Bone Replacement Graft – First Site in Quadrant	Benefits for bone replacement grafts are DENIED when submitted with Hemisection (including any root removal), not including root canal therapy (code D3920).
D4264	Bone Replacement Graft – Each Additional Site in Quadrant	Benefits for bone replacement grafts are DENIED when submitted with Hemisection (including any root removal), not including root canal therapy (code D3920).

D4341	Periodontal Scaling and Root Planing – Four or More Teeth Per Quadrant	Fees for D4341 are NOT BILLABLE TO THE PATIENT within 24 months when done by the same dentist/dental office.
D7411	Excision of benign lesion greater than 1.25 cm	The fee for D7411 is NOT BILLABLE TO THE PATIENT when it is performed in the same area of the mouth on the same day by the same dentist/dental office as any other surgical service.
D7415	Excision of malignant lesion, complicated	The fee for D7415 is NOT BILLABLE TO THE PATIENT it is when it is performed in the same area of the mouth on the same day by the same dentist/dental office as any other surgical service
D7510	Incision and drainage of abscess - intraoral soft tissue	Fees for D7510 are NOT BILLABLE TO THE PATIENT when submitted on the same date of service with all surgery (D7000-D7999), endodontic codes (D3000-D3999), and surgical periodontal procedures (D4210-D4278).

Have you informed us about changes to your office?

DDOR has noticed an increase of claims being billed under non-active and non-credentialed providers. Please note that anytime a new provider joins your practice, or an existing provider leaves, you must notify your Professional Relations team to ensure your practice record is up to date. All participating providers are contractually required to complete our credentialing process once every three years. This process ensures that our network providers are in good standing and have the appropriate liability coverage should an unforeseen event occur. Credentialing of new providers takes between 20-30 days. Claims received prior to approved credentialing cannot be processed and will be returned.

To avoid delays in claim payments and to reduce corrected billings, please make note of the below:

Ensure all dentists are credentialed and active with Delta Dental prior to submitting claims.

- Please email us at dpror@deltadentalor.com to verify the providers status and to obtain any necessary paperwork.

Always list the treating providers name, NPI and license number in the treating provider section of the claim.

- Claims often come in with a NPI not matching the treating dentist's name, or with no NPI listed. Please ensure you have the provider's type I NPI and license in box 54 and 55.

Always submit the claim under the actual dentist who rendered services. If the

patient saw a hygienist, then list the supervising dentist as the treating provider.

- Do not submit all claims under just the owner of the practice. This is considered fraudulent billing and will impact our ability to keep all associates active under your practice as we do require proof of claims to keep records open.

Use the TIN that was active on the date of service being billed.

- If your office has sold or has had a TIN change, please submit all older claims using the TIN active on the date of service being billed. If billed under the new TIN for a date of service prior to its effective date, the claim will be returned.

Please ensure the billing address in box 48 matches the billing address on file with DDOR.

- When this box does not match our records, your claims are unable to be processed via our automated system and will pend for manual review – causing a delay in processing and payment.

Thank you for your support in keeping our records up to date! By doing so you're also helping to keep our claims processing fast and efficient which in return means quicker payments for all!

Remember to reasses your Health through Oral Wellness patients every 12-14 months.

Please ensure your Health through Oral Wellness patients are being reassessed within12-14 months of their last assessment. Patients not reassessed during this frame are at risk of being reassigned to their standard plan benefits.

Helpful Tips!

- Always enter the patient's Subscriber ID and group number into PreViser exactly as they appear on their benefits card. The Subscriber ID is case sensitive.
- Don't forget to submit assessments in PreViser under the patient's secondary DDOR plan if they have one.

We appreciate your commitment to helping your at-risk patients retain the extra preventive benefits they need!

Help support our Diversity, Equity and Inclusion (DEI) efforts.

We are inviting you all, our provider partners, to join us in advancing our DEI initiatives in collectively beneficial way. You are invited to please share your demographic information with us that goes beyond your name and service location. Your invitation offers you the opportunity to share your race, ethnicity, languages spoken, gender and gender identity for use in our provider directories.

Simply complete our short **provider** and **clinic** diversity

surveys to update your online directory listing.

Provider Handbooks
Dentist Handbook (PDF)

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