american association of endodontists

Endodontists' Guide to CDT© 2026

INCLUDES:

Frequently Used Codes for Endodontic Procedures

Code Scenarios

Medical Claim Coding

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Introduction

The *Endodontists' Guide to CDT 2026* was developed by the American Association of Endodontists for endodontists and their office staff. The *Guide* is designed to supplement the American Dental Association's *CDT 2026 Code on Dental Procedures and Nomenclature* by illustrating the proper use of procedural codes commonly encountered in an endodontic practice. The CDT is revised annually, and effective January 1, 2026, dental practices are expected to use CDT 2026 in claims submissions.

The *Guide* includes all endodontic CDT codes (D3000-D3999) and a selection of other codes commonly used by endodontic practices. However, the *Guide* does not include all CDT codes that an endodontic practice might use. The AAE strongly encourages endodontic practices to purchase the *ADA CDT 2026*. If a dental insurance claim is filed using an outdated version of CDT, it will be delayed or even denied. In addition, the ADA's guide includes important information on completing the ADA dental claim form medical codes.

The AAE has additional online resources available for members on dental benefit plans and claims processing.

The AAE wishes to thank the AAE Practice Affairs Committee for their work on this publication and their ongoing advocacy on behalf of AAE members on coding-related issues.

Section I

Frequently Used Codes for Endodontic Procedures

Code on Dental Procedures and Nomenclature (CDT)

These represent the dental codes used most frequently by endodontists, effective for the period January 1, 2026-December 31, 2026.

When nomenclature includes a "by report" notation, attach a detailed narrative explaining the treatment completed. The narrative should provide the "who, what, where, when and why" to support a claim. It should explain what the endodontist did for a patient and why it was medically necessary.

Information in italics was provided by the AAE.

I. Diagnostic D0100-D0999

Clinical Oral Evaluations

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, diagnosis and treatment planning are 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.

D0120 periodic oral evaluation – established patient

Typically, this code is not used in an endodontic practice. It generally is used for new patient exams administered by a general dentist or periodontist.

D0140 limited oral evaluation – problem focused

An evaluation limited to a specific oral health problem. This may require interpretation of information acquired through additional diagnostic procedures. Report additional diagnostic procedures separately. Definitive procedures may be required on the same date as the evaluation.

Typically, patients receiving this type of evaluation have been referred for a specific problem and/or present with dental emergencies, trauma, acute infections, etc.

D0150 comprehensive oral evaluation – new or established

Typically this code is not used in an endodontic practice.

D0160 detailed and extensive oral evaluation – problem focused, by report

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 dysfunction, facial pain of unknown origin, severe systemic diseases requiring multi-disciplinary consultation, etc.

D0170 re-evaluation-limited, problem focused (Established patient; not post-operative visit)

Assessing the status of a previously existing condition. For example:

- a traumatic injury where no treatment was rendered but patient needs follow-up monitoring;
- evaluation for undiagnosed continuing pain;
- soft tissue lesion requiring follow-up evaluation.

D0171 re-evaluation – post-operative office visit

Diagnostic Imaging

Image Capture with Interpretation

Should be taken only for clinical reasons as determined by the patient's dentist. Should be of diagnostic quality and properly identified and dated. Is a part of the patient's clinical record and the original images should be retained by the dentist. Originals should not be used to fulfill requests made by patients or third parties for copies of records.

D0220 intraoral – periapical first radiographic image

D0230 intraoral – periapical each additional radiographic image

D0364 cone beam CT capture and interpretation with limited field of view – less than one whole jaw

D0365 cone beam CT capture and interpretation with field of view of one full dental arch – mandible

D0366 cone beam CT capture and interpretation with field of view of one full dental arch – maxilla, with or without cranium

D0367 cone beam CT capture and interpretation with field of view of both jaws; with or without cranium

D0368 cone beam CT capture and interpretation for TMJ series including two or more exposures

Image Capture Only

D0380 **cone beam CT image capture with limited field of view – less than one whole jaw**

D0381 **cone beam CT image capture with field of view of one full dental arch – mandible**

D0382 **cone beam CT image capture with field of view of one full dental arch – maxilla, with or without cranium**

D0383 **cone beam CT image capture with field of view of both jaws, with or without cranium**

D0384 **cone beam CT image capture for TMJ series including two or more exposures**

Interpretation and Report Only

D0391 **interpretation of diagnostic image by a practitioner not associated with capture of the image, including report**

Post Processing of Image or Image Sets

D0393 **treatment simulation using 3D image volume**

The use of 3D image volumes for simulation of treatment including, but not limited to, dental implant placement, orthognathic surgery and orthodontic movement.

D0394 **digital subtraction of two or more images or image volumes of the same modality**

To demonstrate changes that have occurred over time.

D0395 **fusion of two or more 3D image volumes of one or more modalities**

D0396 **3D printing of a 3D dental surface scan**

A 3D dental surface scan is obtained and transmitted to a 3D printer in office or at a lab.

Tests and Laboratory Examinations

D0460 **pulp vitality tests**

Includes multiple teeth and contralateral comparison(s), as indicated.

● **D0461** **testing for cracked tooth**

Includes multiple teeth and contra lateral comparison(s), as indicated. Diagnostic aids may include but are not limited to pressure sensitivity testing, transillumination, staining, etc.

● Indicates new procedure code.

III. Restorative D2000-D2999

Local anesthesia is usually considered to be part of Restorative procedures.

A one-surface posterior restoration is one in which the restoration involves only one of the five surface classifications (mesial, distal, occlusal, lingual, or facial, including buccal and labial.)

A two-surface posterior restoration is one in which the restoration extends to two of the five surface classifications.

A three-surface posterior restoration is one in which the restoration extends to three of the five surface classifications.

A four-or-more surface posterior restoration is one in which the restoration extends to four or more of the five surface classifications.

A one-surface anterior proximal restoration is one in which neither the lingual nor facial margins of the restoration extend beyond the line angle.

A two-surface anterior proximal restoration is one in which either the lingual or facial margin of the restoration extends beyond the line angle.

A three-surface anterior proximal restoration is one in which both the lingual and facial margins of the restorations extend beyond the line angle.

A four-or-more surface anterior restoration is one in which both the lingual and facial margins extend beyond the line angle and the incisal angle is involved. This restoration might also involve all four surfaces of an anterior tooth and not involve the incisal angle.

Other Restorative Services

D2940 **protective restoration**

Direct placement of a temporary restorative material to protect tooth and/or tissue form. This procedure may be used to relieve pain, promote healing or prevent further deterioration. Not to be used for endodontic access closure, or as a base or liner under a restoration.

D2950 **core buildup, including any pins**

Refers to building up of coronal structure when there is insufficient retention for a separate extracoronal restorative procedure. A core buildup is not a filler to eliminate any undercut, box form, or concave irregularity in a preparation.

D2955 **post removal**

● **D2956** **removal of an indirect restoration on a natural tooth**

Not to be used for a temporary or provisional restoration.

D2976 **band stabilization - per tooth**

A band, typically cemented around a molar tooth, to add support and resistance to fracture until a patient is ready for the full cuspal coverage restoration.

● Indicates new procedure code.

D2989 **excavation of a tooth resulting in the determination of non-restorability**

Decay is excavated to determine the amount of sound tooth structure that is left after excavation. If the tooth is restorable, the appropriate restorative code can be used. However, if tooth is unrestorable report this code.

VIII. Implant Services D6000-D6199

Local anesthesia is usually considered to be part of Implant Services procedure.

D6010 **surgical placement of implant body: endosteal implant**

D6011 **second stage implant surgery**

Surgical access to an implant body for placement of a healing cap or to enable placement of an abutment.

● **D6096** **remove broken implant retaining screw**

X. Oral and Maxillofacial Surgery D7000-D7999

Extractions (Includes local anesthesia, suturing, if needed, and routine postoperative care)

D7140 **extraction, erupted tooth or exposed root (elevation and/or forceps removal)**

Includes removal of tooth structure, minor smoothing of socket bone, and closure, as necessary.

Surgical Extractions (Includes local anesthesia, suturing, if needed, and routine postoperative care)

D7210 **extraction, erupted tooth requiring removal of bone/and or sectioning of tooth, and including elevation of tooth structure, minor smoothing of socket bone and closure.**

Includes related cutting of gingiva and bone, removal of tooth structure, minor smoothing of socket bone and closure.

D7250 **removal of residual tooth roots (cutting procedure)**

Includes cutting of soft tissue and bone, removal of tooth structure, and closure.

Other Surgical Procedures

D7270 **tooth reimplantation and/or stabilization of accidentally avulsed or displaced tooth**

Includes splinting and/or stabilization.

● Indicates new procedure code.

Removal of Tumors, Cysts and Neoplasms Surgical Excision of Intra-osseous Lesions

D7284 excisional biopsy of minor salivary glands

D7460 removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25 cm

D7461 removal of benign nonodontogenic cyst or tumor – lesion diameter greater than 1.25 cm

XII. Adjunctive General Services D9000-D9999

Unclassified Treatment

D9110 palliative (emergency) treatment of dental pain – minor procedure

This is typically reported on a "per visit" basis for emergency treatment of dental pain.

D9120 fixed partial denture sectioning

Separation of one or more connections between abutments and/or pontics when some portion of a fixed prosthesis is to remain intact and serviceable following sectioning and extraction or other treatment. Includes all recontouring and polishing of retained portions.

● **D9128** photobiomodulation therapy - first 15 minute increment, or any portion thereof

● **D9129** photobiomodulation therapy - each subsequent 15 minute increment, or any portion thereof

Anesthesia

D9210 local anesthesia not in conjunction with operative or surgical procedures

D9230 inhalation of nitrous oxide/analgesia, anxiolysis

D9248 non-intravenous conscious sedation

A medically controlled state of depressed consciousness while maintaining the patient's airway, protective reflexes and the ability to respond to stimulation or verbal commands. It includes non-intravenous administration of sedative and/or analgesic agent(s) and appropriate monitoring.

The level of anesthesia is determined by the anesthesia provider's documentation of the anesthetic's effects upon the central nervous system and not dependent upon the route of administration.

● Indicates new procedure code.

Professional Consultation

D9310 **consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician**

A patient encounter with a practitioner whose opinion or advice regarding evaluation and/or management of a specific problem; may be requested by another practitioner or appropriate source. The consultation includes an oral evaluation. The consulted practitioner may initiate diagnostic and/or therapeutic services.

D9310 does not require treatment. The consulting dentist must provide a written narrative back to the referring dentist. If a dental insurer denies a D9310 on grounds that it is a non-covered benefit, the practice can resubmit the claim as a D0140 (limited oral evaluation).

D9311 **consultation with a medical health care professional**

Treating dentist consults with a medical health professional concerning medical issues that may affect patient's planned dental treatment.

Professional Visits

D9430 **office visit for observation (during regularly scheduled hours) – no other services performed**

D9440 **office visit – after regularly scheduled hours**

Drugs

D9610 **therapeutic parenteral drug, single administration**

Includes single administration of antibiotics, steroids, anti-inflammatory drugs, or other therapeutic medications. This code should not be used to report administration of sedative, anesthetic or reversal agents.

D9612 **therapeutic parenteral drugs, two or more administrations, different medications**

Includes multiple administrations of antibiotics, steroids, anti-inflammatory drugs or other therapeutic medications. This code should not be used to report administration of sedatives, anesthetic or reversal agents. This code should be reported when two or more different medications are necessary and should not be reported in addition to code D9610 on the same date.

Miscellaneous Services

D9910 **application of desensitizing medicament**

Includes in-office treatment for root sensitivity. Typically reported on a "per visit" basis for application of topical fluoride. This code is not to be used for bases, liners or adhesives used under restorations.

D9972 **external bleaching – per arch – performed in office**

D9973 **external bleaching – per tooth**

D9974 **internal bleaching – per tooth**

D9985 **sales tax**

D9986 **missed appointment**

D9987 **cancelled appointment**

D9995 **teledentistry – synchronous; real-time encounter**

Reported in addition to other procedures (e.g., diagnostic) delivered to the patient on the date of service.

D9996 **teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review**

Reported in addition to other procedures (e.g., diagnostic) delivered to the patient on the date of service.

D9999 **unspecified adjunctive procedure, by report**

Used for procedure that is not adequately described by a code. Describe procedure.

IV. Endodontics D3000-D3999

Pulp Capping

D3110 **pulp cap – direct (excluding final restoration)**

Procedure in which the exposed pulp is covered with a dressing or cement that protects the pulp and promotes healing and repair.

D3120 **pulp cap – indirect (excluding final restoration)**

Procedure in which the nearly exposed pulp is covered with a protective dressing 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.

Pulpotomy

D3220 **therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament.**

Pulpotomy is the surgical removal of a portion of the pulp with the aim of maintaining the vitality of the remaining portion by means of an adequate dressing.

- To be performed on primary or permanent teeth.
- This is not to be construed as the first stage of root canal therapy.
- This is not to be used for apexogenesis.

D3221 **pulpal debridement, primary and permanent teeth**

Pulpal debridement for the relief of acute pain prior to conventional root canal therapy. This procedure is not to be used when endodontic treatment is completed on the same day.

D3222 **partial pulpotomy for apexogenesis – permanent tooth with incomplete root development**

Removal of a portion of the pulp and application of a medicament with the aim of maintaining the vitality of the remaining portion to encourage continued physiological development and formation of the root. This procedure is not to be construed as the first stage of root canal therapy.

Endodontic Therapy on Primary Teeth

Endodontic therapy on primary teeth with succedaneous teeth and placement of resorbable filling. This includes pulpectomy, cleaning, and filling of canals with resorbable material.

D3230 **pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)**

Primary incisors and cuspids.

D3240 **pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)**

Primary first and second molars.

Endodontic Therapy (Including Treatment Plan, Clinical Procedures and Follow-Up Care)

Includes primary teeth without succedaneous teeth and permanent teeth. Complete root canal therapy; pulpectomy is part of root canal therapy.

Includes all appointments necessary to complete treatment; also includes intra-operative radiographs. Does not include diagnostic evaluation and necessary radiographs/diagnostic images.

D3310 **endodontic therapy, anterior tooth (excluding final restoration)**

D3320 **endodontic therapy, premolar tooth (excluding final restoration)**

D3330 **endodontic therapy, molar tooth (excluding final restoration)**

D3331 **treatment of root canal obstruction; non-surgical access**

In lieu of surgery, the formation of a pathway to achieve an apical seal without surgical intervention because of a non-negotiable root canal blocked by foreign bodies, included but not limited to separated instruments, broken posts or calcification of 50% or more of the roots.

To reduce denials, submit the claim with a narrative and radiographs.

D3332 **incomplete endodontic therapy; inoperable, unrestorable or fractured tooth**

Considerable time is necessary to determine diagnosis and/or provide initial treatment before the fracture makes the tooth unretainable.

To reduce denials, submit the claim with a narrative and radiographs.

D3333 **internal root repair of perforation defects**

Non-surgical seal or perforation caused by resorption and/or decay but not iatrogenic by provider filing claim.

Endodontic Retreatment

D3346 **retreatment of previous root canal therapy – anterior**

D3347 **retreatment of previous root canal therapy – premolar**

D3348 **retreatment of previous root canal therapy – molar**

Apexification/Recalcification

D3351 **apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.)**

Includes opening tooth, preparation of canal spaces, first placement of medication and necessary radiographs. (This procedure may include first phase of complete root canal therapy.)

D3352 **apexification/recalcification – interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space, disinfection, etc.)**

For visits in which the intra-canal medication is replaced with new medication. Includes any necessary radiographs.

D3353 **apexification/recalcification – final visit (includes completed root canal therapy – apical closure/calcific repair of perforations, root resorption, etc.)**

Includes removal of intra-canal medication and procedures necessary to place final root canal filling material including necessary radiographs. (This procedure includes last phase of complete root canal therapy.)

Pulpal Regeneration

D3355 **pulpal regeneration – initial visit**

Includes opening tooth, preparation of canal spaces, placement of medication.

D3356 **pulpal regeneration – interim medication replacement**

D3357 **pulpal regeneration – completion of treatment**

Does not include final restoration.

Apicoectomy/Periradicular Services

Periradicular surgery is a term used to describe surgery to the root surface (e.g. apicoectomy), repair of a root perforation or resorptive defect, exploratory curettage to look for root fractures, removal of extruded filling materials or instruments, removal of broken root fragments, sealing of accessory canals, etc. This does not include retrograde filling material placement.

D3410 **apicoectomy – anterior**

For surgery on root of anterior tooth. Does not include placement of retrograde filling material.

D3421 **apicoectomy – premolar (first root)**

For surgery on one root of a premolar. Does not include placement of retrograde filling material. If more than one root is treated, see D3426.

D3425 **apicoectomy – molar (first root)**

For surgery on one root of a molar tooth. Does not include placement of retrograde filling material. If more than one root is treated, see D3426.

D3426 apicoectomy (each additional root)

Typically used for premolar and molar surgeries when more than one root is treated during the same procedure. This does not include retrograde filling material placement.

D3428 bone graft in conjunction with periradicular surgery – per tooth, single site

Includes non-autogenous graft material.

D3429 bone graft in conjunction with periradicular surgery – each additional contiguous tooth in the same surgical site

Includes non-autogenous graft material.

D3430 retrograde filling – per root

For placement of retrograde filling material during periradicular surgery procedures. If more than one filling is placed in one root, report as D3999 and describe.

D3431 biologic materials to aid in soft and osseous tissue regeneration in conjunction with periradicular surgery

D3432 guided tissue regeneration, resorbable barrier, per site, in conjunction with periradicular surgery

D3450 root amputation – per root

Root resection of a multi-rooted tooth while leaving the crown. If the crown is sectioned, see D3920.

D3460 endodontic endosseous implant

Placement of implant material which extends from a pulpal space into the bone beyond the end of the root.

D3470 intentional reimplantation (including necessary splinting)

For the intentional removal, inspection and treatment of the root and replacement of a tooth into its own socket. This does not include necessary retrograde filling material placement.

D3471 surgical repair of root resorption – anterior

For surgery on root of anterior tooth. Does not include placement of restoration.

D3472 surgical repair of root resorption – premolar

For surgery on root of premolar tooth. Does not include placement of restoration.

D3473 surgical repair of root resorption – molar

For surgery on root of molar tooth. Does not include placement of restoration.

D3501 **surgical exposure of root surface without apicoectomy or repair of root resorption – anterior**

Exposure of root surface followed by observation and surgical closure of the exposed area. Not to be used for or in conjunction with apicoectomy or repair of root resorption.

D3502 **surgical exposure of root surface without apicoectomy or repair of root resorption – premolar**

Exposure of root surface followed by observation and surgical closure of the exposed area. Not to be used for or in conjunction with apicoectomy or repair of root resorption.

D3503 **surgical exposure of root surface without apicoectomy or repair of root resorption – molar**

Exposure of root surface followed by observation and surgical closure of the exposed area. Not to be used for or in conjunction with apicoectomy or repair of root resorption.

Other Endodontic Procedures

D3910 **surgical procedure for isolation of tooth with rubber dam**

D3911 **intraorifice barrier**

Not to be used as a final restoration.

D3920 **hemisection (including any root removal), not including root canal therapy**

Includes separation of a multi-rooted tooth into separate sections containing the root and the overlying portion of the crown. It may also include the removal of one or more of those sections.

D3921 **decoronation or submergence of an erupted tooth**

Intentional removal or coronal tooth structure for preservation of root and surrounding bone.

D3950 **canal preparation and fitting of preformed dowel or post**

Should not be reported in conjunction with D2952, D2953, D2954 or D2957 by the same practitioner.

D3999 **unspecified endodontic procedure, by report**

Used for procedure that is not adequately described by a code. Describe procedure.

Section II

Clinical Coding Scenarios

Clinical Coding Scenario #1: Endodontic Examination with CBCT

A general dentist refers a patient for evaluation of ongoing pain in the upper right quadrant. The patient had multiple restorations in the quadrant and had developed increasing pain in the area. The dentist and patient were unsure which tooth was causing the pain. A problem focused oral examination is performed, including pulp vitality testing. Two periapical radiographs and one bitewing radiograph are taken as well as a limited view CBCT. Periapical radiographs are not conclusive due to the proximity to the sinus and zygomatic arch. The limited view CBCT reveals an area of apical and lateral loss of bone extending the level of the osseous crest on the mesial, associated with the upper second molar. A diagnosis of pulpal necrosis with symptomatic apical and lateral periodontitis is made and the patient is informed that a crown to root fracture is present. Due to the guarded prognosis, extraction is recommended.

What procedure codes would be used to document and report the services provided?

D0140	limited oral evaluation – problem focused
D0460	pulp vitality tests
D0220	intraoral – periapical first radiographic image
D0230	intraoral – periapical each additional radiographic image
D0270	bitewing – single radiographic image
D0364	cone beam CT capture and interpretation with limited field of view – less than one whole jaw

Clinical Coding Scenario #2: Endodontic Evaluation and Root Canal Therapy

A patient is referred for root canal therapy of tooth #31 with the chief complaint of ongoing pain to hot, cold, and biting, as well as a spontaneous low grade toothache. Prior dental history of the tooth includes placement of a full coverage crown 6 months previously. A problem-focused examination including pulp vitality testing is performed and diagnostic, preoperative radiographs (two periapicals and a bitewing) are taken and evaluated. The radiographs shows evidence of widening of the periodontal ligament space at the root apices and close proximity to the inferior alveolar nerve canal. A limited view CBCT is taken, the presence of pathology is confirmed, and the root apices are seen to be directly over the mandibular canal. A diagnosis of symptomatic irreversible pulpitis with symptomatic apical periodontitis is made, and a treatment plan for root canal therapy is recommended. The referring dentist requested that a temporary restoration be placed so that he could restore the access opening in the crown.

Root canal therapy was completed in a single visit, using the pre-operative CBCT as a guide to avoid any violation of the inferior alveolar nerve canal. Upon completion of obturation of the canals, 3mm of a flowable bioceramic restorative material was placed over each canal orifice and over the pulpal floor to prevent microleakage and contamination of the completed root canal therapy. A temporary restoration was placed in the access opening, and the patient was advised to return to her dentist for restoration and repair of the crown.

What procedure codes would be used to document and report the services provided?

D0140	limited oral evaluation – problem focused
D0460	pulp vitality tests
D0220	intraoral – periapical first radiographic image
D0230	intraoral – periapical each additional radiographic image
D0270	bitewing – single radiographic image
D0364	cone beam CT capture and interpretation with limited field of view – less than one whole jaw
D3330	endodontic therapy, molar tooth (excluding final restoration)
D3911	intraorifice barrier

Note: D3911 is a code used to report placement of an intraorifice barrier over the obturated canals when the permanent restoration is not placed at the time of completion of root canal therapy. The barrier is not a final restoration.

Clinical Coding Scenario #3: Root Canal Started by Another Practitioner

A patient presents for endodontic treatment of tooth #29, having had a root canal started on this single rooted tooth in another state while on vacation. The patient is having pain still. An exam is performed and diagnostic, preoperative radiographs (a periapical and a bitewing) and CBCT are taken and evaluated. The radiographic images show evidence of a large periapical radiolucency as well as radiopaque evidence that calcium hydroxide has likely been placed in the root canal space. A treatment plan is made to complete root canal therapy and restore the tooth with a buildup and crown.

During the patient's second visit, the appointment during which the root canal was intended to be completed, it is found that ninety minutes was insufficient to complete the case. A significant amount of purulence was seen actively exuding into the tooth from the periapical tissues. The tooth was dressed with calcium hydroxide and temporized. A third treatment visit was scheduled.

During the third visit the root canal was completed and a core buildup was placed. An intraoperative radiograph and two post-operative radiographs were taken during this appointment. A crown preparation appointment was scheduled for a later date.

What procedure codes would be used to document and report the services provided during each of the three encounters?

Visit #1: Initial Appointment

D0140 limited oral evaluation – problem focused

D0220 intraoral – periapical first radiographic image

D0270 bitewing – single radiographic image

D0364 cone beam CT capture and interpretation with limited field of view – less than one whole jaw

Visit #2: Root Canal Begun, but Not Completed

D3221 pulpal debridement, primary and permanent teeth

NOTE: Root canal was not completed.

Visit #3: Root Canal Completed and Core Buildup Placed

D3320 endodontic therapy, premolar (excluding final restoration)

D2950 core buildup, including any pins when required

Note: The third visit radiographs would be documented in the patient's record but not included in the claim submission. "Endodontic Therapy" subcategory descriptor states that the procedures "…includes intra-operative radiographs…" Any radiographs taken for diagnostic purposes, during visit #1 in this scenario, are appropriately included separately on the claim for that date of service.

Clinical Coding Scenario #4: Pulpectomy

A patient of record calls the office with a severe toothache. He did not sleep well the previous night and needs to be seen by a dentist immediately. The schedule is already fully committed, but accommodations are made to see the patient during the office lunch hour.

The patient presents to the office and periapical and bitewing radiographs and CBCT are taken. A problem-focused examination is performed and the patient is diagnosed with symptomatic irreversible pulpitis and symptomatic apical periodontitis of tooth #30. Definitive treatment is recommended to relieve the patient's pain.

A complete pulpectomy was performed and a temporary restoration was placed as emergency treatment. Three weeks later, the patient returns for completion of the root canal and the access opening closed by placement of composite resin restorative material.

What procedure codes would be used to document and report the services provided during each of the two encounters?

Visit #1

D0140	limited oral evaluation – problem focused
D0220	intraoral – periapical first radiographic image
D0270	bitewing – single radiographic image
D0364	cone beam CT capture and interpretation with limited field of view – less than one whole jaw
D3221	pulpal debridement, primary and permanent teeth

Visit #2

D3330	endodontic therapy, molar tooth (excluding final restoration)
D2391	resin-based composite – one surface, posterior

Note: D2391 is the procedure often used when sealing the access opening in the tooth's crown requires a relatively uncomplicated restoration. When sealing the access opening is more complicated, core buildup (D2950) is more likely to be delivered and reported.

Clinical Coding Scenario #5: Emergency Root Canal Patient

A patient of record presents with a dental emergency of severe pain in tooth #9. Clinical examination is performed and radiographs are taken. A CBCT is taken due to the patient's history of trauma. A diagnosis of symptomatic irreversible pulpitis with symptomatic apical periodontitis is made, and root canal therapy is recommended as emergency treatment.

The following codes would be utilized for what would be a typical and straight forward procedure that is completed in the same day, with the access opening restored with composite resin material:

D0140 limited oral evaluation – problem focused

D0220 intraoral – periapical first radiographic image

D0364 cone beam CT capture and interpretation with limited field of view – less than one whole jaw

Note: If more than one periapical is taken, cite the number of additional images with: D0230 intraoral – periapical each additional radiographic image. If a bitewing radiograph is also taken: D0270 bitewing – single radiographic image.

D3310 endodontic therapy, anterior tooth (excluding final restoration)

D2330 resin-based composite – one surface, anterior

What if I see them for a root canal appointment on emergency basis, then have to refer it out to a specialist?

In this case, if a general dentist opens a tooth on an emergency basis due to pain and then feels the need to refer the case, the following codes could be utilized to document the situation:

D0140 limited oral evaluation – problem focused

D0220 intraoral – periapical first radiographic image

D3221 pulpal debridement, primary and permanent teeth

Notes: The pulpal debridement (D3221), also known as pulpectomy, is done to debride the root canal for the purpose of alleviating pain or preparing the root canal for placement of an intracanal medication when indicated.

A referral is then made to an endodontist for specialty care. The endodontist would then perform and code for the following procedures: a limited oral evaluation; new diagnostic preoperative radiographs to establish the present condition; endodontic therapy; restoration of the access opening if a permanent restoration is placed. (The procedures and coding for access opening restoration would depend upon the restorative situation.)

Clinical Coding Scenario #6: Emergency Incision and Drainage and Endodontic Therapy

A patient presents with significant facial swelling and pain in the upper right quadrant. She reports that she had multiple crowns placed in this quadrant and that her dentist told her that she may need a root canal in the future. Clinical examination is performed and a periapical and bitewing radiographs are taken. In addition, a CBCT scan is taken to aid in the diagnosis. A diagnosis of pulpal necrosis with acute apical abscess of tooth #2 is made, and a treatment plan for incision and drainage of the facial swelling followed by endodontic therapy of tooth is discussed.

Incision and drainage is performed with significant purulent drainage. Root canal therapy of tooth #2 is initiated at the same visit; the root canals are instrumented completely and the tooth is medicated with calcium hydroxide followed by the placement of a temporary restoration.

The patient returns two weeks later and the swelling and discomfort has resolved completely. Root canal therapy of tooth #2 is completed with re-instrumentation followed by obturation of the canals. The access opening is permanently restored with composite.

How would you code for this scenario?

Visit #1

D0140	limited oral evaluation – problem focused
D0220	intraoral – periapical first radiographic image
D0270	bitewing – single radiographic image
D0364	cone beam CT capture and interpretation with limited field of view – less than one whole jaw
D7510	incision and drainage of abscess – intraoral soft tissue
D3221	pulpal debridement, primary and permanent teeth

Note: Root canal procedure was initiated but not completed. Record should note that pulpal debridement was performed on this date of service.

Visit #2

D3330	endodontic therapy, molar tooth (excluding final restoration)
D2391	resin-based composite – one surface, posterior

Clinical Coding Scenario #7: Patient Referral for Apicoectomy

A patient is referred by a friend who is a general dentist. The general dentist referred this patient for an "apico" of tooth #3 since the referring dentist prefers not to do this type of procedure in her practice. It is determined that periapical radiographs and a cone beam computed tomography (CBCT) image are needed to evaluate the complex case prior to determining the treatment plan.

A problem-focused examination was performed, along with capture and evaluation of a CBCT image of a portion of the upper jaw and two periapical radiographs. A diagnosis of chronic apical periodontitis was made and a treatment plan for apicoectomy was confirmed. Included in the plan is a bone graft, which will be used due to the presence of the large lesion that appears to have eroded both the buccal and palatal cortical plates of bone. Consent is received and an appointment is scheduled.

Note: A surgery of this nature is not usually done on an emergency basis and often the examination is done on a day separate from the procedure.

The surgery is performed for tooth #3 on both the MB and DB roots. 3 mm of each root end was resected and a root-end filling was placed in each root end. A confirmation periapical radiograph was taken. An absorbable collagen wound dressing was placed.

Sutures were placed and post-operative instructions given. The patient returned for suture removal after a few days. This follow-up appointment was uneventful and sutures were removed.

What procedure codes would be used to document and report the services provided during each of the three encounters?

Visit #1: Initial Appointment

D0140	limited oral evaluation – problem focused
D0220	intraoral – periapical first radiographic image
D0230	intraoral – periapical each additional radiographic image
D0364	cone beam CT capture and interpretation with limited field of view – less than one whole jaw

Visit #2: Endodontic Procedures Delivered

D3425 apicoectomy – molar (first root)

D3426 apicoectomy (each additional root)

D3430 retrograde filling – per root

D3430 retrograde filling – per root

D3431 biologic materials to aid in soft and osseous tissue regeneration in conjunction with periradicular surgery

Note: Root-end fillings are coded per root. For a tooth #3, often there are two roots, which is why D3430 is reported twice.

Visit #3: Post-Operative Follow Up, Sutures Removed

D0171 re-evaluation – post-operative office visit

Note: Visit #3 is the suture removal appointment that is considered part of the patient's routine follow-up care. There is no CDT code for the post-operative suture removal procedure.

Clinical Coding Scenario #8: Apicoectomy with Bony Defect

A 36-year-old patient presents complaining of pain on tooth #9. The tooth is very dark and the soft tissues buccal to the tooth exhibit swelling and fluctuance. Radiographic examination (two periapical images and a CBCT image of a portion of the lower jaw were captured and interpreted) reveals a very large periapical radiolucency associated with tooth #9. The patient reports a history of a traumatic injury involving the tooth when he was a child. An antibiotic was prescribed.

At a second appointment at a later date, surgical exposure of the area is performed, with an incision extending from the distal of #8 to the distal of #10 to reveal a large area of perforation of the buccal cortical plate. Curettage of the bony defect was performed to reveal the lesion extends to the palatal cortical plate, with a through and through lesion. Apicoectomy of tooth #9 was completed, the bony defect was irrigated, and 2 gm of bone graft material was placed followed by a resorbable collagen membrane.

How would these procedures be documented?

Visit #1: Initial Appointment

Radiographs

D0220 intraoral – periapical first radiographic image

D0230 intraoral – periapical each additional radiographic image

D0364 cone beam CT capture and interpretation with limited field of view – less than one whole jaw

Oral Evaluation

D0140 limited oral evaluation – problem focused

Prescribe antibiotic – No applicable CDT code

Note: D9630 drugs or medicaments dispensed in office for home use is not applicable since the nomenclature states this procedure applies to drugs or medicaments dispensed in the office for home use, and its descriptor specifically excludes writing prescriptions.

Visit #2

Root canal on #9

D3310 endodontic therapy, anterior tooth (excluding final restoration)

Visit #3

Apicoectomy on #9

D3410 apicoectomy – anterior

Note: Curettage and irrigation of the bony defect require no separate CDT code; these actions are considered a component of the D3410 procedure.

Placement of 2 gm of bone graft material to preserve the bone around teeth #8 and #9.

D3428 bone graft in conjunction with periradicular surgery – per tooth, single site

D3429 bone graft in conjunction with periradicular surgery – each additional contiguous tooth in the same surgical site

D3432 guided tissue regeneration, resorbable barrier, per site, in conjunction with periradicular surgery

Note: D7955 repair of maxillofacial soft and/or hard tissue defect could apply depending on how much the defect that requires bone grafting extends beyond the treated tooth. But, D7955 should not be reported in addition to D3428 or D3429.

Clinical Coding Scenario #9: Non-carious Cervical Resorption Lesion

A patient presents with invasive cervical resorption on the buccal of tooth #18. It was discovered during a routine hygiene appointment when a periapical and a bitewing radiograph were taken. The tooth has no symptoms. It is clear that this lesion is not caries, as a cavitated lesion cannot be detected with any type of explorer. There is no periapical radiolucency.

When areas of resorption are suspected, the American Association of Endodontics and the American Association of Oral and Maxillofacial Radiography recommend the following: "Limited field of view CBCT is the imaging modality of choice in the localization and differentiation of external and internal resorptive defects and the determination of appropriate treatment and prognosis."

The CBCT scan is taken and a diagnosis of a Heithersay Class I external cervical invasive resorption on the buccal surface of the tooth #18 is made. The treatment plan includes surgical exposure of the resorptive defect followed by external repair of the resorptive lesion.

A full thickness mucoperiosteal flap is reflected and the area of resorption is identified and excavated. There is no exposure of the pulp in the excavation of the resorptive defect. The area of resorption is then treated with 90% trichloracetic acid to arrest the progression of the resorption. The defect is restored with a resin-modified glass ionomer. The area is surgically closed and sutures are placed. The patient is instructed to return for suture removal and continued follow up to monitor the pulpal status and to identify any onset of pulpitis.

How would you code for this scenario?

D0140	limited oral evaluation – problem focused
D0220	intraoral – periapical first radiographic image
D0270	bitewing – single radiographic image
D0364	cone beam CT capture and interpretation with limited field of view – less than one whole jaw
D3473	surgical repair of root resorption – molar
D2391	resin-based composite – one surface, posterior

Clinical Coding Scenario #10: Surgical Exposure of Root Surface for Exploration

A patient presents for evaluation and treatment of tooth #10, which has a persistent sinus tract. The tooth has a history of root canal therapy two years previously. Radiographic examination with a periapical radiograph reveals a small periapical radiolucency. Clinically, no significant periodontal probing defects are seen, and the sinus tract can be traced to the apex of tooth #10.

When evaluating a previously endodontically treated tooth with a non-healing lesion, the American Association of Endodontics and the American Association of Oral and Maxillofacial Radiography recommend the following:

"Limited field of view CBCT should be the imaging modality of choice when evaluating the non-healing of previous endodontic treatment to help determine the need for further treatment, such as nonsurgical, surgical or extraction."

A CBCT scan is taken, and a diagnosis of chronic apical abscess of previously endodontically treated tooth #10 is made. The treatment plan includes surgical exposure of the periapex of tooth #10 followed by apicoectomy, if indicated.

An submarginal mucoperiosteal flap is reflected, and a perforating defect is seen in the buccal cortex over the periapex of tooth #10. Curettage of the apical lesion is performed, and the root surface can be visualized to reveal a 6 mm vertical root fracture from the mid-root to the apex of the tooth. At this point, the prognosis of the tooth is determined to be guarded and extraction is indicated. Due to treatment planning and esthetic considerations, the extraction will be done at a later date. The area is surgically closed and sutures are placed.

How would you code for this scenario?

D0140	limited oral evaluation – problem focused
D0220	intraoral – periapical first radiographic image
D0364	cone beam CT capture and interpretation with limited field of view – less than one whole jaw
D3501	surgical exposure of root surface without apicoectomy or repair of root resorption – anterior

Note: D3501 describes the procedure of exposing the root surface followed by observation and surgical closure of the exposed area; this procedure is not used for or delivered in conjunction with apicoectomy or repair of root resorption.

Remember, the existence of a code does not mean that this code will be covered by a given patient's dental benefits, despite recommendations by a dental professional.

Clinical Coding Scenario #11: Pulpal Regeneration

Visit #1: Initial Appointment

A 12-year-old patient presents with a somewhat painful tooth #29. The parent noticed that the child avoids chewing on the tooth.

Clinical examination is performed, and radiographs (one bitewing and one periapical) are taken. There is mild swelling in the vestibule, buccal to tooth #29. It is percussion sensitive, palpation sensitive, slightly mobile (class I), and there are no probing depths over 3 mm. The tooth is sensitive to biting on the Tooth Slooth® and is non-responsive to pulp vitality testing. The tooth has never been restored and no caries is present, radiographically or clinically. Radiographically, a moderately-sized periapical radiolucency is present. There is a very tall pulp chamber, making the enamel look like a thin shell, rather than a thick band over the occlusal area of the pulp chamber. The apex of the tooth has an immature foramen with no apical constriction, and the apical opening is over 1 mm wide. The tooth appears 3–5 mm shorter than adjacent tooth #28.

A diagnosis of pulpal necrosis and acute apical abscess is made. The etiology is determined to be that a dens evaginatus tubercle had previously fractured and led to ingress of bacteria and eventual pulpal necrosis. A treatment plan for pulpal regeneration is discussed, and with the parent's consent, treatment is initiated.

Local anesthetic is administered, a rubber dam is placed, and an access opening is made. The canal is appropriately instrumented and irrigated according to established protocols. Calcium hydroxide or antibiotic paste is placed as an intracanal medicament and a temporary restoration is placed.

What CDT codes are applicable for the procedures delivered during this visit?

D0140 limited oral evaluation – problem focused

D0220 intraoral – periapical first radiographic image

D0270 bitewing – single radiographic image

D0460 pulp vitality tests

D3355 pulpal regeneration – initial visit

Visit #2

The patient is asymptomatic at the second visit, three weeks after initiation of treatment. There is no swelling, and the tooth is not abnormally mobile, but the patient is unable to chew normally upon tooth #29. Local anesthetic is administered, a rubber dam is placed, the tooth is re-instrumented, re-irrigated, and re-medicated, and a temporary restoration is placed.

The CDT code for the second visit is:

D3356 pulpal regeneration – interim medication replacement

Visit #3

Three weeks have passed since the second visit. The tooth is now completely normal; all symptoms have resolved. Local anesthetic is administered, a rubber dam is placed, and the canal space is re-irrigated to remove all intracanal medicament. Apical bleeding is initiated, a bioceramic barrier is placed in the cervical area of the root canal, and a composite restoration is placed in the access opening. A final radiograph is taken for documentation and to be used as a baseline for future follow up. Regular follow-up visits are recommended to monitor the maturation of the root of tooth #29.

The CDT codes for this third visit are:

D3357 pulpal regeneration – completion of treatment

D2391 resin-based composite – one surface, posterior

Clinical Coding Scenario #12: Decoronation

A 10-year-old patient of record returns to the office for periodic review tooth #8 with a history of dental trauma and avulsion 2 years ago. At that time, the tooth was reimplanted and root canal therapy was completed. Clinical examination reveals that the tooth exhibits 2 mm infra-positioning, and radiographic examination with periapical radiographs and CBCT reveals evidence of advanced replacement root resorption. The tooth was deemed non-savable and treatment planned for decoronation to retain the root and preserve ridge height and width until patient reaches suitable age for implant placement.

The patient returns for the decoronation procedure, and a mucosal flap is reflected and the tooth is decoronated at the level of the osseous crest. The root canal obturation material is removed to facilitate osseous integration, and the flap is reapproximated and sutured. A post-treatment radiograph is taken. The patient returns for suture removal.

What procedure codes would be used to document and report the services provided during each of these visits?

Visit #1

D0120 periodic oral evaluation – established patient

D0220 intraoral – periapical first radiographic image

D0364 cone beam CT capture and interpretation with limited field of view – less than one whole jaw

Visit #2: Decoronation

D3921 decoronation or submergence of an erupted tooth

Visit #3: Post-operative Follow Up, Sutures Removed

D0171 re-evaluation – post-operative office visit

Note: D3921 describes procedures for Intentional removal of coronal tooth structure for preservation of the root and surrounding bone.

Clinical Coding Scenario #13: Decompression and Root Canal Therapy

Visit #1: Initial Appointment

A 16-year-old patient presents with facial swelling and pain associated with tooth #8. Prior history of this tooth includes a traumatic injury years previously when the patient was hit in the mouth with a baseball.

Clinical examination is performed, and periapical radiographs (at different angles) are taken. There is significant facial swelling and swelling in the buccal vestibule, buccal to tooth #8. The tooth is painful to percussion and palpation and is the only tooth in the area which is non-responsive to pulp vitality testing. The tooth has never been restored and no caries is present, radiographically or clinically. Radiographically, a large apical lucency is seen to encompass the apices of teeth #7 and 9.

A diagnosis of pulpal necrosis and acute apical abscess is made. A treatment plan for initiation of root canal therapy, with the possible need for further intervention is discussed, and with the parent's consent, treatment is initiated.

Local anesthetic is administered, a rubber dam is placed, and an access opening is made. Significant purulent drainage exudes from the canal. The canal is appropriately instrumented and irrigated according to established protocols. Calcium hydroxide is placed as an intracanal medicament and a temporary restoration is placed.

What CDT codes are applicable for the procedures delivered during this visit?

D0140	limited oral evaluation – problem focused
D0220	intraoral – periapical first radiographic image
D0270	bitewing – single radiographic image
D0364	cone beam CT capture and interpretation with limited field of view – less than one whole jaw
D0460	pulp vitality tests
D3221	pulpal debridement, primary and permanent teeth

Visit #2

The patient returns three weeks after initiation of treatment. Although the facial swelling has resolved, there is still swelling in the vestibule. Local anesthetic is administered, a rubber dam is placed, the tooth is accessed and significant purulent exudate can be expressed from the canal with gentle pressure on the vestibular swelling.The tooth is re-instrumented, re-irrigated, and re-medicated with Calcium Hydroxide, and a temporary restoration is placed. Further discussion with the patient's parents about the persistence of the large cyst-like infection includes the recommendation for decompression, as conservative treatment with decompression may allow healing with periapical surgery. With the parents' consent, a vestibular incision is made and a surgical catheter is placed. The patient is given home care instructions to irrigate through the catheter daily.

D7509 marsupialization of odontogenic cyst

Surgical decompression of a large cystic lesion by creating a long-term open pocket or pouch.

Note: D7509 is a code effective January 1, 2023 to report surgical decompression of a large cystic lesion. This code does not refer to surgical excision of a periradicular cyst.

Visit #3, 4, 5

The patient returns two, six, and 10 weeks later for evaluation of healing. He is comfortable and the swelling has not returned. The patency of the surgical catheter is confirmed at each visit and the lesion is irrigated with sterile saline through the catheter.

D0171 re-evaluation post-operative visit

Visit #6

At this visit, the catheter is removed and root canal therapy is completed. Local anesthetic is administered, a rubber dam is placed, the tooth is accessed with no signs of purulent drainage. The canal is irrigated, the Calcium Hydroxide is removed, and the canal is obturated. A final restoration with composite is used to close the access opening.

D3310 endodontic therapy, molar tooth (excluding final restoration)

D2391 resin-based composite – one surface, posterior

Clinical Coding Scenario #14: Removal of an Indirect Restoration on a Natural Tooth

This new code has been unbundled from the pre- existing code for placement of any restoration, either direct or indirect, when a restoration already exists. The argument behind the code is that the removal of a restoration is a separate procedure from the placement of a new restoration.

A patient presents for a root canal procedure on youth #3, but has an existing indirect restoration in place that has caries under the margin, and the plan is to replace that crown. However, it has been decided to remove the crown first, then do the root canal procedure. In this scenario, one might remove the crown, remove the caries, determine restorability, then perform the error canal, and temporize.

In this case, the exam, x-ray and CBCT have already been done.

What CDT codes are applicable for the procedures delivered during this visit?

D2956 removal of an indirect restoration

D3330 root canal of a molar

D3911 intraorifice barrier

Note: The temporary restoration one would place would be bundled in with the D3330, as would the final radiograph(s).

Clinical Coding Scenario #15: Patient Referral for Removal of Fractured Abutment Screw

A patient is referred by a top referring dentist to the endodontist for evaluation and management of a fractured abutment screw in the implant site at tooth #30. The referring dentist, who placed the implant crown several years ago, reports that the screw fractured during crown removal and prefers not to attempt screw retrieval in-office.

The endodontist performs a problem-focused limited evaluation to assess the implant site and determine the feasibility of screw retrieval. A periapical radiograph and a limited field-of-view CBCT are taken to evaluate the implant and confirm that the fractured screw segment remains embedded in the implant body without displacement or damage to the surrounding bone. The findings are as follows: fractured abutment screw segment within the implant body of #30, no signs of peri-implantitis or bone loss, and surrounding soft tissue is healthy.

The treatment plan is to proceed with removal of the fractured screw (D6096). If retrieval is successful and the internal threads are intact, the referring dentist will replace the abutment and crown.

What CDT codes are applicable for the procedures delivered during this visit?

D0140 limited oral evaluation – problem focused

D0220 intraoral – periapical first radiographic image

D0364 cone beam CT capture and interpretation with limited field of view – less than one whole jaw

D6096 remove broken abutment screw

After administering local anesthesia, the endodontist removes the fractured abutment screw using ultrasonic and micro-instrumentation under the operating microscope.

The internal threads of the implant are inspected and verified to be intact. An intraoral periapical radiographic image is obtained to confirm removal. The patient is immediately referred back to the restoring dentist for continuation of care.

D0230 intraoral – periapical (to confirm removal)

Clinical Coding Scenario #16: Detailed and Extensive Endodontic Evaluation

A general dentist refers a patient for root canal therapy of tooth #3, reporting sensitivity to hot, cold, and biting pressure. The referral also requests evaluation of five additional teeth across multiple quadrants to make efficient use of the appointment—some have prior endodontic therapy; others have large restorations or suspected cracks.

A detailed and extensive endodontic evaluation is performed. Pulp vitality and percussion testing are conducted on six total teeth across three quadrants. Periodontal probing and crack assessments are performed on multiple teeth. Diagnostic, preoperative radiographs are reviewed, and multiple limited-field CBCT images (or a full-arch CBCT) are captured and interpreted to evaluate periapical and restorative conditions. Prior radiographs and the restorative history from the referring dentist are reviewed.

Findings include:

- Tooth #3: symptomatic irreversible pulpitis with acute apical periodontitis.
- Tooth #15 (previously treated): periapical radiolucency consistent with asymptomatic apical periodontitis.
- One cracked tooth: asymptomatic irreversible pulpitis with normal apical periodontium.
- Two remaining teeth: normal pulp with normal apical periodontium.

What CDT codes are applicable for the procedures delivered during this visit?

D0160	detailed and extensive oral evaluation – problem focused, by report
D0460	pulp vitality tests
D0220	intraoral – periapical first radiographic image
D0230	intraoral – periapical each additional radiographic image
D0364	cone beam CT capture and interpretation with limited field of view – less than one whole jaw

Practice note: when a full-arch CBCT is captured/interpreted per local protocol, use the appropriate CBCT code accordingly.

Because the evaluation required examination and diagnosis of multiple teeth in several quadrants, including review of prior records, CBCT interpretation, and assessment of both symptomatic and asymptomatic conditions, the visit is appropriately reported as D0160 (detailed and extensive oral evaluation, problem focused, by report) rather than D0140.

Clinical Coding Scenario #17: Lost Composite, Protective Restoration

A 7-year-old presents as an emergency with sensitivity to cold and sweets in the upper left quadrant. Mom is reports that a filling fell out last week and it has been bothering them since but their pediatric dentist is out of town and found your office online. Clinical examination is performed showing tooth #14 had a large occlusal composite missing with exposed dentin and food impaction. Pulp sensibility testing of #14 is more sensitive to cold than the adjacent teeth but there is no lingering, and periapical and bitewing radiographs are taken which show caries confined to dentin with no evidence of lateral or apical widening of the lamina dura. The patient is unable to sit still for extended periods of time so it is determined that only a temporary glass ionomer restoration can be placed to seal over the exposed dentin and prevent further breakdown until they can see their pediatric dentist for a definitive restoration the following week.

The patient and mother consented to proceed with the proposed restoration and local anesthesia is administered, caries are excavated from the occlusal area of tooth #14, sharp areas are smoothed from the enamel margins, and a high-viscosity glass ionomer is placed over the area as a temporary protective restoration. Occlusion is checked and the patient is referred back to their pediatric dentist for replacement with a definitive restoration.

What CDT codes are applicable for the procedures delivered during this visit?

D0140	limited oral evaluation – problem focused
D0220	intraoral – periapical first radiograph image
D0270	bitewing – single radiographic image
D2940	protective restoration

Section III

Medical Claim Coding

Medical Claims

Endodontic practices occasionally file medical claims, typically in two situations:

- A patient is in an accident and suffers trauma to the teeth. The "primary" insurance carrier may be the patient's medical plan or personal injury protection policy within his or her auto insurance.
- The patient's dental plan "payment policy" requires that specific CDT codes (typically apicoectomy codes) must be filed first with the patient's medical plan to see if it is covered under as a "surgical" procedure.

The claim must be filed on a CMS 1500 form using a Current Procedural Terminology (CPT®) code and a medical (International Classification of Disease or ICD-10) diagnostic code for every procedure/service.

To learn more about CPT and ICD-10 codes, visit the American Medical Association's website at https://www.ama-assn.org/topics/cpt-books-products.

Tips for Filing Medical Claims for Dental Procedures

1. It's a best practice to verify with the payer which code set they want, BEFORE SENDING A CLAIM.
2. Most payers will only accept a medical claim that has just one code set – don't include both CDT and CPT on the same claim.
3. If billing a medical insurance, pause on submitting any dental claim until the medical insurance has adjudicated (paid/denied) the claim. Filing both a medical and dental claim at the same time could result in an overpayment requiring refunds.
4. Send the medical insurance EOB when/if you file a dental claim.

180 N. Stetson Ave., Suite 1500
Chicago, IL 60601

Phone: 800-872-3636 (U.S., Canada, Mexico)
or 312-266-7255

Fax: 866-451-9020 (U.S., Canada, Mexico)
or 312-266-9867

Email: info@aae.org

american association of endodontists

@savingyourteeth

@endodontists

/company/endodontists

@savingyourteeth

/rootcanalspecialists

aae.org