

Notice of CDT 2026
Update to Exhibit A, Per Section 31 and in VA Exhibit G, Dental Program Claims
Processing Guidelines
Effective January 1, 2026

The American Dental Association (ADA) has revised the Common Dental Terminology (CDT) for 2026. 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 2026 code, or if you have questions, please contact Professional Services at 1-866-947-9398. This notice of CDT 2026 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
D1352	preventive resin restoration in a moderate to high caries risk patient – permanent tooth
D1705	AstraZeneca Covid-19 vaccine administration – first dose
D1706	AstraZeneca Covid-19 vaccine administration – second dose
D1707	Janssen Covid-19 vaccine administration
D1712	Janssen Covid-19 Vaccine Administration - booster dose
D9248	non-intravenous conscious sedation

New CDT Codes¹

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
D0426	collection, preparation, and analysis of saliva sample – point-of-care
D0461	testing for cracked tooth
D1720	influenza vaccine administration
D5877	duplication of complete denture – maxillary
D5878	duplication of complete denture – mandibular
D5909	maxillary guidance prosthesis with guide flange
D5930	maxillary guidance prosthesis without guide flange
D5938	resection prosthesis, maxillary complete removable
D5939	resection prosthesis, mandibular complete removable
D5940	resection prosthesis, maxillary partial removable
D5941	resection prosthesis, mandibular partial removable
D5942	resection prosthesis, maxillary implant/abutment supported removable prosthesis for edentulous arch

Procedure code	Description
D5943	resection prosthesis, mandibular implant/abutment supported removable prosthesis for edentulous arch
D5944	resection prosthesis, maxillary implant/abutment supported removable prosthesis for the partial edentulous arch
D5945	resection prosthesis, mandibular implant/abutment supported removable prosthesis for the partial edentulous arch
D5946	resection prosthesis, maxillary implant/abutment supported fixed prosthesis for edentulous arch
D5947	resection prosthesis, mandibular implant/abutment supported fixed prosthesis for edentulous arch
D5948	resection prosthesis, maxillary implant/abutment supported fixed prosthesis for the partial edentulous arch
D5949	resection prosthesis, mandibular implant/abutment supported fixed prosthesis for the partial edentulous arch
D6049	scaling and debridement of a single implant in the presence of peri-implantitis inflammation, bleeding upon probing and increased pocket depths, including cleaning of the implant surfaces, without flap entry and closure
D6196	removal of an indirect restoration on an implant retained abutment
D6280	implant maintenance procedures when a full arch removable implant/abutment supported denture is removed and reinserted, including cleansing of prosthesis and abutments – per arch
D9128	photobiomodulation therapy - first 15-minute increment, or any portion thereof
D9129	photobiomodulation therapy - each subsequent 15-minute increment, or any portion thereof
D9224	administration of general anesthesia with advanced airway – first 15-minute increment, or any portion thereof
D9225	administration of general anesthesia with advanced airway – each subsequent 15-minute increment, or any portion thereof
D9244	in-office administration of minimal sedation – single drug – enteral
D9245	administration of moderate sedation – enteral
D9246	administration of moderate sedation – non-intravenous parenteral – first 15-minute increment, or any portion thereof
D9247	administration of moderate sedation – non-intravenous parenteral – each subsequent 15-minute increment, or any portion thereof
D9936	cleaning and inspection of occlusal guard – per appliance

Revised Codes

Procedure code	Description
D0180	comprehensive periodontal evaluation - new or established patient
D0417	collection and preparation of saliva sample for laboratory analysis
D0418	analysis of saliva sample – laboratory
D2391	resin-based composite - one surface, posterior
D5876	add metal substructure to acrylic complete denture - (per arch)
D5934	mandibular guidance prosthesis with guide flange
D5935	mandibular guidance prosthesis without guide flange
D7285	incisional biopsy of oral tissue-hard (bone, tooth)
D7286	incisional biopsy of oral tissue-soft
D9222	administration of deep sedation/general anesthesia – first 15-minute increment, or any portion thereof
D9223	administration of deep sedation/general anesthesia – each subsequent 15-minute increment, or any portion thereof
D9230	administration of nitrous oxide
D9239	administration of moderate sedation - intravenous - first 15 minutes increment, or any portion thereof
D9243	administration of moderate sedation – intravenous - each subsequent 15-minute increment, or any portion thereof

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.

¹The 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 2026 CDT code book.