01 / QUICK REFERENCE

CDT 2027 Complete Billing Cheat Sheet

Essential Changes at a Glance • Effective January 1 - December 31, 2027

28	33	6	0
NEW CODES	REVISIONS	EDITORIAL UPDATES	DELETIONS

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Critical revised-code quick reference

SELECTED CHANGES - VERIFY FINAL DESCRIPTORS

Code	2027 change (paraphrased)	Immediate billing action
D2390	Direct composite crown usable for any tooth	Check posterior coverage and alternate-benefit rules.
D9910	Desensitizing medicament: per tooth	Update tooth-level detail and fee logic.
D9130	TMJ physical therapies: 15-minute increments	Capture time and check unit calculations.
D9913	Cosmetic neuromodulator administration	Use therapeutic pathway only when supported.
D1206 / D1208	Full-mouth topical fluoride applications	Review application reporting and claim edits.
D1354 / D1355	Revised caries-medicament language; per tooth	Retain tooth-specific records.
D8210 / D8220	Adjunctive orthodontic appliance therapy	Refresh local descriptions and benefits checks.

Five rules to keep beside your claim queue

01 Use the edition effective on the documented service date, subject to applicable completion-date policy.

02 No codes were deleted for CDT 2027; revised nomenclature and units can still affect claims.

03 An active CDT code alone never proves that a patient has a covered benefit.

04 New codes may not appear immediately in a payer fee schedule or processing system.

05 Dental and medical insurance use different claims, code sets and supporting records.

Priority for January: Confirm codes and units; update fees, clinical-note templates, eligibility checks and denied-claim monitoring.

Verification status: ADA confirms the 67-change totals. This draft does not replace the licensed official CDT 2027 manual. New-code identifiers and full wording require editorial sign-off.

Not a claim-coding authority. Verify licensed CDT 2027 and current payer policy before use.

02 / EFFECTIVE DATES

CDT 2026 or CDT 2027?

Correct edition selection is generally tied to the date of service, not the date a claim reaches a payer.

THROUGH DECEMBER 31, 2026

Use CDT 2026
Services performed before the 2027 effective date.

JANUARY 1, 2027 ONWARD

Use CDT 2027
Services performed after the 2027 update begins.

Six real-world date-of-service scenarios

Scenario	Applicable edition	Action for the billing team
Dec 30, 2026 service; Jan 5, 2027 submission	CDT 2026	Retain the edition for that service date.
Service performed Jan 4, 2027	CDT 2027	Apply the new code set and supported units.
New 2027 code on a Dec 2026 service	CDT 2026	Select a valid 2026 code supported by notes.
Crown / bridge / denture spans year-end	Payer-specific	Confirm its delivery or completion-date rule.
2026 predetermination; treatment in 2027	CDT 2027	Recheck estimate, code and patient benefits.
2027 corrected claim for 2026 service	CDT 2026	Preserve original service date and code edition.

If a code is invalid for the service date

CARC 1 81 : Procedure code was invalid on the date of service. This is a diagnostic clue, not permission to automatically change the procedure or the documented date.

1. Confirm the actual treatment or applicable completion date.
2. Verify code-set year and exact code validity on that date.
3. Check whether the code was new or revised, and review the record.
4. Follow the payer correction, reconsideration or appeal instructions.
5. Inspect similar claims for a recurring software mapping issue.

FAST EXAMPLE December service + January submission = CDT 2026 (normally).

Exception to check: Multi-visit restorations, dentures and bridges may be governed by payer-specific delivery or completion-date policies. Never rewrite a service date to force a code-year match.

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03 / NEW CODE FAMILIES

New CDT 2027 Procedure Areas

Nine orofacial pain/TMD categories and seven additional categories identified in the editorial brief.

Code-number status: The finalized numeric IDs for the 28 new codes require the licensed CDT 2027 code set. Dashes below are intentional - not missing typesetting.

A. Orofacial pain, TMD and related care • 9 proposed additions

Code*	Procedure area (paraphrased)	Claim-readiness check
—	Occipital nerve block	Confirm dental vs medical pathway and indication.
—	Peripheral nerve block	Identify nerve and clinical reason in notes.
—	Sphenopalatine ganglion block	Confirm covered diagnosis and exclusions.
—	Tendon or ligament injection	Record each injection site; verify reporting unit.
—	Trigger point injection	Identify muscles treated; verify reporting unit.
—	Therapeutic head/neck chemodenervation	State therapeutic purpose and relevant anatomy.
—	Therapeutic salivary gland chemodenervation	Support indication, gland and clinical record.
—	Occlusal orthotic repair or reline	Distinguish maintenance from new appliance.
—	Occlusal orthotic inspection / cleaning	Check frequency rules and covered benefits.

B. Other clinical areas • 7 proposed additions

Code*	Procedure area (paraphrased)	Claim-readiness check
—	Auricular molding	Document site, treatment and benefit review.
—	Nasal molding	Record clinical indication and procedure delivered.
—	Maxillofacial prosthesis repair, by report	Attach case-specific narrative when requested.
—	Non-fluoride preventive medicament, full mouth	Verify material, full-mouth scope and payer rule.
—	Re-cement / re-bond fixed orthodontic appliance	Identify affected appliance and service delivered.
—	Overnight pulse oximetry assessment	Confirm clinical record and applicable benefit.
—	Transition case management, pediatric to adult	Record care transition and service details.

* The March 2026 ADA committee report used placeholder identifiers for new proposals. Do not assign a numeric CDT code until verified against the released licensed 2027 manual or app. All scope and unit details require final-code verification.

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04 / NEW PROSTHETIC CODES

Implant, Splint & Prosthetic Codes

Twelve additional proposed CDT 2027 procedure areas and the documentation decisions that matter.

Before submitting: For every item below, retrieve the assigned 2027 code, final descriptor, unit and applicable benefit policy from an authorized source.

Twelve additions referenced in the editorial brief

#*	Procedure area (paraphrased)	First coding/documentation check
01	Healing cap placement on implant body	Document placement, setting and related procedures.
02	Remove screw-retained indirect implant restoration	State reason for access or implant treatment.
03	Repair existing intra-coronal fixed splint	Identify the existing device and repaired component.
04	Repair existing extra-coronal fixed splint	Record repair, not a replacement service.
05	Remove intra-coronal fixed splint	Document type, tooth sites and reason.
06	Remove extra-coronal fixed splint	Document removal and anatomical details.
07	Maxillary interim fixed denture, partially edentulous	Confirm arch and support structure.
08	Mandibular interim fixed denture, partially edentulous	Confirm arch and support structure.
09	Semi-precision abutment on natural tooth	Distinguish tooth-supported from implant-supported.
10	Replace teeth on complete maxillary denture	Differentiate from base repair or reline.
11	Replace teeth on complete mandibular denture	Differentiate from base repair or reline.
12	Replace teeth plus acrylic on hybrid prosthesis	Verify per-arch reporting in official descriptor.

Distinctions that prevent mismatched coding

REPAIR vs NEW	Document that the existing fixed splint was repaired, rather than newly constructed.
PARTIAL vs COMPLETE	Identify whether the interim implant prosthesis serves a partially or fully edentulous arch.
TOOTH vs IMPLANT	Record whether the semi-precision abutment is supported by natural tooth or implant.
TEETH vs RELINE	Replacement of denture teeth is not automatically the same service as a denture reline.

Healing-cap billing check: Load the fee, record the clinical circumstance, and check bundling or separate-payment rules when associated with D6010 or D6011. Reimbursement is not presumed.

* Row numbers are list positions, not assigned CDT codes. This section is for editorial preparation until each official new code ID is verified.

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05 / REVISED CODES

Revisions & Editorial Updates

Code-group reference compiled from the brief and ADA committee decisions; final code-by-code reconciliation remains required.

Scope note: 33 revisions are confirmed in total. The supplied material lists key code families, not a verified item-by-item register of all 33. Do not treat this page as the complete official change log.

Important revised codes and category changes

Existing code / topic	2027 revision (paraphrased)	Billing action
D2390	Direct composite crown: broader tooth applicability	Check posterior coverage.
D9910	Desensitizing medicament: per-tooth unit	Reprice / record tooth.
D9130	TMJ physical therapies: 15-minute increment	Capture elapsed time.
D9913	Neuromodulator wording identifies cosmetic use	Separate therapeutic review.
D1206 / D1208	Full-mouth topical fluoride application terms	Check reporting scope.
D1354 / D1355	Caries-medicament wording; per-tooth retained	Maintain tooth mapping.
Preventive heading	Related category descriptor revised	Update local labels.
D8210 / D8220	Adjunctive orthodontic appliance therapy	Update descriptions.
Orthodontic heading	Adjunctive-therapy category renamed	Review benefit mapping.
Comprehensive ortho	Comprehensive orthodontic descriptor revised	Review templates.
D8696 / D8697	Repair language includes reattachment	Review procedure selection.
D5942-D5945	Resection-prosthesis terminology revised	Update chart labels.
D6055, D6110-D6113, D6280	Implant/prosthesis terminology updates	Update coding references.
D5511 / D5512	Complete denture-base repair language	Avoid unit assumptions.
D5867 / D6091	Precision-attachment component wording	Confirm component.
D5993, D5995 / D5996	Maintenance / medicament carrier wording	Review detail.
D0802	Indirect 3D surface-scan terminology	Update scan descriptions.

Six editorial updates (wording-oriented)

Code	Editorial area
D0423	Genetic laboratory analysis terminology
D4273	Graft procedure terminology
D5982	Surgical stent descriptor
D5999	Unspecified maxillofacial procedure
D6191	Implant-body wording
D9959	Unspecified sleep procedure wording

Reporting unit watch: D9910 / D1354 / D1355 - tooth; D9130 - 15 minutes; D1206 / D1208 - full mouth. Proposed new procedures may be per muscle, site or arch; confirm in licensed publication.

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06 / CLAIM PATHWAYS

Dental vs. Medical Billing

The correct insurance pathway follows the service, patient diagnosis and applicable payer policy - not just the provider specialty.

DENTAL BENEFIT / CDT

Claim: ADA dental form / 837D
Procedure: appropriate CDT
Check: dental eligibility, code units, tooth/site detail, records and authorization if required.

MEDICAL BENEFIT / CPT

Claim: CMS-1500 / 837P
Codes: appropriate CPT and ICD-10-CM
Check: medical necessity, diagnosis, history, payer policy, authorization and supplies when applicable.

Medical coding examples - not automatic CDT-to-CPT equivalents

Service category	Medical CPT example
Occipital nerve block	64405
Other peripheral nerve/branch block	64450
Sphenopalatine ganglion block	64505
Tendon / ligament injection	20550 or 20551 ; anatomy-dependent
Trigger point: 1 -2 muscles / 3+ muscles	20552 / 20553
Therapeutic head / neck chemodenervation	64612 or 64615, procedure-dependent
Specified salivary-gland chemodenervation	64611 when criteria met

Unit warning: Proposed CDT trigger-point reporting is described in the editorial brief as per muscle; CPT examples distinguish sessions by muscle-count groups. Verify both final CDT units and CPT requirements.

ICD-10-CM diagnosis examples - select only if clinically supported

M79.11	Myalgia of mastication muscle	**M26.623**	Bilateral TMJ arthralgia
M54.81	Occipital neuralgia	**G50.1**	Atypical facial pain
G47.63	Sleep-related bruxism	**K11.7**	Disturbances of salivary secretion

Payer policy examples to check before a medical claim

Cigna: review the current peripheral/cranial nerve block policy and exclusions. Aetna: review its botulinum toxin and TMD clinical bulletins for diagnosis, medical necessity, precertification and prior treatment requirements. Do not infer coverage from this guide.

Never conflate cosmetic and therapeutic codes: D9913 cosmetic neuromodulator administration and therapeutic chemodenervation are distinct. Verify current CPT/ICD mapping and any drug billing independently.

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07 / PAYER READINESS

Payer Adoption & Denial Risks

2026 experience illustrates why a valid CDT code may still lack a loaded fee, covered benefit or accepted claim route.

Historical 2026 signals | NOT 2027 coverage decisions

Payer / program	2026 example / evidence status	What to verify for 2027
UnitedHealthcare	2026 CDT/CPT updates addressed in policy bulletins.	Check applicable 2027 product and dental plan bulletins.
Humana	2026 notice tied new fee entries to related existing codes.	Confirm new-code fee loading and member benefits.
Medi-Cal Dental	CDT-26 resources and May 2026 update published.	Review California 2027 schedules and state notices.
Pennsylvania MA	2026 Aug 1 HCPCS fee changes: NOT CDT proof.	Verify any dental-specific PA MA bulletin separately.
Nevada Medicaid	Draft brief alleges some temporary claims holds.	Obtain primary bulletin before repeating this claim.

When the January remittance does not match expectations

Problem	First action - not necessarily resubmission
New code has no fee	Check payer adoption, contracted fee and claim status.
Plan excludes procedure	Check patient-specific plan limits and patient notice.
Unit edit / mismatch	Compare final descriptor, documented units and filed line.
Wrong code edition	Review service date, code year and system mapping.
Insufficient narrative	Supply accurate clinical records by payer process.
Missing authorization	Review retro-auth, appeal or reconsideration policy.
State claim suspended	Consult the state bulletin and track its pending status.
Wrong claim pathway	Review medical vs dental benefit and corrected claim rules.

Specialty-specific first tasks

Practice area	First January preparation step
General / restorative	Check D2390, fluoride and caries-medicament reporting.
Implants / prosthodontics	Load new healing-cap, removal and prosthetic fees.
Periodontics	Review periodontal carriers and recorded tooth/site detail.
Orthodontics	Update adjunctive appliance labels and repair selection.
Orofacial pain / TMD	Validate new CDT IDs; audit units and medical policies.
Pediatrics / special care	Review preventive care and transition case management.
Sleep-related care	Check oximetry, sleep-service codes and plan pathway.
Maxillofacial prosthetics	Check new repair-by-report and wording changes.

Historical payer facts are included to guide verification, not to predict payment. The Nevada example and dental-specific Pennsylvania adoption require independent primary-source confirmation before publication.

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08 / READINESS & SOURCES

CDT 2027 Implementation Checklist

Seven practical sign-off steps, answers to common billing questions, and primary source links.

Seven steps before January 1, 2027

01 Obtain the official reference
Use the licensed CDT 2027 manual or app to verify all new code IDs and descriptions.

02 Install the practice software update
Validate library year, effective dates, units and electronic claim edits.

03 Load fees and reprice revised units
Add applicable fees; examine D9910 per-tooth and D9130 time-based logic.

04 Update descriptions and treatment plans
Replace old labels and confirm applicable clinical documentation templates.

05 Audit clinical records
Capture procedure purpose, anatomy, units, narratives and supporting findings.

06 Verify payer benefits and adoption
Check network contract, coverage, prior approval, limits and 2027 effective dates.

07 Monitor initial January claims
Track return/rejection queues, zero-pay lines, fee errors, denials and ERAs.

Fast FAQ

When does CDT 2027 start?	January 1, 2027, under applicable date-of-service rules.
Were codes deleted?	No - the ADA reports zero deletions for 2027.
Use new codes on 2026 dates?	No; apply the code set effective on the supported service date.
Are all new codes covered?	No. Eligibility, limitations and reimbursement are payer-specific.
Must fees change?	Review newly assigned codes and those with revised units.
Can a dental practice bill medical?	Sometimes, with the appropriate service, credentials, codes and payer rules.
What to watch in January?	Code validity, fee loading, returns, unit edits, coverage and payments.

Primary source links | open to verify

- **ADA: Code Maintenance Committee**
- **ADA: Dental Claim Form**
- **Aetna: Botulinum toxin CPB**
- **ADA: Official CDT 2027 publication**
- **CMS: Medical / dental claim routes**
- **Medi-Cal: CDT schedules**

Information reviewed: October 19, 2026. Edition: CDT 2027 (effective January 1, 2027). Editorial release gates: Confirm all 28 new IDs, all 33 revisions, all units, and payer examples; obtain a qualified dental coding and clinical review. ADA CDT content is licensed.

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