CDT 2026 Code Scenarios

The following guidance clarifies the application of each of the new, revised, and deleted CDT 2026 codes.

The nomenclatures and descriptors contained in the Code on Dental Procedures and Nomenclature (CDT) provide a standardized language for dental teams. CDT codes serve a variety of purposes. CDT enables dental professionals to clearly communicate proposed and rendered dental procedures to patients, accurately document dental services performed, appropriately bill patients for services rendered, and accurately communicate to third-party payors the dental treatment that was provided and submitted for payment.

The final tally for changes to CDT 2026 includes 31 new codes, 14 revised codes, 9 editorial, and 6 deleted codes, effective January 1, 2026.

When reporting CDT codes, remember the following:

- The addition of a new code or the revision of an existing code does not imply the procedure will be reimbursed by the patient's dental plan. The primary purpose of CDT is to provide dentists with a standardized code set for accurately reporting dental procedures. Dental benefit plans are not obligated to pay for a procedure simply because a code exists.
- CDT codes are organized in 13 categories of service to make them easier to locate. The location of a code in a category does not limit its use to an associated specialty. For example, if a code is in the Periodontics category, this does not mean the procedure may only be performed and/or reported by a periodontist.
- CDT codes are not always listed in numerical order, as with many examples in the Implant Services category and the addition of the Sleep Apnea Services category.

This chapter contains a review of all CDT 2026 code changes adopted by the American Dental Association's Code Maintenance Committee (CMC). The new codes will be outlined first, followed by the revised codes, and then the deleted codes. Each code listed will demonstrate the applicable code changes through changes in text style to highlight the change:

Dxxxx: Indicates existing codes or language within the descriptor or nomenclature.

~~**Dxxxx**~~: Indicates the deletion of a code or words deleted within the descriptor or nomenclature.

Dxxxx: Indicates the addition of a code or words added within the descriptor or nomenclature.

The impact of each 2026 coding change will be reviewed and a scenario provided, when applicable. Note: These scenarios were adapted from the CMC final report for CDT 2026.

For more details on every CDT code, refer to our ***Dental Coding With Confidence***. Order it today at *https://dentalcoding.com/shop/*, or scan the QR code on the inside front cover.

2026 New Code Scenarios

D0426	COLLECTION, PREPARATION, AND ANALYSIS OF SALIVA SAMPLE – POINT-OF-CARE
	The Code Maintenance Committee (CMC) approved D0426 as a new code for documenting point-of-care saliva screens used to help educate and assess conditions within a patient's mouth. These screenings are separate from diagnostic tests that must be sent to a lab for processing. These screenings require the collection of a patient saliva sample (either through swab or solution) which is then processed and analyzed for results on site. Clinicians then review the results with the patient to ensure awareness and understanding.
CODING SCENARIO	A patient undergoes a salivary swab test to look for certain biomarkers of disease. The saliva sample is reviewed on site and the findings are discussed with the patient. Report D0426 for the collection, preparation, and analysis of the saliva sample in office.

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.
	Code D0461 was approved by the Code Maintenance Committee (CMC) as a new code reporting the testing for a cracked tooth. Patients may present with non-descript pain that is reactive to pressure. Cracked tooth syndrome is a possible diagnosis and requires systematic and selective pressure testing to determine a possible diagnosis. The addition of this procedure allows for discrete documentation and reporting when testing for a cracked tooth takes place
CODING SCENARIO	A patient presents with pain on the right side of their mouth. They believe the pain is in an upper tooth but cannot specify further. Selective pressure testing is performed on all upper and lower teeth on the right side to determine which tooth may be symptomatic. Testing reveals that a lower right tooth is reactive to pressure and is the source of pain.

D1720	INFLUENZA VACCINE ADMINISTRATION
	The CMC approved D1720 as a new code reporting the delivery of influenza vaccine within the dental office. CDT codes for COVID-19 and HPV vaccination are already established. Including the dental office as a site to obtain a flu shot will allow more patients to get vaccinated annually.
CODING SCENARIO	A patient presents to the office not having received the influenza vaccine for the specified calendar season (normally September of one calendar year through August of the following year). The patient may request a flu shot or the provider may identify that the person is a candidate to receive a flu shot for that year, and the vaccine would be administered in the appropriate muscle with an intramuscular injection.

D5877	**DUPLICATION OF COMPLETE DENTURE – MAXILLARY** Does not involve all steps used in initial fabrication.
	The Code Maintenance Committee (CMC) approved D5877 due to the importance of being able to distinguish a duplicate denture from an initial complete denture. The work and time taken to complete the task are very different than the initial fabrication (where code D5120 is used).
CODING SCENARIO	A patient just had a new complete maxillary denture fabricated. The patient travels a lot between two different homes and would like a second denture made to store at his second home. You digitally scan and then print a second denture for the patient. The patient did not have to go through all the steps done when his initial denture was fabricated.

D5878	**DUPLICATION OF COMPLETE DENTURE – MANDIBULAR** Does not involve all steps used in initial fabrication.
	The Code Maintenance Committee (CMC) approved D5878 due to the importance of being able to distinguish a duplicate denture from an initial complete denture. The work and time taken to complete the task are very different than the initial fabrication (where code D5110 is used).
CODING SCENARIO	A patient just had a new complete maxillary denture fabricated. The patient travels a lot between two different homes and would like a second denture made to store at his second home. You digitally scan and then print a second denture for the patient. The patient did not have to go through all the steps done when his initial denture was fabricated.

D5909	**MAXILLARY GUIDANCE PROSTHESIS WITH GUIDE FLANGE** Synonymous terminology: guidance device, guidance appliance. A prosthesis which guides the remaining portion of the mandible, left after a partial resection, into a more normal relationship with the maxilla. This allows for some tooth-to-tooth or an improved tooth contact, it may also artificially replace missing teeth and thereby increase masticatory efficiency.
	Code D5909 was approved by the Code Maintenance Committee (CMC) as a new code reporting a maxillary guidance prosthesis with guide flange. A guidance appliance can be fabricated on the maxillary arch to guide the resected mandible into the proper relationship with the maxilla. Usually, the guide flange is on the palatal surface to guide the mandible. For the resected mandible that is not reconstructed, the mandible deviates to the resected side with the prosthesis guiding the mandible into the proper relationship with the maxilla. Hence, the term guidance prosthesis is much more accurate than resection prosthesis.
CODING SCENARIO	A 90 year old female develops mandibular cancer. Due to her age and complicated heart conditions, surgical reconstruction of the mandible is not possible. Hence, her mandibular cancer was resected with the mandible allowed to swing (discontinuity of the mandible). The head and neck surgeon ordered a guidance appliance to minimize the deviation. It is fabricated on the maxillary arch with palatal guide flanges.

D5930	**MAXILLARY GUIDANCE PROSTHESIS WITHOUT GUIDE FLANGE** A prosthesis which helps guide the partially resected mandible to a more normal relation with the maxilla allowing for increased tooth contact. It does not have a flange or ramp, however, it does assist in directional closure. It may replace missing teeth and thereby increase masticatory efficiency.
	Code D5930 was approved by the Code Maintenance Committee (CMC) as a new code reporting a maxillary guidance prosthesis without guide flange. A guidance appliance can be fabricated on the maxillary arch to guide the resected mandible into the proper relationship with the maxilla. For the resected mandible that is not reconstructed, the mandible deviates to the resected side with the prosthesis guiding the mandible into the proper relationship with the maxilla. Hence, the term guidance prosthesis is much more accurate than resection prosthesis.
CODING SCENARIO	A 90 year old female develops mandibular cancer. Due to her age and complicated heart conditions, surgical reconstruction of the mandible is not possible. Hence, her mandibular cancer was resected with the mandible allowed to swing (discontinuity of the mandible). The head and neck surgeon ordered a guidance appliance to minimize the deviation. It is fabricated on the maxillary arch, which aids in directional closure.

D5938	**RESECTION PROSTHESIS, MAXILLARY COMPLETE REMOVABLE** A maxillary complete removable resection prosthesis for the maxillary arch in which a portion of the maxilla is resected and reconstructed with hard or soft tissue.
	The CMC approved D5938 as a new code reporting the fabrication and delivery of a maxillary complete removable resection prosthesis to make the CDT codes consistent with CPT codes. A maxillary resection prosthesis is fabricated on a resected maxilla that has been reconstructed due to tumor or trauma. This prosthesis can be tissue supported, tooth supported, or implant supported. This prosthesis aids in masticatory function while providing support for the lip and cheek.
CODING SCENARIO	A 78 year old female develops maxillary cancer. The surgical plan is resection with reconstruction with a fibula free flap. The patient elects not to have placement of dental implants due to her concern about implant maintenance. After surgery, the patient underwent two debulkings, and a maxillary complete removable resection prosthesis was fabricated for her.

D5939	**RESECTION PROSTHESIS, MANDIBULAR COMPLETE REMOVABLE** A mandibular complete removable resection prosthesis for the mandibular arch in which a portion of the mandibular is resected and reconstructed with hard or soft tissue. Mandibular continuity is maintained or restored.
	The CMC approved D5939 as a new code reporting the fabrication and delivery of a mandibular complete removable resection prosthesis to make the CDT codes consistent with CPT codes. A mandibular resection prosthesis is fabricated on a resected mandible that has been reconstructed due to tumor or trauma. This prosthesis can be tissue supported, tooth supported, or implant supported. Mandibular continuity is maintained or restored. This prosthesis aids in masticatory function while providing support for the lip and cheek.
CODING SCENARIO	A 78 year old female develops mandibular cancer. The surgical plan is resection with reconstruction with a fibula free flap. The patient elects not to have placement of dental implants due to her concern about implant maintenance. After surgery, the patient underwent two debulkings, and a mandibular complete removable resection prosthesis was fabricated for her.

D5940	**RESECTION PROSTHESIS, MAXILLARY PARTIAL REMOVABLE** A maxillary partial removable resection prosthesis for the maxillary arch in which a portion of the maxilla is resected and reconstructed with hard or soft tissue.
	The CMC approved D5940 as a new code reporting the fabrication and delivery of a maxillary partial removable resection prosthesis to make the CDT codes consistent with CPT codes. A maxillary resection prosthesis is fabricated on a resected maxilla that has been reconstructed due to tumor or trauma. This prosthesis can be tissue supported, tooth supported or implant supported. This prosthesis aids in masticatory function while providing support for the lip and cheek.
CODING SCENARIO	A 78 year old female develops maxillary cancer. She has teeth #2-#15 present. She will lose #12-#15 as part of the surgical resection. The surgical plan is resection with reconstruction with a fibula free flap. The patient elects not to have placement of dental implants due to her concern about implant maintenance. After surgery, the patient underwent two debulkings, and a maxillary partial removable resection prosthesis was fabricated for her.

D5941	**RESECTION PROSTHESIS, MANDIBULAR PARTIAL REMOVABLE** A mandibular partial removable resection prosthesis for the mandibular arch in which a portion of the mandibular is resected and reconstructed with hard or soft tissue. Mandibular continuity is maintained or restored.
	The CMC approved D5941 as a new code reporting the fabrication and delivery of a mandibular partial removable resection prosthesis to make the CDT codes consistent with CPT codes. A mandibular resection prosthesis is fabricated on a resected mandible that has been reconstructed due to tumor or trauma. This prosthesis can be tissue supported, tooth supported, or implant supported. Mandibular continuity is maintained or restored. This prosthesis aids in masticatory function while providing support for the lip and cheek.
CODING SCENARIO	A 78 year old female develops mandibular cancer. The surgical plan is resection with reconstruction with a fibula free flap. She has teeth #18-#31 present. The patient is going to lose #18-#21 as part of the resection. The patient elects not to have placement of dental implants in the fibula due to her concern about implant maintenance. After surgery, the patient underwent two debulkings, and a mandibular partial removable resection prosthesis was fabricated for her.

D5942	**RESECTION PROSTHESIS, MAXILLARY IMPLANT/ABUTMENT SUPPORTED REMOVABLE PROSTHESIS FOR EDENTULOUS ARCH** A maxillary implant/abutment supported removable resection prosthesis for the edentulous maxillary arch in which a portion of the maxilla is resected and reconstructed.
	Code D5942 was approved by the Code Maintenance Committee (CMC) as a new code reporting a maxillary complete implant/abutment supported removable prosthesis to make the CDT codes consistent with CPT codes. A maxillary resection prosthesis is fabricated on a resected maxilla that has been reconstructed due to tumor or trauma. This prosthesis can be tissue supported, tooth supported or implant supported. This prosthesis aids in masticatory function while providing support for the lip and cheek.
CODING SCENARIO	A 78 year old female develops maxillary cancer. The surgical plan is resection with reconstruction with a fibula free flap. The patient elects to have placement of dental implants. After surgery, the patient underwent two debulkings with placement of custom locator abutments. A maxillary implant/abutment supported removable resection prosthesis for the edentulous reconstructed maxillary arch was fabricated for her using conventional implant/removable fabrication techniques.

D5943	**RESECTION PROSTHESIS, MANDIBULAR IMPLANT/ABUTMENT SUPPORTED REMOVABLE PROSTHESIS FOR EDENTULOUS ARCH** A mandibular implant/abutment supported removable resection prosthesis for the edentulous mandibular arch in which a portion of the mandible is resected and reconstructed in which mandibular continuity is maintained or restored.
	Code D5943 was approved by the Code Maintenance Committee (CMC) as a new code reporting a mandibular complete implant/abutment supported removable prosthesis to make the CDT codes consistent with CPT codes. A mandibular resection prosthesis is fabricated on a resected mandible that has been reconstructed due to tumor or trauma. This prosthesis can be tissue supported, tooth supported, or implant supported. Mandibular continuity is maintained or restored. This prosthesis aids in masticatory function while providing support for the lip and cheek.
CODING SCENARIO	A 78 year old female develops mandibular cancer. The surgical plan is resection with reconstruction with a fibula free flap. The patient elects to have placement of dental implants. After surgery, the patient underwent two debulkings with placement of custom locator abutments. A mandibular implant/abutment removable resection prosthesis was fabricated for her.

D5944	**RESECTION PROSTHESIS, MAXILLARY IMPLANT/ABUTMENT SUPPORTED REMOVABLE PROSTHESIS FOR THE PARTIAL EDENTULOUS ARCH** A maxillary implant/abutment supported removable resection prosthesis for the partial edentulous maxillary arch in which a portion of the maxilla is resected and reconstructed with hard tissue.
	The CMC approved D5944 as a new code reporting the fabrication and delivery of a maxillary partial implant/abutment supported removable prosthesis to make the CDT codes consistent with CPT codes. A maxillary resection prosthesis is fabricated on a resected maxilla that has been reconstructed due to tumor or trauma. This prosthesis can be tissue supported, tooth supported or implant supported. This prosthesis aids in masticatory function while providing support for the lip and cheek.
CODING SCENARIO	A 78 year old female develops maxillary cancer. The surgical plan is resection with reconstruction with a fibula free flap. The patient elects to have placement of dental implants. After surgery, the patient underwent two debulkings with placement of custom locator abutments. A maxillary implant/abutment supported removable prosthesis for the partial edentulous reconstructed maxillary arch was fabricated for her.

D5945	**RESECTION PROSTHESIS, MANDIBULAR IMPLANT/ABUTMENT SUPPORTED REMOVABLE PROSTHESIS FOR THE PARTIAL EDENTULOUS ARCH** A mandibular implant/abutment supported removable resection prosthesis for the partial edentulous mandibular arch in which a portion of the mandible is resected and reconstructed.
	The CMC approved D5945 as a new code reporting the fabrication and delivery of a mandibular partial implant/abutment supported removable prosthesis to make the CDT codes consistent with CPT codes. A mandibular resection prosthesis is fabricated on a resected mandible that has been reconstructed due to tumor or trauma. This prosthesis can be tissue supported, tooth supported, or implant supported. Mandibular continuity is maintained or restored. This prosthesis aids in masticatory function while providing support for the lip and cheek.
CODING SCENARIO	A 78 year old female develops mandibular cancer. The surgical plan is resection with reconstruction with a fibula free flap. The patient elects to have placement of dental implants. After surgery, the patient underwent two debulkings with placement of custom locator abutments. A mandibular partial implant/abutment removable resection prosthesis was fabricated for her.

D5946	**RESECTION PROSTHESIS, MAXILLARY IMPLANT/ABUTMENT SUPPORTED FIXED PROSTHESIS FOR EDENTULOUS ARCH** A maxillary implant/abutment supported fixed resection prosthesis for the edentulous maxillary arch in which a portion of the maxilla is resected and reconstructed.
	The Code Maintenance Committee (CMC) approved D5946 as a new code reporting a maxillary complete implant/abutment supported fixed prosthesis to make the CDT codes consistent with CPT codes. A maxillary resection prosthesis is fabricated on a resected maxilla that has been reconstructed due to tumor or trauma. This prosthesis can be tissue supported, tooth supported or implant supported. This prosthesis aids in masticatory function while providing support for the lip and cheek.
CODING SCENARIO	A 78 year old female develops maxillary cancer. The surgical plan is resection with reconstruction with a fibula free flap. The patient elects to have placement of dental implants. After surgery, the patient underwent two debulkings. A maxillary implant/abutment supported fixed resection prosthesis for the edentulous reconstructed maxillary arch was fabricated for her using conventional fixed implant fabrication techniques.

D5947	**RESECTION PROSTHESIS, MANDIBULAR IMPLANT/ABUTMENT SUPPORTED FIXED PROSTHESIS FOR EDENTULOUS ARCH** A mandibular implant/abutment supported fixed resection prosthesis for the edentulous mandibular arch in which a portion of the mandible is resected and reconstructed in which mandibular continuity is maintained or restored.
	The Code Maintenance Committee (CMC) approved D5947 as a new code reporting a mandibular complete implant/abutment supported fixed prosthesis to make the CDT codes consistent with CPT codes. A mandibular resection prosthesis is fabricated on a resected mandible that has been reconstructed due to tumor or trauma. This prosthesis can be tissue supported, tooth supported, or implant supported. Mandibular continuity is maintained or restored. This prosthesis aids in masticatory function while providing support for the lip and cheek.
CODING SCENARIO	A 78 year old female develops mandibular cancer. The surgical plan is resection with reconstruction with a fibula free flap. The patient elects to have placement of dental implants. After surgery, the patient underwent two debulkings. A mandibular implant/abutment fixed resection prosthesis was fabricated for her.

D5948	**RESECTION PROSTHESIS, MAXILLARY IMPLANT/ABUTMENT SUPPORTED FIXED PROSTHESIS FOR THE PARTIAL EDENTULOUS ARCH** A maxillary implant/abutment supported fixed resection prosthesis for the partial edentulous maxillary arch in which a portion of the maxilla is resected and reconstructed.
	Code D5948 was approved by the Code Maintenance Committee (CMC) as a new code reporting a maxillary partial implant/abutment supported fixed prosthesis to make the CDT codes consistent with CPT codes. A maxillary resection prosthesis is fabricated on a resected maxilla that has been reconstructed due to tumor or trauma. This prosthesis can be tissue supported, tooth supported or implant supported. This prosthesis aids in masticatory function while providing support for the lip and cheek.
CODING SCENARIO	A 78 year old female develops maxillary cancer. The surgical plan is resection with reconstruction with a fibula free flap. The patient elects to have placement of dental implants. After surgery, the patient underwent two debulkings. A maxillary resection implant/abutment supported fixed resection prosthesis was fabricated for her using conventional fixed implant and 3D technology techniques.

D5949	**RESECTION PROSTHESIS, MANDIBULAR IMPLANT/ABUTMENT SUPPORTED FIXED PROSTHESIS FOR THE PARTIAL EDENTULOUS ARCH** A mandibular implant/abutment supported fixed resection prosthesis for the partial edentulous mandibular arch in which a portion of the mandible is resected and reconstructed.
	Code D5949 was approved by the Code Maintenance Committee (CMC) as a new code reporting a mandibular partial implant/abutment supported fixed prosthesis to make the CDT codes consistent with CPT codes. A maxillary resection prosthesis is fabricated on a resected maxilla that has been reconstructed due to tumor or trauma. This prosthesis can be tissue supported, tooth supported or implant supported. This prosthesis aids in masticatory function while providing support for the lip and cheek.
CODING SCENARIO	A 78 year old female develops mandibular cancer. The surgical plan is resection with reconstruction with a fibula free flap. The patient elects to have placement of dental implants. After surgery, the patient underwent two debulkings during Stage II surgery. A mandibular implant/abutment fixed resection prosthesis was fabricated for her.

D6049 ***(Advisor Corner Response!)***	**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** This procedure is not performed in conjunction with D1110, D4910, or D4346.
	The CMC approved D6049 as a new code reporting scaling and debridement of a single implant in the presence of peri-implantitis. The recent amendment to the CDT Procedure Code D6081 aimed to enhance clarity in the nomenclature associated with mucositis treatment. Mucositis refers specifically to the inflammation of the soft tissues surrounding a dental implant, while peri-implantitis involves the loss of the bone that supports the implant. These two conditions, though related, represent distinct clinical entities with different implications for treatment and prognosis.
CODING SCENARIO	A 65 year old male presents with bone loss and inflammation around a posterior implant. The pocket around the implant is cleaned and debrided without surgical exposure to reduce inflammation and prevent further osseous deterioration.

D6196	**REMOVAL OF AN INDIRECT RESTORATION ON AN IMPLANT RETAINED ABUTMENT** Not to be used for a temporary, provisional, or screw retained restoration.
	The Code Maintenance Committee (CMC) approved D6196 as a new code reporting the removal of a cemented indirect restoration on an implant retained abutment. This code compliments the CDT code D2956 removal of an indirect restoration on a natural tooth added to CDT 2025. There is no current code to document and report this discrete procedure.
CODING SCENARIO	A patient presents with a damaged cement retained abutment supported crown. The dentist removes the crown to enable replacement.

D6280 ***(Advisor Corner Response!)***	**IMPLANT MAINTENANCE PROCEDURES WHEN A FULL ARCH REMOVABLE IMPLANT/ABUTMENT SUPPORTED DENTURE IS REMOVED AND REINSERTED, INCLUDING CLEANSING OF PROSTHESIS AND ABUTMENTS – PER ARCH** This procedure includes active debriding of the implant(s) and examination of all aspects of the implant system, including the occlusion and stability of the prosthesis. The patient is also instructed in thorough daily cleansing of the implant(s).
	Code D6280 was approved by the Code Maintenance Committee (CMC) as a new code reporting the cleaning and inspection of a complete removable implant/abutment supported denture and associated implants. The addition of this code complements other implant maintenance procedure codes when a patient is edentulous in a full arch with an implant supported prosthesis. There currently is no implant maintenance code for patients with a full arch removable implant/abutment supported denture. These procedures are conducted differently from those used for natural teeth because of the unique characteristics of the peri-implant mucosa. Replacement of retentive components is reported separately.
CODING SCENARIO	A patient presents for a scheduled dental cleaning. The patient's maxillary arch has been restored with implants supporting a removable denture using semi-precision abutments and attachments. During the appointment, a comprehensive evaluation of the implants, the denture, and the peri-implant tissues is performed. The implants are debrided to remove any biofilm, plaque, or calculus that has accumulated around the implant surfaces and attachments, and the denture is cleaned. The patient is instructed in the home care of the implants and denture.

D9128	**PHOTOBIOMODULATION THERAPY - FIRST 15 MINUTE INCREMENT, OR ANY PORTION THEREOF** The use of low-level laser therapy to alleviate pain or inflammation, modulate the immune response, and promote tissue healing or regeneration.
	The CMC approved D9128 as a new code reporting the use of photobiomodulation therapy - first 15 minutes. The procedural technique is to apply the appropriate amount of photonic energy to the primary site(s)/region(s) of interest and often the lymphatics, nerves, and other related structures related to and depending on the condition being treated. Such conditions include oral mucositis, TMD, and various other oral conditions such as aphthae, mucosal lesions like Lichen Planus, Pemphigus, or Pemphigoid, and Trigeminal Neuralgia, among others.
CODING SCENARIO	A patient has had an invasive dental procedure performed at a previous appointment and is experiencing post-operative pain and inflammation. Photobiomodulation (PBM) therapy is administered with the appropriate prescribed dosage of light energy to assist in managing the condition, to help alleviate the pain and inflammation, and to promote tissue healing and regeneration.

D9129	**PHOTOBIOMODULATION THERAPY - EACH SUBSEQUENT 15 MINUTE INCREMENT, OR ANY PORTION THEREOF**
	The CMC approved D9129 as a new code reporting the use of photobiomodulation therapy – each subsequent 15 minute increment, or any portion thereof. The procedural technique is to apply the appropriate amount of photonic energy to the primary site(s)/region(s) of interest and often the lymphatics, nerves, and other related structures related to and depending on the condition being treated. Such conditions include oral mucositis, TMD, and various other oral conditions such as aphthae, mucosal lesions like Lichen Planus, Pemphigus, or Pemphigoid, and Trigeminal Neuralgia, among others.
CODING SCENARIO	A patient undergoing chemo or radiation treatment for cancer presents with the condition of oral mucositis. Photobiomodulation (PBM) therapy is administered with the appropriate prescribed dosage of light energy to assist in managing the condition, to help alleviate the pain and inflammation, and to assist in modulating the immune response to promote tissue healing and regeneration.

D9224	**ADMINISTRATION OF GENERAL ANESTHESIA WITH ADVANCED AIRWAY – FIRST 15 MINUTE INCREMENT, OR ANY PORTION THEREOF** With or without co-administration of nitrous oxide. Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of trained personnel and the doctor may safely leave the room. This procedure is determined by the provider's documentation of the presence of an advanced airway such as a supraglottic or subglottic airway device, which includes laryngeal tube, esophageal-tracheal tube (Combitube), laryngeal mask airway, or endotracheal tube.
	Code D9224 was approved by the Code Maintenance Committee (CMC) as a new code reporting general anesthesia with the use of advanced airway techniques - first 15 minute increment, or any portion thereof. Currently, the CDT code uses two codes, which are part of a single set, to represent deep sedation and general anesthesia. These codes are D9222 and D9223 "deep sedation / general anesthesia" for the first 15 minutes and subsequent 15 minutes respectively. Deep sedation and general anesthesia are not the same thing and are not interchangeable. These new codes differentiate between the distinct techniques and armamentarium.
CODING SCENARIO	A pediatric patient needing multiple restorations is seen in a hospital setting for treatment. General anesthesia is achieved, requiring the use of advanced airway techniques.

D9225	**ADMINISTRATION OF GENERAL ANESTHESIA WITH ADVANCED AIRWAY – EACH SUBSEQUENT 15 MINUTE INCREMENT, OR ANY PORTION THEREOF**
	Code D9225 was approved by the Code Maintenance Committee (CMC) as a new code reporting general anesthesia with the use of advanced airway techniques - each subsequent 15 minute increment, or any portion thereof. Currently, the CDT code uses two codes, which are part of a single set, to represent deep sedation and general anesthesia. These codes are D9222 and D9223 "deep sedation / general anesthesia" for the first 15 minutes and subsequent 15 minutes respectively. Deep sedation and general anesthesia are not the same thing and are not interchangeable. These new codes differentiate between the distinct techniques and armamentarium.
CODING SCENARIO	A pediatric patient needing multiple restorations is seen in a hospital setting for treatment. General anesthesia is achieved, requiring the use of advanced airway techniques.

D9244	**IN-OFFICE ADMINISTRATION OF MINIMAL SEDATION – SINGLE DRUG – ENTERAL** In-office administration of a drug, as a single or divided dose, to achieve the desired clinical effect, not to exceed the FDA maximum recommended dose (MRD) for unmonitored home use. The single drug may be administered with or without co-administration of nitrous oxide.
	The Code Maintenance Committee (CMC) approved D9244 as a new code reporting the in-office enteral administration of a single drug to induce minimal sedation. This new code provides greater specificity and clarity in coding sedation procedures compared to the current code D9248, which is being deleted. The proposed additions not only distinguish between different depths of sedation but also specify the route of administration—whether enteral, non-intravenous parenteral, or intravenous.
CODING SCENARIO	A patient has anxiety with dental appointments. The practitioner, after review of the patient's medical history and upon performing the appropriate evaluation, administers the patient a sedative agent orally while the patient is in the dental office to achieve minimal sedation. Once it has an adequate pharmacologic effect, the procedure is initiated either with or without inhalational nitrous oxide

D9245	**ADMINISTRATION OF MODERATE SEDATION – ENTERAL** When moderate sedation is achieved by administration of drug(s) by enteral route only. With or without co-administration of nitrous oxide. The level of anesthesia is determined by the provider's documentation of the anesthetic effects upon the central nervous system.
	The Code Maintenance Committee (CMC) approved D9245 as a new code reporting the in-office enteral administration of drug(s) to induce moderate sedation. This new code provides greater specificity and clarity in coding sedation procedures compared to the current code D9248, which is being deleted. The proposed additions not only distinguish between different depths of sedation but also specify the route of administration — whether enteral, non-intravenous parenteral, or intravenous.
CODING SCENARIO	A patient has anxiety with dental appointments. The practitioner, after review of the patient's medical history and upon performing the appropriate evaluation, administers the patient sedative agents orally while the patient is in the dental office to achieve moderate sedation. Once there is an adequate pharmacologic effect, the procedure is initiated either with or without inhalational nitrous oxide.

D9246	**ADMINISTRATION OF MODERATE SEDATION – NON-INTRAVENOUS PARENTERAL – FIRST 15 MINUTE INCREMENT, OR ANY PORTION THEREOF** When moderate sedation is achieved by administration of drug(s) by parenteral route, not including intravenous. With or without co-administration of nitrous oxide. Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of trained personnel and the doctor may safely leave the room. The level of anesthesia is determined by the provider's documentation of the anesthetic effects upon the central nervous system.
	The CMC approved D9246 as a new code reporting non-intravenous parenteral administration of drug(s) to induce moderate sedation for the first 15 minute increment, or any portion thereof. This new code provides greater specificity and clarity in coding sedation procedures compared to the current code D9248, which is being deleted. The proposed additions not only distinguish between different depths of sedation but also specify the route of administration—whether enteral, non-intravenous parenteral, or intravenous.
CODING SCENARIO	A patient with a needle phobia requests sedation for their dental procedure. The provider determines that enteral administration of a sedative will not be sufficient for the procedure. The provider instead elects to administer a state of moderate sedation with intranasal administration of midazolam. The drug delivery induces a state of moderate sedation, and the provider monitors the patient according to his / her applicable standard of care for monitoring of moderate sedation.

D9247	**ADMINISTRATION OF MODERATE SEDATION – NON-INTRAVENOUS PARENTERAL – EACH SUBSEQUENT 15 MINUTE INCREMENT, OR ANY PORTION THEREOF**
	The CMC approved D9247 as a new code reporting non-intravenous parenteral administration of drug(s) to induce moderate sedation - each subsequent 15 minute increment, or any portion thereof. This new code provides greater specificity and clarity in coding sedation procedures compared to the current code D9248, which is being deleted. The proposed additions not only distinguish between different depths of sedation but also specify the route of administration—whether enteral, non-intravenous parenteral, or intravenous.
CODING SCENARIO	A patient with a needle phobia requests sedation for their dental procedure. The provider determines that enteral administration of a sedative will not be sufficient for the procedure. The provider instead elects to administer a state of moderate sedation with intranasal administration of midazolam. The drug delivery induces a state of moderate sedation, and the provider monitors the patient according to his / her applicable standard of care for monitoring of moderate sedation.

D9936	**CLEANING AND INSPECTION OF OCCLUSAL GUARD – PER APPLIANCE** This procedure does not include any adjustments
	The CMC approved D9936 as a new code reporting the cleaning and inspection of an existing occlusal guard appliance. Adjustments are separately reported with their own code.
CODING SCENARIO	A new patient is scheduled for their initial dental visit. During the visit they present their existing occlusal guard to the hygienist and ask for it to be cleaned and to have the dentist check it. The hygienist and dentist would then complete the additional tasks during the appointment.

2026 Revised Code Scenarios

*Revisions to codes appear in **"Blue Font"** and/or **~~"Red Strikethrough"~~**

D0180	**COMPREHENSIVE PERIODONTAL EVALUATION – NEW OR ESTABLISHED PATIENT** ~~This procedure is indicated for patients showing signs or symptoms of periodontal disease and for patients with risk factors such as smoking or diabetes. It includes~~ A comprehensive evaluation of periodontal conditions, including full mouth probing and periodontal charting~~,~~. Indicated for patients exhibiting signs or symptoms of periodontal disease, systemic medical conditions, or patients with social risk factors. It includes an evaluation for oral cancer, ~~the~~ an evaluation ~~and recording~~ of the patient's ~~dental and~~ medical history, a ~~and~~ general ~~health~~ wellness assessment~~.~~ , and ~~It may~~ includes ~~the~~ an evaluation of current dental conditions ~~and recording of dental caries, missing or unerupted teeth, restorations, and occlusal relationships~~.
	The Code Maintenance Committee (CMC) approved a revision to D0180 to provide clearer language on the procedure's indications and its specific components.
CODING SCENARIO	A new patient presents for a comprehensive evaluation. Evidence of periodontal bone loss is noted and full periodontal probing and charting is performed. Report D0180.

D0417	**COLLECTION AND PREPARATION OF SALIVA SAMPLE FOR LABORATORY ANALYSIS ~~DIAGNOSTIC TESTING~~**
	The CMC approved a revision to D0417 due to the creation of the new code D0426, which reports salivary analysis performed in office or point-of-care. This change promotes uniformity, clarity, and consistent coding application.
	A saliva sample is acquired from a patient to look for biomarkers of disease. The sample is sent to an off site laboratory for analysis. Report D0417.

D0418	**ANALYSIS OF SALIVA SAMPLE – LABORATORY** ~~Chemical or biological analysis of saliva sample for diagnostic purposes.~~
	The CMC approved a revision to D0418 due to the creation of the new code D0426, which reports salivary analysis performed in office or point-of-care. This change promotes uniformity, clarity, and consistent coding application.
	A saliva sample is received from an off site provider and analyzed in a laboratory. Report D0418.

D2391	**RESIN-BASED COMPOSITE – ONE SURFACE, POSTERIOR** ~~Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure.~~
	Code D2391 was revised to provide consistency with other resin restoration codes. Eliminating the descriptor that specifies the carious lesion's status allows providers to accurately document and report one-surface resin-based composite restorations, regardless of lesion depth or diagnosis. Notably, no other restorative code is defined or restricted by the depth of the lesion, creating an inconsistency with how similar procedures are coded. This change also resulted in the deletion of code D1352 preventive resin restoration (PRR), as this procedure will now fall under the code D2391.
CODING SCENARIO	A patient presents with caries on the occlusal surface of #19 confined to the enamel layer. A composite resin restoration was performed. Report D2391.

D5876	**ADD METAL SUBSTRUCTURE TO ACRYLIC ~~FULL~~ COMPLETE DENTURE – ~~(~~PER ARCH~~)~~** Use of metal substructure in a removable complete denture~~s~~ for reinforcement, during fabrication or repair ~~without a framework~~.
	The revision to the nomenclature of D5876 is editorial in nature where the word "complete" is used within the CDT Code when referring to dentures rather than the word "full". Revisions to the descriptor clarify the procedure code's scope, specifying that a substructure may be added during fabrication or repair. Adding "for reinforcement" highlights the function of the substructure, distinguishing it from dentures with a cast metal framework. Thus, the phrase "without a framework" is removed from the descriptor.
CODING SCENARIO	A patient presents with a broken upper maxillary denture. It is determined that the prosthesis would benefit from the addition of a metal reinforcing substructure. The denture is sent to the laboratory for this addition. Report D5876.

D5934	**MANDIBULAR ~~RESECTION~~ GUIDANCE PROSTHESIS WITH GUIDE FLANGE** Synonymous terminology: ~~resection~~ guidance device, ~~resection~~ guidance appliance. A prosthesis which guides the remaining portion of the mandible, left after a partial resection, into a more normal relationship with the maxilla. This allows for some tooth-to-tooth or an improved tooth contact. It may also artificially replace missing teeth and thereby increase masticatory efficiency.
	This code was developed in the early 1980s when the standard of care was resection of the mandible without surgical reconstruction. As a result, the mandible deviated to the resected side with the prosthesis guiding the mandible into the proper relationship with the maxilla. Hence, the term guidance prosthesis is much more accurate than resection prosthesis. New codes have been added for actual resection prostheses.
CODING SCENARIO	A 90 year old female develops mandibular cancer. Due to her age and complicated heart conditions, surgical reconstruction of the mandible is not possible. Hence, her mandibular cancer was resected with the mandible allowed to swing (discontinuity of the mandible). The head and neck surgeon ordered a guidance appliance to minimize the deviation. It is fabricated on the mandibular arch with palatal guide flanges. Report D5934.

D5935	**MANDIBULAR ~~RESECTION~~ GUIDANCE PROSTHESIS WITHOUT GUIDE FLANGE** A prosthesis which helps guide the partially resected mandible to a more normal relation with the maxilla allowing for increased tooth contact. It does not have a flange or ramp, however, to assist in directional closure. It may replace missing teeth and thereby increase masticatory efficiency. ~~Dentists who treat mandibulectomy patients may prefer to replace some, all or none of the teeth in the defect area. Frequently, the defect's margins preclude even partial replacement. Use of a guide (a mandibular resection prosthesis with a guide flange) may not be possible due to anatomical limitations or poor patient tolerance. Ramps, extended occlusal arrangements and irregular occlusal positioning relative to the denture foundation frequently preclude stability of the prostheses, and thus some prostheses are poorly tolerated under such adverse circumstances.~~
	This code was developed in the early 1980s when the standard of care was resection of the mandible without surgical reconstruction. As a result, the mandible deviated to the resected side with the prosthesis guiding the mandible into the proper relationship with the maxilla. Hence, the term guidance prosthesis is much more accurate than resection prosthesis. New codes have been added for actual resection prostheses.
CODING SCENARIO	A 90 year old female develops mandibular cancer. Due to her age and complicated heart conditions, surgical reconstruction of the mandible is not possible. Hence, her mandibular cancer was resected with the mandible allowed to swing (discontinuity of the mandible). The head and neck surgeon ordered a guidance appliance to minimize the deviation. It is fabricated on the mandibular arch without palatal guide flanges. Report D5935.

D7285	**INCISIONAL BIOPSY OF ORAL TISSUE – HARD (BONE, TOOTH)** For partial removal of ~~specimen~~ lesion ~~only~~. This procedure involves biopsy of osseous or intra-osseous lesions (example cyst, tumor) and is not used for apicoectomy/periradicular surgery. This procedure does not entail an excision.
	The term "specimen" refers to the sample sent to the laboratory, not as it exists in situ. "Lesion" is the better term for the tissue as it exists in the patient's mouth. The nomenclature for CDT code D7285 states, "(hard bone or tooth)." This language may make it confusing to providers when reporting an incisional biopsy of an intra-osseous cystic lesion(s) given that the provider is accessing a bony lesion but obtaining soft tissue cystic lining as a specimen. Adding "intra-osseous lesion" with an example of a cystic lesion/tumor to the descriptor will provide clarity and help distinguish the difference between reporting codes D7285 vs. D7286.
CODING SCENARIO	A patient presents for an evaluation of a maxillary cystic lesion for treatment. A panoramic radiograph shows a 3X3 centimeter lesion in the anterior maxilla. Provider elects to perform an incisional biopsy of the lesion for diagnostic purposes prior to definitive treatment. After local anesthesia, a flap is reflected, the area of the lesion is identified, and an osteotomy is created on the buccal surface of the bone to expose part of the lesion. An incisional biopsy of the cystic lining is obtained, and the flap is sutured and closed. Report D7285.

D7286	**INCISIONAL BIOPSY OF ORAL TISSUE – SOFT** For partial removal of a~~n architecturally intact~~ lesion~~specimen only~~. This procedure is not used at the same time as codes for apicoectomy/periradicular curettage. This procedure does not entail an excision.
	The term "specimen" refers to the sample sent to the laboratory, not as it exists in situ. "Lesion" is the better term for the tissue as it exists in the patient's mouth.
CODING SCENARIO	A patient presents with a lesion of the left lateral border of the tongue. After clinical examination, the provider elects to perform an incisional soft tissue biopsy for diagnostic purposes prior to excision of the lesion. Report D7286.

D9222	**ADMINISTRATION OF DEEP SEDATION/GENERAL ANESTHESIA – FIRST 15 MINUTE~~S~~ INCREMENT, OR ANY PORTION THEREOF** With or without co-administration of nitrous oxide. Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of trained personnel and the doctor may safely leave the room ~~to attend to other patients or duties~~. The level of anesthesia is determined by the ~~anesthesia~~ provider's documentation of the anesthetic effects upon the central nervous system ~~and not dependent upon the route of administration~~.
	The CMC Anesthesia working group made changes and/or proposed new nomenclature for all of the time-based anesthesia codes. The nomenclature should have the action verb to parallel the syntax of the other code suggestions. The verbiage for the increments or portion thereof of time should be consistent with the newly proposed codes.
CODING SCENARIO	A patient is seen in a hospital setting and requires general anesthesia. Report D9222 for the administration of general anesthesia for the first 15 minute increment or any portion thereof.

D9223	**ADMINISTRATION OF DEEP SEDATION/GENERAL ANESTHESIA – EACH SUBSEQUENT 15 MINUTE INCREMENT, OR ANY PORTION THEREOF**
	The CMC Anesthesia working group made changes and/or proposed new nomenclature for all of the time-based anesthesia codes. The nomenclature should have the action verb to parallel the syntax of the other code suggestions. The verbiage for the increments or portion thereof of time should be consistent with the newly proposed codes.
CODING SCENARIO	A patient is seen in a hospital setting and requires general anesthesia. Report D9223 for the administration of general anesthesia for each subsequent 15 minute increment or any portion thereof.

D9230	~~**INHALATION**~~ **ADMINISTRATION OF NITROUS OXIDE**~~**/ANALGESIA, ANXIOLYSIS**~~ When nitrous oxide is administered as a single agent.
	The previous CDT code D9230 was ambiguous in its language and did not explicitly clarify whether the procedure code applies when nitrous oxide is used in conjunction with other agents for minimal, moderate, deep sedation, or general anesthesia. This lack of clarity may lead to inconsistent interpretations and applications of the code in clinical practice. Revisions to the nomenclature and descriptor of CDT code D9230 were made to clearly and concisely specify that this code applies exclusively to the administration of nitrous oxide as the sole agent. Related changes for minimal and moderate sedation include language that clearly specifies any concomitant use of nitrous oxide as included in those procedures.
CODING SCENARIO	A patient is seen in office for multiple dental restorations. Due to the patient's level of anxiety, it is determined that they would benefit from the administration of nitrous oxide during the procedure. Report D9230.

D9239	~~**INTRAVENOUS**~~ **ADMINISTRATION OF MODERATE** ~~**(CONSCIOUS)**~~ **SEDATION**~~**/ANALGESIA**~~ **– INTRAVENOUS – FIRST 15 MINUTE**~~**S**~~ **INCREMENT, OR ANY PORTION THEREOF** When moderate sedation is achieved by administration and titration of drug(s) intravenously. With or without co-administration of nitrous oxide. Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of trained personnel and the doctor may safely leave the room ~~to attend to other patients or duties~~. The level of anesthesia is determined by the ~~anesthesia~~ provider's documentation of the anesthetic effects upon the central nervous system ~~and not dependent upon the route of administration~~.
	The CMC Anesthesia working group made changes and/or proposed new nomenclature for all of the time-based anesthesia codes. The nomenclature should have the action verb to parallel the syntax of the other code suggestions. The verbiage for the increments or portion thereof of time should be consistent with the newly proposed codes. Additionally, it addresses the outdated terminology, specifically "conscious sedation."
CODING SCENARIO	A patient is seen in the office for multiple dental restorations. Due to the patient's level of anxiety, it is determined that they would benefit from the administration of moderate intravenous sedation. Report D9239 for the first 15 minute increment or any portion thereof.

D9243	~~**INTRAVENOUS**~~ **ADMINISTRATION OF MODERATE** ~~**(CONSCIOUS)**~~ **SEDATION**~~**/ANALGESIA**~~ **– INTRAVENOUS – EACH SUBSEQUENT 15 MINUTE INCREMENT, OR ANY PORTION THEREOF**
	The CMC Anesthesia working group made changes and/or proposed new nomenclature for all of the time-based anesthesia codes. The nomenclature should have the action verb to parallel the syntax of the other code suggestions. The verbiage for the increments or portion thereof of time should be consistent with the newly proposed codes. Additionally, it addresses the outdated terminology, specifically "conscious sedation."
CODING SCENARIO	A patient is seen in the office for multiple dental restorations. Due to the patient's level of anxiety, it is determined that they would benefit from the administration of moderate intravenous sedation. Report D9243 for each subsequent 15 minute increment or any portion thereof.

2026 Deleted Code Scenarios

~~D1352~~	~~**PREVENTIVE RESIN RESTORATION IN A MODERATE TO HIGH CARIES RISK PATIENT – PERMANENT TOOTH**~~ ~~Conservative restoration of an active cavitated lesion in a pit or fissure that does not extend into dentin; includes placement of a sealant in any radiating non-carious fissures or pits.~~
	The Code Maintenance Committee (CMC) chose to delete D1352 following the revision to D2391 resin-based composite – one surface, posterior, which removed qualifiers about the depth of caries into the tooth. This made D1352 unnecessary and redundant. Importantly, the removal of active caries is inherently a restorative procedure, not a preventive one. Prepping a tooth to address decay involves the same clinical principles and processes as any restorative treatment, and thus does not require a distinct code based on depth of lesion.

~~D1705~~	~~**ASTRAZENECA COVID-19 VACCINE ADMINISTRATION – FIRST DOSE**~~ ~~SARSCOV2 COVID-19 VAC rS-ChAdOx1 5X1010 VP/.5mL IM DOSE 1~~
	The CMC decided to remove D1705 from the code set as the AstraZeneca Covid-19 vaccine is no longer manufactured or supplied.

~~D1706~~	~~**ASTRAZENECA COVID-19 VACCINE ADMINISTRATION – SECOND DOSE**~~ ~~SARSCOV2 COVID-19 VAC rS-ChAdOx1 5x1010 VP/.5mL IM DOSE 2~~
	The CMC decided to remove D1706 from the code set as the AstraZeneca Covid-19 vaccine is no longer manufactured or supplied.

~~D1707~~	~~**JANSSEN COVID-19 VACCINE ADMINISTRATION**~~ ~~SARSCOV2 COVID-19 VAC Ad26 5x1010 VP/.5mL IM SINGLE DOSE~~
	The CMC decided to remove D1707 from the code set as the Janssen Covid-19 vaccine is no longer manufactured or supplied.

~~D1712~~	~~**JANSSEN COVID-19 VACCINE ADMINISTRATION – BOOSTER DOSE**~~ ~~SARSCOV2 COVID-19 VAC Ad26 5x1010 VP/.5mL IM DOSE BOOSTER~~
	The CMC decided to remove D1712 from the code set as the Janssen Covid-19 vaccine is no longer manufactured or supplied.

~~D9248~~	~~**NON-INTRAVENOUS CONSCIOUS SEDATION**~~ ~~This includes non-IV minimal and moderate 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.~~
	The Code Maintenance Committee (CMC) chose to remove D9248 as a part of sweeping changes to all the CDT sedation/anesthesia codes. The CDT code D9248 as written was not discrete. It encompassed different documented depths of sedation involving different monitoring, staffing, and chairside and recovery times. This deletion was accompanied by the addition of several new CDT codes and the revision of several existing codes. These changes not only distinguish between different depths of sedation but also specify the route of administration—whether enteral, non-intravenous parenteral, or intravenous. These distinctions aim to support straightforward coding for each sedation procedure according to its specific characteristics and allow a provider to accurately document and report actions within their scope of licensure.