EQUITABLE UTILIZATION REVIEW PROTOCOLS & GUIDELINES

The procedures listed in this document are subject to clinical review. This means that they will be reviewed by qualified clinical personnel to determine if the submitted treatment was necessary based on the individual patient's oral condition as indicated by x-rays, office narratives including patient history, etc. Even though a procedure may be covered under the policy, it must meet clinical review guidelines in order to be eligible for payment. Sometimes, the review may result in either a lesser alternate benefit payment or a denial.

We recommend that a pre-treatment estimate be submitted for all anticipated work that is considered to be expensive by our insured. A pre-treatment estimate is not a pre-authorization or guarantee of payment or eligibility; rather it is an indication of the estimated benefits available if the described procedures are performed based on eligible services and subject to benefits availability at the time that the pre-treatment is received. A pre-treatment estimate is not required in order to receive benefits for covered services.

THROUGHOUT THIS DOCUMENT, THE FREQUENCY LIMITATIONS NOTED ARE OUR STANDARDS. ACTUAL FREQUENCIES ARE SUBJECT TO INDIVIDUAL CONTRACTUAL LIMITATIONS.

As new CDT codes are added by the ADA, or old codes are deleted, this information will be updated accordingly.

If you have questions, you may Contact Equitable Customer Service at 1-866-274-9887.

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Section 1 – Restorative

(Inlays, Onlays, Build-Ups, Crowns)

Utilization Review Protocols and Guidelines – 1.1

PROCEDURE CODE: D2510 - D2544

PROCEDURE DESCRIPTION: Metallic Inlay/Onlay

D2510 - D2530	**inlay - metallic, 1-3 surfaces**
D2542	**onlay - metallic, 2 surfaces**
D2543	**onlay - metallic, 3 surfaces**
D2544	**onlay - metallic, 4 or more surfaces**

An inlay is an intracoronal cast metallic restoration fabricated in a laboratory environment to correspond to the form of the tooth preparation and then cemented onto the tooth.
An onlay is similar to an inlay; however, it replaces one or more cusps of the tooth.

Clinical Conditions
ALLOWING Benefits: **Current periapical radiographs or digital images and a narrative should indicate:**

<u>For Inlays:</u>

a) **Indications are virtually identical as for an amalgam restoration, replaces loss of tooth structure generally not to exceed one-half of the intracuspal space. Clinical indications to consider only include documented cases in which amalgam restorative material is specifically contraindicated (mercury toxicity supported by patch test results.)**

<u>For Onlays:</u>

a) **Indications for an onlay are the same as for a crown restoration. The primary purpose is cuspal protection.**
b) **Moderate-to-severe damage where cuspal destruction into the core of the tooth and much of the supporting dentin, or one or more cusps is/are entirely missing. Peripheral destruction may cover up to 50% of the tooth surface.**
c) **endodontically treated teeth**

Clinical Conditions
NOT ALLOWING Benefits:

<u>For Inlays and Onlays:</u>

a) **Extensive caries affecting the facial and lingual surfaces of the tooth. Full coverage may be indicated.**
b) **Where there is questionable endodontic status of the tooth, as demonstrated by evidence of unresolved periapical pathology that jeopardizes tooth retention, check history for dates of endodontic therapy (if endodontic therapy is within 6 months approve, if more than 6 months deny).**
c) **Where there is a compromised periodontal status, the tooth has lost more than 1/2 of its attachment unless there is a narrow three-walled defect**

amenable to bone regeneration or the patient has significant existing and unmet periodontal needs.

d) Elective replacement of a previously placed and intact amalgam restoration.

Administrative Guidelines:

Documentation Required: **Current periapical radiographs and a descriptive narrative (if necessary) to describe need.**

Payment Criteria

a) For defective teeth not meeting clinical indications for an inlay or onlay, alternate benefit to an amalgam or resin restoration as appropriate (D2140, D2150, D2160, D2161, D2391, D2392, D2393, D2394).

b) If payment is made and the restoration fails within a 3-year period, necessitating full coverage, deduct cost of inlay/onlay from crown payment.

c) Frequency limitation is 5 years.

Utilization Review Protocols and Guidelines – 1.2

PROCEDURE CODE: D2610 - D2664

PROCEDURE DESCRIPTION: Porcelain/Ceramic and Composite/Resin Inlays/Onlays

D2610 - D2630	**inlay - porcelain/ceramic, 1-3 surfaces**
D2642	**onlay - porcelain/ceramic, 2 surfaces**
D2643	**onlay - porcelain/ceramic, 3 surfaces**
D2644	**onlay - porcelain/ceramic, 4 or more surfaces**
D2650 - D2652	**inlay - resin-based composite, 1-3 or more surfaces**
D2662 - D2664	**onlay - resin-based composite, 2-4 or more surfaces**

An inlay is an intracoronal porcelain/ceramic or composite/resin restoration fabricated in a laboratory environment to correspond to the form of the tooth preparation and then cemented onto the tooth.

An onlay is similar to an inlay; however, it replaces one or more cusps of the tooth. Resin onlays may not have intracoronal designs.

Clinical Conditions
ALLOWING Benefits: **Current periapical radiographs and a narrative should indicate:**

<u>For Inlays:</u>

a) **Indications are virtually identical as for an amalgam restoration, replaces loss of tooth structure generally not to exceed one-half of the intracuspal space. Clinical indications to consider only include documented cases in which amalgam restorative material is specifically contraindicated (mercury toxicity supported by patch test results.)**
b) **An allowance for a metallic inlay should be made if test results support mercury toxicity.**

<u>For Onlays:</u>

a) **Indications for an onlay are the same as for a crown restoration. The primary purpose is cuspal protection.**
b) **Moderate-to-severe damage where cuspal destruction into the core of the tooth and much of the supporting dentin, or one or more cusps is entirely missing. Peripheral destruction may cover up to 50% of the tooth surface.**
c) **Endodontically treated teeth**
d) **Allowance for a metallic onlay should be made in this situation, unless there is a documented mercury toxicity.**

Clinical Conditions
NOT ALLOWING Benefits:

<u>For Inlays and Onlays:</u>

a) **Extensive caries affecting the facial and lingual surfaces of the tooth. Full coverage may be indicated.**
b) **Where there is evidence of a para-functional habit (bruxism).**

c) **Where little or no enamel will result in poor bond strength.**
d) **Where there is questionable endodontic status of the tooth, as demonstrated by evidence of unresolved periapical pathology that jeopardizes tooth retention, check history for dates of endodontic therapy (if endodontic therapy is within 6 months approve, if more than 6 months deny).**
e) **Where there is a compromised periodontal status, the tooth has lost more than 1/2 of its attachment unless there is a narrow three-walled defect amenable to bone regeneration or the patient has significant existing and unmet periodontal needs.**
f) **Elective replacement of a previously placed and intact amalgam restoration.**

Administrative Guidelines:

Documentation Required: **Current periapical radiographs or digital images; and a descriptive narrative (if necessary) to describe need.**

Payment Criteria

a) **For defective teeth not meeting clinical indications for an inlay or onlay, alternate benefit to an amalgam restoration as appropriate (D2140, D2150, D2160, D2161, D2391, D2392, D2393, D2394).**
b) **Evaluate for cosmetic exclusions or limitations. Alternate benefit all posterior non-metallic onlays to metallic onlays.**
c) **If payment is made and the restoration fails within a 3-year period, necessitating full coverage, deduct cost of inlay/onlay from crown payment.**
d) **Frequency limitation is 5 years.**

Utilization Review Protocols and Guidelines – 1.3

PROCEDURE CODE: D2950

PROCEDURE DESCRIPTION: Core Build-Up, including any pins

Refers to building up of an anatomical crown when a restorative crown will be placed, whether or not pins are used.

Clinical Conditions
ALLOWING Benefits: Current periapical radiographs and a narrative should indicate that a tooth being crowned has insufficient remaining tooth structure for mechanical retention of the crown:

<u>For Vital Anterior Teeth:</u>

a) **Moderate to severe damage to central tooth structure involving loss of more than 50% of the central tooth structure.**
b) **Moderate damage to central tooth structure where deep proximal lesions impinge on central core of tooth.**

<u>For Endodontically Treated Anterior Teeth:</u>

a) **Moderate tooth damage with large endodontic access and large proximal lesions, possible loss of incisal angles.**
b) **Severe damage where central destruction extends into core of tooth and much of supporting dentin, peripheral damage greater than 50% of tooth surface.**

<u>For Vital Posterior Teeth:</u>

a) **Moderate to severe damage to central tooth structure involving loss of more than 50% of the central tooth structure and supporting dentin.**
b) **Loss of two or more cusps, total coronal destruction where most of the core of the tooth has been affected and any remaining enamel is undermined.**

<u>For Endodontically Treated Posterior Teeth:</u>

a) **Moderate to severe tooth damage with loss of supporting dentin, wider proximal boxes or more extensive peripheral involvement.**
b) **Total coronal destruction with loss of all supragingival tooth structure.**

Clinical Conditions
NOT ALLOWING Benefits: **<u>Crown Build-Ups are NOT indicated:</u>**

a) **When replacing a Class I (e.g., occlusal) or Class II (e.g., MO, DO, MOD) restoration in a vital tooth.**

b) **Where there is a loss of peripheral tooth structure without loss of central tooth structure.**
c) **In teeth with a questionable periodontal or endodontic status (refer to contraindications for crowns and bridges).**
d) **Where the endodontic access is small and/or small proximal lesions exist, a resin restoration on affected surfaces is clinically acceptable.**

Administrative Guidelines:

Documentation Required: **Current periapical radiographs and a descriptive narrative (if necessary) to describe need.**

Payment Criteria

a) **D2950 payable if procedure code D3310 - D3348 resides in history with the same tooth and no other D25XX, D26XX, D27XX, D29XX, D2930 - D2934, D2970, D6XXX, or D7XXX exists on history with the same tooth number.**
b) **Pins are all inclusive to the D2950.**
c) **If D2950 is reported with a post, all-inclusive to D2954.**
d) **If procedure description is core only.**
e) **If indications are not met, restoration is considered inclusive to the crown restoration.**

Utilization Review Protocols and Guidelines – 1.4

PROCEDURE CODE: D2710 - D2794

PROCEDURE DESCRIPTION:

D2710	**crown - resin-based composite (indirect)**
D2712	**crown - ¾ resin-based composite (indirect)**
D2720 - D2722	**crown - resin with high noble, base, noble metal**
D2740	**crown - porcelain/ceramic substrate**
D2750 - D2752	**crown - porcelain & high noble, base, noble metal**
D2780 - D2783	**crown - ¾ high noble, base, noble metal, ceramic**
D2790 - D2792	**crown - full cast high noble, base, noble metal**
D2794	**crown - titanium**

Clinical Conditions
ALLOWING Benefits: **Current periapical radiographs and a narrative should indicate:**

<u>Crowns indicated for Anterior Teeth:</u>

a) **Moderate to severe damage to peripheral tooth structure where either both incisal angles are involved or greater than 1/3 of the incisal edge is involved.**
b) **Severe damage to peripheral tooth structure where more than 50% of peripheral tooth surface is involved.**
c) **Moderate damage to central tooth structure where deep proximal lesions impinge on the vital core of tooth.**
d) **Severe damage affecting more than 50% of central tooth structure, interventive endodontic therapy may be indicated.**

<u>Crowns are indicated for Posterior Teeth:</u>

a) **Moderate to severe damage where central destruction extends into core of tooth, peripheral destruction may cover up to 50% of tooth surface, one cusp missing.**
b) **Severe damage where central destruction extends into core of tooth and much of supporting dentin, peripheral damage greater than 50% of tooth surface.**
c) **Total coronal destruction where central destruction includes most of core, any remaining enamel is undermined.**
d) **Endodontically treated teeth, onlay is the minimum restoration required where central destruction includes most of the core and any remaining enamel and/or cusps are undermined. Full crown coverage is also acceptable.**

<u>Crowns are indicated for Anterior and Posterior Teeth:</u>

a) **To restore functioning deciduous teeth with no successor.**

Clinical Conditions NOT ALLOWING Benefits:

Crowns are NOT indicated for Anterior Teeth:

a) **Where there is minimal damage to peripheral tooth structure with small lesions, alternate benefit to a composite resin.**
b) **Moderate damage to peripheral tooth structure with one incisal angle involved (less than 1/3 of the incisal edge), alternate benefit to D2335.**
c) **Endodontically treated teeth if access is conservative and there are small proximal lesions, a composite resin may be suitable.**
d) **Where the primary purpose is cosmetic alteration of tooth color, alteration of tooth shape and size, or closure of diastema spacing.**

Crowns are NOT indicated for Posterior Teeth:

a) **Minimal damage with small occlusal, proximal and/or facial lesions, or combined occlusal and proximal, alternate benefit to an amalgam or resin restoration.**
b) **Moderate damage where occlusal or proximal lesions extend 1mm past the DEJ may be restored with an amalgam or resin restoration.**
c) **On periodontally compromised molars with fused roots. Prognosis may be poor.**
d) **On posterior teeth with furcation involvement of Class III (3mm or more), prognosis may be poor.**

Crowns are NOT indicated for Anterior and Posterior Teeth:

a) **Where there is questionable endodontic status of the tooth, as demonstrated by evidence of unresolved periapical pathology that jeopardizes tooth retention, check history for dates of endodontic therapy (if endodontic therapy is within 6 months approve, if more than 6 months deny).**
b) **Where there is a compromised periodontal status, the tooth has lost more than 1/2 of its attachment unless there is a narrow three-walled defect amenable to bone regeneration or the patient has significant existing and unmet periodontal needs.**
c) **For splinting purposes.**
d) **To prevent unpredictable, unanticipated future fractures or to eliminate craze lines in the absence of pathology.**

Administrative Guidelines:

Documentation Required: **Current periapical radiographs and a descriptive narrative (if necessary) to describe need.**

Payment Criteria

a) **D2710 - D2810 payable if procedure code D3310-D3348 resides in history with the same tooth and no other D25XX, D26XX, D27XX, D2930 – D2934, D2970, D6XXX, or D7XXX exists on history with the same tooth number.**

b) D2710 when used as a temporary crown, deduct benefits from the permanent crown.
c) Frequency limitation is 5 years.
d) For teeth not meeting clinical indications, alternate benefit to amalgam or composite restorations (fillings).

Section 2 – Endodontic Therapy

(Pulp Caps, Root Canal Therapy, Root Canal Retreatment, Surgery)

Utilization Review Protocols and Guidelines – 2.1

PROCEDURE CODE: D3110 - D3120

PROCEDURE DESCRIPTION:

D3110 Direct Pulp Cap (Excluding Final Restoration)
D3120 Indirect Pulp Cap (Excluding Final Restoration)

Direct Pulp Cap - The exposed pulp is covered with a dressing or cement that protects the pulp and promotes healing and repair. Can be placed on the same day of the restoration or at a different time.

Indirect Pulp Cap - The nearly exposed pulp is covered with a protective dressing to protect the pulp from additional injury and to promote healing and repair via the formation of secondary dentin. Should not be for bases and liners when all caries has been removed.

Clinical Conditions
ALLOWING Benefits:

Indirect Pulp Cap is Indicated:

a) **When removal of all carious dentin directly overlying the pulp would result in a pulp exposure.**
b) **Where there are minimal or no clinical signs of pulpal degeneration or inflammation in a deeply carious tooth.**
c) **Where there are no signs of periapical pathology of endodontic origin.**

Direct Pulp Cap is Indicated:

a) **When complete caries removal results in a small exposure (<0.5mm) of a vital pulp chamber.**
b) **When a traumatic injury results in a small vital pulpal exposure.**
c) **When there is a small mechanical exposure of a vital pulp chamber.**
d) **When the pulp exposure occurred in a clean, uncontaminated operating field.**

Note:
After an indirect pulp cap has been placed, the tooth can often be restored with a permanent restoration. The trend is moving away from reentry procedures after placement of an indirect pulp cap to assess reparative dentin formation. However, if the status of the pulp is in question after caries excavation, a temporary restoration may be placed in the tooth for a period of up to 3-6 months. There would then be a subsequent procedure to place a permanent restoration or initiate endodontic therapy, if indicated.

Clinical Conditions
NOT ALLOWING Benefits:

Pulp Cap is not Indicated:

a) **In a necrotic tooth.**
b) **In a tooth with an irreversible pulpitis.**
c) **If decay excavation results in a large communication with the pulp chamber (>0.5mm).**

Administrative Guidelines:

Documentation Required: **A descriptive narrative (if necessary) to describe need.**

Payment Criteria

a) **A pulp cap placed in conjunction with a permanent restoration is considered inclusive to (part of) the permanent restoration and does not warrant a separate benefit. The benefit should only be for a permanent restoration. Separate charges are not allowed.**
b) **A pulp cap placed in conjunction with a sedative filling (D2940) to assess pulpal status is considered inclusive to the sedative restoration and does not warrant a separate benefit. The benefit should only be for a temporary restoration. Separate charges are not allowed.**

Utilization Review Protocols and Guidelines – 2.2

PROCEDURE CODE: D3310 - D3330

PROCEDURE DESCRIPTION:

D3310 Anterior Root Canal (Excluding Final Restoration)
D3320 Bicuspid Root Canal (Excluding Final Restoration)
D3330 Molar Root Canal (Excluding Final Restoration)

The treatment of disease and injuries of the pulp and associated periradicular conditions.

Clinical Conditions ALLOWING Benefits:

Endodontic Therapy (Root Canal Treatment) is Indicated:

a) When caries or restorative procedures encroach upon or violate the pulp space resulting in irreversible pulp injury or death.
b) For traumatic injuries resulting in pulp necrosis.
c) For traumatic injuries resulting in tooth avulsion (forcibly tearing away) or subluxation (injury resulting in abnormal loosening of the teeth), submit to the medical carrier if applicable.
d) For crown fractures where there is pulpal exposure.
e) For "Cracked Tooth Syndrome" where the crack communicates with the pulp chamber.
f) For teeth exhibiting periapical pathology which is endodontic in origin.
g) For teeth exhibiting internal or external resorption.
h) For combined periodontal-endodontic lesions.
i) For horizontal root fractures.
j) For primary teeth with periapical pathology, which do not have a permanent successor, and are not within 6 months of exfoliation.
k) For teeth to be used in an overdenture case as long as a clinical condition meets overdenture criteria:
  1) Maxillary arch - shallow vault/atrophic ridge precludes traditional prosthodontics.
  2) Mandibular arch - atrophic ridge precludes traditional prosthodontics.

Clinical Conditions NOT ALLOWING Benefits:

Endodontic Therapy (Root Canal Treatment) is not Indicated:

a) When there is untreated periodontal disease and >50% attachment loss is evident.
b) When the tooth is not restorable.
c) For vertical root fractures.
d) If a tooth is in a non-strategic, unopposed position and will not be used for prosthetic treatment.
e) When there is aberrant (abnormal) root morphology not amenable to endodontic therapy.
f) Where there is excessive crown or root damage.

g) **When there is extensive internal or external resorption.**
h) **When there is an unfavorable crown-to-root ratio (1:1 or greater).**
i) **When intentional endodontics in the absence of disease or injury to solely facilitate a restorative procedure (e.g., overdentures, post, crown) is performed.**

Administrative Guidelines:

Documentation Required: **Current periapical radiograph or digital image and a descriptive narrative (if necessary) to describe need.**

Payment Criteria

a) **Payment is restricted to ADA-certified endodontic filling materials (i.e., Sargenti material is not covered).**
b) **Radiographs taken during the course of endodontic therapy are inclusive to the procedure, a separate benefit is not allowed.**
c) **Payment is based upon the tooth, not the number of canals.**
d) **For endodontic therapy relating to overdentures, refer to item "k" under clinical conditions allowing benefits if the plan design covers this procedure.**
e) **One per tooth per lifetime.**

Utilization Review Protocols and Guidelines – 2.3

PROCEDURE CODE: D3346 - D3348

PROCEDURE DESCRIPTION:

D3346 Retreatment of previous root canal therapy - Anterior
D3347 Retreatment of previous root canal therapy - Bicuspid
D3348 Retreatment of previous root canal therapy - Molar

This procedure may include the removal of a post, pin(s), old root canal filling material, and the procedures necessary to prepare and place the new root canal material. This includes complete root canal therapy. Includes all appointments necessary to complete retreatment; also includes intra-operative radiographs.

Clinical Conditions ALLOWING Benefits:

<u>Endodontic Retreatment is Indicated:</u>

a) **When there are clinical signs of infection or swelling including sinus tracts that are not periodontal in origin.**
b) **When there is persistent discomfort to percussion or palpation.**
c) **When radiographic analysis reveals a lack of osseous repair in an area of periapical radiolucency and an increase in the size of a periapical radiolucency.**
d) **In the presence of a periapical radiolucency where one did not exist pre-operatively.**
e) **If there is a poorly obturated canal with visible unfilled canal space or significant voids in the obturation of the canal.**
f) **Where there is evidence of operator error (canal transportation, broken instrument, perforation).**
g) **In teeth where canal obturation is grossly overextended (3mm - 5mm).**
h) **If canal obturation is significantly short of the apex (5mm or more) or poorly condensed and placement of a post presents the potential to compromise the apical seal.**
i) **If the canal was left untreated (multi-rooted teeth).**
j) **If an endodontically treated tooth was left unrestored and open to contamination (apical leakage).**

Clinical Conditions NOT ALLOWING Benefits:

<u>Endodontic Retreatment is not Indicated:</u>

a) **If there are no clinical symptoms or radiographic periapical pathology present.**
b) **For vertical tooth fractures (extraction recommended).**
c) **If symptoms occur and they are determined to be non-endodontic in origin.**
d) **If the canals are inaccessible or retreatment will not improve the current status of the tooth.**

e) **If the tooth is non-restorable or periodontally compromised (50% or greater attachment loss).**
f) **If a radiolucent area is not enlarging and tooth is asymptomatic relative to preoperative status.**

Note:

1) **Initial root canal therapy typically may take up to 24 months before one can conclude whether sufficient evidence exists to demonstrate resolution. During this period and in the absence of overt clinical symptoms, retreatment benefits should not be allowed.**

Administrative Guidelines:

Documentation Required: **Current periapical radiograph or digital image and/or a descriptive narrative (if necessary) describing unresolved periradicular pathology and/or demonstrating deficiency in the quality of the existing root canal filling.**

Payment Criteria

a) **Check history for prior periodontal treatment if periodontal status of the tooth is questionable.**
b) **Endodontic retreatment on the same tooth/teeth is generally disallowed within 24 months of initial endodontic therapy. If retreatment is requested within 24 months, refer to a dental consultant for separate benefit consideration or whether the initial endodontic benefit should be deducted.**
c) **One per tooth per lifetime.**

Utilization Review Protocols and Guidelines – 2.4

PROCEDURE CODE: D3410 - D3430

PROCEDURE DESCRIPTION:

D3410 Apicoectomy - Anterior
D3421 Apicoectomy - Bicupid (1st root)
D3425 Apicoectomy - Molar (1st root)
D3426 Apicoectomy/Periradicular Surgery - each additional root
D3427 Periradicular Surgery w/o Apicoectomy
D3430 Retrograde Filling - per root

Apicoectomy/Periradicular Surgery refers to the surgery of the root surface of an endodontically treated tooth. This includes apicoectomy, repair of a root perforation or resorptive defects, exploratory curettage to look for root fractures, removal of extruded filling materials or instruments, removal of broken root fragments, sealing of accessory canals, etc. A retrograde filling (usually amalgam) is placed in conjunction with the surgical procedure to create a hermetic seal at the port(s) of entry into the canal space.

Clinical Conditions
ALLOWING Benefits:

Apicoectomy/Periradicular Surgery is Indicated:

a) When there is a need to improve the apical seal when conventional endodontic therapy has failed to accomplish this objective.
b) In cases with inadequate obturation or periapical pathology that cannot be retreated conventionally (e.g., excessive canal calcification, inability to bypass broken instruments, lateral or apical perforations of canal or pulp chamber, inability to bypass shoulders or ledges, inability to remove filling material).
c) In cases where an attempt to retreat conventionally may result in irreparable damage to the tooth.
d) Where there is internal or external resorption resulting in communication between the root canal system and the periradicular tissues.
e) In conjunction with conventional endodontic therapy when there is persistent postoperative discomfort and drainage before or after obturation.
f) Where access to the canal space is prevented due to the presence of crowns and/or posts.
g) In cases of some horizontal root fractures.
h) Where developmental abnormalities exist (i.e., incompletely formed root apices, dens-in-dente).
i) In cases of combined endodontic-periodontal problems necessitating periodontal surgery.
j) Where there is failure to heal after previous endodontic surgery.

Clinical Conditions
NOT ALLOWING Benefits:

Apicoectomy/Periradicular Surgery is not Indicated:

a) As a routine substitute for conventional endodontic therapy.

b) **If the surgical site is inaccessible.**
c) **If the tooth is not restorable.**
d) **In cases of external or internal resorption where the dental consultant determines that the prognosis is poor.**
e) **If there is a pre-existing poor crown-to-root ratio or the surgical procedure will result in a poor crown-to-root ratio.**
f) **When there is untreated periodontal disease and >50% attachment loss is evident.**

Note:
Retrograde fillings are recommended and routinely performed in conjunction with apicoectomies. This procedure is performed to ensure that an apical seal is created in any root end (or lateral canal) that has undergone apical surgery. Materials that can be used for retrograde fillings include amalgam, glass ionomer cements, gutta percha, and zinc oxide and eugenol. Retrograde fillings may not need to be placed in all cases. If, upon or after completion of the apical surgery, it is determined and documented that an inadequate seal of filling material exists at the root end, a retrograde filling is allowed.

Administrative Guidelines:

Documentation Required: **Current periapical radiograph and a descriptive narrative stating the need for a surgical approach.**

Payment Criteria

a) **Check history for prior periodontal treatment if periodontal status of the tooth is questionable.**
b) **Payment is made on a per root basis.**
c) **Benefits allowable for each additional root treated (D3426) are at 50% of the first root. The allowances for D3410, D3421, and D3425 should be equal to each other as they are all single or first roots.**
d) **Charges for retrograde fillings (D3430) should be non-inclusive to an apicoectomy when performed on the same root and the same date as the apicoectomy.**
e) **Osseous grafts (D4263 - D4264) and guided tissue regeneration (D4266 - D4267) are inclusive to the apicoectomy**

Section 3 – Periodontal Therapy – Non-Surgical

(SRP, FM Scaling – Gingivitis, FM Debridement, LDAs)

Utilization Review Protocols and Guidelines – 3.1

PROCEDURE CODE: D4341 - D4342

PROCEDURE DESCRIPTION:

D4341 Periodontal Scaling and Root Planing - 4 or more teeth per Quadrant
D4342 Periodontal Scaling and Root Planing - 1-3 teeth per Quadrant

These procedures involve the instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. It is indicated for patients with periodontal disease and is therapeutic, not prophylactic, in nature. Root planing is the definitive procedure designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or microorganisms. Some soft tissue removal occurs. This procedure may be used as a definitive treatment in some stages of periodontal disease and/or as a part of pre-surgical procedures in others.

Clinical Conditions ALLOWING Benefits:

Scaling and Root Planing is Indicated:

a) **At sites with gingival inflammation, bleeding on probing, suppuration, increased probing depth and progressive attachment or alveolar bone loss.**
b) **In quadrants where a diagnosis of "generalized" moderate to severe periodontitis has been made (Case Types II, III, IV) and the initial probing depths are at least 4mm.**
c) **When radiographic and clinical analysis indicates infrabony pockets, bone loss and/or root surface calculus.**
d) **As an initial treatment before surgical intervention.**

Clinical Conditions NOT ALLOWING Benefits:

Scaling and Root Planing is not Indicated:

a) **In pockets less than 4mm, scaling and root planing in pockets of this depth may lead to clinical attachment loss.**

Administrative Guidelines:

Documentation Required:

a) **Case type (by quadrant), diagnosis and treatment plan.**
b) **Dated, precise initial charting of pocket depths (6 points per tooth).**
c) **Diagnostic quality full mouth radiographic series (panoramic radiograph not an acceptable substitute).**
d) **A descriptive narrative, if necessary.**
e) **Missing teeth, by quadrant.**
f) **Area of treatment by quadrant and/or tooth numbers.**

Payment Criteria

a) **Scaling only or as ongoing maintenance care is not benefited.**

b) Allow a maximum of two (2) quadrants on the same date of service. An additional allowance must be substantiated for the rare occasions when more than two (2) quadrants are indicated or provided on the same date (i.e., medically compromised patients, patients requiring pre-medication).

c) Scaling and root planing should not need to be repeated or benefited one per quadrant within a 24-month period.

d) There may be mixed Case Types by quadrant in an individual patient.

e) Quadrants where less than 4 teeth within the surgical area/site, allow D4342 and pro-rate at 50% of the R&C rate for a full quadrant.

f) If 4 quadrants are submitted on the same date with substantiating criteria, allow payment for 2 quadrants. If no substantiating documentation is submitted, deny the claim and request supporting documentation.

g) For 4 quadrants not meeting "generalized" criteria, allow for a prophylaxis (D1110).

h) For 4 quadrants not meeting bone loss and/or root surface calculus criteria but meeting "generalized" criteria, allow for a D4346.

Utilization Review Protocols and Guidelines – 3.2

PROCEDURE CODE: D4346

PROCEDURE DESCRIPTION: D4346 Scaling in the Presence of Generalized Moderate to Severe Gingival Inflammation - Full Mouth, After Oral Evaluation

The removal of plaque, calculus and stains from supra- and sub-gingival tooth surfaces when there is generalized moderate or severe gingival inflammation in the absence of periodontitis. It is indicated for patients who have swollen, inflamed gingiva, generalized suprabony pockets, and moderate to severe bleeding on probing. Should not be reported in conjunction with prophylaxis, scaling and root planing, or debridement procedures.

Clinical Conditions ALLOWING Benefits:

Full Mouth Scaling is Indicated:

a) When generalized moderate to severe gingival inflammation is present in the absence of periodontitis and therefore infrabony pocketing.
b) When suprabony pocketing due to gingival inflammation is present.
c) When there is generalized bleeding on probing.
d) When there is a narrative describing spongy, red, and inflamed gingival tissue in the absence of infrabony pocketing.

Clinical Conditions NOT ALLOWING Benefits:

Full Mouth Scaling is not Indicated:

a) When excessive plaque and suprabony calculus is present in the absence of generalized moderate to severe gingival inflammation.
b) When periodontitis is present.

Administrative Guidelines:

Documentation Required:

a) Diagnostic quality full mouth radiographs, or in the alternative, bite-wing x-rays supplemented with a panoramic radiograph.
b) Periodontal charting with previous 30 days showing probing depths.
c) Diagnostic intraoral photographs.
d) A descriptive narrative, if necessary.

Payment Criteria

a) Not a substitute for a difficult or hard prophylaxis.
b) Must be preceded by or on the same date as D0120, D0150, D0160, or D0180.
c) Deny if history of D1110, D1120 within 6 months of D4346.
d) Full mouth scaling should not need to be repeated or benefited one per quadrant within a 24-month period.
i) If not meeting "generalized" criteria, allow for a prophylaxis (D1110, D1120), if benefit frequency limitations permit.

j) If D4341 or D4342 is in history within a 24-month period, allowance for D4346 will be reduced by amount paid.

Utilization Review Protocols and Guidelines – 3.3

PROCEDURE CODE: D4355

PROCEDURE DESCRIPTION: D4355 Full Mouth Debridement to Enable a Comprehensive Oral Evaluation and Diagnosis on a Subsequent Visit

This procedure involves the preliminary removal of plaque and calculus that interferes with the ability of the dentist to perform a comprehensive oral evaluation. Not to be completed on the same day as D0120, D0150, D0160, or D0180.

Clinical Conditions ALLOWING Benefits:

Full Mouth Debridement is Indicated:

a) When excessive and generalized plaque and calculus is present to the extent that an oral evaluation cannot be adequately performed.
b) When excessive and generalized plaque and calculus inhibits the dentist and/or hygienist's ability to perform accurate periodontal charting.

Clinical Conditions NOT ALLOWING Benefits:

Full Mouth Debridement is not Indicated:

a) When mild to moderate plaque and calculus is present but does not inhibit performing an oral evaluation.

Administrative Guidelines:

Documentation Required:

a) Diagnostic quality full mouth radiographs, or in the alternative, bite-wing x-rays supplemented with a panoramic radiograph.
b) Diagnostic intraoral photographs.
c) A descriptive narrative, if necessary.

Payment Criteria

a) Must precede D0150, D0160, or D0180 be at least one day.
b) Deny if D0120, D0150, D0160 or D0180 performed within 6 months of D4355.
c) Deny if history of D1110, D1120 within 6 months of D4355.
d) (not filed yet)If not meeting "generalized" criteria, allow for a prophylaxis (D1110, D1120), if benefit frequency limitations permit.
e) If performed within 6 months of D0120, D0150, D0160, or D0180, allow for D1110, D1120 if member is eligible for D1110, D1120. If not eligible for D1110, D1120 due to frequency limitations, deny payment.

Utilization Review Protocols and Guidelines – 3.4

PROCEDURE CODE: D4381

PROCEDURE DESCRIPTION: D4381 Localized Delivery of Antimicrobial Agents (LDAs) Via a Controlled Release Vehicle into Diseased Crevicular Tissue, per Tooth

FDA approved subgingival delivery devices containing antimicrobial medication(s) are inserted into periodontal pockets to suppress the pathogenic microbiota. These devices slowly release the pharmacological agents so they can remain at the intended site of action in a therapeutic concentration for a sufficient length of time.

Clinical Conditions ALLOWING Benefits:

LDAs are Indicated:

a) Following allowing for tissue response (10 - 14 days) and re-evaluation of periodontal scaling and root planing.
b) When 5+ mm pocketing with persistent inflammation remains upon re-evaluation subsequent to periodontal scaling and root planing.

Clinical Conditions NOT ALLOWING Benefits:

LDAs are not Indicated:

a) Following scaling and root planing when re-evaluation shows pocketing less that 5 mm.
b) Following scaling and root planing when re-evaluation does not show inflammation in pockets of 5+ mm.
c) When delivered on the same date as scaling and root planing.
d) When delivered less than 10 days after scaling and root planing.

Administrative Guidelines:

Documentation Required:

a) Periodontal re-evaluation and charting after 10 - 14 days of healing to allow for tissue response to scaling and root planing.
b) A descriptive narrative, if necessary.

Payment Criteria

a) Not allowed on same date or within 10 days of D4341 or D4342.
b) Maximum of 1 site per quadrant per 24 months.

Section 4 – Periodontal Therapy – Surgical

(Gingivectomy, Gingival Flap, Crown Lengthening, Osseous Surgery, Bone Graft, GTR, Pedicle Graft, Connective Tissue Graft, Free Tissue Graft)

Utilization Review Protocols and Guidelines – 4.1

PROCEDURE CODE: D4210

PROCEDURE DESCRIPTION: Gingivectomy or Gingivoplasty - per Quadrant

Involves the excision of the soft tissue wall of the periodontal pocket by either an external or an internal bevel. Performed in shallow to moderate suprabony pockets after adequate initial preparation; for suprabony pockets which need access for restorative dentistry; when moderate gingival enlargements or aberrations are present; and, when there is asymmetrical or unaesthetic gingival topography.

Clinical Conditions ALLOWING Benefits:

Gingivectomy is Indicated:

a) **In suprabony periodontal pockets 5 mm or greater in depth with firm fibrotic walls at least two weeks following root planing procedures.**
b) **To improve soft tissue architecture, such as the elimination of soft tissue craters, irregular gingival margins, and altered passive eruption.**
c) **For treatment of gingival hyperplasia.**

Clinical Conditions NOT ALLOWING Benefits:

Gingivectomy is not Indicated:

a) **When there are infrabony pockets.**
b) **Where pocketing extends beyond the mucogingival line or when there is minimal attached tissue.**
c) **When there is a need to gain access to bone.**
d) **When the soft tissue is highly inflamed.**
e) **When a high caries rate exists.**
f) **When pocket depth is very irregular.**
g) **For patients with poor oral hygiene.**
h) **When there is inadequate plaque control or non-compliance with periodontal maintenance procedures.**
i) **When the sole or primary purpose of the procedure is for cosmetic purposes.**

Administrative Guidelines:

Documentation Required:

a) **Current full mouth radiographs or diagnostic images.**
b) **Case type (by quadrant), diagnosis and treatment plan.**
c) **Dated, precise initial charting of pocket depths (6 points per tooth) and reevaluated pocket depth.**
d) **A descriptive narrative, if necessary.**
e) **Area of treatment by quadrant and/or tooth numbers.**

Payment Criteria

a) **In borderline Type II-III (4-6 mm probings) cases, check history for D4341. If D4341 precedes, a waiting period of at least two weeks should occur to allow proper healing and observation of tissue response. If new probings are not submitted after the D4341, request a reevaluation and new probing chart prior to either predetermining the claim or making payment for the surgical benefit.**
b) **Do not pay on teeth which are being crowned or in preparation for a Class V restoration. In such cases, gingivectomy may be incidental to the tooth preparation and not covered as a separate service.**
c) **Gingivectomy should not need to be repeated or benefited within a 24-month period.**
d) **There may be mixed Case Types by quadrant in an individual patient.**
e) **D4210 is considered to include distal wedge or scaling and root planing when performed on the same date and in the same area as the surgery, and it includes routine postoperative care for a period of 90 days following surgery.**
f) **Panoramic films (D0330) are not a diagnostic substitute for a full mouth radiographic or diagnostic imaging series.**
k) **Quadrants where less than 5 teeth need treatment should be allowed (D4211) a pro-rated benefit (50% of the R&C level for a full quadrant).**
l) **If the service is submitted on a sextant basis (e.g., #6-11), process as 3 teeth (UR), 3 teeth (UL), for specific areas of treatment - determine the appropriate quadrant and pro-rate accordingly. If a later claim (within 24 months) is submitted for any periodontal surgery procedure for the remaining teeth in the quadrant, determine the appropriate quadrant, override system edit that prevents paying due to frequency limitation, and pay the pro-rated amount.**
m) **When different periodontal surgery procedures (except gingival grafts) are provided in any 24 month period in the same area, total approved benefits will be based upon the fee for the most inclusive procedure (if D4210 is followed by D4260 within 24 months, deduct the payment for D4210 from the payment for D4260 and pay the balance of the D4260 payment).**

Utilization Review Protocols and Guidelines – 4.2

PROCEDURE CODE: D4240

PROCEDURE DESCRIPTION: Gingival Flap Procedure - including root planing

A soft tissue flap is reflected or resected to allow debridement of the root surface and the removal of granulation tissue. Osseous recontouring is not accomplished in conjunction with this procedure. This procedure may include open flap curettage, reverse bevel flap surgery, modified Kirkland flap procedure, Widman surgery, and modified Widman surgery. This procedure is performed in the presence of moderate to deep probing depths, loss of attachment, need to maintain esthetics and need for increased access to the root surface and alveolar bone, or to determine the presence of a cracked tooth, fractured root, or external root resorption.

Clinical Conditions ALLOWING Benefits:

Gingival Flap Procedure is Indicated:

a) To provide access to the roots and underlying bone.
b) To treat suprabony pockets probing 5 mm or more in depth.
c) To treat moderate-to-deep bone loss with no irregular bony contours or exostoses, infrabony defects, or deep interproximal craters.

Clinical Conditions NOT ALLOWING Benefits:

Gingival Flap Procedure is not Indicated:

a) When the probing depths are less than 4 mm.
b) In Case Types I or II periodontal disease.
c) When there is inadequate plaque control or non-compliance with periodontal maintenance procedures.
d) Most often when the patient is under the age of 23 years.

Administrative Guidelines:

Documentation Required:

a) Case type (by quadrant), diagnosis and treatment plan.
b) Dated, precise initial charting of pocket depths (6 points per tooth) and reevaluated pocket depth when indicated by infrabony irregularities.
c) Diagnostic quality full mouth radiographic or digital image series.
d) A descriptive narrative, if necessary.
e) Missing teeth, by quadrant.
f) Area of treatment by quadrant and/or tooth numbers.

Payment Criteria

a) Check history for D4341. If D4341 precedes, deduct previous payment from the current payment for D4240.
b) Payment for D4240 is considered to inclusive of any frenectomy, gingival graft, distal wedge, or scaling

and root planing when performed on the same date and in the same area as the D4240. Routine postoperative care is also included for a period of 90 days following surgery.

c) Allow a maximum of two (2) quadrants on the same date of service. An additional allowance must be substantiated for the rare occasions when more than two (2) quadrants are indicated or provided on the same date (i.e., medically compromised patients, patients requiring premedication).

d) Gingivectomy should not need to be repeated or benefited within a 24-month period.

e) There may be mixed Case Types by quadrant in an individual patient.

f) Panoramic films (D0330) are not a diagnostic substitute for a full mouth radiographic or digital image series (D0210).

g) Quadrants where less than 4 teeth and/or tooth positions within the surgical area/site need treatment (D4241), allow and pro-rate at 50% of the R&C rate for a full quadrant.

h) If the service is submitted on a sextant basis (e.g., #6-11), process as 3 teeth (UR), 3 teeth (UL), for specific areas of treatment - determine the appropriate quadrant and pro-rate accordingly. If a later claim (within 24 months) is submitted for any periodontal surgery procedure for the remaining teeth in the quadrant, determine the appropriate quadrant, override system edit that prevents paying due to frequency limitation, and pay the pro-rated amount.

i) When different periodontal surgery procedures (except gingival grafts) are provided in any 24-month period in the same area, total approved benefits will be based upon the fee for the most inclusive procedure (if D4240 is followed by D4260 within 24 months, deduct the payment for D4240 from the payment for D4260 and pay the balance of the D4260 payment).

Utilization Review Protocols and Guidelines – 4.3

PROCEDURE CODE: D4249

PROCEDURE DESCRIPTION: Clinical Crown Lengthening - Hard Tissue

This procedure is employed to allow a restorative procedure or crown with little-to-no tooth structure exposed to the oral cavity. Crown lengthening requires reflection of a flap and is performed in a healthy periodontal environment, as opposed to osseous surgery which, is performed in the presence of periodontal disease. Where there are adjacent teeth, the flap design may involve a larger surgical area.

Clinical Conditions ALLOWING Benefits:

Clinical Crown Lengthening is Indicated:

a) **To prepare a tooth for restoration which has insufficient clinical crown for retention; typically involves the removal of healthy bone to obtain 4mm of retention and 2mm of biological width.**
b) **For removal of hard tissue in an otherwise periodontally healthy mouth.**

Clinical Conditions NOT ALLOWING Benefits:

Clinical Crown Lengthening is not Indicated:

a) **If active periodontal disease exists in the affected area. Deny benefits since the removal of diseased bone does not meet the procedure definition.**
b) **When only soft tissue is removed.**
c) **When there is an inadequate crown-to-root ratio (1:1 or greater).**

Administrative Guidelines:

Documentation Required:

a) **A current periapical radiograph.**
b) **A descriptive narrative, if necessary.**

Payment Criteria

a) **Allow an individual benefit per individual tooth that requires crown lengthening (not adjacent teeth if they do not require crown lengthening), although the procedure itself may involve adjacent teeth for flap access.**
b) **If adjacent teeth require crown lengthening in and of themselves, allow 100% payment for the first tooth and 50% payment for each additional tooth; this is appropriate to recognize that anesthesia, flap entry and closure are not individually necessary for each tooth.**
c) **If performed on the same date and same tooth as a crown preparation, the procedure is then considered incidental to the preparation of the crown. Do not combine charges, but rather, deny payment based on inclusiveness to the crown procedure.**

Utilization Review Protocols and Guidelines – 4.4

PROCEDURE CODE: D4260 - D4261

PROCEDURE DESCRIPTION:

D4260 Osseous Surgery - 4 or more contiguous teeth or spaces per quadrant
D4261 Osseous Surgery - 1-3 contiguous teeth or spaces per quadrant

This procedure modifies the bony support of the teeth by reshaping the alveolar process to achieve a more physiologic form. This may include the removal of supporting bone (ostectomy) or non-supporting bone (osteoplasty). Includes flap entry and closure.

Clinical Conditions ALLOWING Benefits:

<u>Osseous Surgery is Indicated:</u>

a) Where there is a need to gain access to achieve more effective removal of calculus and associated plaque in pocket depths of 5mm or greater, and where there is clinical evidence of bleeding, inflammation, suppuration, increasing pocket depth, or loss of attachment that has not responded to scaling and root planing.
b) When there is radiographic evidence of horizontal or vertical bone loss.
c) In Case Types III, IV or V periodontal disease.
d) When there is a need for osseous recontouring by means of ostectomy or osteoplasty.
  1. Ostectomy - indicated to correct one, two or three-walled osseous defects; to correct reversed architecture; to treat moderate to advanced furcation involvements.
  2. Osteoplasty - indicated to reduce crestal bone thickness in conjunction with ostectomies; reshape cortical projections and facial/lingual ledges to facilitate flap placement; or, for incipient furcation involvement.

Clinical Conditions NOT ALLOWING Benefits:

<u>Osseous Surgery is not Indicated:</u>

a) Where it will result in a poor crown-to-root ratio.
b) When the treatment will encroach on furcations.
c) Where esthetic considerations are a primary focus.
d) In the presence of excessive tooth mobility.
e) Where there is advanced attachment loss.
f) In patients who have not demonstrated adequate plaque control or adherence to supportive periodontal therapy.
g) Where pocket depths are shallow.
h) For Case Types I & II periodontal disease (pocketing <5mm).

Administrative Guidelines:

<u>Documentation Required:</u>

a) **Case type (by quadrant), diagnosis and treatment plan.**
b) **Dated, precise initial charting of pocket depths (6 points per tooth) and reevaluated pocket depth when indicated by infrabony irregularities.**
c) **Diagnostic quality full mouth radiographic or digital image series (panoramic film - D0330 - not acceptable).**
d) **A descriptive narrative, if necessary.**
e) **Missing teeth, by quadrant.**
f) **Area of treatment by quadrant and/or tooth numbers.**

Payment Criteria

a) **In borderline Type II-III (4-6 mm probings) cases, check history for D4341. If D4341 precedes, a waiting period of at least two weeks should occur to allow proper healing and observation of tissue response. If new probings are not submitted after the D4341, request a reevaluation and new probing chart prior to either predetermining the claim or making payment for the surgical benefit.**
b) **Allow a maximum of two (2) quadrants on the same date of service. An additional allowance must be substantiated for the rare occasions when more than two (2) quadrants are indicated or provided on the same date (i.e., medically compromised patients, patients requiring premedication).**
c) **D4260 is considered to include any frenectomy, gingival graft, distal wedge, or scaling and root planing when performed on the same date and in the same area as the D4260. Routine postoperative care is also included for a period of 90 days following surgery.**
d) **When different periodontal surgery procedures (except gingival grafts) are provided in any 24-month period in the same area, total approved benefits will be based upon the fee for the most inclusive procedure.**
e) **Osseous surgery should not need to be repeated or benefited within a 24-month period.**
f) **There may be mixed Case Types by quadrant in an individual patient.**
g) **Panoramic films (D0330) are not a diagnostic substitute for a full mouth radiographic or digital image series (D0210).**
h) **Quadrants where less than 5 teeth and/or tooth positions within the surgical area/site need treatment, allow and pro-rate at 50% of the R&C rate for a full quadrant.**
i) **If the service is submitted on a sextant basis (e.g., #6-11), process as 3 teeth (UR), 3 teeth (UL), for specific areas of treatment - determine the appropriate quadrant and pro-rate accordingly. If a later claim (within 24 months) is submitted for any periodontal surgery procedure for the remaining teeth in the quadrant, determine the appropriate**

quadrant, override system edit that prevents paying due to frequency limitation, and pay the pro-rated amount.

Utilization Review Protocols and Guidelines – 4.5

PROCEDURE CODE: D4263 - D4264

PROCEDURE DESCRIPTION:

D4263 Bone Replacement Graft, first site in quadrant
D4264 Bone Replacement Graft, each additional site in quadrant

This procedure involves the use osseous autographs, osseous allografts, or non-osseous grafts to stimulate periodontal regeneration when the disease process has led to a deformity of the bone. This procedure does not include flap entry and closure, wound debridement, osseous contouring, or the placement of biologic materials to aid in osseous tissue regeneration or barrier membranes. D4263 is reported in addition to a procedure that includes flap entry and closure including but not limited to D4260. Procedure code D4264 is used if performed concurrently with D4263 and allows reporting of the exact number of sites involved.

Clinical Conditions ALLOWING Benefits:

Osseous Grafting is Indicated:

a) **Where there are intraosseous bony defects with pocket depths 5mm or greater.**
b) **In cases of selective furcation involvement, as approved by the dental consultant.**

Clinical Conditions NOT ALLOWING Benefits:

Osseous Grafting is not Indicated:

a) **For cases with horizontal bone loss.**
b) **For defects around implants**

Administrative Guidelines:

Documentation Required:

a) **Current diagnostic quality full mouth radiographic or digital image series (panoramic film - D0330 - not acceptable).**
b) **Dated, precise initial charting of pocket depths (6 points per tooth).**
c) **A descriptive narrative identifying site(s) and a description of the defect(s).**

Payment Criteria

a) **Osseous grafting should not need to be repeated within a 24-month time period.**
b) **Osseous grafting is inclusive to other treatment when reported in conjunction with apicoectomies, root resections, hemisections, extractions, or cyst removals.**
c) **When reported with guided tissue regeneration (GTR) for furcation or intraosseous defects, osseous grafts are considered to be inclusive of the GTR. There is no compelling evidence to support enhanced effectiveness of combination therapy.**
d) **See the periodontal inclusion table below.**

PERIODONTAL INCLUSION TABLE

CODE	REPORTED WITH	FOR COVERED BENEFIT CONDITION
D4260	D4263	allow D4260, allow 50% of D4263
D4260	D4266, D4267	allow D4260, allow 50% of D4266 or D4267
D4266, D4267	D4263	allow D4266 or D4267, D4263 is inclusive
D4260	D4266, D4267, D4263	allow D4260, allow 50% of D4266 or D4267, allow 50% of D4263

Utilization Review Protocols and Guidelines – 4.6

PROCEDURE CODE: D4266 - D4267

PROCEDURE DESCRIPTION:

D4266 Guided Tissue Regeneration - resorbable barrier, per site

D4267 Guided Tissue Regeneration - non-resorbable barrier, per site, (includes membrane removal)

A membrane is placed over the root surfaces or defect area following surgical exposure and debridement. The mucoperiosteal flaps are then adapted over the membrane and sutured. The membrane is placed to exclude epithelium and gingival connective tissue from the healing wound. This procedure may require subsequent surgical procedures to correct the gingival contours. Guided tissue regeneration may also be carried out in conjunction with bone replacement grafts or to correct deformities resulting from inadequate faciolingual bone width in an edentulous area. When guided tissue regeneration is used in association with a tooth, each site on a specific tooth should be reported separately.

Both procedures D4266 and D4267 are relatively similar, with D4267 used to regenerate lost or injured periodontal tissue by directing differential tissue responses; and, it requires a second visit to remove the membrane.

Clinical Conditions
ALLOWING Benefits:

Guided Tissue Regeneration is Indicated:

a) **Where there are intraosseous defects with pocket depths 5mm or greater.**
b) **For Class II maxillary facial and mandibular furcations.**
c) **For dehiscence (an isolated area in which the root is denuded of bone from the margin nearly to the apex) and fenestration (condition of having an open area frequently closed by a membrane) defects.**

Clinical Conditions
NOT ALLOWING Benefits:

Guided Tissue Regeneration is not Indicated:

a) **For Class III furcations.**
b) **For horizontal bone loss.**
c) **For defects around implants**

Administrative Guidelines:

Documentation Required:

a) **Current diagnostic quality full mouth radiographic or diagnostic imaging series (panoramic film - D0330 - not acceptable).**
b) **Dated, precise initial charting of pocket depths (6 points per tooth).**
c) **A descriptive narrative identifying site(s) and a description of the defect(s).**

Payment Criteria

a) **Guided tissue regeneration should not need to be repeated within a 24-month time period.**
b) **Guided tissue regeneration is inclusive to other treatment when reported in conjunction with**

apicoectomies, root resections, hemisections, extractions, or cyst removals.

c) When reported with osseous grafts for furcation or intraosseous defects, osseous grafts are considered to be inclusive of the GTR. There is no compelling evidence to support enhanced effectiveness of combination therapy.

d) See the periodontal inclusion table below.

PERIODONTAL INCLUSION TABLE

CODE	REPORTED WITH	FOR COVERED BENEFIT CONDITION
D4260	D4263	allow D4260, allow 50% of D4263
D4260	D4266, D4267	allow D4260, allow 50% of D4266 or D4267
D4266, D4267	D4263	allow D4266 or D4267, D4263 is inclusive
D4260	D4266, D4267, D4263	allow D4260, allow 50% of D4266 or D4267, allow 50% of D4263

Utilization Review Protocols and Guidelines – 4.7

PROCEDURE CODE: D4270

PROCEDURE DESCRIPTION: Pedicle Soft Tissue Graft

A pedicle flap of gingiva can be raised from an edentulous ridge, adjacent teeth, or from the existing gingiva on the tooth and moved laterally or coronally to replace alveolar mucosa as marginal tissue. The procedure can be used to cover an exposed root or to eliminate a gingival defect if the root is not too prominent in the arch.

Clinical Conditions ALLOWING Benefits:

Gingival Augmentation is Indicated:

a) **For progressive marginal tissue recession AND lack of adequate attached tissue (<2mm).**
b) **Where tooth movement occurring either in natural tooth eruption or with orthodontic therapy results in alveolar bone dehiscence with inadequate thickness of attached gingiva.**
c) **Subgingival placement of restoration margins in areas with an inadequate zone of attached tissue (<2mm).**
d) **Before orthodontic tooth movement in areas with inadequate attached tissue.**

Root Coverage Procedures are Indicated:

a) **In teeth with exposed root surfaces experiencing sensitivity where physical and chemical agents have been exhausted.**
b) **To manage defects resulting from root caries removal and/or cervical abrasions.**

Clinical Conditions NOT ALLOWING Benefits:

Pedicle Soft Tissue Grafts are not Indicated:

a) **When performed strictly for esthetic purpose.**
b) **For tooth brush abrasion in an otherwise periodontally healthy mouth.**
c) **For lack of attached tissue only without disease or additional risk factors.**
d) **When a donor or recipient site is inaccessible or when a donor site will not provide an adequate dimension of gingiva.**

Administrative Guidelines:

Documentation Required:

a) **Periodontal charting of mucogingival condition indicating history and extent of defect.**
b) **A descriptive narrative describing the mucogingival defect.**
c) **For teeth with recession, charting indicating the distance from the CEJ to the free gingival margin and the amount of attached tissue present on all teeth involved.**

Payment Criteria

a) **On a per site basis, 1-2 adjacent teeth equal one site, at code allowance. If multiple adjacent sites are reported, then allow 50% of the code allowance for each additional adjacent site involved in the graft procedure.**
b) **Includes history of application of desensitizing medicament (D9910) for root hypersensitivity.**
c) **Pedicle soft tissue grafts should not need to be repeated unless the graft fails due to periodontal disease or anatomic factors.**
d) **A gingival graft procedure includes any frenectomy, distal wedge or gingivectomy that is performed on the same date and in the same surgical site(s).**
e) **A gingival graft procedure that is performed on the same date and in the same surgical site as a flap surgical procedure is considered inclusive to the flap surgical procedure.**
f) **Allowed once per 24-months.**

Utilization Review Protocols and Guidelines – 4.8

PROCEDURE CODE: D4277 – D4278

PROCEDURE DESCRIPTION: Free Soft Tissue Graft (including recipient and donor site surgeries), first tooth and each additional tooth

Gingival or masticatory mucosa is grafted to create or augment the gingiva at another site, with or without root coverage. This graft may also be used to eliminate the pull of frenum and muscle attachments, to extend the vestibular fornix and to correct localized gingival recession.

Clinical Conditions ALLOWING Benefits:

Gingival Augmentation is Indicated:

a) **For progressive marginal tissue recession AND lack of adequate attached tissue (<2mm).**
b) **Where tooth movement occurring either in natural tooth eruption or with orthodontic therapy results in alveolar bone dehiscence with inadequate thickness of attached gingiva.**
c) **Subgingival placement of restoration margins in areas with an inadequate zone of attached tissue (<2mm).**
d) **Before orthodontic tooth movement in areas with inadequate attached tissue.**

Root Coverage Procedures are Indicated:

a) **In teeth with exposed root surfaces experiencing sensitivity where physical and chemical agents have been exhausted.**
b) **To manage defects resulting from root caries removal and/or cervical abrasions.**

Clinical Conditions NOT ALLOWING Benefits:

Free Soft Tissue Grafts are not Indicated:

a) **When performed strictly for esthetic purpose.**
b) **For tooth brush abrasion in an otherwise periodontally healthy mouth.**
c) **For lack of attached tissue only without disease or additional risk factors.**
d) **When a donor or recipient site is inaccessible or when a donor site will not provide an adequate dimension of gingiva.**

Administrative Guidelines:

Documentation Required:

a) **Periodontal charting of mucogingival condition indicating history and extent of defect.**
b) **A descriptive narrative describing the mucogingival defect.**
c) **For teeth with recession, charting indicating the distance from the CEJ to the free gingival margin and the amount of attached tissue present on all teeth involved.**

d) **Intraoral photographs, if available, especially in cases where the need may not be evident.**

Payment Criteria

a) **On a per site basis, 1-2 adjacent teeth equal one site, at code allowance. If multiple adjacent sites are reported, then allow D4278 for each additional adjacent site involved in the graft procedure.**
b) **History may include application of desensitizing medicament (D9910) for root hypersensitivity.**
c) **Multiple grafts on the same service date:**
    1. **1 tooth and/or 2 teeth graft sites - can occur in all 4 quadrants; not to exceed 6 teeth on the same date of service.**
    2. **2 or 3 or 4 teeth graft sites - can occur in no more than 2 quadrants; not to exceed 6 teeth collectively on the same date of service.**
    3. **5 or 6 teeth graft sites - no more than 1 quadrant on the same date of service.**
    4. **Cross-arch areas (i.e., #22-27) and similar scenarios will be interpreted as equivalent to a quadrant.**
d) **Free soft tissue grafts should not need to be repeated unless the graft fails due to periodontal disease or anatomic factors.**
e) **A gingival graft procedure includes any frenectomy, distal wedge or gingivectomy that is performed on the same date and in the same surgical site(s).**
f) **A gingival graft procedure that is performed on the same date and in the same surgical site as a flap surgical procedure is considered inclusive to the flap surgical procedure.**
g) **Allowed once per 24-months.**

Utilization Review Protocols and Guidelines – 4.9

PROCEDURE CODE: D4273

PROCEDURE DESCRIPTION: Autogenous Connective Tissue Graft (including donor and recipient site surgeries)

Clinical Conditions ALLOWING Benefits:

<u>Gingival Augmentation is Indicated:</u>

a) **For progressive marginal tissue recession AND lack of adequate attached tissue (<2mm).**
b) **Where tooth movement occurring either in natural tooth eruption or with orthodontic therapy results in alveolar bone dehiscence with inadequate thickness of attached gingiva.**
c) **Subgingival placement of restoration margins in areas with an inadequate zone of attached tissue (<2mm).**
d) **Before orthodontic tooth movement in areas with inadequate attached tissue.**

<u>Root Coverage Procedures are Indicated:</u>

a) **In teeth with exposed root surfaces experiencing sensitivity where physical and chemical agents have been exhausted.**
b) **To manage defects resulting from root caries removal and/or cervical abrasions.**

Clinical Conditions NOT ALLOWING Benefits:

<u>Free Soft Tissue Grafts are not Indicated:</u>

a) **When performed strictly for esthetic purpose.**
b) **For tooth brush abrasion in an otherwise periodontally healthy mouth.**
c) **For lack of attached tissue only without disease or additional risk factors.**
d) **When a donor or recipient site is inaccessible or when a donor site will not provide an adequate dimension of gingiva.**

Administrative Guidelines:

<u>Documentation Required:</u>

a) **Periodontal charting of mucogingival condition indicating history and extent of defect.**
b) **A descriptive narrative describing the mucogingival defect.**
c) **For teeth with recession, charting indicating the distance from the CEJ to the free gingival margin and the amount of attached tissue present on all teeth involved.**
d) **Intraoral photographs, if available, especially in cases where the need may not be evident.**

Payment Criteria

a) **On a per site basis, 1-2 adjacent teeth equal one site, at code allowance. If multiple adjacent sites are reported, then allow 50% of the code allowance for each additional adjacent site involved in the graft procedure.**
b) **History may include application of desensitizing medicament (D9910) for root hypersensitivity.**
c) **Multiple grafts on the same service date:**
    1. **1 tooth and/or 2 teeth graft sites - can occur in all 4 quadrants; not to exceed 6 teeth on the same date of service.**
    2. **2 or 3 or 4 teeth graft sites - can occur in no more than 2 quadrants; not to exceed 6 teeth collectively on the same date of service.**
    3. **5 or 6 teeth graft sites - no more than 1 quadrant on the same date of service.**
    4. **Cross-arch areas (i.e., #22-27) and similar scenarios will be interpreted as equivalent to a quadrant.**
d) **Free soft tissue grafts should not need to be repeated unless the graft fails due to periodontal disease or anatomic factors.**
e) **A gingival graft procedure includes any frenectomy, distal wedge or gingivectomy that is performed on the same date and in the same surgical site(s).**
f) **A gingival graft procedure that is performed on the same date and in the same surgical site as a flap surgical procedure is considered inclusive to the flap surgical procedure.**
g) **Allowed once per 24-months.**

Section 5 – Removable Prosthodontics

(Partial Dentures)

Utilization Review Protocols and Guidelines – 5.1

PROCEDURE CODE: D5211 - D5283

PROCEDURE DESCRIPTION:

D5211 Maxillary Partial Denture - Resin Base
D5212 Mandibular Partial Denture - Resin Base
D5213 Maxillary Partial Denture - Cast Metal Framework, Resin Base
D5214 Mandibular Partial Denture - Cast Metal Framework, Resin Base
D5225 Maxillary Partial Denture - Flexible Base
D5226 Mandibular Partial Denture - Flexible Base
D5282 Removable Unilateral Partial Denture - One Piece Cast Metal, Maxillary
D5283 Removable Unilateral Partial Denture - One Piece Cast Metal, Mandibular

All partial dentures include major connectors, connectors, any conventional clasps (regardless of number), rests, and teeth. Cast metal base alloys have less than 60% Au, Pd or Pt content. No code number for immediate partial dentures. For precision partial dentures, report precision attachments with code 5862 by report. Partial dentures for pediatric dentistry are included in this category. Routine post-delivery care is also included.

Clinical Conditions ALLOWING Benefits:

Removable Partial Dentures are Indicated:

a) In partially edentulous patients.
b) In patients with sufficient interarch space.
c) Where there is favorable bone quality and bone quantity in the alveolar ridge.
d) Where there is favorable tissue tolerance in supporting areas.
e) In patients with favorable oral muscular coordination.
f) Where abutment teeth have sufficient bone support and favorable periodontal status.
g) Where abutment teeth are caries free and, if necessary, restored with a restoration capable of withstanding forces from the rests and clasps.

Clinical Conditions NOT ALLOWING Benefits:

Removable Partial Dentures are not Indicated:

a) In patients who are partially edentulous and have a history of difficulty with wearing and function of a removable prosthesis.
b) When there is a history of poor removable partial denture stability and/or retention.
c) If an abutment tooth is not restorable.
d) If there is an existing poor crown-to-root ratio on one or more abutment teeth.
e) In cases of unfavorable number and location of potential natural tooth abutments.
f) In patients with untreated pathology of the soft or hard tissue.
g) In cases where there is a residual root tip at or near the surface of the alveolar bone.

h) **In cases where there is a partial or complete bony impaction that may interfere with partial denture stability or comfort.**
i) **In cases where insufficient interarch space will preclude prosthetic placement.**
j) **Where there is questionable endodontic status of the tooth, as demonstrated by evidence of unresolved periapical pathology that jeopardizes tooth retention, check history for dates of endodontic therapy (if endodontic therapy is within 6 months approve, if more than 6 months deny).**
k) **Where there is a compromised periodontal status, the tooth has lost more than 1/2 of its attachment unless there is a narrow three-walled defect amenable to bone regeneration or the patient has significant existing and unmet periodontal needs.**
l) **On periodontally compromised molars with fused roots. Prognosis may be poor.**
m) **On posterior teeth with furcation involvement of Class lll (3mm or more), prognosis may be poor.**

Administrative Guidelines:

Documentation Required:

a) **Current full mouth radiographs (a panoramic radiograph with periapical radiographs of abutment teeth are an acceptable alternative).**
b) **A descriptive narrative (if necessary) to describe need and unusual circumstances.**
c) **Initial or prior placement dates.**

Payment Criteria

a) **Check history for prior periodontal treatment if periodontal status is questionable.**
b) **Frequency limitation is 5 years.**
c) **If the MISSING TOOTH LIMITATION applies, the removable partial denture is not covered unless the patient has a functioning, natural tooth removed after the initial coverage date. Check history for extraction in the same arch.**
d) **Temporary partial dentures (when covered) will be combined if submitted on the same claim with the permanent removable partial denture or paid and deducted later from the permanent removable partial denture.**
e) **Do not pay if the removable partial denture is beyond the 5 year frequency limitation and can be made serviceable.**
f) **Review for plan provisions:**
   1. **frequency limitations**
   2. **initial placement date(s)**
   3. **temporary services**

Section 6 – Implants

(Partial Dentures)

Utilization Review Protocols and Guidelines – 6.1

PROCEDURE CODE: D6010

PROCEDURE DESCRIPTION: D6010 Surgical Placement of Implant Body: Endosteal Implant, includes second stage surgery and placement of healing cap

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Clinical Conditions ALLOWING Benefits:

Osseointegrated Implants are Indicated:

a) In partially edentulous patients.
b) In cases of unfavorable number and location of potential natural tooth abutments.
c) In cases of single tooth loss to prevent preparation of sound natural teeth or replacement of sound restorations or prothesis.

Clinical Conditions NOT ALLOWING Benefits:

Osseointegrated Implants are not Indicated:

a) In patients with conditions, diseases or treatment that severely compromises healing, e.g., high dose radiation therapy.
b) Where there is poor bone quality, poor bone quantity, infection, or local anatomic aberrations at the proposed implant site.
c) In patients with uncontrolled metabolic disorders.
d) During pregnancy.
e) In patients who are significantly medically compromised (> American Society of Anesthesiology Class II).
f) In patients who are significantly psychologically compromised.
g) In patients with hematologic disorders.
h) In patients with untreated pathology of the soft or hard tissue.
i) In patients with poor motivation or understanding of compliance with oral hygiene procedures and recall procedures.
j) In patients with unrealistic expectations.
k) Where vital anatomic structures may be violated.
l) Where there is insufficient mesio-distal distance for implant placement from proximal natural teeth.
m) In cases demonstrating unattainable prosthetic reconstruction
n) In cases where insufficient interarch space will preclude prosthetic placement.
o) In young patients where the facial bones are still growing and developing, and the teeth are still erupting.

Administrative Guidelines:

Documentation Required:

a) Current full mouth radiographs or digital imaging (a panoramic radiograph with periapical radiographs or

digital images of abutment teeth are an acceptable alternative).

b) A descriptive narrative (if necessary) to describe need and unusual circumstances.

Payment Criteria

a) Frequently not a covered benefit for small groups, may be alternate benefited to another procedure(s).

b) If alternate benefit policy is in place for the replacement of one tooth, payment should be limited to the payout for a three-unit bridge. Teeth on either side of the implant become subject to the 60-month replacement exclusion.

c) If the implant is a covered benefit and the implant fails, replacement of the implant by another implant or a fixed partial denture would not be covered.

f) Review for plan provisions:

1. **frequency limitations (Implant- 1 per lifetime; Fixed partial denture – 1 per 5 years)**
2. **initial placement date(s)**
3. **temporary services**

Utilization Review Protocols and Guidelines – 6.2

PROCEDURE CODE: D6056 - D6194

PROCEDURE DESCRIPTION:

D6056	**implant - pre-fabricated abutment**
D6057	**implant - custom abutment**
D6058 - D6064	**implant - abutment supported crown**
D6065 - D6067	**implant - implant supported crown**
D6068 - D6074	**implant - abutment supported retainer**
D6075 - D6077	**implant - implant supported retainer**
D6110 – D6117	**implant / abutment supported**
D6194	**implant supported retainer**

Clinical Conditions ALLOWING Benefits:

Current periapical radiographs and a narrative should indicate:

<u>Post-Implant Services indicated for:</u>

a) **Successful endosteal implants.**
b) **Solid bone support surrounds the implant.**
c) **Healthy gingival tissue present.**
d) **If not an immediate load implant, adequate healing time for bone formation and integration has occurred (2-3 months).**

Clinical Conditions NOT ALLOWING Benefits:

<u>Post-implant Services are NOT indicated:</u>

a) **When osseous integration is not taking place.**
b) **When adequate healing time has not taken place (2-3 months).**
c) **When infection is present around implant.**

Administrative Guidelines:

<u>Documentation Required:</u> **Current periapical radiographs and a descriptive narrative (if necessary) to describe conditions.**

<u>Payment Criteria</u>

a) **D6056 - D6194 payable if procedure code D6010 resides in history with the same tooth.**
b) **Frequency limitation is 5 years.**

Section 7 – Fixed Partial Prosthodontics (Bridges)

(Bridges, Resin-Bonded Retainers)

Utilization Review Protocols and Guidelines – 7.1

PROCEDURE CODE: D6710 - D6792

PROCEDURE DESCRIPTION: Fixed Partial Denture Retainers - Abutment Crowns

D6710 Indirect resin-based composite
D6720 - D6722 Crown - resin with high noble, base, noble metal
D6750 - D6752 Crown - porcelain & high noble, base, noble metal
D6780 – D6783 Crown - 3/4 cast high noble, base, noble metal, ceramic
D6790 - D6792 Crown - full cast high noble, base, noble metal
D6794 Crown - titanium
D6793 Provisional retainer crown (not covered)

A permanently cemented crown abutment to which one or more pontic teeth are attached. The term "fixed partial denture retainer" has replaced the term "bridge" or "bridgework."

Clinical Conditions
ALLOWING Benefits (*with MTL*):

When there is a "missing tooth limitation" (MTL), the restorative benefits for the individual abutments can be considered according to the following indications:

<u>Abutment Crowns indicated for Anterior Teeth:</u>

a) Moderate to severe damage to peripheral tooth structure where both incisal angles are involved, or greater than 1/3 of the incisal edge is involved.
b) Severe damage to peripheral tooth structure where more than 50% of peripheral tooth surface is involved.
c) Moderate damage to central tooth structure where deep proximal lesions impinge on the vital core of tooth.
d) Severe damage affecting more than 50% of central tooth structure, interventive endodontic therapy may be indicated.

<u>Abutment Crowns are indicated for Posterior Teeth:</u>

a) Moderate to severe damage where central destruction extends into core of tooth, peripheral destruction may cover up to 50% of tooth surface, one cusp missing.
b) Severe damage where central destruction extends into core of tooth and much of supporting dentin, peripheral damage greater than 50% of tooth surface.
c) Total coronal destruction where central destruction includes most of core, any remaining enamel is undermined.
d) Endodontically treated teeth, onlay is the minimum restoration required where central destruction includes most of the core and any remaining enamel and/or cusps are undermined. Full crown coverage is acceptable as an equivalent procedure.

Clinical Conditions NOT ALLOWING Benefits *(with MTL)*:

When there is a "missing tooth limitation" (MTL), restorative benefits for individual abutments should be considered using the following contraindications:

<u>Fixed Retainers are NOT indicated for Anterior Teeth:</u>

a) Where there is minimal damage to peripheral tooth structure with small lesions, alternate benefit to a resin restoration.
b) Moderate damage to peripheral tooth structure with one incisal angle involved (less than 1/3 of the incisal edge), alternate benefit to 2335.
c) In endodontically treated teeth, if the access is conservative and there are small proximal lesions, a resin may be a suitable restoration.
d) Where the primary purpose is cosmetic alteration of tooth color, alteration of tooth shape and size, or closure of diastema spacing.

<u>Fixed Retainers are NOT indicated for Posterior Teeth:</u>

a) Minimal damage with small occlusal, proximal and/or facial lesions, or combined occlusal and proximal, alternate benefit to an amalgam or resin restoration.
b) Moderate damage where occlusal or proximal lesions extend 1mm past the DEJ may be restored with an amalgam or resin restoration.
c) On periodontally compromised molars with fused roots. Prognosis may be poor.
d) On posterior teeth with furcation involvement of Class III (3mm or more), prognosis may be poor.

Clinical Conditions NOT ALLOWING Benefits *(w/o MTL)*:

The following clinical indications NOT ALLOWING benefits applies for fixed partial denture retainers when the missing tooth limitation is NOT applicable:

<u>Fixed Retainers are NOT indicated for Anterior and Posterior Teeth:</u>

a) Where there is questionable endodontic status of the tooth, there is evidence of unresolved periapical pathology that jeopardizes tooth retention, check history for dates of endodontic therapy.
b) Where there is a compromised periodontal status, the tooth has lost more than 1/2 of its attachment unless there is a narrow three-walled defect amenable to bone regeneration or the patient has significant existing and unmet periodontal needs.
c) For splinting purposes or strictly for a tooth to receive a clasp.
d) To prevent unpredictable, unanticipated future fractures or to eliminate craze lines in the absence of pathology.

e) **Cantilever fixed partial dentures with 2 or more pontics.**

Administrative Guidelines: If the "Missing Tooth Limitation" is not applicable, then the restorative status of an abutment tooth is irrelevant. The teeth will automatically qualify for abutment placement as the need for the fixed partial denture to replace the edentulous space defines the restorative need.

Documentation Required:

a) **Current full mouth radiographs (a panoramic radiograph with periapical radiographs of abutment teeth are an acceptable alternative).**
b) **A descriptive narrative (if necessary) to describe need and unusual circumstances.**
c) **Initial or prior placement dates.**

Guidelines for Least Costly Alternative Treatment:

A FIXED partial denture is considered a standard benefit for the following:

a) **Replacement of one missing tooth only.**

A REMOVABLE partial denture is considered a standard benefit for the following:

a) **Replacement of more than one missing tooth in the same arch.**

Payment Criteria

a) **D6710 - D6794 payable if procedure code D3310 - D3348 resides in history with the same tooth and no other D25XX, D26XX, D27XX, D2930 - D2934, D2970, D6XXX, or D7XXX exists on history with the same tooth number.**
b) **D6793 - temporary services will be combined if submitted on the same claim with the permanent fixed partial denture or paid and deducted later from the permanent fixed partial denture.**
c) **Frequency limitation is 5 years.**
d) **If the MISSING TOOTH LIMITATION applies, for abutment teeth not meeting clinical indications, alternate benefit to amalgam or resin restorations.**
e) **If a removable partial denture is not a reasonable alternative, review for alternate benefit guidelines (as it relates to MTL).**
f) **Do not pay if the fixed partial denture is beyond the 5 year frequency limitation and can be made serviceable.**
g) **Not covered when provided in connection with a removable partial denture in the same arch.**
h) **Review for plan provisions:**
    1. **frequency limitations**
    2. **initial placement date(s)**
    3. **temporary services**
    4. **essential for necessary care of teeth**

Utilization Review Protocols and Guidelines – 7.2

PROCEDURE CODE: D6545 - D6548

PROCEDURE DESCRIPTION:

D6545 Retainer - Cast Metal for Resin Bonded Fixed Prosthesis
D6548 Retainer - Porcelain/Ceramic for Resin Bonded Fixed Prosthesis
D6549 Retainer - for Resin Bonded Fixed Prosthesis

A resin bonded fixed prosthesis used primarily to replace a single missing tooth in the anterior aspect of the mouth consisting of two metal retainers (abutments) and a pontic tooth that is permanently bonded to natural teeth. May be used to replace a single missing posterior tooth in certain cases. Pontic teeth are reported separately with appropriate code from the D62XX series.

Clinical Conditions ALLOWING Benefits:

D6545 - D6549 is Indicated:

a) For short span replacement of anterior teeth where ideally there is little to no centric contact and light functional contact.
b) For a single missing posterior tooth.
c) When abutment teeth are decay-free or have small composite restorations.

Clinical Conditions NOT ALLOWING Benefits:

D6545 - D6548 is not Indicated:

a) Where the abutment teeth are decayed or have been moderately to extensively restored, leaving insufficient enamel for bonding.
b) Where there is insufficient horizontal overlap or significant functional guidance which can cause de-bonding.
c) To replace multiple missing posterior teeth.
d) Where there is questionable endodontic status of the tooth, as demonstrated by evidence of unresolved periapical pathology that jeopardizes tooth retention, check history for dates of endodontic therapy (if endodontic therapy is within 6 months approve, if more than 6 months deny).
e) Where there is a compromised periodontal status, the tooth has lost more than 1/2 of its attachment unless there is a narrow three-walled defect amenable to bone regeneration or the patient has significant existing and unmet periodontal needs.
f) When the abutment teeth exhibit short clinical crowns.
g) If there is misalignment of abutment teeth.

Note:

Missing Tooth Limitation is NOT Applicable:

If a missing tooth limitation is not applicable, the teeth will automatically qualify for abutment replacement as the need for the bridge to replace the edentulous space defines the restorative need. Carefully assess the restorative status of the abutment teeth to determine the proper prosthesis that should be placed. If the abutment teeth are virgin teeth or have been minimally restored, a resin-retained bridge could be placed. Extensively restored or decayed abutment teeth offer a poor prognosis for a resin-retained bridge and may require full coverage with a crown.

Missing Tooth Limitation IS Applicable:
For abutment teeth where MISSING TOOTH LIMITATION can be applied, there would be no benefit since the abutment teeth for a resin-retained bridge should not be extensively restored. If extensive restorative treatment of the abutment teeth is indicated, a full coverage traditional bridge would offer a more predictable treatment.

Administrative Guidelines:

Documentation Required:

a) **Current full mouth radiographs or digital imaging (a panoramic radiograph with periapical radiographs or digital images of abutment teeth are an acceptable alternative).**
b) **A descriptive narrative (if necessary) to describe need and unusual circumstances.**
c) **Initial or prior placement dates.**

Payment Criteria

a) **Check history for prior periodontal treatment if periodontal status is questionable.**
b) **Frequency limitation is 5 years.**
c) **If the MISSING TOOTH LIMITATION applies, the removable partial denture is not covered unless the patient has a functioning, natural tooth removed after the initial coverage date. Check history for extraction in the same arch.**
d) **Temporary partial dentures (when covered) will be combined if submitted on the same claim with the permanent removable partial denture or paid and deducted later from the permanent removable partial denture.**
e) **Do not pay if the removable partial denture is beyond the 5 year frequency limitation and can be made serviceable.**
f) **Review for plan provisions:**
    1. **frequency limitations**
    2. **initial placement date(s)**
    3. **temporary services**

Section 8 – Oral Surgery

(Surgical Extractions, Impactions, Residual Tooth Roots)

Utilization Review Protocols and Guidelines – 8.1

PROCEDURE CODE: D7210

PROCEDURE DESCRIPTION: Surgical Removal of an ERUPTED Tooth - requiring elevation of mucoperiosteal flap and removal of bone and/or sectioning of the tooth.

This procedure includes cutting of gingiva and bone, removal of tooth structure and closure.

Clinical Conditions ALLOWING Benefits:

Surgical Removal of an Erupted Tooth is Indicated:

a) **In patients who exhibit especially dense bone.**
b) **For teeth which exhibit bulbous roots.**
c) **For multi-rooted teeth with widely divergent roots.**
d) **For teeth with severe dilacerations or hooks on roots.**
e) **For teeth which have lost most or all of the coronal tooth structure due to decay or fracture and are at or very close to the alveolar crest.**
f) **For teeth that are part of a fixed bridge where the bridge must be sectioned in order to remove the tooth.**

Clinical Conditions NOT ALLOWING Benefits:

Surgical Removal of an Erupted Tooth is not Indicated:

a) **In periodontally compromised teeth lacking sufficient bone support.**
b) **When none of the clinical indications allowing benefits (listed above) are present.**

Administrative Guidelines:

Documentation Required:

a) **A current periapical radiograph or digital image, or panoramic radiograph.**
b) **A descriptive narrative, if necessary.**

Payment Criteria

a) **D7210 is widely misreported where consultant reviews have shown the extractions to be routine. It is a rare situation where multiple teeth (other than third molars) require flap removal and sectioning to extract. Requests for 2 or more 7210's should be investigated, requesting a narrative in addition to the radiographs unless consultant review is conclusive and additional information is not necessary. When appropriate, recode to D7111/D7140.**
b) **Not allowed for periodontally compromised teeth. Teeth that are mobile due to moderate to severe bone loss are not considered surgical extractions. Recode to D7111/D7140.**
c) **Service is considered to include the excision of associated minor cystic or inflamed soft tissue, the sectioning of a bridge to facilitate tooth removal,**

sutures, suture removal and routine post-operative care.

Utilization Review Protocols and Guidelines – 8.2

PROCEDURE CODE: D7230

PROCEDURE DESCRIPTION: Removal of Impacted Tooth - Partial Bony

Part of the crown is covered by bone; requires mucoperiosteal flap elevation and bone removal.

Clinical Conditions ALLOWING Benefits:

Removal of a Partially Impacted Tooth is Indicated:

a) **A tooth that is covered by soft tissue superficially and part of the tooth's contour is below the level of the surrounding alveolar bone. To remove the tooth, the dentist must incise the soft tissue, reflect a soft tissue flap, and remove the bone above the height of the contour. In addition, the tooth may need to be sectioned.**

Administrative Guidelines:

Documentation Required:

a) **A current periapical or panoramic radiograph.**
b) **A descriptive narrative if any unusual circumstances are present.**

Payment Criteria

a) **Primarily for teeth numbers 1, 16, 17, 32. Also for other impacted teeth, including supernumerary teeth.**
b) **Service is considered to include the excision of associated minor cystic or inflamed soft tissue, sutures, suture removal and routine post-operative care.**

Bony Impaction Determination for Benefit Purposes

For a tooth that is vertically positioned:

a) **At or near the occlusal plane (below the CEJ of the adjacent tooth), evaluate whether it is a soft tissue impaction - no bone removal, or a partial bony impaction and pay accordingly.**
b) **If the tooth is not at or near the occlusal plane (below the CEJ of the adjacent tooth), use the 90/10 rule. If the crown of the tooth is 90% encased in bone, pay as a full bony impaction.**

For a tooth that is horizontally or angularly positioned:

a) **If less than 2/3 of the crown is encased in bone and more than 1/3 of the tooth is exposed, evaluate whether it is a soft tissue impaction (no bone removal) or a partial bony impaction and pay accordingly.**

b) If 2/3 or more of the crown is encased in bone and 1/3 of the tooth is exposed, pay as a full bony impaction.

Utilization Review Protocols and Guidelines – 8.3

PROCEDURE CODE: D7240/D7241

PROCEDURE DESCRIPTION: Removal of Impacted Tooth - Complete Bony

Most or all of the crown is covered by bone; requires mucoperiosteal flap elevation, bone removal and may require segmentation of the tooth.

Clinical Conditions
ALLOWING Benefits:

Removal of a Completely Impacted Tooth is Indicated:

a) **A tooth that is almost totally encased in bone to the point that, when the dentist reflects the soft tissue flap, minimal tooth is visible. To remove the tooth, the dentist must remove extensive amounts of bone and the tooth almost always needs to be sectioned.**
b) **Clinical pathology and/or symptoms are present.**

Administrative Guidelines:

Documentation Required:

a) **A current periapical or panoramic radiograph.**
b) **A descriptive narrative if any unusual circumstances are present (usually accompanied by code D7241).**

Payment Criteria

a) **Primarily for teeth numbers 1, 16, 17, 32. Also for other impacted teeth, including supernumerary teeth.**
b) **Service is considered to include the excision of associated minor cystic or inflamed soft tissue, sutures, suture removal and routine post-operative care.**

Bony Impaction Determination for Benefit Purposes

For a tooth that is vertically positioned:

a) **At or near the occlusal plane (below the CEJ of the adjacent tooth), evaluate whether it is a soft tissue impaction - no bone removal, or a partial bony impaction and pay accordingly.**
b) **If the tooth is not at or near the occlusal plane (below the CEJ of the adjacent tooth), use the 90/10 rule. If the crown of the tooth is 90% encased in bone, pay as a full bony impaction.**

For a tooth that is horizontally or angularly positioned:

a) **If less than 2/3 of the crown is encased in bone and more than 1/3 of the tooth is exposed, evaluate whether it is a soft tissue impaction (no bone removal) or a partial bony impaction and pay accordingly.**

b) If 2/3 or more of the crown is encased in bone and 1/3 of the tooth is exposed, pay as a full bony impaction.

Utilization Review Protocols and Guidelines – 8.4

PROCEDURE CODE: D7250

PROCEDURE DESCRIPTION: Removal of Residual Tooth Roots – (cutting procedure).

This procedure includes cutting of soft tissue and bone, removal of tooth structure and closure.

Clinical Conditions ALLOWING Benefits:

Removal of a Residual Tooth Root is Indicated:

a) **When tooth roots or fragments of tooth roots remain in the bone following a previous incomplete tooth extraction.**
b) **When tooth roots or fragments of tooth roots are completely buried and covered by bone.**

Clinical Conditions NOT ALLOWING Benefits:

Removal of a Residual Tooth Root is not Indicated:

a) **When a conservative non-surgical procedure is possible.**
b) **When any part of the tooth or residual root(s) are not completely buried in bone.**
c) **When the previously-stated 2 clinical criteria conditions are not met.**

Administrative Guidelines:

Documentation Required:

a) **A current periapical radiograph or digital image, or panoramic radiograph.**
b) **A descriptive narrative, if necessary.**

Payment Criteria

a) **D7250 is widely misreported where consultant reviews have shown the residual tooth root removal to be either a routine (D7140) or surgical extraction (D7210). When appropriate, recode to D7140 or D7210.**
b) **Not allowed for periodontally compromised teeth. Teeth that are mobile due to moderate to severe bone loss are not considered residual tooth root removal. Recode to D7140.**
c) **Service is considered to include mucogingival flap, cutting of bone and sectioning of tooth to facilitate tooth removal, sutures, suture removal and routine post-operative care.**

Section 9 – General Anesthesia and Sedation

(Deep Sedation/ General Anesthesia)

Utilization Review Protocols and Guidelines – 9.1

PROCEDURE CODE: D9222, D9223

PROCEDURE DESCRIPTION:
D9222 Deep Sedation/General Anesthesia (first 15 minutes) – 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.
D9223 Deep Sedation/General Anesthesia (each add. 15 min.)

Clinical Conditions
ALLOWING Benefits: **Deep Sedation/<u>General Anesthesia is Covered for:</u>**

a) Medical Necessity

Determining necessity requires judgment by the treating dentist as to the patient's physical condition. Aspects of the patient's medical history that would have a direct impact on either patient health and safety or clinical outcomes should be considered in establishing medical necessity. Examples include: mental retardation; Alzheimer's Disease; spastic muscle disorders; heart disease; local anesthesia intolerance; acute infection at the surgical site; uncontrolled diabetes; renal failure; patient non-compliance due to age (usually 2 - 4 years of age); or, any other condition that would make use of general anesthesia medically necessary for minimizing the risk to the patient for any surgical procedure.

b) Dental Necessity

The removal of two partially or fully impacted mandibular teeth (bilaterally) or three or more partially or fully impacted teeth in any locations constitute dental necessity and allowance for general anesthesia coverage.

c) Medical Risk

Extensiveness of the procedure is defined in the context of what critical physical structures in the surgical field are in danger by the procedure. An impacted cuspid removal endangering the orbit or an impacted third molar endangering the sinus meets the criteria; the removal of impacted teeth from within the tuberosity or retromolar area would not meet the criteria.

Clinical Conditions
NOT ALLOWING Benefits: **<u>General Anesthesia is NOT Covered</u>**

a) To strictly allay patient anxiety.
b) When performed for the convenience of the dentist or because the procedure is long and tedious.
c) When performed strictly because the treatment is to be rendered in a hospital or similar setting.
d) When the patient is deemed psychologically unfit in the absence of a pyschiatric consult to support that contention.
e) When treatment performed is deemed procedurally difficult in the absence of meeting medical necessity or medical risk criteria.

Administrative Guidelines:

Documentation Required:

a) **A descriptive narrative demonstrating medical necessity or medical risk of the procedure.**

Payment Criteria

a) **It is not generally necessary to require additional supportive documentation from an oral surgeon since they are well trained in the clinical assessment of meeting medical necessity or medical risk criteria. If there is a question as to whether clinical indications are met, supportive documentation of the physical diagnosis from an attending physician or other appropriately qualified health care provider may be needed to confirm medical necessity or medical risk.**
b) **Benefit coverage is very plan specific.**
c) **Check for coverage under medical plan.**

Section 10 – Consultation

(Consultation by Provider Other Than Requesting Provider)

Utilization Review Protocols and Guidelines – 10.1

PROCEDURE CODE: D9310

PROCEDURE DESCRIPTION: Consultation

Consultation is a diagnostic service provided by a dentist or physician other than the requesting dentist or physician.

Clinical Conditions ALLOWING Benefits:

Consultation:

a) **May be for the purpose of providing the patient a second opinion.**
b) **Generally is requested by the treating dentist of record to obtain an additional diagnostic opinion.**

Clinical Conditions NOT ALLOWING Benefits:

Consultation is Not Allowed by the Treating Dentist for:

a) **Case presentation purposes.**
b) **Treatment plan consultation.**
c) **Evaluation of therapy/treatment rendered.**

Administrative Guidelines:

Documentation Required: **Not Applicable**

Payment Criteria

a) **Performed by the non-referring dentist or physician only, not allowed if reported with non-diagnostic or non-therapeutic treatment on the same date of service by the same dentist.**
b) **Consultation may be performed by any specialist or by another general provider who limits the practice to treating a particular condition or who is rendering a second opinion.**
c) **Consultation includes an oral evaluation.**
d) **The consulted practitioner may initiate diagnostic and/or therapeutic services.**