Appendix D – Dental Utilization Review Criteria Guidelines
Dental Utilization Review Criteria Guidelines, 2017

Introduction

The following criteria will help to standardize the provider’s and consultant’s exercise of professional judgment. If the clinical condition of the patient reflects the criteria required by and such information is fully documented by the provider, the consultant may grant approval if in his/her professional judgment the service request is reasonable and consistent with the dental needs of the patient and conforms to the intent of the program.

Without sufficient acceptable diagnostic information, the consultant has no option but to deny approval or defer a decision. The necessity for the consultant to obtain adequate information and, thereby, to make a judgment on dental necessity is an integral part of the prior authorization and payment process.

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<td>D0160</td>
<td>DETAILED AND EXTENSIVE ORAL EVALUATION - PROBLEM FOCUSED, BY REPORT</td>
<td>A detailed and extensive problem focused evaluation entails extensive diagnostic and cognitive modalities based on the findings of a comprehensive oral evaluation. Integration of more extensive diagnostic modalities to develop a treatment plan for a specific problem is required. The condition requiring this type of evaluation should be described and documented. Examples of conditions requiring this type of evaluation may include dento-facial anomalies, complicated perio-prosthetic conditions, complex temporo-mandibular dysfunction, facial pain of unknown origin, conditions requiring multi-disciplinary consultation, etc. A benefit once per patient per provider. The following procedures are not a benefit when provided on the same date of service with D0160: a. periodic oral evaluation (D0120), b. limited oral evaluation-problem focused (D0140), c. comprehensive oral evaluation- new or established patient (D0150), d. re-evaluation-limited, problem focused (established patient; not post-operative visit) (D0170), e. office visit for observation (during regularly scheduled hours-no other services performed (D9430). f. Consultation-diagnostic service provided by dentist or physician other than requesting dentist or physician (Dental.</td>
<td>1. Written documentation for payment-shall include documentation of findings that supports the existence of one of the following: a. dento-facial anomalies, b. complicated perio-prosthetic conditions, c. complex temporo-mandibular dysfunction, d. facial pain of unknown origin, e. severe systemic diseases requiring multi-disciplinary consultation. Plans generally include an age restriction: extensive oral evaluation cannot be adequately completed on a patient under the age of 3. D0145 is used for reimbursement purposes. A comprehensive oral evaluation- new or established patient (D0150), detailed and extensive oral evaluation (D0160), or comprehensive periodontal evaluation (D0180) is allowed for the same patient and by the same dentist at a subsequent date, after the patient reaches three years of age. DHCF agrees with the age limit and dental provider may bill twice per year per same provider.</td>
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| D0364 | CONE BEAM CT CAPTURE AND INTERPRETATION WITH LIMITED FIELD OF VIEW- LESS THAN ONE WHOLE JAW | Cone Beam CT is covered for the following indications: 1. Evaluation prior to one of the following oral surgery indications:  
A. Removal of maxillo-facial tumor, cyst, neoplasm or other pathologic entities that, due to their size and/or anatomic location, appear to encroach, impinge or are invested in/on critical anatomic structures (i.e., inferior alveolar nerve, maxillary sinus);  
B. Arthroplasty of Temporomandibular (TM) fossae or condyle, TM joint replacement;  
C. Developmental mid-face syndromes such as cleft palate, Treacher-Collins syndromes, etc.;  
D. Surgical reconstruction of severe oral-facial trauma (such as those resulting from motor vehicle accidents, gunshot wounds, boating accidents or other disfiguring trauma).  
**In addition, when Cone Beam CT is requested prior to an oral surgery (a-d above), one of the following criteria must also be satisfied:**  
E. The panoramic radiograph indicates that a deviation from a routine surgical approach is probable and further data necessary to plan such an approach;  
-OR-  
F. Information obtained by a CB/CT Scan is considered critical in determining a surgical plan for the avoidance of disruption, invasion, or fracture of a surrounding critical oral-facial structure. | Written documentation for prior authorization which includes rationale for request and 
A. The panoramic radiograph indicates that a deviation from a routine surgical approach is probable and further data necessary to plan such an approach;  
-OR-  
B. Information obtained by a CB/CT Scan is considered critical in determining a surgical plan for the avoidance of disruption, invasion, or fracture of a surrounding critical oral-facial structure. | Cone Beam CT refers to a tomographic imaging beam that is concentrated to a narrow field of the body, as in the case of dental views. Multi-dimensional images of the hard tissue of the jaw are created to assist the dentist in diagnosis and treatment planning for the patient. Cone beam CT provides an image of hard tissue that has no distortion and is anatomically correct. Views may include cross-sectional axial, coronal, sagittal, cephalometric, or panoramic. Indications that are not covered (list may not be all inclusive) 1. Cone beam CT is not covered when used in conjunction with non-covered dental procedures. 2. Cone beam CT is not covered for other medically-related dental indications not listed as covered. |
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<td>or fracture of a surrounding critical oral-facial structure.</td>
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<td>2. Evaluation prior to orthognathic surgery when coverage criteria under the orthognathic surgery coverage policy are met AND information obtained by a CB/CT Scan is considered critical in determining surgical plan for the avoidance of disruption, invasion or fracture of a surrounding critical oral-facial structure.</td>
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<td>D0365</td>
<td>CONE BEAM CT CAPTURE AND INTERPRETATION WITH FIELD OF VIEW OF ONE FULL DENTAL ARCH - MANDIBLE</td>
<td>See D0364</td>
<td>• Written documentation for prior authorization which includes rationale for request</td>
<td>See D0364</td>
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<td>D0366</td>
<td>CONE BEAM CT CAPTURE AND INTERPRETATION WITH FIELD OF VIEW ONE FULL DENTAL ARCH – MAXILLA, WITH OR WITHOUT CRANIUM</td>
<td>See D0364</td>
<td>• Written documentation for prior authorization which includes rationale for request</td>
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<td>D0367</td>
<td>CONE BEAM CT CAPTURE WITH INTERPRETATION WITH FIELD OF VIEW OF BOTH JAWS, WITH OR WITHOUT CRANIUM</td>
<td>See D0364</td>
<td>• Written documentation for prior authorization which includes rationale for request</td>
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<td>D0470</td>
<td>STUDY MODELS/ DIAGNOSTIC CASTS</td>
<td>Also known as diagnostic models or study models. Benefits are available for diagnostic casts when taken as an initial diagnostic aid in determining a patient’s total treatment plan. Diagnostic casts are for the evaluation of orthodontic benefits only. A benefit: a. once per provider unless special circumstances are documented (such as trauma or pathology which has affected the course of orthodontic treatment). b. for patients under the age of 21.</td>
<td>1. Diagnostic casts are required to be submitted for orthodontic evaluation and are payable only upon authorized orthodontic treatment. Do not send original casts, as casts will not be returned. 2. Diagnostic casts shall be free of voids and be properly trimmed with centric occlusion clearly marked on the casts. 3. Photographs submission via the Qualis Health Provider Portal is preferred.</td>
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<td>There are other situations for which study models/diagnostic cases are needed: D8080 (adolescent orthodontia) D8090 (adult orthodontia) and D8999 (unspecified orthodontia) procedures by report may require study models. Root canal therapy (D3310-D3348) guidelines state: 2. Periapical preoperative diagnostic radiographs of the involved tooth (teeth), additionally sufficient radiographs or other diagnostic material to establish the integrity of the remaining teeth and arches are</td>
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|       |                                          | c. for permanent dentition (unless over the age of 13 with primary teeth still present or has a cleft palate or craniofacial anomaly).  
  **Limitation:**  
  Fees for working models, such as those utilized for preparation of crowns, bridges, periodontal surgical stents, occlusal guards, nightguards etc. are not considered diagnostic in nature and are included in the fees for those procedures. The patient cannot be billed separately for such working models. If definitive prosthetic treatment (crown, bridge, dentures) is completed within 12 months after date of service of diagnostic casts, the fee for diagnostic casts will be deducted from the definitive treatment fee.  
  **Rationale:**  
  Diagnostic models are considered part of the overall treatment rendered.  
  Oral Surgery (D7140-D7960) guidelines state:  
  "For Procedure D7320 (alveoloplasty on an edentulous quadrant.) If radiographs are not sufficient to justify a need, (i.e., for soft tissue procedures) additional diagnostic material (photographs or models) and/or a statement of justification must be presented."  
  **Bridges are a non-covered benefit without prior authorization from DHCF.**                                                                 | 1. Tooth number, pre-operative periapical x-ray and narrative  
  2. Radiographs for payment - submit a pre-operative periapical radiograph.  
  3. Written documentation for payment - shall include a description of the circumstances leading to the traumatic injury.  
  4. Requires a tooth number.                                                                 | required for prior authorization of permanent root canal therapy or retreatment of a previous root canal.                                                                                                                                                                                                                                         |
| D2970 | TEMPORARY CROWN (FRACTURED TOOTH)        | Usually a preformed artificial crown, which is fitted over a damaged tooth as an immediate protective device. This is not to be used as temporization during crown fabrication. A provisional crown billed as a therapeutic measure for a fractured tooth may be allowed, subject to individual consideration.  
  A benefit:  
  a. once per tooth, per provider.  
  b. for permanent teeth only.  
  Not a benefit on the same date of service as:  
  a. palliative (emergency) treatment of dental pain- minor procedure (D9110).  
  b. office visit for observation (during regularly scheduled hours) - no other services performed (D9430).  
  This procedure is limited to the palliative treatment of traumatic injury only and shall meet the criteria for a laboratory processed crown (D2710-D2792). | 1. Tooth number, pre-operative periapical x-ray and narrative  
  2. Radiographs for payment - submit a pre-operative periapical radiograph.  
  3. Written documentation for payment - shall include a description of the circumstances leading to the traumatic injury.  
  4. Requires a tooth number.                                                                 | Comment on D9110:  
  If a tooth has been fractured to involve and/or expose the pulpal tissue (by carious lesion and/or extent of fracture, a pulpectomy (sometimes referred to as "open and broach" which is typically billed out as D9110) is indicated and a provisional or temporary restoration must be placed. In some cases, depending on the extent of the destruction of clinical crown, the only possible restoration is a temporary crown.                                                                                                                                 |
|       |                                          |                                                                                                                                                                                                                                                                                                                                                       |                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                   |
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<td>Rationale: Temporary crowns are used after a tooth is prepped and while awaiting the placement of the permanent crown. They are considered part of the procedure for the permanent crown and the charge is included in the fee for the permanent crown. A separate charge for a temporary crown is not allowed</td>
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**ENDODONTICS (PROCEDURES D3110-D3450)**

**General Policies, Procedures D3110-D3450:**

1. Includes those procedures which provide complete root canal filling on permanent teeth and pulpotomies (pulpectomies) on both deciduous and permanent teeth. Root canal therapy is covered if dentally necessary. It is dentally necessary when pathology is present, when the tooth is nonvital or the pulp has been compromised by caries, trauma, or accident which may lead to the death of the pulp, and the criteria set forth in this manual.

2. The prognosis of the affected tooth, other remaining teeth, and the type of final restoration allowable will be evaluated in considering root canal therapy.

3. Authorization and payment for root canal treatment includes, but is not limited to, any of all of the following procedures:
   a. Any incision and drainage or open and medicating procedure necessary in relation to the root canal therapy.
   b. Vitality test.
   c. Radiographs required during treatment including final treatment radiographs.
   d. Culture.
   e. Medicated treatment.
   f. Final filling of canal(s).
   g. Final treatment radiographs(s).

4. The initial opening into the canal, sealing of the access opening, all treatment visits and routine post-operative visits are included in the fee for the completed endodontic treatment.

5. Necessary postoperative care within a ninety (90)-day period is included in the reimbursement fee.

6. Necessary retreatment within a two (2)-year period is included in the fee for completed endodontic treatment. The time limitation does not apply when the re-treatment procedure is performed by a different provider/office.

7. Root canal therapy is not a benefit when extraction is appropriate for a tooth with a fractured root, external or internal resorption, or one that is easily replaced by addition to an existing removable dental appliance.

8. Root canal treatment must be completed prior to payment.

9. The date of service on the payment request should reflect the final treatment date.

10. Cement bases, and insulating liners are considered part of restorations and are included in the fee for the completed restoration(s).

11. Permanent restoration for an endodontically treated tooth is a benefit when the coverage criteria specified in this manual for the particular restoration are met.

12. A non-resorbable filling material and a resorbable paste or cement should be used (silver points are not acceptable).

13. Films taken as part of the root canal therapy are part of and included in the fee for the completed endodontic therapy.
ROOT CANAL THERAPY (D3310-D3348)

**General Policies, Procedures D3310-D3348:**
1. Root canal treatment procedures D3310 (anterior), D3320 (bicuspid), and D3330 (molar), or retreatment procedures D3346 (anterior), D3347 (bicuspid), and D3348 (molar), are benefits with prior authorization for any permanent tooth and subject to criteria for coverage set forth in this manual.
2. Periapical preoperative diagnostic radiographs of the involved tooth (teeth), additionally sufficient radiographs or other diagnostic material to establish the integrity of the remaining teeth and arches are required for prior authorization of permanent root canal therapy or retreatment of a previous root canal.
3. Root canal therapy is a benefit for permanent teeth when dentally necessary and the final post-treatment restoration of the treated tooth will afford acceptable retention longevity; and:
   a. Missing teeth do not jeopardize the integrity or masticatory function of the dental arches; and
   b. The tooth is necessary to maintain adequate masticatory function; and
   c. Periodontal condition of the tooth and the remaining teeth must be no more involved than Periodontal Case Types II and III, as defined in General Policies - Periodontics procedures D4210 (Gingivectomy or Gingivoplasty) and D4920 (unscheduled dressing change).
4. Root canal therapy may be performed as an emergency service, without prior authorization, under the following conditions, which must be justified by documentation:
   a. Fracture of a coronal portion of a permanent tooth, exposing the vital pulpal tissue.
   b. When a tooth has been accidentally evulsed, the root canal may be performed prior to replacement of the tooth in the socket. These two (2) emergency situations must meet the arch integrity, tooth longevity, and all other criteria listed must be met.
   c. Payment of a root canal performed on an emergency basis is subject to review of documentation describing the emergency and pre-operative x-rays.
5. All endodontic treatment procedures include the removal of posts, silver point and previous root canal filling material, and any procedures necessary to prepare the canals for placement of the canal filling.
6. Films taken as part of the root canal therapy are part of and included in the reimbursement for the root canal therapy.

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### ENDODONTIC RETREATMENT

This procedure may include the removal of a post, pin(s), old root canal filling material, and the procedures necessary to prepare the canals and place the canal filling. This includes complete root canal therapy. A request for endodontic re-treatment must meet **at least one** of the following criteria:

- Apical pathology or a draining fistula.
- Lingering pain from percussion or temperature.
- Teeth must exhibit a minimum of 50% bone support

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| D3346 | RETREATMENT OF PREVIOUS ROOT CANAL - ANTERIOR | An allowance for retreatment will be made when a root canal previously completed by another dentist has failed and retreatment is indicated. Retreatment within 24 months by the same dentist must be reviewed by the Dental Consultant. | 1. Radiographs for prior authorization - submit arch and periapical radiographs demonstrating the medical necessity for retreatment.  
2. Written documentation for prior authorization - if the medical necessity is not evident on the radiographs, documentation shall include the rationale for retreatment.  
3. Requires a tooth number. | |
| D3347 | RETREATMENT OF PREVIOUS ROOT CANAL THERAPY - BICUSPID | | 1. Radiographs for prior authorization - submit arch and periapical radiographs demonstrating the medical necessity for retreatment.  
2. Written documentation for prior authorization - if the medical necessity is not evident on the radiographs, documentation shall include the rationale for retreatment.  
3. Requires a tooth number. | |
| D3348 | RETREATMENT OF PREVIOUS ROOT CANAL - MOLAR | | 1. Radiographs for prior authorization - submit arch and periapical radiographs demonstrating the medical necessity for retreatment.  
2. Written documentation for prior authorization - if the medical necessity is not evident on the radiographs, documentation shall include the rationale for retreatment.  
3. Requires a tooth number. | |
APEXIFICATION/ RECALCIFICATION PROCEDURES (D3351-D3353)

General Policies, Procedures D3351-D3353:

1. Apexification/Apexogenesis is defined as a technique for encouraging continued root formation and apical closure in teeth with incomplete apical development when the pulp is affected by trauma or caries.

2. Final obliteration of the root canal(s) may be accomplished when a radiograph indicates sufficient apical formation. The criteria for authorizing root canal treatment also apply to apexification and must be present prior to the initial pulpotomy treatment.

3. Not payable when procedure D3351 (apexification/recalcification, pulpal regeneration – initial visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.), D3352 (apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.), or D3353 (apexification/recalcification, final visit), and a completed root canal treatment are performed on the same tooth on the same day.

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<td>D3351</td>
<td>APEXIFICATION/ RECALCIFICATION/ PULPAL REGENERATION - INITIAL VISIT</td>
<td>Includes opening tooth, preparation of canal spaces, first placement of medication and necessary radiographs. (This procedure may include first phase of complete root canal therapy). A benefit: a. once per permanent tooth. b. for patients under the age of 21. Not a benefit: a. for primary teeth. b. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests. c. on the same date of service as any other endodontic procedures for the same tooth. This procedure includes initial opening of the tooth, performing a pulpectomy, preparation of canal spaces, lacement of medications and all treatment and post treatment radiographs.</td>
<td>1. Radiographs for prior authorization – submit periapical radiographs. 2. Requires a tooth number. 3. If an interim medication replacement is necessary, use apexification/ recalcification- interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.) (D3352). 4. Upon completion of apexification/ recalcification, prior authorization for the final root canal therapy shall be submitted along with the post-treatment radiograph to demonstrate sufficient apical formation.</td>
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## APICOECTOMY/PERIRADICULAR SERVICES (D3410-D3432)

### General Policies, Procedures D3410-D3430:
1. Apicoectomy/Periradicular Services, procedures D3410, D3421 and D3425, and D3427-D3432 require prior authorization.
2. Apicoectomy/Periradicular surgery, procedures D3410, D3421 and D3425, are defined as the excision of the apical portion of the root of a previously endodontically treated tooth to remove the diseased tissue.
3. These procedures may be indicated when an abnormality or blockage of the root end prevents the cleaning and sealing of the apical portion of a root canal through a coronal approach and the tooth remains symptomatic. They may also be indicated if the tooth is asymptomatic as clinically indicated. This occurs most commonly when there is severe apical curvature, blockage of the canal by calcific deposits, dentinal shavings or pulp chamber debris, or when a canal wall has been perforated or “shelved” during canal enlargement.
4. Procedure D3426 (apicoectomy/each additional root) is payable to a maximum of three (3) roots per tooth.
5. Not a benefit in conjunction with root canal therapy.

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<td>D3426</td>
<td>APICOECTOMY/ (EACH ADDITIONAL ROOT)</td>
<td>Typically used for bicuspids and molar surgeries when more than one root is treated during the same procedure. This does not include retrograde filling material placement. A benefit for permanent teeth only. Not a benefit: a. to the original provider within 90 days of root canal therapy except when a medical necessity is documented. b. to the original provider within 24 months of a prior apicoectomy/ periradicular surgery, same root. c. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests. Only payable the same date of service as procedures D3421 or D3425. The fee for this procedure includes the placement of retrograde filling material and all treatment and post treatment radiographs.</td>
<td>1. Radiographs for prior authorization - submit arch and periapical radiographs demonstrating the medical necessity. 2. Written documentation for prior authorization - if the medical necessity is not evident on the radiographs, documentation shall include the rationale and the identity of the root that requires treatment. 3. Requires a tooth number.</td>
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<td>D3427</td>
<td>PERIRADICULAR SURGERY WITHOUT APICOECTOMY</td>
<td>Typically used for bicuspid and molar surgeries when more than one root is treated during the same procedure. This does not include retrograde filling material placement.</td>
<td>1. Radiographs for prior authorization - submit arch and periapical radiographs demonstrating the medical necessity.</td>
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<td>A benefit for permanent teeth only.</td>
<td>2. Written documentation for prior authorization - if the medical necessity is not evident on the radiographs, documentation shall include the rationale and the identity of the root that requires treatment.</td>
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<td>Not a benefit:</td>
<td>3. Requires a tooth number.</td>
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<td>a. to the original provider within 90 days of root canal therapy except when a medical necessity is documented.</td>
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<td>b. to the original provider within 24 months of a prior Apicoectomy/Periradicular surgery, same root.</td>
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<td>c. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.</td>
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<td>Only payable the same date of service as procedures D3421 or D3425.</td>
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<td>The fee for this procedure includes the placement of retrograde filling material and all treatment and post treatment radiographs.</td>
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<td>D3428</td>
<td>BONE GRAFT IN CONJUNCTION WITH PERIRADICULAR SURGERY- PER TOOTH, SINGLE SITE</td>
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<td>1. Radiographs for prior authorization - submit arch and periapical radiographs demonstrating the medical necessity.</td>
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<td>2. Written documentation for prior authorization - if the medical necessity is not evident on the radiographs, documentation shall include the rationale and the identity of the root that requires treatment.</td>
<td>2. Requires a tooth number.</td>
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<td>3. Requires a tooth number.</td>
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<td>D3429</td>
<td>BONE GRAFT IN CONJUNCTION WITH PERIRADICULAR SURGERY-EACH ADDITIONAL CONTIGUOUS TOOTH IN THE SAME SURGICAL SITE</td>
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<td>1. Radiographs for prior authorization - submit arch and periapical radiographs demonstrating the medical necessity.</td>
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<td>2. Written documentation for prior authorization - if the medical necessity is not evident on the radiographs, documentation shall include the rationale and the identity of the root that requires treatment.</td>
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<td>3. Requires a tooth number.</td>
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<td>D3432</td>
<td>GUIDED TISSUE REGENERATION, RESORBABLE BARRIER, PER SITE, IN CONJUNCTION WITH PERIRADICULAR SURGERY</td>
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<td>1. Radiographs for prior authorization - submit arch and periapical radiographs demonstrating the medical necessity.</td>
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<td>2. Written documentation for prior authorization - if the medical necessity is not evident on the radiographs, documentation shall include the rationale and the identity of the root that requires treatment.</td>
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<td>3. Requires a tooth number.</td>
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Radiographs must be less than one (1) year old and of diagnostic quality, showing the entire treatment site.

**Required Periodontal Charting:**
- Must be dated within 1 year of request and include the patient’s full name.
- Currrent periodontal charting taken (no more than 12 months old) w/4-6 probing depths per tooth

General policy for all periodontal surgical procedures - Periodontal surgical procedures include all necessary postoperative care, finishing procedures, evaluations for three months, as well as any surgical reentry, except soft tissue grafts, for 24-36 months depending on the procedure. When a surgical procedure is billed within three months of the initial surgical procedure by the same dentist/dental office, the fee for the surgery is DISALLOWED. In the absence of documentation of extraordinary circumstances, the fee for additional surgery by the same dentist/dental office for 24 months is DISALLOWED.

Periodontal procedures shall be a benefit for patients age 13 or older. Periodontal procedures shall be considered for patients under the age of 13 when unusual circumstances exist such as aggressive periodontitis and drug-induced hyperplasia and the medical necessity has been fully documented.

Current periapical radiographs of the involved areas and arch radiographs are required for periodontal scaling and root planing (D4341 and D4342) and osseous surgery (D4260 and D4261) for prior authorizations. A panoramic film alone is non-diagnostic for periodontal procedures.

**Gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261)** are a benefit once per quadrant in a 36 month period and shall not be authorized until 30 days following scaling and root planing (D4341 and D4342) in the same quadrant. Patients shall exhibit a minimum of one 5mm+ pocket and radiographic evidence of moderate to severe bone loss to qualify for osseous surgery.

**Scaling and root planing (D4341 and D4342)** can be authorized in conjunction with prophylaxis procedures (D1110 and D1120). However, payment shall not be made for any prophylaxis procedure if the prophylaxis is performed on the same date of service as the scaling and root planing. **NOTE: D4342 does not require Prior Authorization.**

**Gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261)** includes frenulectomy (frenectomy or frenotomy) (D7960), frenuloplasty (D7963) and/or distal wedge performed in the same area on the same date of service.

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<td>D4210</td>
<td>GINGIVECTOMY OR GINGIVOPLASTY-FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT</td>
<td>It is performed to eliminate supra-bony pockets or to restore normal architecture when gingival enlargements or asymmetrical or unaesthetic topography is evident with normal bony configuration. Count tooth bounded spaces for pocket reduction surgery that includes a flap procedure (D4240, D4260). Do not count tooth bounded spaces for D4210, D4341; count only “diseased teeth/periodontium.” A tooth bounded space is the edentulous area bounded by two qualifying teeth. A tooth bounded space counts as one space irrespective of the number of teeth that would normally exist in the space. A benefit: a. for patients age 13 or older except in unusual circumstances b. once per quadrant every 36 months.</td>
<td>1. Quadrant or tooth numbers, current periodontal charting (no more than 12 months old) w/4-6 probing depths per tooth or narrative describing condition of the tissue 2. Photographs for prior authorization - submit photographs of the involved areas. 3. Written documentation for prior authorization – shall include a definitive periodontal diagnosis. 4. A current and complete periodontal evaluation chart is required for prior authorization except in cases of pseudo-pockets as a result of gingival hyperplasia, which is demonstrated on a photograph. 5. Requires a quadrant code.</td>
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### GINGIVECTOMY OR GINGIVOPLASTY (D4210-D4211)

**General Policies, Procedures D4210-D4211:**
1. Gingivectomy or gingivoplasty procedures D4210 and D4211, are benefits in the treatment of moderate to deep gingival pockets (4-5 mm), moderate to severe bone loss, and include the removal of the soft tissue side of the pocket, eliminating the pocket, and creating a new gingival contour.

2. The quadrant shall be indicated on the request for payment.

3. Procedures D4210/D4211 (gingivectomy or gingivoplasty) may be allowable when an isolated pocket(s) has not responded to conservative treatment.
   a. Any combinations of gingivectomy or gingivoplasty (procedures D4210 or D4211), gingival flap procedures including root planing (procedures D4240/D4241) or osseous surgery (procedure D4260/D4261) are benefits once in thirty-six (36) months in the same quadrant.
   b. This procedure requires periodontal charting of the patient’s entire dentition.

4. Procedures D4210/D4211 (gingivectomy or gingivoplasty) may be allowable where a drug-induced hyperplasia is exacerbated in isolated areas.

5. These surgical procedures are directed at correction of the soft tissue around the tooth. Gingivectomy is the excision of the soft tissue wall of the periodontal pocket when the pocket is uncomplicated by extension into the underlying bone. Gingivoplasty is the procedure by which gingival deformities (particularly enlargements) are reshaped and reduced to create normal and functional form.

6. When muco-gingival procedures and osseous surgery are performed in the same quadrant and in the same treatment episode, the procedure code for the most inclusive procedure is appropriate for the quadrant.

### PERIODONTICS (PROCEDURES D4210-D4920)

**General Policies, Periodontal Procedures D4210-4920:**
1. Periodontal Definitions.
   a. Type I-Gingivitis; inflammation of the gingiva, characterized clinically by gingival hyperplasia, edema, retractability, gingival pocket formation, pocket depth less than 4mm and no bone loss.
   b. Type II-Early periodontitis; progression of gingival inflammation into the alveolar bone crest and early bone loss resulting in moderate pocket formation (4-6mm).
   c. Type III- Moderate periodontitis; a more advanced state with increased destruction of periodontal structures associated with moderate-to-deep pockets (5-8mm), moderate-to-severe bone loss and tooth mobility.
   d. Type IV-Advanced periodontitis; further progression of periodontitis with severe destruction of the periodontal structures with increased pocket depth, usually greater than 7-8mm with increased tooth mobility.
   e. Type V-Re refractory periodontitis; continues demonstration of numerous sites of periodontitis where loss of attachment is progressing, even after traditional therapy has been completed and good home care is evident.

2. Periodontal care shall be limited to those patients:
   a. Who exhibit generalized periodontal pocket depths in excess of 4-5 mm.
   b. Who have a minimum of one isolated pocket 5 mm or greater in depth per quadrant, and
   c. Where the isolated pockets of 5 mm or greater in depth have failed to respond to conservative treatment, including emergency treatment of periodontal abscesses.

3. Subgingival curettage, in the generally accepted sense, is a surgical service involving removal of the epithelial lining, granulation tissue, and other pocket contents, and includes the planing of the root surface to remove deposits and smoothing of the root surfaces. It is performed for patients with generalized pocket depths within the range of more than 4-5 mm and a minimum of one isolated pocket over 5 mm in depth per quadrant. This procedure is usually performed with local anesthesia.

4. Periodontal services shall be approved on an ordered schedule initially encompassing only the direct, least invasive measures.

5. In order to make a fair evaluation of prior authorization requests for periodontal procedures the following information shall be included with the request:
   a. Diagnostic radiographs dated within 1 year of the request.
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<td>D4211</td>
<td>GINGIVECTOMY OR GINGIVOPLASTY - ONE TO THREE CONTIGUOUS TEETH, OR TOOTH BOUNDED SPACES PER QUADRANT</td>
<td>It is performed to eliminate supra-bony pockets or to restore normal architecture when gingival enlargements or asymmetrical or unaesthetic topography is evident with normal bony configuration. Crown lengthening involving soft tissue only is appropriately coded as D4211. A benefit:</td>
<td>1. Quadrant or tooth numbers, current periodontal charting (no more than 12 months old) w/4-6 probing depths per tooth or narrative describing condition of the tissue</td>
<td>Consider granting benefit exceptions for individuals &lt;age 13 in exceptional circumstances as concomitant medical conditions and/or wholesale neglect of dental care.</td>
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<td>when gingival enlargements or asymmetrical or unaesthetic topography is evident with normal bony configuration. Crown lengthening involving soft tissue only is appropriately coded as D4211. A benefit:</td>
<td>2. Photographs for prior authorization– submit photographs of the involved areas.</td>
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<td>a. for patients age 13 or older.</td>
<td>3. Written documentation for prior authorization – shall include a definitive periodontal diagnosis.</td>
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<td>b. once per quadrant every 36 months.</td>
<td>4. A current and complete periodontal evaluation chart is required for prior authorization except in cases of pseudo-pockets as a result of gingival hyperplasia, which is demonstrated on a photograph.</td>
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<td>This procedure cannot be prior authorized within 30 days following periodontal scaling and root planning (D4341 and D4342) for the same quadrant.</td>
<td>5. Requires a quadrant code.</td>
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<td>6. If four or more diseased teeth are present in the quadrant, use gingivectomy or gingivoplasty (D4210).</td>
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### General Policies, Procedures D4260-D4261:
1. Osseous Surgery procedures D4260 and D4261, require prior authorization, the following information shall be included with the Prior Authorization Request:
   a. Diagnostic radiographs.
   b. Periodontal charting of pocket depths, bone loss, furcation involvement, bleeding on probing and mobility of all teeth, in addition charting of missing teeth and teeth treatment planned for extraction.
2. A benefit for the surgical eradication of intrabony pockets and sufficient bone contouring to achieve adequate gingival architecture.
3. The quadrant shall be indicated on the Prior Authorization Request.
4. Scaling and root planing procedures D4341/D4342 performed in the same quadrant as osseous surgery must precede the surgery by at least four (4) weeks. When the interval between the procedures is less than four (4) weeks, the scaling and root planing is considered to be included in the fee for the surgery.
5. This procedure requires periodontal charting of the patient’s entire dentition following a minimum evaluation period of four (4) to eight (8) weeks post-operative to scaling and root planing procedures D4341/D4342. NOTE: D4342 does not require prior Authorization.
6. Any combinations of gingivectomy or gingivoplasty (procedures D4210 or D4211), gingival flap procedures including root planing (procedures D4240/D4241) or osseous surgery (procedure D4260/D4261) are benefits once in thirty-six (36) months in the same quadrant.
7. The fee for osseous surgery is considered to include osseous contouring; distal or proximal wedge surgery, frenectomy, scaling and root planing, soft tissue grafts, gingivectomy, and flap procedures. If there is a combination of procedures in one (1) quadrant then the most inclusive procedure applies.

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| D4263 | BONE REPLACEMENT GRAFT FIRST SITE IN QUADRANT    | This procedure involves the use of osseous auto grafts, 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. Other separate procedures may be required concurrent to D4263 and should be reported using their own unique codes. | a. Diagnostic radiographs.  
b. Quadrant or tooth numbers, current periodontal charting (no more than 12 months old) charting of pocket depths, bone loss, furcation involvement. |----------|
| D4264 | BONE REPLACEMENT GRAFT EACH ADDITIONAL SITE IN QUADRANT | This procedure involves the use of osseous autografts, 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. This code is used if performed concurrently with D4263 and allows reporting of the exact number of sites involved. | a. Diagnostic radiographs.  
b. Quadrant or tooth numbers, current periodontal charting (no more than 12 months old) charting of pocket depths, bone loss, furcation involvement. |----------|
### PERIODONTAL SCALING AND ROOT PLANING (D4341-D4342)

**General Policies, Procedures D4341-D4342:** Please refer to Transmittal 10-26 for exception for the special needs population.

1. Periodontal scaling and root planing procedures D4341 and D4342, require prior authorization and shall be authorized by quadrant. The following information shall be included with the Prior Authorization Request:
   a. Diagnostic radiographs.
   b. Periodontal charting of pocket depths, bone loss, furcation involvement, bleeding on probing and mobility of all teeth, in addition charting of missing teeth and teeth treatment planned for extraction.

2. Each quadrant requested must have a minimum of one (1) 5 mm or greater pocket.

3. When justified, a maximum of five (5) quadrant treatments may be authorized in a twelve (12)-month period.

4. Procedures D1110-D1120, prophylaxis, adult & child, are not payable on the same date of service as scaling and root planing procedures D4341/D4342.
   **NOTE:** D4342 does not require prior Authorization

5. Periodontal scaling and root planing procedures D4341/D4342 are not payable same date of service as any surgical periodontal procedure.

6. Generally, periodontal scaling and root planing procedures D4341/D4342 is performed prior to the provision of either procedures D4210/D4211, gingivectomy or gingivoplasty, or procedures D4260/D4261 osseous and muco-gingival surgery.

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| D4341 | PERIODONTAL SCALING AND ROOT PLANING - FOUR OR MORE TEETH PER QUADRANT | This procedure involves 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. A benefit:
   a. for patients age 13 or older.
   b. when there is a minimum of one 4mm+ pocket on each diseased tooth.
   c. once per quadrant every 12 months.
   Exception for special needs population may require procedure more than once a year.
   Gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261) cannot be prior authorized within 30 days following this procedure for the same quadrant.
   Prophylaxis (D1110 and D1120) are not payable on the same date of service |
|       | 1. Full mouth periodontal charting including 4 to 6 probing depths per tooth; indication of furcation involvement, mobility, or bleeding upon probing. Consideration should also be given to include recession if documented. |
|       | 2. Radiographs for prior authorization – submit periapical radiographs of the involved areas and arch radiographs. |
|       | 3. Written documentation for prior authorization – shall include a definitive periodontal diagnosis. |
|       | 4. A current and complete periodontal evaluation chart is required for prior authorization. |
|       | 5. Requires a quadrant code. |
|       | 6. If three or fewer diseased teeth are present in the quadrant, use periodontal scaling and root planning (D4342). |
|       | **NOTE:** D4342 does not require prior approval. |

Consider granting benefit exceptions for individuals <age 13 in exceptional circumstances as concomitant medical conditions and/or wholesale neglect of dental care.

**Please refer to Transmittal 10-26 (link below) due to exceptional circumstances granted to the special needs population for D4341:**

Dental Utilization Review Criteria Guidelines, 2017

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**IMPLANTS AND IMPLANT SUPPORTED PROSTHETICS**

**General Policies, Procedures D6010-D6113**

Dental implants are an accepted method for tooth replacement. The therapeutic goal of dental implants is to support restorations that replace a missing tooth or teeth so as to provide the member comfort and function and to assist in the ongoing maintenance of the remaining intraoral and perioral structures. The first dental implant was a titanium implant in a human volunteer in Sweden by Dr. Per-Ingvar Branemark, a Swedish Orthopedic Surgeon in 1965.

There are three types of dental implants, the endosseous, subperiosteal and transosteal. Dental Implants can be performed as delayed procedures (over months or years) or immediate (at the time of tooth extraction).

An abutment is a connection to a dental implant that is a manufactured component usually made of machined high noble metal, titanium, titanium alloy or ceramic. A custom abutment is fabricated for a specific member using a casting process and usually is made of noble or high noble metal.

Surgical stents are highly recommended for more accurate placement of dental implants.

Factors influencing the selection of patients for dental implants include age, general and dental health and individuals with special needs.

Candidates for dental implants must be age 18 or older and not pregnant.

When a tooth or teeth adjacent to the site of the requested dental implants requires restoration, the tooth or teeth should be treated prior to requesting the dental implant. If the tooth or teeth demonstrate significant disease treat the diseased tooth or teeth prior to submitting for the dental implant request. If there is injury to the tooth or teeth, and/or multiple missing teeth, more conservative treatment shall be considered as an alternative to dental implants to treat the condition and replace all missing teeth.

I. Single dental implants are **medically appropriate** when a functional deficit exists.

II. Dental implant bodies are **medically appropriate** to anchor a removable denture, not a fixed prosthesis, if the traditional removable dentures cannot be worn or are painful.

Coverage is limited to four upper dental implant bodies in the maxilla or two lower dental implant bodies in the mandible for the edentulous patient.

III. Dental implants are **not medically appropriate** in the following situations:

- Presence of local or systemic conditions that may interfere with the normal healing process and subsequent tissue homeostasis.
- Inadequate quality or quantity of alveolar bone and soft tissues.
- The patient currently has active periodontal disease and poor hygiene.
- Replacement of a second molar if used to extend the functional first molar occlusion, unless the patient has an Orthodontic problem.
- Replacement of wisdom teeth (1, 16, 17 and 32).
- When maintenance of the tooth/teeth is/are not considered. By this, it is meant that placement of dental implants in an area which is not truly of functional benefit to the patient or in an arch which should actually be edentulated altogether should not be covered. In this case, it will be up to the Qualis dental reviewer to determine if the patient can reasonably and successfully (or at least adequately) function with non-implant-borne dentures.
- When the teeth are not in occlusion (meeting of the upper and lower teeth when the jaw is closed and the tooth/teeth surfaces come in contact). There is the possibility that the dental implant would be placed in a site unopposed (i.e. not in occlusion) with natural dentition but would be functioning against a denture tooth in the opposing arch.
IV. Four (4) dental implants per arch will be authorized for the partially edentulous patient; for the completely edentulous, four (4) in the maxilla and two (2) in the mandibular area. When more than four (4) teeth are missing in the same arch bilaterally, consideration must be given to a removable partial denture as an alternative benefit.

V. There must be at least 3 mm of inter-dental space between dental implants and naturally existing teeth to maintain periodontal health and form.

VI. If stents are required for dental implant placement, one stent per arch will be allowed.

VII. Dental implants will be re-evaluated via intraoral radiographs or CT scans prior to the authorization of abutments or crowns four to six months after dental implant placement.

VIII. After abutments or crowns are seated, a final intraoral radiograph or CT scan must be reviewed by Qualis Health dental reviewers before any further services in that area can be authorized.

IX. If an anterior tooth has been extracted due to trauma, gross caries or endodontic failure, with good general and periodontal health and controllable risk factors, an anterior dental implant is justified and will be authorized.

X. If bone grafting and augmentation is necessary, there must be a 4-6 months interval with good quality/contrast X-Rays or CT Scan for review by Qualis dental reviewers.

1. Candidates for implants must be age 18 or older and not pregnant.
2. Stable periodontal health and overall dental health in the entire mouth must be demonstrated.
3. Documentation submitted must demonstrate absence of radiographic and clinical calculus, pre-and post-periodontal charting and treatment, and an adult prophylactic/preventive procedure date not to exceed 6 months prior to the request for implant restoration.
4. Tooth (teeth) to be replaced must have an opposing occlusion.
5. Authorization to replace wisdom teeth (1,16,17 and 32) will not be approved.
6. Dental implants that fail will not be replaced. (**).
7. Four (4) implants per arch will be authorized for the partially edentulous patient, and for the completely edentulous, four (4) in the maxilla and two (2) in the mandibular.
8. There must be at least 3 mm of inter-dental space between implants and naturally existing teeth.
9. If stents are required for dental implant placement, one stent per arch will be allowed.
10. Dental implants will be re-evaluated with X-rays and or CT scans prior to the authorization of abutments or crowns after 4-6 months.
11. If bone graft augmentation is necessary, there must be a 6 month interval before a dental implant can be placed and good quality/contrast x-rays or CT scans must be submitted for review.
12. The optimal dimensions of available alveolar bone for most forms of implant placement are: 5mm in width, 13-15 mm in height and 5 mm in length.
13. All requests for dental implants will be reviewed by dentists.
14. Other Contraindications for dental implants will include:
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<td>a. treatment including but not limited to long-term steroid therapy, radiation therapy to a potential implant site, chemotherapy, hemodialysis, heart surgery (within the last six months), recent Myocardial Infarction, (within past 6 months) or hyperbaric oxygen treatment for osteoradionecrosis.</td>
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<td>b. Concomitant use of anticoagulants or medications that contraindicates implant success, such as bisphosphonates</td>
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<td>c. Known illicit drug use (eg. Crack, methamphetamine, heroin, cocaine or other drugs that can be smoked and/or applied to the intraoral tissues)</td>
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<td>d. Uncontrolled metabolic disorders, chronic renal disease, or a severe systemic disease (including but not limited to leukemia and collagen disorders such as systemic lupus erythematosis and scleroderma).</td>
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<td>e. Uncontrolled buliemia, GERD, or other conditions causing acid reflux</td>
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<td>f. Presence of intra- and peri-oral piercings</td>
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<td>g. Unstable psychiatric or chronic illness as noted above included poorly controlled diabetes mellitus with a current Hemoglobin A1c (HgbA1c&gt;7%).</td>
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<td>h. Any history of dental implant failure or intraoral bone graft failure</td>
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**Dental health and history**

- The patient must have generally healthy, well maintained and stable dentition.
- Documentation provided should show absence of radiographic and clinical calculus, a full-mouth periodontal charting, and an adult oral prophylaxis procedure, the date not to exceed 6 months prior to request for implant restoration.
- Initial documentation should clearly indicate any areas of current facial anesthesia, paresthesia, or dysesthesia as might be encountered in a patient with a past history of trauma, oral-maxillofacial surgical procedures, tumors, anatomical anomalies, etc.
- Tooth (teeth) to be replaced must have an opposing occlusion
- The patient must have no dental habits or oral conditions that preclude the placement of implants, including but not limited to:
  - bruxism, craze lines,
  - severe ulceration or erosive lesions,
  - temporomandibular joint disorder or myofascial pain disorder,
  - history of facial fractures (which may preclude the placement of implants, however this will be considered on a case by case situation).
- The patient should have no history of dental implant failure or intraoral bone graft failure.
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| D6010 | SURGICAL PLACEMENT OF IMPLANT BODY: ENDOSTEAL IMPLANT | Includes second stage surgery and placement of healing cap. Coverage is only for replacement of missing natural teeth. Implants done solely to restore a space beyond the normal complement of natural teeth are not covered. | 1. Date of last dental cleaning listed on 719a form box 13  
2. Full mouth radiographs (Panorex or CSX) including Periapicals of site requesting dental implant,  
3. Full-mouth periodontal charting, unless patient is completely edentulous  
4. Requires a tooth number  
5. Clinical justification for the dental implants, including the reasons conventional removable dentures cannot be used to replace the missing teeth;  
6. Requests for edentulous patients must indicate date denture or partial denture was completed and any realignments within 2 years. NOTE: if requests for implants is due to ill-fitting dentures patient must have been in dentures for 2 years and had at least 2 realignments. | All radiographs submitted must be free of tarter and show mouth is stable with no decay or extractions needed.  
A. Dental implants are **not medically appropriate** in the following situations:  
   - Presence of local or systemic conditions that may interfere with the normal healing process and subsequent tissue homeostasis.  
   - Inadequate quality or quantity of alveolar bone and soft tissues.  
   - The patient currently has active periodontal disease and poor hygiene.  
   - Replacement of a second molar if used to extend the functional first molar occlusion, unless the patient has an Orthodontic problem.  
   - Replacement of wisdom teeth (1, 16, 17 and 32).  
   - When maintenance of the tooth/teeth is/are not considered. By this, it is meant that placement of dental implants in an area which is not truly of functional benefit to the patient or in an arch which should actually be edentulated altogether should not be covered. In this case, it will be up to the Qualis dental reviewer to determine if the patient can reasonably and successfully (or at least adequately) function with non-implant-borne dentures.  
   - When the teeth are not in occlusion (meeting of the upper and lower teeth when the jaw is closed and the tooth/teeth surfaces come in contact). There is the possibility |
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- **A.** That the dental implant would be placed in a site unopposed (i.e. not in occlusion) with *natural* dentition but would be functioning against a *denture tooth* in the opposing arch.

- **B.** Four (4) dental implants per arch will be authorized for the partially edentulous patient; for the completely edentulous, four (4) in the maxilla and two (2) in the mandibular area.

- **C.** When more than four (4) teeth are missing in the same arch bilaterally, consideration must be given to a removable partial denture as an alternative benefit.

- **D.** There must be at least 3 mm of inter-dental space between dental implants and naturally existing teeth to maintain periodontal health and form.

- **E.** If stents are required for dental implant placement, one stent per arch will be allowed.

- **F.** Dental implants will be re-evaluated via intraoral radiographs or CT scans prior to the authorization of abutments or crowns four to six months after dental implant placement.

- **G.** After abutments or crowns are seated, a final intraoral radiograph or CT scan must be reviewed by Qualis Health dental reviewers before any further services in that area can be authorized.

- **H.** If an anterior tooth has been extracted due to trauma, gross caries or endodontic failure, with good general and periodontal health and controllable risk factors, an anterior dental implant is justified and will be...
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| D6056  | PREFABRICATED ABUTMENT INCLUDES MODIFICATION AND PLACEMENT | A connection to an implant that is a manufactured component, usually made of machined high noble metal, titanium, titanium alloy or ceramic. Modification of a prefabricated abutment may be necessary and is accomplished by altering its shape using dental bu
ttern/diamonds.                                                                 | 1. Periapical radiograph of fully integrated implant  
2. Requires a tooth number  
3. Arch radiograph showing placed integrated implant  
4. IO photo of healed tissue surrounding healing cap of implant | authorized. 
I. If bone grafting and augmentation is necessary, there must be a 4-6 months interval with good quality/contrast X-Rays or CT Scan for review by Qualis dental reviewers |
| D6058  | ABUTMENT SUPPORTED PORCELAIN / CERAMIC CROWN          | A single crown restoration that is retained, supported and stabilized by an abutment on an implant                                                                                                                                                                                                                                                                                                           | 1. Periapical radiograph of integrated implant with abutment, and arch radiograph with abutment placed  
2. Requires a tooth number  
3. IO photo of healed abutment, which shows healthy gingiva surrounding abutment.  
4. Periodontal charting, if patient has any remaining teeth present (ie: edentulous patients do not require periodontal charting) |                                                                                                                                                                                                                                                                               |
| D6081  | SCALING AND DEBRIDEMENT IN THE PRESENCE OF INFLAMMATION OR MUCOSITIS OF A SINGLE IMPLANT, INCLUDING CLEANING OF THE IMPLANT SURFACES, WITHOUT FLAP ENTRY AND CLOSURE. | Prior Authorization is required. D6081 is billed one unit per tooth position and once per calendar year. The dental provider cannot bill for D6081 on the same date of service for the following scenarios: 1) D1110 and D4910 are billed. 2) D4341, D4342,D4240, D4241, are billed for the same quadrant. 3) D6101 has been reimbursed for the same tooth position in a calendar year. |                                                                                                                                                                                                                                                                               |
| D6085  | PROVISIONAL IMPLANT CROWN                             | One unit per tooth position. Prior Authorization required same reimbursement rate as D2799.                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                               |
## OTHER IMPLANT SERVICES

<table>
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<tr>
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</table>
| D6101  | DEBRIDEMENT OF A PERIIMPLANT DEFECT AND SURFACE CLEANING OF EXPOSED IMPLANT SURFACES, INCLUDING FLAP ENTRY AND CLOSURE | - The implant site must have healed for at least six months and be fully integrated.  
- Direct loading will be considered 
- Implant must have good crown/root ratio  
- Must not have more than two treads above the alveolar crest  
- Implant must not be closer than 1-1.5mm to adjacent roots |
|        |                                                                             | 1. Radiographic Image: full periapical set with bitewings. Panorex with bitewings and PAs of area (not preferable/panorex needs to be high quality) of involved teeth, as well as contralateral and opposing sites.  
2. Pre-op radiographic images of defect and narrative  
3. IO Photo of bony defect area                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                     |
| D6102  | DEBRIDEMENT AND OSSEOUS CONTOURING OF A PERIIMPLANT DEFECT; INCLUDES SURFACE CLEANING OF EXPOSED IMPLANT SURFACES AND FLAP ENTRY AND CLOSURE | As for D6101                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 1. A Radiographic Image: full periapical set with bitewings. Panorex with bitewings and PAs of area (not preferable/panorex needs to be high quality) of involved teeth, as well as contralateral and opposing sites.  
2. Pre-op radiographic images of defect and narrative  
3. IO Photo of bony defect area                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                     |
| D6103  | BONE GRAFT FOR REPAIR OF PERI-IMPLANT DEFECT – not including flap entry and closure or, when indicated, placement of a barrier membrane or biologic materials to aid in osseous regeneration | As for D6101                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 1. Radiographic Image: full periapical set with bitewings. Panorex with bitewings and PAs of area (not preferable/panorex needs to be high quality) of involved teeth, as well as contralateral and opposing sites.  
2. Pre-op radiographic images of defect and narrative  
3. IO Photo of bony defect area                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                     |
| D6104  | BONE GRAFT AT TIME OF IMPLANT PLACEMENT                                      | Placement of a barrier membrane or biologic materials to aid in osseous regeneration are reported separately.  
Criteria as for D6101  
Not allowed on same day as other bone grafting procedures.                                                                                                                                                                                                                                            | 1. Radiographic Image: full periapical set with bitewings. Panorex with bitewings and PAs of area (not preferable/panorex needs to be high quality) of involved teeth, as well as contralateral and opposing sites.  
2. Pre-op radiographic images of defect and narrative  
3. IO Photo of bony defect area                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                     |
| D6110  | IMPLANT SUPPORTED REMOVABLE COMPLETE DENTURE FOR EDENTULOUS ARCH-MAXILLARY ARCH | Removable complete maxillary denture that attaches to abutments  
Criteria for implants must be met and implant/abutment process must be complete prior to requesting overdenture  
If beneficiary has received a maxillary |
|        |                                                                             | 1. Intra Oral (IO) photo showing healthy gingiva surrounding abutment.  
2. Periapical radiograph of integrated implant w abutment placed                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                     |
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<tbody>
<tr>
<td>D6111</td>
<td>IMPLANT SUPPORTED REMOVABLE COMPLETE DENTURE FOR EDENTULOUS ARCH- MANDIBULAR</td>
<td>denture within 5 years, existing denture must be retrofitted to fit newly placed implants and abutments.</td>
<td>Same as D6110</td>
<td>1. Intra Oral (IO) photo showing healthy gingiva surrounding abutment.</td>
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<tr>
<td></td>
<td>ARCH</td>
<td>Removable Mandibular complete denture that attaches to abutments</td>
<td></td>
<td>2. Periapical radiograph of integrated implant w abutment placed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Criteria for implants must be met and implant/abutment process must be complete prior to requesting overdenture</td>
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<tr>
<td></td>
<td></td>
<td>If beneficiary has received a mandibular denture within 5 years, existing denture must be retrofitted to fit</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>newly placed implants and abutments.</td>
<td></td>
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</tr>
<tr>
<td>D6112</td>
<td>IMPLANT SUPPORTED REMOVABLE PARTIAL DENTURE FOR PARTIALLY EDENTULOUS ARCH-</td>
<td>Removable Maxillary partial denture that attaches to abutments</td>
<td>Same as D 6110</td>
<td>1. Intra Oral (IO) photo showing healthy gingiva surrounding abutment.</td>
</tr>
<tr>
<td></td>
<td>MAXILLARY ARCH</td>
<td>Criteria for implants must be met and implant/abutment process must be complete prior to requesting overdenture</td>
<td></td>
<td>2. Periapical radiograph of integrated implant w abutment placed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If beneficiary has received a maxillary partial denture within 5 years, existing denture must be retrofitted to fit newly placed implants and abutments.</td>
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<td>3. Full mouth periodontal charting</td>
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<tr>
<td>D6113</td>
<td>IMPLANT SUPPORTED REMOVABLE PARTIAL DENTURE FOR PARTIALLY EDENTULOUS ARCH-</td>
<td>Removable Mandibular partial denture that attaches to abutments</td>
<td>Same as D6110</td>
<td>1. Intra Oral (IO) photo showing healthy gingiva surrounding abutment.</td>
</tr>
<tr>
<td></td>
<td>MANDIBULAR ARCH</td>
<td>Criteria for implants must be met and implant/abutment process must be complete prior to requesting overdenture</td>
<td></td>
<td>2. Periapical radiograph of integrated implant w abutment placed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If beneficiary has received a mandibular partial denture within 5 years, existing denture must be retrofitted to fit newly placed implants and abutments.</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>3. Full mouth periodontal charting</td>
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</table>
# ORAL SURGERY (PROCEDURES D7140-D7960)

### General Policies, Procedures D7140-D7960:

1. Diagnostic periapical radiographs are required for all surgical procedures that are submitted for authorization and/or payment except:
   - a. For procedures performed on soft tissue structures;
   - b. For Procedure D7320 (alveoplasty on an edentulous quadrant.) If radiographs are not sufficient to justify a need, (i.e., for soft tissue procedures) additional diagnostic material (photographs or models) and/or a statement of justification must be presented.

2. Submitted periapical radiographs should show all aspects of a suspected pathologic area or neoplasm, the entire crown and apices of all teeth to be excised or extracted. In those cases where the radiograph of the crown of the tooth is not complete but there is sufficient evidence presented to substantiate the need for the surgical procedure, the surgical procedure may be allowed.

3. Oral surgery services to correct longstanding abnormalities of the mandible or maxilla, e.g., prognathia or retrognathia, or skin grafts for denture retention purposes or interosseous implants for procedures is not a benefit.

4. Extraction of asymptomatic teeth is not a benefit. The following includes, but is not all inclusive of, conditions which may be considered symptomatic when documented:
   - a. Fully bony impacted supernumerary teeth, mesiodens, or teeth unerupted because of lack of alveolar ridge length.
   - b. Teeth, which are involved with a cyst, tumor, or other neoplasm.
   - c. Unerupted teeth, which are distorting the normal alignment of erupted teeth or causing the resorption of the roots of other teeth.
   - d. Misaligned tooth (teeth), which cause the exacerbation of periodontal disease in adjacent teeth/areas.
   - e. Extractions of primary teeth required to minimize malocclusion or misalignment when there is inadequate space to allow normal eruption of the permanent tooth (teeth).
   - f. Perceptible radiologic pathology that fails to elicit symptoms.
   - g. Extractions that are required to complete dentally necessary orthodontic dental services.

5. Routine postoperative visits (within 30 days following surgical procedure) are considered part of, and included in, the global fee for the surgical procedure.

6. Extractions of asymptomatic deciduous teeth that appear by radiographic evaluation ready to exfoliate naturally are not a benefit.

7. The fees for oral surgery procedures include local anesthesia and routine postoperative visits.

8. The fee for extractions includes the excision of associated minor cystic or inflamed tissue.

9. The charge for a stent in conjunction with oral surgery is part of, and included in the fee for the surgery.

### Code | Description | Criteria and Benefits | Required Documentation | Comments
--- | --- | --- | --- | ---
D7285 | BIOPSY OF ORAL TISSUE – HARD (BONE, TOOTH) | For removal of specimen only. This code involves biopsy of osseous lesions and is not used for apicoectomy/periradicular surgery. A benefit: a. for the removal of the specimen only. b. once per arch, per date of service regardless of the areas involved. Not a benefit with an apicoectomy/periradicular surgery (D3410-D3426), an extraction (D7111-D7250) and an excision of any soft tissues or intraosseous lesions (D7410-D7461) in the same area or region on the same date of service. | 1. Radiographs for payment – submit a pre-operative radiograph. 2. A pathology report from a certified pathology laboratory is required for payment. 3. Requires an arch code. | If during the course of the listed endodontic or oral surgery procedures, the provider finds an unexpected or unanticipated lesion that in his/her professional judgment necessitates excision and biopsy, this should be allowed by special report. The processing of the biopsy (i.e. Laboratory and pathologist fees) are a benefit through the patient’s Medicaid; this information is given to the laboratory processing the specimen. The medical portion will have codes in place so that these secondary fees can be covered. |
<table>
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<tr>
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</table>
| BIOPSY OF ORAL TISSUE (D7285-D7286) | General Policies, Procedures D7285-D7286:  
1. Procedures D7285 (biopsy of oral tissue, hard) and D7286 (biopsy of oral tissue, soft) are benefits as an independent procedure for collecting tissue specimen(s).  
2. Not a benefit in conjunction with the extraction of a tooth or root or excision of any body part or neoplasm in the same area or region on the same day.  
3. Please indicate the area of the lesion and submit operative and pathology reports. | The biopsy of oral tissue is a procedure conducted to collect tissue samples for medical analysis. |                                                                 |          |
| D7310  | ALVEOLOPLASTY IN CONJUNCTION WITH EXTRCTIONS – FOUR OR MORE TEETH OR TOOTH SPACES, PER QUADRANT | The alveoloplasty is distinct (separate procedure) from extractions and/or surgical extractions. Usually in preparation for a prosthesis or other treatments such as radiation therapy and transplant surgery.  
A benefit on the same date of service with two or more extractions (D7140-D7250) in the same quadrant.  
Not a benefit when only one tooth is extracted in the same quadrant on the same date of service. | 1. Radiographs for payment – submit radiographs of the involved areas.  
2. Requires a quadrant code. |          |
| D7320  | ALVEOLOPLASTY NOT IN CONJUNCTION WITH EXTRCTIONS – FOUR OR MORE TEETH OR TOOTH SPACES, PER QUADRANT | No extractions performed in an edentulous area. See D7310 if teeth are being extracted concurrently with the alveoloplasty. Usually in preparation for a prosthesis or other treatments such as radiation therapy and transplant surgery. | 1. Radiographs for payment – submit radiographs of the involved areas if photographs do not demonstrate the medical necessity.  
2. Photographs for payment - submit photographs of the involved areas.  
3. Requires a quadrant code. |          |
| D7340  | VESTIBULOPLASTY-RIDGE EXTENSION (SECONDARY EPITHELIALIZATION) | Benefit allowance includes sutures, local anesthesia and routine post-operative care.  
Benefits are allowed once in a 60 month (5 year) period per arch  
Not a benefit:  
a. on the same date of service with a vestibuloplasty – ridge extension (D7350) same arch.  
b. on the same date of service with | 1. Radiographs for prior authorization – submit radiographs.  
2. Photographs for prior authorization – submit photographs.  
3. Written documentation for prior authorization- shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed |          |
## D7450-D7451

### General Policies, Procedures D7450-D7461:

1. The appropriate procedure number shall be determined by the measurement of the cystic image on the diagnostic x-ray presented unless otherwise documented by report.
2. Payment will not be made without an adequate radiograph of the neoplasm in question.
3. Please identify the area of the lesion and provide the operative and pathology reports.
4. Biopsy D7286 on same day for same area is not a covered service.
5. Postoperative care within a thirty (30)-day period following surgery shall be included in the fee for the services.

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<tr>
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</thead>
<tbody>
<tr>
<td>D7451</td>
<td>REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR – LESION DIAMETER GREATER THAN 1.25 CM</td>
<td>A benefit: a. once per quadrant. b. for the removal of buccal or facial exostosis</td>
<td>1. Radiographs for payment—submit a radiograph of the cyst or tumor. 2. Written documentation for payment—shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history. 3. A pathology report from a certified pathology laboratory is required for payment.</td>
<td>The processing of the biopsy (i.e. Laboratory and pathologist fees) are a benefit through the patient’s Medicaid; this information is given to the laboratory processing the specimen. The medical portion will have codes in place so that these secondary fees can be covered. See # 4 to the left.</td>
</tr>
<tr>
<td>D7460</td>
<td>REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR – LESION DIAMETER UP TO 1.25 CM</td>
<td></td>
<td>1. Radiographs for payment—submit a radiograph of the cyst or tumor. 2. Written documentation for payment—shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history. 3. A pathology report from a certified pathology laboratory is required for payment.</td>
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</tr>
<tr>
<td>D7471</td>
<td>REMOVAL OF LATERAL EXOSTOSIS (MAXILLA OR MANDIBLE)</td>
<td>A benefit: a. once per quadrant. b. for the removal of buccal or facial exostosis</td>
<td>1. Photographs for payment—submit pre-operative photographs. 2. Written documentation for payment—shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed prosthodontic treatment. 3. Requires a quadrant code.</td>
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### Excision of Bone Tissue (D7471-D7490)

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<tr>
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**General Policies, Procedures D7471-D7490:**

1. A benefit when done in conjunction with the construction, reconstruction, or reline of a removable dental prosthesis for the removal of an exostosis, overgrowth, or enlargement of normal bone occurring at the midline of the hard palate.

2. Not a benefit if the condition is:
   a. Asymptomatic; or
   b. Will be bypassed by a dental prosthesis.

3. The extent and severity of this procedure is difficult to diagnose using x-rays only, therefore justification by models, photos, narrative, or other diagnostic modalities may be required.

**D7472 D7473**

**Removal of Torus Palatinus, Remove Torus Mandibularis**

1. A benefit when done in conjunction with the construction, reconstruction, or reline of a removable dental prosthesis for the removal of an exostosis, overgrowth, or enlargement of normal bone occurring on the lingual aspect of the mandible.

2. A benefit once per Quadrant per date of service

3. Not a benefit if the condition is:
   a. Asymptomatic; or
   b. Will be bypassed by a dental prosthesis.

4. The extent and severity of this procedure is difficult to diagnose using x-rays only. Justification by models, photos, narrative, or other diagnostic modalities may be required.

1. Photographs for payment—submit pre-operative photographs.

2. Written documentation for payment—shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed prosthodontic treatment.

3. Requires a quadrant code.

4. The extent and severity of this procedure is difficult to diagnose using x-rays only. Justification by models, photos, narrative, or other diagnostic modalities may be required.
### SURGICAL INCISION (D7510-D7520)

**Procedure D7960: Frenulectomy also known as Frenectomy or Frenotomy- Separate Procedure not Incidental to Another Procedure.**

1. A benefit where it is documented that:
   a. A short labial frenum interferes with the mobility of the central portion of the lip.
   b. A hypertrophy of the frenum and papilla palatina interferes with the proper fitting and retention of a prosthetic appliance.
   c. A hypertrophy of the frenum and overextension to the papilla palatina produces a diastema in children; or
   d. Where attachment of frenum displaces interdental papilla or marginal gingival with consequent periodontal disease.

2. A benefit in cases of ankyloglossia where there is interference with proper mastication or where frenum interferes with the normal use or function of a prosthetic appliance.

3. Appropriate diagnostic material must be submitted in order to process for payment.

4. Routine postoperative care (within 30 days of surgical procedure) is considered part of and included in the global fee for the procedure.

5. Not payable when provided in conjunction with vestibuloplasty, alveoplasty with ridge extension, or excision of hyperplastic tissue.

**Procedure D7970: Excision of Hyperplasic Tissue**

1. Documentation required.

2. Payable when inflammatory hyperplastic tissue interferes with normal mastication or in an edentulous area where the inflammatory hyperplastic tissue interferes with normal use or function of a prosthetic appliance.

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<tr>
<td>D7840</td>
<td>CONDYLECTOMY</td>
<td>Surgical removal of all or portion of the mandibular condyle (separate procedure). Imaging modalities may include panoramic radiograph, periapical and/or occlusal radiographs, maxillary and/or mandibular radiographs, computed tomography, cone beam computed tomography, positron emission tomography, positron emission tomography/computed tomography, and magnetic resonance imaging. In determining studies to be performed for imaging purposes, principles of ALARA (as low as reasonably achievable) should be followed.</td>
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<td>1. Radiographs for prior authorization – submit appropriate imaging</td>
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<td>2. Written documentation for prior authorization – shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.</td>
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<tr>
<td>Code</td>
<td>Description</td>
<td>Criteria and Benefits</td>
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<tr>
<td>D7850</td>
<td>SURGICAL DISCECTOMY, WITH/ WITHOUT IMPLANT</td>
<td>Excision of the intra-articular disc of a joint.</td>
</tr>
<tr>
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<td>Imaging modalities may include panoramic radiograph, periapical and / or occlusal radiographs, maxillary and/or mandibular radiographs, computed tomography, cone beam computed tomography, positron emission tomography, positron emission tomography/ computed tomography, and magnetic resonance imaging. In determining studies to be performed for imaging purposes, principles of ALARA (as low as reasonably achievable should be followed.</td>
</tr>
<tr>
<td>D7860</td>
<td>ARTHROTOMY</td>
<td>Cutting into joint (separate procedure).</td>
</tr>
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<td>Imaging modalities may include panoramic radiograph, periapical and / or occlusal radiographs, maxillary and/or mandibular radiographs, computed tomography, cone beam computed tomography, positron emission tomography, positron emission tomography/ computed tomography, and magnetic resonance imaging. In determining studies to be performed for imaging purposes, principles of ALARA (as low as reasonably achievable should be followed.</td>
</tr>
<tr>
<td>D7940</td>
<td>OSTEOPLASTY – FOR ORTHOGNATHIC DEFORMITIES</td>
<td>Reconstruction of jaws for correction of congenital, developmental or acquired traumatic or a deformity that may be addressed via surgical correction.</td>
</tr>
<tr>
<td></td>
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<td>Imaging modalities may include panoramic radiograph, periapical and / or occlusal radiographs, maxillary and/or mandibular radiographs, computed tomography, cone beam computed tomography, positron emission tomography, positron emission tomography/computed tomography, and magnetic resonance imaging. In determining studies to be performed for imaging purposes, principles of ALARA (as low as reasonably achievable should be followed.</td>
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<td>Code</td>
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| D7953 | BONE REPLACEMENT GRAFT                                                      | Osseous autograft, allograft or non-osseous graft is placed in an extraction or implant removal site at the time of the extraction or removal to preserve ridge integrity (e.g. clinically indicated in preparation for implant reconstruction or where alveolar contour is critical to planned prosthetic reconstruction). Membrane, if used, should be reported separately. | 1. Radiographs for payment – submit a pre-operative photograph.  
2. Written documentation for payment – shall include the rationale demonstrating the medical necessity and the specific area the treatment was performed.  
3. Requires a tooth number or quadrant code.  |                                                |
| D7960 | FRENULECTOMY ALSO KNOWN AS FRENECTOMY OR FRENOTOMY – SEPARATE PROCEDURE NOT IDENTICAL TO ANOTHER | Surgical removal or release of mucosal and muscle elements of a buccal, labial or lingual frenum that is associated with a pathological condition, or interferes with proper oral development or treatment. A benefit once per arch per date of service | 1. Photographs for payment – submit a pre-operative photograph.  
2. Written documentation for payment – shall include the rationale demonstrating the medical necessity and the specific area the treatment was performed.  
3. Requires an arch code.  |                                                |
| D7972 | SURGICAL REDUCTION OF FIBROUS TUBEROSITY                                   | A benefit once per quadrant per date of service. This procedure is included in the fees for other surgical procedures that are performed in the same quadrant on the same date of service | 1. Photographs for payment – submit a pre-operative photograph.  
2. Written documentation for payment – shall include the rationale demonstrating the medical necessity and the actual or proposed prosthodontic treatment.  
3. Requires a quadrant code.  |                                                |
## ORTHODONTIC GENERAL POLICIES (D8000-D8999)

1. Orthodontic procedures are benefits for medically necessary handicapping malocclusion, cleft palate and facial growth management cases for patients under the age of 21 and shall be prior authorized.

2. Only those cases with permanent dentition shall be considered for medically necessary handicapping malocclusion, unless the patient is age 13 or older with primary teeth remaining. Cleft palate and craniofacial anomaly cases are a benefit for primary, mixed and permanent dentitions. Craniofacial anomalies are treated using facial growth management.

3. All necessary procedures that may affect orthodontic treatment shall be completed before orthodontic treatment is considered.

4. Orthodontic procedures are a benefit only when there is written documentation of a craniofacial anomaly from a credentialed specialist on their professional letterhead.

5. The automatic qualifying conditions are:
   a. Cleft palate deformity. If the cleft palate is not visible on the diagnostic casts written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,
   b. Craniofacial anomaly. Written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,
   c. A deep impinging overbite in which the lower incisors are destroying the soft tissue of the palate,
   d. a crossbite of individual anterior teeth causing destruction of soft tissue,
   e. An overjet greater than 9 mm or reverse overjet greater than 3.5 mm,
   f. A severe traumatic deviation (such as loss of a premaxilla segment by burns, accident or osteomyelitis or other gross pathology). Written documentation of the trauma or pathology shall be submitted with the prior authorization request.

6. If the patient's orthodontic bands have to be temporarily removed and then replaced due to a medical necessity, a claim for comprehensive orthodontic treatment of the adolescent dentition (D8080) for rebanding shall be submitted along with a letter from the treating physician or radiologist, on their professional letterhead, stating the reason why the bands needed to be temporarily removed.

### Code: D8080  COMPREHENSIVE ORTHODONTIC TREATMENT OF THE ADOLESCENT DENTITION

These codes should be used when there are multiple phases of treatment provided at different stages of dentofacial development. For example, the use of an activator is generally stage one of a two-stage treatment. In this situation, placement of fixed appliances will generally be stage two of a two-stage treatment. Both phases should be listed as comprehensive treatment modified by the appropriate stage of dental development. This is used to report the coordinated diagnosis and treatment leading to the improvement of a patient's craniofacial dysfunction and/or dentofacial deformity including anatomical, functional and aesthetic relationships. Treatment usually, but not necessarily, utilizes fixed appliances.

1. The following shall be submitted together for prior authorization:
   a. comprehensive orthodontic treatment of the adolescent dentition (D8080), and
   b. periodic orthodontic treatment visit(s) (D8670), and
   c. orthodontic retention (D8680), and
   d. the diagnostic casts (D0470)

2. Written documentation for prior authorization for cleft palate and facial growth management cases shall be submitted:
   a. cleft palate cases require documentation from a credentialed specialist, on their professional letterhead, if the cleft palate is not visible on the diagnostic casts, or

DHCF pays the dental providers a global fee for the entire orthodontic case. Also, D8080 is a covered benefit.
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<td>orthodontic appliances. Adjunctive procedures, such as extractions, maxillofacial surgery, nasopharyngeal surgery, myofunctional or speech therapy and restorative or periodontal care, may be coordinated disciplines. Optimal care requires long-term consideration of patient's needs and periodic re-evaluation. Treatment may incorporate several phases with specific objectives at various stages of dentofacial development. A benefit: a. for handicapping malocclusion, cleft palate and facial growth management cases. b. for patients under the age of 21. c. for permanent dentition (unless the patient is age 13 or older with primary teeth still present or has a cleft palate or craniofacial anomaly). d. once per patient per phase of treatment. All appliances (such as bands, arch wires, headgear and palatal expanders) are included in the fee for this procedure. No additional charge to the patient is permitted. This procedure includes the replacement, repair and removal of brackets, bands and arch wires by the original provider.</td>
<td>b. facial growth management cases require documentation from a credentialed specialist, on their professional letterhead, of the craniofacial anomaly.</td>
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<td>D8090</td>
<td>COMPREHENSIVE DENTAL TREATMENT OF THE ADULT</td>
<td>These codes should be used when there are multiple phases of treatment provided at different stages of dentofacial development. For example, the use of an activator is generally stage one of a two-stage treatment. In this situation, placement of fixed appliances will generally be stage two of a two-stage treatment. Both phases should be listed as comprehensive treatment modified by the appropriate stage of dental development. This is used to report the coordinated diagnosis and treatment leading to the improvement of a patient's craniofacial dysfunction and/or dentofacial deformity including anatomical, functional and aesthetic relationships. Treatment usually, but not necessarily, utilizes fixed appliances.</td>
<td>1. Written documentation for payment – shall include the rationale demonstrating the medical necessity and the specific area the treatment was performed. 2. Completed 719A form should be submitted.</td>
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<td>D8999</td>
<td>UNSPECIFIED ORTHODONTIC PROCEDURE, BY REPORT</td>
<td>Used for procedure that: 1. is not adequately described by a code; 2. has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity. Not a benefit to the original provider for the adjustment, repair, replacement or removal of brackets, bands or arch wires.</td>
<td>1. Prior authorization is required for non-emergency procedures. 2. Radiographs for prior authorization or payment—submit radiographs if applicable for the type of procedure. 3. Photographs for prior authorization or payment—submit photographs if applicable for the type of procedure. 4. Written documentation for prior authorization or payment—describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed or actual treatment. 5. Documentation shall include the medical condition and the specific CDT code associated with the treatment. (describe procedure in narrative format)</td>
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**ADJUNCTIVE GENERAL POLICIES (D9000-D9999)**

**Anesthesia (D9210-D9248)**

1. General anesthesia (D9223) is defined as a controlled state of unconsciousness, accompanied by a partial or complete loss of protective reflexes, including the loss of the ability to independently maintain an airway and respond purposefully to physical stimulation or verbal command, produced by a pharmacologic or non-pharmacologic method or combination thereof.

2. Deep sedation/general anesthesia (D9223) and intravenous conscious sedation/analgesia (D9241 and D9242) shall be considered for payment when it is documented why local anesthesia is contraindicated. Such contraindications shall include but are not limited to the following:
   a. a severe mental or physical handicap,
   b. extensive surgical procedures,
   c. an uncooperative child,
   d. an acute infection at an injection site,
   e. a failure of a local anesthetic to control pain.
3. The administration of deep sedation/general anesthesia (D9223), nitrous oxide (D9230), intravenous conscious sedation/analgesia (D9241 and D9242) and therapeutic parenteral drug (D9610) is a benefit in conjunction with payable associated procedures. Prior authorization or payment shall be denied if any associated procedures by the same provider are denied.

4. Providers who administer general anesthesia (D9223) and/or intravenous conscious sedation/analgesia (D9241 and D9242) shall have valid anesthesia permits.

5. Anesthesia time for general anesthesia and intravenous conscious sedation is defined as the period between the beginning of the administration of the anesthetic agent and the time that the anesthetist is no longer in personal attendance.

6. Sedation is a benefit in conjunction with the surgical removal of wires, bands, splints and arch bars.

**ADJUNCT PROCEDURES (PROCEDURES D9110-D9930)**

1. General anesthesia is an excluded benefit unless provided in conjunction with authorized oral surgery procedures; such as the surgical extraction of impacted teeth, procedures D7220-D7240.

2. This procedure is only payable to providers holding a valid general anesthesia permit; please include the general anesthesia permit number on the claim form.

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<td>D9223</td>
<td>DEEP SEDATION/GENERAL ANESTHESIA – FIRST 30 MINUTES</td>
<td>Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and noninvasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients or duties. The level of anesthesia is determined by the anesthesia provider's documentation of the anesthetic's effects upon the central nervous system and not dependent upon the route of administration. Not a benefit: a. on the same date of service as analgesia, anxiolysis, inhalation of nitrous oxide (D9230), intravenous conscious sedation/analgesia (D9241 and D9242) or non-intravenous conscious sedation (D9248). b. when any associated procedures on the same date of service by the same provider are denied.</td>
<td>1. Written documentation for payment – shall justify the medical necessity based on a mental or physical limitation or contraindication to a local anesthetic agent. 2. An anesthesia record that indicates the anesthetic agent(s) and the anesthesia time shall be submitted for payment. 3. The quantity, in 15-minute increments, that was necessary to complete the treatment shall be indicated on the 719A Form 4. Copy of Anesthesia license on file, if not on file submit a copy</td>
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<tr>
<td>D9223</td>
<td>DEEP SEDATION/GENERAL ANESTHESIA – EACH ADDITIONAL</td>
<td>Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and noninvasive monitoring protocol and</td>
<td>1. Written documentation for payment – shall justify the medical necessity based on a mental or physical</td>
<td>Exception for Howard University Hospital Dentistry, anesthesia services are administered under hospital, not required to submit anesthesia license information</td>
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remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients or duties.

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

**Drugs typically used:** Fentanyl, Versed or Valium, Sodium Bretival

**General anesthesia** is allowed with these services: (when the procedure is a covered benefit):
- Apicoectomy (D3410-D3426);
- Retrograde filling (D3430);
- Root amputation (D3450);
- Hemisection (D3920);
- Surgical extractions (D7210-D7241);
- Root recovery (D7250);
- Coronectomy (D7251);
- Other oral surgery procedures (D7260-D7291);
- Alveoloplasty (D7310-D7321);
- Vestibuloplasty (D7340-D7350);
- Removal of tumors, cysts and neoplasms (D7410-D7461);
- Excision of bone tissue (D7471-D7490);
- Surgical Incision (D7510-D7560);
- Treatment of fractures-simple (D7610-D7680);
- Treatment of fractures-compound (D7710-D7780);
- Reduction of dislocation of temporo-mandibular joint (D7810-D7877);
- Repair of traumatic wounds (D7910);
- Excision of hyperplastic tissue (D7970).

**Required Documentation**

1. Limitation or contraindication to a local anesthetic agent.

2. An anesthesia record that indicates the anesthetic agent(s) and the anesthesia time shall be submitted for payment.

3. The quantity, in 15-minute increments, that was necessary to complete the treatment shall be indicated on the 719A Form.

4. Copy of Anesthesia license on file, if not on file submit a copy.
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<tr>
<td>D6010</td>
<td>Placement of Implant</td>
<td>Special needs patients that is combative during exam/treatment (must be part of waiver program)</td>
<td><strong>Not a benefit:</strong>&lt;br&gt;a. on the same date of service as analgesia, anxiolysis, inhalation of nitrous oxide (D9230), intravenous conscious sedation/analgiesia (D9241 and D9242) or non-intravenous conscious sedation (D9248).&lt;br&gt;b. when all associated procedures on the same date of service by the same provider are denied.</td>
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<td>D9420</td>
<td>HOSPITAL OR AMBULATORY SURGICAL CENTER CALL</td>
<td>Care provided outside the dentist's office to a patient who is in hospital or ambulatory surgical center. Services delivered to the patient on the date of service are documented separately using the applicable procedure codes.</td>
<td>1. The operative report for payment—shall include the total time in the operating room or ambulatory surgical center.&lt;br&gt;2. A benefit for each hour or fraction thereof as documented on the operative report.&lt;br&gt;3. Documentation of past dental treatment notes, radiographs, IO photos may be requested</td>
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<tr>
<td>D9940</td>
<td>OCCLUSAL GUARDS, BY REPORT</td>
<td>Removable dental appliances, which are designed to minimize the effects of bruxism (grinding) and other occlusal factors.</td>
<td>1. IO photographs and radiographs of occlusal/incisal wear&lt;br&gt;2. Arch radiographs</td>
<td>~ Allowed in cases of bruxism only.&lt;br&gt;~ Occlusal guards submitted in conjunction with TMJ therapy are not covered.</td>
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