National Clinical Criteria Guidelines and Practice Parameters

LIBERTY DENTAL PLAN®

Making members shine, one smile at a time™

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PREFACE

LIBERTY Dental Plan's Clinical Criteria Guidelines and Practice Parameters were originally developed in 2005 and are subject to periodic revisions and annual review by the QMI Committee and Board of Directors. The criteria document was developed internally by our Dental Directors with input from participating panel general dentists and specialists. LIBERTY utilizes the American Dental Association's "Dental Practice Parameters," sound dental clinical principles, processes, and evidence to consistently evaluate the appropriateness of dental services that require review.

Plan/Program guidelines supersede the information contained in LIBERTY's Clinical Criteria Guidelines and Practice Parameters document.

The materials provided to you are guidelines used by this Plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract.

NEW PATIENT INFORMATION

Registration information should minimally include:

1. Name, sex, birth date, address and telephone number, cell phone number, e-mail address, name of employer, work address and telephone number.
2. Name and telephone number of person(s) to contact in an emergency.
3. For minors, name of parent(s) or guardian(s) and telephone numbers, if different from above.
4. Medical History - There should be a detailed medical history form comprised of questions which require a "yes" or "no" response, minimally including:
    a. Patient's current health status
    b. Name and telephone number of physician and date of last visit
    c. History of hospitalizations and/or surgeries
    d. History of abnormal (high or low) blood pressure
    e. Current medications, including dosages and indications
    f. History of drug and medication use (including Fen-Phen/Redux and bisphosphonates)
    g. Allergies and sensitivity to medications or materials (including latex)
    h. Adverse reaction to local anesthetics
2. History of diseases:
    a. Cardio-vascular disease, including heart attack, stroke, history of rheumatic fever, existence of pacemakers, valve replacements and/or stents and bleeding problems, etc.
    b. Pulmonary disorders including tuberculosis, asthma and emphysema
    c. Nervous disorders
    d. Endocrinal Disorders including Diabetes, and thyroid abnormalities
    e. Liver or kidney disease, including hepatitis and kidney dialysis.

f. Sexually transmitted diseases

g. Disorders of the immune system, including HIV status/AIDS

h. Other viral diseases

1. Musculoskeletal system, including prosthetic joints and when they were placed.
2. Pregnancy - Follow guidelines in the ADA publication, Women's Oral Health Issues, November 2006.

    a. Document the name of the member's obstetrician and estimated due date.

3. History of cancer, including radiation or chemotherapy
4. Social History relative to the patient's chief complaint and dental history, including any problems or complications with previous dental treatment should always be documented.
5. The medical history form must be signed and dated by the member or member's parent or guardian.
6. Dentist's notes following up on member comments, significant medical issues and/or the need for a consultation with a physician should be documented on the medical history form or in the member's progress notes.
7. Medical alerts reflecting current significant medical conditions must be uniform and conspicuously visible on a portion of the chart used during treatment.
8. The dentist must sign and date all baseline medical histories after review with the member.
9. The medical history should be updated, signed, and dated by the member and the dentist at least annually or as dictated by the member's history and risk factors.

Dental History:

1. Reason for seeking current dental care (Chief Complaint)
2. History of oral surgery, orthodontics, periodontics, etc.
3. Problems with previous dental treatment
4. Complications from local anesthesia
5. Previous Risk Assessments
6. Member's dental goals

Dental Records

Member dental records must be kept and maintained in compliance with applicable State and federal regulations. Complete dental records of active or inactive patients must be accessible for a minimum of 10 years, even if the facility is no longer under contract.

Dental records must be comprehensive, organized, and legible. All entries should be in ink, signed and dated by the treating dentist or other licensed health care professional who performed services.

Contracted dentists must make available copies of all member records upon request within the period stipulated on the request. Records may be requested for grievance resolutions, second opinions and/or for state/federal compliance. The dentist must make records available at no cost to the Plan. Noncompliance may result in disciplinary actions, up to and including transfer of enrollment or closure to new enrollment. Continued non-compliance may result in termination by LIBERTY.

Progress Notes

Progress notes constitute a legal record and must be detailed, legible and indelible. All entries must be signed or initialed and dated by the person providing treatment or include unique identifiers to support the documentation. Entries may be corrected, modified or lined out, but require the name of the person or unique identifier effecting any such changes and reflect the date of the change.

Progress notes must include documentation of anesthetic(s) used or not used including type, strength, vasoconstrictor, and amount, consistent with prevailing practice standards.

All prescriptions must be documented in the progress notes or copies kept in the chart, including the medication, dosage, amount, directions, and number of refills.

Copies of all lab prescriptions and communications should be kept in the chart.

Electronic dental records cannot be modified without identification of the person making the modification and the date of the change.

Informed Consent Process

1. Dentists must document that all recommended treatment options have been reviewed with the member and that the member understood the risks, benefits, alternatives, expectancy of success, as well as the total financial responsibilities for all proposed procedures including the outcome of refusal to have any treatment performed.
2. Appropriate informed consent must be documented, signed, and dated by the member and the dentist for the specific treatment plan that was accepted.
3. Member's refusal of recommended procedures must be documented and signed on a specific "refusal of care" document.

Poor Prognosis

Procedures recommended for teeth with a guarded or poor prognosis (endodontic, periodontal or restorative) are not covered.

Provider's recommendations of endodontic, periodontal, or restorative procedures (including crown lengthening), should consider and document the anticipated prognosis, restorability and/or maintainability of the tooth or teeth involved.

LIBERTY's licensed dental consultants review and adjudicate prognosis determinations for the above procedures based on strength of documentation and supporting evidence submitted such as radiographs and images.

LIBERTY will reconsider poor prognosis determinations for the above procedures upon receipt of a new claim with appropriate documentation and new diagnostic x-ray(s) taken a minimum of six (6) months after the original date of service.

Upgrades and Alternative Treatment

Some upgraded procedures (i.e. metals and porcelain on molars) may not be covered. It is important to review schedule of benefits prior to creating a treatment plan to ensure member is receiving a covered service.

If more than one procedure would be considered appropriate in treating a dental condition, the Alternate Treatment Plan Formula should be utilized and presented: This Formula credits the member's benefited procedure against the cost of the alternative procedure and the member's responsibility is calculated as follows: The usual total cost of the alternate treatment minus (–) the usual cost of the covered procedure plus (+) any listed copayment for the covered procedure.

If the dentist recommends or the member chooses between two covered procedures, the chosen procedure would be covered. Example: if an extraction is agreed to instead of an endodontic procedure, the extraction would be covered.

Alternative treatment plans and options should be documented with a clear and concise indication of the treatment the member has chosen. In such cases, the Alternate Treatment Plan Formula should be presented and documented.

Should a dentist not agree with a procedure requested by a member, the dentist may decline to provide the procedure and request that the member be transferred. In such cases, the dentist is responsible for completion of treatment-in-progress and emergencies until the transfer request is effective.

Consultations, referrals, and their results should be documented.

Infection Control

All contracted dentists must comply with the Centers for Disease Control (CDC) guidelines as well as other related federal and state agencies for sterilization and infection control protocols in their offices. Offices are not allowed to pass an infection control fee onto LIBERTY members.

The Applicable State Request for Pre-Estimate

To confirm benefits, it is highly recommended that a pre-estimate be submitted for large or complex treatment plans.

Minimum required records to be submitted with each request are mounted bitewings and periapical films (mounted right to left) or images of tooth/teeth involved or the edentulous areas if not visible on the bitewings.

1. Images must be of diagnostic quality and medically necessary. All images should reveal contact areas without cone cuts or overlapping, and periapical films should reveal periapical areas and alveolar bone.
2. Images must be identified by the tooth number and include date of exposure, member name, member ID, provider name, and provider ID.
3. All images, regardless of the media, must be submitted together with a completed and signed comprehensive treatment plan that details all needed treatment at the time of examination.
4. The images, digital media, photographs, or printouts must be of sufficient quality to clearly demonstrate for the reviewer, the pathology which is the basis for the authorization request.
5. If radiographs are not taken, provider must include in a narrative sufficient information to confirm diagnosis and treatment plan.
6. Any requested services that are in conjunction or reliant upon the completion of a denied service will also be denied.

CLINICAL ORAL EVALUATION

Comprehensive oral evaluation for new or established patients (CDT Code D0150) This procedure code should be used for new patients or when a patient has had significant changes in health conditions or other unusual circumstances, by report, or established patients who have been absent from active treatment for three or more years. It is a thorough evaluation of the extra-oral and intra-oral hard and soft tissues.

This includes an evaluation for oral cancer, the evaluation and recording of the patient's dental and medical history and a general health assessment. It may include the evaluation and documentation of dental caries, missing or unerupted teeth, restorations, existing prosthesis, occlusal relationships, periodontal conditions (screening and / or charting) hard and soft tissue anomalies, etc.

Periodic oral evaluation – established patient (CDT Code D0120) This procedure code is used for an established patient evaluation on a patient of record to determine any changes in the patient's dental and medical health status since a previous comprehensive or periodic evaluation. This includes an oral cancer evaluation, periodontal screening where indicated, and may require interpretation of information acquired through diagnostic procedures. The findings are discussed with the patient.

Oral Evaluation for a patient under 3 years of age and counseling with primary caregiver (CDT Code D0145) This procedure code is specifically for children under the age of three, preferably within the first six months of the eruption of the first primary tooth, including recording the oral and physical health history, evaluation of caries susceptibility, development of an appropriate preventive oral health regimen and communication with and counseling of the child's parent, legal guardian and / or primary caregiver.

Limited oral examination - problem focused (CDT Code D0140) An evaluation limited to a specific oral health problem or complaint. Typically, patients presenting with this type of evaluation present with a specific problem and/or dental emergency, trauma, acute infections, etc. (An oral evaluation of a patient less than seven years of age should include documentation of the oral and physical health history, evaluation of caries susceptibility and development of an oral health regimen.).

DIAGNOSTIC SERVICES

Image Capture With Interpretation; Should be taken only for clinical reasons as determined by the patient's dentist. Should be of diagnostic quality (reveal contact areas without cone cuts or overlapping, and periapical films should reveal periapical areas and alveolar bone) and properly identified and dated. This is a part of the patient's clinical record and the original images should be retained by the dentist. Originals should not be used to fulfill requests made by patients or third parties for copies of records. Any patient's refusal of radiographs should be documented. The Plan does not consider image capture as a separate reimbursable procedure.

Intraoral - comprehensive series of radiographic images (CDT code D0210) is a radiographic survey of the whole mouth intended to display the crowns, roots of all teeth, interproximal areas, periapical areas, and alveolar bone including edentulous areas.

Intra-oral periapical first radiographic image (CDT Code D0220) and intra-oral periapical each additional radiographic images (CDT code D0230) must include at least three (3) millimeters beyond the apex of the tooth being imaged.

Panoramic radiographic image (CDT code D0330) is a 2D Dental x-ray image that captures the entire mouth including upper and lower jaw, all teeth, temporomandibular (TMJ) joints, and even nasal and sinus area. It is a screening image and is not a substitute for periapical and/or bitewing radiographs when a dentist is performing a comprehensive evaluation except in the case of edentulous patients.

Bitewing images (CDT code(s) D0270-D0274) are radiographic images for upper and lower arch per side, which can be used to diagnose proximal and other carious lesions and bone loss due to periodontal disease.

2D Oral/Facial Photographic Image obtained Intra-orally or Extra-orally (D0350)

2D oral photographic images only reimbursed as a component of orthodontic records or for diagnostic purposes when radiographs cannot be taken due to a medical condition, physical ability, or cognitive function.

Cone beam CT Capture and Interpretations (CDT Code D03064 – D0368) CBCT (D0364-D0368, D0380- D0384) An adjunctive diagnostic aid to be used in conjunction with routine radiographic imagery for diagnosis and treatment planning for partial jaw (D0364,D0380) one full jaw (with or without cranium) (D0365, D0366, D0381, D0382), both jaws (with or without cranium) (D0367, D0383), or TMJ (D0368, D0384) under exceptional circumstances. These may include:

a. Non-specific clinical symptoms related to untreated or previously endodontically treated teeth.
b. Initial treatment of teeth with anatomic variations including additional or calcified canals, and complex morphology.
c. Re-treatment of multi rooted teeth.
d. Cases demonstrating significant risk for a complication such as nerve injury or jaw fracture as well as pathology or trauma workups.
e. For treatment involving implants or implant-related services when implants are a covered benefit.

Diagnostic Casts (D0470)- Diagnostic casts are for the evaluation of orthodontic benefits only and are only payable upon approved orthodontic treatment.

Guidelines for Processing Diagnostic Images for reimbursement:

1. An adequate number of initial radiographs should be taken by the treating provider to make an appropriate diagnosis and treatment plan. Refer to the current, published ADA/FDA radiographic guidelines: *The Selection of Patients for Dental Radiographic Examinations.*
2. Any combination of covered radiographs that meets or exceeds a provider's fee for a complete series may be adjudicated as a complete series, *for benefit purposes only.*
3. In addition, any panoramic images taken in conjunction with periapical and/or bitewing radiograph(s) may be considered as a complete series, *for benefit purposes only.* Furthermore, a panoramic x-ray is not payable when taken on the same date of service as a complete series (D0210).
4. Consistent with industry best practices and standards of care, radiographs that are taken in conjunction with a restorative or surgical procedure are considered inclusive of such procedure and not reimbursable separately.
5. The types and number of radiographic images at periodic oral evaluations or during episodic care should also be prescribed by the dentist and based on current *ADA/FDA* radiographic guidelines, including the complexity of previous and proposed care, caries, periodontal susceptibility, types of procedures and time since the member's last radiographic examination.

Panoramic radiograph (code D0330) is a screening image and is not a substitute for periapical and/or bitewing radiographs when a dentist is performing a comprehensive evaluation except in the case of edentulous patients.

1. All images should be of diagnostic quality and reveal contact areas without cone cuts or overlapping, and periapical films should reveal periapical areas and alveolar bone.
2. Radiographs should exhibit good contrast.
3. Diagnostic digital radiographs should be printed on photographic quality paper and exhibit good clarity and brightness.
4. All radiographs must be mounted, labeled left/right and dated.
5. Any member's refusal of radiographs should be documented.

<u>X-RAY duplication fee</u>

When a member is transferred from one provider to another, diagnostic copies of all x-rays less than two years old should be duplicated for the second provider. If the transfer is initiated by the provider, the member may not be charged any X-ray duplication fees. If the transfer is initiated by the member, many

plans allow the provider to charge a reasonable fee for the cost of copying the X-rays up to a maximum fee of $25.

NOTE: Under some benefit plans, x-ray duplication fees may not be allowed. Refer to the specific benefit plan to determine if a duplication fee is allowable.

Caries risk assessment and documentation with a finding of low risk, medium risk and high risk (CDT Code D0601, D0602, D0603) using recognized assessment tools.

- Only reimbursable every 12 months when completed by the same office.

PREVENTIVE SERVICES

Preventive dentistry includes oral health education and other appropriate procedures to prevent caries and/or periodontal disease, as well as passive appliances designed to prevent tooth movement, thereby promoting overall health.

1. Caries prevention may include the following procedures where appropriate:

a. Patient education in oral hygiene, nutritional and dietary counseling, and motivational interviewing

2. Prophylaxis procedures
3. Topical caries prevention or arresting treatments such as application of Fluorides, and Silver Diamine Fluoride
4. Sealants and/or preventive resin restorations

Periodontal disease prevention may include a comprehensive program of assessment, plaque removal and control in addition to the following procedures:

a. Oral and systemic health information
b. Oral hygiene, dietary and nutritional counseling
c. Prophylaxis procedures on a regular basis
d. Occlusal evaluation
e. Correction of malocclusion and mal-posed teeth
f. Restoration and/or replacement of broken down, missing or deformed teeth

Prophylaxis - adult (CDT Code D1110) Removal of plaque, calculus, and stains from the tooth structures and implants in the permanent and transitional dentition. (Ages 14 and older) It is intended to control local irritational factors.

Prophylaxis child (CDT Code D1120) removal of plaque, calculus, and stains from the tooth structures and implants in the permanent and transitional dentition. or children 13 years and younger,

1. Recognizing medical conditions that may contribute to or precipitate the need for additional prophylaxis procedures, such pregnancy, supported by the patient's physician. Verify plan benefits before performing additional prophylaxis procedures more than plan limitations.

Topical application of fluoride varnish (CDT Code D1206)

Topical application of fluoride excluding varnish (CDT Code D1208)

Sealant- per tooth (CDT Code D1351) may be medically necessary to prevent decay in a pit or fissure on a posterior tooth in which mechanically and/or chemically prepared enamel surfaces are sealed to prevent decay.

Preventive resin restoration in a moderate to high caries risk patient-permanent tooth (CDT Code D1352) may be medically necessary to prevent decay in a pit or fissure or as a conservative restoration in a cavitated lesion that has not extended into dentin.

Space maintenance through passive appliances designed to prevent tooth movement **(CDT Codes D1510 - D1558), Space maintainers (CDT Code D1575)** may be medically necessary in children to preserve the space for future eruption of a permanent tooth and/or to prevent permanent tooth movement/drifting due to premature loss of a primary molar(s).

1. Bilateral Space Maintainer Considerations:
    a. Bilaterally missing primary molars
    b. Unilateral loss of both primary molars
2. Unilateral Space Maintainer Considerations:
    a. Loss of second primary molar
    b. Loss of only first primary molar
        i. Not reimbursable when first permanent molar roots have fully formed, and tooth is in stable occlusion.

Space maintainers are not reimbursable when there is impending eruption of a succedaneous tooth

Application of caries arresting medicament – per tooth (CDT Code D1354) is the treatment of an active non symptomatic carious lesion by topical application of a caries arresting or inhibiting medicament such as Silver Diamine Fluoride without mechanical removal of sound tooth structure. Treatment with silver diamine fluoride will not eliminate the need for restorative dentistry to repair function or aesthetics, but this alternative treatment allows clinicians to temporarily arrest caries with noninvasive methods, particularly young children with primary teeth.

It is generally accepted that two applications of SDF are necessary to ensure the arrest of active carious lesions. Once it has been determined after the two treatments that caries has been arrested, restoration of these carious lesions is generally not necessary in the primary dentition. The two applications may be placed in intervals at the discretion of the treating dentist, and the benefit will be allowed up to two services per tooth in a lifetime.

Caries Preventive Medicament Application (D1355)

1. Preventive procedure contingent on provider diagnosis of member's clinical condition for primary prevention or remineralization
2. Per tooth preventive procedure (not similar to D1206 / 1208 Fl applications which are full mouth procedures).
3. D1355 is not payable on the same day as D1206, D1208
4. Applicable to both Primary and permanent teeth
5. Not payable on 3rd molars or primary teeth that are about to exfoliate
6. Tooth must have no evidence of a carious lesion
7. Prompted by documented Caries Risk Assessment finding of:
    a. High Caries Risk D0603
    b. Moderate Caries Risk D0602
8. Not payable for more than 4 teeth per visit

9. Payable once per tooth every 3 years
10. Narrative Required
11. Cannot be applied to a tooth with an existing restoration
12. Not payable with history of restorations on applicable tooth with the following CDT codes:
    a. D2140-D2161
    b. D2330-D2335
    c. D2390-D2394
    d. D2510-D2941
    e. D2960-D2962
13. Not payable in conjunction with the following codes:
    a. D1351
    b. D1354Other areas of prevention may include:
        i. **Nutritional counseling for control of dental disease (CDT Code D1310)**
        ii. **Tobacco cessation services (CDT Code D1320)**
        iii. **Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use (CDT Code D1321)**.

RESTORATIVE SERVICES

It is appropriate to restore teeth with radiographic evidence of caries, lost tooth structure, defective or lost restorations, and/or for post-endodontic purposes. Guidelines for restorative treatment include:

1. Sequencing of treatment must be appropriate to the needs of the member.
2. Restorative procedures must be reported using valid/current *CDT* procedure codes as published by *The American Dental Association*.
3. Treatment results, including margins, contours and contacts, should be clinically acceptable. The long-term prognosis should be good (estimated at 5 years or more).
4. Local anesthesia is usually considered to be part of restorative procedures.
5. Restorative procedures in operative dentistry include amalgam, composites, crowns, as well as the use of various provisional materials.
6. Tooth preparations, etching procedures, all adhesives (including amalgam bonding agents, liners, bases, and curing are included as part of the restorations.
7. Glass Ionomers when used should be reported as composite restorations.
8. All restorations include polishing as well.

Amalgam & Resin-Based Composite Restorations (CDT Codes D2140-D2161 and D2330-D2394)

Numerous scientific studies conducted over the past several decades, including two large clinical trials published in the *Journal of the American Medical Association*, indicate dental amalgam is a safe, effective cavity-filling material for children and others. In its review of the scientific literature on amalgam safety, the ADA's Council on Scientific Affairs reaffirmed that the scientific evidence continues to support amalgam as a valuable, viable and safe choice for dental patients and agreed with the U.S. Food and Drug

Administration's (FDA) decision not to place any restriction on the use of dental amalgam, a commonly used cavity filling material:

1. An amalgam restoration includes tooth preparation and all adhesives, liners and bases.

An amalgam restoration may be medically necessary when a tooth has a fracture, defective filling or decay penetrating into the dentin. An amalgam restoration should have sound margins, appropriate occlusion and contacts, and must treat all decay that is evident.

2. The procedures of choice for treating caries or the replacement of an existing restoration not undermining the cusps of posterior teeth is generally an amalgam or composite restoration.
3. Facial or buccal restorations are generally considered to be “one surface” restorations, not three surfaces such as MFD or MBD.
4. The replacement of clinically acceptable amalgam fillings with an alternative material (composite, crown, etc.) is considered cosmetic and is not covered unless decay or fracture of the existing filling is present.
5. For posterior primary teeth that have had extensive loss of tooth structure or when it is necessary for preventive reasons, the appropriate treatment is generally a prefabricated stainless-steel crown or porcelain fused to predominantly base metal laboratory processed crown for permanent teeth.
6. For anterior teeth with extensive loss of tooth structure, a porcelain/ ceramic crown may be appropriate.
7. Composite is the procedure of choice for treating caries or replacing an existing restoration not undermining the incisal edges/ cuspal surfaces of a tooth for anterior teeth. Applicable benefit criteria will apply.
8. Decay limited to the incisal edge may still be a candidate for a composite restoration if little to no other surface manifests caries or breakdown.
9. A resin-based composite restoration includes tooth preparation, acid etching, adhesives, liners, bases, and curing.
10. A resin-based composite restoration may be medically necessary when a tooth has a fracture, defective filling, recurrent decay or decay penetrating into the dentin.
11. A composite restoration should have sound margins, appropriate occlusion and contacts and must treat all decay that is evident.

Crowns - Single Restorations Only (CDT Codes D2710 – D2794)

1. Providers must complete any irreversible procedure started regardless of payment or coverage and only bill for indirect restorations when the service is completed (permanently cemented).
2. Crown services must be documented using valid procedure codes in the American Dental Association’s Current Dental Terminology (CDT).
3. When submitting a dental claim for reimbursement of multi-step procedures (i.e., crowns, dentures, etc.), the date of service shall be the date of insertion.
4. Post-operative radiograph(s) showing the delivery of the crown must be included with claim submission for payment.

A crown may be medically necessary when the tooth is present and:

1. The tooth has evidence of decay, fracture, failing restoration, etc., undermining more than 50% of the tooth.

2. When a significant fracture is identified, or when a significant portion (50% or more) of the tooth has broken or is missing and has good endodontic, periodontal and/or restorative prognoses, and is not required due to wear from attrition, abrasion, abfraction and/or erosion.
3. There is a significantly defective crown (defective margins or marginal decay) or there is recurrent decay.
4. Replacement of existing crowns require radiographic evidence or, if not evident on radiograph, an intra-oral photo (i.e., open margins or recurrent decay on buccal/lingual) supporting the necessity for replacement.
5. The tooth is in functional occlusion.
6. When anterior teeth have incisal edges/corners that are undermined or missing because of caries or a defective restoration, or are fractured off, a labial veneer may not be sufficient. The treatment of choice may be a porcelain fused to metal crown or a porcelain/ceramic substrate crown.
7. The tooth has a good endodontic, periodontic and restorative prognosis with a minimum crown/root ratio of 50% and a life expectancy of at least five years.
8. Incisal/occlusal wear that is consistent with normal attrition over time is not covered (unless meets any of the other stated criteria for coverage)
9. Crowns for purposes of esthetics only are not covered (i.e., diastema closure, tooth misalignment/position, color match, etc.)

Final crowns for teeth with a good prognosis should be sequenced after performing necessary endodontic and/or periodontal procedures and such teeth should exhibit a minimum crown/root ratio of 1:1.

In some cases, additional documentation (i.e., intra-oral photos) may be needed when pathology and/or tooth destruction is not evident radiographically to support the need for a full coverage restoration.

Stainless steel crowns (Codes D2930 – D2933) are primarily used on deciduous teeth but are also appropriate on adult teeth in some cases including Complete eruption of a posterior tooth has not yet completed.

1. Enamel defect causing patient discomfort/pain or resulting in inadequate occlusion (i.e., Enamel hypoplasia)
2. Patient's disability/inability to withstand typical crown preparation.

Upgrades

Plan designs limit the total maximum amount chargeable to a member for any combination of upgrades to $250 per unit.

Typical upgrades include:

1. Choice of metal – noble, high noble, titanium alloy or titanium porcelain on molar teeth porcelain margins, by report
2. Porcelain margin upgrades may be reported as D2999 for single crowns or as D6999 for abutment crowns.
3. Based on the plan design, porcelain margins may be charged separately. A reasonable charge should be made ($100 or less per unit). Signed informed consent accepting the optional nature of this feature must be present.

Core Buildup, including any pins when required (CDT Code D2950) must show evidence that the tooth requires additional structure to support and retain a crown. Otherwise, the service will be considered included as part of the crown restoration.

1. Core buildup refers to building up of coronal structure when there is insufficient retention for an extra-coronal restorative procedure.
2. A core buildup is not a filler to eliminate any undercut, box form, or concave irregularity in a preparation.
3. Not to be used to restore minimal recurrent caries that are likely to be removed during routine crown preparation.

Post and core (CDT Codes D2952, D2953 and D2954) By CDT definitions, each of these procedures includes a "core." Therefore, a core buildup (D2950) cannot be billed with D2952- D2954 for the same tooth, during the same course of treatment. Requires prior authorization for member of 21 years of age and older.

1. The tooth is functional, has had root canal treatment and requires additional structure to support and retain a crown.
2. Post and core in addition to crown (Code D2952), is an indirectly fabricated post and core custom fabricated as a single unit.
3. Prefabricated post and core in addition to crown (Code D2954) is built around a prefabricated post. This procedure includes the core material.

Pin retention (D2951) or restorative foundation may be medically necessary when a tooth requires a foundation for a restoration.

Repair of a restorative material failure may be medically necessary when submitted documentation establishes restorative material failure.

Outcomes and standards set by the specialty boards shall apply:

1. Margins, contours, contacts and occlusion must be clinically acceptable.
2. Tooth preparation should provide adequate retention and not infringe on the dental pulp.
3. Crowns should be designed with a minimum life expectancy or service life of five years.

CDT D2999 - Narrative describing the procedure performed along with any necessary supporting documentation required with claim submission.

ENDODONTIC SERVICES

Endodontic therapy (CDT Codes D3310-D3353) must be supported by a definitive pulpal and periapical diagnosis when considering possible endodontic procedures. An endodontic assessment may include tests to evaluate the source of pain and the stimuli that reproduce the symptoms such as:

1. Thermal
2. Electric
3. Percussion
4. Palpation
5. Mobility
6. Non-symptomatic radiographic lesions

Pulpal and apical tests are part of the examination, evaluation and treatment process and therefore are inclusive and not reimbursable when billed separately.

Treatment planning for endodontic procedures may include consideration of the following:

1. Strategic importance of the tooth or teeth
2. Prognosis – endodontic procedures for teeth with a guarded or poor five-year prognosis (endodontic, periodontal, or restorative) are not covered.
3. Excessively curved or calcified canals
4. Presence and severity of periodontal disease
5. Restorability and tooth fractures
6. Occlusion - Teeth that are predisposed to fracture following endodontic treatment should be protected with an appropriate restoration; most posterior teeth should be restored with a full coverage restoration.

Endodontic Pulpal Debridement and Palliative Treatment

If root canal therapy (RCT) is continued at the same facility, initial pulpal debridement is an integral part of the RCT. The member's copayment for the RCT is payment in full. Hence, no separate fee may be charged for pulpal debridement (CDT Code D3221) or palliative treatment (CDT Code D9110).

If a member is referred to a specialist for RCT after initiating **pulpal debridement (D3221)** or **palliative treatment (D9110)** on a tooth, the General Dentist may appropriately report either procedure D3221 or if that procedure is not listed, the procedure D9110 for palliative treatment.

Incomplete endodontic therapy: inoperable, unrestorable fractured tooth (Code D3332) is appropriate to report if, after initiating pulpal debridement (D3221) on a tooth a dentist determines that RCT is contradicted or inappropriate for the tooth due to clinical findings that were unexpected (i.e pulpal floor fracture) or not initially evident that may lend itself to an unfavorable outcome or poor prognosis.

If a member had a pulpal debridement (D3221) during an out-of-area emergency, root canal therapy may remain a covered benefit.

If RCT was started prior to the member's eligibility with the Plan, completion of the root canal therapy may not be covered.

Note: For benefit purposes, providers should document endodontic dates of service as the dates when procedures have been entirely completed, subject to review.

Endodontic services must be accompanied by a diagnosis supported by an evaluation of:

1. Pre-operative periapical radiographic images and documentation of pulp vitality testing, clinical exam, documentation of symptomology in verification of endodontic diagnosis
2. Documentation of existence of periodontic/endodontic lesions or periapical involvement
3. Documentation of tooth mobility and occlusion affecting endodontic diagnosis

Treatment planning for endodontic procedures & prognosis may include consideration of the following:

1. Documentation of comprehensive endodontic treatment plan
2. Strategic importance of the tooth or teeth
3. Presence and severity of periodontal disease
4. Restorability

a. Mitigating circumstances including patient compliance.

b. Accessibility and level of complexity of endodontic site.

c. Risk of poor outcomes due to smoking, diabetes, and other systemic diseases.

5. Following an appropriate informed consent process, if a member elects to proceed with a procedure that is not covered, the member is responsible for the dentist's usual fee. The dentist should have the member sign appropriate informed consent documents and financial agreements.
6. Teeth that are predisposed to fracture following endodontic treatment should be protected with an appropriate restoration; most teeth should be restored with a full coverage restoration.
7. Occlusion

Clinical Guidelines:

1. Diagnostic pre-operative periapical radiographic images of teeth to be endodontically treated must reveal all periapical areas and alveolar bone.
2. A rubber dam should be used and documented or evidenced radiographically for endodontic procedures.
3. Documentation of use of all materials in the procedure including identification of material used for endodontic obturation must be present.
4. The endodontic filling material should evidence adequate density and length with respect to the apex of the tooth root. All canals should be obturated.
5. Post-operative periapical radiograph(s), showing all canals and apices, must be taken immediately after completion of endodontic treatment, and included with claim submission for payment.
6. In the absence of symptoms, post-operative radiographs should be taken at appropriate periodic intervals.

Endodontic referral necessity

In cases where a defect or decay is seen to be "approaching" the pulp of a tooth and the need for endodontic treatment is not clear, LIBERTY expects the General Dentist to proceed with the decay removal and provisionalization prior to any referral to an Endodontist.

Endodontic Materials and Irrigation

Providers are contractually obligated to charge no more than the listed copayment for covered root canal procedures whether the dentist uses *BioPure*, diluted bleach, saline, sterile water, local anesthetic and/or any other acceptable alternative to irrigate the canal. Similarly, all evaluations and/or materials associated and/or are required within the standard operating procedure of root canal therapy are considered inclusive of the treatment for benefit purposes and shall not be unbundled or billed separately. These materials include but are not limited to pulpal testing, rubber dam, files, gutta percha, temporary restorative filling material, etc.

Providers may not unbundle dental procedures in an attempt to overcharge enrollees. The provider agreement and plan addenda determine what enrollees are to be charged for covered dental procedures. Even if the facility offered *BioPure* as an alternative to diluted bleach and the enrollee agreed to pay more for it, it would be considered an overcharge.

Note regarding inappropriate unbundling/coding for endodontic irrigation:

D9630 – Providers should not use this procedure code when reporting endodontic irrigation (*BioPure)*. This procedure code is primarily used to report material dispensed for home use, not to report drugs or medicaments used in the dental office.

Treatment of root canal obstruction; non-surgical access (CDT Code D3331) is defined as:

> *In lieu of surgery, the formation of a pathway to achieve an apical seal without surgical intervention because of a non-negotiable root canal blocked by foreign bodies, including but not limited to*

separated instrument, broken posts, or calcification of 50% or more of the length of the root. (CDT 2022)

Procedure D3331 is a separate, accepted procedure code. However, this additional treatment is not automatically needed to complete every endodontic procedure. In addition, this procedure should not be submitted with endodontic retreatment procedures D3346, D3347 or D3348 unless appropriate and evidenced.

LIBERTY Dental Plan will not approve a benefit for this procedure when submitted as part of a predetermination request, prior to actual treatment.

However, LIBERTY's licensed dental consultants will evaluate all available documentation on a case-by case basis when this procedure is completed and submitted for payment. Providers should submit a brief narrative or copies of the member's progress notes, to document that this additional treatment was needed and performed.

Pulpotomy (CDT Codes D3220-D3222) A pulpotomy may be indicated in a primary or permanent tooth when pulpal pathology is limited to the coronal pulp and the tooth has a reasonable period of retention function and prognosis.

Apexification (CDT Code D3351-D3353) may be indicated in a permanent tooth when there is evidence of a vital and normal pulp with an incompletely developed root or roots to allow maturation and completion of the root apex. Endodontic treatment should be completed when the root is fully formed.

Pulp Capping (CDT Codes D3110, D3120D3110, D3120)

1. This procedure is not to be used for bases and liners
2. Direct pulp capping (D3110) is a procedure in which the exposed pulp is covered with a dressing or cement that protects the pulp and promotes healing and repair. It is indicated for mechanical or accidental pulp exposures in relatively young teeth and may be indicated in the presence of a small, exposed vital or normal pulp
3. Indirect pulp capping (D3120) (re-mineralization) is indicated in teeth with caries in close proximity to the pulp without signs of pulpal degeneration or radiographic evidence of apical pathology or root resorption. A protective dressing is placed to protect the pulp from additional injury and promote healing and repair via the formation of secondary dentin. This code is not to be used for liners and bases. a. Indirect pulp treatment in primary teeth is preferable to a pulpotomy when the pulp is normal or has a diagnosis of reversible pulpitis. Teeth with immature roots should be selected to promote continued root development and apexogenesis

Endodontic surgical treatment should be considered only in special circumstances, including:

1. The root canal system cannot be instrumented and treated non-surgically
2. There is active root resorption
3. Access to the canal is obstructed
4. There is gross over-extension of the root canal filling
5. Periapical or lateral pathology persists and cannot be treated non-surgically

Root fracture is present or strongly suspected restorative considerations make conventional endodontic treatment difficult or impossible.

Endodontic procedures may not be covered when a tooth or teeth have a poor prognosis due to:

1. Untreated or advanced periodontal disease
2. Gross destruction of the clinical crown and/or root decay at or below the alveolar bone
3. A poor crown/root ratio

CDT D3999 - Narrative describing the procedure performed along with any necessary supporting documentation required with claim submission

PERIODONTIC SERVICES

Evaluation for evidence of periodontal disease is considered essential for all patients irrespective of age. If pocket depths do not exceed 3 mm and there is no bleeding on probing it is appropriate to document the member's periodontal status as Type I

Comprehensive periodontal oral evaluations – new or existing patient (CDT Code D0180) is indicated for patients showing signs or symptoms of periodontal disease and for patients with risk factors such as smoking or diabetes. It includes evaluation of periodontal conditions, probing and charting, an evaluation for oral cancer, the evaluation and recording of the patient's medical and dental history and general health assessment, in addition to the evaluation and recording of dental caries, missing or unerupted teeth, restorations, and occlusal relationships.

Comprehensive periodontal evaluations should include the following:

1. Quality and quantity of gingival tissue
2. Documentation: six-point periodontal probing for each tooth
3. The location of bleeding, exudate, plaque and/or calculus
4. Significant areas of recession, mucogingival problems, level and amount of attached gingiva
5. Mobility
6. Open or improper contacts
7. Furcation involvement
8. Occlusal contacts or interferences

Following the completion of a comprehensive evaluation, a diagnosis and treatment plan should be complete

Full mouth debridement to enable a comprehensive oral periodontal evaluation and diagnosis on a subsequent visit (CDT Code 4355) This procedure would be followed by the completion of a comprehensive periodontal evaluation at a subsequent appointment. This rescheduling may allow some initial soft tissue response and shrinkage prior to performing full mouth periodontal probing.

Note, this procedure:

1. Must be supported by radiographs or if necessary, intra-oral photos as evidence of heavy calculus
2. Is not a replacement code for procedure D1110
3. Is not appropriate nor reimbursable on the same day as procedure D0180

Scaling in the presence of generalized moderate or severe gingival inflammation (CDT Code D4346) is "The removal of plaque, calculus and stains from supra- and sub-gingival tooth surfaces when there is generalized moderate or severe gingival inflammation in the absence of periodontitis. It is indicated for patients who have swollen, inflamed gingiva, generalized suprabony pockets, and moderate to severe

bleeding on probing. It should not be reported in conjunction with prophylaxis, scaling and root planing, or debridement procedures."

1. This procedure is for generalized moderate to severe gingival inflammation.
2. The ADA suggests that "generalized" would apply when 30% or more of the patient's teeth at one or more sites are involved, which is analogous to the AAP definition of generalized chronic periodontitis.
3. The Loe & Silness Gingival Index can be a guideline for defining "moderate to severe inflammation"
4. Moderate inflammation - redness, edema, glazing; bleeding on probing (mild inflammation lacks bleeding on probing)
5. Severe inflammation - marked redness and edema, ulceration; tendency toward spontaneous bleeding
6. This is a therapeutic procedure, to treat a diagnosed disease.
7. It is based on a diagnosis, not on intensity of treatment required.
8. It is appropriate for patients who do not have periodontitis (i.e. attachment loss).
9. It is performed after a periodic or comprehensive exam.
10. It can be performed on same date of service as the exam.
11. It is a full mouth procedure, not a per quadrant procedure.
12. Can be used for any age patient, and in any dentition stage (note that benefits vary by each member's plan design).
13. "...in conjunction with..." means on the same date of service. Prophylaxis and scaling and root planing procedures may be performed at a future date, after Code D4346, as long as the codes thereafter are used appropriately.
14. Periodontal Maintenance (Code D4910) is not appropriate as a follow-up to Code D4346, since Code D4346 isn't performed to treat periodontal disease.
15. Consider this procedure code when the patient's periodontium is not healthy, and the periodontal disease diagnosis is limited to soft tissue (gingivitis) and is generalized but has not progressed to the advanced disease stage with bone loss (periodontitis).

Periodontal scaling and root planing (4 or more teeth and one to three teeth respectively) (CDT Code D4341- D4342) Treatment involves the instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. It is indicated for patients with periodontal disease and is considered therapeutic and 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 part of pre-surgical procedures in others. (CDT 2022). Scaling and root planing is indicated for patients who have infrabony pockets due to attachment loss in addition to swollen, inflamed gingival, and moderate to severe bleeding on probing. The presence of subgingival plaque and calculus alone does not indicate the need for scaling and root planing.

The absence of calculus should be evident on post treatment radiographs. These procedures are:

1. Considered to be within the scope of a General Dentist or a dental hygienist

2. Indicated when a full mouth series of radiographs reveals evidence of bone loss to expose root surfaces and is supported by full mouth periodontal pocket charting demonstrating at least 4 mm pocket depths with documented signs of inflammation.
3. It is common for radiographs to reveal evidence of interproximal root calculus. If LIBERTY determines that there are too few teeth with a good prognosis in each respective quadrant, we may approve an alternate, more appropriate code (i.e., D4342).
4. Periodontal scaling and root planing is arduous and time consuming, involving instrumentation of the crown and root surfaces to remove plaque, calculus, and infected cementum typically under local anesthetic. Following scaling and root planing, post-operative discomfort and sensitivity is often experienced by patients.
5. To minimize the potential post-operative discomfort for members, prevent excessive anesthesia, and to help ensure sufficient time is allotted for thorough scaling and root planing, no more than 2 quadrants of SRP will be payable by the plan when completed on the same date of service unless a medical or other condition is present that would justify such AND there is demonstration of sufficient clinical treatment time to adequately perform judicious scaling and root planing of the submitted quadrants. Per clinical review, in the absence of such information, LIBERTY may limit the approval to no more than 2 quadrants on any given date of service.
6. Any localized scaling and root planing would be included within periodontal maintenance procedure CDT Code D4910.
7. It is usually not appropriate to perform D1110 and D4341 on the same date of service. LIBERTY's licensed dental consultants may review documented rationale for any such situations on a case-by case basis.
8. Periodontal maintenance at regular intervals should be instituted subsequent to scaling and root planing to maintain the periodontal condition or improve the tissue response. Periodontal pocket depths and gingival status should be recorded periodically.
9. The patient's homecare compliance or lack thereof and instructions should be documented.

Definitive vs. Pre-Surgical scaling and root planing:

For early stages of periodontal disease, this procedure is used as definitive non-surgical treatment, and the member may not need to be referred to a Periodontist based upon tissue response and the member's oral hygiene.

For later stages of periodontal disease, the procedure may be considered pre-surgical treatment, and the member may need to be referred to a Periodontist, again based on tissue response and the member's oral hygiene.

Note: LIBERTY Dental Plan requires that both definitive and pre-surgical scaling and root planing to be provided at a primary facility before considering referral requests to a periodontal specialist.

If a clinician recommends and/or completes more than two quadrants per appointment, documentation supporting the additional quadrant(s) must be included with any claim and in the member's progress notes. This documentation should include:

1. Amount of Local anesthesia used. If it is not used, the reason(s) should be documented. The use of topical anesthetics is part of and included in this procedure.
2. Existing medical or other condition that supports such treatment.
3. Length of appointment time allotted for procedure.

Other Periodontic Services

Periodontal maintenance (CDT Code D4910) at regular intervals should be instituted following scaling and root planing if the periodontal condition has improved to a controllable level. Periodontal pocket depths and gingival status should be recorded periodically. The patient's homecare compliance and instructions should be documented.

Periodontal maintenance and supportive therapy intervals should begin not less than four weeks following primary care treatment of periodontal disease, and should be individualized, based on the patient's risk profile, although three-month recalls are common for many patients.

a. Periodontal Maintenance (Code D4910) may be allowed for 3 years (or even longer) when there is a history of periodontal therapy evident in the patient's treatment record (by report, by LIBERTY record, or by narrative) and a current periodontal chart is provided. Without a history of periodontal therapy (i.e., D4341/D4342), periodontal maintenance is not indicated and therefore will not be covered.

Periodontal Irrigation (CDT Code D4921) Periodontal irrigation is an adjunctive procedure in periodontal treatment and/or in the presence of gingival inflammation.

a. D4921 is considered inclusive, for benefit purposes, of periodontal procedures (D1110, D1120, D4341/42, D4346, D43455, D4910) and is therefore not covered when completed in conjunction with such procedures. Furthermore, members cannot be billed for this service if the periodontal procedure is a covered benefit nor denied treatment of the covered periodontal service.

Note: A patient's refusal of irrigation does not constitute grounds for requesting a patient transfer.

Soft Tissue Management Programs (STMP)

The following benefited procedures may not be bundled within fees for soft tissue management programs:

1. Periodontal evaluation/pocket charting/re-evaluation (these procedures are considered part of and included in the evaluation codes).
2. Gross debridement and scaling/root planing.
3. Plans may cover one prophylaxis procedures in a 12-month period, which includes oral hygiene instructions (refer to the plan-specific benefits, limitations and exclusions). Prophylaxis is not appropriate on the same date as root planing or full mouth debridement.
4. Patients must sign an elective treatment form if they choose to accept soft tissue management procedures in addition to the procedures listed above.

Drugs or medicaments dispensed in the office for home use (CDT Code 9630) .Should not be used in reporting irrigation with chlorhexidine or prescriptions written. Documentation and/or narrative of drugs/medicaments dispensed in office must be submitted with claim submission.

Localized delivery of antimicrobial agents (Code D4381) via a controlled release vehicle into diseased crevicular tissue, per tooth.

1. Benefits are not available when D4381 is performed with D4341 or D4342 in the same quadrant on the same date of service.
2. Dentists may consider the appropriate use of local delivery antimicrobials for chronic periodontitis patients AFTER the following steps:
    a. A clinician has completed D4341/D4342 and allowed a minimum 4-week healing period. Upon re-evaluation the patient's pockets are re-probed and re-evaluated to determine the clinical response to the scaling and root planing.

b. Re-evaluation confirms that several teeth were non-responsive to scaling and root planing, with localized residual pocket depths of 5 mm or deeper plus inflammation.

LIBERTY dental consultants may approve D4381 benefits for non-responsive cases following scaling and root planing on a report basis:

1. In such cases, benefits may be approved for two teeth per quadrant in any 12-month period.
2. Other procedures, such as systemic antibiotics or surgery, should be considered when multiple teeth with 5 mm pockets or deeper exist in the same quadrant.

Treatment alternatives such as systemic antibiotics or periodontal surgery instead of procedure D4381 may be considered when:

1. Multiple teeth with pocket depths of 5 mm or deeper in the same quadrant that were non-responsive to non-surgical periodontal treatment (D4341/D4342)
2. Procedure D4381 was completed at least 4weeks after D4341 but a re-evaluation of the patient's clinical response confirms that D4381 failed to control periodontitis (i.e., a reduction of localized pocket depths)
3. Anatomical defects are present (i.e., infrabony defects)

Source: *American Academy of Periodontology Position Paper, Systemic Antibiotics in Periodontics. November 2004*

WARNINGS/PRECAUTIONS: This procedure may be contra-indicated during pregnancy.

Source: *May cause fetal harm during pregnancy,* ADA/PDR Guide to DENTAL THERAPEUTICS, Fourth Edition

Periodontal surgical procedures:

Periodontal surgical procedures are covered when the following factors are present:

1. The patient must exhibit a willingness to accept periodontal treatment and practice an appropriate oral hygiene regimen prior to consideration for periodontal surgical procedures.
2. Case history, including patient motivation to comply with treatment and oral hygiene status, must be documented.
3. Patient motivation may be documented in a narrative by the attending dentist and/or by a copy of patient's progress notes documenting patient follow through on recommended regimens.
4. In most cases, there must be evidence of scrupulous oral hygiene for at least three months prior to the pre-authorization for periodontal surgery.
5. Consideration for a direct referral to a Periodontist would be considered on a case-by-case basis. However, definitive and pre-surgical scaling and root planing, oral hygiene instructions and other pre- and non-surgical procedures should be completed by a general dentist prior to specialist referral consideration.
6. Periodontal surgical procedures are covered only in cases that exhibit a favorable long-term prognosis. Surgical procedures for the retention of teeth that are being used as prosthetic abutments are covered only when the teeth would exhibit adequate bone support for the forces to which they are, or will be, subjected.
7. Periodontal pocket reduction surgical procedures should result in the removal of residual calculus and granulation tissue with improved physiologic form of the gingival tissues.

a. Osseous surgery and regenerative procedures should also correct and reshape deformities in the alveolar bone where indicated.

b. Soft tissue gingival grafting should be done to correct gingival defects where appropriate.

8. If LIBERTY determines that there are too few teeth with a good prognosis in each respective quadrant, we may approve an alternate, more appropriate code.

Gingivectomy/Gingivoplasty (CDT Codes D4210 - D4212)- 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.

1. May be covered in cases where the pocket depths are 5 mm's or greater, following soft tissue responses to periodontal treatment.
2. Indication for performance of the gingivectomy is the complete elimination of the suprabony fibrous pockets or pseudo-pockets.
3. Appropriate radiographs and periodontal charting must be submitted with the request for these services.
4. Intra-oral photos should be included to support the need for gingivoplasty services to restore abnormal gingival architectures, asymmetry, etc.
5. D4212- Gingivectomy or gingivoplasty to allow access for a restorative procedure.

    a. Management of soft tissues performed during a restorative or tooth preparation procedure, including final impressions, is considered, for insurance purposes, to be part of and included in those procedures and therefore not separately reimbursable.

Osseous Surgery (CDT Codes D4260 and D4261) may be covered in cases where the pocket depths are 5 mms or greater following soft tissue responses to scaling and root planing documented at a periodontal maintenance procedure, and there is objective evidence of periodontal bone deformity. Consideration should be given for long-standing pockets of 5 mm following previous surgical intervention, which may or may not require further surgical intervention.

1. Periodontal pocket reduction surgical procedures may be covered in cases where the pocket depths are 5 mm or deeper, following the re-evaluation of soft tissue responses to scaling and root planing.
2. Osseous surgery procedures may not be covered if:

    a. Pocket depths are 4 mm or less and appear to be maintainable by non-surgical means (i.e., periodontal maintenance and root planing)

    b. Patients are smokers or diabetics whose disease is not being adequately managed.

3. No more than 2 quadrants of osseous surgery will be payable by the plan when completed on the same date of service unless a medical or other condition is present that would justify such.

Clinical crown lengthening – hard tissue (CDT Code D4249) This procedure is employed to allow restorative procedure on a tooth with little or no tooth structure exposed to the oral cavity. Crown lengthening requires reflection of a full thickness flap and removal of bone, altering the crown to root ratio. It is performed in a healthy periodontal environment, as opposed to osseous surgery, which is performed in the presence of periodontal disease. (CDT 2022)

It would not be considered good clinical practice to perform a periodontal surgical procedure on the same tooth on the same date of service as a final impression for a fixed or removable prosthesis, as healing has not occurred, which could change the tooth / tissue / bone architecture substantially affecting the outcome

of the prosthesis. As a result, this service is not reimbursable when done on the same date of service as crowns, bridges or a removable prosthesis.

LIBERTY considers the management of soft tissues performed during a restorative procedure or crown preparation with final impressions to be a part of and included in the fee for the related procedure. Providers may not charge LIBERTY or the member a separate fee for D4249 if it is performed on the same tooth on the same day as preparation and final impressions for a crown.

Bone replacement grafting (CDT Codes D4263 and D4264) in conjunction with osseous surgery involves the use of grafts to stimulate periodontal osseous regeneration when the disease process has led to a documented deformity of the bone surrounding a tooth or teeth. This procedure requires the presence of a tooth at the site of the grafting and may not be used in conjunction with an extraction procedure.

Biologic materials and/or guided tissue regeneration (CDT Codes D4265 – D4267) may be used during osseous surgery to help correct a documented deformity of the bone surrounding a natural tooth or teeth and is necessary to aid in osseous regeneration.

D4266 and D4267 should not be used for peri-implant defects. D6106 & D6107 are indicated for peri-implant defects.

Removal of non-resorbable barrier (D4286) Considered inclusive when completed by same provider who placed the non-restorable material or barrier.

Soft or connective tissue grafting (CDT Codes D4277 and D4278) may be used to correct a documented mucogingival defect when:

1. Marginal tissue is insufficient, and the tooth or teeth have a good prognosis (i.e., periodontal prognosis, endodontic prognosis and restorative prognosis).
2. Mucogingival grafting is required in presence of gingival recession or lack of keratinized gingiva and generally requires intra-oral photographic evidence of the mucogingival defect.

Affected teeth must have good endodontic, periodontal and restorative prognosis.

Note: LIBERTY may determine that the graft requested is better described under a different procedure code.

Provisional splinting (CDT Codes D4320 and D4321) may be necessary when documentation demonstrates the need for interim stabilization of mobile teeth.

Lasers

Lasers are considered as instruments or tools used to deliver care, and not procedures. Any use of a laser is part of and included in the fee of the CDT designated and provided procedure. A valid *ADA/CDT* procedure code for the more inclusive procedure should be reported.

Laser-Mediated Sulcular and/or Pocket Debridement

It is LIBERTY's assertion:

> *If one considers the clinical parameters of reductions in probing depth or gains in clinical attachment level, the dental literature indicates that when used as an adjunct to SRP, mechanical, chemical, or laser curettage has little to no benefit beyond SRP alone. The available evidence consistently shows that therapies intended to arrest, and control periodontitis depend primarily on effective debridement of the root surface and not removal of the lining of the pocket soft tissue wall, i.e., curettage. Currently, there is minimal evidence to support use of a laser for the purpose of subgingival debridement, either as a monotherapy or adjunctive to SRP.*

CDT D4999 Narrative describing the procedure performed along with any necessary supporting documentation required with claim submission.

Source: *American Academy of Periodontology, April 2011*

FIXED PROSTHODONTIC SERVICES

Fixed prosthodontics is the area of prosthodontics focused on permanently attached (fixed) dental prostheses. Such dental restorations, also referred to as indirect restorations, include crowns, bridges (fixed dentures), inlays, onlays, and veneers.

1. Scope for ~~a~~ fixed bridges are not covered benefits in the presence of untreated moderate to severe periodontal disease, as evidenced in x-rays, or when a proposed abutment tooth or teeth have poor crown/root ratios. A bridge will not be covered if the abutment teeth, do not exhibit a good long term endodontic, periodontic and restorative prognosis with a minimum crown/root ratio of 50% and a life expectancy of at least five years.
2. Evaluation and diagnosis of any patient's periodontal status or active disease should be documented with recent full mouth periodontal probing and then submitted for any benefit determination request. Replacement of existing crowns require radiographic evidence or, if not evident on radiograph, an intra-oral photo (i.e., open margins or recurrent decay on buccal/lingual) supporting the necessity for replacement.
3. Bridge abutments should generally be full coverage crowns.
4. A cantilevered pontic for the replacement of a missing posterior tooth is not covered. However, a mesial cantilevered pontic may be considered for the replacement of a maxillary lateral incisor when an adequate adjacent cuspid can be used for the abutment crown.
5. Third molars should generally not be replaced, particularly if the replacement would not be functional.
6. CDT crown codes that are submitted should be accurate and specific for bridges. Single crown codes (i.e., D2740) used instead of the retainer crown codes will not be accepted.

**Post-operative radiograph(s) showing the delivery of the bridge must be included with claim submission.

REMOVABLE PROSTHODONTICS

Providers may report the dates of service for these procedures to be the dates when these removable appliances are delivered to member.

Conventional Complete Dentures (CDT Codes D5110 and D5120)

1. Complete dentures are the appliances of last resort, particularly in the mandibular arch. Patients should be fully informed of their significant limitations. A complete denture may not be covered if some teeth are still present in the arch and extraction of the remaining teeth is not necessary.
2. Establishing vertical dimension is a part of and included in the fee/process for fabricating a complete denture (standard, interim or immediate). Therefore, benefits for a complete denture are not limited or excluded in any way simply because of the necessity to establish vertical dimension.
3. Removable prosthetic (immediate and conventional complete dentures, partial dentures) services include routine post-delivery care, adjustments, and soft liners for twelve months.
4. Proper patient education and orientation to the use of removable dentures should be part of the diagnosis and treatment plan. Educational materials regarding these prostheses are highly encouraged to avoid misunderstandings and grievances, and to manage patient expectations.
5. Complete dentures may not be covered for replacement if an existing appliance can be made satisfactorily functional by relining or repair.

6. Complete dentures may not be covered if a clinical evaluation reveals the presence of a satisfactory appliance, even if a patient demands replacement due to their own perceived functional and/or cosmetic problems.
7. **All tooth extractions in the arch should be completed, and adequate healing time should be given prior to the final impression.**

Immediate Complete Dentures (CDT Codes 5130-5140)

1. Immediate complete dentures are fabricated prior to and inserted immediately after all remaining teeth are removed in that arch.
2. While immediate dentures offer the benefit of never having to be without teeth, they must be relined (refitted on the inside) during the healing period after the extractions have been performed. The reason for such relining is that the shape of the supporting soft tissues and bone changes significantly during healing, causing the denture to become loose.
3. An informed consent outlining the benefits and drawbacks of immediate dentures should be signed by the patient prior to fabrication of immediate dentures.
4. Immediate Denture(s) may be designed to be the permanent set of dentures or are planned to be interim/temporary for the post-extraction healing phase only. Clear understanding of the intent of the provider regarding whether or not the immediate denture(s) will be the final definitive dentures or just used as an interim appliance should be clearly stated in the treatment plan that is signed by the member. **Partial Dentures (CDT Codes D5211-5281)**

1. A removable partial denture is normally not indicated for a single tooth replacement of non-functional second or third molars.
2. Partial dentures may be covered when posterior teeth require replacement on both sides of the same arch.
3. Partial dentures may not be covered for replacement if an existing appliance can be made satisfactorily functional by relining or repair.
4. Partial dentures may not be covered if a clinical evaluation reveals the presence of a satisfactory appliance, even if a patient demands replacement due to their own perceived functional and/or cosmetic problems.
5. Unilateral removable partial dentures are rarely appropriate, as they may be readily swallowed or inhaled into a patient's lungs.
6. Abutment teeth should be restored prior to the fabrication of a removable appliance and may be covered if such teeth meet the same standalone benefit requirements for that restoration..
7. Partials should be designed to minimize any harm to the remaining natural teeth.
8. Materials used for removable partial dentures should be strong enough to resist breakage during normal function, nonporous, color stable, esthetically pleasing, non-toxic and non-abrading to the opposing or supporting dentition.
9. A partial denture will not be covered if the remaining teeth, especially abutment teeth, do not exhibit a good long term endodontic, periodontic and restorative prognosis with a minimum crown/root ratio of 50%.
10. A partial denture will not be covered if untreated moderate-severe periodontal disease is present.

Complete or partial denture adjustments (CDT Codes D5410 – 5422) are payable after 6 months of initial seat date and may be necessary after a reline to complete or partial denture has taken place.

Repairs to complete and partial removable dentures (CDT Codes D5511 – D5671) must include documentation that demonstrates the appliance is broken or in need of repair.

Relines for Complete and Partial Removable Dentures (CDT Codes D5730 – D5761):

1. Supporting soft tissues and bone shrink over time, resulting in decreased retention and/or stability of the appliance.
2. A rebase or reline of a partial or complete denture would be covered if documentation demonstrates that the appliance is ill-fitting and may be corrected by rebasing or relining, resulting in a serviceable appliance.

The coverage of relines and repairs may be subject to various limitations, such as early follow-up repairs or relines after recent delivery.

Interim Removable Partial Dentures (CDT Codes D5810 - D5821)

1. These appliances are only intended to temporarily replace extracted teeth during the healing period before fabrication of a subsequent fixed or removable partial denture or implant. Benefits may not exist for both an interim and definitive partial denture.
2. The submitted documentation must show that the existing partial denture is unserviceable.
3. Removable partial dentures are covered when posterior teeth require replacement on both sides of the same arch or multiple edentulous areas are present (excluding non-functional second or third molars) and the remaining teeth have a good prognosis.
4. Discussion of coverage and benefits for any interim appliances that are planned to be interim or temporary should be clearly discussed and agreed upon by the member before proceeding with optional, elective, upgraded or non-covered services. Evidence of such a discussion would be member signature on informed consent forms, treatment plan documents, chart progress notes and/or financial consent forms.

Tissue conditioning (CDT Codes D5765 and D5851) may be required when documentation shows that the tissue under a removable appliance is unhealthy or must be treated prior to fabricating a new appliance or rebasing or relining an existing appliance.

A precision attachment (Code D5862) The placement of a precision attachment requires documentation that it is medically necessary to stabilize a removable appliance. Each pair of components (male and female) is one precision attachment.

Unspecified removable prosthodontic procedure, by report (CDT D5899): Used for a procedure that is not adequately described by a code.

1. Denture upgrades including but not limited to, porcelain teeth, inscriptions, gold, etc., are not covered by the plan and should not be billed as D5899.
2. Narrative describing the procedure performed along with any necessary supporting documentation required with claim submission.

DENTAL IMPLANT SERVICES

A thorough history and clinical examination leading to the evaluation of the member's general health and diagnosis of his/her oral condition must be completed prior to the establishment of an appropriate treatment plan. Implants are a great way to restore function for patients when utilized effectively and appropriately. The purpose of our implant guidelines is to help ensure providers are considering a member's entire oral

condition when treatment planning to confirm members are receiving an appropriate and comprehensive approach to replacing all missing teeth and restoring their function. Implants may be a covered benefit when considered appropriate, and logical treatment consistent with professional industry standards given the patient's current oral condition and the following guidelines are met:

1. Full mouth x-rays and a comprehensive treatment plan required with pre-authorization requests.
2. Considerable coverage includes but not limited to; implant(s) placed in the posterior region must oppose fixed dentition thereby creating increased functionality for the patient once the implant is restored.
3. Fixed dentition is defined as:
    a. Natural tooth
    b. Existing or approved fixed partial denture (bridge)
    c. Existing or approved implant

Any planned fixed partial denture/implant must be on the same pre-authorization and approved to be considered for occlusion purposes.

In addition to the above criteria, the following criteria and guidelines apply for implant placement (D6010, D6013):

1. Anterior Region Criteria requires that the utilization of the implant benefit must result in a full complement of anterior teeth for that arch; No anterior teeth can remain missing in the same arch.
2. Posterior Region: Criteria requires that there must be at least 8 points of existing posterior contact at the time of request for services.
    a. Contact defined as occlusion between fixed dentitions.
    b. Contact of one upper and one lower posterior tooth equals 2 points of contact

*Post-operative periapical radiograph(s), showing placement of the implant, must be taken and included with claim submission for payment

Prefabricated/Custom Abutments (D6056, D6057): When utilized, abutments attach to an implant body, and provide support and retention for a crown. Custom abutments are laboratory processed and specific for an individual application.

Implant Supported (D6065-66, D6082-88) & Abutment Supported Single Crowns (D6058-66)

1. Abutment supported crowns are retained and supported by an abutment which connects to the implant.
2. Implant supported crowns do not utilize an abutment and are directly retained, supported, and stabilized by the implant body.
    a. Implant supported crowns that are submitted with an abutment for the same implant will not be covered as these services together are not compatible.
3. Opposing fixed dentition is required for crown coverage consideration.

*Post-operative radiograph(s) showing the delivery of the abutment and/or crown must be included with claim submission for payment.

Note: Exceptions to these criteria may be considered on a case-by-case basis for implant coverage

Bone Graft at Time of Implant Placement (CDT Code D6104) For this service to be covered at an existing edentulous site, bone grafting at the time of implant placement requires intra-oral photos or CBCT supporting the need for additional bone when it is not evident on x-rays alone.

Guided Tissue Regeneration (D6106-7)- This procedure does not include flap entry and closure, or, when indicated, wound debridement, osseous contouring, bone replacement grafts, and placement of biologic materials to aid in osseous regeneration. This procedure is used for peri-implant defects and during implant placement. Supporting documentation requirements of D6104 apply for these services.

Removal of implant body not requiring bone removal nor flap elevation (D6105)

Alveoloplasty (CDT Codes D7310/11 - D7320/21) Must be in preparation for a prosthesis (conventional or implant supported full denture) to be considered for coverage. Documentation must be provided supporting the need for this service (i.e., excessive bony buccal undercuts) as not all denture cases require alveoloplasty.

Any minor bone leveling or removal at the implant site is considered inclusive of the surgical placement of the implant (D6010). Similarly, any necessary bone removal following an extraction is inclusive of the extraction procedure.

Removable Appliances (CDT Codes D5211-D5228) Are not covered in the same arch as approved posterior implants or fixed partial dentures. D5820, D5821- Interim Removable Partial Dentures will only be considered in such scenarios

Implant Supported Fixed Partial Dentures (Bridges) (Denture (CDT Codes D6068-D6077, D6194) Are a covered benefit when the criteria for implant placement have been met**.**

1. Implant Fixed Partial Dentures that utilize a natural tooth as an abutment are not covered under the plan.
2. CDT codes specific for implant retainer crowns must be used. Single crown codes (i.e D2740, D6058) used instead of the implant retainer crown codes will not be accepted. In addition, the type of retainer crown (implant retained vs abutment retained) should be consistent with any associated treatment of the implant.

Implant Supported Dentures (CDT Codes D6110-D6117)

1. **Full Dentures (Removable: D6110/D6111 Fixed: D6114/D6115** Opposing occlusion not considered for implant placement for implant supported full dentures.
    a. Implants placed to retain and support dentures are covered when considered necessary due to inadequate existing retention. In full denture cases, up to four implants will be covered on the upper arch and two covered on the lower arch unless documentation supports the need for additional implants.
2. **Partial Dentures (Removable: D6112/D6113, Fixed: D6116/D6117)**
    a. Periodontal prognosis of existing dentition must be favorable
    b. Are not covered in the presence of untreated moderate to severe periodontal disease.
    c. Implant placement for support of an implant supported partial denture is covered only when there are insufficient existing teeth to support a conventional removable partial denture.

*Due to the design of removable implant supported dentures, abutments used in conjunction with these dentures are semi-precision abutments (D6191/DD6192). Fixed implant supported dentures utilize prefabricated or custom abutments (D6056/D6057). Requests for implant supported dentures with incompatible abutments will not be covered.

Semi-precision Abutments/Attachments (D6191, D6192): Includes the placement of the semi-precision abutment to the implant body (D6191) and the luting of the semi-precision attachment to the removable prosthesis (D6192) Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant (D6197)

A conservative treatment plan should be considered prior to providing a member with one or more implants. Treatment plans utilizing implants must consider the prognosis of the existing teeth in that arch. If existing dentition reveals poor periodontal prognosis, implants may not be covered. Implants are not covered benefits in the presence of untreated moderate to severe periodontal disease.

Note: Crown(s) and fixed partial prosthetics for dental implants may be contraindicated for the following reasons:

a. Adverse systemic factors such as diabetes and history of recent smoking habit

b. Poor oral hygiene and tissue management by the member.

c. Inadequate Osseo-integration of the dental implant(s), (mobility) prior to loading

d. Excessive parafunction or occlusal loading

e. Poor positioning of the dental implant(s)

f. Excessive loss of bone around the implant prior to its restoration

g. Inadequate number of implants or poor bone quality for long span prostheses

h. Need to restore the appearance of gingival tissues in high esthetic areas.

i. When the member is under sixteen (16) years of age, unless unusual conditions prevail.

Restoration

The restoration of dental implants differs in many ways from the restoration of teeth, and as such, the restoration of dental implants has separate guidelines.

1. Care must be exercised when restoring dental implants so that the occlusal and lateral loading of the prosthesis does not damage the integration of the dental implant system to the bone or affect the integrity of the implant system itself.
2. Care must also be exercised when designing the prosthesis so that the hardness of the material used is compatible with that of the opposing occlusion.
3. Jaw relationship and inter-arch vertical distance should be considered in the initial treatment plan and selection of retentive and restorative appliances.

Outcomes

1. The appearance of fixed prosthetic appliances for implants may vary considerably depending on the location, position and number of implants to be restored.
2. The appearance of the appliances must be appropriate to meet the functional and esthetic needs of the member.
3. The appearance and shape of the fixed prosthesis must exhibit contours that are in functional harmony with the remaining hard and soft tissues of the mouth.
4. They must exhibit good design form to facilitate good oral hygiene, even in cases where the prosthesis may have a ridge lap form.

5. Fixed implant prostheses must incorporate a strategy for removal of the appliance without damage to the implant, or adjacent dentition, so that the implant can be utilized in cases where there is further loss of teeth, or where repair of the appliance is necessary.
6. Multiple unit fixed prostheses for implants must fit precisely and passively to avoid damage to the implants or their integration to the bone.
7. It is a contra-indication to have a fixed dental prosthesis abutted by both dental implant(s) and natural teeth (tooth) without incorporating a design to alleviate the stress from an osseointegrated (non-movable) abutment to a natural tooth supported by the periodontal ligament allowing slight movement.
8. It is the responsibility of the restoring dentist to evaluate the initial acceptability of the implants prior to proceeding with a restoration.
9. It is the responsibility of the restoring dentist to instruct the member in the proper care and maintenance of the implant system and to evaluate the member's care initially following the final placement of the prosthetic restoration.
10. Fixed partial prostheses, as well as single unit crowns, are expected to have a minimum life expectancy or service life of five (5) years.

FIXED PROSTHODONTIC SERVICES

Fixed partial dentures (bridgework) are considered beyond the scope of the Medicaid dental program. However, the fabrication of fixed partial denture shall be considered of prior authorization only when medical condition or employment preclude the use of removable partial denture.

Retainer Pontics and crown (CDT Codes D6205-6793) are used when a single posterior tooth is missing on one side of an arch and there are clinically adequate abutment teeth on each side of the missing tooth, the general choices to replace the missing tooth would be a fixed bridge or an implant.

1. If it is also necessary to replace teeth on the opposite side of the same arch, the benefit would generally be a removable partial denture instead of the fixed bridge.
2. Fixed bridges are not covered benefits in the presence of untreated moderate to severe periodontal disease, as evidenced radiographically, or when a proposed abutment tooth or teeth have poor crown/root ratios.
3. When up to all four incisors are missing in an arch, the potential abutment teeth are clinically adequate, and implants are not appropriate, possible benefits for a fixed bridge may will be evaluated on a case-by-case basis. Evaluation and diagnosis of any patient's periodontal status or active disease should be documented with recent full mouth periodontal probing and then submitted for any benefit determination request.
4. Dental Consultants may deny the replacement of an existing bridge and may ask for additional information regarding the treating dentist's plans for the other edentulous areas.
5. Bridge abutments should generally be full coverage crowns.
6. A distal cantilevered pontic is generally inappropriate for the replacement of a missing posterior tooth. However, a mesial cantilevered pontic but may be acceptable for the replacement of a maxillary lateral incisor when an adequate adjacent cuspid can be used for the abutment crown.
7. Third molars should generally not be replaced, particularly if the replacement would not be functional.

Outcomes:

- Margins, contours and contacts should be clinically acceptable.

- Prognosis should be good for long term longevity.

ORAL SURGERY

Extractions may be indicated in the presence of pathology including but not limited to non-restorable caries, untreatable periodontal disease, pulpal and periapical disease not amendable to endodontic therapy, to facilitate surgical removal of a cyst or neoplasm, or when overriding medical conditions exist, providing compelling justification to eliminate existing or potential sources of oral infection.

a) Local anesthesia is considered to be part of Oral and Maxillofacial Surgical procedures.

b) For dental benefit reporting purposes, a quadrant is defined as four or more contiguous teeth and / or teeth spaces distal to the midline.

c) Classification of impactions shall be based on the anatomical position of the tooth rather than the surgical technique employed in the removal.

d) Classification of surgical extractions will be based upon the tooth's presentation in the diagnostic radiographs provided. When radiographs do not accurately depict the tooth condition or presentation, written documentation and/or photographs shall be considered.

Extractions (CDT Codes D7111 – D7251)

1. Services that are considered part of the Extraction procedure include but are not limited to, local anesthetic, minor bone contouring and/or removal at site, socket irrigation, hemostatic agents, sutures, and routine post operative care. These services are considered inclusive of the extraction procedure for benefit purposes and should not be unbundled or billed separately.
2. Each dental extraction should be based on a clearly recorded diagnosis for which extraction is the treatment of choice of the dentist and the patient.
3. For extraction of a deciduous tooth (Codes D7111 and D7140) there must be evidence of medical necessity showing that the tooth has pathology and will not exfoliate soon (within the next six months) as evidenced radiographically by greater than 50% of the residual root present, or a patient complaint of acute pain.

Extractions erupted tooth or exposed root (elevation and / or forceps removal) (Code D7140) An uncomplicated extraction of an erupted or exposed root includes removal of all tooth structure, minor smoothing of socket bone and closure, as necessary. Extraction of an erupted tooth may be needed when the tooth has significant decay, is causing irreversible pain and/or infection, or is impeding the eruption of another tooth.

Extraction of an erupted tooth requiring removal of bone and / or sectioning of the tooth and including elevation of mucoperiosteal flap if indicated (Code D7210) requires documentation removal of bone and/or sectioning that tooth, including elevation of a mucoperiosteal flap if indicated.

An impacted tooth is "An unerupted or partially erupted tooth that is positioned against another tooth, bone, or soft tissue so that complete eruption is unlikely." (CDT)

Removal of Impacted tooth – soft tissue (Code D7220) is a tooth with the occlusal surface covered by soft tissue, and extraction requires elevation of a mucoperiosteal flap.

Removal of Impacted tooth – partially bony (Code D7230) is a tooth with part of the crown covered by bone and requires elevation of a mucoperiosteal flap and bone removal.

Removal of Impacted tooth – complete bony (Code D7240) is a tooth with most (50% or more) or all of the crown covered with bone and requires elevation of a mucoperiosteal flap and bone removal.

Removal of Impacted tooth – completely bony with unusual surgical conditions (Code D7241) requires documentation of unusual surgical complications due to factors such nerve dissection required, separate closure of maxillary sinus required or aberrant tooth position. Codes D7241 and D7250 are contraindicated against each other within 90 days of recipient, regardless of provider who rendered service.

Removal of residual tooth roots (Cutting procedure) (Code D7250) requires cutting of soft tissue and bone and includes closure. Pre- op x-rays are required with claim submission.

The prophylactic removal of an impacted, partially erupted or erupted tooth that appear to exhibit an unimpeded path of eruption and/or exhibit no active pathology is not covered.

a. Removal of third molars to prevent future crowding or misalignment is not covered.

b. Pericoronitis is considered to be pathology. By definition, completely covered and unerupted third molars cannot exhibit pericoronitis.

c. Narratives describing the presence of pericoronitis on a fully erupted tooth are ambiguous. In such cases, the radiographic presentation will be the determining factor in the determination of coverage. Symptoms consistent with normal tooth eruption (i.e., pressure, teeth breaking through gums) and not attributable to pathology or impeded eruption are not covered.

During our clinical review of requests for extraction of impacted and/or erupted teeth, LIBERTY may determine that treatment better fits the description of a different, more appropriate procedure code. In that situation, LIBERTY may approve the extraction under a different code.

Other Oral Surgery Services

1. **Removal of residual tooth roots (Code D7250)** may be needed when the residual tooth root is pathological or is interfering with another procedure.
2. **Sinus perforation or oroantral fistula closure (CDT Code D7260)** requires documentation that there is a pathological opening into the sinus. Pre-op x-rays are required with claim submission.
3. **Tooth re-implantation and/or stabilization of an accidentally avulsed or displaced tooth (CDT Code D7270)** requires documentation that a tooth or teeth has been accidentally avulsed or displaced as well as post-op x-rays.
4. **A biopsy of oral tissue (CDT Codes D7285 and D7286)** requires documentation that there is a suspicious lesion in the mouth that needs evaluation and the harvesting of oral tissue.
5. **A surgical procedure to facilitate tooth movement (CDT Codes D7292 – D7300)** requires documentation that demonstrates the medical necessity of a surgical procedure to facilitate appropriate tooth positioning.
6. **Alveoloplasty-Preparation of Ridge (CDT Codes D7310 – D7321**) requires documentation that demonstrates the medical necessity for the surgical recontouring of the alveolus.
7. **Excision of soft tissue or intra-osseous lesions (CDT Codes D7410 – D7465)** requires documentation of the presence of an intra-oral lesion and the medical necessity to remove it.
8. **Excision of bone tissue (CDT Codes D7471 and D7490)** requires documentation that a bony growth interferes with the ability to function or wear a prosthesis.
9. **Incision and drainage of an abscess (CDT Codes D7510 - D7521)** requires documentation that shows an oral infection that requires drainage. This service is not reimbursable on same date of service as an extraction of associated tooth.
10. **Removal of a foreign body (CDT Code D7530**), non-vital bone or a tooth fragment requires documentation that it is medically necessary to remove it.

11. **Open/closed reduction of a fracture (CDT Codes D7610 – D7780)** requires documentation that demonstrates evidence of a broken jaw.
12. **Reduction of dislocation (CDT Codes D7810 and D7899)** and management of other temporomandibular joint dysfunctions require documentation showing a dislocation or other pathological condition of the temporomandibular joint.
13. **Repair of traumatic wounds (CDT Codes D7910 D7912)** and other repair procedures requires documentation showing that it is medically necessary to suture a traumatic wound and/or other repair procedures.
14. **Bone replacement graft for ridge preservation- per site (D7953)** Graft is placed in an extraction or implant removal site at the time of extraction or removal to preserve ridge integrity for purposes of planned future implant placement or where alveolar contour is critical to planned prosthetic reconstruction.
    a Planned treatment at this site and a narrative must be submitted with this service for consideration of coverage.
    b This service may not be covered in the absence of implant benefits.
15. **Frenulectomy or frenuloplasty (CDT Code D7960 – D7963)** requires documentation that demonstrates evidence that a muscle attachment is associated with a pathological condition or interfering with proper oral development or treatment.
16. **Excision of hyperplastic tissue (CDT Code D7970)** or reduction of a fibrous tuberosity (Code D7972) requires documentation that demonstrates the medical necessity of removing redundant soft tissue to facilitate a removable prosthesis.
17. **Excision of pericoronal gingiva (CDT Code D7971)** requires documentation that demonstrates the medical necessity of removing inflammatory or hypertrophied tissues surrounding partially erupted or impacted teeth.

ORTHODONTIC SERVICES

Orthodontic services (D8010-8670) require proper documentation that demonstrate medically necessity for orthodontic services for approval. Comprehensive Orthodontic services are a covered benefit only when medically necessary based on the member's specific plan. LIBERTY will review and cover medically necessary orthodontic services as defined in the member's specific plan documents. Not all dental plans, for which LIBERTY administers include orthodontic coverage. Orthodontics services are only payable once in a lifetime on a month-to-month basis.

1. Limited orthodontic treatment of the primary dentition (CDT Code D8010) is used for children and primary teeth.
2. Limited orthodontic treatment of the transitional dentition (CDT Code D8020) used for children who are in the process of losing their primary teeth and have some permanent teeth already present.
3. Limited orthodontic treatment of the adult dentition (CDT Code D8040) is used for adults who are undergoing minor correction and minimal movement.
4. Comprehensive dental treatment adolescent (CDT Code D8080) and Comprehensive dental treatment adult (CDT Code 8090) may incorporate more than one phase of treatment. Expander, partial fixed appliance and headgear is used in stage one whereas placement of full arch fixed appliance is done in stage two.
5. Orthodontic retention (CDT Code D8680**)** removal of appliance, construction, and placement of retainer(s).

Extractions solely for orthodontic treatment purposes and do not meet plan criteria for an extraction are only covered when accompanied by a pre-approved Medicaid orthodontic treatment plan when applicable.

LIBERTY's Clinical Review team will review authorization requests and determine coverage of orthodontic services in accordance to established state requirements, and group benefit guidelines. Each orthodontic submission must include applicable scoring requirements i.e., Handicapping Labio-Lingual Deviation Index Form (HLD) and/or Orthodontic Medical Necessity Form (OMN), Cephalometric analysis tracings, orthodontic study models and radiographic evidence for review.

All the following documentation must be received:

1. Panoramic imaging
2. Cephalometric imaging
3. 5-7 intraoral photographs

RETROSPECTIVE REVIEW

Prospective and retrospective review will require documentation that demonstrates medical necessity. This documentation can include diagnostic radiographic or photographic images, the results of tests or examinations, descriptions of conditions in progress notes and/or a written narrative providing additional information. In cases where objective information (such as diagnostic images) conflicts with subjective information (such as written descriptions), objective information will be given preference in making a determination.

Retrospective review of services that had been previously pre-authorized will require documentation confirming that the procedure(s) was (were) completed as authorized and within the standard of care as defined by Liberty Dental Plan's Criteria Guidelines and Practice Parameters

ADJUNCTIVE GENERAL SERVICES

Palliative treatment of dental pain (CDT Code D9110) responsibility for palliative treatment, even for procedures that may meet specialty care referral guidelines, is that of the contracted primary care dentist. Palliative services are applicable per visit, not per tooth, and include all the treatment provided during the visit other than necessary x-rays. A narrative of the emergency and the palliative treatment should be documented and is required with claim submission.

Fixed Partial Denture Sectioning (CDT Code D9120)

1. This procedure involves separation of one or more connections between abutments and/or pontics when some portion of a fixed prosthesis is to remain intact and serviceable following sectioning and extraction or other treatment. It includes all recontouring and polishing of retained portions.
2. The submitted documentation must show it is medically necessary to section and remove part of a fixed partial denture and that the remaining tooth or teeth has a good prognosis.
3. X-rays are required with claim submission.

Application of desensitizing medicament (CDT Code D9910) includes in-office treatment for root sensitivity. Typically reported on a "per visit" basis for application of topical fluoride. This code is not to be used for bases, liners, or adhesives used under restorations. A narrative is required with claim submission.

Application of desensitizing resin for cervical and / or root surface per tooth (Code D9911) typically reported on a "per tooth" basis for application of adhesive resins. This code is not to be used for bases, liners, or adhesives used under restorations. A narrative is required with claim submission.

Anesthesia local or regional block anesthesia not in or in conjunction with operative or surgical procedures (CDT Codes D9210-D9212 – D9215):

a. Local or regional block anesthesia is part of and included in conjunction with operative or surgical procedures.

b. Submitted documentation must show that it is necessary to anesthetize part of the mouth when it is not in conjunction with operative or surgical procedures.

Deep Sedation/General Anesthesia or Intravenous moderate sedation/analgesia (CDT Codes D9222/9223, /D9223, D9239/9243/D9243) For dental codes related to general or IV anesthesia, the provider must show the actual beginning and end times in the recipient's dental record.

a. Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in continuous attendance with the patient. Anesthesia services are considered completed when the patient may be safely left under observation of trained personnel and the doctor may leave the room.

b. The level of anesthesia is determined by the anesthesia provider's documentation of the anesthetic's effect upon the central nervous system and does not depend on the route of administration.

c. It is expected that dentists performing anesthesia on patients be properly licensed by their state's regulatory body and comply with all monitoring requirements dictated by the licensing body.

d. LIBERTY provides benefits for covered general Anesthesia ("GA") or Intravenous ("IV") sedation in a dental office setting ONLY when medical necessity is demonstrated by the following requirements, conditions, and guidelines:

   i. A medical condition that requires monitoring (e.g., cardiac, severe hypertension)

   ii. An underlying medical condition exists which would render the patient non-compliant without the GA or IV sedation (e.g., cerebral palsy, epilepsy, developmental/intellectual disability, Down syndrome) iii. Documentation of failed conscious sedation (if available) iv. A condition where severe infection would render local anesthesia ineffective.

Requirements for Documentation: The medical necessity for treatment with GA or IV sedation in a dental office setting must be clearly documented in the patient's dental record. A narrative is required with claim submission.

The following oral surgical procedures may qualify for GA or IV Sedation:

1. Removal of impacted teeth.
2. Surgical root recovery from maxillary antrum (sinus).
3. Surgical exposure of impacted or unerupted cuspids (for orthodontic cases, the orthodontic treatment must have been approved in advance).
4. Radical excision of lesions in excess of 1.25 cm.
5. Children under the age determined by applicable state regulations with an extensive treatment plan may qualify for a GA or IV sedation benefit.

6. Analgesia and additional IV sedation-15 minutes (Code D9230 – D9243) requires documentation of medical necessity to alleviate discomfort or anxiety associated with dental treatment.

Drugs or medicaments dispensed in the office for home use (Code 9630) should not be used in reporting irrigation with chlorhexidine.

Non-intravenous Conscious Sedation (CDT Code D9248) (includes non-IV minimal and moderate sedation). This is a medically controlled state of depressed consciousness that still maintains the patient's airway, protective reflexes and ability to respond to stimulation or verbal commands. It includes non-intravenous administration of sedative and/or analgesic agent(s) and appropriate monitoring.

a. The submitted documentation must demonstrate the medical necessity of non-IV conscious sedation.

b. The level of anesthesia is determined by the anesthesia provider's documentation of the anesthetic's effect upon the central nervous system and does not depend on the route of administration.

Processing Guideline: Nitrous Oxide is considered inclusive with Non-Intravenous Conscious Sedation (Code D9248).

*All submitted claims for sedation must include the sedation log for the associated procedure.