Ohio Clinical Criteria Guidelines and Practice Parameters

LIBERTY DENTAL PLAN®

Making members shine, one smile at a time™

Contents

Plan	Liberty Dental Plan
Exhibit	AN-UM01-INS-A-D010-Diagnostic Services -12302024
Criteria	Diagnostic Services
Prior Authorization	No

Contents

A. Diagnostic Imaging:

Disclaimer on as low as reasonably achievable (ALARA):

Imaging should be prescribed by the treating provider and obtained based on the individual needs of the patient according to principles of ALARA. Determination is based on risk assessment, observation, and medical necessity. Imaging should not be taken based on the plan's benefits or limitations. Documentation should contain the dentist's written evaluation of the diagnostic radiographs.

1. D0210 Intraoral - comprehensive series of radiographic images
    a. 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.
        i. Coverage is 1 (D0210) every 5 years per provider

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

3. D0240 Intraoral, occlusal radiographic image
    a. Required when a dentist needs to examine the roof or floor of the mouth to identify issues like impacted teeth, jaw fractures, cysts, abscesses, foreign objects, supernumerary teeth, or abnormalities, particularly when a standard dental radiograph would not provide enough detail in those areas. It can also be used to assess the development and positioning of teeth that haven't fully erupted yet.

4. D0250 Extra-oral 2D projection radiographic image, stationary radiation source
    a. Include but not limited to lateral skull, posterior-anterior skull, submentovertex, waters, reverse tomes, oblique mandibular body, lateral ramus.

5. D0270-D0274 Bitewing radiographic images
    a. 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.
        i. Coverage is 1 of (D0270, D0272, D0273, D0274) every 6 months

6. D0321 Other TMJ radiographic images, by report
    a. TMJ specific radiographic imaging, documentation and narrative required with claim submission

7. D0330 Panoramic radiographic image
    a. 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 areas. 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.
        a. Coverage is 1 (D0330) every 5 years

8. D0340 2D cephalometric radiographic image, measurement and analysis
    a. Imaging is a component of orthodontic records. Records obtained for orthodontic treatment deemed not medically necessary are also considered not medically necessary and therefore will not be reimbursed.

9. D0350 2D Oral/Facial Photographic Image Obtained Intra-orally or Extra-orally
    a. 2D oral photographic images only reimbursed as a component of orthodontic records or for general diagnostic purposes when radiographs cannot be taken due to a medical condition, physical ability, or cognitive function.

10. D0367 Cone beam CT capture and interpretations
    a. An adjunctive diagnostic aid to be used in conjunction with other radiographic imaging for diagnosis and treatment planning for both jaws (with or without cranium) under exceptional circumstances. These may include:
        i. Non-specific clinical symptoms related to untreated or previously endodontically treated teeth.
        ii. Initial treatment of teeth with anatomic variations including additional or calcified canals, and complex morphology.
        iii. Re-treatment of multi rooted teeth.
        iv. Cases demonstrating significant risk for a complication such as nerve injury or jaw fracture as well as pathology or trauma workups.
        v. Other, by prior approval

11. D0372 - D0389 Intraoral tomosynthesis
    a. By report: include a detailed description of the services performed, the rationale, and the time and materials required with claim submission

12. D0396 3D printing of a 3D dental surface scan
    a. By report: include a detailed description of the services performed, the rationale, and the time and materials required with claim submission

13. D0801- D0804 3D dental/facial surface scan, direct and indirect
    a. By report: include a detailed description of the services performed, the rationale, and the time and materials required with claim submission

B. Image Capture with Interpretation

Images should be taken only for clinical reasons as determined by the patient's dentist and should be of diagnostic quality (e.g. 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 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.

C. Guidelines for Processing Diagnostic Images for Reimbursement

1. The treating provider should take an adequate number of initial radiographs to facilitate an accurate diagnosis and treatment plan. Refer to the current ADA/AAPD/FDA guidelines: *The Selection of Patients for Dental Radiographic Examinations.*
2. Any combination of covered radiographs that meets or exceeds the cost of a complete series may be adjudicated as a complete series for benefit purposes.
3. Additionally, any panoramic images taken along with periapical and/or bitewing radiographs may be considered a complete series for benefit purposes. However, a panoramic x-ray is not reimbursable when taken on the same date of service as a complete series (D0210).
4. In line with industry best practices and standards of care, radiographs taken during a restorative or surgical procedure are considered part of the procedure and are not reimbursed separately.
5. The types and number of radiographic images taken during periodic oral evaluations or episodic care should be prescribed by the dentist and based on current ADA/AAPD/FDA radiographic guidelines. This includes factors such as the complexity of previous and proposed care, caries risk, periodontal health, the type of procedures, and the time since the patient's last radiographic exam.
6. Diagnostic digital radiographs should be printed on photographic-quality paper and must have ~~good~~ diagnostic clarity and brightness.
7. All radiographs must be properly mounted, labeled with left/right orientation, and dated.
8. Inadequate documentation may result in denial.

D. Tests, Examination, and Reports

1. D0470 Diagnostic casts
    a. Diagnostic casts are for the evaluation of orthodontic benefits only and are only payable upon approved orthodontic treatment. Diagnostic casts obtained for orthodontic treatment deemed not medically necessary are also considered not medically necessary and therefore will not be

reimbursed. Diagnostic casts are considered inclusive with restorative procedures and are not separately reimbursable.

2. D0604 – D0606 Antigen/Antibody/Molecular testing for a public health related pathogen including coronavirus
    a. Clinical Laboratory Improvements Act (CLIA) Certificate of Waiver required with claim submission

E. Appendix

1. American Academy of Pediatric Dentistry. Prescribing dental radiographs for infants, children, adolescents, and individuals with special health care needs. The Reference Manual of Pediatric Dentistry. Chicago, Ill.: American Academy of Pediatric Dentistry; 2024:313-7

2. Benavides, E., Krecioch, J. R., Connolly, R. T., Allareddy, T., Buchanan, A., Spelic, D., O'Brien, K. K., Keels, M. A., Mascarenhas, A. K., Duong, M.-L., Aerne-Bowe, M. J., Ziegler, K. M., & Lipman, R. D. (2024). Optimizing radiation safety in dentistry: Clinical recommendations and regulatory considerations. *The Journal of the American Dental Association*, *155*(4). https://doi.org/10.1016/j.adaj.2023.12.002

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, Public Health Service, & Food and Drug Administration. (2021). *The Selection of Patients for Dental Radiographic Examinations*. https://www.fda.gov/radiation-emitting-products/medical-x-ray-imaging/selection-patients-dental-radiographic-examinations

Plan	Liberty Dental Plan
Exhibit	AN-UM01-INS-B-D200- Restorative Services -12302024
Criteria	Restorative Services
Prior Authorization	Varies by Procedure

Contents

A. D2140, D2150, D2160, D2161, D2330-D2332, D2335, D2390-D2394 Direct Restorations

1. Definition
    a. Direct Restorations are restorations where the procedure is rendered entirely in the patient's mouth without the use of a lab to eliminate pathology and/or restore it to function
2. Applicable CDT Codes
    a. D2140 - Amalgam, one surface, primary or permanent
    b. D2150 - Amalgam, two surfaces, primary or permanent
    c. D2160 - Amalgam, three surfaces, primary or permanent
    d. D2161 - Amalgam, four or more surfaces, primary or permanent
    e. D2330 - Resin-based composite, one surface, anterior
    f. D2331 - Resin-based composite, two surfaces, anterior
    g. D2332 - Resin-based composite, three surfaces, anterior
    h. D2335 - Resin-based composite, four or more surfaces
    i. D2390 - Resin-based composite crown, anterior
    j. D2391 - Resin-based composite, one surface, posterior
    k. D2392 - Resin-based composite, two surfaces, posterior
    l. D2393 - Resin-based composite, three surfaces, posterior
    m. D2394 - Resin-based composite, four or more surfaces, posterior
3. Clinical Indications
    a. Primary caries penetrating dentin
    b. Fracture
    c. Recurrent caries

d. Defective or avulsed restorations
e. Reversible pulpitis caused by the loss of tooth structure

4. Documentation Required
    a. No prior authorization requirements
    b. Documentation required in the patient record:
        i. Pre-operative bitewing radiograph(s) in addition to periapical radiograph(s) or panoramic radiograph showing the entire tooth (teeth) to be restored
        ii. Narrative including diagnosis, tooth number and surfaces restored, and materials used
    c. Claim submission requires no additional documentation
5. Limitations
    a. Replacing clinically acceptable amalgam restorations with alternative materials (such as composite or crowns) is considered cosmetic and is not covered unless it meets any of the other stated criteria for coverage.
    b. Restorations due to loss of vertical dimension, attrition, erosion, abfraction, or abrasion are considered aesthetic and are not covered unless they meet any of the other stated criteria for coverage.
    c. The tooth must have a long-term prognosis including favorable endodontic, periodontal, and restorative health. A tooth may be deemed non-restorable if one or more of the following criteria are present:
        i. The tooth presents with greater than a 75% loss of the clinical crown, or
        ii. The tooth has less than 50% bone support, or
        iii. The root has furcation involvement, or
        iv. The tooth has subosseous and/or furcation caries, or
        v. The tooth is a primary tooth with exfoliation imminent within 6 months, marked by less than half the deciduous root remaining, or
        vi. The tooth apex is surrounded by severe pathologic destruction of the bone which would not be resolved by endodontic therapy.
6. Other Clinical Considerations
    a. The finished restoration must have well-defined margins, proper occlusion and contacts, and must address all relevant decay.
    b. Numerous scientific studies conducted over the past several decades, including two major clinical trials published in the *Journal of the American Medical Association*, have demonstrated that dental amalgam is a safe and effective restorative material for children and adults alike. In its review of the available scientific literature on amalgam safety, the ADA's Council on Scientific Affairs confirmed that evidence continues to support amalgam as a

valuable, viable, and safe option for dental patients. The Council also endorsed the U.S. Food and Drug Administration's (FDA) decision not to impose any restrictions on the use of dental amalgam, which remains a widely used restorative material.

c. Medical necessity determination based on other circumstances will be required in the absence of any of the above clinical criteria.

7. Administrative Considerations
    a. Restorations include local anesthesia, tooth preparation, acid etching, adhesives, liners, bases, and curing as part of the procedure and these cannot be billed separately.
    b. Facial or buccal restorations are generally considered "one-surface" restorations, not multiple surfaces like MFD or MBD. The proximal contact must be broken to report the mesial or distal surface.
    c. Periodontal splinting is not classified as a direct restoration.

B. D2542, D2543, D2544, D2642-D2644, D2662-D2664 Onlays (Non-Covered Service)

1. Definition
    a. Onlays are used when a dental restoration must be made extraorally to cover one or more cusp tips and the connecting occlusal surfaces but does not include the entire external surface of the tooth.
2. Applicable CDT Codes
    a. D2542 - onlay - metallic - two surfaces
    b. D2543 - onlay - metallic - three surfaces
    c. D2544 - onlay - metallic - four or more surfaces
    d. D2642 - onlay - porcelain/ceramic - two surfaces
    e. D2643 - onlay - porcelain/ceramic - three surfaces
    f. D2644 - onlay - porcelain/ceramic - four or more surfaces
    g. D2662 - onlay - resin-based composite - two surfaces
    h. D2663 - onlay - resin-based composite - three surfaces
    i. D2664 - onlay - resin-based composite - four or more surfaces
3. Clinical Indications
    a. Tooth has less than 50% tooth destruction due to caries or fracture, but the tooth requires cusp support and other restorative materials have a poor prognosis.
4. Documentation Required
    a. Prior authorization required, submit:
        i. Pre-operative bitewing(s) and periapical or panoramic radiograph(s) showing the complete crown and apices,

ii. Narrative of medical necessity

b. Claim submission requires no additional documentation

c. Note: Radiographs should be unaltered by AI. AI radiographs may be submitted as adjunctive documentation only.

5. Limitations
    a. Onlays are considered beyond the scope of the Medicaid dental program. However, the fabrication of onlays shall be considered with prior authorization only when medical condition or employment preclude the use of other restorative materials.
    b. Restorations due to esthetics, attrition, erosion and/or abfraction without a secondary qualifier such as caries or fracture are not eligible.
    c. Teeth must have a long-term prognosis including favorable endodontic, periodontal, and restorative health. A tooth may be deemed non-restorable if one or more of the following criteria are present:
        i. The tooth presents with greater than a 75% loss of the clinical crown, or
        ii. The tooth has less than 50% bone support, or
        iii. The root has furcation involvement, or
        iv. The tooth has subosseous and/or furcation caries, or
        v. The tooth apex is surrounded by severe pathologic destruction of the bone which would not be resolved by endodontic therapy.
6. Other Clinical Considerations
    a. Restorations that are less than halfway up the ridge from fossa to cusp tip are generally not considered onlays. Complete coverage of at least one cusp tip is required.
    b. When restorations extend past the height of contour on the buccal or lingual surface an onlay may not be sufficient. The treatment of choice may be a full coverage crown.
    c. Medical necessity determination based on other circumstances will be required in the absence of any of the above clinical criteria.
7. Administrative Considerations
    a. Local anesthesia, diagnostic casts, and temporization while the onlay is being fabricated is considered inclusive to the global fee and cannot be billed separately.
    b. For reimbursement, the date of service shall be the date of delivery to the patient.

C. D2740, D2751, D2752 Crowns

1. Definition
    a. A crown is an indirect restoration made outside of the patient's mouth covering all cusps and extending past the height of contour on all surfaces of a permanent tooth.

2. Applicable CDT Codes
    a. D2740 - Crown, porcelain/ceramic
    b. D2751 - Crown, porcelain fused to predominantly base metal
    c. D2752 - Crown, porcelain fused to noble metal
3. Clinical Indications
    a. The tooth has evidence of primary to recurrent caries, fracture, defective restoration, etc., undermining more than 50% of the tooth and amalgam or other restorative procedures have a poor prognosis:
        i. Molars must have pathologic destruction to the tooth by caries or trauma and must involve four or more surfaces and two or more cusps,
        ii. Bicuspids must have pathologic destruction to the tooth by caries or trauma and must involve three or more surfaces and at least one cusp,
        iii. Anterior teeth must have pathologic destruction to the tooth by caries or trauma and must involve four or more surfaces and include at least 50% of the incisal edge. Composite, not crowns, are the procedure of choice for treating caries or replacing an existing restoration not undermining the incisal edge of a tooth for anterior teeth.
    b. Symptomatic reversible pulpitis due to a cracked or broken tooth, or
    c. Root canal therapy requiring full coverage for posterior teeth, or
    d. Marginal caries on an existing crown.
4. Documentation Required
    a. Preauthorization is required, submit:
        i. Pre-operative bitewing radiograph(s) in addition to periapical radiograph(s) or panoramic radiograph showing the entire tooth (teeth) to be restored.
        ii. Additional documentation (i.e. intra-oral photo) is required when pathology and/or tooth destruction is not evident radiographically to support the need for a full coverage restoration.
        iii. A narrative of medical necessity is recommended.
    b. Claim submission must include:
        i. A post-operative radiograph(s) of the seated crown or photograph(s) of an impression taken of the seated crown as recommended by the American College of Prosthodontists
    c. Note: Radiographs should be unaltered by AI. AI radiographs may be submitted as adjunctive documentation only
5. Limitations
    a. Coverage is limited to permanent teeth only.
    b. Crowns where a least expensive professionally acceptable treatment (LEPAT) exists are not covered.
    c. Crowns for purposes of aesthetics only are not covered (i.e., diastema closure, tooth

misalignment/position, color match, etc.).

d. Replacement crowns are allowed only on teeth with recurrent decay or missing crowns. Open margins, in the absence of decay, are considered cleansable and do not require replacement.
e. Restorations due to loss of vertical dimension, attrition, erosion, abfraction, or abrasion are considered aesthetic and are not covered unless they-meet any of the other stated criteria for coverage.
f. Splinted crowns and double abutments are not allowed.
g. The tooth must be free of disease and have a long-term prognosis including favorable endodontic, periodontal, and restorative health. A tooth may be deemed non-restorable if one or more of the following criteria are present:
    i. The tooth presents with greater than a 75% loss of the clinical crown, or
    ii. The tooth has less than 50% bone support, or
    iii. The root has furcation involvement, or
    iv. The tooth has subosseous and/or furcation caries, or
    v. The tooth apex is surrounded by severe pathologic destruction of the bone which would not be resolved by endodontic therapy.

6. Other Clinical Considerations
    a. A request for a crown following root canal therapy must meet the following criteria:
        i. Request must include a dated post-endodontic radiograph, and
        ii. Tooth must be filled within two millimeters of the radiological apex unless there is a curvature or calcification of the canal that limits the ability to fill the canal to the apex, and
        iii. The tooth must be properly condensed/obturated without voids in the apical third of the tooth root, and
        iv. The tooth must oppose a natural tooth, crown, or denture in the opposite arch or be an abutment for a partial denture.
    b. Outcomes and standards set by the specialty boards shall apply:
        i. Margins, contours, contacts and occlusion must be clinically acceptable, and
        ii. Tooth preparation should provide adequate retention and not infringe on the dental pulp, and
        iii. Crowns are expected to have a minimum life expectancy or service life of 5 years (60 months).
    c. Medical necessity determination based on other circumstances will be required in the absence of any of the above clinical criteria
7. Administrative Considerations
    a. Treatment rendered without necessary pre-authorization is subject to retrospective review.
    b. The fee for crowns includes the temporary crown that is placed on the prepared tooth and worn while

the permanent crown is being fabricated.

c. For reimbursement, the date of service shall be the date of delivery to the patient.

d. Local anesthesia and diagnostic casts are considered inclusive to the global fee.

D. D2950 Core Build-Ups

1. Definition
    a. Core build up refers to the addition of material to the coronal structure when there is insufficient retention for an extra-coronal restorative procedure.
2. Applicable CDT Codes
    a. D2950 - Core buildup, including any pins when required
3. Clinical Indications
    a. Permanent teeth that meet crown criteria and
    b. Clinical crown breakdown greater than 50% or is at a level where the build-up material is necessary for crown retention
4. Documentation Required
    a. No prior authorization requirements
    b. Documentation required in the patient record:
        i. Pre-operative bitewing radiograph(s) in addition to periapical radiograph(s) or panoramic radiograph showing the entire tooth (teeth) to be restored.
        ii. Additional documentation (i.e. intra-oral photo) is required when pathology and/or tooth destruction is not evident radiographically.
    c. Claim submission requires no additional documentation.
    d. Note: Radiographs should be unaltered by AI. AI radiographs may be utilized as adjunctive documentation only
5. Limitations
    a. Coverage is limited to permanent teeth,
    b. 1 (D2950) per tooth every 60 months,
    c. The tooth must be free of disease and have a long-term prognosis including favorable endodontic, periodontal, and restorative health. A tooth may be deemed non-restorable if one or more of the following criteria are present:
        i. The tooth presents with greater than a 75% loss of the clinical crown,
        ii. The tooth has less than 50% bone support,
        iii. The root has furcation involvement,
        iv. The tooth has subosseous and/or furcation caries,
        v. The tooth apex is surrounded by severe pathologic destruction of the bone which would not

be resolved by endodontic therapy

6. Other Clinical Considerations
    a. A core buildup is not intended to correct undercuts, box forms, or concave irregularities in the preparation.
    b. It should not be used to restore minor primary or recurrent caries that will be removed during routine crown preparation.
    c. Core build ups are used to rebuild the internal anatomy of a tooth. Direct composite or amalgam restorations are fully functional, meaning they restore proper occlusion, normal anatomy and proximal contacts when relevant.
    d. Medical necessity determination based on other circumstances will be required in the absence of any of the above clinical criteria.
7. Administrative Considerations
    a. Pin retention (D2951), when medically necessary, is included in the global fee.
    b. Prefabricated or cast post and core procedures (D2952, D2953, and D2954) include a core build up in the global fee and is not separately covered for the same tooth.
    c. When sufficient documentation is not presented on the medical necessity of the core buildup, the core buildup will be considered inclusive to the extracoronal restoration.
    d. Local anesthesia is inclusive to the global fee.

E. D2952, D2954 Post and Cores

1. Definition
    a. Prefabricated or indirectly fabricated post and core are procedures that restores a tooth's structure and function by inserting a post and core into the root canal space for necessary stability and force resistance.
2. Applicable CDT Codes
    a. D2952- Post and core in addition to crown, indirectly fabricated
    b. D2954 - Prefabricated post and core in addition to crown
3. Clinical Indications
    a. Endodontically treated permanent anterior tooth (teeth) and
        i. Clinical crown breakdown is greater than 50% where the post is necessary for core and crown retention, and
        ii. A minimum of 2mm of ferrule exists circumferentially, and
        iii. A core buildup (D2950) alone would not suffice.
4. Documentation Required

a. Requires prior authorization, and the provider should submit:
    i. Pre-operative periapical radiograph(s) showing the entire tooth (teeth) to be restored.
    ii. Additional documentation (i.e. intra-oral photo) is required when pathology and/or tooth destruction is not evident radiographically.
    iii. Narrative is optional but recommended:
        1. Include when the root canal therapy will be rendered if post-endodontic therapy radiograph(s) is not included.
b. Claim submission requires no additional documentation.
c. Note: Radiographs should be unaltered by AI. AI radiographs may be submitted as adjunctive .

5. Limitations
    a. Coverage is limited to endodontically treated, permanent anterior teeth
    b. The tooth must be free of disease and have a long-term prognosis including favorable endodontic, periodontal, and restorative health. A tooth may be deemed non-restorable if one or more of the following criteria are present:
        i. The tooth presents with greater than a 75% loss of the clinical crown
        ii. The tooth has less than 50% bone support
        iii. The root has furcation involvement
        iv. The tooth has subosseous and/or furcation caries
        v. The tooth apex is surrounded by severe pathologic destruction of the bone which would not be resolved by endodontic therapy
6. Other Clinical Considerations
    a. For D2952, the post and core are custom fabricated as a single unit.
    b. Medical necessity determination based on other circumstances will be required in the absence of any of the above clinical criteria.
7. Administrative Considerations
    a. Includes a core build up as part of the global fee, so do not report D2950 in addition to D2952 or D2954.
    b. Local anesthesia is inclusive to the global fee.

F. D2951 Pin Retention

1. Definition
    a. Pins are inserted into the peripheral tooth structure and aid in the retention of an amalgam or composite restoration when there is insufficient coronal tooth structure present
2. Applicable CDT Codes
    a. D2951- -Pin retention, per tooth, in addition to restoration
3. Clinical Indications

a. Less than 50% pathologic tooth destruction, and
b. Significant loss of the external walls of coronal tooth structure.

4. Documentation Required
    a. No prior authorization requirements
    b. Documentation required in the patient record:
        i. Pre-operative bitewing radiograph(s) in addition to or periapical radiograph(s) or panoramic radiograph showing the entire tooth (teeth) to be restored
        ii. Narrative including diagnosis, tooth number and surfaces restored, and materials used
    c. Claim submission requires no additional documentation
    d. Note: Radiographs should be unaltered by AI. AI radiographs may be utilized as adjunctive documentation only.
5. Limitations
    a. Coverage is limited to permanent teeth.
    b. The tooth must be free of disease and have a long-term prognosis including favorable endodontic, periodontal, and restorative health. A tooth may be deemed non-restorable if one or more of the following criteria are present:
        i. The tooth presents with greater than a 75% loss of the clinical crown
        ii. The tooth has less than 50% bone support
        iii. The root has furcation involvement
        iv. The tooth has subosseous and/or furcation caries
        v. The tooth apex is surrounded by severe pathologic destruction of the bone which would not be resolved by endodontic therapy
6. Other Clinical Considerations
    a. Medical necessity determination based on other circumstances will be required in the absence of any of the above clinical criteria
7. Administrative Considerations
    a. Pins are considered inclusive with the global core buildup procedure (D2950)
    b. Pins are reported on a per tooth basis rather than a per pin basis
    c. Pin retention is reimbursed per tooth up to a maximum of 3 pins per tooth
    d. Local anesthesia is inclusive to the global fee

G. D2960, D2961, D2962 Veneers (Non-Covered Service)

1. Definition
    a. A veneer is an indirect restoration that includes preparation of the interproximal surfaces and/or

covering the incisal edge.

2. Applicable CDT Codes
    a. D2960 - labial veneer (resin laminate) - direct
    b. D2961 - labial veneer (resin laminate) - indirect
    c. D2962 - labial veneer (porcelain laminate) - indirect
3. Clinical Indications
    a. When the incisal edges of anterior teeth are undermined and other restorative options have a poor prognosis to treat:
        i. Caries
        ii. Symptomatic tooth structure loss
        iii. Other pathologic tooth loss
4. Required Documentation
    a. Considered beyond the scope of the Medicaid dental program but may be eligible in some cases where medical necessity can be determined and a least expensive professionally acceptable treatment (LEPAT) does not exist.
    b. Prior authorization required, submit:
        i. Pre-operative bitewings and/or periapical images showing the entire tooth including the crown and apices, and
        ii. Narrative of medical necessity, and
        iii. Intra-oral images are recommended.
    c. Claim submission requires no additional documentation.
    d. Note: Radiographs should be unaltered by AI. AI radiographs may be submitted as adjunctive documentation only.
5. Limitations
    a. Veneers for purposes of aesthetics only are not covered (i.e., diastema closure, tooth misalignment/position, color match, etc.).
    b. Restorations due to loss of vertical dimension, attrition, erosion, abfraction, or abrasion are considered aesthetic and are not covered unless it meets any of the other stated criteria for coverage.
    c. The tooth (teeth) must have a long-term prognosis including favorable endodontic, periodontal, and restorative health. A tooth may be deemed non-restorable if one or more of the following criteria are present:
        i. The tooth presents with greater than a 75% loss of the clinical crown
        ii. The tooth has less than 50% bone support
        iii. The root has furcation involvement
        iv. The tooth has subosseous and/or furcation caries

v. The tooth apex is surrounded by severe pathologic destruction of the bone which would not be resolved by endodontic therapy

6. Other Clinical Considerations
    a. Medical necessity determination based on other circumstances will be required in the absence of any of the above clinical criteria
7. Administrative Consideration
    a. Local anesthesia, diagnostic casts, and temporization while the veneer is being fabricated are considered inclusive to the global fee and cannot be billed separately.
    b. For reimbursement, the date of service shall be the date of delivery to the patient

Plan	Liberty Dental Plan
Exhibit	AN-UM01-INS-C-D300-Endodontic Services-12302024
Criteria	Endodontic Services
Prior Authorization	No

Contents

A. D3320 Pulpotomy

1. Definition

    a. A pulpotomy is the removal of the coronal portion of a vital pulp with the goal of maintaining the vitality of the root portion of the pulp by utilizing a therapeutic dressing

2. Applicable CDT Codes

    a. D3220 - Therapeutic pulpotomy (excluding final restoration)

3. Clinical Indications

    a. Exposed vital pulps of primary or permanent teeth

    b. Irreversible pulpitis of primary teeth

4. Documentation Required

    a. No prior authorization requirements

    b. Documentation required in the patient record:

        i. Pre-operative bitewing radiograph(s) in addition to periapical radiograph(s) or panoramic radiograph showing the entire tooth (teeth) to be restored

        ii. Narrative demonstrating medical necessity

c. Claim submission requires no additional documentation

d. Note: Radiographs should be unaltered by AI. AI radiographs may be utilized as adjunctive documentation only.

5. Limitations

a. Coverage is limited to patients younger than age 21.

b. The tooth must have a long-term prognosis including favorable endodontic, periodontal, and restorative health. A tooth may be deemed non-restorable if one or more of the following criteria are present:

i. The tooth presents with greater than a 75% loss of the clinical crown

ii. The permanent tooth has less than 50% bone support

iii. The root has furcation involvement

iv. The tooth has subosseous and/or furcation caries

v. The tooth is a primary tooth with exfoliation imminent within 6 months, marked by less than half the deciduous root remaining

6. Other Clinical Considerations

a. A dental dam or rubber dam is required for adequate isolation from the oral cavity during the procedure. They are considered the standard of care for endodontic procedures according to the American Association of Endodontists.

b. Not indicated on a tooth with a necrotic pulp or a periapical radiolucency (PARL), and the provider should consider other endodontic treatment.

c. Medical necessity determination based on other circumstances will be required in the absence of any of the above clinical criteria.

7. Administrative Considerations

a. This code should not be used to report the first stage of endodontic therapy.

b. This code should not be used to report apexogenesis or apexification

c. Local anesthesia and temporization is inclusive to the global fee.

B. D3310-D3330 Endodontic Therapy

1. Definition

   a. Endodontic therapy is a procedure that involves the cleaning, shaping and obturation of the roots of a permanent tooth.

2. Applicable CDT Codes

   a. D3310 - Endodontic therapy, anterior tooth (excluding final restoration)

   b. D3320 - Endodontic therapy, premolar tooth (excluding final restoration)

   c. D3330 - Endodontic therapy, molar tooth (excluding final restoration)

3. Clinical Indications

   a. Symptomatic or asymptomatic irreversible pulpitis with or without periapical disease, or

   b. Necrotic pulp with or without periapical disease, or

   c. Cracked or fractured teeth with pulpal involvement

4. Documentation Required

   a. No prior authorization requirements

   b. Documentation required in the patient record:

      i. Pre-operative bitewing radiograph(s) in addition to periapical radiograph(s) or panoramic radiograph showing the entire tooth (teeth) to be restored

      ii. Post-obturation radiograph(s) showing the entire tooth (teeth) treated verifying a homogenous radiopaque appearance, free of voids, and filled to the working length as

recommended by the American Association of Endodontists

iii. Narrative demonstrating medical necessity

c. Claims submission requires:

i. Pre-operative bitewing radiograph(s) in addition to periapical radiograph(s) or panoramic radiograph showing the entire tooth (teeth) to be restored

ii. Post-obturation radiograph(s) showing the entire tooth (teeth) treated verifying a homogenous radiopaque appearance, free of voids, and filled to the working length as recommended by the American Association of Endodontists

iii. Narrative of medical necessity if the radiograph(s) do not show disease supporting endodontic therapy

d. Note: Radiographs should be unaltered by AI. AI radiographs may be utilized as adjunctive documentation only

5. Limitations

a. Coverage is limited to permanent teeth

b. The tooth must have a long-term prognosis including favorable endodontic, periodontal, and restorative health. A tooth may be deemed non-restorable if one or more of the following criteria are present:

i. The tooth presents with greater than a 75% loss of the clinical crown.

ii. The tooth has less than 50% bone support.

iii. The root has furcation involvement.

iv. The tooth has subosseous and/or furcation caries.

v. The tooth apex is surrounded by severe pathologic destruction of the bone which would not be resolved by endodontic therapy

c. The tooth must oppose a natural tooth, crown, or denture in the opposing arch or be an

abutment for a partial denture

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

6. Other Clinical Considerations

a. A dental dam or rubber dam is required for adequate isolation from the oral cavity during the procedure. They are considered the standard of care for endodontic procedures according to the American Association of Endodontists.

b. Tooth must be filled within two millimeters of the radiological apex unless there is a curvature or calcification of the canal that limits the ability to fill the canal to the apex.

c. The tooth must be properly condensed/obturated without voids in the apical third of the tooth root.

d. 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 provider to proceed with the decay removal prior to any referral to an endodontist.

e. Medical necessity determination based on other circumstances will be required in the absence of any of the above clinical criteria

7. Administrative Considerations

a. Payment includes all diagnostic tests, evaluations, images, and postoperative treatment.

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

c. Includes all appointments necessary to complete the procedure.

d. For reimbursement, the date of service shall be the date of completion.

e. Local anesthesia, irrigation, and temporization is inclusive to the global fee and cannot be billed separately.

C. D3351-D3353 Apexification

1. Definition

    a. Apexification is the removal of a necrotic pulp and placement of a medicament to induce a calcified barrier in a root with an open apex or to promote the continued development of an immature root in a tooth with a necrotic pulp.

2. Applicable CDT Codes

    a. D3351 - Apexification/recalcification, initial visit

    b. D3352 - Apexification/recalcification, interim medication replacement

    c. D3353 - Apexification/recalcification, final visit

3. Clinical Indications

    a. D3351 - Apexification/recalcification, initial visit

        i. Pulpal tissue is necrotic and the roots are not fully formed

    b. D3352 - Apexification/recalcification, interim medication replacement

        i. Replacement of the medicament and periodic monitoring of the roots

    c. D3353 - Apexification/recalcification, final visit

        i. The root(s) have fully developed and/or the apex is closed

4. Documentation Required

    a. No prior authorization requirements

    b. Documentation required in the patient record:

        i. Pre-operative bitewing radiograph(s) in addition to periapical radiograph(s) or panoramic radiograph showing the entire tooth (teeth) to be treated.

ii. Periodic working periapical radiographs reflecting the progress of interim treatment showing the entire tooth (teeth) treated.

iii. Post-operative periapical radiograph(s) showing the entire tooth (teeth) treated.

iv. Narrative demonstrating medical necessity.

c. Claim submission must include:

i. Pre-operative bitewing radiograph(s) in addition to periapical radiograph(s) or panoramic radiograph showing the entire tooth (teeth) to be treated.

ii. Periodic working periapical radiographs reflecting the progress of interim treatment showing the entire tooth (teeth) treated if applicable.

iii. Post-operative periapical radiograph(s) showing the entire tooth (teeth) treated if applicable.

iv. Narrative demonstrating medical necessity recommended

d. Note: Radiographs should be unaltered by AI. AI radiographs may be utilized as adjunctive documentation only.

5. Limitations

a. Coverage is limited to permanent teeth

6. Other Clinical Considerations

a. A dental dam or rubber dam is required for adequate isolation from the oral cavity during the procedure. They are considered the standard of care for endodontic procedures according to the American Association of Endodontists.

b. Medical necessity determination based on other circumstances will be required in the absence of any of the above clinical criteria.

7. Administrative Considerations

a. The final visit includes obturation and placement of endodontic therapy filing material as the final treatment.

b. Root canal therapy/endodontic therapy should not be billed in conjunction with D3353.

c. Payment includes all diagnostic tests, evaluations, images, and postoperative treatment.

d. Local anesthesia, irrigation, and temporization is inclusive to the global fee.

D. D3410 Anterior Apicoectomy

1. Definition

   a. An anterior apicoectomy is surgery on the root of an anterior permanent tooth in which part of the root is removed

2. Applicable CDT Codes

   a. D3410 - Apicoectomy, anterior

3. Clinical Indications

   a. Active root resorption, or

   b. Access to the canal is obstructed, or

   c. Gross over-extension of the root canal filling, or

   d. Periapical or lateral pathology persists and cannot be treated non-surgically, or

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

4. Documentation Required

   a. No prior authorization requirements

   b. Documentation required in the patient record:

i. Pre-operative bitewing radiograph(s) in addition to periapical radiograph(s) or panoramic radiograph showing the entire tooth (teeth) to be restored

ii. Post-operative periapical radiograph(s) showing the entire tooth (teeth) restored

iii. Narrative demonstrating medical necessity

c. Claim submission requires no additional documentation

d. Note: Radiographs should be unaltered by AI. AI radiographs may be utilized as adjunctive documentation only

5. Limitations

a. Coverage is limited to permanent anterior teeth

6. Other Clinical Considerations

a. Medical necessity determination based on other circumstances will be required in the absence of any of the above clinical criteria

7. Administrative Considerations

a. Payment includes all diagnostic tests, evaluations, images, and postoperative treatment

b. Biopsy of oral tissue hard (D7285) and biopsy of oral tissue – soft (D7286) cannot be reported with apicoectomy

c. The retrograde filling (D3430) is considered inclusive to the procedure and cannot be billed separately

d. Local anesthesia is inclusive to the global fee

Plan	Liberty Dental Plan
Exhibit	AN-UM01-INS-D-D400-Periodontic Services -12302024
Criteria	Periodontic Services
Prior Authorization	Varies by Procedure

Contents

A. D4210, D4211 Gingivectomy/Gingivoplasty

1. Definition

    a. A gingivectomy/gingivoplasty is a surgical procedure to reshape enlarged gingival tissue around a fully erupted tooth (teeth) when a normal bony configuration is present

2. Applicable CDT Codes

    a. D4210 - Gingivectomy or gingivoplasty, four or more teeth per quadrant

    b. D4211 - Gingivectomy or gingivoplasty, one to three teeth per quadrant

3. Clinical Indications

    a. Pocket depths are 5 milimeters or greater following periodontal scaling and root planing and suprabony fibrous pockets or pseudo-pockets are present

4. Documentation Required

    a. Prior authorization required, submit:

        i. Pre-operative radiographs showing the entire tooth (teeth) for the area to be treated
        ii. Imaging of diagnostic casts or intraoral photos
        iii. Periodontal charting
        iv. Narrative is optional but recommended

    b. Claim submission requires no additional documentation

    c. Note: Radiographs should be unaltered by AI. AI radiographs may be submitted as adjunctive

documentation only

5. Limitations

    a. Coverage is limited to the correction of severe hyperplasia or hypertrophic gingivitis
    b. Procedures performed to improve aesthetics only are not covered
    c. Considered inclusive if performed on the same day in the same area as scaling and root planning (D4341, D4342) or a frenectomy (D7961, D7962)
    d. Considered inclusive if performed during a restorative or tooth preparation procedure, including final impressions

6. Other Clinical Considerations

    a. Medical necessity determination based on other circumstances will be required in the absence of any of the above clinical criteria

7. Administrative Considerations

    a. Not appropriate usage if due to irritation from orthodontic brackets or ill-fitting dentures
    b. Includes routine postoperative care and local anaesthesia in the global fee

B. D4286 Removal of Non-Resorbable Barrier

1. Definition

    a. Removal of a non-resorbable barrier is the second stage surgical removal of a barrier material that does not dissolve in the body and must be manually removed

2. Applicable CDT Codes

    a. D4286 - Removal of non-resorbable barrier

3. Clinical Indications

    a. The natural tooth (teeth), implant(s), or edentulous area(s) require removal of a non-resorbable barrier

4. Documentation Required

    a. Prior authorization required, submit:

        i. Pre-operative radiographs showing the entire area to be treated

ii. Narrative of medical necessity

b. Claim submission requires no additional documentation

c. Note: Radiographs should be unaltered by AI. AI radiographs may be submitted as adjunctive documentation only

5. Limitations

a. Removal is considered inclusive when completed by same facility that placed the non-resorbable material or barrier

6. Other Clinical Considerations

a. Medical necessity determination based on other circumstances will be required in the absence of any of the above clinical criteria

7. Administrative Considerations

a. Includes routine postoperative care and local anaesthesia in the global fee

C. D4341, D4342 Periodontal Scaling and Root Planing

1. Definition

a. Periodontal scaling and root planing is a non-surgical procedure involving the instrumentation of the crown and root surfaces of teeth to remove plaque and calculus.

2. Applicable CDT Codes

a. D4341 - Periodontal scaling and root planing, four or more teeth per quadrant

b. D4342 - Periodontal scaling and root planing, one to three teeth per quadrant

3. Clinical Indications

a. Periodontal disease with at least 4mm pocket depths in conjunction with radiographic bone loss, subgingival calculus, and documented signs of inflammation

i. The presence of subgingival calculus alone does not warrant treatment

4. Documentation Required

a. Prior authorization required, submit:

i. Periodontal treatment plan and history

ii. A completed copy of an ADA periodontal chart or the equivalent that exhibits pocket depths with all six surfaces charted

iii. Current, properly mounted, labeled and readable periapical images of the mouth and posterior bitewing images showing evidence of root surface calculus and bone loss, indicating a true periodontic disease state

b. Claim submission requires no additional documentation

c. Note: Radiographs should be unaltered by AI. AI radiographs may be submitted as adjunctive documentation only

5. Limitations

a. 1 of (D4341, D4342) per quadrant every 24 months

b. To reduce member discomfort and ensure adequate treatment time, no more than 2 quadrants will be reimbursed on the same day, unless a medical condition or sedation/general anesthesia justifies the additional treatment.

c. D1110 and D4341 are not reimbursed on the same day, but exceptions may be considered on a case-by-case basis with supporting documentation.

d. No payment is made for scaling and root planing performed in conjunction with oral prophylaxis (D1110) or gingivectomy/gingivoplasty (D4210, D4211).

6. Other Clinical Considerations

a. Periodontal maintenance should follow scaling and root planing to preserve or improve tissue health, with periodic pocket depth and gingival assessments.

b. Member’s adherence to homecare instructions should be documented in the patient chart.

c. For early stages of periodontal disease, scaling and root planing serves as definitive non-surgical treatment, and the member may not require referral to a periodontist, depending on tissue response and the patient's oral hygiene. In more advanced stages, this procedure may be considered pre-surgical treatment, and referral to a periodontist may be necessary, again based on tissue response and the patient's oral hygiene.

i. Note: LIBERTY requires that both definitive and pre-surgical scaling and root planing be completed at the primary facility before any referral to a periodontal specialist is considered.

d. LIBERTY may recommend a more appropriate code (e.g., D4342) if there are fewer teeth showing bone loss and presence of calculus, or when fewer teeth show a good long-term prognosis due to restorative, endodontic, or periodontal reasons.

e. Medical necessity determination based on other circumstances will be required in the absence of any of the above clinical criteria.

7. Administrative Considerations

a. Local anaesthetic and periodontal irrigation (D4921) are considered inclusive to the procedure and cannot be billed separately or during re-evaluation. A patient's refusal of irrigation does not constitute grounds for requesting a patient transfer.

b. Can be performed by a dentist or dental hygienist

c. Localized scaling and root planing is covered under periodontal maintenance (D4910)

D. D4910 Periodontal Maintenance

1. Definition

a. Periodontal maintenance is the procedure initiated following periodontal therapy when the supragingival and subgingival removal of plaque and calculus occur.

2. Applicable CDT Codes

a. D4910 - Periodontal maintenance

3. Clinical Indications

a. Prior scaling and root planning where the periodontal condition has stabilized to a manageable level

i. While three-month recalls are standard for many patients, these intervals should be customized based on each patient's specific needs

4. Documentation Required

a. No prior authorization requirements

b. Claim submission requires no additional documentation, except:

i. If no prior history of scaling and root planing (SRP) was performed while the patient

was covered under LIBERTY, then a narrative including the patient's chart notes for the SRP is required.

5. Limitations

   a. 1 (D4910) every 365 days

   b. No payment is made for periodontic maintenance if no scaling and root planing (D4341, D4342) was performed within the previous 24 months.

   c. No payment is made for periodontic maintenance performed in conjunction with prophylaxis (D1110) nor within 30 days of scaling and root planing (D4341, D4342).

6. Other Clinical Considerations

   a. Intervals for periodontal maintenance and supportive care should commence no sooner than four weeks after the primary treatment for periodontal disease, with the timing tailored to the individual patient's risk factors.

   b. Recording of periodontal pocket depths and gingival status should occur at each periodontal maintenance appointment.

   c. Documentation of the patient's adherence to homecare instructions is required in the patient chart.

   d. Medical necessity determination based on other circumstances will be required in the absence of any of the above clinical criteria.

7. Administrative Considerations

   a. Includes site specific scaling and root planing as indicated and polishing of teeth

   b. Can be performed by a dentist or dental hygienist

   c. Local anaesthetic and periodontal irrigation (D4921) are considered inclusive to the procedure and cannot be billed separately. A patient's refusal of irrigation does not constitute grounds for requesting a patient transfer.

Plan	Liberty Dental Plan
Exhibit	AN-UM01-INS-E-D500-Removable Prosthodontic Services-12302024
Criteria	Removable Prosthodontic Services
Prior Authorization	Varies by Procedure

Contents

A. D5110, D5120, D5130, D5140 Complete/Immediate Dentures

1. Definition
    a. A complete/immediate denture is an appliance intended to restore the function of an edentulous arch
2. Applicable CDT Codes
    a. D5110 - Complete denture, maxillary
    b. D5120 - Complete denture, mandibular
    c. D5130 - Immediate denture, maxillary
    d. D5140 - Immediate denture, mandibular
3. Clinical Indications
    a. Completely edentulous arch without an existing functional denture or denture that can be made functional
    b. Remaining dentition in the arch is non-restorable and extractions are planned
4. Documentation Required

a. Prior authorization required, submit:

   i. FMX or panoramic radiograph

   ii. Narrative of medical necessity explaining treatment needs including pending extractions or restorative needs if applicable

   iii. When a prior authorization request is submitted for a resident of a long-term care facility, it must be accompanied by the following documents:

      1. A copy of the resident's most recent nursing care plan, and

      2. A copy of a consent form signed by the resident or the resident's authorized representative, and

      3. A dentist's signed statement describing the oral examination and assessing the resident's ability to wear dentures.

b. Claim submission requires no additional documentation

c. Note: Radiographs should be unaltered by AI. AI radiographs may be submitted as adjunctive documentation only

5. Limitations

   a. 1 of (D5110, D5130) every 8 years, or as justified by medical necessity

   b. 1 of (D5120, D5140) every 8 years, or as justified by medical necessity

   c. A preformed denture with teeth already mounted (i.e., a denture module for which no impression is made of the patient) is not covered.

   d. Authorization for a denture will not be granted if dentures made for the patient in the recent past were unsatisfactory because of irremediable psychological or physiological reasons.

   e. Dentures will not be covered for replacement if the existing appliance can be adequately restored with a reline or repair, even if the patient requests a replacement due to perceived functional or cosmetic issues.

   f. Dentures may not be covered if some teeth remain in the arch and extraction of the remaining teeth is not deemed necessary.

6. Other Clinical Considerations

    a. A prescription for dentures must be based on the total condition of the mouth, the patient's ability to adjust to dentures, and the patient's desire to wear dentures.

    b. All tooth extractions in the arch should be completed, and sufficient healing time (at least 4-6 weeks) should be allowed before taking the final impression.

    c. An immediate denture is delivered upon the extraction of the remaining teeth of that arch for instant use.

    d. Medical necessity determination based on other circumstances will be required in the absence of any of the above clinical criteria

7. Administrative Considerations

    a. Payment includes the entire process of fabricating the denture, including all steps from start to finish to produce and deliver a functional denture, as well as any necessary relining or adjustments for six months post-delivery.

    b. No payment is made if an evaluation is performed solely for the purpose of adjusting dentures, except as specified in Chapter 5160-28 of the Administrative Code.

    c. Diagnostic casts (D0470) are considered part of the global fee.

    d. For reimbursement, the date of service shall be the date of delivery to the patient.

    e. Establishing vertical dimension is considered part of the denture fabrication process and is included in the fee.

B. D5211-D5214, D5225, D5226 Partial Dentures

1. Definition

    a. Partial dentures are an appliance utilized when the absence of several teeth, but not all, in the arch severely impacts the ability chew or the absence of anterior teeth affects the appearance of the face

2. Applicable CDT Codes

    a. D5211 Maxillary partial denture, resin base

b. D5212 Mandibular partial denture, resin base

c. D5213 Maxillary partial denture, cast metal, resin base

d. D5214 Mandibular partial denture, cast metal, resin base

e. D5225 Maxillary partial denture, flexible base

f. D5226 Mandibular partial denture, flexible base

3. Clinical Indications

    a. Partial edentulous arch without an existing functional partial denture or partial denture that can be made functional

4. Documentation Required

    a. Prior authorization required, submit:

        i. FMX or panoramic radiograph

        ii. Narrative of medical necessity explaining treatment needs including pending extractions or restorative needs if applicable

        iii. When a prior authorization request is submitted for a resident of a long-term care facility, it must be accompanied by the following documents:

            1. A copy of the resident's most recent nursing care plan, and

            2. A copy of a consent form signed by the resident or the resident's authorized representative, and

            3. A dentist's signed statement describing the oral examination and assessing the resident's ability to wear partial dentures.

    b. Claim submission requires no additional documentation .

    c. Note: Radiographs should be unaltered by AI. AI radiographs may be submitted as adjunctive documentation only

5. Limitations

    a. 1 of (D5110, D5130) every 8 years

b. 1 of (D5120, D5140) every 8 years

c. Authorization for a partial denture will not be granted if partial dentures made for the patient in the recent past were unsatisfactory because of irremediable psychological or physiological reasons.

d. Partial dentures will not be covered for replacement if the existing appliance can be adequately restored with a reline or repair, even if the patient requests a replacement due to perceived functional or cosmetic issues.

e. A removable partial denture is not considered medically necessary when replacing a single second or third molar without an opposing tooth and will not be covered for reimbursement.

f. All definitive treatments (e.g., extractions, restorations, endodontic therapy, crowns) must be completed before taking the final impression for the partial denture.

g. A partial denture will not be covered if untreated moderate to severe periodontal disease is present.

h. A partial denture will not be covered if the remaining teeth, particularly abutment teeth, do not have a long-term prognosis or are not free of disease. The remaining dentition must have favourable endodontic, periodontal, and restorative health. A tooth may be deemed non-restorable if one or more of the following criteria are present:

i. The tooth presents with greater than a 75% loss of the clinical crown

ii. The tooth has less than 50% bone support

iii. The root has furcation involvement

iv. The tooth has subosseous and/or furcation caries

v. The tooth apex is surrounded by severe pathologic destruction of the bone which would not be resolved by endodontic therapy

6. Other Clinical Considerations

a. A prescription for partial dentures must be based on the total condition of the mouth, the patient's ability to adjust to partial dentures, and the patient's desire to wear partial

dentures

b. All tooth extractions in the arch should be completed, and sufficient healing time (at least 4-6 weeks) should be allowed before taking the final impression.

c. Medical necessity determination based on other circumstances will be required in the absence of any of the above clinical criteria.

7. Administrative Considerations

a. Payment includes the entire process of fabricating the partial denture, including all steps from start to finish to produce and deliver a functional partial denture, as well as any necessary relining or adjustments for six months post-delivery.

b. No payment is made if an evaluation is performed solely for the purpose of adjusting partial dentures, except as specified in Chapter 5160-28 of the Administrative Code.

c. Diagnostic casts (D0470) are considered part of the global fee.

d. For reimbursement, the date of service shall be the date of delivery to the patient.

e. Establishing vertical dimension is considered part of the partial denture fabrication process and is included in the fee. Therefore, benefits for partial dentures are not limited or excluded due to the need to establish vertical dimension.

C. D5511-D5512, D5520, D5611-D5612, D5621-D5622, D5630, D5640, D5650, D5660 Repairs to Complete/Partial Dentures

1. Definition

a. Repairs to complete and partial dentures including adding teeth or clasps are procedures utilized to service an existing defective appliance to make it functional again

2. Applicable CDT Codes

a. D5511 - Repair broken complete denture base, mandibular

b. D5512 - Repair broken complete denture base, maxillary

c. D5520 - Replace missing or broken teeth, complete denture

d. D5611 - Repair resin partial denture base, mandibular

e. D5612 - Repair resin partial denture base, maxillary

f. D5621 - Repair cast partial framework, mandibular

g. D5622 - Repair cast partial framework, maxillary

h. D5630 - Repair or replace broken retentive clasping materials, per tooth

i. D5640 - Replace broken teeth, per tooth

j. D5650 - Add tooth to existing partial denture

k. D5660 - Add clasp to existing partial denture, per tooth

3. Clinical Indications

    a. Defective base, clasp or tooth

    b. Recently extracted tooth in the same arch as the appliance

4. Documentation Required

    a. No prior authorization requirements

    b. Documentation required in the patient record:

        i. Narrative of medical necessity

        ii. Photos of the defective area(s) are recommended

    c. Claim submission requires no additional documentation

5. Limitations

    a. Not covered within six months of the delivery date of a new prosthesis

6. Other Clinical Considerations

    a. Direct self-curing materials are not allowed.

    b. The appliance must be processed and finished with materials chemically compatible with the existing denture base.

    c. Medical necessity determination based on other circumstances will be required in the absence of any of the above clinical criteria.

7. Administrative Considerations

a. For reimbursement, the date of service shall be the date of delivery to the patient.

b. Diagnostic casts (D0470) are considered part of the global fee.

D. D5750, D5751, D5760, D5761 Relines

1. Definition

    a. Relines are procedures utilized when a partial or complete denture is ill-fitting and can be made functional again

2. Applicable CDT Codes

    a. D5750 - Reline complete maxillary denture, indirect

    b. D5751 - Reline complete mandibular denture, indirect

    c. D5760 - Reline maxillary partial denture, indirect

    d. D5761 - Reline mandibular partial denture, indirect

3. Clinical Indications

    a. Ill-fitting prosthesis presenting functional or injurious problems

4. Documentation Required

    a. No prior authorization requirements

    b. Documentation required in the patient record:

        i. Narrative of medical necessity

        ii. Photos of the defective area(s) are recommended

    c. Claim submission requires no additional documentation

5. Limitations

    a. Not separately reimbursable within 6 months of (D5212, D5214, D5226)

    b. 1 (D5750) every 3 years

    c. 1 (D5751) every 3 years

d. 1 (D5760) every 3 years

e. 1 (D5761) every 3 years

6. Other Clinical Considerations

    a. Direct self-curing materials are not allowed.

    b. The appliance must be processed and finished with materials chemically compatible with the existing denture base.

    c. Medical necessity determination based on other circumstances will be required in the absence of any of the above clinical criteria.

7. Administrative Considerations

    a. All relining procedures include post-delivery care for six months after the seat date and are not separately reimbursed.

    b. Relines within the first six months of placement are included in the adjustment period of the appliance and are not separately reimbursed.

    c. For reimbursement, the date of service shall be the date of delivery to the patient.

    d. Diagnostic casts (D0470) are considered part of the global fee.

E. D9999 Unspecified Removable Prosthodontic Procedure

1. Definition

    a. Unspecified removable prosthodontic procedure is used to report a procedure not adequately described by an existing covered or non-covered code.

2. Applicable CDT Codes

    a. D9999 - Unspecified removable prosthodontic procedure, by report

3. Clinical Indications

    a. Any procedure not adequately described by an existing covered or non-covered code

4. Documentation Required

a. Prior authorization required, submit:

    i. Narrative of medical necessity

    ii. Any other documentation or radiographs needed to show medical necessity

b. Note: Radiographs should be unaltered by AI. AI radiographs may be submitted as adjunctive documentation only

5. Limitations

    a. None

6. Other Clinical Considerations

    a. Medical necessity must be adequately documented for coverage consideration

7. Administrative Considerations

    a. None

Plan	Liberty Dental Plan
Exhibit	AN-UM01-INS-F-D610-Dental Implant Services-12302024
Criteria	Dental Implant Services
Prior Authorization	Varies by Procedure

Contents

A. Disclosure

Implant Codes D6010-D6199, excluding D6089, D6105, D6106, D6107, and D6197, are considered beyond the scope of the Medicaid dental program and are not covered

B. D6105 Removal of Implant Body

1. Definition
    a. Removal of an implant body without bone removal or flap elevation references a non-surgical technique to remove an implant
2. Applicable CDT Codes
    a. D6105 Removal of implant body not requiring bone removal or flap elevation
3. Clinical Criteria
    a. Failing implant body
4. Required Documentation
    a. Prior authorization required, submit:
        i. Pre-operative periapical(s) or panoramic radiograph clearly showing the entire implant
        ii. Narrative of medical necessity recommended
    b. Claim submission requires no additional documentation
    c. Note: Radiographs should be unaltered by AI. AI radiographs may be submitted as adjunctive documentation only
5. Limitations

a. Not reimbursable if removal occurs within six months of placement when performed by the same dentist or dental facility.

6. Other Clinical Considerations
    a. Medical necessity determination based on other circumstances will be required in the absence of any of the above clinical criteria.
7. Administrative Considerations
    a. Local anesthesia and routine follow up is inclusive to the global fee.

C. D6106, D6107 Guided Tissue Regeneration

1. Definition
    a. Guided tissue regeneration is a procedure where a resorbable or non-resorbable membrane is placed around an implant to promote bone regeneration.
2. Applicable CDT Codes
    a. D6106 Guided tissue regeneration, resorbable barrier, per implant
    b. D6107 Guided tissue regeneration, non-resorbable barrier, per implant
3. Clinical Criteria
    a. Peri-implant defect
4. Required Documentation
    a. Prior authorization required, submit:
        i. Pre-operative periapical(s) or panoramic radiograph clearly showing the entire implant
        ii. Narrative of medical necessity recommended
    b. Claim submission requires no additional documentation
    c. Note: Radiographs should be unaltered by AI. AI radiographs may be submitted as adjunctive documentation only
5. Limitations
    a. Not covered during implant placement as implant placement is not a benefit of the Medicaid dental program
6. Other Clinical Considerations
    a. Medical necessity determination based on other circumstances will be required in the absence of any of the above clinical criteria

7. Administrative Considerations
    a. Local anesthesia is inclusive to the global fee

D. D6197 Replacement of Restorative Material

1. Definition
    a. Replacement of restorative material to close the access opening of a screw-retained implant supported prosthesis is a procedure involves the removal and replacement of the restorative material in the access opening of a screw retained implant.
2. Applicable CDT Codes
    a. D6197 Replacement of restorative material, close access opening of screw-retained implant supported prosthesis, per implant
3. Clinical Criteria
    a. Defective restorative material in access opening of a screw retained implant prosthesis
    b. Avulsed restorative material in access opening of a screw retained implant prosthesis
4. Required Documentation
    a. Prior authorization required, submit:
        i. Pre-operative intraoral photo(s) of the defective area
        ii. Narrative of medical necessity
    b. Claim submission requires no additional documentation
5. Limitations
    a. None
6. Other Clinical Considerations
    a. Medical necessity determination based on other circumstances will be required in the absence of any of the above clinical criteria.
7. Administrative Considerations
    a. Local anesthesia is inclusive to the global fee
    b. Not to be reported for endodontic access closure, routine fixed implant prosthesis maintenance, or initial access closure

Plan	Liberty Dental Plan
Exhibit	AN-UM01-INS-G-D620-Fixed Prosthodontic Services-12302024
Criteria	Fixed Prosthodontic Services
Prior Authorization	Not Covered

Contents

A. D6205, D6210-D612, D6214, D6240-D6243, D6245, D6250-D6252, D6710, D6720-D6722, D6740, D6750-D6753, D5780-D6784, D6790-D6794 Fixed Partial Denture

1. Definition

    a. A fixed partial denture (fixed bridgework or bridge) is a laboratory fabricated prosthesis designed to fill empty tooth spaces by attaching a pontic to the neighboring teeth to stabilize the bite and maintain arch integrity.

2. Applicable CDT Codes

    a. D6205 pontic - indirect resin-based composite

    b. D6210 pontic - cast high noble metal

    c. D6211 pontic - cast predominantly base metal

    d. D6212 pontic - cast noble metal

    e. D6214 pontic - titanium and titanium alloys

    f. D6240 pontic - porcelain fused to high noble metal

    g. D6241 pontic - porcelain fused to predominantly base metal

    h. D6242 pontic - porcelain fused to noble metal

    i. D6243 pontic - porcelain fused to titanium and titanium alloys

    j. D6245 pontic - porcelain/ceramic

    k. D6250 pontic - resin with high noble metal

    l. D6251 pontic - resin with predominantly base metal

m. D6252 pontic - resin with noble metal

n. D6710 retainer crown - indirect resin-based composite

o. D6720 retainer crown - resin with high noble metal

p. D6721 retainer crown - resin with predominantly base metal

q. D6722 retainer crown - resin with noble metal

r. D6740 retainer crown - porcelain/ceramic

s. D6750 retainer crown - porcelain fused to high noble metal

t. D6751 retainer crown - porcelain fused to predominantly base metal

u. D6752 retainer crown - porcelain fused to noble metal

v. D6753 retainer crown - porcelain fused to titanium and titanium alloys

w. D6780 retainer crown - 3/4 cast high noble metal

x. D6781 retainer crown - 3/4 cast predominantly base metal

y. D6782 retainer crown - 3/4 cast noble metal

z. D6783 retainer crown - 3/4 porcelain/ceramic

aa. D6784 retainer crown ¾ - titanium and titanium alloys

bb. D6790 retainer crown - full cast high noble metal

cc. D6791 retainer crown - full cast predominantly base metal

dd. D6792 retainer crown - full cast noble metal

ee. D6793 interim retainer crown - further treatment or completion of diagnosis necessary prior to final impression

ff. D6794 retainer crown - titanium and titanium alloys

3. Clinical Indications

    a. Includes all the following:

        i. Missing tooth (teeth) or empty tooth spaces

        ii. An adjacent tooth (teeth) or to the space being replaced known as an abutment or

retainer

1. For all teeth excluding maxillary lateral incisor replacement, at least two immediately adjacent teeth, one on each side of the space being replaced are required
2. For maxillary lateral incisor replacement, the canine immediately adjacent to the space being replaced is required

4. Documentation Required
    a. Prior authorization required, submit:
        i. Bitewings and/or select PAs showing the apices and coronal tooth structure of the abutment teeth
        ii. Intraoral photos or radiographs showing the patient's complete dentition including the space to be restored
        iii. Narrative of medical necessity
    b. Claim submission requires no additional documentation
    c. Note: Radiographs should be unaltered by AI. AI radiographs may be submitted as adjunctive documentation only
5. Limitations
    a. Considered beyond the scope of the Medicaid dental program but may be eligible in some cases where medical necessity can be determined, and a least expensive professionally acceptable treatment (LEPAT) does not exist
    b. Abutment teeth must have a long-term prognosis including favorable endodontic, periodontal, and restorative health. A tooth may be deemed non-restorable if one or more of the following criteria are present:
        i. The tooth presents with greater than a 75% loss of the clinical crown
        ii. The tooth has less than 50% bone support
        iii. The root has furcation involvement
        iv. The tooth has subosseous and/or furcation caries

v. The tooth apex is surrounded by severe pathologic destruction of the bone which would not be resolved by endodontic therapy

6. Other Clinical Considerations

   a. Fixed partial denture abutments should generally be full coverage crowns.

   b. A distal cantilevered pontic is 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.

   c. Third molars are not to be replaced if the replacement would not be functional.

   d. Margins, contours and contacts should be clinically acceptable.

   e. Additional abutments that are not necessary to improve the stability and ability of the fixed partial denture to withstand functional forces will not be covered.

7. Administrative Considerations

   a. Includes routine temporization, diagnostic casts, and local anesthetics

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

   c. CDT crown codes that are submitted should be accurate and specific for fixed partial dentures. Single crown codes (i.e., D2740) used instead of the retainer crown codes will not be accepted.

Plan	Liberty Dental Plan
Exhibit	AN-UM01-INS-H-D700-Oral Surgery Services-12302024
Criteria	Oral Surgery Services
Prior Authorization	Varies by Procedure

Contents

A. D7140 Simple Extraction

1. Definition
    a. A simple extraction refers to the extraction of an erupted tooth or exposed root using forceps or elevation
2. Applicable CDT Codes
    a. D7140 - Extraction, erupted tooth or exposed root
3. Clinical Indications
    a. Non-restorable caries, untreatable
    b. Periodontal disease, pulpal or periapical disease not treatable with endodontic therapy
    c. To facilitate the removal of cysts or neoplasms
    d. When underlying medical conditions require removal to eliminate existing or potential sources of oral infection
    e. Restorable tooth but patient elects extraction over restoration with documented informed consent
    f. When orthodontic considerations necessitate removal and prior authorization for a LIBERTY approved orthodontic treatment plan has been obtained
    g. In cases of jaw fracture to facilitate fixation and/or reduction
4. Documentation Required
    a. No prior authorization requirements
    b. Documentation required in the patient record:
        i. Pre-operative periapical radiograph(s) or panoramic radiograph showing the entire tooth (teeth) extracted
        ii. Extractions will be classified according to the tooth’s presentation in the diagnostic radiographs provided. If the radiographs do not accurately depict the tooth's condition, written documentation and/or photographs will be considered
    c. Claim submission requires no additional documentation

d. Note: Radiographs should be unaltered by AI. AI radiographs may be submitted as adjunctive documentation only

5. Limitations
    a. 1 (D7140) per tooth in a lifetime
    b. Prophylactic removal of an impacted, partially erupted, or erupted tooth that has an unimpeded path of eruption and exhibits no active disease is not covered
        i. Removal of third molars to prevent future crowding or misalignment is not a covered service
        ii. Pericoronitis is recognized as treatable pathologic condition. By definition, fully covered and unerupted third molars cannot have pericoronitis
        iii. Narratives indicating pericoronitis on a fully erupted tooth are ambiguous. In these cases, the radiographic presentation will be the determining factor for coverage. Symptoms consistent with normal tooth eruption (e.g., pressure or teeth breaking through the gingiva) and not caused by pathology or impeded eruption are not covered.
6. Other Clinical Considerations
    a. For the extraction of a deciduous tooth, there must be medical necessity demonstrating that the tooth has disease and will not exfoliate within the next six months. This may be evidenced radiographically by more than 50% of the residual root remaining or through a patient complaint of acute and/or chronic pain.
    b. Each dental extraction must be supported by a clearly documented diagnosis indicating that extraction is the treatment of choice, as determined by both the dentist and the patient
    c. Medical necessity determination based on other circumstances will be required in the absence of any of the above clinical criteria
7. Administrative Considerations
    a. Services considered part of the extraction procedure include, but are not limited to, local anesthesia, minor bone contouring or removal at the extraction site, socket irrigation, hemostatic agents, sutures, and routine postoperative care. These services are included in the extraction procedure for benefit purposes and should not be billed separately or unbundled.
    b. Elevation of a mucoperiosteal flap is inclusive to the global fee.
    c. The incidental removal of a cyst or lesion attached to the root(s) of an extraction is considered part of the extraction or surgical fee and is not separately billable.
    d. In most cases, extractions that render a patient edentulous must be deferred until

authorization to construct a denture has been given unless clinical factors deem otherwise, such as infection or trauma.

B. D7210 Surgical Extraction

1. Definition
    a. A surgical extraction refers to the extraction of an erupted tooth that requires the removal of bone or sectioning of the tooth.
2. Applicable CDT Codes
    a. D7210 - Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth
3. Clinical Indications
    a. Non-restorable caries, untreatable
    b. Periodontal disease, pulpal or periapical disease not treatable with endodontic therapy
    c. To facilitate the removal of cysts or neoplasms
    d. When underlying medical conditions require removal to eliminate existing or potential sources of oral infection
    e. Restorable tooth but patient elects an extraction over restoration with documented informed consent
    f. When orthodontic considerations necessitate removal and prior authorization for a LIBERTY approved orthodontic treatment plan has been obtained
    g. In cases of jaw fracture to facilitate fixation and/or reduction
4. Documentation Required
    a. No prior authorization requirements
    b. Documentation required in the patient record:
        i. Pre-operative periapical radiograph(s) or panoramic radiograph showing the entire tooth (teeth) extracted
        ii. Extractions will be classified according to the tooth’s presentation in the diagnostic radiographs provided. If the radiographs do not accurately depict the tooth's condition, written documentation and/or photographs will be considered
    c. Claim submission requires no additional documentation
    d. Note: Radiographs should be unaltered by AI. AI radiographs may be submitted as adjunctive documentation only

5. Limitations
    a. 1 (D7210) per tooth in a lifetime
    b. Prophylactic removal of an impacted, partially erupted, or erupted tooth that has an unimpeded path of eruption and exhibits no active pathology is not covered
        i. Removal of third molars to prevent future crowding or misalignment is not a covered service
        ii. Pericoronitis is recognized as a pathologic condition. By definition, fully covered and unerupted third molars cannot have pericoronitis.
        iii. Narratives indicating pericoronitis on a fully erupted tooth are ambiguous. In these cases, the radiographic presentation will be the determining factor for coverage. Symptoms consistent with normal tooth eruption (e.g., pressure or teeth breaking through the gingiva) and not caused by pathology or impeded eruption are not covered A
6. Other Clinical Considerations
    a. Elevation of a mucoperiosteal flap on its own does not necessitate a surgical extraction (D7210). A simple extraction (D7140) may be more appropriate if the removal of bone and/or the sectioning of the tooth is not also indicated.
    b. For the extraction of a deciduous tooth, there must be medical necessity demonstrating that the tooth has pathologic condition and will not exfoliate within the next six months. This may be evidenced radiographically by more than 50% of the residual root remaining or through a patient complaint of acute and/or chronic pain.
    c. Each dental extraction must be supported by a clearly documented diagnosis indicating that extraction is the treatment of choice, as determined by both the dentist and the patient.
    d. Medical necessity determination based on other circumstances will be required in the absence of any of the above clinical criteria.
7. Administrative Considerations
    a. Services considered part of the extraction procedure include, but are not limited to, local anesthesia, minor bone contouring or removal at the extraction site, socket irrigation, hemostatic agents, sutures, and routine postoperative care. These services are included in the extraction procedure for benefit purposes and should not be billed separately or unbundled.
    b. The incidental removal of a cyst or lesion attached to the root(s) of an extraction is considered part of the extraction or surgical fee and is not separately billable.
    c. In most cases, extractions that render a patient edentulous must be deferred until

authorization to construct a denture has been given unless clinical factors deem otherwise, such as infection or trauma.

C. D7220 Soft Tissue Extraction

1. Definition
    a. A soft tissue extraction indicates the tooth is located below the soft tissue and the coronal portion of the tooth is not covered by bone
2. Applicable CDT Codes
    a. D7220 - Removal of impacted tooth, soft tissue
3. Clinical Indications
    a. To treat severe pain due to impaction
    b. To treat infection or abscess formation associated with the tooth
    c. To facilitate the removal of cysts or neoplasms
    d. When underlying medical conditions require removal to eliminate existing or potential sources of oral infection
    e. The prevent further damage to adjacent teeth
    f. When orthodontic considerations necessitate removal and prior authorization for a LIBERTY approved orthodontic treatment plan has been obtained
4. Documentation Required
    a. Prior authorization only required for removal of impacted third molars, submit:
        i. Pre-operative periapical radiograph(s) or panoramic radiograph showing the entire tooth (teeth) extracted
        ii. Extractions will be classified according to the tooth’s presentation in the diagnostic radiographs provided. If the radiographs do not accurately depict the tooth's condition, written documentation and/or photographs will be considered
    b. Claim submission requires no additional documentation
    c. Note: Radiographs should be unaltered by AI. AI radiographs may be submitted as adjunctive documentation only
5. Limitations
    a. 1 (D7220) per tooth in a lifetime
    b. Prophylactic removal of an impacted, partially erupted, or erupted tooth that has an

unimpeded path of eruption and exhibits no active disease is not covered

i. Removal of third molars to prevent future crowding or misalignment is not a covered service
ii. Pericoronitis is recognized as a pathologic condition. By definition, fully covered and unerupted third molars cannot have pericoronitis.
iii. Narratives indicating pericoronitis on a fully erupted tooth are ambiguous. In these cases, the radiographic presentation will be the determining factor for coverage. Symptoms consistent with normal tooth eruption (e.g., pressure or teeth breaking through the gingiva) and not caused by disease or impeded eruption are not covered.

6. Other Clinical Considerations
    a. The classification of impactions is based on the anatomical position of the tooth, not the surgical technique used for removal
    b. Each dental extraction must be supported by a clearly documented diagnosis indicating that extraction is the treatment of choice, as determined by both the dentist and the patient
    c. Medical necessity determination based on other circumstances will be required in the absence of any of the above clinical criteria
7. Administrative Considerations
    a. Services considered part of the extraction procedure include, but are not limited to, local anesthesia, minor bone contouring or removal at the extraction site, socket irrigation, hemostatic agents, sutures, and routine postoperative care. These services are included in the extraction procedure for benefit purposes and should not be billed separately or unbundled.
    b. The incidental removal of a cyst or lesion attached to the root(s) of an extraction is considered part of the extraction or surgical fee and is not separately billable.
    c. In most cases, extractions that render a patient edentulous must be deferred until authorization to construct a denture has been given unless clinical factors deem otherwise, such as infection or trauma.

D. D7230 Partially Bony Extraction

1. Definition
    a. A partially bony extraction indicates less than 50% of the crown is covered by bone
2. Applicable CDT Codes

a. D7230 - Removal of impacted tooth, partially bony

3. Clinical Indications
    a. To treat severe pain due to impaction
    b. To treat infection or abscess formation associated with the tooth
    c. To facilitate the removal of cysts or neoplasms
    d. When underlying medical conditions require removal to eliminate existing or potential sources of oral infection
    e. The prevent further damage to adjacent teeth
    f. When orthodontic considerations necessitate removal and prior authorization for a LIBERTY approved orthodontic treatment plan has been obtained
4. Documentation Required
    a. No prior authorization requirements
    b. Documentation required in the patient record:
        i. Pre-operative periapical radiograph(s) or panoramic radiograph showing the entire tooth (teeth) extracted
        ii. Extractions will be classified according to the tooth's presentation in the diagnostic radiographs provided. If the radiographs do not accurately depict the tooth's condition, written documentation and/or photographs will be considered
    c. Claim submission requires no additional documentation
    d. Note: Radiographs should be unaltered by AI. AI radiographs may be submitted as adjunctive documentation only
5. Limitations
    a. 1 (D7230) per tooth in a lifetime
    b. Prophylactic removal of an impacted, partially erupted, or erupted tooth that has an unimpeded path of eruption and exhibits no active pathology is not covered
        i. Removal of third molars to prevent future crowding or misalignment is not a covered service
        ii. Pericoronitis is recognized as a pathologic condition. By definition, fully covered and unerupted third molars cannot have pericoronitis
        iii. Narratives indicating pericoronitis on a fully erupted tooth are ambiguous. In these cases, the radiographic presentation will be the determining factor for coverage. Symptoms consistent with normal tooth eruption (e.g., pressure or teeth breaking through the gingiva) and not caused by pathology or impeded eruption are not

covered.

6. Other Clinical Considerations
    a. The classification of impactions is based on the anatomical position of the tooth, not the surgical technique used for removal.
    b. Each dental extraction must be supported by a clearly documented diagnosis indicating that extraction is the treatment of choice, as determined by both the dentist and the patient.
    c. Medical necessity determination based on other circumstances will be required in the absence of any of the above clinical criteria.
7. Administrative Considerations
    a. Services considered part of the extraction procedure include, but are not limited to, local anesthesia, minor bone contouring or removal at the extraction site, socket irrigation, hemostatic agents, sutures, and routine postoperative care. These services are included in the extraction procedure for benefit purposes and should not be billed separately or unbundled.
    b. The incidental removal of a cyst or lesion attached to the root(s) of an extraction is considered part of the extraction or surgical fee and is not separately billable.
    c. In most cases, extractions that render a patient edentulous must be deferred until authorization to construct a denture has been given unless clinical factors deem otherwise, such as infection or trauma.

E. D7240 Completely Bony Extraction

1. Definition
    a. A completely bony extraction indicates more than 50% of the crown is covered by bone and no unusual complications occurred during removal.
2. Applicable CDT Codes
    a. D7240 - Removal of impacted tooth, completely bony
3. Clinical Indications
    a. To treat severe pain due to impaction
    b. To treat infection or abscess formation associated with the tooth
    c. To facilitate the removal of cysts or neoplasms
    d. When underlying medical conditions require removal to eliminate existing or potential sources of oral infection

e. The prevent further damage to adjacent teeth
f. When orthodontic considerations necessitate removal and prior authorization for a LIBERTY approved orthodontic treatment plan has been obtained

4. Documentation Required
   a. Prior authorization required, submit:
      i. Pre-operative periapical radiograph(s) or panoramic radiograph showing the entire tooth (teeth) extracted
      ii. Extractions will be classified according to the tooth's presentation in the diagnostic radiographs provided. If the radiographs do not accurately depict the tooth's condition, written documentation and/or photographs will be considered
   b. Claim submission requires no additional documentation
   c. Note: Radiographs should be unaltered by AI. AI radiographs may be submitted as adjunctive documentation only
5. Limitations
   a. 1 (D7240) per tooth in a lifetime
   b. Prophylactic removal of an impacted, partially erupted, or erupted tooth that has an unimpeded path of eruption and exhibits no active disease is not covered
      i. Removal of third molars to prevent future crowding or misalignment is not a covered service
      ii. Pericoronitis is recognized as a pathologic condition. By definition, fully covered and unerupted third molars cannot have pericoronitis.
      iii. Narratives indicating pericoronitis on a fully erupted tooth are ambiguous. In these cases, the radiographic presentation will be the determining factor for coverage. Symptoms consistent with normal tooth eruption (e.g., pressure or teeth breaking through the gingiva) and not caused by pathology or impeded eruption are not covered.
6. Other Clinical Considerations
   a. The classification of impactions is based on the anatomical position of the tooth, not the surgical technique used for removal.
   b. Each dental extraction must be supported by a clearly documented diagnosis indicating that extraction is the treatment of choice, as determined by both the dentist and the patient.
   c. Medical necessity determination based on other circumstances will be required in the absence of any of the above clinical criteria.

7. Administrative Considerations
    a. Services considered part of the extraction procedure include, but are not limited to, local anesthesia, minor bone contouring or removal at the extraction site, socket irrigation, hemostatic agents, sutures, and routine postoperative care. These services are included in the extraction procedure for benefit purposes and should not be billed separately or unbundled.
    b. Treatment rendered without necessary prior authorization is subject to retrospective review.
    c. The incidental removal of a cyst or lesion attached to the root(s) of an extraction is considered part of the extraction or surgical fee and is not separately billable.

F. D7241 Completely Bony Extraction with Complications

1. Definition
    a. A completely bony extraction with unusual complications indicates more than 50% of the crown is covered by bone and extraction resulted in particularly exceptional circumstances related to anatomy such as nerve dissection, separate closure of a maxillary sinus, and aberrant tooth position.
2. Applicable CDT Codes
    a. D7241 - Removal impacted tooth, complete bony, complication
3. Clinical Indications
    a. To treat severe pain due to impaction
    b. To treat infection or abscess formation associated with the tooth
    c. To facilitate the removal of cysts or neoplasms
    d. When underlying medical conditions require removal to eliminate existing or potential sources of oral infection
    e. The prevent further damage to adjacent teeth
    f. When orthodontic considerations necessitate removal and prior authorization for a LIBERTY approved orthodontic treatment plan has been obtained
4. Documentation Required
    a. Prior authorization required, submit:
        i. Pre-operative periapical radiograph(s) or panoramic radiograph showing the entire tooth (teeth) extracted
        ii. Extractions will be classified according to the tooth’s presentation in the diagnostic radiographs provided. If the radiographs do not accurately depict the tooth's

condition, written documentation and/or photographs will be considered

b. Claim submission requires no additional documentation
c. Note: Radiographs should be unaltered by AI. AI radiographs may be submitted as adjunctive documentation only

5. Limitations
   a. 1 (D7241) per tooth in a lifetime
   b. Prophylactic removal of an impacted, partially erupted, or erupted tooth that has an unimpeded path of eruption and exhibits no active pathology is not covered
      i. Removal of third molars to prevent future crowding or misalignment is not a covered service.
      ii. Pericoronitis is recognized as a pathologic condition. By definition, fully covered and unerupted third molars cannot have pericoronitis
      iii. Narratives indicating pericoronitis on a fully erupted tooth are ambiguous. In these cases, the radiographic presentation will be the determining factor for coverage. Symptoms consistent with normal tooth eruption (e.g., pressure or teeth breaking through the gingiva) and not caused by pathology or impeded eruption are not covered.
6. Other Clinical Considerations
   a. The classification of impactions is based on the anatomical position of the tooth, not the surgical technique used for removal.
   b. Each dental extraction must be supported by a clearly documented diagnosis indicating that extraction is the treatment of choice, as determined by both the dentist and the patient.
   c. Medical necessity determination based on other circumstances will be required in the absence of any of the above clinical criteria.
7. Administrative Considerations
   a. Services considered part of the extraction procedure include, but are not limited to, local anesthesia, minor bone contouring or removal at the extraction site, socket irrigation, hemostatic agents, suture placement and removal, and routine postoperative care. These services are included in the extraction procedure for benefit purposes and should not be billed separately or unbundled.
   b. Treatment rendered without necessary prior authorization is subject to retrospective review.
   c. The incidental removal of a cyst or lesion attached to the root(s) of an extraction is considered part of the extraction or surgical fee and is not separately billable.

d. In most cases, extractions that render a patient edentulous must be deferred until authorization to construct a denture has been given unless clinical factors deem otherwise, such as infection or trauma.

G. D7250 Removal of Residual Tooth Root

1. Definition
    a. Removal of residual tooth roots refers to the extraction of retained tooth root(s) that requires the cutting of soft tissue and bone.
2. Applicable CDT Codes
    a. D7250 - Removal of residual tooth roots (cutting procedure)
3. Clinical Indications
    a. A root is diseased or presenting a clinical problem
    b. A root interferes with another medically necessary procedure
4. Documentation Required
    a. Prior authorization required, submit:
        i. Pre-operative periapical radiograph(s) or panoramic radiograph showing the entire tooth (teeth) extracted
        ii. Extractions will be classified according to the tooth's presentation in the diagnostic radiographs provided. If the radiographs do not accurately depict the tooth's condition, written documentation and/or photographs will be considered.
    b. Claim submission requires no additional documentation.
    c. Note: Radiographs should be unaltered by AI. AI radiographs may be submitted as adjunctive documentation only.
5. Limitations
    a. 1 (D7250) per tooth in a lifetime
    b. The prophylactic removal of asymptomatic roots or roots exhibiting no overt clinical disease is not a covered benefit.
6. Other Clinical Considerations
    a. Each dental extraction must be supported by a clearly documented diagnosis indicating that extraction is the treatment of choice, as determined by both the dentist and the patient.
    b. Medical necessity determination based on other circumstances will be required in the absence

of any of the above clinical criteria.

7. Administrative Considerations
    a. Services considered part of the extraction procedure include, but are not limited to, local anesthesia, minor bone contouring or removal at the extraction site, socket irrigation, hemostatic agents, sutures, and routine postoperative care. These services are included in the extraction procedure for benefit purposes and should not be billed separately or unbundled.
    b. Treatment rendered without necessary prior authorization is subject to retrospective review.
    c. The incidental removal of a cyst or lesion attached to the root(s) of an extraction is considered part of the extraction or surgical fee and is not separately billable.
    d. In most cases, extractions that render a patient edentulous must be deferred until authorization to construct a denture has been given unless clinical factors deem otherwise, such as infection or trauma.

H. D7260 Fistula Closure

1. Definition
    a. Oralantral fistula closure is a surgical procedure that closes an abnormal opening or communication between the oral cavity and the maxillary sinus.

2. Applicable CDT Codes
    a. D7260 - Oroantral fistula closure

3. Clinical Criteria
    a. An opening exists between the oral cavity and maxillary sinus and
    b. The opening is greater than 5mm in diameter or otherwise deemed unable to spontaneously close that would otherwise lead to a sinus infection or other pathologic or functional problems.

4. Documentation Required
    a. No prior authorization requirements
    b. Documentation required in the patient record:

i. Pre-operative radiograph(s) of the area treated

ii. Narrative of medical necessity

c. Claim submission requires no additional documentation

d. Note: Radiographs should be unaltered by AI. AI radiographs may be submitted as adjunctive documentation only

5. Limitations

a. None

6. Other Clinical Considerations

a. Medical necessity determination based on other circumstances will be required in the absence of any of the above clinical criteria

7. Administrative Considerations

a. Local anesthesia is inclusive to the global fee

I. D7270 Tooth Reimplantation and/or Stabilization

1. Definition

a. Tooth reimplantation and/or stabilization is procedure that treats an accidentally avulsed or displaced tooth though reimplantation of the natural tooth and/or stabilization of the traumatized tooth with bonded wire.

2. Applicable CDT Codes

a. D7270 - Tooth reimplantation and/or stabilization, accident

3. Clinical Criteria

a. Avulsed or displaced tooth due to trauma

4. Documentation Required

a. No prior authorization requirements

b. Documentation required in the patient record:
    i. Pre-operative periapical radiograph(s) showing the entire tooth (teeth) treated
    ii. Narrative of medical necessity
c. Claim submission requires no additional documentation
d. Note: Radiographs should be unaltered by AI. AI radiographs may be submitted as adjunctive documentation only

5. Limitations
    a. None
6. Other Clinical Considerations
    a. Medical necessity determination based on other circumstances will be required in the absence of any of the above clinical criteria.
7. Administrative Considerations
    a. Includes splinting and/or stabilization
    b. Any adjustments, removal of splint, or follow up visits are inclusive to the global fee
    c. Local anesthesia is inclusive to the global fee

J. D7280 Exposure of an Unerupted Tooth

1. Definition
    a. Exposure of an unerupted tooth is a surgical procedure where the tissue is reflected and bone is removed as necessary to expose the crown of an impacted tooth to aid in eruption
2. Applicable CDT Codes
    a. D7280 - Exposure of an unerupted tooth
3. Clinical Criteria
    a. Impacted tooth that is medically necessary for a fully functioning dentition and

b. Natural eruption of the tooth failed

4. Documentation Required

    a. Prior authorization required, submit:

        i. Pre-operative radiograph(s) showing the entire tooth (teeth) to be treated

        ii. Narrative of medical necessity

    b. Claim submission requires no additional documentation

    c. Note: Radiographs should be unaltered by AI. AI radiographs may be submitted as adjunctive documentation only

5. Limitations

    a. Not covered for a tooth that is planned to be extracted

6. Other Clinical Considerations

    a. Medical necessity determination based on other circumstances will be required in the absence of any of the above clinical criteria

7. Administrative Considerations

    a. Local anesthesia is inclusive to the global fee

K. D7283 Placement of a Device to Facilitate Eruption

1. Definition

    a. Placement of a device to the facilitate eruption of an impacted tooth references a procedure where a device is attached to surgically exposed tooth to aid in its eruption

2. Applicable CDT Codes

    a. D7283 - Placement, device to facilitate eruption, impaction

3. Clinical Criteria

a. Surgically exposed tooth that is medically necessary for a fully functioning dentition and

b. Requires aid in eruption

4. Documentation Required

    a. Prior authorization required, submit:

        i. Pre-operative radiograph(s) showing the entire tooth (teeth) to be treated

        ii. Narrative of medical necessity

    b. Claim submission requires no additional documentation

    c. Note: Radiographs should be unaltered by AI. AI radiographs may be submitted as adjunctive documentation only

5. Limitations

    a. Not covered for a tooth that is planned to be extracted

6. Other Clinical Considerations

    a. Medical necessity determination based on other circumstances will be required in the absence of any of the above clinical criteria

7. Administrative Considerations

    a. Local anesthesia is inclusive to the global fee

L. D7281 Excisional Biopsy of Minor Salivary Glands

1. Definition

    a. An excisional biopsy of minor salivary glands is the excision of architecturally intact salivary gland organs that is utilized as part of the workup for suspected Sjogren's syndrome

2. Applicable CDT Codes

    a. D7284 - Excisional biopsy of minor salivary glands

3. Clinical Criteria
    a. Patient has signs and symptoms of Sjogren's syndrome
4. Documentation Required
    a. Prior authorization required, submit:
        i. Narrative of medical necessity
        ii. Pre-operative intraoral photo(s) showing the area to be excised is recommended
    b. Claim submission requires no additional documentation
5. Limitations
    a. No payment will be made in conjunction with another biopsy on the same date of service
6. Other Clinical Considerations
    a. A copy of the pathology report should remain as part of the patient record
    b. Medical necessity determination based on other circumstances will be required in the absence of any of the above clinical criteria
7. Administrative Considerations
    a. Local anesthesia is inclusive to the global fee

M. D7285 Incisional Biopsy of Hard Oral Tissue

1. Definition
    a. An incisional biopsy of hard oral tissue involves a biopsy of osseous lesions and includes partial removal only for histological evaluation.
2. Applicable CDT Codes
    a. D7285 - Incisional biopsy of oral tissue, hard (bone, tooth)
3. Clinical Criteria

a. Suspicious lesion of bone or tooth in the mouth necessitating evaluation and tissue harvesting

4. Documentation Required
    a. No prior authorization required
    b. Claim submission requires:
        i. A copy of the pathology report with the claim
5. Limitations
    a. Not covered in conjunction with apicoectomy or periradicular surgery
6. Other Clinical Considerations
    a. Medical necessity determination based on other circumstances will be required in the absence of any of the above clinical criteria
7. Administrative Considerations
    a. Local anesthesia is inclusive to the global fee

N. D7286 Incisional Biopsy of Soft Oral Tissue

1. Definition
    a. An incisional biopsy of soft oral tissue involves a biopsy of soft tissue lesions and includes partial removal only for histological evaluation.
2. Applicable CDT Codes
    a. D7286 - Incisional biopsy of oral tissue, soft
3. Clinical Criteria
    a. Suspicious lesion of soft tissue in the mouth necessitating evaluation and tissue harvesting
4. Documentation Required
    a. No prior authorization required

b. Claim submission requires:

i. A copy of the pathology report with the claim

5. Limitations

a. Not covered in conjunction with apicoectomy (D3410) for the same area on the same date

b. Not covered in conjunction with marsupialization of odontogenic cyst (D7509) for the same area on the same date

6. Other Clinical Considerations

a. Medical necessity determination based on other circumstances will be required in the absence of any of the above clinical criteria

7. Administrative Considerations

a. Should not be used to report a brush biopsy

b. Local anesthesia is inclusive to the global fee

O. D7310, D7311, D7320 Alveoloplasty

1. Definition

a. Alveoloplasty is a distinct and separate procedure from that related to individual extractions that includes the significant reshaping of bone in preparation for a prosthesis

2. Applicable CDT Codes

a. D7310 - Alveoloplasty with extractions, four or more teeth per quadrant

b. D7311 - Alveoloplasty with extractions, one to three teeth per quadrant

c. D7320 - Alveoloplasty, w/o extractions, four or more teeth per quadrant

3. Clinical Criteria

a. Anatomic irregularities requiring surgical correction in preparation for a prosthesis

i. Typically caused by trauma, irregular growth patterns or the result of an irregular ridge after multiple extractions

4. Documentation Required
    a. No prior authorization required
    b. Documentation required in the patient record:
        i. Pre-operative radiograph(s) and/or intraoral photos of the area(s) treated
        ii. Narrative of medical necessity
    c. Claim submission requires no additional documentation
    d. Note: Radiographs should be unaltered by AI. AI radiographs may be submitted as adjunctive documentation only
5. Limitations
    a. 1 of (D7310, D7311, D7320) per quadrant in a lifetime
    b. Covered only in conjunction with the construction of a prosthodontic appliance
6. Other Clinical Considerations
    a. Medical necessity determination based on other circumstances will be required in the absence of any of the above clinical criteria
7. Administrative Considerations
    a. Minor recontouring of bone is considered inclusive to extractions and not separately billable
    b. Frenectomy (D7961/D7962) is considered inclusive to the procedure if performed on the same date and same area
    c. Local anesthesia is inclusive to the global fee

P. D7450, D7451, D7460, D7461 Removal of Benign Odontogenic or Nonodontogenic Cyst

1. Definition

a. Removal of a benign odontogenic or nonodontogenic cyst is a surgical procedure resulting in the complete removal of a benign lesion and histological evaluation.

2. Applicable CDT Codes
    a. D7450 - Removal, benign odontogenic cyst/tumor, up to 1.25 cm
    b. D7451 - Removal, benign odontogenic cyst/tumor, greater than 1.25 cm
    c. D7460 - Removal, benign nonodontogenic cyst/tumor, up to 1.25 cm
    d. D7461 - Removal, benign nonodontogenic cyst/tumor, greater than 1.25 cm
3. Clinical Criteria
    a. A differential diagnosis has accurately identified the presence of a benign odontogenic or nonodontogenic cyst
4. Documentation Required
    a. No prior authorization required
    b. Documentation required in the patient record:
        i. Pre-operative radiograph(s) and/or intraoral photos of the area(s) treated
        ii. Narrative of medical necessity, treatment, and findings
    c. Claim submission requires:
        i. A copy of the pathology report with the claim
5. Limitations
    a. No payment will be made in conjunction with another biopsy in the same area on the same date of service
6. Other Clinical Considerations
    a. Medical necessity determination based on other circumstances will be required in the absence of any of the above clinical criteria
7. Administrative Considerations

a. Local anesthesia is inclusive to the global fee

Q. D7471-D7473 Removal of Exostosis or Torus

1. Definition
    a. Removal of exostosis or torus is a surgical procedure in which a slow-growing bony mass is excised:
        i. Lateral exostosis is on the cheek side of the maxilla or mandible
        ii. Torus palatinus is on the midline of the roof of the mouth
        iii. Torus mandibularis is on the lingual side of the mandible
2. Applicable CDT Codes
    a. D7471 - Removal of lateral exostosis, maxilla or mandible
    b. D7472 - Removal of torus palatinus
    c. D7473 - Removal of torus mandibularis
3. Clinical Criteria
    a. To remove bony undercuts or protuberances that prevent or would prevent a dental prosthesis from fitting properly
    b. To treat or prevent significant soft tissue trauma
    c. To correct significant functional issues related to speech, swallowing, mastication, or oral hygiene
4. Documentation Required
    a. No prior authorization required
    b. Documentation required in the patient record:
        i. Pre-operative outlined diagnostic cast and/or intraoral photos of the area(s) treated

ii. Narrative of medical necessity

c. Claim submission requires no additional documentation

d. Note: Radiographs should be unaltered by AI. AI radiographs may be submitted as adjunctive documentation only

5. Limitations

a. None

6. Other Clinical Considerations

a. Medical necessity determination based on other circumstances will be required in the absence of any of the above clinical criteria

7. Administrative Considerations

a. Local anesthesia is inclusive to the global fee

R. D7509 Marsupialization of Odontogenic Cyst

1. Definition

a. Marsupialization of odontogenic cyst is a surgical procedure involving an incision into a large cystic lesion creating an opening to allow for drainage for a longer period of time

2. Applicable CDT Codes

a. D7509 - Marsupialization of odontogenic cyst

3. Clinical Criteria

a. Large soft tissue mass is present and requires a gradual reduction in size to preserve a tooth or where immediate removal would result in significant bone damage.

4. Documentation Required

a. Prior authorization required, submit:

i. Narrative of medical necessity

ii. Pre-operative radiograph(s) and/or intraoral photo(s) showing the area to be treated

b. Claim submission requires no additional documentation

c. Note: Radiographs should be unaltered by AI. AI radiographs may be submitted as adjunctive documentation only

5. Limitations

a. Not payable on the same date as removal of a benign odontogenic cyst (D7450, D7451, D7460, D7461)

6. Other Clinical Considerations

a. Drainage and removal occur at separate intervals

b. Medical necessity determination based on other circumstances will be required in the absence of any of the above clinical criteria

7. Administrative Considerations

a. A biopsy is considered inclusive to the global fee therefore a soft tissue biopsy (D7286) of the same area on the same date is not payable.

b. Local anesthesia is inclusive to the global fee.

S. D7510, D7520 Incision and Drainage of an Abscess

1. Definition

a. Incision and drainage of an abscess for intraoral soft tissue is a surgical procedure where an incision is made through the mucosa or gingival sulcus of a periodontal or odontogenic abscess allowing for drainage

b. Incision and drainage of an abscess for extraoral soft tissue is a surgical procedure where an incision is made through an external site on the face, such as skin, to allow for drainage of an abscess or cellulitis

2. Applicable CDT Codes

a. D7510 - Incision and drainage of abscess - intraoral soft tissue

b. D7520 - Incision and drainage of abscess, - extraoral soft tissue

3. Clinical Criteria

    a. The spread of infection into adjacent fascial spaces resulting in acute facial swelling and

    b. Requires drainage through an extraoral site on the face

4. Documentation Required

    a. No prior authorization required

    b. Documentation required in the patient record:

        i. Pre-operative radiograph(s) and/or intraoral photos of the area(s) treated

        ii. Narrative of medical necessity, findings, and treatment

    c. Claim submission requires no additional documentation

    d. Note: Radiographs should be unaltered by AI. AI radiographs may be submitted as adjunctive documentation only

5. Limitations

    a. Procedure is inclusive to extractions, apicoectomies, excision of foreign bodies, or other treatment on the same date of service for the same area

6. Other Clinical Considerations

    a. Medical necessity determination based on other circumstances will be required in the absence of any of the above clinical criteria

7. Administrative Considerations

    a. Follow up visits are inclusive to the global fee

    b. Local anesthesia is inclusive to the global fee

T. D7670, D7671 Open and Closed Reduction of Alveolus

1. Definition
    a. Open and closed reduction of the alveolus is a surgical procedure aimed at restoring the alignment and stability of the teeth. It may involve wiring, banding, or splinting the teeth together to prevent movement
        i. An open reduction of the alveolus involves surgically exposing the fractured alveolar bone through an incision in the gum tissue to reposition the bone fragments
        ii. A "closed reduction" realigns the fractured alveolar bone without making an incision but rather using manual manipulation
2. Applicable CDT Codes
    a. D7670 - Alveolus, closed reduction, may include stabilization of teeth
    b. D7671 - Alveolus, open reduction, may include stabilization of teeth
3. Clinical Criteria
    a. Displacement of the alveolar bone fragments resulting in the misalignment of teeth and impacting function
4. Documentation Required
    a. No prior authorization required
    b. Documentation required in the patient record:
        i. Pre-operative radiograph(s) and/or intraoral photos of the area(s) treated
        ii. Narrative of medical necessity, findings, and treatment
    c. Claim submission requires no additional documentation
    d. Note: Radiographs should be unaltered by AI. AI radiographs may be submitted as adjunctive documentation only
5. Limitations

a. None

6. Other Clinical Considerations

    a. Medical necessity determination based on other circumstances will be required in the absence of any of the above clinical criteria.

7. Administrative Considerations

    a. Local anesthesia is inclusive to the global fee.

U. D7899 Unspecified TMD Therapy

1. Definition

    a. Unspecified TMD therapy is used for a procedure that is not adequately described by a code

2. Applicable CDT Codes

    a. D7899 - Unspecified TMD therapy, by report

3. Clinical Criteria

    a. None

4. Documentation Required

    a. Prior authorization required, submit:

        i. Narrative of medical necessity

        ii. Any supporting documentation, pre-operative radiographs, or images to support the medical necessity of the procedure

    b. Claim submission requires no additional documentation

    c. Note: Radiographs should be unaltered by AI. AI radiographs may be submitted as adjunctive documentation only

5. Limitations

a. None

6. Other Clinical Considerations

    a. Medical necessity determination based on other circumstances will be required in the absence of any of the above clinical criteria

7. Administrative Considerations

    a. Local anesthesia is inclusive to the global fee

    b. Used when a procedure is not adequately described by another existing code

V. D7956, D7957 Guided Tissue Regeneration of an Edentulous Area

1. Definition

    a. Guided tissue regeneration of an edentulous area involves placing a material to support bone regeneration

2. Applicable CDT Codes

    a. D7956 - Guided tissue regeneration, edentulous area, resorbable barrier, per site

    b. D7957 - Guided tissue regeneration, edentulous area, non-resorbable barrier, per site

3. Clinical Criteria

    a. Ridge preservation to support a planned prosthesis

    b. Ridge augmentation to support a planned prosthesis

4. Documentation Required

    a. Prior authorization required, submit:

        i. Narrative of medical necessity including the planned prosthesis

        ii. Pre-operative radiograph(s) or a CBCT showing the area to be treated

        iii. Intra-oral photo(s) of the area if the medical necessity cannot be determined by the

radiographs alone

b. Claim submission requires no additional documentation

c. Note: Radiographs should be unaltered by AI. AI radiographs may be submitted as adjunctive documentation only

5. Limitations

a. None

6. Other Clinical Considerations

a. Medical necessity determination based on other circumstances will be required in the absence of any of the above clinical criteria

7. Administrative Considerations

a. Not suitable for use around an implant placement or natural tooth

b. Follow up visits are included with D7956

c. Coverage is limited to areas that are critical to the success of a planned prosthesis

d. Coverage does not include bone regeneration to support implants

e. Local anesthesia is inclusive to the global fee

W. D7961, D7962 Frenectomy/Frenulectomy

1. Definition
   a. The excision of a frenum/tethered tissue that inhibits the ability to develop or function normally, including inability to nurse, speech difficulties, and inability to wear prostheses, depending on patient age
2. Applicable CDT Codes
   a. D7961- buccal/labial frenectomy (Frenulectomy)
   b. D7962 - lingual frenectomy (Frenulectomy)
3. Clinical Indications
   a. Restricted lip and tongue movements resulting in significant impairment such as failure to latch in infants, speech difficulties in children, and prosthesis interference

or tissue damage in all age groups.

b. Gingival recession caused by a frenum attachment
c. To eliminate large diastemas between teeth in conjunction with approved orthodontic treatment in the permanent dentition
d. To eliminate interference with a prosthetic appliance
    i. Treatment should be considered after repeated attempts to adjust the appliance without improvement before compromising the appliance

4. Documentation Required
    a. No prior authorization requirements
    b. Documentation required in the patient record:
        i. Narrative of medical necessity including the frenum location, the pathological condition it caused, a description of how it interferes with the proper oral development or function, and history of ineffective non-surgical management
        ii. Any available documentation from physicians/paediatricians, speech pathologists, oral surgeons, otolaryngologists, etc should be provided
        iii. Digital photographs showing the pathology of the affected area(s)
        iv. In the case of frenectomy or surgical intervention in an infant related to feeding difficulty, a letter from a physician corroborating need for surgery is required
    c. Claim submission requires:
        i. Narrative of medical necessity and photographs
5. Limitations
    a. Treatment will not be reimbursed if performed on the same day at the same site of other surgical procedures, such as a gingivectomy or alveoloplasty, as a frenectomy/Frenulectomy is considered inclusive to these procedures
    b. For restricted lip and tongue movements resulting in significant impairment such as failure to latch or speech difficulties:
        i. Treatment will not be reimbursed without a history of unsuccessful attempts in non-surgical management
    c. For gingival recession caused by a frenum attachment:
        i. Treatment will not be reimbursed if the position of the frenum is not causing inflammation, recession, pocket formation, and/or possible loss of

the alveolar bone and/or tooth

d. For eliminating large diastemas between teeth in conjunction with approved orthodontic treatment:
    i. Treatment will not be reimbursed until the permanent incisors and cuspids have fully erupted and any diastema has had an opportunity to close naturally
    ii. Treatment will only be reimbursed with approved orthodontic treatment
e. For eliminating interference with a prosthetic appliance:
    i. Treatment will not be reimbursed if performed prior to prosthetic appliance placement as necessity will be based on documented failure to retain the appliance despite adjustments

6. Other Clinical Considerations
    a. Medical necessity determination based on other circumstances will be required in the absence of any of the above clinical criteria
    b. Age categories are those consistent with accepted medical terminology
7. Administrative Considerations
    a. Local anesthesia is considered inclusive to the global fee

X. D7970 Excision of Hyperplastic Tissue

1. Definition
    a. Excision of hyperplastic tissue is used to describe the removal of an overgrowth of soft tissue
2. Applicable CDT Codes
    a. D7970 - Excision of hyperplastic tissue, per arch
3. Clinical Criteria
    a. Epulis
    b. Overgrowth of soft tissue due to multiple factors including but not limited to:
        i. Orthodontic appliances

ii. Medication

iii. Poor oral hygiene

4. Documentation Required

a. No prior authorization required

b. Documentation required in the patient record:

i. Pre-operative outlined diagnostic cast and/or intraoral photos of the area(s) treated

ii. Narrative of medical necessity

c. Claim submission requires no additional documentation

d. Note: Radiographs should be unaltered by AI. AI radiographs may be submitted as adjunctive documentation only

5. Limitations

a. None

6. Other Clinical Considerations

a. Medical necessity determination based on other circumstances will be required in the absence of any of the above clinical criteria

7. Administrative Considerations

a. Reported on a per arch basis

b. Local anesthesia is inclusive to the global fee

Plan	Liberty Dental Plan
Exhibit	AN-UM01-INS-I-D800-Orthodontic Services-12302024
Criteria	Orthodontic Services
Prior Authorization	Yes

Contents

A. D8080, D8670 Orthodontic Treatment

1. Definition
    a. Comprehensive orthodontic treatment includes a coordinated diagnosis and treatment of the entire dentition. The result is improvement of a patient's craniofacial dysfunction and or dentofacial deformity as well as creating a functional and ideal class I molar/canine relationship when possible. This may include anatomical, functional and/or aesthetic relationships.
    b. Periodic orthodontic treatment visits report the ongoing orthodontic adjustments for active orthodontic treatment.
2. Applicable CDT Codes
    a. D8080 - Comprehensive orthodontic treatment of the adolescent dentition
    b. D8670 - Periodic orthodontic treatment visit
3. Clinical Indications
    a. Orthodontic service is medically necessary when its purpose is to restore or establish structure or function, to ameliorate or prevent disease or physical or psychosocial injury, or to promote oral health. Coverage of comprehensive orthodontic service is limited to treatment of existing or developing malocclusion, misalignment, or malposition of teeth that has, or

may have, an adverse medical or psychosocial impact on the patient.

i. Automatic qualifying conditions:
    1. Cleft palate deformity or cranio-facial anomaly
    2. Deep impinging overbite with severe soft tissue damage
    3. Crossbite of individual anterior teeth when clinical attachment loss and recession of the gingival margin are present
    4. Severe traumatic deviations
    5. Impacted permanent anteriors where extraction is not indicated
    6. Overjet greater than 9mm with incompetent lips or reverse overjet greater than 3.5mm with reported masticatory/speech difficulties

ii. A score of 26 or higher on the Ohio Medicaid Handicapping Labio-Lingual Deviations (HLD) Index Score Sheet

iii. Patients who do not meet one of the automatic qualifying conditions and do not score 26 or above on the HLD Index, may be eligible for services dependent upon professional assessment of LIBERTY if medical necessity is documented and submitted for review.

4. Documentation Required
    a. Prior authorization required
        i. For all cases submit the following with current imaging:
            1. A completed and signed HLD analysis and narrative describing the nature of the severe physically handicapping malocclusion, along with any documentation relevant to determining the nature and extent of the handicap
            2. A completed Referral Evaluation for Comprehensive Orthodontic Treatment (ODM 03630)
            3. A panoramic and/or mounted full mouth series of intra-oral x-rays
            4. A cephalometric x-ray with lips together and teeth in centric occlusion including cephalometric analysis / tracing; and,
            5. Photographs of frontal and profile views with lips together
            6. Intra-oral photographs depicting right and left occlusal relationships as well as an anterior view or photos of articulated models (Do NOT send stone casts)
            7. Maxillary and mandibular occlusal photographs

8. A treatment plan including the length and cost of treatment

ii. For patients-who do not meet one of the automatic qualifying conditions and do not score 26 or above on the HLD Index but medically necessity is documented, submit all the above documentation (see 4ai) and a separate document with:

1. Principal diagnosis and significant associated diagnosis; and,
2. Prognosis; and,
3. Date of onset of the illness or condition and etiology if known; and,
4. Clinical significance or functional impairment caused by the illness or condition; and,
5. Specific services to be rendered by each discipline and anticipated time for achievement of goals; and,
6. Therapeutic goals to be achieved by each discipline and anticipated time for achievement of goals; and,
7. Extent of previous services that were provided to address the illness/condition and results of the prior care; and,
8. Any other relevant documentation available which may assist LIBERTY in making a determination.

iii. Note: Radiographs should be unaltered by AI. AI radiographs may be submitted as adjunctive documentation only

5. Limitations
   a. Coverage is limited to patients younger than age 21
   b. 1 (D8080) in a lifetime
   c. D8670 is only payable with active, ongoing, and LIBERTY approved comprehensive orthodontic treatment (D8080)
   d. Purely cosmetic orthodontic service is not covered.
6. Other Clinical Considerations
   a. Medical necessity determination based on other circumstances will be required in the absence of any of the above clinical criteria
7. Administrative Considerations
   a. Payment for D8080 is for the initial placement visit and includes the first quarter of treatment
   b. Payment for D8670 will not be made in the same quarter as D8080
   c. When prior authorization for comprehensive orthodontic service is denied, payment may still

be made for images, cephalometric films, tracings, and diagnostic models. Full-mouth and panoramic images do not require prior authorization; separate claims may be submitted for these items.

d. After active treatment is completed, payment may be made for retention service, once per arch, under the original prior authorization. Payment will not be made for active treatment after retention service is begun.

e. Prior authorization covers the entire course of comprehensive orthodontic treatment, up to a maximum of eight quarters, as long as the patient remains eligible for Medicaid services. If the patient becomes ineligible for Medicaid during the course of treatment, coverage and payment will continue through the end of the last quarter during which the patient is eligible. It is then the responsibility of the patient and the dentist to determine how payment is to be made for subsequent treatment

f. Payment for active treatment is payment in full. No additional payment can be sought from the patient or a third-party payer if the treatment requires more than eight quarters. A request for coverage beyond 8 calendar quarters must be accompanied by extraordinary supporting documentation

B. D8220 Fixed Appliance

1. Definition
    a. Fixed appliance therapy refers to a passive appliance that cannot be removed by the patient intended to break a harmful habit that may impact the growth or development of a patient
2. Applicable CDT Codes
    a. D8220 - Fixed appliance therapy
3. Clinical Indications
    a. Parafunctional habits including but not limited to thumb sucking and tongue thrusting
4. Documentation Required
    a. Prior authorization required, submit:
        i. Diagnostic models or photographs of the mouth
        ii. Narrative of medical necessity
5. Limitations
    a. Excludes treatment for bruxism or TMD

6. Other Clinical Considerations
    a. Medical necessity determination based on other circumstances will be required in the absence of any of the above clinical criteria
7. Administrative Considerations

C. D8680 Orthodontic Retention

1. Definition
    a. Orthodontic retention is used to describe the orthodontic retain appliances delivered immediately after active orthodontic treatment has been completed. This includes the removal of active appliances as well as fabrication and delivery of fixed and/or removable orthodontic retainers
2. Applicable CDT Codes
    a. D8680 - Orthodontic retention (removal of appliances, construction and placement of retainer(s))
3. Clinical Indication
    a. Retention is indicated in any situation where there is a high risk of teeth shifting back to their original position after orthodontic treatment including but not limited to closing midline diastemas, managing severe tooth rotations, maintaining position after significant tooth movement, cases with reduced periodontal support, anterior crowding, space closure following extraction, managing impacted teeth, and situations where patient compliance might be an issue, particularly when significant labial-lingual tooth position changes have occurred
    b. Removal of appliances is indicated after completion of active orthodontic treatment
4. Documentation Required
    a. Prior authorization required, submit current:
        i. Photographs of frontal and profile views with lips together
        ii. Intra-oral photographs depicting right and left occlusal relationships as well as an anterior view or photos of articulated models (Do NOT send stone casts)
        iii. Maxillary and mandibular occlusal photographs
        iv. A panoramic and/or mounted full mouth series of intra-oral x-rays
    b. Note: Radiographs should be unaltered by AI. AI radiographs may be submitted as adjunctive documentation only

5. Limitations
    a. Coverage is limited to patients younger than 21
    b. 1 (D8680) per arch in a lifetime
    c. D8680 is only payable after completion of LIBERTY approved comprehensive orthodontic treatment (D8080)
6. Other Clinical Considerations
    a. Medical necessity determination based on other circumstances will be required in the absence of any of the above clinical criteria
7. Administrative Considerations
    a. D8680 is reported once whether the retention is placed in one arch or both arches
    b. The HLD Index can be located in the Provider Resource Library. Please select Ohio for the relevant list and click on "Ohio Medicaid HLD Index."

D. D8999 Unspecified Orthodontic Procedure

1. Definition
    a. Unspecified orthodontic procedure is used to report a procedure not adequately described by an existing covered or non-covered code
2. Applicable CDT Codes
    a. D8999 - Unspecified orthodontic procedure, by report
3. Clinical Indications
    a. Any procedure not adequately described by an existing covered or non-covered code
4. Documentation Required
    a. Prior authorization required, submit:
        i. Narrative of medical necessity
        ii. Any other documentation or radiographs needed to show medical necessity
    b. Note: Radiographs should be unaltered by AI. AI radiographs may be submitted as adjunctive documentation only
5. Limitations
    a. None
6. Other Clinical Considerations
    a. Medical necessity must be adequately documented for coverage consideration
7. Administrative Considerations

a. None

Disclaimer: Mail-Order Orthodontic Aligners

A. LIBERTY does not consider mail-order orthodontic aligner kits to be a covered benefit. Therefore, LIBERTY will not reimburse providers or members for purchasing mail-order orthodontic kits.

B. Rationale- Orthodontic benefits are payable only for services performed by a licensed dentist. This requirement is imposed primarily for member protection, as it ensures that any procedures performed are necessary, appropriate and delivered within the standards of good dental practice. In the case of many mail order aligner kits, a dentist does not physically examine or oversee the patient care as he or she self-administers a series of orthodontic aligners at home. It is especially important that a dentist monitor that patient during orthodontic treatment, since refinements, revisions and adjustments of aligners are expected and very common. A dentist has the ability and requisite training to properly monitor treatment progress, which is imperative in orthodontic treatment.

E. Appendix:

Ohio Medicaid Orthodontic Initial Assessment
Handicapping Labio-Lingual Deviations (HLD) Index Score Sheet

(You will need this score sheet and a Boley Gauge or a scaled millimeter disposable ruler)

ENROLLEE INFORMATION			
Enrollee's Name	**Date of Birth**	**Enrollee ID#**	
Street Address			
City		**State**	**Zip Code**
Orthodontist's Signature	**NPI ID#**		
Assessment Date			

INSTRUCTIONS

1. Position the enrollee's teeth in centric occlusion
2. Record all measurements in the order given and round off to the nearest millimeter (mm)
3. Enter score "0" if the condition is absent
4. Enter the requested provider and patient information above. Provider must **sign and date** at the bottom;
5. Use the accompanying "HLD Index Scoring Instructions" for guidance in completion of the assessment;
6. Submit pages 1 and 2 along with a prior approval request and all necessary diagnostic and supporting documentation (refer to the "Orthodontic Criteria" in the Provider Reference Guide (PRG)

CONDITIONS OBSERVED						HLD SCORE
#1 – #6 ARE AUTOMATIC QUALIFYING CONDITIONS						
1.	Cleft palate deformity or cranio-facial anomaly. *INDICATE AN "X" IF PRESENT AND SCORE NO FURTHER*					
2.	Deep impinging overbite with severe soft tissue damage. *INDICATE AN "X" IF PRESENT AND SCORE NO FURTHER*					
3.	Crossbite of individual anterior teeth when clinical attachment loss and recession of the gingival margin are present. *INDICATE AN "X" IF PRESENT AND SCORE NO FURTHER*					
4.	Severe traumatic deviations. *INDICATE AN "X" IF PRESENT AND SCORE NO FURTHER*					
5.	Impacted permanent anteriors where extraction is not indicated. *INDICATE AN "X" IF PRESENT AND SCORE NO FURTHER*					
6.	Overjet greater than 9mm with incompetent lips or reverse overjet greater than 3.5mm with reported masticatory/speech difficulties *INDICATE AN "X" IF PRESENT AND SCORE NO FURTHER*					
THE CONDITIONS FOR #7-#14 MUST TOTAL 26 OR MORE TO QUALIFY FOR TREATMENT						
7.	Overjet equal to or less than 9 mm					
8	Overbite in mm					
9	Mandibular Protrusion (reverse overjet) in mm equal to or less than 3.5 mm				x5 =	
10	Open bite in mm				x4 =	
IF BOTH ANTERIOR CROWDING AND ECTOPIC ERUPTION ARE PRESENT IN THE ANTERIOR PORTION OF THE SAME ARCH, SCORE ONLY THE MOST SEVERE CONDITION. DO NOT COUNT BOTH CONDITIONS						
11	Ectopic eruption (Identify by tooth number, and count each tooth, excluding third molars)		total numbers	total	x3=	
12	Anterior crowding (Score one for MAXILLA, and/or one for MANDIBLE)	maxilla	mandible	total	x5=	
13	Labio-Lingual spread in mm					
14	Posterior unilateral crossbite (must involve two or more adjacent teeth, one of which must be a molar. No score for bi-lateral posterior crossbite)					
					TOTAL SCORE (must score 26 points or greater to qualify)	

Comments:

NOTE: If a patient does not meet one of the automatic qualifying conditions and does not score 26 or above on the HLD index, he/she may be eligible for services dependent upon professional assessment of LIBERTY Dental Plan (LDP) if medical necessity is documented. Attach medical evidence and appropriate documentation for each of the following eight areas on a separate piece of paper in addition to completing the HLD score sheet above.

1) Principal diagnosis and significant associated diagnosis; and,
2) Prognosis; and,
3) Date of onset of the illness or condition and etiology if known; and,
4) Clinical significance or functional impairment caused by the illness or condition; and,
5) Specific services to be rendered by each discipline and anticipated time for achievement of goals; and
6) Therapeutic goals to be achieved by each discipline and anticipated time for achievement of goals; and,
7) Extent of previous services that were provided to address the illness/condition and results of the prior care; and,
8) Any other relevant documentation available which may assist LDP in making a determination.

ALL REQUESTS FOR PRIOR AUTHORIZATION MUST INCLUDE:

I. A completed and signed HLD analysis and narrative describing the nature of the severe physically handicapping malocclusion, along with any documentation relevant to determining the nature and extent of the handicap; and,
II. A panoramic and/or mounted full mouth series of intra-oral x-rays; and,
III. A cephalometric x-ray with lips together and teeth in centric occlusion including cephalometric analysis / tracing; and
IV. Photographs of frontal and profile views with lips together; and,
V. Intra-oral photographs or photos of articulating models (do not send stone casts) depicting right and left occlusal relationships as well as an anterior view; and,
VI. Maxillary and mandibular occlusal photographs; and,
VII. A treatment plan including the length and cost of treatment

Subjective statements submitted by the provider or others must be substantiated by objective documentation such as photographs, radiographs, credible medical documentation, etc. verifying the nature and extent of the severe physical handicapping malocclusion. Requests where there is significant disparity between the subjective documentation (e.g. handicapping labio-lingual deviation (HLD) index report) and objective documentation (e.g. photographs and / or x-rays) will result in a return for clarification without review.

I certify that I am the furnishing provider and that all the information and documentation submitted is true, accurate and complete to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal penalty and/or prosecution under applicable federal and state laws.

_____ _____

Provider Signature Date

Ohio Medicaid Orthodontic Initial Assessment
Handicapping Labio-Lingual Deviations (HLD) Index
SCORING INSTRUCTIONS

The intent of the HLD index is to measure the presence or absence, and the degree, of the handicap caused by the components of the Index, and not to diagnose 'malocclusion.' All measurements are made with a Boley Gauge (or a disposable ruler) scaled in millimeters. Absence of any conditions must be recorded by entering '0.' ***(Refer to the attached score sheet.)***

The following information should help clarify the categories on the HLD Index:

	CONDITION	INSTRUCTIONS
1.	**Cleft Palate Deformity or Cranio-Facial Anomoly**	Acceptable documentation must include diagnostic casts or intraoral photograph(s) of the deformity or anomaly and a written consultation report by a qualified specialist or Craniofacial Panel) Indicate an 'X' on the score sheet. Do not score any further if present. (This condition is automatically considered a handicapping malocclusion.)
2.	**Deep Impinging Overbite with Severe Soft Tissue Damage**	Indicate an 'X' on the score sheet when lower incisors are destroying the soft tissue of the palate and tissue laceration and/or clinical attachment loss are present. Do not score any further if present. (This condition is automatically considered a handicapping malocclusion.)
3.	**Crossbite of Individual Anterior Teeth**	Indicate an 'X' on the score sheet when clinical attachment loss and recession of the gingival margin are present. Do not score any further if present. (This condition is automatically considered a handicapping malocclusion.)
4.	**Severe Traumatic Deviation**	Traumatic deviations are, for example, loss of a premaxilla segment by burns or by accident; the result of osteomyelitis; or other gross pathology. Indicate an 'X' on the score sheet and attach documentation and description of condition. Do not score any further if present. (This condition is automatically considered a handicapping malocclusion.)
5.	**Impacted Permanent Anterior Teeth**	Demonstrate that anterior tooth (teeth) (incisors and / or cuspids) is (are) impacted (soft or hard tissue); exposure and passive eruption is unlikely; extraction would compromise the integrity of the arch; and the tooth (teeth) are treatment planned to be exposed ligated/banded and brought into the normal arch form; and, there is, or will be sufficient arch space for correction. Indicate with an" X" on the score sheet and do not score any further. (This condition is automatically considered a handicapping malocclusion.)
6.	**Overjet Greater than 9mm or Mandibular Protrusion (reverse overjet) Greater than 3.5mm**	Overjet is greater than 9mm with incompetent lips or the reverse overjet (mandibular protrusion) is greater than 3.5mm with reported masticatory and speech difficulties. Indicate with an "X" on the score sheet and do not score any further. (This condition is automatically considered a handicapping malocclusion.)
7.	**Overjet Equal to or less than 9mm**	This is recorded with the patient's teeth in centric occlusion and measured from the labial portion of the lower incisors to the labial of the upper incisor. The measurement may apply to a protruding single tooth as well as to the whole arch. Round this measurement to the nearest millimeter on the score sheet.
8	**Overbite in Millimeters**	A pencil mark on the tooth indicating the extent of overlap facilitates this measurement. It is measured by rounding off to the nearest millimeter and entered on the score sheet. ('Reverse' overbite may exist in certain conditions and should be measured and recorded.)
9.	**Mandibular Protrusion (reverse overjet) Equal to or less than 3.5mm**	Score exactly as measured from the labial of the lower incisor to the labial of the upper incisor. The measurement in millimeters is entered on the score sheet and multiplied by five (5). A reverse overbite, if present, should be shown under "overbite"
10.	**Open Bite in Millimeters**	This condition is defined as the absence of incisal contact in the anterior region. It is measured from incisal edge of a maxillary central incisor to incisal edge of a corresponding mandibular incisor, in millimeters. The measurement is entered on the score sheet and multiplied by four (4). In cases of pronounced protrusion associated with open bite, measurement of the open bite is not always possible. In those cases, a close approximation can usually be estimated.
11.	**Ectopic Eruption**	Count each tooth, excluding third molars. Each qualifying tooth must be more than 50% blocked out of the arch. Count only one tooth when there are mutually blocked out teeth. Enter the number of qualifying teeth on the score sheet and multiply by three (3). If anterior crowding (condition #11) also exists in the same arch, score the condition that scores the most points. **DO NOT COUNT BOTH CONDITIONS.** However, posterior ectopic teeth can still be counted separately from anterior crowding when they occur in the same arch.
12.	**Anterior Crowding**	Arch length insufficiency must exceed 3.5mm. Mild rotations that may react favorably to stripping or mild expansion procedures are not to be scored as crowded. Score one (1) for a crowded maxillary arch and/or one (1) for a crowded mandibular arch. Enter total on the score sheet and multiply by five (5). If ectopic eruption (condition #10) exists in the anterior region of the same arch, count the condition that scores the most points. **DO NOT COUNT BOTH CONDITIONS.** However, posterior ectopic teeth can still be counted separately from anterior crowding when they occur in the same arch.
13.	**Labio-Lingual Spread**	A Boley Gauge (or a disposable ruler) is used to determine the extent of deviation from a normal arch. Where there is only a protruded or lingually displaced anterior tooth, the measurement should be made from the incisal edge of that tooth to the normal arch line. Otherwise, the total distance between the most protruded anterior tooth and the most lingually displaced adjacent anterior tooth is measured. If multiple anterior crowding of teeth is observed, all deviations from the normal arch should be measured for labio-lingual spread, but only the most severe individual measurement should be entered on the score sheet.
14.	**Posterior Unilateral Crossbite**	This condition involves two or more adjacent teeth, one of which must be a molar. The crossbite must be one in which the maxillary posterior teeth involved may either be both palatal or both completely buccal in relation to the mandibular posterior teeth. The presence of posterior unilateral crossbite is indicated by a score of four (4) on the score sheet.**NO SCORE FOR BI-LATERIAL CROSSBITE**

Plan	Liberty Dental Plan
Exhibit	AN-UM01-INS-J-D900-Adjunctive General Services -12302024
Criteria	Adjunctive General Services
Prior Authorization	Varies by Procedure

Contents

A. D9222, D9223, D9239, D9243 Deep/Conscious Sedation

1. Definition
    a. Deep sedation/general anesthesia refers to the administration of medicament(s) resulting in depression of consciousness during dental treatment where the patient is not easily aroused
    b. Intravenous moderate (conscious) sedation refers to the administration of medicament(s) resulting in depression of consciousness during dental treatment where the patient responds purposefully to verbal commands, given through the intravenous route.
2. Applicable CDT Codes
    a. D9222 - Deep sedation/general anesthesia, first 15-minute increment
    b. D9223 - Deep sedation/general anesthesia, each subsequent 15-minute increment
    c. D9239 Intravenous moderate (conscious) sedation/analgesia, first 15-minute increment
    d. D9243 Intravenous moderate (conscious) sedation/analgesia, each subsequent 15-minute increment
3. Clinical Indications
    a. A medical condition requiring monitoring (e.g., cardiac issues, severe hypertension);
    b. An underlying medical condition that would make the patient non-compliant without GA or IV sedation (e.g., cerebral palsy, epilepsy, developmental or intellectual disabilities, Down syndrome);
    c. Documentation of failed conscious sedation (if applicable);
    d. A condition where severe infection would make local anesthesia ineffective

4. Documentation Required
    a. No prior authorization requirements
    b. Documentation required in the patient record:
        i. The medical necessity for using general anesthesia (GA) or IV sedation in a dental office setting must be clearly documented in the patient's dental record
    c. Claim submission must include:
        i. A narrative explaining the medical necessity for anesthesia or sedation
5. Limitations
    a. Maximum of 1 (D9222, D9239) per day
    b. Maximum of 4 (D9223, D9243) per day
    c. Not allowed on same day as D9239, D9243
    d. Only payable when administered with covered and/or approved treatment and medically necessary
6. Other Clinical Considerations
    a. The level of anesthesia is determined by the documentation of the anesthetic's effect on the central nervous system, rather than the method of administration.
    b. Providers performing anesthesia must be appropriately licensed by the state regulatory body and adhere to all monitoring and staffing requirements set by that body.
    c. A sedation log must be documented in the patient record.
    d. Consider that some cases may require hospital care. This includes but is not limited to patients with:
        i. Severe Medical Conditions
            1. Patients with significant comorbidities classified as by the American Society of Anesthesiologists (ASA) Class III or IV, where dental treatment poses a higher risk in an outpatient setting.
        ii. Behavioral or Special Needs
            1. Patients with behavioral issues, severe anxiety, or developmental disabilities who require sedation or specialized care.
        iii. Acute Dental Emergencies
            1. Cases involving acute infections, trauma, or other urgent conditions where immediate intervention is necessary to prevent further health complications.
        iv. Infection Management
            1. Situations where oral infections are severe enough to warrant

hospitalization for drainage or surgical treatment.

v. Complex Treatment Needs

1. When dental issues are part of a broader medical condition requiring multidisciplinary care in a hospital setting

e. Medical necessity determination based on other circumstances will be required in the absence of any of the above clinical criteria.

7. Administrative Considerations
   a. The provider must document the actual start and end times of anesthesia in the patient's dental record.
   b. Anesthesia time begins when the provider administers the anesthetic agent and initiates the appropriate anesthesia and non-invasive monitoring protocols, remaining in continuous attendance with the patient. Anesthesia services are considered complete when the patient can be safely left under the observation of trained personnel, allowing the provider to leave the room. Anesthesia time will not include any period during which the anesthesia provider chooses to remain with the patient for recovery when other qualified personnel can provide safe supervision.

B. D9230 Inhalation of Nitrous Oxide

1. Definition
   a. Inhalation of nitrous oxide refers to the administration of nitrous oxide gas via inhalation that is used as a sedative and pain medication during dental treatment.
2. Applicable CDT Codes
   a. D9230 - Inhalation of nitrous oxide/analgesia, anxiolysis
3. Clinical Indications
   a. For pediatric patients, medical and behavioral conditions such as anxiety, gag reflexes, muscular tones disorders
   b. For adult patients, medical and behavioral conditions such as anxiety, low pain tolerance, or intellectual disability
4. Documentation Required
   a. Prior authorization required for adults ages 21 and older, submit:
      i. Narrative of medical necessity, including treatment to be rendered
   b. Claim submission requires no additional documentation
5. Limitations
   a. Only payable when administered with covered and/or approved treatment and medically necessary
6. Other Clinical Considerations
   a. A sedation log must be documented in the patient record

b. Medical necessity determination based on other circumstances will be required in the absence of any of the above clinical criteria

7. Administrative Considerations
    a. Nitrous oxide is considered inclusive if submitted with sedation codes D9239, D9243, D9222 and D9223, and will not be reimbursed separately

C. D9920 Behavior Management

1. Definition
    a. Behavior management represents the extra time taken to complete a procedure in addition to the normal procedure time
2. Applicable CDT Codes
    a. D9920 - Behavior management, by report
3. Clinical Indications
    a. Significant fear, anxiety or uncooperative behavior during a dental procedure
4. Documentation Required
    a. Prior authorization required, submit:
        i. Narrative of medical necessity
5. Limitations
    a. None
6. Other Clinical Considerations
    a. Medical necessity determination based on other circumstances will be required in the absence of any of the above clinical criteria
7. Administrative Considerations
    a. Reported in 15-minute increments of extra time needed

D. D9947 Sleep Apnea Appliance

1. Definition
    a. Sleep apnea appliance is a custom appliance fabricated and delivered to treat sleep apnea that meets approved industry criteria for sleep apnea appliances
2. Applicable CDT Codes
    a. D9947 - Custom sleep apnea appliance fabrication and placement
3. Clinical Indications
    a. Mild to moderate obstructive sleep apnea and unable to tolerate CPAP therapy
4. Documentation Required
    a. Prior authorization required, submit:
        i. Narrative of medical necessity

ii. MD note documenting a diagnosis of sleep apnea

5. Limitations
    a. A sleep apnea appliance will not be covered for replacement if the existing appliance can be adequately restored with a repair, even if the patient requests a replacement due to perceived functional or cosmetic issues
6. Other Clinical Considerations
    a. Diagnosis of sleep apnea should occur by a licensed sleep specialist
    b. Medical necessity determination based on other circumstances will be required in the absence of any of the above clinical criteria
7. Administrative Considerations
    a. Payment includes the entire process of fabricating the sleep apnea appliance, including all steps from start to finish to produce and deliver a functional appliance, as well as any necessary relines, repairs, or adjustments for six months post delivery
    b. For reimbursement, the date of service shall be the date of delivery to the patient
    c. Diagnostic casts (D0470) are considered part of the global fee

E. D9948 Adjustment of Sleep Apnea Appliance

1. Definition
    a. Adjustment of sleep apnea appliance refers to the modification of a sleep apnea appliance to make it functional again
2. Applicable CDT Codes
    a. D9948 - Adjustment of custom sleep apnea appliance
3. Clinical Indications
    a. Improper fit or function of an existing sleep apnea appliance
4. Documentation Required
    a. Prior authorization required, submit:
        i. Narrative of medical necessity
        ii. MD note documenting a diagnosis of sleep apnea
5. Limitations
    a. Adjustments within the first six months of placement are included in the global fee for the appliance and are not separately reimbursed
6. Other Clinical Considerations
    a. Medical necessity determination based on other circumstances will be required in the

absence of any of the above clinical criteria

7. Administrative Considerations
    a. None

F. D9949 Repair of Sleep Apnea Appliance

1. Definition
    a. Repair of sleep apnea appliance refers to the correction of a defect impacting the functionality of a sleep apnea appliance
2. Applicable CDT Codes
    a. D9949 - Repair of custom sleep apnea appliance
3. Clinical Indications
    a. Significant defects or cracks in the sleep apnea appliance
    b. Loose components in the sleep apnea appliance
4. Documentation Required
    a. Prior authorization required, submit:
        i. Narrative of medical necessity
        ii. MD note documenting a diagnosis of sleep apnea
5. Limitations
    a. Repairs within the first six months of placement are included in the global fee for the appliance and are not separately reimbursed
6. Other Clinical Considerations
    a. Direct self-curing materials are not allowed
    b. The appliance must be processed and finished with materials chemically compatible with the existing appliance
    c. Medical necessity determination based on other circumstances will be required in the absence of any of the above clinical criteria
7. Administrative Considerations
    a. None

G. D9953 Reline of Sleep Apnea Appliance

1. Definition
    a. Reline of sleep apnea appliance refers to the laboratory refitting of the intaglio surface of a sleep apnea appliance
2. Applicable CDT Codes

a. D9953 - Reline custom sleep apnea appliance (indirect)

3. Clinical Indications
   a. Poor fit of a sleep apnea appliance
4. Documentation Required
   a. Prior authorization required, submit:
      i. Narrative of medical necessity
      ii. MD note documenting a diagnosis of sleep apnea
5. Limitations
   a. Relines within the first six months of placement are included in the global fee for the appliance and are not separately reimbursed
6. Other Clinical Considerations
   a. Medical necessity determination based on other circumstances will be required in the absence of any of the above clinical criteria
7. Administrative Considerations
   a. None

H. D9997 Dental Case Management:

1. Definition
   a. Dental case management refers to the modifications in the rendering of treatment for patients with physical, medical, developmental, or cognitive conditions resulting in substantial functional limitations or incapacitation
2. Applicable CDT Codes
   a. D9997 - Dental case management, patients with special health care needs
3. Clinical Indications
   a. Any modifications in the environment required to adequately treat a patient with special health care needs
4. Documentation Required
   a. Prior authorization required, submit:
      i. Narrative of medical necessity
5. Limitations
   a. None
6. Other Clinical Considerations

a. Medical necessity determination based on other circumstances will be required in the absence of any of the above clinical criteria

7. Administrative Considerations
    a. None

I. D9999 Unspecified Adjunctive Procedure

1. Definition
    a. Unspecified adjunctive procedure is used to report a procedure not adequately described by an existing covered or non-covered code
2. Applicable CDT Codes
    a. D9999 - Unspecified adjunctive procedure, by report
3. Clinical Indications
    a. Any procedure not adequately described by an existing covered or non-covered code
4. Documentation Required
    a. Prior authorization required, submit:
        i. Narrative of medical necessity
        ii. Any other documentation or radiographs needed to show medical necessity
    b. Note: Radiographs should be unaltered by AI. AI radiographs may be submitted as adjunctive documentation only
5. Limitations
    a. None
6. Other Clinical Considerations
    a. Medical necessity must be adequately documented for coverage consideration
7. Administrative Considerations
    a. None