

Arizona Clinical Criteria Guidelines and Practice Parameters



LIBERTY DENTAL PLAN®

Making members shine, one smile at a time™



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Disclosure

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

Preface

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

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

New Patient Information

Registration information should minimally include:

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

- e. Liver or kidney disease, including hepatitis and kidney dialysis
 - f. Sexually transmitted diseases
 - g. Disorders of the immune system, including HIV status/AIDS
 - h. Other viral diseases
- 6. Musculoskeletal system, including prosthetic joints and when they were placed.
- 7. Pregnancy: Follow guidelines in the ADA publication, Women's Oral Health Issues, November 2006.
 - a. Document the name of the member's obstetrician and estimated due date.
- 8. History of cancer, including radiation or chemotherapy.
- 9. Social History, relative to the patient's chief complaint and dental history, including any problems or complications with previous dental treatment should always be documented.
- 10. The medical history form must be signed and dated by the member or member's parent or guardian.
- 11. Dentist's notes following up on member comments, significant medical issues, and/or the need for a consultation with a physician should be documented on the medical history form or in the member's progress notes.
- 12. Medical alerts reflecting current significant medical conditions must be uniform and conspicuously visible on a portion of the chart used during treatment.
- 13. The dentist must sign and date all baseline medical histories after review with the member.
- 14. The medical history should be updated, signed, and dated by the member and the dentist at least annually or as dictated by the member's history and risk factors.

Dental History

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

Dental Records

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

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

Contracted dentists must make available copies of all member records upon request within the period stipulated on the request. Records may be requested for grievance resolutions, second opinions and/or for state/federal compliance. The dentist must make records available at no cost to the Plan.

Noncompliance may result in disciplinary actions, up to and including transfer of enrollment or closure to new enrollment. Continued non-compliance may result in termination by Liberty.

Progress Notes

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

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

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

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

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

Informed Consent Process

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

Poor Prognosis

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

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

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

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

Upgrades and Alternative Treatment

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

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

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

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

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

Consultations, referrals, and their results should be documented.

Infection Control

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

The Applicable Request for Pre-Estimate

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

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

1. Images must be of diagnostic quality and medically necessary. All images should reveal contact areas without cone cuts or overlapping, and periapical films should reveal periapical areas and alveolar bone.
2. Images must be identified by the tooth number and include date of exposure, member name, member ID, provider name, and provider ID.

3. All images, regardless of the media, must be submitted together with a completed and signed comprehensive treatment plan that details all needed treatment at the time of examination.
4. The images, digital media, photographs, or printouts must be of sufficient quality to clearly demonstrate for the reviewer, the pathology which is the basis for the authorization request.
5. If radiographs are not taken, provider must include in a narrative sufficient information to confirm the diagnosis and treatment plan.
6. Any requested services that are dependent on or related to the completion of a denied service will also be denied.

Clinical Oral Evaluations

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

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

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

Comprehensive oral evaluation – new or established patient (D0150) This procedure should be used for new patients or when a patient has had significant changes in health conditions or other unusual circumstances, by report, or established patients who have been absent from active treatment for three or more years. It is a thorough evaluation of the extraoral and intraoral hard and soft tissues. This includes an evaluation for oral cancer, the evaluation and recording of the patient's dental and medical history and a general health assessment. It may include the evaluation and documentation of dental caries, missing or unerupted teeth, restorations, existing prosthesis, occlusal relationships, periodontal conditions (screening and / or charting) hard and soft tissue anomalies, etc.

Diagnostic

Diagnostic imaging should be taken only for clinical reasons as determined by the patient's dentist. Should be of diagnostic quality (reveal contact areas without cone cuts or overlapping, and periapical films should reveal periapical areas and alveolar bone) and properly identified and dated. This is a part of the patient's clinical record, and the original images should be retained by the dentist. Originals should not be used to fulfill requests made by

patients or third parties for copies of records. Any patient's refusal of radiographs should be documented. The Plan does not consider image capture as a separate reimbursable procedure.

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

Intraoral – periapical first radiographic image (D0220) and Intraoral – periapical each additional radiographic image (D0230) Must include at least three (3) millimeters beyond the apex of the tooth being imaged.

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

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

2D oral/facial photographic image obtained intra-orally or extra-orally (D0350) 2D oral photographic images are only reimbursed as a component of orthodontic records or for diagnostic purposes when radiographs cannot be taken due to a medical condition, physical ability, or cognitive function.

Cone beam CT capture and interpretations (D0364 – D0368) and Cone beam CT image capture (D0380 – D0384) An adjunctive diagnostic tool to be used in conjunction with routine radiographic imagery for diagnosis and treatment planning for partial jaw (D0364, D0380) one full jaw with or without cranium (D0365, D0366, D0381, D0382), both full jaws with or without cranium (D0367, D0383) or TMJ (D0383, D0384) under exceptional circumstances. These include:

1. Non-specific clinical symptoms associated with untreated or previously endodontically treated teeth.
2. Initial treatment of teeth with anatomical variations including additional or calcified canals, and complex morphology.
3. Re-treatment of multi-rooted teeth.
4. Cases that demonstrate significant risk for a complication such as nerve injury or jaw fracture, as well as pathology or trauma workups.
5. Treatment involving implants or implant-related services when implants are a covered benefit.

Testing for cracked tooth (D0461) Includes multiple teeth and contra lateral comparison(s), as indicated. Diagnostic aids may include but are not limited to pressure sensitivity testing, transillumination, staining, etc.

Specialized diagnostic testing to confirm or rule out a cracked tooth when routine exam findings are inconclusive.

Documentation Requirements:

Provider must record:

1. Symptoms consistent with cracked tooth (at least one):
 - a. Bite pain

- b. Pain on release
 - c. Chewing sensitivity
 - d. Cold sensitivity
 - e. Localized unexplained pain
- 2. Tooth number involved
- 3. Initial exam findings that were inconclusive (e.g., normal radiograph, unclear pain source)
- 4. Special tests performed, such as:
 - a. Bite test
 - b. Transillumination
 - c. Magnification exam
 - d. Selective biting
 - e. Staining or fiber-optic testing
- 5. Test results and recommended next treatment

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

Guidelines for Processing Diagnostic Images for reimbursement:

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

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

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

X-Ray Duplication Fee

When a member is transferred from one provider to another, diagnostic copies of all x-rays less than two years old should be duplicated for the second provider. If the transfer is initiated by the provider, the member cannot be charged any x-ray fees. If the transfer is initiated by the member, many plans allow the provider to charge a reasonable fee for copying the x-rays up to a maximum of \$25.

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

Preventive

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

1. Caries prevention may include patient education in oral hygiene, nutritional and dietary counseling, and motivational interviewing, where appropriate.
2. Prophylaxis procedures
3. Topical caries prevention or arresting treatments such as application of Fluorides, and Silver Diamine Fluoride.
4. Sealants
5. Periodontal disease prevention may include a comprehensive program of assessment, plaque removal, and control in addition to the following procedures:
 - a. Oral and systemic health information
 - b. Oral hygiene, dietary and nutritional counseling
 - c. Prophylaxis procedures on a regular basis
 - d. Occlusal evaluation
 - e. Correction of malocclusion and malposed teeth

- f. Restoration and/or replacement of broken, missing, or deformed teeth

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

Prophylaxis – child (D1120) Removal of plaque, calculus, and stains from the tooth structures and implants in the permanent and transitional dentition. or children 13 years and younger. Recognizing medical conditions that may contribute to or precipitate the need for additional prophylaxis procedures, such pregnancy, supported by the patient's physician. Verify plan benefits before performing additional prophylaxis procedures more than plan limitations.

Topical application of fluoride varnish (D1206)

Topical application of fluoride – excluding varnish (D1208)

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

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

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

Caries preventive medicament application – per tooth (D1355)

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

9. Payable four per tooth per benefit year.
10. Narrative required.
11. Cannot be applied to tooth with an existing restoration.
12. Not payable with history of restorations on applicable tooth with the following CDT codes (D2140-D2161, D2330-D2335, D2390-D2394, D2510-D2941, D2960-D2962)
13. Not payable in conjunction with D1351 or D1354.
14. Other areas of prevention may include:
 - a. Nutritional counseling for control of dental disease (D1310).
 - b. Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use (D1321).

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

Bilateral Space Maintainer Criteria:

1. Bilateral missing primary molars.
2. Unilateral loss of both primary molars.

Unilateral Space Maintainer Considerations:

- a. Loss of the second primary molar.
- b. Loss of only the first primary molar.
- c. Not reimbursable when first permanent molar roots have fully formed, and tooth is in stable occlusion.

Restorative

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

1. Sequencing treatment must be appropriate to the specific needs of the member.
2. Restorative procedures must be reported using valid/current CDT procedure codes as published by the American Dental Association.
3. Treatment results, including margins, contours, and contacts, should be clinically acceptable. The long-term prognosis good (estimated at five years or more).
4. Local anesthesia is usually considered to be part of restorative procedures.
5. Restorative procedures in operative dentistry include amalgam, composite, crowns, as well as the various provisional materials.

6. Tooth preparations, etching, adhesives (including amalgam bonding agents), liners, bases, and curing are considered part of the restorations).
7. Glass ionomers when used should be reported as composite restorations.
8. All restorations include polishing as well.

Amalgam & Resin-Based Composite Restorations (D2140-D2161 and D2330-D2394) Numerous scientific studies conducted over the past several decades, including two large clinical trials published in the Journal of the American Medical Association, indicate dental amalgam is a safe, effective cavity-filling material for children and others. In its review of the scientific literature on amalgam safety, the ADA's Council on Scientific Affairs reaffirmed that the scientific evidence continues to support amalgam as a valuable, viable and safe choice for dental patients and agreed with the U.S. Food and Drug Administration's (FDA) decision not to place any restriction on the use of dental amalgam, a commonly used cavity filling material:

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

11. A composite restoration should have sound margins, appropriate occlusion and contacts and must treat all decay that is evident.
12. A surface can only be billed once per tooth per date of service. For example, if MO and DO are submitted for the same tooth, this will be paid as an MOD.

Crowns- Single Restorations Only (D2710 – D2794)

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

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

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

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

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

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

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

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

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

Pin retention (D2951). Or restorative foundation may be medically necessary when a tooth requires a foundation for a restoration. Repair of a restorative material failure may be medically necessary when submitted documentation establishes restorative material failure.

Outcomes and standards set by the specialty boards shall apply:

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

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

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

Unspecified restorative procedure, by report (D2999). Narrative describing the procedure performed along with any necessary supporting documentation required with claim submission.

Endodontics

Pulp Capping (D3110, D3120). This procedure is not to be used for bases and liners.

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

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

Endodontic Pulpal Debridement and Palliative Treatment

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

If a member is referred to a specialist for RCT after pulpal debridement (D3221) or palliative treatment (D9110) has been performed on a tooth, the general dentist may report either procedure D3221, or if that procedure is not applicable, D9110 for palliative treatment.

Endodontic therapy (D3310–D3353) Must be supported by a definitive pulpal and periapical diagnosis when considering possible endodontic procedures. An endodontic may include tests to evaluate the source of pain and stimuli that reproduce the symptoms, such as thermal, electric, percussion, palpation, mobility, or non-symptomatic radiographic lesions.

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

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

1. Strategic importance of the tooth or teeth.
2. Prognosis – endodontic procedures for teeth with a guarded or poor five-year prognosis (endodontic, periodontal, or restorative) are not covered.
3. Excessively curved or calcified canals.
4. Presence and severity of periodontal disease.
5. Restorability and tooth fractures.

6. **Occlusion-** Teeth that are predisposed to fracture following endodontic treatment should be protected with an appropriate restoration; most posterior teeth should be restored with a full coverage restoration.

Treatment of root canal obstruction; non-surgical access (D3331) In lieu of surgery, the formation of a pathway to achieve an apical seal without surgical intervention because of a non-negotiable root canal blocked by foreign bodies, including but not limited to separated instrument, broken posts, or calcification of 50% or more of the length of the root. (CDT 2022).

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

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

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

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

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

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

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

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

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

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

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

1. Documentation of comprehensive endodontic treatment plan.

2. Strategic importance of the tooth or teeth
3. Presence and severity of periodontal disease
4. Restorability:
 - a. Mitigating circumstances including patient compliance.
 - b. Accessibility and level of complexity of endodontic site.
 - c. Risk of poor outcomes due to smoking, diabetes, and other systemic diseases.
5. Following an appropriate informed consent process, if a member elects to proceed with a procedure that is not covered, the member is responsible for the dentist's usual fee. The dentist should have the member sign appropriate informed consent documents and financial agreements.
6. Teeth that are predisposed to fracture following endodontic treatment should be protected with an appropriate restoration; most teeth should be restored with a full coverage restoration.
7. Occlusion

Clinical Guidelines:

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

Endodontic referral necessity

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

Endodontic Materials and Irrigation

Providers are contractually obligated to charge no more than the listed copayment for covered root canal procedures whether the dentist uses BioPure, diluted bleach, saline, sterile water, local anesthetic and/or any other acceptable alternative to irrigate the canal. Similarly, all evaluations and/or materials associated and/or are required within the standard operating procedure of root canal therapy are considered

inclusive of the treatment for benefit purposes and shall not be unbundled or billed separately. These materials include but are not limited to pulpal testing, rubber dam, files, gutta percha, temporary restorative filling material, etc.

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

Note regarding inappropriate unbundling/coding for endodontic irrigation:

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

Endodontic surgical treatment (D3410-D3473) Should be considered only in specific circumstances:

1. When the root canal system cannot be instrumented and treated non-surgically.
2. When there is active root resorption.
3. When access to the canal is obstructed.
4. When there is gross over-extension of the root canal filling.
5. When periapical or lateral pathology persists and cannot be managed non-surgically.
6. When a root fracture is present or strongly suspected restorative considerations make conventional endodontic difficult or impossible.

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

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

Unspecified endodontic procedure, by report (D3999) A narrative describing the procedure performed, along with any necessary supporting documentation required with the claim submission.

Periodontics

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

Comprehensive periodontal evaluation – new or established patient (D0180) Is indicated for smoking or diabetes. It includes evaluation of periodontal conditions, probing and charting, an evaluation for oral cancer, the evaluation and recording of the patient's medical and dental history and general health assessment, in addition to the evaluation and recording of dental caries, missing or unerupted teeth, restorations, and occlusal relationships.

Comprehensive periodontal evaluation should include:

1. Quality and quantity of gingival tissue.
2. Six-point periodontal probing for each tooth, with detailed documentation.
3. Location of the bleeding, exudate, plaque, and/or calculus.
4. Significant area of recession, mucogingival problems, level and extent of attached gingiva.
5. Assessment of tooth mobility.
6. Open or improper contacts.
7. Furcation involvement.
8. Occlusal contacts and interferences.

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

Gingivectomy/Gingivoplasty (D4210- D4212) It is performed to eliminate supra-bony pockets or to restore normal architecture when gingival enlargements or asymmetrical or unaesthetic topography is evident with normal bony configuration.

1. May be covered in cases where the pocket depths are 5 mm's or greater, following soft tissue responses to periodontal treatment.
2. Indication for performance of the gingivectomy is the complete elimination of the suprabony fibrous pockets or pseudo-pockets.
3. Appropriate radiographs and periodontal charting must be submitted with the request for these services.
4. Intra-oral photos should be included to support the need for gingivoplasty services to restore abnormal gingival architectures, asymmetry, etc.
5. D4212- Gingivectomy or gingivoplasty to allow access for a restorative procedure.
 - a. Management of soft tissues performed during a restorative or tooth preparation procedure, including final impressions, is considered, for insurance purposes, to be part of and included in those procedures and therefore not separately reimbursable.

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

It would not be considered good clinical practice to perform a periodontal surgical procedure on the same tooth on the same date of service as a final impression for a fixed or removable prosthesis, as healing has not occurred, which could change the tooth / tissue / bone architecture substantially affecting the outcome of the prosthesis. As a result, this service is not reimbursable when done on the same day of service as crowns, bridges or a removable prosthesis.

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

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

1. Periodontal pocket reduction surgery may be covered in cases where the pockets depths are 5 mm or deeper, following re-evaluation of soft tissue responses to scaling and root planing.
2. Osseous surgery procedures may not be covered if:
 - a. Pocket depths are 4 mm or less and appear to be maintainable by non-surgical means (e.g., periodontal maintenance or root planing).
 - b. Patients are smokers or diabetics whose disease is not being adequately managed.
3. No more than two quadrants of osseous surgery will be payable by the plan when completed on the same date of service unless a medical or other condition is present that would justify such.

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

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

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

Free soft tissue graft procedure (including recipient and donor surgical sites) (D4277–D4278) May be used to correct a documented mucogingival defect when:

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

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

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

Provisional splinting (D4320, D4321) May be necessary when documentation demonstrates the need for interim stabilization of mobile teeth.

Splint-natural teeth or prosthetic crowns (Intra-coronal: D4322; Extra-coronal: D4323). May be necessary when documentation demonstrates the need for stabilization of mobile teeth.

Periodontal Scaling and Root Planing (D4341, four or more teeth per quadrant; D4342 one to three teeth per quadrant) Treatment involves the instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. It is indicated for patients with periodontal disease and is considered therapeutic and not prophylactic in nature. Root planing is the definitive procedure designed for the removal of cementum and dentin that is rough and / or permeated by calculus or contaminated with toxins or microorganisms. Some soft tissue removal occurs. This procedure may be used as a definitive treatment in some stages of periodontal disease and / or as part of pre-surgical procedures in others. (CDT

2022). Scaling and root planing is indicated for patients who have infrabony pockets due to attachment loss in addition to swollen, inflamed gingival, and moderate to severe bleeding on probing. The presence of subgingival plaque and calculus alone does not indicate the need for scaling and root planing.

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

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

8. Periodontal maintenance at regular intervals should be instituted subsequent to scaling and root planing to maintain the periodontal condition or improve the tissue response. Periodontal pocket depths and gingival status should be recorded periodically.
9. The patient's homecare compliance or lack thereof and instructions should be documented.

Definitive vs. pre-surgical scaling and root planing:

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

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

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

1. Amount of local anesthesia used. If none were used, the reason(s) should be documented. The use of topical anesthetics is part of and included in this procedure.
2. Existing medical or other conditions that support such treatment.
3. Length of the appointment time allotted for procedure.

Scaling in the presence of generalized moderate or severe gingival inflammation (D4346) Is "The removal of plaque, calculus and stains from supra- and sub-gingival tooth surfaces when there is generalized moderate or severe gingival inflammation in the absence of periodontitis. It is indicated for patients who have swollen, inflamed gingiva, generalized suprabony pockets, and moderate to severe bleeding on probing. It should not be reported in conjunction with prophylaxis, scaling and root planing, or debridement procedures."

1. This procedure is for generalized moderate to severe gingival inflammation.
2. The ADA suggests that "generalized" would apply when 30% or more of the patient's teeth at one or more sites are involved, which is analogous to the AAP definition of generalized chronic periodontitis.
3. The Loe & Silness Gingival Index can be a guideline for defining "moderate to severe inflammation".
4. Moderate inflammation- redness, edema, glazing; bleeding on probing (mild inflammation lacks bleeding on probing).
5. Severe inflammation- marked redness and edema, ulceration; tendency toward spontaneous bleeding.
6. This is a therapeutic procedure, to treat a diagnosed disease.
7. It is based on a diagnosis, not on intensity of treatment required.

8. It is appropriate for patients who do not have periodontitis (i.e. attachment loss).
9. It is performed after a periodic or comprehensive exam.
10. It can be performed on same date of service as the exam.
11. It is a full mouth procedure, not a per quadrant procedure.
12. Can be used for any age patient, and in any dentition stage (note that benefits vary by each member's plan design).
13. "...in conjunction with..." means on the same date of service. Prophylaxis and scaling and root planing procedures may be performed at a future date, after Code D4346, as long as the codes thereafter are used appropriately.
14. Periodontal Maintenance (Code D4910) is not appropriate as a follow-up to Code D4346, since Code D4346 isn't performed to treat periodontal disease.
15. Consider this procedure code when the patient's periodontium is not healthy, and the periodontal disease diagnosis is limited to soft tissue (gingivitis) and is generalized but has not progressed to the advanced disease stage with bone loss (periodontitis).

Full mouth debridement to enable a comprehensive oral periodontal evaluation and diagnosis on a subsequent visit (D4355) This procedure would be followed by the completion of a comprehensive periodontal evaluation at a subsequent appointment. This rescheduling may allow some initial soft tissue response and shrinkage prior to performing full mouth periodontal probing.

The procedure includes the following requirements:

1. Must be supported by radiographs or if necessary, intraoral photos as evidence of heavy calculus.
2. Is not a replacement code for procedure D1110.
3. Is not appropriate or reimbursable on the same day as procedure D0180.

Periodontal surgical procedures

Periodontal surgical procedures are covered under the following conditions:

1. The patient must exhibit a willingness to accept periodontal treatment and practice appropriate oral hygiene prior to considered for periodontal surgical procedures.
2. Case history, including patient motivation to comply with treatment and oral hygiene status, must be documented.
3. Patient motivation may be documented in a narrative by the attending dentist and/or by a copy of patients progress notes documenting patient follow through on recommended regimens.
4. In most cases, there must be evidence of scrupulous oral hygiene for at least three months prior to the pre-authorization for periodontal surgery.
5. Consideration for a direct referral to a Periodontist would be considered on a case-by-case basis. However, definitive and pre-surgical scaling and root planing, oral hygiene instructions and other pre- and non-surgical procedures should be completed by a general dentist prior to specialist referral consideration.

6. Periodontal surgical procedures are covered only in cases that exhibit a favorable long-term prognosis. Surgical procedures for the retention of teeth that are being used as prosthetic abutments are covered only when the teeth would exhibit adequate bone support for the forces to which they are, or will be, subjected.
7. Periodontal pocket reduction surgery should result in the remove of residual calculus and granulation tissue while improved physiological form of the gingival tissues.
 - a. Osseous surgery and regenerative procedures should also correct and reshape deformities in the alveolar bone where indicated.
 - b. Soft tissue gingival grafting should be done to correct gingival defects when appropriate.
8. If Liberty determines that there are too few teeth with a good prognosis in a particular quadrant, an alternate, more appropriate code may be approved.

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

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

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

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

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

Note: A patient's refusal of irrigation does not justify requesting a patient transfer.

Soft Tissue Management Programs (STMP)

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

1. Periodontal evaluation/pocket charting/re-evaluation (these procedures are considered part of and included in the evaluation codes).
2. Gross debridement and scaling/root planing.
3. Plans may cover one prophylaxis procedure per 12-month period, which includes oral hygiene instructions (refer to plan-specific benefits, limitations, and exclusions). Prophylaxis is not appropriate on the same date as root planing or full mouth debridement.

4. Patients must sign an elective treatment form if they choose to accept soft tissue management procedures in addition to the procedures listed above.

Drugs or medicaments dispensed in the office for home use (D9630) Should not be used in reporting irrigation with chlorhexidine or prescriptions written. Documentation and/or narrative of drugs/medicaments dispensed in office must be submitted with claim submission.

Laser

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

Laser-Mediated Sulcular and/or Pocket Debridement

It is Liberty's assertion:

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

Unspecified periodontal procedure, by report (D4999) Narrative describing the procedure performed, along with any required supporting documentation required with claim submission.

Source: *American Academy of Periodontology, April 2011.*

Prosthodontics, removable

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

Complete dentures (D5110 – D5120)

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

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

Immediate Dentures (D5130 – D5140, D5227, D5228)

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

Partial Dentures (D5211 – D5286)

1. A removable partial denture is normally not indicated for a single tooth replacement of non-functional second or third molars.
2. Partial dentures may be covered when posterior teeth require replacement on both sides of the same arch.
3. Partial dentures may not be covered for replacement if an existing appliance can be made satisfactorily functional by relining or repair.
4. Partial dentures may not be covered if a clinical evaluation reveals the presence of a satisfactory appliance, even if a patient demands replacement due to their own perceived functional and/or cosmetic problems.
5. Unilateral removable partial dentures are rarely appropriate, as they may be readily swallowed or inhaled into a patient's lungs.
6. Abutment teeth should be restored prior to the fabrication of a removable appliance and may be covered if such teeth meet the same standalone benefit requirements for that restoration.
7. Partials should be designed to minimize any harm to the remaining natural teeth.
8. Materials used for removable partial dentures should be strong enough to resist breakage during normal function, nonporous, color stable, aesthetically pleasing, non-toxic, and non-abrasive to the opposing or supporting teeth.

9. A partial denture will not be covered if the remaining teeth, especially abutment teeth, do not exhibit good long-term endodontic, periodontic and restorative prognosis with a minimum crown-to-root ratio of 50%.

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

Complete or partial denture adjustments (D5410 – D5422) Are payable after 6 months of initial seat date and may be necessary after a reline to complete or partial denture has taken place.

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

Denture procedures, rebase (D5710 – D5725) and reline (D5730 – D5761)

1. Supporting soft tissues and bone shrink over time, resulting in decreased retention and/or stability of the appliance.
2. A rebase or reline of a partial or complete denture would be covered if documentation demonstrates that the appliance is ill-fitting and may be corrected by rebasing or relining, resulting in a serviceable appliance.
3. The coverage of relines and repairs may be subject to various limitations. Such as early follow-up repairs or relines after recent delivery.

Interim prosthesis (D5810- D5821)

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

Tissue conditioning (D5850, D5851) May be required when documentation shows that the tissue under a removable appliance is unhealthy or must be treated prior to fabricating a new appliance or rebasing or relining an existing appliance.

Precision attachment, by report (D5862) The placement of a precision attachment requires documentation demonstrating it is medically necessary to stabilize a removable appliance. Each pair of components (male and female) constitutes one precision attachment.

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

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

Maxillofacial Prosthetics

Medically necessary when:

1. Documented surgical, traumatic, or congenital defect of oral/maxillofacial structures.
2. Defect causes functional impairment (speech, swallowing, chewing, esthetics, airway).
3. Standard prosthodontic appliances cannot restore function.
4. Requested prosthesis will improve function or enable oral rehabilitation.
5. Appliance design corresponds to location, shape, and severity of defect.

Maxillary guidance prosthesis with guide flange (D5909) Synonymous terminology: guidance appliance. A prosthesis which guides the remaining portion of the mandible, left after a partial resection, into a more normal relation with the maxilla. This allows for some tooth-to-tooth or an improved tooth contact, it may also artificially replace missing teeth and thereby increase masticatory efficiency.

Maxillary guidance prosthesis with guideout flange (D5930) A prosthesis which helps guide the partially resected mandible to a more normal relation with the maxilla allowing for increased tooth contact. It does not have a flange or ramp, however, it does assist in directional closure. It may replace missing teeth and thereby increase masticatory efficiency.

Resection prosthesis, maxillary complete removable (D5938) and mandibular (D5939) A maxillary/mandibular complete removable resection prosthesis for the maxillary/mandibular arch in which a portion of the maxilla/mandibular is resected or reconstructed with hard or soft tissues. Mandibular continuity is maintained or restored.

Resection prosthesis, maxillary partial removable (D5940) and mandibular (D5941) A maxillary/mandibular partial removable resection prosthesis for the maxillary/mandibular arch in which a portion of the maxilla/mandibular is resected and reconstructed with hard or soft tissue. Mandibular continuity is maintained or restored.

Implants Services

A thorough history and clinical examination leading to the evaluation of the member's general health and diagnosis of his/her oral condition must be completed prior to the establishment of an appropriate treatment plan. Implants are a great way to restore function for patients when utilized effectively and appropriately. The purpose of our implant guidelines is to help ensure providers are considering a member's entire oral condition when treatment planning to confirm members are receiving an appropriate and comprehensive approach to replacing all missing teeth and restoring their function. Implants may be a covered benefit when considered appropriate, and logical treatment consistent with professional industry standards given the patient's current oral condition and the following guidelines are met:

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

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

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

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

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

Scaling and debridement of a single implant in the presence of peri-implantitis inflammation, bleeding upon probing and increased pocket depths, including cleaning of the implant surfaces, without flap entry and closure (D6049)

This procedure is not performed in conjunction with D1110, D4910 or D4346.

Medically necessary when the following all apply:

1. Implant is present
2. Documented inflammation, mucositis, or early peri-implant changes
3. Debridement required to prevent progression to peri-implantitis
4. Routine prophylaxis (D1110/D1120) insufficient for implant site
5. Service will improve or stabilize peri-implant health

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

Implant and abutment supported single crowns (D6058 – D6067, D6082 – D6088)

1. Abutment supported crowns are retained and supported by an abutment which connects to the implant.
2. Implant supported crowns do not utilize an abutment and are directly retained, supported, and stabilized by the implant body.
3. Implant supported crowns that are submitted with an abutment for the same implant will not be covered, as these services together are not compatible.
4. Opposing fixed dentition is required for crown coverage consideration.
5. Post-operative radiographs showing the delivery of the abutment and/or crown must be included with the claim submission for payment.

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

Implant supported fixed partial dentures (Bridges) (D6068 – D6077, D6194) Are a covered benefit when the criteria for implant placement have been met.

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

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

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

Guided tissue regeneration (D6106, D6107) This procedure does not include flap entry and closure, or, when indicated, wound debridement, osseous contouring, bone replacement grafts, and placement of biologic materials to aid in osseous regeneration. This procedure is used for peri-implant defects and during implant placement. Supporting documentation requirements of D6104 apply for these services.

Alveoloplasty (D7310, D7311, D7320, D7321) Must be in preparation for a prosthesis (conventional or implant supported full denture) to be considered for coverage. Documentation must be provided supporting the need for this service (i.e., excessive bony buccal undercuts) as not all denture cases require alveoloplasty.

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

Removable partial dentures (D5211 – D5228) Are not covered in the same arch as approved posterior implants or fixed partial dentures. D5820, D5821 Interim removeable partial dentures will only be considered in such scenarios.

Implant supported dentures (D6110 – D6117)

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

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

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

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

Note: Crowns and fixed partial prosthetics for dental implants may be contraindicated for the following reasons:

1. Adverse systemic factors such as diabetes and history of recent smoking habit.
2. Poor oral hygiene and tissue management by the member.
3. Inadequate osseointegration of the dental implant(s), including mobility prior to loading.
4. Excessive parafunction or occlusal loading.
5. Poor positioning of the dental implant(s).
6. Excessive bone loss around the implant before restoration.
7. Inadequate number of implants or poor bone quality for long-span prostheses.
8. Need to restore the appearance of gingival tissues in high aesthetic areas.
9. When the member is under the age of sixteen (16), unless unusual conditions prevail.

Restoration Guidelines

Restoring dental implants differ in many ways from restoration of teeth. The following guidelines should be followed:

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

Outcomes

1. The appearance of fixed prosthetic appliances for implants may vary considerably depending on the location, position and number of implants to be restored. The shape and appearance of the fixed prosthesis should harmonize with the remaining hard and soft tissues of the mouth.
2. The appearance of the appliances must be appropriate to meet the functional and esthetic needs of the member.
3. The appearance and shape of the fixed prosthesis must exhibit contours that are in functional harmony with the remaining hard and soft tissues of the mouth.
4. They must exhibit good design form to facilitate good oral hygiene, even in cases where the prosthesis may have a ridge lap form.
5. Fixed implant prostheses must incorporate a strategy for removal of the appliance without damage to the implant, or adjacent dentition, so that the implant can be utilized in cases where there is further loss of teeth, or where repair of the appliance is necessary.
6. Multiple unit fixed prostheses for implants must fit precisely and passively to avoid damage to the implants or their integration to the bone.
7. It is a contra-indication to have a fixed dental prosthesis abutted by both dental implant(s) and natural teeth (tooth) without incorporating a design to alleviate stress from an Osseo integrated (non- movable) abutment to a natural tooth supported by the periodontal ligament allowing slight movement.
8. It is the responsibility of the restoring dentist to evaluate the initial acceptability of the implants prior to proceeding with restoration.
9. It is the of the restoring dentist to instruct the member in the proper care and maintenance of the implant responsibility system and to evaluate the member's care initially following the final placement of the prosthetic restoration.
10. Fixed partial prostheses, as well as single unit crowns, are expected to have a minimum life expectancy or service life of five (5) years.

Prosthodontic, fixed

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

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

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

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

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

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

6. A distal cantilevered pontic is generally inappropriate for the replacement of a missing posterior tooth. However, a mesial cantilevered pontic may be acceptable for the replacement of a maxillary lateral incisor when an adequate adjacent cuspid can be used for the abutment crown.
7. Third molars should generally not be replaced, particularly if the replacement would not be functional.

Outcomes

1. Margins, contours and contacts should be clinically acceptable.
2. Prognosis should be good for long-term longevity.

Oral & Maxillofacial Surgery

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

1. Local anesthesia is part of oral and maxillofacial surgical procedures.
2. For dental benefit reporting, a quadrant is defined as four or more contiguous teeth or tooth spaces, distally to midline.
3. Classification of impactions is based on the anatomical position of the tooth, not the surgical technique used for removal.
4. Classification of surgical extractions will be based upon the presentation of the tooth diagnostic radiographs provided. When radiographs do not accurately depict the tooth condition or presentation, written documentation and/or photographs should be considered.

Extractions (D7111 – D7251)

1. Services that are considered part of the Extraction procedure include but are not limited to, local anesthetic, minor bone contouring and/or removal at site, socket irrigation, hemostatic agents, sutures, and routine post operative care. These services are considered inclusive of the extraction procedure for benefit purposes and should not be unbundled or billed separately.
2. Each dental extraction should be based on a clearly recorded diagnosis for which extraction is the choice of treatment of the dentist and the patient.
3. For extraction of a deciduous tooth (Codes D7111, D7140, D7210) there must be evidence of medical necessity showing that the tooth has pathology and will not exfoliate soon (within the next six months) as evidenced radiographically by greater than 50% of the residual root present, or a patient complaint of acute pain.

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

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

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

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

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

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

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

Removal of residual tooth roots (D7250) May be needed when the residual tooth root is pathological or is interfering with another procedure.

Sinus perforation or oroantral fistula closure (D7260) Requires documentation that there is a pathological opening into the sinus. Pre-op x-rays are required with the claim.

Tooth re-implantation and/or stabilization of an accidentally avulsed or displaced tooth (D7270) Requires documentation that a tooth or teeth have been accidentally avulsed or displaced as well as post-op x-rays.

A biopsy of oral tissue (D7285, D7286) Requires documentation that there is a suspicious lesion in the mouth that needs evaluation and the harvesting of oral tissue.

A surgical procedure to facilitate tooth movement (D7292 – D7300) Requires documentation demonstrating the medical necessity of surgery to achieve appropriate tooth positioning.

Alveoloplasty-Preparation of Ridge (D7310 – D7321) Requires documentation that demonstrates the medical necessity for the surgical recontouring of the alveolus.

Excision of soft tissue or intra-osseous lesions (D7410 – D7465) Requires documentation of the presence of an intra-oral lesion and the medical necessity for its removal.

Excision of bone tissue (D7471 – D7490) Requires documentation that a bony growth interferes with the ability to function or wear prosthesis.

Incision and drainage of an abscess (D7510 – D7521) Requires documentation that shows an oral infection requires drainage. This service is not reimbursable on the same date of service as an extraction of the associated tooth.

Removal of a foreign body (D7530) Non-vital bone or tooth fragment requires documentation proving the medical necessity for its removal.

Open/closed reduction of a fracture (D7610 – D7780) Requires documentation showing evidence of a broken jaw.

Reduction of dislocation (D7810, D7820 and D7899) Management of other temporomandibular joint dysfunctions require documentation showing a dislocation or other pathological condition of the temporomandibular joint.

Repair of traumatic wounds (D7910 – D7912) Other repair procedures require documentation showing that it is medically necessary to suture a traumatic wound or other repair procedures.

Bone replacement graft for ridge preservation- per site (D7953) Graft is placed in an extraction or implant removal site at the time of extraction or removal to preserve ridge integrity for purposes of planned future implant placement or where alveolar contour is critical to planned for prosthetic reconstruction.

- a. Planned treatment and a narrative of necessity must be submitted for consideration of coverage.
- b. This service may not be covered if the implant benefits are not included.

Frenulectomy or frenuloplasty (D7961 – D7963) Requires documentation that demonstrates evidence that a muscle attachment is associated with a pathological condition or is interfering with proper oral development or treatment.

Excision of hyperplastic tissue (D7970) and reduction of fibrous tuberosity (D7972) Requires documentation that demonstrates the medical necessity for removing redundant soft tissue to facilitate a removable prosthesis.

Excision of pericoronal gingiva (D7971) Requires documentation that demonstrates the medical necessity of removing inflammatory or hypertrophic tissue surrounding partially erupted or impacted teeth.

Orthodontics

Orthodontic services (D8010 – D8671) Require proper documentation that demonstrate medical necessity for orthodontic services for approval. Comprehensive Orthodontic services are a covered benefit only when medically necessary based on the member's specific plan. Liberty will review and cover medically necessary orthodontic services as defined in the member's specific plan documents. Not all dental plans, for which Liberty administers include orthodontic coverage. Orthodontics services are only payable once in a lifetime on a month-to-month basis.

Limited orthodontic treatment of the primary dentition (D8010) Is used for children and primary teeth.

Limited orthodontic treatment of the transitional dentition (D8020) Is used for children who are in the process of losing their primary teeth and have some permanent teeth already present.

Limited orthodontic treatment of the adult dentition (D8040) Is used for adults who are undergoing minor correction and minimal movement.

Comprehensive dental treatment adolescent (D8080) and Comprehensive dental treatment adult (D8090, D8091) May incorporate more than one phase of treatment. Expander, partial fixed appliance, and headgear is used in stage one whereas placement of full arch fixed appliance is done in stage two.

Orthodontic retention (D8680) Removal of appliance, construction, and placement of retainer(s).

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

Liberty's Clinical Review team will review authorization requests and determine coverage of orthodontic services in accordance with established state requirements, and group benefit guidelines. Each orthodontic submission must include Cephalometric analysis tracings, orthodontic study models and radiographic evidence for review.

All the following documentation must be received:

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

Retrospective Review

Prospective and retrospective reviews require documentation to support medical necessity. This documentation can include diagnostic radiographic or photographic images, the results of the test or examinations, descriptions of conditions in progress notes and/or a written narrative providing additional information. In cases where objective information (e.g., diagnostic images) conflicts with subjective information (e.g., written descriptions), objective information will take precedence in the determination process.

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

Adjunctive General Services

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

Fixed partial denture sectioning (D9120)

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

Anesthesia local or regional block anesthesia not in or in conjunction with operative or surgical procedures (D9210 – D9215)

1. Local or regional block anesthesia is considered part of and included with operative or surgical procedures.
2. Submitted documentation must show that it is medically necessary to anesthetize part of the mouth when it is not in conjunction with an operative or surgical procedure.

Deep sedation/general anesthesia or moderate sedation/analgesia – intravenous (D9222, D9223, D9239 – D9243) For dental procedures related to general or IV anesthesia, the provider must show the actual start and end times in the patient's dental record.

1. 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 doctor chooses to remain with the patient for recovery when other qualified personnel can provide safe supervision.
2. 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.
3. Providers performing anesthesia must be appropriately licensed by the state regulatory body and adhere to all monitoring and staffing requirements set by that body.
4. Liberty covers general anesthesia (GA) or intravenous (IV) sedation in a dental office setting only when medical necessity is demonstrated through the following conditions and guidelines:
 - a. A medical condition requiring monitoring (e.g., cardiac issues, severe hypertension).
 - b. An underlying medical condition exists which 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.
5. Documentation Requirements: 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. A narrative is required with claim submissions.
6. The following oral surgical procedures may be eligible for GA or IV sedation:
 - a. Extraction of impacted teeth.
 - b. Surgical root recovery from the maxillary sinus (antrum).
 - c. Surgical exposure of impacted or unerupted cuspids (for orthodontic cases, prior approval of the orthodontic treatment is required).
 - d. Radical excision of lesions greater than 1.25 cm.

- e. Children under the age determined by applicable state regulations with an extensive treatment plan may qualify for GA or IV sedation benefit.
- 7. Analgesia and additional IV sedation (D9230 – D9243) require documentation to of medical necessity to alleviate discomfort or anxiety associated with dental treatment.

Administration of general anesthesia with advanced airway-first 15 minute increment, or any portion of thereof (D9224) With or without co-administration of nitrous oxide. Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of trained personnel and the doctor may safely leave the room.

This procedure is determined by the provider's documentation of the presence of an advanced airway such as supraglottic or subglottic airway device, which includes laryngeal tube, esophageal-tracheal tube (Combitube), laryngeal mask airway, or endotracheal tube.

Administration of general anesthesia with advanced airway-each subsequent 15 minute increment, or any portion thereof (D9225)

Inhalation of nitrous oxide/analgesia, anxiolysis (D9230) When nitrous oxide is administered as a single agent. The administration of nitrous oxide for anxiolysis should be determined based on the patient's medical and behavioral conditions, the complexity of the dental procedure, and whether alternative behavioral modification methods are being used.

For children over the age of 12, the narrative must clearly describe the specific severe behavioral issue, the relevant medical or behavioral condition, and/or the complexity of the dental treatment being provided.

In-office administration of minimal sedation-single drug-enteral (D9244) In-office administration of a drug, as a single or divided dose, to achieve the desired clinical effect, not to exceed the FDA maximum recommended dose (MRD) for unmonitored home use. The single drug may be administered with or without co-administration of nitrous oxide.

Administration of moderate sedation-enteral (D9245) When moderate sedation is achieved by administration of drug(s) by enteral route only. With or without co-administration of nitrous oxide. The level of anesthesia is determined by the provider's documentation of the anesthetic effects upon the central nervous system.

Administration of moderate sedation-non-intravenous parenteral-first 15 minute increment, or any portion thereof (D9246) When moderate sedation is achieved by administration of drug(s) by parenteral route, not including intravenous. With or without co-administration of nitrous oxide.

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

The level of anesthesia is determined by the provider's documentation of the anesthetic effects upon the central nervous system.

Administration of moderate sedation-non-intravenous parenteral-each subsequent 15 minute increment, or any portion thereof (D9247)

Note: All claims for sedation must include a sedation log corresponding to the procedure.

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

Cleaning and inspection of occlusal guard-per appliance (D9936) This procedure does not include any adjustments.

Approval Criteria:

D9936 may be considered when the following **all** apply:

1. **Member has an existing occlusal guard previously delivered**
Documentation must confirm the appliance is currently in use. One of the following must be met. Acceptable evidence includes:
 - a. Prior claim for guard delivery (e.g., D9944, D9945, D9946), **or**
 - b. Current intraoral photo showing the guard, **or**
 - c. Chart documentation noting the delivery date of the guard.
2. **Appliance demonstrates clinically indicated need for maintenance**
At least **one** of the following must be documented:
 - a. Plaque biofilm accumulation on the guard.
 - b. Staining or deposits unremovable by patient brushing.
 - c. Odor or signs of bacterial colonization.
 - d. Wear patterns requiring evaluation (not adjustments).
 - e. Patient reports irritation, tissue redness, or ulceration related to the guard.
 - f. Evidence of material breakdown (surface roughness, micro-abrasions).

Process for Rendering Covered Dental Services in Ambulatory Surgical Centers (ASC) and Hospital

Code D9420 will require a Medical Necessity Review.

1. D9420 is to be used for situations when the client is developmentally disabled, mentally ill, or especially uncooperative and difficult to manage AND has experienced failed attempts at advanced behavior management techniques in the traditional office setting.
2. Preauthorization's must include:
 - a. **Treatment plan.** The treatment plan should include all related services. If a treatment plan cannot be submitted, the provider may document in the narrative how a treatment plan will be developed, along with a detailed narrative of why no treatment plan is being submitted, and a detailed narrative outlining medical necessity for dental treatment to be performed in an ambulatory surgical center or hospital facility setting.

- b. Radiographs/Clinical Photos. The photos should help demonstrate medical necessity of care. If radiographs or clinical photos are unable to be captured. Provider should include a unique and descriptive narrative regarding member's oral health conditions and provide radiographs for prepayment review if services require documentation of medical necessity prior to payment.
- 3. Code D9420 will be denied if the narrative provided does not meet the threshold of medical necessity,
- 4. Code D9420 will be denied if no eligible services are approved or proposed (i.e. member receiving at least one covered service).
- 5. All Dental offices are required to provide a Site Application contact for your local network manager.
- 6. When submitting services performed in an ASC or hospital setting, providers must list the address where the services are rendered and must match the site application.