# Appendix D - Dental Utilization Review Criteria Guidelines
# June 2026

Introduction

DENTAL GRID

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

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

| Code | Description | Criteria and Benefits | Required Documentation | Comments |
|---|---|---|---|---|
| **D0160** | **DETAILED AND EXTENSIVE ORAL EVALUATION – PROBLEM FOCUSED, BY REPORT** | A detailed and extensive problem focused evaluation entails extensive diagnostic and cognitive modalities based on the findings of a comprehensive oral evaluation. Integration of more extensive diagnostic modalities to develop a treatment plan for a specific problem is required. The condition requiring this type of evaluation should be described and documented.<br><br>Examples of conditions requiring this type of evaluation may include dento-facial anomalies, complicated perio-prosthetic conditions, complex temporo-mandibular dysfunction, facial pain of unknown origin, conditions requiring multi-disciplinary consultation, etc.<br><br>A benefit once per six months per patient per provider.<br><br>The following procedures are not a benefit when provided on the same date of service with D0160:<br>a. periodic oral evaluation (D0120),<br>b. limited oral evaluation-problem focused (D0140),<br>c. comprehensive oral evaluation- new or established patient (D0150),<br>d. re-evaluation-limited, problem focused (established patient; not post- operative visit) (D0170),<br>e. office visit for observation (during regularly scheduled hours-no other services performed (D9430).<br>f. Consultation-diagnostic service provided by dentist or physician other than requesting dentist or physician (Dental provider who billed for D0160 cannot also bill for D9310 on the same date of service.<br>**Limitation:** | 1. Written documentation for prior authorization shall include documentation of findings that supports the existence of one of the following:<br>a. dento-facial anomalies,<br>b. complicated perio-prosthetic conditions,<br>c. complex temporo-mandibular dysfunction,<br>d. facial pain of unknown origin,<br>e. severe systemic diseases requiring multi-disciplinary consultation. | Plans generally include an age restriction: extensive oral evaluation cannot be adequately completed on a patient under the age of 3.<br>D0145 is used for reimbursement purposes.<br>A comprehensive oral evaluation- new or established patient (D0150), detailed and extensive oral evaluation (D0160), or comprehensive periodontal evaluation (D0180) is allowed for the same patient and by the same dentist at a subsequent date, after the patient reaches three years of age.<br><br>The dental provider may bill once per six months per same provider. |

| Code | Description | Criteria and Benefits | Required Documentation | Comments |
|---|---|---|---|---|
| | | Either one comprehensive oral evaluation (D0150), one detailed and extensive oral evaluation (D0160), or one comprehensive periodontal evaluation (D0180) is allowed | | |
| **D0364** | **CONE BEAM CT CAPTURE AND INTERPRETATION WITH LIMITED FIELD OF VIEW- LESS THAN ONE WHOLE JAW** | Cone Beam CT is covered for the following indications:<br>1. Evaluation prior to one of the following oral surgery indications:<br>A. Removal of maxillo-facial tumor, cyst, neoplasm or other pathologic entities that, due to their size and/or anatomic location, appear to encroach, impinge or are invested in/on critical anatomic structures (i.e., inferior alveolar nerve, maxillary sinus);<br>B. Arthroplasty of Temporomandibular (TM) fossae or condyle, TM joint replacement;<br>C. Developmental mid-face syndromes such as cleft palate, Treacher-Collins syndromes, etc.;<br>D. Surgical reconstruction of severe oral-facial trauma (such as those resulting from motor vehicle accidents, gunshot wounds, boating accidents or other disfiguring trauma).<br>**In addition, when Cone Beam CT is requested prior to an oral surgery (a-d above), one of the following criteria must also be satisfied:**<br>E. The panoramic radiograph indicates that a deviation from a routine surgical approach is probable and further data necessary to plan such an approach;<br>-OR-<br>F. Information obtained by a CB/CT Scan is considered critical in determining a surgical plan for the avoidance of disruption, invasion, or fracture of a surrounding critical oral-facial structure.<br>2. Evaluation prior to orthognathic surgery when coverage criteria under the orthognathic surgery coverage policy are met AND information obtained by a CB/CT Scan is considered critical in determining surgical plan for the avoidance of disruption, invasion or fracture of a surrounding critical oral-facial structure.<br>3. Diagnosis for patients who present with contradictory or nonspecific clinical signs and | Written documentation for prior authorization which includes rationale for request and<br>A. The panoramic radiograph indicates that a deviation from a routine surgical approach is probable and further data necessary to plan such an approach;<br>-OR-<br>B. Information obtained by a CB/CT Scan is considered critical in determining a surgical plan for the avoidance of disruption, invasion, or fracture of a surrounding critical oral-facial structure. | **Cone Beam CT** refers to a tomographic imaging beam that is concentrated to a narrow field of the body, as in the case of dental views. Multi-dimensional images of the hard tissue of the jaw are created to assist the dentist in diagnosis and treatment planning for the patient. Cone beam CT provides an image of hard tissue that has no distortion and is anatomically correct. Views may include cross-sectional axial, coronal, sagittal, cephalometric, or panoramic.<br>Indications that are not covered (list may not be all inclusive)<br>1. Cone beam CT is not covered when used in conjunction with non-covered dental procedures.<br>2. Cone beam CT is not covered for other medically related dental indications not listed as covered.<br>CT to assist with the dental implant evaluation and placement of the implant. (D0364-D0367).<br>**References:**<br>**Position statement of the American Academy of Oral and Maxillofacial Radiology on selection criteria for the use of radiology in dental implantology with emphasis on cone beam computed tomography**<br>https://aaomr.org/common/Uploaded%20files/Position%20Papers/aaomr_implants_position_paper.pdf<br>**AAE and AAOMR Joint Position Statement: Use of Cone-Beam Computed Tomography in Endodontics 2025 Update**<br>https://www.oooojournal.net/article/S2212-4403%2825%2901213-1/pdf |

| Code | Description | Criteria and Benefits | Required Documentation | Comments |
|---|---|---|---|---|
| | | symptoms associated with untreated or previously endodontically treated teeth.<br>4. Treatment of teeth with the potential for extra canals and suspected complex morphology, such as mandibular anterior teeth, and maxillary and mandibular premolars and molars, and dental anomalies.<br>5. Identification and localization of calcified canals.<br>6. Clinical examination and 2-D intraoral radiography are inconclusive in the detection of vertical root fracture.<br>7. Evaluation of the nonhealing of previous endodontic treatment to help determine the need for further treatment, such as nonsurgical, surgical or extraction.<br>8. Nonsurgical retreatment to assess endodontic treatment complications, such as overextended root canal obturation material, separated endodontic instruments, and localization of perforations.<br>9. Presurgical treatment planning to localize root apex/apices and to evaluate the proximity to adjacent anatomical structures. | | |
| **D0365** | **CONE BEAM CT CAPTURE AND INTERPRETATION WITH FIELD OF VIEW OF ONE FULL DENTAL ARCH - MANDIBLE** | **See D0364** | • Written documentation for prior authorization which includes rationale for request | **See D0364** |
| **D0366** | **CONE BEAM CT CAPTURE AND INTERPRETATION WITH FIELD OF VIEW ONE FULL DENTAL ARCH – MAXILLA, WITH OR WITHOUT CRANIUM** | **See D0364** | • Written documentation for prior authorization which includes rationale for request | **See D0364** |
| **D0367** | **CONE BEAM CT CAPTURE WITH INTERPRETATION WITH FIELD OF VIEW** | **See D0364** | • Written documentation for prior authorization which includes rationale for request | **See D0364** |

| Code | Description | Criteria and Benefits | Required Documentation | Comments |
|---|---|---|---|---|
| | **OF BOTH JAWS, WITH OR WITHOUT CRANIUM** | | | |
| **D0470** | **STUDY MODELS/ DIAGNOSTIC CASTS** | Also known as diagnostic models or study models. Benefits are available for diagnostic casts when taken as an initial diagnostic aid in determining a patient's total treatment plan. Diagnostic casts are for the evaluation of orthodontic benefits only.<br><br>A benefit:<br>a. once per provider unless special circumstances are documented (such as trauma or pathology which has affected the course of orthodontic treatment).<br>b. for patients under the age of 21.<br>c. for permanent dentition (unless over the age of 13 with primary teeth still present or has a cleft palate or craniofacial anomaly).<br><br>**Limitation:**<br>Fees for working models, such as those utilized for preparation of crowns, bridges, periodontal surgical stents, occlusal guards, nightguards etc. are not considered diagnostic in nature and are included in the fees for those procedures. The patient cannot be billed separately for such working models. If definitive prosthetic treatment (crown, bridge, dentures) is completed within 12 months after date of service of diagnostic casts, the fee for diagnostic casts will be deducted from the definitive treatment fee.<br><br>**Rationale:**<br>Diagnostic models are considered part of the overall treatment rendered. | 1. Diagnostic casts are required to be submitted for orthodontic evaluation and are reimbursed only upon authorized orthodontic treatment. Do not send original casts, as casts will not be returned.<br><br>2. Diagnostic casts shall be free of voids and be properly trimmed with centric occlusion clearly marked on the casts.<br><br>3. Photographs submission via the Comagine Health Provider Portal is preferred. | There are other situations for which study models/diagnostic cases are needed: D8080 (adolescent orthodontia) and D8999 (unspecified orthodontic procedure by report) may require study models.<br><br>Oral Surgery (D7140-D7960) guidelines state: "For Procedure D7320 (alveoloplasty on an edentulous quadrant.) If radiographs are not sufficient to justify a need, (i.e., for soft tissue procedures) additional diagnostic material (photographs or models) and/or a statement of justification must be presented."<br><br>**Bridges are a non-covered benefit without prior authorization from the District of Columbia Department of Health Care Finance (DHCF).** |

| Code | Description | Criteria and Benefits | Required Documentation | Comments |
|---|---|---|---|---|
| **RESTORATIVE (PROCEDURES D2000-D2999)** | | | | |
| **General Policies, Procedure D2799:**<br>1. D2799 (Interim Crown-Further Treatment or Completion of Diagnosis Necessary Prior to Final Impression). | | | | |
| **D2799** | **Provisional Crown-Further Treatment or Completion of Diagnosis Necessary Prior to Final Impression) is a covered benefit under DC Medicaid.** | 1. D2799 Is not to be used as a temporary crown for routine crown restoration procedures.<br>2. D2799 is placed for an extended period of time (generally 6 months or more) to allow for other treatment and/or completion of diagnosis prior to the final impression/restoration. | 1. Pre-operative radiograph of the tooth.<br>2. Full Mouth series of radiographs.<br>3. Narrative of Medical necessity must include how long the Interim crown will be utilized as an interim crown.<br>4. Requires a tooth number. | |

## ENDODONTICS (PROCEDURES D3110-D3450)

### General Policies, Procedures D3110-D3450:

1. Includes those procedures which provide complete root canal filling on permanent teeth and pulpotomies (pulpectomies) on both deciduous and permanent teeth. Root canal therapy is covered if dentally necessary. It is dentally necessary when pathology is present, when the tooth is nonvital or the pulp has been compromised by caries, trauma, or accident which may lead to the death of the pulp, and the criteria set forth in this manual.
2. The prognosis of the affected tooth, other remaining teeth, and the type of final restoration allowable will be evaluated in considering root canal therapy.
3. Authorization and reimbursement for root canal treatment includes, but is not limited to, any of all of the following procedures:
   a. Any incision and drainage or open and medicating procedure necessary in relation to the root canal therapy.
   b. Vitality test.
   c. Radiographs required during treatment including final treatment radiographs.
   d. Culture.
   e. Medicated treatment.
   f. Final filling of canal(s).
   g. Final treatment radiographs(s).
4. The initial opening into the canal, sealing of the access opening, all treatment visits and routine post-operative visits are included in the fee for the completed endodontic treatment.
5. Necessary postoperative care within a ninety (90)-day period is included in the reimbursement fee.
6. Necessary retreatment within a two (2)-year period is included in the fee for completed endodontic treatment. The time limitation does not apply when the re-treatment procedure is performed by a different provider/office.
7. Root canal therapy is not a benefit <u>when extraction is appropriate</u> for a tooth with a fractured root, external or internal resorption, or one that is easily replaced by addition to an existing removable dental appliance.
8. Root canal treatment must be completed prior to the request for reimbursement.
9. The date of service on the reimbursement request should reflect the final treatment date.
10. Cement bases, and insulating liners are considered part of restorations and are included in the fee for the completed restoration(s).
11. Permanent restoration for an endodontically treated tooth is a benefit when the coverage criteria specified in this manual for the particular restoration are met.
12. A non-resorbable filling material and a resorbable paste or cement should be used (silver points are not acceptable).
13. Radiographs are taken as part of the root canal therapy are part of and included in the fee for the completed endodontic therapy.

## ROOT CANAL THERAPY (PROCEDURES D3310-D3348)

### General Policies, Procedures D3310-D3348:

1. Retreatment procedures D3346 (anterior), D3347 (bicuspid), and D3348 (molar), are benefits with prior authorization for any permanent tooth and subject to criteria for coverage set forth in this manual.
2. Periapical preoperative diagnostic radiographs of the involved tooth (teeth), additionally sufficient radiographs or other diagnostic material to establish the integrity of the remaining teeth and arches are required for prior authorization of permanent root canal therapy or retreatment of a previous root canal.
3. Root canal therapy is a benefit for permanent teeth when dentally necessary and the final post-treatment restoration of the treated tooth will afford acceptable retention longevity; and:
   a. Missing teeth do not jeopardize the integrity or masticatory function of the dental arches; and
   b. The tooth is necessary to maintain adequate masticatory function; and
   c. Periodontal condition of the tooth and the remaining teeth must be no more involved than Periodontal Case Types II, as defined in General Policies - Periodontics procedures (D4000-D4999).
4. **Root canal therapy (D3310-D3330) may be performed without prior authorization.**
5. All endodontic treatment procedures include the removal of posts, silver point and previous root canal filling material, and any procedures necessary to prepare the canals for placement of the canal filling.
6. Radiographs taken as part of the root canal therapy are part of and included in the reimbursement for the root canal therapy.
7. Radiographs submitted should include the name of the patient, date of birth, and date the x-ray was taken.

## ENDODONTIC RETREATMENT (PROCEDURES D3346-D3348)

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

The existing root canal fill is inadequate (poorly condensed, overfilled, underfilled).

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

| | | | | |
|---|---|---|---|---|
| **D3346** | **RETREATMENT OF PREVIOUS ROOT CANAL ANTERIOR** | An allowance for retreatment will be made when a root canal previously completed by another dentist has failed and retreatment is indicated. Retreatment within 24 months by the same dentist must be reviewed by the Dental Consultant.<br><br>Will not be approved for teeth exhibiting poor or questionable prognosis due to advanced periodontal disease, a crown to root ratio of less than 50%, poor restorability, and/or carious destruction of the clinical crown at or below the osseous crest. | 1. Radiographs for prior authorization – submit a periapical preoperative diagnostic radiograph of the involved tooth showing the root apex and surrounding bone, demonstrating the medical necessity for retreatment.<br>2. Written documentation for prior authorization - if the medical necessity is not evident on the radiographs, documentation shall include the rationale for retreatment. Provide the date of the | |

| | | | | |
|---|---|---|---|---|
| | | | previous root canal obturation if performed by the same provider.<br><br>If a fistula is present, an oral photograph of the respective tooth must be provided.<br>3. Periodontal assessment of the tooth<br>4. Requires a tooth number. | |
| **D3347** | **RETREATMENT OF PREVIOUS ROOT CANAL THERAPY - BICUSPID** | An allowance for retreatment will be made when a root canal previously completed by another dentist has failed and retreatment is indicated.<br>Retreatment within 24 months by the same dentist must be reviewed by the Dental Consultant.<br><br>Will not be approved for teeth exhibiting poor or questionable prognosis due to advanced periodontal disease, a crown to root ratio of less than 50%, poor restorability, and/or carious destruction of the clinical crown at or below the osseous crest. | 1. Radiographs for prior authorization - submit a periapical preoperative diagnostic radiograph showing the root apex and surrounding bone, demonstrating the medical necessity for retreatment.<br>2. Written documentation for prior authorization - if the medical necessity is not evident on the radiographs, documentation shall include the rationale for retreatment. Provide the date of the previous root canal obturation for the respective tooth if performed by the same provider.<br>If a fistula is present, an oral photograph of the respective tooth must be provided.<br>3. Periodontal assessment of tooth.<br>4. Requires a tooth number. | |
| **D3348** | **RETREATMENT OF PREVIOUS ROOT CANAL - MOLAR** | An allowance for retreatment will be made when a root canal previously completed by another dentist has failed and retreatment is indicated.<br>Retreatment within 24 months by the same dentist must be reviewed by the Dental Consultant.<br><br>Will not be approved for teeth exhibiting poor or questionable prognosis due to advanced periodontal disease, a crown to root ratio of less than 50%, poor restorability, and/or carious destruction of the clinical crown at or below the osseous crest. | 1. Radiographs for prior authorization - submit a periapical preoperative diagnostic radiograph showing the root apex and surrounding bone, demonstrating the medical necessity for retreatment.<br>2. Written documentation for prior authorization - if the medical necessity is not evident on the radiographs, documentation shall include the rationale for retreatment. Provide the date of the previous root canal obturation for the respective tooth if performed by the same provider.<br>If a fistula is present, an oral photograph of the respective tooth must be provided.<br>3. Periodontal assessment of tooth.<br>4. Requires a tooth number. | |

## APEXIFICATION/ RECALCIFICATION (PROCEDURES D3351-D3353)

### General Policies, Procedures D3351-D3353:

1. Apexification/Apexogenesis is defined as a technique for encouraging continued root formation and apical closure in teeth with incomplete apical development when the pulp is affected by trauma or caries.
2. Final obliteration of the root canal(s) may be accomplished when a radiograph indicates sufficient apical formation. The criteria for authorizing root canal treatment also apply to apexification and must be present prior to the initial pulpotomy treatment.
3. Not reimbursed when procedure D3351 (apexification/recalcification, pulpal regeneration – initial visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc. ), D3352 (apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.), or D3353 (apexification/recalcification, final visit), and a completed root canal treatment are performed on the same tooth on the same day.
4. Radiographs submitted should include the name of the patient, date of birth, and date the x-ray was taken.

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

## APICOECTOMY/PERIRADICULAR SERVICES (PROCEDURES D3410-D3473)

**General Policies, Procedures D3410-D3503:**

1. Apicoectomy/Periradicular Services, procedures D3410, D3421, D3425, and D3426 do not require prior authorization. D3471-D3473 require prior authorization.
2. Apicoectomy/Periradicular surgery, procedures D3410, D3421, D3425, and D3426 are defined as the excision of the apical portion of the root of a previously endodontically treated tooth to remove the diseased tissue.
3. These procedures may be indicated when an abnormality or blockage of the root end prevents the cleaning and sealing of the apical portion of a root canal through a coronal approach and the tooth remains symptomatic. They may also be indicated if the tooth is asymptomatic as clinically indicated. This occurs most commonly when there is severe apical curvature, blockage of the canal by calcific deposits, dentinal shavings or pulp chamber debris, or when a canal wall has been perforated or "shelved" during canal enlargement.
4. Procedure D3426 (apicoectomy/ each additional root) is reimbursed for a maximum of three (3) roots per tooth.
5. Not a benefit in conjunction with root canal therapy.
6. Radiographs submitted should include the name of the patient, date of birth, and date the x-ray was taken.

| | | | | |
|---|---|---|---|---|
| **D3428** | **BONE GRAFT IN CONJUNCTION WITH PERIRADICULAR SURGERY- PER TOOTH, SINGLE SITE** | 1. Periradicular surgery requires bone removal to access the root area being treated and can hinder the long-term prognosis for the tooth.<br><br>2. A bone graft (D3428) is placed to enhance the healing process for the tooth.<br><br>3. Involves the use of non-autogenous graft to stimulate bone growth when periradicular pathology has led to the deformity of bone.<br><br>4. D3428 includes any non-autogenous graft material.<br><br>5. Periradicular surgery (D3471, D3472, and D3473) for the respective tooth must be approved. | 1. Radiographs for prior authorization - submit panoramic x-rays or a full mouth series of radiographs demonstrating the medical necessity.<br><br>2. Written documentation for prior authorization - if the medical necessity is not evident on the radiographs, documentation shall include the rationale and the identity of the root that requires treatment.<br><br>3. Requires a tooth number. | |
| **D3429** | **BONE GRAFT IN CONJUNCTION WITH PERIRADICULAR SURGERY-EACH ADDITIONAL CONTIGUOUS TOOTH IN THE SAME SURGICAL SITE** | 1. SEE D3428<br><br>2. D3428 must be approved for the respective tooth.<br><br>3. D3429 is utilized when an additional bone graft is placed in a tooth contiguous to the graft placed on the tooth approved for D3428.<br><br>4. D3429 can only be used for a tooth contiguous to the tooth approved for D3428.<br><br>5. Periradicular surgery (D3471, D3472, and D3473) for the respective tooth must be approved. | 1. Radiographs for prior authorization - submit panoramic x-rays or a full mouth series demonstrating the medical necessity.<br><br>2. Written documentation for prior authorization - if the medical necessity is not evident on the radiographs, documentation shall include the rationale and the identity of the root that requires treatment.<br><br>3. Requires a tooth number. | |

| | | | | |
|---|---|---|---|---|
| **D3432** | **GUIDED TISSUE REGENERATION, RESORBABLE BARRIER, PER SITE, IN CONJUNCTION WITH PERIRADICULAR SURGERY** | 1. D3432 is used for the regeneration of tissue associated with periradicular surgery and is requested as a separate procedure.<br><br>2. A barrier membrane is placed to stabilize the periradicular surgery site so that new bone can mature and heal without interference from the healing soft tissue.<br><br>3. This type of barrier membrane is resorbed and does not require a second surgery for removal.<br><br>4. Periradicular surgery (D3471, D3472, and D3473) for the respective tooth must be approved. | 1. Radiographs for prior authorization - submit panoramic x-rays or a full mouth series of x-rays demonstrating the medical necessity.<br><br>2. Written documentation for prior authorization - if the medical necessity is not evident on the radiographs, documentation shall include the rationale and the identity of the root that requires treatment.<br><br>3. Requires a tooth number. | |
| **D3471** | **SURGICAL REPAIR OF ROOT RESORPTION-ANTERIOR** | For surgery on root of anterior teeth.<br><br>There is evidence of external root resorption on the respective tooth.<br><br>D3471 does not include retrograde filling material placement.<br><br>A benefit for permanent teeth only.<br><br>Not a benefit:<br>a. To the original provider within 90 days of root canal therapy except when a medical necessity is documented.<br>b. To the original provider within 24 months of a prior Apicoectomy/Periradicular surgery, same root.<br>c. The same date of service as procedures D3410, D3421, D3425, or D3426.<br><br>The fee for this procedure includes all treatment and post treatment radiographs. | 1. Radiographs for prior authorization - submit panoramic x-rays or a full mouth series of x-rays demonstrating the medical necessity.<br><br>2. Written documentation for prior authorization - if the medical necessity is not evident on the radiographs, documentation shall include the rationale and the identity of the root that requires treatment.<br><br>3. Requires a tooth number. | |
| **D3472** | **SURGICAL REPAIR OF ROOT RESORPTION-PREMOLAR** | For surgery on root of premolar teeth.<br><br>There is evidence of external root resorption on the respective tooth.<br><br>D3472 does not include retrograde filling material placement. | 1. Radiographs for prior authorization - submit panoramic x-rays or a full mouth series of x-rays demonstrating the medical necessity.<br><br>2. Written documentation for prior authorization - if the medical necessity is | |

| | | | | |
|---|---|---|---|---|
| | | A benefit for permanent teeth only.<br><br>Not a benefit:<br>a. To the original provider within 90 days of root canal therapy except when a medical necessity is documented.<br>b. To the original provider within 24 months of a prior Apicoectomy/Periradicular surgery, same root.<br>c. The same date of service as procedures D3410, D3421, D3425, or D3426.<br><br>The fee for this procedure includes all treatment and post treatment radiographs. | not evident on the radiographs, documentation shall include the rationale and the identity of the root that requires treatment.<br>3. Requires a tooth number. | |
| **D3473** | **SURGICAL REPAIR OF ROOT RESORPTION-MOLAR** | For surgery on root of molar teeth.<br><br>There is evidence of external root resorption on the respective tooth.<br><br>D3473 does not include retrograde filling material placement.<br><br>A benefit for permanent teeth only.<br><br>Not a benefit:<br>a. To the original provider within 90 days of root canal therapy except when a medical necessity is documented.<br>b. To the original provider within 24 months of a prior Apicoectomy/Periradicular surgery, same root.<br>c. The same date of service as procedures D3410, D3421, D3425, or D3426.<br><br>The fee for this procedure includes all treatment and post treatment radiographs. | 1. Radiographs for prior authorization - submit panoramic x-rays or a full mouth series of x-rays demonstrating the medical necessity.<br>2. Written documentation for prior authorization - if the medical necessity is not evident on the radiographs, documentation shall include the rationale and the identity of the root that requires treatment.<br>3. Requires a tooth number. | |

| OTHER ENDODONTIC PROCEDURES | | | | |
|---|---|---|---|---|
| **D3921** | **DECORONATION OR SUBMERGENCE OF AN ERUPTED TOOTH** | 1. The purpose of decornation or submergence of an erupted tooth and then retention of the root is to preserve ridge height and width of bone surrounding the retained root until the patient is ready for the placement of an implant or prosthesis that depends on adequate bone for support.<br>2. A Decoronation or submergence procedure is performed to remove the clinical crown and gutta percha from the roots wherein the remaining root structure and surrounding bone are not affected.<br>3. After an appropriate interval, the remaining root is removed, and the implant or prosthesis is placed.<br>4. The procedure is performed when an extraction is contraindicated due to the risk of medication or radiation induced osteonecrosis. | 1. Radiographs for prior authorization - submit panoramic x-rays or a full mouth series of x-rays demonstrating the medical necessity.<br>2. Narrative to support the medical necessity to preserve the alveolar bone to maintain adequate width and height of the alveolus for the respective tooth for future implant placement.<br>3. Requires a tooth number. | |

## PERIODONTICS (PROCEDURES D4000-D4999): General Policies and Procedures

Radiographs must be **less than one (1) year old** and of diagnostic quality, showing the entire treatment site.

Radiographs submitted should include the name of the patient, date of birth, and date the x-ray was taken.

**Required Periodontal Charting:**

- **Must be dated within 1 year of request and include the patient's full name.**
- **Current periodontal charting taken (no more than 12 months old) w/6 point probing depths per tooth**

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

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

Current full mouth series of x-rays or panoramic x-rays are required for periodontal scaling and root planing procedures (D4341 and D4342)) for prior authorizations. A panoramic radiograph alone is non-diagnostic for periodontal procedures.

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

Gingivectomy or gingivoplasty (D4210 and D4211) includes three months of post-operative care and any surgical re-entry for 36 months. Documentation of extraordinary circumstances and/or medical conditions will be given consideration on a case-by- case basis.

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

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

## PERIODONTICS (PROCEDURES D4210-D4920)

### General Policies, Periodontal Procedures D4210-4920:

1. Periodontal Classifications.
   a. Periodontal Health, Gingival Diseases and Conditions
      - Periodontal Health and Gingival Health
      - Gingivitis: Dental Biofilm-Induced
      - Gingival Diseases: Non-Dental Biofilm-Induced

   b. Periodontitis
      - Necrotizing Periodontal Diseases
      - Periodontitis
      - Periodontitis as a Manifestation of Systemic Disease
      - Periodontal Abscesses and Endodontic-Periodontal Lesions

   c. Periodontal Manifestations of Systemic Diseases and Developmental and Acquired Conditions
      - Systemic Diseases or Conditions Affecting Periodontal Supporting Tissues
      - Mucogingival Deformities and Conditions
      - Traumatic Occlusal Forces

- Tooth-and Prosthesis-Related Factors

d. Peri-Implant Diseases and Conditions
- Peri-Implant Health
- Peri-Implant Mucositis
- Peri-Implantitis
- Peri-Implant Soft and Hard Tissue Deficiencies

2. Stages of Periodontitis

a. Stage 1
- Clinical Attachment Level 1-2mm
- Radiographic Bone loss in coronal third (<15%)
- No tooth loss due to Periodontitis

b. Stage II
- Clinical Attachment Level 3-4mm
- Radiographic Bone Loss (15%-33%)
- No tooth loss due to Periodontitis

c. Stage III
- Clinical Attachment Level ≥ 5mm
- Radiographic Bone loss extending to mid-third of root and beyond
- Tooth loss due to Periodontitis of ≤4 teeth

d. Stage IV
- Clinical Attachment Level ≥ 5mm
- Radiographic Bone loss extending to mid-third of root and beyond
- Tooth loss due to Periodontitis of ≥ 5 teeth

3. Periodontal care shall be limited to those patients:

a. Who exhibits generalized periodontal pocket depths in excess of 4-5 mm.
b. Who has a minimum of one isolated pocket 5 mm or greater in depth per quadrant, and
c. Where the isolated pockets of 5 mm or greater in depth have failed to respond to conservative treatment, including emergency treatment of periodontal abscesses.

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

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

6. In order to make a fair evaluation of prior authorization requests for periodontal procedures the following information shall be included with the request:

a. Diagnostic radiographs dated within 1 year of the request.
b. Periodontal charting of pocket depths, bone loss, furcation involvement, bleeding on probing and mobility of all teeth, in addition to charting missing and tooth treatment planned for extraction. Additional documentation of recession is also a consideration, as it points to one aspect of the preexisting condition of the hard and soft tissue.

7. Guidelines for Reviewing Periodontal Treatment.

   a. Gingivitis, is little or no bone loss. Prophylaxis shall be adequate to control these cases. Authorization for sub-gingival curettage, muco-gingival or osseous surgery for these cases shall not be granted.
   b. Stages II and III (periodontal destruction, deep pockets (4-6 mm+), moderate to severe bone loss. The major emphasis of periodontal care rendered by the general dentist shall be the treatment of Stages II and III, provided in an ordered schedule of services. Generally, initial treatment shall be limited to nonsurgical services such as sub-gingival curettage, followed by an evaluation period of a minimum of four (4) weeks.
   c. Stages IV (deep pockets, very severe bone loss, advanced mobility patterns) shall not be authorized or rendered.

## GINGIVECTOMY OR GINGIVOPLASTY (PROCEDURES D4210-D4212)

### General Policies, Procedures D4210-D4211:

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

2. The quadrant shall be indicated on the request for prior authorization.

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

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

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

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

| | | | | |
|---|---|---|---|---|
| **D4210** | **GINGIVECTOMY OR GINGIVOPLASTY-FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT** | It is performed to eliminate supra-bony pockets or to restore normal architecture when gingival enlargements or asymmetrical or unaesthetic topography is evident with normal bony configuration. Count tooth bounded spaces for pocket reduction surgery that includes a flap procedure (D4240). Do not count tooth bounded spaces for D4210, D4341; count only "diseased teeth/periodontium." A tooth bounded space is the edentulous area bounded by two qualifying teeth. A tooth bounded space counts as one space irrespective of the number of teeth that would normally exist in the space.<br><br>A benefit: | 1. Quadrant , current periodontal charting (no more than 12 months old) with 6 points per tooth and narrative describing condition of the tissue.<br><br>2. Full Mouth Series of radiographs.<br><br>3. Photographs for prior authorization- submit photographs of the areas involved.<br><br>4. Written documentation for prior authorization – shall include a definitive periodontal diagnosis.<br><br>5. A current and complete periodontal evaluation chart is required for prior authorization except in cases of pseudo- | Reference:<br><br>**2018 Classification of Periodontal and Peri-Implant Diseases and Conditions**<br><br>https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/jcnde/perio_classification_update.pdf?rev=8f7c08b974ea4e7ba7f95c672500b2a1&hash=C8261BF25BB2C6E85E482579B36043BB |

| | | | | |
|---|---|---|---|---|
| | | a. for patients aged 13 or older except in unusual circumstances<br>b. once per quadrant every 36 months<br><br>This procedure cannot be prior authorized within 30 days following periodontal scaling and root planning (D4341 and D4342) for the same quadrant. | pockets as a result of gingival hyperplasia, which is demonstrated on a photograph.<br><br>6. Requires a quadrant number. | |
| **D4211** | **GINGIVECTOMY OR GINGIVOPLASTY - ONE TO THREE CONTIGUOUS TEETH, OR TOOTH BOUNDED SPACES PER QUADRANT** | 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.<br>Crown lengthening involving soft tissue only is appropriately coded as D4211.<br><br>A benefit:<br>a. for patients aged 13 or older.<br><br>b. once per quadrant every 36 months.<br><br>This procedure cannot be prior authorized within 30 days following periodontal scaling and root planning (D4341 and D4342) for the same quadrant. | 1. Quadrant, current periodontal charting (no more than 12 months old) with 6 points per tooth or narrative describing condition of the tissue<br><br>2. Full Mouth Series of radiographs.<br><br>3. Photographs for prior authorization- submit photographs of the areas involved.<br><br>4. Written documentation for prior authorization – shall include a definitive periodontal diagnosis.<br><br>5. A current and complete periodontal evaluation chart is required for prior authorization except in cases of pseudo-pockets as a result of gingival hyperplasia, which is demonstrated on a photograph.<br><br>6. Requires a quadrant number.<br><br>7. If four or more diseased teeth are present in the quadrant, use gingivectomy or gingivoplasty (D4210). | Benefit exceptions for individuals <age 13 will be considered in exceptional circumstances as concomitant medical conditions and/or wholesale neglect of dental care. |
| **D4212** | **GINGIVECTOMY OR GINGIVOPLASTY TO ALLOW ACCESS FOR RESTORATIVE PROCEDURES PER TOOTH** | When rendered on the same date as the preparation of a crown or other restoration is included in the global fee for the restoration.<br><br>Gingivectomies for restorative access should ideally be followed by an appropriate healing period before placing the restoration. | 1. Current periodontal charting (no more than 12 months old) with 6 points per tooth or narrative describing condition of the tissue.<br><br>2. Full Mouth Series of radiographs.<br><br>3. Photographs for prior authorization- submit photographs of the respective teeth for the request.<br><br>4. A current and complete periodontal evaluation chart is required for prior authorization. | |

| | | | | |
|---|---|---|---|---|
| | | | 5. Narrative of Medical necessity.<br>6. Requires a tooth number. | |
| **OTHER PERIODONTAL SURGERY (PROCEDURES D4240- D4261)** | | | | |
| **D4240** | **GINGIVAL FLAP PROCEDURE INCLUDING ROOT PLANNING – FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT** | A soft tissue flap is reflected or resected to allow debridement of the root surface and the removal of granulation tissue.<br><br>This procedure is performed in the presence of moderate to deep probing depths, loss of attachment, a need to maintain esthetics, a need for increased access to the root surface and alveolar bone, or to determine the presence of a cracked tooth, fractured root, or external root resorption.<br><br>Scaling and root planing procedures (D4341, D4342) do not precede this procedure. Scaling and root planing are included with D4240.<br><br>One D4240 per quadrant per 24 months | 1. Current periodontal charting (no more than 12 months old) with 6 points per tooth and narrative describing condition of the tissue.<br>2. Full Mouth Series of radiographs.<br><br>3. Photographs for prior authorization- submit photographs of the areas involved.<br>4. Narrative of Medical necessity.<br>5. Requires a quadrant number. | Reference:<br><br>**2018 Classification of Periodontal and Peri-Implant Diseases and Conditions**<br><br>https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/jcnde/perio_classification_update.pdf?rev=8f7c08b974ea4e7ba7f95c672500b2a1&hash=C8261BF25BB2C6E85E482579B36043BB |
| **D4241** | **GINGIVAL FLAP PROCEDURE INCLUDING ROOT PLANNING – ONE TO THREE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT** | A soft tissue flap is reflected or resected to allow debridement of the root surface and the removal of granulation tissue.<br><br>This procedure is performed in the presence of moderate to deep probing depths, loss of attachment, a need to maintain esthetics, a need for increased access to the root surface and alveolar bone, or to determine the presence of a cracked tooth, fractured root, or external root resorption.<br><br>Scaling and root planing procedures (D4341, D4342) do not precede this procedure. Scaling and root planing are included with D4241.<br><br>One D4241 per quadrant per 24 months | 1. Current periodontal charting (no more than 12 months old) with 6 points per tooth and narrative describing condition of the tissue.<br><br>2. Full Mouth Series of radiographs.<br><br>3. Photographs for prior authorization- submit photographs of the areas involved.<br>4. Narrative of Medical necessity.<br>5. Requires a quadrant number. | |
| **D4249** | **CLINICAL CROWN LENGHTENING-HARD TISSUE** | This procedure is performed to allow a restorative procedure on a tooth with little or no tooth structure to be exposed in the oral cavity.<br><br>This procedure requires<br>1. Reflection of a full thickness flap, and removal of bone.<br>2. Removal of bone to expose more tooth structure. | 1. Full Mouth Series of radiographs.<br><br>2. Photographs for prior authorization- submit photographs for the respective teeth.<br><br>3. Current periodontal charting (no more than 12 months old) with 6 points per tooth or narrative describing condition of the tissue. | |

| | | | | |
|---|---|---|---|---|
| | | 3. To be rendered in a healthy periodontal environment.<br>4. A healing period of at least six (6) weeks prior to the crown preparation for the tooth.<br><br>Once per lifetime per tooth. | 4. Narrative of Medical necessity.<br><br>5. Requires a tooth number. | |
| **D4260** | **OSSEOUS SURGERY (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant** | This procedure is performed to treat teeth with periodontal pocketing and bone loss to more effectively remove the plaque buildup that causes inflammation and continued attachment/bone loss. The procedure also removes some of the bone to create easier to clean contours and reposition the gingival flaps more apically.<br><br>This procedure requires<br>1. Reflection of a full thickness flap.<br>2. Removal of supporting bone (ostectomy) and/or non-supporting bone (osteoplasty).<br>3. To be rendered in a healthy periodontal environment.<br>4. A healing period of at least six (6) weeks prior to the crown preparation for the tooth. | 1. Full Mouth Series of radiographs.<br><br>2. Current periodontal charting (no more than 12 months old) with 6 points per tooth and a narrative describing condition of the tissue.<br><br>3. Narrative of Medical necessity.<br><br>4. Requires a quadrant. | |
| **D4261** | **OSSEOUS SURGERY (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant** | This procedure is performed to treat teeth with periodontal pocketing and bone loss to more effectively remove the plaque buildup that causes inflammation and continued attachment/bone loss. The procedure also removes some of the bone to create easier to clean contours and reposition the gingival flaps more apically.<br><br>This procedure requires<br>1. Reflection of a full thickness flap.<br>2. Removal of supporting bone (ostectomy) and/or non-supporting bone (osteoplasty).<br>3. To be rendered in a healthy periodontal environment. | 1. Full Mouth Series of radiographs.<br><br>2. Current periodontal charting (no more than 12 months old) with 6 points per tooth and narrative describing condition of the tissue.<br><br>3. Narrative of Medical necessity.<br><br>4. Requires a quadrant. | |

| | | | | |
|---|---|---|---|---|
| | | 4. A healing period of at least six (6) weeks prior to the crown preparation for the tooth. | | |

## BONE REPLACEMENT GRAFT PER QUADRANT (D4263-D4267)

**General Policies, Procedures D4263-D4264:**

1. A diagnosis of Stage III or Stage IV periodontal disease is required for D4263 to be considered for prior authorization.
2. When bone loss results in deep, narrow pockets, a bone replacement graft may be placed to treat the bony defect.
3. Bone replacement grafts procedures (D4263 and D4264) are limited to periodontal defects associated with a natural tooth.
4. If the bone replacement graft is placed in an extraction site or implant removal site for the purpose of socket preservation D7953 is to be requested.
5. If the bone replacement graft is placed for ridge augmentation in edentulous areas D7950 is to be requested.

| | | | | |
|---|---|---|---|---|
| **D4263** | **BONE REPLACEMENT GRAFT FIRST SITE IN QUADRANT** | This procedure involves the use of osseous auto grafts, osseous allografts or non-osseous grafts to stimulate periodontal regeneration when the disease process has led to a deformity of the bone. This procedure does not include flap entry and closure, wound debridement, osseous contouring or the placement of biologic materials to aid osseous tissue regeneration or barrier membranes. Other separate procedures may be required concurrent to D4263 and should be reported using their own unique codes. | 1. Diagnostic radiographs.<br>2. Current periodontal charting (no more than 12 months old) charting of pocket depths, bone loss, furcation involvement.<br>3. Requires tooth number | **Reference:**<br><br>**2018 Classification of Periodontal and Peri-Implant Diseases and Conditions**<br><br>https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/jcnde/perio_classification_update.pdf?rev=8f7c08b974ea4e7ba7f95c672500b2a1&hash=C8261BF25BB2C6E85E482579B36043BB |
| **D4264** | **BONE REPLACEMENT GRAFT EACH ADDITIONAL SITE IN QUADRANT** | This procedure involves the use of osseous autografts, osseous allografts or non-osseous grafts to stimulate periodontal regeneration when the disease process has led to a deformity of the bone. This procedure does not include flap entry and closure, wound debridement, osseous contouring or the placement of biologic materials to aid osseous tissue regeneration or barrier membranes. This code is used if performed concurrently with D4263 and allows reporting of the exact number of sites involved. | 1. Diagnostic radiographs.<br>2. Current periodontal charting (no more than 12 months old) charting of pocket depths, bone loss, furcation involvement.<br>3. Requires tooth number(s). | |
| **D4265** | **BIOLOGIC MATERIALS TO AID IN SOFT AND OSSEOUS TISSUE REGENERATION, PER SITE** | This procedure is used after laying a gingival flap (D4240/D4241) and/or during osseous surgery (D4260/D4261), biologic materials may be placed in a periodontal defect to aid in the regeneration of soft and osseous tissue. | 1. Diagnostic radiographs.<br>2. Current periodontal charting (no more than 12 months old) charting of pocket depths, bone loss, furcation involvement.<br>3. Narrative of Medical necessity.<br>4. Describe the location of the area being treated with the biologic materials.<br>5. Identify the specific material used for periodontal regenerative procedures.<br>6. Requires tooth number(s). | |

| | | | | |
|---|---|---|---|---|
| **D4266** | **GUIDED TISSUE REGENERATION, NATURAL TEETH – RESORBABLE BARRIER, PER SITE** | This procedure can be used for periodontal defects around natural teeth.<br>A barrier membrane for guided tissue regeneration (GTR) is placed to prevent the fast-growing gingiva from attaching to the root before the new bone can mature and attach to the root.<br>The resorbable barrier membrane (D4266) is integrated into the regeneration site and/or resorbed or broken down by the body in the healing process. This type of barrier membrane does not require a second surgery for removal. | 1. Diagnostic radiographs and intra-oral photos to document the need for GTR.<br>2. Current periodontal charting (no more than 12 months old) charting of pocket depths, bone loss, furcation involvement.<br>3. A diagnosis of moderate to severe periodontal disease with 5mm pocket depths or greater with treatable bony defects.<br>4. Narrative of Medical necessity.<br>5. Identify the specific material used for the guided tissue regenerative procedure.<br>6. Requires tooth number(s). | There is a 24-month exclusion period for the delivery of the same procedure to treat the same area of the mouth. |
| **D4267** | **GUIDED TISSUE REGENERATION, NATURAL TEETH – NON- RESORBABLE BARRIER, PER SITE** | This procedure can be used for periodontal defects around natural teeth.<br>A barrier membrane for guided tissue regeneration (GTR) is placed to prevent the fast growing gingival from encroaching on the surgical site until new bone has had time to fill in the periodontal defect.<br>The non-resorbable barrier membrane (D4267) requires a second surgery to remove it four to six weeks after placement. | 1. Diagnostic radiographs and intra-oral photos to document the need for GTR.<br>2. Current periodontal charting (no more than 12 months old) charting of pocket depths, bone loss, furcation involvement.<br>3. A diagnosis of moderate to severe periodontal disease with 5mm pocket depths or greater with treatable bony defects.<br>4. Narrative of Medical necessity<br>5. Identify the specific material used for the guided tissue regenerative procedure.<br>6. Requires tooth number(s). | There is a 24 month exclusion period for the delivery of the same procedure to treat the same area of the mouth.<br><br>The removal of the non-resorbable barrier is included in the reimbursement rate for D4267. |

## PERIODONTAL SCALING AND ROOT PLANING (D4341-D4342)

### General Policies, Procedures D4341-D4342:

1. Periodontal scaling and root planing procedures D4341 and D4342 require prior authorization and shall be authorized by quadrant, the following information shall be included with the Prior Authorization Request:
   a. Diagnostic radiographs.
   b. Periodontal charting of pocket depths, bone loss, furcation involvement, bleeding on probing and mobility of all teeth, in addition charting of missing teeth and teeth treatment planned for extraction.
2. Each quadrant requested must have a minimum of one (1) 5 mm or greater pocket.
3. When justified, a maximum of five (5) quadrant treatments may be authorized in a twelve (12)-month period.
4. Procedures D1110-D1120, prophylaxis, adult & child, are not reimbursed for the same date of service as scaling and root planing procedures D4341/D4342.
5. Periodontal scaling and root planing procedures D4341/D4342 are not reimbursed for the same date of service as any surgical periodontal procedure.
6. Generally, periodontal scaling and root planing procedures D4341/D4342 are performed prior to the provision of either procedures D4210/D4211, gingivectomy or gingivoplasty, or procedures D4260/D4261 osseous and muco-gingival surgery.
7. The full mouth periodontal charting should also show 4mm and above pocket depths and bone loss seen on the x-rays (BWX/PA) with the presence of calculus on the root surface in multiple quadrant(s).

| | | | | |
|---|---|---|---|---|
| **D4341** | **PERIODONTAL SCALING AND ROOT PLANING - FOUR OR MORE TEETH PER QUADRANT** | This procedure involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. It is indicated for patients with periodontal disease and is therapeutic, not prophylactic, in nature. Root planing is the definitive procedure designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or microorganisms. Some soft tissue removal occurs. This procedure may be used as a definitive treatment in some stages of periodontal disease and/or as a part of pre-surgical procedures in others.<br><br>A benefit:<br>1. For patients aged 13 or older.<br>2. When there is a minimum of one 4mm+ pocket on each diseased tooth.<br>3. Once per quadrant every 12 months. Exception for special needs population may require procedure more than once a year.<br><br>Gingivectomy or gingivoplasty (D4210 and D4211) cannot be prior authorized within 30 days following this procedure for the same quadrant. | 1. Full mouth periodontal charting including 6 point probing depths per tooth; indication of furcation involvement, mobility, or bleeding upon probing. Consideration should also be given to include recession if documented.<br><br>2. Radiographs for prior authorization – submit full mouth series of x-rays or a panoramic x-ray.<br><br>3. A visual examination should be documented and submitted with intraoral photos and bitewings if radiographs (FMX/PANO) were unable to be obtained for the clinical review.<br><br>4. Bitewings can reveal horizontal and vertical bone loss patterns, calculus deposits, and interproximal defects that support the diagnosis of periodontal disease requiring D4341.<br><br>5. Written documentation for prior authorization – shall include a definitive periodontal diagnosis.<br><br>6. A current and complete periodontal evaluation chart is required for prior authorization. | **Reference:**<br><br>**2018 Classification of Periodontal and Peri-Implant Diseases and Conditions**<br><br>https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/jcnde/perio_classification_update.pdf?rev=8f7c08b974ea4e7ba7f95c672500b2a1&hash=C8261BF25BB2C6E85E482579B36043BB<br><br>Benefit exceptions for individuals <age 13 will be considered in exceptional circumstances as concomitant medical conditions and/or wholesale neglect of dental care.<br><br>Exceptional circumstances are granted to the special needs' population for D4341<br><br>**When radiographic evidence or periodontal charting is not possible:**<br>The request for authorization without radiographic evidence and periodontal charting must be submitted with a detailed written narrative of the reason for the inability to provide radiographic evidence and |

| | | | | |
|---|---|---|---|---|
| | | | 7. Requires a quadrant number.<br><br>8. If three or fewer diseased teeth are present in the quadrant, use periodontal scaling and root planning (D4342). | periodontal charting. All written documentation submitted on the 719A form must be supported by documentation in the patient's record of treatment indicating the medical necessity for this service as required by District of Columbia Municipal Regulations (DCMR), Title 17, Chapter 42, Section 4213.4. **This documentation is subject to review upon request by the District.**<br><br>The narrative submitted requesting authorization for scaling and root planing must include the following:<br><br>• Classification of the periodontal case stage according to the American Academy of Periodontology;<br>• Documentation of teeth with mobility noted including the presence of pathology and periodontal prognosis;<br>• A minimum of four (4) teeth must be affected in the quadrant;<br>• Quadrants requested for scaling and root planing;<br>• Documentation of the teeth in quadrant with root surface calculus; and<br>• Documentation of the teeth in quadrant with loss of clinical attachment. |
| **D4342** | **PERIODONTAL SCALING AND ROOT PLANING – ONE TO THREE TEETH PER QUADRANT** | This procedure involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. It is indicated for patients with periodontal disease and is therapeutic, not prophylactic, in nature. Root planing is the definitive procedure designed for the removal of cementum and dentin that is rough, and/or | 1. Full mouth periodontal charting including 6 point probing depths per tooth; indication of furcation involvement, mobility, or bleeding upon probing. Consideration should also be given to include recession if documented. | Benefit exceptions for individuals <age 13 will be considered in exceptional circumstances as concomitant medical conditions and/or wholesale neglect of dental care. |

| | | | | |
|---|---|---|---|---|
| | | permeated by calculus or contaminated with toxins or microorganisms. Some soft tissue removal occurs. This procedure may be used as a definitive treatment in some stages of periodontal disease and/or as a part of pre-surgical procedures in others.<br><br>A benefit:<br>1. For patients aged 13 or older.<br>2. When there is a minimum of one 4mm+ pocket on each diseased tooth.<br>3. Once per quadrant every 12 months. Exception for special needs population may require procedure more than once a year.<br><br>Gingivectomy or gingivoplasty (D4210 and D4211) cannot be prior authorized within 30 days following this procedure for the same quadrant. | 2. Radiographs for prior authorization – submit full mouth series of x-rays or a panoramic x-ray.<br><br>3. A visual examination should be documented and submitted with intraoral photos and bitewings if radiographs (FMX/PANO) were unable to be obtained for the clinical review.<br><br>4. Bitewings can reveal horizontal and vertical bone loss patterns, calculus deposits, and interproximal defects that support the diagnosis of periodontal disease requiring D4342.<br><br>5. Written documentation for prior authorization – shall include a definitive periodontal diagnosis.<br><br>6. A current and complete periodontal evaluation chart is required for prior authorization.<br><br>7. Requires a quadrant number. | |

| SURGICAL STENT/RADIOGRAPHIC SURGICAL IMPLANT INDEX | | | | |
|---|---|---|---|---|
| **D5982** | **SURGICAL STENT FOR SOFT TISSUE HEALING** | Synonymous terminology: periodontal stent, skin graft stent, columellar stent. Stents are utilized to apply pressure to soft tissues to facilitate healing and prevent cicatrization or collapse. A surgical stent may be required in surgical and post-surgical revisions to achieve close approximation of tissues. Usually such materials as temporary or interim soft denture liners, gutta percha, or dental modeling impression compound may be used.<br><br>The surgical stent is required to protect the surgical site and promote healing of oral soft tissues following surgical procedure<br><br>Surgical Stent is required to protect or stabilize oral soft tissue following surgery, including:<br><br>• Periodontal flap surgery<br>• Gingivectomy or gingivoplasty<br>• Free gingival graft or connective tissue graft<br>• Vestibuloplasty<br>• Frenectomy or frenuloplasty<br>• Excision of oral lesions<br>• Other oral or periodontal surgical procedures requiring protection of the surgical site | 1. Full mouth radiographs (Panorex or full mouth series of x-rays) including Periapicals of the site needing a surgical stent<br>2. Pre-operative photos<br>3. Arch, quadrant, teeth number (s), or range of teeth being treated<br>4. Full-mouth periodontal charting unless the patient is edentulous<br>5. Clinical narrative to justify how the stent will protect or stabilize the surgical site | One surgical stent per surgical site |
| **D6190** | **RADIOGRAPHIC/ SURGICAL IMPLANT INDEX, BY REPORT** | A radiographic index or a surgical guide used to assist in surgical implant placement**.** | 1. Full mouth radiographs (Panorex or full mouth series of x-rays) including Periapicals of the site requesting dental implant,<br>2. Full-mouth periodontal charting, unless patient is completely edentulous<br>3. Requires tooth (implant site) number<br>4. Clinical justification for the dental implants, including the reasons conventional removable dentures cannot be used to replace the missing teeth.<br>5. **Narrative to include the name and contact information of the dental provider who will restore the dental implant**. | One unit per arch. |

# IMPLANTS AND IMPLANT SUPPORTED PROSTHETICS

## General Policies, Procedures D6010-D6113

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

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

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

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

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

Dental implants in patients with kidney disease require a strict multidisciplinary approach to manage increased risks of infection, bleeding, and altered bone healing. The preoperative plan must include formal nephrologist clearance, targeted complete blood counts (CBC), and comprehensive metabolic blood tests to ensure surgical safety.

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

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

**IMPLANTS AND IMPLANT SUPPORTED PROSTHETICS**

**Implants:** (Implant Readiness)

A. Before requesting implants, periodontal health and dental health (endodontic, extractions, crowns and filings) must be completed.
Pre-screening and determining eligibility for the implants using periodontal charting, x-rays and a narrative stating why this procedure is necessary. Radiographs submitted should include the name of the patient, date of birth, and date the x-ray was taken.

B. All extraction sites for implants must be healed and radiopaque.

C. Additional requirements for the Implant Site:

1. Bone grafting: D7953 Bone Replacement Graft/ridge preservation is allowed to restore bone height for extraction sites that are a candidates for implant placement.
2. The implant site - no ridge augmentation is needed.
3. Bone grafting at the time of implant placement is not recognized because the implant site should be ready/healing of the bone.

D. S**econd molar implants** will be determined by the review of the clinical narrative and supporting documentation for the request.

E. CT scan **(D0365/66/67)** are allowed to assist the provider in the evaluation of the implant site and placement.

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

II. Dental implant bodies are **medically appropriate** to anchor a removable denture, not a fixed prosthesis, if the traditional removable dentures cannot be worn or are painful. Coverage is limited to four upper dental implant bodies in the maxilla or two lower dental implant bodies in the mandible for the edentulous patient.

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

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

IV. Four (4) dental implants per arch will be authorized for the partially edentulous patient; for the completely edentulous, four (4) in the maxilla and two (2 )in the mandibular area. When more than four (4) teeth are missing in the same arch, consideration must be given to a removable partial denture as an alternative benefit.

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

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

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

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

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

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

1. Candidates for implants must be age 18 or older and not pregnant.
2. Stable periodontal health and overall dental health in the entire mouth must be demonstrated.
3. Documentation submitted must demonstrate absence of radiographic and clinical calculus, pre-and post-periodontal charting and treatment, and an adult prophylactic/preventive procedure date not to exceed 6 months prior to the request for implant restoration.
4. Tooth (teeth) to be replaced must have an opposing occlusion.
5. Authorization to replace wisdom teeth (1,16,17 and 32) will not be approved.
6. Dental implants that fail shall not be replaced. (**).
7. Four (4) implants per arch shall be authorized for the partially edentulous patient, and for the completely edentulous, four (4) in the maxilla and two (2 ) in the mandibular.

8. There must be at least 3 mm of inter-dental space between implants and naturally existing teeth.
9. If stents are required for dental implant placement, one stent per arch shall be allowed.
10. Dental implants will be re-evaluated with X-rays and or CT scans prior to the authorization of abutments or crowns after 4-6 months.
11. If bone graft augmentation is necessary, there must be a 6-month interval before a dental implant can be placed and good quality/contrast x-rays or CT scans must be submitted for review.
12. The optimal dimensions of available alveolar bone for most forms of implant placement are: 5mm in width, 13-15 mm in height and 5 mm in length.
13. All requests for dental implants, implant abutments, and implant crowns shall be reviewed by dentists
14. Other Contraindications for dental implants shall include:
    a. Treatment including but not limited to long-term steroid therapy, radiation therapy to a potential implant site, chemotherapy, hemodialysis, heart surgery (within the last six months), recent Myocardial Infarction, (within past 6 months) or hyperbaric oxygen treatment for osteoradionecrosis.
    b. Concomitant use of anticoagulants or medications that contraindicates implant success, such as bisphosphonates
    c. Known illicit drug use (e.g., Crack, methamphetamine, heroin, cocaine or other drugs that can be smoked and/or applied to the intraoral tissues)
    d. Uncontrolled metabolic disorders, chronic renal disease, or a severe systemic disease (including but not limited to leukemia and collagen disorders such as systemic lupus erythematosus and scleroderma).
    e. Uncontrolled bulimia, GERD, or other conditions causing acid reflux
    f. Presence of intra- and peri-oral piercings
    g. Unstable psychiatric or chronic illness as noted above included poorly controlled diabetes mellitus with a current Hemoglobin A1c( HgbA1c>7%).
    h. Any history of dental implant failure or intraoral bone graft failure

**Medical and Dental health history**

- The patient must have generally healthy, well maintained and stable dentition.
- Medical History
- Documentation provided should show absence of radiographic and clinical calculus, a full-mouth periodontal charting, and an adult oral prophylaxis procedure, the date not to exceed 6 months prior to request for implant restoration.
- Initial documentation should clearly indicate any areas of current facial anesthesia, paresthesia, or dysesthesia as might be encountered in a patient with a past history of trauma, oral-maxillofacial surgical procedures, tumors, anatomical anomalies, etc.
- Tooth (teeth) to be replaced must have an opposing occlusion
- The patient must have no dental habits or oral conditions that preclude the placement of implants, including but not limited to:
  - bruxism, craze lines,
  - severe ulceration or erosive lesions,
  - temporomandibular joint disorder or myofascial pain disorder,
  - history of facial fractures (which may preclude the placement of implants; however this will be considered on a case by case situation).
- The patient should have no history of dental implant failure or intraoral bone graft failure.

| SURGICAL SERVICES | | | | |
|---|---|---|---|---|
| **D6010** | **SURGICAL PLACEMENT OF IMPLANT BODY: ENDOSTEAL IMPLANT** | Includes second stage surgery and placement of healing cap Coverage is only for replacement of missing natural teeth. Implants done solely to restore a space beyond the normal complement of natural teeth are not covered. | 1. Date of last oral prophylaxis for the beneficiary listed on the 719a form in the Justification section.<br>2. Full mouth series of x-rays or Panorex including periapical of the site treatment planned for the dental implant,<br>3. Full-mouth periodontal charting, unless patient is completely edentulous<br>4. Requires a tooth (implant site) number<br>5. Clinical justification for the dental implants, including the reasons conventional removable dentures cannot be used to replace the missing teeth.<br>6. **Narrative to include the name and contact information of the dental provider who will restore the dental implant.**<br>7. Requests for edentulous patients must indicate date denture or partial denture was completed and any realignments within 2 years. NOTE: if requests for implants are due to ill-fitting dentures patient must have been in dentures for 2 years and had at least 2 realignments. | **References:**<br><br>**Oral and Craniomaxillofacial Implant Surgery** https://aaoms.org/wp-content/uploads/2024/04/implant_surgery.pdf<br><br>**Dental implant treatment for renal failure patients on dialysis: a clinical guideline**<br><br>https://pmc.ncbi.nlm.nih.gov/articles/PMC5709544/<br><br>All radiographs submitted must be free of tartar and show mouth is stable with no decay or extractions needed.<br><br>A. Dental implants are **not medically appropriate** in the following situations:<br>○ Presence of local or systemic conditions that may interfere with the normal healing process and subsequent tissue homeostasis.<br>○ Inadequate quality or quantity of alveolar bone and soft tissues.<br>○ The patient currently has active periodontal disease and poor hygiene.<br>○ Replacement of a second molar if used to extend the functional first molar occlusion, unless the patient has an Orthodontic problem.<br>○ Replacement of wisdom teeth (1, 16,17 and 32).<br>○ When maintenance of the tooth/teeth is/are not considered. By this, it is meant that placement of dental implants in an area which is not truly of functional benefit to the patient or in an arch which should be edentulated altogether should not be covered. In this case, it will be up to |

| | | | | |
|---|---|---|---|---|
| | | | | the Comagine dental reviewer to determine if the patient can reasonably and successfully (or at least adequately) function with non-implant-borne dentures.<br>o When the teeth are not in occlusion (meeting of the upper and lower teeth when the jaw is closed and the tooth/teeth surfaces come in contact). There is the possibility that the dental implant would be placed in a site unopposed (i.e. not in occlusion) with *natural* dentition but would be functioning against a *denture tooth* in the opposing arch.<br>B. Four (4) dental implants per arch will be authorized for the partially edentulous patient; for the completely edentulous, four (4) in the maxilla and two (2 )in the mandibular area.<br>C. When more than four (4) teeth are missing in the same arch, consideration must be given to a removable partial denture as an alternative benefit.<br>D. There must be at least 3 mm of inter-dental space between dental implants and naturally existing teeth to maintain periodontal health and form.<br>E. If stents (D6190) are required for dental implant placement, one stent per arch will be allowed.<br>F. Dental implants will be re-evaluated via intraoral radiographs, intraoral photos, or CT scans **prior** to the authorization of abutments or crowns four to six months after dental implant placement. |

| | | | | |
|---|---|---|---|---|
| | | | | G. After abutments or crowns are seated, a final intraoral radiograph or CT scan must be reviewed by Comagine Health dental reviewers before any further services in that area can be authorized.<br>H. If an anterior tooth has been extracted due to trauma, gross caries or endodontic failure, with good general and periodontal health and controllable risk factors , an anterior dental implant is justified and will be authorized.<br>I. If bone grafting and augmentation is necessary, there must be a 4-6 months interval with good quality/ contrast X-Rays or CT Scan for review by Comagine dental reviewers |
| **D6100** | **SURGICAL REMOVAL OF IMPLANT BODY** | One unit per dental implant site. | 1. Periapical radiograph of the implant.<br>2. Requires a tooth (implant site) number.<br>3. Delivery date of implant if known.<br>4. Clinical narrative to support the removal of the implant body.<br>5. Photo(s) of the implant body with required documentation. | |
| **D6101** | **DEBRIDEMENT OF A PERIIMPLANT DEFECT AND SURFACE CLEANING OF EXPOSED IMPLANT SURFACES, INCLUDING FLAP ENTRY AND CLOSURE** | • The implant site must have healed for at least six months and be fully osseous integrated.<br>• Implant must have good crown/root ratio<br>• Must not have more than two threads above the alveolar crest<br>• Implant must not be closer than 1-1.5mm to adjacent roots | 1. Radiographic Image: full periapical set with bitewings. Panorex with bitewings and PAs of area (not preferable/panorex needs to be high quality) of involved teeth, as well as contralateral and opposing sites.<br>2. Pre-op radiographic images of defect of the implant and narrative<br>3. Intraoral Photo of the bony defect area<br>4. Requires tooth (implant site )number<br>5. Clinical narrative to debridement of the implant<br>6. The implant site must have healed for at least six months<br>7. Evidence of a bony defect surrounding the dental implant. | One unit per implant site |
| **D6102** | **DEBRIDEMENT AND OSSEOUS CONTOURING OF A PERIIMPLANT** | • The implant site must have healed for at least six months and be fully osseous integrated.<br>• Direct loading will be considered<br>• Implant must have good crown/root ratio<br>• Must not have more than two threads above the alveolar crest | 1. A Radiographic Image: full periapical set with bitewings. Panorex with bitewings and PAs of area (not preferable/panorex needs to be high quality) of involved teeth, as well as contralateral and opposing sites. | One unit per implant site |

| | | | | |
|---|---|---|---|---|
| | **DEFECT; INCLUDES SURFACE CLEANING OF EXPOSED IMPLANT SURFACES AND FLAP ENTRY AND CLOSURE** | • Implant must not be closer than 1-1.5mm to adjacent roots | 2. Pre-op radiographic images of defect and narrative.<br>3. Intra Oral Photo of the bony defect area.<br>4. Requires tooth (implant site) number.<br>5. Clinical narrative to support the debridement of the implant | |
| **D6103** | **BONE GRAFT FOR REPAIR OF PERI-IMPLANT DEFECT – <u>not including</u> flap entry and closure or, when indicated, placement of a barrier membrane or biologic materials to aid in osseous regeneration** | • The implant site must have healed for at least six months and be fully osseous integrated.<br>• Direct loading will be considered<br>• Implant must have good crown/root ratio<br>• Must not have more than two threads above the alveolar crest<br>• Implant must not be closer than 1-1.5mm to adjacent roots | 1. Radiographic Image: full periapical set with bitewings. Panorex with bitewings and PAs of area (not preferable/panorex needs to be high quality) of involved teeth, as well as contralateral and opposing sites.<br>2. Pre-op radiographic images of defect and narrative.<br>3. Intra Oral Photo of the bony defect area.<br>4. Clinical narrative to support the bone graft for the implant.<br>5. Requires a tooth (implant site) number. | |
| **D6104** | **BONE GRAFT AT TIME OF IMPLANT PLACEMENT** | Placement of a barrier membrane or biologic materials to aid in osseous regeneration are reported separately.<br><br>Criteria as for D6101<br><br>Not allowed on same day as other bone grafting procedures. | 1. Radiographic Image: full periapical set with bitewings. Panorex with bitewings and PAs of area (not preferable/ panorex needs to be high quality) for the implant site, as well as contralateral and opposing sites.<br>2. Pre-op radiographic images of defect and narrative.<br>3. Intraoral Photo of bony defect area.<br>4. Requires tooth (implant site) number. | |
| **D6105** | **REMOVAL OF IMPLANT BODY NOT REQUIRING BONE REMOVAL OR FLAP ELEVATION** | The non-surgical removal of an implant body that does not require flap elevation and bone removal at the implant site. | 1. Periapical radiograph of the implant.<br>2. Requires tooth (implant site) number.<br>3. Delivery date of implant if known.<br>4. Clinical narrative to support the removal of the implant body.<br>5. Photo(s) of the implant body with required documentation. | One unit per dental implant site. |

| | | | | |
|---|---|---|---|---|
| **D6106** | **GUIDED TISSUE REGENERATION, RESORBABLE BARRIER, PER IMPLANT** | This procedure is used for peri-implant defects<br>A barrier membrane for guided tissue regeneration (GTR) is placed around an implant that has osseous defects due to peri-implantitis.<br><br>A bone graft is not always required when a barrier membrane is used. Some regeneration techniques encourage bone regrowth without the need for a bone graft.<br><br>This type of barrier membrane does not require a second surgery for removal. | 1. Diagnostic radiographs and intra-oral photos to document the need for GTR.<br>2. Current periodontal charting (no more than 12 months old) charting of pocket depths, bone loss, furcation involvement.<br>3. Narrative of Medical necessity.<br>4. Identify the specific material used for the guided tissue regenerative procedure.<br>5. Requires tooth (implant site) number. | There is a 24-month exclusion period for the delivery of the same procedure to treat the same area of the mouth. |
| **D6107** | **GUIDED TISSUE REGENERATION, NON-RESORBABLE BARRIER, PER IMPLANT** | This procedure is used for peri-implant defects<br>A non-resorbable barrier membrane is placed for guided tissue regeneration (GTR) around an implant that has osseous defects due to peri-implantitis.<br><br>A bone graft is not always required when a barrier membrane is used. Some regeneration techniques encourage bone regrowth without the need for a bone graft.<br><br>This type of barrier membrane requires a second surgery for removal. | 1. Diagnostic radiographs and intra-oral photos to document need for GTR.<br>2. Current periodontal charting (no more than 12 months old) charting of pocket depths, bone loss, furcation involvement.<br>3. Narrative of Medical necessity<br>4. Identify the specific material used for the guided tissue regenerative procedure.<br>5. Requires tooth (implant site) number. | There is a 24-month exclusion period for the delivery of the same procedure to treat the same area of the mouth.<br><br>The removal of the non-resorbable barrier is included in the reimbursement rate for D6106. |
| **IMPLANT SUPPORTED PROSTHETICS** | | | | |
| **D6056** | **PREFABRICATED ABUTMENT INCLUDES MODIFICATION AND PLACEMENT** | A connection to an implant that is a manufactured component, usually made of machined high noble metal, titanium, titanium alloy or ceramic.<br>Modification of a prefabricated abutment may be necessary and is accomplished by altering its shape using dental burrs/diamonds. | 1. Periapical radiograph of fully integrated implant.<br>2. Requires a tooth (implant site) number.<br>3. Panoramic x-rays showing placed integrated implant.<br>4. Intraoral photo of the healed tissue surrounding the healing cap of the implant. | |
| **D6058** | **ABUTMENT SUPPORTED PORCELAIN / CERAMIC CROWN** | A single crown restoration that is retained, supported and stabilized by an abutment on an implant. | 1. Periapical radiograph of integrated implant with abutment.<br>2. Requires a tooth (implant site) number<br>3. Intraoral photo of healed abutment, which shows healthy gingiva surrounding abutment.<br>4. Periodontal charting, if the patient has any remaining teeth present (i.e.: edentulous patients do not require periodontal charting). | . |

| | | | | |
|---|---|---|---|---|
| | | | 5. If an implant provisional crown was approved **(D6085)** then intraoral photos and x-rays of the implant provisional crown must be included. | |
| **D6082** | **IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE ALLOYS** | A single crown restoration that is retained, supported and stabilized by an implant. | 1. Periapical radiograph of fully integrated implant<br>2. Requires a tooth (implant site) number.<br>3. Panoramic x-ray showing placed integrated implant.<br>4. Intra oral photo of the healed tissue surrounding the healing cap of the implant. | |
| **D6083** | **IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO NOBLE ALLOYS** | A single crown restoration that is retained, supported and stabilized by an implant. | 1. Periapical radiograph of fully integrated implant.<br>2. Requires a tooth (implant site) number.<br>3. Panoramic x-rays showing placed integrated implant.<br>4. Intra oral photo of the healed tissue surrounding the healing cap of the implant. | |
| **D6084** | **IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS** | A single crown restoration that is retained, supported and stabilized by an implant. | 1. Periapical radiograph of fully integrated implant.<br>2. Requires a tooth (implant site) number.<br>3. Panoramic x-ray showing placed integrated implant.<br>4. Intra oral photo of the healed tissue surrounding the healing cap of the implant. | |
| **D6085** | **INTERIM IMPLANT CROWN** | One unit per dental implant site. | 1. Periapical radiograph of fully integrated implant.<br>2. Requires a tooth (implant site) number<br>3. Panoramic x-ray showing placed integrated implant.<br>4. Intra oral photo of healed tissue surrounding healing cap of implant.<br>5. Narrative of Medical necessity to include how long the Interim crown will be utilized as an interim crown. | |
| **D6110** | **IMPLANT SUPPORTED REMOVABLE COMPLETE DENTURE FOR EDENTULOUS ARCH- MAXILLARY ARCH** | Removable complete maxillary denture that attaches to abutments<br><br>Criteria for implants must be met, and implant/abutment process must be complete prior to requesting overdenture | 1. Intraoral (IO) photo showing healthy gingiva surrounding abutment.<br><br>2. Periapical radiograph of integrated implant with the abutment placed. | |

| | | | | |
|---|---|---|---|---|
| | | If beneficiary has received a maxillary denture within 5 years, existing denture must be retrofitted to fit newly placed implants and abutments. | | |
| **D6111** | **IMPLANT SUPPORTED REMOVABLE COMPLETE DENTURE FOR EDENTULOUS ARCH- MANDIBULAR ARCH** | Removable Mandibular complete denture that attaches to abutments<br><br>Criteria for implants must be met, and implant/abutment process must be complete prior to requesting overdenture<br><br>If beneficiary has received a mandibular denture within 5 years, existing denture must be retrofitted to fit newly placed implants and abutments. | 1. Intraoral (IO) photo showing healthy gingiva surrounding the abutment.<br>2. Periapical radiograph of integrated implant with the abutment placed. | |
| **D6112** | **IMPLANT SUPPORTED REMOVABLE PARTIAL DENTURE FOR PARTIALLY EDENTULOUS ARCH- MAXILLARY ARCH** | Removable Maxillary partial denture that attaches to abutments<br><br>Criteria for implants must be met, and implant/abutment process must be complete prior to requesting overdenture<br><br>If beneficiary has received a maxillary partial denture within 5 years, existing denture must be retrofitted to fit newly placed implants and abutments. | 1. Intraoral (IO) photo showing healthy gingiva surrounding the abutment.<br>2. Periapical radiograph of integrated implant with the abutment placed.<br>3. Full mouth periodontal charting. | |
| **D6113** | **IMPLANT SUPPORTED REMOVABLE PARTIAL DENTURE FOR PARTIALLY EDENTULOUS ARCH- MANDIBULAR ARCH** | Removable Mandibular partial denture that attaches to abutments<br><br>Criteria for implants must be met, and implant/abutment process must be complete prior to requesting overdenture<br><br>If beneficiary has received a mandibular partial denture within 5 years, existing denture must be retrofitted to fit newly placed implants and abutments. | 1. Intraoral (IO) photo showing healthy gingiva surrounding abutment.<br>2. Periapical radiograph of integrated implant with the abutment placed.<br>3. Full mouth periodontal charting. | |

| OTHER IMPLANT SERVICES | | | | |
|---|---|---|---|---|
| **D6049** | **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 reports the non-surgical and debridement of a single implant when there is bone loss present due to inflammation (peri-implantitis).<br><br>D6049 is reported per implant treated. | 1. Full mouth periodontal charting including 6 point probing depths per tooth and implant site; and bleeding sites is required for prior authorization. Consideration should also be given to include recession if documented.<br>2. Radiographs for prior authorization – submit periapical radiographs of the involved areas.<br>3. Written documentation for prior authorization – shall include a definitive diagnosis of the type of peri-implant disease and condition, characterized by bleeding upon probing, and increased pocket depths.<br>4. Intra-oral photos of the implant site.<br>5. Requires a tooth (implant site) number. | **Reference:**<br><br>**2018 Classification of Periodontal and Peri-Implant Diseases and Conditions**<br><br>https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/jcnde/perio_classification_update.pdf?rev=8f7c08b974ea4e7ba7f95c672500b2a1&hash=C8261BF25BB2C6E85E482579B36043BB<br><br>D6049 is billed one unit per dental implant site and once per calendar year.<br><br>The dental provider cannot request or bill for D6049 if D60081 is approved for the same implant site in the same calendar year.<br><br>The dental provider cannot bill for D6049 on the same date of service for the following scenarios:<br><br>1. D1110 , D4346, and D4910.<br>2. D6101 has been reimbursed for the same dental implant site in a calendar year. |

| | | | | |
|---|---|---|---|---|
| **D6081** | **SCALING AND DEBRIDEMENT IN THE PRESENCE OF INFLAMMATION OR MUCOSITIS OF A SINGLE IMPLANT, INCLUDING CLEANING OF THE IMPLANT SURFACES, WITHOUT FLAP** | Prior Authorization is required. D6081 is billed one unit per dental implant site and once per calendar year | 1. Full mouth periodontal charting including 6 point probing depths per tooth and implant site; and bleeding sites. Consideration should also be given to include recession if documented.<br>2. A current and complete periodontal evaluation chart is required for prior authorization.<br>3. Radiographs for prior authorization – submit periapical radiographs of the involved areas.<br>4. Written documentation for prior authorization – shall include a definitive diagnosis of the type of peri-implant disease and condition and bone level at the implant site<br>5. Intra-oral photos of the implant site.<br>6. Requires a tooth (implant site) number. | **Reference:**<br><br>**2018 Classification of Periodontal and Peri-Implant Diseases and Conditions**<br><br>https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/jcnde/perio_classification_update.pdf?rev=8f7c08b974ea4e7ba7f95c672500b2a1&hash=C8261BF25BB2C6E85E482579B36043BB<br>The dental provider cannot request or bill for D6081 if D6049 is approved for the same implant site in the same calendar year.<br><br>The dental provider cannot bill for D6081 on the same date of service for the following scenarios:<br><br>1. D1110, D4346, and D4910.<br>2. D6101 has been reimbursed for the same dental implant site in a calendar year. |
| **D6096** | **REMOVE BROKEN IMPLANT RETAINING SCREW** | One unit per dental implant site.<br><br>The implant retaining screw is broken and the remaining screw fragment could not be removed using standard and conventional techniques. | 1. Periapical radiograph of the broken implant screw.<br>2. Requires a tooth (implant site) number.<br>3. Clinical narrative to support the removal of the broken implant retaining screw.<br>4. Photo(s) of the fractured implant screw. | |

## ORAL SURGERY (PROCEDURES D7140-D7960)

### General Policies, Procedures D7140-D7960:

1. Diagnostic periapical radiographs are required for all surgical procedures that are submitted for authorization and/or reimbursement except:
   a. For procedures performed on soft tissue structures.
   b. For Procedure D7320 (alveoloplasty on an edentulous quadrant.) If radiographs are not sufficient to justify a need, (i.e., for soft tissue procedures) additional diagnostic material (photographs or models) and/or a statement of justification must be presented.
2. Submitted periapical radiographs should show all aspects of a suspected pathologic area or neoplasm, the entire crown and apices of all teeth to be excised or extracted. In those cases where the radiograph of the crown of the tooth is not complete but there is sufficient evidence presented to substantiate the need for the surgical procedure; the surgical procedure may be allowed. Radiographs submitted should include the name of the patient, date of birth, and date the x-ray was taken.
3. Oral surgery services to correct longstanding abnormalities of the mandible or maxilla, e.g., prognathia or retrognathia, or skin grafts for denture retention purposes or interosseous implants for procedures is not a benefit.

4. Extraction of asymptomatic teeth is not a benefit. The following includes, but is not all inclusive of, conditions which may be considered symptomatic when documented:
   a. Fully bony impacted supernumerary teeth, mesiodens, or teeth unerupted because of lack of alveolar ridge length.
   b. Teeth, which are involved with a cyst, tumor, or other neoplasm.
   c. Unerupted teeth, which are distorting the normal alignment of erupted teeth or causing the resorption of the roots of other teeth.
   d. Misaligned tooth (teeth), which cause the exacerbation of periodontal disease in adjacent teeth/areas.
   e. Extractions of primary teeth required to minimize malocclusion or misalignment when there is inadequate space to allow normal eruption of the permanent tooth (teeth).
   f. Perceptible radiologic pathology that fails to elicit symptoms.
   g. Extractions that are required to complete dentally necessary orthodontic dental services.
5. Routine postoperative visits (within 30 days following surgical procedure) are considered part of, and included in, the global fee for the surgical procedure.
6. Extractions of asymptomatic deciduous teeth that appear by radiographic evaluation ready to exfoliate naturally are not a benefit.
7. The fees for oral surgery procedures include local anesthesia and routine postoperative visits.
8. The fee for extractions includes the excision of associated minor cystic or inflamed tissue.
9. The charge for a stent in conjunction with oral surgery is part of and included in the fee for the surgery.

| | | | | |
|---|---|---|---|---|
| **D7251** | **CORONECTOMY – INTENTIONAL PARTIAL TOOTH REMOVAL** | Intentional partial tooth removal is performed when a neurovascular complication is likely if the entire impacted tooth is removed. | 1. Written documentation for prior authorization which includes rationale for the request.<br>2. Panorex.<br>3. Requires a tooth number. | |

## BIOPSY OF ORAL TISSUE (D7285-D7286)

**General Policies, Procedures D7285-D7286:**

1. Procedures D7285 (biopsy of oral tissue, hard) and D7286 (biopsy of oral tissue, soft) are benefits as an independent procedure for collecting tissue specimen(s).
2. D7286 does not require prior authorization.
3. Not a benefit in conjunction with the extraction of a tooth or root or excision of any body part or neoplasm in the same area or region on the same day.
4. Please indicate the area of the lesion and submit operative and pathology reports.

| | | | | |
|---|---|---|---|---|
| **D7285** | **BIOPSY OF ORAL TISSUE – HARD (BONE, TOOTH)** | For removal of specimen only. This code involves biopsy of osseous lesions and is not used for apicoectomy/periradicular surgery.<br><br>A benefit:<br>a. for the removal of the specimen only.<br>b. once per arch, per date of service regardless of the areas involved.<br>Not a benefit with an apicoectomy/ periradicular surgery (D3410-D3426), an extraction (D7111-D7250) and an excision of any soft tissues or intraosseous lesions (D7410-D7461) in the same area or region on the same date of service. | 1. Radiographs for prior authorization – submit a pre-operative radiograph.<br>2. A pathology report from a certified pathology laboratory is required for prior authorization.<br>3. Requires an arch number. | If during the listed endodontic or oral surgery procedures, the provider finds an unexpected or unanticipated lesion that in his/her professional judgment necessitates excision and biopsy, this should be allowed by special report.<br>The processing of the biopsy (i.e. Laboratory and pathologist fees) is a benefit through the patient's Medicaid; this information is given to the laboratory processing the specimen.<br>The medical portion will have codes in place so that these secondary fees can be covered. |

## ALVEOLOPLASTY (D7310-D7350)

**General Policies, Procedures D7310-D7320:**

1. Alveolectomy (alveoloplasty) is a collective term for the operation by which the shape and condition of the alveolar process is improved for preservation of the residual bone.
2. Tuberosity reductions are considered to be included as part of the global fee for an alveoloplasty or multiple extractions in the same quadrant.
3. Some form of alveolectomy is indicated in almost every case of multiple extractions and frequently in single extractions as well. Normally alveolectomy procedures necessary in conjunction with the extraction of teeth are included as part of the extraction procedures.

| | | | | |
|---|---|---|---|---|
| **D7310** | **ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS – FOUR OR MORE TEETH OR TOOTH SPACES, PER QUADRANT** | The alveoloplasty is distinct (separate procedure) from extractions and/or surgical extractions. Usually in preparation for a prosthesis or other treatments such as radiation therapy and transplant surgery.<br><br>A benefit on the same date of service with two or more extractions (D7140-D7250) in the same quadrant.<br><br>Not a benefit when only one tooth is extracted in the same quadrant on the same date of service. | 1. Radiographs for prior authorization–submit radiographs of the involved areas.<br>2. Requires a quadrant number.<br>3. Clinical narrative to support the request for the alveoloplasty. | |
| **D7320** | **ALVEOLOPLASTY NOT IN CONJUNCTION WITH EXTRACTIONS – FOUR OR MORE TEETH OR TOOTH SPACES, PER QUADRANT** | No extractions performed in an edentulous area. See D7310 if teeth are being extracted concurrently with the alveoloplasty. Usually in preparation for a prosthesis or other treatments such as radiation therapy and transplant surgery. | 1. Radiographs for prior authorization– submit radiographs of the involved areas if photographs do not demonstrate the medical necessity.<br>2. Photographs for prior authorization-submit photographs of the areas involved.<br>3. Requires a quadrant number.<br>4. Clinical narrative to support the request for the alveoloplasty. | |
| **D7340** | **VESTIBULOPLASTY-RIDGE EXTENSION (SECONDARY EPITHELIALIZATION)** | Benefit allowance includes sutures, local anesthesia and routine post-operative care.<br><br>Benefits are allowed once in a 60-month (5 year) period per arch<br><br>Not a benefit:<br>a. on the same date of service with a vestibuloplasty – ridge extension (D7350) same arch.<br>b. on the same date of service with extractions (D7111- D7250) same arch. | 1. Radiographs for prior authorization – submit radiographs.<br>2. Photographs for prior authorization – submit photographs.<br>3. Written documentation for prior authorization- shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed prosthodontic treatment.<br>4. Requires an arch number. | |

| | | | | |
|---|---|---|---|---|
| **D7350** | **VESTIBOULOPLASTY-RIDGE EXTENSION (INCLUDING SOFT TISSUE GRAFTS, MUSCLE REATTACHMENT, REVISION OF SOFT TISSUE ATTACHMENT AND MANAGEMENT OF HYPERTROPHIED AND HYPERPLASTIC TISSUE)** | Benefit allowance includes sutures, local anesthesia and routine post-operative care.<br><br>Benefits are allowed once in a 60-month (5 year) period per arch<br><br>Not a benefit:<br>a. on the same date of service with a vestibuloplasty – ridge extension (D7340) same arch.<br>b. on the same date of service with extractions (D7111- D7250) same arch. | 1. Radiographs for prior authorization – submit radiographs.<br>2. Photographs for prior authorization – submit photographs.<br>3. Written documentation for prior authorization- shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed prosthodontic treatment.<br>4. Requires an arch number. | |

| EXCISION OF CYST (D7450-D7461) | | | | |
|---|---|---|---|---|
| **General Policies, Procedures D7450-D7461:**<br>1. The appropriate procedure number shall be determined by the measurement of the cystic image on the diagnostic x-ray presented unless otherwise documented by report.<br>2. Prior authorization will not be made without an adequate radiograph of the neoplasm in question.<br>3. Please identify the area of the lesion and provide the operative and pathology reports.<br>4. Biopsy D7286 on same day for same area is not a covered service.<br>5. Postoperative care within a thirty (30)-day period following surgery shall be included in the fee for the services. | | | | **The processing of the biopsy (i.e. Laboratory and pathologist fees) is a benefit through the patient's Medicaid; this information is given to the laboratory processing the specimen. The medical portion will have codes in place so that these secondary fees can be covered.** |
| **D7451** | **REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR – LESION DIAMETER GREATER THAN 1.25 CM** | | 1. Radiographs for prior authorization–submit a radiograph of the cyst or tumor.<br>2. Written documentation for prior authorization- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.<br>3. A pathology report from a certified pathology laboratory is required for prior authorization. | |
| **D7460** | **REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR – LESION DIAMETER UP TO 1.25 CM** | | 1. Radiographs for prior authorization- submit a radiograph of the cyst or tumor.<br>2. Written documentation for prior authorization- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.<br>3. A pathology report from a certified pathology laboratory is required for prior authorization. | |

## EXCISION OF BONE TISSUE (D7471-D7490)

### General Policies, Procedures D7471-D7490:

1. A benefit when done in conjunction with the construction, reconstruction, or reline of a removable dental prosthesis for the removal of an exostosis, overgrowth, or enlargement of normal bone occurring at the midline of the hard palate.
2. Not a benefit if the condition is:
   a. Asymptomatic; or
   b. Will be bypassed by a dental prosthesis.
3. The extent and severity of this procedure is difficult to diagnose using x-rays only, therefore justification by models, photos, narrative, or other diagnostic modalities may be required.

| | | | | |
|---|---|---|---|---|
| **D7471** | **REMOVAL OF LATERAL EXOSTOSIS (MAXILLA OR MANDIBLE)** | A benefit:<br>a. once per quadrant.<br>b. for the removal of buccal or facial exostosis | 1. Photographs for prior authorization–submit pre-operative photographs.<br>2. Written documentation for prior authorization- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed prosthodontic treatment.<br>3. Requires a quadrant number. | |
| **D7472** | **REMOVAL OF TORUS PALATINUS,** | 1. A benefit when done in conjunction with the construction, reconstruction, or reline of a removable dental prosthesis for the removal of an exostosis, and overgrowth which develops in the midline of the roof of the mouth.<br>2. A benefit once per lifetime.<br>3. Not a benefit if the condition is:<br>a. Asymptomatic; or<br>b. Will be bypassed by a dental prosthesis. | 1. Photographs for prior authorization – submit pre-operative photographs.<br>2. Written documentation for prior authorization- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed prosthodontic treatment.<br>3. The extent and severity of this procedure is difficult to diagnose using x-rays only. Justification by models, photos, narrative, or other diagnostic modalities may be required. | |
| **D7473** | **REMOVAL OF TORUS MANDIBULARIS** | 1. A benefit when done in conjunction with the construction, reconstruction, or reline of a removable dental prosthesis for the removal of an exostosis, overgrowth, or enlargement of normal bone occurring on the lingual aspect of the mandible.<br>2. A benefit once per Quadrant per date of service<br>3. Not a benefit if the condition is:<br>a. Asymptomatic; or<br>b. Will be bypassed by a dental prosthesis. | 1. Photographs for prior authorization – submit pre-operative photographs.<br>2. Written documentation for prior authorization- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed prosthodontic treatment.<br>3. Requires a quadrant number. | |

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

## SURGICAL INCISION (D7509-D7530)

**General Policies Procedures D7509 - D7530:**

1. D7509 – Marsupialization of Odontogenic Cyst is a covered benefit that requires prior authorization
2. D7510 – Incision and Drainage of Abscess-Intra-Oral Soft Tissues is a covered benefit and does not require prior authorization.
3. D7511 – Incision and Drainage of Abscess- Intra-Oral Soft Tissue-Complicated is not a covered benefit.
4. D7520 – Incision and Drainage of Abscess-Extra-Oral Soft Tissue is a covered benefit and does not require prior authorization
5. D7530 – Removal of Foreign Body from Mucosa, Skin, or Subcutaneous Alveolar Tissue is a covered benefit and does not require prior authorization

| | | | | |
|---|---|---|---|---|
| **D7509** | **MARSUPIALIZATION OF ODONTOGENIC CYST** | This procedure involves an incision into a large maxillary or mandibular cystic lesion and making a window, typically removing a portion of the cyst for biopsy and creating a longer-term opening from the outside similar to a pouch, allowing for decompression or drainage. | 1. Submit a radiograph of the cyst .<br>2. Written documentation for prior authorization- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.<br>3. Requires tooth number or quadrant number. | |

## OTHER ORAL SURGERY PROCEDURES (D7840-D7999)

### Procedure D7961: Buccal/ Labial Frenulectomy - Separate Procedure not Incidental to Another Procedure.

1. A benefit where it is documented that:
   a. A short labial frenum interferes with the mobility of the central portion of the lip.
   b. A hypertrophy of the frenum and papilla palatina interferes with the proper fitting and retention of a prosthetic appliance.
   c. A hypertrophy of the frenum and overextension to the papilla palatine produces a diastema in children; or
   d. Where attachment of frenum displaces interdental papilla or marginal gingival with consequent periodontal disease.
   e. Where a restriction of the labial frenum is negatively impacting infant feeding.
2. Appropriate diagnostic material must be submitted in order to process for the prior authorization.
3. Routine postoperative care (within 30 days of surgical procedure) is considered part of and included in the global fee for the procedure.
4. Not reimbursed when provided in conjunction with vestibuloplasty, alveoloplasty with ridge extension, or excision of hyperplastic tissue.

### Procedure D7962 Lingual Frenectomy (Frenulectomy) – Separate Procedure not Incidental to Another Procedure.

1. A benefit where it is documented that:
   a. An unusually strong lingual frenum that is affecting speech and mastication.
   b. A benefit in cases of ankyloglossia where there is interference with proper mastication.
   c. The lingual frenum interferes with the normal use or function of a prosthetic appliance.
   d. The lingual frenum exhibits a restriction that is negatively impacting infant feeding.
2. Appropriate diagnostic material must be submitted in order to process for the prior authorization.
3. Routine postoperative care (within 30 days of surgical procedure) is considered part of and included in the global fee for the procedure.
4. Not reimbursed when provided in conjunction with vestibuloplasty, alveoloplasty with ridge extension, or excision of hyperplastic tissue.

### Procedure D7970: Excision of Hyperplasic Tissue – Per Arch

1. D7970 is used to remove hyperplastic tissue.
2. Reimbursed when inflammatory hyperplasic tissue interferes with normal mastication or in an edentulous area where the inflammatory hyperplasic tissue interferes with normal use or function of a prosthetic appliance.

| | | | | |
|---|---|---|---|---|
| **D7840** | **CONDYLECTOMY** | Surgical removal of all or portion of the mandibular condyle (separate procedure).<br><br>Imaging modalities may include panoramic radiograph, periapical and /or occlusal radiographs, maxillary and/or mandibular radiographs, computed tomography, cone beam computed tomography, positron emission tomography, positron emission tomography/computed tomography, and magnetic resonance imaging. In determining studies to be performed for imaging purposes, principles of ALARA (as low as reasonably achievable should be followed. | 1. Radiographs for prior authorization – submit an appropriate imaging.<br>2. Written documentation for prior authorization – shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history. | |
| **D7850** | **SURGICAL DISCECTOMY, WITH/ WITHOUT IMPLANT** | Excision of the intra-articular disc of a joint.<br><br>Imaging modalities may include panoramic radiograph, periapical and /or occlusal radiographs, maxillary and/or mandibular radiographs, computed tomography, cone beam computed tomography, positron emission tomography, positron emission tomography/ computed tomography, and magnetic resonance imaging. In determining studies to be performed for imaging purposes, principles of ALARA (as low as reasonably achievable should be followed. | 1. Radiographs for prior authorization – submit appropriate imaging.<br><br>2. Written documentation for prior authorization – shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.<br><br>3. An operative report shall be submitted. | |
| **D7860** | **ARTHROTOMY** | Cutting into joint (separate procedure).<br><br>Imaging modalities may include panoramic radiograph, periapical and /or occlusal radiographs, maxillary and/or mandibular radiographs, computed tomography, cone beam computed tomography, positron emission tomography, positron emission tomography/ computed tomography, and magnetic resonance imaging. In determining studies to be performed for imaging purposes, principles of ALARA (as low as reasonably achievable should be followed. | 1. Radiographs for prior authorization – submit appropriate imaging<br><br>2. Written documentation for prior authorization – shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.<br><br>3. An operative report shall be submitted . | |
| **D7940** | **OSTEOPLASTY – FOR ORTHOGNATHIC DEFORMITIES** | Reconstruction of jaws for correction of congenital, developmental or acquired traumatic or a deformity that may be addressed via surgical correction.<br><br>Imaging modalities may include panoramic radiograph, periapical and /or occlusal radiographs, maxillary and/or mandibular radiographs, computed tomography, cone beam computed tomography, positron emission tomography, positron emission tomography/computed tomography, and magnetic resonance imaging. In determining studies to be performed for imaging purposes, principles of ALARA (as low as reasonably achievable should be followed. | 1. Radiographs for prior authorization – submit appropriate imaging.<br><br>2. Written documentation for prior authorization – shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, and the proposed treatment.<br><br>3. An operative report shall be submitted for prior authorization. | |

| | | | | |
|---|---|---|---|---|
| **D7950** | **OSSEOUS, OSTEOPERIOSTEAL, OR CARTILAGE GRAFT OF THE MANDIBLE OR MAXILLA – AUTOGENOUS OR NONAUTOGENOUS, BY REPORT** | This procedure is for ridge augmentation or reconstruction to increase height, width and/or volume of residual alveolar ridge.<br><br>D7950 is not for grafting procedures for the following:<br>1. Periodontal disease<br>2. In conjunction with an extraction<br>3. Implant removal<br>4. Other disease conditions. | 1. Diagnostic radiographs and intra-oral photos to document need for the graft.<br>2. Narrative of Medical necessity.<br>3. Identify the specific material used for the guided tissue regenerative procedure.<br>4. Requires the specific arch for the graft. | |
| **D7953** | **BONE REPLACEMENT GRAFT** | Osseous autograft, allograft or non-osseous graft is placed in an extraction or implant removal site at the time of the extraction or removal to preserve ridge integrity (e.g. clinically indicated in preparation for implant reconstruction or where alveolar contour is critical to planned prosthetic reconstruction). Membrane, if used, should be reported separately. | 1. Radiographs for prior authorization – submit a pre-operative photograph.<br>2. Written documentation shall include the rationale demonstrating the medical necessity and the specific area the treatment was performed.<br>3. Requires a tooth or implant site number. | |
| **D7956** | **GUIDED TISSUE REGENERATION, EDENTULOUS AREA-RESORBABLE BARRIER, PER SITE** | This procedure is for placing a resorbable barrier membrane for bone regeneration in edentulous areas, such as ridge augmentation or sinus lifts.<br><br>A bone graft is not always required when a barrier membrane is used. Some regeneration techniques encourage bone regrowth without the need for a bone graft.<br><br>This type of barrier membrane does not require a second surgery for removal. | 1. Diagnostic radiographs and intra-oral photos to document the need for GTR.<br>2. Tooth (implant site) number(s).<br>3. Narrative of Medical necessity.<br>4. Identify the specific material used for the guided tissue regenerative procedure. | There is a 24 month exclusion period for the delivery of the same procedure to treat the same area of the mouth. |
| **D7957** | **GUIDED TISSUE REGENERATION, EDENTULOUS AREA-NON- RESORBABLE BARRIER, PER SITE** | This procedure is for placing a non-resorbable barrier membrane for bone regeneration in edentulous areas, such as ridge augmentation or sinus lifts.<br><br>A bone graft is not always required when a barrier membrane is used. Some regeneration techniques encourage bone regrowth without the need for a bone graft.<br><br>This type of barrier membrane requires a second surgery for removal. | 1. Diagnostic radiographs and intra-oral photos to document the need for GTR.<br>2. Tooth (implant site) number(s).<br>3. Narrative of Medical necessity.<br>4. Identify the specific material used for the guided tissue regenerative procedure. | There is a 24-month exclusion period for the delivery of the same procedure to treat the same area of the mouth.<br><br>The removal of the non-resorbable barrier is included in the reimbursement rate for D7957. |
| **D7961** | **BUCCAL/LABIAL FRENULECTOMY –** | Surgical removal or release of mucosal and muscle elements of a buccal or labial frenum that is associated with a pathological condition, , a speech concern identified by a licensed speech-language pathologist, or interferes with proper oral development, infant feeding, or treatment. | 1. Photographs for prior authorization – submit a pre-operative photograph.<br>2. Written documentation for prior authorization – shall include the rationale demonstrating the medical necessity and the specific area the treatment to be performed. | |

| | | | | |
|---|---|---|---|---|
| | | A benefit once per arch per lifetime | 3. Requires the specific arch. | |
| **D7962** | **LINGUAL FRENULECTOMY** | Surgical removal or release of mucosal and muscle elements of a lingual frenum that is associated with a pathological condition, a speech concern identified by a licensed speech-language pathologist, or interferes with proper oral development, infant feeding, or treatment.<br><br>A benefit once per arch per lifetime | 1. Photographs for prior authorization – submit a pre-operative photograph.<br>2. Written documentation for prior authorization – shall include the rationale demonstrating the medical necessity and the specific area the treatment to be performed. | |
| **D7970** | **EXCISION OF HYPERPLATIC TISSUE-PER ARCH** | Excision of hyperplastic tissue caused by an ill-fitting denture. | 1. Photographs for prior authorization – submit a pre-operative photograph.<br>2. Written documentation for prior authorization – shall include the rationale demonstrating the medical necessity and the specific area the treatment to be performed.<br>3. Requires an arch number. | |
| **D7972** | **SURGICAL REDUCTION OF FIBROUS TUBEROSITY** | A benefit once per quadrant per date of service.<br><br>This procedure is included in the fees for other surgical procedures that are performed in the same quadrant on the same date of service | 1. Photographs for prior authorization–submit a pre-operative photograph.<br>2. Written documentation– shall include the rationale demonstrating the medical necessity and the actual or proposed prosthodontic treatment.<br>3. Requires a quadrant number. | |
| **D7979** | **NON-SURGICAL SIALOLITHOTOMY** | A sialolith is removed from the gland or ductal portion of the gland without surgical incision into the gland or the duct of the gland, for example via manipulation, ductal dilation, or any other non-surgical method. | 1. Photographs –submit a pre-operative photograph.<br>2. Written documentation– shall include the patient's symptoms and rationale demonstrating the medical necessity for the procedure.<br>3. Requires a quadrant number. | |

## ORTHODONTIC GENERAL POLICIES (D8000-D8999)

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

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

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

4. The Handicapping Labio-Lingual Deviations (HLD) Index is a quantitative, objective method for evaluating prior authorization requests for comprehensive orthodontic treatment. The HLD Index form allows for identification of certain automatic qualifying conditions and provides a single score, based on a series of measurements, which represent the presence, absence, and degree of handicap. The HLD Index form must be submitted with all PA requests for comprehensive orthodontic treatment.

5. The beneficiary's orthodontia provider shall demonstrate that the beneficiary meets at least one of the following criteria:

   a. The beneficiary has an adjusted score greater than or equal to fifteen (15) on the Handicapping Labio-Lingual Deviation (HLD) Index.

   b. Exhibits one (1) or more of the following Automatic Qualifying Conditions that causes dysfunction due to a handicapping malocclusion and is supported by evidence in the beneficiary' treatment records:

      1. Cleft palate deformity. If the cleft palate is not visible on the diagnostic casts written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,
      2. Craniofacial anomaly. Written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,
      3. A deep impinging overbite in which the lower incisors are destroying the soft tissue of the palate where tissue laceration and/or clinical attachment loss are present,
      4. A crossbite of individual anterior teeth causing clinical attachment loss where recession of the gingival margin is present,
      5. An overjet greater than 9 mm or reverse overjet (mandibular protrusion) is greater than 3.5 mm,
      6. A severe traumatic deviation (such as loss of a premaxilla segment by burns, accident or osteomyelitis or other gross pathology). Written documentation of the trauma or pathology shall be submitted with the prior authorization request.

   c. Has otherwise established a medical need for orthodontic treatment by demonstrating two (2) or more of the conditions below and justified the need in an accompanying narrative prepared by the ordering or referring dentist, orthodontist, primary care physician, speech pathologist, or behavioral health provider:

      1. A speech pathology that has proven non-responsive to medical treatment without orthodontic treatment, which has been diagnosed by a licensed speech therapist.
      2. Dysfunctional masticatory capacity as a result of the existing relationship between the maxillary and mandibular arches.
      3. Significant facial asymmetry.
      4. Severe maxillary, mandibular, or bi-maxillary protrusion or other physical deviation; or
      5. Other conditions that affect the medical, social, or emotional function of the patient as demonstrated by objective evidence provided by the patient's primary care physician or behavioral health provider.

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

| | | | | |
|---|---|---|---|---|
| **D8080** | **COMPREHENSIVE ORTHODONTIC TREATMENT OF THE ADOLESCENT DENTITION** | These codes should be used when there are multiple phases of treatment provided at different stages of dentofacial development. For example, the use of an activator is generally stage one of a two-stage treatment. In this situation, placement of fixed appliances will generally be stage two of a two-stage treatment. Both phases should be listed as comprehensive treatment modified by the appropriate stage of dental development. This is used to report the coordinated diagnosis and treatment leading to the improvement of a patient's craniofacial dysfunction and/or dentofacial deformity including anatomical, functional and aesthetic relationships. Treatment usually, but not necessarily, utilizes fixed orthodontic appliances. Adjunctive procedures, such as extractions, maxillofacial surgery, nasopharyngeal surgery, myofunctional or speech therapy and restorative or periodontal care, may be coordinated disciplines. Optimal care requires long-term consideration of patient's needs and periodic re-evaluation. Treatment may incorporate several phases with specific objectives at various stages of dentofacial development.<br><br>A benefit:<br>a. for handicapping malocclusion, cleft palate and facial growth management cases.<br>b. **for patients under the age of 21.**<br>c. for permanent dentition (unless the patient is age 13 or older with primary teeth still present or has a cleft palate or craniofacial anomaly).<br>d. once per patient per lifetime.<br><br>All appliances (such as bands, arch wires, headgear, and palatal expanders) are included in the fee for this procedure. No additional charge to the patient is permitted.<br><br>This procedure includes the replacement, and repair of brackets, bands and arch wires by the original provider. | 1. The following shall be submitted together for prior authorization:<br>a. Completed DC HLD Scoring sheet.<br>b. comprehensive orthodontic treatment of the adolescent dentition (D8080), and<br>c. diagnostic casts (D0470).<br><br>2. Written documentation for prior authorization for cleft palate and facial growth management cases shall be submitted:<br>a. cleft palate cases require documentation from a credentialed specialist, on their professional letterhead, if the cleft palate is not visible on the diagnostic casts, or<br>b. facial growth management cases require documentation from a credentialed specialist, on their professional letterhead, of the craniofacial anomaly. | DHCF reimburses the dental providers a global fee for the entire orthodontic case. D8680 Orthodontic Retention (Removal of Appliances, Construction and Placement of Retainers) does not require prior authorization.<br><br>One per lifetime |
| **D8091** | **COMPREHENSIVE ORTHODONTIC TREATMENT WITH ORTHOGNATHIC SURGERY** | These codes should be used when there are multiple phases of treatment provided at different stages of dentofacial development. For example, the use of an activator is generally stage one of a two-stage treatment. In this situation, placement of fixed appliances will generally be stage two of a two-stage treatment. Both phases should be listed as | 1. The following shall be submitted together for prior authorization:<br>a. Completed DC HLD Scoring sheet.<br>b. Comprehensive orthodontic treatment with Orthognathic surgery (D8091), | DHCF reimburses the dental providers a global fee for the entire orthodontic case. D8680 Orthodontic Retention (Removal of Appliances, Construction and Placement of Retainers) does not require prior authorization. |

| | | | | |
|---|---|---|---|---|
| | | comprehensive treatment modified by the appropriate stage of dental development. This is used to report the coordinated diagnosis and treatment leading to the improvement of a patient's craniofacial dysfunction and/or dentofacial deformity including anatomical, functional and aesthetic relationships. Treatment usually, but not necessarily, utilizes fixed orthodontic appliances. Adjunctive procedures, such as extractions, maxillofacial surgery, nasopharyngeal surgery, myofunctional or speech therapy and restorative or periodontal care, may be coordinated disciplines. Optimal care requires long-term consideration of patient's needs and periodic re-evaluation. Treatment may incorporate several phases with specific objectives at various stages of dentofacial development.<br><br>A benefit:<br>a. for handicapping malocclusion, cleft palate and facial growth management cases.<br>b. **for patients under the age of 21.**<br>c. for permanent dentition (unless the patient is age 13 or older with primary teeth still present or has a cleft palate or craniofacial anomaly).<br>d. once per patient per lifetime.<br><br>All appliances (such as bands, arch wires, headgear, and palatal expanders) are included in the fee for this procedure. No additional charge to the patient is permitted.<br><br>This procedure includes the replacement, and repair of brackets, bands and arch wires by the original provider. | c. Classification of craniofacial abnormalities and/or malocclusion, and<br>c. diagnostic casts (D0470).<br><br>2. Supporting documentation of the medical necessity for correction of maxillary and mandibular skeletal deformities associated with masticatory malocclusion. The documentation must demonstrate that the skeletal deformities are contributing to significant dysfunction and preclude adequate treatment through dental therapeutics and orthodontics alone.<br><br>3. Skeletal, facial, or craniofacial deformity defined by study models and pre-orthodontic imaging such as cephalometric radiographs and cephalometric diagrams with standard computer-generated measurements.<br><br>4. Written documentation for prior authorization for cleft palate and facial growth management cases shall be submitted:<br><br>a. cleft palate cases require documentation from a credentialed specialist, on their professional letterhead, if the cleft palate is not visible on the diagnostic casts, or<br>b. facial growth management cases require documentation from a credentialed specialist, on their professional letterhead, of the craniofacial anomaly. | One per lifetime |
| **D8695** | **REMOVAL OF FIXED ORTHODONTIC APPLIANCES FOR REASONS OTHER** | D8695 should not be reported by the current treating dentist when the removal of the oral appliances is a part of the normal sequence of treatment or when the appliances are removed after the completion of treatment. | 1. Written documentation for prior authorization– shall include the rationale demonstrating the reason for the premature removal of the appliance and | |

| | | | | |
|---|---|---|---|---|
| | **THAN COMPLETTION OF TREATMENT** | | indicate that the dentist who removed the appliances and they are not the dentist that placed the orthodontic appliance.<br>2. Intraoral photos. | |
| **D8703** | **REPLACEMENT OF LOST OR BROKEN RETAINER-MAXILLARY** | The replacement of lost or broken maxillary retainer previously placed post-orthodontics. | 1. Written documentation for prior authorization– shall include the rationale demonstrating the reason the retainer needs to be replaced. | Two per lifetime |
| **D8704** | **REPLACEMENT OF LOST OR BROKEN RETAINER-MANDIBULAR** | The replacement of lost or broken mandibular retainer previously placed post-orthodontics. | 1. Written documentation for prior authorization– shall include the rationale demonstrating the reason the retainer needs to be replaced. | Two per lifetime |
| **D8999** | **UNSPECIFIED ORTHODONTIC PROCEDURE, BY REPORT** | Used for procedure that:<br>1. Is not adequately described by a CDT code.<br>2. Has a CDT code that is not a benefit, but the patient has an exceptional medical condition to justify the medical necessity.<br><br>Not a benefit to the original provider for the adjustment, repair, replacement or removal of brackets, bands or arch wires. | 1. Prior authorization is required for non-emergency procedures.<br>2. Radiographs for prior authorization -submit radiographs if applicable for the type of procedure.<br>3. Photographs for prior authorization -submit photographs if applicable for the type of procedure.<br>4. Written documentation for prior authorization– describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed or actual treatment.<br>5. Documentation shall include the medical condition and the specific CDT code associated with the treatment. (describe procedure in narrative format). | |

## ADJUNCTIVE GENERAL POLICIES (D9000-D9999)

### Anesthesia (D9210-D9248)

1. Deep Sedation /General anesthesia **(D9222 – D9225)**

    a. Deep Sedation is a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

    b. General Anesthesia is a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

2. Moderate Anesthesia (D9245-D9247) is a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

3. Deep sedation/general anesthesia **(D9222 – D9225) and moderate anesthesia (D9245-D9247)** shall be considered for prior authorization when it is documented why local anesthesia is contraindicated. Such contraindications shall include but are not limited to the following:

    a. a severe mental or physical handicap,

    b. extensive surgical procedures,

    c. an uncooperative child,

    d. an acute infection at an injection site,

    e. a failure of a local anesthetic to control pain.

4. The administration of deep sedation/general anesthesia **(D9222 – D9225) and moderate anesthesia (D9245-D9247),** and nitrous oxide (D9230), is a benefit in conjunction with Medicaid covered associated procedures. Prior authorization shall be denied if any associated procedures by the same provider are denied.

5. Providers who administer general anesthesia **(D9222- D9225) and moderate anesthesia (D9245-D9247)** shall have valid anesthesia permits.

6. Anesthesia time for deep anesthesia/general anesthesia and moderate anesthesia. 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.

7. Minimal Anesthesia (D9244) - is a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and physical coordination may be impaired, airway reflexes, and ventilatory and cardiovascular functions are unaffected. This is typically accomplished by a single oral dose of a sedative or an analgesic administered before the procedure.

8. Inhalation of Nitrous Oxide/Analgesia, Anxiolysis (D9230) does not require prior authorization.

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

## ADJUNCT PROCEDURES (PROCEDURES D9000-D9999)

1. General anesthesia is an excluded benefit unless provided in conjunction with authorized oral surgery procedures, such as the surgical extraction of impacted teeth, procedures D7220-D7240.
2. This procedure is only reimbursed to providers holding a valid DEA number ; please include the DEA number on the 719A form.
3. The dentist who will perform the administration of sedation or general anesthesia shall have passed Dental Sedation/Anesthesia Competency Assessment Exam for the specific level of sedation requested.
4. Only a dentist who holds an appropriate Class I, II, or III certification issued by the respective state Board of Health for the office location may administer an anesthetic technique in order to attain a level beyond anxiolysis for the practice of dentistry.
5. Radiographs submitted should include the name of the patient, date of birth, and date the x-ray was taken.

| | | | | |
|---|---|---|---|---|
| **D9222** | **ADMINISTRATION OF DEEP SEDATION/ GENERAL ANESTHESIA – FIRST 15 MINUTE INCREMENT, OR ANY PORTION THEREOF** | Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and noninvasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients or duties. The level of anesthesia is determined by the anesthesia provider's documentation of the anesthetic's effects upon the central nervous system and not dependent upon the route of administration.<br>**Deep Sedation/General anesthesia** is allowed with these services: (when the procedure is a covered benefit):<br>Apicoectomy (D3410-D3426).<br>Retrograde filling (D3430).<br>Root amputation (D3450).<br>Hemisection (D3920).<br>Surgical extractions (D7210-D7241).<br>Root recovery (D7250).<br>Coronectomy (D7251).<br>Other oral surgery procedures (D7260-D7291).<br>Alveoloplasty (D7310-D7321).<br>Vestibuloplasty (D7340-D7350).<br>Removal of tumors, cysts and neoplasms (D7410-D7461).<br>Excision of bone tissue (D7471-D7490).<br>Surgical Incision (D7509- D7560).<br>Treatment of fractures-simple (D7610-D7680).<br>Treatment of fractures-compound (D7710-D7780).<br>Reduction of dislocation of temporo-mandibular joint (D7810-D7877). | 1. Written documentation for prior authorization–shall justify the medical necessity based on a mental or physical limitation or contraindication to rendering the procedure under local anesthesia or administering minimal or moderation sedation (D9244, D9245, and D9246).<br>2. A visual examination should be documented and submitted with intraoral photos if radiographs (FMX/PANO) were unable to be obtained for the clinical review. The additional information is required to justify the proposed treatment and the amount of anesthesia requested.<br>3. An anesthesia record that indicates the anesthetic agent(s) and the anesthesia time shall be submitted for prior authorization.<br>4. The quantity for the first 15-minutes , that is necessary to complete the treatment, shall be indicated on the 719A Form.<br>5. Copy of Anesthesia license and DEA# on file, if not on file submit a copy. | The dental provider cannot request D9224, D9225, D9230, D9244, D9245, D9246, and D9247 for the same patient on the same day of the administration of general anesthesia (D9222)<br><br>Providers must complete proposed treatment plan in one visit to minimize the number of appointments required to complete the treatment plan. If one visit is not feasible, supporting documentation based on clinical need and/or medical necessity must be submitted to justify a request for additional units of D9222 for subsequent dental appointments.<br><br>**References:**<br><br>ADA Guidelines for the Use of Sedation and General Anesthesia by Dentists<br><br>American Society of Anesthesiologists' Statement on Continuum of Depth of Sedation: Definition of General Anesthesia and Level of Sedation/Analgesia |

| | | | | |
|---|---|---|---|---|
| | | Repair of traumatic wounds (D7910).<br>Excision of hyperplastic tissue (D7970).<br>Placement of Implant D6010<br>Special needs patients that are combative during exam/treatment ( must be part of waiver program)<br><br>Not a benefit:<br>a. on the same date of service as analgesia, anxiolysis, inhalation of nitrous oxide (D9230),<br>b. when any associated procedures on the same date of service by the same provider are denied. | | |
| **D9223** | **ADMINISTRATION OF DEEP SEDATION/ GENERAL ANESTHESIA – EACH SUBSEQUENT 15 MINUTE INCREMENT, OR ANY PORTION THEREOF** | Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and noninvasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients or duties.<br><br>The level of anesthesia is determined by the anesthesia provider's documentation of the anesthetic's effects upon the central nervous system and not dependent upon the route of administration.<br><br>**Deep Sedation/General anesthesia** is allowed with these services: (when the procedure is a covered benefit):<br>Apicoectomy (D3410-D3426).<br>Retrograde filling (D3430).<br>Root amputation (D3450).<br>Hemisection (D3920).<br>Surgical extractions (D7210-D7241).<br>Root recovery (D7250).<br>Coronectomy (D7251).<br>Other oral surgery procedures (D7260-D7291).<br>Alveoloplasty (D7310-D7321).<br>Vestibuloplasty (D7340-D7350).<br>Removal of tumors, cysts and neoplasms (D7410-D7461).<br>Excision of bone tissue (D7471-D7490).<br>Surgical Incision (D7509- D7560). | 1. Written documentation for prior authorization–shall justify the medical necessity based on a mental or physical limitation or contraindication to rendering the procedure under local anesthesia or administering minimal or moderation sedation (D9244, D9245, and D9247).<br>2. An anesthesia record that indicates the anesthetic agent(s) and the anesthesia time shall be submitted for prior authorization.<br>3. A visual examination should be documented and submitted with intraoral photos if radiographs (FMX/PANO) were unable to be obtained for the clinical review. The additional information is required to justify the proposed treatment and the amount of anesthesia requested.<br>4. An anesthesia record that indicates the anesthetic agent(s) and the anesthesia time shall be submitted for prior authorization.<br>5. The quantity, in 15-minute increments, that was necessary to complete the treatment shall be indicated on the 719A Form .<br>6. Copy of Anesthesia license and DEA# on file, if not on file submit a copy. | Exception for Howard University Hospital Dentistry, Children's National Medicaid Center, MedStar Washington Hospital Center's anesthesia services are administered under hospital, not required to submit anesthesia license information with requests.<br><br>The dental provider cannot request D9224, D9225, D9230, D9244, D9245, D9246, and D9247 for the same patient on the same day of the administration of general anesthesia (D9223)<br><br>Providers must complete proposed treatment plan in one visit to minimize the number of appointments required to complete the treatment plan. If one visit is not feasible, supporting documentation based on clinical need and/or medical necessity must be submitted to justify a request for additional units of D9224 for subsequent dental appointments.<br><br>References:<br><br>ADA Guidelines for the Use of Sedation and General Anesthesia by Dentists<br><br>American Society of Anesthesiologists' Statement on Continuum of Depth of Sedation: Definition of General Anesthesia and Level of Sedation/Analgesia |

| | | | | |
|---|---|---|---|---|
| | | Treatment of fractures-simple (D7610-D7680).<br>Treatment of fractures-compound (D7710-D7780).<br>Reduction of dislocation of temporo-mandibular joint (D7810-D7877).<br>Repair of traumatic wounds (D7910).<br>Excision of hyperplastic tissue (D7970).<br>Placement of Implant D6010<br>Special needs patients that are combative during exam/treatment ( must be part of waiver program)<br><br>**<u>Not a benefit:</u>**<br>a. on the same date of service as analgesia, anxiolysis, inhalation of nitrous oxide (D9230).<br>b. when all associated procedures on the same date of service by the same provider are denied. | | |
| **D9224** | **ADMINISTRATION OF GENERAL ANESTHESIA WITH ADVANCED AIRWAY – FIRST 15 MINUTE INCREMENT, OR ANY PORTION THEREOF** | Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and noninvasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients or duties.<br><br>**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.**<br><br>The level of anesthesia is determined by the anesthesia provider's documentation of the anesthetic's effects upon the central nervous system and not dependent upon the route of administration.<br><br>**<u>General anesthesia</u>** is allowed with these services: (when the procedure is a covered benefit):<br>Apicoectomy (D3410-D3426).<br>Retrograde filling (D3430).<br>Root amputation (D3450).<br>Hemisection (D3920). | 1. Written documentation for prior authorization–shall justify the medical necessity based on a mental or physical limitation or contraindication to rendering the procedure under local anesthesia or administering minimal or moderation sedation (D9244, D9245, and D9246).<br><br>2. To support the request for D9224, clinical documentation **must clearly demonstrate why an advanced airway was medically necessary to ensure the patient's safety.** According to guidance from the American Dental Association and the standards outlined in the ADA Guidelines for the Use of Sedation and General Anesthesia by Dentists, the record should indicate that **the patient required general anesthesia with airway management beyond basic support,** such as endotracheal intubation or a laryngeal mask airway. The documentation should describe the patient's clinical condition and risk factors—such as significant medical comorbidities, airway compromise, inability to | The dental provider cannot request D9222, D9230, D9244, D9245, D9246, and D9247 for the same patient on the same day of the administration of general anesthesia (D9224)<br><br>Providers must complete proposed treatment plan in one visit to minimize the number of appointments required to complete the treatment plan. If one visit is not feasible, supporting documentation based on clinical need and/or medical necessity must be submitted to justify a request for additional units of D9224 for subsequent dental appointments.<br><br>References:<br><br>ADA Guidelines for the Use of Sedation and General Anesthesia by Dentists<br><br>American Society of Anesthesiologists' Statement on Continuum of Depth of Sedation: Definition of General Anesthesia and Level of Sedation/Analgesia |

| | | | | |
|---|---|---|---|---|
| | | Surgical extractions (D7210-D7241).<br>Root recovery (D7250).<br>Coronectomy (D7251).<br>Other oral surgery procedures (D7260-D7291).<br>Alveoloplasty (D7310-D7321).<br>Vestibuloplasty (D7340-D7350).<br>Removal of tumors, cysts and neoplasms (D7410-D7461).<br>Excision of bone tissue (D7471-D7490).<br>Surgical Incision (D7509- D7560).<br>Treatment of fractures-simple (D7610-D7680).<br>Treatment of fractures-compound (D7710-D7780).<br>Reduction of dislocation of temporo-mandibular joint (D7810-D7877).<br>Repair of traumatic wounds (D7910).<br>Excision of hyperplastic tissue (D7970).<br>Placement of Implant D6010<br>Special needs patients that are combative during exam/treatment ( must be part of waiver program)<br><br>**Not a benefit:**<br>c. on the same date of service as analgesia, anxiolysis, inhalation of nitrous oxide (D9230).<br><br>when all associated procedures on the same date of service by the same provider are denied. | maintain a patent airway, risk of aspiration, severe anxiety or behavioral limitations, or the complexity and duration of the procedure—that made advanced airway control necessary rather than minimal or moderate sedation. **The clinical narrative must establish that without advanced airway management, the patient's safety and ability to tolerate the procedure would have been compromised, thereby meeting the ADA standard for the administration of deep sedation or general anesthesia.**<br><br>3. A visual examination should be documented and submitted with intraoral photos if radiographs (FMX/PANO) were unable to be obtained for the clinical review. The additional information is required to justify the proposed treatment and the amount of anesthesia requested.<br><br>4. An anesthesia record that indicates the anesthetic agent(s) and the anesthesia time shall be submitted for prior authorization.<br><br>5. The quantity for the first 15-minutes , that is necessary to complete the treatment shall be indicated on the 719A Form.<br><br>6. Copy of Anesthesia license and DEA# on file, if not on file submit a copy. | |
| **D9225** | **ADMINISTRATION OF GENERAL ANESTHESIA WITH ADVANCED AIRWAY – EACH SUBSEQUENT** | Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and noninvasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under | 1. Written documentation for prior authorization–shall justify the medical necessity based on a mental or physical limitation or contraindication to rendering the | The dental provider cannot request D9223, D9230, D9244, D9245, D9246, and D9247 for |

| | | | | |
|---|---|---|---|---|
| | **15 MINUTE INCREMENT, OR ANY PORTION THEREOF** | the observation of trained personnel and the doctor may safely leave the room to attend to other patients or duties.<br><br>**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.**<br><br>The level of anesthesia is determined by the anesthesia provider's documentation of the anesthetic's effects upon the central nervous system and not dependent upon the route of administration.<br><br>**General anesthesia** is allowed with these services: (when the procedure is a covered benefit):<br>Apicoectomy (D3410-D3426).<br>Retrograde filling (D3430).<br>Root amputation (D3450).<br>Hemisection (D3920).<br>Surgical extractions (D7210-D7241).<br>Root recovery (D7250).<br>Coronectomy (D7251).<br>Other oral surgery procedures (D7260-D7291).<br>Alveoloplasty (D7310-D7321).<br>Vestibuloplasty (D7340-D7350).<br>Removal of tumors, cysts and neoplasms (D7410-D7461).<br>Excision of bone tissue (D7471-D7490).<br>Surgical Incision (D7509- D7560).<br>Treatment of fractures-simple (D7610-D7680).<br>Treatment of fractures-compound (D7710-D7780).<br>Reduction of dislocation of temporo-mandibular joint (D7810-D7877).<br>Repair of traumatic wounds (D7910).<br>Excision of hyperplastic tissue (D7970).<br>Placement of Implant D6010<br>Special needs patients that are combative during exam/treatment ( must be part of waiver program)<br><br>**Not a benefit:** | procedure under local anesthesia or administering minimal or moderation sedation (D9244, D9245, and D9246).<br><br>2. To support the request for D9225, clinical documentation **must clearly demonstrate why an advanced airway was medically necessary to ensure the patient's safety.** According to guidance from the American Dental Association and the standards outlined in the ADA Guidelines for the Use of Sedation and General Anesthesia by Dentists, the record should indicate that the **patient required general anesthesia with airway management beyond basic support**, such as endotracheal intubation or a laryngeal mask airway. The documentation should describe the patient's clinical condition and risk factors—such as significant medical comorbidities, airway compromise, inability to maintain a patent airway, risk of aspiration, severe anxiety or behavioral limitations, or the complexity and duration of the procedure—that made advanced airway control necessary rather than minimal or moderate sedation. **The clinical narrative must establish that without advanced airway management, the patient's safety and ability to tolerate the procedure would have been compromised, thereby meeting the ADA standard for the administration of deep sedation or general anesthesia.**<br><br>3. A visual examination should be documented and submitted with intraoral photos if radiographs (FMX/PANO) were unable to be | the same patient on the same day of the administration of general anesthesia (D9224)<br><br>Providers must complete proposed treatment plan in one visit to minimize the number of appointments required to complete the treatment plan. If one visit is not feasible, supporting documentation based on clinical need and/or medical necessity must be submitted to justify a request for additional units of D9225 for subsequent dental appointments.<br><br>References:<br><br>ADA Guidelines for the Use of Sedation and General Anesthesia by Dentists<br><br>American Society of Anesthesiologists' Statement on Continuum of Depth of Sedation: Definition of General Anesthesia and Level of Sedation/Analgesia |

| | | | | |
|---|---|---|---|---|
| | | d. on the same date of service as analgesia, anxiolysis, inhalation of nitrous oxide (D9230).<br><br>when all associated procedures on the same date of service by the same provider are denied. | obtained for the clinical review. The additional information is required to justify the proposed treatment and the amount of anesthesia requested.<br>4. An anesthesia record that indicates the anesthetic agent(s) and the anesthesia time shall be submitted for prior authorization.<br>5. The quantity for the first 15-minutes , that is necessary to complete the treatment shall be indicated on the 719A Form.<br>6. Copy of Anesthesia license on file, if not on file submit a copy. | |
| **D9244** | **IN-OFFICE ADMINSTRATION OF MINIMAL SEDATION – SINGLE DRUG - ENTERAL** | 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 (RMD) for unmonitored home use. The single drug may be administered with or without co-administration of nitrous oxide.<br><br>Enteral refers to any technique of administration in which the agent is absorbed through the gastrointestinal (GI) tract or oral mucosa (i.e. , oral, rectal, sublingual).<br><br>Any concomitant use of nitrous oxide is included in the procedure and not claimed separately. | 1. A clinical narrative that justifies the reasons why minimal sedation is necessary.<br>2. Provide the name of medication to be used, dosage, route of administration, and list of proposed dental procedures on 719A form.<br>3. A visual examination should be documented and submitted with intraoral photos if radiographs (FMX/PANO) were unable to be obtained for the clinical review. The additional information is required to justify the proposed treatment and anesthesia requested.<br>4. Copy of Anesthesia license and DEA# on file, if not on file submit a copy. | The dental provider cannot request D9222-D9225, D9230, D9245, D9246, and D9247 for the same patient on the same day of the administration of general anesthesia (D9244)<br><br>References:<br><br>ADA Guidelines for the Use of Sedation and General Anesthesia by Dentists<br><br>American Society of Anesthesiologists' Statement on Continuum of Depth of Sedation: Definition of General Anesthesia and Level of Sedation/Analgesia |
| **D9245** | **ADMINISTRATION OF MODERATE SEDATION- ENTERAL** | Moderate sedation is achieved by administration of drug(s) by enteral route only. With or without co-administration of nitrous oxide.<br><br>Enteral refers to any technique of administration in which the agent is absorbed through the | 1. A clinical narrative that justifies the reasons why minimal sedation is necessary.<br>2. Provide the name of medication to be used, dosage, route of | The dental provider cannot request D9222-D9225, D9230, D9244, D9246, and D9247 for the same patient on the same day of the administration of general anesthesia (D9245)<br><br>References: |

| | | | | |
|---|---|---|---|---|
| | | gastrointestinal (GI) tract or oral mucosa (i.e. , oral, rectal, sublingual).<br><br>Any concomitant use of nitrous oxide is included in the procedure and not claimed separately. | administration, and list of proposed dental procedures on 719A form.<br><br>3. A visual examination should be documented and submitted with intraoral photos if radiographs (FMX/PANO) were unable to be obtained for the clinical review. The additional information is required to justify the proposed treatment and anesthesia requested.<br><br>4. Copy of Anesthesia license on file, if not on file submit a copy. | ADA Guidelines for the Use of Sedation and General Anesthesia by Dentists<br><br>American Society of Anesthesiologists' Statement on Continuum of Depth of Sedation: Definition of General Anesthesia and Level of Sedation/Analgesia |
| **D9246** | **ADMINISTRATION OF MODERATE SEDATION – NON-INTRAVENOUS PARENTERAL – FIRST 15 MINUTE INCREMENT, OR ANY PORTION THEREOF** | Moderate sedation is achieved by administration of drug(s) by enteral route only. With or without co-administration of nitrous oxide.<br><br>Parenteral refers to a technique of administration in which the drug in which the drug bypasses the gastrointestinal (GI) tract (i.e. , intramuscular (IM), intravenous (IV), intranasal (IN), submucosal (SM), subcutaneous (SC), intraosseous (IO).<br><br>Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and noninvasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients or duties. | 1. A clinical narrative that justifies the reasons why moderate sedation is necessary.<br>2. Provide the name of medication to be used, dosage, route of administration, and list of proposed dental procedures on 719A form.<br><br>3. A visual examination should be documented and submitted with intraoral photos if radiographs (FMX/PANO) were unable to be obtained for the clinical review. The additional information is required to justify the proposed treatment and anesthesia requested.<br><br>4. Copy of Anesthesia license and DEA# on file, if not on file submit a copy. | The dental provider cannot request D9222-D9225, D9230, D9244, and D9245 for the same patient on the same day of the administration of general anesthesia (D9245)<br><br>References:<br><br>ADA Guidelines for the Use of Sedation and General Anesthesia by Dentists<br><br>American Society of Anesthesiologists' Statement on Continuum of Depth of Sedation: Definition of General Anesthesia and Level of Sedation/Analgesia |
| **D9247** | **ADMINISTRATION OF MODERATE SEDATION – NON-INTRAVENOUS PARENTERAL –EACH** | Moderate sedation is achieved by administration of drug(s) by enteral route only. With or without co-administration of nitrous oxide.<br><br>Parenteral refers to a technique of administration in which the drug in which the drug bypasses the | 1. A clinical narrative that justifies the reasons why moderate sedation is necessary.<br>2. Provide the name of medication to be used, dosage, route of | The dental provider cannot request D9222-D9225, D9230, D9244, and D9245 for the same patient on the same day of the administration of general anesthesia (D9245)<br><br>References: |

| | | | | |
|---|---|---|---|---|
| | **SUBSEQUENT 15 MINUTE INCREMENT, OR ANY PORTION THEREOF** | gastrointestinal (GI) tract (i.e. , intramuscular (IM), intravenous (IV), intranasal (IN), submucosal (SM), subcutaneous (SC), intraosseous (IO).<br><br>Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and noninvasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients or duties. | administration, and list of proposed dental procedures on 719A form.<br><br>3. A visual examination should be documented and submitted with intraoral photos if radiographs (FMX/PANO) were unable to be obtained for the clinical review. The additional information is required to justify the proposed treatment and anesthesia requested.<br><br>4. Copy of Anesthesia license and DEA# on file, if not on file submit a copy. | ADA Guidelines for the Use of Sedation and General Anesthesia by Dentists<br><br>American Society of Anesthesiologists' Statement on Continuum of Depth of Sedation: Definition of General Anesthesia and Level of Sedation/Analgesia |
| **D9420** | **HOSPITAL OR AMBULATORY SURGICAL CENTER CALL** | Care provided outside the dentist's office to a patient who is in hospital or ambulatory surgical center. Services delivered to the patient on the date of service are documented separately using the applicable procedure codes.<br><br>Not a benefit:<br><br>a. for an assistant surgeon.<br><br>b. for time spent compiling the patient's history, writing reports or for postoperative or follow up visits. | 1. The operative report for prior authorization – shall include the total time in the operating room or ambulatory surgical center.<br><br>2. A benefit for each hour or fraction thereof as documented on the operative report.<br><br>3. Documentation of past dental treatment notes, radiographs, IO photos may be requested. | |

| | | | | |
|---|---|---|---|---|
| **D9944** | **OCCLUSAL GUARDS – HARD APPLIANCE, FULL ARCH** | Removable dental appliances, which are designed to minimize the effects of bruxism (grinding) and other occlusal factors.<br>~ Allowed in cases of bruxism only.<br>~ Occlusal guards submitted in conjunction with TMJ therapy are not covered. | 1. Intraoral photographs of occlusal / incisal wear.<br>2. Panoramic radiograph or full mouth series of x-rays.<br>3. Written documentation for prior authorization – shall include the diagnosis and rationale demonstrating the medical necessity for the appliance.<br>4. Requires the specific arch. | |
| **D9945** | **OCCLUSAL GUARDS – SOFT APPLIANCE, FULL ARCH** | Removable dental appliances, which are designed to minimize the effects of bruxism (grinding) and other occlusal factors.<br>~ Allowed in cases of bruxism only.<br>~ Occlusal guards submitted in conjunction with TMJ therapy are not covered. | 1. Intraoral photographs of occlusal / incisal wear.<br>2. Panoramic radiograph or full mouth series of x-rays.<br>3. Written documentation for prior authorization – shall include the diagnosis and rationale demonstrating the medical necessity for the appliance.<br>4. Requires the specific arch. | |
| **D9946** | **OCCLUSAL GUARDS – HARD APPLIANCE, PARTIAL ARCH** | Removable dental appliances, which are designed to minimize the effects of bruxism (grinding) and other occlusal factors.<br>~ Allowed in cases of bruxism only.<br>~ Occlusal guards submitted in conjunction with TMJ therapy are not covered. | 1. Intraoral photographs of occlusal / incisal wear.<br>2. Panoramic radiograph or full mouth series of x-rays.<br>3. Written documentation for prior authorization – shall include the diagnosis and rationale demonstrating the medical necessity for the appliance.<br>4. Requires the specific arch. | |
| **D9947** | **CUSTOM SLEEP APPLIANCE FABRICATION AND PLACEMENT** | The patient does not have a contraindication to the use of an oral appliance.<br>Dental conditions that interfere with or will not support an oral appliance. Examples include braces, retainers, the largely edentulous patient, active periodontal disease, anatomical defects, or other related conditions.<br>Patients that do not have the manual dexterity to place and remove the sleep apnea appliance. | 1. A prescription for the sleep apnea appliance from a physician who is board certified by the AASM or sleep board eligible.<br>2. Written documentation that the patient is unable to use Continuous Positive Airway Pressure (CPAP) machine or demonstrate non-compliance with CPAP.<br>3. Clinical narrative to include the description of the sleep appliance and the expected outcome.<br>4. Full mouth series of radiographs or panorex. | General symptoms alone such as snoring, trouble sleeping, nighttime wakening, or falling asleep during the day are not sufficient for diagnosing sleep apnea in the absence of a sleep study (PSG-polysomnography.)<br>**Sleep Apnea is not a dental condition. Therefore, ordering and interpreting objective tests aiming to establish the diagnosis of obstructive sleep apnea (OSA) or primary snoring is conducted by the physician board certified by the American** |

| | | | | |
|---|---|---|---|---|
| | | The patient is allowed one oral sleep apnea appliance within a 60-month period.<br><br>Any adjustment or repair of the sleep apnea appliances are included in the first six (6) months of wear after delivery.<br><br>If the sleep appliance is lost or broken, the dental provider will need to submit supporting documentation with a clinical narrative, photos if applicable, for review. | 5. Periodontal charting.<br>6. Medical and dental history.<br>7. The qualified dentist to provide the sleep apnea appliance (D9947) must have at least one of the following: certification in dental sleep medicine by a non-profit organization, designation as the dental director of a dental sleep medicine facility accredited by a non-profit organization, or documentation of recognized continuing education in dental sleep medicine (e.g., American Dental Association Continuing Education Recognition Program [ADA CERP] or Academy of General Dentistry Program Approval for Continuing Education [AGD PACE]) provided by a dental sleep medicine focused non-profit organization or accredited dental school in the last two years.<br>8. Requires the specific arch. | **Academy of Sleep Medicine (AASM) or sleep board eligible.** |
| **D9951** | **OCCLUSAL ADJUSTMENT-LIMITED** | The reshaping of the occlusal surfaces of teeth to create a harmonious contact relationship between the maxillary and mandibular teeth.<br><br>D9951 is not indicated when the procedure only involves the occlusal (bite) adjustment in the post-delivery for a direct or indirect restoration or a fixed or removable prosthesis.<br><br>If the occlusal adjustment is required within a short period of completion of a restorative procedure, it is considered a part of the global fee for the restorative procedure. | 1. Written documentation for prior authorization – shall include the diagnosis and rationale demonstrating the medical necessity.<br><br>2. The specific teeth requiring occlusal adjustment. | |
| **D9952** | **OCCLUSAL ADJUSTMENT-COMPLETE** | D9952 may require study casts to be mounted on an articulator to analyze occlusal disharmony.<br><br>D9952 is indicated to achieve functional relationships and masticatory efficiency in conjunction with restorative, orthodontia, orthognathic surgery, or jaw trauma.<br>D9952 is for a comprehensive series of visits, not a single visit.<br><br>D9952 is reimbursed once per lifetime. | 1. Written documentation for prior authorization – shall include the diagnosis and rationale demonstrating the medical necessity.<br>2. The specific teeth requiring occlusal adjustment.<br>3. If needed in conjunction with restorative treatment, orthodontics, orthognathic surgery, or jaw trauma. | |

| | | | | |
|---|---|---|---|---|
| **D9953** | **RELINE CUSTOM SLEEP APNEA APPLIANCE (INDIRECT)** | This procedure is utilized to indirectly reline an appliance that is specifically custom fabricated to treat sleep apnea. | 1. The qualified dentist to reline the sleep apnea appliance (D9947) must have at least one of the following: certification in dental sleep medicine by a non-profit organization, designation as the dental director of a dental sleep medicine facility accredited by a non-profit organization, or documentation of recognized continuing education in dental sleep medicine (e.g., American Dental Association Continuing Education Recognition Program [ADA CERP] or Academy of General Dentistry Program Approval for Continuing Education [AGD PACE]) provided by a dental sleep medicine focused non-profit organization or accredited dental school in the last two years.<br>2. Clinical narrative to document an ill-fitting sleep apnea device.<br>3. Full Mouth series of radiographs or panorex.<br>4. Photos of the sleep apnea appliance. | Not reimbursed to the provider of placement within six (6) months of the sleep apnea appliance placement. |
| **D9959** | **UNSPECIFIED SLEEP APNEA SERVICES, BY REPORT** | This procedure is utilized to report a procedure not adequately described by an existing sleep apnea code. | 1. The qualified dentist rendering the sleep apnea procedure (D9959) must have at least one of the following: certification in dental sleep medicine by a non-profit organization, designation as the dental director of a dental sleep medicine facility accredited by a non-profit organization, or documentation of recognized continuing education in dental sleep medicine (e.g., American Dental Association Continuing Education Recognition Program [ADA CERP] or Academy of General Dentistry Program Approval for Continuing Education [AGD PACE]) provided by a dental sleep medicine focused non-profit organization or accredited dental school in the last two years. | General symptoms alone such as snoring, trouble sleeping, nighttime wakening, or falling asleep during the day are not sufficient for diagnosing sleep apnea in the absence of a sleep study (PSG-polysomnography.)<br><br>**Sleep Apnea is not a dental condition. Therefore, ordering and interpreting objective tests aiming to establish the diagnosis of obstructive sleep apnea (OSA) or primary snoring is conducted by the physician board certified by the American Academy of Sleep Medicine (AASM) or sleep board eligible.** |

| | | | | |
|---|---|---|---|---|
| | | | 2. The dental provider must submit the following:<br><br>a. clinical narrative outlining the specific nature of the treatment,<br>b. dental records to document prior placement of sleep apnea device,<br>c. the materials and techniques used,<br>d. the time and resources required,<br>e. the clinical justification for the procedure.<br><br>3. Full mouth series of radiographs or panorex.<br><br>4. Periodontal charting.<br><br>5. Medical and dental history. | |