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Dental Services
Corporate Medical Policy

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Blue Cross and Blue Shield of Vermont (BCBSVT) Medical Policies are developed to provide clinical guidance and are based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. The applicable group/individual contract and member certificate language determines benefits that are in effect at the time of service. Since medical practices and knowledge are constantly evolving, BCBSVT reserves the right to review and revise its medical policies periodically. To the extent that there may be any conflict between medical policy and contract language, the member's contract language takes precedence.

Description

Dental services include those procedures which are performed on sound natural teeth and supporting structures, lips, tongue, roof and floor of the mouth, accessory sinuses, salivary glands or ducts, jaws (i.e., mandible and maxilla, including orthognathic services), to correct a congenital anomaly or accidental injury, reduce a dislocation, repair a fracture, excise tumors, cysts or exostosis, or drain abscesses with cellulitis.

Definitions

Preventive dentistry is the branch of dentistry that deals with the preservation of healthy teeth and gums and the prevention of dental caries and oral disease.

Primary (Deciduous) Dentition: Teeth developed and erupted first in order of time.

Transitional Dentition: The final phase of the transition from primary to adult teeth, in which the deciduous molars and canines are in the process of shedding and the permanent successors are emerging.

Adolescent Dentition: The dentition that is present after the normal loss of primary teeth and prior to cessation of growth.

Permanent (Adult) Dentition: The dentition that is present after the cessation of growth.

Erupted tooth: Is characterized by the upward movement of a tooth through the jawbone and the breakthrough of the gum to project into the mouth[1].

Impacted tooth: Is characterized by a tooth not being fully erupted into the oral cavity. This may be due to insufficient space in the dental arch to accommodate eruption of the tooth, ectopic or abnormal position of the tooth, the presence of associated pathology, or other reasons[2].

Sound natural tooth: A sound, natural tooth is a tooth that is whole or properly restored (restoration with amalgams only); is without impairment, periodontal conditions or other conditions; and is not in need of the treatment provided for any reason other than accidental injury. A tooth previously restored with a crown, inlay, onlay, or porcelain restoration, or treated by endodontics, is not a sound natural tooth.

Policy- Part A:

We cover only the following dental services under the medical benefit:

Treatment for or in connection with an accidental injury to the jaws, sound natural teeth, mouth or face provided a continuous course of dental treatment is started within six months of the accident (in the event of an emergency, you must contact us as soon as reasonably possible for approval of continued treatment);

- Surgery to correct gross deformity resulting from major disease or surgery. Surgery must take place within six months of the onset of disease or within six months after surgery except as otherwise required by law. Gross deformity is defined as readily visible and disfiguring and/or functionally disabling. Gross deformity does not include absence of teeth.
- Facility and anesthesia charges for significant dental treatment for members who are unable to be treated safely and effectively in an office setting due to age or severe disability. Note: Dental procedures may not be covered.

When the service or procedure is eligible:

Accidental Injury - Benefits are available with prior approval for accidental injury to the jaw, sound natural teeth, mouth or face.

The Plan will provide separate benefits for root canal procedures, which may be required before crowns can be installed. Benefits for dental implants or prostheses,

[1] *http://meddict.org/term/eruption-of-teeth/*

[2] *www.aaoms.org/docs/practice_mgmt/.../impacted_third_molars.pdf*

which are necessary due to accidental injury, may be provided with prior approval from the Plan.

Under individual consideration (by prior approval), Facility and Anesthesia Charges – may be covered for members who are 7 years of age or younger; 12 years of age or younger with phobias or a mental illness documented by a licensed physician or mental health professional; and members with severe disabilities that preclude office based dental care due to safety considerations. (Examples include, but are not limited to, severe autism, cerebral palsy, hemorrhagic disorders, and severe congestive heart failure.) Note: Dental services may not be covered.

Gross Deformity Corrective Surgery - this is usually extensive surgery, such as orthognathic procedures. It includes surgery to correct cleft palate or skeletal deformities. Prior approval is required.

When service or procedure is not eligible:

The Plan provides **no** benefits for the following services unless the subscriber contract specifically allows the benefit:

- Surgical removal of teeth, including removal of wisdom teeth;
- Gingivectomy;
- Tooth implants (including those for the purpose of anchoring oral appliances);
- Care for periodontitis;
- Repair or replacement of damaged dental prosthesis;
- Injury to teeth or gums as a result of chewing or biting;
- Orthodontics including orthodontics performed as adjunct to orthognathic surgery;
- Pre- and post-operative care (we consider most pre-and post-operative visits part of the surgical benefit, so we do not provide additional benefits for these services);
- Procedures designed primarily to prepare the mouth for dentures (including alveolar augmentation, bone grafting, frame implants, ramus mandibular stapling).
- Extraction of soft tissue impacted teeth is not covered.
- Dental care not prior approved by the Plan.
- Out of network services without prior approval for managed care contracts;
- Dental care not specified above under “When the service or procedure is eligible” (including subsequent visits for fitting and adjustment of oral appliances).

Policy- Part B:

The following dental services apply to individuals up to age 21 (and through the end of the Plan year in which a member turns 21), on a qualified health plan product or have the pediatric dental rider:

*Please refer to Attachment I for eligible dental services under this benefit.

Section 1- Diagnostics:

Clinical Oral Evaluation Services-

Clinical oral evaluations recognize the cognitive skills necessary for patient evaluation. The collection and recording of some data and components of the dental examination may be delegated; however, the evaluation, diagnosis and treatment planning are the responsibility of the dentist. As with all procedure codes, there is no distinction made between the evaluations provided by general practitioners and specialists. Providers should report additional diagnostic and/or definitive procedures separately.

Periodic oral evaluation- established patient- An evaluation performed on a patient to determine any changes in the patient's dental and medical health status since a previous comprehensive or periodic evaluation. This includes an oral cancer evaluation and periodontal screening where indicated, and may require interpretation of information acquired through additional diagnostic procedures. Provider should report additional diagnostic procedures separately.

Periodic oral evaluations are limited to one per patient per 180 days. In order to determine medical necessity for additional visits, prior authorization is required.

Limited oral evaluation- problem focused- An evaluation limited to a specific oral health problem or complaint. This may require interpretation of information acquired through additional diagnostic procedures. Definitive procedures may be required on the same day as this evaluation.

Typically, patients receiving this type of evaluation present with a specific problem and/or dental emergencies, trauma, acute infections, etc.

Limited oral evaluations are limited to one per patient per provider per date of service. Additional limited oral evaluations are not covered.

Oral Evaluation for a patient under three years of age and counseling with primary Caregiver- Diagnostic and preventive services performed for a child under the age of three, preferably within the first six months of the eruption of the first primary tooth, including recording the oral and physical health history, evaluation of caries susceptibility, development of an appropriate preventive oral health regimen and communication with and counseling of the child's parent, legal guardian and/or primary caregiver.

Providers cannot bill for oral hygiene instructions (procedure code D1330) on the same date of service as procedure code D0145.

This service is limited to one per patient per 180 days. In order to determine medical necessity for additional evaluations, prior approval is required.

Comprehensive oral evaluation- An evaluation used by a general dentist and/or a specialist when evaluating a patient comprehensively. This applies to new patients; established patients who have had a significant change in health conditions or other unusual circumstances, by report, or established patients who have been absent from active treatment for three or more years. It is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues. This includes an evaluation for oral cancer where indicated, the evaluation and recording of the patient's dental and medical history and a general health assessment. It may include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, existing prostheses, occlusal relationships, periodontal conditions (including periodontal screening and/or charting), hard and soft tissue anomalies, etc.
Additional diagnostic procedures should be reported separately.

Comprehensive oral evaluations are limited to one visit per member per provider per three years. In order to determine medical necessity for additional visits earlier than the three year limit, prior approval is required.

Re-evaluation- Limited, problem focused (established patient; not post- operative visit) - An evaluation to assess the status of a previously existing condition. For example:

- A traumatic injury where no treatment was rendered but patient needs follow-up monitoring;
- Evaluation for undiagnosed continuing pain;
- Soft tissue lesion requiring follow-up evaluation.

This service is NOT to be used for a post-operative visit.

The benefit limit for Re-evaluations is one per member per provider per date of service. Additional re-evaluations are not covered.

Radiographs-

**Intraoral- complete series of radiographic images (including bitewings) - A radiographic survey of the whole mouth, usually consisting of 14-22 periapical and posterior bitewing images intended to display the crowns and roots of all teeth, periapical areas and alveolar bone.

The benefit limit for Intraoral- complete series of radiographic images (including bitewings) is limited to one survey per member per two years. Additional surveys are not covered.

Other images captured with interpretation are eligible based on medical necessity, they include:

- Occlusal radiographic images
- Extraoral radiographic images

- Bitewings (limited to one set per 180 days. To determine medical necessity for additional images, prior approval is required).
- **Panoramic radiographic images (Benefit limited to one set per member per two years).
- Cephalometric radiographic image
- Oral/facial photographic images

This includes photographic images, including those obtained by intraoral and extraoral cameras, excluding radiographic images. These photographic images should be a part of the patient's clinical record.

The benefit limit for Cephalometric film and oral/facial photographic images is one per member per two years. Additional Cephalometric films and oral/facial photographic images are not covered.

We only allow one panoramic set or one Intraoral- complete series (including bitewings) per member per two years, not both. Prior approval is required to determine medical necessity if both panoramic and a complete series are required within a two year period.

Cone Beam CT- Cone Beam CT (CBCT) systems are designed to allow for high resolution imaging of the hard and soft tissues of the maxillofacial region. CBCT allows for short scanning times and radiation doses significantly less than traditional medical scanning techniques[3].

Benefits for cone beam CT may be considered when one through five of the below criteria are met:

1) Prior approval is requested and approved.
2) Clinical documentation must be provided and establish that the services are related to an accidental injury or gross deformity.
3) Interpretation of previous radiographic procedures is submitted.
4) A planned surgery to repair the accidental injury or to correct gross deformity is documented.
5) Demonstration that the cone beam CT is critical to the planned surgical procedure.

We do not provide benefits for cone beam CT for the evaluation of:

1) Oral appliance
2) Temporomandibular joint dysfunction
3) Obstructive sleep apnea

Other diagnostic procedures-

Diagnostic casts/diagnostic models or study models (Benefit limited to one set per member per two years. Additional casts/ models are not covered).

Unspecified diagnostic procedure, by report- A procedure code used for services that are not adequately described by another, more specific code.

[3] *http://www.aaoms.org*

*Medical review is necessary for **all** unlisted/unspecified procedures. See administrative and contractual guidance section for instructions.

Section 2- Preventive Treatment:

Dental prophylaxis- The removal of plaque, calculus and stains from the tooth structures in the permanent and transitional dentition teeth in adults and primary deciduous and transitional dentition teeth in children. It is intended to control local irritational factors.

Dental prophylaxis is limited to one per member per 180 days. To determine medical necessity for additional visits within 180 days, prior authorization is required. Provider must submit clinical documentation describing the need for additional prophylaxes.

Topical Fluoride Treatment- Prescription-strength fluoride product designed solely for use in the dental office. Fluoride is delivered to the dentition under the direct supervision of a dentist or physician. Fluoride must be applied separately from prophylaxis paste.

Topical Fluoride Treatments are limited to one treatment per member per 180 days. To determine medical necessity for additional treatments within 180 days, prior authorization is required.

Topical Fluoride Varnish- Therapeutic application for moderate to high caries risk patients. The application of topical fluoride varnish is delivered in a single visit and involving the entire oral cavity. It is not to be used for desensitization.

Fluoride varnish treatment is recommended only for moderate or high caries risk patients. Risk assessment must be established by the provider. Appropriate pretreatment radiographs indicating presence of decay, existing restorations and missing teeth and indication of recently placed restorations within the last year would indicate risk assessment.

Fluoride varnish applications are limited to one application per member per 180 days. To determine medical necessity for additional treatments within 180 days, prior authorization is required.

Sealants- Mechanically and/or chemically prepared enamel surface sealed to prevent decay.

Benefit limited to one sealant per tooth per five years. Additional sealants on the same tooth are not covered.

Once a sealant is placed, the provider is responsible for the maintenance of that sealant for a period of five years.

Space Maintenance- Space maintainers are passive appliances designed to prevent tooth movement for children who have had premature loss of deciduous teeth. The

space maintainer is utilized to maintain the space until the eruption of the permanent teeth.

Benefit limited to one identical space maintainer per member per two years. Additional space maintainers are not covered.

Section 3- Restorative:

Amalgam Restorations (including polishing) - Tooth preparation, all adhesives (including amalgam bonding agents), liners and bases are included as part of the restoration.

Benefit limited to one identical Amalgam restoration per tooth per two years. Additional amalgam restorations are not covered.

Resin-Based Restorations- Resin-based composite refers to a broad category of materials including but not limited to composites. May include bonded composite, light-cured composite, etc. Tooth preparation, acid etching, adhesives (including resin bonding agents), liners and bases and curing are included as part of the restoration. Glass ionomers, when used as restorations, should be reported with resin-based restorations.

Benefit limited to one identical Resin-based restoration per tooth per two years. Additional resin-based restorations are not covered.

If pins are used for amalgam or resin-based restorations, they may be reported separately.

Crowns (Cast & Prefabricated)-

Crowns are considered medical necessary when the following criteria are met:

When there is evidence of extensive decay or fracture determined by radiographic examination demonstrating that a tooth cannot be restored to normal function by routine restorations (amalgam or composite). Often, a tooth with a large restoration in place will have a portion of the tooth fracture due to thin remaining enamel walls or unsupported cusps in bicuspid or molar teeth. Most often, these fractures are visible on radiographs but the difficulty is determining the extensiveness of the fracture for the necessity for a crown or for another extensive restoration.

Cast crowns require prior approval and have a benefit limit of one crown per tooth per five years.

When Crowns are not covered:

Crown placement is **not** covered for a member with an active periodontal prognosis. Determining the periodontal health of a tooth determines the longevity for a cast crown. A crown placed in the presence of active periodontal disease (periodontal pocketing, alveolar bone erosion and loss, loss of periodontal membrane attachment

fibers) is inappropriate since the longevity for retaining the tooth without periodontal therapy intervention is uncertain. In this situation, the cast crown will be denied pending periodontal therapy.

Crown placement is **not** covered for a member with an active endodontic prognosis. Any evidence of endodontic pathology (thickening of the periapical area or a periapical abscess) will result in a denial of the cast crown pending endodontic therapy.

Crowns for diagnoses considered cosmetic are **not** covered. This includes but not limited to:

- Discolored Teeth
- Teeth out of alignment
- Teeth heavily restored in the front of the mouth
- Replacement of discolored crown
- Closure of diastema or space in teeth
- Crown for the sole purpose of replacing a silver amalgam restoration without medical necessity to do so.

Other restorative procedures -

Protective restoration/ Sedative filling- This is a direct placement of a restorative material to protect tooth and/or tissue form. This procedure may be used to relieve pain, promote healing, or prevent further deterioration. Not to be used for endodontic access closure, or as a base or liner under restoration.

Core buildup, including any pins when required- Core buildup refers to building up of coronal structure when there is insufficient retention for a separate extracoronal restorative procedure. A core buildup is a filler to eliminate any undercut, box form, or concave irregularity in a preparation.

Pin retention- per tooth, in addition to restoration-
Benefit limited to once per tooth per two years. Additional pin retention per tooth is not covered.

Labial veneer (resin laminate) - Chair side- Labial/facial direct resin bonded veneers are restorations utilizing thin shells of resin composite that are bonded to the labial surface of the tooth. They are used to restore the facial surfaces of teeth or to correct defect in tooth size and appearance.

Labial veneers require prior approval and have a benefit limit of one per tooth per five years. Medical necessity determination is reviewed the same as crowns, Please see criteria above.

Unspecified restorative procedure, by report- A restorative procedure code used for services that are not adequately described by another, more specific code.

* Medical review is necessary for **all** unlisted/unspecified procedures. See administrative and contractual guidance section for instructions.

Local anesthesia is considered to be a component of all restorative procedures.

Section 4- Endodontics:

Pulpotomy-

Therapeutic Pulpotomy (excluding final restoration)- removal of pulp coronal to the dentinocemental junction and application of medicament- Pulpotomy is the surgical removal of a portion of the pulp with the aim of maintaining the vitality of the remaining portion by means of an adequate dressing. Pulpotomy is performed on primary or permanent teeth. It is not to be construed as the first stage of root canal therapy and is not meant to be used for apexogenesis.

Pulpal debridement, primary and permanent teeth- This is for the relief of acute pain prior to conventional root canal therapy.

This procedure is not to be performed when endodontic treatment is completed on the same date.

Endodontic therapy of primary teeth- Endodontic therapy is a procedure performed on primary teeth with succedaneous teeth and placement of resorbable filling. This includes pulpectomy, cleaning, and filling of canals with resorbable material.

Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration) - Performed on the primary incisors and cuspids.

Pulpal therapy (resorbable filling)- posterior, primary tooth (excluding final restoration)- Performed on the primary first and second molars.

Benefits for Pulpotomy and Pulpal therapy are limited to one per tooth per lifetime. Additional pulpotomy and pulpal therapy per tooth is not covered.

Endodontic Therapy (Including treatment plan, clinical procedures and follow-up care) - This includes primary teeth without succedaneous teeth and permanent teeth. Complete root canal therapy; pulpectomy is part of root canal therapy. Endodontic therapy includes all appointments necessary to complete treatment and intra-operative radiographs.

Diagnostic evaluation and necessary radiographs/diagnostic images may be billed separately.

Benefits for Endodontic therapy are limited to three teeth per lifetime. Endodontic therapy beyond three teeth per lifetime is not covered.

Endodontic Retreatment is not a covered service.

Apexification/ Recalcification procedures- Apexification is a method of inducing a calcified barrier at the apex of a non-vital tooth with incomplete root formation. Recalcification is the replacement of lost calcium.

Pulp regeneration- Pulpal regeneration is the procedure by which unhealthy pulp tissue can be removed from the inside of an immature (developing) permanent tooth. Medications are placed inside the pulp chamber in order to induce formation of living replacement tissue. This new tissue functions in a similar manner to an uninjured dental pulp by allowing the root of the tooth to continue to develop and grow. When indicated, an advantage of this technique over conventional root canal therapy in children is a stronger tooth that is less likely to weaken or fracture in the future.

Pulp regeneration is restricted to age 16 and under. Prior approval is required for Pulp regeneration. Pre-operative radiographs must accompany the prior approval request.

Apicoectomy/ Periradicular Services- Periradicular surgery is a term used to describe surgery to the root surface (e.g., Apicoectomy), repair of a root perforation or resorptive defect, exploratory curettage to look for root fractures, removal of extruded filling materials or instruments, removal of broken root fragments, sealing of accessory canals, etc.
Apicoectomy/ Periradicular surgery does not include retrograde filling material placement.

Benefits for Apicoectomy procedures are limited to one per tooth per lifetime. Additional Apicoectomy procedures are not covered.

Other Endodontic Procedures -

Surgical procedure for isolation of tooth with rubber dam.

Hemisection (including any root removal), not including root canal therapy. This includes separation of multi-rooted tooth into separate sections containing the root and the overlying portion of the crown. It may also include the removal of one or more of those sections.

Unspecified endodontic procedure, by report- An endodontic procedure code used for services that are not adequately described by another, more specific code.

* Medical review is necessary for **all** unlisted/unspecified procedures. See administrative and contractual guidance section for instructions.

Local anesthesia is considered to be a component of all endodontic procedures.

Section- 5- Periodontics:

Periodontic Surgical Services-

Gingivectomy or gingivoplasty- This service is preformed to eliminate suprabony pockets or to restore normal architecture when gingival enlargements or asymmetrical or unaesthetic topography is evident with normal bony configuration.

Gingival flap procedure- A soft tissue flap is reflected or resected to allow debridement of the root surface and the removal of granulation tissue.

Medical necessity for gingivectomy, gingivoplasty and gingival flap procedures is determined when clinical documentation suggests evidence of periodontal probing of at least 5mm pockets.

Clinical crown lengthening- hard tissue- This procedure is employed to allow restorative procedure or crown with little or no tooth structure exposed to the oral cavity.

Osseous surgery (including flap entry and closure) -This procedure modifies the bony support of the teeth by reshaping the alveolar process to achieve a more physiologic form. This procedure includes the removal of supporting bone (ostectomy) and/or non-supporting bone (osteoplasty).

Medical necessity for osseous surgical procedures is determined when clinical documentation suggests evidence of periodontal probing of 5mm pockets or more. Additionally, radiographic evidence of bone loss or deterioration must be present.

Pedicle soft tissue graft & Free soft tissue graft procedures- A pedicle flap of gingival can be raised from an edentulous ridge, adjacent teeth, or from the existing gingival on the tooth and moved laterally or coronally to replace alveolar mucosa as marginal tissue. The procedure can be used to cover an exposed root or to eliminate a gingival defect if the root is not too prominent in the arch.

Medical necessity is determined by the degree of recession of the gingival tissue and the amount of loss of attachment to the periodontal membrane, all of which should be indicated in periodontal charting.

Documentation including periodontal charting indicating necessity for a pedicle soft tissue graft should accompany a prior approval request.

Local anesthesia is considered to be a component of all periodontal procedures.

Prior approval is required for **all** periodontal surgical services and has a benefit limit of four procedures per member per lifetime. Pretreatment radiographs and current periodontal records are required with the prior approval submission.

Other Periodontal Procedures –

Provisional splinting- An interim stabilization of mobile teeth. A variety of methods and appliances may be employed for this purpose.

Periodontal scaling and root planing- This procedure involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. This procedure is indicated for patients with periodontal disease and is therapeutic, not prophylactic.

Medical necessity for periodontal scaling and root planing are determined by the extensiveness and depth of the calculus by radiographic evidence.

Prior approval is required for **all** periodontal scaling and root planing procedures. Documentation as well as pre-procedural radiographs are required with the prior approval submission and must indicate the need for periodontal scaling and root planing.

Benefits for periodontal scaling and root planing are limited to four quadrants per member per year. Additional periodontal scaling and root planing is not covered.

Full mouth debridement to enable comprehensive evaluation and diagnosis- The gross removal of plaque and calculus that interfere with the ability of the dentist to perform a comprehensive oral evaluation. This preliminary procedure does not preclude the need for additional procedures.

A prophylaxis cannot be completed on the same date of service as a full mouth debridement.

The benefit limit for Full mouth debridement is one per member per three years. Prior approval is required if an additional full mouth debridement is necessary within a three-year period. In order to determine medical necessity, full mouth radiographs are required with the prior approval request.

Periodontal maintenance- A procedure following periodontal therapy and continues at varying intervals. It includes removal of the bacterial plaque and calculus from supragingival and subgingival regions, site specific scaling and root planing where indicated, and polishing the teeth.

The benefit limit for periodontal maintenance is one per member per 180 days. To determine medical necessity for additional maintenance, periodontal charting and radiographs with prior approval is required.

Unspecified periodontal procedure, by report - A periodontal procedure code used for services that are not adequately described by another, more specific code.

*Medical review is necessary for **all** unlisted/unspecified procedures. See administrative and contractual guidance section for instructions.

Section- 6- Removable Prosthodontics:

Complete dentures, immediate dentures and overdentures- Prosthetic devices constructed to replace missing teeth which are supported by surrounding soft and hard tissues of the oral cavity.

A complete lower denture will not be allowed when it will oppose upper natural teeth.

Immediate dentures have a benefit limit of one per arch per lifetime. Additional immediate dentures are not covered. Immediate dentures will only be considered when six or fewer anterior teeth are remaining in the arch. Following the delivery of an immediate denture, a complete denture will not be allowed for a minimum of five years.

An overdenture will only be considered when two or fewer teeth are remaining in the arch. Remaining teeth must be sound and free of decay. Remaining teeth must be periodontally healthy to support an overdenture.

Partial Dentures- A prosthetic device used when one or more natural teeth remain in the upper or lower arch. A fixed (permanent) bridge replaces one or more teeth by placing crowns on the teeth on either side of the space and attaching artificial teeth to them. This "bridge" is then cemented into place. A partial denture fills in the spaces created by missing teeth and it prevents other teeth from changing position.

Prior approval is required for all removable prosthodontics. Full arch radiographs must accompany the prior approval request.

Dentures will not be allowed if existing dentures are serviceable.

Denture Adjustments- Alterations made to a denture through a variety of means to acquire improved comfort and fit.

Denture Repairs- Is the process of reuniting or replacing broken or worn parts of a denture.

Benefits for denture adjustments and repairs are limited to one per denture per 180 days. Additional adjustments and repairs are not covered.

Denture Rebases- Rebasing is a procedure similar to relining except the denture is sent to a laboratory for several days. When the denture is returned to the patient it comes back not only relined, but with all the surrounding plastic above replaced. The only parts of the old denture that remain after a rebase are the teeth.

Denture Relines- Is a procedure where the surface of the denture is modified or replaced with a new lining. The lining is formed to contour to the person's gum line Relining allows for a more secure fit, preventing the dentures from moving around or rubbing painfully against the gums. It also prevents the dentures from breaking prematurely.

Medical necessity for denture rebases and relines will be determined based on evidence of sufficient change in the supporting arch structures of the mouth to cause the denture to be ill-fitting.

Denture rebases and relines have a benefit limit of one per denture per two years and require prior approval. Additional denture rebases and relines are not covered.

Other removable prosthetic services-

Tissue Conditioning- Treatment relines using materials designed to heal unhealthy ridges prior to more definitive final restoration.

Tissue conditioning has a benefit limit of one per denture per two years. Additional tissue conditioning beyond this limit is not covered.

Unspecified removable prosthodontic procedure, by report - A removable prosthodontic procedure code used for services that are not adequately described by another, more specific code. Procedure must be described.

*Medical review is necessary for **all** unlisted/unspecified procedures. See administrative and contractual guidance section for instructions.

Local anesthesia is considered to be a component of all removable prosthodontic procedures.

Section- 7- Fixed Prosthodontics:

Fixed prosthodontics are prosthetic devices such as dental crowns, bridgework, and dental implants that replace missing teeth inside the mouth. Since they are attached to natural teeth or tooth roots for support, fixed prosthodontics are not regularly removed and are used instead of removable dental devices such as dentures and partials.

Fixed Partial Denture Pontics/Retainers-Crowns- An artificial (false) tooth, usually attached to a dental prosthesis that replaces a missing tooth. A dentist may recommend placement of a pontic when a patient's natural tooth is missing due to dental trauma, root resorption, advanced periodontal disease or failed endodontic therapy.

Fixed partial denture Pontics/ Retainer-Crowns require prior approval and have a benefit limit of one per tooth per five years.

Other Fixed partial Denture Services-

Please refer to the procedural coding table below for a list of other fixed partial denture services. Some procedures require prior approval.

Unspecified fixed prosthodontic procedure, by report- A fixed partial prosthodontic procedure code used for services that are not adequately described by another, more specific code. Procedure must be described.

*Medical review is necessary for **all** unlisted/unspecified procedures. See administrative and contractual guidance section for instructions.

Local anesthesia is considered to be a component of all fixed prosthodontic procedures.

Section- 8- Dental Related Oral and Maxillofacial Surgery:

Extractions-

Simple extractions- Are performed on teeth that are visible in the mouth, they require only the use of instruments to elevate and/or grasp the visible portion of the tooth.

Simple extractions of deciduous or erupted teeth include local anesthesia, suturing if needed and routine post operative care. Simple extractions are eligible based on medical necessity.

Surgical extractions- Involves the removal of teeth that cannot be easily accessed, either because they have broken under the gum line or because they have not erupted fully. Surgical extractions almost always require an incision. In a surgical extraction the doctor may also remove some of the overlying and/or surrounding jawbone tissue. Frequently, the tooth may be split into multiple pieces to facilitate its removal.

Coronectomy- A medical procedure to prevent damage to the alveolar nerve during the extraction of the lower third molars (wisdom teeth). The process is a deliberate partial tooth removal and is done when removing the whole tooth is likely to cause neurovascular complications.

Benefit limit for Coronectomy is one tooth per lifetime. Additional Coronectomy are not covered.

Surgical extractions are eligible based on medical necessity.

Surgical extractions and Coronectomy include local anesthesia, suturing if needed and routine post operative care.

Other Surgical Procedures-

Oroantral fistula closure- Excision of fistulous tract between maxillary sinus and oral cavity and closure by advancement flap.

Primary closure of a sinus perforation- Subsequent to surgical removal of tooth, exposure of sinus requiring repair, or immediate closure of Oroantral or oralnasal communication in absence of fistulus tract.

Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth- This procedure includes splinting and stabilization.

Surgical access of an unerupted tooth- An incision is made and the tissue is reflected and bone removed as necessary to expose the crown of an impacted tooth not intended to be extracted.

Mobilization of erupted or malpositioned tooth to aid eruption- Is a procedure to move/dislocate teeth to eliminate stiffening and immobility. An extraction is not done in conjunction with this procedure.

Placement of device to facilitate eruption of impacted tooth- Is the placement of an orthodontic bracket, band or other device on an unerupted tooth, after its exposure, to aid in its eruption.

Surgical Biopsies, Excisions and incisions of Lesions-

Biopsy of oral tissue- A biopsy of oral tissue is the removal of part, or all, of a lesion to enable histopathological examination and definitive diagnosis. Careful handling of the soft tissues is imperative to ensure the pathologist receives a representative sample of the lesion, in order to make an accurate diagnosis. A biopsy of hard (bone, tooth) oral tissue is for the removal of the specimen only. A biopsy of soft oral tissue is for surgical removal of an architecturally intact specimen only[4].

Excisional Biopsy- An excisional biopsy removes the entire lesion and a small margin of normal tissue. It is therefore both curative and diagnostic.

Incision and drainage of abscess- Surgical incision and drainage is a commonly used technique in oral surgery to treat dental infections which have progressed to oral swellings. It involves incision through mucosa, including periodontal origins[5].

Surgical biopsies, excisions and incisions listed in this policy are eligible based on medical necessity.

Harvest of bone for use in autogenous grafting procedure- Also called autografts; these types of grafts are made from the patient's own bone, harvested from elsewhere in the body. Typical harvest sites include the chin, jaw, bone of the lower leg (tibia), hip (iliac crest) or the skull (cranium)[6].

Harvest of bone for use in autogenous grating procedure requires prior approval.

Alveoloplasty- Surgical Preparation of Ridge- Is a procedure to shape the alveolar process using surgical methods. It is done if a person has bony projections, sharp crestal bones or undercuts. This procedure may be done in preparation for prosthesis or other treatments such as radiation therapy and transplant surgery.

Vestibuloplasty- The vestibule can be found in the oral cavity between the cheek and gums. Vestibuloplasty is a surgical procedure where the oral vestibule is deepened by changing the soft tissue attachments .The purpose is to increase the denture

[4] http://www.surgical-dentistry.info/files/Dental_Update_-_The_Surgical_Management_of_the_Oral_Soft_Tissues_-_Biopsy.pdf

[5] http://www.dentistry.utoronto.ca/dpes/oral-maxillofacial-surgery/patients/surgical-incision-and-drainage-patient

[6] http://www.charlotteoralsurgery.com/oral-surgery-charlotte-nc/bone-grafting-charlotte-nc.html

foundation area and improve the quality of the soft tissues available for support. This procedure may be done in preparation for prosthetic implantation[7].

Occlusal orthotic device, by report-
Benefit limit one appliance per member per year. Additional appliances are not covered.

Repair of traumatic wounds-

Simple and complicated suturing excludes closures of surgical incisions.

Complicated suturing involves reconstruction requiring delicate handling of tissues and wide undermining for meticulous closure.

Simple and complicated suturing is eligible based on medical necessity.

Other repair procedures-

Frenulectomy- Is the surgical removal or release of mucosal muscle elements of a buccal, labial or lingual frenum that is associated with a pathological condition, or interferes with proper oral development or treatment.

This is also known as frenectomy or frenotomy- Separate procedure not incidental to another procedure.

Excision of pericoronal gingival- The surgical removal of inflammatory or hypertrophied tissues surrounding partially erupted/impacted teeth.

Surgical reduction of fibrous tuberosity- A tuberosity is a rounded bony protrusion at the back of your last molar located at the upper jaw. It is covered by gum tissue. Through a tuberosity reduction, it will make the tuberosity smaller[8].

Services listed under other repair procedures are eligible based on medical necessity.

Unspecified oral surgery procedure, by report- An oral surgery procedure code used for services that are not adequately described by another, more specific code. Procedure must be described.

*Medical review is necessary for **all** unlisted/unspecified procedures. See administrative and contractual guidance section for instructions.

Unless otherwise specified, services listed under "Other surgical procedures" are eligible based on medical necessity.

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[7] http://www.rightdiagnosis.com/surgery/vestibuloplasty.htm and http://www.ffofr.org/education/lectures/complete-dentures/complete-dentures-reconstructive-preprosthetic-surgery/

[8] http://www.cosmeticdentistryguide.co.uk/articles/tuberosity-reduction.html

Local anesthesia is considered to be a component of all oral and maxillofacial procedures.

Section- 9- Implant Services:

Debridement of a Peri-implant defect and surface cleaning of exposed implant surfaces, including flap entry and closure.

Debridement and osseous contouring of a Peri-implant defect, includes surface cleaning or exposed implant surfaces and flap entry and closure.

Bone graft for repair of Peri-implant defect- Not including flap entry and closure or, when indicated, placement of a barrier membrane or biologic materials to aid in osseous regeneration.

The procedures listed above for Implants services is eligible based on medical necessity. Payment is not implied for the placement of new implants; however, the maintenance of existing implants is supported.

Section- 10- Orthodontics:

Orthodontic treatment listed in this policy may be used more than once for the treatment of a particular member depending on the particular circumstances. A member may require more than one interceptive procedure or more than one limited procedure depending on their particular problem.

1. Orthodontic procedures must be performed by dentists who qualify as orthodontists under their scope of practice and under the Vermont Code of Regulations.

2. Orthodontic procedures may be medically necessary for handicapping malocclusions, cleft palate and facial growth management cases.

3. Medically necessary handicapping malocclusion cases are considered for those with permanent dentition, unless the patient is age 13 or older with primary teeth remaining. Cleft palate and craniofacial anomaly cases for primary, mixed and permanent dentitions may be considered medically necessary.

4. All necessary procedures that may affect orthodontic treatment shall be completed prior to orthodontic treatment.

5. There are six automatic qualifying conditions for medical necessary orthodontics:
    a) Cleft palate deformity. If the cleft palate is not visible on the diagnostic cast, written documentation from a credentialed specialist shall be submitted on their professional letterhead along with the prior authorization request.
    b) Craniofacial anomaly. Written documentation from a credentialed specialist must be submitted on their professional letterhead with the prior authorization request.

c) Deep impinging overbite in which the lower incisors are destroying the soft tissue in the palate.
d) A cross-bite of individual anterior teeth causing destruction of the soft tissue.
e) An over jet greater than 9 mm or reverse over jet greater than 3.5 mm.
f) A severe traumatic deviation (such as a loss of pre-maxilla segment by burns, accident or osteomyelitis or other gross pathology). Written documentation of the trauma or pathology must be submitted with the prior authorization.

6. All other comprehensive orthodontic procedures may be considered for coverage only when submitted diagnostic casts verify a minimum score of 26 points on the Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form, DC016 (06/09).

7. When a member transfers from one orthodontist to another, a new prior authorization must be submitted.

8. When a member has already qualified for the orthodontic program and has been receiving treatment, the balance of the originally authorized treatment shall be authorized to the new orthodontist to complete the case. Diagnostic casts, California Score Sheet Form and photographs are not required for a transfer case that has already been approved. When a member has been receiving orthodontic treatment that has not been previously approved, pre-treatment diagnostic casts and current photographs are required. If pre-treatment casts are not available, then current diagnostic casts must be submitted. Prior authorization for the balance of the orthodontic treatment shall be allowed or denied based on the California Dental Program's evaluation of the diagnostic casts and photographs.

9. When additional periodic orthodontic treatment visits are necessary beyond the maximum allowed to complete the case, prior authorization is required. Current photographs are necessary to justify the necessity.

10. If the member's orthodontic treatment is interrupted and orthodontic bands are prematurely removed, the member no longer qualifies for continued orthodontic treatment.

11. If the member's orthodontic bands have to be removed for medical reasons and then replaced, a claim for re-banding must be submitted along with a letter from the treating physician, on their professional letterhead, stating the reason why the bands had to be removed.

Limited orthodontic treatment- Is an orthodontic treatment procedure with a limited objective, not necessarily involving the entire dentition. It may be directed at the only existing problem, or at only one aspect of a larger problem in which a decision is made to defer or forego more comprehensive therapy.

Interceptive orthodontic treatment- Is an extension of preventive orthodontic treatment procedure that may include localized tooth movement. Such treatment may occur in the primary or transitional dentition and may include such procedure as the redirection of ectopically erupting teeth, correction of dental crossbite or recovery of space loss where overall space is inadequate. When initiated during the incipient sates of a developing problem, interceptive orthodontics may reduce the severity of the malformation and mitigate its cause. Complicating factors such as skeletal disharmonies, overall space deficiency or other condition may require subsequent comprehensive therapy. Interceptive orthodontic procedures involve orthodontic treatment on a minor scale compared to comprehensive orthodontic treatment. It usually involves the movement of a few or less misplaced teeth, for example misplaced teeth causing a minor cross bite. A full scale scoring examination is not necessary. Pre-treatment diagnostic casts and photographs must be submitted with prior approval to determine medical necessity.

Comprehensive orthodontic treatment-
The comprehensive orthodontic treatment procedures report the coordinated diagnosis and treatment leading to the improvement of a patient's craniofacial dysfunction and/or dentofacial deformity which may include anatomical, functional and/or esthetic relationships. Treatment may utilize fixed and/or removable orthodontic appliances and may also include functional and/or orthopedic appliances in growing and non-growing patients. Comprehensive orthodontics may include treatment may incorporate phases focusing on specific objective at various stages of dentofacial development.

Minor treatment to control harmful habits- Appliance therapy to treat thumb sucking and tongue thrusting. Pre-construction diagnostic casts and photographs must be submitted with prior approval to determine medical necessity.

Replacement of lost or broken retainer-

The replacement of a lost or broken retainer is limited to one per patient per arch per lifetime with prior approval. A narrative must be included with the prior approval describing the circumstances regarding the lost or broken retainer and necessity for the replacement of the retainer.

Unspecified orthodontic procedure, by report- An orthodontic procedure code used for services that are not adequately described by another, more specific code. Procedure must be described.

A detailed report must be submitted describing the condition requiring the unspecified orthodontic procedure and the procedure itself. Any supporting evidence, such as diagnostic study models and/or photographs is necessary.

Reimbursement for orthodontic treatment includes all necessary maintenance to and replacement of brackets and wires.

Prior approval is required for **all** Orthodontic procedures.

Section- 11- Adjunctive General Services:

Palliative (emergency) treatment of dental pain- a minor procedure typically reported on a "per visit" basis for emergency treatment of dental pain.

Hospital or ambulatory surgical center call- Care provided outside the dentist's office to a patient who is in a hospital or ambulatory surgical center.

Behavior management - This procedure may be rendered in addition to treatment provided. Behavior management is inclusive when anesthesia is billed on the same date of service.

Mouth guards-

An occlusal mouth guard is a removable dental appliance, which is designed to minimize the effects of bruxism (grinding) and other occlusal factors.

Occlusal analysis and adjustments

Fabrication of athletic mouth guard

Occlusal and athletic mouth guards have a benefit limit of one per member per two years. Additional mouth guards are not covered.

External & Internal bleaching- per tooth.

External & Internal bleaching is almost always a cosmetic procedure. This service requires prior authorization. If it is determined that bleaching is strictly for cosmetic indications, the service will deny as not covered.

Anesthesia- Including inhalation of nitrous oxide/ analgesia, anxiolysis, deep sedation, intravenous conscious sedation/ analgesia, non-intravenous conscious sedation.

General and intravenous anesthesia may be considered medically necessary for some but not all oral surgery and surgical extractions, some instances may include:

- Multiple extractions at the same time (5 or more)
- Multiple surgical extractions at the same time involving 2 lower third molars
- Extraction of an abscessed tooth when local anesthesia would be ineffective
- Extensive restorative work on a child under the age of 7
- Underlying medical conditions necessitating GA or IV Sedation
- Extensive oral surgery procedures, e.g., removal of lateral exostoses or tori

All general and intravenous sedation performed in conjunction with oral surgery procedures, including but not limited to surgical extractions are subject to prior approval.

Unspecified adjunctive procedure, by report- An adjunctive procedure code used for services that are not adequately described by another, more specific code. Procedure must be described.

*Medical review is necessary for **all** unlisted/unspecified procedures. See administrative and contractual guidance section for instructions.

When services are not covered

Services not specifically listed as eligible above.

Member contract exclusion: "Services that are over the limitation or maximum set forth in the member's contract".

Cosmetic procedures are specific exclusion under the subscriber's contract.

The term, "cosmetic and reconstructive procedures" includes procedures ranging from purely cosmetic to purely reconstructive. Benefit application has the potential to be confusing to members because there is an area of overlap where cosmetic procedures may have a reconstructive component and reconstructive procedures may have a cosmetic component. These procedures are categorized and benefits are authorized based upon the fundamental purpose of the procedure. The American Medical Association and the American Society of Plastic Surgeons have agreed upon the following definitions:

- Cosmetic procedures are those that are performed to reshape normal structures of the body in order to improve the patient's appearance and self-esteem.
- Reconstructive procedures are those procedures performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. It is generally performed to improve function, but may also be done to approximate a normal appearance.

In order to be considered medically necessary, the goal of reconstructive surgery must be to correct an abnormality in order to restore physiological function to the extent possible. As such, for reconstructive surgery to be considered medically necessary there must be a reasonable expectation that the procedure will correct or significantly improve a functional deficit*.

*Functional deficit is defined as:
A. Pain or other physical deficit that interferes with activities of daily living; or
B. Impaired physical activity

Administrative and Contractual Guidance

Benefit Determination Guidance

Prior approval is required for many services listed in this policy. Benefits are subject to all terms, limitations and conditions of the subscriber contract.

When submitting for services that require medical review or prior approval, the following Information is necessary

Consideration for prior approval of benefits may be obtained by submitting the following information in writing to the Plan'(s) or delegates' dental management department (see below for address and fax information):

1. Pre-treatment estimate plan, including approximate cost of treatment;
2. History of the problem, if accident related, include the date and the details of accident;
3. X-rays, if available (X-rays will be returned to the sender);
4. If applicable, rationale for requiring hospital based services and anesthesia and;
5. CDT, CPT and/or HCPCS codes that will be submitted.

For members under 21 years of age (and through the end of the Plan year in which a member turns 21), who receive their benefits through a qualified health plan (Part B of this policy & Attachment I) or who have the pediatric dental rider submit the above to:

CBA Blue Dental
P.O. Box 9350
S. Burlington, VT 05407-9350
Fax: 802-864-8115
DentalClaims@cbabluevt.com

For all other individuals and for services not outlined in attachment I, please submit the above to:

Blue Cross and Blue Shield of Vermont
Attn: IHM
PO Box 186
Montpelier, VT 05601
Fax: 802-371-3491

BCBSVT advises dentists and oral surgeons and members to consult the member documents to determine if there are exclusions or other benefit limitations applicable to the service requested. The conclusion that a particular service is medically or dentally necessary does not constitute an indication or warranty that the service requested is a covered benefit payable by BCBSVT.
For NEHP members, an approved authorization may be required. Some dental claims are processed by an intermediary, and therefore not medically managed by BCBSVT. Please verify benefits and authorization requirements with the member's Blue Plan or dental carrier prior to rendering services.

Benefits for FEP members may vary. Please consult the FEP Service Plan Brochure.

If the member receives benefits through a self-funded (ASO) group, benefits may vary or not apply. To verify benefit information, please refer to the member's plan documents or contact the customer service department.

Audit Information

BCBSVT may conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in the medical policy. If an audit identifies instances of non-compliance with this medical policy, BCBSVT may recoup all non-compliant payments.

Eligible Providers

Doctor of dental surgery, DDS
Doctor of dental medicine, DMD

Related Policies

Temporomandibular Joint Disease

Policy Implementation/Update information

06/2013	Policy developed to comply with the Affordable Care Act and the State of VT RFP.
03/2014	Added CDT code: D1110 for adult prophylaxis. Approved by DHVA on 3/21/14 performed on children as young as 13 yrs of age. RLJ.

Approved by BCBSVT Medical Directors Date Approved

Spencer Borden MD
Chair, Medical Policy Committee

Robert Wheeler MD
Chief Medical Officer

Attachment I
CDT Coding Table & Instructions

Code Type	Number	Brief Description	Policy Instructions
The following codes will be considered as medically necessary when applicable criteria have been met.			
CDT	D0120	Periodic oral evaluation- established patient	Prior approval required for more than one visit in 180 days.
CDT	D0140	Limited oral evaluation- problem focused	Limited to one per member per provider per date of service.
CDT	D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	Prior approval required for more than one visit in 180 days.
CDT	D0150	Comprehensive oral evaluation- new or established patient	Limited to one visit per member per provider per three years. Prior approval required if a visit is required earlier than the three year limit.
CDT	D0170	Re-evaluation- limited, problem focused (established patient; not post-operative visit)	Benefit limited of one per member per provider per date of service.
CDT	D0210	Intraoral- complete series of radiographic images (including bitewings)	Benefit limited to one survey per member per two years. *See policy above regarding intraoral-complete series & panoramic images*
CDT	D0220	Intraoral- periapical, first radiographic image	Limited to 6 per date of service. Prior approval required for additional images.
CDT	D0230	Intraoral- periapical, each additional radiographic image	
CDT	D0240	Intraoral- occlusal radiographic image	
CDT	D0250	Extraoral- first radiographic image	

CDT	D0260	Extraoral- each additional radiographic image	
CDT	D0270	Bitewing- single radiographic image	Bitewing radiographs are limited to one set per 180 days. Prior approval required for additional images.
CDT	D0272	Bitewings- two radiographic images	
CDT	D0273	Bitewings- three radiographic images	
CDT	D0274	Bitewings- four radiographic images	
CDT	D0330	Panoramic radiographic image	Benefit limited to one set per member per two years. *See policy above regarding panoramic images & intraoral- complete series*
CDT	D0340	Cephalometric radiographic image	Benefit limited to one per member per two years.
CDT	D0350	Oral/facial photographic images obtained intraorally or extraorally	
CDT	D0364	Cone beam CT capture and interpretation with limited field of view- less than one whole jaw.	Prior approval required *See policy above for instructions*
CDT	D0365	Cone beam CT capture and interpretation with field of view of one full dental arch- mandible.	
CDT	D0366	Cone beam CT capture and interpretation with field of view of one full dental arch- maxilla, with or without cranium	
CDT	D0367	Cone beam CT capture and interpretation with field of view of both jaws; with or without cranium	
CDT	D0368	Cone beam CT capture and interpretation for TMJ series including two or more exposures	
CDT	D0391	Interpretation and diagnostic image by a practitioner not associated with capture of the image, including report	

CDT	D0470	Diagnostic models	Benefit limited to one set per member per two years.
CDT	D0999	Unspecified diagnostic procedure, by report	Medical review required.
CDT	D1110	Prophylaxis- Adult	Prior approval required for more than one visit in 180 days.
CDT	D1120	Prophylaxis- Child	
CDT	D1206	Topical application of fluoride varnish	
CDT	D1208	Topical application of Fluoride	
CDT	D1330	Oral hygiene instructions	Limited to children four years old and younger. Limited to one per year. Prior approval required for additional visits.
CDT	D1351	Sealant- Per Tooth	Benefit limited to one per tooth per five years. Pend a "U9" modifier when submitting claims for the placement of sealants on deciduous second molars and bicuspids.
CDT	D1352	Preventive resin restoration in a moderate to high caries risk patient- permanent tooth	
CDT	D1510	Space maintainer- fixed- unilateral	Benefit limited to one identical space maintainer per member per two years.
CDT	D1515	Space maintainer- fixed- bilateral	
CDT	D1525	Space maintainer- removable- bilateral	

CDT	D1550	Re-cementation of space maintainer	
CDT	D2140	Amalgam-one surface, primary or permanent	Benefit limited to one identical restoration per tooth per two years.
CDT	D2150	Amalgam-two surfaces, primary or permanent	
CDT	D2160	Amalgam-three surfaces, primary or permanent	
CDT	D2161	Amalgam-four or more surfaces, primary or permanent	
CDT	D2330	Resin-based composite- one surface, anterior	
CDT	D2331	Resin-based composite- two surfaces, anterior	
CDT	D2332	Resin-based composite- three surfaces, anterior	
CDT	D2335	Resin-based composite- four or more surfaces or involving incisal angle (anterior)	
CDT	D2390	Resin-based composite crown, anterior	
CDT	D2391	Resin-based composite- one surface, posterior	
CDT	D2392	Resin-based composite-two surfaces, posterior	
CDT	D2393	Resin-based composite- three surfaces, posterior	
CDT	D2394	Resin-based composite- four or more surfaces or involving incisal angle (posterior)	
CDT	D2720	Crown- resin with high noble metal	Prior Approval is required. Cast & Prefabricated crowns are limited to one per tooth per five years.
CDT	D2740	Crown- porcelain/ceramic substrate	
CDT	D2750	Crown- porcelain fused to high noble metal	
CDT	D2751	Crown- porcelain fused to predominantly base metal	
CDT	D2752	Crown- porcelain fused to noble metal	

CDT	D2790	Crown- full cast high noble metal	
CDT	D2791	Crown- full cast predominantly base metal	
CDT	D2792	Crown- full case noble metal	
CDT	D2920	Recement crown	
CDT	D2930	Prefabricated stainless steel crown- primary tooth	
CDT	D2931	Prefabricated stainless steel crown- permanent teeth	
CDT	D2932	Prefabricated resin crown	
CDT	D2933	Prefabricated stainless steel crown with resin window	
CDT	D2940	Protective restoration	
CDT	D2950	Core buildup, including any pins when required	
CDT	D2951	Pin retention- per tooth, in addition to restoration	Benefit limited to once per tooth per two years
CDT	D2952	Post and core in addition to crown, indirectly fabricated	Single unit code
CDT	D2954	Prefabricated post and core in addition to crown	Includes the core material
CDT	D2960	Labial veneer (resin laminate)- Chair side	Prior approval required. Benefit limited to one per tooth per five years.
CDT	D2980	Crown repair necessitated by restorative material failure	
CDT	D2981	Inlay repair necessitated by restorative material failure	
CDT	D2982	Onlay repair necessitated by restorative material failure	
CDT	D2983	Veneer repair necessitated by restorative material failure	
CDT	D2999	Unspecified restorative procedure, by report	Medical review required.
CDT	D3220	Therapeutic pulpotomy	Benefit limited to one per tooth per lifetime.

CDT	D3221	Pulpal debridement, primary and permanent teeth	
CDT	D3230	Pulpal therapy (resorbable filling) Anterior, primary tooth	
CDT	D3240	Pulpal therapy (resorbable filling) Posterior, primary tooth	
CDT	D3310	Endodontic therapy, anterior tooth (excluding final restoration)	Benefit limited to three teeth per lifetime.
CDT	D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	
CDT	D3330	Endodontic therapy, molar (excluding final restoration)	
CDT	D3351	Apexification/ Recalcification- initial visit (apical closure/ calcific repair of perforations, root resorption, pulp space disinfection, etc.)	
CDT	D3352	Apexification/ Recalcification- interim medication replacement	
CDT	D3353	Apexification/ Recalcification- final visit (includes completed root canal therapy- apical closure/ calcific repair of perforations, root resorption, etc.)	
CDT	D3355	Pulpal Regeneration- initial visit	PA required. Restricted to individuals 16 years of age and younger.
CDT	D3356	Pulpal Regeneration- interim medication replacement	PA required. Restricted to individuals 16 years of age and younger.
CDT	D3357	Pulpal Regeneration- completion of treatment	PA required. Restricted to individuals 16 years of age and younger.

CDT	D3410	Apicoectomy- anterior	Benefit limited to one per tooth per lifetime.
CDT	D3421	Apicoectomy- bicuspid (first root)	Benefit limited to one per tooth per lifetime. Report code: D3426 Apicoectomy (each additional root) if treating more than one root.
CDT	D3425	Apicoectomy- molar (first root)	
CDT	D3426	Apicoectomy-each additional root	Use this code when more than one root is treated during the same procedure.
CDT	D3427	Periradicular surgery without apicoectomy	PA required.
CDT	D3430	Retrograde filling- per root	If more than one filling is placed in one root, report as D3999 and describe.
CDT	D3450	Root amputation- per root	Report code: D3920 if the crown is sectioned.
CDT	D3910	Surgical procedure for isolation of tooth with rubber dam	
CDT	D3920	Hemisection (including any root removal), not including root canal therapy.	
CDT	D3999	Unspecified endodontic procedure, by report	Medical review required.
CDT	D4210	Gingivectomy or gingivoplasty- four or more contiguous teeth or tooth bounded spaces per quadrant	Prior approval required. See section #5 above. Benefit limited to four procedures per lifetime.
CDT	D4211	Gingivectomy or gingivoplasty- one to three contiguous teeth or tooth bounded spaces per quadrant	

CDT	D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	
CDT	D4240	Gingival flap procedure, including root planing- four or more contiguous teeth or tooth bounded spaces per quadrant	
CDT	D4241	Gingival flap procedure, including root planing- one to three contiguous teeth or tooth bounded spaces per quadrant	
CDT	D4249	Clinical crown lengthening- hard tissue	
CDT	D4260	Osseous surgery (including flap entry and closure)- four or more contiguous teeth or tooth bounded spaces per quadrant	
CDT	D4261	Osseous surgery (including flap entry and closure)- one to three contiguous teeth or tooth bounded spaces per quadrant	
CDT	D4270	Pedicle soft tissue graft procedure	
CDT	D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft	
CDT	D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site	
CDT	D4320	Provisional splinting- intracoronal	
CDT	D4321	Provisional splinting- extracoronal	

CDT	D4341	Periodontal scaling and root planing- four or more teeth per quadrant	Prior approval is required for all periodontal scaling and root planing procedures. Benefits are limited to four quadrants per member per year.
CDT	D4342	Periodontal scaling and root planing- one to three teeth per quadrant	
CDT	D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	Benefit limited to one per member per three years. Prior approval required if additional treatment is necessary.
CDT	D4910	Periodontal maintenance	Benefit limited to one per member per 180 days. Prior approval required if additional maintenance is necessary.
CDT	D4999	Unspecified periodontal procedure, by report	Medical review required.
CDT	D5110	Complete denture- maxillary	Prior approval required. Benefit limited to one per arch per five years.
CDT	D5120	Complete denture- mandibular	
CDT	D5130	Immediate denture- maxillary	Prior approval required
CDT	D5140	Immediate denture- mandibular	Prior approval required
CDT	D5863	Overdenture- complete maxillary	*out of numeric sequence.* Prior approval required. Benefit limited to one per arch per five years.
CDT	D5865	Overdenture- complete mandibular	
CDT	D5211	Maxillary partial denture- resin base (including any conventional clasps, rests and teeth)	Prior approval required. Benefit limited to one per arch per five years.

CDT	D5212	Mandibular partial denture- resin base (including any conventional clasps, rests and teeth)	
CDT	D5213	Maxillary partial denture- cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	
CDT	D5214	Mandibular partial denture- cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	
CDT	D5410	Adjust complete denture- maxillary	Benefit limited to one per denture per 180 days
CDT	D5411	Adjust complete denture- mandibular	
CDT	D5421	Adjust partial denture- maxillary	
CDT	D5422	Adjust partial denture- mandibular	
CDT	D5510	Repair broken complete denture base	
CDT	D5520	Repair missing or broken teeth- complete denture (each tooth)	
CDT	D5610	Repair resin denture base	
CDT	D5620	Repair cast framework	
CDT	D5630	Repair or replace broken clasp	
CDT	D5640	Replace broken teeth- per tooth	
CDT	D5650	Add tooth to existing partial denture	
CDT	D5660	Add clasp to existing partial denture	
CDT	D5710	Rebase complete maxillary denture	Prior approval is required. Benefit limited to one per denture per two years
CDT	D5711	Rebase complete mandibular denture	
CDT	D5720	Rebase maxillary partial denture	
CDT	D5721	Rebase mandibular partial denture	
CDT	D5750	Reline complete maxillary denture (laboratory)	

CDT	D5751	Reline complete mandibular denture (laboratory)	
CDT	D5760	Reline maxillary partial denture (laboratory)	
CDT	D5761	Reline mandibular partial denture (laboratory)	
CDT	D5850	Tissue conditioning, maxillary	Benefit limited to one per denture per two years
CDT	D5851	Tissue conditioning, mandibular	
CDT	D5899	Unspecified removable prosthodontic procedure, by report	Medical review required.
CDT	D6101	Debridement of a Peri-implant defect and surface cleaning of exposed implant surfaces, including flap entry and closure	Payment is not implied for the placement of new implants; however the maintenance of existing implants is supported.
CDT	D6102	Debridement and osseous contouring of a Peri-implant defect, includes surface cleaning or exposed implant surfaces and flap entry and closure	
CDT	D6103	Bone graft for repair of Peri-implant defect- Not including flap entry and closure or, when indicated, placement of a barrier membrane or biologic materials to aid in osseous regeneration	
CDT	D6210	Pontic- cast high noble metal	Prior approval is required. Benefit limited to one per tooth per five years
CDT	D6211	Pontic- cast predominantly base metal	
CDT	D6212	Pontic- cast noble metal	
CDT	D6240	Pontic- porcelain fused to high noble metal	
CDT	D6241	Pontic-porcelain fused to predominantly base metal	
CDT	D6242	Pontic- porcelain fused to noble metal	

CDT	D6545	Retainer- case metal of resin bonded fixed prosthesis	
CDT	D6750	Crown- porcelain fused to high noble metal	
CDT	D6751	Crown- porcelain fused to predominantly base metal	
CDT	D6752	Crown- porcelain fused to noble metal	
CDT	D6790	Crown- full cast high noble metal	
CDT	D6791	Crown- full cast predominantly base metal	
CDT	D6792	Crown- full cast noble metal	
CDT	D6930	Recement fixed partial denture	
CDT	D6980	Fixed partial denture repair necessitated by restorative material failure	Prior Approval required
CDT	D6985	Pediatric partial denture, fixed	Prior Approval required
CDT	D6999	Unspecified fixed prosthodontic procedure, by report	Medical review required.
CDT	D7111	Extractions, coronal remnants- deciduous tooth	
CDT	D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	
CDT	D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	
CDT	D7220	Removal of impacted tooth- soft tissue	
CDT	D7230	Removal of impacted tooth- partially bony	
CDT	D7240	Removal of impacted tooth- completely bony	

CDT	D7241	Removal of impacted tooth- completely bony, with unusual surgical complications	
CDT	D7250	Surgical removal of residual tooth roots (cutting procedure)	
CDT	D7251	Coronectomy- intentional partial tooth removal	Prior approval required. Limited to one tooth per lifetime
CDT	D7260	Oroantral fistula closure	
CDT	D7261	Primary closure of a sinus perforation	
CDT	D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	
CDT	D7280	surgical access of an unerupted tooth	
CDT	D7282	Mobilization of erupted or malpositioned tooth to aid eruption	
CDT	D7283	Placement of device to facilitate eruption of impacted tooth	Surgical exposure separately reported using D7280
CDT	D7285	Biopsy of oral tissue- hard (bone, tooth)	
CDT	D7286	Biopsy of oral tissue- soft	
CDT	D7295	Harvest of bone for use in autogenous grating procedure	Prior Approval required
CDT	D7310	Alveoloplasty in conjunction with extractions- four or more teeth or tooth spaces, per quadrant	
CDT	D7311	Alveoloplasty in conjunction with extractions- one to three teeth or tooth spaces, per quadrant	
CDT	D7320	Alveoloplasty **NOT** in conjunction with extractions- four or more teeth or tooth spaces, per quadrant	
CDT	D7340	Vestibuloplasty- ridge extension (secondary epithelialization)	

CDT	D7350	Vestibuloplasty- ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	
CDT	D7410	Excision of benign lesion up to 1.25cm	
CDT	D7411	Excision of benign lesion greater than 1.25cm	
CDT	D7412	Excision of benign lesion, complicated	
CDT	D7413	Excision of malignant lesion up to 1.25cm	
CDT	D7414	Excision of malignant lesion greater than 1.25cm	
CDT	D7415	Excision of malignant lesion, complicated	
CDT	D7465	Destruction of lesion(s) by physical or chemical method, by report	*out of numeric sequence.*
CDT	D7440	Excision of malignant tumor- lesion diameter up to 1.25cm	
CDT	D7441	Excision of malignant tumor- lesion diameter greater than 1.25cm	
CDT	D7450	Removal of benign odontogenic cyst or tumor- lesion diameter up to 1.25cm	
CDT	D7451	Removal of benign odontogenic cyst or tumor- lesion diameter greater than 1.25cm	
CDT	D7460	Removal of benign **Non**-odontogenic cyst or tumor- lesion diameter up to 1.25cm	
CDT	D7461	Removal of benign **Non**-odontogenic cyst or tumor- lesion diameter greater than 1.25cm	

CDT	D7471	Removal of lateral exostosis (maxilla or mandible)	
CDT	D7472	Removal of torus palatinus	
CDT	D7473	Removal of torus mandibularis	
CDT	D7485	Surgical reduction of osseous tuberosity	
CDT	D7510	Incision and drainage of abscess-intraoral soft tissue	
CDT	D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	
CDT	D7880	Occlusal orthotic appliance	Benefit limited to one appliance per member per year.
CDT	D7910	Suture of recent small wounds up to 5cm	
CDT	D7911	Complicated suture- up to 5cm	
CDT	D7912	Complicated suture- greater than 5cm	
CDT	D7960	Frenulectomy	
CDT	D7971	Excision of pericoronal gingiva	
CDT	D7972	Surgical reduction of fibrous tuberosity	
CDT	D7999	Unspecified oral surgery procedure, by report	Medical review required.
CDT	D8010	Limited orthodontic treatment of the primary dentition	Prior Approval required. Please place a "U" to indicate upper and an "L" to indicate lower in the "surface" section of the claim form.
CDT	D8020	Limited orthodontic treatment of the transitional dentition	
CDT	D8030	Limited orthodontic treatment of the adolescent dentition	
CDT	D8040	Limited orthodontic treatment of the adult dentition	

CDT	D8050	Interceptive orthodontic treatment of the primary dentition	
CDT	D8060	Interceptive orthodontic treatment of the transitional dentition	
CDT	D8070	Comprehensive orthodontic treatment of the transitional dentition	
CDT	D8080	Comprehensive orthodontic treatment of the adolescent dentition	
CDT	D8090	Comprehensive orthodontic treatment of the adult dentition	
CDT	D8210	Removable appliance therapy	
CDT	D8220	Fixed appliance therapy	
CDT	D8692	Replacement of lost or broken retainer	
CDT	D8999	Unspecified orthodontic procedure, by report	
CDT	D9110	Palliative (emergency) treatment of dental pain- minor procedure	
CDT	D9220	Deep sedation/ general anesthesia- first 30 minutes	Prior approval required
CDT	D9221	Deep sedation/ general anesthesia- each additional 15 minutes	Prior approval required
CDT	D9230	Inhalation of nitrous oxide/ analgesia, anxiolysis	
CDT	D9241	Intravenous conscious sedation/ analgesia- first 30 minutes	Prior approval required
CDT	D9242	Intravenous conscious sedation/ analgesia- each additional 15 minutes	Prior approval required
CDT	D9248	Non-Intravenous conscious sedation	
CDT	D9420	Hospital or ambulatory surgical center call	
CDT	D9920	Behavior management	Report in 15 minute increments.

CDT	D9940	Occlusal guard, by report	Benefit Limited to one per member per two years.
CDT	D9941	Fabrication of athletic mouth guard	
CDT	D9950	Occlusal analysis- mounted case	
CDT	D9951	Occlusal adjustment- limited	
CDT	D9952	Occlusal adjustment- complete	
CDT	D9974	Internal bleaching- per tooth	Prior Approval required.
CDT	D9999	Unspecified adjunctive procedure, by report	Medical review required.
Type of Service		Dental, Oral Surgery	
Place of Service		Office, Outpatient	