

Liberty Dental Plan Criteria and Guidelines

(Revised 12-7-09)

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The standards in this section are partially based on respected dental organizations such as the American Dental Association (Dental Practice Parameters), the American Academy of Periodontology and the California Dental Association (Guidelines for the Assessment of Clinical Quality and Professional Performance). In addition, this Criteria was critiqued by a peer-based panel of licensed dentists. The procedure codes and nomenclature in this section of the Provider Reference Guide are from Current Dental Terminology, CDT 2009/2010, copyright the American Dental Association. This section of the Provider Reference Guide contains Liberty Dental Plan's Clinical Criteria and Guidelines. All enrollee benefits are subject to their specific plan designs.

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CLINICAL DENTISTRY GUIDELINES

New Patient Information

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

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- g. Disorders of the immune system, including HIV status/AIDS
- h. Other viral diseases
- h. Musculoskeletal system, including prosthetic joints and when they were placed
- 10. Pregnancy
 - a. Document the name of the patient's obstetrician and estimated due date.
 - b. Follow current guidelines in the *ADA* publication, *Women's Oral Health Issues*.
- 11. History of cancer, including radiation or chemotherapy
- 12. The medical history form must be signed and dated by the patient or patient's parent or guardian.
- 13. Dentist's notes following up patient comments, significant medical issues and/or consultation with a physician should be documented on the medical history form or in the progress notes.
- 14. Medical alerts for significant medical conditions must be uniform and conspicuously located on a portion of the chart used and visible during treatment and should reflect current conditions.
- 15. The dentist must sign and date all baseline medical histories after review with the patient.
- 16. The medical history should be updated at appropriate intervals, dictated by the patient's history and risk factors, and must be done at least annually and signed by the patient and dentist.

Baseline Clinical Evaluation Documentation

- A. Observations of the initial evaluation are to be recorded in writing and charted graphically where appropriate, including missing or impacted teeth, existing restorations, prior endodontic treatment(s), fixed and removable appliances.
- B. Assessment of TMJ status (necessary for adults) and/or classification of occlusion (necessary for minors) should be documented.
- C. Full mouth periodontal probing and diagnosis must be documented, including an evaluation of bone levels, gingival recession, inflammation, etiologic factors (e.g., plaque and calculus), mobility, and furcation involvements.
- D. A soft tissue/oral cancer examination of the lips, cheeks, tongue, gingiva, oral mucosal membranes, pharynx and floor of the mouth must be documented.
- E. Periodontal evaluations and oral cancer screenings should be updated at appropriate intervals, dictated by the patient's history and risk factors, and must be done at least annually.

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Radiographs

- A. An attempt should be made to obtain any recent radiographs from the previous dentist.
- B. An adequate number of initial radiographs should be taken to make an appropriate diagnosis and treatment plan, per current FDA/ADA radiographic guidelines.
- C. D0210 Intraoral – complete series (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. *CDT 2009/2010, page 7.*

Benefits for this procedure are determined within each plan design.

Any combination of covered radiographs that meets or exceeds a provider's fee for a complete series will be adjudicated as a complete series, *for benefit purposes only.*

In addition, any panoramic film taken in conjunction with periapical and/or bitewing radiograph(s) will be considered as a complete series, *for benefit purposes only.*

- D. Decisions about the types of recall films should also be made by the dentist and based on current FDA/ADA radiographic guidelines, including the complexity of previous and proposed care, caries, periodontal susceptibility, types of procedures and time since the patient's last radiographic examination.
- E. A panoramic radiograph is a screening film and is not a substitute for periapical and/or bite wing radiographs when a dentist is performing a comprehensive evaluation.
- F. Diagnostic radiographs should reveal contact areas without cone cuts or overlapping, and periapical films should reveal periapical areas and alveolar bone.
- G. Radiographs should exhibit good contrast
- H. Diagnostic digital radiographs should be printed on photographic quality paper and exhibit good clarity and brightness.
- I. Recent radiographs must be mounted, labeled left/right and dated
- J. Any patient refusal of radiographs should be documented
- K. X-ray duplication fee

When a patient is transferred from one provider to another, diagnostic copies of all x-rays less than two years old should be duplicated for the second provider.

If the transfer is initiated by the provider, the patient may not be charged any X-ray duplication fees.

If the transfer is initiated by the patient, many plans allow the provider to charge for the actual cost of copying the X-rays up to a maximum fee of \$25.

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NOTE: X-ray duplication fees may not be allowed. Refer to specific plan designs.

Prevention

Preventive dentistry may include clinical tests, dental health education and other appropriate procedures to prevent caries and/or periodontal disease.

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

- patient education in oral hygiene and dietary instruction
- periodic evaluations and prophylaxis procedures
- topical or systemic fluoride treatment
- sealants

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

- oral and systemic health information
- oral hygiene and dietary instructions
- prophylaxis procedures on a regular basis
- occlusal evaluation
- correction of malocclusion and malposed teeth
- restoration and/or replacement of broken down, missing or deformed teeth

C. D1110 and D1120 – prophylaxis procedures

Plan policy- Procedure D1110 applies to patients who are 14 years old and older.

Plan Policy - Procedure D1120 applies to patients who are 13 years old and younger.

D. D1203 and D1204 – topical application of fluoride procedures

Plan Policy - Procedure D1203 applies to patients who are 13 years old and younger.

Plan Policy - Procedure D1204 applies to patients who are 14 years old and older.

E. Other areas of prevention may include:

- smoking cessation programs
- discontinuing the use of smokeless tobacco
- good dietary and nutritional habits for general health

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- elimination of mechanical and/or chemical factors that cause irritation
- space maintenance in children where indicated for prematurely lost posterior teeth

F. Recognizing medical conditions that may contribute to or precipitate the need for additional prophylaxis procedures, supported by the patient's physician

Treatment Planning

- A. Treatment plans should be comprehensive and documented in ink.
- B. Treatment plans should be consistent with the clinical evaluation findings and diagnosis.
- C. Procedures should be sequenced in an order of need consistent with diagnostic and evaluation findings and in compliance with accepted professional standards. Normal sequencing would include relief of pain, discomfort and/or infection, treatment of extensive caries and pulpal inflammation including endodontic procedures, periodontal procedures, restorative procedures, replacement of missing teeth, prophylaxis and preventive care and establishing an appropriate recall schedule.
- D. Informed Consent Process
- a. Dentists must document that all recommended treatment options have been reviewed with the patient and that the patient understood the risks, benefits, alternatives, expectancy of success, the total financial responsibilities for all proposed procedures.
 - b. In addition, the patient should be advised of the likely results of doing no treatment.
 - c. Appropriate informed consent documentation must be signed and dated by the patient and dentist for the specific treatment plan that was accepted.
 - d. If a patient refuses recommended procedures, the patient must sign a specific "refusal of care" document.

E. Poor Prognosis

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

When providers recommend endodontic, periodontal or restorative procedures (including crown lengthening), they should take into account and document the anticipated prognosis, restorability and/or maintainability of the tooth or teeth involved.

Liberty's licensed dental consultants adjudicate prognosis determinations for the above procedures on a case-by-case basis.

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

- F. Some upgraded procedures (i.e. metals and porcelain on molars) may not be covered.

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- G. If more than one procedure would be considered appropriate in treating a dental condition, the Alternate Treatment Plan Formula should be utilized and presented: This Formula credits the patient's benefited procedure against the cost of the alternative procedure and the patient's responsibility is calculated as follows: The usual total cost of the alternate treatment minus (–) the usual cost of the covered procedure plus (+) any listed copayment for the covered procedure.
- H. If the dentist recommends or the patient chooses between two covered procedures, the chosen procedure would be covered. Example: if an extraction is agreed to instead of an endodontic procedure, the extraction would be covered.
- I. Alternative treatment plans and options should be documented with a clear and concise indication of the treatment the patient has chosen. In such cases, the Alternate Treatment Plan Formula should be presented and documented.
- J. Should a dentist not agree with a procedure requested by a patient, the dentist may decline to provide the procedure and request that the patient be transferred. In such cases, the dentist is responsible for completion of treatment-in-progress and emergencies until the transfer request is effective.
- K. Consultations, referrals and their results should be documented.

Progress Notes

- A. Progress notes constitute a legal record and must be detailed, legible and in ink.
- B. All entries must be signed or initialed and dated by the person providing treatment.
- C. Entries may be corrected, modified or lined out, but require the name of the person making any such changes and the date.
- D. The names and amounts of all local anesthetics must be documented, including the amount of any vasoconstrictor present. If no local anesthetic is used for a procedure that normally requires it (i.e. scaling and root planing), the related rationale should be documented.
- E. All prescriptions must be documented in the progress notes or copies kept in the chart, including the medication, strength, amount, directions and number of refills.
- F. Copies of all lab prescriptions should be kept in the chart.
- G. For paperless dental records, computer entries cannot be modified without identification of the person making the modification and the date of the change.

Endodontics

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

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1. Diagnostic techniques used when considering possible endodontic procedures may include an evaluation of:
 - a. Pain and the stimuli that induce or relieve it by the following tests:
 - i. Thermal
 - ii. Electric
 - iii. Percussion
 - iv. Palpation
 - v. Mobility
 - b. Non-symptomatic radiographic lesions
2. Treatment planning for endodontic procedures may include consideration of the following:
 - a. Strategic importance of the tooth or teeth
 - b. Prognosis – endodontic procedures for teeth with a guarded or poor 5-year prognosis (endodontic, periodontal or restorative) are not covered
 - c. Presence and severity of periodontal disease
 - d. Restorability and tooth fractures
 - e. Excessively curved or calcified canals
 - f. Following an appropriate informed consent process, if a patient elects to proceed with a procedure that is not covered, the member is responsible for the dentist's usual fee. The dentist should have the member sign appropriate informed consent documents and financial agreements.
 - g. Teeth that are predisposed to fracture following endodontic treatment should be protected with an appropriate restoration; most posterior teeth should be restored with a full coverage restoration.
 - h. Occlusion
3. Clinical Guidelines
 - a. Diagnostic pre-operative radiographs of teeth to be endodontically treated must reveal all periapical areas and alveolar bone.
 - b. A rubber dam should be used and documented (radiographically or in the progress notes) for most endodontic procedures. Documentation is required for any inability to use a rubber dam.
 - c. Gutta percha is the endodontic filling material of choice and should be densely packed and sealed. All canals should be obturated.
 - d. Post-operative radiograph(s), showing all canals and apices, must be taken immediately after completion of endodontic treatment.
 - e. In the absence of symptoms, post-operative radiographs should be taken at appropriate periodic intervals.
4. Endodontic referral necessity?

In cases where a defect or decay is seen to be “approaching” the pulp of a tooth and the need for endodontic treatment is not clear, Liberty expects the general dentist to proceed with the decay removal and possible temporization prior to any referral to an endodontist.

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5. Endodontic Irrigation

Providers are contractually obligated to charge no more than the listed copayment for covered root canal procedures whether the dentist uses BioPure, diluted bleach, saline, sterile water, local anesthetic and/or any other acceptable alternative to irrigate the canal.

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

Note regarding inappropriate unbundling/coding for endodontic irrigation:

D9630 – Providers should not use this procedure code when reporting endodontic irrigation (BioPur).

The American Dental Association states that: “This procedure code would be used for material dispensed for home use, not to report drugs or medicaments used in the dental office.” *CDT 2009/2010, page 174*

6. D3331 treatment of root canal obstruction; non-surgical access

Liberty Dental Plan acknowledges that procedure D3331 is a separate, accepted procedure code. However, this additional treatment is not automatically needed to complete every endodontic procedure. In addition, this procedure should not be submitted with endodontic retreatment procedures D3346, D3347 or D3348.

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

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

7. Pulpotomy

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

b. Apexification may be indicated in a permanent tooth when there is evidence of a vital and normal pulp with an incompletely developed root or roots to allow maturation and

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completion of the root apex. Endodontic treatment should be completed when the root is fully formed.

8. Pulp Cap
 - a. This procedure is not to be used for bases and liners
 - b. Direct pulp capping is indicated for mechanical or accidental pulp exposures in relatively young teeth and may be indicated in the presence of a small, exposed vital or normal pulp
 - c. Indirect pulp capping (re-mineralization) is indicated to attempt to minimize the possibility of pulp exposure in very deep caries in vital teeth
9. Endodontic surgical treatment should be considered only in special circumstances, including:
 - a. The root canal system cannot be instrumented and treated non-surgically
 - b. There is active root resorption
 - c. Access to the canal is obstructed
 - d. There is gross over-extension of the root canal filling
 - e. Periapical or lateral pathosis persists and cannot be treated non-surgically
 - f. Root fracture is present or strongly suspected
 - g. Restorative considerations make conventional endodontic treatment difficult or impossible
10. Endodontic procedures may not be covered when a tooth or teeth have a poor prognosis due to:
 - a. untreated or advanced periodontal disease
 - b. gross destruction of the clinical crown and/or root decay at or below the alveolar bone
 - c. a poor crown/root ratio

Oral Surgery

- A. Each dental extraction should be based on a clearly recorded diagnosis for which extraction is the treatment of choice of the dentist and the patient.
- B. General dentists are expected to provide routine oral surgery, including:
 1. uncomplicated extractions
 2. routine surgical extractions
 3. incision and drainage of intra-oral abscesses
 4. minor surgical procedures and postoperative services
- C. Extractions may be indicated in the presence of non-restorable caries, untreatable periodontal disease, pulpal and periapical disease not amendable to endodontic therapy, to facilitate surgical removal of a cyst or neoplasm, or when overriding medical conditions exist, providing compelling justification to eliminate existing or potential sources of oral infection.
- D. When teeth are extracted, all portions of the teeth should be removed. If any portion of a tooth (or teeth) is not removed, patient notification must be documented.

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- E. Local anesthesia is preferred in the absence of specific indications for the use of general anesthesia.
- F. Minor contouring of bone and soft tissues during a surgical extraction is considered to be a part of and included in a surgical extraction, D7210.
- G. Bone grafting (D7953) for ridge preservation may be indicated in preparation for implant placement or where alveolar contour is critical to planned prosthetic reconstruction.
- H. Documentation of a surgical procedure should include: recording the tooth number, tissue removed and a description of the surgical method used; a record of unanticipated complications such as: failure to remove planned tissue/root tips; displacement of tissue to abnormal sites; unusual blood loss; presence of lacerations and other surgical or non-surgical defects.
- I. Third molar extractions & benefit determinations

Liberty's licensed dental consultants adjudicate benefits on a case-by-case basis.

It is appropriate to report procedure D7220, D7230, D7240 or D7241 for the removal of an impacted tooth, with active pathology.

"Impacted tooth: An unerupted or partially erupted tooth that is positioned against another tooth, bone, or soft tissue so that complete eruption is unlikely." *CDT 2009/2010, page 204*

The prophylactic removal of a tooth or teeth that appear to exhibit an unimpeded path of eruption and/or exhibit no active pathology is not covered.

The removal of third molars, or any other tooth, where pathology such as infection, non-restorable carious lesions, cysts, tumors, and damage to adjacent teeth is evident may be covered.

The extraction of third molars based on general and inconclusive findings such as crowding, headaches, pressure, earaches, or natural pains associated with eruption is not covered. The removal of asymptomatic, unerupted, third molars in the absence of active pathology may not be covered. By definition, completely covered and unerupted third molars cannot exhibit pericoronitis.

- J. All suspicious lesions should be biopsied and examined microscopically.
- K. D9220 – deep sedation / general anesthesia

When D9220 is listed as a covered procedure, benefits may be approved in conjunction with the following approved impaction extractions: D7230, D7240 and D7241.

Licensed dental consultants adjudicate D9220 benefits for other, simpler extractions on a case-by-case basis, with consideration for:

1. medical necessity and/or special needs patients
2. the extent and/or number of infected teeth
3. alveoloplasty and/or procedures involving the excision of bone

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L. D7953 bone replacement graft for ridge preservation – per site

“Osseous autograft, allograft or non-osseous graft is placed in an extraction site at the time of the extraction to preserve ridge integrity (e.g., clinically indicated in preparation for implant reconstruction or where alveolar contour is critical to planned prosthetic reconstruction). *CDT 2009/2010, page 64*”

Code D7953 should be reported when the bone graft is placed in an extraction site at the time of the extraction to preserve ridge integrity.” (See above for indications.) *CDT 2009/2010, page 169*

M. D4263 bone replacement graft – first 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 lead to a deformity of the bone...”. *CDT 2009/2010, page 25*

“Code D4263 should be reported when the bone graft is performed to stimulate periodontal regeneration when the disease process has led to deformity of the bone around an existing tooth.” *CDT 2009/2010, page 169*

Note: Benefits for bone graft procedures are based on individual plan designs, including limitations and exclusions.

Periodontics

All children, adolescents and adults should be evaluated for evidence of periodontal disease. If pocket depths do not exceed 3 mm and there is no bleeding on probing or evidence of radiographic bone loss, it is appropriate to document the patient’s periodontal status as being within normal limits (WNL).

Comprehensive oral evaluations should include the quality and quantity of gingival tissues. Additional components of the evaluation would include documenting: six-point periodontal probing for each tooth, the location of bleeding, exudate, plaque and calculus, significant areas of recession, mucogingival problems, mobility, open or improper contacts, furcation involvement, and occlusal contacts or interferences. Following the completion of a comprehensive evaluation, a diagnosis and treatment plan should be completed.

Periodontal treatment sequencing:

A. D4355 - 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.” *CDT 2009/2010, page 28*

In most cases, this procedure would be followed by the completion of a comprehensive evaluation at a subsequent appointment. This rescheduling may allow some initial soft tissue response and shrinkage prior to performing full mouth periodontal probing.

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Note, this procedure:

1. must be supported by radiographic evidence of heavy calculus
2. is not a replacement code for procedure D1110
3. is not appropriate on the same day as procedure D0150 or D0180

B. D4341/D4342 - Scaling and root planing

Treatment involves the instrumentation of the crown and root surfaces of the teeth to remove plaque, calculus, biofilm and stains from these surfaces. The absence of calculus should be evident on post treatment radiographs. These procedures are:

- considered to be within the scope of a general dentist or a dental hygienist
- supported when full mouth periodontal pocket charting demonstrates at least 4 mm pocket depths. It is common for radiographs to reveal evidence of bone loss and/or the presence of interproximal calculus.
- Scaling and root planing procedures (D4341/D4342) are generally not performed in the same quadrants or areas for 2 years following initial completion of these services. In the interim, any localized scaling and root planning would be included within periodontal maintenance procedure D4910.

Definitive or Pre-Surgical scaling and root planing:

1. For early stages of periodontal disease, this procedure is used as definitive treatment and the patient may not need to be referred to a periodontist based upon tissue response and the patient's oral hygiene.
2. For later stages of periodontal disease, the procedure may be considered pre-surgical treatment and the patient may need to be referred to a periodontist, again based on tissue response and the patient's oral hygiene.

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

Two quadrants per appointment

Periodontal scaling and root planing is arduous and time consuming, involving instrumentation of the crown and root surfaces of the teeth to remove plaque, calculus, and stains from these surfaces.

As a guideline, Liberty Dental Plan benefits only two quadrants per appointment. If a clinician recommends and/or completes more than two quadrants per appointment, documentation supporting the additional quadrant(s) must be included in the patient's records and/or progress notes.

- Local anesthesia is commonly used. If it is not used, the reason(s) should be documented. The use of topical anesthetics is considered to be a part of and included in this procedure.
- Home care oral hygiene techniques should be introduced and demonstrated.

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- A re-evaluation following scaling and root planing should be performed. This re-evaluation should be performed at least 4-6 weeks later and include: a description of tissue response; pocket depths changes; sites with bleeding or exudate; evaluation of the patient's homecare effectiveness.

D1110 and D4341

It is usually not appropriate to perform D1110 and D4341 on the same date of service. Liberty's licensed dental consultants may review documented rationale for any such situations on a case-by-case basis.

- Adjunctive localized delivery antimicrobial agents may be used selectively for several residual pockets depths of at least 5 mm's, at least four weeks after completion of scaling and root planing.
- It may be appropriate to bypass scaling and root planing in certain limited circumstances and proceed directly to surgical treatment such as in the presence of severe acute infection, or where direct visualization of deep root areas is needed.
- Periodontal maintenance at regular intervals should be instituted following scaling and root planing if the periodontal condition has improved to a controllable level. Periodontal pocket depths and gingival status should be recorded periodically.
- The patient's homecare compliance and instructions should be documented.

Irrigation, periodontal/D4999 - by report

If an enrollee elects not to have elective irrigation with other procedures (i.e. D1110, D4355, D4341, D4342 or D4910), contracted dentists may not limit the enrollee's access to other benefited procedures.

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

Notes on appropriate coding:

D4999 – The American Dental Association recommends using this generic procedure code when reporting irrigation (chlorhexidine). *CDT 2009/2010, page 158*

D9630 – The American Dental Association implies that providers should not use this procedure code when reporting irrigation (chlorhexidine).

"This procedure code would be used for material dispensed for home use, not to report drugs or medicaments used in the dental office." *CDT 2009/2010, page 174*

D4381 Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report

Benefits are not available when D4381 is performed with D4341 or D4342 in the same quadrant on the same date of service.

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Dentists may consider the appropriate use of local delivery antimicrobials for chronic periodontitis patients as an adjunct to procedures D4341/D4342 (scaling and root planing) AFTER the following steps*:

1. A clinician has completed D4341/D4342 and allowed a minimum 4-week healing period. Then, the patient's pockets are re-probed and re-evaluated to determine the clinical response to the scaling and root planing.
2. Re-evaluation confirms that several teeth were non-responsive to scaling and root planing, with localized residual pocket depths of 5 mm's or deeper plus inflammation.

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

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

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

- Multiple teeth with pocket depths of 5 mm's or deeper exist in the same quadrant
- Procedure D4381 was completed at least 4-weeks after D4341 but a re-evaluation of the patient's clinical response confirms that D4381 failed to control periodontitis (i.e. a reduction of localized pocket depths)
- Anatomical defects are present (i.e. intrabony defects)

* *American Academy of Periodontology Statement on Local Delivery of Sustained or Controlled Release Antimicrobials as Adjunctive Therapy in the Treatment of Periodontitis. May, 2006*

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

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

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

C. Periodontal surgical procedures

- The patient must exhibit a willingness to accept periodontal treatment and practice an appropriate oral hygiene regimen prior to consideration for periodontal surgical procedures.
- Case history, including patient motivation to comply with treatment and oral hygiene status, must be documented.
- Patient motivation may be documented in a narrative by the attending dentist and/or by a copy of patient's progress notes documenting patient follow through on recommended regimens.
- In most cases, there must be evidence of scrupulous oral hygiene for at least three months prior to the pre-authorization for periodontal surgery.

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- Consideration for a direct referral to a periodontist would be considered on a by report basis.
- Periodontal surgical procedures are covered only in cases that exhibit a favorable long-term prognosis. Surgical procedures for the retention of teeth that are being used as prosthetic abutments is covered only when the teeth would exhibit adequate bone support for the forces to which they are, or will be, subjected.
- Periodontal pocket reduction surgical procedures may be covered in cases where the pocket depths are 5 mm's or deeper, following soft tissue responses to scaling and root planing.
- Osseous surgery procedures may not be covered if:
 1. pocket depths are 4 mm's or less and appear to be maintainable by non-surgical means (i.e. periodontal maintenance and root planing)
 2. patients are smokers or diabetics who's disease is not being adequately managed
- Periodontal pocket reduction surgical procedures should result in the removal of residual calculus and granulation tissue with improved physiologic form of the gingival tissues.
- Osseous surgery and regenerative procedures should also correct and reshape deformities in the alveolar bone where indicated.
- Soft tissue gingival grafting should be done to correct gingival deficiencies where appropriate.

D4249 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. Crown lengthening requires reflection of a flap and is performed in a healthy periodontal environment, as opposed to osseous surgery, which is performed in the presence of periodontal disease. Where there are adjacent teeth, the flap design may involve a larger surgical area.” *CDT 2009/2010, page 25*

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

- D. Periodontal maintenance and supportive therapy intervals should be individualized, although three month recalls are common for many patients.

Restorative

Diagnosis and Treatment Planning

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

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Restorative treatment must be identified using valid procedure codes as found in the current edition of the American Dental Association's Current Dental Terminology (CDT). This source includes nomenclature and descriptors for each procedure code.

Sequencing of treatment must be appropriate to the needs of the patient. Treatment results, including margins, contours and contacts, should be clinically acceptable. The long-term prognosis should be good (5 years or more). Guidelines for the Assessment of Clinical Quality and Professional Performance and standards set by the specialty boards shall apply.

- A. Restorative dentistry includes the restoration of hard tooth structure lost as a result of caries, fracture, erosion, attrition, or trauma.
- B. Restorative procedures in operative dentistry include amalgam, composites, inlays, onlays, crowns, as well as the use of various temporary materials.

Amalgam fillings, safety & benefits

American Dental Association Statement: Food and Drug Administration Action on Dental Amalgam

“WASHINGTON, July 28, 2009—The American Dental Association (ADA) agrees with the U.S. Food and Drug Administration's (FDA) decision not to place any restriction on the use of dental amalgam, a commonly used cavity filling material...

Dental amalgam is a cavity-filling material made by combining mercury with other metals such as silver, copper and tin. Numerous scientific studies conducted over the past several decades, including two large clinical trials published in the April 2006 Journal of the American Medical Association, indicate dental amalgam is a safe, effective cavity-filling material for children and others. And, in its 2009 review of the scientific literature on amalgam safety, the ADA's Council on Scientific Affairs reaffirmed that the scientific evidence continues to support amalgam as a valuable, viable and safe choice for dental patients...”

Amalgam free dental offices - If a dentist chooses not to provide amalgam fillings, alternative posterior fillings must be made available for Liberty patients. Any listed amalgam copayments would still apply.

Any alleged “allergies” to silver amalgam fillings must be supported in writing from a physician who is a board certified allergist. Any benefit issues related to dental materials and “allergies” will be adjudicated on a case-by-case basis by a licensed Liberty Dental Plan dentist consultant.

- C. The choice of restorative materials depends on the nature and extent of the defect to be restored, location in the mouth, stress distribution expected during mastication and esthetic requirements.
 - i. The procedures of choice for treating caries or the replacement of an existing restoration not involving or undermining the cusps of posterior teeth is generally amalgam or composite.
 - ii. The procedures of choice for treating caries or the replacement of an existing restoration not involving or undermining the incisal edges of an anterior tooth is composite.

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- iii. Restorations for chipped teeth may be covered.
- iv. The replacement of clinically acceptable amalgam fillings with an alternative materials (composite, crown, etc.) is considered cosmetic and is not covered.
- v. Restorative procedures for teeth exhibiting a poor prognosis due to gross carious destruction of the clinical crown at/or below the bone level, advanced periodontal disease, untreated periapical pathology or poor restorability are not covered.
- vi. Pulpotomies and pre-formed crowns for primary teeth are covered only if the tooth is expected to be present for at least six months.
- vii. For posterior primary teeth that have had extensive loss of tooth structure, the appropriate treatment is generally a prefabricated stainless steel crown or for anterior teeth, a stainless steel or prefabricated resin crown.
- viii. When incisal edges of anterior teeth are undermined because of caries or replacement of a restoration undermining the incisal edges or a fracture, the procedures of choice may be veneers or crowns, either porcelain fused to metal or porcelain/ceramic substrate.
- ix. An onlay should be considered when there is sufficient tooth structure, but cusp support is needed. An inlay is usually not a restoration of choice.
- x. An inlay is usually not a restoration of choice.

Preventive Resin Restorations

There is no accepted *CDT procedure code* for Preventive Resin Restorations. Such restorations must be reported as one of the following *CDT procedures*:

D1351 sealant – per tooth

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

If the resin restoration does not penetrate dentin, D1351 is appropriate.

D2330, D2391 or D2392 - Resin-based composites

If the resin restoration does penetrate dentin, one of the resin-based composite codes is appropriate.

D9910/D9911 - Desensitizing

Appropriate reporting of these procedures is clearly detailed below.

All acid etching, adhesives (including resin bonding agents), liners, bases and/or curing techniques are considered to be a part of and included in amalgam and composite restoration procedures. None of these included procedures may be unbundled and/or charged as a separate service.

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“D9910 – application of desensitizing medicament

Includes in-office treatment for root sensitivity. Typically reported on a “per visit” basis for application of topical fluoride. This code is not to be used for bases, liners or adhesives under restorations.

D9911 – application of desensitizing resin for cervical and/or root surface, per tooth

Typically reported on a “per tooth” basis for application of adhesive resins. This code is not to be used for bases, liners, or adhesives used under restorations.” *CDT 2009/2010, page 74*

Crowns and Fixed Bridges

Note: Providers may document the date of service for these procedures to be the date when final impressions are completed, subject to review.

Upgrades

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

Typical upgrades include:

- Choice of metal – noble, high noble, titanium alloy or titanium
- porcelain on molar teeth
- porcelain margins, by report
(porcelain margin upgrades may be reported as D2999 for single crowns or as D6999 for abutment crowns)

Single Crowns

- A. When bicuspid and anterior crowns are covered, the benefit is usually a porcelain fused to a base metal crown or a porcelain/ceramic substrate crown.
- B. When molar crowns are indicated due to caries, an undermined or fractured off cusp or the necessary replacement of a restoration due to pathology, the benefit is usually a base metal crown.
- C. Porcelain/ceramic substrate crowns on molars are susceptible to fracture and are generally not appropriate.
- D. When anterior teeth have incisal edges/corners that are undermined or missing because of caries, a defective restoration or are fractured off, a labial veneer may not be sufficient. The treatment of choice may then become a porcelain fused to a base metal crown or porcelain/ceramic substrate crown.
- E. Final crowns for teeth with a good prognosis should be sequenced after performing necessary endodontic and/or periodontic procedures and such teeth should exhibit a minimum crown/root ratio of 50%.

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- F. Crown services must be documented using valid procedure codes as found in the *American Dental Association's Current Dental Terminology (CDT)*.

Brand name dental materials/alternatives

While Liberty requires that its contracted dentists utilize accepted and approved dental materials approved by the FDA when treating eligible patients, it does not require that they offer brand name restorations, crowns or bridges in lieu of generic alternatives.

However, if a contracted dentist elects to do so, appropriate American Dental Association (ADA) procedure codes listed in the current version of the Current Dental Terminology (CDT) reference manual must be presented to identify the alternate procedure(s) and the applicable Evidence of Coverage shall determine the patient's total financial responsibility.

For example, a patient's benefit and copayment responsibility for D2750 would apply whether the dentist offered a generic porcelain fused to high noble crown or a crown made of porcelain fused to either a precious foil coping (e.g. Sunrise) or composite metal coping (e.g. Captek).

Similarly, a patient's benefit and copayment for D2740 applies regardless of the technique or ceramic/porcelain materials used to produce a non-metallic crown. If a contracted dentist offers a covered, generic, all ceramic/porcelain crown or any brand name alternative (e.g., Vitadur-N, Hi-Ceram, Optec HSP, In-Ceram, Empress, Cerec, AllCeram, Procera, Lava, etc.), the same copayment would apply.

Post and core procedures include buildups

"D2952 post and core in addition to crown, indirectly fabricated post and core are custom fabricated as a single unit.

"D2954 prefabricated post and core in addition to crown core is built around a prefabricated post. This procedure includes the core material" *CDT 2009/2010, page 18*.

By CDT definitions, each of these procedures includes a "core". Therefore, providers may not unbundle procedure D2950 core buildup, including any pins and report it separately from either of these procedures for the same tooth during the same course of treatment.

K. Outcomes

- Margins, contours and contacts must be clinically acceptable
- Prognosis should be good for a minimum of 5-years
- *Guidelines for the Assessment of Clinical Quality and Professional Performance*, published by *The California Dental Association*, and standards set by the specialty boards shall apply.

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Fixed Bridges

- A. When a single posterior tooth is missing on one side of an arch and there are clinically adequate abutment teeth on each side of the missing tooth, the general choices to replace the missing tooth would be a fixed bridge or an implant.

If it is also necessary to replace teeth on the opposite side of the same arch, the benefit would be a removable partial denture instead of the fixed bridge.

- B. Fixed bridges are not covered benefits in the presence of untreated moderate to severe periodontal disease, as evidenced in x-rays, or when a proposed abutment tooth or teeth have poor crown/root ratios.
- C. When up to all four incisors are missing in an arch, the potential abutment teeth are clinically adequate and implants are not appropriate, possible benefits for a fixed bridge would will be evaluated on a *case-by-case* basis. Evaluation and diagnosis of any patient's periodontal status or active disease should be documented with recent full mouth periodontal probing and submitted with any benefit determination.
- D. Bridge abutments would generally be full coverage crowns.
- E. A distal cantilevered pontic is generally inappropriate for the replacement of a missing posterior tooth. However, a mesial cantilevered pontic but may be acceptable for the replacement of a maxillary lateral incisor when an adequate adjacent cuspid can be used for the abutment crown.
- F. Third molars should generally not be replaced, particularly when they are not functional.
- G. Outcomes
- i. Margins, contours and contacts should be clinically acceptable
 - ii. Prognosis should be good for long term longevity
 - iii. Guidelines for the Assessment of Clinical Quality and Professional Performance of the California Dental Association shall apply.
- I. Full Mouth Reconstruction

Full mouth reconstruction describes the process of restoring (rebuilding) a patient's remaining teeth. This treatment typically involves 10 or more units of fixed crown and bridge procedures, including the establishment of a new vertical dimension.

Most plans do not cover the crown and fixed bridge procedures involved in Full Mouth Reconstruction. However, this limitation does not exclude benefits for any other covered procedures (i.e. endodontic therapy, extractions, buildups or post & cores).

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Removable Prosthodontics

Note: Providers may document the date of service for these procedures to be the date when final impressions are completed, subject to review.

A. Partial Dentures

- i. A removable partial denture is normally not indicated for a single tooth replacement of non-functional second or third molars.
- ii. Partial dentures are covered when posterior teeth require replacement on both sides of the same arch.
- iii. Full or partial dentures are not covered for replacement if an existing appliance can be made satisfactory by relining or repair.
- iv. Full or partial dentures are not covered if a clinical evaluation reveals the presence of a satisfactory appliance, even if a patient demands replacement due to their own perceived functional and/or cosmetic problems.
- v. Unilateral removable partial dentures are rarely appropriate.
- vi. Abutment teeth should be restored prior to the fabrication of a removable appliance and would be covered if the teeth meet the same stand alone benefit requirements of a single crown.
- vii. Partials should be designed so that they do not harm the remaining teeth.
- viii. Materials used for removable partial dentures must be strong enough to resist breakage during normal function, nonporous, color stable, esthetically pleasing, non-toxic and non-abrading to the opposing or supporting dentition.
- ix. Appliances should be designed to cause no damage to abutment teeth and/or periodontal tissues, and to facilitate oral hygiene.
- x. Flexible partial dentures (D5225/D5226) include the following brands: *Valplast*, *Thermoflex*, *Flexite*, etc.
- xi. *Combo Partials* – because these appliances may include cast metals, they would be appropriately reported as D5213/D5214.

B. Complete Dentures

- i. Complete dentures are the appliances of last resort, particularly in the mandibular arch. Patients should be fully informed of their significant limitations.
- ii. Establishing vertical dimension is considered to be a part of and included in the fee/process for fabricating a complete denture (standard, interim or immediate). Therefore, benefits for a complete denture are not limited or excluded in any way simply because of the necessity to establish vertical dimension.

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C. Interim Complete Dentures

These non-covered appliances are only intended to replace teeth during the healing period, prior to fabrication of a subsequent, covered complete denture.

D. Immediate Complete Dentures

These covered dentures are inserted immediately after a patient's remaining teeth are removed. While immediate dentures offer the benefit of never having to be without teeth, they must be relined (refitted on the inside) during the healing period after the extractions have been performed. The reason for such relining is that the shape of the supporting soft tissues and bone changes significantly during healing, causing the denture to become loose. In many cases, immediate dentures must be discarded and replaced with non-covered (limitation) standard complete dentures within the first six months.

E. Repairs and Relines

- i. Repair of a partial or complete denture is covered if it results in a serviceable appliance, subject to limitations.
- ii. Supporting soft tissues and bone shrink over time, resulting in decreased retention and/or stability of the appliance. A reline of a partial or complete denture would be covered (limitations may apply) if the procedure would result in a serviceable appliance.

Implants

A. General Guidelines

1. A thorough history and clinical examination leading to the evaluation of the patient's general health and diagnosis of his/her oral condition must be completed prior to the establishment of an appropriate treatment plan.
2. A conservative treatment plan should be considered prior to providing a patient with one or more implants. Crown(s) and fixed partial prosthetics for dental implants may be contraindicated for the following reasons:
 - Adverse systemic factors such as diabetes and smoking
 - Poor oral hygiene and tissue management by the patient
 - Inadequate osseointegration (movable) of the dental implant(s)
 - Excessive para-function or occlusal loading
 - Poor positioning of the dental implant(s)
 - Excessive loss of bone around the implant prior to its restoration
 - Mobility of the implant(s) prior to placement of the prosthesis
 - Inadequate number of implants or poor bone quality for long span prostheses

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- Need to restore the appearance of gingival tissues in high esthetic areas
- When the patient is under 16 years of age, unless unusual conditions prevail

B. Restoration

- i. The restoration of dental implants differs in many ways from the restoration of teeth, and as such, the restoration of dental implants has separate guidelines.
- ii. Care must be exercised when restoring dental implants so that the occlusal and lateral loading of the prosthesis does not damage the integration of the dental implant system to the bone or affect the integrity of the implant system itself.
- iii. Care must also be exercised when designing the prosthesis so that the hardness of the material used is compatible with that of the opposing occlusion.
- iv. Jaw relationship and intra arch vertical distance should be considered in the initial treatment plan and selection of retentive and restorative appliances.

C. Outcomes

- ii. The appearance of fixed prosthetic appliances for implants may vary considerably depending on the location, position and number of implants to be restored.
- iii. The appearance of the appliances must be appropriate to meet the functional and esthetic needs of the patient.
- iv. The appearance and shape of the fixed prosthesis must exhibit contours that are in functional harmony with the remaining hard and soft tissues of the mouth.
- v. They must exhibit good design form to facilitate good oral hygiene, even in cases where the prosthesis may have a ridge lap form.
- vi. Fixed implant prostheses must incorporate a strategy for removal of the appliance without damage to the implant, or adjacent dentition, so that the implant can be utilized in cases where there is further loss of teeth, or where repair of the appliance is necessary.
- vii. Multiple unit fixed prostheses for implants must fit precisely and passively to avoid damage to the implants or their integration to the bone.
- viii. It is a contra-indication to have a fixed dental prosthesis abutted by both dental implant(s) and natural teeth (tooth) without incorporating a design to alleviate the stress from an osseointegrated (non-movable) abutment to a natural tooth.
- ix. It is the responsibility of the restoring dentist to evaluate the initial acceptability of the implants prior to proceeding with a restoration.

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- x. It is the responsibility of the restoring dentist to instruct the patient in the proper care and maintenance of the implant system and to evaluate the patient's care initially following the final placement of the prosthetic restoration.
- xi. Fixed partial prostheses, as well as a single unit crowns, are expected to have a minimum prognosis for 5-years of service.