Dental Clinical Criteria

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Introduction

The clinical criteria are based upon procedure codes in the Current Dental Terminology® (CDT 2018), American Dental Association®.

CareFirst’s Dental Clinical Criteria have been developed, revised and updated periodically. They are reviewed and approved by the CareFirst Dental Advisory Committee (DAC) and/or the Oral and Maxillofacial Surgery Advisory Committee (OMSFAC). The DAC is comprised of the Dental Director who acts as chairperson for the committee and 12 practicing network dentists. The OMSFAC is comprised of the Dental Director who acts as chairperson for the committee and six (6) network oral surgeons.

The criteria is derived from reviews of the current dental literature, subject textbooks, other insurance companies, and
• Practice Parameters, American Association of Periodontology (www.perio.org)
• Parameters of Care, American Association of Oral and Maxillofacial Surgery (www.aaoms.org)
• Oral Health Policies and Clinical Guidelines, American Academy of Pediatric Dentistry (www.aapd.org)
• Position Statements, American Association of Dental Consultants (www.aadc.org)
• Dental Practice Parameters, American Dental Association (www.ada.org)

Dental Benefits
Dental care benefits are provided as defined in the members’ contracts. The members’ contracts may exclude or impose frequency limits on certain procedures and may vary based on regulatory requirements and/or the level of coverage purchased by the employer group or individual. In-network dentists agree to CareFirst’s Schedule of Allowances. Covered services are allowed a benefit only when dentally or medically necessary as determined by CareFirst.

Alternate Benefits
Member contracts state “in the event there are alternative dental procedures that meet generally accepted standards of professional dental care for a Member’s condition, benefits will be based upon the lowest cost alternative.”

The Professional Review Process
• All review of clinical information is performed by qualified dental staff.
• Only a licensed dentist may deny a procedure as “not medically or dentally necessary”, “cosmetic in nature”, “experimental or investigational”.
• Only a licensed dentist may consider a procedure or claim on appeal.
• Administrative denials are based on member contract provisions (i.e., benefit limitations, exclusions and annual contract period maximum) and do not require the review of a licensed professional.

Required Clinical Information
Procedures requiring professional review always require supporting clinical documentation. Please refer to the list of required documentation included as part of this document.
Sending your Clinical Information to CareFirst

- **Paper claims:** Mail your claims to the address indicated on the back of the member's membership card.
- **Attachments and clinical documentation:** The submission of electronic attachments (radiographs, progress notes, charting, photos, etc.) is highly recommended and may be submitted to CareFirst through an electronic attachment vendor of choice.
- **Electronic claims:** CareFirst accepts electronic dental claims - use payer ID: 00580.
Diagnostic

Requests for services must meet the following basic criteria:

Tests and Examinations

Collection of microorganisms for culture and sensitivity D0415
- Considered for benefit only in cases when moderate to severe infection requires identification of the infective organism to effectively target antimicrobial therapy.

Oral Pathology Laboratory

Accession of exfoliative cytologic smears, microscopic examination, preparation and transmission of written report D0486
- Pathological analysis of cytological sample of disaggregated transepithelial cells.
- Written report of findings.
Restorative

Requests for services must meet the following basic criteria:

Inlay / Onlay Restorations D2510 – D2664
- Limited to permanent teeth.
- Any restorative procedure must be required as a result of extensive caries or trauma.
- A direct restoration is not feasible.
- Patient has a documented allergy to direct restorative materials.
- Onlays must completely cover at least one (1) cusp of the posterior tooth and involve multiple surfaces.
- Onlays must cover the complete incisal edge of an anterior tooth and more than one (1) surface.
- Free of endodontic signs/symptoms
- The tooth must present with a minimum of 50 percent bone support.
- The patient must be free of active periodontal disease.

Crowns D2710 - D2799
- Limited to permanent teeth.
- Any restorative procedure must be required as a result of extensive caries or trauma.
- A direct or other more conservative restoration is not feasible.
- An endodontically treated tooth must show adequate root canal fill without excessive over fill and be asymptomatic.
- The tooth must present with a minimum of 50 percent bone support.
- The patient must be free of active periodontal disease.

Other restorative services

Buildup D2950
- Limited to permanent teeth.
- The tooth must be sufficiently broken down that a buildup is required for adequate support and retention of a crown.
- Buildups are not considered for inlays or onlays as dentally necessary due to the retention of multiple tooth surfaces.
- Minor restorations of carious areas, liners, bases or blocking out undercuts in a preparation do not qualify as a buildup (D2949).
- Closing of endodontic access cavity does not qualify as a build-up.

Post and core D2952 – D2954, D2957
- Limited to permanent teeth.
- The tooth must be endodontically treated.
- The endodontically treated tooth must show adequate root canal fill without excessive over fill.
- The tooth must present with a minimum of 50 percent bone support.

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- The tooth must be sufficiently broken down where a more conservative base or buildup would be contraindicated.
- The risk of root fracture or splitting the root by placing a post is minimal.

**Veneers D2960 – D2962**
- Limited to permanent anterior teeth.
- Must not be performed primarily for cosmetic reasons.
- Any restorative procedure must be required as a result of caries or trauma.
- A direct or other more conservative restoration is not feasible.
- The tooth must present with a minimum of 50 percent bone support.
- The patient must be free of active periodontal disease.
- Must be free of endodontic signs or symptoms.
Endodontics

Requests for services must meet the following basic criteria:

Endodontic therapy on primary teeth D3230, D3240
- Tooth must demonstrate advanced caries or trauma.
- Root fracture must be absent.
- Clinical crown must be sufficient to retain a restoration, prefabricated resin or stainless steel crown.
- Tooth must not be near exfoliation – root resorption may not exceed 50 percent.

Endodontic therapy on permanent teeth D3310 – D3330, D3346 – D3348
- All canals must be instrumented, cleaned and sealed within 2mm of the radiographic apex.
- Tooth must present with endodontic pathology, symptoms.
- Tooth must be restorable.
- Tooth must present with at least 50 percent bone support.
- Patient must be free of periodontal disease.

Bone graft in conjunction with periradicular surgery D3428, D3429
- Surgical defect must be large enough to require graft for adequate healing without significant residual defect.

Biologic materials to aid in soft and osseous tissue regeneration in conjunction with periradicular surgery D3431
- Biologic materials must result in significant improvement in tissue regeneration and healing.
- May be considered incidental by CareFirst when used in conjunction with bone grafting and/or guided tissue regeneration (GTR).

Guided tissue regeneration, resorbable barrier, per site, in conjunction with periradicular surgery D3432
- Use of the resorbable barrier for GTR must result in significant improvement in tissue regeneration and healing.

Canal preparation and fitting of performed dowel or post D3950
- This service may not be reported in conjunction with D2952 – D2954 or D2957 by the same practitioner.
- This service may be reported by an endodontist when performed as ancillary to endodontic therapy but not by the dentist who is preparing the canal for the post and also placing the post and fabricating the core.
Periodontics

Requests for services must meet the following basic criteria:

**Gingival flap procedure, including root planing D4240, D4241**
- Gingival pockets must be moderately deep (5 – 8 mm) with loss of attachment. Tissue flap must be necessary to access root calculus (modified Kirkland or Widman surgery).
- May be required to access or determine the presence of a cracked tooth, fractured root or external root resorption.
- No additional benefit is allowed for the use of a laser.
- Code may not be used in conjunction with D4210, D4211, D4260 and D4261.

**Osseous surgery D4260, D4261**
- Should be preceded by scaling and root planing by four to six (4 – 6) weeks to reduce gingival and osseous inflammation prior to surgery.
- In cases where pockets are not expected to be resolved with scaling and root planing (SRP) due to their depth (7 + mm) and plaque control is adequate, it may be more therapeutic to go directly to surgery. A detailed narrative should accompany these requests.
- Post SRP evaluation should be a factor in determining the need for surgical intervention.
- Includes reshaping the alveolar process to achieve a more physiologic form.
- D4210, 4211, D4240 and D4241 are considered incidental to D4260 and D4261 by CareFirst.

**Bone replacement graft – first site in quadrant D4263**
- This procedure involves the use of autografts, allografts or non-osseous grafts to stimulate periodontal regeneration when the disease process has resulted in bone deformity.
- Bone grafts are frequently performed in conjunction with osseous surgery but may be billed as unique procedures.
- CareFirst considers two (2) contiguous sites to be one site and allows benefits accordingly.
- Do not use this code with implants (see codes D6103 – D6104).
- Do not use this code in conjunction with periradicular surgery (see codes D3428).

**Bone replacement graft – each additional site in quadrant D4264**
- This procedure involves the use of autografts, allografts or non-osseous grafts to stimulate periodontal regeneration when the disease process has resulted in bone deformity.
- Bone grafts are frequently performed in conjunction with osseous surgery but may be billed as unique procedures.
- CareFirst considers two (2) contiguous sites to be one (1) site and allows benefits accordingly.
- This code will be considered when three (3) or more teeth in the quadrant are directly involved in the grafting procedure.

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• May be considered incidental when used in conjunction with bone grafting and/or GTR.
• Do not use this code with implants (D6103, D6104).
• Do not use this code in conjunction with periradicular surgery.

**Biologic materials to aid in soft and osseous tissue regeneration D4265**
• These materials may be used alone or with other regenerative materials such as bone and barrier membranes.
• This procedure does not include surgical entry and closure, debridement, osseous contouring or placement of graft materials and membranes.
• CareFirst will consider allowing a benefit for this service when traditional regenerative procedures alone are unlikely to provide resolution of the tissue defect.
• A narrative detailing the necessity of the material is helpful in determining this additional regenerative benefit.
• Do not use this code in conjunction with periradicular surgery (D3432).

**Guided tissue regeneration (GTR) – resorbable barrier, per site D4266**
• This procedure may be used as appropriate following surgical exposure and debridement to help close and protect the wound before approximation of the mucoperiosteal flap.
• GTR is appropriate when the surrounding soft and hard tissue is insufficient to retain the graft material.
• A narrative detailing the necessity of the membrane material is helpful in determining this additional regenerative benefit.
• Do not use this code in conjunction with periradicular surgery.

**Guided tissue regeneration (GTR) – non-resorbable barrier, per site D4267**
• This procedure is used to regenerate lost or injured periodontal tissue by directing differential tissue responses.
• The membrane is placed to exclude epithelium and gingival connective tissue from the healing site.
• GTR is appropriate when the surrounding soft and hard tissue is insufficient to retain the graft material.
• A narrative detailing the necessity of the membrane material is helpful in determining this additional regenerative benefit.

**Pedicle soft tissue graft procedure D4270**
• A minimum amount of attached gingival remains, i.e., < 2mm.
• Procedure is required for reasons other than cosmetics, i.e., mucogingival defect, root sensitivity treated unsuccessfully by desensitizing techniques or placement of restoration, to increase the band of keratinized/attached gingival, and/or to thicken the gingival housing at a prospective implant site.
• Procedure includes both recipient bed preparation and obtaining donor tissue, including use of allograft material such as AlloDerm.
• Considered incidental to frenulectomy (D7960) or frenuloplasty (D7963) by CareFirst
Subepithelial connective tissue graft procedures, per tooth D4273

- A minimum amount of attached gingival remains, i.e., <2mm.
- Procedure is required for reasons other than cosmetics, i.e., mucogingival defect, root sensitivity treated unsuccessfully by desensitizing techniques or placement of restoration, to increase the band of keratinized/attached gingival, and/or to thicken the gingival housing at a prospective implant site.
- Procedure includes both recipient bed preparation and obtaining donor tissue, including use of allograft material such as Alloderm.
- Considered incidental to frenulectomy (D7960) or frenuloplasty (D7963) by CareFirst.
Soft tissue allograft D4275
- Must meet same criteria as other soft tissue grafts.
- No donor site is required.
- Allograft material is inclusive. No additional charge for the graft material is allowed.

Combined connective tissue and double pedicle graft D4276
- Must meet same criteria as other soft tissue grafts.
- Appropriate to correct advanced gingival recession.

Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft D4277
- A minimum amount of attached gingival remains i.e., < 2mm.
- Procedure is required for reasons other than cosmetics, i.e., mucogingival defect, root sensitivity treated unsuccessfully by desensitizing techniques or placement of restoration to increase the band of keratinized/attached gingival, and/or to thicken the gingival housing at a prospective implant site.
- Procedure includes both recipient bed preparation and obtaining donor tissue, including use of allograft material such as Alloderm.
- Considered incidental to frenulectomy (D7960) or frenuloplasty (D7963) by CareFirst.

Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in the same graft site D4278
- A minimum amount of attached gingival remains i.e., < 2mm.
- Procedure is required for reasons other than cosmetics, i.e., mucogingival defect, root sensitivity treated unsuccessfully by desensitizing techniques or placement of restoration to increase the band of keratinized/attached gingival, and/or to thicken the gingival housing at a prospective implant site.
- Procedure includes both recipient bed preparation and obtaining donor tissue, including use of allograft material such as Alloderm.
- Not to be reported in conjunction with frenulectomy (D7960) or frenuloplasty (D7963).

Autogenous connective tissue graft procedure (including donor and recipient surgical sites) D4283
- Code D4283 is used in conjunction with D4273 when more than one tooth position in the same graft site is involved.
- Includes donor and graft site.
- CareFirst considers two contiguous grafts as a single site.

Non-autogenous connective tissue graft (including recipient surgical site and donor material) D4285
- Code D4285 is used in conjunction with D4275 when more than one tooth position in the same graft site is involved.
- Includes donor material and recipient surgical site.
- CareFirst considers two continuous grafts as a single site.
Periodontal scaling and root planing D4341, D4342
- Gingival pockets > 4mm.
- Radiographic evidence of active horizontal and/or vertical bone loss must be apparent.
- There must be loss of attachment or apical migration of the attachment.
- SRP of four (4) quadrants in same appointment must be accompanied by rationale for doing four (4) quadrants in the same visit, anesthesia used, length of appointment and degree of provider (DDS, DMD, RDH).
- May be repeated every two (2) years, only if medically necessary.
- May be necessary as a pre-surgical or definitive therapy.
- Contraindicated as a definitive therapy in cases where the bone loss is so severe that there would be little to no therapeutic effect.

Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation D4346
- Must be proceeded by an oral evaluation (D0120, D0150, D0180).
- May be performed on the same day as an oral evaluation.
- Full mouth procedure.
- Patient should be 14 years or older.
- D4346 is necessary when:
  - Oral exam and periodontal charting indicate the patient presents with:
    - Generalized moderate to severe gingival inflammation involving ten (10) or more teeth
    - Moderate to heavy plaque and/or calculus
    - 2-4 mm pocketing. There may be pseudopocketing.
    - Bleeding points
    - No vertical or horizontal bone loss
    - No loss of attachment

Gingival irrigation D4921
- Not a covered benefit as there is insufficient scientific evidence regarding clinical efficacy.

Periodontal maintenance D4910
- Is a benefit under most dental plans when preceded by a definitive periodontal procedure (D4240, D4260 and D4341) by no more than two (2) years.
- Allowed up to twice per contract year beginning twelve (12) weeks post definitive periodontal procedure.
- Includes SRP, if required and polishing teeth.
Prosthodontics (Removable)

Requests for services must meet the following basic criteria:

- Replacement of any fixed or removable prosthesis is limited to five (5) years.
- There must be at least one (1) missing tooth (2 – 15, 18 – 31).
- Teeth 1, 16, 17 and 32 are not eligible for replacement.

Overdentures – complete D5863, D5865
- Any retained teeth must present with at least 50 percent bone support.
- Retained teeth must be permanent teeth at appropriate tooth positions for good retention and stability.
- Implants and mini implants may be used to enhance retention and stability.
- Implants may be acceptable when there are no retained natural teeth and insufficient stability and retention to retain prosthodontic appliance is anticipated or exists.

Overdentures – partial D5864, D5866
- Any retained teeth must present with at least 50 percent bone support.
- Retained teeth must be permanent teeth at appropriate tooth positions for good retention and stability.
- Implants and mini implants may be used to enhance retention and stability.
- Implants may be acceptable when there are retained natural teeth in the arch.
- Implants and natural teeth both may not be used for retention of the device.
Implants and Related Services (D6000-D6199)

Requests for services must meet the following basic Clinical Criteria:

1. Limited to the replacement of permanent teeth.
2. Must replace a missing permanent tooth (2 – 15, 18 – 31 only).
3. Replacements of teeth 1, 16, 17 and 32 are not covered.
4. Implant must have good crown to “root” ratio.
5. Must be fully integrated.
6. Must not have more than two (2) threads exposed above the alveolar crest.
7. Implant must not be closer than 1.5 mm to adjacent roots or implants.
8. The alveolar ridge must present with good quality bone of adequate mass and density.
9. When adjacent teeth require crowns or demonstrate significant disease or injury and/or there are multiple missing teeth, a more conservative treatment modality may be considered as an alternate benefit to treat the condition and replace all missing teeth.
10. Implants may be contraindicated in young patients whose growth is expected to continue.
11. Consideration must be given to using the natural teeth as abutments for a fixed bridge as an alternate benefit in cases where an edentulous space is bordered by broken down, grossly decayed, fractured or heavily restored teeth. These teeth must meet the criteria for crowns or abutments.
12. When three (3) or more teeth are missing in the same arch bilaterally, consideration will be given to a removable partial denture as an alternate benefit (least expensive alternative treatment (LEAT)).
13. Immediate placement of an implant body into an extraction site is an acceptable procedure in many cases. These procedures may include placement of autogenous or allograft bone material in conjunction with GTR membrane.
14. Biologic mediators, Extracellular Matrix Derivative (EMD) may be considered incidental by CareFirst when used in conjunction with bone grafting and/or GTR.
15. Active periodontal disease must have been treated and under control before implant placement to avoid possible complications.
16. No benefit will be allowed in conjunction with a mini implant supported fixed prosthetic device (crown, bridge).

Other General Considerations:

1. The use of synthetic bone graft material is not recommended since these materials appear to act as bone fillers, but do not generate the formation of new bone or periodontal membrane.
2. Implants may not be covered in some plans.
3. If implants are not covered, then all services associated with the implant service including but not limited to maintenance and repairs, periodontal services for implants and implant removal are excluded from coverage.
4. In the case of surgical placement of implants, there is no alternative surgical treatment option; therefore, no alternate benefit is available. An alternate benefit may be applied to the prosthetic portion of the implant treatment plan (removable full or partial dentures).
Second stage implant surgery D6011

- Will be permitted a benefit allowance only in limited situations when uncovering an implant is necessary. Most implants do not require a second stage surgery.
- Surgical access to an implant body for placement of a healing cap or to enable placement of an abutment.
- Includes flap procedure and suturing.
- Not medically necessary for mini-implant.

Surgical placement of mini implant D6013

- Mini implants are indicated for retention of full dentures that would otherwise be unstable.
- Not indicated to retain or support fixed or removable partial dentures.
- Not indicated to retain or support crowns.
- Includes the retrofitting of existing prosthesis.
- Does not require surgical flap and osteotomy.
- Does not require second stage surgery (D6011).
- Does not require surgical stent (D6190) for placement.

Bone graft or repair of periimplant defect D6103

- Necessary when there is an osseous or soft tissue defect at an existing implantsite.
- May be necessary when surgical intervention is required to access the defect.
- Does not include flap entry and closure.
- Does not include barrier membrane or biologic materials.
- Do not use codes D4263, D4264 or D7953.

Bone graft at time of implant placement D6104

- Bone graft may be indicated to repair an osseous defect or improve architecture.
- Grafting may be indicated when implant is placed immediately into an extraction socket.
- Do not use D4263, D4264 or D7953 to report bone grafting in conjunction with implant placement.
Fixed Prosthodontics

Requests for services must meet the following basic criteria:

Fixed Partial Denture Pontics

Pontics D6205 – D6252 (D6253 is not covered)
- Limited to the replacement of permanent teeth.
- Must replace a missing permanent tooth (2 – 15, 18 – 31 only).
- Replacements of teeth 1, 16, 17 and 32 are not covered.
- Pontic space must be 75 percent the mesial – distal length of the missing tooth.
- The associated abutment teeth must demonstrate a good five (5) year prognosis.
- If the retainer is denied, the pontic will be denied.
- Two (2) pontic length, maximum.
- Cantilevers should not involve more than one (1) pontic and the related abutment must have at least 75 percent bone support.
- Non-functional teeth are not considered for benefits.

Inlays / Onlays D6545 – D6634
- Limited to permanent teeth.
- Any restorative procedure must be required as a result of caries or trauma.
- Onlay must completely cover at least one (1) cusp of the posterior tooth and involve multiple surfaces.
- Onlays must cover the complete incisal edge of an anterior tooth and more than one (1) surface.
- The tooth must present with a minimum of 50 percent bone support.
- The patient must be free of active periodontal disease.
- Non-functional teeth are not considered for benefits.

Retainers crowns D6710 – D6794 (D6793 is not covered)
- Limited to permanent teeth (2 – 15, 18 – 31).
- An endodontically treated tooth must show adequate root canal fill without excessive over fill.
- Endodontics must be completed before teeth are prepared and the bridge is placed.
- The tooth must present with a minimum of 50 percent bone support.
- The patient must be free of active periodontal disease.
- If pontics are allowed an alternate benefit, the abutment crowns (retainers) will be considered for benefits independently based upon their clinical status.
- Non-functional teeth are not considered for benefits.
- Abutment teeth should demonstrate zero mobility.
Other Fixed Partial Denture Services

*Pediatric partial denture, fixed D6985*

- A fixed prosthetic restoration replaces one (1) or more missing teeth in the primary, transitional or permanent dentition.
- This restoration attaches to natural teeth, tooth roots, or implants and it is not removable by the patient.
- Growth must be considered when using fixed restorations in the developing dentition.

**Recommendations:**

- Fixed prosthetic restorations to replace one (1) or more missing teeth may be indicated to:
  - establish esthetics;
  - maintain arch space or integrity in the developing dentition;
  - prevent or correct harmful habits; or
  - improve function.

(AAPD REFERENCE MANUAL V37/NO6 15/16 - MAY2015)
Oral Surgery

Requests for services must meet the following basic criteria:

Other Surgical Procedures

Oraltral fistula closure D7260 and Primary closure of a sinus perforation D7261
- Oral – antral communication must require surgical intervention for repair and healing.

Mobilization of erupted or malpositioned tooth to aid eruption D7282
- Tooth must be ankylosed.
- May not be associated with an extraction.

Biopsy of oral tissue D7285, D7286
- For pathological examination of abnormal tissue or lesion.
- Not to be used with apicoectomy / periradicular surgery.

Brush biopsy D7288
- Sample collection of abnormally appearing mucosa or oral mucosal lesion.
- Biopsy may be required for definitive diagnosis.

Surgical excision of soft tissue lesions and intra-osseous lesions D7410 – D7415, D7440, D7441, D7450, D7451, D7460, D7461, D7465
- Tissue must appear abnormal or suspicious.

Excision of bone tissue D7471 – D7473, 7485
- Tissue must appear abnormal or suspicious.

Other Repair Procedures

Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla D7950
- Procedure is considered necessary and appropriate when:
  - Performed to repair a significant osseous defect in the maxilla or mandible which may be caused by disease or injury, beyond that of a periodontal defect which is commonly referred to as a block graft.
  - The procedure includes ridge augmentation or reconstruction to increase height, width and/or volume of the alveolar ridge.
  - The procedure includes obtaining and placing the graft material (autogenous graft or allograft) and any related follow up visit.
  - Placement of a barrier membrane, if used, may be reported separately.

Sinus augmentation with bone or bone substitutes D7951 – D7952
- The area must be edentulous.
- Must be done for implant site preparation.

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• May be appropriate at time of implant placement when implant stability is obtained with existing bone.
• Short, wide implant body use is contraindicated.
• Placed in the absence of sinus pathology.
• Implant and implant services are covered services in the plan.

**Bone replacement graft for ridge preservation D7953**
• Post extraction site presents with compromised bone mass.
• At least one osseous plate is fenestrated or presents with dehiscence or is fractured resulting in a major defect.

**Frenulectomy and Frenuloplasty D7960, D7963**
• Procedure is considered necessary and appropriate when:
  o The child is a young infant and the child is having difficulty “latching” or unable to latch for feeding.
  o Excessive lingual attachment is impeding speech or swallowing.
  o High labial attachment is preventing eruption of teeth.
  o High labial attachment is creating a diastema or causing tooth rotation.
  o Necessary to avoid or proceed with orthodontic treatment.

**Surgical reduction of fibrous tuberosity D7972**
• Soft tissue must be hypertrophied and interfere with occlusion.
• Excessive tissue interferes with appropriate denture flange extension.
Orthodontic Treatment

CareFirst Dental Contracts

Non Affordable Care Act (Non-ACA) or Commercial Contracts

Requests for orthodontic services for members covered under CareFirst Dental Contracts are provided according to contract – no Dental Director Review is required.

Benefit is provided to members that meet the following criteria:
- Orthodontic coverage is provided in the member’s contract,
- The member is eligible to receive orthodontic benefit (for example, a member’s contract may provide coverage for orthodontic services but limited to dependents) and
- The orthodontic treatment is to reduce or eliminate an existing malocclusion.

Health Care Reform (HCR) – Affordable Care Act (ACA) Contracts

Orthodontic benefits for members covered under HCR – ACA contracts are limited to comprehensive orthodontic treatment (procedure codes D8070 – D8090). All other orthodontic treatment procedure codes are considered excluded from contract and, therefore, a benefit will not be provided – examples of non-covered services include:

- Limited orthodontic treatment (D8010 – D8040)
- Interceptive orthodontic treatment (D8050 – D8060) and
- Minor treatment appliances to control harmful habits (D8210 and D8220).

Requests for orthodontic comprehensive services for members covered under HCR – ACA contracts require a pre-treatment estimate (PTE) and must meet the following requirements:

Comprehensive Orthodontic Treatment D8070 – D8090

- Benefits for orthodontic services will only be available until the end of the calendar year in which the member turns age 19 if the member:
  - Has fully erupted permanent teeth with at least 1/2 to 3/4 of the clinical crown being exposed (unless the tooth is impacted or congenitally missing); and
  - Has a severe, dysfunctional, handicapping malocclusion that meets a minimum score of 15 on the Handicapping Labio-Lingual Deviations Index (HLD) or a minimum score of 25 on the Salzmann Evaluation Index (depends upon jurisdiction). Points are not awarded for aesthetics, therefore, additional points for aesthetics will not be considered as part of the determination.
  - The following documentation must be submitted with the request for a PTE:
    1. Current ADA claim form with service code requested and fee;
    2. Diagnostic study models (correctly trimmed) with waxbites in centric relation;
    3. Cephalometric head film with measurements and analysis;
    4. Panoramic or full series radiographs;
    5. Clinical summary with diagnosis;
6. Appropriate State mandated HLD or Salzmann Evaluation assessment form completed and signed by the orthodontist (dentist); and
7. Treatment plan including anticipated duration of active treatment.

➢ Covered benefit for D8070 – 8090, if a PTE is approved, includes:
   1. Retainers – one (1) set (included in comprehensive orthodontics).
   2. Retainer replacement allowed one (1) per arch per lifetime within 24 months of date of debanding, if necessary.
   3. Rebonding or recementing fixed retainer.
   4. Orthodontic therapy is covered once per lifetime.
   5. Periodic treatment visits; not to exceed 24 months (the member must be eligible for Covered Dental Services on each date of service, except as specifically stated in the Extension of Benefits section of the Agreement).

Please Note:
1. The pre-treatment estimate is required before any treatment begins. Diagnostic records and examination do not require PTE. If treatment commences before authorization is received from CareFirst, no benefit will be allowed.
Adjunctive General Services

Unclassified Treatment

Fixed partial denture sectioning D9120

- Sectioning of one or more connections between pontics and/or abutments;
- Some portion of the fixed prosthesis must remain intact and serviceable following sectioning;
- Usually extraction of an abutment tooth is involved;
- Includes recontouring and polishing of the retained pontics;
- Teeth must be in functional occlusion;
- Abutment teeth must have adequate bone support.
History of Document

Introduction

11/6/12
Periodic review and update: Added “Electronic dental claims available effective January 2013”.

1/8/14
Periodic review and update: First paragraph changed (CDT 2013 to CDT 2014). Second paragraph added “and/or the Oral Maxillofacial Surgery Advisory Committee” to the first sentence, changed “9” to “10” practicing network dentists”, added new sentence “The OMSFAC is comprised of the Dental Director who acts as a chairperson for the committee and 6 network oral surgeons”. Under Dental Benefits added a new sentence “Covered services are allowed a benefit only when dentally or medically necessary as determined by CareFirst. Under Alternate Benefits added “treats or” to last sentence. Under Sending your Clinical Information to CareFirst changed Electronic claims bullet deleted “will accept” added “accepts” and “Use payer ID: 00580”.

1/1/15
CDT 2015 and periodic review and updates:
First paragraph changed (CDT 2014 to CDT 2015). Second paragraph split first sentence “CareFirst’s Dental Criteria…and updated periodically. They are reviewed…” Under “Dental Benefits” – second sentence “The members’ contracts…by the employer group” added “or individual”. Under “Alternate Benefits” – revised paragraph “Member contracts state, ‘in the event…” Under “Sending your Clinical Information to CareFirst” – added Tesia Clearinghouse as an electronic attachment vendor.

1/1/16
First sentence “The clinical criteria are based upon procedure codes in the Current Dental Terminology (CDT 2016), American Dental Association”, updated CDT 2015 to 2016.

1/1/17

1/1/18
Periodic review and update: First paragraph changed (CDT 2017 to CDT 2018). Second Paragraph, third sentence “The DAC is comprised of the Dental Director...and “10” practicing network dentists.” Changed “10” to “12” practicing network dentists.
Diagnostics

1/1/16
Under “Tests and examinations” – Procedure code D0425 deleted by ADA (CDT 2016) effective 1/1/16, removed reference to this code.
Restorative

1/8/14
Periodic review and update: Under Crowns D2710 – D2799, second bullet added “extensive”, forth bullet added “and be asymptomatic”.

1/1/15
CDT 2015 and periodic review and updates:

1/1/16
Under “Other restorative services” – Procedure code D2970 deleted by ADA (CDT 2016) effective 1/1/16, removed reference to this code.

Other Restorative Services

11/6/12
Periodic review and update: Clinical guidelines added for temporary crown (fractured tooth) D2970.

1/8/14
CDT 2014: Under Buildup D2950, third bullet added “(D2949)”
Periodic review and update: Under Veneers D2960 – D2962, first bullet added “anterior”.

1/1/15
CDT 2015 and periodic review and updates:
Under “Other restorative services” – second bullet, deleted “not for onlays and inlays”, added “Buildups not considered for inlays or onlays as dentally necessary due to the retention of multiple tooth surfaces”.
Added bullet “Closing of endodontic access cavity does not qualify as a buildup”.

Endodontics

11/6/12
Periodic review and update: Clinical guidelines added for canal preparation and fitting of performed dowel or post D3950.

1/8/14
Periodic review and update: Added clinical guidelines for endodontic therapy on permanent teeth section as indicated below:
“Endodontic therapy on permanent teeth D3310 – D3330, D3346 – D3348
• Allowed services for teeth 2 – 15, 18 – 31
• All canals must be instrumented, cleaned and sealed within 2mm of the radiographic apex.
• Tooth must present with endodontic pathology
• Tooth must be restorable
• Tooth must present with at least 50 percent bone support
• Patient must be free of periodontal disease”

CDT 2014 update: Added clinical guidelines for Bone graft in conjunction with periradicular surgery – D3428, D3429, Biologic materials to aid in soft and osseous tissue regeneration in conjunction with periradicular surgery – D3431 and Guided tissue regeneration, resorbable barrier, per site, in conjunction with periradicular surgery – D3432.

1/1/15
CDT 2015 and periodic review and updates:
Under “Biologic materials to aid in soft and osseous tissue regeneration in conjunction with periradicular surgery – D3431”, added bullet “May be considered incidental by CareFirst when used in conjunction with bone grafting and/or GTR”.
Under “Biologic materials to aid in soft an osseous tissue regeneration in conjunction with periradicular surgery – D3431, second bullet “May be considered incidental...added “by CareFirst”.

Periodontics

11/6/12
Periodic review and update: D4240, D4241 – added “code may not be used in conjunction with D4210, D4211, D4260 and D4261”.
Clinical guidelines added for D4263, D4264, D4265, D4266 and D4267, D4273 – added “not to be reported in conjunction with frenulectomy (D7960) or frenuloplasty (D7963)”.
CDT 2013 update: Clinical guidelines added for new ADA CDT 2013 effective 1/1/13 – procedure codes D4277, D4278.

1/8/14
Periodic review and update: Under Osseous surgery D4260, D4261, added new bullet “D4210, D4211, D4240, D4241 are considered incidental to D4260, D4261”.
Under Subepithelial connective tissue graft procedures, per tooth D4273, changed forth bullet from “Not to be reported in conjunction with frenulectomy (D7960) or frenuloplasty (D7963)” to “Considered incidental to frenulectomy (D7960) or frenuloplasty (D7963)”.
Under Free soft tissue graft procedure (including donor site surgery), first tooth or dentulous tooth position in graft D4277, changed forth bullet from “Not to be reported in conjunction with frenulectomy (D7960) or frenuloplasty (D7963)” to “Considered incidental to frenulectomy (D7960) or frenuloplasty (D7963)”.
1/1/15
CDT 2015 and periodic review and updates:
Under “Bone replacement graft – first site in quadrant D4263”, added bullets: “Do not use this code with implants (see codes D6103, D6104)” and “Do not use this code in conjunction with periradicular surgery (see code D3428)”.
Under “Bone replacement graft – each additional site in quadrant D4264”, added bullets: “May be considered incidental when used in conjunction with bone grafting and/or GTR”, “Do not use this code with implants D6103, D6104)”, “Do not use this code in conjunction with periradicular surgery”.
Under “Biologic materials to aid in soft and osseous tissue regeneration D4265”, added bullet: “Do not use this code in conjunction with periradicular surgery (D3432)”.
Under “Guided tissue regeneration – resorbable barrier, per site D4266”, added bullet: “Do not use this code in conjunction with periradicular surgery”.
Under “Subepithelial connective tissue graft procedures, per tooth D4273”, third bullet corrected typo - added “of” “Procedure includes both recipient...including use “of” allograft material such as Alloderm”, forth bullet “Considered incidental to frenulectomy...added “by CareFirst”.
Added “Soft tissue allograft D4275”
Added “Combined connective tissue and double pedicle graft D4276”
Under “Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft D4277” – third bullet corrected typo - added “of” “Procedure includes both recipient...including use “of” allograft material such as Alloderm”, forth bullet “Considered incidental to frenulectomy...added “by CareFirst”.
Under “Gingival irrigation D4321”, “Not a covered benefit...insufficient scientific evidence...” added “scientific”.

1/1/16
Added new ADA CDT 2016 procedure codes and clinical guidelines to D4283 and D4285 effective 1/1/16.

1/1/17

1/1/18
Added clinical guidelines for ADA CDT procedure code D4270.

Prosthodontics – removable

1/16/13

1/15/15
CDT 2015 and periodic review and updates:
Under “Overdentures – complete D5863, D5865” forth bullet added “…and insufficient stability and retention to retain prosthodontic appliance”.
Under “Overdentures – partial D5864, D5866”, forth bullet added “in the arch”.
1/1/17
Under “Overdentures – complete D5863, D5865” fourth bullet, added “...is anticipated or exists.”

Implants and Related Services

11/6/12
CDT 2013 update: Clinical guidelines added for new ADA CDT 2013 effective 1/1/13 – procedure codes D6103, D6104.

1/1/15
CDT 2015 and periodic review and updates:
General Clinical Criteria heading changed to “Requests for services must meet the following basic clinical criteria”.
Under “General Clinical Criteria” #12 – added “(LEAT)”, #14 – deleted “(D4265) have not been approved by the FDA for this use and are, therefore, not covered”, #14 added “may be considered incidental by CareFirst when used in conjunction with bone grafting and/or GTR”.
Under “General Considerations”, heading changed to “Other General Considerations”
Under “Bone graft or repair of periimplant defect D6103” – first bullet deleted “Reported” added “Necessary”. Second bullet, deleted “Surgical”, added “May be necessary when surgical”.

Fixed Partial Dentures

11/6/12
CDT 2013 update: Deleted procedure codes D6254, D6795, D6970, D6972, D6973, D6976, D6977 – deleted text reference and guidelines to codes.
Clinical guidelines added for pediatric partial denture, fixed – D6985.

1/8/14
Periodic review and update: Under General Clinical Criteria, item #7 changed “2 mm” to “1.5 mm”, added new item “16. No benefit will be allowed in conjunction with a mini implant supported fixed prosthetic device (crown, bridge)”.
Under General Considerations, item #4, deleted “in the form of” from last sentence.

1/1/17
Updated AADP reference manual to latest version “V37/NO6 15/16 – MAY 2015.”
Oral Surgery

11/6/12
CDT 2013 update: Added new ADA CDT 2013 procedure code “sinus augmentation via a vertical approach (D7952) to the D7951 clinical guidelines.

1/1/17
Periodic review and update: New clinical guidelines added for osseous, osteoperiosteal or cartilage graft D7950, frenulectomy D7960 and frenuloplasty D7963.

Orthodontic Treatment

1/8/14
Health Care Reform update: Added new Orthodontic Treatment section and clinical criteria in compliance with the Affordable Care Act, Essential Pediatric Dental Benefit.

1/1/15
CDT 2015 and periodic review and updates:
Under “Comprehensive Orthodontic Treatment D8070 – 8090”, under “Benefits for orthodontic services will only be available until the end of the calendar year in which the member turns age 19 if the member:” – second bullet “…Salzmann Evaluation Criteria Index…” – deleted the word “Criteria”.

1/1/17
Under “Please Note,” deleted bullet #2.

Adjunctive General Services

1/1/16
Under Unclassified Treatment – added new clinical guidelines for D9120 effective 1/1/16.