DENTAL COVERAGE POLICY – Addt'l Procedures to construct new Crown under existing partial denture framework

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION:

CODES:
D2971 -Additional procedures to construct new crown under existing partial denture framework

CRITERIA:

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:
1 per 5 years

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2015

DENTAL COVERAGE POLICY - Adjustments to Dentures

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION:

Adjustments to complete/partial dentures within six months of delivery are considered part of the initial placement and not billable to the patient. After the six-month period, benefits are limited to one adjustment in a 36-month period.

CODES:

D5410 - Adjust complete denture-maxillary
D5411 - Adjust complete denture-mandibular
D5421 - Adjust partial denture-maxillary
D5422 - Adjust partial denture-mandibular

CRITERIA:

No review required.

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

Limited to one (1) adjustments in a 36-month period

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2015

DENTAL COVERAGE POLICY- Alveoloplasty

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION:

Alveoloplasties are limited to once per quadrant in a five-year period.

CODES:

D7310 - Alveoloplasty in conjunction with extractions-four or more teeth or tooth spaces, per quadrant
D7311 - Alveoloplasty in conjunction with extractions-one to three teeth or tooth spaces, per quadrant: not covered.
D7320 - Alveoloplasty not in conjunction with extractions-four or more teeth or tooth spaces, per quadrant
D7321- Alveoloplasty not in conjunction with extractions-one to three teeth or tooth spaces, per quadrant

CRITERIA:

No review required.

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2015

DENTAL COVERAGE POLICY – Amalgams and Composites

Blue Cross Blue Shield of Rhode Island

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION:

Amalgam and composite restorations are placed to restore functionality to a tooth that has been broken down by caries (decay) or fractured. Restorations may be made to permanent and/or primary teeth and may involve one to four or more surfaces of a tooth.

The placement of amalgam or composite restorations includes liners, base, pulp cap, bonding adhesive and polishing. Local anesthesia is considered to be part of the restorative procedure. Most subscriber contracts state that composite (white) restorations on posterior teeth are not a covered benefit; however, the allowance for the corresponding amalgam (silver) restoration (same tooth surfaces) is made for this restoration, with the patient responsible for payment of the difference between the allowance and the dentist's charge.

When restorations with multiple surfaces on the same tooth are submitted, processing is as follows:

- For anterior and/or posterior teeth, a combination of occlusal (or incisal) surfaces and interproximal surfaces - pay as **one** multi-surfaced restoration with each submitted surface represented, (i.e., #3 MOB), each surface considered ONCE for a restoration.

The buccal surface on a posterior restoration may be considered as a separate one-surface restoration if it is NOT connected to the other restoration(s) and a different material is used

CODES:

D2140 -Amalgam-one surface, primary or permanent
D2150 -Amalgam-two surfaces, primary or permanent
D2160 -Amalgam-three surfaces, primary or permanent
D2161 -Amalgam-four or more surfaces, primary or permanent
D2330 -Resin-based composite-one surface, anterior
D2331 -Resin-based composite-two surfaces, anterior
D2332 -Resin-based composite-three surfaces, anterior
D2335 -Resin-based composite-four or more surfaces or involving incisal angle (anterior)
D2390 -Resin-based composite crown, anterior
D2391 -Resin-based composite-one surface, posterior
D2392 -Resin-based composite-two surfaces, posterior
D2393 -Resin-based composite-three surfaces, posterior
D2394 -Resin-based composite-four or more surface, posterior

CRITERIA:

No review required.

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

Benefits for the replacement of an existing amalgam/composite restoration are payable after 24 months have passed since the previous placement the restoration. If a filling (same surfaces) are replaced within 24-month period by same participating dentist/office, it is considered a provider liability.

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2015

DENTAL COVERAGE POLICY – Anatomical Crown Exposure

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION:

This procedure is utilized in an otherwise peridontally healthy area to remove enlarged gingival tissue and bone (ostectomy) to provide an anatomically correct gingival relationship.

CODES:

D4230-Anatomical crown exposure-four or more contiguous teeth per quadrant: Not covered.
D4231-Anatomical crown exposure-one to three teeth per quadrant: Not covered.

CRITERIA:

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2015

DENTAL COVERAGE POLICY-Anesthesia

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/23/2014

INTERNAL POLICY DESCRIPTION

Local anesthesia is considered part of the operative procedure(s) performed, and there is no separate benefit. General anesthesia and intravenous sedation are a separate benefit when performed in conjunction with specific oral surgery procedures.

CODES:

D9210 - Local anesthesia not in conjunction with operative or surgical procedures: Not covered
D9211 - Regional block anesthesia: Inclusive
D9212 - Trigeminal division block anesthesia: Inclusive
D9215 - Local anesthesia in conjunction with operative or surgical procedures
D9219 – Evaluation for deep sedation or general anesthesia: Not covered.
D9223 – Deep sedation/general anesthesia – each 15 min increments
D9230 - Inhalation of nitrous oxide / anxiolysis, analgesia-not covered
D9243 – Intravenous conscious sedation/analgesia – each 15 min increments
D9248 - Non-intravenous conscious sedation: Not covered

CRITERIA:

LIMITATIONS: Benefits for general anesthesia and IV sedation are limited to coverage only when performed in conjunction with the following procedure codes:
D7210-D7251; D7260-D7261; D7280-D7286; D7290; D7340-D7350; D7471-D7473; D7485; D7520 & D7521; D7610-D7671; D7830; D7999 - if determined by Dental Consultant
D9220/9221: Limited to 60 minutes. If additional units are needed, consideration will be made on an individual basis with rationale and treatment notes.
FREQUENCY: N/A

DOCUMENTATON:

A detailed narrative, along with any clinical documentation that is available, including X-rays, treatment chart, photo, etc

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2015

DENTAL COVERAGE POLICY-Apexification/Recalcification

EFFECTIVE DATE: 01/01/2016

POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION

Apexification and recalcification procedures are performed in circumstances of traumatic injuries to the apices, or incomplete closure of the apex/apices of a permanent tooth. X-rays and intra-canal medication are necessary in these cases.

CODES:

D3351 - Apexification/recalcification– initial visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.) "Includes opening tooth, preparation of canal spaces, first placement of medication and necessary radiographs. (This procedure may include first phase of complete root canal therapy.)"
D3352 - Apexification/recalcification - For visits in which the intra-canal medication is replaced with new medication and necessary radiographs. (This procedure may include first phase of complete root canal therapy)
D3353 - Apexification/recalcification-final visit (include completed root canal therapy-apical closure/calcific repair of perforations, root resorption, etc.)
D3355 - Pulpal regeneration - intial visit (includes opening tooth, preparation of canal spaces, placement of medication)
D3356 - Pulpal regeneration - interim medication replacement
D3358 - Pulpal regeneration - completion of treatment (does not include final restoration)

CRITERIA:

No review required.

LIMITATIONS:

Not covered on primary teeth and permanent teeth of members under age 15.

DOCUMENTATION:

FREQUENCY:

D3355, D3356, D3358- Covered once per tooth per lifetime.

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2015

DENTAL COVERAGE POLICY – Apically Positioned Flap

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION:

Procedure is used to preserve kerantinized gingiva in conjunction with osseous resection and second stage implant procedure. Procedure may also be used to preserve kerantinized/attached gingiva during surgical exposure of labially impacted teeth, and may be used during treatment of peri-implantitis.

CODES:

D4245-Apically positioned flap

CRITERIA:

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

Considered integral to the greater procedure.

PER ADA CDT 2015

DENTAL COVERAGE POLICY-Apicoectomy/Perirad Surgery

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION

Periradicular surgery is a term used to describe surgery to the root at the apex or along the root surface, e.g., apicoectomy, repair of a root perforation or resorptive defect, exploratory curettage to look for root fractures, removal of extruded filling material or instruments, removal of broken root fragments, sealing of accessory canals, etc. This does not include retrograde filling material placement.

CODES:

D3410 - Apicoectomy-anterior
D3421 - Apicoectomy-bicuspid (first root)
D3425 - Apicoectomy-molar (first root)
D3426 - Apicoectomy-(each additional root)
D3427 - Periradicular surgery without apicoectomy
D3432 - Guided tissue regeneration, resorbable barrier, per site, in conjunction with periradicular surgery: Not covered.

CRITERIA:

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

Retrograde filling is considered a separate procedure.
Not allowed within 30 days following RCT treatment.

PER ADA CDT 2015

DENTAL COVERAGE POLICY - Complete Dentures

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION:

Benefits for complete dentures include adjustments, reline/rebase, or repairs for six months following delivery of the denture to the patient. Insertion date (delivered to the mouth) is considered the completion date for a partial denture and benefits are payable for that date of service (not impression date).

Specialized procedures - Specialized procedures are considered non-covered by Blue Cross Dental and the patient is responsible for payment. These services are to be performed with the consent of the patient **prior** to initiation of treatment. Documentation of the patient's acceptance of the treatment plan and payment responsibility is recommended.

CODES:

D5110 - Complete denture-maxillary
D5120 - Complete denture-mandibular

CRITERIA:

No review required.

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

Benefit once in 5-year period.

RELATIONSHIP TO OTHER CODES: (for payment purposes)

One removable partial denture, complete or immediate denture or replacement of all teeth and acrylic on a cast metal framework (D5670, D5671) is allowed per arch per five-year period

PER ADA CDT 2015

DENTAL COVERAGE POLICY- Coping

EFFECTIVE DATE: 03/21/2009
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION:

Not a covered benefit; patient liable for payment.

CODES:

D2975 -Coping: Not covered

CRITERIA:

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2015

DENTAL COVERAGE POLICY – Core Buildups

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION:

A core build-up provides a foundation upon which a crown will be fabricated. A tooth is deemed in need of a core build-up if it requires the replacement of missing tooth structure for the purpose of obtaining adequate resistance and retention for the crown. If the purpose of the restoration involves pulpal insulation, undercut elimination, cast bulk reduction, box formation or eliminating concave irregularities in the preparation, or for any other purposes other than obtaining adequate retention, the replacement of tooth structure should not be considered a core build-up.

CODES:

D2950 -Core buildup, including any pins

CRITERIA:

The Dental Consultant will review for large restorations mesial-distal with substantial depth, or with little supporting tooth structure buccal-lingual, also validating the need for a core build-up. If a tooth has been fractured or decayed, leaving minimal tooth structure to adequately provide retention for crown placement, a core build-up is indicated.

LIMITATIONS:

Not covered for members under age 14 unless clinical rationale is provided.
Not covered on primary teeth.

DOCUMENTATION:

Pre-operative periapical xray and photo (if applicable and available)

FREQUENCY:

Replacement limited to once in 5 years

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2015

DENTAL COVERAGE POLICY – Crown Lengthening

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION:

This procedure is employed to allow access to sound tooth structure for a restorative procedure or crown placement for adequate crown height and/or margins. Crown lengthening requires reflection of a flap and bone removal, 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.

CODES:

D4249-Clinical crown lengthening-hard tissue

CRITERIA:

Two or more on same date of service requires review.

LIMITATIONS:

DOCUMENTATION:

Pre-operative periapical xray

FREQUENCY:

Benefit once per tooth per lifetime

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2015

DENTAL COVERAGE POLICY- Crown Repair

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION:

Crown repairs are subject to individual consideration by Dental Consultant review. The review requires adequate clinical documentation.

CODES:

D2980 -Crown repair necessitated by restorative material failure
D2981 - Inlay repair necessitated by restorative material failure: Not covered
D2982- Onlay repair necessitated by restorative material failure
D2983 - Veneer repair necessitated by restorative material failure: Not covered

CRITERIA:

The allowance for a crown repair will be determined by considering the time, difficulty and materials used in the process to repair the crown.

LIMITATIONS:

DOCUMENTATION:

X-rays, treatment notes, detailed narrative, photo if available, copy of the lab charges (if applicable)

FREQUENCY:

Repairs are limited to once in 36 months and should be considered inclusive with the crown benefit if performed within 60 months of insertion by the same dentist/dental office.

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2015

DENTAL COVERAGE POLICY – Crowns

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION:

Blue Cross Dental recommends that the most conservative treatment should be attempted to restore a tooth. Crowns are covered when a tooth is decayed or fractured to the degree that an amalgam or composite filling is inadequate to restore the tooth's functionality. A tooth must have a sound endodontic and periodontal prognosis to be considered eligible for crown coverage.
Cementation/insertion date (delivered to the mouth) is considered the completion date for a crown and benefits are payable for that date of service (not prep date).
There is a five-year time limitation for replacement of a crown and/or other major restorative procedures. Study models and temporary crowns are considered part of the overall major restorative procedure. The benefit for a crown includes the preparation, impressions, insertion and post-operative care
Recementation of a crown, within 12months of delivery of the crown, is considered part of the comprehensive procedure and the patient is not responsible for payment.
Generally, crowns are allowed only on permanent teeth. In the case of a retained deciduous tooth without a permanent successor, consideration for a crown is given if the tooth has sufficient periodontal support. Individual consideration review by the Dental Consultant is required in these cases.
A crown may be contractually denied with the patient responsible for payment if the following conditions exist:

- Treatment to restore tooth structure that is lost due to attrition, erosion and/or abrasion (unless imminent pulpal danger)
- Placement of a crown on a "peg lateral" for cosmetic reasons (consideration if fractured/decayed per guidelines)
- Placement of a crown on a tooth for reasons deemed cosmetic in nature
- Crowns placed solely to increase vertical dimension, restore occlusion, or correct congenital defects

Specialized procedures - Specialized procedures are considered non-covered by Blue Cross Dental and the patient is responsible for payment. These services are to be performed with the consent of the patient **prior** to initiation of treatment. Documentation of the patient's acceptance of the treatment plan and payment responsibility is recommended. A porcelain labial margin (porcelain butt joint) is an example of a specialized restorative procedure. defects.

CODES:

D2710 -Crown-resin-based composite (indirect)
D2712 -Crown-3/4 resin-based composite (indirect)
D2720 -Crown-resin with high noble metal
D2721 -Crown-resin with predominantly base metal
D2722 -Crown-resin with noble metal
D2740 -Crown-porcelain/ceramic substrate
D2750 -Crown-porcelain fused to high noble metal

D2751 -Crown-porcelain fused to predominantly base metal
D2752 -Crown-porcelain fused to noble metal
D2780 -Crown-3/4 cast high noble metal
D2781 -Crown-3/4 cast predominantly base metal
D2782 -Crown-3/4 cast noble metal
D2783 -Crown-3/4 porcelain/ceramic
D2790 -Crown-full cast high noble metal
D2791-Crown-full cast predominantly base metal
D2792 -Crown-full cast noble metal
D2794 -Crown-titanium

CRITERIA:

Dental Consultant Review

Specific criteria for crown treatment includes:

- Any large existing restorations must involve at least 50% of the tooth structure
- Additional surface exhibits large area of decay
- Cuspal fracture/incisal fracture (of at least 50% of incisal angle)
- Extensive recurrent decay
- Posterior teeth – existing restoration of at least three surfaces, leaving thin walls on other surfaces
- Anterior teeth – existing restoration of at least two surfaces or with proximity to the pulp
- Radiographic evidence of a poor endodontic prognosis will result in the denial of major restorative procedures (patient responsible for payment)
- If there is inadequate bone support (approximately 2/3's or more loss at site) demonstrated in the x-ray(s), the treatment site will be considered at risk for a long-term periodontal prognosis and denied (patient responsible for payment) for major restorative procedures. Adequate bone support is evaluated based upon the following:
- pocket depths
- mobility
- bone density
- vertical and/or horizontal bone loss
- length and condition of the roots
- furcation involvement
- on-going treatment by a periodontist
- age of patient

Craze lines do not qualify as a "crack" in a tooth. If a tooth has been diagnosed with "cracked tooth syndrome", appropriate documentation must be submitted to demonstrate that the tooth is symptomatic. Blue Cross Dental recommends submitting a detailed narrative and/or treatment chart denoting the history of symptoms.

If a tooth has undergone a hemisection, only one crown per tooth (not section of a tooth) is allowed.

Cerec crowns are considered a covered benefit and should be reported using code D2740 and indicated on the submission (notation at bottom) as "Cerec".

LIMITATIONS:

Not covered for members under age 14 unless clinical rationale is provided.

DOCUMENTATION:
Pre-operative periapical x-rayor if tooth is endodontically treated, a post-operative endo periapical x-ray showing all apices, detailed narrative (if applicable)

FREQUENCY:
One onlay **OR** crown per tooth in a five-year period.

RELATIONSHIP TO OTHER CODES: (for payment purposes)

Study models and temporary crowns are inclusive

Recementation of a crown, within 12months of delivery of the crown, is considered part of the comprehensive procedure and the patient is not responsible for payment.

PER ADA CDT 2015

DENTAL COVERAGE POLICY -Dental Prophylaxis

EFFECTIVE DATE: 1/1/2016
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION:

Most groups cover two (2) dental prophylaxis per member in a 12 month period.. A prophylaxis is pro-rated when performed on the same date of service as periodontal scaling and root planing by the same dentist/dental office. There is no special consideration for "difficult" prophylaxis

CODES:

D1110 -Prophylaxis - adult (age 13 or older are eligible for this code)
D1120 -Prophylaxis - child (no upper age limit)

CRITERIA:

LIMITATIONS:

DOCUMENTATION:

Periodontal charting and detailed narrative (for third cleaning)

FREQUENCY:

Two (2) cleanings per patient per 12 months

RELATIONSHIP TO OTHER CODES: (for payment purposes)

Considered integral when performed on the same day, or within 45 days, by the same dentist, as two or more limited sites or one or more quadrants of scaling and root planing.

PER ADA CDT 2015

DENTAL COVERAGE POLICY - Denture Rebase and Reline

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION:

A rebase or reline to a complete or partial denture, performed within six months of delivery of the denture, is considered part of the initial fee for the denture and a participating dentist may not charge the member.

CODES:

Dental Rebase Procedures
D5710 - Rebase complete maxillary denture
D5711 - Rebase complete mandibular denture
D5720 - Rebase maxillary partial denture
D5721 - Rebase mandibular partial denture
Dental Reline Procedures
D5730 - Reline complete maxillary denture (chairside)
D5731 - Reline complete mandibular denture (chairside)
D5740 - Reline maxillary partial denture (chairside)
D5741 - Reline mandibular partial denture (chairside)
D5750 - Reline complete maxillary denture (laboratory)
D5751 - Reline complete mandibular denture (laboratory)
D5760 - Reline maxillary partial denture (laboratory)
D5761 - Reline mandibular partial denture (laboratory) No review required.

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

Benefit for rebase or reline: once in a 36 month period, per arch.

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2015

DENTAL COVERAGE POLICY -Distal or Proximal Wedge Procedure

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION:

This procedure is performed in an edentulous area adjacent to a periodontally involved tooth. Gingival incisions are utilized to allow removal of a tissue wedge to gain access and correct the underlying osseous defect and to permit close flap adaptation.

CODES:

D4274- Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)

CRITERIA:

No review required.

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

Once per site per 36 months.

RELATIONSHIP TO OTHER CODES: (for payment purposes)

Distal wedge procedure is denied as integral if performed on same day, same dentist as other periodontal treatment.A participating dentist may not bill the patient for the difference in the charges.

PER ADA CDT 2015

DENTAL COVERAGE POLICY-Drugs

EFFECTIVE DATE: 09/17/2009
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION

Coverage does not include drugs as dental benefits.

CODES:

D9610 - Therapeutic parenteral drug, single administration: Not covered
D9612 - Therapeutic parenteral drugs, two or more administrations, different medications: Not covered
D9630 - Other drugs and/or medicaments, by report: Not covered

CRITERIA:

LIMITATIONS: N/A

FREQUENCY: N/A

DOCUMENTATON: N/A

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2015

DENTAL COVERAGE POLICY-Endodontic Retreatment

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION

Retreatment of a root canal, when performed by the same dentist as the original treatment, is considered part of the original root canal for up to 12 months and the patient cannot be charged for additional treatment during this period.

CODES:

D3346 - Retreatment of previous root canal therapy - anterior
D3347 - Retreatment of previous root canal therapy - bicuspid
D3348 - Retreatment of previous root canal therapy – molar

CRITERIA:

Dental Consultant Review required only when provided within 30 days prior to an extraction.

LIMITATIONS:

Once per tooth per lifetime.

DOCUMENTATION: Pre-operative, post-operative periapical xrays and narrative

FREQUENCY:

Benefits for retreatment of a root canal by a different dentist (than performed the original endodontic treatment) are allowed. Retreatment by the same dentist (that performed the original root canal) is not allowed within 12months.

RELATIONSHIP TO OTHER CODES: (for payment purposes)
Exams, palliative treatment, pulp tests, apical curettage, x-rays (related to root canal retreatment), local anesthetic are considered part of the treatment.

PER ADA CDT 2015

DENTAL COVERAGE POLICY-Endodontics on Primary Teeth

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION

Blue Cross Dental covers endodontic treatment on permanent teeth only. Therefore, root canal therapy on primary teeth is not a covered benefit.

Exception: If a primary tooth is in need of a root canal and there is no permanent successor to the primary tooth, consideration for benefits will be made. The Dental Consultant will review these exceptions.

CODES:

D3230 - Pulpal therapy (resorbable filling)-anterior, primary tooth (excluding final restoration): Not covered
D3240 - Pulpal therapy (resorbable filling)-posterior, primary tooth (excluding final restoration): Not covered

CRITERIA:

Consultant review required

LIMITATIONS:

DOCUMENTATION:

Preoperative periapical xray

FREQUENCY: N/A

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2015

DENTAL COVERAGE POLICY- Extractions

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION:

Extractions include local anesthesia, suturing if needed, and routine post-operative care. If an attempt to extract a tooth fails, it is not considered a completed procedure and should not be submitted for benefits. The entire tooth and roots must be extracted to be considered for benefits.

CODES:

D7111 - Extraction, coronal remnants-deciduous tooth
D7140 - Extraction, erupted tooth or exposed root (elevation and/or forceps removal)

CRITERIA:

No review required.

LIMITATIONS:

Some groups may have coverage for simple extractions (non-surgical) only. The coverage may/ may not apply an alternate benefit of a simple extraction allowance for surgical extractions-D7210with the member liable for the difference in payment up to the dentist's charge.

DOCUMENTATION:

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

D7111 is considered integral to extraction if reported by the same dentist who extracted the tooth.

PER ADA CDT 2015

DENTAL COVERAGE POLICY- Fixed Partial Denture Implant Supported

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2014

INTERNAL POLICY DESCRIPTION:

The listed procedure codes are covered if there is an implant rider.

CODES:

D6075 - Implant supported retainer for ceramic FPD
D6076 - Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy or high noble metal)
D6077 - Implant supported retainer for cast metal FPD (titanium, titanium alloy or high noble metal)
D6114 -Implant/abutment supported fixed denture for edentulous arch-maxillary
D6115 -Implant/abutment supported fixed denture for edentulous arch-mandibular
D6116 -Implant/abutment supported fixed denture for partially edentulous arch-maxillary
D6117 -Implant/abutment supported fixed denture for partially edentulous arch-maxillary

CRITERIA:

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2015

DENTAL COVERAGE POLICY- Fixed Partial Denture, Implant/Abutment Supported

Blue Cross Blue Shield of Rhode Island

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION:

Abutment supported retainers for fixed bridges (over implants) are covered if there is an implant rider. The procedure should be submitted with the appropriate implant code(s), e.g. D6068, D6069). There is a five-year limitation for replacement of the abutment supported retainers for fixed bridges.

Specialized procedures are considered non-covered, and are a patient liability up to the dentist's charge.

CODES:D6068-Abutment supported retainer for porcelain/ceramic FPD
D6069-Abutment supported retainer for porcelain fused to metal FPD (high noble metal)
D6070-Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)
D6071-Abutment supported retainer for porcelain fused to metal FPD (noble metal)
D6072-Abutment supported retainer for cast metal FPD (high noble metal)
D6073-Abutment supported retainer for cast metal FPD (predominantly base metal)
D6074-Abutment supported retainer for cast metal FPD (noble metal)
D6075 - Implant supported retainer for ceramic FPD
D6076 - Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy or high noble metal)
D6077 - Implant supported retainer for cast metal FPD (titanium, titanium alloy or high noble metal)
D6093 - Recement implant/abutment supported fixed partial denture
D6114 -Implant/abutment supported fixed denture for edentulous arch-maxillary
D6115 -Implant/abutment supported fixed denture for edentulous arch-mandibular
D6116 -Implant/abutment supported fixed denture for partially edentulous arch-maxillary
D6117 -Implant/abutment supported fixed denture for partially edentulous arch-maxillary
D6194-Abutment supported retainer crown for FPD (titanium)

CRITERIA:

Successful implant placement to support/stabilize the prosthesis.

LIMITATIONS:

DOCUMENTATION:

Post-operative panorex or set of periapical X-rays

FREQUENCY:

Five-year limitation for replacement

RELATIONSHIP TO OTHER CODES: (for payment purposes)

If replacing an existing conventional prosthesis, allowance may be reduced if within the five-year limitation.

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DENTAL COVERAGE POLICY- Fixed Partial Dentures

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2014

INTERNAL POLICY DESCRIPTION

No replacement of teeth beyond the normal complement if allowed. Benefits for a fixed bridge are applicable in one calendar year, and individual units of the bridge may not be applied to multiple calendar years. Benefits are payable upon insertion/delivery of the fixed bridge.

CODES:

Fixed Partial Denture Pontics
D6205-Pontic-indirect resin based composite
(Not be used as a temporary or provisional prosthesis)
D6210-Pontic-cast high noble metal
D6211-Pontic-cast predominantly base metal
D6212-Pontic-cast noble metal
D6214-Pontic-titanium
D6240-Pontic-porcelain fused to high noble metal
D6241-Pontic-porcelain fused to predominantly base metal
D6242-Pontic-porcelain fused to noble metal
D6245-Pontic-porcelain/ceramic
D6250-Pontic-resin with high noble metal
D6251-Pontic-resin with predominantly base metal
D6252-Pontic-resin with noble metal
D6253-provisional pontic-further treatment or completion of diagnosis necessary prior to final impression: Not covered

Fixed Partial Denture Retainers - Inlays/Onlays
D6545-Retainer-cast metal for resin bonded fixed prosthesis
D6548-Retainer-porcelain/ceramic for resin bonded fixed prosthesis
D6549- Resin retainer- for resin bonded fixed prosthesis
D6600-Inlay-porcelain/ceramic, two surfaces
D6601-Inlay-porcelain/ceramic, three or more surfaces
D6602-Inlay-cast high noble metal, two surfaces
D6603-Inlay-porcelain/ceramic, three or more surfaces
D6604-Inlay-cast predominantly base metal, two surfaces
D6605-Inlay-cast predominantly base metal, three or more surfaces
D6606-Inlay-cast noble metal, two surfaces
D6607-Inlay-cast noble metal, three or more surfaces

D6624-Inlay-titanium: *Porcelain/ceramic onlays are given an alternate benefit of an amalgam or metallic onlay, determined by the Dental Consultant review based on criteria for full crown coverage. Patient is responsible for difference in payment up to dentist's charge*
D6608-Onlay-porcelain/ceramic, two surfaces
D6609-Onlay-porcelain/ceramic, three or more surfaces
D6610-Onlay-cast high noble metal, two surfaces
D6611-Onlay-cast high noble metal, three or more surfaces
D6612-Onlay-cast predominantly base metal, two surfaces
D6613-Onlay-cast predominantly base metal, three or more surfaces
D6614-Onlay-cast noble metal, two surfaces
D6615-Onlay-cast noble metal, three or more surfaces
D6634-Onlay-titanium

Fixed Partial Denture Retainers-Crowns
D6710-Crown-indirect resin based composite(not to be used as a temporary or provisional prosthesis)
D6720-Crown-resin with high noble metal
D6721-Crown-resin with predominantly base metal
D6722-Crown-resin with noble metal
D6740-Crown-porcelain/ceramic
D6750-Crown-porcelain fused to high noble metal
D6751-Crown-porcelain fused to predominantly base metal
D6752-Crown-porcelain fused to noble metal
D6780-Crown-3/4 cast high noble metal
D6781-Crown-3/4 cast predominantly base metal
D6782-Crown-3/4 cast noble metal
D6783-Crown-3/4 porcelain/ceramic
D6790-Crown-full cast high noble metal
D6791-Crown-full cast predominantly base metal
D6792-Crown-full cast noble metal
D6793-Provisional retainer crown-further treatment or completion of diagnosis necessary prior to final impression: Not covered
D6794-Crown-titanium

CRITERIA:
Dental Consultant Review

The need for pontics will be evaluated based on the amount of space between the abutment teeth, and the number of natural teeth being replaced.
Pontics are not benefitted when replacing teeth beyond the normal complement. Extra pontics are a patient liability up to the dentist's charge.

In the case where an abutment tooth does not appear to provide adequate support for the bridge in terms of crown/root ratio, the Dental Consultant may deny the entire bridge. Double abutments may be considered upon Dental Consultant review.

LIMITATIONS:
Not covered for members under age 14 unless clinical rationale is provided.

DOCUMENTATION:
Preoperative periapical X-rays of the entire treatment site (all teeth in the treatment plan) are required for review. If there are special circumstances related to the treatment, a detailed narrative is recommended. **It is imperative that a "Request for Review" form is submitted with a predetermination or payment claim for a treatment plan that involves one(or more) of these exceptions to the five-year limitation for replacement.**

FREQUENCY:
One per 60 months.
RELATIONSHIP TO OTHER CODES: (for payment purposes)
See above.

PER ADA CDT 2015

DENTAL COVERAGE POLICY- Frenulectomy

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION:

CODES:
D7960 - Frenulectomy (also known as a frenectomy or frenotomyD7963 – Frenuloplasty

CRITERIA:
No review required

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)
Frenulectomy and frenuloplasty are integral to eachother.
If performed on same day, same dentist as endodontic, oral surgery and/or periodontal surgery, it is considered integral.

PER ADA CDT 2015

DENTAL COVERAGE POLICY –Full Mouth Debridement

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION:

CODES:
D4355 - Full mouth debridement to enable comprehensive evaluation and diagnosis

CRITERIA:

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:
Once per lifetime

RELATIONSHIP TO OTHER CODES: (for payment purposes)
Denied as integral if performed on same day, same dentist as prophylaxis (D1110) or scaling and root planing (D4341/D4342). Payment will not be made if reported on same day, same dentist as periodontal maintenance or within 12 months FOLLOWING routine prophylaxis, periodontal maintenance or scaling and root planing as this is inappropriate treatment sequence.

PER ADA CDT 2015

DENTAL COVERAGE POLICY – Gingival Flap Procedure

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION:

A soft tissue flap is reflected or resected to allow debridement of the root surface and the removal of granulation tissue. Osseous recontouring is not accomplished in conjunction with this procedure. May include open flap curettage, reverse bevel flap surgery, modified Kirkland flap procedure, and modified Widman surgery. This procedure is performed in the presence of moderate to deep probing depths, loss of attachment, need to maintain esthetics, need for increased access to the root surface and alveolar bone, or to determine the presence of a cracked tooth, fractured root, or external root resorption. Other procedure may be required concurrent to D4240/D4241 and should be reported separately using their own unique codes.

CODES:

D4240-Gingival flap procedure, including root planing-four or more contiguous teeth or tooth bounded spaces per quadrant
D4241-Gingival flap procedure, including root planing-one to three contiguous teeth or tooth bounded spaces per quadrant

CRITERIA:

Consultant review required.

LIMITATIONS:

Limited to once per 36 months per mouth area.

DOCUMENTATION: Pre-treatment radiographs, periodontal charting and narrative.
More than two quadrans provided on the same date requires an explanation as to why services were provided on the same date.

FREQUENCY:

If submitted by the same dentiston the same date of service in the same mouth area as extractions, periodontal surgery (except soft tissue grafts), , and oral surgery procedures, this procedure will be considered part of the more comprehensive procedure for reimbursement purposes. A participating dentist may not bill the patient for the difference in the charges.
Not covered within 36 months following gingival flap, surgical procedures or scaling and root planing in the same mouth area.

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2015

DENTAL COVERAGE POLICY- Gingivectomies

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION:

Gingivectomy involves the excision of gingiva by an internal or external bevel or laser therapy. This procedure will assist in the elimination of suprabony pockets, and/or allow access for the placement of restorations. In cases of gingival enlargement, a gingivectomy may be performed to restore normal architecture to the soft tissues and may also be referred to as "gingivoplasty".

A gingivectomy is considered dentally necessary when there is evidence of gingival hyperplasia and/or diseased soft tissue conditions which require excision to restore the health of the tissue or access to sound tooth structure. Both gingivectomy and gingivoplasty procedures are surgical procedures and are usually performed in the early stages of periodontal disease to prevent progression to more serious periodontal conditions.

CODES:

D4210 -Gingivectomy or gingivoplasty-four or more contiguous teeth or tooth bounded tooth spaces per quadrant
D4211 -Gingivectomy or gingivoplasty-one to three contiguous teeth or tooth bounded tooth spaces per quadrant
D4212 - Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth: Not covered.

CRITERIA:

D4210, D4211 - Requires Dental Consultant review (as applicable)

LIMITATIONS:

DOCUMENTATION:

Periapical xray, periodontal charting, detailed clinical narrative including diagnosis

FREQUENCY:

One treatment per site/area in a 36-month period

RELATIONSHIP TO OTHER CODES: (for payment purposes)

If performed in the same treatment area, on the same date of service as periodontal scaling and root planing, osseous surgery or flap surgery, the gingivectomy is considered part of the more comprehensive procedure and will not be a separate benefit. A participating dentist may not charge the patient separately.
A gingivectomy is not benefitted at the same treatment site as a crown lengthening procedure.
If a restoration (filling, crown, etc.) is performed at the same treatment site, on the same date of service as D4211, no separate benefit is allowed.

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DENTAL COVERAGE POLICY – Gold Foil Restorations and Inlays

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION:

Gold foil restorations and inlays are considered alternative restorations. Gold foil restorations are not covered. Metallic and composite inlays are restorations that may be composed of precious metals, semi-precious metals, non-precious metals, or composite materials. These restorations are not a covered benefit, however, the allowance for the corresponding amalgam restoration (same tooth surfaces) is made for this restoration, with the patient responsible for payment of the difference up to the dentist's charge.
These services should be performed with the consent of the patient **prior** to the initiation of treatment. Documentation of the patient's acceptance of the treatment plan and payment responsibility is recommended.

CODES:

D2410 -Gold foil-one surface: Not covered.
D2420 -Gold foil-two surface: Not covered.
D2430 -Gold foil-three surface: Not covered.
D2510 -Inlay-metallic-one surface
D2520 -Inlay-metallic-two surfaces
D2530 -Inlay-metallic-three or more surfaces
D2610 -Inlay-porcelain/ceramic-one surface
D2620 -Inlay-porcelain/ceramic-two surfaces
D2630 -Inlay-porcelain/ceramic-three or more surfaces
D2650 -Inlay-resin-based composite-one surface
D2651 -Inlay-resin-based composite-two surfaces
D2652 -Inlay-resin-based composite-three or more surface

CRITERIA:

No review required

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2015

DENTAL COVERAGE POLICY- Guided Tissue Regeneration

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION:

A membrane is placed over the root surfaces or defect area following surgical exposure and debridement. The mucoperiosteal flaps are then adapted over the
the membrane and sutured. The membrane is place to exclude epithelium and gingival connective tissue from the healing wound. This procedure may require subsequent surgical procedures to correct the gingival contours. Guided tissue regeneration may also be carried out in conjunction with bone replacement grafts or to correct deformities resulting from inadequate faciolingual bone width in an edentulous area. When guided tissue regeneration is used in association with a tooth, each site on a specific tooth should be reported separately. Other separate procedures may be required concurrent to D4266/D4267 and should be reported using their own unique codes.

CODES:

D4266 - Guided tissue regeneration - resorbable barrier, per site: This procedure does not include flap entry and closure, or when indicated, wound debridement, osseous contouring, bone replacement grafts, and placement of biologic materials to aid in osseous regeneration. This procedure can be used for periodontal and peri-implant defects.
D4267 - Guided tissue regeneration - nonresorbable barrier, per site: This procedure does not include flap entry and closure, or when indicated, wound debridement, osseous contouring, bone replacement grafts, and placement of biologic materials to aid in osseous regeneration. This procedure can be used for periodontal and peri-implant defects.

CRITERIA:

Covered to treat specific periodontal defects.

LIMITATIONS:

DOCUMENTATION:

Current pre operative radiographs, periodontal charting, detailed narrative.

FREQUENCY:

Allow once per site per lifetime

RELATIONSHIP TO OTHER CODES: (for payment purposes)

Not covered in conjunction with extraction, cyst removal, apicoectomy or implants.
Not covered when provided in conjunction with a soft tissue graft for root coverage.

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DENTAL COVERAGE POLICY-Hemisection

EFFECTIVE DATE: 03/23/2009
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION

Hemisection involves the separation of a multi-rooted tooth into separate sections containing the root and overlying portion of the crown. It may include the removal of one or more of those sections. Replacement of the missing section of the tooth with a crown or pontic is not a covered benefit.

CODES:

D3920-Hemisection (including any root removal), not including root canal therapy

CRITERIA:

Dental Consultant Review

The Dental Consultant evaluates the treatment site to determine if the remaining tooth structure has a sound periodontal prognosis, and generally a good long-term prognosis.

LIMITATIONS:

DOCUMENTATION:

Predetermination: Pre-operative periapical.
Claim for services: Pre-operative and post-operative periapical xray.

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

Cannot perform hemisection on same tooth as a root amputation.

PER ADA CDT 2015

DENTAL COVERAGE POLICY -Immediate Dentures

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION:

For immediate dentures, benefits for one laboratory reline is allowed within six months of insertion of the denture.
Insertion date (delivered to the mouth) is considered the completion date for a partial denture and benefits are payable for that date of service (not impression date).
Specialized procedures - Specialized procedures are considered non-covered by Blue Cross Dental and the patient is responsible for payment. These services are to be performed with the consent of the patient **prior** to initiation of treatment. Documentation of the patient's acceptance of the treatment plan and payment responsibility is recommended.

CODES:

D5130 - Immediate denture-maxillary
D5140 - Immediate denture-mandibular

CRITERIA:

No review required.

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

Once per arch in a 5-year period .

RELATIONSHIP TO OTHER CODES: (for payment purposes)

One removable partial denture, complete or immediate denture or replacement of all teeth and acrylic on a cast metal framework (D5670, D5671) is allowed per arch per five-year period

PER ADA CDT 2015

DENTAL COVERAGE POLICY- Implant Abutments

EFFECTIVE DATE: 03/27/2009
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION:

Implant services are not a covered benefit unless specified in the group contract. If a group purchases an Implant Rider, there is a $3,500 lifetime maximum benefit for implant services. Coverage is at 50% and all implant services are subject to Dental Consultant review for all dentists.

Plans with prosthodontic coverage may include benefits for single-tooth implants only. These benefits are allowed in cases where only one natural tooth requires replacement and is an alternate treatment plan to a three-unit bridge.

CODES:

D6056- Prefabricated abutment-includes modification and placement
D6057- Custom fabricated abutment-includes placement
D6051- Interim abutment: Not covered
D6052 - Semi-precision attachment abutment: Not covered

CRITERIA:

Dental Consultant Review
The implant will be evaluated for successful placement.

LIMITATIONS:

DOCUMENTATION:

Postoperative X-ray and a narrative describing any special circumstances related to the service.

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2015

DENTAL COVERAGE POLICY- Implant Removal, By Report

EFFECTIVE DATE: 03/27/2009
POLICY LAST UPDATED: 03/30/2009

INTERNAL POLICY DESCRIPTION:

Implant services are not a covered benefit unless specified in the group contract. If a group purchases an Implant Rider, there is a $3,500 lifetime maximum benefit for implant services. Coverage is at 50% and all implant services are subject to Dental Consultant review for all dentists.

Plans with prosthodontic coverage may include benefits for single-tooth implants only. These benefits are allowed in cases where only one natural tooth requires replacement and is an alternate treatment plan to a three-unit bridge.

Benefits for removal of an implant requires coverage for implant services.

CODES:

D6100-Implant removal, by report

CRITERIA:

Dental Consultant Review
The Dental Consultant reviews removal of an implant on an individual consideration (IC) basis. Individual consideration is given for time, degree of difficulty and materials used to complete the procedure.

LIMITATIONS:

DOCUMENTATION:

Pre-operative and post-operative peripical xray, narrative

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2015

DENTAL COVERAGE POLICY- Implant Services

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION:

The listed procedure codes is covered if there is an implant rider: .

CODES:

D6055 - Connecting bar – implant supported or abutment supported Utilized to stabilize and anchor a prosthesis.
D6092 - Recement implant/abutment supported crown

CRITERIA:

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2015

DENTAL COVERAGE POLICY- Implant Supported Prosthetics

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION:

The listed procedure codes is covered if there is an implant rider: .

CODES:

D6055 - Connecting bar – implant supported or abutment supported Utilized to stabilize and anchor a prosthesis.

CRITERIA:

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2015

DENTAL COVERAGE POLICY- Implant Supported Removable Dentures

EFFECTIVE DATE: 03/30/2009
POLICY LAST UPDATED: 11/14/2014

INTERNAL POLICY DESCRIPTION:

Implant services are not a covered benefit unless specified in the group contract. If a group purchases an Implant Rider, there is a $3,500 lifetime maximum benefit for implant services. Coverage is at 50% and all implant services are subject to Dental Consultant review for all dentists.

Implant supported dentures (complete and partial) are given an alternate benefit of a conventional prosthesis of the same type. The patient is responsible for the difference in payment, up to the dentist's charge.

CODES:

D6110-Implant/abutment supported removable denture for edentulous arch-maxillary
D6111-Implant/abutment supported removable denture for edentulous arch-mandibular
D6112-Implant/abutment supported removable denture for partially edentulous arch-maxillary
D6113-Implant/abutment supported removable denture for partially edentulous arch-mandibular

CRITERIA:

Successful implant placement to support/stabilize the prosthesis.

LIMITATIONS:

DOCUMENTATION:

Post-operative panorex or set of periapical X-rays

FREQUENCY:

Five-year limitation for replacement

RELATIONSHIP TO OTHER CODES: (for payment purposes)

If replacing an existing conventional prosthesis, allowance may be reduced if within the five-year limitation.

PER ADA CDT 2015

DENTAL COVERAGE POLICY-Incomplete Endodontic Therapy

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 03/14/2012

INTERNAL POLICY DESCRIPTION

Considerable time is necessary to determine diagnosis and/or provide initial treatment before the fracture makes the tooth unretainable. This procedure is not covered and the dentist may bill the member.

CODES:

D3332 - Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth: Not covered.

CRITERIA:

LIMITATIONS:

DOCUMENTATION:

FREQUENCY: N/A

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2015

DENTAL COVERAGE POLICY- Infection Control

EFFECTIVE DATE: 05/05/2008
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION:

Infection control includes, but is not limited to, the use of supplies and techniques i.e., surgical gloves, paper goods, instruments, disposables, sterilization procedures, etc., and the cost for these are included in the reimbursement for dental services.

BCBSRI considers these materials and procedures to be part of the overall service provided, are not separately reimbursable, and a participating dentist may not charge the member.

CODES:

D9999 -Unspecified adjunctive procedure, by report
(may be submitted under other D x999 codes)

CRITERIA:

LIMITATIONS:

Considered inclusive; may not be charged to the member

DOCUMENTATION:

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2015

DENTAL COVERAGE POLICY - Interim Prosthesis

EFFECTIVE DATE: 10/15/2009
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION:

Interim prosthesis are not a covered benefit.

CODES:

D5810 - Interim complete denture (maxillary)
D5811 - Interim complete denture (mandibular)
D5820 - Interim partial denture (maxillary)
D5821- Interim partial denture (mandibular)

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2015

DENTAL COVERAGE POLICY-Internal Root Repair of Perf. Defects

EFFECTIVE DATE: 02/19/2009
POLICY LAST UPDATED: 03/14/2012

INTERNAL POLICY DESCRIPTION

Perforation repairs, (recalicification), should be considered as part of the overall root canal treatment if the perforation occurred during the root canal treatment (iatrogenic occurrence), and is being performed by the same dentist.

Treatment of a natural resorptive defect (due to natural resorption or decay), would be considered as a separate benefit. In these cases, the perforation repair is an attempt to allow the periodontal ligament to re-attach and allow bone healing in the area. (This is differential between perforation repair and apexification in an immature tooth that is an attempt to form an apical calcium bridge.)

CODES:

D3333 - Internal root repair of perforation defects

CRITERIA:

Dental Consultant Review
I.C. review based on specific scenario (above), time, materials used and difficulty of treatment. If extenuating circumstances are identified, the Endodontic Specialty Consultant will conduct the review.

LIMITATIONS:

DOCUMENTATION: Pre-operative, post-operative periapical xrays and narrative

FREQUENCY: N/A

RELATIONSHIP TO OTHER CODES: (for payment purposes)
May be considered part of the overall endodontic treatment per review

PER ADA CDT 2015

DENTAL COVERAGE POLICY-Miscellaneous Services

EFFECTIVE DATE: 09/17/2009
POLICY LAST UPDATED: 11/14/2014

INTERNAL POLICY DESCRIPTION

There is no coverage for the below services.

CODES:

D9910 - Application of desensitizing medicament: Not covered
D9911 - Application of desensitizing resin for cervical and/or root surface, per tooth: Not covered
D9920 - Behavior management, by report: Not covered
D9930 - Treatment of complications (post-surgical)-unusual circumstances, by report: Not covered
D9932 - Cleaning and inspection of removable complete denture, maxillary: Considered part of examination.
D9933 - Cleaning and inspection of removable complete denture, mandibular: Considered part of examination.
D9934 - Cleaning and inspection of removable partial denture, maxillary: Considered part of examination.
D9934 - Cleaning and inspection of removable partial denture, mandibular: Considered part of examination.
D9941 - Fabrication of athletic mouthguard: Not covered
D9942 - Repair and/or reline of occlusal guard: Not covered
D9950 - Occlusion analysis-mounted case: Not covered
D9951 - Occlusal adjustment-limited: Not covered
D9952 - Occlusal adjustment-complete: Not covered
D9970 - Enamel microabrasion: Not covered
D9971 - Odontoplasty 1-2 teeth; includes removal of enamel projections: Not covered
D9972 - External bleaching-per arch-performed in office: Not covered
D9973 - External bleaching-per tooth: Not covered
D9974 - Internal bleaching-per tooth: Not covered
D9975 - External bleaching for home application, per arch; includes materials and fabrication of custom trays: Not covered.
D9985 - Sales tax: Not covered.
D9986 – Missed appointment: Not covered
D9987 – Cancelled appointment- Not covered

CRITERIA:

LIMITATIONS: N/A

FREQUENCY: N/A

DOCUMENTATON: N/A

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2015

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DENTAL COVERAGE POLICY-Non Covered Endodontics

EFFECTIVE DATE: 03/23/2009
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION

Procedures listed are considered non-covered by BCBSRI. Member is liable for charge if services are performed.

CODES:

D3428 - Bone graft in conjunction with periradicular surgery - per tooth, single site: Not covered.
D3429 - Bone graft in conjunction with periradicular surgery - each additional contiguous tooth in same surgical site: Not covered.
D3431 - Biologic materials to aid in soft and osseous tissue regeneration in conjunction with periradicular surgery: Not covered.
D3460 - Endodontic endosseous implant: Not covered
D3470 - Intentional reimplantation (including necessary splinting): Not covered
D3910 - Surgical procedure for isolation of tooth with rubber dam: Not covered
D3950 - Canal preparation and fitting of performed dowel or post: Not covered

CRITERIA:

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2015

DENTAL COVERAGE POLICY – Non-covered Maxillofacial Prosthetics

EFFECTIVE DATE: 09/16/2009
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION:

Maxillofacial Prosthetics are non-covered dental benefits.

CODES:

D5911 - Facial moulage (sectional)
D5912 - Facial moulage (complete)
D5913 - Nasal prosthesis
D5914 - Auricular prosthesis
D5915 - Orbital prosthesis
D5916 - Ocular prosthesis
D5919 - Facial prosthesis
D5922 - Nasal septal prosthesis
D5923 - Ocular prosthesis, interim
D5924 - Cranial prosthesis
D5925 - Facial augmentation implant prosthesis
D5926 - Nasal prosthesis, replacement
D5927 - Auricular prosthesis, replacement
D5928 - Orbital prosthesis, replacement
D5929 - Facial prosthesis, replacement
D5931 - Obturator prosthesis, surgical
D5932 - Obturator prosthesis, definitive
D5933 - Obturator prosthesis, modification
D5934 - Mandibular resection prosthesis with guide flange
D5935 - Mandibular resection prosthesis without guide flange
D5936 - Obturator prosthesis, interim
D5937 - Trismus appliance (not for TMD treatment)
D5951 - Feeding aid
D5952 - Speech aid prosthesis, pediatric
D5953 - Speech aid prosthesis, adult
D5954 - Palatal augmentation prosthesis
D5955 - Palatal lift prosthesis, definitive
D5958 - Palatal lift prosthesis, interim
D5959 - Palatal lift prosthesis, modification
D5960 - Speech aid prosthesis, modification
D5982 - Surgical stent
D5983 - Radiation carrier
D5984 - Radiation shield
D5985 - Radiation cone locator
D5986 - Fluoride gel carrier
D5987 - Commissure splint

D5988 - Surgical splint
D5991 - Vesiculobullous medicament carrier
D5992 - Adjust maxillofacial prosthetic appliance
D5993 - "Maintenance and cleaning of a maxillofacial prosthesis (extra or intraoral) other than required adjustments, by report" Maintenance and cleaning of a maxillofacial prosthesis.
D5994 - Periodontal medicament carrier with peripheral seal - laboratory processed.

CRITERIA:

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2015

DENTAL COVERAGE POLICY -Non-Covered Non-Surgical Perio

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION:

Procedures listed are considered non-covered by BCBSRI. Member is liable for charge if services are performed.

CODES:

D4320 - Provisional splinting - intracoronal This is an interim stabilization of mobile teeth. A variety of methods and appliances may be employed for this purpose. Identify the teeth involved: Not covered
D4321 - Provisional splinting - extracoronal This is an interim stabilization of mobile teeth. A variety of methods and appliances may be employed for this purpose. Identify the teeth involved: Not covered
D4381 - Localized delivery of anitmicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report: Not covered
D4921 - Gingival irrigation -per quadrant: Considered integral to greater procedures.

CRITERIA:

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

D4921 considered integral to greater procedure. Member not liable for charge when performed by a participating dentist.

PER ADA CDT 2015

DENTAL COVERAGE POLICY – Osseous Grafting

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION:

CODES:

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 led to a deformity of the bone. This procedure does not include flap entry and closure, wound debridement, osseous contouring, or the placement of biologic materials to aid in osseous tissue regeneration or barrier membranes. Other separate procedures may be required concurrent to D4263 and should be reported using their own unique codes.
D4264 - Bone replacement graft - each additional site in quadrant This procedure involves the use of osseous autografts, osseous allografts, or non-osseous grafts to stimulate periodontal regeneration when the disease process has led to a deformity of the bone. This procedure does not include flap entry and closure, wound debridement, osseous contouring, or the placement of biologic materials to aid in osseous tissue regeneration or barrier membranes. This code is used if performed concurrently with D4263 and allows reporting of the exact number of sites involved.
D4265 - Biologic materials to aid in soft and osseous tissue regeneration: Not covered

CRITERIA:

Dental consultant review required for multiple bone grafts on the same day but the same dentist.

LIMITATIONS:

DOCUMENTATION:

Current periapical xrays
Current periodontal charting

FREQUENCY:

1 per site per 36 months

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2015

DENTAL COVERAGE POLICY – Occlusal Guards

EFFECTIVE DATE: 09/17/2009
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION:

Occlusal guards are covered only when specified by the group. If covered, occlusal guards are limited to once in a 5 year period.
A nightguard is a removable dental appliance that has been designed to minimize the effects of bruxism (griding), and other occlusal factors, on the dentition.

This appliance would be covered when evidence of clenching and/or grinding has damaged the dentition to reduce further damage/breakdown.

A nightguard is not used and will not be a covered benefit to treat temporomandibular joint dysfunction, sleep apnea or snoring.
This appliance also does not serve as an athletic mouthguard or orthodontic retainer.

CODES:

D9940 - Occlusal guard, by report: Not covered (unless group specified)

CRITERIA:

No review required.

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

Once in a 5 year period

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2015

DENTAL COVERAGE POLICY – Onlays

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION:

Onlays are used as restorations on posterior teeth and involve coverage of at least one cusp. Teeth must have three surfaces involved in order to qualify for an onlay benefitThere is a five-year time limitation for replacement of an onlay and/or other major restorative procedures. Benefits for an onlay **or** a crown per tooth are allowed in a five-year period..
Cementation/insertion date (delivered to the mouth) is considered the completion date for an onlay and benefits are payable for that date of service (not prep date.) Study models and temporary restorations are considered part of the overall major restorative procedure. This benefit also includes preparation, impressions, insertion and post-operative care. Recementation of an onlay, within 12months of delivery of the onlay, is considered part of the comprehensive procedure and the patient is not responsible for payment.
Onlays are allowed only on permanent teeth. An onlay may be contractually denied, with the patient responsible for payment, if the following conditions exist:

- Treatment to restore tooth structure that is lost due to attrition, erosion and/or abrasion (unless imminent pulpal danger)
- Placement of an onlay on a tooth for reasons deemed cosmetic in nature

Onlay placed solely to increase vertical dimension, restore occlusion, or correct congenital defects.

CODES:

D2542 -Onlay-metallic-two surfaces: Not covered; may receive alternate benefit of amalgam.
D2543 -Onlay-metallic-three surfaces
D2544 -Onlay-metallic-four or more surfaces
D2642 -Onlay-porcelain/ceramic-two surfaces: Not covered; may receive alternate benefit of amalgam.
D2643 -Onlay-porcelain/ceramic-three surfaces
D2644 -Onlay-porcelain/ceramic-four or more surfaces
D2662 -Onlay-resin-based composite-two surfaces: Not covered; may receive alternate benefit of amalgam.
D2663 -Onlay-resin-based composite-three surfaces
D2664 -Onlay-resin-based composite-four or more surfaces

CRITERIA:

Dental Consultant Review

The consultant will consider for benefits when a tooth is decayed or fractured to the degree that an amalgam or composite filling is inadequate to restore the tooth. A tooth must have a sound endodontic and periodontal prognosis to be considered eligible for crown coverage. Specific guideline criteria for a crown must be met to qualify for this service.
Craze lines do not qualify as a "crack" in a tooth. If a tooth has been diagnosed with "cracked tooth syndrome", appropriate documentation must be submitted to demonstrate that the tooth is

symptomatic. Blue Cross Dental recommends submitting a detailed narrative and/or treatment chart denoting a history of symptoms.

LIMITATIONS:

DOCUMENTATION:
A pre-operative periapical x-ray or bitewing x-ray (if tooth is not endo-treated), detailed narrative (if applicable)

FREQUENCY:
One onlay **OR** crown per tooth in a five-year period.

RELATIONSHIP TO OTHER CODES: (for payment purposes)
Recementation of an onlay, within 12months of delivery of the onlay, is considered part of the comprehensive procedure and the patient is not responsible for payment.

PER ADA CDT 2015

DENTAL COVERAGE POLICY-Oral Evaluations

EFFECTIVE DATE: 1/1/2016
POLICY LAST UPDATED: 11/14/2014

INTERNAL POLICY DESCRIPTION

Most groups cover one (1) oral examination per 12 months (first oral evaluation code received for processing in the calendar year.) Some groups may vary and include coverage for two (2) exams in per 12 months

CODES:

D0120 -Periodic oral evaluation-established patient: one (1) per 12 months
D0140 -Limited oral evaluation-problem focused: one (1) per 12 months
D0145 -Oral evaluation for a patient under three years of age and counseling with primary caregiver: one (1) per 12 months if under 3 years of age
D0150 -Comprehensive oral evaluations-new or established patient: full allowance if the patient has no history of active treatment (including exams) by the same dentist/dental office in the past 3 years; if patient has had treatment in this time period, allowance will be equal to that of a periodic oral evaluation and the participating dentist cannot charge the patient for the difference.
D0160 -Detailed and extensive oral evaluation-problem focused: Not Covered
D0170 -Re-evaluation-limited, problem focused (established patient; not post-operative visit): Not Covered
D0171 –Re-evaluation – post operative visit: Not covered
D0180 -Comprehensive periodontal evaluation-new or established patient: usually performed by a specialist -Not Covered
D0190 - Screening of a patient - A screening, including state or federally mandated screenings, to determine an individual's need to be seen by a dentist for diagnosis - Not Covered.
D0191 - Assessment of a patient - A limited clinical inspection that is performed to identify possible signs of oral or systemic disease, malformation, or injury, and the potential need for referral for diagnosis and treatment - Not Covered.

CRITERIA:

LIMITATIONS: N/A

FREQUENCY: Once per 12 months, unless otherwise specified by contract.

DOCUMENTATON: N/A

RELATIONSHIP TO OTHER CODES: (for payment purposes)

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DENTAL COVERAGE POLICY-Oral Pathology Laboratory

EFFECTIVE DATE: 11/26/2008
POLICY LAST UPDATED: 01/01/2016

INTERNAL POLICY DESCRIPTION

The procedure codes listed are generally performed in a pathology laboratory and do not include the removal of a tissue sample from the patient, therefore are not covered procedures.

CODES:

D0472 -Accession of tissue, gross examination, preparation and transmission of written report: Not covered
D0473 -Accession of tissue, gross and microscopic examination, preparation and transmission of written report: Not covered
D0474 -Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report: Not covered
D0480 -Accession of exfoliative cytologic smears, microscopic examination, preparation and transmission of written report: Not covered
D0486 - Accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report" "Pathological analysis, and written report of findings, of cytologic sample of disaggregated transepithelial cells: Not covered.
D0475 -Decalcification procedure: Not covered
D0476 -Special stains for microorganisms: Not covered
D0477 -Special stains, not for microorganisms: Not covered
D0478 -Immunohistochemical stains: Not covered
D0479 -Tissue in-situ hybridization, including interpretation: Not covered
D0481 -Electron microscopy-diagnostic: Not covered
D0482 -Direct immunofluorescence: Not covered
D0483 -Indirect immunofluorescence: Not covered
D0484 -Consultation on slides prepared elsewhere: Not covered
D0485 -Consultation, including preparation of slides from biopsy material supplied by a referring source: Not covered
D0502 -Other oral pathology procedures, by report: Not covered
D0999 -Unspecified diagnostic procedure, by report: I.C. review (individual consideration)

CRITERIA:

LIMITATIONS: N/A

FREQUENCY: N/A

DOCUMENTATON: N/A

RELATIONSHIP TO OTHER CODES: (for payment purposes)

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DENTAL COVERAGE POLICY-Orthodontics

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION

Dependents up to the age of 19 are eligible for orthodontic benefits if the specific contract includes orthodontic coverage. Benefits continue until December 31st in the year of the member's 19th birthday, and is subject to a separate lifetime orthodontic maximum allowance. Adult orthodontic coverage is available, but is group specific and not part of the customary orthodontic benefits.
Automatic payments are generated to participating dentists providing the orthodontic treatment. The initial payment, most commonly 35% of the total allowance calculated for the treatment, is made based on the banding date. The monthly payments are determined by dividing the remainder of the total allowance by the number of months estimated to complete treatment. The automatic payments end when the benefits are exhausted and the dentist should notify BCBSRI if treatment is terminated. Changes in benefits or member eligibility may also cause termination of the payments.
Payment for all orthodontic treatment caseswill be generated quarterly.
If a member has started orthodontic treatment with coverage by another carrier and the group is acquired by BCBSRI, the benefit maximum for ortho services is usually carried over from the previous carrier. *Example:* Previous insurer has paid $900 towards orthodontic services, and BCBSRI has a lifetime maximum limit for orthodontics of $1,200. BCBSRI will pay an additional $300 towards the orthodontic treatment.
The fee for orthodontic treatment includesappliances and post-treatment stabilization (retainer).

CODES:

D8010 - Limited orthodontic treatment of the primary dentition
D8020 - Limited orthodontic treatment of the transitional dentition
D8030 - Limited orthodontic treatment of the adolescent dentition
D8040 - Limited orthodontic treatment of the adult dentition
D8050 - Interceptive orthodontic treatment of the primary dentition
D8060 - Interceptive orthodontic treatment of the transitional dentition
D8070 - Comprehensive orthodontic treatment of the transitional dentition
D8080 - Comprehensive orthodontic treatment of the adolescent dentition
D8090 - Comprehensive orthodontic treatment of the adult dentition
D8210 - Removable appliance therapy
D8220 - Fixed appliance therapy
D8660 - Pre-orthodontic treatment visit: Not covered
D8670 - Periodic orthodontic treatment visit (as part of contract): Not covered
D8680 - Orthodontic retention (removal of appliances, construction and placement of retainer(s))
D8681 – Removable orthodontic retainer adjustment: Not covered
D8690 - Orthodontic treatment (alternative billing to a contract fee)
D8691 - Repair of orthodontic appliance
D8692 - Replacement of lost or broken retainer: Not covered

D8693 - Rebonding or recementing of fixed retainers: Not covered
D8694 - Repair of fixed retainers, includes reattachment: Not covered

CRITERIA:

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2015

DENTAL COVERAGE POLICY- Osseous Surgery

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION:

Osseous surgery is a benefit when a patient exhibits moderate to advanced periodontal disease. It is performed to modify the bony support of teeth by reshaping the alveolar process in order to achieve a more physiologic form.

CODES:

D4260 -Osseous surgery (including flap entry and closure)-four or more contiguous teeth or tooth bounded spaces per quadrant
D4261 -Osseous surgery (including flap entry and closure)-one to three contiguous teeth or tooth bounded spaces per quadrant

CRITERIA:

Consultant review required.
Pocket depths of 5mm or more and radiographic evidence of interproximal bone loss and/or vertical bone loss support the need for osseous surgery. The number of teeth within a quadrant, with qualifying pocket depths and radiographic evidence of bone loss, determines the appropriate code, D4260 or D4261.

LIMITATIONS:

DOCUMENTATION:

Current periodontal charting and xrays
More than 2 quadrants performed on the same day requires explanation as to why services were provided on the same date.

FREQUENCY:

Denied if performed within 36-months of osseous surgery, grafting or guided tissue regeneration in the same mouth area.Patient not liable for payment if performed by the same dentist/dental office; patient liable if different dentist/dental office. Once per mouth area per 36 months.

RELATIONSHIP TO OTHER CODES: (for payment purposes)

Crown lengthening procedures performed by the same dentist on the same date of service as osseous surgery (same treatment site) are considered inclusive and a participating dentist may not bill the patient separately for these services.
If performed within 36 months of gingival flap or gingivectomy (same treatment site), payment for osseous surgery will be offset with gingival flap or gingivectomy.

PER ADA CDT 2015

DENTAL COVERAGE POLICY- Other Covered Surgical Procedures

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION:

CODES:
D7280 - Surgical access of an unerupted tooth
D7283 - Placement of device to facilitate eruption of impacted tooth
D7291 - Transseptal fiberotomy/supra crestal fiberotomy, by report
D7970 - Excision of hyperplastic tissue - per arch
D7971 - Excision of pericoronal gingiva

CRITERIA:
No review required.

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:
Allowed once per tooth per lifetime.
Fiberotomy (D7291) limited to permanent anterior teeth and first bicuspids.
D7971 will be considered integral to endodontic and/or periodontal surgical procedures on the same date, same dentist, same mouth area.

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2015

DENTAL COVERAGE POLICY- Other Fixed Partial Denture Services

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 09/21/2009

INTERNAL POLICY DESCRIPTION:

Additional posts used in conjunction with post and cores for bridge abutments are considered part of the comprehensive service and there is no additional benefit. Participating dentists may not charge the member. Repairs to fixed partial dentures are reviewed on an I.C. basis by the Dental Consultant and consideration for time, materials and degree of difficulty is given to determine benefits.

CODES:

D6920 - Connector bar: Not covered
D6940 – Stress breaker: Not covered
D6980 - Fixed partial denture repair necessitated by restorative material failure: IC Review
D6985 - Pediatric partial denture, fixed: Not covered

CRITERIA:

Dental Consultant Review
D- 6980: Individual consideration is given for time, degree of difficulty and materials used to complete the procedure.

LIMITATIONS:

DOCUMENTATION:

Narrative and copy of laboratory charges (if applicable)
Pre-operative periapical, if available

FREQUENCY:

D6980 is considered integral within 60 months of insertion. After 60 months, allowed once per 12 months per tooth.

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2015

DENTAL COVERAGE POLICY- Other Implant Services

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION:

The listed procedure codes are non-covered dental benefits.

CODES:

D6012 - Surgical placement of interim implant body for transitional prosthesis: endosteal implant
D6080 - Implant maintenance procedures, when prostheses are removed and reinserted, including cleansing of prosthesis and abutments
D6090 - Repair implant supported prosthesis, by report
D6095 - Repair implant abutment, by report
D6091 - Replacement of semi-precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment
D6103 - Bone graft for repair of periimplant defect- not including entry and closure or, when indicated, placement of a barrier membrane or biologic materials to aid in osseous regeneration
D6190 - Radiographic/surgical implant index, by report

CRITERIA:

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2015

DENTAL COVERAGE POLICY- Other Non-Covered Surgical Procedures

Blue Cross Blue Shield of Rhode Island

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION:

The listed procedure codes are **non-covered** dental benefits.

CODES:

D7260 Oral antral fistula closure
D7261 Primary closure of a sinus perforation
D7272 - Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization)
D7282 - Mobilization of erupted or malpositioned tooth to aid eruption: not covered.
D7285 Biopsy of oral tissue-hard
D7286 Biopsy of oral tissue-soft
D7287 - Exfoliative cytological sample collection
D7288 - Brush biopsy-transepithelial sample collection
D7290 - Surgical repositioning of teeth: not covered.
D7292 - Surgical placement: temporary anchorage device [screw retained plate] requiring surgical flap
D7293 - Surgical placement: temporary anchorage device requiring surgical flap
D7294 - Surgical placement: temporary anchorage device without surgical flap
D7295 - Harvest of bone for use in autogenous grafting procedure
D7410 Radical excision - lesion diameter up to 1.25 cm
D7411 Excision of benign lesion greater than 1.25 cm
D7412 Excision of benign lesion, complicated
D7413 Excision of malignant lesion up to 1.25 cm
D7414 Excision of malignant lesion greater than 1.25 cm
D7415 Excision of malignant lesion, complicated
D7440 Excision of malignant tumor- lesion diameter up to 1.25 cm
D7441 Excision of malignant tumor - lesion diameter greater than 1.25 cm
D7465 - Destruction of lesion(s) by physical or chemical method, by report
D7461 Removal of nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm
D7471 Removal of exostosis - maxilla or mandible
D7490 - Radical resection of maxilla or mandible
D7520 Incision and drainage of abscess - extraoral soft tissue
D7521 Incision and drainage of abscess - extraoral soft tissue (includes drainage of multiple facial spaces)
D7530 Removal of foreign body, skin, or subcutaneous alveolar tissue
D7540 Removal of reaction-producing foreign bodies - musculoskeletal system
D7550 Sequestrectomy for osteomyelitis
D7560 Maxillary sinusotomy for removal of tooth fragment or foreign body
D7610 Maxilla, open reduction (teeth immobilized if present)
D7620 Maxilla, closed reduction (teeth immobilized if present)

D7630 Mandible, open reduction (teeth immobilized if present)
D7640 Mandible, closed reduction (teeth immobilized if present)
D7650 Malar and/or zygomatic arch, open reduction
D7660 Malar and/or zygomatic arch, closed reduction
D7670 Alveolus, closed reduction, may include stabilization of teeth
D7671 Alveolus, open reduction, may include stabilization of teeth
D7680 - Facial bone-complicated reduction with fixation and multiple surgical approaches
D7710 Maxilla - open reduction
D7720 Maxilla - closed reduction
D7730 Mandible - open reduction
D7740 Mandible - closed reduction
D7750 Malar and/or zygomatic arch - open reduction
D7760 Malar and/or zygomatic arch - closed reduction
D7770 Alveolus, open reduction, may include stabilization of teeth
D7771 Alveolus, closed reduction stabilization of teeth
D7780 - Facial bones-complicated reduction with fixation and multiple surgical approaches
D7810 - Open reduction of dislocation
D7820 - Closed reduction of dislocation
D7830 - Manipulation under anesthesia
D7840 - Condylectomy
D7850 - Surgical discectomy, with/without implant
D7852 - Disc repair
D7854 - Synovectomy
D7856 - Myotomy
D7858 - Joint reconstruction
D7860 - Arthrotomy
D7865 - Arthroplasty
D7870 - Arthrocentesis
D7871 - Non-arthroscopic lysis and lavage
D7872 - Arthroscopy-diagnosis, with or without biopsy
D7873 - Arthroscopy-surgical; lavage and lysis of adhesions
D7874 - Arthroscopy-surgical; disc repositioning and stabilization
D7875 - Arthroscopy-surgical; synovectomy
D7876 - Arthroscopy-surgical;discectomy
D7877 - Arthroscopy-surgical; debridement
D7880 - Occlusal orthotic device, by report
D7881 – Occlusal orthotic device adjustment
D7899 - Unspecified TMD therapy, by report
D7910 Suture of recent small wounds up to 5 cm
D7911 Complicated suture - up to 5 cm
D7912 Complicated suture - greater than 5 cm
D7920 - Skin graft (identify defect covered, location and type of graft)
D7921 - Collection and application of autologous blood concentrate product
D7940 - Osteoplasty-for orthognathic deformities
D7941 - Osteotomy-mandibular rami
D7943 - Osteotomy-mandibular rami with bone graft; includes obtaining the graft
D7944 - Osteotomy-segmented or subapical
D7945 - Osteotomy-body of mandible

D7946 - LeFort I (maxilla-total)
D7947 - LeFort I (maxilla-segmented)
D7948 - LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion)-without bone graft
D7949 - LeFort II or LeFort III-with bone graft
D7950 - Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla-autogenous or nonautogenous, by report
D7951- Sinus augmentation with bone or bone substitutes via a lateral open approach
D7952- Sinus augmentation via a vertical approach
D7953 - Bone replacement graft for ridge preservation – per site
D7955 - Repair of maxillofacial soft and/or hard tissue defect
D7972 - Surgical reduction of fibrous tuberosity
D7980 - Sialolithotomy
D7981 - Excision of salivary gland, by report
D7982 – Sialodochoplasty
D7983 - Closure of salivary fistula
D7990 - Emergency tracheotomy
D7991 - Coronoidectomy
D7995 - Synthetic graft-mandible or facial bones, by report
D7996 - Implant-mandible for augmentation purposes (excluding alveolar ridge), by report
D7997 - Appliance removal (not by dentist who place appliance), includes removal of archbar
D7998 - Intraoral placement of a fixation device not in conjunction with a fracture

CRITERIA:

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2015

DENTAL COVERAGE POLICY- Other Oral Surgical Procedures

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION:

ALSO SEE POLICY: OTHER NON COVERED SURGICAL PROCEDURES

CODES:

OPD7270	Tooth reimplantation and/or stabilization of accidentally avulsed or displaced tooth
BD7450	Removal of odontogenic cyst or tumor - lesion diameter up to 1.25 cm
D7451	Removal of odontogenic cyst or tumor - lesion diameter greater than 1.25 cm
D7460	Removal of nonodontogenic cyst or tumor-lesion diameter up to 1.25 cm
D7472	Removal of torus palatinus
D7473	Removal of torus mandibularis
D7485	Surgical reduction of osseous tuberosity
D7972	Surgical reduction of fibrous tuberosity

CRITERIA:

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

Removal of small cysts (D7450) are considered integral to extractions and surgical procedures if performed in the same area of the mouth on the same day by the same dentist.

PER ADA CDT 2015

DENTAL COVERAGE POLICY -Other Preventive Services

EFFECTIVE DATE: 11/26/2008
POLICY LAST UPDATED: 01/01/2016

INTERNAL POLICY DESCRIPTION:

CODES:

D1310 -Nutritional counseling for control of dental disease:Not covered
D1320 -Tobacco counseling for the control and prevention of oral disease:Not covered
D1330 -Oral hygiene instruction:Not covered

CRITERIA:

No review required.

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2015

DENTAL COVERAGE POLICY - Overdentures

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION:

CODES:
D5863 - Overdenture - complete maxillary
D5864 - Overdenture - partial maxillary
D5865 - Overdenture - complete mandibular
D5866 - Overdenture - partial mandibular

CRITERIA:
No review required.

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:
Five year limitation on replacement.

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2015

DENTAL COVERAGE POLICY-Palliative Treatment

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION

Palliative treatment is emergency treatment of dental pain involving a minor procedure.

Allow palliative treatment same date of service as an emergency exam and/or x-rays. If any definitive procedure is performed on the same date of service as palliative treatment, the palliative will be considered inclusive of the definitive procedure with no separate allowance, and a participating dentist may not charge the member for the palliative treatment.

CODES:

D9110 -Palliative (emergency) treatment of dental pain-minor procedure

CRITERIA:

No review required; if submitted with a narrative, reason for palliative is recorded for tracking/audit purposes.

LIMITATIONS: N/A

One palliative treatment per date of service

FREQUENCY: 2 per 12 months

RELATIONSHIP TO OTHER CODES: (for payment purposes)

- Inclusive of any definitive treatment performed same date of service

PER ADA CDT 2015

DENTAL COVERAGE POLICY -Partial Dentures

Blue Cross Blue Shield of Rhode Island

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION:

Benefits for partial dentures include adjustments, reline/rebase or repair within six months following the delivery of the partial denture to the patient. . Flexible base partial dentures are considered an alternative covered treatment to a conventional partial denture. Benefits are made for additional teeth that must be added to a partial due to tooth loss.
Insertion date (delivered to the mouth) is considered the completion date for a partial denture and benefits are payable for that date of service (not impression date).

CODES:

D5211- Maxillary partial denture-resin base (including any conventional clasps, rest and teeth)
D5212 - Mandibular partial denture-resin base (including any conventional clasps, rest and teeth)
D5213 - Maxillary partial denture-cast metal frameworkwith resin denture bases (including any conventional clasps, rest and teeth)
D5214 - Mandibular partial denture-cast metal framework with resin denture bases (any conventional clasps, rest and teeth)
D5221 - Immediate maxillary partial denture- resin base (including any conventional clasps, rest and teeth)
D5222 - Immediate mandibular partial denture- resin base (including any conventional clasps, rest and teeth)
D5223 - Immediate maxillary partial denture- cast metal framework with resin denture bases (including any conventional clasps, rest and teeth)
D5224 - Immediate mandibular partial denture- cast metal framework with resin denture bases (including any conventional clasps, rest and teeth)
D5225 - Maxillary partial denture-flexible base (including any clasps, rests and teeth)
D5226 - Mandibular partial denture-flexible base (including any clasps, rests and teeth)
D5281 - Removable unilateral partial denture-one piece cast metal (including clasps and teeth)

CRITERIA:

No review required.

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

One removable partial denture, complete or immediate denture or replacement of all teeth and acrylic on a cast metal framework (D5670, D5671) is allowed per arch per five-year period

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2015

DENTAL COVERAGE POLICY –Periodontal Maintenance

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION:

This procedure is instituted following periodontal therapy and continues at varying intervals, determined by the clinical evaluation of the dentist, for the life of the dentition or any implant replacements. It includes removal of the bacterial plaque and calculus from supragingival and subgingival regions, site specific scaling and root planing where indicated, and polishing the teeth. If new or recurring periodontal disease appears, additional diagnostic and treatment procedures must be considered.

CODES:

D4910-Periodontal maintenance

CRITERIA:

No review required.

LIMITATIONS:

Allowed under periodontal benefit, if available.

DOCUMENTATION:

If previous perio treatment not in history, chart notes demonstrating history of previous periodontal services

FREQUENCY:

Limited to two (2) services in a 12 month period.

RELATIONSHIP TO OTHER CODES: (for payment purposes)

At least one of the following procedures must be in patient's history to qualify for perio maintenance: osseous surgery, gingivectomy/gingivoplasty by quadrant, flap procedures, tissue grafts, root planing and scaling.
Routine prophylaxis (D1110) should not be performed on the same day.
D4910 will be considered integral to scaling and root planing or surgical periodontal procedures on same day, same dentist.

PER ADA CDT 2015

DENTAL COVERAGE POLICY- Periodontal Scaling & Root Planing

Blue Cross Blue Shield of Rhode Island

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION:

This is the most frequently reported non-surgical adjunctive periodontal procedure. Plaque and calculus are removed from the crown and root surfaces of teeth through instrumentation as a therapeutic approach to periodontal disease. Root planing involves the removal of cementum and dentin that is rough and may have calculus, toxins or microorganisms attached to the surfaces. Some soft tissue debridement may occur during scaling and root planing; however, this is incidental curettage of the soft tissues. Scaling and root planing has been shown to reduce pocket depth and gingival inflammation associated with periodontal disease.
Periodontal scaling and root planing may be subject to Dental Consultant review

CODES:

D4341 -Periodontal scaling and root planing-four or more teeth per quadrant
D4342 -Periodontal scaling and root planing-one to three teeth per quadrant

CRITERIA:

Pocket depths of 4mm or more andradiographic evidence of calculus and interproximal bone loss) for scaling and root planing. The number of teeth within a quadrant with qualifying pocket depths and demonstrated bone loss determines the appropriate code, D4341 or D4342.

LIMITATIONS:

DOCUMENTATION:

Current periodontal charting, xrays

FREQUENCY:

Allow one (1) D4341 or D4342 per quadrant within 36months . If the procedure is performed within 36 months, the member is liable for payment.

RELATIONSHIP TO OTHER CODES: (for payment purposes)

If periodontal scaling and root planing is performed on the same day as periodontal surgery, it is considered part of the more comprehensive procedure and is not paid separately; a participating dentist may not charge the patient.
When periodontal scaling and root planing (D4341) is billed with a prophylaxis (D1110) on the same date of service, and by the same provider, reimbursement will not be made for D1110.
Prophylaxis is considered integral when performed on the same day, or within 45 days, by the same dentist, as two or more limited sites or one or more quadrants of scaling and root planing.

When one limited site (D4342) is provided on same day, same dentist as a prophylaxis (D1110, D1110 is integral to D4342.
Consideration will be made by a dental consultant for D1110 on same day, same dentist as two limited sites of D4342.

PER ADA CDT 2015

DENTAL COVERAGE POLICY – Pins and Posts

EFFECTIVE DATE: 12/16/2008
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION:

Pin placement in conjunction with amalgam and/or composite restorations are allowed on a per tooth basis. Pins used in conjunction with a core build-up are included in the fee for the build-up and are not separately billable.

Additional posts (indirectly fabricated or prefabricated) are considered part of the comprehensive procedure of a post and core. A participating dentist may not charge the patient for additional pins as a separate procedure.

CODES:

D2951 -Pin retention-per tooth, in addition to restoration
D2953 -Each additional indirectly fabricated post -same tooth
D2957 -Each additional prefabricated post-same tooth

CRITERIA:

No review required

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2015

DENTAL COVERAGE POLICY – Post and Cores

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION:

A post and core provides a foundation upon which a crown will be fabricated. A tooth is deemed in need of a post and core if it has been endodontically treated and requires the replacement of missing tooth structure for the purpose of obtaining adequate resistance and retention for the crown.

CODES:

D2952 -Post and core in addition to crown, indirectly fabricated
D2953 -Each additional indirectly fabricated post -same tooth
D2954 -Prefabricated post and core in addition to crown
D2957 -Each additional prefabricated post-same tooth

CRITERIA:

Dental Consultant Review

The Dental Consultant evaluates the endodontic treatment (well-condensed, complete fill, etc.) and the periodontal condition of the treatment site to assure the tooth is periodontally sound to support a crown. Most teeth, once endodontically treated, will qualify for the post and core.

LIMITATIONS:

Not covered for members under age 14 unless clinical rationale is provided.

DOCUMENTATION:

Endodontic post-operative periapical x-ray

FREQUENCY:

One post and core per tooth in a five-year period.

RELATIONSHIP TO OTHER CODES: (for payment purposes)

Core build-up same date of service as a post and core is considered inclusive with the post and core with no additional benefits.

Additional pins and posts required for a post and core are considered inclusive with the comprehensive procedure.

D2952 will be allowed as D2954.

PER ADA CDT 2015

DENTAL COVERAGE POLICY – Post Removal

Blue Cross Blue Shield of Rhode Island

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION:

The removal of a post(s) is considered part of the procedure for a post and core and a participating dentist may not charge the patient separately.

CODES:

D2955 -Post removal

CRITERIA:

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

Considered part of a post and core procedure.

PER ADA CDT 2015

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DENTAL COVERAGE POLICY- Precision Attachment

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION

CODES:

D5862-Precision attachment (removable prosthetics): Not covered.
D6950 - Precision attachment "A male and female pair constitutes one precision attachment, and is separate from the prosthesis.": Not covered.

CRITERIA:

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2015

DENTAL COVERAGE POLICY- Pre-Surgical/Surgical Services

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION:

The listed procedure codes are covered if there is an implant rider:

CODES:

D6011 - Second stage implant surgery
D6013 - Surgical placement: mini implant
D6040 - Surgical placement: eposteal implant
D6050 - Surgical placement: transosteal implant
D6101 - Debridement of periimplant defect and surface cleaning of exposed implant surfaces, including flap entry and closure
D6102 - Debridement and osseous contouring of periimplant defect; includes surface cleaning of exposed implant surfaces and flap entry and closure
D6104 - Bone graft at time of implant placement

CRITERIA:

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2015

DENTAL COVERAGE POLICY-Professional Consultations

EFFECTIVE DATE: 09/17/2009
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION

Consultations are covered only if group-specified.

CODES:

D9310 - Consultation-diagnostic service provided by dentist or physician other than requesting dentist or physician: Not covered unless group-specified
D9410 - House/extended care facility call: Not covered
D9420 - Hospital or ambulatory surgical center call Care provided outside the dentist's office to a patient who is in a hospital or ambulatory surgical center. Services delivered to the patient on the date of service are documented separately using the applicable procedure codes: Not covered.
D9430 - Office visit for observation (during regularly scheduled hours)-no other services performed: Not covered
D9440 - Office visit-after regularly scheduled hours: Not covered
D9450 - Case presentation, detailed and extensive treatment planning: Not covered

CRITERIA:

LIMITATIONS: N/A

FREQUENCY: N/A

DOCUMENTATON: N/A

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2015

DENTAL COVERAGE POLICY – Protective/Sedative Fillings

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION:

Sedative fillings are used as a temporary restoration intended to relieve pain to attempt to prevent the need for endodontic treatment.

CODES:

D2940 - Protective restoration, Direct placement of a restorative material to protect tooth and/or tissue form. This procedure may be used to relieve pain, promote healing, or prevent further deterioration. Not to be used for endodontic access closure, or as a base or liner under a restoration. Not covered
D2941 - Interim therapeutic restoration - primary dentition - placement of an adhesive restorative material following caries debridement by hand or other method for the management of early childhood caries. Not considered a definitive restoration. Not covered
D2949 - Restorative foundation for an indirect restoration - placement of a restorative material to yield a more ideal form, including eliminating any undercuts. Not covered.

CRITERIA:

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2015

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DENTAL COVERAGE POLICY – Provisional Crowns

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION:

A provisional crown is used as an interim restoration for a period of at least six (6) months, usually during a healing period or for completion of other related procedures or for aesthetics.

A provisional crown is not to be considered as a temporary crown used for routine prosthetic services. Provisional crowns are not a covered benefit and the patient is responsible for payment up to the dentist's charge.

CODES:

2799 -Provisional crown: Not covered

CRITERIA:

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2015

DENTAL COVERAGE POLICY-Pulp Capping

EFFECTIVE DATE: 01/12/2009
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION

Pulp caps are considered part of a final restoration and are not separately billable. These procedures are processed as inclusive with the minor or major restorative procedures, sedative fillings or stainless steel crowns. A pulp cap is processed as a denial, member is not liable, when filed **without** another service rendered on the same date for the same tooth.

CODES:

D3110 - Pulp cap-direct (excluding final restoration): Inclusive with restoration
D3120 - Pulp cap-indirect (excluding final restoration): Inclusive with restoration

CRITERIA:

LIMITATIONS:

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

Always inclusive.

PER ADA CDT 2015

DENTAL COVERAGE POLICY-Pulpotomy

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION

Therapeutic pulpotomy is performed on primary or permanent teeth with the goal to maintain the vitality of the tooth. This procedure involves the removal of pulpal tissue from the chamber/coronal area, with no instrumentation of the canals, and is very effective in relieving pain. While the intention is to maintain the vitality of the tooth, a root canal may be required at a later date.

Pulpal debridement is performed to relieve acute pain prior to conventional root canal therapy. If performed on the same date of service as a root canal, or within three (3) months, by the same dentist/dental office, it is considered part of the fee for the root canal procedure. Participating dentists may not charge the patient separately for this procedure in these cases.

CODES:

D3220 – Therapeutic pulpotomy (excluding final restoration)-removal of pulp coronal to the dentinocemental junction and application of medicament - Pulpotomy is the surgical removal of a portion of the pulp with the aim of maintaining the vitality of the remaining portion by means of an adequate dressing.

- To be performed on primary teeth.
- This is not to be construed as the first stage of root canal therapy
- Not to be used for apexogenesis

D3221 – Pulpal debridement, primary and permanent teeth - Pulpal debridement for the relief of acute pain prior to conventional root canal therapy. This procedure is not to be used when endodontic treatment is completed on the same day.

D3222 – Partial pulpotomy for apexogenesis-permanent tooth with incomplete root development - Removal of a portion of the pulp and application of a medicament with the aim of maintaining the vitality of the remaining portion to encourage continued physiological development and formation of the root. This procedure is not to be construed as the first stage of root canal therapy.

CRITERIA:

No review required.

LIMITATIONS:

D3222 - applicable only to permanent teeth with incomplete root development

FREQUENCY:

D3222- Once per tooth per lifetime

RELATIONSHIP TO OTHER CODES: (for payment purposes)

If a pulpotomy is performed within a 90-day period prior to a root canal, or same date of service, by the same dentist/dental office, it is considered part of the root canal and is not separately reimbursed. If partial pulpectomy for apexogenesis is performed within 90-days prior to a root canal, or same date of service, by the same dentist/dental office, it is considered part of the root canal and is not separately reimbursed.

PER ADA CDT 2015

DENTAL COVERAGE POLICY-Radiographs

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2014

INTERNAL POLICY DESCRIPTION

X-rays should be taken only for clinical necessity and must be of acceptable diagnostic quality, properly identified (tooth#, L/R side) and dated. As part of the patient's clinical record, original images should be retained by the dentist, and copies submitted for use to fulfill claim review requirements. BCBSRI does not reimburse for copying costs for any part of clinical records. It is reasonable to expect that X-rays submitted for claims review are taken within a year of the treatment.

A full-mouth series of X-rays (FMX) includes ten (10) or more periapical films and a set of bitewing X-rays. Most groups cover a FMX **or** a panoramic film once in 60 months. However, some groups vary in their time limitations, allowing either a FMX or panorex once in 24, 36 or 60 months. The specific subscriber coverage should be checked for the applicable time limitation. In all cases, the need for full mouth radiographs should be determined by the patient's oral condition, rather than the contract benefit.

A panoramic film and bitewing X-rays taken within the same calendar year are benefitted up to the allowance for a FMX. If the pano and bwx are taken by the same dentist/dental office, a participating dentist cannot charge the member for the difference in payment. If taken by a different dentist, the member is liable for the difference

Periapical xrays taken on the same date of service, by the same dentist as a panorex are considered integral and not payable as a separate procedure.

Most plans have a limit of one (1) set of bitewings in a 12 month period for members under age 19 and one (1) set per 18 month period for members age 19 and older, but may vary with specific group coverage. Bitewing X-rays taken on the same date of service/within the same calendar year as a FMX (D0210) are considered part of the FMX, and not payable as a separate procedure.

A maximum of four (4) periapical X-rays are payable in a 12-month period. Xrays taken in addition to, or in excess of the limits as outlined in this policy will be member liability.

CODES:

D0210 -Intraoral-complete series of radiograph images (including bitewings): one(1) in 60 months-varies by contract (or one (1) panorex taken in that same time period)
D0220 -Intraoral-periapical first radiographic images: four (4) periapical X-rays are payable in a 12-month period
D0230 -Intraoral-periapical each additional radiographic image: four (4) periapical X-rays are payable in a 12-month period
D0240 -Intraoral-occlusal radiographic image : limited to two (2) occlusal films in a 24-month period under age 7

D0250 -Extraoral-first radiographic image : Not covered. D0251 – Extraoral posterior dental radiographic image: Not covered.
D0260 -Extraoral-each additional radiographic image: Not covered.
D0270 -Bitewing-single radiographic image
D0272 -Bitewings-two radiographic images
D0273 -Bitewings-three radiographic images
D0274 -Bitewings-four radiographic images
D0277 -Vertical bitewings - 7 to 8 radiographic images
D0290 -Posterior-anterior or lateral skull and facial bone survey radiographic image: Not covered.
D0310 - Sialography: Not covered.
D0320 -Temporomandibular joint arthrogram, including injection: Not covered
D0321 -Other temporomandibular joint films, by report: Not covered.
D0322 -Tomographic survey: Not covered
D0330 -Panoramic radiographic image: one (1) in 60 months-varies by contract (or one (1) FMX in the same time period).
D0340 -Cephalometric radiographic image: one (1) per lifetime.
D0350 -Oral/facial photographic images obtained intraorally or extraorally: Not covered.
D0351 – 3D Photographic Image: Not covered
D0364 - Cone beam CT capture and interpretation with field of view of one full dental arch - less than one whole jaw: Not covered
D0365 - Cone beam CT capture and interpretation with field of view of one full dental arch - mandible: Not covered
D0366 - Cone beam CT capture and interpretation with field of view of one full dental arch - maxilla, with or without cranium: Not covered
D0367 - Cone beam CT capture and interpretation with field of view of both juaws; with or without cranium: Not covered
D0368 - Cone beam CT capture and interpretation for TMJ series including two or more exposures: Not covered
D0369 - Maxillofacial MRI capture and interpretation: Not covered
D0370 - Maxillofacial ultrasound capture and interpretation: Not covered
D0371 - Sialoendoscopy capture and interpretation: Not covered
D0380 - Cone beam CT capture with limited field of view - less than one whole jaw: Not covered
D0381 - Cone beam CT capture with field of view of one full dental arch - mandible: Not covered
D0382 - Cone beam CT capture with field of view of one full dental arch - maxilla, with or without cranium: Not covered
D0383 - Cone beam CT capture with field of view of one full dental arch - : Not covered
D0384 - Cone beam CT capture for TMJ series including two or more exposures: Not covered
D0385 - Maxillofacial MRI capture: Not covered
D0386 - Maxillofacial ultrasound capture: Not covered
D0391 - Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report : Not covered
D0393 - Treatment simulation using 3D image volume: Not covered
D0394 - Digital subtraction of two or more images or image volumes of the same modality: Not covered
D0395 - Fusion of two or more 3D image volumes of one or more modalities: Not covered

CRITERIA:
No review required.

LIMITATIONS:
Members under age 6 are not eligible for more than 2 BWX (not eligible D0273; D0274)
D0240 limited to members age 7 and younger, 2 films per 24 month period

D0330 – for members under age 5, rationale must be submitted for consideration for payment

FREQUENCY: Specific to the type of radiograph and the member contract

DOCUMENTATON:

RELATIONSHIP TO OTHER CODES: (for payment purposes):
See above.

PER ADA CDT 2015

DENTAL COVERAGE POLICY- Recement Fixed Partial Denture

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION

Recementation for fixed bridges are considered part of the initial comprehensive procedure if performed within twelve (12) months of the insertion (delivery date) by the same dentist. A participating dentist may not charge a member for a recementation within twelve months of insertion. If a different dentist/dental office performs the recementation in this time period, a benefit for the procedure will be made. After the twelve -month time period, the benefit is for one recementation of a bridge in a 36-month period. Additional recementations within the 36-month time frame are a member liability.

CODES:

D6930-Recement fixed partial denture

CRITERIA:

No review required.

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

One recementation per fixed bridge in a 36-month period

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2015

DENTAL COVERAGE POLICY – Recementations

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION:

Recementation for inlays, onlays, post and cores and crowns are considered part of the initial comprehensive procedure if performed within twelve (12) months of the insertion (delivery date) by the same dentist. A participating dentist may not charge a member for a recementation within twelve months of insertion as a separate procedure. If a different dentist/dental office performs the recementation in this time period, an allowance for a separate benefit will be made. After the twelve-month time period, benefit for one recementation (per tooth) in a 36-month period. Additional recementations within 36 months are a member liability.

CODES:

D2910 -Recement inlay, onlay or partial coverage restoration
D2915 -Recement cast or prefabricated post and core
D2920 -Recement crown
D2921 - Reattachment of tooth fragment, incisal edge or cusp - Not covered.

CRITERIA:

No review required

LIMITATIONS:

Considered integral when performed within 12 months of initial insertion.

DOCUMENTATION:

FREQUENCY:

One in a 36-month period per tooth

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2015

DENTAL COVERAGE POLICY - Repairs to Dentures

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION:

Repairs to complete/partial dentures within six months of delivery are considered part of the initial placement and a participating dentist cannot bill the patient.

CODES:

Complete Dentures
D5510 - Repair broken complete denture base
D5520 - Replace missing or broken teeth-complete denture (each tooth)
Partial Dentures
D5610 - Repair resin denture base
D5620 - Repair cast framework
D5630 - Repair or replace broken clasp
D5640 - Replace broken teeth - per tooth
D5650 - Add tooth to existing partial denture
D5660 - Add clasp to existing partial denture
D5670 - Replace all teeth and acrylic on cast metal framework (maxillary)
D5671 - Replace all teeth and acrylic on cast metal framework (mandibular)

CRITERIA:

No review required.

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

No benefits within 6 months of delivery (dentist liable)
Repairs once per 36 month period, per arch.
Replacement of all teeth (D5670. D5671) is once per arch per 60 months.

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2015

DENTAL COVERAGE POLICY-Retrograde Fillings

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION

A retrograde filling is not always required following an apicoectomy, but is usually performed to assist in sealing the apices and preventing further infection.

CODES:

D3430 - Retrograde filling - per root

CRITERIA:

No review required.

LIMITATIONS:

DOCUMENTATION:

FREQUENCY: One retrograde filling per root.

RELATIONSHIP TO OTHER CODES: (for payment purposes)

Separate payment for apicoectomy.
Not allowed within 30 days following root canal treatment.

PER ADA CDT 2015

DENTAL COVERAGE POLICY-Root Amputation

EFFECTIVE DATE: 02/19/2009
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION

Root amputations are usually performed to preserve a tooth that has a large bony defect and loss of periodontal support around one root of a multi-rooted tooth. A root amputation may be appropriate treatment when one root appears to be cracked and the others are healthy.. To be considered successful, the crown of the tooth and at least one healthy root of the tooth must remain intact. Total success of this treatment is difficult to assess immediately. "Complete" healing may require 6-12 months, and the area of the root amputation would exhibit bone healing, minimal pocketing/tissue inflammation.

CODES:

D3450 - Root amputation - per root

CRITERIA:

Dental Consultant Review

The Dental Consultants evaluates the treatment site to determine if the remaining tooth structure has a sound periodontal prognosis, and generally a good long-term prognosis.
The treatment site will be evaluated for removal of a root and to confirm that the crown and at least one healthy root remains intact.

LIMITATIONS:

DOCUMENTATION:

Predetermination: Pre-operative periapical.
Claim for services: Pre-operative and post-operative periapical xray.

FREQUENCY:

One retrograde filling per root.

RELATIONSHIP TO OTHER CODES: (for payment purposes)

Cannot perform hemisection on same tooth as a root amputation.

PER ADA CDT 2015

DENTAL COVERAGE POLICY-Treatment of Root Canal Obstruction

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 03/14/2012

INTERNAL POLICY DESCRIPTION

This procedure should be considered a component of the root canal procedure

CODES:

D3331 – Treatment of root canal obstruction; non-surgical access

CRITERIA:

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

Will be considered part of a root canal treatment when performed by the same dentist/dental office.

PER ADA CDT 2015

DENTAL COVERAGE POLICY-Root Canals

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION

Root canals are performed to treat a diseased, injured or non-vital pulp in a tooth. Patients may experience varying levels of pain when a root canal is needed, some requiring immediate treatment. This procedure involves removing the pulp canal, cleaning, shaping and filling the canals. Final restoration of an endodontically-treated tooth may include an amalgam, composite, post & core and/or often, a crown.

Root canals include all procedures required to complete the service. Exams (performed by specialists), palliative treatment, pulp test, extirpation of pulp, pulpotomy, and pulpal debridement performed 90 days within the date of service of the root canal, by the same dentist, are considered inclusive with the root canal. Pre-operative, working and post-operative x-rays, and local anesthetic performed on the same date of service as the root canal are inclusive. The final restoration is excluded. Benefits are payable upon completion of the root canal and based on the tooth treated, not the number of canals treated, (i.e., anterior, bicuspid, molar).

Root canals that are performed only to accommodate use of a precision attachment, (or other device), are not a covered benefit.

CODES:

D3310 -Endodontic therapy, anterior tooth (excluding final restoration)
D3320 -Endodontic therapy, bicuspid tooth (excluding final restoration)
D3330 -Endodontic therapy, molar (excluding final restoration)

CRITERIA:

Dental Consultant Review
The treated tooth is evaluated for the following:

- Complete fill to the apex of each canal-checked for a fill that is extremely short of the apex; has visible patent canal space left unfilled; has poorly condensed fill; excessive over-extension of filling material
- Calcification in the canals that prevent complete fill to apex
- A sound periodontal prognosis

LIMITATIONS:

DOCUMENTATION:

Pre-operative, post-operative periapical xrays

FREQUENCY:

Benefits for retreatment of a root canal by a different dentist (than performed the original endodontic treatment) are allowed. Retreatment by the same dentist (that performed the original root canal) is not allowed within 12 months.

RELATIONSHIP TO OTHER CODES: (for payment purposes)

Exams, palliative treatment, pulp tests, pulpotomy, pulpal debridement, x-rays (related to root canal), local anesthetic are considered part of the root canal treatment.

Group Limitations: Some groups may have coverage for root canals on anterior (front) teeth only. The coverage may/may not apply an alternate benefit of an anterior root canal allowance for root canals performed on posterior teeth, with the member liable for the difference in payment up to the dentist's charge.

Root canal treatment will be be offset by the amount benefitted for pulpal regeneration when pulpal regeneration was done within 12 months prior to the root canal treatment.

PER ADA CDT 2015

DENTAL COVERAGE POLICY -Sealants

EFFECTIVE DATE: 1/1/2015
POLICY LAST UPDATED: 11/14/2014

INTERNAL POLICY DESCRIPTION:

CODES:

D1351 -Sealant-per tooth: if covered by contract, sealants performed on permanent molars for patients through the age of 15; replacements limited to three-year time period.
D1352 - Preventive resin restoration in a moderate to high caries risk patient – permanent tooth Conservative restoration of an active cavitated lesion in a pit or fissure that does not extend into dentin; includes placement of a sealant in any radiating non-carious fissures or pits: Not covered.
D1353 – Sealant repair- per tooth: Not covered.
D1354 – Interim caries arresting medicament application

CRITERIA:

No review required.

LIMITATIONS:

D1351 -Covered through age 15
D1354 – Covered through age 12; Silver Nitrate and Silver Diamine Fluoride only

DOCUMENTATION:

FREQUENCY:

D1351 -Once per site in a 36 month period
D1354 – Two per 12 months ages 1-6; once per 12 months ages 7-12.

RELATIONSHIP TO OTHER CODES: (for payment purposes)

Considered integral if placed on the same tooth, same day by the same provider as a restoration, or when replaced within 12 months following initial placement by the same dentist.

PER ADA CDT 2015

DENTAL COVERAGE POLICY Single Crowns: Implant/Abut.Supported

EFFECTIVE DATE: 09/21/2009
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION:

Crowns over implants are covered if the member's contract includes prosthodontic coverage. The service should be submitted for benefits with the appropriate implant crown code(s). Benefits are at 50% and there is a five-year limitation for replacement of these crowns. Abutments are not a covered benefit.

CODES:

D6058 - Abutment supported porcelain/ceramic crown
D6059 - Abutment supported porcelain fused to metal crown (high noble metal)
D6060 - Abutment supported porcelain fused to metal crown (predominantly base metal)
D6061 - Abutment supported porcelain fused to metal crown (noble metal)
D6062 - Abutment supported cast metal crown (high noble metal)
D6063 - Abutment supported cast metal crown (predominantly base metal)
D6064 - Abutment supported cast metal crown (noble metal)
D6094 - Abutment supported crown (titanium)
D6065 - Implant supported porcelain/ceramic crown
D6066 - Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)
D6067 - Implant supported metal crown (titanium, titanium alloy, high noble metal)

CRITERIA:

No review required.

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2015

DENTAL COVERAGE POLICY- Single Tooth Implant

EFFECTIVE DATE: 05/13/2009
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION:

A single tooth implant is covered if the member has prosthodontic coverage; the procedure is being performed as an alternative to a three-unit fixed bridge and meets the BCBSRI criteria for dental necessity. (This benefit does not apply for replacement of a single tooth that is the last tooth (most distal position) in quadrant, even if opposing teeth are present.)

CODES:

D6010-Surgical placement of implant body: endosteal implant
D6056-Prefabricated abutment-includes placement
D6057-Custom abutment-includes placement

CRITERIA:

Dental Consultant Review
The treatment site is evaluated for the following:

- Only one missing tooth in treatment area; two adjacent teeth present
- Remaining adjacent teeth and periodontal tissues appear to be healthy; no indication, in x-rays or other clinical documentation reviewed, that adjacent teeth are in need of major dental services, i.e., major restorative or periodontal services, or extraction

Bone and surrounding periodontal tissues at treatment site are healthy, and existing conditions indicate a single tooth implant can be supported.

LIMITATIONS:

Limited to replacement of a single missing tooth where natural teeth are present on either side.

DOCUMENTATION:

Predetermination: Pre-operative periapical xray or panorex, a narrative, if applicable.
Payment of claim: Post-operative periapical xray or panorex, narrative, if applicable.

FREQUENCY:

Limited to a five-year replacement of the implant services

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2015

DENTAL COVERAGE POLICY -Space Maintainers

EFFECTIVE DATE: 1/1/2016
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION:

Space maintainers are a covered benefit for patients through age 13. The removal of a space maintainer is a benefit if the removal is performed by a different dentist/dental office that placed the space maintainer. If performed by the same dentist/dental office that placed the appliance, the benefit is denied and the patient cannot be charged for the removal. The removal is considered part of the overall procedure in this case if performed by the inserting dentist. If a space maintainer is lost, the replacement is a patient responsibility.

CODES:

D1510 -Space maintainer-fixed-unilateral
D1515 -Space maintainer-fixed-bilateral
D1520 -Space maintainer-removable-unilateral
D1525 -Space maintainer-removable-bilateral
D1550 -Re-cementation of space maintainer
D1555 -Removal of fixed space maintainer

CRITERIA:

No review required.

LIMITATIONS:

Covered through age 13
Limited to premature loss of primary molars and permanent first molars, or primary molars and permanent first molars that have not/will not develop.

DOCUMENTATION:

FREQUENCY:

Once per site in a 5 year period; re-cementation once in a 6-month period.

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2015

DENTAL COVERAGE POLICY – Stainless Steel/Pre-Fab Crowns

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION:

The stainless steel and pre-fabricated crowns (listed) are covered only when a tooth cannot be restored by a filling. Some of the crowns are specifically for deciduous teeth and limited to coverage for patients to 14 years of age. Other specific limitations are listed with each code, as applicable. Stainless steel crowns, unlike other crowns, are considered a minor restorative procedure and are benefitted at the same level as amalgam and resin composite restoration coverage.

CODES:

D2929 - Prefabricated porcelain/ceramic crown-primary tooth
D2930 -Prefabricated stainless steel crown-primary tooth
D2931 -Prefabricated stainless steel crown-permanent tooth
D2932 -Prefabricated resin crown
D2933 -Prefabricated stainless steel crown with resin window
D2934 -Prefabricated esthetic coated stainless steel crown-primary tooth

CRITERIA:

For consideration of retained deciduous tooth for members age 14 and older, pre-operative periapical xray to evaluate long term prognosis.

LIMITATIONS:

One per tooth per lifetime to age 14.D2932, D2933, D2934 Eligible on primary teeth C-H and M-R. All other teeth will be allowed benefit of D2930, D2931 and subject to same benefit limitation of regular stainless steel crown.

DOCUMENTATION:

FREQUENCY:

All of the crowns listed are subject to once per lifetime, per tooth.

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2015

DENTAL COVERAGE POLICY- Stress Breaker

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION

Stress breakers are used to relieve abutment teeth from harmful stresses.

CODES:

D6940-Stress breaker- Not covered.

CRITERIA:

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2015

DENTAL COVERAGE POLICY- Surgical Extractions

Blue Cross Blue Shield of Rhode Island

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION:

Blue Cross Dental treatment guidelines for each specific extraction/impaction procedure code are in accordance with the CDT descriptors for extractions and impactions.

General anesthesia and IV sedation are covered benefits with specified oral surgery procedures (see anesthesia policy). Local anesthetic, elevation of the flap, bone removal, sectioning of tooth, removal of the tooth structure, closure and suturing, suture removal and routine post-operative care are included in the global fee for the surgical extraction or the impaction. Treatment for dry socket is considered postoperative care and is included in the benefit for the surgical procedure - for three visits.

If an attempt to extract a tooth fails, it is not considered a completed procedure and should not be submitted for benefit consideration. The entire tooth must be extracted.

Removal of residual roots (root is encased in bone) requires incision into the gingiva area, and possibly bone, to access the root for extraction and is considered integral if performed by the same dentist who extracted the tooth.

CODES:

D7210 - Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated" "Includes related cutting of gingiva and bone, removal of tooth structure, minor smoothing of socket bone and closure
D7220-Removal of impacted tooth - soft tissue
D7230-Removal of impacted tooth - partially bony
D7240-Removal of impacted tooth - completely bony
D7241-Removal of impacted tooth - completely bony, with unusual surgical complications
D7250-Surgical removal of residual tooth roots (cutting procedure)
D7251- Coronectomy – intentional partial tooth removal Intentional partial tooth removal is performed when a neurovascular complication is likely if the entire impacted tooth is removed.

CRITERIA:

Dental Consultant Review required for the following procedures for members under age 15 or over age 30.

D7230 - part of crown covered by bone; requires flap elevation and bone removal
D7240 - most or all of crown is covered by bone; requires flap elevation and bone removal
D7241 - most or all of crown covered by bone; unusually difficult or complicated due to factors such as nerve dissection, separate closure of maxillary sinus required,
or aberrant tooth position
Dental consultant review required for all members:

D7251- Coronectomy – intentional partial tooth removal Intentional partial tooth removal is performed when a neurovascular complication is likely if the entire impacted tooth is removed.

LIMITATIONS:

Third molar partial and complete bony impaction removal is not routinely covered for members under age 15 or over age 30. Documentation can be submitted for consideration.

DOCUMENTATION:

On a pre-payment basis: Pre-operative periapical radiographs of the entire treatment site**.**

For a claim for actual services**:** Pre-operative and post-operative radiograph, copy of the clinical notes describing the specific symptoms and copy of the operative report

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2015

DENTAL COVERAGE POLICY- Surgical Incision

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION:

CODES:
D7510 - Incision and drainage of abscess-intraoral soft tissue
D7511 - Incision and drainage of abscess-intraoral soft tissue-complicated (includes drainage of multiple fascial spaces)

CRITERIA:
Consultant review required.

LIMITATIONS:

DOCUMENTATION:
Narrative and/or operative report.

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)
Considered integral to other surgical procedures provided on same day, same dentist

PER ADA CDT 2015

DENTAL COVERAGE POLICY- Surgical Placement of Implant Body

Blue Cross Blue Shield of Rhode Island

EFFECTIVE DATE: 03/27/2009
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION:

Implant services are not a covered benefit unless specified in the group contract. If a group purchases an Implant Rider, there is a $3,500 lifetime maximum benefit for implant services. Coverage is at 50% and all implant services are subject to Dental Consultant review for all dentists.
Plans with prosthodontic coverage may include benefits for single-tooth implants only. These benefits are allowed in cases where only one natural tooth requires replacement with an implant as an alternative treatment to a three-unit bridge. (See specific policy)
Crowns over implants are covered if the contract includes prosthodontic coverage and should be submitted with the appropriate implant crown code(s). The benefit is at 50% and replacement of these crowns has a five-year limitation..

CODES:

D6010-Surgical placement of implant body: endosteal implant

CRITERIA:

Dental Consultant Review
The periodontal condition of the treatment site is evaluated for predeterminations. to assist the Dental Consultant in the assessment. A post-operative X-ray demonstrating successful placement of the implant and a narrative describing any special circumstances related to the service are required for review of a payment claim.

LIMITATIONS:

DOCUMENTATION:

Predetermination: Pre-operative periapical X-ray. If a bone graft is required, a narrative describing the treatment plan is recommended.
Payment of Claim: Post-operative periapical xray and narrative describing and special circumstances related to the service

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2015

DENTAL COVERAGE POLICY- Surgical Revision, per tooth

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION:

This procedure is to refine the results of a previously provided surgical procedure and is considered integral to the initial surgical procedure. This may require a surgical procedure to modify the irregular contours of hard or soft tissue. A mucoperiosteal flap may be elevated to allow access to reshape alveolar bone. The flaps are replaced or repositioned and sutured.

CODES:

D4268-Surgical revision procedure, per tooth

CRITERIA:

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

Considered integral to initial procedure.

PER ADA CDT 2015

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DENTAL COVERAGE POLICY – Temporary Crowns

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION:

A preformed artificial crown, fitted over a damaged tooth as an interim protective device. This code is not for temporization during crown fabrication.

CODES:

D2970 -Temporary crown (fractured tooth):

CRITERIA:

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

Once per tooth per lifetime.

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2015

DENTAL COVERAGE POLICY – Tests and Examinations

Blue Cross Blue Shield of Rhode Island

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION:

Tests and analysis related to the following procedures are conducted in the dental office and/or laboratory, and most are non-covered procedures.

CODES:

D0415 -Collection of microorganisms for culture and sensitivity: Not covered
D0416 -Viral culture: Not covered
D0417 -Collection and preparation of saliva sample for laboratory diagnostic testing: Not covered
D0418 -Analysis of saliva sample: Not covered
D0421-Genetic test for susceptibility to oral diseases: Not covered
D0422 – Collection and preparation of genetic sample material for laboratory analysis and report: Not covered.
D0423 – Genetic test for susceptibility to diseases – specimen analysis: Not covered.
D0425 -Caries susceptibility tests: Not covered
D0431-Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures: Not covered
D0460 -Pulp vitality tests: are considered part of the comprehensive procedure. D0470 -Diagnostic casts: are considered part of the comprehensive procedure.
D0601 - Caries risk assessment and documentation, with a finding of low risk: Not covered
D0602 - Caries risk assessment and documentation, with a finding of moderate risk: Not covered
D0603 - Caries risk assessment and documentation, with a finding of high risk: Not covered

CRITERIA:

No review required.

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

Pulp vitality tests are limited to two in a calendar year

RELATIONSHIP TO OTHER CODES: (for payment purposes)

Diagnostic casts, when considered part of a comprehensive procedure, are not separately reimbursed.

PER ADA CDT 2015

DENTAL COVERAGE POLICY – Tissue Grafts

Blue Cross Blue Shield of Rhode Island

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION:

These procedures are performed on teeth that have inadequate or no attached gingiva, to cover an exposed root, eliminate a gingival defect, eliminate the pull of frena and muscle attachments, to extend the vestibular fornix or to correct localized gingival recession.
These procedures are reimbursed by the number of "sites" treated. The following information is related to CDT defined "sites":

- If three contiguous teeth have areas of soft tissue recession, each area of recession is a single site.
- If three contiguous teeth have adjacent but separate osseous defects, each defect is a single site.
- If three contiguous teeth have a communicating interproximal osseous defect, it should be considered a single site.
- All non-communicating osseous defects are single sites.
- All edentulous non-communicating tooth positions are single sites.
- Depending on the dimensions of the defect, up to three contiguous edentulous tooth positions may be considered a single site.

Tooth Bounded Space is defined as a space created by one or more missing teeth that has a tooth on each side.

CODES:

D4270 -Pedicle soft tissue graft procedure
D4273 -Subepithelial connective tissue graft procedures, per tooth
D4275 - Soft tissue allograft
D4276 - Combined connective tissue and double pedicle graft, per tooth
D4277 - Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft
D4278 - Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in the same graft.
D4283 - Autogenous connective tissue graft procedure (used with D4273)
D4285 - Non-autogenous connective tissue graft procedure (used with D4275)

CRITERIA:

Dental Consultant review required.

LIMITATIONS:

DOCUMENTATION:

Current periodontal charting
Narrative

FREQUENCY:

Denied if performed within 36-months on the same treatment sites. If the service is performed within 36 months, the member is liable for payment.

RELATIONSHIP TO OTHER CODES: (for payment purposes)

Considered integral if performed on the same day, same site as osseous surgery.

Not covered in conjunction with an implant (either to accommodate the placement of the implant or anytime thereafter).

Distal wedge procedure is denied as integral if performed on same day, same dentist as other periodontal treatment.

PER ADA CDT 2015

DENTAL COVERAGE POLICY -Topical Fluoride Treatment

EFFECTIVE DATE: 11/01/2010
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION:

Fluoride treatments are paid as a separate procedure, although almost always performed in conjunction with dental prophylaxis. Benefits are contract specific. The benefit is limited to patients up to age 19.

CODES:

D1206 -Topical fluoride varnish; therapeutic application for moderate to high caries risk patients
D1208 - Topical application of fluoride

CRITERIA:

No review required.

LIMITATIONS:

Covered through age 19 (most groups)

DOCUMENTATION:

FREQUENCY:

One (1) per member up to age 19 per calendar year (most groups)

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2014

DENTAL COVERAGE POLICY - Unscheduled Dressing Change

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION:

Considered inclusive with periodontal procedures and extractions

CODES:

D4920-Unscheduled dressing change (by someone other than treating dentist): Not covered.

CRITERIA:

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)
Inclusive when performed by same participating dentist/dental office.
PER ADA CDT 2015

DENTAL COVERAGE POLICY-Unspec. Adjunctive Procedure

EFFECTIVE DATE: 09/17/2009
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION

This code is used for a procedure that does not fit a description of an existing CDT code.

CODES:

D9999 -Unspecified adjunctive procedure, by report

CRITERIA:

Individual consideration is given for time, degree of difficulty and materials used to complete the procedure. If the Dental Consultant determines that the procedure performed meets the description of an existing CDT code, the dentist may be contacted to re-submit the claim with the appropriate code.

LIMITATIONS:

FREQUENCY:

DOCUMENTATON:

A detailed narrative, along with any clinical documentation that is available, including X-rays, treatment chart, photo, etc

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2015

DENTAL COVERAGE POLICY-Unspec. Maxillofacial Prosthesis Procedure

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION

This code is used for a procedure that does not fit a description of an existing CDT code.

CODES:

D5999 -Unspecified maxillofacial prosthesis, by report: Not covered

CRITERIA:

LIMITATIONS:

DOCUMENTATION:

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2015

DENTAL COVERAGE POLICY- Unspec. Oral Surgery Procedure

EFFECTIVE DATE: 03/25/2009
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION

This code is used for a procedure that does not fit a description of an existing CDT code.

CODES:

D7999 -Unspecified oral surgery procedure, by report

CRITERIA:

Dental Consultant Review

Individual consideration is given for time, degree of difficulty and materials used to complete the procedure. If the Dental Consultant determines that the procedure performed meets the description of an existing CDT code, the dentist may be contacted to re-submit the claim with the appropriate code.

LIMITATIONS:

DOCUMENTATION:

A detailed narrative, along with any clinical documentation that is available, including X-rays, treatment chart, photo, etc.

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2015

DENTAL COVERAGE POLICY-Unspecified Endodontic Procedure

EFFECTIVE DATE: 03/23/2009
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION

This code is used for a procedure that does not fit a description of an existing CDT code.

CODES:

D3999 -Unspecified endodontic procedure, by report

CRITERIA:

Dental Consultant Review

Individual consideration is given for time, degree of difficulty and materials used to complete the procedure. If the Dental Consultant determines that the procedure performed meets the description of an existing CDT code, the dentist may be contacted to re-submit the claim with the appropriate code.

LIMITATIONS:

DOCUMENTATION:

A detailed narrative, along with any clinical documentation that is available, including X-rays, treatment chart, photo, etc.

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2015

DENTAL COVERAGE POLICY-Unspecified Implant Procedure

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION

This code is used for a procedure that does not fit a description of an existing CDT code.

CODES:

D6199 -Unspecified implant procedure, by report

CRITERIA:

Dental Consultant Review

Individual consideration is given for time, degree of difficulty and materials used to complete the procedure. If the Dental Consultant determines that the procedure performed meets the description of an existing CDT code, the dentist may be contacted to re-submit the claim with the appropriate code.

LIMITATIONS:

This code will only be considered when the member has an implant rider benefit.

DOCUMENTATION:

A detailed narrative, along with any clinical documentation that is available, including X-rays, treatment chart, photo, etc.

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2015

DENTAL COVERAGE POLICY-Unspecified Orthodontics

EFFECTIVE DATE: 03/25/2009
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION

This code is used for a procedure that does not fit a description of an existing CDT code.

CODES:

D8999 **-**Unspecified orthodontic procedure, by report

CRITERIA:

Dental Consultant Review

Individual consideration is given for time, degree of difficulty and materials used to complete the procedure. If the Dental Consultant determines that the procedure performed meets the description of an existing CDT code, the dentist may be contacted to re-submit the claim with the appropriate code.

LIMITATIONS:

DOCUMENTATION:

Detailed narrative, along with any clinical documentation that is available, including X-rays, treatment chart, photo, etc.

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2015

DENTAL COVERAGE POLICY- Unspecified Periodontal Procedure

EFFECTIVE DATE: 03/24/2009
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION

This code is used for a procedure that does not fit a description of an existing CDT code.

CODES:

D4999-Unspecified periodontal procedure, by report

CRITERIA:

Dental Consultant Review

Individual consideration is given for time, degree of difficulty and materials used to complete the procedure. If the Dental Consultant determines that the procedure performed meets the description of an existing CDT code, the dentist may be contacted to re-submit the claim with the appropriate code.

LIMITATIONS:

DOCUMENTATION:

A detailed narrative, along with any clinical documentation that is available, including X-rays, treatment chart, photo, etc.

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2015

DENTAL COVERAGE POLICY- Unspecified Preventive Procedure

EFFECTIVE DATE: 10/02/2013
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION

This code is used for a procedure that does not fit a description of an existing CDT code.

CODES:

D1999-Unspecified preventive procedure, by report

CRITERIA:

Dental Consultant Review

Individual consideration is given for time, degree of difficulty and materials used to complete the procedure. If the Dental Consultant determines that the procedure performed meets the description of an existing CDT code, the dentist may be contacted to re-submit the claim with the appropriate code.

LIMITATIONS:

DOCUMENTATION:

A detailed narrative, along with any clinical documentation that is available, including X-rays, treatment chart, photo, etc.

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2015

DENTAL COVERAGE POLICY-Unspecified Prostho Procedure

EFFECTIVE DATE: 03/25/2009
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION

This code is used for a procedure that does not fit a description of an existing CDT code.

CODES:

D6999 -Unspecified fixed prosthodontic procedure, by report

CRITERIA:

Dental Consultant Review

Individual consideration is given for time, degree of difficulty and materials used to complete the procedure. If the Dental Consultant determines that the procedure performed meets the description of an existing CDT code, the dentist may be contacted to re-submit the claim with the appropriate code.

LIMITATIONS:

DOCUMENTATION:

A detailed narrative, along with any clinical documentation that is available, including X-rays, treatment chart, photo, etc.

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2015

DENTAL COVERAGE POLICY- Unspecified Removable Prosthetics

EFFECTIVE DATE: 03/25/2009
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION

This code is used for a procedure that does not fit a description of an existing CDT code.

CODES:

D5899-Unspecified removal prosthodontic procedure, by report

CRITERIA:

Dental Consultant Review

Individual consideration is given for time, degree of difficulty and materials used to complete the procedure. If the Dental Consultant determines that the procedure performed meets the description of an existing CDT code, the dentist may be contacted to re-submit the claim with the appropriate code.

LIMITATIONS:

DOCUMENTATION:

A detailed narrative, along with any clinical documentation that is available, including X-rays, treatment chart, photo, etc.

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2015

DENTAL COVERAGE POLICY- Unspecified Restorative Procedure

EFFECTIVE DATE: 12/16/2008
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION

This code is used for a procedure that does not fit a description of an existing CDT code.

CODES:

D2999-Unspecified restorative procedure, by report

CRITERIA:

Dental Consultant Review

Individual consideration is given for time, degree of difficulty and materials used to complete the procedure. If the Dental Consultant determines that the procedure performed meets the description of an existing CDT code, the dentist may be contacted to re-submit the claim with the appropriate code.

LIMITATIONS:

DOCUMENTATION:

A detailed narrative, along with any clinical documentation that is available, including X-rays, treatment chart, photo, etc.

FREQUENCY:

RELATIONSHIP TO OTHER CODES: (for payment purposes)

PER ADA CDT 2015

DENTAL COVERAGE POLICY- Vestibuloplasty

EFFECTIVE DATE: 01/01/2016
POLICY LAST UPDATED: 11/14/2013

INTERNAL POLICY DESCRIPTION:

Benefits for vestibuloplasty are limited to once in a lifetime, per arch (maxillary/mandibular).

CODES:

D7340 - Vestibuloplasty-ridge extension (secondary epithelialization)
D7350 - Vestibuloplasty-ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)

CRITERIA:

Complex vestibuloplasty and vestibuloplasty reported with removal of hyperplastic tissue requires Dental Consultant review.

LIMITATIONS:

DOCUMENTATION:

Operative notes

FREQUENCY:

Once per lifetime, per arch

RELATIONSHIP TO OTHER CODES: (for payment purposes)

If submitted with periodontal surgery in the same mouth area, same day, same dentist it is considered integral.

PER ADA CDT 2015

DENTAL COVERAGE POLICY-Pediatric Dental Benefit

Blue Cross Blue Shield of Rhode Island

EFFECTIVE DATE: 10/01/2015
POLICY LAST UPDATED: 10/01/2015

OVERVIEW

Effective January 1, 2014, Pediatric Services including oral care has been defined as an Essential Health Benefit. For those plans that have coverage for essential health benefits, this policy defines the oral care services that will be covered for children from the ages of 0 up to the child's 19th birthday.

DENTAL REVIEW CRITERIA

Please refer to the coding section for the specific service that requires dental consultant review. If review is required, refer to the corresponding category of service below for the documentation requirements.

Major Restorative Services
Criteria:
- Periodontically and endodontically sound permanent tooth
- Sufficient breakdown as demonstrated on a radiograph

Required documentation:
- Pre-operative periapical xray
- Intra-oral photo (if available)
- Detailed narrative (if applicable)

Endodontic Services
Criteria:
- Sound periodontal prognosis
- If post service review:
  - Complete fill to the apex of each canal or calcification that prevent complete fill

Required documentation:
- Pre-operative and post-operative periapical xrays.
- A working film may not be substituted for a post-operative film.

Periodontal Services
Criteria:
- Scaling and root planning – Pocket depths of 4mm or more or radiographic evidence of calculus and interproximal bone loss (the number of teeth with qualifying pocket depths determine the appropriate code D4341; D4342)
- Osseous surgery - Pocket depths of 5mm or more and radiographic evidence of interproximal bone loss (the number of teeth with qualifying pocket depths determine the appropriate code D4260; D4261)
- Tissue grafts – 2mm of less of attached gingiva per treatment site

Required documentation:

- Periapical xrays of treatment area
- Full mouth periodontal chart
- Detailed narrative (if applicable)

Removable Prosthodontic Services
Required documentation:

- Detailed narrative.

Implant Services
Criteria:

- If an arch can be restored with a standard prosthesis or restoration, no benefits will be allowed for the implant or implant related services.

Required documentation:

- Pre-operative panorex or intraoral complete series
- Detailed narrative.
- If payment of claim: Post-operative film of implant, with above documentation is required for review.

Fixed Prosthodontics

Criteria:

- Periodontically and endodontically sound permanent abutment teeth

Required documentation:

- Pre-operative periapical xrays of entire treatment site
- If there are special circumstances related to the treatment, a detailed narrative is recommended.

Oral Surgery

Required documentation:

- Pre-operative xray of treatment site
- Narrative (if applicable)

Orthodontic Services
***Services will not be covered when the dentition contains any more primary teeth than the primary second molars.**

In addition: One of the following criteria must be met for services to be covered under this benefit:

- Maxillary/Mandibular incisor relationship: overjet of 9 mm or more with impingement where the lower incisors are impinging the palate.

- Anterior crossbite equal to or greater than 5mm (short term , interceptive therapy covered only)

- Anterior open bite (canine to canine)
- More than 1 impacted permanent tooth when the dentition contains no more primary teeth than the primary second molars.
- Posterior-unilateral crossbite involving three or more adjacent, permanent teeth, one of which must be a molar (no eruption/dentition requirements for this qualifier).
- Cleft palate deformities submitted by the surgical team.

- Treatment for skeletal deformities will be considered on an individual basis and must be submitted by the surgical team.

Required Documentation for dental consultant review:

- Extra-oral photos – including frontal and profile
- 5 Intra-oral photos – R/L buccal, U/L occlusal, and front incisor view
- Panoramic film
- Lateral cephalometric film
- Frontal cephalometric film (for surgical cases)
- Consultation report with diagnosis and treatment plan

Major Restorative Services-

- The following services are limited to 1 tooth per 60 months
- onlay metallic
- core buildup
- prefabricated post and core
- crowns

Endodontic Services-

- Therapeutic pulpotomy (excluding final restoration) – If a root canal is performed within 90 days of the pulpotomy, the pulpotomy is not a covered service and will beconsidered part of the root canal procedure
- Parital pulpotomy for apexogenesis – permanent tooth with incomplete root formation- If a root canal is performed within 90 days of the pulpotomy, the pulpotomy is not a covered service and will be considered part of the root canal procedure
- Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration) – Up to age 6 for primary incisiors, Up to age 11 for primary canines- Limited to once per tooth per lifetime
- Pulpal therapy (resorabable filling) – posterior, primary tooth (excluding final restoration) – Up to age 11 for primary molars – Limited to once per tooth per lifetime

Periodontal Services -

- Gingivectomy or gingivoplasty – four or more teeth
- Gingivectomy or gingivoplasty – one to three teeth 36 months
- Gingival flap procedure, including root planing, four or more teeth
- Clinical crown lengthening-hard tissue
- Osseous surgery (including flap entry and closure), four or more contiguous teeth or bounded teeth spaces per quadrant
- Pedicle soft tissue graft – Limited to once, per site, per 36 months
- Subepithelial connective tissue graft procedures- Limited to once per site, per 36 months
- Periodontal scaling and root planning-four or more teeth per quadrant-Limited to once per site per 24 months
- Periodontal scaling and root planning-one to three teeth per quadrant-Limited to once per site per 24 months
- Full mouth debridement to enable comprehensive evaluation and diagnosis-Limited to one per lifetime

- Periodontal maintenance – Limited to 4 per 12 months

Implant Services-

o Implants and related services are allowed once, per type of service (i.e. endosteal OR eposteal, porcelain OR metal crown), per treatment site per 60 months.

Fixed Prosthodontics -

o One fixed partial denture per treatment area per 60 months.

Oral Surgery -

Orthodontic Services -

- Orthodontic services are not covered for:
- Repair of damaged orthodontic appliances
- Replacement of lost or missing appliances
- Services to alter vertical dimension and/or restore or maintain the occlusion, such as procedures that include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation and restoration for misalignment of teeth.

PRIOR AUTHORIZATION

Dental Consultant review required

POLICY STATEMENT

Pediatric oral care services listed in this policy are covered as part of the members medical coverage for children from the ages of 0 up to child's 19th birthday when the benefit plan includes coverage for essential health benefits

No coverage is available under the members medical coverage for services not listed in this policy. These procedures would be considered not covered and are the member's responsibility up to the dentist's charge.

Orthodontic Services

Orthodontic services are not covered for:

- Repair of damaged orthodontic appliances
- Replacement of lost or missing appliances
- Services to alter vertical dimension and/or restore or maintain the occlusion, such as procedures that include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation and restoration for misalignment of teeth.

If a member has started orthodontic treatment with coverage by another carrier, or no insurance coverage at all, and the treatment meets BCBSRI medical criteria for coverage, the benefit maximum for orthodontic services will be prorated according to the length of time remaining in the treatment plan. *Example:* The member has completed 12 months of a 24 month orthodontic treatment plan before becoming enrolled. BCBSRI will pay 50% (12 months remaining/24 months total) of the allowable fee towards the orthodontic treatment.

For members who began orthodontic treatment with coverage under a BCBSRI dental plan and transitioned to the Pediatric Dental Benefit without coverage disruption, orthodontic payments will be made in

accordance with the terms of the plan that was in place when treatment began. Should additional orthodontic benefits be requested, the dental necessity criteria for coverage under the EHB-Pediatric Dental Benefit must be met. Payment will never exceed the Blue Cross Dental allowance for treatment rendered.

COVERAGE

Benefits may vary between groups/contracts. Please refer to the appropriate Subscriber Agreement for applicable pediatric dental benefits/coverage.

BACKGROUND

Effective January 1, 2014, Qualified Health Plans (QHPs) are required to cover Essential Health Benefits (EHBs), as defined in Section 1302(b) of the Patient Protection and Affordable Care Act. Pediatric Services including oral and vision care has been defined as essential Health Benefits. This policy defines the oral care services that will be covered for members from the ages of 0 up to the members 19th birthday. http://www.ncsl.org/issues-research/health/state-ins-mandates-and-aca-essential-benefits.aspx -5As groups renew in 2014, most benefit plans will need to include these EHBs (some exceptions may apply to certain large groups; consult your Subscriber Agreement or Benefit Booklet for details).

CODING

Claims are filed on CDT forms and if approved, will be processed under the members medical benefit.

DIAGNOSTIC SERVICES

- D0120 Periodic oral evaluation (one per 6 months)
- D0140 Limited oral evaluation (one per 6 months)
- D0150 Comprehensive oral evaluation (one per 3 years)
- D0160 Detailed and extensive oral evaluation, problem focused, by report (one per patient, per provider per 12 months per eligible diagnosis)
- D0180 Comprehensive periodontal evaluation (one per 3 years)
- D0210 Intraoral – complete series of radiographic images (one per 5 years, not eligible under age 5)
- D0220 Intraoral – periapical first radiographic image (4 per 12 months)
- D0230 Intraoral – periapical each additional radiographic image (4 per 12 months)
- D0240 Intraoral – occlusal film (2 in 24 months, not eligible age 8 and over)
- D0270 Bitewing – single radiographic image (maximum of 4 bitewings per 6 months)
- D0272 Bitewings – two radiographic images (maximum of 4 bitewings per 6 months)

  D0273 Bitewings - three radiographic images (mazimum of 4 bitewings per 6 months)
- D0274 Bitewings – four radiographic images (maximum of 4 bitewings per 6 months)
- D0277 Vertical Bitewings – 7 to8 radiographic images (maximum of 4 bitewings per 6 months)
- D0330 Panoramic radiographic image (one per 5 years, not eligible under age 5)
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- D0350 Oral/Facial photographic images

  D0391 Interpretation of diagnostic image by a practitioner not associated with capture of the image
- D0470 Diagnostic casts

PREVENTIVE SERVICES

- D1110 Prophylaxis – Adult (age 13 or older) (one per 6 months)
- D1120 Prophylaxis – Child (one per 2 months)

  D1206 Topical application of fluoride varnish (2 per 12 months)
- D1208 Topical application of fluoride, excluding varnish (2 per 12 months)
- D1351 Sealant-per tooth – unrestored permanent molars (1 per tooth per 36 months)
- D1352 Preventive resin restoration in a moderate to high caries risk patient – permanent tooth (under age 16- permanent molars only) (once per tooth per lifetime)

D1354 Interim caries arresting medicament application (one per 12 months ages 7-12; two per 12 months ages 1-6)

- D1510 Space maintainer –fixed- unilateral (under age 14- primary molars and permanent first molars only) (once per tooth per 5 years)
- D1515 Space maintainer-fixed-bilateral (under age 14- primary molars and permanent first molars only) (once per tooth per 5 years)
- D1520 Space maintainer-removable-unilateral (under age 14- primary molars and permanent first molars only) (once per tooth per 5 years)
- D1525 Space maintainer-removable-bilateral (under age 14- primary molars and permanent first molars only) (once per tooth per 5 years)
- D1550 Re-cementation of fixed space maintainer

D1555 Removal of fixed spaced maintainer

MINOR RESTORATIVE SERVICES (Once per surface, per tooth per 24 months)

- D2140 Amalgam-one surface, primary or permanent
- D2150 Amalgam-two surface, primary or permanent
- D2160 Amalgam-three surface, primary or permanent
- D2161 Amalgam-four or more surfaces, primary or permanent
- D2330 Resin-based composite-one surface, anterior
- D2331 Resin-based composite-two surface, anterior
- D2332 Resin-based composite-three surface anterior
- D2335 Resin-based composite-four or more surfaces or involving incisal angle (anterior)

D2391 Resin-based composite – once surface, posterior (allowed at amalgam allowance)
D2392 Resin-based composite- two surface, posterior (allowed at amalgam allowance)
D2393 Resin-based composite – three surface, posterior (allowed at amalgam allowance)
D2394 Resin-based composite – foru or more surfaces, posterior (allowed at amalgam allowance)

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- D2940 Protective resoration
- D2951 Pin retention-per tooth, in addition to restoration

MAJOR RESTORATIVE SERVICES (allowed once per tooth per 5 years) (Dental Consultant review required for all major restorative services)

- D2510 Inlay-metallic-one surface (allowed at amalgam restoration allowance)
- D2520 Inlay-metallic-two surfaces (allowed at amalgam restoration allowance)
- D2530 Inlay-metallic-three surfaces (allowed at amalgam restoration allowance)
- D2542 Onlay-metallic-two surfaces (allowed at amalgam restoration allowance)
- D2543 Onlay-metallic-three surfaces
- D2544 Onlay-metallic-four or more surfaces
- D2740 Crown-porcelain/ceramic substrate
- D2750 Crown-porcelain fused to high noble metal
- D2751 Crown-porcelain fused to predominantly base metal
- D2752 Crown-porcelain fused to noble metal
- D2780 Crown-3/4 cast high noble metal
- D2781 Crown-3/4 cast predominantly base metal
- D2783 Crown-3/4 porcelain/ceramic
- D2790 Crown-full cast high noble metal
- D2791 Crown-full cast predominantly base metal
- D2792 Crown-full cast noble metal
- D2794 Crown-titanium

D2910 Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration

D2920 Re-cement or re-bond crown
D2929 Prefabricated porcelain/ceramic crown-primary tooth
D2930 Prefabricated stainless steel crown – primary tooth (once per tooth per lifetime)
D2931 Prefabricated stainless steel crown – permanent tooth (once per tooth per lifetime)
D2932 Prefabricated resin crown (allowed at stainless steel allowance)
D2933 Prefabricated stainless steel crown with resin window (allowed at stainless steel allowance)
D2934 Pefabricated esthetic coated stainless steel crown – primary tooth

- D2950 Core buildup, including any pins (not covered on primary teeth)
- D2954 Prefabricated post and core, in addition to crown (not covered on primary teeth)
- D2980 Crown repair necessitated by restorative material failure

D2981 Inlay repair necessitated by restorative material failure
D2982 Onlay repair necessitated by restorative material failure
D2983 Veneer repair necessitated by restorative material failure
D2990 Resin infiltration of incipient smooth surface lesions

ENDODONTIC SERVICES

- D3220 Therapeutic pulpotomy (excluding final restoration)
- D3222 Partial pulpotomy for apexogenesis – permanent tooth with incomplete root formation)
- D3230 Pulpal therapy (resorbable filling) – (anterior, primary tooth under age 6; posteriorprimary tooth under age 11) (once per tooth per lifetime)
- D3240 Pulpal therapy (resorabable filling) – posterior, primary tooth (excluding final restoration) (anterior, primary tooth under age 6; posteriorprimary tooth under age 11) (once per tooth per lifetime)
- D3310 Endodontic therapy, anterior tooth (excluding final restoration) (once per tooth per lifetime) (Dental Consultant review required)
- D3320 Endodontic therapy, bicuspid tooth (excluding final restoration) (once per tooth per lifetime) (Dental Consultant review required)
- D3330 Endodontic therapy, molar (excluding final restoration) (once per tooth per lifetime) (Dental Consultant review required)
- D3346 Retreatment of previous root canal therapy-anterior (once per tooth per lifetime) (Dental Consultant review required)
- D3347 Retreatment of previous root canal therapy-bicuspid (once per tooth per lifetime) (Dental Consultant review required)
- D3348 Retreatment of previous root canal therapy-molar (once per tooth per lifetime) (Dental Consultant review required)
- D3351 Apexification/recalcification/pulpal regeneration –initial visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)
- D3352 Apexification/recalcification/pulpal regeneration –interim medication replacement
- D3353 Apexification/recalcification/pulpal regeneration –final visit (includes completed root canal therapy- apical closure/ calcific repair of perforations, root resorption,etc)
- D3355Pulpal regeneration – initial visit

D3356 Pulpal regeneration – interim medication replacement
D3357 Pulpal regeneration – completion of treatment (eligible on permanent teeth only, under age 15) (once per tooth per lifetime)

- D3410 Apicoectomy/periradicular surgery –anterior o D3421 Apicoectomy/periradicular surgery –bicuspid (first root)
- D3425 Apicoectomy/periradicular surgery –molar (first foot)

- D3426 Apicoectomy/periradicular surgery –(each additional root)
- D3450 Root amputation-per root (Dental Consultant review required)
- D3920 Hemisection (including any root removal)-not including root canal therapy (Dental Consultant review required)

PERIODONTAL SERVICES (allowed once per area of the mouth per 36 months) (Dental Consultant review required for periodontal services)

- D4210 Gingivectomy or gingivoplasty – four or more teeth o D4211 Gingivectomy or gingivoplasty – one to three teeth
  D4212 Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth
- D4240 Gingival flap procedure, including root planing, four or more teeth
  D4241 Gingival flap procedure, including root planing-one to three contiguous teeth or tooth bounded spaces per quadrant
- D4249 Clinical crown lengthening-hard tissue
- D4260 Osseous surgery (including flap entry and closure), four or more contiguous teeth or bounded teeth spaces per quadrant)
  D4261 Osseous surgery (including flap entry and closure), one to three contiguous teeth or tooth bounded spaces per quadrant
  D4266 Guided tissue regeneration- resorbable barrier, per site
  D4267 Guided tissue regeneration – non-resorbable barrier, per site (includes membrane removal)
- D4270 Pedicle soft tissue graft o D4273 Subepithelial connective tissue graft procedures
  D4277 Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in a graft
  D4278 Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site
  D4283 Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site
- D4341 Periodontal scaling and root planning-four or more teeth per quadrant (once per site per 24 months)
- D4342 Periodontal scaling and root planning-one to three teeth per quadrant) (once per site per 24 months)
- D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis (one per lifetime)
- D4910 Periodontal maintenance (4 per 12 months)

PROSTHODONTIC SERVICES (Prostheses limited to once per arch per 5 years)

- D5110 Complete denture-maxillary
- D5120 Complete denture-mandibular
- D5130 Immediate denture-maxillary
- D5140 Immediate denture-mandibular
- D5211 Maxillary partial denture-resin base (including any conventional clasps, rests and teeth)
- D5212 Mandibular partial denture-resin base (including any conventional clasps, rests and teeth)
- D5213 Maxillary partial denture-cast metal framework with resin denture base (including any conventional clasps, rests and teeth)
- D5214 Mandibular partial denture-cast metal framework with resin denture base (including any conventional clasps, rests and teeth)
  D5221 Immediate maxillary partial denture-resin base
  D5222 Immediate mandibular partial denture – resin base
  D5223 Immediate maxillary partial denture – cast metal framework with resin denture bases
  D5224 Immediate mandibular partial denture- cast metal framework with resin denture bases

- D5281 Removable unilateral partial denture-one piece cast metal (including clasps and teeth)
- D5410 Adjust complete denture-maxillary
- D5411 Adjust complete denture-mandibular
- D5421 Adjust parital denture-maxillary
- D5422 Adjust partial denture-mandibular
- D5510 Repair broken complete denture base
- D5520 Replace missing or broken teeth-complete denture (each tooth)
- D5610 Repair resin denture base
- D5620 Repair cast framework
- D5630 Repair or replace broken clasp
- D5640 Replace broken teeth-per tooth
- D5650 Add tooth to existing partial denture
- D5660 Add clasp to existing partial denture
- D5710 Rebase complete maxillary denture-Limited to once per 36 months
- D5711 Rebase complete mandibular denture-Limited to once per 36 months
- D5720 Rebase maxillary partial denture – Limited to once per 36 months
- D5721 Rebase mandibular parital denture- Limited to once per 36 months
- D5730 Reline complete maxillary denture (chairside)-Limited to once per 36 months
- D5731 Reline complete mandibular denture (chairside)- Limited to once per 36 months
- D5740 Reline maxillary partial denture (chairside)- Limited to once per 36 months
- D5741 Reline mandibular partial denture (chairside)- Limited to once per 36 months
- D5750 Reline complete maxillary denture (laboratory)- Limited to once per 36 months
- D5751 Reline complete mandibular denture (laboratory)- Limited to once per 36 months
- D5760 Reline maxillary partial denture (laboratory)- Limited to once per 36 months
- D5761 Reline manidbular partial denture (laboratory) – Limited to once per 36 months
-

IMPLANT SERVICES (limited to one per tooth/site per 5 years) (Dental Consultant review required)

- D6010 Endosteal implant (once per tooth per lifetime)
  D6011 Second stage implant surgery (once per tooth per lifetime)
-
  D6013 Surgical placement of mini implant (once per tooth per lifetime)
- D6040 Eposteal Implant (once per tooth per lifetime)
- D6050 Transosteal Implant, including hardware (once per tooth per lifetime)
-
- D6055 Connecting bar – implant or abutment supported
- D6056 Prefabricated abutment
- D6058 Abutment supported porcelain ceramic crown
- D6059 Abutment supported porcelain fused to high noble metal crown
- D6060 Abutment supported porcelain fused to predominantly base metal crown
- D6061 Abutment supported porcelain fused to noble metal crown
- D6062 Abutment supported cast high noble metal crown
- D6063 Abutment supported cast predominantly base metal crown
- D6064 Abutment supported cast noble metal crown
- D6065 Implant supported porcelain ceramic crown
- D6066 Implant supported porcelain fused to high noble metal crown
- D6067 Implant supported metal crown
- D6068 Abutment supported retainer for porcelain /ceramic fixed partial denture
- D6069 Abutment supported retainer for porcelain fused to high noble metal fixed partial denture
- D6070 Abutment supported retainer for porcelain fused to predominantly base metal fixed partial denture

- D6071 Abutment supported retainer for porcelain fused to noble metal fixed partial denture
- D6072 Abutment supported retainer for cast high noble metal fixed partial denture
- D6073 Abutment supported retainer for cast predominantly base metal fixed partial denture
- D6074 Abutment supported retainer for cast noble metal fixed partial denture
- D6075 Implant supported retainer for ceramic fixed partial denture
- D6076 Implant supported retainer for porcelain fused to high noble metal fixed partial denture
- D6077 Implant supported retainer for cast metal fixed partial denture
- o D6080 Implant maintenance procedures
- D6090 Repair implant supported prosthesis
- D6091 Replacement of semi-precision or precision attachment
- D6095 Repair implant abutment
- D6100 Implant removal

D6101 Debridement of periimplant defect or defects surrounding a single implant
D6102 Debridement and osseous contouring of a periimplant defect or defects surrounding a single implant
D6103 Bone graft for repair of peri-implant defect
D6104 Bone graft at time of implant placement
D6110 Implant /abutment supported removable denture for edentulous arch-maxillary
D6111 Implant/abutment supported removable denture for edentulous arch – mandibular
D6112 Implant/abutment supported removable denture for partially edentulous arch-maxillary
D6113 Implant/abutment supported removable denture for partially edentulous arch-mandibular
D6114 Implant/abutment supported fixed denture for edentulous arch-maxillary
D6115 Implant/abutment supported fixed denture for edentulous arch- mandibular
D6116 Implant/abutment supported fixed denture for partially edentulous arch-maxillary
D6117 Implant/abutment supported fixed denture for partially edentulous arch- mandibular
D6190 Radiographic/surgical implant index, by report

FIXED PROSTHODONTICS (limited to one per tooth per 5 years) (Dental Consultant review required)

- D6210 Pontic-cast high noble metal
- D6211 Pontic-cast predominantly base metal
- D6212 Pontic-cast noble metal
- D6214 Pontic-titanium
- D6240 Pontic-porcelain fused to high noble metal
- D6241 Pontic-porcelain fused to predominantly base metal
- D6242 Pontic-porcelain fused to noble metal
- D6245 Pontic-porcelain/ceramic
- D6548 Retainer-porcelain/ceramic for resin bonded fixed prosthesis

D6549 Resin retainer – porcelain/ceramic for resin bonded fixed prosthesis
D6600 Inlay- porcelain/ceramic, two surfaces
D6601 Inlay- porcelain/ceramic, three or more surfaces
D6602 Inlay – cast high noble metal, two surfaces
D6603 Inlay – cast high noble metal, three or more surfaces
D6604 Inlay – cast predominantly base metal, two surfaces
D6605 Inlay – cast predoniminantly metal, three or more surfaces
D6606 Inlay – cast noble metal, two surfaces
D6607 Inlay – cast noble metal, three or more surfaces
D6608 Onlay – porcelain/ceramic, two or more surfaces
D6609 Onlay- porcelain/ceramic, three or more surfaces
D6610 Onlay – cast high noble metal, two surfaces
D6611 Onlay – cast high noble metal, three or more surfaces

D6612 Onlay – cast predominantly base metal, two surfaces
D6613 Onlay – cast predominantly base metal, three or more surfaces
` D6614 Onlay – cast noble metal, two surfaces
D6615 Onlay – cast noble metal, three or more surfaces
- D6740 Crown-porcelain/ceramic
- D6750 Crown-porcelain fused to high noble metal
- D6751 Crown-porcelain fused to predominantly base metal
- D6752 Crown-porcelain fused to noble metal
- D6780 Crown-3/4 cast high noble metal
- D6781 Crown-3/4 cast predominantly base metal
- D6782 Crown-3/4 cast noble metal
- D6783 Crown-3/4 porcelain/ceramic
- D6790 Crown-full cast high noble metal
- D6791 Crown-full cast predominantly metal
- D6792 Crown-full cast noble metal
- D6930 Recement fixed partial dentureo D6980 Fixed partial denture repair necessitated by restorative material failure

ORAL SURGERY (Dental Consultant review required)
- D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
- D7210 Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
- D7220 Removal of impacted tooth-soft tissue
- D7230 Removal of impacted tooth-partially bony
- D7240 Removal of impacted tooth-completely bony
- D7241 Removal of impacted tooth-completely bony with unusual surgical complications
- D7250 Surgical removal of residual tooth roots (cutting procedure)
- D7251 Coronectomy-intentional partial tooth removal
- D7270 Tooth reimplantation and/or stabilization of accidentally avulsed or displaced tooth
- D7280 Surgical access of an unerupted tooth
- D7310 Alveoloplasty in conjunction with extractions-per quadrant
- D7311 Alveoloplasty in conjunction with extractions-one to three teeth or tooth spaces, per quadrant
- D7320 Alveoloplasty not in conjunction with extractions-per quadrant
- D7321 Alveoloplasty not in conjunction with extractions-one to three teeth or tooth spaces, per quadrant
- D7471 Removal of lateral exostosis (maxilla or mandible)
- D7510 Incision and drainage of abscess- intraoral soft tissue
- D7910 Suture of recent small wounds-up to 5 cm
D7921 Collection and application of autologous blood concentrate product (once per 36 months)
- D7971 Excision of pericoronal gingival

ADJUNCTIVE SERVICES
- D9110 Palliative (emergency) treatment of dental pain-minor procedure
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D9223 Deep sedation/general anesthesia – 15 min increments – Limited to 60 minutes
D9230 Inhalation of nitrous oxide/analgesia, anxiolysis (eligible under age 13 when medically necessary)
D9243 Intravenous conscious sedation/analgesia – 15 min increments – Limited to 60 minutes

D9248 Non-intravenous moderate (conscious) sedation (eligible under age 13 when medically necessary)o D9310 Consultation- diagnostic service provided by a dentist or physician other than
requesting dentist or physician (1 per patient per provider per 12 months for specialities other than pedodontist or orthodontist)

- o D9610 Therapeutic drug injection, by report
- o D9930 Treatment of complications (post-surgical)-unusual circumstances, by report (Dental Consultant review required)
- o D9940 Occlusal guard, by report (eligible age 13-18) (once per 12 months)

ORTHODONTIC SERVICES (Dental Consultant review required)

The following services are covered under medical only when the services meet the criteria for coverage in this policy (see above)

D0340 Cephalometric radiographic image

- o D8010 Limited orthodontic treatment of the primary dentition
- o D8020 Limited orthodontic treatment of the transitional dentition
- o D8030 Limited orthodontic treatment of the adolescent dentition
- o D8040 Limited orthodontic treatment of the adult dentition
- o D8050 Interceptive orthodontic treatment of the primary dentition
- o D8060 Interceptive orthodontic treatment of the transitional dentition
- o D8070 Comprehensive orthodontic treatment of the transitional dentition
- o D8080 Comprehensive orthodontic treatment of the adolescent dentition
- o D8090 Comprehensive orthodontic treatment of the adult dentition
- o D8210 Removable appliance therapy
- o D8220 Fixed appliance therapy
- o
- o D8670 Periodic orthodontic treatment visit *
- o D8680 Orthodontic retention (removal of appliances, construction and placement of retainer(s)
- o D8999 Unspecified orthodontic procedure, by report

* these services are typically reimbursed as part of the global services

RELATED POLICIES

Not applicable.

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