healthplex
333 Earle Ovington Blvd, Suite 300, Uniondale, NY 11553

HEALTHPLEX REFERENCE MANUAL FOR DENTAL SERVICES: LIMITED AND COMPREHENSIVE PLANS

Please Note: This manual is a supplement to be used in conjunction with an enrollee's Dental Plan's Certificate of Coverage (COC) or Evidence of Coverage (EOC) a well as the applicable contract between you and/or the Health Plan and Healthplex. The information in your COC, EOC and/or contract supersedes this document.

Accessibility Statement

The clinical review criteria, internal rule, protocol or guideline relied upon to make a decision for a requested dental service is available to an enrollee or their designee upon request and free of charge. Oral interpretation and alternate formats of written material for enrollees with special needs are also available.

Where applicable and upon request by an enrollee, any written notices/information shall be translated into a preferred non-English language.

Please contact Healthplex Customer Service for help with questions, language and/or interpretative services by phone at 866-795-6493 or email to: info@healthplex.com.

Introduction

The Healthplex guidelines and clinical criteria apply to the procedure codes, nomenclature and descriptors outlined in the most current version of the Current Dental Terminology (CDT) reference manual published by the American Dental Association.

This document includes information pertaining to the most frequently billed services. Exceptions to published limitations are given on a case-by-case basis considering individual factors including but not limited to age, comorbidities, special needs and access to the local delivery system.

Dental Benefit Administration

Benefits for planned or rendered dental care are provided as defined in the members' contracts, which in addition to clinical criteria may include exclusions, limitations and administrative guidelines for certain procedures. Contracts vary depending on regulatory requirements and/or plan-specific rules and level of coverage.

Healthplex Clinical Criteria

Healthplex's guidelines, protocols and review criteria for dental services are developed and maintained by the Healthplex Dental Director, are reviewed at least annually and are updated as needed.

Criteria are created from an aggregate of information from:

- Current dental literature;
- Practice Parameters from the American Association of Periodontology (www.perio.org);
- Parameters of Care from the American Association of Oral and Maxillofacial Surgery (www.aaoms.org);
- Oral Health Policies and Clinical Guidelines from the American Academy of Pediatric Dentistry (www.aapd.org);
- Position Statements from the American Association of Dental Consultants (www.aadc.org);
- Dental Practice Parameters from the American Dental Association (www.ada.org);
- Evaluation of new and emerging technologies from participating dental professionals;
- Guidance documents issued by applicable regulatory oversight entities; and
- Public information from other insurance companies.

Criteria are reviewed and approved at least annually by Healthplex's Utilization Management Committee, whose clinical members, at a minimum, include the Dental Director (a licensed Dentist), a member of the Healthplex Clinical Review Staff (typically a General Dentist or an Orthodontist), a practicing network general dentist, an Oral Surgeon, an Endodontist, and a Periodontist.

The Professional Review Process

All Clinical Reviewers shall be actively licensed dental professionals with an appropriate level of education, training, and professional experience in clinical practice. Only a clinical peer reviewer, a licensed dentist, shall render an adverse determination if based on medical necessity rather than plan guidelines.

Clinical Reviewers shall evaluate requested services based on plan specific guidelines, clinical application of review criteria, patient condition, health history, and demographics (including but not limited to geographical area, assessment of the local delivery system, age, complications, progress of treatment, home environment and social habits). Based on an aggregate of these factors, the Reviewer shall indicate if the services are approved, denied, or if further information is needed to render a determination. Individual cases may be elevated to a Dental Director and/or their designated representative for consideration of special circumstances as necessary.

Scope of Coverage for Comprehensive Services Programs

A Limited Benefit Dental Plan, including certain Medicare plans, provides coverage for routine preventive and diagnostic dental services to maintain oral health and to prevent the need for more extensive dental procedures.

A Comprehensive Benefit Dental Plan , including certain Medicare plans, provides coverage for routine preventive and diagnostic dental services as well as services needed restore the dental condition.

Healthplex Limited & Comprehensive Dental Benefit Plans include access to a network of dentists who have agreed to accept reduced fees for covered services, which provides the opportunity for a member to incur minimal out of pocket expenses.

Statement About Incentives

Healthplex, Inc. shall not, with respect to utilization review activities, permit or provide compensation or anything of value to its employees, agents, or contractors based on:

1. A percentage of the amount by which a claim is reduced for payment or the number of claims or the cost of services for which the person has denied authorization or payment; or
2. Any other method that encourages the rendering of an adverse determination.

Healthplex, Inc. does not use incentives to encourage barriers to care and service. Decision-making is based solely on appropriateness of care and service combined with the applicable dental plan's scope of coverage. Healthplex, Inc. does not specifically reward any individual for issuing any denial of coverage or for encouraging decisions that result in underutilization.

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COVERED PROCEDURES

I. DIAGNOSTIC SERVICES

Summary

A. Diagnostic Summary

Diagnostic services include an oral examination, caries risk assessment and select radiographs to assess the current status and to develop a treatment plan for the maintenance and/or restoration of a patient's oral health. Diagnostic procedures do not generally require prior approval or application of clinical criteria.

Examinations

B. Comprehensive Evaluation

A comprehensive evaluation is a thorough examination and recording of the extraoral and intraoral hard and soft tissues. This applies to new patients, established patients who have had a significant change in health conditions or other unusual circumstances such as established patients who have been absent from active treatment for three or more years.

Documentation should include the patient's dental and medical history as well as medical consultation/clearance if indicated, evaluation and charting of dental caries, missing or unerupted teeth, restorations, prosthetic appliances, occlusal relationships, periodontal conditions (including periodontal charting), hard and soft tissue anomalies and any other pertinent information.

Reimbursement is generally limited to one exam (comprehensive, periodic, consultation or limited focused) every 6 months and includes diagnosis, treatment planning and oral cancer screening.

C. Periodic Evaluation

A periodic evaluation is performed on a patient of record to determine any changes to dental and/or medical health status since the previous evaluation.

Reimbursement is generally limited to one exam (comprehensive, periodic, consultation or limited focused) every 6 months and includes diagnosis, treatment planning and oral cancer screening.

D. Limited Evaluation – Problem Focused

A limited evaluation is performed when a patient presents with a specific problem, complaint and/or dental emergency.

Please note: Follow-up visits related to previous treatment are not billable and therefore shall not be considered for separate reimbursement.

If a limited/problem focused evaluation does not share a limitation with other types of evaluations, reimbursement is generally allowed once every six months and is not

separately payable if rendered on the same day as another exam or consultation.

Radiographs

E. Radiograph Summary

To minimize a patient's radiation exposure, Healthplex recommends that providers exercise professional judgment and utilize the guidelines for prescribing dental radiographs published by the American Dental Association in collaboration with the U.S. Food & Drug Administration available online at: http://www.ada.org/~/media/ADA/Member%20Center/FIles/Dental_Radiographic_Examinations_2012.ashx.

Radiographs may be necessary in order to obtain a determination for certain services. Please mount, date, and label **copies** of the most recent radiographs available. Originals should **always** be retained by the dentist.

Please note: Radiographs submitted to Healthplex will NOT be returned. Healthplex recommends submitting digital radiograph copies whenever possible.

F. Complete or Comprehensive Series of Radiographic Images

A complete or comprehensive series is comprised of individual radiographs or a panoramic radiograph plus bitewings. The maximum reimbursement for individual radiographs shall be limited to the allowance for a complete/comprehensive series.

Reimbursement is typically limited to either a complete/comprehensive series or a panoramic radiograph every 36-months.

G. Panoramic Radiographs

Reimbursement is typically limited to either a complete/comprehensive series or a panoramic radiograph every 36-months.

H. Cone Beam Computed Tomography (CBCT) Scans

CBCT is unproven and not medically necessary for routine dental diagnosis due to insufficient evidence of efficacy and/or safety.

If the CBCT is included within your dental plan's scope of coverage, consideration will be generally limited to those necessary for diagnosis and treatment related to implants or oral surgery and will be evaluated on a case-by-case basis. A narrative of necessary for this type of image and a panoramic radiograph are required in order to determine if the scan meets criteria for approval.

I. Cephalometric Radiographs

Cephalometric radiographs are payable once every 12 months to an orthodontist or oral surgeon for diagnostic purposes related to orthodontic treatment only.

Diagnostic Casts

J. Diagnostic Casts

Diagnostic casts are payable to an orthodontist for diagnostic purposes related to orthodontic treatment only. Diagnostic casts related to prosthetics are considered included in the allowance for the related billable service.

II. PREVENTIVE SERVICES

Summary

A. Preventive Summary

Preventive services include routine prophylaxis, topical application of fluoride, sealants, oral hygiene instructions and space maintenance therapy. The goal of providing routine preventive dental services is to maintain oral health and to prevent the need for more extensive dental procedures.

Prophylaxis

B. Prophylaxis (Cleaning)

Prophylaxis includes necessary scaling and polishing for the removal of plaque, calculus and stains from the tooth structures.

Reimbursement is routinely allowed once every 6 months.

Fluoride

C. Topical Application of Fluoride – Excluding Varnish

Topical Fluoride treatments in the form of gel, foam, and rinses applied in dental office as a caries preventive agent. Topical application of fluoride is allowed once every 6 months. Refer to the benefit brochure for applicable age limitations.

D. Topical Application of Fluoride Varnish

Fluoride varnish may be the preferred delivery method for individuals receiving head and neck radiation therapy and/or moderate to high caries risk individuals with a medical or cognitive impairment Xerostomia. Fluoride varnish is generally allowed once every 6 months. Refer to the benefit brochure for applicable age limitations.

Sealants

E. Sealants

Sealants should be applied to occlusal surfaces (and buccal/lingual pits and grooves when applicable) of previously unrestored and caries free erupted first and second permanent molars.

Sealants are indicated for the following:

- Caries prevention in pit and fissures on permanent molars
- Non-cavitated carious lesions
- Caries prevention in primary molars that are expected to have a reasonable period of retention

Sealants are not indicated for the following:

- In the presence of rampant caries and multiple interproximal lesions
- Extrinsic staining of pits and fissures
- For cavitated carious lesions

Sealants shall be limited to once every 60 months. Refer to the benefit brochure for applicable age limitations.

Space Maintainer

F. Space Maintainers

A space maintainer is covered when indicated due to the premature loss of a primary tooth.

Space Maintainers are **contraindicated** for the following:

- When permanent tooth/teeth is/are close to eruption
- Severe crowding already exists Space has already been lost

Exclusions:

- Dental services that are not Necessary

Limitations:

- Lifetime reimbursement for a unilateral appliance is once per quadrant and for a bilateral appliance is once per arch.
- Any Space Maintainer adjustments are inclusive for 6 months
- Removal of a fixed appliance is limited to once per lifetime to an office other than that of the original rendering provider.
- Refer to the benefit brochure for applicable age limitations.

III. RESTORATIVE SERVICES

Summary

A. Restorative Summary

Restorative services most commonly include amalgam and composite restorations, post and core, and crown. Amalgam and composite restorations as well as stainless steel crowns do not require prior approval or application of clinical criteria. Prior authorization is recommended for all other covered restorative procedures as clinical criteria apply.

Restorations placed solely for abrasion, attrition or for cosmetic purposes are beyond the scope of the program.

Repeated unexplained failure of any type of restoration will result in peer review and may necessitate removal of the dentist from the network and/or further disciplinary action.

Coverage Limitations and Exclusions

- Dental Services that are not necessary
- Any dental procedure performed solely for cosmetic/aesthetic reasons (cosmetic procedures are those procedures that improve physical appearance)
- Any dental procedure not directly associated with dental disease
- Clinical situations that can be effectively treated by a less costly, dental appropriate alternative procedure will be assigned a benefit based on the least costly procedure
- All indirect restorations like crowns, bridge abutments, pontics, inlays, onlays, post and core are covered once per tooth per 60 consecutive months

Amalgam & Composite Restorations

B. Direct Restorations

Direct Restorations are indicated for the following:

- To replace tooth structure lost to caries or trauma
- To replace restorative material lost in the course of accessing pulp chamber for endodontic therapy
- To replace existing restorations that exhibit recurrent decay, fracture or marginal defects

In addition to the above, Glass Ionomer restorations are indicated for the following:

- When teeth cannot be isolated properly to allow placement of resin restorations
- As an alternative to resin sealants when the teeth cannot be properly isolated (patient cooperation, partially erupted teeth)
- Class I, II, III and V restorations on primary teeth
- Class III and V restorations on permanent teeth that cannot be isolated in high-risk patients

- As a caries control plan for high-risk patients using atraumatic techniques

Direct Restorations are not indicated for the following:

- Teeth with a hopeless prognosis
- Incipient enamel only lesions extending less than halfway to the dentino-enamel junction (DEJ)
- Primary teeth that are near exfoliation or less than 50% of the tooth root remains Composite resin restorations are not indicated for patients with heavy bruxism Composite resin restorations are not indicated for patients with extensive active caries, or high caries risk
- Amalgam restorations are not indicated for placement on teeth in which they will have contact with gold restorations

Total restoration per tooth by amalgam and/or composite is not to exceed the allowable fee for a four surface restoration within 24 months. Direct Restorations are expected to last a reasonable amount of time but no less than 24 months.

If an amalgam or composite restoration is billed on the same day as a post and core or a core build-up, separate reimbursement shall not be available for the restoration.

Bases, cements, liners, pulp caps, bonding agents and local anesthetic are included in the restorative service fees and shall not be reimbursed separately.

C. Protective Restoration

A protective restoration is indicated for the following:

- To relieve pain
- To promote healing
- To prevent further deterioration
- To retain tissue form

A protective restoration is not indicated for the following:

- As a liner or base for a definitive restoration
- Not for endodontic access closure
- Not for pulp capping
- As a definitive restoration

D. Interim Therapeutic Restoration - Primary Dentition Interim

Therapeutic restorations are indicated for the following:

- For very young, uncooperative or special needs patients
- When traditional tooth preparation for an Amalgam or Composite restoration is not feasible or must be postponed

E. Resin Infiltration of Incipient Smooth Surface Lesions

This service is typically used for treating white spots, demineralized enamel from orthodontic treatment, for aesthetic purposes. The code describes a proprietary product (Icon Smooth Surface Caries Infiltration, DMG America Ridgefield park, New Jersey) and

will not be reimbursed due to insufficient evidence of efficacy.

Post and Core

F. Post and Core

A request for a post and core shall be automatically approved if the tooth has recent history of approved endodontic treatment. In the absence of recent endodontic treatment, the request requires clinical review of pre-operative radiographs and a full mouth treatment plan to substantiate medical necessity.

Consideration for post and core or core build-up is contingent upon the approval of the corresponding root canal and crown.

Crowns

G. Crowns

A request for a crown shall be automatically approved if the tooth has recent history of approved endodontic treatment. In the absence of recent endodontic treatment, the request requires clinical review of pre-operative radiographs and a full mouth treatment plan to substantiate medical necessity.

Payment for a crown includes any adjustments or re-cementation necessary during the six month period following its initial placement.

The determination of coverage will be based on the status of the individual tooth as well as the condition of the remaining teeth and supporting tissue. Factors considered include but are not limited to: medical necessity, periodontal condition, restorative prognosis, endodontic prognosis, missing teeth, integrity of the opposing dentition, and existing or proposed prosthesis in the same or opposing arch.

A crown will not be approved if the tooth can be reasonably restored with a filling.

Damaged teeth should be restored using procedures that remove the least amount of tooth structure necessary to restore normal function.

Crowns are indicated for the following:

- Extensive caries or tooth fractures
- To replace large defective restorations
- Complete cusp fractures
- Endodontically treated teeth (unless only need to restore the access opening on an anterior tooth) that are asymptomatic with a good apical seal
- Symptomatic “cracked tooth syndrome” (not enamel craze lines)
- Full coverage restoration of a primary tooth without a permanent successor

Crowns are not indicated for the following:

- If a more conservative means of restoration is acceptable
    - If the buccal and lingual walls are intact
- If root resorption is present

- For teeth with untreated/uncontrolled periodontal disease or periapical pathology Unstable, active caries
- Poor oral hygiene
- Teeth that do not have a favorable Crown/root ratio

Coverage Limitations:

- Clinical situations that can be effectively treated by a less costly, dental appropriate alternative procedure will be assigned a benefit based on the least costly procedure
- Limited to 1 restoration per natural or prosthetic tooth per consecutive 60 months without regard to the material used or type of restoration placed (standard crown, inlay, onlay, pontic, bridge abutment, or implant crown)

Exclusions:

- Replacement of indirect restorations if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the dental provider. If replacement is due to patient non-compliance, the patient is liable for the cost of replacement.
- Fixed restoration procedures for complete oral rehabilitation reconstruction Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion
- Laboratory based Crowns for the purposes of provisional splinting

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IV. ENDODONTIC SERVICES

Summary

A. Endodontic Summary

Endodontic services most commonly include pulpotomy, root canal therapy, retreatment of previous root canal therapy, and apicoectomy. Clinical criteria apply to all covered endodontic procedures with exception of pulpotomy, therefore prior authorization for these services is recommended. Noted patterns of endodontic treatment failure will result in peer review and may necessitate removal of the dentist from the network and/or further disciplinary action.

When endodontic therapy is indicated in an urgent situation, it is expected that appropriate palliative measures shall be initiated. Please contact Healthplex with any questions related to coverage and/or to request an expedited prior authorization.

If endodontic therapy is rendered in the absence of a prior authorization, please submit your claim with recent pre-operative and post-operative radiographs for retrospective review.

Endodontic therapy is indicated for the following:

- A restorable, mature, completely developed permanent or primary tooth with irreversible pulpitis, necrotic pulp, or frank vital pulpal exposure
- Teeth with radiographic periapical pathology
- Primary teeth without a permanent successor
- When needed for prosthetic rehabilitation

Endodontic therapy is not indicated for the following:

- Teeth with a poor long-term prognosis
- Teeth with inadequate bone support or advanced or untreated periodontal disease
- Teeth with incompletely formed root apices

Pulpotomy

B. Pulpotomy

The aim of pulpotomy is to maintain the vitality of the remaining portion by means of an adequate dressing. It is not to be construed as the first stage of root canal therapy. Therefore, if root canal is performed by the same provider, any allowance paid shall be deducted from the fee for root canal therapy.

Reimbursement for a pulpotomy is available once per tooth. Refer to the benefit brochure for applicable age limitations.

Therapeutic Pulpotomy is indicated for the following:

- Exposed vital pulps or irreversible pulpitis of primary teeth where there is a reasonable period of retention expected (approximately one year)

- As an emergency procedure in permanent teeth until root canal treatment can be accomplished
- As an interim procedure for permanent teeth with immature root formation to allow continued root development

Therapeutic Pulpotomy is not indicated for the following:

- Primary teeth with insufficient root structure, internal resorption, furcal Perforation or periradicular pathosis that may jeopardize the permanent successor
- Removal of pulp apical to the dentinocemental junction

Pulpal Therapy

C. Pulpal Therapy

Pulpal therapy shall include pulpectomy, cleaning, and filling of canals with resorbable material.

A post-operative radiograph is requested upon completion. If canals are not sufficiently filled to the apex, benefit for pulpotomy will be allowed.

Reimbursement for a pulpal therapy is available once per tooth. Refer to the benefit brochure for applicable age limitations.

Root Canal Therapy

D. Root Canal Therapy

Reimbursement for root canal therapy shall include pulpal extirpation, endodontic treatment to include complete filling of the canal(s) with permanent material, all necessary radiographs during treatment, a radiograph demonstrating proper completion, and follow-up care.

The acceptable standard employed for endodontic procedures dictates that the canal(s) be completely filled apically and laterally. In cases where the root canal filling does not meet acceptable standards, Healthplex reserves the right to require that the procedure be redone at no additional cost. Refund may be requested for any reimbursement made for an inadequate service.

Requests for endodontic therapy or retreatment require clinical review of pre-operative radiographs and a full mouth treatment plan. The determination of coverage will be based on the status of the individual tooth as well as the condition of the remaining teeth and supporting tissue. Factors considered include but are not limited to:

- Medical necessity
- Periodontal condition
- Restorative prognosis
- Missing teeth
- Presence of root resorption

- ♦ Integrity of the opposing dentition
- ♦ Existing or proposed prosthesis in the same or opposing arch

Reimbursement for root canal therapy and/or retreatment is once per tooth.

Apicoectomy

E. Apicoectomy

Please refer to clinical criteria for endodontic therapy listed in the root canal section above.

Apicoectomy will be considered only if one or more of the following conditions exist:

- Overfilled canal (previously treated tooth) or displaced root canal filling irritating periapical tissues
- Canal cannot be filled properly due to excessive root curvature or calcification, fractured root tip, broken instrument in canal, or perforation of the apical third of canal
- Periapical pathology not resolved by previous endodontic therapy
- A post which cannot be removed.

Reimbursement for apicoectomy is once per tooth

Apexification

F. Apexification

Requests for reimbursement for apexification require clinical review of pre-operative radiographs to substantiate medical necessity. Factors such as restorative prognosis and presence of open apices are considered for determination of coverage.

Apexification/Recalcification is indicated for the following:

- Incomplete apical closure in a permanent tooth root
- External root resorption or when the possibility of external root resorption exists
- Necrotic pulp, irreversible pulpitis, or periapical lesion
- For prevention or arrest of resorption
- Perforations or root fractures that do not communicate with oral cavity

Apexification/Recalcification is not indicated for the following:

- Tooth with a completely closed apex

Reimbursement for apexification is once per tooth.

V. PERIODONTIC SERVICES

Summary

A. Periodontic Summary

Clinical criteria apply to all covered periodontic procedures, therefore prior authorization for these services is recommended.

When periodontal services are indicated, the provider must keep on file documentation of the need for treatment, including a copy of the pre-treatment evaluation of the periodontium, a general description of the tissues (i.e. color, shape, and consistency), the location and measurement of periodontal pockets, the description of the type and amount of bone loss, the periodontal diagnosis, the amount and location of subgingival calculus deposits, and tooth mobility.

Exclusions:

- Any Dental Procedure performed solely for cosmetic/aesthetic reasons
- Any Dental Procedure not directly associated with dental disease
- Procedures that are considered to be Experimental, Investigational or Unproven
- Dental Services that are not Necessary
- Periodontal procedures related to implant treatment will not be covered if the corresponding implant is not covered

Periodontal scaling & root planning (SRP)

B. SRP

Periodontal scaling & root planing is indicated for patients with moderate to severe periodontal disease and is therapeutic not prophylactic in nature. It involves instrumentation of the crown and root surfaces to remove plaque and calculus.

Current periodontal charting in conjunction with appropriate radiographs should be submitted for review. Factors such as pocket depth and bone loss shall be considered. For approval of the requested quadrant, there must be a minimum of one pocket of at least 5mm or one pocket of at least 4mm with evidence of bone loss of more than 2mm from the CEJ (cemento/enamel junction).

If less than 4 teeth are present in the quadrant, the allowance shall be prorated.

Please note that your periodontal charting must be an accurate representation of the patient's current condition. Noted patterns of inconsistency between periodontal charting and radiographs and/or dental history will result in peer review and may necessitate removal of the dentist from the network and/or further disciplinary action.

Reimbursement for each quadrant is available once every 24 months.

Periodontal Surgery

C. Periodontal Surgery

Covered periodontal surgery most commonly includes gingivectomy/gingivoplasty and osseous surgery.

Current periodontal charting and/or photos in conjunction with appropriate radiographs and a narrative substantiating the causative factor(s) should be submitted for clinical review for prior authorization. Factors such as pocket depth, bone loss, hygiene status and likelihood of maintaining dental health shall be considered. For approval of the requested quadrant, there must be a minimum of one pocket of at least 5mm or one pocket of at least 4mm with evidence of bone loss of more than 2mm from the CEJ (cemento/enamel junction) or moderate to severe bone loss radiographically. The teeth in the applicable area must be restorable.

If less than 4 teeth are present in the quadrant, the allowance shall be prorated.

In the event that periodontal surgery is approved, reimbursement for necessary covered ancillary procedures like soft and hard tissue grafts will be allowed as indicated.

D. Gingivectomy/Gingivoplasty

Gingivectomy/Gingivoplasty is indicated for the following:

- Elimination of suprabony pockets, exceeding 3mm, if the pocket wall is fibrous and firm and there is an adequate zone of keratinized tissue
- Elimination of gingival enlargements/overgrowth
- Elimination of suprabony periodontal abscesses
- Exposure of soft tissue impacted teeth to aid in eruption
- To reestablish gingival contour following an episode of acute necrotizing ulcerative gingivitis
- To allow restorative access, including root surface caries

Gingivectomy/Gingivoplasty is not indicated for the following:

- When bone surgery is required for infrabony defects, or for the purpose of examining bone shape and morphology
- Situations in which the bottom of the pocket is apical to the mucogingival junction

Reimbursement for each quadrant of Gingivectomy/Gingivoplasty is available once every 12 months.

E. Osseous Surgery

Osseous Surgery is indicated for the following:

- Patients with a diagnosis of moderate to advanced or Refractory periodontal disease
- When less invasive therapy (i.e., non-surgical periodontal therapy, Flap procedures) has failed to eliminate disease

Reimbursement for each quadrant of Osseous Surgery is generally available once every 60 months.

Crown Lengthening

F. Crown Lengthening

Current appropriate radiographs should be submitted for review. The tooth must be restorable and must present with insufficient structure for retaining a crown.

Clinical crown lengthening – hard tissue is indicated for the following:

- In an otherwise periodontally healthy area to allow a restorative procedure on a tooth with little to no crown exposure
- To allow preservation of the biological width for restorative procedures

VI. PROSTHETIC SERVICES

Summary

A. Prosthetic Summary

Prosthetic services most commonly include removable dentures. Clinical criteria apply to all covered prosthetics without regard to material, therefore prior authorization for these services is recommended. Full and/or partial dentures are covered when they are required to alleviate a serious health condition or one that affects employability.

Fixed partial dentures are not generally considered within the scope of services covered by the program if a lower cost, reasonably functional alternative is feasible. If extenuating circumstances exist, please submit a prior authorization request with a narrative for consideration.

When included with the benefit package, implants shall be considered when medically necessary.

In situations where it is impractical to obtain pre-operative radiographs on a patient in a nursing home or long term care facility, a written narrative by the dentist stating that the patient is in a physical and mental state sufficient to function with dentures is required for authorization.

Claims are not to be submitted until the prosthetics are completed and delivered to the member.

Prosthetic services like dentures are generally covered once arch per 60 consecutive months. Refer to your benefit brochure for exceptions and limitations for prosthetic replacements. Consideration of replacement outside of this expectation shall be based on documented medical necessity and individual circumstances.

Removable Prosthetic Services

B. Removable Prosthetics

Dentures, both partial and complete, shall be considered when masticatory function is likely to impair the general health of the patient or when the existing prosthesis is unserviceable or if recent extensive physiological change (i.e. recent extraction of 4 or more teeth, marked weight loss, trauma, etc.) has occurred. Exceptions based on medical necessity for individual factors shall be considered on a case by case basis.

Requests for replacement dentures whether unserviceable, lost, stolen, or broken prior to the applicable frequency limitation must include a letter explaining the circumstances and what was or will be done to ensure longevity of the new denture if approved.

C. Complete dentures

- If initial placement for a non-edentulous arch, a full mouth treatment plan and preoperative radiographs are required to substantiate medical necessity.

- If initial placement for an edentulous arch, the request shall be automatically approved.
- For replacement of an existing complete denture, prior insertion date and reason for replacement are needed for a determination of coverage.

D. Partial dentures

- If initial placement, a full mouth treatment plan and preoperative radiographs are required to substantiate medical necessity.
- For replacement of an existing partial denture, a full mouth treatment plan, preoperative radiographs, prior insertion date and reason for replacement are needed for a determination of coverage.
- Please note that all necessary restorative work must be completed before fabrication of a partial denture.

The determination of coverage will be based on:

- Radiographic evaluation of the status of the dentition as well as appropriateness of the proposed treatment plan (i.e. planned extractions, prognosis of remaining teeth, etc.).
- Partial dentures will be allowed if there is at least one missing tooth.
- Abutments for a partial denture must be free of active periodontal disease and have adequate bone support.

Partial dentures can be considered for patients age 15 and above. An interim prosthesis (codes D5820/D5821) can be considered for patients between ages 5 to 15.

E. Immediate Dentures

Immediate prosthetic appliances are not routinely covered. It is expected that tissues will be allowed to heal for a minimum for 4-6 weeks prior to taking the final impression(s).

F. Implant Supported Dentures

An implant supported prosthetic shall be considered using the medical necessity criteria related to the implants. Please refer to the Implant section below.

Denture Repairs, Relines, and Adjustments

G. Repair/Reline/Adjust

Payment for a new prosthesis includes any adjustments necessary during the 6 month period following delivery.

If the reimbursement for any combination of repairs, relines, and/or adjustments shall exceed 50% of the cost of a new denture, please submit a prior authorization request for consideration of a new denture.

Reimbursement for repairs, relines and adjustments are generally available once every 12 months. Rebase is generally allowed once every 36 months.

H. Rebase and Reline Procedures

Denture Rebasing is indicated for the following:

- When changes to the residual ridge result in loss of denture stability, retention, or occlusal disharmony
- When the base has fractured or cracked

Denture Rebasing is not indicated for the following:

- When the prosthesis is broken or worn to the extent that replacement is warranted
- When the occlusion or structural integrity of the denture teeth are no longer functional
- When a Reline is sufficient

Denture Relining is indicated for the following:

- When changes to the residual ridge result in loss of denture stability, retention, or occlusal disharmony

Denture Rebasing and Relining are not indicated for the following:

- When the prosthesis is broken or worn to the extent that it is no longer functional and replacing the appliance is warranted
- Unresolved soft tissue hyperplasia or stomatitis

Coverage Limitations

- Limited to Relining/Rebasing performed more than 6 months after the initial insertion

Implant Services

I. Implants

Prior approval requests for implants must include current diagnostic x-rays allowing evaluation of the entire dentition and a complete treatment plan.

In the event that an implant is approved, other necessary services required for the dental implant surgery like bone grafting will considered on a case by case basis.

If bone grafting is necessary, there should be a 3-6 month healing period before the implant can be placed.

Treatment on an existing implant will be evaluated on a case by case basis.

If your dental plan does not include coverage for implants, any dental service related to the out of scope implant treatment will not be covered.

Fixed Bridgework

J. Bridgework

Prior approval requests for fixed bridgework must include current diagnostic x-rays allowing evaluation of the entire dentition and a complete treatment plan.

Fixed partial dentures are not generally considered within the scope of services covered by the program if a lower cost, reasonably functional alternative is feasible. If extenuating circumstances exist, please submit a prior authorization request with a narrative for consideration.

Fixed partial dentures may be indicated for the following:

- Replacement of missing permanent teeth in which the Retainer/Abutment teeth have a favorable long-term prognosis
- Resin Bonded appliances (e.g., Maryland Bridge) are indicated for the replacement of one missing tooth and unrestored/undamaged Retainer/Abutment teeth

Fixed partial dentures are not indicated for the following:

- Members with rampant caries and/or poor oral hygiene
- When Retainer/Abutment teeth have untreated endodontic pathology or periodontal disease or an unfavorable crown: root ratio
- When teeth intended as Retainers/Abutments have inadequate remaining tooth structure
- When a tooth to be used as a Retainer/Abutment has tipped or drifted into edentulous space
- Cantilever and Resin Bonded fixed partial dentures (Maryland Bridge) are not indicated for the following:
    - In an area with malocclusion, heavy occlusion or parafunctional habits (e.g., nail biting, bruxism, clenching)
    - A Pontic width discrepancy
    - Additionally, Resin Bonded appliances are not indicated in the following situations:
        - Compromised enamel
        - Deep vertical overlap

Coverage Limitations:

- Clinical situations that can be effectively treated by a less costly, dental appropriate alternative procedure will be assigned a benefit based on the least costly procedure
- Limited to 1 restoration per natural or prosthetic tooth per consecutive 60 months without regard to the material used or type of restoration placed (standard crown, inlay, onlay, pontic, bridge abutment, or implant crown)

VII. ORAL AND MAXILLOFACIAL SURGICAL SERVICES

Summary

A. Oral Surgery Summary

Oral Surgery procedures most commonly include extractions, alveoloplasty, and biopsies.

Reimbursement requests for all oral surgery procedures with exception of non-surgical extractions require clinical review of applicable diagnostics (i.e. pre-operative radiographs, biopsy report, and/or narrative) to substantiate medical necessity.

Oral surgical services (i.e. extractions or exposures) for orthodontic purposes are covered only if the corresponding orthodontic treatment has been approved by Healthplex.

Oral surgical services for implant purposes are covered only if the corresponding implant treatment has been approved by Healthplex.

Extractions

B. Extractions

Removal of tooth, soft tissue associated with the root, curettage of the socket, local anesthesia, required suturing, and routine post-operative care are included in the fees for extractions and will not be reimbursed separately. Excision of tissue, particularly cyst removal, requires supporting documentation when billed as an adjunct to tooth extraction.

Extraction of impacted teeth should only be undertaken when conditions arising from such impactions warrant their removal. Extraction of asymptomatic teeth or those where medical/dental necessity cannot be demonstrated shall be disallowed.

Coverage is based on medical necessity and the anatomical position of the tooth.

Surgical extraction of an erupted tooth is indicated for any of the following:

- No clinical tooth is visible in the mouth
- The fracture of tooth or roots during a non-surgical extraction procedure
- Erupted teeth with unusual root morphology (dilacerations, cementosis)
- Erupted teeth with developmental abnormalities that would make non-surgical extraction unsafe or cause harm
- When fused to adjacent tooth
- In the presence of periapical lesions
- For maxillary posterior teeth whose roots extend into the maxillary sinus
- When tooth has been crowned or treated endodontically

Excision and Biopsy	**C. Excision** Excision of tissue, particularly cyst removal, requires supporting documentation when billed as an adjunct to tooth extraction. Excision and biopsy submitted on the same day is considered a duplicate service. Benefit only for the excision shall be considered. **D. Biopsy** Removal or biopsy of a periapical granuloma, dentigerous or odontogenic cyst is generally considered an integral part of the extraction and is not separately billable. Any claim for a biopsy must be accompanied with a biopsy report.
Incision and Drainage	**E. Incision and Drainage** Incision and drainage procedures include the insertion and removal of drain(s). When submitted on the same day as another definitive service in the same quadrant, supporting documentation (i.e. radiographs or treatment record) is required for consideration for separate reimbursement.
Alveoloplasty	**F. Alveoloplasty** When submitted in conjunction with surgical extractions in the same quadrant, alveoloplasty is considered included in the allowance for the surgical service and not reimbursable as a separate procedure. If submitted without extractions in the same quadrant, a narrative substantiating medical necessity is required. If alveoloplasty is performed for less than 4 teeth or tooth spaces in the quadrant, a partial quadrant will be allowed.
Other Surgical Services	**G. Other** For all other covered oral surgical services, please submit pre-operative radiographs with a narrative substantiating medical necessity for consideration.

VIII. ORTHODONTIC SERVICES

Summary

A. Orthodontic Summary

Limited, Interceptive and Comprehensive orthodontic services must be prior authorized. Limited or Interceptive orthodontic services will be considered for the treatment of the primary or transitional dentition. Limited or Comprehensive orthodontic services will be considered for treatment of the transitional, adolescent or permanent dentition.

For comprehensive orthodontic treatment, please refer to the benefit brochure for scope of coverage. The coverage categories are:

- Class I Malocclusion with overbite, overjet, or open bite
- Class I Malocclusion with blocked cuspids
- Class I Malocclusion with severe crowding
- Class II Handicapping Malocclusion
- Class III Handicapping Malocclusion

The pre-orthodontic treatment visit does not require prior authorization. Reimbursement is available once per 12 months prior to initiation of orthodontic treatment and includes the consultation; therefore, consultation will not be reimbursed separately.

Limited Orthodontic Treatment

B. Limited

If within the scope of coverage, consideration is given for treatment with a limited objective, not involving the entire dentition. It may be directed at the only existing problem or at only one aspect of a larger problem in which a decision is made to defer or forego more comprehensive therapy.

For prior authorization the following shall be submitted:

- Narrative of clinical findings and treatment plan;
- Diagnostic photographs;
- Diagnostic radiographs of the entire dentition;

Reimbursement is limited to once per lifetime for an approved course of orthodontic treatment.

Comprehensive Orthodontic Treatment

C. Comprehensive

Comprehensive orthodontic treatment will only be considered for the adolescent or permanent dentition.

For prior authorization requests the following shall be submitted:

- Narrative of clinical findings for dysfunction or deformity and dental diagnosis;
- The comprehensive orthodontic treatment plan;
- Diagnostic cast or digital study models;
- Diagnostic photographs;
- Diagnostic panoramic radiographs and cephalometric films with tracing (when applicable);
- For orthognathic surgical cases: the surgical consult, complete treatment plan and approval for surgical treatment with a statement signed by the parent/guardian and recipient that they understand and accept the proposed treatment is necessary; and,
- Medical diagnosis (when applicable).

Please note: All needed dental treatment (preventive and restorative) should be completed prior to initiating orthodontic treatment.

In addition to submission requirements already noted, the following must be met:

- The prior authorization request to start a case must include treatment visits. Treatment visits will be considered for quarterly intervals. The maximum number of treatment visits to be considered on any one prior authorization is 4;
- After the initial 4 quarterly treatment visits, recertification for the remainder of the treatment is necessary. Please submit current progress photographs with a copy of the treatment record for review.
- The case start date is considered to be the banding date which must occur within six (6) months of approval;

- The case fee includes active and retention phase of treatment and is based on eligibility and age limitations.

Documentation for Completion of Comprehensive Cases – Final Records

Attestation of case completion must be submitted on the provider's letterhead to document that active treatment had a favorable outcome and that the case is ready for retention. Procedure code D8680, orthodontic retention shall be submitted on the visit to remove the bands and place the case in retention.

IX. ADJUNCTIVE GENERAL SERVICES

Summary

A. Summary

Adjunctive general services most commonly include general anesthesia, intravenous sedation, consultations and palliative services provided for relief of dental pain.

Refer to the benefit brochure for scope of coverage regarding anesthesia and sedation.

Palliative Treatment

B. Palliative

Reimbursement is per visit and is generally limited to once every 6 months and is not separately payable if rendered on the same day as another payable procedure other than diagnostic services.

Please include tooth number or area and a description of the procedure rendered.

Please note: Follow-up visits related to previous treatment are not billable and therefore shall not be considered for separate reimbursement.

Intravenous Conscious Sedation and General Anesthesia

C. Sedation

Intravenous conscious sedation and general anesthesia are payable only if the provider holds a current certification and licensure to administer such anesthesia per state and federal guidelines.

For cases requiring intravenous sedation or general anesthesia, providers must retain the anesthesia record which documents time and amounts of drugs administered, pulse rate, blood pressure, respiration, etc. in the patient's treatment record.

Healthplex recommends that providers exercise professional judgment when diagnosing the necessity for administration of intravenous sedation or general anesthesia. Apprehension alone is not typically considered a medical necessity.

Anesthesia/sedation procedures within the scope of coverage will be allowed only if the corresponding dental treatment has been approved by Healthplex.

Consultation (D9310)

D. Consultation

A consultation includes an oral evaluation and will only be reimbursed to a specialist.

If a consultation is considered an exam, one exam (regardless of the code or type of exam) in a 6 month period is allowed. If a consultation is considered independent of the exam limitation, reimbursement for the consultation is generally limited to once per 3 months (per treatment plan). Refer to your benefit brochure.