Dental Utilization Review General Guidelines

Lines of Business	*Document Type*
Commercial, Medicare	Policy
Who This Applies To	***States***
Health Services	Idaho, Montana, Oregon, Washington

Commercial and Medicare Policy

PacificSource is committed to assessing and applying current regulatory standards, widely-used treatment guidelines, and evidenced-based clinical literature when developing clinical criteria for coverage determination. Each policy contains a list of sources (references) that serves as the summary of evidence used in the development and adoption of the criteria. The evidence was considered to ensure the criteria provide clinical benefits that promote patient safety and/or access to appropriate care. Each clinical policy is reviewed, updated as needed, and readopted, at least annually, to reflect changes in regulation, new evidence, and advancements in healthcare.

Clinical Guidelines are written when necessary to provide guidance to providers and members in order to outline and clarify coverage criteria in accordance with the terms of the Member's policy. This Clinical Guideline only applies to PacificSource Health Plans, PacificSource Community Health Plans, and PacificSource Community Solutions in Idaho, Montana, Oregon, and Washington. Because of the changing nature of medicine, this list is subject to revision and update without notice. This document is designed for informational purposes only and is not an authorization or contract. Coverage determinations are made on a case-by-case basis and subject to the terms, conditions, limitations, and exclusions of the Member's policy. Member policies differ in benefits and to the extent a conflict exists between the Clinical Guideline and the Member's policy, the Member's policy language shall control. Clinical Guidelines do not constitute medical advice nor guarantee coverage.

Background

Coverage for a dental procedure code is based on PacificSource reimbursement and utilization review guidelines and documentation requirements. The guidelines and documentation requirements are based on evidence-based clinical literature and standards of practice. Although a procedure code may be listed in the PacificSource review guidelines or considered dentally appropriate and necessary, a member's individual or group benefit contract may not cover all procedures. The member's benefit contract language takes precedence over all criteria. See member benefit book for specific contract limitations and exclusions.

The Dental Utilization Review General Guidelines and Dental Utilization Review Guidelines by Procedures policies are intended to work together to outline the guidelines and documentation requirements for dental coverage and reviews. The Dental Utilization Review General Guidelines policy lists the general policies and definitions that apply to all dental categories of services and procedure codes. The Dental Utilization Review Guidelines by Procedure policy lists the individual dental procedure codes (D0100-D9999) and their procedure name, description, and category of services (also known as procedure code group) and, as applicable, outlines the guideline criteria and documentation requirements for a procedure code or specific category of service.

The procedure code name, description, and category are based on information provided in the Code on Dental Procedures and Nomenclature (CDT Code) reference manual which is owned and licensed by the American Dental Association (ADA). Per the CDT Code manual, "Dental procedure codes are not always listed in numeric order. The reason is that existing numeric sequences within a named division often do not have unassigned codes available within the sequence when a CDT code is added."

Criteria

This Dental Utilization Review General Guidelines policy covers guidelines that are applicable to all categories of services. The Dental Utilization Review Guidelines by Procedure Codes policy covers guidelines applicable to specific categories of services and procedure codes.

General Guidelines for All Categories of Services

- If the procedure reported was the result of an accident, it should be submitted to the patient's medical and/or liability insurer first
- Frequency limitations consider claims history that reflects a procedure that has been performed or uploaded from another carrier
- Dental benefits are determined based on clinically appropriate treatment and may be subject to alternate benefit provisions or downgrades when multiple clinically acceptable options exist. Providers are expected to bill the procedure code that accurately reflects the treatment provided
- Images:
    - Images must be less than 24 months old, of diagnostic quality, and properly oriented if submitted for documentation purposes. A date of exposure and patient (member) identifier must be indicated on all images
    - If image is not of diagnostic quality, no payment is made and the fee for the image is not billable to the member by an in-network dentist
    - No payment is made for duplication (copying) of diagnostic images for insurance purposes, and the fee is not billable to the member by an in-network dentist
- Infection control is considered a component of all dental procedures performed and is included in the fee for the dental services provided. Separate fees are not billable to the member by an in-network dentist
- Laser biostimulation: Laser biostimulation as a standalone procedure is denied as experimental, investigational, or unproven (E/I/U)
- Laser disinfection:
    - Laser disinfection is a technique, not a procedure. No payment is made for laser disinfection, and the fee is not billable to the member by an in-network dentist
    - Laser disinfection as a standalone procedure is denied as experimental, investigational, or unproven (E/I/U)
- Low-level laser therapy (LLLT):
    - No payment is made for low-level laser therapy when performed as part of another procedure, and the fee is not billable to the member by an in-network dentist.

- Low-level laser therapy as a standalone procedure is denied as experimental, investigational, or unproven (E/I/U)

Guidelines for Specific Categories of Services and Dental Procedure Codes

- See the PacificSource Dental Utilization Review Guidelines by Procedure Codes policy which lists the codes, and as applicable, review guidelines and documentation requirements under the following categories of services.

Category of Services	Procedure Code Range
Diagnostic	D0100 – D0999
Preventive	D1000 – D1999
Restorative	D2000 – D2999
Endodontics	D3000 – D3999
Periodontics	D4000 – D4999
Prosthodontics, Removable	D5000 – D5899
Maxillofacial Prosthetics	D5900 – D5999
Implant Services	D6000 – D6199
Prosthodontics, Fixed	D6200 – D6999
Oral and Maxillofacial Surgery	D7000 – D7999
Orthodontics	D8000 – D8999
Adjunctive General Services	D9000 – D9999
Sleep Related Breathing Disorders and Airway Management Services	D9947 – D9959
Evidence-Based Dentistry	D0100 – D9999

Definitions

In administering the dental utilization review guideline policies, the following definitions apply:

Adolescent Dentition – The dentition that is present after the normal loss of primary teeth and prior to cessation of growth that would affect orthodontic treatment.

Adult Dentition – The dentition that is present after the cessation of growth that would affect orthodontic treatment.

Allowed Amount – For a participating dentist: the fee profile. For an out-of-network dentist, the allowance is equal to the fee set in the FairHealth (usual and customary) table.

Alternate Benefit – When a non-covered procedure is performed and the member's individual or group benefit contract covers a least costly alternative procedure; an alternate benefit may be applied. The member is held responsible for the difference up to the dentist's charge.

Approve – The procedure has been reviewed and qualifies for coverage in accordance with the guidelines set forth in the applicable policy document. The procedure is subject to all deductibles, co-insurance, and maximums under the member's benefit contract.

Approved Amount – For an in-network dentist, the fee profile. For an out-of-network dentist, the submitted charge. If a patient with a PPO plan sees a dentist who is out-of-network PPO but in-network.

CLASSIFICATION OF MATERIALS

- **Classification of Metals** – (Source: ADA Council on Scientific Affairs) – The noble metal classification system supports reporting various alloys used in dentistry. The alloys are defined based on the percentage of metal content.

Classification	Requirement
High Noble Alloys	Noble Metal Content greater than or equal to (≥) 60% (gold + platinum group*) and gold ≥ 40%
Titanium and Titanium Alloys	Titanium greater than or equal to (≥) 85%
Noble Alloys	Noble Metal Content greater than or equal to (≥) 25% (gold + platinum group*)
Predominantly Base Alloys	Noble Metal Content less than (<) 25% (gold + platinum group*)

Note: Metals of the platinum group are platinum, palladium, rhodium, osmium, and ruthenium.

- **Porcelain / Ceramic** – Refers to materials containing predominantly inorganic refractory compounds including porcelains, glasses, ceramics, and glass-ceramics.
- **Resin** – Refers to any resin-based composite, including fiber or ceramic reinforced polymer compounds, and glass isomers.

Deny (i.e., Not Approved) – The procedure has been reviewed and does not qualify for benefits under the guidelines set forth in the applicable policy document. A procedure may also be denied for contractual reasons. Whenever a procedure is denied, unless otherwise stated, the member is held responsible up to the dentist's charge.

Descriptor – A written narrative that further defines the nature and intended use of a single Procedure Code, or group of such codes. A Descriptor, when present, follows the applicable Procedure Code and its Nomenclature. Descriptors that apply to a series of Procedure Codes precede that series of codes.

Explanation of Restorations – The location and characteristics of restorations are described in the following table.

Location	Number of Surfaces	Characteristics
Anterior	1	Placed on one of the following five surface classifications – Mesial, Distal, Incisal, Lingual, or Facial (or Labial).
	2	Placed, without interruption, on two of the five surface classifications – e.g., Mesial-Lingual.
	3	Placed, without interruption, on three of the five surface classifications – e.g., Lingual-Mesial-Facial (or Labial.
	4 or more	Placed, without interruption, on four or more of the five surface classifications – e.g., Mesial-Incisal-Lingual-Facial (or Labial).

Posterior	1	Placed on one of the following five surface classifications – Mesial, Distal, Occlusal, Lingual, or Buccal.
	2	Placed, without interruption, on two of the five surface classifications – e.g., Mesial-Occlusal.
	3	Placed, without interruption, on three of the five surface classifications – e.g., Lingual-Occlusal-Distal.
	4 or more	Placed, without interruption, on four or more of the five surface classifications – e.g., Mesial-Occlusal-Lingual-Distal.

Experimental, Investigational, or Unproven (E/I/U) – Medical and behavioral healthcare procedures, pharmaceuticals, and devices (collectively "technologies") where peer-reviewed and evidence-based literature indicates the technology remains under scientific review, is not in general use or a community standard, has not been found to be safe and efficacious, and has not been shown to have a demonstratable benefit.

Narrative – A written explanation by a dentist that describes a patient's dental condition, including diagnosis, clinical findings, treatment plan, and rationale for the proposed procedure, to support a treatment claim or documentation within the patient's clinical record. Note: Narratives as documentation are not considered legal entities nor are they contemporaneous in nature. The patient record/clinical notes are considered a legal document and are contemporaneous.

Nomenclature – The written title of a Procedure Code. Nomenclature may be abbreviated when printed on claim forms or other documents that are subject to space limitation. Any such abbreviation does not constitute a change to the Nomenclature.

Not Billable to the Patient – No payment is made by PacificSource, and the member is held harmless. This only applies to in-network dentists.

Primary Dentition – Teeth developed and erupted first in order of time.

Procedure Code – A five-character alphanumeric code beginning with the letter "D" that identifies a specific dental procedure. A Procedure Code cannot be changed or abbreviated.

Quadrant – For dental reporting purposes, a quadrant is four or more continuous teeth and/or teeth spaces distal to the midline.

Site – A term used to describe a single area, position, or locus. The word "site" is frequently used to indicate an area of soft tissue recession on a single tooth or an osseous defect adjacent to a single tooth; also used to indicate soft tissue defects and/or osseous defects in edentulous tooth positions.

- If two contiguous teeth have areas of soft tissue recession, each tooth is a single site.
- If two contiguous teeth have adjacent but separate osseous defects, each defect is a single site.
- If two 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-contiguous tooth positions are single sites.

- Up to two contiguous edentulous tooth positions may be considered a single site.

Specialized Procedure – Describes a dental service or procedure that is used when unusual or extraordinary circumstances exist and is not generally used when conventional methods are adequate.

Submitted Amount – The dentist's charge for the service.

Tooth Bounded Space – A space created by one or more missing teeth that has a tooth on each side.

Tooth Surface – Tooth surfaces are reported on the HIPAA standard electronic dental transaction and the ADA Dental Claim Form using the letters in the following table.

Tooth Surface	Code
Buccal	B
Distal	D
Facial (or Labial)	F
Incisal	I
Lingual	L
Mesial	M
Occlusal	O

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

Related Policies

Dental Procedures Covered Under Medical

Dental Utilization Review Guidelines (in ADA CDT order) by Procedure Codes

Dental Utilization Review Guidelines (in numerical order) by Procedure Codes

References

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Appendix A. Document Control – to update appendix fields, go to Properties Wizard

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