

National Clinical Criteria Guidelines and Practice Parameters



LIBERTY DENTAL PLAN[®]

Making members shine, one smile at a time[™]



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Preface

Liberty Dental Plan's Clinical Criteria Guidelines and Practice Parameters were initially developed in 2005 and are periodically updated and reviewed annually by the QMI Committee and the Board of Directors. These clinical guidelines, processing standards, and practice parameters were created internally by our Dental Directors with input from participating general dentists and specialists. Liberty follows the American Dental Association's "Dental Practice Parameters" and incorporates established dental clinical principles, processes, and evidence to consistently assess the appropriateness of dental services that require review.

Please note that Plan/Program guidelines take precedence over the information outlined in Liberty's Clinical Criteria Guidelines and Practice Parameters document.

The materials provided serve as guidelines used by this Plan to authorize, modify, or deny care for individuals with similar conditions. However, specific care and treatment may vary based on individual needs and the benefits outlined in your contract.

As not all codes have been included in this document, please consult the ADA CDT Dental Procedure Code Manual for additional code descriptors and guidance.

New Patient Information

Providers are expected to obtain and maintain complete registration, medical, and dental history information for all new patients in alignment with accepted professional standards. At a minimum, records should include:

- **Patient demographics and emergency contacts**, including parent/guardian details for minors.
- **Comprehensive medical history**, signed and updated regularly, documenting significant health conditions, medications, allergies, pregnancy status, and physician contact information. The dentist must review and sign all baseline and updated histories, document follow-up on significant findings, and ensure medical alerts are clearly flagged in the chart.
- **Dental history**, including chief complaint, prior specialty care, complications with previous treatment or anesthesia, risk assessments, patient goals, and relevant social history.

These elements are considered essential components of high-quality patient care and are expected to be part of routine provider practice.

Dental Records

Member dental records must comply with all applicable state and federal regulations. Records for both active and inactive patients must remain accessible for at least ten (10) years, regardless of contract status.

Records must be complete, well-organized, legible, and include all required documentation. Entries must be made in ink and signed and dated by the treating dentist or other licensed provider delivering the service. When using an electronic health record (EHR), dentists should follow industry-standard practices for creating, updating, and amending notes. Generally, an amendment or addendum to a dental note should be made as soon as an error or omission is discovered, and ideally within 24 to 72 hours, to ensure accuracy and compliance.

Contracted dentists must provide copies of member records upon request, within the specified timeframe, and at no cost to the Plan. Records may be requested for purposes including grievance resolution, second opinions, or regulatory compliance.

Failure to meet these requirements may result in corrective action, including transfer of enrollment, closure to new enrollment, or termination of the provider's contract for continued non-compliance.

Progress Notes

Progress notes are part of the legal record and must be permanent, detailed, and legible. Each entry must be signed, initialed, and dated by the treating provider, or include a unique identifier that links the entry to the individual.

- **Corrections/Modifications:** Any change to the record must clearly show the name or identifier of the person making the change and the date it was made. Electronic records must also capture this information automatically.
- **Anesthetics:** Document all anesthetics used (or confirm none were used), including type, strength, vasoconstrictor, and amount, in line with current practice standards.
- **Prescriptions:** All prescriptions must be documented in the notes or maintained as copies in the chart, including drug name, dosage, quantity, directions, and refills.
- **Laboratory Records:** Copies of lab prescriptions and related communications must also be retained in the patient chart.

Informed Consent Process

Dentists are required to document that all recommended treatment options have been reviewed with the members, including:

- Risks, benefits, and alternatives.
- Likelihood of success.
- Financial responsibilities for proposed procedures.
- Consequences of declining treatment.

Documentation Requirements

- Informed consent must be signed and dated by both the member and the dentist for the accepted treatment plan.
- Refusal of recommended care must be documented on a signed "refusal of care" form.

Private Pay Agreements

- Dentists may establish private pay agreements with members for non-covered services, provided the agreement is made prior to treatment.
- Members must be informed of alternative treatment plans, including covered procedures or those requiring prior authorization, along with their advantages, disadvantages, and associated costs.
- When prior approval is required, providers are encouraged to submit all necessary documentation for review and determination before treatment begins.

Medical Necessity

Care is approved when it is determined to be *medically necessary*. This means the treatment or services:

- Are required to prevent, evaluate, diagnose, correct, or cure a disorder or condition, or to prevent its worsening, consistent with accepted standards of dentistry.

- Prevent the onset, progression, or deterioration of a disease, condition, or disability.
- Address conditions that endanger life or cause pain, suffering, illness, or infirmity.
- Follow accepted medical and dental practices.
- Are member-centered, taking into account the individual's clinical needs, environment, and personal values. These criteria do not replace clinical judgment; treatment decisions must reflect the patient's unique circumstances.
- Are delivered in the most appropriate, safe, and cost-effective setting consistent with the diagnosis.
- Are not provided for convenience.
- Are provided only when no better or less costly covered service, treatment, or setting is available.

Poor Prognosis

Procedures recommended for teeth with a guarded or poor prognosis (including endodontic, periodontal, or restorative treatments) are not covered. A poor prognosis refers to a tooth that is unlikely to remain functional for at least five (5) years. This determination is based on inadequate periodontal support or insufficient remaining tooth structure to properly sustain the recommended restoration or treatment. In other words, even with intervention, the tooth is expected to fail over time and carries a high risk of complications or eventual loss.

When recommending endodontic, periodontal, or restorative procedures (including crown lengthening), providers should assess and document the expected prognosis, restorability, and/or maintainability of the affected tooth or teeth.

Liberty's licensed dental consultants review and make determinations regarding prognosis for these procedures based on the quality of documentation and supporting evidence provided, such as radiographs and images.

Liberty will reconsider poor prognosis determinations for these procedures if a new claim is submitted with appropriate documentation and diagnostic x-rays taken at least six (6) months after the original date of service.

Upgrades and Alternative Treatment

Certain material upgrades to procedures (such as high noble metals or porcelain on molars) may not be covered. It is essential to review the schedule of benefits before developing a treatment plan to ensure that the member is receiving a covered service.

Alternative treatment options should be documented with a clear indication of the procedure the member has selected.

If a dentist disagrees with a procedure requested by the member, they may decline to provide the procedure and may request a transfer. In this case, the dentist remains responsible for completing any ongoing treatments and handling emergencies until the transfer is processed and/or in accordance with State regulations.

All consultations, referrals, and their outcomes must be clearly documented.

Infection Control

All contracted dentists are required to adhere to the sterilization and infection control guidelines set forth by the Centers for Disease Control (CDC) and other relevant federal and state agencies. Offices are prohibited from charging Liberty members an infection control fee.

The Applicable Request for Pre-Estimate

To verify benefits, it is strongly recommended that a pre-estimate be submitted for large or complex treatment plans.

The minimum required records for each request include current bitewing and periapical radiographs (mounted right to left) or images of the involved teeth or edentulous areas if they are not visible on the bitewings.

1. Images must be of diagnostic quality and medically necessary. All images should clearly show contact areas without cone cuts or overlapping, and periapical films should display the periapical areas and alveolar bone.
 - a. AI-enhanced notated radiographs may be included as a supplement to conventional radiographs to provide additional documentation.
2. Each image must be labeled with the tooth number and include the date of exposure, member name, member ID, provider name, and provider ID.
3. All images, regardless of format, must be submitted with a completed and signed comprehensive treatment plan that documents all required treatment identified at the time of examination.
4. The images, digital media, photographs, or printouts must be of sufficient quality to clearly demonstrate the pathology that supports the authorization request.
5. If radiographs are not provided, the provider must include a narrative with sufficient details to confirm the diagnosis and treatment plan.

Any requested services that are dependent on or related to the completion of a denied service will also be denied.

Clinical Oral Evaluation

Please refer to plan benefits for specific frequency limits, guidelines restrictions and material upgrades. Procedures considered inclusive of other codes will be reimbursed at \$0. Services

performed solely to support or complete another procedure will be denied when the primary procedure is not covered or is denied.

Comprehensive oral evaluation – new or established patient (D0150). This procedure is used for new patients or for established patients who have experienced significant changes in their health status or other unusual circumstances, as documented by report. It is **also appropriate for patients returning after an absence from active treatment of three or more years.** The comprehensive oral evaluation involves a thorough assessment of both extraoral and intraoral hard and soft tissues. It includes an oral cancer screening, a review and documentation of the patient’s medical and dental history, and an overall health assessment. When indicated, it may also include evaluation and documentation of dental caries, missing or unerupted teeth, restorations, existing prostheses, occlusal relationships, periodontal conditions (screening and/or charting), and other hard or soft tissue anomalies.

Periodic oral evaluation – established patient (D0120). This procedure code is used for an established patient evaluation on a patient of record to determine any changes in the patient’s dental and medical health status since a previous comprehensive or periodic evaluation. This includes an oral cancer evaluation, periodontal screening where indicated, and may require interpretation of information acquired through diagnostic procedures. The findings are discussed with the patient.

Limited oral examination- problem focused (D0140). Since this is an evaluation focused on a specific oral health issue or complaint, it should not be used in combination with codes D0120, D0145, D0160, or D0180. Evaluations performed for adjustments following the placement of restorations or appliances, or as part of multi-phase treatments (e.g., dentures), will not be reimbursed.

Oral Evaluation for a patient under 3 years of age and counseling with primary caregiver (D0145). This procedure code is specifically for children under the age of three, preferably within the first six months of the eruption of the first primary tooth, including recording the oral and physical health history, evaluation of caries susceptibility, development of an appropriate preventive oral health regimen and communication with and counseling of the child’s parent, legal guardian and / or primary caregiver.

Evaluations Diagnostic

Image capture with interpretation must be performed solely for clinical reasons as determined by the patient's dentist. The images must demonstrate good contrast, be of diagnostic quality (showing contact areas without cone cuts or overlapping, and periapical films must reveal the periapical areas and alveolar bone) and be properly identified and dated. These images are considered part of the patient's clinical record, and the original images must be retained by the dentist. Original images should not be used to fulfill requests from patients or third parties for copies of records. Any refusal of radiographs by the patient must be documented. The Plan does not consider image capture to be a separately reimbursable procedure.

Intraoral- comprehensive series of radiographic images (D0210) is a radiographic survey of the whole mouth intended to display the crowns, roots of all teeth, interproximal areas, periapical areas, and alveolar bone including edentulous areas.

Intra-oral periapical first radiographic image (D0220) and intra-oral periapical each additional radiographic images (D0230) must include at least three (3) millimeters beyond the apex of the tooth being imaged.

Panoramic radiographic image (D0330). Panoramic radiographs are used as a screening tool and should not replace periapical or bitewing radiographs during a comprehensive dental evaluation, unless the patient is edentulous.

Bitewing images (D0270-D0274) are radiographic images for upper and lower arch per side, which can be used to diagnose proximal and other carious lesions and bone loss due to periodontal disease.

2D oral/facial photographic image obtained intra-orally or extra-orally (D0350). 2D oral photographic images are reimbursed only as part of orthodontic records or for diagnostic purposes when radiographs cannot be taken due to medical conditions, physical limitations, or cognitive impairments.

Cone beam CT capture and interpretations (D0364 – D0368) and cone beam CT capture (D0380-D0384). An adjunctive diagnostic tool to be used alongside routine radiographic images for diagnosis and treatment planning in exceptional cases. These include:

1. Non-specific clinical symptoms associated with untreated or previously endodontically treated teeth.
2. Initial treatment of teeth with anatomical variations, such as additional or calcified canals, or complex morphology.
3. Re-treatment of multi-rooted teeth.
4. Cases with a high risk of complications, such as nerve injury, jaw fractures, pathology, or trauma assessments.
5. Treatment involving implants or implant-related services, when implants are a covered benefit.

Collection and preparation of saliva sample for laboratory diagnostic testing (D0417).

Analysis of saliva sample – laboratory (D0418).

Testing for cracked tooth (D0461). Includes multiple teeth and contra lateral comparison(s), as indicated. Diagnostic aids may include but are not limited to pressure sensitivity testing, transillumination, staining, etc.

Diagnostic casts (D0470). Diagnostic casts are used solely for the evaluation of orthodontic benefits and are reimbursed only after orthodontic treatment is approved. Review the plan benefits to determine whether prior authorization is required for orthodontic treatment and/or the orthodontic workup.

Guidelines for Processing Diagnostic Images for reimbursement:

1. The treating provider should take an adequate number of initial radiographs to facilitate an accurate diagnosis and treatment plan. Refer to the current ADA/FDA guidelines: The Selection of Patients for Dental Radiographic Examinations.
2. Any combination of covered radiographs that meets or exceeds the cost of a complete series may be adjudicated as a complete series for benefit purposes.
3. Additionally, any panoramic images taken along with periapical and/or bitewing radiographs may be considered a complete series for benefit purposes. However, a panoramic x-ray is not reimbursable when taken on the same date of service as a complete series (D0210).
4. **A panoramic radiograph** is a screening image and is not a substitute for periapical and/or bitewing radiographs when a dentist is performing a comprehensive evaluation except in the case of edentulous patients.
 - a. All images should be of diagnostic quality and reveal contact areas without cone cuts or overlapping, and periapical films should reveal periapical areas and alveolar bone.
 - b. Radiographs should exhibit good contrast.
 - c. Diagnostic digital radiographs should be printed on photographic quality paper and exhibit good clarity and brightness.
 - d. All radiographs must be mounted, labeled left/right and dated.
 - e. Any member's refusal of radiographs should be documented.
5. In line with industry's best practices and standards of care, radiographs taken during a restorative, endodontic, or surgical procedure are considered part of the procedure and are not reimbursed separately.
6. The types and number of radiographic images taken during periodic oral evaluations or episodic care should be prescribed by the dentist and based on current ADA/FDA radiographic guidelines. This includes factors such as the complexity of previous and proposed care, caries risk, periodontal health, the type of procedures, and the time since the patient's last radiographic exam.

Radiograph duplication fee

When a member is transferred from one provider to another, diagnostic copies of all radiographs taken within the past two years should be provided to the new provider. If the transfer is initiated by the provider, the member cannot be charged any fees for duplicating the radiographs. However, if the transfer is initiated by the member, many plans permit the provider to charge a reasonable fee for duplicating the X-rays, typically up to a maximum of \$25.

Note: Some benefit plans may not allow x-ray duplication fees. Please refer to the specific benefit plan to determine whether such a fee is permissible.

Caries risk assessment and documentation with a finding of low risk, medium risk and high risk (D0601, D0602, D0603). Requires the use of a recognized assessment tool. Only reimbursable every 12 months when completed by the same office.

Preventive

Please refer to plan benefits for specific frequency limits, guidelines restrictions and material upgrades. Procedures considered inclusive of other codes will be reimbursed at \$0. Services performed solely to support or complete another procedure will be denied when the primary procedure is not covered or is denied.

Preventive dentistry includes oral health education and other appropriate procedures to prevent caries and/or periodontal disease, as well as passive appliances designed to prevent tooth movement, thereby promoting overall health.

1. Caries prevention may include patient education in oral hygiene, nutritional and dietary counseling, and motivational interviewing, where appropriate.
2. Prophylaxis procedures.
3. Topical caries prevention or arresting treatments such as application of Fluorides, and Silver Diamine Fluoride.
4. Sealants and/or preventive resin restorations.
5. Periodontal disease prevention may include a comprehensive program of assessment, plaque removal and control in addition to the following procedures:
 - a. Oral and systemic health information
 - b. Oral hygiene, dietary and nutritional counseling
 - c. Prophylaxis procedures on a regular basis
 - d. Occlusal evaluation
 - e. Correction of malocclusion and malposed teeth
 - f. Restoration and/or replacement of broken, missing or deformed teeth

Prophylaxis (Adult: D1110; Child: D1120). Medical conditions that contribute to or necessitate additional prophylaxis procedures, such as pregnancy, may be considered when supported by the patient's physician. Be sure to verify plan benefits before performing any prophylaxis procedures that exceed the plan's limitations.

Topical Fluoride Treatment (In-Office Procedure). Application of a prescription-strength fluoride product intended exclusively for professional use in a dental office. The fluoride is applied to the

teeth under the direct supervision of a licensed dental professional. Fluoride must be applied separately and not mixed with or substituted for prophylaxis paste. Not applicable for over-the-counter fluoride products or take-home fluoride rinses.

Topical application of fluoride varnish (D1206)

Topical application of fluoride excluding varnish (D1208)

Other Preventive Services:

- **Nutritional counseling for control of dental disease (D1310)**
- **Tobacco counseling for the control and prevention of oral disease (D1320)**
- **Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use (D1321)**

Sealant- per tooth (D1351). May be medically necessary to prevent decay in a pit or fissure of a caries-free posterior tooth by sealing mechanically and/or chemically prepared enamel surfaces. If a fissurotomy is required, it is considered part of the procedure and cannot be billed separately.

Application of Caries Arresting Medicament – per tooth (D1354). This procedure involves the topical application of a caries-arresting medicament, such as silver diamine fluoride (SDF), to an active, asymptomatic carious lesion without removal of sound tooth structure. The goal is to arrest caries using a noninvasive approach, most often in young children with primary teeth.

SDF does not replace restorative dentistry to restore function or aesthetics, but it can delay or reduce the need for intervention. Evidence supports that two applications per tooth are generally necessary to effectively arrest caries. Coverage is limited to a maximum of two applications per tooth per lifetime. If tooth structure is removed and restoration is placed at the same visit, the SDF application is considered inclusive to the restorative procedure and is not separately reimbursable. Providers are encouraged to verify state-specific guidelines regarding coverage and frequency, as these may take precedence over plan policy and affect reimbursement.

Caries preventive medicament application- per tooth (D1355). Procedure aimed at primary prevention or remineralization, depending on the provider's diagnosis of the patient's clinical condition. The provider should adhere to the following guidelines:

1. D1355 cannot be reimbursed if provided on the same day as D1206 or D1208.
2. Applies to both primary and permanent teeth.
3. Not reimbursable for primary teeth that are about to exfoliate or for third molars.
4. The tooth must show no signs of carious lesions or have a history of previous restorations.
5. Eligibility is based on a documented Caries Risk Assessment indicating High Caries Risk (D0603) or Moderate Caries Risk (D0602).
6. Not reimbursable for more than four teeth per visit.
7. Reimbursable once per tooth every three years.

8. A narrative justifying the procedure is required.
9. Not reimbursable when provided in combination with D1351 or D1354.

Fixed and Removable Space Maintainers (D1510- D1558, D1575).

Space maintainers are designed to preserve arch length, width, and perimeter by maintaining the relative position of the existing teeth using passive fixed or removable appliances. They may be medically necessary for children to reserve space for the eruption of a permanent tooth and/or to prevent shifting or drifting of permanent teeth following the premature loss of a primary molar or molars.

Space maintainers are not reimbursable if the succedaneous tooth is about to erupt. When selecting the first primary molar as an anchor tooth, root resorption and stability must be considered. The long-term prognosis of the anchor tooth should be favorable. Space maintenance using teeth with a poor prognosis is not reimbursable.

Space maintainers may be indicated under the following circumstances:

1. **Bilateral Space Maintainer Criteria (D1516, D1517, D1526, D1527):**
 - a. Bilateral premature loss of primary molars.
 - b. Unilateral premature loss of both primary molars.
2. **Unilateral Space Maintainer Criteria (D1510, D1520, D1575):**
 - a. Premature loss of the second primary molar.
 - b. Premature loss of only the first primary molar.
 - c. Not reimbursable if the roots of the first permanent molar are fully formed and the tooth is in stable occlusion.
 - d. If more than one unilateral space maintainer is requested in the same arch on the same date of service, it will be considered a single bilateral space maintainer and reimbursed accordingly.

Restorative Treatment

Please refer to plan benefits for specific frequency limits, guidelines restrictions and material upgrades. Procedures considered inclusive of other codes will be reimbursed at \$0. Services performed solely to support or complete another procedure will be denied when the primary procedure is not covered or is denied.

Restorative treatment is appropriate for teeth showing radiographic evidence of caries, lost tooth structure, defective or lost restorations, and/or post-endodontic needs. Guidelines for restorative procedures include:

1. Treatment sequencing must align with the specific needs of the patient.
2. Restorative procedures should be reported using valid, current CDT codes as published by the American Dental Association.
3. Restorations due to wear from attrition, abrasion, abfraction, or erosion are not covered without the presence of decay or fracture.

4. Treatment outcomes, including margins, contours, and contacts, should be clinically acceptable, with a long-term prognosis estimated at five years or more.
5. Local anesthesia is considered a part of restorative procedures and is not reimbursable separately.
6. Restorative procedures in operative dentistry include amalgam, composite, glass ionomer restorations, crowns, and various provisional materials.
7. Tooth preparations, etching, adhesives (including bonding agents), liners, bases, and curing are considered part of the restorative process.
8. When used, glass ionomers should be reported as composite restorations.
9. Restorations involving contiguous surfaces must be billed under the appropriate multi-surface restorative procedure code and will not be reimbursed as separate, unbundled surfaces.
10. Polishing is included with all restorative procedures.

Amalgam & Resin-Based Composite Restorations (D2140-D2161 and D2330-D2394). Extensive scientific research, including two major clinical trials published in the *Journal of the American Medical Association*, has shown that dental amalgam is a safe and effective restorative material for both children and adults. The ADA Council on Scientific Affairs, after reviewing the scientific evidence, reaffirmed that amalgam remains a safe, valuable, and reliable treatment option. The Council also supported the U.S. Food and Drug Administration's decision not to restrict its use, noting that amalgam continues to be widely used in dental practice.

General Guidelines:

1. An amalgam or composite restoration may be medically necessary when a tooth has a fracture, defective filling, or decay that has penetrated the dentin. The finished restoration must have well-defined margins, proper occlusion and contacts, and must address all visible decay.
2. For treating caries or replacing a restoration that does not undermine the cusps of posterior teeth, an amalgam or composite restoration is typically the preferred option.
3. Facial or buccal restorations are generally considered "one-surface" restorations, not multiple surfaces like MFD or MBD.
4. Replacing clinically acceptable amalgam restorations with alternative materials (such as composite or crowns) is considered cosmetic and is not covered unless there is decay or fracture present.
5. For posterior primary teeth with significant loss of tooth structure or for preventive purposes, a prefabricated stainless-steel crown is generally the recommended treatment.
6. For anterior teeth with extensive loss of tooth structure, a porcelain or ceramic crown may be appropriate.

7. Composite is the preferred choice for treating caries or replacing an existing restoration on anterior teeth, provided it does not undermine the incisal edges or cuspal surfaces. Applicable benefit criteria will apply.
8. Decay limited to the incisal edge may still be treated with a composite restoration if little to no other caries or breakdown is present on the tooth.
9. All restorations include tooth preparation, acid etching, adhesives, liners, bases, and curing as part of the procedure.

Crowns- Single Restorations Only (D2710 – D2794).

General Guidelines:

1. Crowns are a covered benefit when clinically appropriate and medically necessary.
2. Providers must complete any irreversible procedures that have been initiated before proceeding with or completing crown restorations, regardless of payment or coverage status.
3. Crown procedures should be recorded using the appropriate CDT code based on the type of crown provided.
4. When submitting a dental claim for crown reimbursement, the date of service must be the date of insertion.
5. Claims must include documentation of marginal integrity, typically verified with dental radiographs per American College of Prosthodontics recommendations, for payment consideration. Providers should note that state-specific regulations take precedence over Liberty Dental Plan requirements, and all claims will be reviewed accordingly. It is the provider's responsibility to understand and comply with the applicable state rules when submitting documentation.
6. A crown may be medically necessary when the tooth is present and:
 - a. The tooth is in functional occlusion.
 - b. The tooth shows evidence of decay, fracture, failing restoration, or other conditions affecting more than 50% of the tooth structure.
 - c. A significant fracture is present, or 50% or more of the tooth is missing or broken, with a favorable prognosis for endodontic, periodontal, and/or restorative treatment, and the crown is not needed due to wear from attrition, abrasion, abfraction, or erosion.
 - d. There is a significantly defective crown (e.g., poor margins, marginal decay, or fractured porcelain), making the crown non-serviceable, or there is recurrent decay.
 - e. The tooth has a good prognosis for endodontic, periodontal, and restorative treatment, with a minimum crown-to-root ratio of 50% and an expected life span of at least five years.

7. The replacement of existing crowns requires radiographic evidence or, if not visible on radiograph, an intraoral photo (e.g., showing open margins or recurrent decay on the buccal or lingual surfaces) to support the need for replacement.
8. For anterior teeth with undermined, missing, or fractured incisal edges or corners due to caries or defective restoration, a labial veneer may not be sufficient. In these cases, a crown may be the treatment of choice.
9. Incisal or occlusal wear consistent with normal attrition over time is not covered, unless it meets other stated criteria for coverage.
10. Crowns requested for purely aesthetic purposes (e.g., diastema closure, tooth misalignment, color matching, enamel only fractures) are not covered.
11. Final crowns for teeth with a good prognosis should be placed after necessary endodontic and/or periodontal procedures, with the tooth exhibiting a minimum crown-to-root ratio of 1:1.
12. In certain cases, additional documentation (such as intraoral photos) may be required when pathology or tooth destruction is not evident on radiographs to justify the need for a full-coverage restoration.
13. Preventive or prophylactic crown placement is not covered. Coverage is not provided for asymptomatic fracture lines or for fracture lines limited to enamel only.
14. Crowns are expected to have a minimum service life of five years.

Resin Infiltration of Incipient Smooth Surface Lesions (D2991). D2991 is a separate procedure code used for resin infiltration of early, non-cavitated smooth-surface lesions (typically interproximal). Unlike D1354, which arrests active lesions with a medicament, D2991 involves infiltrating the lesion with a low-viscosity resin to stabilize the enamel and prevent further progression.

Key Differences:

- *D1354* applies a topical medicament (e.g., SDF) to arrest active caries in asymptomatic lesions, often in primary teeth.
- *D2991* uses resin infiltration to treat incipient, non-cavitated lesions confined to enamel or outer dentin, typically before cavitation occurs.

Coverage Note:

While D1354 is generally recognized as a covered service in limited circumstances, D2991 may not be a covered benefit. Dentists are strongly encouraged to verify patient-specific coverage before performing resin infiltration.

Stainless steel crowns (D2930 – D2933). Primarily used on deciduous teeth, but also appropriate for adult teeth in certain cases, including:

1. Enamel defects that cause discomfort or pain for the patient, or result in poor occlusion (e.g., enamel hypoplasia).

2. The patient's disability or inability to tolerate standard crown preparation procedures.
3. Incomplete eruption of a posterior permanent tooth.

Upgrades:

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

1. Selection of metal substrate, such as noble, high noble, titanium alloy, or titanium with porcelain margins on molar teeth, by report.
2. Porcelain margin upgrades can be reported as D2999 for single crowns or D6999 for abutment crowns.
3. Depending on the plan design, porcelain margins may be billed separately, with a reasonable charge not exceeding \$100 per unit. A signed informed consent, acknowledging the optional nature of this feature, must be on file.

Core Buildup, including any pins when required (D2950). The treating dentist must provide evidence that the tooth requires additional structural support to retain and support a crown. If this evidence is not provided, the service will be considered part of the crown restoration.

1. Core buildup refers to the process of adding material to the coronal structure when there is insufficient retention for an extra-coronal restorative procedure.
2. A core buildup is not intended to correct undercuts, box forms, or concave irregularities in the preparation.
3. It should not be used to restore minor recurrent caries that will likely be removed during the routine crown preparation.

Post and core (D2952, D2953 and D2954). By CDT definitions, each of these procedures includes a "core." Therefore, a core buildup (D2950) cannot be billed with D2952 - D2954 for the same tooth, during the same course of treatment.

For a post and core to be considered, the tooth must be functional, have undergone successful root canal treatment, and require additional structure to support and retain a crown. Requires prior authorization for members of 21 years of age and older.

Pin retention (D2951) or restorative foundation may be medically necessary when a tooth requires a foundation for a restoration. Repair of a restorative material failure may be medically necessary when submitted documentation establishes restorative material failure.

Unspecified restorative procedure, by report (D2999). A narrative outlining the procedure performed, along with any supporting documentation of medical necessity is required for claim submission.

Endodontics

Please refer to plan benefits for specific frequency limits, guidelines restrictions and material upgrades. Procedures considered inclusive of other codes will be reimbursed at \$0. Services performed solely to support or complete another procedure will be denied when the primary procedure is not covered or is denied.

Endodontic therapy (D3310–D3353) must be supported by a definitive pulpal and periapical diagnosis when considering potential endodontic procedures. Pulpal and apical tests are integral to the examination, evaluation, and treatment process and, therefore, are included in the overall treatment and not reimbursable when billed separately.

When planning for endodontic procedures, the following factors should be considered:

1. Strategic restorative importance – The significance of the tooth or teeth in the overall restorative plan.
2. Prognosis – Endodontic treatment for teeth with a guarded or poor five-year prognosis (whether endodontic, periodontal, or restorative) is not covered.
3. Canal Conditions – Excessively curved or calcified canals.
4. Periodontal Health – The presence and severity of periodontal disease.
5. Restorability and Tooth Fractures – The potential for restoring the tooth and the risk of fractures.
 - a. Mitigating circumstances, including patient compliance.
 - b. Accessibility and the level of complexity of the endodontic site.
6. Systemic Risk Factors – The risk of poor outcomes due to factors such as smoking, diabetes, and other systemic diseases.
7. Informed Consent – After proper informed consent, if the patient chooses to proceed with a procedure that is not covered, they will be responsible for the dentist's usual fee. The dentist should have the patient sign the appropriate informed consent forms and financial agreements.
8. Occlusion – Teeth that are at high risk of fracture after endodontic treatment should be protected with an appropriate restoration; most posterior teeth should receive full coverage restorations.

Endodontic procedures may not be covered when a tooth or teeth have a poor prognosis due to:

1. Untreated or advanced periodontal disease.
2. Severe destruction of the clinical crown or root decay at or below the alveolar bone.
3. A poor crown-to-root ratio.
4. The absence of an opposing occluding tooth (non-functional occlusion).

Clinical Guidelines:

1. Pre-operative diagnostic periapical radiographs of the teeth to be treated endodontically must clearly show all periapical areas and the surrounding alveolar bone.
2. A rubber dam should be used during endodontic procedures, and its use must be documented or verified through radiographic evidence.
3. Documentation must include a record of all materials used in the procedure, including identification of the material used for endodontic obturation.
4. The endodontic filling material should demonstrate adequate density and length, reaching within 2mm of the radiographic apex of the tooth root, with all canals properly obturated.
5. Post-operative periapical radiographs, showing all canals and apices, must be taken immediately after completing the endodontic treatment and submitted with the claim for payment.
6. In the absence of symptoms, post-operative radiographs should be taken at appropriate periodic intervals as necessary.

Endodontic Pulpal Debridement and Palliative Treatment

If root canal therapy (RCT) is continued at the same facility, initial pulpal debridement is considered an integral part of the RCT. The member's copayment for the RCT covers the entire treatment, meaning no separate fee can be charged for pulpal debridement (D3221) or palliative treatment (D9110).

If a member is referred to a specialist for RCT after pulpal debridement (D3221) or palliative treatment (D9110) has been performed on a tooth, the general dentist may report either procedure D3221, or if that procedure is not applicable, D9110 for palliative treatment.

Incomplete endodontic therapy: inoperable, unrestorable fractured tooth (D3332) is appropriate to report if, pulpal debridement (D3221) has been initiated and the dentist determines that RCT is not appropriate due to clinical findings that were unforeseen (such as a pulpal floor fracture) or initially undetected, and which may lead to a poor prognosis or unfavorable outcome.

If pulpal debridement (D3221) was performed during an out-of-area emergency, root canal therapy may still be covered as a benefit.

If RCT was initiated prior to the member's eligibility with the Plan, completion of the root canal therapy may not be covered.

Note: For benefit purposes, providers should document the dates of service for endodontic procedures as the dates when the treatments are fully completed, subject to review.

Endodontic services must be accompanied by a diagnosis that includes an evaluation of the following:

1. Pre-operative periapical radiographs, documentation of pulp vitality testing, a clinical exam, and documentation of symptomology to verify the endodontic diagnosis.
2. Documentation of any periodontal/endodontic lesions or periapical involvement.
3. Documentation of tooth mobility and occlusion issues affecting the endodontic diagnosis.

Endodontic referral necessity

In cases where a defect or decay is "approaching" the pulp of a tooth and the need for endodontic treatment is uncertain, Liberty expects the General Dentist to first remove the decay and provide provisional restoration before referring the patient to an Endodontist.

Endodontic Materials and Irrigation

Providers are contractually required to charge no more than the listed copayment for covered root canal treatments, regardless of whether the dentist uses BioPure, diluted bleach, saline, sterile water, local anesthetic, or any other acceptable alternative for canal irrigation. Additionally, all evaluations, materials, and procedures integral to the standard root canal treatment process are included in the overall treatment cost for benefit purposes and should not be billed separately or unbundled. These items may include, but are not limited to, pulpal testing, rubber dams, files, gutta percha, temporary restorative materials, and others.

Providers are prohibited from unbundling dental procedures to overcharge enrollees. The provider agreement and associated plan addenda specify the charges that may be applied for covered dental services. Even if BioPure is offered as an alternative to diluted bleach and the enrollee agrees to pay extra for it, such an additional charge would be considered an overcharge.

Note on inappropriate unbundling/coding for endodontic irrigation:

D9630 should not be used to report endodontic irrigation with BioPure. This code is intended for reporting materials dispensed for home use, not for drugs or medicaments used within the dental office.

Treatment of root canal obstruction; non-surgical access (D3331) is a separate, accepted procedure code. However, this procedure is not required for every endodontic treatment and should not automatically be performed.

Additionally, D3331 should not be submitted in conjunction with endodontic retreatment procedures (D3346, D3347, or D3348) unless there is appropriate justification and supporting evidence.

Liberty Dental Plan will not approve benefits for this procedure when submitted as part of a predetermination request before the actual treatment is performed.

Liberty's licensed dental consultants will review all submitted documentation on a case-by-case basis when this procedure is performed and submitted for payment. Providers should include a brief narrative or copies of the members' progress notes to demonstrate that additional treatment was necessary and completed.

Pulpotomy (D3220-D3222). A pulpotomy may be indicated for a primary or permanent tooth when pulpal pathology is confined to the coronal pulp, and the tooth has a reasonable chance of retention and long-term function.

Codes D3220 and D3222 should not be used as the initial stage of root canal therapy and will not be reimbursed separately.

Code D3221 should not be billed if root canal therapy is performed on the same date of service.

Apexification (D3351-D3353) may be appropriate for a permanent tooth with an incompletely developed root or roots, allowing for maturation and closure of the root apex. Endodontic treatment should be completed once the root has fully developed.

Pulp Capping (D3110, D3120). Not to be used for bases and liners. Not payable in conjunction with any covered endodontic procedure.

Direct pulp capping (D3110) is indicated for mechanical or accidental pulp exposures in relatively young teeth and may be considered when there is a small, exposed, vital, and healthy pulp.

Indirect pulp capping (D3120) (re-mineralization) is indicated for teeth with caries that are near the pulp but show no signs of pulpal degeneration or radiographic evidence of apical pathology or root resorption.

In primary teeth, indirect pulp treatment is preferred over pulpotomy when the pulp is healthy or diagnosed with reversible pulpitis. Teeth with immature roots should be prioritized to encourage continued root development and apexogenesis.

Endodontic surgical treatment (D3410-D3473) should be considered only in specific circumstances, such as:

1. When the root canal system cannot be treated non-surgically.
2. When there is active root resorption.
3. When access to the canal is obstructed.
4. When there is significant over-extension of the root canal filling.
5. When periapical or lateral pathology persists and cannot be managed non-surgically.
6. When a root fracture is present or strongly suspected, or when restorative factors make conventional endodontic treatment difficult or unfeasible.

Unspecified endodontic procedure, by report (D3999). A narrative describing the procedure performed, along with any required supporting documentation, must be included with the claim submission.

Periodontics

Please refer to plan benefits for specific frequency limits, guidelines restrictions and material upgrades. Procedures considered inclusive of other codes will be reimbursed at \$0. Services

performed solely to support or complete another procedure will be denied when the primary procedure is not covered or is denied.

Evaluation of periodontal disease is essential for all patients, regardless of age. When pocket depths are 3 mm or less, and there is no bleeding upon probing, the patient's periodontal status should be classified as Type I.

Comprehensive Periodontal Oral Evaluation– New or Existing Patient (D0180) is indicated for new or existing patients who show signs or symptoms of periodontal disease or present risk factors such as smoking, diabetes, systemic medical conditions, or relevant social factors. The evaluation includes full-mouth probing, periodontal charting, assessment of current dental conditions, oral cancer screening, review of medical history, and overall wellness assessment.

The evaluation should include:

1. Assessment of the quality and quantity of gingival tissue.
2. Six-point periodontal probing for each tooth, with detailed documentation.
3. Identification of areas with bleeding, exudate, plaque, or calculus.
4. Evaluation of recession, mucogingival issues, and the level and extent of attached gingiva.
5. Assessment of tooth mobility.
6. Detection of open or improper contacts.
7. Evaluation of furcation involvement.
8. Examination of occlusal contacts and interferences.

Following the evaluation, a periodontal diagnosis should be established, and an individualized treatment plan developed to address the patient's specific needs.

Full mouth debridement to enable a comprehensive oral periodontal evaluation and diagnosis on a subsequent visit (D4355) is performed to facilitate a comprehensive periodontal evaluation and diagnosis during a follow-up visit. This procedure is intended to be followed by a complete periodontal evaluation at a later appointment, allowing time for an initial soft tissue response and shrinkage before performing full mouth periodontal probing.

The procedure includes the following requirements:

1. It must be supported by radiographs or, if necessary, intra-oral photographs that document the presence of heavy calculus.
2. It is not a substitute for procedure D1110.
3. It is not appropriate or reimbursable on the same day as procedure D0180.

Scaling in the Presence of Generalized Moderate or Severe Gingival Inflammation (D4346) is indicated for patients with generalized moderate or severe gingival inflammation without signs of periodontitis (no attachment loss). Clinical features include swollen, inflamed gingiva, generalized supra-bony pockets, and moderate to severe bleeding on probing.

- Generalized is defined as involvement of $\geq 30\%$ of teeth, consistent with ADA and AAP definitions.
- Moderate inflammation: redness, edema, glazing, with bleeding on probing.
- Severe inflammation: marked redness, edema, ulceration, and tendency for spontaneous bleeding.

Key Considerations:

- This is a therapeutic, full-mouth procedure intended to treat gingival inflammation, not periodontal disease, and should not be reported with prophylaxis, scaling and root planing, or debridement procedures.
- It can be performed on the same day as a periodic or comprehensive examination and is appropriate for patients of any age or dentition stage.
- Prophylaxis or scaling and root planing may follow D4346 using the appropriate codes; D4910 is not a suitable follow-up.
- Use D4346 when periodontal health is compromised due to gingivitis but not periodontitis with bone loss.

Periodontal Scaling and Root Planing (D4341, four or more teeth per quadrant; D4342 one to three teeth per quadrant) are indicated for patients with periodontal disease, including infrabony pockets, attachment loss, swollen gingiva, and moderate to severe bleeding on probing.

- The procedure removes rough, calculus-laden cementum and dentin; some soft tissue removal may occur.
- Subgingival plaque alone does not justify treatment. Post-treatment radiographs should show the absence of calculus.

Clinical Guidelines:

1. It can be performed by a general dentist or dental hygienist.
2. Indicated when full-mouth radiographs show bone loss and periodontal charting demonstrates pockets $\geq 4\text{mm}$ with signs of inflammation.
3. Interproximal root calculus is generally evident on radiographs. Fewer affected teeth or good prognosis may warrant D4342 instead of D4341.
4. No more than two quadrants of scaling and root planing (SRP) are reimbursable per day unless documentation shows a medical justification and sufficient treatment time. Without such documentation, approval is limited to two quadrants per date of service.
5. Localized scaling and root planing for maintenance is reported using D4910.
6. D1110 and D4341 are generally not reimbursed on the same day; exceptions require documentation.

7. Periodontal maintenance should follow scaling and root planing, including periodic pocket depth and gingival assessments.
8. Document the member's adherence to homecare instructions.

Definitive vs. pre-surgical scaling and root planing:

For early stages of periodontal disease, scaling and root planing serves as definitive non-surgical treatment, and the member may not require referral to a periodontist, depending on tissue response and the patient's oral hygiene.

In more advanced stages, this procedure may be considered pre-surgical treatment, and referral to a periodontist may be necessary, again based on tissue response and the patient's oral hygiene.

Note: Liberty encourages general dentists to complete the initial scaling and root planing, including any pre-surgical treatment, at the primary facility before referring the patient to a periodontal specialist whenever possible.

If more than two quadrants are treated in a single appointment, documentation supporting the additional quadrants must be submitted with the claim and included in the member's progress notes. This documentation should include:

1. The amount of local anesthesia used, or reasons if none were used. (Topical anesthetics are included in the procedure.)
2. Any medical or other conditions that justify the additional treatment.
3. Duration of the appointment.

Other Periodontic Services

Periodontal maintenance (D4910) should be initiated at regular intervals following scaling and root planing, provided that the periodontal condition has stabilized to a manageable level. Periodic recording of periodontal pocket depths and gingival status is essential. Additionally, documentation of the patient's adherence to homecare instructions is required.

The intervals for periodontal maintenance and supportive care should commence no sooner than four weeks after the primary treatment for periodontal disease, with the timing tailored to the individual patient's risk factors. While three-month recalls are standard for many patients, these intervals should be customized based on each patient's specific needs.

D4910 may be covered for up to three years (or longer) when there is a documented history of periodontal therapy in the patient's treatment record—whether via report, Liberty record, or narrative—along with a current periodontal chart. In the absence of a prior history of periodontal therapy (e.g., D4341/D4342), periodontal maintenance is not indicated and, therefore, will not be covered.

Periodontal Irrigation (D4921) is an adjunctive procedure used in periodontal treatment or when gingival inflammation is present.

For benefit purposes, D4921 is considered inclusive of other periodontal procedures (such as D1110, D1120, D4341/42, D4346, D4355, D4910) and is not reimbursed when performed in

conjunction with these treatments. Additionally, this service cannot be billed separately if it is part of a covered periodontal procedure, nor can treatment be denied based solely on the inclusion of the covered periodontal service.

Note: A patient's refusal of periodontal irrigation does not justify a request for patient transfer.

Soft Tissue Management Programs (STMP)

The following procedures are not considered part of the soft tissue management program fees and may not be bundled with them:

1. Periodontal evaluation, pocket charting, and re-evaluation (these are included in the evaluation codes).
2. Gross debridement and scaling/root planing.
3. Plans may cover one prophylaxis procedure per 12-month period, which includes oral hygiene instructions (refer to plan-specific benefits, limitations, and exclusions). Prophylaxis cannot be performed on the same day as root planing or full mouth debridement.
4. Patients must sign an elective treatment form if they choose to undergo soft tissue management procedures in addition to the procedures listed above.

Drugs or medicaments dispensed in the office for home use (D9630). Should not be used in reporting irrigation with chlorhexidine or prescriptions written. Documentation and/or narrative of drugs/medicaments dispensed in office must be included with claim submission.

Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth (D4381). Benefits for D4381 are **not available** when performed on the same quadrant and date of service as D4341 or D4342.

Recommended Use:

Dentists may consider D4381 for patients with chronic periodontitis after completing initial non-surgical therapy:

1. **Initial Treatment:** Complete scaling and root planing (D4341/D4342) and allow a minimum 4-week healing period.
2. **Re-evaluation:** Re-probe pockets to assess clinical response. D4381 may be considered if several teeth remain non-responsive, with localized residual pocket depths ≥ 5 mm and inflammation.

Benefit Guidelines:

1. Approval may be granted for up to two teeth per quadrant within a 12-month period with evidence of periodontal pocket depth greater than or equal to 5mm with inflammation and prior scaling and root planing (SRP) within the past 36 months.
2. Treatment is not covered when used routinely during periodontal maintenance (D4910) or as a preventive measure without clear signs of active, site-specific disease (e.g., ≥ 5 mm pocket depth, bleeding, inflammation).

3. Repeated use at the same site without documented clinical improvement, such as persistent pocketing, inflammation, or no evidence of healing, is not reimbursable.
4. If multiple teeth in the same quadrant have pockets ≥ 5 mm, consider alternative approaches, including systemic antibiotics, periodontal surgery, or referral to a periodontist.

When Alternative Treatments May Be Preferred:

1. Multiple teeth in a quadrant remain non-responsive to D4341/D4342.
2. D4381 performed ≥ 4 weeks after scaling and root planing fails to reduce pocket depths or control periodontitis.
3. Anatomical defects (e.g., infrabony defects) are present.
4. Sites with pocket depths > 6 mm may benefit more from adjunctive systemic antibiotics.

References:

American Academy of Periodontology, Systemic Antibiotics in Periodontics, 2004.
Antibiotics in the Treatment of Periodontitis: A Systematic Review of the Literature, 2021.

Warnings/Precautions:

May be contraindicated during pregnancy due to potential fetal harm (ADA/PDR Guide to Dental Therapeutics, 4th Edition).

Periodontal surgical procedures

Periodontal surgical procedures are covered under the following conditions:

1. The patient must demonstrate a willingness to undergo periodontal treatment and maintain an appropriate oral hygiene routine before being considered for periodontal surgery.
2. The patient's case history, including their motivation to comply with treatment and the status of their oral hygiene, must be documented.
3. The patient's motivation may be documented in a narrative by the attending dentist or through progress notes that show the patient's adherence to the recommended regimen.
4. In most cases, there must be evidence of diligent oral hygiene maintained for at least three months before pre-authorization for periodontal surgery.
5. Referral to a periodontist will be considered on a case-by-case basis. However, prior to considering a referral, the general dentist must complete definitive scaling and root planing, provide oral hygiene instructions, and perform other necessary pre-surgical or non-surgical procedures.
6. Periodontal surgery is only covered when there is evidence of a favorable long-term prognosis. Surgical procedures for retaining teeth used as prosthetic abutments are covered only if the teeth have adequate bone support to withstand the forces they are, or will be, subjected to.

7. Periodontal pocket reduction surgery should aim to remove residual calculus and granulation tissue while improving the physiological form of the gingival tissues.
 - a. Osseous surgery and regenerative procedures should correct and reshape any alveolar bone deformities where indicated.
 - b. Soft tissue gingival grafting should be performed to address gingival defects when appropriate.
8. If Liberty determines that there are too few teeth with a good prognosis in a particular quadrant, an alternate, more appropriate code may be approved.

Gingivectomy/Gingivoplasty (D4210- D4212) may be covered when pocket depths are 5 mm or greater, following the soft tissue response to non-surgical periodontal treatment, and when complete removal of suprabony fibrous pockets or pseudo-pockets is required.

Appropriate radiographs and periodontal charting must be submitted with the request for these services. Additionally, intra-oral photos should be included to support the need for gingivoplasty services to restore abnormal gingival architectures, asymmetry, etc.

Management of soft tissues performed during a restorative or tooth preparation procedure, per tooth, including final impressions, is considered, for insurance purposes, to be part of and included in those procedures and therefore not separately reimbursable with code D4212.

Osseous surgery (D4260- D4261), which includes full-thickness flap elevation and closure, reshapes the alveolar bone to achieve a more physiological form. This procedure involves removing the supporting bone (ostectomy) and/or non-supporting bone (osteoplasty). Other procedures performed concurrently with D4260 or D4261 should be reported with their own codes.

1. Periodontal pocket reduction surgery may be covered when pocket depths are 5 mm or deeper, following re-evaluation after scaling and root planing, with evidence of periodontal bone deformity.
 - a. Consideration should be given to long-standing pockets of 5 mm following prior surgery, which may or may not require further intervention.
2. Osseous surgery is generally not covered if:
 - a. Pocket depths are 4 mm or less and can be managed with non-surgical treatments (e.g., periodontal maintenance or root planing).
 - b. The patient is a smoker or diabetic whose condition is not well-controlled.
3. No more than two quadrants of osseous surgery will be reimbursed on the same date of service unless justified by medical or other conditions.

Clinical Crown Lengthening – Hard Tissue (D4249) exposes additional tooth structure to facilitate restorative procedures on teeth with limited or no visible tooth structure. The procedure involves reflecting a full-thickness flap and removing bone, which alters the crown-to-root ratio. Unlike osseous surgery, crown lengthening is performed in a healthy periodontal environment.

Key Points:

- Periodontal surgery should not be performed on the same tooth on the same day as taking a final impression for a fixed or removable prosthesis, as healing has not occurred and tissue or bone changes could affect the prosthesis outcome. This service is not reimbursable when done on the same day as crowns, bridges, or removable prostheses.
- Management of soft tissues during restorative procedures or crown preparation with final impressions is included in the fee for the related procedure. Providers may not bill Liberty or the patient separately for D4249 when performed on the same tooth on the same day as crown preparation and final impressions.

Bone Replacement Grafting (D4263–D4264), performed alongside osseous surgery, uses graft material to promote periodontal bone regeneration when disease has caused documented bone defects around one or more teeth.

Key Points:

- A natural tooth must be present at the graft site; this procedure cannot be performed with an extraction.
- Documentation in the patient’s dental record must include graft type, quantity, lot number, expiration date, and manufacturer information.

Biologic materials and/or guided tissue regeneration (D4265 – D4267) may be used during osseous surgery to help correct a documented deformity of the bone surrounding a natural tooth or teeth and is necessary to aid in osseous regeneration.

Note: D4266 and D4267 should not be used for peri-implant defects. D6106 and D6107 are indicated for peri-implant defects.

Removal of non-resorbable barrier (D4286). Considered inclusive when completed by same provider who placed the non-restorable material or barrier.

Free soft tissue graft procedure (including recipient and donor surgical sites) (D4277 – D4278) may be used to correct a documented mucogingival defect under the following conditions:

1. The marginal tissue is insufficient, and the tooth or teeth have a favorable prognosis (e.g., periodontal, endodontic, and restorative prognosis).
2. Mucogingival grafting is needed due to gingival recession or a lack of keratinized gingiva, typically requiring intra-oral photographic documentation of the mucogingival defect.
3. Affected teeth must have good endodontic, periodontal and restorative prognosis.

Note: Liberty may determine that the graft requested is better described under a different procedure code.

Splint-natural teeth or prosthetic crowns (Intra-coronal: D4322; Extra-coronal: D4323) may be necessary when documentation demonstrates the need for stabilization of mobile teeth.

Laser Use in Periodontal Therapy

Lasers are considered tools for delivering care, not standalone procedures. Any laser use is included in the fee for the designated CDT procedure, and the appropriate ADA/CDT code for the overall procedure must be reported.

Laser-Mediated Sulcular and/or Pocket Debridement:

- Clinical evidence indicates that when used as an adjunct to scaling and root planing (SRP), mechanical, chemical, or laser curettage provides little to no additional benefit in reducing probing depths or improving clinical attachment levels.
- Effective control and arrest of periodontitis primarily depend on thorough root surface debridement, rather than removal of soft tissue from the pocket wall (curettage).
- Current evidence is limited to support the use of lasers for subgingival debridement, either as a standalone therapy or in combination with SRP.

Source: *American Academy of Periodontology, April 2011*

Unspecified periodontal procedure, by report (D4999). A narrative describing the procedure performed, along with any required supporting documentation, must be included with the claim submission.

Removable Prosthodontics

Please refer to plan benefits for specific frequency limits, guidelines restrictions and material upgrades. Procedures considered inclusive of other codes will be reimbursed at \$0. Services performed solely to support or complete another procedure will be denied when the primary procedure is not covered or is denied.

General Guidelines:

1. Providers must report the dates of service for these procedures as the dates when the removable appliances are delivered to the patient.
2. Establishing vertical dimension is considered part of the denture fabrication process (whether standard, interim, or immediate) and is included in the fee. Therefore, benefits for dentures are not limited or excluded due to the need to establish vertical dimension.
3. Removable prosthetic services, including immediate and conventional complete dentures and partial dentures, cover routine post-delivery care, adjustments, and soft liners for 6 months.
4. Proper patient education on the use of removable dentures should be incorporated into the diagnosis and treatment plan. Providing educational materials about these prostheses is strongly recommended to avoid misunderstandings, manage patient expectations, and reduce grievances.

5. Dentures will not be covered for replacement if the existing appliance can be adequately restored with a relined or repair.
6. Dentures will not be covered for replacement if a clinical evaluation shows the presence of a satisfactory appliance, even if the patient requests a replacement due to perceived functional or cosmetic issues.
7. All tooth extractions in the arch should be completed, and sufficient healing time (at least 4-6 weeks) should be allowed before taking the final impression.

Conventional Complete Dentures (D5110 – D5120)

1. Complete dentures may not be covered if some teeth remain in the arch and extraction of the remaining teeth is not deemed necessary.
2. Codes D5110-D5120 cover the entire process of fabricating a denture, including all steps from start to finish to create and deliver a functional prosthesis.

Immediate Dentures (D5130 – D5140, D5227 – D5228)

1. Immediate dentures are fabricated before and inserted immediately following the completion of all planned extractions in the arch.
2. While immediate dentures provide the advantage of avoiding a period without teeth, they may need to be relined during the healing period after the extractions.
3. Immediate dentures may be designed as either permanent or temporary, intended only for the post-extraction healing phase. The treatment plan should clearly indicate whether the immediate dentures will serve as the final dentures or as a temporary appliance, and this should be documented in a treatment plan signed by the patient.
4. An informed consent form, detailing the benefits and potential drawbacks of immediate dentures, as well as clarifying whether the dentures will be interim or definitive, should be signed by the patient prior to fabrication.
5. Codes D5130-D5140 and D5227-D5228 cover the entire process of fabricating the denture, including all steps from start to finish to produce and deliver a functional denture, as well as any necessary relining during the healing period.

Partial Dentures (D5211 – D5286)

1. A removable partial denture is generally not indicated for replacing a single non-functional second or third molar.
2. Partial dentures may be covered when posterior teeth need to be replaced on both sides of the same arch.

3. All definitive treatments (e.g., extractions, restorations, endodontic therapy, crowns) must be completed before taking the final impression for the partial denture.
4. Partial dentures should be designed to minimize any potential damage to the remaining natural teeth.
5. Materials used for removable partial dentures should be durable enough to withstand normal function, nonporous, color stable, aesthetically pleasing, non-toxic, and non-abrasive to the opposing or supporting teeth.
6. A partial denture will not be covered if the remaining teeth, particularly abutment teeth, do not have a good long-term prognosis, including a minimum crown-to-root ratio of 50%.
7. A partial denture will not be covered if untreated moderate to severe periodontal disease is present.
8. Codes D5211-D5286 encompass the entire process of fabricating the partial denture, including all steps from start to finish to create and deliver a functional appliance.

Complete or partial denture adjustments (D5410 – D5422) within six months of prosthesis delivery are considered part of the original prosthesis fee and are not reimbursable. Adjustments are payable only after six months. They are also not reimbursable on the same date as the initial insertion or on the same date as any repair, rebase, or relines procedure.

Repairs to complete and partial removable dentures (D5511 – D5671) must include documentation that demonstrates the appliance is broken, in need of repair, or that a clasp and/or tooth needs to be added.

Rebase (D5710 – D5725) and Relines (D5730 – D5761) for complete and partial removable dentures:

1. A rebase or relines of a partial or complete denture may be covered if documentation shows that the appliance is ill-fitting and can be corrected by rebasing or relining to restore its functionality.
2. Coverage for relines and repairs may be subject to limitations, such as restrictions on early follow-up repairs or relines shortly after the appliance's delivery.

Interim removable partial dentures (D5810- D5821)

1. These appliances are intended solely as temporary replacements for extracted teeth during the healing period, prior to the fabrication of a subsequent fixed or removable partial denture or implant. Benefits will not be provided for both an interim and definitive partial denture.

2. Submitted documentation must demonstrate that the existing partial denture is no longer serviceable.
3. The coverage and benefits for any interim appliances, which are intended to be temporary, should be clearly discussed and agreed upon with the patient before proceeding with elective, upgraded, or non-covered services. Evidence of this discussion should be documented through the patient's signature on informed consent forms, treatment plans, progress notes, or financial consent forms.
4. Codes D5810-D5821 cover the entire process of fabricating a denture, including all steps from start to finish to produce and deliver a functional appliance.

Tissue conditioning (D5850 – D5851) may be required when documentation shows that the tissue under a removable appliance is unhealthy or must be treated prior to fabricating a new appliance or rebasing or relining an existing appliance.

Precision attachment (D5862). The placement of a precision attachment requires documentation demonstrating its medical necessity to stabilize a removable appliance. Each set of components (male and female) constitutes one precision attachment.

Overdenture – complete maxillary (D5863). Natural tooth borne.

Overdenture – partial maxillary (D5864). Natural tooth borne.

Overdenture – complete mandibular (D5865). Natural tooth borne.

Overdenture – partial mandibular (D5866). Natural tooth borne.

Replacement of replaceable part of semi-precision or precision attachment, per attachment (D5867).

Add metal substructure to acrylic complete denture – per arch (D5876). Use of metal substructure in a removable complete denture for reinforcement, during fabrication or repair.

Duplication of complete denture – maxillary (D5877). Does not involve all steps used in initial fabrication.

Duplication of complete denture – mandibular (D5878). Does not involve all steps used initial fabrication.

Unspecified removable prosthodontic procedure, by report (D5899). Used for procedures that are not sufficiently described by a specific code. A narrative outlining the procedure performed, along with any required supporting documentation, must be submitted with the claim.

Mandibular guidance prosthesis with guide flange (D5934). A prosthesis which guides the remaining portion of the mandible, left after a partial resection, into a more normal relationship with the maxilla. This allows for some tooth-to-tooth or an improved tooth contact; it may also artificially replace missing teeth and thereby increase masticatory efficiency.

Mandibular guidance prosthesis without guide flange (D5935).

Surgical stent (D5982). Surgical stent for soft tissue healing.

Note: Denture upgrades, including but not limited to porcelain teeth, inscriptions, gold, etc., are not covered by the plan and should not be billed under D5899.

Implants

Please refer to plan benefits for specific frequency limits, guidelines restrictions and material upgrades. Procedures considered inclusive of other codes will be reimbursed at \$0. Services performed solely to support or complete another procedure will be denied when the primary procedure is not covered or is denied.

General Guidelines (D6010 – D6013):

1. A comprehensive medical history and clinical examination must be conducted to assess the patient's overall health and diagnose their oral condition before developing an appropriate treatment plan.
2. The purpose of our implant guidelines is to help ensure providers are considering a member's entire oral condition when treatment planning to confirm members are receiving an appropriate and comprehensive approach to replacing all missing teeth and restoring their function.
3. Implants may be a covered benefit when deemed appropriate and consistent with professional standards, and medically necessary considering the patient's current oral condition and the following guidelines:
 - a. Full mouth x-rays and a comprehensive treatment plan are required with pre-authorization requests.
 - b. Consideration of coverage includes the following criteria and is applicable to the implant body and subsequent restoration:
 - i. Reimbursement is limited to the minimum number of implants clinically necessary to achieve stable function and occlusion based on the documented treatment plan.
 - ii. Anterior Region: The implant must restore a full set of anterior teeth in the arch, with no missing anterior teeth remaining in that arch.
 - iii. Posterior Region: The implant must oppose fixed dentition, thereby enhancing functionality once restored.

- iv. Fixed dentition is defined as:
 - 1. A natural tooth
 - 2. An existing or approved fixed partial denture (bridge)
 - 3. An existing or approved implant
 - v. The member needs to have a stabilized occlusion that is not dependent on the completion of the proposed treatment plan.
 - vi. Stabilized occlusion is defined as having at least eight (8) points of existing posterior contact at the time of the service request.
 - 1. Contact is defined as occlusion between fixed dental restorations.
 - vii. Contact between one upper and one lower posterior tooth equals two (2) points of contact.
 - viii. When multiple edentulous spaces exist in the same arch, a removable partial denture is the prosthetic option unless implants are medically necessary and no other functional alternative can correct the condition.
- 4. For fully edentulous arches, coverage is limited to the minimum number of implants that are clinically necessary to support an overdenture. Any planned fixed partial denture or implant must be included in the same pre-authorization request and approved to ensure proper occlusion.
 - 5. D6010 covers the surgical placement of the implant body, second-stage surgery, and the placement of the healing cap. **D6011 will not be reimbursed separately.**
 - 6. Post-operative periapical radiographs showing the placement of the implant **must be included with the claim for payment.**
 - 7. Any existing implant must meet coverage criteria to be considered for an implant restoration.

Scaling and debridement of a single implant in the presence of peri-implantitis inflammation, bleeding upon probing and increased pocket depths, including cleaning of the implant surfaces, without flap entry and closure (D6049). This procedure is not performed in conjunction with D1110, D4910, or D4346.

Prefabricated/custom abutments (D6056- D6057). When used, abutments attach to the implant body and provide support and retention for a crown. Custom abutments are laboratory-fabricated and tailored for a specific application.

Implant supported and abutment supported single crowns (D6058 – D6067, D6082 – D6088).

- 1. Abutment-supported crowns are retained and supported by an abutment that connects to the implant.

2. Implant-supported crowns are directly retained, supported, and stabilized by the implant body, without the use of an abutment.
3. Implant-supported crowns submitted with an abutment for the same implant will not be covered, as these services are incompatible when provided together.
4. Opposing fixed dentition is required for consideration of crown coverage.
5. Post-operative radiographs showing the placement of the abutment and/or crown must be submitted with the claim for payment.

Note: Exceptions to these criteria may be considered on a case-by-case basis for implant coverage.

Implant maintenance procedures when a full arch fixed hybrid prosthesis is removed and reinserted, including cleansing of prosthesis and abutments (D6080). This procedure includes active debriding of the implant(s) and examination of all aspects of the implant system, including the occlusion and stability of the prosthesis. The patient is also instructed in thorough daily cleansing of the implant(s).

Bone graft at time of implant placement (D6104). For coverage at an existing edentulous site, bone grafting at the time of implant placement requires supporting documentation, such as intra-oral photos or CBCT scans, to demonstrate the need for additional bone when it is not visible on x-rays alone. Bone type, amount, lot number, expiration date, and/or manufacturer sticker must appear in the member's dental records.

Guided Tissue Regeneration (D6106 – D6107). This procedure is used for peri-implant defects and during implant placement. For coverage at an existing edentulous site, guided tissue regeneration at the time of implant placement requires supporting documentation, including lot number with the specific product brand and material, intra-oral photos and/or CBCT scans, to demonstrate the need for additional bone when it is not visible on x-rays alone.

Radiographic/Surgical Implant Index, by report (D6190) will be considered for coverage only when the associated dental implant is approved for coverage. All treatment notes, radiographic/CBCT images, laboratory prescriptions and laboratory invoices should be made part of the member's treatment record to be made available upon request in support of requested implant index.

Removal of an indirect restoration on an implant retained abutment (D6196). Not to be used for a temporary, provisional, or screw retained restoration.

Removable partial dentures (D5211 – D5228). Removable dentures are not covered in the same arch as approved posterior implants or fixed partial dentures. Interim partial dentures may be considered in such cases.

Implant supported retainer/pontic for fixed partial dentures (Bridges) (D6068-D6077, D6194, D6205-D6253). These are a covered benefit when the criteria for implant placement are met.

1. Implant-supported fixed partial dentures that use a natural tooth as an abutment are not covered under the plan.

2. The appropriate CDT codes for implant retainer crowns must be used. Single crown codes (e.g., D2740, D6058) are not acceptable in place of the implant retainer crown codes. Additionally, the type of retainer crown (implant-retained vs. abutment-retained) must align with the corresponding implant treatment.
3. Claims must include documentation of marginal integrity, typically verified with dental radiographs per American College of Prosthodontics recommendations, for payment consideration. Providers should note that state-specific regulations take precedence over Liberty Dental Plan requirements, and all claims will be reviewed accordingly. It is the provider's responsibility to understand and comply with the applicable state rules when submitting documentation.

Implant/Abutment-Supported Dentures (D6110–D6117)

1. Complete Dentures

- **Removable (D6110–D6111) and Fixed (D6114–D6115):**
 - a. Opposing occlusion is **not required** for implant placement.
 - b. Implants used to retain and support dentures are **covered, when necessary**, due to inadequate retention.
 - c. Coverage limits for full denture cases: limited to the minimal number of implants that is clinically necessary to support the overdenture. Additional implants may be considered when documentation supports clinical necessity, such as in cases of significant anatomical limitations, severe bone resorption, or other extraordinary medical conditions that warrant additional implant support for adequate function and stability.
 - d. Fixed dentures will only be considered when documentation demonstrates that a removable implant-supported denture would not provide adequate function or retention.

2. Partial Dentures

- **Removable (D6112–D6113) and Fixed (D6116–D6117):**
 - a. Remaining teeth must have a favorable periodontal prognosis.
 - b. Implant placement is not covered if moderate to severe periodontal disease is untreated.
 - c. Implant placement is covered only when there are insufficient natural teeth to support a conventional removable partial denture.

Note:

- Removable implant-supported dentures use semi-precision abutments (D6191/D6192).
- Fixed implant-supported dentures use prefabricated or custom abutments (D6056/D6057).
- Requests for dentures with incompatible abutments will not be covered.

Treatment Plan Considerations

A conservative treatment plan should be prioritized before recommending one or more implants for a patient. When developing a treatment plan involving implants, the prognosis of the remaining natural teeth in the same arch must be considered. If the existing dentition shows a poor periodontal prognosis, implants may not be covered. Implants are not covered in the presence of untreated moderate to severe periodontal disease.

Contraindications for Implant Restoration

Crowns and fixed partial prosthetics for dental implants may be contraindicated for the following reasons:

1. Adverse systemic conditions such as uncontrolled diabetes or recent smoking history.
2. Poor oral hygiene and tissue management by the patient.
3. Inadequate osseointegration of the implant(s), including mobility prior to loading.
4. Excessive parafunction or occlusal loading on the implant.
5. Poor positioning of the implant(s).
6. Excessive bone loss around the implant before restoration.
7. Inadequate number of implants or poor bone quality for long-span prostheses.
8. Aesthetic concerns, especially when restoring the appearance of gingival tissues in high aesthetic areas.
9. When the member is under the age of sixteen (16), unless exceptional circumstances apply.

Restoration Guidelines

Restoring dental implants requires special considerations, as it differs from restoring natural teeth. The following guidelines should be followed:

1. Occlusal and lateral loading of the prosthesis must be carefully managed to avoid damaging the implant's integration with the bone or compromising the integrity of the implant system.
2. The material hardness used for the restoration should be compatible with the opposing occlusion.
3. Jaw relationships and inter-arch vertical distance should be evaluated in the initial treatment plan, guiding the selection of retentive and restorative appliances.
4. The restoration must meet both functional and aesthetic needs, ensuring the appliance appears appropriate and serves its purpose.

5. The shape and appearance of the fixed prosthesis should harmonize with the remaining hard and soft tissues of the mouth.
6. Prostheses must be designed for good oral hygiene, including accessibility for cleaning even if the design has a ridge lap form.
7. Fixed implant prostheses should be designed to facilitate removal without damage to the implant or surrounding teeth, allowing for future repairs or the potential for further restorations if additional teeth are lost.
8. Multiple-unit fixed prostheses must fit precisely and passively to avoid damage to the implants or their integration with the bone.
9. Implant-supported dentures that utilize a natural tooth as an abutment are not covered.
10. The restoring dentist is responsible for evaluating the initial acceptability of the implants before proceeding with restoration.
11. The restoring dentist must instruct the patient on proper care and maintenance of the implant system and evaluate the patient's care post-placement of the restoration.
12. Implant crowns and fixed partial prostheses are expected to have a minimum service life of five (5) years.

Fixed Prosthodontic Services

Please refer to plan benefits for specific frequency limits, guidelines restrictions and material upgrades. Procedures considered inclusive of other codes will be reimbursed at \$0. Services performed solely to support or complete another procedure will be denied when the primary procedure is not covered or is denied.

General Guidelines (D6200 – D6999):

1. The term "fixed partial denture" or FPD is synonymous with fixed bridge or bridgework.
2. A fixed partial denture (bridge) is not considered medically necessary when bilateral edentulous spaces are present, unless the patient has a documented medical condition that contraindicates the use of a removable prosthesis and evidence of removable partial denture failure is clearly documented through appropriate clinical records.
3. Medical necessity must be clearly documented to support the recommendation for a bridge in cases where a removable partial denture would adequately restore the member's form, function, and esthetics, especially in cases of bilateral edentulous spaces.

4. Understanding that there are reduced biting forces in the anterior region, bridge coverage will be considered for the following scenarios:
 - a. Replacement of a single maxillary anterior tooth, or
 - b. Replacement of two adjacent mandibular anterior teeth.
 - c. Exceptions will be considered on a case-by-case basis, following the medical necessity documentation requirements outlined above.
5. Fixed partial dentures are not covered in the presence of untreated moderate to severe periodontal disease, as shown in radiographs, or when the proposed abutment teeth have poor crown-to-root ratios. A full mouth periodontal evaluation with recent probing should be submitted for review when requesting benefits.
6. The design and span of the fixed partial denture, as well as the supporting abutment teeth must have a good long-term prognosis—considering endodontic, periodontal, and restorative factors—with a minimum crown-to-root ratio of 50% and a life expectancy of at least five (5) years.
7. To justify the replacement of an existing fixed partial denture, radiographic evidence (or intra-oral photos, if radiographs are insufficient) showing the need for replacement (e.g., open margins or recurrent decay) must be provided.
8. Dental consultants may deny the replacement of a fixed partial denture and may request additional information about the treatment plan for other edentulous areas.
9. A cantilevered pontic for replacing a missing posterior tooth is not covered. However, a mesial cantilevered pontic may be considered for replacing a maxillary lateral incisor if an adequate adjacent cuspid can serve as the abutment.
10. Third molars should generally not be replaced unless the replacement is deemed functional.
11. The appropriate CDT codes for crowns must be submitted for fixed partial dentures. Single crown codes (e.g., D2740) will not be accepted in place of retainer crown codes.

Oral Surgery

Please refer to plan benefits for specific frequency limits, guidelines restrictions and material upgrades. Procedures considered inclusive of other codes will be reimbursed at \$0. Services performed solely to support or complete another procedure will be denied when the primary procedure is not covered or is denied.

Extractions may be necessary due to pathology such as non-restorable caries, untreatable periodontal disease, pulpal or periapical disease not treatable with endodontic therapy, to facilitate the removal of cysts or neoplasms, or when underlying medical conditions require removal to eliminate existing or potential sources of oral infection.

General Guidelines:

1. Local anesthesia is considered part of oral and maxillofacial surgical procedures.
2. For dental benefit reporting, a quadrant is defined as four or more contiguous teeth or tooth spaces, extending distally from the midline.
3. The classification of impactions is based on the anatomical position of the tooth, not the surgical technique used for removal.
4. Radiographs are required for all extraction requests to determine whether the surgical extraction code submitted is supported by the clinical presentation. Surgical extractions will be classified based on the diagnostic radiographs provided. If the radiographs do not clearly depict the tooth's condition, supplemental written documentation and/or photographs may also be reviewed. Claims submitted without radiographs will not be considered complete.

Extractions (D7111 – D7251).

1. Services considered part of the extraction procedure include, but are not limited to, local anesthesia, minor bone contouring or removal at the extraction site, socket irrigation, hemostatic agents, sutures, and routine postoperative care. These services are included in the extraction procedure for benefit purposes and should not be billed separately or unbundled.
2. Each dental extraction must be supported by a clearly documented diagnosis indicating that extraction is the treatment of choice, as determined by both the dentist and the patient.
3. For the extraction of a deciduous tooth (D7111 and D7140), there must be medical necessity demonstrating that the tooth has pathology and will not exfoliate within the next six months. This may be evidenced radiographically by more than 50% of the residual root remaining or through a patient complaint of acute pain.
4. Prophylactic removal of an impacted, partially erupted, or erupted tooth that has an unimpeded path of eruption and exhibits no active pathology is not covered.
 - a. Removal of third molars to prevent future crowding or misalignment is not a covered service.
 - b. Pericoronitis is recognized as pathology. By definition, fully covered and unerupted third molars cannot have pericoronitis.
 - c. Narratives indicating pericoronitis on a fully erupted tooth are ambiguous. In these cases, the radiographic presentation will be the determining factor for coverage. Symptoms consistent with normal tooth eruption (e.g., pressure or teeth breaking through the gingiva) and not caused by pathology or impeded eruption are not covered.

Extractions erupted tooth or exposed root (elevation and / or forceps removal) (D7140). An uncomplicated extraction of an erupted or exposed root includes removal of all tooth structure, minor smoothing of socket bone and closure, as necessary. Extraction of an erupted tooth may be needed when the tooth has significant decay, is causing irreversible pain and/or infection, or is impeding the eruption of another tooth.

Extraction of an erupted tooth requiring removal of bone and / or sectioning of the tooth and including elevation of mucoperiosteal flap if indicated (D7210) requires documentation removal of bone and/or sectioning that tooth, including elevation of a mucoperiosteal flap if indicated.

An impacted tooth is “An unerupted or partially erupted tooth that is positioned against another tooth, bone, or soft tissue so that complete eruption is unlikely.” (CDT)

Removal of Impacted tooth – soft tissue (D7220) is a tooth with the occlusal surface covered by soft tissue, and extraction requires elevation of a mucoperiosteal flap.

Removal of Impacted tooth – partially bony (D7230) is a tooth with part of the crown covered by bone and requires elevation of a mucoperiosteal flap and bone removal.

Removal of Impacted tooth – complete bony (D7240) is a tooth with most (50% or more) or all of the crown covered with bone and requires elevation of a mucoperiosteal flap and bone removal.

Removal of Impacted tooth – completely bony with unusual surgical conditions (D7241) requires documentation of unusual surgical complications due to factors such nerve dissection required, separate closure of maxillary sinus required or aberrant tooth position. Codes D7241 and D7250 are contraindicated against each other within 90 days of recipient, regardless of provider who rendered service.

During the clinical review of requests for the extraction of impacted and/or erupted teeth, Liberty may determine that the treatment is better described by a different, more appropriate procedure code. In such cases, Liberty may approve the extraction under a different code.

Other Oral Surgery Services

1. **Removal of residual tooth roots (D7250)** may be necessary when a root is pathological or interferes with another procedure. Preoperative radiographs are required for claim submission.
2. **Sinus perforation or oroantral fistula closure (D7260, D7261)** requires documentation of a pathological opening into the sinus. Preoperative radiographs must also be submitted with the claim.
3. **Tooth re-implantation and/or stabilization of an accidentally avulsed or displaced tooth (D7270)** requires documentation of accidental avulsion or displacement, along with pre- and post-operative radiographs.
4. **A biopsy of oral tissue (D7285 – D7286)** requires documentation of a suspicious lesion in the mouth that necessitates evaluation and tissue harvesting.

5. **A surgical procedure to facilitate tooth movement (D7292 – D7300)** requires documentation demonstrating the medical necessity of surgery to achieve appropriate tooth positioning.
6. **Alveoloplasty-Preparation of Ridge (D7310 – D7321)** requires documentation supporting the medical necessity for surgical recontouring of the alveolus, such as excessive bony undercuts.
 - a. It must be done in preparation for a prosthesis (conventional or implant-supported complete denture) to be considered for coverage. Documentation should support the need for the procedure (e.g., excessive bony undercuts), as not all denture cases require alveoloplasty.
 - b. Minor bone leveling or removal at the implant site is included in the surgical placement of the implant (D6010, D6013), and bone removal following an extraction is included in the extraction procedure.
7. **Excision of soft tissue or intra-osseous lesions (D7410 – D7465)** requires documentation of an intra-oral lesion and the medical necessity for its removal.
8. **Excision of bone tissue (D7471 – D7490)** requires documentation indicating that a bony growth interferes with function or the ability to wear a prosthesis.
9. **Incision and drainage of an abscess (D7510 – D7521)** requires documentation showing that an oral infection requires drainage. This service is not reimbursable on the same date of service as an extraction of the associated tooth.
10. **Removal of a foreign body (D7530)**, non-vital bone, or a tooth fragment requires documentation proving the medical necessity for its removal.
11. **Open/closed reduction of a fracture (D7610 – D7780)** requires documentation showing evidence of a broken jaw.
12. **Reduction of dislocation (D7810, D7820 and D7899)** and management of other temporomandibular joint dysfunctions require documentation of a dislocation or other pathological condition of the temporomandibular joint.
13. **Repair of traumatic wounds (D7910 – D7912)** and other repair procedures requires documentation showing medical necessity for suturing a traumatic wound or performing other repairs.
14. **Collection & Application of Autologous Blood Concentrate Product (D7921)** is reported when the provider collects a patient's own blood, processes it (typically into platelet-rich plasma or fibrin), and applies it to a surgical site to enhance healing. Common procedures where D7921 are appropriate include larger than usual bone defects, implant placement, and certain periodontal surgeries. Not applicable for the use of synthetic or donor-derived products. Considered medically necessary only when used with a covered surgical procedure and the patient has a medical condition that may impair healing (e.g., diabetes, osteoporosis, immunosuppressive disorders).

- a. **Documentation Requirements**
 1. Date and statement of blood draw.
 2. Processing method and application site(s).
 3. Narrative supporting medical necessity and choice of autologous product.
 4. Pertinent medical history, radiographs/photos, and cross-referenced procedures.
 - b. **Limitations**
 1. Not covered for synthetic or donor materials.
 2. Not reimbursable if collection and application occur on different dates.
 3. Adjunctive only; not a replacement for primary surgical procedure codes.
15. **Bone replacement graft for ridge preservation- per site (D7953)** involves placing a graft at the time of extraction or implant removal to preserve ridge integrity for future implant placement or critical alveolar contour for prosthetic reconstruction.
 - a. Planned treatment and a narrative of necessity must be submitted for consideration of coverage.
 - b. This service may not be covered if the implant benefits are not included.
 - c. Bone type, amount, lot number, expiration date, and/or manufacturer sticker must appear in the member's dental records.
 16. **Frenulectomy or frenuloplasty (D7961 – D7963)** requires documentation showing that a muscle attachment is associated with a pathological condition or is interfering with proper oral development or treatment.
 17. **Excision of hyperplastic tissue (D7970) or reduction of a fibrous tuberosity (D7972)** requires documentation showing the medical necessity for removing redundant soft tissue to facilitate a removable prosthesis.
 18. **Excision of pericoronal gingiva (D7971)** requires documentation showing the medical necessity of removing inflammatory or hypertrophic tissue surrounding partially erupted or impacted teeth.

Orthodontic Services

Please refer to plan benefits for specific frequency limits, guidelines restrictions and material upgrades. Procedures considered inclusive of other codes will be reimbursed at \$0. Services performed solely to support or complete another procedure will be denied when the primary procedure is not covered or is denied.

General Guidelines:

Orthodontic services (**D8010 – D8670**) require appropriate documentation to demonstrate medical necessity for approval. Comprehensive orthodontic care is a covered benefit only when deemed medically necessary, based on the member's specific plan. Liberty will review and approve medically necessary orthodontic services as defined in the member's plan documents. Please note that not all dental plans administered by Liberty include orthodontic coverage. Additionally, orthodontic services are payable only once in a lifetime, on a month-to-month basis.

Limited orthodontic treatment of the primary dentition (D8010) is used for children and primary teeth.

Limited orthodontic treatment of the transitional dentition (D8020) is used for children who are in the process of losing their primary teeth and have some permanent teeth already present.

Limited orthodontic treatment of the adult dentition (D8040) is used for adults who are undergoing minor correction and minimal movement.

Comprehensive dental treatment adolescent (D8080) and Comprehensive dental treatment adult (D8090) may incorporate more than one phase of treatment. Expander, partial fixed appliance, and headgear is used in stage one whereas placement of full arch fixed appliance is done in stage two.

Orthodontic retention (D8680) removal of appliance, construction, and placement of retainer(s).

Extractions performed solely for orthodontic purposes and that do not meet the plan's criteria for extraction are only covered when accompanied by a pre-approved orthodontic treatment plan, when applicable.

Liberty's Clinical Review team will assess authorization requests and determine coverage based on state requirements and group benefit guidelines. Each orthodontic submission must include relevant documentation, such as:

- Handicapping Labio-Lingual Deviation Index (HLD) Form and/or Orthodontic Medical Necessity (OMN) Form
- Cephalometric image and analysis tracings
- Orthodontic photographs (frontal and profile views, as well as anterior and right and left occlusal relationships, maxillary, and mandibular occlusal photos)
- Radiographic evidence (panoramic image and/or mounted full mouth series) for review.

Retrospective Review

Both prospective and retrospective reviews require documentation to support medical necessity. This documentation may include diagnostic radiographs or photographs, test or examination results, descriptions of conditions in progress notes, and/or a written narrative providing further details. In cases where objective information (e.g., diagnostic images) conflicts with subjective information (e.g., written descriptions), objective information will take precedence in the determination process.

For retrospective reviews of services that were previously pre-authorized, documentation must confirm that the procedure(s) were completed as authorized and in accordance with the standard of care, as defined by Liberty Dental Plan's Criteria Guidelines and Practice Parameters.

Adjunctive General Services

Please refer to plan benefits for specific frequency limits, guidelines restrictions and material upgrades. Procedures considered inclusive of other codes will be reimbursed at \$0. Services performed solely to support or complete another procedure will be denied when the primary procedure is not covered or is denied.

Palliative treatment of dental pain- per visit (D9110). The contracted primary care dentist is responsible for providing palliative treatment, even for procedures that may fall under specialty care referral guidelines. Palliative services are billed on a per-visit basis, not per-tooth, and include all treatments provided during the visit, excluding necessary x-rays. Any additional treatment provided on the same day as D9110 is considered inclusive and will not be reimbursed separately. A narrative detailing the emergency and the palliative treatment provided must be documented and submitted with the claim.

Fixed Partial Denture Sectioning (D9120)

1. This procedure involves separating one or more connections between abutments and/or pontics, with the intention of retaining a portion of the fixed prosthesis intact and functional following sectioning, extraction, or other treatment. It includes all necessary recontouring and polishing of the retained portions.
2. The submitted documentation must demonstrate the medical necessity of sectioning part of a fixed partial denture and provide evidence that the remaining teeth have a favorable prognosis.
3. Radiographs must be included with the claim submission.

Application of desensitizing medicament (D9910) covers in-office treatment for root sensitivity, usually reported on a "per visit" basis for the application of topical fluoride. It should not be used for bases, liners, or adhesives placed under restorations. A narrative explaining the necessity of the treatment is required with the claim submission.

Application of desensitizing resin for cervical and / or root surface per tooth (D9911) generally reported on a "per tooth" basis for the application of adhesive resins. It should not be used for bases, liners, or adhesives placed under restorations. A narrative justifying the necessity of the treatment must be included with the claim submission.

Anesthesia local or regional block anesthesia not in or in conjunction with operative or surgical procedures (D9210 – D9215):

1. Local or regional block anesthesia is considered part of and included with operative or surgical procedures.
2. Submitted documentation must demonstrate the medical necessity of anesthetizing a specific area of the mouth when it is not performed in conjunction with an operative or surgical procedure.

Administration of Deep Sedation/General Anesthesia (D9222 – D9223), General anesthesia with advanced airway (D9224 – D9225), (Intravenous moderate (conscious) sedation/analgesia (D9239 – D9243), In-office administration of minimal sedation – single drug – enteral (D9244), Moderate sedation – enteral (D9245) or Moderate sedation – non-intravenous parenteral (D9246-D9247).

For dental procedures involving general or IV anesthesia, the provider must document the actual start and end times of anesthesia in the patient's dental record.

1. Anesthesia time begins when the provider administers the anesthetic agent and initiates the appropriate anesthesia and non-invasive monitoring protocols, remaining in continuous attendance with the patient. Anesthesia services are considered complete when the patient can be safely left under the observation of trained personnel, allowing the provider to leave the room. Anesthesia time will not include any period during which the doctor chooses to remain with the patient for recovery when other qualified personnel can provide safe supervision.
2. The level of anesthesia is determined by the documentation of the anesthetic's effect on the central nervous system, rather than the method of administration.
3. Providers performing anesthesia must be appropriately licensed by the state regulatory body and adhere to all monitoring and staffing requirements set by that body.
4. Liberty covers general anesthesia (GA) or intravenous (IV) sedation in a dental office setting only when medical necessity is demonstrated through the following conditions and guidelines:
 - a. A medical condition requiring monitoring (e.g., cardiac issues, severe hypertension);
 - b. An underlying medical condition that would make the patient non-compliant without GA or IV sedation (e.g., cerebral palsy, epilepsy, developmental or intellectual disabilities, Down syndrome);
 - c. Documentation of failed conscious sedation (if applicable);

- d. A condition where severe infection would make local anesthesia ineffective.
5. **Documentation Requirements:** The medical necessity for using general anesthesia (GA) or IV sedation in a dental office setting must be clearly documented in the patient's dental record. A narrative detailing the medical necessity for anesthesia or sedation must be included with all claim submissions. A complete anesthesia or sedation log is also required.
 6. The following oral surgical procedures may be eligible for GA or IV sedation:
 - a. Extraction of impacted teeth;
 - b. Surgical removal of roots from the maxillary sinus (antrum);
 - c. Surgical exposure of impacted or unerupted cuspids (for orthodontic cases, prior approval of the orthodontic treatment is required);
 - d. Radical excision of lesions greater than 1.25 cm;
 - e. Children under the age specified by applicable state regulations with a complex treatment plan may qualify for GA or IV sedation.
 7. Analgesia and additional IV sedation (D9230 – D9243) require documentation to demonstrate the medical necessity for alleviating discomfort or anxiety associated with dental treatment.

Administration of nitrous oxide (D9230). When nitrous oxide is administered as a single agent. The administration of nitrous oxide for anxiolysis should be determined based on the patient's medical and behavioral conditions, the complexity of the dental procedure, and whether alternative behavioral modification methods are being used.

For children over the age of 12, the narrative must clearly describe the specific severe behavioral issue, the relevant medical or behavioral condition, and/or the complexity of the dental treatment being provided.

Note: All claims for sedation must include a sedation log corresponding to the procedure.

Drugs or medicaments dispensed in the office for home use (9630) should not be reported for irrigation with chlorhexidine.

Bleaching Procedures (D9972 – D9975). Bleaching procedures are primarily performed for esthetic purposes and are therefore considered **cosmetic in nature**. Because bleaching is considered a cosmetic procedure, these codes are generally not covered under most dental plans.

Key Points:

- Dentists should advise patients that bleaching does not treat disease, restore function, or replace necessary restorative care.
- **All necessary restorative treatment should be completed prior to initiating bleaching procedures** to ensure optimal outcomes and to avoid the need for shade correction after restorations are placed.
- When bleaching is performed, clinical documentation should note the indication, method (e.g., in-office application, take-home trays, internal bleaching), and the teeth or arches treated.
- Reimbursement, if available, will follow **plan-specific provisions**; providers are responsible for verifying coverage prior to treatment.
- **Special Note on Internal Bleaching (D9974, D9975):**
Internal bleaching of non-vital teeth may occasionally be considered when associated with discoloration following endodontic treatment. Coverage is plan-dependent and not routinely included.