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HEALTHPLEX REFERENCE MANUAL FOR DENTAL SERVICES: FUNDAMENTAL PLANS

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

A. Accessibility Statement

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

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

Please contact Healthplex Customer Service for help with questions, language and/or interpretative services by phone at 1-800-468-9868 or email to: info@healthplex.com.

B. Introduction

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

This document includes information pertaining to the most frequently billed services. Exceptions to published limitations are given on a case-by-case basis considering individual factors including but not limited to age, comorbidities, special needs and access to the local delivery system. This document is a supplement to be used in conjunction with the Dental Policy and Procedure Code Manual published by New York State as well as the applicable contract between the enrollee and/or the Health Plan and Healthplex.

C. Dental Benefit Administration

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

If a patient is enrolled in a managed care plan that provides coverage for essential services, benefits are available when services are rendered by an in network or participating provider only. For a list of participating providers, please go online to: http://www.yourdentalplan.com/healthplex.

Participating providers are contracted to accept the reimbursement for each covered dental service as payment in full up to the plan's benefit maximum (if applicable). The member will still be responsible for copayments and deductibles where applicable.

Coverage must be in force at the time a service is rendered in order for benefits to be payable. Eligibility must be checked prior to rendering services for every appointment.

D. Healthplex Clinical Criteria

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

Criteria are created from an aggregate of information from:

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

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

E. The Professional Review Process

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

Clinical Reviewers shall evaluate requested services based on plan specific guidelines, clinical application of review criteria, patient condition, and health history. Based on an aggregate of these factors, the Reviewer shall indicate if the services are approved, denied, or if further information is needed to render a determination. Individual cases may be elevated to a Dental Director and/or their designated representative for consideration of special circumstances as necessary.

When diagnostic information is needed for a clinical reviewer to render a determination, it must be supplied with the request for dental services. If necessary information is not submitted in a timely manner, the request for services will be denied.

F. Scope of Coverage for Essential Services Programs

Programs like Essential Health Plan, Child Health Plus, Exchange and Affordable Care Act Marketplace and Medicaid provide coverage for essential dental services rather than comprehensive care.

Healthplex makes decisions for requested dental services by utilizing the New York State's definition of essential services as described in the Dental Policy and Procedure Code Manual extracted from Version 2024 below:

"When reviewing requests for services the following guidelines will be used:

Caries index, periodontal status, recipient compliance, dental history, medical history and the overall status and prognosis of the entire dentition, among other factors, will be taken into consideration when considering medical necessity. Treatment is considered appropriate when the prognosis of the tooth is favorable. Treatment may be appropriate where the total number of teeth which require or are likely to require treatment is not considered excessive or when maintenance of the tooth is considered essential or appropriate in view of the overall dental status of the recipient. Treatment of deciduous teeth when exfoliation is reasonably imminent will not be routinely reimbursable. Claims submitted for the treatment of deciduous cuspids and molars for children ten (10) years of age or older, or for deciduous incisors in children five (5) years of age or older may be pended for professional review. As a condition for payment, it may be necessary to submit, upon request, radiographic images and other information to support the appropriateness and necessity of these restorations. Extraction of deciduous teeth will only be reimbursed if injection of a local anesthetic is required.

As utilized in the Manual eight (8) posterior points of contact refers to four (4) maxillary and four (4) mandibular (molars/premolars) in natural or prosthetic functional contact with each other."

For the criteria to be used when determining medical necessity for Crowns, Endodontics, Prosthodontics and Implant Services, refer to the specific sections in the Policy and Procedure Manual

One (1) missing maxillary anterior tooth or two (2) missing mandibular anterior teeth may be considered an esthetic problem that warrants a prosthetic replacement."

In each procedure code category contained within the detail of this document, Healthplex explains how it applies the principle of essential dentistry to each request for services.

G. **General Exclusions include but are not limited to:**

1. Fixed bridgework, except for cleft palate stabilization, or when a removable prosthesis would be contraindicated
2. Immediate full or partial dentures
3. Crown lengthening, except when associated with medically necessary crown or endodontic treatment.
4. Dental work for cosmetic reasons or because of the personal preference of the member or provider
5. Periodontal surgery, except when associated with implants or implant related services
6. Gingivectomy or gingivoplasty, except for the sole correction of severe hyperplasia or hypertrophy associated with drug therapy, hormonal disturbances or congenital defects
7. Adult orthodontics, except in conjunction with, or as a result of, approved orthognathic surgery necessary in conjunction with an approved course of orthodontic treatment or the on-going treatment of clefts
8. Placement of sealants for members under 5 or over 15 years of age
9. Improper usage of panoramic images (D0330) along with intraoral complete series of images (D0210)
10. Services that are directly related to a non-approved procedure may not be considered for reimbursement
11. Dental treatment rendered by a non-participating provider are not covered. The member will be responsible for all costs incurred as a result of treatment rendered out of network
12. Crowns for patients under age 6 and/or prosthetics (bridgework/dentures) for patients under age 16 unless request was submitted with documentation to substantiate medical necessity
13. Services outside the scope of coverage will not be considered for reimbursement. For a list of covered procedure codes applicable to a program that follows the essential scope of coverage as defined by New York State, please view the Fee Schedule available online at: https://www.emedny.org/ProviderManuals/Dental/index.aspx
14. Procedures which are medical in nature should be the responsibility of the medical plan or liabilty insurer.

H. Services Which Do Not Meet Existing Standards of Professional Practice Are Not Reimbursable These services include but are not limited to:

1. Partial dentures provided prior to completion of all Phase I restorative treatment which includes necessary extractions, removal of all decay and placement of permanent restorations
2. Other dental services rendered when teeth are left untreated
3. Extraction of clinically sound teeth
4. Treatment provided when there is either no clinical indication of need noted in the treatment record or rendered in excess of standards. Procedures should not be performed without documentation of clinical necessity. Published "frequency limits" are general reference points on the anticipated frequency for that procedure. Actual frequency must be based on the clinical needs of the individual member
5. Restorative treatment of teeth that have a hopeless prognosis and should be extracted
6. Taking of unnecessary or excessive radiographic images
7. Services not completed
8. "Unbundling" of procedures
9. Treatment of deciduous teeth when exfoliation is reasonably imminent
10. Extraction of deciduous teeth without clinical necessity
11. General dental services or services outside the scope of a limited practice that are rendered by a specialty provider unless prior authorized

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I. **Statement About Incentives**

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

1. A percentage of the amount by which a claim is reduced for payment or the number of claims or the cost of services for which the person has denied authorization or payment; or

2. Any other method that encourages the rendering of an adverse determination.

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

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COVERED PROCEDURES

I. DIAGNOSTIC SERVICES

Summary

Diagnostic Summary

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

Examinations

B. Comprehensive Evaluation

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

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

Periodic Evaluation

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

Reimbursement is generally limited to one exam (periodic, consultation focused) per provider group every 6 months and includes diagno planning and oral cancer screening.

Limited Evaluation – Problem Focused

A limited evaluation is performed when a patient presents with a specific problem, complaint and/or dental emergency. Follow-up visits related to previous treatment are not billable and therefore shall not be considered for separate reimbursement.

If a limited/problem focused evaluation does not share a limitation with other types of evaluations, reimbursement is generally allowed once every six months and is not separately payable if rendered on the same day as another exam or consultation.

Radiographs

E. Radiograph Summary

To minimize a patient's radiation exposure, Healthplex recommends that providers exercise professional judgment and utilize the guidelines for prescribing dental radiographs published by the American Dental Association in collaboration with the U.S. Food & Drug Administration available online on the ADA website.

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

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

F. Recall x-rays

Recall x-rays typically consist of bitewings and periapical radiographs. Recall x-rays are payable 2 times per 12 months.

G. Complete or Comprehensive Series of Radiographic Images

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

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

H. Panoramic Radiographs

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

I. Intraoral Occlusal Radiographs

Reimbursement is typically limited to twice every 36 months.

J. Cone Beam Computed Tomography (CBCT) Scans

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

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

If approved, one cone beam scan OR intraoral tomosynthesis image is allowed every 36 months.

K. Cephalometric Radiographs

Cephalometric radiographs are payable once every 36 months to an orthodontist or oral surgeon for diagnostic purposes related to orthodontic treatment only.

Diagnostic Casts

L. Diagnostic Casts

Diagnostic casts are payable to an orthodontist for diagnostic purposes related to orthodontic treatment only.

Diagnostic casts related to prosthetics are considered included in the allowance for the related billable service.

II. PREVENTIVE SERVICES

Summary

Preventive Summary

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

Prophylaxis

Prophylaxis (Cleaning)

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

Reimbursement is routinely allowed once every 6 months. Beneficiaries with disabilities are eligible for prophylaxis as often as every three months.

Fluoride

C. Topical Application of Fluoride – Excluding Varnish

Topical Fluoride treatments in the form of gel, foam, and rinses applied in dental office as a caries preventive agent. Topical application of fluoride is allowed once every 6 months for patients up to age 20. Beneficiaries with disabilities (adults and children) are eligible for topical fluoride as often as every three months.

D. Topical Application of Fluoride Varnish

Topical application of fluoride varnish Reimbursable once per three (3) month period for members, from eruption of first tooth is through age 20 (inclusive). For individuals 21 years of age and older D1206 is only approvable for those individuals identified with a Restriction Exception code of RE 81 (“TBI Eligible”) or RE 95 (“OPWDD/Managed Care Exemption”), or, in cases where salivary gland function has been compromised through surgery, radiation, or disease.

Sealants

Sealants

Sealants should be applied to occlusal surfaces (and buccal/lingual pits and grooves when applicable) of previously unrestored and caries free erupted first and second permanent molars. Tooth number is required. Buccal and lingual grooves are included in the reimbursement per tooth.

Sealants are indicated for the following:

- Caries prevention in pit and fissures on permanent molars
- Non-cavitated carious lesions
- Caries prevention in previously unrestored permanent first and second molars that exhibit no signs of occlusal or proximal caries

Sealants are not indicated for the following:

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

Sealants shall be limited to once every 60 months for patients between the ages of 5 and 15 (inclusive).

Space Maintainer

Space Maintainers

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

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

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

Exclusions:

- Dental services that are not Necessary

Limitations:

- Reimbursement once per year for both unilateral (per quadrant) and bilateral (per arch) appliances, when medically necessary.
- Any Space Maintainer adjustments are inclusive for 6 months.
- Only fixed appliances are reimbursable.
- Re-cementation is payable once every year.
- Removal of a fixed appliance is limited to once per lifetime to an office other than that of the original rendering provider.
- Refer to the benefit brochure for applicable age limitations.

III. RESTORATIVE SERVICES

Summary

A. Restorative Summary

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

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

Occlusal correction is considered part of the restoration and will not be separately billable or reimbursed.

Coverage Limitations and Exclusions

Published frequency limits are general reference points on the anticipated frequency for that procedure [and that] actual frequency must be based on the clinical needs of the individual member.

1. Restoration of the tooth must be determined essential by using the criteria for approval as defined in the section titled '**Scope of Coverage for Essential Services Programs**' on pages 3-4 of this manual
2. Dental Services that are not necessary
3. Any dental procedure performed solely for cosmetic/aesthetic reasons (cosmetic procedures are those procedures that improve physical appearance)
4. Any dental procedure not directly associated with dental disease
5. All indirect restorations like crowns, bridge abutments, pontics, inlays, onlays, post and core are covered once per tooth per 60 consecutive months
6. Restorations placed solely for abrasion, attrition or for cosmetic purposes are beyond the scope of the program
7. Prefabricated resin crowns are allowed once every 24 months

Amalgam & Composite Restorations

Direct Restorations

Direct Restorations are indicated for the following:

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

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

- When teeth cannot be isolated properly to allow placement of resin restorations
- As an alternative to resin sealants when the teeth cannot be properly isolated (patient cooperation, partially erupted teeth)

- Class I, II, III and V restorations on primary teeth
- Class III and V restorations on permanent teeth that cannot be isolated in high-risk patients
- As a caries control plan for high-risk patients using atraumatic techniques

Direct Restorations are not indicated for the following:

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

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

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

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

C. Protective Restoration

A protective restoration is indicated for the following:

A. To relieve pain
B. To promote healing
C. To prevent further deterioration
D. To retain tissue form

A protective restoration is not indicated for the following:

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

D. Interim Therapeutic Restoration - Primary Dentition Interim

Therapeutic restorations are indicated for the following:

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

E. Resin Infiltration of Incipient Smooth Surface Lesions

This service is typically used for treating white spots, demineralized enamel from orthodontic treatment, for aesthetic purposes. The code describes a proprietary product (Icon Smooth Surface Caries Infiltration, DMG America Ridgefield park, New Jersey) and will not be reimbursed due to insufficient evidence of efficacy.

Post and Core

F. Post and Core

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

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

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

Restoration of the tooth must be determined essential by using the criteria for approval as defined in the section titled '**Scope of Coverage for Essential Services Programs**' on pages 3~~-4~~ of this manual.

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

Reimbursement for a post and core is available once every 60 months.

Crowns

G. Crowns

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

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

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

Restoration of the tooth must be determined essential by using the criteria for approval as defined in the section titled '**Scope of Coverage for Essential Services Programs**' on pages 3-4 of this manual.

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

Crowns include any necessary core buildups.

Crowns are indicated for the following:

- If restoring the tooth is determined essential by using the criteria for approval as defined in the section titled '**Scope of Coverage for Essential Services Programs**' on pages 3-4 of this manual.
- Extensive caries or tooth fractures
- To replace large defective restorations
- Complete cusp fractures
- Endodontically treated teeth (unless only need to restore the access opening on an anterior tooth) that are asymptomatic with a good apical seal
- Symptomatic "cracked tooth syndrome" (not enamel craze lines)
- Full coverage restoration of a primary tooth without a permanent successor

- Crowns for members under the age of 21 will be covered when medically necessary. In determining whether a requested crown is medically necessary, the following factors may be considered:
    - The periodontal status, member compliance and overall status and prognosis of the tooth is favorable.
    - The tooth is not routinely restorable with a filling.

- Crowns for members 21 years of age and over will be covered when medically necessary. In determining whether a crown is medical necessary, the following factors may be considered:
    - There is a documented medical condition which precludes extraction.
    - The tooth is a critical abutment for an existing or proposed prosthesis.
    - If the tooth is a posterior tooth, the following additional factors may be considered:
    - The periodontal status, member compliance and overall status and prognosis of the tooth is favorable.
    - The tooth is not routinely restorable with a filling.
    - There are eight (8) or more natural or prosthetic points of contact present.

- If the posterior tooth is a molar, treatment of the molar is necessary to maintain functional or balanced occlusion of the patient's dentition.
- Consideration for a third (3rd) molar will be given if the third (3rd) molar occupies the first (1st) or second (2nd) molar position.

• Note: Requests for treatment on unopposed molars MUST include a narrative documenting medical necessity

If the tooth is an anterior tooth, the following additional factors may be considered:

- The periodontal status, member compliance and overall status and prognosis of the tooth is favorable.
- The tooth is not routinely restorable with a filling.

Caries index, periodontal status, and the overall status and prognosis of the entire dentition, as well as recipient compliance, dental history, and medical history, among other factors, will be taken into consideration when determining medical necessity. Treatment is considered appropriate where the prognosis of the tooth is favorable. Treatment may be appropriate where the total number of teeth which require or are likely to require treatment is not considered excessive or when maintenance of the tooth is considered essential or appropriate in view of the overall dental status of the recipient.

A crown may be considered if there is a medical condition which contraindicates extraction.

Coverage Limitations:

Published frequency limits are general reference points on the anticipated frequency for that procedure [and that] actual frequency must be based on the clinical needs of the individual member.

1. Limited to 1 restoration per natural or prosthetic tooth per consecutive 60 months without regard to the material used or type of restoration placed (standard crown, inlay, onlay, pontic, bridge abutment, or implant crown)
2. A crown will not be approved is the tooth can be reasonably restored with filling

Exclusions:

3. Replacement of indirect restorations if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the dental provider. If replacement is due to patient non-compliance, it may not be medically necessary
4. Fixed restoration procedures for complete oral rehabilitation reconstruction
5. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion and/or TMJ
6. Laboratory based Crowns for the purposes of provisional splinting

IV. ENDODONTIC SERVICES

Summary

A. Endodontic Summary

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

Restoration of the tooth must be determined essential by using the criteria for approval as defined in the section titled '**Scope of Coverage for Essential Services Programs**' on pages 3-4of this manual.

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

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

Endodontic therapy is indicated for the following:

- If restoring is determined essential by using the criteria for approval as defined in the section titled '**Scope of Coverage for Essential Services Programs**' on pages 3-4of this manual.
- A restorable, mature, completely developed permanent or primary tooth with irreversible pulpitis, necrotic pulp, or frank vital pulpal exposure
- Teeth with radiographic periapical pathology
- Primary teeth without a permanent successor
- When needed for prosthetic rehabilitation

Caries index, periodontal status, and the overall status and prognosis of the entire dentition, as well as recipient compliance, dental history, and medical history, among other factors, will be taken into consideration when determining medical necessity. Treatment is considered appropriate where the prognosis of the tooth is favorable. Treatment may be appropriate where the total number of teeth which require or are likely to require treatment is not considered excessive or when maintenance of the tooth is considered essential or appropriate in view of the overall dental status of the recipient.

Pulpotomy

B. Pulpotomy

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

Reimbursement for a pulpotomy is available once per tooth for a patient up to age 20.

Therapeutic Pulpotomy is indicated for the following:

- Exposed vital pulps or irreversible pulpitis of primary teeth where there is a reasonable period of retention expected (approximately one year)
- As an emergency procedure in permanent teeth until root canal treatment can be accomplished
- As an interim procedure for permanent teeth with immature root formation to allow continued root development

Therapeutic Pulpotomy is not indicated for the following:

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

Pulpal Therapy

C. Pulpal Therapy

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

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

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

Root Canal Therapy

D. Root Canal Therapy

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

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

Requests for endodontic therapy or retreatment require clinical review of pre-operative radiographs and a full mouth treatment plan.

Restoration of the tooth must be determined essential by using the criteria for approval as defined in the section titled '**Scope of Coverage for Essential Services**

Programs' on pages 3-4 of this manual.

For a patient age 21 and over, endodontic therapy will be covered when medically necessary. In determining whether endodontic treatment is medically necessary, the following factors may be considered:

- There is documented medical condition which precludes extraction of the tooth.
- The tooth is a critical abutment for an existing or proposed prosthesis.
- If the tooth is a posterior tooth, the following additional factors may be considered:
    - The periodontal status, member compliance and overall status and prognosis of the tooth is favorable.
    - There are eight (8) or more natural or prosthetic posterior points of contact present
    - If the posterior tooth is a molar, treatment of the molar is necessary to maintain functional or balanced occlusion of the patient's dentition
    - Consideration for a third molar will be given if the third molar occupies the first or second molar position
    - Note: requests for treatment on unopposed molars must include a narrative documenting medical necessity

If the tooth is an anterior tooth, the following additional factors may be considered:

- The periodontal status, member compliance and overall status and prognosis of the tooth is favorable

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

Apicoectomy

E. Apicoectomy

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

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

- If restoration of the tooth is determined essential by using the criteria for approval as defined in the section titled '**Scope of Coverage for Essential Services Programs**' on pages 3-4 of this manual.
- Overfilled canal (previously treated tooth) or displaced root canal filling irritating periapical tissues
- Canal cannot be filled properly due to excessive root curvature or calcification, fractured root tip, broken instrument in canal, or perforation of the apical third of canal
- Periapical pathology not resolved by previous endodontic therapy

- A post which cannot be removed.

Reimbursement for apicoectomy is once per tooth.

Apexification

F. Apexification

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

Apexification/Recalcification is indicated for the following:

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

Apexification/Recalcification is not indicated for the following:

- Tooth with a completely closed apex

Reimbursement for apexification is once per tooth.

V. PERIODONTIC SERVICES

Summary

A. Periodontic Summary

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

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

The most common covered periodontic services are periodontal scaling & root planing and gingivectomy/gingivoplasty. Clinical criteria apply to all covered periodontic procedures, therefore prior authorization for these services is recommended.

Exclusions:

1. Any Dental Procedure performed solely for cosmetic/aesthetic reasons
2. Any Dental Procedure not directly associated with dental disease
3. Procedures that are considered to be Experimental, Investigational or Unproven
4. Dental Services that are not Necessary
5. Periodontal procedures related to implant treatment will not be covered if the corresponding implant is not covered
6. Periodontal surgery (except for gingivectomy/gingivoplasty), which is not within the scope of the services covered by the program
7. Periodontal splinting is not covered

Periodontal scaling & root planning (SRP)

B. Scaling & Root Planing

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

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

the CEJ (cemento/enamel junction).

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

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

Only two quadrants are payable on a single date of service. Reimbursement for each quadrant is available once every 24 months.

Periodontal Surgery

C. Periodontal Surgery

Covered periodontal surgery includes gingivectomy/gingivoplasty only. This service is reimbursable solely for the correction of severe hyperplasia or hypertrophy associated with drug therapy, hormonal disturbances or congenital defects.

Current periodontal charting and/or photos in conjunction with appropriate radiographs and a narrative substantiating the causative factor(s) should be submitted for clinical review for prior authorization.

If less than 4 teeth are present in the quadrant, a partial quadrant will allowed.

If approval criteria is met, the service is covered once per quadrant every 12 months.

Bone Graft & Ancillary Procedures

D. Bone Grafts and Related Ancillary Procedures

Covered procedure codes will only be approved if a corresponding implant has been approved. as meeting the criteria for medical necessity. Please refer to the criteria within the 'Implants' section of this manual.

Periodontal Maintenance

E. Periodontal Maintenance

This procedure is considered duplicative of a standard cleaning (prophylaxis). Enrollees are allowed to have two periodontal maintenance procedures every 12 months OR one cleaning every 6 months.

VI. PROSTHETIC SERVICES

Summary

A. Prosthetic Summary

Prosthetic services most commonly include removable dentures. Clinical criteria apply to all covered prosthetics without regard to material, therefore prior authorization for these services is recommended.

Fixed partial dentures are not generally considered within the scope of services covered by the program. If extenuating circumstances exist, please submit a prior authorization request with a narrative for consideration.

Implants shall be considered when the stringent medical necessity criteria is met and shall only be considered if other covered functional alternatives for prosthetic replacement will not correct the patient's dental condition.

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

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

Approval for prosthetic services like dentures is generally available once per arch every 8 years or consecutive 96 months. Consideration of replacement shall be based on documented medical necessity and individual circumstances.

Removable Prosthetic Services

B. Removable Prosthetics

Full and/or partial dentures are covered by Medicaid when they are determined to be medically necessary, including when necessary to alleviate a serious condition or one that is determined to affect employability. This service requires prior approval. Complete dentures and partial dentures, whether unserviceable, lost, stolen, or broken will not be replaced for a minimum of eight (8) years from initial placement except when determined to be medically necessary by the Department or its agent. Prior approval requests for replacement dentures prior to eight (8) years must include a completed Form **Justification of Need for Replacement Prosthesis Form** signed by the patient's dentist, explaining the specific circumstances that necessitates replacement of the denture. If replacement dentures are requested within the eight (8) year period after they have already been replaced once, then the dentist's supporting documentation must include an explanation of preventative measures instituted to alleviate the need for further replacements.

General Guidelines for All Removable Prosthesis:

- Requests for partial dentures will be reviewed based on the presence/absence of eight (8) points of natural or prosthetic posterior occlusal contact and/or one (1) missing maxillary anterior or two (2) missing mandibular anterior teeth.
- Complete and/or partial dentures will be approved only when the existing prosthesis is not serviceable and cannot be relined or rebased. Reline or rebase of an existing prosthesis will not be reimbursed when such procedures are performed in addition to a new prosthesis for the same arch within six (6) months of the delivery of a new prosthesis. Only "tissue conditioning" (D5850 or D5851) is payable within six (6) months prior to the delivery of new prosthesis.
- Six (6) months of post-delivery care from the date of insertion is included in the reimbursement for all newly fabricated prosthetic appliances. This included rebasing, relining, adjustments, and repairs. Cleaning of removable prosthesis or soft tissue not directly related to natural teeth is not a covered service. Prophylaxis and/or scaling and root planning is only payable when performed on natural dentition.
- "Immediate" prosthetic appliances are not a covered service. An appropriate length of time for healing should be allowed before taking a final impression. Generally, it is expected that tissue will need a minimum of four (4) to six (6) weeks for healing. Claims for denture insertion occurring within four (4) weeks of extraction(s) will pend for professional review.
- Claims are not to be submitted until the denture(s) are completed and delivered to the member. The "date of service" used on the claim is the date that the denture(s) are delivered. If the prosthesis cannot be delivered or the member has lost eligibility following the date of the "decisive appointment" claims should be submitted following the guidelines for "Interrupted Treatment".
- Medicaid payment is considered payment in-full. Except for members with a "spend down," members cannot be charged beyond the Medicaid fee. Deposits, down-payments, or advance payments are prohibited.
- An implant supported prosthetic shall be considered using the medical necessity criteria related to the implants. Please refer to the Implant section below.

C. Implant Supported Dentures

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

Denture Repairs, Relines, and Adjustments

D. Repair/Reline/Adjust

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

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

Reimbursement for chair-side relines are available once every 12 months. Reimbursement for indirect relines are available once every 24 months. Adjustments are allowed 4 times per year after the 6 month period following delivery.

E. Rebase and Reline Procedures

Denture Rebasing is indicated for the following and is usually covered once every 5 years:

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

Denture Rebasing is not indicated for the following:

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

Denture Relining is indicated for the following:

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

Denture Rebasing and Relining are not indicated for the following:

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

Coverage Limitations

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

Tissue Conditioning

F. Tissue Conditioning

Reimbursement is available once every 5 years.

Implant Services

G. Implants

Dental implants, including single implants, and implant related services will be covered by Medicaid when medically necessary. Prior approval requests for implants must have supporting documentation from the patient's dentist. The patient's dentist's office must submit a completed Form **Evaluation of the Dental Implant Patient Form** documenting, among other things, the patient's medical history, current medical conditions being treated, list of all medications currently being taken by the patient, explaining why implants are medically necessary and why other covered functional alternatives for prosthetic replacement will not correct the patient's dental condition, and certifying that the patient is an appropriate candidate for implant placement. If the patient's dentist indicates that the patient is currently being treated for a serious medical condition, the Department may request further documentation from the patient's treating physician

General Guidelines: The dentist's explanation as to why other covered functional alternatives for prosthetic replacement will not correct the patient's dental condition will be reviewed based on the presence/absence of eight (8) points of natural or prosthetic posterior occlusal contact and/or one (1) missing maxillary anterior or two (2) missing mandibular anterior teeth.

- A complete treatment plan addressing all phases of care is required and should include the following:
    - Accurate pretreatment charting;
    - Complete treatment plan addressing all areas of pathology;
    - Inter-arch distances;
    - Number, type and location of implants to be placed;
    - Design and type of planned restoration(s);
    - Sufficient number of current, diagnostic radiographs and/or CT scans allowing for the evaluation of the entire dentition

- If bone graft augmentation is needed there must be a 4 to 6-month healing period before a dental implant can be placed

- Dental implant code D6010 will be re-evaluated via intraoral radiographs or CT scans prior to the authorization of abutments, crowns, or dentures four to six months after dental implant placement.
- Treatment on an existing implant/implant prosthetic will be evaluated on a case-by-case basis.
- Documentation must include a list of all medications currently being taken and all conditions currently being treated.
- All cases will be considered based upon supporting documentation and current standards of care.

Fixed Bridgework	**H. Bridgework** Fixed partial dentures are not generally considered within the scope of services covered by the program except for cleft palate stabilization, or when a removeable prosthesis would be contraindicated. If extenuating circumstances exist, please submit a prior authorization request with a narrative for consideration.

VII. ORAL AND MAXILLOFACIAL SURGICAL SERVICES

Summary

A. Oral Surgery Summary

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

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

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

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

Extractions

B. Extractions

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

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

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

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

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

Excision and Biopsy

C. Excision

Excision of tissue, particularly cyst removal, requires supporting documentation when billed as an adjunct to tooth extraction.

Excision and biopsy submitted on the same day is considered a duplicate service. Benefit only for the excision shall be considered.

D. Biopsy

Removal or biopsy of a periapical granuloma, dentigerous or odontogenic cyst is generally considered an integral part of the extraction and is not separately billable. Any claim for a biopsy must be accompanied with a biopsy report.

Incision and Drainage

E. Incision and Drainage

Incision and drainage procedures include the insertion and removal of drain(s). When submitted on the same day as another definitive service in the same quadrant, supporting documentation (i.e. radiographs or treatment record) is required for consideration for separate reimbursement.

Alveoloplasty

F. Alveoloplasty

When submitted in conjunction with surgical extractions in the same quadrant, alveoloplasty is considered included in the allowance for the surgical service and not reimbursable as a separate procedure.

If submitted without extractions in the same quadrant, a narrative substantiating medical necessity is required.

If alveoloplasty is performed for less than 4 teeth or tooth spaces in the quadrant, a partial quadrant will be allowed.

Other Surgical Services

G. Other

For all other covered oral surgical services, please submit pre-operative radiographs with a narrative substantiating medical necessity for consideration.

VIII. ORTHODONTIC SERVICES

Summary

A. Orthodontic Summary

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

For comprehensive orthodontic treatment, if the total score on the HLD Assessment Tool is equal to or greater than 26, the pre-orthodontic treatment work-up can proceed. If the total score on the HLD Assessment Tool is less than 26 points, please submit documentation of the extenuating functional difficulties and/or medical anomaly with the submission.

Orthodontic treatment is only covered if treatment that meets the criteria for approval is started prior to the patient's 21st birthday.

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

Providers will generally be reimbursed for orthodontic treatment that meets the criteria for approval at a negotiated case rate. The provider shall continue a course of treatment to completion and will be reimbursed the case rate for completed treatment without regard for the length of time necessary to complete such treatment plan.

Limited Orthodontic Treatment

B. Limited

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

For prior authorization the following shall be submitted:

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

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

Comprehensive Orthodontic Treatment

C. Comprehensive

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

For prior authorization requests the following shall be submitted:

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

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

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

- The prior authorization request to start a case must include treatment visits.

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

Documentation for Completion of Comprehensive Cases – Final Records

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

Prior Authorization for Orthodontic Services Transferred or Started Outside of the Program

For continuation of care for transfer cases, a prior authorization must be submitted to request the remaining treatment visits for case completion. The following must be submitted with the prior authorization:

- A copy of the initial orthodontic case approval if applicable;
- A copy of the orthodontic treatment notes if available from provider that

started the case;
- Recent diagnostic photographs; and,
- The date when active treatment was started and the expected number of months for active treatment.

IX. ADJUNCTIVE GENERAL SERVICES

Summary

A. Summary

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

Palliative Treatment

B. Palliative

Reimbursement is per visit and is generally limited to twice every 12 months and is not separately payable if rendered on the same day as another payable procedure other than diagnostic services.

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

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

Inhalation, Non Intravenous Conscious Sedation and General Anesthesia	**C. Sedation** Inhalation of Nitrous Oxide/Analgesia, Anxiolysis and Non-Intravenous Conscious Sedation are separately reimbursable for members/enrollees through 20 years of age (inclusive) with documentation of clinical necessity and in conjunction with covered dental services. For members/enrollees 21 years of age and older, D9230 and D9248 are only approvable for those members/enrollees identified with a intellectual/developmental disability. Intravenous conscious sedation and general anesthesia are payable only if the provider holds a current certification and licensure to administer such anesthesia per state and federal guidelines. For cases requiring intravenous sedation or general anesthesia, providers must retain the anesthesia record which documents time and amounts of drugs administered, pulse rate, blood pressure, respiration, etc. in the patient's treatment record. Healthplex recommends that providers exercise professional judgment when diagnosing the necessity for administration of intravenous sedation or general anesthesia. Apprehension alone is not typically considered a medical necessity. Anesthesia/sedation procedures within the scope of coverage will be allowed only if the corresponding dental treatment has been approved by Healthplex.
Consultation (D9310)	**D. Consultation** A consultation includes an oral evaluation and will only be reimbursed to a specialist. Reimbursement for a consultation is generally limited to once per 6 months (per treatment plan).
Guard Occlusal	**E. Occlusal Guard** One occlusal guard is allowed every 12 months.