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## HEALTHPLEX CLINICAL CRITERIA FOR DENTAL SERVICES: LIMITED BENEFIT & COMPREHENSIVE SERVICES

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### Introduction

The Healthplex clinical criteria applies 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.

Healthplex's Clinical 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](http://www.perio.org));
- Parameters of Care from the American Association of Oral and Maxillofacial Surgery ([www.aaoms.org](http://www.aaoms.org));
- Oral Health Policies and Clinical Guidelines from the American Academy of Pediatric Dentistry ([www.aapd.org](http://www.aapd.org));
- Position Statements from the American Association of Dental Consultants ([www.aadc.org](http://www.aadc.org));
- Dental Practice Parameters from the American Dental Association ([www.ada.org](http://www.ada.org));
- Evaluation of new and emerging technologies from participating dental professionals; and
- Public information from other insurance companies.

Criteria are reviewed and approved at least annually by Healthplex's Utilization Management Committee, whose clinical members 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, a Periodontist and a Registered Nurse.

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.

### **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.

### **The Professional Review Process**

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

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

### **Scope of Coverage for Comprehensive Services Programs**

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

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

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

### **Statement About Incentives**

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

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

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

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# COVERED PROCEDURES

## A. DIAGNOSTIC SERVICES

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### **Diagnostic Procedures 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.

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### **Comprehensive Evaluation**

A comprehensive evaluation is a thorough examination and recording of the extraoral and intraoral hard and soft tissues.

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.

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.

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

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### **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 limited to one exam (comprehensive or periodic) every 6 months and includes diagnosis, treatment planning and oral cancer screening.

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### **Limited Evaluation – problem focused**

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

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

Reimbursement is generally limited to once every six months and is not separately payable if rendered on the same day as another exam or consultation.

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## Radiographs

To minimize a patient's radiation exposure, Healthplex recommends that providers exercise professional judgment and utilize the guidelines for prescribing dental radiographs published by the American Dental Association in collaboration with the U.S. Food & Drug Administration available online at: [http://www.ada.org/~media/ADA/Member%20Center/Files/Dental\\_Radiographic\\_Examinations\\_2012.ashx](http://www.ada.org/~media/ADA/Member%20Center/Files/Dental_Radiographic_Examinations_2012.ashx).

A complete series (to be comprised of individual radiographs or a panoramic radiograph plus bitewings) is payable once every 36 months. Panoramic radiographs are payable once every 36 months. Reimbursement is typically limited to either a complete series or a panoramic radiograph within the 36 month limitation.

The maximum reimbursement for individual radiographs shall be limited to the fee for a complete series.

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

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

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

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## 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 billable service.

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## **B. PREVENTIVE SERVICES**

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### **Preventive Services 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. Preventive procedures do not require prior approval or application of clinical criteria.

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### **Prophylaxis**

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.

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### **Fluoride**

Topical application of fluoride is allowed once every 6 months. Refer to the benefit brochure for applicable age limitations.

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### **Sealants**

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

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

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### **Space Maintainer**

A space maintainer is covered when indicated due to the premature loss of a primary tooth. Removal of a fixed appliance is limited to once per lifetime to an office other than that of the original rendering provider.

Lifetime reimbursement for a unilateral appliance is once per quadrant and for a bilateral appliance is once per arch. Refer to the benefit brochure for applicable age limitations.

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## C. RESTORATIVE SERVICES

### **Restorative Services Summary**

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

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

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

### **Amalgam & Composite Restorations**

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

Restorations are expected to last a reasonable amount of time but no less than 24 months.

Total restoration per tooth by amalgam and/or composite is not to exceed the allowable fee for a four surface restoration within 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.

### **Post and Core & Crowns**

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A request for a post and core and/or 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.

Consideration for post and core or core build-up is contingent upon the approval of the corresponding root canal and crown. Payment for a post and core and/or crown includes any adjustments or re-cementation necessary during the six month period following its initial placement.

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

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

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

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## D. ENDODONTIC SERVICES

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### **Endodontic Services Summary**

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

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

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

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### **Pulpotomy**

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

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

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### **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.

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### **Root Canal Therapy**

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

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

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

- ◆ Medical necessity
- ◆ Periodontal condition
- ◆ Restorative prognosis
- ◆ Missing teeth
- ◆ Presence of root resorption
- ◆ Integrity of the opposing dentition
- ◆ Existing or proposed prosthesis in the same or opposing arch

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

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### **Apicoectomy**

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

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

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

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

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### **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.

Reimbursement for apexification is once per tooth.

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## E. PERIODONTIC SERVICES

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### **Periodontic Services Summary**

The most common 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.

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.

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### **Periodontal scaling & root planing**

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

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

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

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

Reimbursement for each quadrant is available once every 24 months.

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### **Periodontal Surgery**

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

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

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

Reimbursement for each quadrant is available once every 12 months.

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

**Crown  
Lengthening**

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

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## F. PROSTHETIC SERVICES

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### **Prosthetic Services Summary**

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

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

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

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

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

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### **Removable Prosthetic Services**

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

Requests for replacement dentures whether unserviceable, lost, stolen, or broken prior to the applicable frequency limitation must include a letter from the patient's physician and dentist which explains the specific circumstances that necessitate replacement of the denture. The letter must clearly indicate how the denture(s) will alleviate the patient's serious health condition or improve employability.

For requests for a complete denture:

- ◆ If initial placement for a non-edentulous arch, a full mouth treatment plan and preoperative radiographs are required to substantiate medical necessity.
- ◆ If initial placement for an edentulous arch, the request shall be automatically approved.
- ◆ For replacement of an existing complete denture, prior insertion date and reason for replacement are needed for a determination of coverage.

For requests for a partial denture:

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

The determination of coverage will be based on:

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

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

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

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

Refer to the benefit brochure for frequency limitations for prosthetic replacements. Consideration of replacement outside of this expectation shall be based on documented medical necessity and individual circumstances.

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**Denture  
Repairs,  
Relines, and  
Adjustments**

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

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**Implant  
Services**

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

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

If bone grafting is necessary, there should be a 4-6 month healing period before the implant can be placed.

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

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**Fixed  
Bridgework**

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

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

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## G. ORAL AND MAXILLOFACIAL SURGICAL SERVICES

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### **Oral Surgical Services**

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

### **Summary**

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.

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### **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. The extraction of asymptomatic teeth or those teeth where medical/dental necessity cannot be demonstrated shall be disallowed.

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

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### **Excision and Biopsy**

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

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

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### **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.

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**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, please submit a narrative substantiating medical necessity.

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

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**Other Surgical Services**

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

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## H. ORTHODONTIC SERVICES

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### **Orthodontic Services Summary**

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

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

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

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

### **Limited Orthodontic Treatment**

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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.

### **Interceptive Orthodontic Treatment**

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If within the scope of coverage, consideration is given when interceptive orthodontic treatment may eliminate the need for or reduce the severity or duration of comprehensive orthodontic treatment. Approval for the interceptive treatment when not part of the comprehensive case will include all appliances, insertion, treatment visits, repairs, removal and retention. As a result, the provider shall complete the case even if eligibility is terminated.

For prior authorization requests the following shall be submitted:

- ◆ Narrative of clinical findings for dysfunction or deformity and dental diagnosis;

- ◆ Orthodontic treatment plan to include description of appliance(s);
- ◆ Diagnostic photographs;
- ◆ Diagnostic panoramic radiographs and cephalometric films with tracing (when applicable); and,

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

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**Comprehensive Orthodontic Treatment**

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

For prior authorization requests the following shall be submitted:

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

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

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

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

**Documentation for Completion of Comprehensive Cases – Final Records**

Attestation of case completion must be submitted on the provider’s letterhead to document that active treatment had a favorable outcome and that the case is ready

for retention. Procedure code D8680, orthodontic retention shall be submitted on the visit to remove the bands and place the case in retention.

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## I. ADJUNCTIVE GENERAL SERVICES

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### **Adjunctive General Services Summary**

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

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

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### **Palliative Treatment**

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

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

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

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### **Intravenous Conscious Sedation and General Anesthesia**

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.

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### **Consultation (D9310)**

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

Reimbursement for a consultation is generally limited to once per 3 months (per treatment plan).

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