UTILIZATAION MANAGEMENT	DentaQuest			
	Policy and Procedure			
	Policy Name:	Establishment and Adoption of Utilization Review Criteria and Clinical Guidelines	Policy ID:	**UM01-INS**
	Approved By:		Effective Date:	05/01/2018
	States:	All	Last Revision Date:	9/20/2018
	Application:	All Lines of Business		

PURPOSE

Written clinical criteria for the delivery of covered services are the primary component of the medical management and utilization review process. They provide consistent clinical guidelines for making determinations for coverage. The determination of medical necessity is often necessary for prior authorization or retrospective review for claims processing. This policy creates a consistent process for establishing and maintaining guidelines and criteria for the Utilization Management Program.

POLICY

To ensure consistent and equitable determination of coverage for certain covered services, the Company has implemented a process for establishing clinical criteria for many services, where applicable and reasonable. The specifics of criteria applicable are outlined or referenced within the Provider Office Reference Manual. Affected parties may request a copy of all applied criteria.

PROCEDURE

A. Formulation/Establishment

Written criteria and clinical guidelines utilized in the process of benefit determination are developed based on: Medicare and State Medicaid guidelines, *National Correct Coding Initiatives*, professional educational materials (e.g. Best Practice Guidelines of AOA, AAO), specific health plan developed guidelines, accepted industry standards of care, State and Health Plan specific requirements, as well as the information contained in the current CDT© and CPT© Manual published by the American Medical Association. Specialty organizations include:

- The American Academy of Pediatric Dentistry
- The Academy of General Dentistry
- The American Endodontic Society
- The American Orthodontic Society
- The American Association of Oral and Maxillofacial Surgery
- The American Academy of Ophthalmology
- The American Optometric Association

Medical necessity and benefit guidelines may be further defined by CMS, the State, the Plan, or through the adoption of other outside source written criterion or guidelines. Reference to the source of such guideline and criterion may be found in the Provider Office Reference Manual. All clinically based guidelines and criterion implemented and utilized for making medical necessity determinations shall meet the following overriding goals; in that they must:

1. Provide for consistency.
2. Allow for individualized application.

3. Be consistent with generally accepted professional medical standards.
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available.
5. Be formulated in a manner not primarily intended for the convenience of the Member, the Member's caretaker or the Provider; e.g. The fact that a provider has prescribed, recommended or approved medical or allied care, goods or a service does not, in itself, make such care, goods or services medically necessary or a medical necessity.
6. Not be established based in any way on the goal of limiting services, access, or financial incentive.

B. Adoption

Utilization Review Criteria and Guidelines are adopted after the DentaQuest Peer Review Committee, through collaboration, reviews, refines, and then approves the final version of a Policy.

Where and when required as a consequence of specific client contractual obligations, the Company has established a policy whereby any Company-developed clinical guidelines will be submitted to any such client (Plan) for documentation purposes, when and if requested. Such clinical guideline(s) shall be adopted for UM program use upon formal approval of the DentaQuest Peer Review Committee in the usual way. A client (Plan) has the right to submit recommendations for edits which will be reviewed by the DentaQuest Peer Review Committee.

C. New and Emerging Technology

New and emerging diagnostic and treatment technologies continue to be developed. DentaQuest must address the inclusion of these services to respond to Plans (Clients) and Members clinical needs and to maintain access to the most current standards of care. As such, the company has a formalized process to assess coverage on an ongoing basis, for determination of medical necessity or evolving standards of care.

DentaQuest utilizes the expertise of the DentaQuest Peer Review Committee members and when indicated, invited subject matter expects, to evaluate whether new technologies, and new applications of existing technologies, shall be provided as covered services or included in a Plan benefit package; and for development of appropriate clinical guidelines that might apply. A formal evaluation shall be initiated when the Clinical Director, a Provider, or client Health Plan (Medical Director) requests an opinion or petitions DentaQuest for such assessment. The Peer Review Committee is responsible for conducting the review and submitting an opinion to the full Quality Oversight Committee for discussion and final determination. The Peer Review Committee shall consider the following sources and documents:

1. A statement of whether or not the American Academy of Ophthalmology or American Dental Association has endorsed the new technology as a standard of care or clinically appropriate diagnostic or management option.
2. A statement of whether the new technology or new application of an existing technology has met with approval of the FDA, where applicable.
3. When DentaQuest is delegated this function, and the request is initiated by a Plan, a written opinion statement from the Plan (Client) involved, as to whether they feel the service should be considered for coverage under the overall benefit package or for an individual case.
4. In the event that the involved Plan includes Medicaid or Medicare Members and DentaQuest is delegated this function, current coverage status of the investigated service by the state and/or CMS.
5. If initiated by a Provider, a written request from the Provider offering evidence of clinical justification and supporting documentation.

6. Written opinion statement from a relevant specialist and/or professional who has expertise in the technology.

The Committee Chairperson shall be responsible for coordinating the initial research and receipt and distribution of the indicated materials. The Committee shall provide a written opinion for the request within 45 days of receipt. Upon acceptance of any emerging technology as a covered service in any market, the clinical guidelines will be formulated in the usual way, subject to robust scrutiny for coverage delineation, and possible Plan approval of the appropriateness of any new guidelines.

D. Ongoing and Annual Assessment

The development and implementation processes and all current criteria will be assessed on an ongoing basis and modified, when indicated, based on updated professional literature, emerging technology, and evolving standards of care. Established Clinical Guidelines are reviewed for acceptance by the Peer Review Committee on a yearly basis. The Clinical Director shall be responsible for distributing the current guidelines to Committee members during the first quarter each calendar year. Committee minutes shall reflect Committee assessment, documentation of recommended revisions, and approval of final versions. Final Annual Approval shall be completed not later than May 31st of the subsequent year.

FORMS AND RELATED DOCUMENTS

- UM01-INS-VIS-SOP – Adoption of UM Criteria For Anthem Companies
- UM01-INS-VIS-SOP – Clinical Algorithms

EXHIBITS

- **Exhibit A –** Short Procedure Units (SPU) Criteria
- **Exhibit B –** Periodontal Clinical Criteria
- **Exhibit C –** Dental Extraction Clinical Criteria
- **Exhibit D –** Crown Criteria
- **Exhibit E –** Prosthodontic Criteria
- **Exhibit F –** Endodontic Criteria
- **Exhibit G –** Radiographic Criteria
- **Exhibit H –** Bone Tissue Excision Criteria
- **Exhibit I –** Non-Restorable Tooth Criteria
- **Exhibit L –** Removable Prosthodontics Criteria
- **Exhibit M –** Administration of Nitrous Oxide
- **Exhibit N –** Orthodontic Criteria – Salzmann Index
- **Exhibit O –** General Anesthesia and IV Sedation Criteria
- **Exhibit P –** Orthodontic Criteria – Handicapping Lingual-Labial Deviation (HLD Index)
- **Exhibit S –** Onlay Criteria
- **Exhibit T –** Veneer Criteria

Exhibit A – Short Procedure Units (SPU) Criteria

All SPU cases must be pre-authorized. A narrative and documentation (radiographs, etc.) demonstrating need must be provided for consideration.

In most cases, short procedures units are approved (for procedures covered by health plan) if the following is (are) involved:

A. Young children requiring extensive operative procedures such as multiple restorations, treatment of abscesses or oral surgical procedures if prior authorization documentation indicates that in-office treatment (nitrous oxide or IV sedation) is not appropriate and hospitalization is not solely based upon reducing, avoiding or controlling apprehension.

B. Patients requiring extensive dental procedures and classified as American Society of Anesthesiologists (ASA) Class III and ASA Class IV (Class III – patients with uncontrolled disease or significant systemic disease; for example, poorly controlled hypertension, poorly controlled diabetes, upper respiratory infection, an arrhythmia, recent MI, recent stroke, new chest pain, etc. Class IV – patient with severe systemic disease that is a constant threat to life)

C. Medically compromised patients whose medical history indicates that the monitoring of vital signs or the availability of resuscitative equipment is necessary during dental procedures.

D. Patients requiring extensive dental procedures with a medical history of uncontrolled bleeding, severe cerebral palsy, or other medical condition that renders in-office treatment not medically appropriate.

E. Patients requiring extensive dental procedures who have documentation of psychosomatic disorders that require special treatment.

F. Persons with cognitive disabilities requiring extensive dental procedures whose prior history indicates hospitalization is appropriate.

G. Hospitalized individuals who need extensive restorative or surgical procedures, or whose physician has requested a dental consultation.

Exhibit B – Periodontal Clinical Criteria

A. Documentation may be needed for pre-authorization of procedure.
   1. Loss of clinical attachment, including radiographic evidence of bone loss (type of pre-operative radiographs required varies with plan – full mouth preferred and most current Bitewing radiographs)
   2. Pre-operative periodontal charting (When periodontal charting is requested for surgical and non-surgical procedures it must be submitted with a periodontal chart dated no more than twelve (12) months prior to the date of service.
   3. Detailed treatment plan
   4. Treatment Records

B. Codes
   1. DentaQuest adheres to the code definitions as described in the American Dental Association Current Dental Terminology User's Manual. Decisions regarding benefits are made on the basis of the documentation provided.
   2. Periodontal scaling and root planing, (D4341, D4342) per quadrant involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. It is indicated for patients with periodontal disease and is therapeutic, not prophylactic in nature. Root planing is the definitive procedure designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or microorganisms. Some soft tissue removal occurs. This procedure may be used as a definitive treatment in some stages of periodontal disease and as a part of pre-surgical procedures in others.

C. Criteria
   1. According to the American Academy of Periodontology, "scaling and root planing procedures are intended to be used for scaling and root planing, not for scaling alone, so there must be some loss of attachment. Otherwise, these is no exposed root surface to plane". Even if appropriate probing depths (usually > 4mm are present, if there is no attachment loss, root planning cannot be accomplished so codes D4341/D4342 should not be submitted for payment. Periodontal scaling is prescribed/performed for patients who exhibit loss greater than 4 mm and/or the presence of subgingival calculus.
   2. Benefits for periodontal services are available only when billed for natural teeth.
   3. Prophylaxis procedures (D1110), (D1120), full mouth scaling (D4346) or Gross Debridement (D4355) are considered a component when submitted on the same date of service as Scaling and Root Planing.
   4. Teeth must have a good long-term prognosis to qualify for any periodontal procedures.
   5. All periodontal procedures include routine postoperative care and local anesthesia.

Exhibit C – Dental Extraction Clinical Criteria

Documentation needed for pre-authorization of procedure.

A. Panorex, bitewing radiographs or periapical radiographs showing the entire tooth (teeth) to be extracted as well as opposing teeth

B. Narrative demonstrating medical necessity

1. A decision regarding benefits is made on the basis of the documentation provided.
2. Treatment rendered without necessary pre-authorization is subject to retrospective review.

C. Codes: DentaQuest adheres to the code definitions as described in the American Dental Association Current Dental Terminology User's Manual.

D. Criteria
1. The prophylactic removal of asymptomatic teeth or teeth exhibiting no overt clinical pathology is not a covered benefit.
2. The removal of primary teeth whose exfoliation is imminent is not a covered benefit.
3. In most cases, extractions that render a patient edentulous must be deferred until authorization to construct a denture has been given.
4. Alveoloplasty (code D7310) in conjunction with a surgical extraction in the same quadrant is not a covered benefit.
5. Extractions performed as a part of a course of orthodontics are covered only if the orthodontic case is a covered benefit.
6. The extraction of primary or permanent teeth does not require authorization unless:
   a. Teeth are impacted wisdom teeth
   b. Residual roots requiring surgical removal
   c. Surgical extraction of erupted teeth.
7. Removal of primary teeth whose exfoliation is imminent does not meet criteria for extraction.

E. Documentation needed for authorization procedure:
1. Diagnostic Quality periapical and/or panoramic radiographs,
2. Radiographs must be mounted, contain the patient name and the date the radiographs were taken, not the date of submission
3. Duplicate radiographs must be labeled Right (R) and Left (L), include the patient name and the date the radiograph(s) were taken, not the date of submission.
4. Extraction of impacted wisdom teeth or surgical removal of residual tooth roots will require a written narrative of medical necessity.

F. Documentation needed for emergent authorization procedure: In emergency situations when prior authorization is not possible, extractions will require review prior to payment.

G. Documentation requirements for emergent retrospective review will include:
1. Diagnostic Quality periapical and/or panoramic radiographs.
2. Radiographs must be mounted, contain the patient name and the date the radiographs were taken, not the date of submission
3. Duplicated radiographs must be labeled Right (R) and Left (L), include the patient name and the date the radiograph(s) were taken, not the date of submission.
4. Extraction of impacted wisdom teeth or surgical removal of residual tooth roots will require a written narrative of medical necessity.

H. Authorization for extraction of impacted third molars:
   1. Benefit review decisions for authorization of the extraction of impacted third molar teeth will be based upon medical necessity and upon appropriate code utilization for the current ADA codes D7220, D7230, D7240, and D7241.
   2. The prophylactic removal of disease-free third molars is not covered.
   3. Impacted third molars that do not show radiographic evidence of complete root formation will not qualify for an authorization for extraction.
   4. Impacted third molars that do not show pathology will not qualify for an authorization for extraction.
   5. Impacted third molars that do not demonstrate radiographic aberrant tooth position beyond normal variations will not qualify for an authorization for extraction.
   6. Normal eruption discomfort and localized inflammatory conditions will not qualify impactions for an authorization for extraction.
   7. Lack of eruptive space will not qualify for an authorization for extraction of impacted third molars.

Reference: American Association of Oral Maxillofacial Surgeons and American Dental Association

Exhibit D – Crown Criteria

I. Pre-Authorization Documentation

A. Documentation may be needed for pre-authorization of procedure:
   1. Panorex or, at minimum, 4 bitewing radiographs showing clearly the adjacent and opposing teeth
   2. Treatment rendered without necessary pre-authorization is subject to retrospective review.

II. Codes

A. DentaQuest adheres to the code definitions as described in the American Dental Association Current Dental Terminology User's Manual.

B. In general, crowns are allowed only for teeth needing multi-surface restorations where amalgams and other materials have a poor prognosis.

C. Molars must have pathologic destruction to the tooth by caries or trauma, and must involve four or more surfaces and two or more cusps.

D. Bicuspids must have pathologic destruction to the tooth by caries or trauma, and must involve three or more surfaces and at least one cusp.

E. Anterior teeth must have pathologic destruction to the tooth by caries or trauma, and must involve four or more surfaces and at least 50% of the incisal edge.

F. Crown build-up procedures are allowed on teeth that meet crown criteria, where clinical crown breakdown is at a level where the build-up material is necessary for crown retention.

G. A request for a crown following root canal therapy must meet the following criteria:
   1. One month must have passed since the root canal therapy was completed.
   2. Request must include a dated post-endodontic radiograph.
   3. Tooth must be filled within two millimeters of the radiological apex, unless there is a curvature or calcification of the canal that limits the ability to fill the canal to the apex.
   4. The filling must be properly condensed/obdurated.
   5. To be covered, a tooth must oppose a crown or denture in the opposite arch or be an abutment for a partial denture.
   6. The patient must be free from active and advanced periodontal disease.
   7. The fee for crowns includes the temporary crown that is placed on the prepared tooth and worn while the permanent crown is being fabricated.
   8. Pre-fabricated or cast post and core procedures are allowed on endodontically treated teeth where clinical crown breakdown is at a level where the post and core is necessary for crown retention.

Exhibit E – Prosthodontic Criteria

A. The following documentation may be needed for authorization of procedure:
   1. Detailed treatment plan
   2. Appropriate radiographs showing clearly the adjacent and opposing teeth must be submitted for authorization review; bitewings, periapicals or panorex.
   3. Treatment rendered without necessary authorization requires appropriate radiographs showing clearly the adjacent and opposing teeth be submitted with the claim for review for payment.

B. Codes: DentaQuest adheres to the code definitions as described in the American Dental Association Current Dental Terminology User's Manual.

C. General Criteria
   1. Prosthetic services are intended to restore oral form and function due to premature loss of permanent teeth that would result in significant occlusal dysfunction.
   2. A denture is determined to be an initial placement if the patient has never worn prosthesis.
   3. Partial dentures are covered only for recipients with good oral health and hygiene, good periodontal health (AAP Type I or II), and a favorable prognosis where continuous deterioration is not expected.
   4. Radiographs must show no untreated cavities or active periodontal disease in the abutment teeth, and abutments must be at least 50% supported in bone.
   5. As part of any removable prosthetic service, dentists are expected to instruct the patient in the proper care of the prosthesis.
   6. In general, if there is a pre-existing removable prosthesis (includes partial and full dentures); it must be at least 5 years old and unserviceable to qualify for replacement.

   Approval for partial dentures to replace posterior teeth will not be allowed if there are in each quadrant at least three (3) peridontially sound posterior teeth in fairly good position and occlusion with opposing dentition. Approval for cast partial dentures for anterior teeth generally will not be given unless one or more anterior teeth in the same arch are missing.

D. Criteria: Authorizations for prosthesis do not meet criteria:
   1. If there is a pre-existing prosthesis which is not at least 5 years old and unserviceable.
   2. If good oral health and hygiene, good periodontal health, and a favorable prognosis are not present.
   3. If there are untreated cavities or active periodontal disease in the abutment teeth.
   4. If abutment teeth are less than 50% supported in bone.
   5. If there are 8 or more posterior teeth in occlusion.
   6. If the recipient cannot accommodate and properly maintain the prosthesis (i.e. Gag reflex, potential for swallowing the prosthesis, severely handicapped).
   7. If the recipient has a history or an inability to wear a prosthesis due to psychological or physiological reasons.
   8. If a partial denture, less than five years old, is converted to a temporary or permanent complete denture.
   9. If extensive repairs are performed on marginally functional partial dentures, or when a new partial denture would be better for the health of the recipient. However, adding teeth and/or a clasp to a partial denture is a covered benefit if the addition makes the denture functional.
   10. If there is a pre-existing prosthesis, it must be at least 5 years old and unserviceable to qualify for replacement.
   11. Adjustments, repairs and relines are included with the denture fee within the first 6 months after insertion. After that time has elapsed:
   12. Adjustments are reimbursed at one per calendar year per denture.

13. Repairs are reimbursed at two repairs per denture per year, with five total denture repairs per 5 years.
14. Relines are reimbursed once per denture every 36 months.
15. A new prosthesis is not reimbursed within 24 months of reline or repair of the existing prosthesis unless adequate documentation has been presented that all procedures to render the denture serviceable have been exhausted.
16. Replacement of lost, stolen, or broken dentures less than 5 years of age does not meet criteria for pre-authorization of a new denture.
17. The use of Preformed dentures with teeth already mounted (that is, teeth set in acrylic before the initial impression) cannot be used for the fabrication of a new denture.
18. All prosthetic appliances are inserted in the mouth and adjusted before a claim is submitted for payment.
19. When billing for partial and complete dentures, dentists must list the date that the dentures or partials were inserted as the date of service. Recipients must be eligible on that date in order for the denture service to be covered.

Reference: American Association of Prosthodontics and American Dental Association

Exhibit F – Endodontic Criteria

A. In most cases, no prior-authorization is required. A dated post-operative radiograph must be submitted for retrospective review.

B. Codes: DentaQuest adheres to the code definitions as described in the American Dental Association Current Dental Terminology User's Manual.

C. Criteria: Root canal therapy is performed in order to maintain teeth that have been damaged through trauma or carious exposure.

D. Root canal therapy must meet the following criteria:
   1. Fill must be within two millimeters of the radiological apex, unless there is a curvature or calcification of the canal that limits ability to fill canal to apex.
   2. Fill must be properly condensed/obdurated.
   3. Filling material must not extend beyond the apex.

E. Root canal therapy is not a covered benefit in the following situations:
   1. Gross periapical or periodontal pathosis is demonstrated radiographically (caries subcrestal or to the furcation, deeming the tooth non-restorable).
   2. The general oral condition does not justify root canal therapy due to loss of arch integrity.
   3. Third molars, unless they are an abutment for a partial denture
   4. Tooth does not demonstrate 50% bone support
   5. When performed in anticipation of placement of an overdenture
   6. Using filling material not accepted by the Federal Food and Drug Administration (FDA), e.g. Sargenti filling material

F. Root canal therapy for permanent teeth includes diagnosis, extirpation of the pulp, shaping and enlarging the canals, temporary fillings, filling and obliteration of root canal(s), and progress radiographs, including a root canal fill radiograph.

G. In cases where the root canal filling does not meet DentaQuest's treatment standards, DentaQuest can require the procedure to be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after DentaQuest reviews the circumstances.

References: American Society of Endodontics and American Dental Association

Exhibit G – Radiographic Criteria

I. Radiographic Examination of the New Patient

A. Child - Primary Dentition (with closed proximal contacts): Posterior bitewings

B. Child - Transitional Dentition: Individualized Periapical/Occlusal series with posterior bitewings OR Panoramic X-ray with posterior bitewing

C. Adolescent (Ages 16-19; permanent dentition prior to eruption of third molars): Individualized examination consisting of selected periapicals and posterior bitewings

D. Adult - Dentulous: Individualized examination consisting of selected periapicals with posterior bitewings

E. Adult - Edentulous: Individualized examination consisting of Panoramic X-ray or Periapical Series of such quality that all relevant structures of the oral cavity (including possible impacted teeth and/or root tips) may be viewed.

II. Radiographic Examination of the Recall Patient

A. Patients with clinical caries or other high-risk factors for caries:
   1. Child – Primary and Transitional Dentition: Posterior bitewings at a 6-12 month interval
   2. Adolescent (ages 16-19): Posterior bitewings at a 6-12 month interval
   3. Adult – Dentulous: Posterior Bitewings at 6-12 month interval
   4. Adult – Edentulous: Examination for occult disease in this group cannot be justified on the basis of prevalence, morbidity, mortality, radiation dose, and cost. Therefore, DentaQuest recommends that no radiographs be obtained for edentulous recall patients without clinical signs and symptoms.

B. Patients with no clinical caries and no other high risk factors for caries:
   1. Child – Primary dentition (with closed proximal contacts): Posterior bitewings at 12-24 month interval
   2. Adolescent (ages 16-19): Posterior bitewings at 12-24 month interval
   3. Adult – Dentulous: Posterior bitewings at 24-36 month intervals

C. Patients with periodontal disease, or a history of periodontal treatment for Child (Primary and Transitional Dentition), Adolescent, and Adult (Dentulous).

D. Individualized radiographic survey consisting of selected periapicals and/or bitewings of areas with clinical evidence or a history of periodontal disease (except nonspecific gingivitis).

E. Growth and Development Assessment:
   1. Child – Primary Dentition: No radiographs prior to the eruption of the first permanent tooth at recall visits in the absence of clinical signs or symptoms.
   2. Child – Transitional Dentition: At first recall visit after the eruption of the first permanent tooth, individualized periapical/occlusal series or panoramic X-ray
   3. Adolescent (ages 16-19): Single set of periapicals of the third molars or panoramic X-ray
   4. Adult: DentaQuest recommends that no radiographs be obtained in the absence of clinical signs or symptoms.

III. Reimbursement

A. Reimbursement for radiographs includes exposure of the radiograph, developing, mounting and radiographic interpretation.

B. Reimbursement for multiple x-rays of the same tooth or area may be denied if DentaQuest determines the number to be redundant, excessive or not in keeping with the federal policies relating to radiation exposure. DentaQuest uses the guidelines published by the Department of Health and Human Services, Center for Devices and Radiological Health. These guidelines were published in conjunction with the Food and Drug Administration.

C. DentaQuest requires that, in order to be reimbursed, radiographs must meet quality standards of readability. In cases where a radiograph does not meet DentaQuest's treatment standards, DentaQuest can require that the procedure be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Dental Consultant reviews the circumstances.

Reference: Center for Devices and Radiological and the American Dental Association

Exhibit H – Bone Tissue Excision Criteria

To ensure the proper seating of a removable prosthesis (partial or full denture) some treatment plans may require the removal of excess bone tissue prior to the fabrication of the prosthetic. Clinical guidelines have been formulated for the dental Consultant to ensure that the removal of tori (mandibular and palatal) is an appropriate course of treatment prior to prosthodontic treatment.

A. Codes related to the removal of exostoses are subject to prior authorization and may be compensable when submitted in conjunction with appropriate documentation. These determinations are made by the appropriate dental specialist/Consultant.

B. Prior authorization requirements:
    1. Appropriate radiographs (bitewings, periapical or panorex) and/or intraoral photographs and bone scans, which clearly identify the exostoses, must be submitted.
    2. Treatment plan – includes prosthetic plan.
    3. Narrative of medical necessity, if appropriate.

Exhibit I – Non-Restorable Tooth Criteria

In the application of clinical criteria for benefit determination, Dental Consultants must consider the overall dental health. A tooth that is determined to be non-restorable may be subject to an alternative treatment plan. Clinical guidelines have been formulated for the Dental Consultant to ensure that an appropriate determination of benefits is made.

A tooth may be deemed non-restorable if one or more of the following criteria are present:

1. The tooth presents with greater than a 75% loss of the clinical crown
2. The tooth has less than 50% bone support
3. The tooth has subosseous and/or furcation caries
4. The tooth is a primary tooth with exfoliation imminent
5. The tooth apex is surrounded by severe pathologic destruction of the bone

The overall dental condition (i.e. periodontal) of the patient is such that an alternative treatment plan would be better suited to meet the patient's needs

Exhibit L – Removable Prosthodontics Criteria

DentaQuest adheres to the following policy for evaluating and approving full and partial dentures in order to maintain consistency throughout its dental networks.

I. Documentation May be Needed for Pre-Authorization of Procedure

A. Detailed treatment plan

B. Sufficient and appropriate radiographs showing clearly the adjacent and opposing teeth must be submitted for pre-authorization; bitewings, periapicals or panorex.

C. Treatment rendered without necessary pre-authorization requires sufficient and appropriate radiographs showing clearly the adjacent and opposing teeth be submitted for retrospective review and payment; bitewings, periapicals or panorex.

II. Codes

DentaQuest adheres to the code definitions as described in the American Dental Association Current Dental Terminology User's Manual.

III. Criteria

A. General

1. Prosthetic services are intended to restore oral form and function due to premature loss of permanent teeth that would result in significant occlusal dysfunction.
2. A denture is determined to be an initial placement if the patient has never worn a prosthesis.
3. Partial dentures are covered only for recipients with good oral health and hygiene, good periodontal health (AAP Type I or II), and a favorable prognosis where continuous deterioration is not expected.
4. Radiographs must show no untreated cavities or active periodontal disease in the abutment teeth, and abutments must be at least 50% supported in bone.
5. As part of any removable prosthetic service, dentists are expected to instruct the patient in the proper care of the prosthesis.
6. In general, if there is a pre-existing removable prosthesis (includes partial and full dentures); it must be at least 5 years old and unserviceable to qualify for replacement.

Approval for partial dentures to replace posterior teeth will not be allowed if there are in each quadrant at least three (3) peridontially sound posterior teeth in fairly good position and occlusion with opposing dentition. Approval for cast partial dentures for anterior teeth generally will not be given unless one or more anterior teeth in the same arch are missing.

B. Removable prosthesis is not a covered benefit:

1. If there is a pre-existing prosthesis which is not at least 5 years old and unserviceable.
2. If good oral health and hygiene, good periodontal health, and a favorable prognosis are not present.
3. If there are untreated cavities or active periodontal disease in the abutment teeth.
4. If abutment teeth are less than 50% supported in bone.
5. If there are 8 or more posterior teeth in occlusion.
6. If the recipient cannot accommodate and properly maintain the prosthesis (e.g. Gag reflex, potential for swallowing the prosthesis, severely handicapped).
7. If the recipient has a history or an inability to wear a prosthesis due to psychological or physiological reasons.
8. If the recipient does not have a good attendance record.

9. If a partial denture is converted to a temporary or permanent complete denture.
10. If extensive repairs are performed on marginally functional partial dentures, or when a new partial denture would be better for the health of the recipient. However, adding teeth and/or a clasp to a partial denture is a covered benefit if the addition makes the denture functional.

C. Benefit Limits
1. If there is a pre-existing prosthesis, it must be at least 5 years old and unserviceable to qualify for replacement.
2. Adjustments, repairs and relines are included with the denture fee within the first 6 months after insertion. After that time has elapsed:
    a. Adjustments are compensable at one per calendar year per recipient.
    b. Repairs are compensated at 2 repairs per denture per year, with 5 total denture repairs per 5 years.
    c. Relines are compensable once per denture every 36 months.
3. A new prosthesis is not compensable within 24 months of reline or repair of the existing prosthesis.
4. Replacement of lost or broken dentures less than 5 years of age is not a covered benefit.
5. Preformed dentures with teeth already mounted (that is, teeth set in acrylic before the initial impression) are not a covered benefit.
6. The fee for complete and partial dentures includes six months of post-insertion follow-up care including adjustments, repairs and relines.
7. All prosthetic appliances are inserted in the mouth and adjusted before a claim is submitted for payment.
8. When billing for partial and complete dentures, dentists must list the date that the final impressions were taken as the date of service. Recipients must be eligible on the date the final impressions are taken in order for the denture service to be covered.

Reference: American Association of Prosthodontics and American Dental Association

Exhibit M – Administration of Nitrous Oxide

DentaQuest adheres to the following policy for evaluating approving General Anesthesia and IV Sedation in order to maintain consistency throughout its dental networks.

I. Documentation May be Needed for Pre-Authorization of Procedure

A. Treatment plan (pre-authorized if necessary)

B. Narrative describing medical necessity for use of nitrous oxide.

C. Treatment rendered under emergency conditions, when pre-authorization is not possible, requires submission of a treatment plan and narrative of medical necessity for retrospective review and payment.

II. Codes

DentaQuest adheres to the code definitions as described in the American Dental Association Current Dental Terminology User's Manual.

III. Criteria

A. In most cases requests for nitrous oxide are authorized (for procedures covered by health plan) if any of the following criteria are met:
   1. Extensive or complex procedures such as:
      a. Four (4) or more simple and/or surgical extractions
      b. Impacted wisdom teeth
      c. Surgical root recovery from maxillary antrum
      d. Surgical exposure of impacted or unerupted cuspids
      e. Radical excision of lesions in excess of 1.25 cm.

   2. And/or one of the following medical conditions may apply:
      a. Underlying hazardous medical condition (cerebral palsy, epilepsy, mental retardation, including Down's syndrome), which would render patient non-compliant.
      b. Documented failed local anesthetic or a condition where severe periapical infection would render local anesthesia ineffective
      c. Acute situational anxiety in patients
      d. Patients less than a certain age with extensive procedures. This includes the following that can be considered extensive: restorations, pulpotomies, or stainless steel crowns.
         i. Patients less than 9 years of age must have 6 or more teeth with extensive procedures
         ii. Patients less than 6 years of age must have 4 or more teeth with extensive procedures
      e. Patient is less than 3 years old.

Reference: American Association of Oral Maxillofacial Surgeons and American Dental Association

Exhibit N – Orthodontic Criteria – Salzmann Index

To ensure consistent and equitable determination of coverage for orthodontic dental services, DentaQuest Dental Consultants may use the Salzmann Index criteria to be considered when making prior authorization decisions.

As required by some State regulation or Plan contracts, DentaQuest utilizes the Salzmann Index for assessing orthodontic benefit requests. The documentation requires a completed ADA claim form, an occludable set of study models, and a treatment plan. Requests may be submitted with cast plaster study models or electronically. All submitted study models must be intact and free from damage to ensure appropriate decision-making. Non-diagnostic or defective models may result in a denied benefit decision.

I. Review Criteria: Malocclusion Severity Assessment by J.A. Salzmann, DDS, F.A.P.H.A.

A. All orthodontic services require prior authorization by DentaQuest's Dental Consultant, and are provided for comprehensive orthodontic service due to handicapping malocclusion causing speech, eating/mastication, or psychological problems.

B. Orthodontic treatment is not authorized for cosmetic and/or aesthetic reasons. Treatment is only allowed for individual's age 20 and younger meeting the Salzmann Index criteria. If treatment begins prior to the age of 21 and the recipient exceeds the age during treatment, care is provided through completion.

C. DentaQuest utilizes a Modified Salzmann Index Angling System for scoring orthodontic cases for necessity of care. A total score requirement is established by the State or Plan.

II. Summary of Instructions for Completing a Modified Salzmann Index

A. Score

1. 2 points for each maxillary anterior tooth affected.
2. 1 point for each mandibular incisor and all posterior teeth affected.

B. Missing teeth: Count the teeth; remaining roots of teeth are scored as a missing tooth.

C. Crowding: Score the points when there is not sufficient space to align a tooth without moving other teeth in the same arch.

D. Rotation: Score the points when one or both proximal surfaces are seen in anterior teeth, or all or part of the buccal or lingual surface in posterior teeth are turned to a proximal surface of an adjacent tooth. The space needed for tooth alignment is sufficient in rotated teeth for their proper alignment.

E. Spacing: Score teeth, not spacing. Score the points when:

1. **Open Spacing:** One or both interproximal tooth surfaces and adjacent papillae are visible in an anterior tooth; both interproximal surfaces and papillae are visible in a posterior tooth
2. **Closed Spacing:** Space is not sufficient to permit eruption of a tooth that is partially eruption

F. Overjet: Score the points when the mandibular incisors occlude on or over the maxillary mucosa in back of the maxillary incisors, and the mandibular incisor crowns show labial axial inclination.

G. Overbite: Score the points when the maxillary incisors occlude on or opposite labial gingival mucosa of the mandibular incisor teeth.

H. Cross-Bite: Score the points when the maxillary incisors occlude lingual to mandibular incisors, and the posterior teeth occlude entirely out of occlusal contact.

I. Open-Bite: Score the points when the teeth occlude above the opposing incisal edges and above the opposing occlusal surfaces of posterior teeth.

J. Mesiodistal Deviations: Relate mandibular to opposing maxillary teeth by full cusp for molars; buccal cusps of premolars and canines occlude mesial or distal to accepted normal interdental area of maxillary premolars.

III. Instruction for Using the "Handicapping Malocclusion Assessment Record"

I. Introduction: This assessment record (not an examination) is intended to disclose whether a handicapping malocclusion is present and to assess its severity according to the criteria and weights (point values) assigned to them. The weights are based on tested clinical orthodontic values from the standpoint of the effect of the malocclusion on dental health, function, and esthetics. The assessment is not directed to ascertain the presence of occlusal deviations ordinarily included in epidemiological surveys of malocclusion. Etiology, diagnosis, planning, complexity of treatment, and prognosis are not factors in this assessment. Assessments can be made from casts or directly in the mouth. An additional assessment record form is provided for direct mouth assessment of mandibular function, facial asymmetry, and lower lip position.

II. Intra-Arch Deviations: The casts are placed, teeth upward, in direct view. When the assessment is made directly in the mouth, a mouth mirror is used. The number of teeth affected is entered as indicated in the "Handicapping Malocclusion Assessment Record." The scoring can be entered later.

III. Anterior Segment: A value of 2 points is scored for each tooth affected in the maxilla and 1 point in the mandible.

1. Missing teeth are assessed by actual count. A tooth with only the roots remaining is scored as missing
2. Crowded refers to tooth irregularities that interrupt the continuity of the dental arch when the space is insufficient for alignment without moving other teeth in the arch. Crowded teeth may or may not also be rotated. A tooth scored as crowded is not scored also as rotated
3. Rotated refers to tooth irregularities that interrupt the continuity of the dental arch but there is sufficient space for alignment. A tooth scored as rotated is not scored also as crowded or spaced.
4. Spacing
    a. Open spacing refers to tooth separation that exposes to view the interdental papilla on the alveolar crest. Score the number of papillae visible (not teeth).
    b. Closed spacing refers to partial space closure that does not permit a tooth to complete its eruption without moving other teeth in the same arch. Score the number of teeth affected.

IV. Posterior Segment: A value of 1 point is scored of each tooth affected.

1. Missing teeth are assessed by actual count. A tooth with only the roots remaining is scored as missing

2. Crowded refers to tooth irregularities that interrupt the continuity of the dental arch when the space is insufficient for alignment. Crowded teeth may or may not also be rotated. A tooth scored as crowded is not scored also as rotated
3. Rotated refers to tooth irregularities that interrupt the continuity of the dental arch and all or part of the lingual or buccal surface faces some part or all of the adjacent proximal tooth surfaces. There is sufficient space for alignment. A tooth scored as rotated is not scored also as crowded
4. Spacing
    a. Open spacing refers to interproximal tooth separation that exposes to view the mesial and distal papillae of a tooth. Score the number of teeth affected (Not the spaces).
    b. Closed spacing refers to partial space closure that does not permit a tooth to erupt without moving other teeth in the same arch. Score the number of teeth affected.

V. Interarch Deviations: When casts are assessed for interarch deviations, they first are approximated in terminal occlusion. Each side assessed is held in direct view. When the assessment is made in the mouth, terminal occlusion is obtained by bending the head backward as far as possible while the mouth is held wide open. The tongue is bent upward and backward on the palate and the teeth are quickly brought to terminal occlusion before the head is again brought downward. A mouth mirror is used to obtain a more direct view in the mouth.

VI. Anterior Segment: A value of 2 points is scored for each affected maxillary tooth only.

1. Overjet refers to labial axial inclination of the maxillary incisors in relation to the mandibular incisor, permitting the latter to occlude on or over the palatal mucosa. If the maxillary incisors are not in labial axial inclination, the condition is scored as overbite only
2. Overbite refers to the occlusion of the maxillary incisors on or over the labial gingival mucosa of the mandibular incisors, while the mandibular incisors themselves occlude on or over the palatal mucosa in back of the maxillary incisors. When the maxillary incisors are in labial axial inclination, the deviation is scored also as overjet
3. Cross-bite refers to maxillary incisors that occlude lingual to their opponents in the opposing jaw, when the teeth are in terminal occlusion
4. Open-bite refers to vertical interarch dental separation between the upper and lower incisors when the posterior teeth are in terminal occlusion. Open-bite is scored in addition to overjet if the maxillary incisor teeth are above the incisal edges of the mandibular incisors when the posterior teeth are in terminal occlusion Edge-to-edge occlusion in not assessed as open-bite

VII. Posterior Segment: A value of 1 point is scored for each affected tooth.

1. Cross-bite refers to teeth in the buccal segment that are positioned lingually or buccally out of entire occlusal contact with the teeth in the opposing jaw when the dental arches are in terminal occlusion
2. Open-bite refers to the vertical interdental separation between the upper and lower segments when the anterior teeth are in terminal occlusion. Cusp-to-cusp occlusion is not assessed as open-bite
3. Anteroposterior deviation refers to the occlusion forward or rearward of the accepted normal of the mandibular canine, first and second premolars, and first molar in relation to the opposing maxillary teeth. The deviation is scored when it extends a full cusp or more in the molar and the premolars and canine occlude in the interproximal area mesial or distal to the accepted normal position.

Exhibit O – General Anesthesia and IV Sedation Criteria

DentaQuest adheres to the following policy for evaluating approving anesthesia during dental treatment including Local Anesthesia, General Anesthesia and IV Sedation in order to maintain consistency throughout its dental networks.

Codes: DentaQuest adheres to the code definitions as described in the American Dental Association Current Dental Terminology User's Manual

I. GENERAL ANESTHESIA

A. Documentation may be needed for pre-authorization of procedure
   1. Treatment plan (pre-authorized if necessary)
   2. Narrative describing medical necessity for General Anesthesia or IV Sedation.
   3. Treatment rendered under emergency conditions, when pre-authorization is not possible, requires submission of a treatment plan and narrative of medical necessity for retrospective review and payment.

B. Codes: DentaQuest adheres to the code definitions as described in the American Dental Association Current Dental Terminology User's Manual.

C. Criteria: In most cases requests for general anesthesia or IV sedation are authorized (for procedures Covered by health plan) if any of the following criteria are met:
   1. Extensive or complex oral surgical procedures such as:
      a. Four (4) or more simple and/or surgical extractions in more than one quadrant in one appointment
      b. Impacted wisdom teeth
      c. Surgical root recovery from maxillary antrum
      d. Surgical exposure of impacted or unerupted cuspids
      e. Radical excision of lesions in excess of 1.25 cm
   2. And/or one of the following medical conditions may apply:
      a. Medical condition(s) which require monitoring (e.g. cardiac problems, severe hypertension)
      b. Underlying complex medical condition (cerebral palsy, epilepsy, intellectual disability, Down's syndrome), which would render patient non-compliant
      c. Documented failed sedation or a condition where severe periapical infection would render local anesthesia ineffective
      d. Patients 3 years old and younger with extensive procedures to be accomplished

II. LOCAL ANESTHESIA

A. Documentation: Documentation is generally not required when local anesthesia is being prior authorized in conjunction with dental treatment
   1. Narrative describing medical necessity may be required if local anesthesia is being performed without dental treatment.
   2. Local anesthesia performed not in conjunction with dental treatment under emergency conditions, when pre-authorization is not possible, may require submission of a treatment plan and narrative of medical necessity for retrospective review.

B. Criteria: Local Anesthesia including local anesthetic injections for regional nerve blocks, local tissue infiltration and topical anesthetic sprays and gels are considered an integral part of completing dental treatment. These services are considered unbundled when submitted separately from the dental treatment service and are disallowed.

Exhibit P – Orthodontic Criteria – Handicapping Lingual-Labial Deviation (HLD Index)

To ensure consistent and equitable determination of coverage for orthodontic dental services some Plans or states require the use of the Handicapping Lingual Labial Deviation (HLD) Index to be considered when making prior authorization decisions. Total qualifying Index scores may vary by State or Plan requirement.

A. As required by some State regulation or Plan contracts, DentaQuest utilizes the Handicapping Lingual Labial Deviation Index for assessing orthodontic benefit requests. The documentation required for these requests include a completed ADA claim form, an occludable set of trimmed study models, and a treatment plan. Requests may be submitted with cast plaster study models or electronically. All submitted study models must be intact and free from damage to ensure appropriate decision-making. Non-diagnostic or defective models may result in a denied benefit decision.

B. All orthodontic services require prior authorization by one of DentaQuest's Dental Consultants. Orthodontic services are only considered for those recipients with permanent dentitions. The recipient presents with a fully erupted set of permanent teeth. At least ½ to ¾ of the clinical crown is exposed, unless the tooth is impacted or congenitally missing. (Cleft palate cases and unusual oral-facial anomalies may receive special consideration for treatment during the transitional dentition).

C. Treatment does not begin prior to receiving notification from DentaQuest indicating coverage or non-coverage for the proposed treatment plan. Dentists who begin treatment before receiving their approved (or denied) prior authorization are financially obligated to complete treatment at no charge to the patient; or face termination of their Provider Agreement.

Exhibit S – Onlay Criteria

DentaQuest adheres to the following policy for evaluating onlay restorations in order to maintain consistency throughout its dental networks.

I. Pre-Treatment Documentation

A. Documentation may be needed for pre-service review of procedure:
   1. Periapical x-ray showing clearly the full length of the tooth in review, including the entire clinical crown through the apex of the root.
   2. Panorex or, at minimum, 4 bitewing radiographs showing clearly the adjacent and opposing teeth.
   3. Treatment rendered without necessary pre-service review is subject to retrospective review.

II. Codes

A. DentaQuest adheres to the code definitions as described in the American Dental Association Current Dental Terminology User's Manual.

B. In general, onlays are allowed only for teeth needing multi-surface restorations where amalgams and other materials have a poor prognosis.

C. Molars must have pathologic destruction to the tooth by caries or trauma, and must involve four or more surfaces and two or more cusps.

D. Bicuspids must have pathologic destruction to the tooth by caries or trauma and must involve three or more surfaces and at least one cusp.

E. Build-up procedures are not allowed in conjunction with onlays.

F. A request for a onlay following root canal therapy must meet the following criteria:
   1. One month must have passed since the root canal therapy was completed.
   2. Request must include a dated post-endodontic radiograph.
   3. Tooth must be filled within two millimeters of the radiological apex, unless there is a curvature or calcification of the canal that limits the ability to fill the canal to the apex.
   4. The filling must be properly condensed/obdurated.
   5. To be covered, a tooth must oppose a crown or denture in the opposite arch or be an abutment for a partial denture.
   6. The patient must be free from active and advanced periodontal disease.
   7. The fee for onlays includes the temporary restoration that is placed on the prepared tooth and worn while the onlay restoration is being fabricated.

Exhibit T – Veneer Criteria

DentaQuest adheres to the following policy for evaluating veneers in order to maintain consistency throughout its dental networks.

I. Pre-Treatment Documentation

A. Documentation may be needed for pre-service review of procedure:
   1. Periapical x-ray showing clearly the full length of the tooth in review, including the entire clinical crown through the apex of the root.
   2. Panorex or, at minimum, 4 bitewing radiographs showing clearly the adjacent and opposing teeth
   3. Treatment rendered without necessary pre-service review is subject to retrospective review.

II. Codes

A. DentaQuest adheres to the code definitions as described in the American Dental Association Current Dental Terminology User's Manual.

B. In general, veneers are allowed only for anterior teeth needing multi-surface restorations where amalgams and other materials have a poor prognosis.

C. Anterior teeth must have pathologic destruction to the tooth by caries or trauma and must involve four or more surfaces **and** at least 50% of the incisal edge.

D. Build-up procedures are not allowed in conjunction with veneers.

E. A request for a veneer following root canal therapy must meet the following criteria:
   1. One month must have passed since the root canal therapy was completed.
   2. Request must include a dated post-endodontic radiograph.
   3. Tooth must be filled within two millimeters of the radiological apex unless there is a curvature or calcification of the canal that limits the ability to fill the canal to the apex.
   4. The filling must be properly condensed/obdurated.
   5. To be covered, a tooth must oppose a crown or denture in the opposite arch or be an abutment for a partial denture.
   6. The patient must be free from active and advanced periodontal disease.
   7. The fee for veneers includes the temporary restoration that is placed on the prepared tooth and worn while the veneer is being fabricated.