Policy Title: Evaluation Criteria

Number: TD-O-4000

Subject: Define general and specific criteria to process claims with treatment

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TennDent Quality Monitoring/Improvement Committee Approval: On File

Approval Date: 9/23/2011

Scope:

TennDent Network Providers, TennCare Members, TennDent staff and Bureau of TennCare

Purpose:

To identify clinical criteria guidelines and documentation required of participating providers and used by TennDent for making medical necessity determinations pre and post treatment.

Authoritative Reference:

TennCare Medical Necessity Rules 1200-13-13, 1200-13-14, 1200-13-16

Policy:

Criteria is posted on the TennDent website, in the Provider Office Reference Manual and reviewed at Network Provider Training Sessions.

Denial Criteria

If it is determined that the treatment submitted as a predetermination or a claim in for pay does not meet the medical necessity rule the reason for the denial will be documented in the notepad on the claim. Within twenty four hours of the medical necessity decision the claim will be denied with the
appropriate reason code and a letter generated to the member outlining the reason for the denial and information on how to appeal. An explanation of benefits will be mailed to the provider and the supporting documentation for each claim will be maintained electronically.

Evaluation Criteria

1. All covered dental services must also be medically necessary as defined by TennCare Rules. The clinical criteria presented are the criteria that TennDent dental benefit reviewers will use for making medical necessity determinations for those specific procedures. In addition, please review the general benefit limitations for certain dental procedures. Exceptions to general benefit limitations may be made on an individual enrollee basis if medically necessary.

2. Failure to submit the required documentation may result in a disallowed request and denied payment of a claim related to that request.

3. Prior authorization is required for orthodontic treatment, complex oral surgery procedures, endodontic treatment, prosthodontic treatment, and any procedure requiring in-patient or outpatient treatment in any hospital or surgery center.

4. Whether a procedure does or does not require prior authorization, all procedures require acceptable documentation standards be met. Documentation for all procedures rendered must justify the need for the procedure performed due to medical necessity. Appropriate diagnostic pre-operative radiographs clearly showing the adjacent and opposing teeth and substantiating any pathology or caries present are required. Post-operative radiographs are required for endodontic procedures and permanent crown placement to confirm quality of care. In the event that radiographs are not available or cannot be obtained, diagnostic quality intraoral photographs must substantiate the need for procedures rendered.

5. Failure to provide the required documentation, audit findings, or the failure to maintain acceptable practice standards may result in sanctions including, but not limited to, recoupment of benefits on paid claims, follow-up audits, or removal from the TennDent Provider Panel.

6. Multistage procedures are reported and may be reimbursed upon completion. The completion date is the date of insertion for removable prosthetic appliances. The completion date for immediate dentures is the date that the remaining teeth are removed and the denture is inserted. The completion date for fixed partial dentures and crowns, onlays, and inlays is the cementation date regardless of the type of cement utilized. The completion date for endodontic treatment is the date the canals are permanently filled.

Criteria for Dental Extractions

Although all extractions must be medically necessary, not all procedures require authorization. Extraction of primary or permanent teeth in individuals under age 21 does not require authorization unless the teeth are impacted wisdom teeth or residual tooth roots to be surgically removed.

Removal of primary teeth whose exfoliation is imminent does not meet criteria for extraction.
Documentation needed for authorization procedure:

a. Appropriate diagnostic radiographs that are labeled Right (R) and Left (L) and the date the radiographs were taken, not submitted, showing clearly the adjacent and opposing teeth submitted for authorization review; bitewings, periapicals or panorex.

b. Treatment rendered under emergency conditions, when authorization is not possible, will still require that appropriate radiographs showing clearly the adjacent and opposing teeth be submitted with the claim for review for payment.

c. For patients under age 21, extraction of impacted wisdom teeth or surgical removal of residual tooth roots will require a written narrative of medical necessity.

d. If extractions are approved, an operating room or ambulatory surgical center (ASC) authorization may also be approved including general anesthesia benefits if the appropriate criteria are met.

Authorization for extraction of impacted third molars

a. Benefit review decisions for authorization of extracting 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.

b. The prophylactic removal of disease-free third molars is not covered.

- Impacted third molars that do not show radiographic evidence of complete root formation will not qualify for authorization for extraction.
- Impacted third molars that do not show pathology will not qualify for an authorization for extraction.
- Impacted third molars that do not demonstrate radiographic aberrant tooth position beyond normal variations will not qualify for authorization for extraction.
- Normal eruption discomfort and localized inflammatory conditions will not qualify impactions for extraction.

Criteria for Cast Crowns

Documentation needed for authorization of procedure:

- Appropriate diagnostic radiographs showing clearly the adjacent and opposing teeth should be submitted for prior authorization or with the claim once service has been rendered; bitewings, periapicals or panorex.

Criteria:

- In general, criteria for crowns will be met only for permanent teeth needing multi-surface restorations or where other restorative materials have a poor prognosis.
- Permanent molar teeth should have pathologic destruction to the tooth by caries or trauma, and should involve four or more surfaces and two or more cusps.
- Permanent bicuspids teeth should have pathologic destruction to the tooth by...
caries or trauma, and should involve three or more surfaces and at least one cusp.

- Permanent anterior teeth should 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.

A request for a crown following root canal therapy must meet the following criteria:

- Request should include a dated post-endodontic radiograph.
- Tooth should be filled sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the ability to fill the canal to the apex.
- The filling must be properly condensed/obturated. Filling material does not extend excessively beyond the apex.

To meet criteria, a crown must be opposed by a tooth or dentures in the opposite arch or are an abutment for a partial denture.

- The patient must be free from active and advanced periodontal disease.
- The fee for crowns includes the temporary crown that is placed on the prepared tooth and worn while the permanent crown is being fabricated.

Cast crowns on permanent teeth are expected to last five years. Authorizations for crowns will not meet criteria if:

- A lesser means of restoration is possible.
- Tooth has subosseous and/or furcation caries.
- Tooth has advanced periodontal disease.
- Tooth is a primary tooth.
- Crowns are being planned to alter vertical dimension.
- Tooth has no apparent pathologic destruction due to caries or trauma.

Criteria for Endodontics

Documentation needed for authorization of procedure:

- Sufficient and appropriate diagnostic radiographs showing clearly the adjacent and opposing teeth and a pre-operative radiograph of the tooth to be treated; bitewings, periapicals or panorex. A dated post-operative radiograph must be submitted for review for payment.

Note: Failure to submit the required documentation may result in a denied request and denied payment of a claim related to that request.

Extensive treatment plans including endodontics, implants, prosthodontics, or multiple crowns may require a second opinion as determined by TennDent.

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

Root canal therapy must meet the following criteria:

- Fill should be sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the dentist’s ability to fill the canal to the apex.
- Fill must be properly condensed/obturated. Filling material does not extend excessively beyond the apex.

Authorizations for root canal therapy will not meet criteria if:

- Gross periapical or periodontal pathosis is demonstrated radiographically (caries subcrestal or to the furcation, deeming the tooth non-restorable).
- The general oral condition does not justify root canal therapy due to loss of arch integrity.
- Root canal therapy is for third molars, unless they are an abutment for a partial denture.
- Tooth does not demonstrate 50 percent bone support.
- Root canal therapy is in anticipation of placement of an overdenture.
- A filling material not accepted by the Federal Food and Drug Administration (e.g. Sargenti filling material) is used.

Other considerations:

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

Criteria for Stainless Steel Crowns

Prophylactic use of stainless steel crowns is not a covered benefit.

Although authorization for stainless steel crowns is not required, documentation justifying the need for treatment using stainless steel crowns must be made available upon request for review by TennDent pre-operatively or post-operatively and include the following:

- Appropriate diagnostic radiographs clearly showing the adjacent and opposing teeth and pathology or caries-detecting intraoral photographs if radiographs could not be made.
- Copy of patient’s dental record with complete caries charting and dental anomalies
- Copy of detailed treatment plan.
• In general, criteria for stainless steel crowns will be met only for teeth needing multi-surface restorations or where amalgams, composites, and other restorative materials have a poor prognosis.

• Permanent molar teeth should have pathologic destruction to the tooth by caries or trauma, and should involve four or more surfaces and/or two or more cusps.

• Permanent bicuspid teeth should have pathologic destruction to the tooth by caries or trauma, and should involve three or more surfaces and at least one cusp.

• Permanent anterior teeth should have pathologic destruction to the tooth by caries or trauma, and should involve four or more surfaces and at least 50 percent of the incisal edge.

• Primary anterior teeth should have pathologic destruction to the tooth by caries or trauma and should involve two or more surfaces or incisal decay resulting in an enamel shell.

• Primary molars should have pathologic destruction to the tooth by caries or trauma, and should involve two or more surfaces or substantial occlusal decay resulting in an enamel shell.

• Primary teeth that have had a pulpotomy or pulpectomy performed.

**Note:** TennDent may require a second opinion for requests of more than 4 stainless steel crowns per patient.

**Note:** Following utilization review, if a dentist fails to adhere to the medical necessity criteria for stainless steel crowns, TennDent will initiate corrective action for that Provider, which may include imposition of prior authorization for this service.

An authorization for a crown on a permanent tooth following root canal therapy must meet the following criteria:

• Claim should include a dated post-endodontic radiograph.

• Tooth should be filled sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the dentist’s ability to fill the canal to the apex.

• The filling must be properly condensed/obturated. Filling material does not extend excessively beyond the apex.

To meet criteria, a crown must be opposed by a tooth or denture in the opposite arch or be an abutment for a partial denture.

• The patient must be free from active and advanced periodontal disease.

• The permanent tooth must be at least 50 percent supported in bone.

• Stainless steel crowns on permanent teeth are expected to last five years.

Criteria for treatment using stainless steel crowns will not be met if:

• A lesser means of restoration is possible.

• Tooth has subosseous and/or furcation caries.
• Tooth has advanced periodontal disease.
• Tooth is a primary tooth with exfoliation imminent.
• Crowns are being planned to alter vertical dimension.
• Tooth has no apparent pathologic destruction due to caries or trauma.

Criteria for Authorization of Operating Room (OR) Cases or Ambulatory Surgical Center (ASC)

All OR cases or ASCs must have prior authorization (except in emergencies).

Providers must submit the following documents for review by TennDent for authorization of OR cases or ASC:

• Completed TennCare Inpatient and Outpatient Hospital Readiness Pre-admission Form in Section 15.
• Copy of the patient’s dental record including health history, charting of the teeth and existing oral conditions.
• Diagnostic radiographs or caries-detecting intraoral photographs.
• Copy of treatment plan. A completed ADA claim form submitted for an authorization may serve as a treatment plan.
• Narrative describing medical necessity for OR or ASC.

On occasion, due to the lack of physical or emotional maturity, or a disability, a patient may not cooperate enough for radiographs or intraoral photographs to be made. If this occurs, it must be noted in the patient record and narrative describing medical necessity. Dentists who “routinely” fail to submit radiographs or intraoral photographs may be denied authorization for treatment.

Extensive treatment plans including endodontics, implants, prosthodontics, or multiple crowns may require a second opinion as determined by TennDent.

The Provider is responsible for choosing facilities/Providers from Enrollee’s MCO panel, obtaining all necessary authorizations, and obtaining a medical history and physical examination by the patient’s primary care physician. TennDent would not recommend that Providers submit this documentation with the authorization request but would assume that this information would be documented in the patient record.

Criteria:
In most situations, OR or ASC cases will be authorized for procedures covered by TennCare if the following is (are) involved:

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

• 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 recent MI, recent stroke,
new chest pain, etc. Class IV – patient with severe systemic disease that is a constant threat to life).

- Medically compromised patients whose medical history indicates that the monitoring of vital signs or the availability of resuscitative equipment is necessary during extensive dental procedures.
- Patients requiring extensive dental procedures with a medical history of uncontrolled bleeding, severe cerebral palsy, or other medical condition that renders in-office treatment medically appropriate.
- Patients requiring extensive dental procedures who have documentation of psychosomatic disorders that require special treatment.
- Cognitively disabled individuals requiring extensive dental procedures whose prior history indicates hospitalization is appropriate.

**Criteria for Removable Prosthodontics (Full and Partial Dentures)**

Documentation needed for authorization of procedure:

- Appropriate diagnostic radiographs showing clearly the adjacent and opposing teeth must be submitted for authorization review; bitewings, periapicals or panorex.

Prosthetic services are intended to restore oral form and function due to premature loss of permanent teeth that would result in significant occlusal dysfunction.

- A denture is determined to be an initial placement if the patient has never worn prosthesis. This does not refer to just the time a patient has been receiving treatment from a certain Provider.
- 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.
- Radiographs must show no untreated cavities or active periodontal disease in the abutment teeth, and abutments must be at least 50 percent supported in bone.
- As part of any removable prosthetic service, dentists are expected to instruct the patient in the proper care of the prosthesis.
- 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.
- In general, a partial denture will be approved for benefits if it replaces one or more anterior teeth, or replaces two or more posterior teeth unilaterally or replaces three or more posterior teeth bilaterally, excluding third molars, and it can be demonstrated that masticatory function has been severely impaired. The replacement teeth should be anatomically full sized teeth.

Authorizations for removable prosthesis will not meet criteria:

- If there is a pre-existing prosthesis that is not at least 5 years old and unserviceable
• If good oral health and hygiene, good periodontal health, and a favorable prognosis are not present.
• If there are untreated cavities or active periodontal disease in the abutment teeth.
• If abutment teeth are less than 50 percent supported in bone.
• If the recipient cannot accommodate and properly maintain the prosthesis (lodge, gag reflex, potential for swallowing the prosthesis, severely handicapped).
• If the recipient has a history or an inability to wear a prosthesis due to psychological or physiological reasons.
• If a partial denture, less than five years old, is converted to a temporary or permanent complete denture.
• 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.

Benefit criteria:
• If there is a pre-existing prosthesis, it must be at least 5 years old and unserviceable to qualify for replacement.
• Adjustments, repairs and relines are included with the denture fee within the first 6 months after insertion.

After that time has elapsed:
• Adjustments will be reimbursed at one per calendar year per denture.
• Repairs will be reimbursed at two repairs per denture per year, with five total denture repairs per 5 years.
• Relines will be reimbursed once per denture every 36 months.
• A new prosthesis will not be 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.
• Replacement of lost, stolen, or broken dentures less than 5 years of age will not meet criteria for pre-authorization of a new denture.
• 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.
• All prosthetic appliances shall be inserted in the mouth and adjusted before a claim is submitted for payment.
• 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.
Criteria for the Excision of Bone Tissue

To ensure the proper seating of a removable prosthetic (partial or full denture) some treatment plans may require the removal of excess bone tissue prior to the fabrication of the prosthesis. 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 prosthetic treatment.

Current ADA codes D7471, D7472, and D7473 are related to the removal of exostoses. These codes are subject to prior authorization and may be reimbursed when submitted in conjunction with a treatment plan that includes removable prosthetics. These determinations will be made by the appropriate dental specialist/consultant.

Pre-authorization requirements:

- Appropriate radiographs and/or intraoral photographs and/or study models which clearly identify the exostosis must be submitted for authorization review; bitewings, periapicals or panorex.
- Copy of detailed treatment plan— including prosthetic plan.
- Narrative of medical necessity.

Criteria for the Determination of a Non-Restorable Tooth

TennDent will deny coverage for the services for patients 21 and over*. 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.

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

- The tooth presents with greater than a 75 percent loss of the clinical crown.
- The tooth has less than 50 percent bone support.
- The tooth has subosseous and/or furcation caries.
- The tooth is a primary tooth with exfoliation imminent.
- 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.

Criteria for General Anesthesia and IV Sedation

Documentation needed for authorization of procedure:

- Diagnostic radiographs or intraoral photographs
- Treatment plan (authorized if necessary).
- Narrative describing medical necessity for General Anesthesia or IV Sedation.
- Treatment rendered under emergency conditions, when prior authorization is not possible, will still require submission of appropriate documentation with the claim for review for payment.

Requests for general anesthesia or IV sedation will be authorized (for procedures covered by TennCare) if any of the following criteria are met:
Extensive or complex oral surgical procedures such as:

- Impacted wisdom teeth.
- Surgical root recovery from maxillary antrum.
- Surgical exposure of impacted or unerupted cuspids.
- Radical excision of lesions in excess of 1.25 cm.

And/or one of the following medical conditions:

- Medical condition(s) which require monitoring (e.g. cardiac problems, severe hypertension).
- Underlying hazardous medical condition (cerebral palsy, epilepsy and mental retardation) which would render patient non-compliant.
- Documented failed sedation or a condition where severe periapical infection would render local anesthesia ineffective.
- Patients 8 years old and younger with extensive procedures to be accomplished.

Criteria for Restraint of Pediatric and Special Needs Patients

Participating providers must comply with the following rules of the Tennessee Board of Dentistry, 0460-01-.18. Failure to comply may result in penalties up to, but not limited to, termination from participation as a provider with the TennCare program:

1. Purpose – The purpose of this rule is to recognize the unfortunate fact that pediatric and special needs patients may need to be restrained in order to prevent injury and to protect the health and safety of the patients, the dentist, and the dental staff. To achieve this it will be important to build a trusting relationship between the dentist, the dental staff and the patient. This will necessitate that the dentist establishes communication with the patient and promote a positive attitude towards oral and dental health in order to alleviate fear and anxiety and to deliver quality dental care.

2. Training Requirement – Prior to administering restraint, the dentist must have received formal training at a dental school or during an American Dental Association accredited residency program in the methods of restraint described in paragraph (4) of this rule.

3. Pre-Restraint Requirements
   a. Prior to administering restraint, the dentist shall consider:
      i. The need to diagnose and treat the patient;
      ii. The safety of the patient, dentist, and staff;
      iii. The failure of other alternate behavioral methods;
      iv. The effect on the quality of dental care;
      v. The patient’s emotional development; and
      vi. The patient’s physical condition.
b. Prior to administering restraint, the dentist shall obtain written informed consent from the parent or legal guardian and document such consent in the dental record, unless the parent or legal guardian is restraining or immobilizing the patient by use of the method described in subparagraph (4) (b) of this rule.

4. Methods of Restraint

a. The Hand-Over-Mouth Exercise (HOME) Method

This method may be used for a healthy child who is able to understand and cooperate but who exhibits defiant, aggressive, or hysterical behavior during dental treatment. Use of this method shall never obstruct the patient’s airway nor be used:

   i. With patients whose age, disability, or emotional immaturity prevent them from being able to understand and/or cooperate;

   ii. When patients are under the influence of medications which prevent them from being able to understand and/or cooperate;

   iii. When patients have an airway obstruction or when restraint will prevent the patient from breathing; or,

   iv. When the parent or legal guardian has not given written informed consent for this method to be utilized.

b. The Physical Restraint or Medical Immobilization Method

This method may be used to partially or completely immobilize the patient for required diagnosis and/or treatment if the patient cannot cooperate due to lack of maturity, mental or physical handicap, failure to cooperate after other behavior management techniques have failed and/or when the safety of the patient, dentist, or dental staff would be at risk without using protective restraint. This method should only be used to reduce or eliminate untoward movement, protect the patient and staff from injury, and to assist in the delivery of quality dental treatment. If restraint or immobilization is deemed necessary, the least restrictive technique shall be used.

Use of this method shall not be used:

   i. With cooperative patients;

   ii. On patients who, due to their medical or systemic condition, cannot be immobilized safely;

   iii. As punishment; or,

   iv. Solely for the convenience of the dentist and/or dental staff

5. Dental hygienists and dental assistants shall not use the methods described in paragraph 4 by themselves, but may assist the dentist as necessary.

6. The patient’s record shall include:

   a. Written informed consent from parents or legal guardians;

   b. Type of method used;

   c. Reason for use of that method;
d. Duration of method used; and,

e. If restraint or immobilization is used, type of restraint or immobilization used.

7. Parents or legal guardians must be informed in advance of what treatment the patient will receive and why the use of restraints may be required. Parents or legal guardians shall be informed of the office policy concerning parental presence, the benefits and risks of parental presence, and of their opportunity to choose a different practitioner for the child if they are not comfortable with the office policy.

8. Parents or legal guardians may not be denied access to the patient during treatment in the dental office unless the health and safety of the patient, parent or guardian, or dental staff would be at risk. The parent or guardian shall be informed of the reason they are denied access to the patient and both the incident of the denial and the reason for the denial shall be documented in the patient’s dental record.

Criteria for Periodontal Treatment

Documentation needed for authorization of procedure:

1. Diagnostic radiographs – periapicals or bitewings preferred.
2. Copy of detailed treatment plan.
3. Narrative of medical necessity addressing pre- and post-operative prognosis for surgical cases.
4. Intraoral photographs clearly identifying the condition in cases of gingival hyperplasia.

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.

It is anticipated that this procedure would be requested in cases of severe periodontal conditions (i.e. late Type II, III, IV periodontitis) where definitive comprehensive root planning requiring local/regional block anesthesia and several appointments would be indicated.

From the American Academy of Periodontology (AAP) Policy on Scaling and Root Planing:

“Periodontal scaling is a treatment procedure involving instrumentation of the crown and root surfaces of the teeth to remove plaque, calculus, and stains from these surfaces. It is performed on patients with periodontal disease and is therapeutic, not prophylactic, in nature. Periodontal scaling may precede root planing, which is the definitive, meticulous treatment procedure to remove cementum and/or dentin that is rough and may be permeated by calculus, or contaminated with toxins or microorganisms. Periodontal scaling and root planing are arduous and time consuming. They may need to be repeated and may require local anesthetic.”

Criteria:

• Four (4) of eight (8) teeth affected in the quadrant.
• Periodontal charting indicating 4mm or more pocket depths in multiple sites.

• Additionally at least one of the following must be present:
a. Radiographic evidence of root surface calculus
b. Radiographic evidence of significant loss of bone support

Orthodontic Treatment Criteria

Orthodontic services are covered for Enrollees under 21. Orthodontic treatment for cosmetic purposes is not a covered benefit. If TennDent does not score the Enrollee’s malocclusion severity assessment (MSA) at 28 or above, TennDent will determine whether orthodontic services are medically necessary to treat one of the medical conditions contained in the definition of handicapping malocclusion. If TennDent has determined that malocclusion scores 28 or above on the TennDent approved MSA, orthodontic services are covered. The following outlines the policies and procedures associated with Orthodontics covered under the TennCare dental program:

1. Enrollees must be referred to an orthodontist by a General or Pediatric Dentist.
2. TennDent will refer Enrollees to licensed orthodontists or pedodontists who have received specialty training in orthodontics as part of their core curriculum.
3. Providers should contact TennDent on each date of service to verify eligibility. Orthodontic services will only be reimbursed if rendered on a day when the Enrollee is eligible.
4. Orthodontic cases must be submitted to TennDent for approval through one of the following means:
   a) Submission of a duplicate set of photographs (photographs will not be returned) to include:
      i. Facial photographs (right and left profiles in addition to a straight on facial view)
      ii. Frontal view, in occlusion, straight on view
      iii. Frontal view, in occlusion, from a low angle
      iv. Right buccal view, in occlusion
      v. Left buccal view, in occlusion
      vi. Maxillary occlusal view
      vii. Mandibular occlusal view
   b) Submission of the alginate to OrthoCAD. OrthoCAD will enable dental Providers to send electronic models to TennDent electronically. OrthoCAD offers a low cost alternative to submitting plaster models. The threat of broken, lost or otherwise compromised models is eliminated. All you need is a computer and Internet access.
   c) In lieu of the above photographic requirement, TennDent will accept a duplicate set of quality photographs of study models (photographs will not be returned) with the following parameters:
      i. Occlusal view of the maxillary arch
      ii. Occlusal view of the mandibular arch
      iii. Right buccal view, in occlusion
iv. Left buccal view, in occlusion
v. Facial view, straight on and low angle, in occlusion
vi. Posterior view of models in occlusion
vii. TennDent will accept a duplicate cast of the study models. Study models will not be returned.

Authorization
Duplicate photographs and all other applicable documentation sent to TennDent by the Provider via regular mail or OrthoCAD. Photographs and other documentation will not be returned to the dentist. TennDent’s orthodontic consultants utilize the photographs, OrthoCAD, radiographs and any applicable narrative to determine the medical necessity of the case.

Only eligible TennCare Enrollees will be considered for orthodontic treatment.

Denials
If the case is denied, pre-determination EOB will be sent to the Provider notifying them of the denied case within 24 hours of the denial determination. The Enrollee will also receive written notification of the denial.

For denied cases, the models, radiographs, and any other accompanying materials will not be returned to the Provider. TennDent is required to keep the records in order to meet state required turnaround time for potential Enrollee appeals.

The denied cases will automatically have a claim generated from TennDent for the pre-orthodontic treatment visit (CDT code D8660).

Approvals
If the case is approved, the Provider will receive an approved predetermination form. The approved authorization will include authorization for one (1) comprehensive orthodontic treatment of the adolescent dentition (CDT code D8080) and up to twenty-three (23) periodic orthodontic treatments (CDT code D8670).

Once the orthodontic appliance has been placed (banding), the Provider should submit for procedure code D8080 – Comprehensive Orthodontic Treatment of the Adolescent Dentition.

Ortho claims are recommended to be submitted through the Dental Office Toolkit or electronically through a clearinghouse.

Related Policies and Procedures
Prior Authorization of Treatment Policy
Prior Authorization of Treatment Procedure
Utilization Review Program

Related Documents
Provider Office Reference Manual