**Policy Title: Evaluation Criteria**

**Number:** TD-O-4000

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

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**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**

All covered dental services must also be medically necessary for TennCare members under the age of 21 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 presented in the Coverage Limits Policy. Exceptions to general benefit limitations may be made on an individual enrollee basis if medically necessary.

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

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.

For all procedures, every Provider in the TennDent program is subject to random chart/treatment audits. These audits may occur in the Provider’s office as well as in the office of TennDent. Based on the findings of any audit, the Provider will be notified of the results of the audit. In the event that audit findings require examination by the TennDent Peer Review Committee, any requested records must be made available upon request to TennDent.

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.

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. Additionally, the provider may be referred to the Bureau of TennCare for possible actions impacting the providers ability to participate in the TennCare Medicaid, Cover Kids, and other states Medicaid and/ or CHIP programs.

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.
• Appropriate diagnostic radiographs showing the completed restoration must be in the patient’s
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.
- **Patients are eligible for cast crowns on teeth 3, 14, 19 and 30 at age 16.**
- **Patients are eligible for cast crowns on teeth 2, 15, 18, and 31 at age 18.**
- **Patients are eligible for cast crowns on teeth (4-13; 20-29) at age 18**
  - 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 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 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 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 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 and payment 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 periapical radiograph must be submitted showing properly obturated canal(s), 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.

1. **Pulpotomy Criteria:**

Pulpotomies must meet the following criteria:

A pulpotomy is performed in a primary tooth with extensive caries but without evidence of radicular pathology when caries removal results in a carious or mechanical pulp exposure. The coronal pulp is amputated and the remaining vital radicular pulp tissue is treated with a long-term clinically successful medicament.

A pulpotomy is indicated when caries removal results in pulp exposure in a primary tooth with a normal pulp or reversible pulpitis or after a traumatic pulp exposure. The objective is to maintain an asymptomatic tooth without clinical signs of sensitivity, pain, or swelling.

2. **Root Canal Therapy 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 Provision of Dental Treatment in an Inpatient/Outpatient Hospital Facility (“Hospital”) or in an Ambulatory Surgical Center (ASC)**

1. Provision of dental treatment in hospital or ASC requires informed consent.
2. Provision of dental treatment in hospital or ASC requires prior authorization from TennDent unless such dental treatment constitutes an emergency.

Providers requesting PA for dental treatment in hospital or ASC must submit the following documentation with their PA request in order for TennDent to determine whether the PA request meets medical necessity and clinical criteria:

   a. Completed TennCare Inpatient and Outpatient Hospital Readiness Pre-admission Form. This form must evidence that the requesting dental provider attempted to treat the patient in-office and, where appropriate, referred the patient to a pediatric dentist or other specialist. Absent evidence of attempted in-office treatment and/or referral to pediatric
dentist or other specialist, prior authorization may be denied by TennDent.

b. Copy of the patient’s dental record including health history, charting of the teeth and existing oral conditions.

c. Diagnostic radiographs or caries-detecting intraoral photographs.

i. 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. Once the patient is sedated in the medical setting (hospital or ASC) diagnostic radiographs or intraoral photographs must be made and submitted with the claim to satisfy the authorization of the medical necessity requirement.

d. Copy of treatment plan. A completed ADA claim form submitted for an authorization may serve as a treatment plan.

e. Narrative describing medical necessity for conferring dental treatment in hospital/ASC.

3. The dental provider requesting PA for hospital/ASC-based dental treatment must have obtained authorization from the patient’s TennCare MCO and must ensure each of the following:

a. The selected hospital/ASC participates in the TennCare patient’s MCO network.

b. The requisite medical staff, anesthesiologists, etc. are participants in the TennCare patient’s MCO network.

c. The dental provider has consulted with the patient’s primary care physician concerning the dental care to be conferred in hospital/ASC.

d. The patient’s primary care physician has examined the patient and supplied the dental provider with the patient’s up-to-date medical evaluation.

e. The patient’s medical evaluation has been supplied to TennDent.

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

5. Criteria:

Dental treatment requested to be conferred in a Hospital/ASC may 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 and Fixed Prosthodontics

1. 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 dental caries 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 dental caries 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.

2. Criteria for Fixed Prosthodontics

The replacement of missing teeth with fixed Prosthesis (bridges, implant supported crowns) in most cases does not satisfy the medical necessity guidelines by being the least costly alternative course of treatment that is adequate for the enrollee’s medical condition.

Documentation needed for authorization of procedure:

• Treatment must be preauthorized.

• A detailed narrative explaining why a removable prosthesis is not an adequate treatment alternative.

• Appropriate diagnostic radiographs showing clearly the adjacent and opposing teeth must be submitted for authorization review, bitewings, periapicals and/or panoramic radiograph.

Fixed prosthetic services are intended to restore oral form and function due to premature loss of permanent teeth that would result in significant occlusal dysfunction and only in cases where removable prosthesis are contraindicated.

• A fixed prosthesis is a once in a lifetime benefit.

• Patients must be 16 years of age to be considered for fixed prosthesis.

• Only permanent teeth may be used as abutments for fixed prosthesis.

• Fixed prosthesis 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 of periodontal and/or tooth structure is not expected.

• Radiographs must show no active periodontal disease adjacent to the abutment teeth and abutments must be at least 50% supported in Bone.
• As part of the fixed prosthetics service, dentists are expected to provide patients with adequate instructions in the care of the prosthesis.

• In general, fixed prosthetics in the posterior area of the mouth must replace two or more adjacent missing teeth

Authorizations for fixed prosthesis will not meet criteria:

• It is determined that a removable prosthesis can provide adequate service to the patient.

• If good oral health and hygiene, good periodontal health and a favorable prognosis are not present.

• If there is active periodontal disease around the abutment teeth.

• If abutment teeth are less than 50% supported in bone.

• If the posterior edentulous space is equivalent to the size of only one permanent tooth.

• If the patient cannot adequately care for the prosthesis.

• If the patient is under 16 years old.

• If the patient has had a fixed prosthesis placed in the same posterior quadrant or anterior segment.

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

Network Dentists who conduct in office sedation must comply with the rules and regulations established by the Tennessee Board of Dentistry as they apply to sedation. Failure of Dentists to provide compliant documentation of sedation in the patient record will result in the provider being requested to implement a corrective action plan and recoupment of monies paid for non-compliant 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.

**Authority:** T.C.A. §§4-5-202, 4-5-204, 63-5-105, and 63-5-108.

**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:
  - Radiographic evidence of root surface calculus
  - Radiographic evidence of significant loss of bone support
Criteria for Minor Treatment to Control Harmful Habits

Removable appliance therapy (8210) and fixed appliance therapy (8220) treatments are covered services to control harmful habits. These treatment services include appliances for thumb sucking and tongue thrusting. Removable indicates patient can remove appliance. Fixed indicates patient cannot remove appliance.

Procedure code 8220 or 8210 requires prior authorization and must be submitted with the following documentation:

1. A duplicate set of pre-treatment study models or a duplicates set of diagnostic pre-treatment digital photographs that clearly demonstrate that there is existing damage to the permanent arch alignment being created by the thumb habit or tongue thrust. Radiographs, photographs, or study models will not be returned.

2. A panoramic radiograph, if available.

3. A letter from a speech pathologist documenting the thumb habit or tongue thrust is causing speech pathology, if available or

4. A letter from the primary care physician indicating the thumb habit or tongue thrust is causing a nutritional problem, if available.

The allowable fee includes records, adjustment appointments and any appliance repairs or replacements. The procedure can only be performed once in a lifetime.

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
   d) TennDent will accept a duplicate cast of the study models. Study models will not be returned.

5. A completed TennCare Orthodontic Readiness Necessity Form must be submitted to TennDent by the Orthodontist or Pediatric dentist who is seeking authorization.

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.

As an eligible TennCare Enrollee returns for periodic orthodontic treatments (CDT code D8670), the Provider must submit a claim for each visit.

Providers may bill up to one periodic orthodontic treatment per calendar month for the same eligible TennCare Enrollee pursuant to rendering service.

Cost of retainers and 12 months of adjustments are included in procedure code D8080 – Comprehensive Orthodontic Treatment.

TennDent will pay authorized periodic orthodontic treatments (CDT code D8670) for a maximum count of twenty-three (23). Any periodic orthodontic treatments (CDT code D8670) beyond the number approved will not be billable and are included in the case rate. Any periodic orthodontic treatments (CDT code D8670) authorized, but not performed will not be paid. Reimbursement is based on the Enrollee’s eligibility at the time of service.

Eligible TennCare Enrollees shall not be charged for missed appointments.

If a Provider is unable to maintain a professional relationship with a TennCare Enrollee, the Provider may terminate the relationship. Upon termination of the relationship by the Provider with the TennCare Enrollee, such termination reason should be provided to the TennCare Enrollee. Enrollees that have been terminated by a Provider shall be referred back to TennDent by the Provider.

Eligible TennCare Enrollees shall not be charged for broken brackets. Consideration for broken brackets is built into the orthodontic rate. It is understood, however, that excessive breakage that is deemed to be unacceptable to the Provider may prevent the Provider from maintaining a professional relationship with an Enrollee.

Orthodontic Continuation of Care (New Patient)

TennDent requires the following information for possible payment of continuation of care cases:

- Completed Orthodontic Continuation of Care Form.
• Completed ADA claim form listing services to be rendered.
• A copy of Enrollee's prior approval including the total approved case fee, banding fee, and periodic orthodontic treatment fees.
• If the Enrollee is private pay or transferring from a commercial insurance program, original diagnostic photographs (or OrthoCAD equivalent), radiographs (optional).

If the Enrollee started treatment under commercial insurance or private pay or another State Medicaid program, we must receive the ORIGINAL photographs of the diagnostic models (or OrthoCAD), or radiographs (optional), banding date, and a detailed payment history.

It is the Provider’s and Enrollee’s responsibility to get the required information. Cases cannot be setup for possible payment without complete information.

**Orthodontics Continuation (Debanding only)**

If the Provider determines that a referred Enrollee’s case is complete and should transition to the retention phase of treatment, the Provider should submit an authorization request, including narrative, for procedure code D8680 – Orthodontic Retention.

TennDent’s orthodontic consultants review the authorization request and determine case based on the information provided.

If the authorization is approved, upon debanding the Provider will submit a claim for the orthodontic retention (CDT code D8680) with the debanding date.

Orthodontic Retention includes debanding, retainers, and 12 months of adjustments.

**Criteria for Space Maintainers**

1. **Criteria for Unilateral Space Maintainer-Fixed – D1510**

   Space maintainers may be considered for payment if medically necessary for members ages 2 through 12 based on the following criteria:

   1. If the primary cuspsids, primary first molars or primary second molars is missing or needs to be extracted due to pathology.
   2. Limited to once per lifetime per quadrant.
   3. Any stainless steel crown or orthodontic band that is part of the space maintainer is included in the space maintainer fee for the fixed space maintainer.
   4. Re-cementation for the first six months is included in the fee for the D1510 code. After six months, re-cementation is covered under the D1550 code.
5. Repair or replacement of the appliance is not reimbursed.

6. Space loss in the primary dentition results when the primary cuspids, 1st primary molars, or 2nd primary molars are lost. In the cases where any of these teeth are lost, a lingual arch for bilateral loss would meet medical necessity requirements or a unilateral space maintainer would meet medical necessity requirements when the loss is unilateral except in the case of the cuspids where a lingual arch is recommended whether the loss is unilateral or bilateral.

If a child loses any anterior tooth/teeth (DEFG or NOPQ) and they have teeth ABC and HIJ or KLM and RST in place, the arch space will not be lost. Requests for a lingual arch or pedi-partial with prosthetic teeth for D, E, F, or G to assist in speech, tongue posture and swallowing does not meet medical necessity for space maintenance. Depending on the age of the child, speech patterns, swallowing techniques, and tongue posture are not problems with the loss of the anterior teeth. Appliances for esthetic purposes resulting from the loss of anterior primary teeth are not a covered procedure in the TennCare program. The same criteria are true in the lower arch as well.

If the primary cuspids, 1st primary molars, and 2nd primary molars are in place, the loss of any or all of the anterior teeth will not result in loss of arch space and therefore, no space maintainer is necessary for anterior tooth loss.

2. Criteria for Fixed lingual Arch Space Maintainer-Fixed-Bilateral – D1515

Space maintainers may be considered for payment if medically necessary for members ages 2 through 12 based on the following criteria:

1. Is limited to once in a lifetime for each arch.

2. Any associated stainless steel crown or orthodontic band that is part of the fixed space maintainer is included in the fee for the fixed space maintainer. A crown and a space maintainer cannot be submitted separately for payment if the space maintainer is attached to the crown.

3. D1515 is a lingual arch space maintainer. It does not meet medical necessity requirement when only primary centrals or laterals are missing. Primary cuspids, primary first molars or primary second molars must be missing or need to be extracted due to pathology.

4. Repair or replacement of the appliance is not reimbursed.

5. Re-cementation is included in the fee for the D1515 for six months after placement. Following six months, re-cementation is covered under D1550.
6. Space loss in the primary dentition results when the primary cuspids, 1st primary molars, or 2nd primary molars are lost. In the cases where any of these teeth are lost, a lingual arch for bilateral loss would meet medical necessity requirements or a unilateral space maintainer would meet medical necessity requirements when the loss is unilateral except in the case of the cuspids where a lingual arch is recommended whether the loss is unilateral or bilateral.

If a child loses any anterior tooth/teeth (DEFG or NOPQ) and they have teeth ABC and HIJ or KLM and RST in place, the arch space will not be lost. Requests for a lingual arch or pedi-partial with prosthetic teeth for D, E, F, or G to assist in speech, tongue posture and swallowing is not necessary for space maintenance. Depending on the age of the child, speech patterns, swallowing techniques, and tongue posture are not problems with the loss of the anterior teeth. Appliances for esthetic purposes resulting from the loss of anterior primary teeth are not a covered procedure in the TennCare program. The same is true in the lower arch as well. If the primary cuspids, 1st primary molars, and 2nd primary molars are in place, the loss of any or all of the anterior teeth will not result in loss of arch space and therefore, no space maintainer is necessary for anterior tooth loss. Space loss in the primary dentition results when the primary cuspids, 1st primary molars, or 2nd primary molars are lost. In the cases where any of these teeth are lost, a lingual arch for bilateral loss qualifies as medically necessary or a unilateral space maintainer qualifies as medically necessary when the loss is unilateral except in the case of the cuspids where a lingual arch is recommended whether the loss is unilateral or bilateral.

**Criteria for Occlusal Guards**

An occlusal guard (9940) is a removable appliance designed to minimize the effect of bruxism and other occlusal factors. To determine medical necessity the following criteria must be met:

1. Occlusal guards require prior authorization.

2. Occlusal guards do not meet medical necessary guidelines for patients with primary teeth or are in the mixed dentition.

3. A narrative must be included on or with the claim defining why the occlusal guard is medically necessary. Occlusal guards for the purpose of tooth whitening trays, TMD (temporomandibular disorder) treatment or athletic mouth guards are not considered medically necessary criteria.

4. The fee for the occlusal guard includes six months of follow up care, including adjustments.
Criteria for Frenectomy (Frenulectomy or Frenotomy)

Maxillary Frenectomy

Documentation required for authorization:

- Requires pre-authorization
- Must provide narrative confirming medical necessity (see criteria below)
- Should not be rendered until the permanent incisors and cuspids have erupted and the diastema has had an opportunity to close naturally
- Digital photographs must be provided

Mandibular Labial Frenectomy

Documentation required for authorization:

- Requires pre-authorization
- Must provide narrative confirming medical necessity (see criteria below)
- Digital photographs must be provided

Mandibular Lingual Frenectomy

Documentation required for authorization:

- Requires pre-authorization
- Must provide narrative confirming medical necessity (see criteria below)
- Any available documentation from speech pathologists, pediatricians, oral surgeons, otolaryngologists, or lactation specialists should be provided

Criteria:

I. Maxillary frenectomy: Treatment should not be rendered until the permanent incisors and cuspids have fully erupted any diastema has had an opportunity to close naturally. If orthodontic therapy is indicated, the frenectomy should be performed only after the diastema is closed as much as possible to achieve stable results.

II. Mandibular labial frenectomy: Treatment should be considered if the position of the mandibular labial frenum is causing inflammation, recession, pocket formation, and possible loss of the alveolar bone and/or tooth.

III. Mandibular lingual frenectomy: Treatment should be considered if the position of the lingual frenum is considered to be a contributing factor in malocclusion. A complete orthodontic evaluation, diagnosis and treatment plan are necessary prior to performing a frenectomy in this area. If it is suspected that the position of the
lingual frenum is a contributing factor in altered speech patterns, a letter from a speech pathologist, pediatrician, oral surgeon, otolaryngologist and/or a lactation specialist must be included with the claim.

**Related Policies and Procedures**

Prior Authorization of Treatment Policy  
Prior Authorization of Treatment Procedure  
Utilization Review Program

**Related Documents**

Provider Office Reference Manual