FDB Medicare Authorization and Referral Guidelines

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INTRODUCTION

Florida Dental Benefits' (FDB) Utilization Management Plan is an integral process implemented to ensure the (a) equitable access to care across the plan's dental network; (b) placement of controls and safeguards against unnecessary or inappropriate use of services and against excess payments and; (c) proper assessment of quality of those services.

The FDB Dental Director is responsible for the oversight of FDB's utilization management functions and authorization and referral guidelines that are consistent with recognized standards of care and are compliant with State and Federal statutes and requirements.

FDB's Utilization Management Plan and Referral and Authorization Guidelines promote the most effective and appropriate use of available services incorporating the requirements and guidelines set forth by State and Federal programs as well as the requirements and recommendations of the Current Dental Terminology Book (CDT) and the American Dental Association. This is done in a way that is consistent with recognized dental standards of care, while assuring timely delivery of service and care. All utilization management decisions are made in a fair, impartial and consistent manner that serves the best interest of our members. These criteria are reviewed annually by FDB's Dental Director and the Peer Review Committee, whom are actively practicing dental practitioners. The FDB Utilization Management Plan is described in your FDB Provider Manual.

All requests for pre-authorizations, post service authorizations and referrals are reviewed by an FDB Dental Consultant. In the event that any of the procedures rendered and/or submitted for authorization, referral and payment are not consistent with the guidelines, **FDB reserves the right to deny the authorization, referral, and/or payment.**

Following an appropriate informed consent process, if a patient elects to proceed with a procedure that is not covered, the member is responsible for the dentist's usual fee. The dentist should have the member sign appropriate informed consent documents and financial agreements.

MEDICARE ADVANTAGE PLANS

FDB contracts with multiple Medicare Advantage Plans (Medicare HMOs) to provide their members with dental benefits. Dental is not a required benefit for Medicare Advantage Plans, however, most plans provide dental benefits to their members to enhance their benefit offering. Please note that Medicare Dental Plan Benefits vary depending on the specific Medicare HMO. Guidelines apply if the specific dental benefit is included on the list of covered procedures for the Medicare dental plan. The following are pre-authorization guidelines for the Medicare plans which FDB administers.

"Medical Necessity" refers to dental services that:

- A dental provider, exercising prudent clinical judgement would provide a patient.
- In accordance with generally accepted standards of dental practice. "Generally accepted standards of dental practice" are based on credible scientific evidence published in peer-reviewed, medical literature recognized by the dental community.
- Clinically appropriate and considered effective for the patients' condition.
- Not primarily for the convenience of the patient or any healthcare provider.
- Not more costly than an alternative service or sequence of services likely to produce equivalent therapeutic or diagnostic results.

RESTORATIVE GUIDELINES FOR THE GENERAL DENTIST

Fillings

Restorative treatment must be identified using valid procedure codes as found in the current edition of the American Dental Association's Current Dental Terminology (CDT). This source includes descriptors for each procedure. Sequencing of treatment must be appropriate to the needs of each patient. It is appropriate to restore teeth with radiographic evidence of carries, lost tooth structure, defective and/or lost restoration.

Guidelines:

- Treatment results, including margins, contours and contacts must be clinically acceptable. The long-term prognosis must be good.
- Restorative procedures include the restoration of hard tooth structure lost as a result of carries or fracture.
- The replacement of clinically acceptable amalgam fillings with alternative materials (composite) is considered cosmetic and is not covered unless decay or fracture is present.
- Restorative procedures for teeth exhibiting a poor prognosis due to gross carious destruction of the tooth structure/crown at/or below the bone level, advanced periodontal disease, untreated periapical pathology or poor restorability are not covered.
- All acid etching, adhesives (including resin bonding agents), liners, bases and/or curing techniques are considered to be a part of and included in the amalgam and composite restoration procedures. None of these included procedures may be unbundled and/or charged as a separate service.

Required documentation for processing of pre-authorizations or claims:
Applies to pre-authorizations/claims involving 4 surface anterior restorations:

- Completed dental claim form
- Appropriate radiographs clearly showing the tooth/teeth in question: photograph, panoramic, full mouth series, bitewings or periapicals
- Dental notes and/or a proposed treatment plan

Crowns

- All crowns must be pre-authorized.
- Billing and reimbursement for cast crowns, cast post and cores and/or any other fixed prosthetics shall be based on the cementation date.
- The fee for crowns may include the temporary crown that is placed on the prepared tooth and worn while the permanent crown is being fabricated for permanent teeth. This depends on the specific dental benefits outlined in the Evidence of Coverage for the plan.
- The fee for crowns includes lab fees.
- Cast crowns on permanent teeth are expected to last, at a minimum, five years.

Guidelines:

- 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.
- In general, criteria for crowns will be met only for permanent teeth needing multi-surface restorations where other restorative materials have a poor prognosis.
- Permanent molar teeth must 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 must 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 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.
- Zirconia crowns will be covered and paid as D2740 Crown – porcelain/ceramic. Member should not be charged additional fee for zirconia.

Crowns/post and core will **NOT** be approved if:

- A more cost-effective means of restoration is possible that provides quality care and meets the standard of care.
- Tooth has sub osseous and/or furcation caries.
- Tooth has advanced periodontal disease.
- Tooth does not demonstrate 50% bone support.
- Tooth is a primary tooth.
- Crowns are being planned to alter vertical dimension.
- An existing crown is present with an open margin without decay
- An existing crown is present with chipped or fractured porcelain without decay.

Required documentation for processing of pre-authorizations or claims:

- Completed dental claim form.
- Appropriate radiographs clearly showing the tooth/teeth in question: photograph, panoramic, full mouth series, bitewings or periapicals.
- Narrative of medical necessity.
- Pre and post operative x-rays for claims.

ENDODONTIC GUIDELINES FOR THE GENERAL DENTIST

Guidelines:

- Diagnostic pre-operative radiographs of teeth to be endodontically treated must reveal all periapical areas and alveolar bone.
- Teeth that are predisposed to fracture following endodontic treatment should be protected with an appropriate restoration; most posterior teeth should be restored with a full coverage restoration.
- 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.
- Root canal therapy will not be covered on third molars, unless they are an abutment for a partial denture.
- Tooth must demonstrate 50% bone support for a root canal to be approved.

Required documentation for processing of pre-authorizations or claims:
Applies to pre-authorizations/claims

- Completed dental claim form
- Diagnostic pre-operative radiographs of teeth to be endodontically treated must reveal all periapical areas and alveolar bone.
- Post-operative radiograph(s), showing all canals and apices, must be taken immediately after completion of endodontic treatment.
- Narrative of medical necessity.

PERIODONTIC GUIDELINES FOR THE GENERAL DENTIST

D4355 Full mouth debridement is performed to enable a comprehensive evaluation and diagnosis on a subsequent visit. Full mouth debridement involves the preliminary removal of plaque and calculus that interferes with the ability of the dentist to perform a comprehensive oral evaluation. This procedure is not to be completed on the same day as D0150, D0160, or D0180.

Guidelines:

- This procedure would be followed by the completion of a comprehensive evaluation at a subsequent appointment. This rescheduling may allow some initial soft tissue response and shrinkage prior to performing full mouth periodontal probing.

- This procedure must be supported by radiographic evidence of heavy calculus.
- This procedure is not a replacement for D1110.
- The procedure is not to be billed with a D0150 or D0180 on the same day.

Required documentation for processing of pre-authorizations or claims:
Applies to pre-authorizations/claims
- Completed dental claim form
- Appropriate radiographs clearly showing the tooth/teeth in question: photograph, panoramic, full mouth series, bitewings or periapicals
- Dental notes/narrative and/or a proposed treatment plan

D4341/D4342 Periodontal Scaling and Root-Planing, per quadrant, is described as involving 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.
Guidelines:
- Periodontal charting indicating abnormal pocket depths in multiple sites (5mm or greater).
- Radiographic evidence of root surface calculus.
- The provider must submit a narrative with each SRP pre-authorization or claim.
- Scaling and root planing procedures (D4341/D4342) are generally not performed in the same quadrants or areas for 1 year following initial completion of these services. In the interim, any localized scaling and root planing would be included within periodontal maintenance procedure D4910.
- Scaling and root planning should be performed on a maximum of two quadrants per date of service. If a clinician recommends/completes more than two quadrants per appointment, documentation supporting the additional quadrant(s) must be included with any claim and in the patient's progress notes. The use of topical anesthetics is considered a part of and included in this procedure.
- It is usually not appropriate to perform D1110 and D4341/D4342 on the same date of service. The FDB Dental Consultant may review documented rationale for any such situations on a case-by-case basis.

Required documentation for processing of pre-authorizations or claims:
Applies to pre-authorizations/claims
- Completed dental claim form
- Periodontal charting indicating abnormal pocket depths in multiple sites (5mm or greater).
- Appropriate radiographs clearly showing the tooth/teeth in question: photograph, panoramic, full mouth series, bitewings or periapicals
- Narrative of medical necessity.

ORAL SURGERY GUIDELINES FOR THE GENERAL DENTIST

Routine, uncomplicated extractions, removal of soft tissue impactions and minor surgical procedures are considered basic services and the responsibility of the general dentist.

Only when it is beyond the scope of the general dentist, may the member be referred to a participating FDB Oral Surgeon. All referrals to a participating FDB Oral Surgeon must be pre-authorized by an FDB Dental Consultant.

Required documentation for processing of pre-authorizations, referrals or claims:
- Completed claim form
- Appropriate radiographs clearly showing the tooth/teeth in question: panoramic, full mouth series, bitewings or periapicals
- Narrative and/or a proposed treatment plan

Third molar extractions:
The following criteria are required for the approval of third molar extractions.

- Recurrent pericoronitis
- Non-restorable carious lesion
- Dentigerous cyst
- Internal or external resorption
- Periodontal disease in connection with an adjacent third molar
- Any potential future damage to the adjacent tooth
- Pathology involving a third molar
- FDB will not authorize or reimburse for any surgical extraction of third molars which are asymptomatic and do not exhibit any evidence of pathology

Emergency pre-authorizations:
Requests for emergency oral surgery procedures should not exceed two teeth per request. Exceptions are made on a case-by-case basis upon prior discussion with and approval by the FDB Dental Consultant.

Notes:

- When submitting a request for pre-authorization or post-service authorization (claim) for the procedures listed below, please ensure that the treatment rendered is consistent with the procedure code description noted below:
  - 7210 – Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated. Includes related cutting of gingiva and bone, removal of tooth structure, minor smoothing of socket bone and closure.
  - 7250 – Removal of residual tooth roots (cutting procedure). Includes cutting of soft tissue and bone, removal of tooth structure, and closure.

REMOVABLE PROSTHODONTIC GUIDELINES FOR THE GENERAL DENTIST

Prosthetic appliances are intended to restore proper function due to premature loss of permanent teeth that would otherwise result in significant occlusal disfunction. Full or partial dentures are NOT covered if a clinical evaluation indicates the presence of a satisfactory appliance.

Required documentation for processing of pre-authorizations:

- All full or partial dentures must be pre-authorized.
- Treatment plan.
- Appropriate radiographs showing clearly the adjacent and opposing teeth (panoramic, full mouth series, bitewings or periapicals)
- Narrative of medical necessity.

Additional requirements, notes and best practices:

- Complete Dentures are an appliance of last resort. Members should be informed of the significant limitations.
- Partial Dentures are covered when:
  - posterior teeth (excluding 3rd molars) are missing on both sides of the same arch
  - 2 or more teeth are missing from each quadrant of a single arch.
  - Members practice good oral health and hygiene, good periodontal health and there is a favorable prognosis where continuous deterioration is not expected.
- Full or Partial Dentures will NOT be covered if an existing appliance can be made satisfactory by repair or relining.
- Partial Dentures are NOT typically indicated for single tooth replacement of a non-functional second or third molar.

- Partial Dentures require abutment teeth to be:
  - 50% or greater supported by bone
  - in good oral health and hygiene
  - have no untreated cavities or active periodontal disease
  - present a favorable prognosis
- Dentures will include all adjustments performed within the first 6 months of the date the dentures were delivered.
- Providers should document the date of service as the date when the prosthetic appliances are delivered. Recipient must be eligible on that date in order for the service to be a covered benefit.
- Partial Dentures should be designed so they do not harm any remaining teeth.
- Partial Dentures should be designed to cause no damage to the abutment teeth and/or periodontal tissue.
- Partial dentures with acrylic clasps (such as Valplast also known as “Combo Partials”) are considered under the coverage for D5213 or D5214.
- Educational materials regarding these prostheses are highly encouraged at the treatment planning and delivery phase of the appliance to avoid any confusion and to manage patient expectations.

IMPLANT GUIDELINES FOR THE GENERAL DENTIST

A conservative treatment plan should be considered prior to providing a patient with one or more implants.

Guidelines:

- The member must be in good general and oral health to be a candidate for implants. This includes adequate bone in the jaw in order to support the implant.
- A thorough history and clinical examination of the patient’s general health and diagnosis of his/her oral condition must be completed to establish an appropriate treatment plan.
- The patient must be free from active and advanced periodontal disease.
- Implant services may be contraindicated for the following reasons:
  - poor oral hygiene and tissue management by the patient
  - adverse factors such as diabetes and smoking
  - inadequate osseo-integration (movable) of the dental implant
  - excessive para-function or occlusal loading
  - poor positioning of the dental implant
  - excessive loss of bone around the implant prior to its restoration
  - mobility of the implant prior to placement of the prostheses
  - inadequate number of implants or poor bone quality for long span prostheses
  - the implant does not restore the patient to function or restore the anterior teeth
  - for anterior implants- if the implant does not restore all anterior teeth to function
  - for posterior implants- if the patient is missing multiple teeth on both sides of the jaw (excluding 3rd molars)
  - when the patient is under 16 years of age
- The restoration of dental implants differs from the restoration of teeth.
  - Care must be exercised when restoring dental implants so the occlusal and lateral loading of the prosthesis does not damage the integration of the dental implant system to the bone or affect the integrity of the implant system itself.
  - Care must be exercised when designing the prosthesis so that the hardness of the material used is compatible with that of the opposing occlusions.
  - Jaw relationship and intra arch vertical distance should be considered in the initial treatment plan and selection of retentive and restorative appliances.
- The fee for implants is inclusive of lab fees.

Required documentation for processing of pre-authorizations or claims:

- All implant services must be pre-authorized
- A complete treatment plan addressing all phases of care and all areas of pathology
- Appropriate radiographs showing clearly the adjacent and opposing teeth (panoramic, full mouth series or CT scan)
- Narrative of medical necessity
- Post operative x-rays
- Providers should document the date of services as:
    - Placement of implant(s)
    - Placement of abutment
    - Placement of crown/overdenture
- Recipient must be eligible on the date of service in order for the service to be a covered benefit
- Educational materials regarding implants are highly encouraged at the treatment planning and delivery phase to avoid any confusion and to manage patient expectations