FloridaDentalBenefits 

FDB Medicare Authorization and Referral Guidelines

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Florida Dental Benefits, Inc.
PO Box 347650
Coral Gables, FL 33234
Phone: 877-674-7901
Fax: 305-674-7999
www.FDBenefits.com
Provider Portal:

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, who 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 judgment, would provide to a patient.
- Are in accordance with generally accepted standards of dental practice, supported by credible scientific evidence and professional guidelines recognized by the dental community.
- Are clinically appropriate and considered effective for the patient's condition, and are expected to restore or maintain oral health and function, or prevent significant deterioration of oral condition.
- Are not primarily for the convenience of the patient or any healthcare provider.
- Are not more costly than an alternative service or sequence of services likely to produce equivalent therapeutic or diagnostic results.
- Apply only to services that are otherwise covered under the member's specific Medicare Advantage dental benefit.
- Must be supported by appropriate clinical documentation, including radiographs, charting, and provider narrative, as applicable.

MEMBERS WITH MEDICARE AND MEDICAID COVERAGE (DUAL-ELIGIBLE MEMBERS)
Some members covered under FDB-administered Medicare Advantage dental plans may also have Medicaid coverage. **Members with both Medicare and Medicaid coverage (dual-eligible members) may be eligible for additional dental benefits beyond those available under their Medicare Advantage dental plan.** These additional benefits may include expanded coverage for certain dental services, subject to applicable Medicaid eligibility, coverage criteria, and limitations.

Providers must contact FDB prior to rendering services to dual-eligible members to ensure proper benefit determination and coordination. All requests for pre-authorization, referrals, and claims submission for members with Medicaid coverage must be submitted through FDB, in accordance with FDB guidelines and instructions.

Failure to contact FDB prior to treatment or to submit required documentation as directed may result in denial of authorization or payment.

MEDICARE-COVERED DENTAL SERVICES INEXTRICABLY LINKED TO MEDICARE-COVERED MEDICAL CARE
In limited circumstances, **Medicare may cover certain dental services when the dental service is inextricably linked to, and an integral part of, a Medicare-covered medical service**. Coverage is determined by Medicare medical policy and applies only when the dental service is necessary for the success of the covered medical treatment.

Examples of dental services that may be covered by Medicare when inextricably linked to a covered medical service include, but are not limited to:

- Dental extractions or oral procedures required prior to or in conjunction with radiation therapy or chemotherapy for cancer treatment.
- Dental services required prior to organ transplant surgery to eliminate sources of infection.
- Dental services that are performed as part of the treatment of a traumatic facial or jaw injury.
- Dental services that are directly related to a covered medical surgical procedure involving the jaw or oral structures.

If a dental provider is aware that a dental service may be inextricably linked to a Medicare-covered medical service, the dental provider must contact FDB prior to submitting a pre-authorization request or claim. FDB will assist with benefit determination and appropriate submission guidance.

Failure to notify FDB in advance may result in denial of authorization or payment.

MEMBER BENEFIT COVERAGE AND ELIGIBILITY
Dental services administered by FDB are subject to the specific dental benefits available under each member's plan. Coverage varies by Medicare Advantage plan and may be further impacted by additional coverage considerations, including Medicaid eligibility, when applicable.

Coverage of any dental service is not guaranteed and is determined based on the member's specific benefit plan, eligibility status, and applicable authorization requirements at the time services are rendered. Services that are not listed as covered benefits under the members' plan are not eligible for payment, even if the service is clinically appropriate.

Providers are responsible for verifying member eligibility and benefit coverage prior to rendering services. The member must be eligible on the date of service for the dental service to be considered a covered benefit. Pre-authorization approval does not guarantee payment if the member is not eligible on the date services are rendered or if benefit limitations are exceeded.

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. Restorative treatment must be supported by clinical or radiographic evidence of active caries, fracture, loss of tooth structure, or failure of an existing restoration.

Guidelines:

- Treatment results, including margins, contours and contacts must be clinically acceptable. The restored tooth should demonstrate a reasonable expectation of functional longevity.
- Restorative procedures include the restoration of hard tooth structure lost as a result of carries or fracture and must address all clinically evident pathology.
- Replacement of an existing restoration is covered only when there is documented recurrent decay, fracture, or material failure that compromises tooth integrity or function.
- The replacement of clinically acceptable restorations for material preference or cosmetic reasons is not covered. Restorative procedures for teeth exhibiting 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.
- The number of surfaces billed must accurately reflect the extent of tooth structure involved and restored, consistent with CDT definitions and supported by clinical documentation.
- 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. These components may not be unbundled or billed separately.

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 demonstrating the clinical condition of the tooth or teeth involved (panoramic, full mouth series, bitewings, periapicals, or intraoral photographs when radiographs do not adequately demonstrate the condition).
- Dental notes and/or a proposed treatment plan supporting medical necessity**.**

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.
- The fee for crowns includes lab fees.
- Cast crowns on permanent teeth are expected to last, at a minimum, five years when placed on teeth with a favorable prognosis.

Guidelines:

- To meet criteria, a crown must be opposed by a functional and stable tooth or denture in the opposite arch or be an abutment for a partial denture.
- The patient must be free from active or advanced periodontal disease, and any periodontal condition must be treated and stabilized prior to crown placement.
- In general, criteria for crowns will be met only for permanent teeth exhibiting loss of 50% or more of the coronal tooth structure, where direct restorative materials would be expected to have a poor prognosis.
- Permanent teeth must demonstrate pathologic destruction due to caries or trauma resulting in loss of 50% or more of the coronal tooth structure, as documented clinically and/or radiographically.

- Zirconia crowns will be covered and paid as D2740 Crown – porcelain/ceramic. Member should not be charged an additional fee for zirconia. No additional charges may be billed to the member for zirconia material.

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 or insufficient periodontal support to maintain long-term function.
- Tooth does not demonstrate at last 50% bone support.
- Tooth is a primary tooth.
- Crowns are being planned to alter vertical dimension.
- An existing crown is present without associated decay or pathology.
- An existing crown is present with chipped or fractured porcelain without decay, functional impairment, or loss of tooth integrity.
- Crowns will not be covered when tooth structure loss is due primarily to attrition or abrasion and there is no evidence of caries, fracture, or structural failure compromising tooth integrity or function.
- Crown replacement requested solely for esthetic concerns or material preference is not covered.
- Build-up is not required when there is sufficient tooth strength and retention for the crown procedure.
- Build-ups must be supported by documented loss of tooth structure that compromises retention and may not be used to correct preparation form or replace existing restorations. Clinical and radiographic findings do not demonstrate loss of 50% or more of the coronal tooth structure, and the tooth can be predictably restored with a direct restoration.
- Loss of tooth structure is due primarily to attrition or abrasion, including occlusal or incisal wear, without caries, fracture, or structural compromise requiring full-coverage restoration.

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 addressing restorability, prognosis, and functional occlusion.
- Pre and post operative x-rays for claims.

FIXED BRIDGES (FIXED PARTIAL DENTURES)

Fixed bridges (fixed partial dentures) may be considered to replace missing teeth when clinically appropriate to restore oral function and when abutment teeth demonstrate adequate health, stability, and prognosis to support a fixed prosthesis. **Coverage for fixed bridges is limited (when available) to three (3) unit bridges only, consisting of two abutment teeth and one pontic.**

Guidelines:

- Fixed bridges may be considered when one tooth is missing, and replacement is necessary to restore function.
- Abutment teeth must be periodontally stable, restorable, and capable of supporting a fixed prosthesis.
- Abutment teeth generally require full-coverage restorations.
- The periodontal condition of all abutment teeth must be treated and stabilized prior to bridge placement.
- Occlusion and functional loading must be evaluated to ensure the proposed bridge will not place excessive stress on abutment teeth.
- Replacement of missing teeth should be limited to functional teeth. Replacement of third molars is generally not indicated.
- When multiple posterior teeth are missing on both sides of the same arch, a removable partial denture is generally considered a more appropriate treatment option.

- Cantilever bridges are generally not appropriate for posterior tooth replacement. Limited anterior cantilevers may be reviewed on a case-by-case basis when supported by appropriate clinical documentation.

Fixed Bridges **will NOT be approved** if:
- Abutment teeth are not stable, restorable, or demonstrate a poor prognosis.
- Abutment teeth have untreated moderate to severe periodontal disease.
- Abutment teeth demonstrate inadequate bone support or unfavorable crown-to-root ratios.
- A more cost-effective treatment option (such as a removable partial denture) is available and expected to provide equivalent functional outcomes.
- The proposed bridge would replace non-functional teeth or teeth without opposing occlusion.
- The bridge is requested primarily for esthetic reasons.
- Replacement of an existing bridge is requested without documented pathology, functional failure, or structural compromise.

Required documents for processing of pre-authorizations or claims:
- All bridges must be pre-authorized.
- Appropriate radiographs clearly showing:
    - All proposed abutment teeth
    - Bone levels and periodontal support
    - Adjacent and opposing dentition.
- Periodontal charting for all proposed abutment teeth.
- Narrative of medical necessity addressing:
    - Teeth being replaced
    - Condition and prognosis of abutment teeth
    - Rationale for fixed bridge versus removable prosthodontic or implant alternatives
    - Expected functional outcome.
- 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 and be of diagnostic quality sufficient to assess restorability and prognosis.
- 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 when clinically appropriate and supported by the treatment plan.
- Tooth should be filled sufficiently close to the radiological apex to ensure that an apical seal is achieved.
- The filling must be properly condensed/obturated. Filling material does not extend excessively beyond the apex in a manner that compromises prognosis.
- Root canal therapy will not be covered on third molars, unless they are an abutment for a partial denture or otherwise required to maintain a functional prosthesis.
- Tooth must demonstrate at least 50% bone support and be considered restorable with a reasonable expectation of long-term function for a root canal to be approved.

Endodontic treatment **will NOT be approved** if:
- The tooth has a poor or non-restorable prognosis due to insufficient remaining tooth structure.
- Advanced periodontal disease is present and has not been treated or stabilized.
- The tooth is non-functional and not required to support a prosthesis or maintain occlusion
- Extraction represents a more predictable, cost-effective, and clinically appropriate treatment option.

Required documentation for processing of pre-authorizations or claims:
- Completed dental claim form.
- Diagnostic pre-operative radiographs of teeth to be endodontically treated must reveal all periapical areas and alveolar bone levels and restorability of the tooth.
- Post-operative radiograph(s), showing all canals and apices, must be taken immediately after completion of endodontic treatment.
- Narrative of medical necessity addressing diagnosis, restorability, periodontal status, and expected functional outcome.

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 intended as a preliminary service only and does not replace definitive periodontal therapy.** 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 or photographic evidence of heavy calculus.
- This procedure is not a replacement for D1110 or periodontal scaling and root planing.
- 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:
- 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. This service is indicated for patients with diagnosed periodontal disease and evidence of attachment loss, and is therapeutic rather than preventive in nature.

Guidelines:
- Periodontal charting indicating abnormal pocket depths in multiple sites of 5mm or greater, consistent with periodontal disease.
- Radiographic evidence of root surface calculus and/or bone loss consistent with periodontal disease.
- The provider must submit a narrative with each SRP pre-authorization or claim documenting diagnosis, severity and treatment rationale.
- Scaling and root planing procedures (D4341/D4342) are generally not performed in the same quadrants or areas for at least 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. Requests exceeding two quadrants must be supported by documentation demonstrating clinical necessity and adequate treatment time. 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. Any exceptions must be clearly documented and are subject to clinical review.

Required documentation for processing of pre-authorizations or claims:
- Completed dental claim form.
- Periodontal charting indicating abnormal pocket depths in multiple sites of 5mm or greater.
- Appropriate radiographs clearly demonstrating bone levels, calculus and disease severity (panoramic, full mouth series, bitewings or periapicals).
- Narrative of medical necessity addressing diagnosis, disease severity, quadrant selection, and planned periodontal maintenance.

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 when within the provider's scope of practice and clinical competency.

Referral to a participating FDB Oral Surgeon is appropriate **only when the procedure is clinically complex or beyond the scope of the general dentist.** 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 involved, associated pathology and surgical complexity (panoramic, full mouth series, bitewings or periapicals).
- Narrative and/or a proposed treatment plan addressing diagnosis, surgical complexity, and rationale for referral when applicable.

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.
- Documented risk of damage to the adjacent tooth supported by clinical or radiographic findings.
- Pathology involving a third molar.
- FDB will not authorize or reimburse for any surgical extraction of third molars that are asymptomatic and lack documented clinical or radiographic pathology.

Emergency pre-authorizations:
Requests for emergency oral surgery procedures should not exceed two teeth per request. Requests exceeding two teeth must include documentation demonstrating emergent clinical necessity and are subject to FDB Dental Consultant review and approval.

Notes:

- When submitting a request for pre-authorization or post-service authorization (claim) for the procedures listed below, the treatment rendered must be consistent with the CDT procedure code description. Documentation must support the level of surgical complexity billed.
  - 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. Coverage is based on functional need rather than patient preference. 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 addressing tooth loss, functional deficits, and alternative treatment considerations.
- Appropriate radiographs clearly showing adjacent and opposing dentition, bone levels, and abutment tooth condition (panoramic, full mouth series, bitewings or periapicals)
- Narrative of medical necessity addressing functional impairment, prognosis of remaining dentition, and expected outcome.

Additional requirements, notes and best practices:

- Complete Dentures are an appliance of last resort. Members should be informed of the significant limitations prior to treatment planning.
- Partial Dentures are covered when:
  - posterior teeth (excluding 3rd molars) are missing on both sides of the same arch, resulting in functional compromise.
  - 2 or more teeth are missing from each quadrant of a single arch and replacement is necessary to restore function.
  - Members practice good oral health and hygiene, good periodontal health and a favorable long-term prognosis of remaining dentition.
- Full or Partial Dentures will NOT be covered if an existing appliance can be made satisfactory by repair or relining to restore function and comfort.
- Partial Dentures are NOT typically indicated for single tooth replacement of a non-functional second or third molar or when there is no opposing occlusion.

Partial Dentures require abutment teeth to be:

  - at least 50% supported by bone
  - in good oral health and hygiene
  - free from untreated caries or active periodontal disease at the time of prosthesis fabrication
  - demonstrate a favorable prognosis sufficient to support long-term function of the appliance.
- Dentures will include all adjustments performed within the first 6 months of the date the dentures were delivered.
- Providers must document the date of service as the date the prosthetic appliances is delivered. Recipient eligibility must be active on the delivery date for coverage to apply.
- Partial Dentures must be designed to minimize stress on remaining teeth, abutment teeth, and periodontal tissues, and to facilitate long-term oral health and hygiene.
- Partial dentures with acrylic clasps (such as Valplast also known as “Combo Partials”) are considered under the coverage for D5213 or D5214. Material choice alone does not alter coverage or reimbursement.

- Providers are strongly encouraged to provide patient education at the treatment planning and delivery phases to address functional limitations, maintenance requirements, and realistic expectations of removable prostheses.

IMPLANT GUIDELINES FOR THE GENERAL DENTIST

Dental implants are artificial tooth roots placed into the jawbone to support a dental prosthesis. Implants are considered elective, high-cost services and may be considered only when conventional prosthodontic treatment options are not feasible, not clinically appropriate, or have a poor long-term prognosis.
Guidelines:

- A thorough clinical evaluation and review of the patient's general and oral health must be completed prior to requesting implant placement.
- 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.
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- Periodontal health and dental health (including endodontic, restorative, and extraction needs) must be addressed and stabilized prior to implant therapy. Implant treatment planning should be conservative and based on the patient's ability to maintain oral hygiene and long-term implant health.
- Implant services may not be appropriate for the following reasons:
    - poor oral hygiene and tissue management by the patient
    - adverse factors such as diabetes and smoking that are uncontrolled or poorly managed
    - 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) and a removable prosthesis represents a more appropriate treatment option
    - when the patient is under 16 years of age
    - the implant is proposed to replace a non-functional tooth or a tooth without opposing occlusion
    - a less costly, clinically appropriate alternative treatment is available and expected to produce equivalent functional outcomes
- The restoration of dental implants differs from the restoration of natural 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.
    - a less costly, clinically appropriate alternative treatment is available and expected to produce equivalent functional outcomes
- 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, missing teeth, functional deficits and all areas of pathology.
- Appropriate radiographs clearly demonstrating adjacent teeth, opposing occlusion, bone levels, and implant site anatomy (panoramic, full mouth series, periapicals, or CT scan when indicated)
- Narrative of medical necessity addressing functional need, alternative treatment options considered, prognosis, and justification for implant therapy.
- Post operative radiographs
- Providers should document the date of service for:
    - Placement of implant(s)
    - Placement of abutment
    - Placement of crown or overdenture
- Claims for implant abutments will be eligible for payment only after the implant has adequately healed, osseointegration has been achieved, and the abutment has been placed.
- Recipient must be eligible on the date of service for coverage to apply.
- Documentation of patient education regarding implant maintenance and limitations is strongly encouraged.