Dental Claim Documentation Guidelines.

Each benefit plan defines which services are covered, excluded, and subject to dollar caps or other limits. Members and their dentists will need to refer to the member's benefit plan to determine if any exclusions or other benefit limitations apply. Unless otherwise noted, all services must be submitted using valid and current Dental Procedures and Nomenclature (CDT®) codes. **

These guidelines are used to authorize, modify, or deny care for people with similar illnesses or conditions. Specific care and treatment may vary depending on individual needs and the benefits covered under your contract.

All claims are subject to plan provisions which may or may not include an alternate benefit provision, missing but unreplaced provision, and frequency limitations. Most services are also subject to review. Please note that coverage of a specific service does not guarantee payment for that service. The documentation submitted with the claim must demonstrate a clear need for the service, Coverage of a specific service does not guarantee payment for that service. The documentation submitted with the claim must demonstrate a clear need for the service

Coverage determinations are based on the information available to the insurer at the specific point in time when the claim or pre-determination is reviewed. We encourage complete and accurate information to be submitted promptly to ensure a fair and timely assessment.

We reserve the right to request additional information and/or documentation for all services listed or unlisted below.

CDT code**	Documentation required	Coverage guidelines
Restorative		
D2929-D2390 D2542-D2544 D2642-D2644 D2662-D2664 D2710-2799 D2930 D2960-D2962	Current dated pre-operative radiographs[1] Prior placement date and rationale for replacement, if applicable	Restorative services may not be covered for teeth exhibiting a poor or questionable prognosis due to advanced periodontal disease, a crown root ratio of less than 50%, untreated periapical pathology, poor restorability and/or carious destruction of the clinical crown at or below the osseous crest. To qualify for full crown coverage, at least one of the following criteria must apply to a tooth that is in functional occlusion: • At least 50% loss of tooth structure due to decay or fracture, affecting incisal angles or undermining one or more posterior cusps with a compromised mesial or distal marginal ridge • An existing restoration encompassing at least half of the tooth structure, which requires replacement due to extensive recurrent decay or fracture • The tooth was endodontically treated Full crowns placed to repair teeth that are worn down from attrition, abrasion, erosion or abfraction aren't covered under most plans because those structural losses are not from tooth decay. Crowns to repair teeth damaged by traumatic injury such as a car accident or sports-related injury are also excluded from dental plan coverage, as they are
D2950	Pre-operative and post-operative photographs showing the buildup in place OR pre-operative and post-operative radiographs showing the buildup in place	
D2952, D2954	Current dated pre-operative radiographs showing the completed root canal[1]	
D2971	Current dated pre-operative radiographs[1] Narrative[2]	

CDT code**	Documentation required	Coverage guidelines
		typically eligible for coverage in the patient's medical plan or as part of other insurance coverage related to the accidental injury. Crowns strictly for cosmetic reasons are not covered (i.e., diastema/gap closure, tooth misalignment, color match, etc.) For unique cases with extenuating circumstances, please provide a narrative with a full description and any supporting documentation to help with the determination of benefits. In cases where crowns may not appear to meet criteria for full crown coverage, pre-operative intra-oral photographs may also be submitted as supporting documentation in addition to radiographs. <ADA Claims Submissions: Crowns and Core Buildups>
Endodontics		
D3331	Current dated pre-operative radiographs and post-operative radiographs[1] Conclusive radiographic evidence/image showing the obstruction (mid-treatment X-ray, endodontic microscopic image)	D3331: Documentation is required to support the obstruction of 50% or more of the length of the tooth. Mid-treatment X-rays may be submitted as documentation of the obstruction. D3331 will not be benefited to the same provider that inadvertently causes the obstruction (iatrogenically). D3331 is considered inclusive to retreatment procedures D3346, D3347 and/or D3348.

CDT code**	Documentation required	Coverage guidelines
	Narrative describing the blockage[2]	Endodontic services may not be covered for teeth exhibiting a poor or questionable prognosis due to advanced periodontal disease, a crown root ratio of less than 50%, poor restorability, and/or carious destruction of the clinical crown at or below the osseous crest. Aetna considers BioPure, MTAD, EDTA inclusive to the primary endodontic service. Additionally, the use of irrigants (diluted bleach, sterile water, saline, local anesthetic, BioPure, MTAD, EDTA – as an alternative to diluted bleach and/or other medicaments to irrigate the canal(s)) are also considered part of the primary endodontic service. CDT code D9630 should not be submitted for benefits for irrigation.
D3428-D3429	Current dated pre-operative radiographs[1]	
D3310-D3330, D3346-D3348	Predeterminations: Current dated pre-operative radiographs[1] Dated Services: Current dated pre-operative radiographs[1] Current dated post operative radiographs[1]	
D3431	Narrative[2] Material Used	
D3432	Current dated pre-operative radiographs[1]	
Periodontal		
		Periodontal services may not be covered for teeth exhibiting a poor or questionable prognosis due to advanced periodontal disease, a crown root ratio of less than 50%, untreated periapical pathology, poor restorability and/or carious destruction of the clinical crown at or below the osseous crest. According to the American Academy of Periodontology and European Federation of Periodontology, depending on the treatment performed, patient reevaluation should occur at six weeks to three months post-

CDT code**	Documentation required	Coverage guidelines
		therapy. The consensus report from the most recent American Academy of Periodontology World Workshop indicates that a six-week interval is usually adequate to assess the initial response to therapy.
D4210 & D4211	Current dated pre-operative periodontal charting[3] Current dated pre-operative radiographs[1] Narrative[2]	D4210 & D4211 require 5-8 mm periodontal pocketing to be considered for benefits. D4210 & D4211 are not benefited when submitted with D4341 & D4342 (scaling and root planing) or D4260 & D4261 (osseous surgery) if performed on the same date of service. D4210 & D4211 are considered inclusive to scaling and root planing, a distal wedge (D4274) and frenectomy procedure (D7960). D4211 will not be benefited for removal of hypertrophied tissue around a partially erupted or impacted tooth where the more appropriate code is D7971 – excision of peri coronal gingiva or operculectomy. D4210 & D4211 when submitted with a restoration or crown, pre-operative radiographs and narrative are also required. D4211 is not benefitted when the more appropriate code is D4212 (gingivectomy or gingivoplasty to allow access for restorative procedure) or D4230/D4231 (anatomical root exposure).
D4212	Current dated pre-operative radiographs or photographic image showing the extent of the lesion below the gumline.[1] Narrative[2]	
D4240 & D4241	Current dated pre-operative periodontal charting[3] Current dated pre-	<Dental Clinical Policy Bulletin 012>

CDT code**	Documentation required	Coverage guidelines
	operative radiographs[1]	
D4245	Current dated pre-operative radiographs[1] Current dated pre-operative periodontal charting[3]	<Dental Clinical Policy Bulletin 012> Procedure to preserve keratinized gingiva in conjunction with osseous resection when an adequate band of keratinized tissue is present. Narrative and/or detailed clinical notes may support claim submission.
D4249	Current dated pre-operative radiographs[1]	D4249 requires reflection of a full thickness flap and removal of bone, altering the crown to root ratio. Soft tissue 'crown lengthening' will not be benefited as D4249. A minimum of four to six weeks is required prior to final preparation/impressions to be considered for benefits. It is performed in a healthy periodontal environment.
D4260 & D4261	Current dated pre-operative periodontal charting[3] Current dated pre-operative radiographs[1]	D4260 & D4261 require a comprehensive periodontal charting indicating pocket depths of 5-8 mm. D4260 & D4261 will not be eligible for benefits if a full thickness flap has not been reflected, and bone had not been reshaped. <Dental Clinical Policy Bulletin 012>
D4263 (First Site in Quadrant), D4266, D4267	Current dated pre-operative periodontal charting[3] Identify each site/tooth	This code pertains to a retained natural tooth/teeth. <Dental Clinical Policy Bulletin 013>

CDT code**	Documentation required	Coverage guidelines
D4264 (Each Additional Site in the Quadrant)	Current dated pre-operative radiographs[1] Note: A single code for multiple sites is not valid.	
D4265	Narrative[2] Material Used Agents Drugs used for this treatment	<Dental Clinical Policy Bulletin 005> <Dental Clinical Policy Bulletin 009>
D4268	Current dated pre-operative Radiographs[1] Narrative with tooth/teeth numbers and rationale for surgical revision[2] Note: Date of surgical revision should be no more than 24 months and generally no less than 6 months from the date of the initial surgery.	<Dental Clinical Policy Bulletin 005> <Dental Clinical Policy Bulletin 009>
D4270, D4273, D4275, D4276, D4277, D4278, D4283 & D4285	For each tooth/site proposed to receive a soft tissue graft, A chart or narrative containing the following Mucogingival Data Tooth # _____ MM Recession __	<Dental Clinical Policy Bulletin 007>

CDT code**	Documentation required	Coverage guidelines
	____ MM Attached Gingiva _____ MM Attached Keratinized Gingiva ____ Pre-operative photos if available	
D4274	Current dated pre-operative periodontal charting[3] Current dated pre-operative radiographs[1]	Considered inclusive to other surgical procedures such as extractions, periodontal surgical procedures performed on the same area and same date of service.
D4322 & D4323	Current dated pre-operative radiographs[1] Current dated pre-operative periodontal charting[3] Prior periodontal treatment history Teeth numbers being treated	Splinting does not treat the underlying cause of periodontal disease. Splinting will help minimize some of the effects on teeth of periodontal disease, but the overall prognosis remains unchanged without continued monitoring by the provider and the patient's adherence to strict oral hygiene. Not to be used for treatment of a traumatic injury.
D4341 & D4342	Current dated pre-operative periodontal charting[3] Current dated pre-operative radiographs[1] Chart notes that include administration of local anesthetic and details regarding the treatment performed and	According to the American Academy of Periodontology treatment guidelines, periodontal health should be achieved in the least invasive manner, often via scaling and root planing. Periodontal scaling and root planing (CDT code D4341/4342) is distinctly different from a dental prophylaxis (CDT code D1110) and scaling in the presence of generalized moderate or severe

CDT code**	Documentation required	Coverage guidelines
	length of appointment	gingival inflammation (CDT code D4346). Key to scaling and root planing is the instrumentation and removal of deposits from the root surfaces of the tooth for patients with indicators of chronic periodontitis as described in the ADA's guide, "Claims Submission: Scaling and Root Planing." <ADA Claims Submission: Scaling and Root Planing (SRP)> Scaling and root planing typically take a substantial amount of time per quadrant and routinely requires local anesthetic. The length and nature of the procedure and use of local anesthetic normally necessitate multiple appointments, with one or two quadrants being performed per appointment. For a submission of D4341, the quadrant must include at least 4 teeth with periodontitis, and a submission of D4342 is appropriate for a partial quadrant that includes 1-3 teeth with periodontitis. Periodontal maintenance visits (D4910) would also include site-specific scaling and root planing for any number of teeth. Documentation to support a diagnosis of chronic periodontitis and the delivery of scaling and root planing must consist of the following: 1. Periodontal charting that records pocket depths at 6 points per tooth, bleeding on

CDT code**	Documentation required	Coverage guidelines
		probing, gingival recession, frenum involvement, and furcation defects. With periodontitis, pocket depths are usually at least 4mm, but **we do not base benefit determinations solely on pocket depth.** 2. Full mouth radiographs or digital images that clearly show bone loss. 3. Chart notes that show whether a local anesthetic was administered, and details regarding the treatment performed. 4. Documentation of length of appointment 5. The diagnostic materials must demonstrate the following: • Clinical loss of periodontal attachment • Radiographic evidence of crestal bone loss, without which root planing cannot be performed. • Radiographic evidence of root surface calculus The LANAP technique does not have an ADA CDT code. Document this technique if used. The procedure is most accurately coded as D4341 - Periodontal Scaling and Root Planing, four or more teeth per quadrant or D4342 - Periodontal Scaling and Root Planing - one to three teeth, per

CDT code**	Documentation required	Coverage guidelines
		quadrant. Planing - one to three teeth, per quadrant.
D4381	Current dated pre-operative periodontal charting[3] Current dated pre-operative radiographs[1]	D4381 requires a comprehensive periodontal charting indicating a refractory pocket depth of 5 – 7mm. D4381 will not be considered for benefits prior to a minimum of four (4) weeks for adequate response to root planing and scaling before reevaluation. D4381 will not be considered for benefits when applied to multiple sites (full quadrant) with pocketing and/or inflammation or when other more extensive periodontal treatment modalities (for example, surgery) may be more appropriate. .
Prostheses		
D5875	Narrative[1]	
Implant Services		
D6010-D6050, D6104	Current dated full mouth pre-operative radiographs and/or panoramic radiograph[1] Extraction dates of teeth to be replaced Date of prior prosthetic placement (fixed and/or removable dentures, if applicable) Numbers of all missing teeth Tooth number of proposed implants	

CDT code**	Documentation required	Coverage guidelines
D6052-D6079 D6094, D6097 D6194 D6110-D6117 D6191 & D6194	Current dated full mouth pre-operative radiographs and/or panoramic radiograph[1] Extraction dates of teeth to be replaced Date of prior prosthetic placement (fixed and/or removable dentures, if applicable) Numbers of all missing teeth Tooth number (s) of proposed treatment sites (s) • The radiographs should be post-operative to the implant placement, but pre-operative to the crown and /or bridge placement.	
D6081	Current dated pre-operative radiographs[1] Current dated pre-operative periodontal charting[3]	
D6090, D6091, D6093, D6095, D6096 D6100	Narrative[2] Date of prior implant placement	
D6101, D6102, D6103	Current dated pre-operative radiographs[1]	

CDT code**	Documentation required	Coverage guidelines
	Current dated pre-operative periodontal charting[3]	
D6106 & D6107	Current dated full mouth pre-operative radiographs and/or panoramic radiograph[1]	
Prosthodontics, fixed	**Prosthodontics, fixed**	
D6205-D6252 D6545, D6549 D6600-D6634 D6710-D6794 D6985	Current dated full mouth pre-operative radiographs and/or panoramic radiograph[1] Extraction dates of teeth to be replaced Date of prior prosthetic placement (fixed and/or removable dentures, and rationale), and rationale for replacement if applicable Numbers of all missing teeth	Prosthodontic services may not be covered for teeth exhibiting a poor or questionable prognosis due to advanced periodontal disease, a crown to root ratio of less than 50%, untreated periapical pathology, poor restorability and/or carious destruction of the clinical crown at or below the osseous crest. Plan exclusions, including alternate benefit provision, missing and unreplaced, and frequency limitations, may also apply**.**

Oral And		

Maxillofacial Surgery		
D7210-D7240	Current dated full mouth pre-operative radiographs and/or panoramic radiograph[1]	
D7241	Current dated full mouth pre-operative radiographs and/or panoramic radiograph[1] Narrative – All D7241 to include rationale for unusual surgical complications[2]	
D7250	Current dated full mouth pre-operative radiographs and/or panoramic radiograph[1]	
D7251	Current dated full mouth pre-operative radiographs and/or panoramic radiograph[1] Narrative[2] –to include rationale for unusual surgical complications	<Dental Clinical Policy Bulletin 015>
D7310-D7311	Current dated full mouth pre-operative radiographs and/or panoramic radiograph[1]	
D7450-D7461	Current dated pre-operative radiographs[1]	
D7950-D7953	Current dated full mouth pre-operative radiographs and/or panoramic radiograph[1] Narrative describing the planned prosthetic reconstruction[2] Number of missing	

	tooth or area Numbers of all missing teeth	
D7956 & D7957	Current dated full mouth pre-operative radiographs and/or panoramic radiograph[1] Identify each site/tooth	
Orthodontics		
D8010-D8090	Total treatment fee Estimated number of months of treatment Initial banding date	
Miscellaneous		**<**Dental Clinical Policy Bulletin 015**>**
D9128	Narrative describing the condition being treated and presence of oral mucositis[2] Separate statement from the physician or radiation oncologist verifying the patient has received head and neck radiation and developed oral mucositis[2]	
D9130	PT evaluation/data sheets – A written plan of care. • This form is to be used for the 1st submission of D9130. This form is to be used for the 26th submission of D9130	<Medical Clinical Policy Bulletin 0363> The written plan of care must include the diagnosis, date of onset or exacerbation of the disorder, long- and short-term goals that are specific, quantitative and objective, a reasonable estimate of when the goals will be reached, the frequency and duration of treatment and the specific treatment techniques and/or exercises to be used in treatment.

		The plan must include signatures of the patient's attending dentist and physical therapist if applicable.
D9223, D9243 D9248 D9222, D9239 (effective 1/1/2018)	Current dated pre-operative radiographs[1] Narrative. Including documentation of the medically compromising condition that necessitates anesthesia or sedation[2] Anesthesia records	D9223, D9243 and D9248 (D9222, D9239 effective 1/1/2018) will be considered eligible for benefits when one or more of the following criteria are met: • Placement of two or more endosteal implants (D6010) on the same date of service or placement of one eposteal (D6040) or transosteal (D6050) implant. • Removal of one or more impacted teeth on the same day (applies to codes D7230, D7240, D7241 and D7251). • The extraction of five or more teeth. • More than one surgical extraction (D7210, D7220 and D7250) involving more than one quadrant on the same day. • Full edentulous arch alveoplasty or alveolectomy (applies to code D7320 – two quadrants). • One or more quadrants of periodontal surgery performed on the same day qualify for General Anesthesia (GA) (D4240-D4241, D4260-D4261). Osseous and soft tissue grafts (D4263, D4264, D4270, D4271, D4273, D4275, D4276, D4277, D4278, D4283, D4285) do not separately qualify for GA. • Surgical root recovery from the maxillary antrum (sinus). • Tooth transplantation.

		• Surgical access of one or more unerupted teeth (D7280). • Full arch stomatoplasty/vestibuloplasty. • Radical excision of lesions in excess of 1.25 cm (1/2in.). • Removal of one (or more) exostosis(es) code D7471 – D7485. • Radical resection or ostectomy with or without bone graft. • Two or more implant removals (D6100) performed on the same day. • Two or more D7950 performed on the same day. Members exhibiting physical, intellectual, or medically compromising conditions, for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities, cannot be expected to provide a successful result and which, under anesthesia, can be expected to produce a superior result.
D9951 - D9952	Current dated pre-operative radiographs[1] Narrative including testing methods, patient symptoms and tooth numbers treated[2]	
D9951 - D9952	Current dated pre-operative radiographs[1] Narrative including testing methods, patient symptoms and tooth numbers treated[2]	

By Report Procedures		
D2999 D3999 D4999 D5899 D5999 D6199 D6999 D7999 D8999 D9999	Narrative describing specific clinical conditions addressed by the procedure, rationale demonstrating need, pertinent history and treatment plan[2] Radiographs, if applicable, to assist in describing clinical condition[1]	
General Comments		
1	**Quality of radiographs:** All radiographic images should be of diagnostic quality, depicting appropriate structures including the apex of the tooth, dated, mounted and labeled right and left. Submitted radiographs should be duplicate, less than 36 months old and labeled with the patient's name and the provider's name and address. *Radiographs must be unannotated/unmarked (with no color-coded overlays). DO NOT SEND ORIGINAL RADIOGRAPHS SINCE THEY WILL	

	NOT BE RETURNED. ELECTRONIC IMAGES OF THE RADIOGRAPHS WILL BE RETAINED BY AETNA®.		
2	**Written narratives:** Must be clear, legible and provide a rationale for the proposed treatment. Example: describe specific clinical conditions addressed by the procedure		
3	**Periodontal charting:** Must be comprehensive full mouth, legible, dated, documented with probing depths (six per tooth), recorded in mm. per tooth, labeled right and left, mandibular and maxillary, with classified furcation defects and tooth mobility recorded as 1st, 2nd or 3rd degree. May also include gingival margins, the amount of keratinized tissue, and amount of remaining attached gingiva and level of recession.		
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	These guidelines represent frequently submitted procedures which require attachments and are not all inclusive. There may be other dental procedures not listed which require additional documentation. Submit only a completed claim for routine dental procedures such as cleanings and minor restorations, unless otherwise requested		