INITIAL STATEMENT OF REASONS

Title XIX of the Social Security Act is a federal/state entitlement program that pays for medical assistance for certain individuals and families with low incomes and resources. This program, known as Medicaid, became law in 1965 as a cooperative venture jointly funded by the federal and state governments to assist states in furnishing medical assistance to eligible needy persons. Medi-Cal is California's Medicaid program. It provides vital health and long-term care coverage to 6.5 million low-income children, their parents, elderly and disabled Californians. Medi-Cal is administered by the California Department of Health Care Services (Department).

Welfare and Institutions (W&I) Code, Sections 10725 and 14124.5 authorizes the Director of the Department to adopt, amend or repeal regulations as necessary and proper to carry out the purposes and intent of the statutes governing the Medi-Cal Program. W&I Code Section 14132 sets forth the Medi-Cal schedule of benefits, which includes dental services. The Department's Medi-Cal Dental Services Program (Program) is responsible for the delivery of dental services to eligible Medi-Cal beneficiaries.

Medi-Cal currently covers a comprehensive package of dental benefits for children and a limited package for adults. Covered procedures include diagnostic and preventive procedures such as examinations and prophylaxis (cleaning), restorative procedures such as fillings and oral surgery procedures. Some procedures, such as crowns, dentures and root canals require prior authorization.

Over 90% of Medi-Cal beneficiaries are eligible for these dental procedures through the fee-for-service program, often referred to as Denti-Cal. Delta Dental of California (Delta) has served as the fiscal intermediary for the fee-for-service program since 1974. Delta contracts directly with dental providers and authorizes treatments and processes claims.

California State Senate Bill 456 (Chapter 635, Statutes of 2001) added Division 110 (commencing with section 130300) to the Health and Safety (H&S) Code and is known as the Health Insurance Portability and Accountability Act (HIPAA) of 2001. H&S Code section 130301(f) provides that federal HIPAA rules directly apply to state and county departments that provide health coverage, health care, mental health services, and alcohol and drug treatment programs. Additionally, H&S Code section 130301(h) provides that the implementation of HIPAA shall be accomplished as required by federal law and regulations. H&S Code section 130301(c) further provides that "administrative simplification is a key feature of HIPAA" requiring the development of uniform standards for the coding and transmission of claims. These provisions of the H&S Code subject the Department to federal HIPAA rules and regulations for the implementation of uniform standard code sets.

In August of 1996 Congress enacted the Health Insurance Portability and Accountability Act of 1996. This Act, specifically 45 Code of Federal Regulations (CFR), Subpart J, Section 162.1002 adopted as the standard medical data code set, the Code on Dental Procedures and Nomenclature, as published, maintained and distributed by the American Dental Association (ADA), for dental services. This provision requires the Program to convert from the use of three-digit local procedure codes, which are unique to California, to the national standard Current Dental Terminology 4 (CDT-4) procedure codes as compiled and copyrighted by the ADA. The current version of these codes is called CDT 2011-2012. The current MOC, Chapter 8.1, uses the outdated CDT 4 codes. These procedure codes are used by the Program, Delta, and dental providers for the identification and billing of dental services provided to Medi-Cal beneficiaries.

W&I Code, Section 14133.9 requires the Department to publicize and continue to develop its list of objective medical criteria that guide the professional judgment of Department consultants in their decisions as to whether a service is medically necessary and should be authorized. The Manual of Criteria for Medi-Cal Authorization (MOC), last revised January 1, 2006, which is incorporated by reference into Title 22, California Code of Regulations (CCR), Section 51003, is the method by which the Department has met this requirement. Chapter 8.1 of the MOC is dedicated to the dental criteria.

This proposed regulatory action will: implement the new updated 2011-2012 national standard CDT codes as mandated by HIPAA, update the dental criteria associated with the national standard CDT procedure codes and assure the Program meets current standards of dental practice.

This regulatory action specifically accomplishes the following:

- Amends CCR section 51003(e) with a revision date for the MOC,
- Amends Chapter 8.1 of the MOC, which is incorporated by reference in CCR section 51003(e) and includes revised criteria for the 12 major dental procedure categories.

Following is a detailed discussion explaining the changes made to Title 22, CCR and the dental criteria including the justification for each change.

Section 51003 - Amended

Section 51003(e) has been amended to change the revision date for the “Manual of Criteria for Medi-Cal Authorization” from January 1, 2006 to April 11, 2011. This revision of the MOC is specific to the Dental Services Program Chapter 8.1 This MOC revision is due to the change in the updated 2011-2012 CDT national standard codes as mandated by the federal Health Insurance and Portability and Accountability Act of 1996 and includes new and revised dental criteria.

MOC Chapter 8.1 – Amended

Chapter 8.1 of the MOC is specifically organized into 12 major dental procedure categories as currently utilized by the ADA and major commercial dental insurers across the nation. These major dental procedure categories include:

- Diagnostic Dental Procedures (D0100-D0999)
- Preventive Dental Procedures (D1000-D1999)
- Restorative Dental Procedures (D2000-D2999)
- Endodontic Dental Procedures (D3000-D3999)
- Periodontal Dental Procedures (D4000-D4999)
- Removable Prosthodontic Dental Procedures (D5000-D5899)
- Maxillofacial Prosthetic Dental Procedures (D5900-D5999)
- Implant Dental Procedures (D6000-D6199)
- Fixed Prosthodontic Dental Procedures (D6200-D6999)
- Oral and Maxillofacial Surgery Dental Procedures (D7000-D7999)
- Orthodontic Dental Procedures (D8000-D8999) and
- Adjunctive Dental Procedures (D9000-D9999)

A specific range of CDT procedure codes are included under each major dental procedure category. The general requirements and criteria that apply to each procedure code are described under Chapter 8.1 of the MOC and include the following:

- If the procedure or service requires prior authorization and if so the documentation, radiograph or photograph requirements that must be submitted to the Program for prior authorization,
- The documentation, radiograph or photograph requirements that must be submitted to the Program for payment, and
- If and under what conditions the procedure or service is a covered benefit under the Program.

<u>Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form, DC016 (06/09)</u>

The revised Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form, DC016 (06/09), here in after referred to as the (DC016 Form) is issued by the Program to providers and is used to determine the medical necessity of orthodontic treatment for patients under the age of 21.

References to this form are indicated on the following pages of the MOC: 8.1.5, 8.1.96, 8.1.98 and 8.1.99.

The DC016 Form has experienced the following revisions since the previous revision date of 10/05:

Condition #6A has been revised to include “with incompetent lips” and “with masticatory and speech difficulties”. Incompetent lips are when the upper jaw has become overdeveloped in a vertical direction with the upper and lower lips not meeting together at rest. It is possible to have an overjet greater than 9mm and not have incompetent lips so the phrase has been added to the criterion. Incompetent lips can cause abnormal drying of the front part of the mouth which could lead to decay on the front teeth as well as masticatory and speech difficulties leading to a medical necessity for orthodontic treatment. This is considered an automatic exception for treatment and no further scoring is required by the provider.

SCORING INSTRUCTIONS

Instruction #6A has been revised to include “with incompetent lips”, “with masticatory and speech difficulties” and “Photographs shall be submitted for this automatic exception”. Incompetent lips are when the upper jaw has become overdeveloped in a vertical direction with the upper and lower lips not meeting together at rest. It is possible to have an overjet greater than 9mm and not have incompetent lips so the phrase has been added to the instruction. Incompetent lips can cause abnormal drying of the front part of the mouth which could lead to decay on the front teeth as well as masticatory and speech difficulties leading to a medical necessity for orthodontic treatment. This is considered an automatic exception for treatment and no further scoring is required by the provider. Photographs are required because the condition is not apparent on radiographs due to the lips being soft tissue and radiolucent.

Diagnostic General Policies (Diagnostic Procedures D0100-D0999)

These policy amendments were adopted for CDT 2011-2012 to specify the general requirements that apply to diagnostic dental procedures.

1.c) The term “Care” was inadvertently left out of “Department of Health Care Services,” and has been included.

1.e) i),ii), iii) These new criteria to the MOC have been added as they were erroronously left out of the last version. Time limitations are necessary because after a certain period conditions in the mouth may have changed, therefore not giving an accurate depiction of the state of the patient’s teeth or other hard tissue. Arch radiographs are not necessary for children because procedures common to children involve restorations and extractions and not more complex procedures as found in adults.

Changes happen more rapidly with primary teeth due to the size of the teeth and the relatively short period of time they are present in the mouth versus permanent teeth so the radiographs for permanent teeth are more valid for a longer period of time.

Changes in arch integrity, that is the condition of all the teeth in the upper or lower arches, happen even more slowly than an individual tooth. Changes would be the amount of decay or the level of bone around all the teeth in an arch.

The time periods assigned to each of the types of radiographs and teeth is based on Program experience from a clinical and utilization standpoint.

With the addition of new criteria under 1.e) all the following criteria have been re-designated ending with the new criterion 1.l).

1. f) This criterion amendment gives providers more explicit instructions on how to label radiographs and mirrors the requirements in the criteria for procedure D0350- Oral/Facial Photographic Images. Adding the tooth/quadrant/area requirement is more specific than just left or right sides of the patient's mouth.

1.g) This criterion has been amended to correct grammar.

1.j) This criterion has been amended to correct grammar.

1.k) This criterion amendment adding "integrity" is to clarify to providers that arch films, radiographs of all existing teeth, are required for certain procedures to establish that the overall condition of the patient's mouth will support the requested treatment. If arch integrity is not adequate then a full denture (extracting all remaining teeth in an arch) may be the best treatment option.

1.k)i) This criterion amendment deleting "the first trimester of" is to include the whole pregnancy period as being exempt from the requirement of arch integrity films for certain procedures. Standard of practice dictates that during pregnancy only routine maintenance procedures such as prophylaxis and emergency procedures to relive pain should be preformed. These procedures do not require arch integrity films.

1. l) This amendment adds implants to the list of procedures that replace teeth and require prior authorization. Implants have always needed prior authorization and were inadvertently left off the list in the last version of the MOC.

2. b) This amendment corrects the title for the Department of Health Care Services.

Diagnostic Procedures (D0100 – D0999)

This category provides a comprehensive explanation of the requirements that apply to diagnostic dental procedures in an effort to conform to the current dental standards of practice. Amendments are made to conform to new CDT 2011-2012 codes as required by H&S Code Section 130301. Diagnostic dental procedures

include examinations, radiographs and photographs. The criteria for diagnostic dental procedures are individually specified in procedure codes D0100-D0999.

Procedure D0120
Periodic Oral Evaluation- Established Patient
Change in title of procedure adding "Established Patient".

Procedure D0140
Limited Oral Evaluation- Problem Focused
3. The Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form, DC016 has been modified with a new date of 06/09.

5. The Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form, DC016 has been modified with a new date of 06/09.

Procedure D0145
Oral Evaluation For A Patient Under Three Years Of Age And Counseling With Primary Caregiver
This new code includes a new criterion that procedure D0145 can only be billed as procedures D0120 or D0150 and is not payable separately. Procedures D0120 and D0150 are not age specific and also cover patients under three years of age.

Procedure D0180
Comprehensive Periodontal Evaluation- New Or Established Patient
This criteria amendment gives providers a clearer instruction on what alternate procedure should be billed and has been changed due to simply offer clarity for providers.

Procedure D0273
Bitewings- Three Films
This new code includes a new criterion that procedure D0273 can only be billed as procedures D0270 and D0272 and is not payable separately. This criterion conforms to the current billing system.

Procedure D0350
Oral/Facial Photographic Images
The title of this procedure has changed adding "Photographic" and deleting "(Includes Intra And Extraoral Images)".

3. This criteria amendment gives providers more instances and clarifies when photographs are not a benefit.

Procedure D0360
Cone Beam CT- Craniofacial Data Capture
This is a new code and is not a benefit.

Procedure D0362
Cone Beam- Two Dimensional Image Reconstruction Using Existing Data, Includes Multiple Images
This is a new code and is not a benefit.

Procedure D0363
Cone Beam- Three Dimensional Image Reconstruction Using Existing Data, Includes Multiple Images
This is a new code and is not a benefit.

Procedure D0415
Collection Of Microorganisms For Culture And Sensitivity
The title of this procedure has changed from “Bacteriologic Studies for Determination of Pathologic Agents”.

Procedure D0416
Viral Culture
This is a new code and is not a benefit.

Procedure D0417
Collection And Preparation Of Saliva Sample For Laboratory Diagnostic Testing
This is a new code and is not a benefit.

Procedure D0418
Analysis Of Saliva Sample
This is a new code and is not a benefit.

Procedure D0421
Genetic Test For Susceptibility To Oral Diseases
This is a new code and is not a benefit.

Procedure D0431
Adjunctive Pre-Diagnostic Test That Aids In Detection Of Mucosal Abnormalities Including Premalignant And Malignant Lesions, Not To Include Cytology Or Biopsy Procedures
This is a new code and is not a benefit.

Procedure D0475
Decalcification Procedure
This is a new code and is not a benefit.

Procedure D0476
Special Stains For Microorganisms
This is a new code and is not a benefit.

Procedure D0477
Special Stains, Not For Microorganisms
This is a new code and is not a benefit.

Procedure D0478
Immunohistochemical Stains
This is a new code and is not a benefit.

Procedure D0479
Tissue In-Situ Hybridization, Including Interpretation
This is a new code and is not a benefit.

Procedure D0480
Accession Of Exfoliative Cytologic Smears, Microscopic Examination, Preparation And Transmission Of Written Report
The title of this procedure has changed from “Processing And Interpretation Of Cytologic Smears, Including The Preparation And Transmission Of Written Report”.

Procedure D0481
Electron Microscopy
This is a new code and is not a benefit.

Procedure D0482
Direct Immunofluorescence
This is a new code and is not a benefit.

Procedure D0483
Indirect Immunofluorescence
This is a new code and is not a benefit.

Procedure D0484
Consultation On Slides Prepared Elsewhere
This is a new code and is not a benefit.

Procedure D0485
Consultation, Including Preparation Of Slides From Biopsy Material Supplied By Referring Source
This is a new code and is not a benefit.

Procedure D0486
Accession Of Transepithelial Cytologic Sample, Microscopic Examination, Preparation And Transmission Of Written Report
This is a new code and is not a benefit.

Preventive General Policies (Preventive Procedures D1000-D1999)

These policy amendments were adopted for CDT 2011-2012 to specify the general requirements that apply to preventive dental procedures.

1. Dental Prophylaxis and Fluoride Treatment range has been extended to include a new fluoride code D1206.

1. a) Obsolete combination prophylaxis/fluoride codes D1201 and D1205 have been deleted and changed to new codes.

1. b) Obsolete combination prophylaxis/fluoride codes D1201 and D1205 have been deleted. New fluoride code D1206 has been added. The criterion that the fluoride treatment be delivered in a dental office under direct supervision of a dental professional has been deleted due to newly passed AB 667 (to take affect January 1, 2010) that allows for general supervision and for the fluoride treatment to be placed in other situations from a dental office such as a school.

1. d) Fluoride codes are now stand alone and are not associated with prophylaxis so the statement exempting them is no longer needed.

1. e) Prophylaxis and fluoride codes for children are stand alone and no longer in combination with the deletion of D1201. New fluoride code D1206 has been added. An "-" was added between six and month to correct grammar.

1. f) Prophylaxis and fluoride codes for adults are stand alone and no longer in combination with the deletion of D1205. New fluoride code D1206 has been added. An "-" was added between 12 and month to correct grammar.

1.g) Obsolete combination prophylaxis/fluoride codes D1201 and D1205 have been deleted. New fluoride code D1206 has been added.

1. h), i) and j) Obsolete combination prophylaxis/fluoride codes D1201 and D1205 have been deleted so there is no need for criteria regarding frequency limitations between these combinations.

Preventive Procedures (D1000 – D1999)

This category provides a comprehensive explanation of the requirements that apply to preventive dental procedures in an effort to conform to the current dental standards of practice. Amendments are made to conform to new CDT 2011-2012 codes as required by H&S Code Section 130301**.** Preventive dental procedures include prophylaxis, topical fluoride treatments and space maintenance. The criteria for preventive dental procedures are individually specified in procedure codes D1000-D1999.

Procedure D1110
Prophylaxis- Adult
2. Obsolete combination prophylaxis/fluoride codes D1201 and D1205 have been deleted so there is no need for criteria regarding frequency limitations between these combinations.

4. This is a new criterion associated with the new benefit D4910- Periodontal Maintenance. Prophylaxis procedures are a part of periodontal maintenance.

Procedure D1120
Prophylaxis- Child
2. Obsolete combination prophylaxis/fluoride code D1201 has been deleted so there is no need for criteria regarding frequency limitations between this combination.

4. This is a new criterion associated with the new benefit D4910- Periodontal Maintenance. Prophylaxis procedures are a part of periodontal maintenance.

Procedure D1201
Topical Application Of Fluoride (Including Prophylaxis)- Child
This is a deleted code.

Procedure D1203
Topical Application Of Fluoride - Child
Change in title of procedure deleting "(Prophylaxis Not Included)".

2. Obsolete combination prophylaxis/fluoride code D1201 has been deleted so there is no need for criteria regarding frequency limitations between this combination. New fluoride code D1206 has been added. In addition, the title for procedure D1206 has also been added.

3. a. This criterion is no longer needed because prophylaxis and fluoride procedures are now strictly separate procedures and can be performed on the same day.

3.b. D1201 is a deleted code.

With the deletion of criteria 3. previous 4. has become the new 3.

Procedure D1204
Topical Application Of Fluoride - Adult
Change in title of procedure deleting "(Prophylaxis Not Included)".

2. Obsolete combination prophylaxis/fluoride codes D1201 and D1205 have been deleted so there is no need for criteria regarding frequency limitations between

these combinations. New fluoride code D1206 has been added. In addition, the title for procedure D1206 has also been added.

3. a. This criterion is no longer needed because prophylaxis and fluoride procedures are now strictly separate procedures and can be performed on the same day.

3.b. This criterion has been deleted because code D1205 has been deleted.

With the deletion of criteria 3. previous 4. has become the new 3.

Procedure D1205
Topical Application Of Fluoride (Including Prophylaxis) - Adult
This is a deleted code.

Procedure D1206
Topical Fluoride Varnish; Therapeutic Application For Moderate To High Caries Risk Patients
This is a new code and is a benefit.

1. This is a new criterion that is included to inform providers that there are no submission requirements for payment of this procedure to prevent unnecessary submittal of information.

2.a. and b. These are new criteria that are included as a deterrent to dental decay (also known as caries) and maintaining good oral health for the patient. The frequency limitations informs providers that a fluoride treatment is only a benefit once in a six-month period for children and once in a 12-month period for adults (regardless of other fluoride procedures, D1203 and D1204) because these frequencies are all that would be medically necessary and are for utilization control purposes within the Program.

3. This is a new criterion that specifies that this procedure is a full mouth procedure only so the treatment benefits all of the patient's teeth.

Procedure D1351
Sealant- Per Tooth
3. a. This expands the criterion to include third molars that have drifted to a functional second molar position due to the loss of an adjacent molar tooth.

3. d. "Sealed" has replaced "placed" to be more descriptive for clarity purposes.

Procedure D1352
Preventive Resin Restoration In A Moderate To High Caries Risk Patient- Permanent Tooth
This is a new code and is a benefit that is similar to procedure D1351.

1. This new criterion clearly specifies, to the provider, that there are no documentation requirements for payment.

2. This is a new criterion to inform providers what is required on the claim for a specific tooth code and surface code. Permanent teeth are numbered 1 through 32. Surface codes are M (mesial), O (occlusal), D (distal), F (facial), B (buccal) and L (lingual) and represent the various sides of a tooth.

3. a. This is a new criterion that specifies which tooth type this procedure is exclusive to.

3. b. This is a new criterion that specifies under what conditions this procedure is a benefit. There must be an active decay process which does not go through the enamel portion of the tooth into the dentin portion.

3. c. This is a new criterion that specifies this procedure is only for children (considered under the age of 21 years old).

3. d. This is a new criterion. The phrase “per provider” is included so the original provider is responsible for any replacements in the 36-month period and this gives the patient the option of having another dentist replace the sealant without penalty to that dentist. The phrase “regardless of surfaces sealed” holds the provider responsible (for 36 months) for all the sealants on a tooth, even if they are not connected.

4. This is a new criterion that places a warranty period of 36 months on the original provider for any repair or replacement. This is to prevent the provider from charging the patient during this 36 month period and holds the provider responsible.

Procedure D1510
Space Maintainer- Fixed- Unilateral
2. “Pre-operative” has been added to the radiograph requirements to be more specific to providers as to the type of radiograph to be submitted for payment.

Procedure D1515
Space Maintainer- Fixed- Bilateral
2. “Pre-operative” has been added to the radiograph requirements to be more specific to providers as to the type of radiograph to be submitted for payment.

3. An “s” has been added to molar for grammatical correctness since bilateral means more than one molar is involved.

Procedure D1520
Space Maintainer- Removable- Unilateral
2. “Pre-operative” has been added to the radiograph requirements to be more specific to providers as to the type of radiograph to be submitted for payment.

Procedure D1525
Space Maintainer- Removable-
Bilateral
2. “Pre-operative” has been added to the radiograph requirements to be more specific to providers as to the type of radiograph to be submitted for payment.

3. An “s” has been added to molar for grammatical correctness since bilateral means more than one molar is involved.

Procedure D1555
Removal Of Fixed Space Maintainer
This is a new code and is a benefit.

1. This is a new criterion that is necessary due to the emergency nature of this procedure, since there would not be time for a provider to request prior authorization.

2. This is a new criterion that is included to inform providers that there are no submission requirements for payment of this procedure to prevent unnecessary submittal of information.

3. This is a new criterion that is necessary for claims processing, since it informs providers what quadrant code or arch code, as applicable, is required on the claim form for payment. Quadrant codes are UR (upper right), UL (upper left), LL (lower left) and LR (lower right). Arch codes are U (upper) or L (lower).

4. This is a new criterion because payment to the original provider who placed the space maintainer includes the eventual removal.

Restorative General Policies (Restorative Procedures D2000-D2999)

These policy amendments were adopted for CDT 2011-2012 to specify the general requirements that apply to restorative dental procedures.

1.b) This criterion has been amended for grammatical correctness.

1.d) This new criterion is to offer clarity for providers as to the necessary amount of tooth destruction before a two or three surface restoration is payable.

With the addition of new criteria under 1.d) all the following criteria have been redesignated ending with the new criterion 1.p).

1.o) This addition to this criterion is to better inform providers that radiographs (and photographs, as applicable) are to be submitted to prove a medical necessity when requesting a replacement restoration that falls within the time limitation for replacement and is being used for utilization control purposes.

2.B.c) This criterion amendment deletes prior authorization and corrects an error in the previous MOC Chapter 8.1. Prior authorization has never been required for prefabricated crowns.

2.B.d) This criterion amendment deletes the word "cast" to mirror the deletion of "cast" from the titles of the indirectly fabricated post codes D2952 and D2953.
3.h) This criterion has been amended to correct a wrong code listing.

3.j) This criterion amendment deletes the word "cast" to mirror the deletion of "cast" from the titles of the indirectly fabricated post codes D2952 and D2953.

Restorative Procedures (D2000 – D2999)
This category provides a comprehensive explanation of the requirements that apply to restorative dental procedures in an effort to conform to the current dental standards of practice. Amendments are made to conform to new CDT 2011-2012 codes as required by H&S Code Section 130301. Restorative dental procedures include amalgam restorations, resin-based composite restorations, laboratory processed crowns, cast and prefabricated post and cores and prefabricated crowns. The criteria for restorative dental procedures are individually specified in procedure codes D2000-D2999.

Procedure D2710
Crown- Resin Based Composite (Indirect)
Change in title of procedure adding "Based Composite".

Procedure D2712
Crown- ¾ Resin Based Composite (Indirect)
This is a new code and mirrors the criteria for the procedure D2710. The only difference is that this restoration does not cover the entire tooth (3/4) versus D2710 which covers the entire tooth.

Permanent anterior teeth (age 13 or older) and permanent posterior teeth (ages 13 through 20)

1. This criterion is based on a criterion that is located in the Chapter 8.1 MOC on Page 8.1.24, D2710 1. Both D2710 and D2712 are resin based crowns (D2710 covers the whole tooth where D2712 covers ¾ of the tooth). D2710 requires prior authorization so prior authorization will also be required for D2712.

2. This criterion is based on a criterion that is located in the Chapter 8.1 MOC on Page 8.1.24, D2710 2. Both D2710 and D2712 are resin based crowns (D2710 covers the whole tooth where D2712 covers ¾ of the tooth). D2710 requires arch and periapical radiographs so it will also be required for D2712.

3. This criterion is based on a criterion that is located in the Chapter 8.1 MOC on Page 8.1.24, D2710 3. Both D2710 and D2712 are resin based crowns (D2710 covers the whole tooth where D2712 covers ¾ of the tooth). D2710 requires a tooth code so a tooth code will also be required for D2712.

4.a. This criterion is based on a criterion that is located in the Chapter 8.1 MOC on Page 8.1.24, D2710 4a. Both D2710 and D2712 are resin based crowns (D2710 covers the whole tooth where D2712 covers ¾ of the tooth). D2710 is a benefit once in a five year period so the same criterion will also be required for D2712.

4.b. This criterion is based on a criterion that is located in the Chapter 8.1 MOC on Page 8.1.24, D2710 4b. Both D2710 and D2712 are resin based crowns (D2710 covers the whole tooth where D2712 covers ¾ of the tooth). D2710 is a crown that is fabricated outside the patient's mouth (indirectly) so the same criterion will also be required for D2712.

5.a. This criterion is based on a criterion that is located in the Chapter 8.1 MOC on Page 8.1.24, D2710 5a. Both D2710 and D2712 are resin based crowns (D2710 covers the whole tooth where D2712 covers ¾ of the tooth). D2710 is a not benefit for patients under the age of 13 so the same criterion will also be required for D2712.

5.b. This criterion is based on a criterion that is located in the Chapter 8.1 MOC on Page 8.1.24, D2710 5b. Both D2710 and D2712 are resin based crowns (D2710 covers the whole tooth where D2712 covers ¾ of the tooth). D2710 is a not a benefit for 3rd molars so the same criterion will also be required for D2712.

5.c. This criterion is based on a criterion that is located in the Chapter 8.1 MOC on Page 8.1.24, D2710 5c. Both D2710 and D2712 are resin based crowns (D2710 covers the whole tooth where D2712 covers ¾ of the tooth). D2710 is a not a benefit for use as a temporary crown so the same criterion will also be required for D2712.

<u>Permanent posterior teeth (age 21 or older)</u>

1. This criterion is based on a criterion that is located in the Chapter 8.1 MOC on Page 8.1.24, D2710 1. Both D2710 and D2712 are resin based crowns (D2710 covers the whole tooth where D2712 covers ¾ of the tooth). D2710 requires prior authorization so prior authorization will also be required for D2712.

2. This criterion is based on a criterion that is located in the Chapter 8.1 MOC on Page 8.1.24, D2710 2. Both D2710 and D2712 are resin based crowns (D2710 covers the whole tooth where D2712 covers ¾ of the tooth). D2710 requires arch and periapical radiographs so it will also be required for D2712.

3. This criterion is based on a criterion that is located in the Chapter 8.1 MOC on Page 8.1.24, D2710 3. Both D2710 and D2712 are resin based crowns (D2710 covers the whole tooth where D2712 covers ¾ of the tooth). D2710 requires a photograph when radiographs do not demonstrate the existence of a partial denture so a photograph for the same reason will also be required for D2712.

4. This criterion is based on a criterion that is located in the Chapter 8.1 MOC on Page 8.1.24, D2710 4. Both D2710 and D2712 are resin based crowns (D2710 covers the whole tooth where D2712 covers ¾ of the tooth). D2710 requires a tooth code so a tooth code will also be required for D2712.

5.a. This criterion is based on a criterion that is located in the Chapter 8.1 MOC on Page 8.1.24, D2710 5a. Both D2710 and D2712 are resin based crowns (D2710 covers the whole tooth where D2712 covers ¾ of the tooth). D2710 is a benefit once in a five year period so the same criterion will also be required for D2712.

5.b. This criterion is based on a criterion that is located in the Chapter 8.1 MOC on Page 8.1.24, D2710 5b. Both D2710 and D2712 are resin based crowns (D2710 covers the whole tooth where D2712 covers ¾ of the tooth). D2710 is a crown that is fabricated outside the patient's mouth (indirectly) so the same criterion will also be required for D2712.

5.c. This criterion is based on a criterion that is located in the Chapter 8.1 MOC on Page 8.1.24, D2710 5c. Both D2710 and D2712 are resin based crowns (D2710 covers the whole tooth where D2712 covers ¾ of the tooth). D2710 requires that it is only a benefit when it is to be used as an abutment for a partial denture so the same criterion will also be required for D2712.

5.d. This criterion is based on a criterion that is located in the Chapter 8.1 MOC on Page 8.1.24, D2710 5d. Both D2710 and D2712 are resin based crowns (D2710 covers the whole tooth where D2712 covers ¾ of the tooth). D2710 requires that if a crown and a partial denture are to be requested that they be on the same Treatment Authorization Request (TAR) so the same criterion will also be required for D2712.

6.a. This criterion is based on a criterion that is located in the Chapter 8.1 MOC on Page 8.1.24, D2710 6a. Both D2710 and D2712 are resin based crowns (D2710 covers the whole tooth where D2712 covers ¾ of the tooth). D2710 is not a benefit for third molars so the same criterion will also be required for D2712.

6.b. This criterion is based on a criterion that is located in the Chapter 8.1 MOC on Page 8.1.24, D2710 6b. Both D2710 and D2712 are resin based crowns (D2710 covers the whole tooth where D2712 covers ¾ of the tooth). D2710 is not a benefit for use as a temporary crown so the same criterion will also be required for D2712.

Procedure D2740
Crown- Porcelain /Ceramic Substrate
Change in title of procedure deleting "Fused".

Procedure D2794
Crown- Titanium
This is a new code and is not a benefit.

Procedure D2910
Recement Inlay, Onlay, Or Partial Coverage Restoration
Change in title of procedure adding "Onlay, Or Partial Coverage Restoration".

Procedure D2915
Recement Cast Or Prefabricated Post And Core
This is a new code and criterion informing providers that this procedure is included in the fee for a recementation of a new or preexisting crown and is not payable separately.

Procedure D2934
Prefabricated Esthetic Coated Stainless Steel Crown- Primary Tooth
This is a new code and is not a benefit.

Procedure D2940
Protective Restoration
Change in title of procedure deleting "Sedative Filling" and adding "Protective Restoration".

2. This is a new criterion that eliminates written documentation and substitutes radiographic documentation (as described under Restorative General Policies, D2000-D2999). Radiographic documentation allows for a better determination of medical necessity than written documentation. Pre-operative refers to a radiograph taken before the procedure is completed.

6. The elimination of "intended to relieve pain" broadens the reason to perform a protective restoration from simply pain ("sedative") to also protecting the tooth from further deterioration ("protective").

Procedure D2952
Post and Core In Addition To Crown, Indirectly Fabricated
Change in title of procedure deleting "Cast" and adding "Indirectly Fabricated".

Procedure D2953
Each Additional Indirectly Fabricated Post- Same Tooth
Change in title of procedure deleting “Cast” and adding “Indirectly Fabricated”.

Procedure D2971
Additional Procedures To Construct New Crown Under Existing Partial Denture Framework
This is a new code and criterion informing providers that this procedure is included in the fee for a laboratory processed crown.

Procedure D2975
Coping
This is a new code and is not a benefit.

Endodontic General Policies (Endodontic Procedures D3000-D3999)

These policy amendments were adopted for CDT 2011-2012 to specify the general requirements that apply to endodontic dental procedures.

a) This amendment to the criterion adds the new code D3222- Partial Pulpotomy For Apexogenesis- Permanent Tooth With Incomplete Root Development to the list of endodontic procedures requiring prior authorization.

Endodontic Procedures (D3000 – D3999)
This category provides a comprehensive explanation of the requirements that apply to endodontic dental procedures in an effort to conform to the current dental standards of practice. Amendments are made to conform to new CDT 2011-2012 codes as required by H&S Code Section 130301. Endodontic dental procedures include pulpotomies, endodontic therapy, endodontic retreatment, apexification/recalcifications and apicoectomies. The criteria for endodontic dental procedures are individually specified in procedure codes D3000-D3999.

Procedure D3221
Pulpal Debridement, Primary And Permanent Teeth
6. This amendment to the criterion is to give providers a better explanation of what subsequent code to bill for after the initial billing of D3221, if medically necessary.

Procedure D3222
Partial Pulpotomy For Apexogenesis- Permanent Tooth With Incomplete Root Development
This is a new code and mirrors the criteria for D3351- Apexification/ Recalcification- Initial Visit (Apical Closure/Calcific Repair Of Perforations, Root Resorption, Etc.) through criterion number 5. Both procedure D3351 and D3222 are used to close the opening at the tip of the tooth root (apexogenesis and

apexification), only the methods used are different for each procedure. Criterion numbers 7 and 8 were not included because D3351 is the first in a possible series of procedures where D3222 is a stand alone procedure.

1. This criterion is based on a criterion that is located in the Chapter 8.1 MOC on Page 8.1.35, D3351 1. Both procedures are used to close the tip of the root, D3351 requires prior authorization so prior authorization will also be required for D3222.

2. This criterion is based on a criterion that is located in the Chapter 8.1 MOC on Page 8.1.35, D3351 2. D3351 requires periapical radiographs so the same criterion will also be required for D3222.

3. This criterion is based on a criterion that is located in the Chapter 8.1 MOC on Page 8.1.35, D3351 3. D3351 requires a tooth code so the same criterion will also be required for D3222.

4. a. through b. These criteria are based on a criterion that is located in the Chapter 8.1 MOC on Page 8.1.35, D3351 4. a.-b. D3351 is a benefit once per permanent tooth and for patients under the age of 21 so the same criterion will also be required for D3222.

5. a. through c. These criteria are based on criteria that are located in the Chapter 8.1 MOC on Page 8.1.35, D3351 5 a.-c. D3351 is not a benefit for primary teeth, for third molars and on the same date of service as any other endodontic procedures so the same criterion will also be required for D3222.

6. This is a new criterion because this procedure is meant for vital teeth unlike procedure D3351.

Procedure D3310
Endodontic Therapy, Anterior Tooth (Excluding Final Restoration)
Change in title of procedure adding “Endodontic Therapy” and “Tooth”.

Procedure D3320
Endodontic Therapy, Bicuspid Tooth (Excluding Final Restoration)
Change in title of procedure adding “Endodontic Therapy” and “Tooth”.

Procedure D3330
Endodontic Therapy, Molar Tooth (Excluding Final Restoration)
Change in title of procedure adding “Endodontic Therapy” and “Tooth”.

Procedure D3332
Incomplete Endodontic Therapy; Inoperable, Unrestorable Or Fractured Tooth
Change in title of procedure adding “Unrestorable”.

Procedure D3351
Apexification/Recalcification/Pulpal Regeneration- Initial Visit (Apical Closure/Calcific Repair Of Perforations, Root Resorption, Pulp Space Disinfection, Etc).
Change in title of procedure adding “Pulpal Regeneration” and “Pulp Space Disinfection”.

2. Arch radiographs have been deleted from this criterion. Arch radiographs are not necessary for children because procedures common to children involve restorations and extractions and not more complex procedures as found in adults.

Procedure D3352
Apexification/Recalcification/Pulpal Regeneration- Interim Medication Replacement (Apical Closure/Calcific Repair Of Perforations, Root Resorption, Pulp Space Disinfection, Etc).
Change in title of procedure adding “Pulpal Regeneration” and “Pulp Space Disinfection”.

Procedure D3354
Pulpal Regeneration- (Completion Of Regenerative Treatment In An Immature Permanent Tooth With A Necrotic Pulp); Does Not Include Final Restoration
This is a new code and is not a benefit.

Procedure D3410
Apicoectomy/Periradicular Surgery-Anterior
6.a. This amendment to the criterion gives the provider an opportunity to perform the procedure within the 90 day time limitation if a valid medical necessity is documented.

Procedure D3421
Apicoectomy/Periradicular Surgery-Bicuspid (First Root)
6.a. This amendment to the criterion gives the provider an opportunity to perform the procedure within the 90 day time limitation if a valid medical necessity is documented. This is added to conform to its counterpart D3410 (see above).

Procedure D3425
Apicoectomy/Periradicular Surgery- Molar (First Root)
6.a. This amendment to the criterion gives the provider an opportunity to perform the procedure within the 90 day time limitation if a valid medical necessity is documented. This is added to conform to its counterpart D3410 (see above).

Procedure D3426
Apicoectomy/Periradicular Surgery- (Each Additional Root)
6.a. This amendment to the criterion gives the provider an opportunity to perform the procedure within the 90 day time limitation if a valid medical necessity is documented. This is added to conform to its counterpart D3410 (see above).

Periodontal General Policies (Periodontic Procedures D4000-D4999)

These policy amendments were adopted for CDT 2011-2012 to specify the general requirements that apply to periodontal dental procedures.

b). This amendment to the criterion adds a new benefit, D4910- Periodontal Maintenance, to the list of periodontal procedures not requiring documentation.

h). This amendment to the criterion deletes "bounded tooth" and adds "tooth bounded" in its place. This is due to the change in the title of several periodontal procedures, D4210, D4211, D4240, D4241, D4260, D4261 and D4341.

l). This amendment to the criterion deletes "and/or fluoride" due to the elimination of prophylaxis/fluoride combinations in the code and deletes an obsolete code D1205. D1120 is left from the previous range of "(D1110- D1205)".

m). This amendment to the criterion adds a new, associated procedure, D7963- Frenuloplasty.

Periodontal Procedures (D4000 – D4999)
This category provides a comprehensive explanation of the requirements that apply to periodontal dental procedures in an effort to conform to the current dental standards of practice. Amendments are made to conform to new CDT 2011-2012 codes as required by H&S Code Section 130301. Periodontal dental procedures include gingivectomy or gingivoplasties, osseous surgeries, and periodontal scaling and root planing. The criteria for periodontal dental procedures are individually specified in procedure codes D4000-D4999.

Procedure D4210
Gingivectomy or Gingivoplasty- Four Or More Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant
Change in title of procedure deleting "Bounded Teeth" and adding "Tooth Bounded".

6. This criterion has been amended to correct grammar.

Procedure D4211
Gingivectomy or Gingivoplasty- One To Three Contiguous Teeth, Or Tooth Bounded Spaces Per Quadrant

Change in title of procedure adding “Contiguous” and “Or Tooth Bounded Spaces”.

Procedure D4230
Anatomical Crown Exposure- Four Or More Contiguous Teeth Per Quadrant
This is a new code and is not a benefit.

Procedure D4231
Anatomical Crown Exposure- One To Three Teeth Per Quadrant
This is a new code and is not a benefit.

Procedure D4240
Gingival Flap Procedure, Including Root Planing- Four Or More Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant
Change in title of procedure deleting “Bounded Teeth” and adding “Tooth Bounded”.

Procedure D4241
Gingival Flap Procedure, Including Root Planing- One To Three Contiguous Teeth Or Tooth Bounded Spaces, Per Quadrant
Change in title of procedure adding “Contiguous” and “Or Tooth Bounded Spaces”.

Procedure D4245
Apically Positioned Flap
Change in title of procedure deleting “Apical” and adding “Apically”.

Procedure D4249
Clinical Crown Lengthening- Hard Tissue
This criterion has been amended from not a benefit to included in the fee for a completed restorative service so the provider cannot bill the patient.

Procedure D4260
Osseous Surgery (Including Flap Entry and Closure)- Four Or More Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant
Change in title of procedure deleting “Bounded Teeth” and adding “Tooth Bounded”.

6. This criterion has been amended to correct grammar.

Procedure D4261
Osseous Surgery (Including Flap Entry and Closure)- One To Three Contiguous Teeth Or Tooth Bounded Spaces , Per Quadrant
Change in title of procedure adding “Contiguous” and “Or Tooth Bounded Spaces”.

Procedure D4273
Subepithelial Connective Tissue Graft Procedures, Per Tooth
Change in title of procedure adding an “s” to Procedure and “Per Tooth”.

Procedure D4276
Combined Connective Tissue And Double Pedicle Graft, Per Tooth
Change in title of procedure adding “Per Tooth”.

Procedure D4341
Periodontal Scaling And Root Planing- Four Or More Teeth Per Quadrant
Change in title of procedure deleting “Contiguous” and “Or Bounded Teeth Spaces”.

6. This criterion has been amended to correct grammar.

9. This criterion has been amended to delete the obsolete prophylaxis/fluoride combinations D1201 and D1205.

Procedure D4342
Periodontal Scaling And Root Planing- One To Three Teeth Per Quadrant
Change in title of procedure deleting “,” before “Per Quadrant”.

9. This criterion has been amended to delete the obsolete prophylaxis/fluoride combinations D1201 and D1205.

Procedure D4381
Localized Delivery Of Antimicrobial Agents Via A Controlled Release Vehicle Into Diseased Crevicular Tissue, Per Tooth, By Report
Change in title of procedure deleting “Chemotherapeutic” and adding “Antimicrobial”.

Procedure D4910
Periodontal Maintenance
Change in title of procedure deleting “Procedures”.
This is an existing code and is now a benefit.

1. This is a new criterion and does not require prior authorization because it is meant as an ongoing maintenance procedure after all necessary scaling and root planings have been completed.

2.a. This is a new criterion because this procedure is meant for patients who cannot adequately care for themselves due to a physical or mental disability.

2.b. This is a new criterion because this procedure is meant as an ongoing maintenance procedure after all necessary scaling and root planings.

2.c. This is a new criterion because it is meant as an ongoing maintenance procedure after all necessary scaling and root planings.

2.d. This is a new criterion because the time limitation of once per calendar quarter is a periodontal standard of care and has been recommended by the Program's staff periodontist.

2.e. This is a new criterion because the patient is eligible for another scale and root planing after 24 months following the last one and would not require a periodontal maintenance procedure. Periodontal maintenance is meant to be used between the 24 month limitation period for scale and root planings.

3. This is a new criterion because it is meant as an ongoing maintenance procedure after all necessary scaling and root planings.

4. This is a new criterion because prophylaxis procedures are a lesser treatment than periodontal maintenance and are covered in the maintenance procedures that are done by the same provider.

5. This is a new criterion to distinguish this procedure from the scale and root planing procedures which are performed per mouth quadrant.

Prosthodontics (Removable) General Policies (Prosthodontics (Removable) Procedures D5000-D5899)

These policy amendments were adopted for CDT 2011-2012 to specify the general requirements that apply to prosthodontic (removable) dental procedures.

1.a) This criterion has been amended to delete the last sentence because these procedures are a benefit under certain specific conditions.

1.c.) This criterion has been amended to add "and implants" because implants are a benefit under certain specific conditions and replace natural tooth roots.

1.f) This criterion has been amended to add restorative (fillings and crowns) to the list of procedures that shall be addressed before a partial denture is considered because they can impact the design of the denture. "Addressed" has been added in place of "completed" so the provider has the option of submitting a comprehensive treatment plan before completion of these endodontic, restorative and surgical procedures.

Prosthodontic (Removable) Procedures (D5000 – D5899)
This category provides a comprehensive explanation of the requirements that apply to prosthodontic (removable) dental procedures in an effort to conform to the current dental standards of practice. Amendments are made to conform to new CDT 2011-2012 codes as required by H&S Code Section 130301.

Prosthodontic (removable) dental procedures include complete dentures, partial dentures, adjustments and repairs to dentures and reline and tissue conditioning to dentures. The criteria for prosthodontic (removable) dental procedures are individually specified in procedure codes D5000-D5899.

Procedure D5211
Maxillary Partial Denture- Resin Base (Including Any Conventional Clasps, Rests And Teeth)
9.b. This criterion has been amended to remove a redundancy (eliminate D5211 which is the title of the procedure) and remove D5213 (which is a cast metal maxillary partial denture). By just leaving partial denture it will apply to all types of partial dentures, resin base and cast metal. Chairside relines are a benefit for all partial denture types.

9.c. This criterion has been amended to remove a redundancy (eliminate D5211 which is the title of the procedure) and remove D5213 (which is a cast metal maxillary partial denture). By just leaving partial denture it will apply to all types of partial dentures, resin base and cast metal. Chairside relines are a benefit for all partial denture types.

Procedure D5212
Mandibular Partial Denture- Resin Base (Including Any Conventional Clasps, Rests And Teeth)
9.b. This criterion has been amended to remove a redundancy (eliminate D5212 which is the title of the procedure) and remove D5214 (which is a cast metal mandibular partial denture). By just leaving partial denture it will apply to all types of partial dentures, resin base and cast metal. Chairside relines are a benefit for all partial denture types.

9.c. This criterion has been amended to remove a redundancy (eliminate D5212 which is the title of the procedure) and remove D5214 (which is a cast metal mandibular partial denture). By just leaving partial denture it will apply to all types of partial dentures, resin base and cast metal. Chairside relines are a benefit for all partial denture types.

Procedure D5213
Maxillary Partial Denture- Cast Metal Framework With Resin Denture Bases (Including Any Conventional Clasps, Rests and Teeth)
8.b. This criterion has been amended to remove a redundancy (eliminate D5213 which is the title of the procedure) and add “cast” since a laboratory reline is only a benefit for a cast partial denture.

8.c. This criterion has been amended to remove a redundancy (eliminate D5213 which is the title of the procedure) and add “cast” since a laboratory reline is only a benefit for a cast partial denture.

9.b. This criterion has been amended to remove a redundancy (eliminate D5213 which is the title of the procedure) and remove D5211 (which is a resin based maxillary partial denture). By just leaving partial denture it will apply to all types of partial dentures, resin base and cast metal. Chairside relines are a benefit for all partial denture types.

9.c. This criterion has been amended to remove a redundancy (eliminate D5213 which is the title of the procedure) and remove D5211 (which is a resin based maxillary partial denture). By just leaving partial denture it will apply to all types of partial dentures, resin base and cast metal. Chairside relines are a benefit for all partial denture types.

Procedure D5214
Mandibular Partial Denture- Cast Metal Framework With Resin Denture Bases (Including Any Conventional Clasps, Rests and Teeth)
8.b. This criterion has been amended to remove a redundancy (eliminate D5214 which is the title of the procedure) and add “cast” since a laboratory reline is only a benefit for a cast partial denture.

8.c. This criterion has been amended to remove a redundancy (eliminate D5214 which is the title of the procedure) and add “cast” since a laboratory reline is only a benefit for a cast partial denture.

9.b. This criterion has been amended to remove a redundancy (eliminate D5214 which is the title of the procedure) and remove D5212 (which is a resin based mandibular partial denture). By just leaving partial denture it will apply to all types of partial dentures, resin base and cast metal. Chairside relines are a benefit for all partial denture types.

9.c. This criterion has been amended to remove a redundancy (eliminate D5214 which is the title of the procedure) and remove D5212 (which is a resin based mandibular partial denture). By just leaving partial denture it will apply to all types of partial dentures, resin base and cast metal. Chairside relines are a benefit for all partial denture types.

Procedure D5225
Maxillary Partial Denture- Flexible Base (Including Any Conventional Clasps, Rests And Teeth)
This is a new code and is not a benefit.

Procedure D5226
Mandibular Partial Denture- Flexible Base (Including Any Conventional Clasps, Rests And Teeth)
This is a new code and is not a benefit.

Procedure D5620
Repair Cast Framework
Correction in the title of this procedure adding left off “D”.

Procedure D5741
Reline Mandibular Partial Denture (Chairside)
2.c. The misspelled word “mandibulary” was replaced with the correct spelling “mandibular”.

Maxillofacial Prosthetic General Policies (Maxillofacial Prosthetic Procedures D5900-D5999)

No amendments to Maxillofacial Prosthetic General Policies.

Maxillofacial Prosthetic Procedures (D5900 – D5999)
This category provides a comprehensive explanation of the requirements that apply to maxillofacial prosthetic dental procedures in an effort to conform to the current dental standards of practice. Amendments are made to conform to new CDT 2011-2012 codes as required by H&S Code Section 130301. Maxillofacial prosthetic dental procedures include facial moulages, nasal, orbital, auricular, ocular, obturator, palatal lift and facial prosthesis, speech aids, surgical stents, radiation carriers and shields, fluoride carriers and commissure and surgical splints. The criteria for maxillofacial prosthetic dental procedures are individually specified in procedure codes D5900-D5999.

Procedure D5991
Topical Medicament Carrier
This is a new code and mirrors the criteria for procedure D5983- Radiation Carrier. These types of carriers are identical; the only difference is that D5983 is used specifically to apply radiation to an area (for cancer treatments) versus the D5991 which is meant for medications other than radiation.

1. This criterion is based on a criterion that is located in the Chapter 8.1 MOC on Page 8.1.62, D5983 1. D5983 requires specific written documentation for payment so the same criterion will also be required for D5991.

2. This criterion is based on a criterion that is located in the Chapter 8.1 MOC on Page 8.1.62, D5983 2. D5983 requires an arch code for payment so the same criterion will also be required for D5991.

Procedure D5992
Adjust Maxillofacial Prosthetic Appliance, By Report
This is a new code and is not a benefit.

Procedure D5993
Maintenance And Cleaning Of A Maxillofacial Prosthesis (Extra Or Intraoral) Other Than Required Adjustments, By Report
This is a new code and is not a benefit.

Implant Services General Policies (Implant Procedures D6000-D6199)

These policy amendments were adopted for CDT 2011-2012 to specify the general requirements that apply to implant dental procedures.

a) iv) This new criterion expands the list of medical conditions that would necessitate the need for implants and is one of the most common reasons in trauma cases where implants might be needed.

Implant Service Procedures (D6000 – D6199)
This category provides a comprehensive explanation of the requirements that apply to implant service dental procedures in an effort to conform to the current dental standards of practice. Amendments are made to conform to new CDT 2011-2012 codes as required by H&S Code Section 130301. Implant service dental procedures include endosteal, eposteal and transosteal implants, abutments and retainers. The criteria for implant service dental procedures are individually specified in procedure codes D6000-D6199.

Procedure D6010
Surgical Placement Of Implant Body: Endosteal Implant
3. This amendment to the criterion expands the listing of possible radiographs needed for prior authorization by including panoramic radiographs. Panoramic radiographs are commonly used in implant cases as they give a full, complete depiction of the upper and lower jaws facilitating implant placement. The addition of “as applicable” gives the provider an option as to which radiographs to submit.

Procedure D6020
Abutment Placement Or Substitution: Endosteal Implant
This is a deleted code.

Procedure D6055
Connecting Bar- Implant Supported Or Abutment Supported
Change in title of procedure deleting “Dental Implant Supported” and adding “Implant Supported Or Abutment Supported”.

Procedure D6056
Prefabricated Abutment, Includes Placement
Change in title of procedure adding “Includes Placement”.

Procedure D6057
Custom Abutment, Includes Placement
Change in title of procedure adding “Includes Placement”.

Procedure D6091
Replacement Of Semi-Precision Or Precision Attachment (Male Or Female Component) Of Implant/Abutment Supported Prosthesis, Per Attachment
This is a new code and mirrors the criteria for procedure D6010- Surgical Placement Of Implant: Endosteal Implant. All other implant or implant supported prosthesis have the same criteria.

1. This criterion is based on a criterion that is located in the Chapter 8.1 MOC on Page 8.1.65, D6010 1. D6010 states that exceptional medical conditions must be present to be reviewed for medical necessity so the same criterion will also be required for D6091.

2. through 5. These criteria are based on criteria that are located in the Chapter 8.1 MOC on Page 8.1.65, D6010 2.-5. D6010 requires prior authorization, arch and pre-operative periapical radiographs, photographs as applicable and written documentation for prior authorization so the same criteria will also be required for D6091.

6. This criterion is based on a criterion that is located in the Chapter 8.1 MOC on Page 8.1.65, D6010 6. D6010 states that a tooth or arch code is required so the same criteria will also be required for D6091.

Procedure D6092
Recement Implant/Abutment Supported Crown
This is a new code and mirrors the criteria for procedure D2920- Recement Crown. The only difference is that a D6092 crown is supported by an implant rather than a natural tooth as is D2920.

1. This criterion is based on a criterion that is located in the Chapter 8.1 MOC on Page 8.1.28, D2920 1. D2920 states that prior authorization is not necessary so the same criterion will also be required for D6092.

2. This criterion is based on a criterion that is located in the Chapter 8.1 MOC on Page 8.1.28, D2920 2. D2920 states that radiographs, photographs and written documentation are not required for payment so the same criterion will also be required for D6092.

3. This criterion is based on a criterion that is located in the Chapter 8.1 MOC on Page 8.1.28, D2920 3. D2920 states a tooth code is necessary so the same criterion will also be required for D6092.

4. and 5. These criteria are based on criteria that are located in the Chapter 8.1 MOC on Page 8.1.28, D2920 4.-5. D2920 states the original provider is responsible for all recementations within the first 12 months of placement and it is not a benefit within 12 months of a previous recementation by the same provider so the same criterion will also be required for D6092.

Procedure D6093
Recement Implant/Abutment Supported Fixed Partial Denture
This is a new code and is a benefit.

1. This is a new criterion necessary due to the emergency nature of this procedure, since there would not be time for a provider to request prior authorization.

2. This is a new criterion that is included to inform providers that there are no submission requirements for payment of this dental procedure to prevent unnecessary submittal of information.

3. This is a new criterion that informs providers that a quadrant code is required for claims processing and payment. Quadrant codes are UR (upper right), UL (upper left), LL (lower left) and LR (lower right).

4. and 5. These are new criteria established for utilization control purposes within the Program and because a properly placed crown should last at least 12 months, according to past Program experience.

Procedure D6094
Abutment Supported Crown (Titanium)
This is a new code and mirrors the criteria for procedure D6010- Surgical Placement Of Implant: Endosteal Implant. All other implant or implant supported prosthesis have the same criteria.

1. This criterion is based on a criterion that is located in the Chapter 8.1 MOC on Page 8.1.65, D6010 1. D6010 states that exceptional medical conditions must be present to be reviewed for medical necessity so the same criterion will also be required for D6094.

2. through 5. These criteria are based on criteria that are located in the Chapter 8.1 MOC on Page 8.1.65, D6010 2.-5. D6010 requires prior authorization, arch and pre-operative periapical radiographs, photographs as applicable and written documentation for prior authorization so the same criteria will also be required for D6094.

6. This criterion is based on a criterion that is located in the Chapter 8.1 MOC on Page 8.1.65, D6010 6. D6010 states that a tooth or arch code is required so the same criteria will also be required for D6094.

Procedure D6190
Radiographic/Surgical Implant Index, By Report
This is a new code that is included in the fee for D6010- Surgical Placement Of Implant: Endosteal Implant so the provider cannot bill the patient.

Procedure D6194
Abutment Supported Retainer Crown For FPD (Titanium)
This is a new code and mirrors the criteria for procedure D6010- Surgical Placement Of Implant: Endosteal Implant. All other implant or implant supported prosthesis have the same criteria. See below for D6010 criteria:

1. This criterion is based on a criterion that is located in the Chapter 8.1 MOC on Page 8.1.65, D6010 1. D6010 states that exceptional medical conditions must be present to be reviewed for medical necessity so the same criterion will also be required for D6164.

2. through 5. These criteria are based on criteria that are located in the Chapter 8.1 MOC on Page 8.1.65, D6010 2.-5. D6010 requires prior authorization, arch and pre-operative periapical radiographs, photographs as applicable and written documentation for prior authorization so the same criteria will also be required for D6164.

6. This criterion is based on a criterion that is located in the Chapter 8.1 MOC on Page 8.1.65, D6010 6 D6010 states that a tooth or arch code is required so the same criteria will also be required for D6164.

Fixed Prosthodontic General Policies (Fixed Prosthodontic Procedures D6200-D6999)

These policy amendments were adopted for CDT 2011-2012 to specify the general requirements that apply to fixed prosthodontic dental procedures.

m) This criterion has been amended by extending the range to include the new code D6634- Onlay- Titanium.

Fixed Prosthodontic Procedures (D6200 – D6999)
This category provides a comprehensive explanation of the requirements that apply to fixed prosthodontic dental procedures in an effort to conform to the current dental standards of practice. Amendments are made to conform to new CDT 2011-2012 codes as required by H&S Code Section 130301. Fixed prosthodontic dental procedures include pontics, retainers and cast and prefabricated post and cores. The criteria for fixed prosthodontic dental procedures are individually specified in procedure codes D6200-D6999.

Procedure D6205
Pontic- Indirect Resin Based Composite
This is a new code and is not a benefit.

Procedure D6214
Pontic- Titanium
This is a new code and is not a benefit.

Procedure D6254
Interim Pontic
This is a new code and is not a benefit.

Procedure D6624
Inlay- Titanium
This is a new code and is not a benefit.

Procedure D6634
Onlay- Titanium
This is a new code and is not a benefit.

Procedure D6710
Crown- Indirect Resin Based Composite
This is a new code and is not a benefit.

Procedure D6794
Crown- Titanium
This is a new code and is not a benefit.

Procedure D6795
Interim Retainer Crown
This is a new code and is not a benefit.

Procedure D6930
Recement Fixed Partial Denture
These criteria have been amended to mirror procedure D2920- Recement Crown with an exception that a fixed partial denture covers several teeth and requires a quadrant code instead of a single tooth code. This procedure is the same as a recement crown, except a fixed partial denture is being recemented instead of a single tooth crown.

1. This criterion is based on a criterion that is located in the Chapter 8.1 MOC on Page 8.1.28, D2920 1. D2920 states that prior authorization is not necessary so the same criterion will also be required for D6930.

2. This criterion is based on a criterion that is located in the Chapter 8.1 MOC on Page 8.1.28, D2920 2. D2920 states that radiographs, photographs and written

documentation are not required for payment so the same criterion will also be required for D6930.

3. This criterion is partially based on a criterion that is located in the Chapter 8.1 MOC on Page 8.1.28, D2920 3. D2920 states that a tooth code is required. Since a fixed partial denture covers several teeth (instead of one tooth) the requirement has been changed to quadrant code instead of tooth code as stated in D2920.

4. and 5. These criteria are based on criteria that are located in the Chapter 8.1 MOC on Page 8.1.28, D2920 4.-5. D2920 states the original provider is responsible for all recementations within the first 12 months of placement and it is not a benefit within 12 months of a previous recementation by the same provider so the same criterion will also be required for D6930.

Procedure D6970
Post and Core In Addition To Fixed Partial Denture Retainer, Indirectly Fabricated
Change in title of procedure deleting “Cast” and adding “Indirectly Fabricated”.

Procedure D6971
Cast Post as Part Of Fixed Partial Denture Retainer
This is a deleted code.

Procedure D6976
Each Additional Indirectly Fabricated Post- Same Tooth
Change in title of procedure deleting “Cast” and adding “Indirectly Fabricated”.

This criterion has been amended to remove deleted code D6971 and add D6972-Prefabricated Post And Core In Addition to Fixed Partial Denture Retainer which is another form of post that was left out of the last version of the MOC.

Oral and Maxillofacial Surgery General Policies (Oral and Maxillofacial Surgery Procedures D7000-D7999)

These policy amendments were adopted for CDT 2011-2012 to specify the general requirements that apply to oral and maxillofacial surgery dental procedures.

1.a) “Asymptomatic” and “symptomatic” are being deleted and replaced with “medically necessary” to provide greater consistency in language throughout the MOC. The focus in this section is on what is medically necessary.

1.a) i) Current standards of practice have changed due to utilization data demonstrating that the lack of alveolar ridge length is no longer a major factor in the eruption of teeth.

1.a) iii) “Severely” has been added to emphasize the abnormal condition that must be present for the removal of unerupted teeth.

1.a) v) “Gingival inflammation” has been changed to “pericornitis” to be more specific as to the abnormal condition requiring treatment.

1.a) ix) This new criterion allows for the extraction of a tooth when there is no other option to treat the tooth due to severe destruction or bone loss.

1.b) This new criterion under a new “b)” is added to prevent the extraction of wisdom teeth (3rd molars) when there are no symptoms or a medical necessity for extraction. This prevents providers from extracting wisdom teeth because they “might” cause a problem in the future. A medical necessity (pain, damage to adjacent teeth, infection of tooth or surrounding gums) must be present for the Program to allow an extraction.

1.c) This criterion under “c”, formerly “b)”, has been modified due to the change in title of D7210 (Surgical Removal Of Erupted Tooth Requiring Removal Of Bone And/Or Sectioning Of Tooth And Including Elevation Of Mucoperiosteal Flap, If Indicated). This is to inform providers what is required and included when a surgical extraction is billed.

Former “c)” and “d)” have been redesignated to “d)” and “e)” respectively.

4. Repair Procedures (D7910- D7998)
This has been amended to expand the range to a new procedure D7998- Intraoral Placement Of a Fixation Device Not In Conjunction With A Fracture.

Oral and Maxillofacial Surgery Procedures (D7000 – D7999)
This category provides a comprehensive explanation of the requirements that apply to oral and maxillofacial surgery dental procedures in an effort to conform to the current dental standards of practice. Amendments are made to conform to new CDT 2011-2012 codes as required by H&S Code Section 130301. Oral and maxillofacial surgery procedures include extractions, alveoloplasties, vestibuloplasties, surgical excision of soft tissue and intra-osseous lesions, excision of bone tissue, treatment of simple and compound fractures, reduction of dislocation and management of temporomandibular joint dysfunctions, suturing of wounds and other repair procedures. The criteria for oral and maxillofacial surgery dental procedures are individually specified in procedure codes D7000-D7999.

Procedure D7111
Extraction, Coronal Remnants- Deciduous Tooth
Change in title of procedure adding “Extraction”.

Procedure D7210
Surgical Removal Of Erupted Tooth Requiring Removal Of Bone And/Or Sectioning Of Tooth, And Including Elevation Of Mucoperiosteal Flap If Indicated
Change in title of procedure deleting “Elevation Of Mucoperiosteal Flap And” and adding “And Including Elevation Of Mucoperiosteal Flap If Indicated”.

Procedure D7251
Cornectomy- Intentional Partial Tooth Removal
This is a new code and is not a benefit.

Procedure D7280
Surgical Access Of An Unerupted Tooth
3. This criterion has been amended to delete the requirement that the patient must be under active orthodontic treatment. A new code D7283- Placement Of Device To Facilitate Eruption Of Impacted Tooth now covers this type of patient, therefore criterion was added to D7280 to demonstrate medical necessity for this procedure.

5. This criterion has been amended to delete the requirement that the patient must be under active orthodontic treatment. A new code D7283- Placement Of Device To Facilitate Eruption Of Impacted Tooth now covers this type of patient.

5.a. This is a new criterion to specify that this procedure is not a benefit for patients age 21 or older since most permanent teeth are erupted by age 21 so there is no need for this procedure.

5.b This is a new criterion established for utilization control purposes within the Program since third molars (wisdom teeth) normally do not impact a patient’s chewing ability and are typically extracted.

6. This criterion has been deleted since it is covered in 5.a. above.

7. This criterion has been deleted since this procedure is no longer for orthodontic patients.

Procedure D7281
Surgical Exposure Of Impacted Or Unerupted Tooth To Aid Eruption
This is a deleted code.

Procedure D7283
Placement Of Device To Facilitate Eruption Of Impacted Tooth
This is a new code and is a benefit.

1. Prior authorization is required due to the fact that this procedure is considered a non-emergency, elective procedure and such procedures require prior authorization.

2. and 3. These are new criteria for a pre-operative radiograph and written documentation that are necessary so the Program can verify the need for this procedure based on medical necessity since this procedure is usually only performed for orthodontic reasons and is restricted to this use in the MOC.

4. This is a new criterion to inform providers what is required on the TAR for a specific tooth number (code). Permanent teeth are numbered 1 through 32.

5. This is a new criterion that the patient must be under active orthodontic treatment. Placement of a device to facilitate tooth eruption is a common orthodontic practice.

6.a. This is a new criterion that follows the age limitation for orthodontic treatment that is located in the MOC under Orthodontic General Policies b).

6.b. This is a new criterion established for utilization control purposes within the Program since third molars (wisdom teeth) normally do not impact a patient's chewing ability and are typically extracted unless they have drifted forward (1st or 2nd molar position) into a functional position.

Procedure D7286
Biopsy Of Oral Tissue- Soft
Change in title of procedure deleting "(All Others)".

Procedure D7287
Exfoliative Cytological Sample Collection
Change in title of procedure deleting "Cytology" and adding "Exfoliative" and "Cytological".

Procedure D7288
Brush Biopsy- Transepithelial Sample Collection
This is a new code and is not a benefit.

Procedure D7292
Surgical Placement: Temporary Anchorage Device [Screw Retained Plate] Requiring Surgical Flap
This is a new code and is not a benefit.

Procedure D7293
Surgical Placement: Temporary Anchorage Device Requiring Surgical Flap
This is a new code and is not a benefit.

Procedure D7294
Surgical Placement: Temporary Anchorage Device Without Surgical Flap
This is a new code and is not a benefit.

Procedure D7295
Harvest Of Bone For Use In Autogenous Grafting Procedure
This is a new code and is not a benefit.

Procedure D7310
Alveoloplasty In Conjunction With Extractions- Four Or More Teeth Or Tooth Spaces Per Quadrant
Change in title of procedure adding “Four or More Teeth or Tooth Spaces”.

3. This criterion has been amended to make this procedure a benefit on the same date of service with two or more extractions in the same quadrant. Previously this procedure was for an alveoloplasty when only one extraction was involved with the alveoloplasty included in the fee for the extraction. Two or more extractions require a more extensive recontouring of bone which is what an alveoloplasty does.

4. This is a new criterion informing providers that an alveoloplasty is not a benefit when only one extraction is performed as it is included in the fee for the extraction.

Procedure D7311
Alveoloplasty In Conjunction With Extractions- One To Three Teeth Or Tooth Spaces Per Quadrant
This new code includes a new criterion that procedure D7311 can only be billed as procedure D7310 and is not payable separately because alveoloplasty is not a benefit when only one extraction is performed as it is included in the fee for the extraction.

Procedure D7320
Alveoloplasty Not In Conjunction With Extractions- Four Or More Teeth Or Tooth Spaces Per Quadrant
Change in title of procedure adding “Four or More Teeth or Tooth Spaces”.

4. This is a new criterion which allows providers to perform this procedure regardless of the number of teeth or tooth spaces. The new code D7321- Alveoloplasty Not in Conjunction with Extractions- One to Three Teeth or Tooth Spaces, Per Quadrant directs providers to bill D7320 instead.

5. This criterion has been amended to delete D7111 which was erroneously included in the last version of the MOC. D7111 is a procedure for primary (baby) teeth and should not be included in D7320 which is meant for permanent teeth only.

Procedure D7321
Alveoloplasty Not In Conjunction With Extractions- One To Three Teeth Or Tooth Spaces Per Quadrant
This new code includes a new criterion that procedure D7321 can only be billed as procedure D7320 and is not payable separately.

Procedure D7490
Radical Resection Of Maxilla Or Mandible
Change in title of procedure adding “Maxilla Or” and deleting “With Bone Graft”.

Procedure D7511
Incision And Drainage Of Abscess- Intraoral Soft Tissue- Complicated (Includes Drainage Of Multiple Fascial Spaces)
This is a new code and mirrors the criteria for procedure D7510- Incision and Drainage of Abscess- Intraoral Soft Tissue. The only difference is that this procedure covers more complex cases.

1. This criterion is based on a criterion that is located in the Chapter 8.1 MOC on Page 8.1.84, D7510 1. D7510 states that written documentation is necessary for payment so the same criteria will also be required for D7511.

2. This criterion is based on a criterion that is located in the Chapter 8.1 MOC on Page 8.1.84, D7510 2. D7510 states that a quadrant code is necessary for payment so the same criteria will also be required for D7511.

3. This criterion is based on a criterion that is located in the Chapter 8.1 MOC on Page 8.1.84, D7510 3. D7510 states that it is a benefit once per quadrant per date of service so the same criteria will also be required for D7511.

4. This criterion is based on a criterion that is located in the Chapter 8.1 MOC on Page 8.1.84, D7510 4. D7510 states that it is not a benefit when any other treatment is performed in the same quadrant on the same date of service except necessary photographs or radiographs so the same criterion will also be required for D7511.

5. This criterion is based on a criterion that is located in the Chapter 8.1 MOC on Page 8.1.84, D7510 5. D7510 states that the fee for the procedure includes the incision, placement and removal of a surgical draining device so the same criteria will also be required for D7511.

Procedure D7521
Incision and Drainage Of Abscess- Extraoral Soft Tissue- Complicated (Includes Drainage Of Multiple Fascial Spaces)
This is a new code and mirrors the criteria for procedure D7520- Incision and Drainage of Abscess- Extraoral Soft Tissue. The only difference is that this procedure covers more complex cases.

1. This criterion is based on a criterion that is located in the Chapter 8.1 MOC on Page 8.1.85, D7520 1. D7520 states that written documentation is necessary for payment so the same criteria will also be required for D7521.

2. This criterion is based on a criterion that is located in the Chapter 8.1 MOC on Page 8.1.85, D7520 2. D7520 states that the fee for the procedure includes the incision, placement and removal of a surgical draining device so the same criteria will also be required for D7521.

Procedure D7840
Condylectomy
3. This criterion has been amended to delete "or operative report". Operative reports cannot be used for prior authorization because they are filled out after the procedure is completed. This was an error in the previous version of the MOC.

Procedure D7850
Surgical Discectomy, With/Without Implant
3. This criterion has been amended to delete "or operative report". Operative reports cannot be used for prior authorization because they are filled out after the procedure is completed. This was an error in the previous version of the MOC.

Procedure D7852
Disc Repair
3. This criterion has been amended to delete "or operative report". Operative reports cannot be used for prior authorization because they are filled out after the procedure is completed. This was an error in the previous version of the MOC.

Procedure D7854
Synovectomy
3. This criterion has been amended to delete "or operative report". Operative reports cannot be used for prior authorization because they are filled out after the procedure is completed. This was an error in the previous version of the MOC.

Procedure D7858
Joint Reconstruction
3. This criterion has been amended to delete "or operative report". Operative reports cannot be used for prior authorization because they are filled out after the procedure is completed. This was an error in the previous version of the MOC.

Procedure D7860
Arthrotomy
3. This criterion has been amended to delete "or operative report". Operative reports cannot be used for prior authorization because they are filled out after the procedure is completed. This was an error in the previous version of the MOC.

Procedure D7865
Arthroplasty
3. This criterion has been amended to delete “or operative report”. Operative reports cannot be used for prior authorization because they are filled out after the procedure is completed. This was an error in the previous version of the MOC.

Procedure D7944
Osteotomy- Segmented Or Subapical
Change in title of procedure deleting “Per Sextant or Quadrant”.

Procedure D7951
Sinus Augmentation With Bone Or Bone Substitutes
This is a new code and is a benefit.

1. This is a new criterion requiring prior authorization because this is not considered an emergency procedure and prior authorization is needed for utilization control purposes within the Program.

2. and 3. These are new criteria that are necessary so the Program can verify the need for this procedure based on medical necessity and is based on a recommendation from Delta Dental staff oral surgeons.

4. This is a new criterion because this procedure is mainly used in conjunction with implant services to augment the sinus to facilitate implant placement.

5. This is a new criterion to verify that the procedure authorized was the procedure performed and also based on a recommendation from staff Delta Dental oral surgeons.

Procedure D7953
Bone Replacement Graft For Ridge Preservation- Per Site
This is a new code and is not a benefit.

Procedure D7955
Repair of Maxillofacial Soft And/Or Hard Tissue Defect
Change in title of procedure adding “/Or”.

Procedure D7960
Frenulectomy- Also Known As Frenectomy Or Frenotomy- Separate Procedure Not Incidental To Another Procedure
Change in title of procedure adding “ Also Known As” and “Separate Procedure Not Incidental To Another Procedure”.

Procedure D7963
Frenuloplasty
This is a new code and mirrors the criteria for procedure D7960- Frenulectomy Also Known As Frenectomy or Frenotomy - Separate Procedure Not Incidental To Another Separate Procedure. The only difference in this procedure is that it involves repositioning muscle attachments where a frenulectomy does not.

1. and 2. These criteria are based on criteria that are located in the Chapter 8.1 MOC on Page 8.1.93, D7960 1.-2. D7960 states that pre-operative photographs and specific written documentation are required so the same criteria will also be required for D7963.

3. This criterion is based on a criterion that is located in the Chapter 8.1 MOC on Page 8.1.93, D7960 3. D7960 states that an arch code is are required for payment so the same criteria will also be required for D7963.

4. This criterion is based on a criterion that is located in the Chapter 8.1 MOC on Page 8.1.93, D7960 4. D7960 states it is a benefit once per arch per date of service so the same criteria will also be required for D7963.

Procedure D7998
Intraoral Placement Of A Fixation Device Not In Conjunction With A Fracture
This is a new code and is not a benefit.

Orthodontic General Policies (Orthodontic Procedures D8000-D8999)
e) The Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form, DC016 has been modified with a new date of 06/09.

g)i) The Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form, DC016 has been modified with a new date of 06/09.

Orthodontic Procedures (D8000 – D8999)
This category provides a comprehensive explanation of the requirements that apply to orthodontic dental procedures in an effort to conform to the current dental standards of practice. Amendments are made to conform to new CDT 2011-2012 codes as required by H&S Code Section 130301. Orthodontic procedures include appliance therapy to control harmful habits, comprehensive orthodontic treatment of the adolescent dentition, periodic orthodontic treatment visits, orthodontic retention, repair of orthodontic appliances and replacement of lost or broken retainers. The criteria for orthodontic dental procedures are individually specified in procedure codes D8000-D8999.

Procedure D8080
Comprehensive Orthodontic Treatment Of The Adolescent Dentition
1.e. The Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form, DC016 has been modified with a new date of 06/09.

Procedure D8210
Removable Appliance Therapy
4.b. This criterion has been amended to delete the redundant language “during the patient’s lifetime” and adding “per patient”.

Procedure D8220
Fixed Appliance Therapy
4.b. This criterion has been amended to delete the redundant language “during the patient’s lifetime” and adding “per patient”.

Procedure D8660
Pre-Orthodontic Treatment Visit
2.e. The Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form, DC016 has been modified with a new date of 06/09.

4.b. This criterion has been amended to delete the redundant language “that is only payable”.

4.d. This criterion has been amended to delete the redundant language “during the patient’s lifetime”.

Procedure D8670
Periodic Orthodontic Treatment Visit (As Part of Contract)
3.c. This criterion has been amended to delete “month” and replace it with “quarter” per W&I Code, Section 14132.23.

4.a. This criterion has been amended to delete “24 monthly” and replace it with “8 quarterly” and to delete “12” and “monthly” and replace it with “4” and “quarterly” per W&I Code, Section 14132.23.

4.b.i) This criterion has been amended to delete “10 monthly” and replace it with “4 quarterly” and to delete “5” and “monthly” and replace it with “2” and “quarterly” per W&I Code, Section 14132.23.

4.b.ii) This criterion has been amended to delete “14 monthly” and replace it with “5 quarterly” and to delete “7” and “monthly” and replace it with “3” and “quarterly” per W&I Code, Section 14132.23.

4.b.iii) This criterion has been amended to delete “30 monthly” and replace it with “10 quarterly” and to delete “15” and “monthly” and replace it with “5” and “quarterly” per W&I Code, Section 14132.23.

4.c.i) This criterion has been amended to delete “10 monthly” and replace it with “4 quarterly” and to delete “5” and “monthly” and replace it with “2” and “quarterly” per W&I Code, Section 14132.23.

4.c.ii) This criterion has been amended to delete “14 monthly” and replace it with “5 quarterly” and to delete “7” and “monthly” and replace it with “3” and “quarterly” per W&I Code, Section 14132.23.

4.c.iii) This criterion has been amended to delete “24 monthly” and replace it with “8 quarterly” and to delete “12” and “monthly” and replace it with “4” and “quarterly” per W&I Code, Section 14132.23.

Procedure D8693
Rebonding Or Recementing: And/Or Repair, As Required, Of Fixed Retainers
This is a new code and is a benefit.

1. This is a new criterion necessary due to the emergency nature of this procedure, since there would not be time for a provider to request prior authorization.

2. This is a new criterion that is included to inform providers that there are no submission requirements for payment of this dental procedure to prevent unnecessary submittal of information.

3. This is a new criterion that is necessary for claims processing, since it informs providers what arch code is required on the claim form for payment. Arch codes are U (upper) and L (lower).

4.a. and b. and 5. These are new criteria established for utilization control purposes within the Program. Exceptions are noted for additional requests only if medically necessary due to an unusual circumstance and must be documented. Orthodontic patients must be under the age of 21 to be a benefit.

Adjunctive General Policies (Adjunctive Procedures D9000-D9999)

These policy amendments were adopted for CDT 2011-2012 to specify the general requirements that apply to adjunctive dental procedures.

e) This criterion has been amended to reflect the change in wording of procedure D9610- therapeutic parenteral drug, deleting “injection, by report” and adding “parenteral”.

g) This criterion has been amended to include “and supplies” to cover disposable supplies used on the patient (such as tubing, IV lines etc.) in addition to the actual drug used to achieve anesthesia (the agent). The term “is” is changed to “are” for correct grammar.

Adjunctive Service Procedures (D9000 – D9999)
This category provides a comprehensive explanation of the requirements that apply to adjunctive service dental procedures in an effort to conform to the current dental standards of practice. Amendments are made to conform to new CDT 2011-2012 codes as required by H&S Code Section 130301. Adjunctive service procedures include palliative (emergency) treatment of dental pain, anesthesia, professional visits and occlusion analysis and treatment. The criteria for adjunctive service dental procedures are individually specified in procedure codes D9000-D9999.

Procedure D9120
Fixed Partial Denture Sectioning
This is a new code and is a benefit.

1. This is a new criterion necessary due to the emergency nature of this procedure, since there would not be time for a provider to request prior authorization. Previously this procedure would have been paid under the code D9110- Palliative (Emergency) Treatment Of Dental Pain- Minor Procedure.

2. This is a new criterion necessary so the Program can verify the need, and payment, for this procedure based on medical necessity.

3. This is a new criterion to inform providers what is required on the claim for a specific tooth number (code). Permanent teeth are numbered 1 through 32. Retained tooth is one of the anchor teeth that holds a bridge in place.

4. This is a new criterion necessary because if both abutment teeth (a fixed partial denture has at least two abutment teeth) are extracted then it is included in the fee for the extraction. At least one abutment retained means either the abutment crown is left intact to cover the tooth or a new crown will be necessary to cover the tooth.

Procedure D9215
Local Anesthesia In Conjunction With Operative Or Surgical Procedures
Change in title of procedure adding “In Conjunction With Operative or Surgical Procedures”.

Procedure D9220
Deep Sedation/General Anesthesia- First 30 Minutes
4.b. This criterion has been amended to add “on the same date of service’’ to simply offer clarity for providers.

Procedure D9221
Deep Sedation/General Anesthesia- Each Additional 15 Minutes
5.b. This criterion has been amended to add “on the same date of service’’ to simply offer clarity for providers.

Procedure D9230
Inhalation Of Nitrous Oxide/ Anxiolysis, Analgesia
Change in title of procedure deleting “Analgesia, Anxiolysis,” and adding “/Anxiolysis, Analgesia”.

4.b. This criterion has been amended to add “on the same date of service’’ to simply offer clarity for providers.

Procedure D9241
Intravenous Conscious Sedation/Analgesia- First 30 Minutes
4.b. This criterion has been amended to add “on the same date of service’’ to simply offer clarity for providers.

Procedure D9242
Intravenous Conscious Sedation/Analgesia- Each Additional 15 Minutes
5.b. This criterion has been amended to add “on the same date of service’’ to simply offer clarity for providers.

Procedure D9248
Non-Intravenous Conscious Sedation
5.b. This criterion has been amended to add “on the same date of service’’ to simply offer clarity for providers.

Procedure D9310
Consultation- Diagnostic Service Provided By Dentist Or Physician Other Than Requesting Dentist Or Physician
Change in title of procedure deleting “Practitioner Providing Treatment” and adding “Requesting Dentist Or Physician”.

Procedure D9420
Hospital Or Ambulatory Surgical Center Call
Change in title of procedure adding “Or Ambulatory Surgical Center”.

Procedure D9610
Therapeutic Parenteral Drug, Single Administration
Change in title of procedure deleting “Injection, By Report” and adding “Parenteral” and “Single Administration”.

3.b. This criterion has been amended to add “on the same date of service’’ to simply offer clarity for providers.

Procedure D9612
Therapeutic Parenteral Drug, Two Or More Administrations, Different Medications
This new code includes a criterion that procedure D9612 can only be billed as procedure D9610 and is not payable separately.

Procedure D9910
Application Of Desensitizing Medicament
4.b. New fluoride varnish code (D1206) added and obsolete fluoride/prophy codes (D1201 and D1205) deleted.

Procedure D9942
Repair And/Or Reline Of Occlusal Guard
This is a new code and is not a benefit.

STATEMENTS OF DETERMINATION

A. ALTERNATIVES CONSIDERED

The Department has determined that no reasonable alternative considered by the Department or that has otherwise been identified and brought to the attention of the Department would be more effective in carrying out the purpose for which this action is proposed, or would be as effective and less burdensome to affected private persons than the proposed action.

B. LOCAL MANDATE DETERMINATION

The Department has determined that the regulations would not impose a mandate on local agencies or school districts, nor are there any costs for which reimbursement is required by Part 7 (commencing with Section 17500) of Division 4 of the Government Code.

C. ECONOMIC IMPACT STATEMENT

The Department has made an initial determination that the regulations would not have a significant statewide adverse economic impact directly affecting

businesses, including the ability of California businesses to compete with businesses in other states.

The Department has determined that the regulations would not significantly affect the following:

1. The creation or elimination of jobs within the State of California.

2. The creation of new businesses or the elimination of existing businesses within the State of California.

3. The expansion of businesses currently doing business within the State of California.

D. EFFECT ON SMALL BUSINESSES

The Department has determined that the regulations would affect small businesses since many Medi-Cal dental providers meet the criteria for small business. Medi-Cal is a voluntary program for both service providers and beneficiaries. Therefore, only those businesses that choose to be Medi-Cal providers for Dental Services would be affected by these regulations.

E. HOUSING COSTS DETERMINATION

The Department has made the determination that the regulations would not have a significant effect on housing costs.