INTRODUCTION TO GUARDIAN CLINICAL POLICY

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INTRODUCTION TO GUARDIAN CLINICAL POLICY

The Guardian Clinical Policies are developed by licensed dentists and reviewed periodically. The intent is to ensure that clinical criteria are current with dental terminology, evidence-based research and clinical trends.

Patients and dentists should be aware that benefit designs are often made by the purchasers of the plan, which is often the employer and, in most cases, not the patient. Once benefit design decisions are made, each covered service under the plan must meet clinical guidelines to be reimbursable.

The clinical team at The Guardian Life Insurance Company of America makes every effort to stay current with standard clinical practices. Given this knowledge, clinical guidelines are developed for many procedure codes to determine when a procedure will be covered as medically necessary.

In all instances in which a claim has been denied, on the basis of medical necessity, the dentist may submit an appeal. The appeal will be reviewed by a different clinician than the one who reviewed the claim originally.

When submitting an appeal, it is helpful to submit as much information as possible; such as radiographs, periodontal charting (if relevant), clinical notes and photographs (if available and if relevant.) The Guardian dentist consultant is better able to understand the position of the treating dentist if he/she is provided as much information as possible. Treatment notes should be legible and clinical (chart) notes are required, instead of only a post-treatment narrative.

In instances in which there is a difference of clinical opinion, the decision of the Guardian consultant will be final with regard to benefit determination, (unless there are state regulations which require an external review.)

This policy will be revised and updated periodically.

Dental offices are encouraged to request a predetermination or a prior authorization whenever there is any question of benefits or coverage.

General Clinical Guidelines*

Providers are encouraged to submit as much information as possible with the original claim submission. Intra-oral photographs, when available, are often helpful in claim determination.

Providers are also strongly encouraged to request a predetermination or a preauthorization whenever there is a question of benefits and/or coverage.

Guardian does not provide benefits for:
• Procedures performed for cosmetic reasons or otherwise not
consistent with clinical guidelines.

- Procedures performed due to abrasion, erosion, attrition or abfraction.
- Teeth with poor or questionable prognosis (The final decision regarding prognosis will reside with the Guardian dentist consultant, unless a state mandates external review.)
- Considerations for the determination of poor or questionable prognosis include, but are not limited to:
  - Significant loss of tooth structure
  - Poor crown/root ratio
  - Furcation involvement
  - Decay extending below the crestal bone
  - Advanced bone loss
  - Poor endodontic prognosis

**ALTERNATE TREATMENT**

If more than one type of service can be used to treat a dental condition, Guardian must follow the contract and base benefits on the least expensive service, which is within the range of professionally accepted standards of dental practice as determined by a licensed Guardian dentist consultant.

**CRACKED TOOTH SYNDROME**

Cracked tooth syndrome is a separation in the continuity of the tooth structure. It can also involve a tooth with missing enamel dentin as the result of trauma.

Cracked tooth syndrome is not craze or crack lines with or without staining.

As much diagnostic information as possible should be submitted to support a diagnosis of cracked tooth syndrome.

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**Clinical Guidelines: Periodontics**

**SCALING AND ROOT PLANING**

Applies to codes: 4341, 4342.

4341 and/or 4342 are indicated when there is pathology present in the supporting structures of the teeth as evidenced in radiographs, and in conjunction with 5 mm pockets or more, attributable to a loss of attachment. 4342 is the correct code when less than 4 teeth in the quadrant require treatment. Root planning is defined as a definitive nonsurgical therapeutic treatment involving the judicious and thorough planing of the root surface of the teeth. This procedure is therapeutic in nature. The following policies apply to the adjudication of codes 4341 and 4342:

1. 5 mm of pocket depth is required for a 4341/4342
2. 4341/4342 are not benefited in the absence of visible pathologic radiographic bone loss.
3. Edentulous spaces, tooth-bounded spaces, are not counted.
4. No more than 2 quadrants of 4341 may be benefitted on the same date of service; except for reasons of medical necessity as determined by the Guardian dentist consultant. Issues of patient and/or provider convenience are not considered medical necessity.

**Documentation:** Both a full mouth periodontal charting and an FMX are required for 4341; panoramic radiographs are not sufficient. When insufficient information is received, the claim will be pended until additional information is received. If necessary, chart notes may be requested. Narratives are not the same as chart notes. Narratives will not be used for purposes of benefit determination.

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**CROWN LENGTHENING**
Applies to code: 4249

Crown lengthening is performed to expose sound tooth structure by removing bone prior to prosthetic procedures. It is not performed in the presence of periodontal disease. It is not a payable benefit on the same day as osseous surgery or the placement of a restoration. It is expected that 5-6 weeks will elapse between the date of the crown lengthening and the preparation of the tooth for indirect restoration.

**MUCOGINGIVAL SURGERY**

Applies to codes: 4270, 4273, 4275, 4276, 4277, 4278, 4283, 4285

Mucogingival surgery will not be a covered benefit if the level of attached gingiva with recession appears to be within normal limits. The recession must be progressive and there must be less than 2 mm of attached keratinized tissue remaining. Generic narratives will not be accepted; attached gingiva for each tooth must be recorded. Mucogingival surgery is not a covered benefit when done for reasons of sensitivity or cosmetics.

It is strongly recommended that intra-oral photographs be submitted with claims for mucogingival surgery.

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**Clinical Guidelines: Prosthodontics**

Applies to codes: 2510-2530, 2542-2544, 2610-2630, 2642-2644, 2650-2652, 2662-2664, 2710-2799, 2960-2962

**CROWNS, INLAYS, ONLAYS AND VENEERS**

Indirect restorations are covered benefits only when there is decay or injury to the tooth. Covered benefits for crowns, inlays, onlays and veneers are allowed only when necessary due to decay or injury and/or when the tooth cannot be restored with a direct restoration. (Injury does not include damage to teeth, appliances or dental prostheses which results solely from chewing or biting food or other substances.)

Crowns, Inlays, Onlays and Veneers are not covered benefits when done for cosmetic reasons. These services are also not covered benefits when done for due to attrition, abrasion, erosion or abfraction or to alter the occlusion.

Crowns, Inlays, Onlays and Veneers will not be covered when, in the opinion of the Guardian consultant, there is an untreated periodontal or endodontic condition that will compromise the longevity of the tooth. These services are not a covered benefit when the tooth is not in occlusion.

**CORE BUILD-UP**

Applies to Code: 2950

Post and cores and core build-ups are allowed only when there is insufficient circumferential tooth structure remaining to retain a full coverage indirect restoration. Core build-ups are not covered for inlays, onlays and partial crowns.

Procedures performed for the purposes of pulpal insulation or blocking out of undercuts are not considered core build-ups. The following conditions must be present:

- Less than 3 mm of sound dentin remains circumferentially after tooth preparation
- There are one or more missing cusps
- Diagnostic quality radiographs or photographs to demonstrate the need for a core build-up
- A core buildup is not a filler to eliminate any undercut, box form, or concave irregularity in a preparation.

**POST AND CORE**

Applies to Codes: 2952, 2954

Post and cores on anterior teeth are not indicated in the absence of decay or injury that substantially diminish the remaining tooth structure. Endodontically treated anterior teeth, without restorations, decay, injury or the loss of substantial coronal structure, may be restored with a direct

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*All clinical guidelines are subject to individual consideration by the Guardian dentist consultants based on the unique circumstances of the case.*
restoration without the need for a post and core.

There is accumulating scientific evidence that now indicates that the adverse outcomes of prophylactic extraction outweigh the benefits.

One or more of the following conditions must be present for the tooth to qualify for benefit coverage:

- The presence of caries, clinically visible fracture, or pulpal involvement
- Pathological cyst formation of 2 mm or greater
- Bone loss or caries on the adjacent second molar that cannot be treated adequately without removal of the third molar
- More than one documented episode of pericoronitis as evidenced in the clinical notes
- Ectopic position of tooth preventing the eruption of an adjacent tooth
- Periodontal disease involving the second molar caused by the position of the third molar and of greater severity than the periodontal condition which will follow removal of the third molar.
- Osteomyelitis or cellulitis
- Internal/external resorption of the tooth or adjacent tooth
- Tooth/teeth impeding orthognathic surgery, reconstructive surgery, or trauma surgery.
- Overlying removable prosthesis
- Impaction preventing the eruption of the second molar

Conditions NOT qualifying for benefit coverage:

- Asymptomatic impacted teeth and tooth buds
- Impacted teeth with no apparent pathology
- Removal of teeth to “prevent crowding” or future periodontal disease
- Removal for non-specific symptoms such as “headaches,” “jaw pain,” or TMJ discomfort.

Clinical Guidelines: Oral Surgery*

THIRD MOLAR IMPACTIONS

Applies to codes: 7220; 7230; 7240; 7241; 7251

It is highly recommended that third molar extractions be preauthorized, so that there is no question on the part of either the patient or the treating dentist about the Guardian benefit determination. The request for pre-authorization should include clinical notes and radiographic images, in which the teeth in question are clearly visible.

Coding for the removal of third molars is based upon anatomic position of the tooth, not the technique necessary for removal. Classification is based upon the ADA CDT descriptors.

Current scientific literature supports the premise that it is preferable to retain impacted third molars when there is no indication of pathology or imminent pathology.

The American Association of Oral and Maxillofacial Surgeons (AAOMS) in a 2015 document stated:

“Predicated on the best evidence-based data, third molar teeth that are associated with disease, or are at high risk of developing disease, should be surgically managed. In the absence of disease or significant risk of disease, active clinical and radiographic surveillance is indicated.”

*All clinical guidelines are subject to individual consideration by the Guardian dentist consultants based on the unique circumstances of the case.
**Coding of Impactions:** If, in the opinion of the Guardian dentist consultant, the procedure has been coded incorrectly, and does not accurately reflect the position of the tooth with regard to the gingiva and the osseous anatomy, (as defined by the ADA in CDT) then at the discretion of the Guardian dentist consultant the claim will be given an alternate benefit to more accurately reflect the procedure which was performed.

**SURGICAL EXTRACTIONS**

 Applies to Codes: 7210

Code 7210 is a covered benefit when bone removal or sectioning of the tooth is required for tooth removal. When these conditions do not exist, an alternate benefit of a non-surgical extraction will be applied.

**Clinical Guidelines: General Anesthesia and IV Sedation***

 Applies to Codes: 9222; 9223; 9239; 9243; 9248

General Anesthesia and IV Sedation are covered benefits only when administered by a properly licensed dentist or nurse anesthetist in a dental office in conjunction with covered oral surgical procedures and when medically necessary. Pre-authorization of general anesthesia/ deep sedation is highly recommended. In the absence of pre-authorization, payment may be denied, if the criteria are not met. Medical necessity is defined by the presence of any of the following situations:

- The patient is under 6 years of age and is either uncooperative or requires complex treatment OR
- Surgical procedures are performed in 3 or more quadrants OR
- The patient exhibits physical, intellectual or medically compromising conditions
- The patient has sustained oral-facial trauma

If there is a dispute regarding the necessity of general anesthesia, the treating dentist may request an appeal.