Health Evidence Review Commission's Oral Health Advisory Panel

March 6, 2024

1:00 PM - 3:00 PM

Online Meeting

Join online meeting here

+16692545252,,1614824051#

Section 1.0

Call to Order

AGENDA
ORAL HEALTH ADVISORY PANEL (OHAP)
March 6, 2024
1:00 -3:00 pm
Online meeting
(All agenda items are subject to change and times listed are approximate)

#	Time	Item	Presenter
1	1:00	Call to Order, Review of Minutes	Ariel Smits
2	1:05	Straightforward items 1) Edits to the tongue tie guideline	Ariel Smits
3	2:00	New discussion items: 1) Dental telehealth 2) Fluoride varnish frequency 3) Frenectomy for tongue tie 4) Input from the OHA dental coding/rules workgroup	Ariel Smits
4	2:45	Other Business	Ariel Smits
5	2:55	Public Comment	
6	3:00	Adjournment	Ariel Smits

Note: Public testimony will be taken on each topic per HERC policy at the time at which that topic is discussed. Public testimony not related to a topic on the agenda will be taken at the end of the meeting.

Highlights

Health Evidence Review Commission's
Oral Health Advisory Panel (OHAP)

Virtual Meeting
October 11, 2023
1:00 PM – 3:00 PM

Members Present: Gary Allen, DMD; Karen Nolon; Laura McKeane; Dayna Steringer; Deborah Loy; Stacy Geisler, DMD, MD; Manu Chaudhry, DMD; Alison Noble.

Staff Present: Ariel Smits, MD, MPH; Jason Gingerich; Liz Walker; Daphne Peck.

Also Attending: Jessica Dusek**,** Janet Herb, and Amy Umphlett (OHA); Samantha Shepherd, Stephanie Asher, Mathew Sinnott, Pixie Needham, Jonathan Kim, sayj, Heather Simmons, Alyssa Franzen (CareOregon), Gita Yitta (AllCare CCO), Cathleen Olesitse, Jennie, Kimberley, Kathy, Laura Blanke, Vesna Hopkins, Yuberca Ward.

Roll Call/Minutes Approval/Staff Report

The meeting was called to order at 1:00 PM and roll was called. Highlights from 11/4/2022 meeting were reviewed and no changes were suggested.

- **Topic: 2024 CDT code placements**

• D0396: The staff suggestion was to place on line 469 DENTAL CONDITIONS (E.G., CARIES, FRACTURED TOOTH) Treatment ADVANCED RESTORATIVE (I.E., BASIC CROWNS). OHAP discussed that the 3D dental scan was similar to D0470 (diagnostic casts) which is currently on the Excluded file. Both D0396 and D0470 are used for crowns, dentures and orthodontic care. Current OHA dental rule states that these codes are not to be billed separately. OHAP members discussed that the code for the 3D scan which is used to make the 3D print (D0801-D0802 3d dental surface scan) are on line 256. Both D0396 and D0470 can be used for determination of the orthodontic benefit, which would make these types of procedures diagnostic. OHAP recommended after discussion that D0396 be placed on the Diagnostic Procedures File, and that D0470 and D0801-D0802 also be placed on the Diagnostic Procedure File. D0801-D0802 would be removed from line 256. OHA rulemaking will take place in the first quarter of 2024 and discussion could occur then about whether the rule should continue to require that these codes be bundled and not paid separately. HERC staff were directed to look at the ADA rulebook for all CDT codes that are considered diagnostic for consideration for placement on the Diagnostic Procedures File. HERC staff and OHA staff were directed to look at the dental rule (OAR 410-123-1200) for all codes that are listed as not separately billable and

see if this is still appropriate. The codes representing the services not separately billable in this rule will be brought to the next OHAP meeting for review. OHAP requested a meeting in the first quarter of 2024 to review the diagnostic CDT codes, the non-separately billable codes, and any CDT codes on the Excluded file.

• D1301: There was discussion about whether a dental office could bill separately for immunization counseling, or whether this was bundled into the actual vaccine administration fee. Smits noted that medical offices can bill separately for vaccine counseling, and be paid for this even if the patient elects to not receive the vaccine. The final decision was to place this code on the preventive services line.

• D0276: no discussion

• D2989: minimal discussion

• D2991: HERC staff literature review found several evidence-based reviews on hydroxyapatite which found that it can be beneficial in dental care products (toothpaste, mouthwash, etc.) but that its use in dentistry needs clinical trials. There was discussion that there are commercially available medicaments with hydroxyapatite which could be used in a dental office. There was discussion about making this code Excluded, but OHAP felt that it would be better placed on line 646 to make it clear that it was non-covered.

• D6089: This code is part of implant care. OHAP felt that this was outside the scope of general dentists, and should only be done by an implant trained oral health provider. The recommended placement was on the implant line

• D7284: There was discussion about whether this code was diagnostic or a surgical procedure. There is another CDT code for the pathology associated with the biopsy. Salivary glands can be excised for both diagnostic purposes, for example, to diagnose Sjogren's syndrome or evaluate an abnormal appearing gland. It can also be done as a therapeutic procedure, to remove a large or painful gland. OHAP determined that even when done as a therapeutic procedure, this procedure still had an element of being a diagnostic test and should be on the Diagnostic Procedures file.

•D7939: minimal discussion

•D9938 and D9939: no discussion

•D9954 and D9955: The Oregon Dental Board site was accessed, and it clearly states that the fabrication of an oral appliance is within the scope of a dentist, but only after a diagnosis of obstructive sleep apnea has been made by a physician. There was minimal discussion regarding the fabrication of an oral appliance. From the dental board site: "dentists legally are not in a position to diagnose sleep disordered breathing and sleep apnea; a physician must make the diagnosis and then prescribe oral appliance therapy before the dentist can treat it."

HERC staff noted that there were two HCPCS codes for oral appliances (K1027 and E0486) that are currently listed as "never reviewed." All of these codes should be added to the sleep apnea line. Use of oral appliances is governed by the sleep apnea treatment guideline. CDT D9947-D9951 which code for fabrication and adjustment of oral devices are on line 202.

•D9956: There was considerable debate about whether dentists could legally order a sleep study. The dental board site was accessed as noted above, and it was confirmed that diagnosing obstructive sleep apnea is outside the scope of practice for dentists in Oregon. This code was recommended for the Excluded file.

•D9957: This code had been suggested by staff to be placed on the sleep apnea line. However, due to the concern that diagnosis of OSA was outside of Oregon dental licensure, it was unclear if screening for OSA would be in scope. HERC staff was directed to ask the dental board about whether screening for OSA is in scope; if so, this code should be Diagnostic Procedures file. If not, D9957 should be Excluded.

- **Discussion on denture and implant coverage**

HERC staff have heard OHA member concern regarding lack of coverage for dentures and dental implants. Staff asked the OHAP what they would recommend for coverage expansion if funding for additional dental services was procured.

Members are aware of frustration around coverage of dentures. Allen noted that adult dentures are not a mandatory benefit under Medicaid by federal rule, and are only covered to the extent allowed by the Oregon Legislature. There are budgetary constraints to expanding benefits in these areas. Denture benefits are very expensive.

Suggestions for the most beneficial expansions of denture benefit would be to allow partial dentures for fewer numbers of missing teeth, when the front teeth are involved, or for missing premolars. There was discussion about allowing denture replacement sooner than currently allowed (10 years for full dentures) when the dentures are lost or stolen. Other members noted that current rule does allow denture replacement when stolen, lost in natural disaster, or other circumstances outside of the member's control. It was noted that earlier replacement may not be part of the rates for dental organizations. One member suggested focusing any additional funding on treatments to retain natural teeth, such as crowns after root canals. Currently, this benefit is very limited by age and type of teeth. Coverage of crowns was also cut years ago by rule/Legislative intent due to budget issues.

- **Additional topics discussed**

Allen requested that frenulectomy (lip tie) be limited to members under age 21 in the Prioritized List guideline. These services were limited to children in rule, but have been dropped from the current OHA dental rule for unclear reasons. OHAP requested that the

guideline regarding frenulectomy be modified to indicate that coverage is limited to patients under the age of 21.

- **Public Comment:** no additional public comment was received

- **Issues for next meeting:**

• Review of diagnostic CDT code placement
• Review of current excluded CDT codes in OHA rule

- **Next meeting:**
    - TBD

Section 2.0

Consent Agenda-

Straightforward Items

Frenectomy for Tongue Tie

Coverage Question: Should frenectomy be added as a treatment for tongue tie?

Question source: Holly Jo Hodges, CCO medical director

Background:

The lingual frenum is the small band of tissue connecting the tongue to the floor of the mouth. Ankyloglossia, also known as "tongue-tie," is a congenital condition in which a neonate is born with an abnormally short, thickened, or tight lingual frenulum that restricts mobility of the tongue. It variably causes reduced anterior tongue mobility and has been associated with functional limitations in breastfeeding, swallowing, articulation as well as orthodontic problems including malocclusion, open bite, and separation of lower incisors, mechanical problems related to oral clearance, and psychological stress This condition may be surgically corrected, often as an office procedure in neonates, by simple excision (i.e. frenectomy, frenotomy), or with a more extensive procedure (frenulotomy or frenuloplasty). The focus on this issue is for frenotomy and frenuloplasty, which are more extensive procedures used to address concerns about social function, speech and dental or orthodontic work. While the major focus of the AHRQ report was about breastfeeding outcomes, frenotomy (a simple clipping procedure which can be performed with a scissors) is already covered for breastfeeding issues and no change is proposed.

Currently, frenotomy (the incision into the frenum) is covered for treatment of tongue tie. Dr. Hodges has seen requests for frenectomy (a more invasive procedure involving the removal of the frenum) for this condition. Frenectomy is considered one possible treatment of this condition. Currently, frenectomy is only covered for cancer of the mouth.

Frenotomy (also known as frenulotomy) is the clipping or cutting of the frenum under the tongue, generally and using straight scissors to divide the frenulum, generally without sedation. The ensuing wound does not typically require repair. This is done mainly for breastfeeding latching issues. Laser frenotomy or frenulotomy has also been described. Frenotomy may be done by ENTs, dentists, or other professionals.

Frenectomy or frenuloplasty is more technically involved than frenotomy or frenulotomy. Frenectomy is the complete removal of the frenulum. It can be done surgically or using a laser device. Frenuloplasty generally refers to rearranging tissue or adding grafts after making incisions and closing the resultant wound in a specific pattern to lengthen the anterior tongue. Specific types of frenuloplasty include Z-frenuloplasty, which involves making a longitudinal incision along the length of the lingual frenulum combined with perpendicular incisions at tongue tip and floor of the mouth. These cuts create a Z-type incision. Submucosal flaps are then elevated, and transposed flaps are sutured closed, resulting in increased tongue length and mobility. A second type of frenuloplasty involves a horizontal division at the base of the frenulum where a harvested buccal mucosal graft is inserted and affixed to fill the defect created by the incision. Horizontal-to-vertical frenuloplasty is a third type in which a horizontal incision is created at mid-frenulum to release the tethering fibrotic band. The incision is then converted to a vertical orientation and closed with sutures to effectively elongate the anterior tongue. Frenuloplasty is most commonly performed under a general anesthetic and used in older infants and children or in more

complex frenulum repairs. This procedure is usually performed for patients with concerns of developing periodontal disease.

Previous HSC/HERC reviews:

No previous review of CPT 41115 was found.

The CDT code for frenectomy was reviewed in 2013, but the actual code reviewed at that time represented all of the following procedures: frenulectomy, frenectomy and frenotomy (previous CDT code D7960 FRENULECTOMY - ALSO KNOWN AS FRENECTOMY OR FRENOTOMY). This review created the current frenotomy guideline for tongue tie. CDT D7960 was replaced with two codes in 2020, which were reviewed as part of the new code review. During that review, D7962 (lingual frenectomy) was added to the dental caries line and the feeding problems in newborns line. In November 2022, D7962 was removed from the dental caries line and added to the lower tongue tie line (now line 590). The other daughter code of D7960 was D7961 (Buccal / labial frenectomy (frenulectomy)) which refers to lip tie release and was placed on the dental caries line and line 653 MISCELLANEOUS CONDITIONS WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY with a guideline.

Frenectomy for Tongue Tie

Current Prioritized List/Coverage status:

CPT/CDT code	Code description	Used for	Current placement
41010	Incision of tissue connecting tongue and floor of mouth	Frenotomy, simple tongue frenum clipping for "tongue-tie"	18 FEEDING PROBLEMS IN NEWBORNS 163 CARCINOMA IN SITU OF UPPER AIRWAY, INCLUDING ORAL CAVITY 590 TONGUE TIE AND OTHER ANOMALIES OF TONGUE
41115	Removal of tissue connecting tongue and floor of mouth	Frenectomy, frenuloplasty (more extensive surgery)	163 285 CANCER OF ORAL CAVITY, PHARYNX, NOSE AND LARYNX 590
D7961	Buccal / labial frenectomy (frenulectomy)	"Lip tie"	341 DENTAL CONDITIONS (E.G., SEVERE CARIES, INFECTION) 653 MISCELLANEOUS CONDITIONS WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY
D7962	Lingual frenectomy (frenulectomy)	also known as frenulotomy for frenotomy used for simple clipping of the frenum	18,590
D7963	Frenuloplasty	Frenectomy, frenuloplasty (more extensive surgery)	341

GUIDELINE NOTE 48, FRENULECTOMY/FRENULOTOMY

Lines 341,653

Labial frenulectomy/frenulotomy (D7961) is included on this line for patients under age 21 in the following situations:

A) When deemed to cause gingival recession
B) When deemed to cause movement of the gingival margin when frenum is placed under tension.
C) Maxillary labial frenulectomy not covered until age 12 and above.

Otherwise, D7961 is included on Line 653.

GUIDELINE NOTE 139, FRENOTOMY FOR TONGUE TIE IN NEWBORNS

Lines 18,590

Ankyloglossia (ICD-10-CM Q38.1) is included on Line 18 for pairing with frenotomy (CPT 41010, CDT D7962) only when it interferes with breastfeeding. Otherwise, Q38.1 and CPT 41010 and CDT D7962 are included on Line 590.

Frenectomy for Tongue Tie

Evidence:

1) **AHRQ 2015**, systematic review of treatments for ankyloglossia or ankyloglossia with concomitant lip-tie in neonates and infants with breastfeeding difficulties and in children aged 0-18 years
    a. Studies
        i. 1 poor quality RCT and 9 observational studies addressed speech and articulation concerns.
    b. Breastfeeding: All included studies used frenotomy
    c. Speech and articulation concerns (in older children):
        i. 2 poor quality retrospective cohort series on frenotomy
        ii. Relevant case series examined different treatment methods including simple division with scalpel, scissors, and CO2 laser, frenuloplasty, and the addition of genioglossus myotomy. All studies reported positive outcomes and none reported significant harms, but as noted, these studies provide no comparative effectiveness data.
        iii. One poor quality RCT randomized children presenting to a cleft lip and palate-craniofacial clinic between 1999 and 2003 with a tight frenulum (<15mm), an articulation or speech problem related to tongue tie, and/or age greater than 3 years to four-flap Z-frenuloplasty or horizontal-to-vertical frenuloplasty. The study included 16 children with articulation problems, of whom 11 underwent four-flap Z-frenuloplasty (7 male, 4 female) and the remainder (2 male, 3 females) horizontal-to-vertical frenuloplasty. Ages were similar between treatment groups (Z-frenuloplasty: mean 5.7 ± 2.14 vs. horizontal-to-vertical: mean 5.56 ± 1.52). Ten of eleven children in the Z-plasty arm had two orders of magnitude improvement (i.e., severe to mild) and seven had complete resolution of articulation problems. In contrast, no patients in the horizontal-to-vertical group had two order of magnitude improvement or complete resolution. Two had one level improvement in articulation and three had none.
    d. Social concerns related to tongue mobility
        i. One study identified on social concerns which studied frenotomy
    e. Conclusions
        i. Speech outcomes: Given the lack of good-quality studies and limitations in the measurement of outcomes, we considered the strength of the evidence for the effect of surgical interventions to improve speech and articulation to be insufficient.
        ii. Social concerns related to tongue mobility: With only one poor-quality comparative study, strength of evidence related to the ability of treatment for ankyloglossia to alleviate social concerns is currently insufficient. Also, with only three comparative studies with small sizes and limitations in the measurement of outcomes related to tongue mobility, we considered the strength of evidence for the effect of surgical interventions to improve the short-term outcome of mobility to be insufficient
        iii. Overall conclusions: A small body of evidence suggests that frenotomy may be associated with improvements in breastfeeding as reported by mothers, and potentially in nipple pain. However, with small, inconsistently conducted studies, strength of evidence is low to insufficient, preventing us from drawing firm conclusions at this time. Research is lacking on nonsurgical interventions, as

well as on outcomes other than breastfeeding, particularly speech and dental outcomes. In particular, there is a lack of evidence on significant long-term outcomes, such as exclusive breastfeeding at 6 months of age or at 1 year of age, growth, and other measures of health outcomes. Harms are minimal and rare; the most commonly reported harm is self-limited bleeding

Other payer policies:

1) Aetna 2023
    a. Aetna considers lingual or labial frenectomy, frenotomy, or frenuloplasty medically necessary for ankyloglossia when newborn feeding difficulties or childhood articulation problems exist.
    b. CPT 41010 and 41115 are both covered
2) UHC 2023
    a. Frenulectomy and Frenuloplasty are indicated for the following:
        i. When attachment of the Frenum is coronal to the mucogingival junction, within the free gingiva, or in the papilla causing a diastema, gingival recession, or stripping
        ii. When the position attachment of the Frenum is interfering with proper oral hygiene
        iii. Prior to the construction of a removable denture replacing teeth in the area of aberrant frenal attachment
        iv. When there is a functional disturbance, including, but not limited to mastication, swallowing, and speech
        v. For Ankyloglossia or papillary penetrating attachment of maxillary labial Frenum in newborns when there is interference with feeding
    b. Coverage includes both CPT 41010 and 41115
3) VA 2010
    a. Surgery for tongue-tie is not covered except in cases where total or complete ankyloglossia is documented.
    b. Includes both CPT 41010 and 41115

OHAP input:

Frenectomy for Tongue Tie

HERC staff summary: Frenectomy/frenuloplasty for speech issues was studied only in children with craniofacial anomalies and found to be helpful in one poor quality RCT and several observational studies. Coverage of frenectomy for children with craniofacial anomalies and speech difficulties can be done on an individual review basis. Frenectomy and frenuloplasty are more extensive procedures with more risks of harms.

In addition, the Prioritized List should be clarified regarding coverage of frenectomy/frenuloplasty only for periodontal issues or treatment of cancer.

A high quality systematic review from a highly trusted source (AHRQ) found evidence only for frenotomy for breast feeding outcomes. As previously reviewed by HERC, the evidence for breast feeding outcomes is mixed and the strength of evidence is low; however, given the low risk nature of the intervention, the HERC elected to cover this procedure for breast feeding difficulties. Staff recommend no changes in coverage of frenotomy for breastfeeding outcomes. Due to lack of evidence, frenectomy and frenuloplasty should not be covered for breastfeeding issues, and the guideline needs to be clarified to reflect noncoverage.

HERC staff recommendations:

1) Add CDT D7963 (Frenuloplasty) to line 590 TONGUE TIE AND OTHER ANOMALIES OF TONGUE
2) Modify GN139 as shown below
3) Add CPT 41115 (Removal of tissue connecting tongue and floor of mouth) and CDT D7963 to line 217 DENTAL CONDITIONS (E.G., PERIODONTAL DISEASE) Treatment BASIC PERIODONTICS and 254 DEFORMITIES OF HEAD AND HANDICAPPING MALOCCLUSION
    a. Remove CPT 41115 and CDT D7963 from line 341 DENTAL CONDITIONS (E.G., SEVERE CARIES, INFECTION) Treatment ORAL SURGERY
4) Modify GN 48 as shown below

GUIDELINE NOTE 139, FRENOTOMY FOR TONGUE TIE IN NEWBORNS

Lines 18,590

Ankyloglossia (ICD-10-CM Q38.1) is included on Line 18 for pairing with frenotomy (CPT 41010, CDT D7962) only when it interferes with breastfeeding. Otherwise, Q38.1 and CPT 41010 and CDT D7962 are included on Line 590. Frenectomy/frenuloplasty (CPT 41115, CDT D7963) when used for treatment of tongue tie is only included on line 590 due to lack of evidence. See Guideline Note 48 for other coverage of frenectomy/frenuloplasty.

GUIDELINE NOTE 48, FRENULECTOMY/FRENULOTOMY**/FRENECTOMY**

Lines 163,285,217,254,~~341,~~590,653

Labial frenulectomy/frenulotomy (D7961) and lingual frenectomy/frenuloplasty (CPT 41115, CDT D7963) are ~~is~~ included on ~~this~~ line 254 for patients under age 21 in the following situations:

A) When deemed to cause gingival recession
B) When deemed to cause movement of the gingival margin when frenum is placed under tension.
C) ~~Maxillary labial frenulectomy not covered until~~ The patient is age 12 and above.

Frenectomy for Tongue Tie

CPT 41115 and CDT D7961 and D7963 are included on line 254 when used as part of orthodontic treatment for severe malocclusion.

CPT 41115 is included on lines 163 and 285 when used as part of the treatment of cancer of the oral cavity.

Otherwise D7961 is included on Line 653; CDT D7963 and CPT code 41115 are on line 590.

Effective Health Care Program

Comparative Effectiveness Review
Number 149

Treatments for Ankyloglossia and Ankyloglossia With Concomitant Lip-Tie

AHRQ
Agency for Healthcare Research and Quality
Advancing Excellence in Health Care • www.ahrq.gov

Comparative Effectiveness Review

Number 149

Treatments for Ankyloglossia and Ankyloglossia With Concomitant Lip-Tie

Prepared for:
Agency for Healthcare Research and Quality
U.S. Department of Health and Human Services
540 Gaither Road
Rockville, MD 20850
www.ahrq.gov

Contract No. 290-2012-00009-I

Prepared by:
Vanderbilt Evidence-based Practice Center
Nashville, TN

Investigators:
David O. Francis, M.D., M.S.
Sivakumar Chinnadurai, M.D., M.P.H.
Anna Morad, M.D.
Richard A. Epstein, Ph.D., M.P.H.
Sahar Kohanim, M.D.
Shanthi Krishnaswami, M.B.B.S., M.P.H.
Nila A. Sathe, M.A., M.L.I.S.
Melissa L. McPheeters, Ph.D., M.P.H.

AHRQ Publication No. 15-EHC011-EF
May 2015

Treatments for Ankyloglossia and Ankyloglossia With Concomitant Lip-Tie

Structured Abstract

Objectives. We systematically reviewed the literature on surgical and nonsurgical treatments for infants and children with ankyloglossia and ankyloglossia with concomitant lip-tie.

Data sources. We searched MEDLINE® (PubMed®), PsycINFO®, Cumulative Index of Nursing and Allied Health Literature (CINAHL®) and Embase (Excerpta Medica Database), as well as the reference lists of included studies and recent systematic reviews. We conducted the searches between September 2013 and August 2014.

Review methods. We included studies of interventions for ankyloglossia published in English. Two investigators independently screened studies against predetermined inclusion criteria and independently rated the quality of included studies. We extracted data into evidence tables and summarized them qualitatively.

Results. We included 58 unique studies comprising 6 randomized controlled trials (RCTs) (3 good, 1 fair, 2 poor quality), 3 cohort studies (all poor quality), 33 case series, 15 case reports, and 1 unpublished thesis. Most studies assessed the effects of frenotomy (a procedure in which the lingual frenulum is divided) on breastfeeding-related outcomes. Four RCTs reported improvements in breastfeeding efficacy using either maternally reported or observer ratings, while two RCTs using observer ratings found no improvement. Mothers consistently reported improved breastfeeding effectiveness after frenotomy, but outcome measures were heterogeneous and short term. Future studies could provide additional data to confirm or change the measure of effectiveness; thus, we consider the strength of evidence (SOE; confidence in the estimate of effect) to be low at this time. Furthermore, this literature is characterized by (1) a lack of details about the surgical procedure, (2) cointerventions allowed variably in control groups, and (3) diversity of provider settings. Pain outcomes improved for mothers of frenotomized infants compared with control in one study of 6-day old infants but not in studies of infants a few weeks older. Given these inconsistencies and the small number of comparative studies and participants, the SOE is low for an immediate reduction in nipple pain. Three studies with significant limitations reported improvements in other feeding outcomes with frenotomy, and four poor-quality studies reported some improvements in speech articulation but mixed results related to overall speech sound production. Three poor-quality comparative studies noted some improvements in social concerns and gains in tongue mobility in treated participants. SOE for all of these outcomes is insufficient. SOE is moderate for minor and short-term bleeding following surgery and insufficient for other harms (reoperation, pain).

Conclusions. A small body of evidence suggests that frenotomy may be associated with improvements in breastfeeding as reported by mothers, and potentially in nipple pain, but with small short-term studies, inconsistently conducted, SOE is generally low to insufficient. Comparative studies reported improvements in some measures of speech, but assessment of outcomes was inconsistent. Few studies addressed tongue mobility and self-esteem issues.

Research is lacking on nonsurgical interventions, as well as on outcomes other than breastfeeding.

Section 3.0

New Discussion Items

Teledentistry

Coverage Question: Should the telehealth guideline be modified to specify when various teledentistry services are covered?

Question source: Holly Jo Hodges, CCO medical director

Background: Dr. Hodges is part of the Oregon Health Leadership Council (OHLC), which has been looking at dental telehealth. Dr. Hodges noted that no current teledentistry codes are included in the current telehealth guideline and she is requesting guidance on when CCOs/DCOs should cover teledentistry.

The OHLC is considering the following services as possibly appropriate for teledentistry:

1) Preventive dental or oral health screenings for children: the OHLC is looking for guidance on the following CDT codes:
    a. D1206 Fluoride varnish application
    b. D1310 Nutritional counseling
    c. D1320 Tobacco counseling
    d. D1321 High-risk counseling
    e. D1330 Oral hygiene instruction
2) Emergency department follow-up for non-traumatic dental conditions: the OHLC is looking for guidance on CDTs:
    a. D0190 Screening of a patient
    b. D0191 Assessment of a patient
    c. D1310 Nutritional counseling for the control of dental disease
    d. D1320 Tobacco counseling for the control and prevention of oral disease
    e. D1321 Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use
    f. D1330 Oral hygiene instruction
    g. D9991-D9994: Dental case management
    h. D9997 Dental case management - patients with special health care needs
3) Certain services are appropriate for facilitated telehealth visits where a dental professional, such as an expanded practice dental hygienist (EPDH) or dental therapist, is located with the patient while the treating or consulting provider is in a separate location. Services that should be considered for these visits are (but are not necessarily limited to): CDT D0120-D0180

OHLC is considering the following recommendations for in-person visits:

1) Assessments for children in DHS custody: recommending an in-person visit with a dental professional
2) Oral evaluations for adults with diabetes: recommending an in-person visit with a dental professional

Teledentistry

Teledentistry, according to the ADA's Comprehensive Policy Statement on Teledentistry, refers to the use of telehealth systems and methodologies in dentistry. Teledentistry can include patient care and education delivery using, but not limited to, the following modalities:

- Live video (synchronous): Live, two-way interaction between a person (patient, caregiver, or provider) and a provider using audiovisual telecommunications technology.
- Store-and-forward (asynchronous): Transmission of recorded health information (for example, radiographs, photographs, video, digital impressions and photomicrographs of patients) through a secure electronic communications system to a practitioner, who uses the information to evaluate a patient's condition or render a service outside of a real-time or live interaction.
- Remote patient monitoring (RPM): Personal health and medical data collection from an individual in one location via electronic communication technologies, which is transmitted to a provider (sometimes via a data processing service) in a different location for use in care and related support of care.
- Mobile health (mHealth): Health care and public health practice and education supported by mobile communication devices such as cell phones, tablet computers, and personal digital assistants (PDA).

Previous HSC/HERC reviews:

Teledentistry was discussed in 2017 by OHAP and VBBS/HERC in relation to review of new CDT codes for teledentistry. During that review, OHAP members asked for limitations on the types of services that could be provided with these codes. HSD was charged with creating rules regarding teledentistry.

Current Oregon Administrative Rules on teledentistry (available at https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=285136) allow D0191 (assessment of a patient), D0120-D0180 (oral evaluations), and D9995-D9996 (teledentistry). "As stated in ORS 679.543 and this rule, payment for dental services may not distinguish between services performed using teledentistry, real time, or store-and-forward and services performed in-person."

Current Prioritized List/Coverage status:

CDT Code	Code Description	Current Line(s)
D0120-D0180	Oral evaluation	D0120, D0145, D0150, D0180: 53 PREVENTIVE DENTAL SERVICES D0140, D0160, D0170: 54 DENTAL CONDITIONS (E.G., INFECTION, PAIN, TRAUMA) D0171: Excluded
D0190	Screening of a patient	3 PREVENTION SERVICES WITH EVIDENCE OF EFFECTIVENESS
D0191	Assessment of a patient	3, 53
D1206	Topical application of fluoride varnish	3, 53
D1310	Nutritional counseling for the control of dental disease	53

Teledentistry

D1320	Tobacco counseling for the control and prevention of oral disease	5 TOBACCO DEPENDENCE
D1321	Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use	53
D1330	Oral hygiene instruction	53
D9991-D9994	Dental case management	NEVER REVIEWED
D9995	Teledentistry - synchronous; real-time encounter	54
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review	54
D9997	Dental case management - patients with special health care needs	ANCILLARY PROCEDURES

ANCILLARY GUIDELINE A5, TELEHEALTH, TELECONSULTATIONS AND ONLINE/TELEPHONIC SERVICES

Telehealth services include a variety of health services provided by synchronous or asynchronous electronic communications, including secure electronic health portal, audio, or audio and video and clinician-to-clinician virtual consultations.

Criteria for coverage

The clinical value of the telehealth service delivered must reasonably approximate the clinical value of the equivalent services delivered in-person.

Coverage of telehealth services requires the same level of documentation, medical necessity, and coverage determinations as in-person visits.

Examples of covered telephone or online services include but are not limited to:

A) Extended counseling when person-to-person contact would involve an unwise delay or exposure to infectious disease.
B) Treatment of relapses that require significant investment of provider time and judgment.
C) Counseling and education for patients with complex chronic conditions.

Examples of non-covered telehealth services include but are not limited to:

A) Prescription renewal.
B) Scheduling a test.
C) Reporting normal test results.
D) Requesting a referral.
E) Services which are part of care plan oversight or anticoagulation management (CPT codes 99339-99340, 99374-99380 or 99363-99364).
F) Services which relate to or take place within the postoperative period of a procedure provided by the physician are not separately covered. (Such a service is considered part of the procedure and is not be billed separately.)

Teledentistry

Codes eligible for telehealth delivery include 90785, 90791, 90792, 90832-90834, 90836, 90837-90840, 90846, 90847, 90951, 90952, 90954, 90955, 90957, 90958, 90960, 90961, 90963, 90964-90970, 96116, 96156-96171, 96160, 96161, 97802-97804, 99201-99205, 99211-99215, 99231-99233, 99307-99310, 99354-99357, 99406-99407, 99495-99498, G0108-G0109, G0270, G0296, G0396, G0397, G0406-G0408, G0420, G0421, G0425-G0427, G0438-G0439, G0442-G0447, G0459, G0506, G0508, G0509, G0513, G0514, G2086-G2088. Additional codes are covered when otherwise appropriate according to this guideline note and other applicable coverage criteria.

The originating site code Q3014 is covered only when the patient is present in an appropriate health care setting and receiving services from a provider in another location.

Clinician to Patient Services billed using specified codes indicating telephone or online service delivery

Covered telephonic and online services include services related to evaluation, assessment and management as well as other technology-based services (CPT 98966-98968, 99441-99443, 99421-99423, 98970-98972, G2012, G2061-G2063, G2251-G2252).

Covered telephone and online services billed using these codes do not include either of the following:

A) Services related to a service performed and billed by the physician or qualified health professional within the previous seven days, regardless of whether it is the result of patient-initiated or physician-requested follow-up.
B) Services which result in the patient being seen within 24 hours or the next available appointment.

Clinician-to-Clinician Consultations (telephonic, online or using electronic health record)

Covered interprofessional consultations delivered online, through electronic health records or by telephone (CPT 99446-99449, 99451-99452).

Store and Forward

Store and forward codes (HCPCS G2010, G2250) are only covered when billed concurrently with a code that includes medical decision making and communication with the patient (for example, HCPCS G2012).

Expert guidelines:

1) ADA policy on teledentistry
    a) Available at: https://www.ada.org/en/about/governance/current-policies/ada-policy-on-teledentistry
        i) Accessed 2/9/2024
    b) The ADA believes that examinations performed using teledentisty can be an effective way to extend the reach of dental professionals, increasing access to care by reducing the effect of distance barriers to care.

Teledentistry

OHAP input:

HERC staff summary: The ADA recommends use of teledentistry as a way to extend the reach of dental professionals. The current telehealth guideline does not include any mention of teledentistry. In general, assessments and counseling appear to be reasonable services to be provided via teledentistry.

OHAP should advise HERC staff on whether to add a section on teledentistry; if so, what should this section contain?

HERC staff recommendation:

1) Consider modifying Ancillary Guideline A5 as shown below

ANCILLARY GUIDELINE A5, TELEHEALTH, TELECONSULTATIONS AND ONLINE/TELEPHONIC SERVICES

Telehealth services include a variety of health services provided by synchronous or asynchronous electronic communications, including secure electronic health portal, audio, or audio and video and clinician-to-clinician virtual consultations.

Criteria for coverage

The clinical value of the telehealth service delivered must reasonably approximate the clinical value of the equivalent services delivered in-person.

Coverage of telehealth services requires the same level of documentation, medical necessity, and coverage determinations as in-person visits.

Examples of covered telephone or online services include but are not limited to:

A) Extended counseling when person-to-person contact would involve an unwise delay or exposure to infectious disease.
B) Treatment of relapses that require significant investment of provider time and judgment.
C) Counseling and education for patients with complex chronic conditions.

Examples of non-covered telehealth services include but are not limited to:

A) Prescription renewal.
B) Scheduling a test.
C) Reporting normal test results.
D) Requesting a referral.
E) Services which are part of care plan oversight or anticoagulation management (CPT codes 99339-99340, 99374-99380 or 99363-99364).
F) Services which relate to or take place within the postoperative period of a procedure provided by the physician are not separately covered. (Such a service is considered part of the procedure and is not be billed separately.)

Teledentistry

Codes eligible for telehealth delivery include 90785, 90791, 90792, 90832-90834, 90836, 90837-90840, 90846, 90847, 90951, 90952, 90954, 90955, 90957, 90958, 90960, 90961, 90963, 90964-90970, 96116, 96156-96171, 96160, 96161, 97802-97804, 99201-99205, 99211-99215, 99231-99233, 99307-99310, 99354-99357, 99406-99407, 99495-99498, G0108-G0109, G0270, G0296, G0396, G0397, G0406-G0408, G0420, G0421, G0425-G0427, G0438-G0439, G0442-G0447, G0459, G0506, G0508, G0509, G0513, G0514, G2086-G2088. Codes eligible for teledentistry include D0190, D9191, D1310, D1320, D1321, D1330 and D9991-D9997. Services are appropriate for facilitated telehealth visits where a dental professional, such as an EPDH or dental therapist, is located with the patient while the treating or consulting provider is in a separate location include: D0120-D0170, D0180, and D1206. Additional codes are covered when otherwise appropriate according to this guideline note and other applicable coverage criteria.

The originating site code Q3014 is covered only when the patient is present in an appropriate health care setting and receiving services from a provider in another location.

Clinician to Patient Services billed using specified codes indicating telephone or online service delivery

Covered telephonic and online services include services related to evaluation, assessment and management as well as other technology-based services (CPT 98966-98968, 99441-99443, 99421-99423, 98970-98972, G2012, G2061-G2063, G2251-G2252).

Covered telephone and online services billed using these codes do not include either of the following:

A) Services related to a service performed and billed by the physician or qualified health professional within the previous seven days, regardless of whether it is the result of patient-initiated or physician-requested follow-up.
B) Services which result in the patient being seen within 24 hours or the next available appointment.

Clinician-to-Clinician Consultations (telephonic, online or using electronic health record)

Covered interprofessional consultations delivered online, through electronic health records or by telephone (CPT 99446-99449, 99451-99452).

Store and Forward

Store and forward codes (HCPCS G2010, G2250) are only covered when billed concurrently with a code that includes medical decision making and communication with the patient (for example, HCPCS G2012).

D9995 and D9996 – ADA Guide to Understanding and Documenting Teledentistry Events

Developed by the ADA, this guide is published to educate dentists and others in the dental community on these procedures and their codes first published in CDT 2018 and effective January 1, 2018.

Introduction

CDT 2018 marks the first time teledentistry codes have been added to the code set. Teledentistry provides the means for a patient to receive services when the patient is in one physical location and the dentist or other oral health or general health care practitioner overseeing the delivery of those services is in another location. This mode of patient care makes use of telecommunication technologies to convey health information and facilitate the delivery of dental services without the physical constraints of a brick and mortar dental office.

The two full CDT Code entries are:

D9995 teledentistry – synchronous; real-time encounter

Reported in addition to other procedures (e.g., diagnostic) delivered to the patient on the date of service.

D9996 teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review

Reported in addition to other procedures (e.g., diagnostic) delivered to the patient on the date of service.

The following pages contain a number of Questions and Answers, and Scenarios, all intended to provide readers with insight and understanding of how care is delivered and reported when teledentistry is a facet of the process.

Questions and Answers

1. What is telehealth and teledentistry?

   Telehealth is not a specific service; it refers to a broad variety of technologies and tactics to deliver virtual medical, health, and education services. As an umbrella term, it is further defined when applied to specific health care disciplines, such as dentistry.

   Teledentistry, according to the ADA's *Comprehensive Policy Statement on Teledentistry*, refers to the use of telehealth systems and methodologies in dentistry. Teledentistry can include patient care and education delivery using, but not limited to, the following modalities:

   - Live video (synchronous): Live, two-way interaction between a person (patient, caregiver, or provider) and a provider using audiovisual telecommunications technology.
   - Store-and-forward (asynchronous): Transmission of recorded health information (for example, radiographs, photographs, video, digital impressions and photomicrographs of patients) through a secure electronic communications system to a practitioner, who uses the information to evaluate a patient's condition or render a service outside of a real-time or live interaction.
   - Remote patient monitoring (RPM): Personal health and medical data collection from an individual in one location via electronic communication technologies, which is transmitted

to a provider (sometimes via a data processing service) in a different location for use in care and related support of care.

- Mobile health (mHealth): Health care and public health practice and education supported by mobile communication devices such as cell phones, tablet computers, and personal digital assistants (PDA).

2. Why are there two teledentistry CDT Codes, but four delivery modalities?

   Delivery of Remote Patient Monitoring (RPM) and Mobile Health (mHealth) may occur in either a synchronous or asynchronous information exchange environment.

3. What prompts the need for teledentistry?

   Teledentistry is a means to an end – a patient's oral health. The reason or reasons why a teledentistry event occurs depends on the circumstances, such as when all persons who must be involved are not able to be in the same physical location. Another determining facet is the judgment of the dentist or other oral health or general health practitioner, all acting in accordance with applicable state law, regulation or licensure.

4. How is a teledentistry event affected when the health care practitioners are in different states?

   A teledentistry event is subject to applicable state law, regulation or licensure. All involved persons (the dentist or other oral health or general health care practitioner) must determine if a teledentistry event can occur when all participants are not in the same state.

5. What are the notable attributes of a synchronous encounter reported with D9995, and asynchronous teledentistry reported with C9996?

   Synchronous teledentistry (D9995) is delivery of patient care and education where there is live, two-way interaction between a person or persons (e.g., patient; dental, medical or health caregiver) at one physical location, and an overseeing supervising or consulting dentist or dental provider at another location. The communication is real-time and continuous between all participants who are working together as a group. Use of audiovisual telecommunications technology means that all involved persons are able to see what is happening and talk about it in a natural manner.

   Asynchronous teledentistry (D9996) is different as there is no real-time, live, continuous interaction with anyone who is not at the same physical location as the patient. Also known as store-and-forward, asynchronous teledentistry involves transmission of recorded health information (e.g., radiographs, photographs, video, digital impressions and photomicrographs of patients) through a secure electronic communications system to another practitioner for use at a later time.

6. Who would document and report a D9995 or D9996 CDT Code?

   The dentist who oversees the teledentistry event, and who via diagnosis and treatment planning completes the oral evaluation, documents and reports the appropriate teledentistry CDT code. Applicable state regulations may also determine the oral health or general health practitioner who documents and reports these codes.

   As noted in their descriptors, either one or the other teledentistry code is reported in addition to other procedures delivered to the patient on the date of service. In addition, both the individuals collecting records in the off-site setting and the dentist reviewing the records should document those activities in the progress notes in the patient's chart.

7. Are there CDT Codes for: a) documenting collection and transmission of information in a teledentistry event; and b) for receipt of the information?

   There are no such discrete codes. As noted in the answer to question #6, the collection, transmission and receipt actions should be noted in the patient's record. An unspecified procedure by report code may also be used as part of this documentation, with the required narrative report containing the pertinent information.

8. Who would document and report other procedures delivered during a teledentistry event?

   The dentist or other oral health or general health practitioner acting in accordance with applicable state law, regulation or licensure, reports the appropriate CDT Code for these procedures, such as prophylaxis, topical fluoride application, diagnostic images. Supervision requirements within a state practice act determine whether the dentist must document and report all the other procedures, or if they may be reported whole or in part by another type of licensed practitioner.

   More than one claim submission may be necessary when:

   - there is a continuum of care that begins with a teledentistry encounter at a remote location, and continues with other services being delivered at a dental practice location, or
   - state practice acts permit different licensed health care practitioners to submit claims for the particular services they provided during the teledentistry encounter.

   Notes:

   a) Teledentistry is a mode of dental service delivery that, when applicable, is reported in addition to the other procedures provided to the patient.

   b) Procedure delivery is by a natural person (e.g., dentist); the billing entity may be a natural person or a legal person (i.e., the facility where the service is delivered).

   c) The ADA's "Comprehensive Policy Statement on Teledentistry" states that dentists and allied dental personnel who deliver services through teledentistry modalities must be licensed or credentialed in accordance with the laws of the state in which the patient receives service. The delivery of services via teledentistry must comply with the state's scope of practice laws, regulations or rules.

9. Who has responsibility for services delivered via teledentistry?

   Responsibility, and liability, for services delivered is determined by applicable state law and regulations. Each dentist, hygienist and others involved in a teledentistry appointment should become familiar with applicable state or federal regulations to determine their liability exposure, and whether or not the person receiving care becomes their patient of record. Please note that "patient of record" may be defined differently under applicable state regulations. This could be a factor to consider in a teledentistry event where the patient and some members of the team of providers are in different states.

10. With responsibility comes potential liability – what should I do to protect myself and my practice when I engage in teledentistry?

    As noted in the answer to question #9 (immediately above) liability is determined by applicable state law and regulations. This concern should be discussed with your personal legal counsel and insurance advisor to determine whether or not your existing liability insurance policies cover

this risk. Additional personal, professional and practice insurance coverage may be needed to address any coverage gaps.

11. How would D9995 or D9996 be reported on a dental claim submission?

    A claim submission includes the services provided to one patient. Each claim detail line identifies the particular procedure and the date it was delivered to the patient. D9995 or D9996 are reported in addition to the codes for other procedures (e.g., prophylaxis; diagnostic imaging) reported separately when the patient presents for care.

    Appendix 1 contains special claim completion instructions for the ADA Dental Claim Form (©2012). These instructions are envisioned as the model for reporting teledentistry CDT Codes on the HIPAA standard electronic dental claim transaction (837Dv5010).

12. Are D9995 and D9996 used when a claim for teledentistry is submitted to a medical benefit plan?

    D9995 and D9996 are CDT Codes that are applicable to claims filed against a dental benefit plan. Dental claim content, format and completion instructions differ from claims filed against a medical benefit plan. Claims filed against a medical benefit plan use a unique format, are prepared with different code sets, and follow their own completion instructions. Medical benefit claims are outside the scope of this guide.

13. What documentation should I maintain in my patient records, and what will be needed on a claim submission when reporting D9995 and D9996?

    The patient record must include the CDT Code that reflects the type of teledentistry encounter, and there may be additional state documentation requirements to satisfy. A claim submission must include all required information as described in the completion instructions for the ADA paper claim form and the HIPAA standard electronic dental claim. Some government programs (e.g., Medicaid) may have additional claim reporting requirements.

14. What dental benefit plan coverage – commercial or governmental – is anticipated?

    Current dental benefit plan coverage and reimbursement provisions should apply to services delivered in-office and via teledentistry. However, there is no expectation that commercial and government dental benefit plans must create new coverage provisions pertaining to teledentistry. Further, coverage and reimbursement for D9995 and D9996 is likely to vary between commercial benefit plan offerings and by state for government programs (e.g. Medicaid).

    The ADA's "Comprehensive Policy Statement on Teledentistry" sets an expectation of consistent and equitable coverage for all procedures associated with teledentistry services – as noted in the following extract.

    > **Reimbursement:** Dental benefit plans and all other third-party payers, in both public (e.g. Medicaid) and private programs, shall provide coverage for services using teledentistry technologies and methods (synchronous or asynchronous) delivered to a covered person to the same extent that the services would be covered if they were provided through in-person encounters. Coverage for services delivered via teledentistry modalities will be at the same levels as those provided for services provided through in-person encounters and not be limited or restricted based on the technology used or the location of either the patient or the provider as long as the health care provider is licensed in the state where the patient receives service.

This policy statement concerns equitable application of existing coverage and reimbursement provisions, and recognizes that dental benefit plan coverage and reimbursement provisions are likely to vary.

15. How would dental benefit plan reimbursements, meaning claim payments, be processed when more than one oral health or medical health practitioner is involved in a teledentistry encounter?

    Dental benefit plan reimbursements are, as today, payable to the billing entity on the claim submission, who may be a natural person (e.g., dentist) or a legal person (e.g., dental practice). Allocation of reimbursements is subject to the business relationships between the reimbursement's recipient and other oral health or medical health practitioners involved in the teledentistry event – such relationships are outside the scope of this guide.

Coding Scenarios

Note: These two scenarios assume that the persons and services involved are in accordance with local state practice act, laws, rules, and regulations

1. Assessments at Senior Living Facility – A "Real-Time" Teledentistry Encounter

A hygienist is scheduled to meet with residents of a local senior living facility in order to assess their potential need for dental treatment. The facility does not have dedicated space or equipment for dental assessments, so the hygienist brings a laptop computer and an intraoral camera. This equipment is used to enable information capture and a real-time connection with the dentists via a HIPAA-compliant (Security and Privacy) connection that uses encryption and a secure "cloud" server.

During her or his visit the hygienist records patient information that includes perio probing and charting, a visual oral cancer examination, and capture of high-quality intraoral diagnostic images. The dentist through this real-time connection sees 10 patients exhibiting evidence of the need for immediate or further care (e.g., restorations; soft tissue biopsies). Several of the senior living facility residents schedule their care at the affiliated brick and mortar dental practice.

What CDT Codes would be used to document the services provided on the day of this real-time encounter?

In this scenario patients present for diagnostic and evaluative procedures. The dentist is at a different physical location with complete and immediate access to patient information being captured, and the ability to interact vocally and visually with the patient

The following procedure codes are reported by the oral health or general health practitioner, as applicable, **for each patient** who received the services described.

D0191 assessment of a patient

D0350 2D oral/facial photographic image obtained intra-orally or extra-orally

D0351 3D photographic image

Note: The types of diagnostic image (2-D or 3-D), as well as the number of separate images captured would be determined by the dentist to adequately document the clinical condition.

D01xx (oral evaluation CDT Code – determined and reported by the dentist – or by another oral health or general health practitioner in accordance with applicable state law**)**

D9995 teledentistry – synchronous; real-time encounter

Note: D9995 is reported once for each patient, in the same manner as CDT Code "D9410 house/extended care facility call" (once per date of service per patient) to document the type of teledentistry interaction in this setting on the date of service.

2. Screening Services at an Off-Site Setting - A "Store and Forward" Teledentistry Encounter

A hygienist in an off-site setting collects a full set of electronic dental records as allowed in the state where the facility is located. These records include radiographs, photographs, charting of dental conditions, health history, consent, and applicable progress notes. This stored information is forwarded to the dentist via a HIPAA-compliant (Security and Privacy) connection that uses encryption and a secure "cloud" server. At a later time the dentist completes a comprehensive oral examination, diagnosis, and treatment plan.

What CDT Codes would be used to document the services provided in this scenario?

In this scenario the individual interacts only with the hygienist. Information collected is conveyed to the dentist for diagnosis, evaluation and treatment planning at a later time, and possibly at a different location. This dentist has no live vocal or visual interaction with the individual or hygienist during information collection.

The following procedure codes are reported, as applicable, **for each individual** who received the services described above.

D0190 screening of a patient

D0350 2D oral/facial photographic image obtained intra-orally or extra-orally

D0351 3D photographic image

Note: The types of diagnostic image (2-D or 3-D), as well as the number of separate images captured would be determined by the clinical condition being documented.

D9996 teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review

Note: D9996 is reported once for each individual to document the type of teledentistry interaction in this setting on the date of service.

Appendix 1

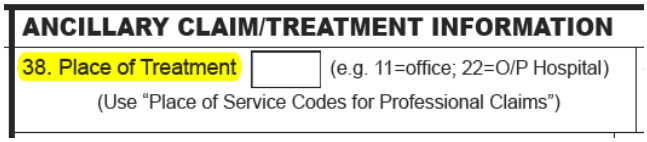
Special Claim Completion Instructions – Coding a Teledentistry Event

A teledentistry event claim or encounter submission involves reporting the appropriate Place of Service (POS) code and CDT Code.

- POS code **02** (Telehealth – the location where health services and health related services are provided or received, through telecommunication technology) was added to that code set effective January 1, 2017.
- CDT Codes **D9995** and **D9996** are effective January 1, 2018. These codes are reported in addition to other services (e.g., diagnostic) reported separately when the patient presents for care. They document services provided by the dentist, or other practitioner providing care, who is not in direct contact with the patient at the time of the encounter.

These instructions apply only to the ADA Dental Claim Form. Please contact your practice management system vendor for guidance when reporting D9995 or D9996 on the HIPAA standard electronic dental claim (837D v 5010).

POS code **02** is recorded in Item # 38 on the claim form.



Note: POS is at the Claim level for dental services, which means it pertains to all services reported on the claim submission.

D9995 or **D9996** is recorded on **any** unused line (1 through 10) in the 'Record of Services Provided' section of the form.

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

The following special instructions for Items 24 - 31 apply to the service line on which D9995 or D9996 is reported.

24. Procedure Date (MM/DD/CCYY): **Enter** date the dental procedures delivered in the teledentistry encounter were performed. The date must have two digits for the month, two for the day, and four for the year.

25. Area of Oral Cavity: Not Used

26. Tooth System: Not Used

27. Tooth Number(s) or Letter(s): Not Used

28. Tooth Surface: Not Used

29. Procedure Code: **Enter** D9995 or D9996 as applicable. Only one type of teledentistry service may be reported for the encounter.

    29a Diagnosis Code Pointer: Not Used

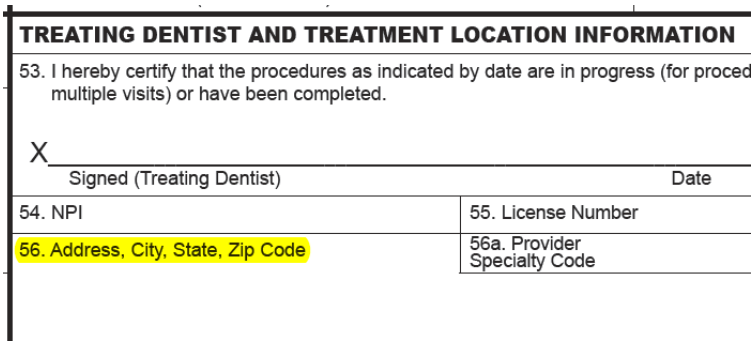
    29b Quantity: Cannot be greater than "1"

30. Description: **Enter** "Teledentistry – Synchronous" or "Teledentistry – Asynchronous" as applicable.

31. Fee: **Enter** the full fee for the reported teledentistry procedure that is related to the other procedures delivered in the encounter.

    Note: A full fee may be zero dollars.

In addition to the above, Item # 56 in the claim's "Treating Dentist and Treatment Location" block is the location where the patient being treated is physically located, and may differ from the where the "treating dentist" is located.



TREATING DENTIST AND TREATMENT LOCATION INFORMATION	
53. I hereby certify that the procedures as indicated by date are in progress (for proced multiple visits) or have been completed.	
X_____ Signed (Treating Dentist)	Date
54. NPI	55. License Number
56. Address, City, State, Zip Code	56a. Provider Specialty Code

56. Address, City, State, Zip Code: Enter the physical location where the treatment was rendered. Must be a street address, not a Post Office Box.

Questions or Assistance?

Call 800-621-8099 or send an email to dentalcode@ada.org

Notes:

- This document includes content from the ADA publication – *Current Dental Terminology (CDT)* ©2017 American Dental Association (ADA). All rights reserved.
- This document includes content from the ADA publication – *ADA Dental Claim Form* ©2012 American Dental Association (ADA). All rights reserved.
- Version History

Date	Version	Remarks – Change Summary
07/17/2017	1	Initial publication

Fluoride Varnish Frequency

Coverage Question: Should the guideline regarding fluoride varnish be updated to clarify the number of covered applications per year?

Question source: Metrics and Scoring Committee

Background:

The Metrics & Scoring Committee is looking at possibly including topical fluoride varnish for kids. It's a national measure and requires two applications. Currently, the guideline on fluoride varnish allows two applications per year for average risk children and up to 4 per year for high risk children. It was discussed at OHAP in the past that Medicaid eligibility (i.e. low socioeconomic status) is one of the qualifying definitions of moderate to high risk for which varnish is indicated. All patients under OHP would thus meet this definition of risk. Metrics and Scoring would like clarification of the number of covered applications per year.

Previous HSC/HERC reviews:

The fluoride varnish guideline was last reviewed in 2013. At that time, a 2009 MED report and the 2006 ADA guideline were reviewed. Both of these sources recommended fluoride varnish twice per year.

Current Prioritized List/Coverage status:

Code	Code Description	Current Lines(s)
D1206	Topical application of fluoride varnish	3 PREVENTION SERVICES WITH EVIDENCE OF EFFECTIVENESS 53 PREVENTIVE DENTAL SERVICES
D1208	Topical application of fluoride excluding varnish	53 PREVENTIVE DENTAL SERVICES

GUIDELINE NOTE 17, PREVENTIVE DENTAL CARE

Lines 3,53

Dental cleaning is limited to once per 12 months for adults and twice per 12 months for children up to age 19 (D1110, D1120). More frequent dental cleanings may be required for certain higher risk populations.

Fluoride varnish (99188) is included on Line 3 for use with children 18 and younger during well child preventive care visits. Fluoride treatments (D1206 and D1208) are included on Line 53 PREVENTIVE DENTAL SERVICES for use with adults and children during dental visits. The total number of fluoride applications provided in all settings is not to exceed four per twelve months for a child at high risk for

dental caries and two per twelve months for a child not at high risk. The number of fluoride treatments is limited to once per 12 months for average risk adults and up to four times per 12 months for high-risk adults.

Evidence:

1) **Chou 2023**, USPSTF review of preventive interventions for oral health in children and adolescents aged 5 to 17 years
    a. A good-quality systematic review (searches through May 2013) included 14 trials of fluoride varnish vs placebo or no varnish in children 5 years or older (n = 6965)
        i. Fluoride varnish was most commonly administered as 5% sodium fluoride varnish (22 600 ppm) every 6 months
        ii. In all trials, varnish was applied by dental professionals in schools or local clinics
    b. The systematic review found fluoride varnish associated with a DMFS/DFS-prevented fraction of 0.43 (95% CI, 0.30-0.57) at 1 to 4.5 years (14 trials; n = 3419)
    c. When administered by dental professionals or in school settings, fluoride supplements compared with placebo or no intervention were associated with decreased change from baseline in the number of decayed, missing, or filled permanent teeth (DMFT index) or decayed or filled permanent teeth (DFT index) (mean difference, −0.73 [95% CI, −1.30 to −0.19]) at 1.5 to 3 years (6 trials; n = 1395)
    d. The harms of preventive interventions were sparsely reported, although serious harms were not described
    e. Conclusions: Administration of fluoride supplements, fluoride gels, varnish, and sealants in dental or school settings improved caries outcomes
2) **Chou 2021**, USPSTF review of preventive interventions for oral health in children and adolescents under age 5
    a. Fifteen trials evaluated topical fluoride. Sample sizes ranged from 123 to 2536 (total 9541 participants)
        i. Three trials were rated good quality and the rest fair quality
        ii. Fluoride varnish was most commonly administered as 5% sodium fluoride every 6 months. Topical fluoride was administered by a dental health professional in all trials in which this information was reported
    b. Topical fluoride was associated with significant decreased caries increment (13 trials, n = 5733; mean difference, −0.94 [95% CI, −1.74 to −0.34]
    c. Topical fluoride was associated with improved outcomes, with a number needed to treat to prevent 1 child with incident caries of about 14 (95% CI, 8 to 50)
    d. Limited evidence on harms associated with topical fluoride indicated no increased risk of fluorosis or adverse events vs placebo. Serious adverse events were not reported, though some children had difficulty tolerating the varnish application because of odor or taste
    e. Conclusion: Dietary fluoride supplementation and fluoride varnish were associated with improved caries outcomes in higher-risk children and settings

Expert guidelines:

1) **American Academy of Pediatric Dentistry 2023,** fluoride therapy

Fluoride Varnish Frequency

a. Recommends professionally-applied topical fluoride treatments such as five percent NaFV or 1.23 percent F gel preparations at least twice per year to reduce incidence of dental caries.

2) **USPSTF 2023**, Screening and Preventive Interventions for Oral Health in Children and Adolescents Aged 5 to 17 Years
    a. The evidence is insufficient to assess the balance of benefits and harms of preventive interventions performed by primary care clinicians for oral health conditions, including dental caries
        i. I recommendation
3) **USPSTF 2021**, Screening and Interventions to Prevent Dental Caries in Children Younger Than 5 Years
    a. Apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption
        i. B level recommendation
4) **American Dental Association 2013**, fluoride guideline
    a. For patients at elevated risk of developing caries
        i. Younger than 6 years: 2.26 percent fluoride varnish at least every three to six months
            1. Moderate certainty evidence; benefit outweighs potential harms
        ii. 6-18 years: 2.26 percent fluoride varnish at least every three to six months or 1.23 percent fluoride (APF*) gel for four minutes at least every three to six months
            1. Moderate certainty evidence; benefit outweighs potential harms
        iii. Older than 18 years: 2.26 percent fluoride varnish at least every three to six months or 1.23 percent fluoride (APF*) gel for four minutes at least every three to six months
            1. Based on expert opinion

OHAP input:

HERC staff summary:

Systematic reviews from a highly trusted source (USPSTF) found evidence of reduced caries incidence with the use of fluoride varnish. The studies included in these reviews generally applied varnish every 6 months. Expert guidelines all recommend the use of fluoride varnish “at least every 6 months” in children, with the ADA recommending varnish “at least every 3 to 6 months.”

HERC staff recommend considering modifications to guideline note 17 to clarify that coverage of fluoride varnish is covered up to 4 times a year for children.

HERC staff recommendation:

Fluoride Varnish Frequency

1) Modify GN17 as shown below

GUIDELINE NOTE 17, PREVENTIVE DENTAL CARE

Lines 3,53

Dental cleaning is limited to once per 12 months for adults and twice per 12 months for children up to age 19 (D1110, D1120). More frequent dental cleanings may be required for certain higher risk populations.

Fluoride varnish (99188) is included on Line 3 for use with children 18 and younger during well child preventive care visits. Fluoride treatments (D1206 and D1208) are included on Line 53 PREVENTIVE DENTAL SERVICES for use with adults and children during dental visits. The total number of fluoride applications provided in all settings is not to exceed four per twelve months for children up to age 19 ~~a child at high risk for dental caries and two per twelve months for a child not at high risk~~. The number of fluoride treatments is limited to once per 12 months for average risk adults and up to four times per 12 months for high-risk adults.

JAMA | US Preventive Services Task Force | EVIDENCE REPORT

Screening, Referral, Behavioral Counseling, and Preventive Interventions for Oral Health in Children and Adolescents Aged 5 to 17 Years

A Systematic Review for the US Preventive Services Task Force

Roger Chou, MD; Christina Bougatsos, MPH; Jessica Griffin, MS; Shelley S. Selph, MD, MPH; Azrah Ahmed, BA; Rongwei Fu, PhD; Chad Nix, MSc; Eli Schwarz, DDS, MPH, PhD

IMPORTANCE Dental caries is common in children and adolescents aged 5 to 17 years and potentially amenable to primary care screening and prevention.

OBJECTIVE To systematically review the evidence on primary care screening and prevention of dental caries in children and adolescents aged 5 to 17 years to inform the US Preventive Services Task Force.

DATA SOURCES MEDLINE, Cochrane Central Register of Controlled Trials, and Cochrane Database of Systematic Reviews (to October 3, 2022); surveillance through July 21, 2023.

STUDY SELECTION Diagnostic accuracy of primary care screening instruments and oral examination; randomized and nonrandomized trials of screening and preventive interventions and systematic reviews of such studies; cohort studies on primary care oral health screening and preventive intervention harms.

DATA EXTRACTION AND SYNTHESIS One investigator abstracted data; a second checked accuracy. Two investigators independently rated study quality. Random-effects meta-analysis was performed for fluoride supplements and xylitol; for other preventive interventions, pooled estimates were used from good-quality systematic reviews.

MAIN OUTCOMES AND MEASURES Dental caries, morbidity, functional status, quality of life, harms; diagnostic test accuracy.

RESULTS Three systematic reviews (total 20 684 participants) and 19 randomized clinical trials, 3 nonrandomized trials, and 1 observational study (total 15 026 participants) were included. No study compared screening vs no screening. When administered by dental professionals or in school settings, fluoride supplements compared with placebo or no intervention were associated with decreased change from baseline in the number of decayed, missing, or filled permanent teeth (DMFT index) or decayed or filled permanent teeth (DFT index) (mean difference, −0.73 [95% CI, −1.30 to −0.19]) at 1.5 to 3 years (6 trials; n = 1395). Fluoride gels were associated with a DMFT- or DFT-prevented fraction of 0.18 (95% CI, 0.09-0.27) at outcomes closest to 3 years (4 trials; n = 1525), fluoride varnish was associated with a DMFT- or DFT-prevented fraction of 0.44 (95% CI, 0.11-0.76) at 1 to 4.5 years (5 trials; n = 3902), and resin-based sealants were associated with decreased risk of carious first molars (odds ratio, 0.21 [95% CI, 0.16-0.28]) at 48 to 54 months (4 trials; n = 440). No trial evaluated primary care counseling or dental referral. Evidence on screening accuracy, silver diamine fluoride, xylitol, and harms was very limited, although serious harms were not reported.

CONCLUSIONS AND RELEVANCE Administration of fluoride supplements, fluoride gels, varnish, and sealants in dental or school settings improved caries outcomes. Research is needed on the effectiveness of oral health preventive interventions in primary care settings and to determine the benefits and harms of screening.

Viewpoint page 1623 and **Editorial** page 1629

Multimedia

Related article page 1666 and **JAMA Patient Page** page 1703

Supplemental content

CME at jamacmelookup.com

Author Affiliations: Pacific Northwest Evidence-based Practice Center, Department of Medical Informatics and Clinical Epidemiology, Oregon Health & Science University, Portland (Chou, Bougatsos, Griffin, Selph, Ahmed, Fu); Division of General Internal Medicine, Oregon Health & Science University, Portland (Chou); Oregon Health & Science University–Portland State University School of Public Health, Portland (Fu); School of Medicine, Oregon Health & Science University, Portland (Nix); School of Dentistry, Division of Dental Public Health, Oregon Health & Science University, Portland (Schwarz).

Corresponding Author: Roger Chou, MD, Oregon Health & Science University, 3181 SW Sam Jackson Park Rd, Mail Code BICC, Portland, OR 97239 (chour@ohsu.edu).

JAMA. 2023;330(17):1674-1686. doi:10.1001/jama.2023.20435

JAMA | US Preventive Services Task Force | EVIDENCE REPORT

Screening and Interventions to Prevent Dental Caries in Children Younger Than 5 Years

Updated Evidence Report and Systematic Review for the US Preventive Services Task Force

Roger Chou, MD; Miranda Pappas, MA; Tracy Dana, MLS; Shelley Selph, MD; Erica Hart, MBS; Rongwei F. Fu, PhD; Eli Schwarz, DDS, PhD, MPH

IMPORTANCE A 2014 review for the US Preventive Services Task Force (USPSTF) found that oral fluoride supplementation and topical fluoride use were associated with reduced caries incidence in children younger than 5 years.

OBJECTIVE To update the 2014 review on dental caries screening and preventive interventions to inform the USPSTF.

DATA SOURCES Ovid MEDLINE, the Cochrane Central Register of Controlled Trials, and the Cochrane Database of Systematic Reviews (to September 2020); surveillance through July 23, 2021.

STUDY SELECTION Randomized clinical trials (RCTs) on screening, preventive interventions, referral to dental care; cohort studies on screening and referral; studies on diagnostic accuracy of primary care oral examination or risk assessment; and a systematic review on risk of fluorosis included in prior USPSTF reviews.

DATA EXTRACTION AND SYNTHESIS One investigator abstracted data; a second checked accuracy. Two investigators independently rated study quality.

RESULTS Thirty-two studies (19 trials, 9 observational studies, and 4 nonrandomized clinical intervention studies [total 106 694 participants] and 1 systematic review [19 studies]) were included. No study evaluated effects of primary care screening on clinical outcomes. One study (n = 258) found primary care pediatrician examination associated with a sensitivity of 0.76 (95% CI, 0.55 to 0.91) and specificity of 0.95 (95% CI, 0.92 to 0.98) for identifying a child with cavities, and 1 study found a risk assessment tool associated with sensitivity of 0.53 and specificity of 0.77 (n = 697, CIs not reported) for a child with future caries. No new trials of dietary fluoride supplementation were identified. For prevention, topical fluoride compared with placebo or no topical fluoride was associated with decreased caries burden (13 trials, n = 5733; mean caries increment [difference in decayed, missing, and filled teeth or surfaces], −0.94 [95% CI, −1.74 to −0.34]) and likelihood of incident caries (12 trials, n = 8177; RR, 0.80 [95% CI, 0.66 to 0.95]; absolute risk difference, −7%) in higher-risk populations or settings, with no increased fluorosis risk. Evidence on other preventive interventions was limited (education, xylitol) or unavailable (silver diamine fluoride), and no study directly evaluated primary care dentistry referral vs no referral.

CONCLUSIONS AND RELEVANCE There was no direct evidence on benefits and harms of primary care oral health screening or referral to dentist. Dietary fluoride supplementation and fluoride varnish were associated with improved caries outcomes in higher-risk children and settings.

Editorial page 2139

Multimedia

Related article page 2172 and JAMA Patient Page page 2223

Supplemental content

Related article at jamahealthforum.com

Author Affiliations: Department of Medical Informatics and Clinical Epidemiology, Pacific Northwest Evidence-based Practice Center, Oregon Health & Science University, Portland (Chou, Pappas, Dana, Selph, Hart, Fu); Division of General Internal Medicine and Geriatrics, Oregon Health & Science University, Portland (Chou); School of Public Health, Oregon Health & Science University–Portland State University, Portland (Fu, Schwarz); School of Dentistry, Oregon Health & Science University, Portland (Schwarz).

Corresponding Author: Roger Chou, MD, Pacific Northwest Evidence-based Practice Center, Oregon Health & Science University, 3181 SW Sam Jackson Park Rd, Mail Code BICC, Portland, OR 97239 (chour@ohsu.edu).

JAMA. 2021;326(21):2179-2192. doi:10.1001/jama.2021.15658

Fluoride Therapy

Latest Revision

2023

How to Cite: American Academy of Pediatric Dentistry. Fluoride therapy. The Reference Manual of Pediatric Dentistry. Chicago, Ill.: American Academy of Pediatric Dentistry; 2023:352-8.

Abstract

This best practice provides information for practitioners regarding the use of fluoride as an aid in preventing and controlling dental caries in pediatric dental patients. These recommendations address systemic fluoride (water fluoridation, dietary fluoride supplements), topical fluoride delivery via professional application (acidulated phosphate fluoride gel or foam, sodium fluoride varnish, silver diamine fluoride), and home-use products (toothpastes, mouthrinses) as well as the associated risks of fluoride agents. The standard level for community water fluoridation (0.7 parts per million fluoride) helps balance the risk of caries and the possibility of dental fluorosis from excessive fluoride ingestion during the early years of tooth development. Specific recommendations for dietary supplementation of fluoride for children ages six months through 16 years are based on fluoride levels in the drinking water, other dietary sources of fluoride, use of a fluoridated toothpaste, and caries risk. The specific needs of each patient determine the appropriate use of systemic and topical fluoride products, whether delivered in a professional clinical or a home setting. Fluoride has proven to be an effective therapy in reducing the prevalence of dental caries in infants, children, adolescents, and persons with special needs.

Through a collaborative effort of the American Academy of Pediatric Dentistry Councils on Clinical Affairs and Scientific Affairs, this best practice was revised to offer updated information and recommendations to assist healthcare practitioners and parents in using fluoride therapy for management of caries risk in pediatric patients.

KEYWORDS: ADOLESCENT; CHILD; FLUORIDATION; FLUORIDE; ORAL HEALTH; SILVER DIAMINE FLUORIDE; TOOTHPASTE

Purpose

The American Academy of Pediatric Dentistry intends these recommendations to help practitioners make decisions concerning appropriate use of fluoride as part of the comprehensive oral health care for infants, children, adolescents, and persons with special health care needs.

Methods

This document was initially developed by the Liaison with Other Groups Committee, adopted in 1967[1] and last revised by the Council on Clinical Affairs in 2018[2]. To update this guidance, an electronic search of the PubMed®/MEDLINE database was conducted using the terms: fluoride caries prevention, fluoridation, fluoride gel, fluoride varnish, fluoride toothpaste, fluoride therapy, silver diamine fluoride, and topical fluoride; fields: all; limits: within last five years, English. Because 4077 papers were identified through these electronic searches, an alternate strategy of limiting the information gathering to systematic review using the term fluoride caries prevention yielded 116 new systematic reviews or trials since 2017. Expert opinions and clinical practices also were relied upon for these recommendations.

Background

Fluoride has been a major factor in the decline in prevalence and severity of dental caries in the United States (**U.S.**) and other economically developed countries. It has several caries-protective mechanisms of action. Topically, low levels of fluoride in plaque and saliva inhibit the demineralization of sound enamel and enhance the remineralization of demineralized enamel.[3,4] The topical effect may be enhanced when combined with good oral hygiene practices at home and use of a fluoride dentifrice.[5] Fluoride also inhibits dental caries by affecting the metabolic activity of cariogenic bacteria.[6] High levels of fluoride, such as those attained with the use of topical gels or varnishes, produce a temporary layer of calcium fluoride-like material on the enamel surface. The fluoride is released when the pH drops in response to acid production and becomes available to remineralize enamel or affect bacterial metabolism.[7] Although fluoride-rich enamel is less acid-soluble than enamel with less fluoride, the topical and remineralization effects of fluoride have been found to have a greater impact on caries prevention than incorporation of fluoride into developing teeth.[8]

Community water fluoridation

Fluoridation of community drinking water is the most equitable and cost-effective method of delivering fluoride to all members of most communities.[9] As of 2018, 73 percent of the U.S. population on community water systems had access to fluoridated water.[10] Water fluoridation at the level of 0.7-1.2 milligrams (**mg**) fluoride ion per liter (i.e., parts per million fluoride [**ppm F**]) was introduced in the U.S. in the 1940s. Since community water is now one of several sources of fluoride,

ABBREVIATIONS

CaF: Calcium fluoride. **F:** Fluoride. **FSIQ:** Full scale intelligent quotient. **IQ:** Intelligence quotient. **mg:** Milligrams. **mg/kg:** Milligrams per kilogram. **NaFV:** Sodium fluoride varnish. **ppm F:** Parts per million fluoride. **SDF:** Silver diamine fluoride. **U.S.:** United States.

Clinician Summary of USPSTF Recommendation

Screening and Preventive Interventions for Oral Health in Children and Adolescents Aged 5 to 17 Years

November 2023

What does the USPSTF recommend?

I Statement

For asymptomatic children and adolescents aged 5 to 17 years:
The evidence is insufficient to assess the balance of benefits and harms of routine screening performed by primary care clinicians for oral health conditions, including dental caries.

I Statement

The evidence is insufficient to assess the balance of benefits and harms of preventive interventions performed by primary care clinicians for oral health conditions, including dental caries.

To whom does this recommendation apply?

This recommendation applies to children and adolescents aged 5 to 17 years.

What's new?

This is a new USPSTF recommendation.

How to implement this recommendation?

- The USPSTF found insufficient evidence to recommend for or against routine screening or preventive interventions for oral health conditions in the primary care setting for children and adolescents.
- The USPSTF is calling for more research on addressing oral health in nondental primary care settings, particularly in persons who are more likely to experience oral health conditions and on social factors that contribute to disparities in oral health.
- In the absence of evidence, primary care clinicians should use their clinical expertise to decide whether to perform these services.

What additional information should clinicians know about this recommendation?

- The USPSTF has a separate existing recommendation for children younger than 5 years that recommends prescribing oral fluoride supplements starting at age 6 months for children younger than 5 years whose water supply is deficient in fluoride and applying fluoride varnish to the primary teeth of all children younger than 5 years starting at the age of primary tooth eruption.
- Dental caries refers to a multifactorial disease process resulting in demineralization of the teeth.
- The evidence review focused on dental caries as the most common oral health condition and the most potentially amenable to primary care interventions.

The USPSTF recognizes that clinical decisions involve more considerations than evidence alone. Clinicians should understand the evidence but individualize decision making to the specific patient or situation.

U.S. Preventive Services TASK FORCE

Why is this recommendation and topic important?

- Dental caries is a common chronic condition of childhood; in 2011 in the US, more than 50% of children aged 6 to 11 years had dental caries in primary teeth and 17% had caries in permanent teeth.
- Developmental defects in teeth, inadequate salivary composition or flow, frequent intake of dietary sugars (in foods and beverages), suboptimal fluoride exposure, and oral hygiene practices (eg, lack of tooth brushing and flossing) can increase susceptibility to dental caries.
- In the US, oral health disparities are shaped by unequally affordable and accessible dental care and other disadvantages related to social determinants of health (eg, living in a rural area or immigration status).
- Dental caries disproportionately affects persons living in poverty; Asian, Black, Hispanic/Latino, Native American/Alaska Native, and Native Hawaiian/Pacific Islander children and adolescents; children with special health care needs; children experiencing homelessness; children living in urban or rural underserved areas; and children with public insurance or without insurance.

What are other relevant USPSTF recommendations?

The USPSTF has issued recommendations on screening and interventions to prevent dental caries in children younger than 5 years.

The USPSTF has issued recommendations on screening and preventive interventions for oral health in adults.

What are additional tools and resources?

- The Health Resources and Services Administration's oral health factsheet and report on *Integration of Oral Health and Primary Care Practice* emphasize optimal collaborations between primary care clinicians and oral health professionals.
- The US Department of Health and Human Services' *Report of the Surgeon General* and the National Institutes of Health's report *Oral Health in America: Advances and Challenges* comprehensively describe the importance of oral health to overall health and highlight advances and challenges toward improving oral health in the US.
- The Community Preventive Services Task Force recommends fluoridation of community water sources to reduce dental caries and school-based dental sealant delivery programs to prevent dental caries.

Where to read the full recommendation statement?

Visit the USPSTF website or the *JAMA* website to read the full recommendation statement. This includes more details on the rationale of the recommendation, including benefits and harms; supporting evidence; and recommendations of others.

Clinician Summary of USPSTF Recommendation

Screening and Interventions to Prevent Dental Caries in Children Younger Than 5 Years

December 2021

What does the USPSTF recommend?

Children younger than 5 years:

B Grade

Prescribe **oral fluoride supplementation** starting at age 6 months for children whose water supply is deficient in fluoride.

Children younger than 5 years:

B Grade

Apply **fluoride varnish** to the primary teeth of all infants and children starting at the age of primary tooth eruption.

Children younger than 5 years:

I Statement

The evidence is insufficient to assess the balance of benefits and harms of **routine screening** examinations for dental caries performed by primary care clinicians in children younger than 5 years.

To whom does this recommendation apply?

This recommendation applies to children younger than 5 years without signs or symptoms of dental caries.

What's new?

This recommendation is consistent with the 2014 USPSTF recommendation.

How to implement this recommendation?

- **Prescribe:** Prescribe oral fluoride supplementation beginning at age 6 months to children whose water supply is deficient in fluoride (<0.6 parts fluoride per million parts water [ppm F]).
- **Apply:** Apply topical fluoride varnish to the primary teeth in all infants and children once primary teeth erupt. Typically, fluoride varnish is applied with a small brush and is available as 5% sodium fluoride (2.26 F%).

Clinicians may consider using "My Water's Fluoride", a CDC tool that may assist in determining local water system fluoridation status.

The USPSTF recognizes that clinical decisions involve more considerations than evidence alone. Clinicians should understand the evidence but individualize decision making to the specific patient or situation.

U.S. Preventive Services TASK FORCE

www.uspreventiveservicestaskforce.org

What additional information should clinicians know about this recommendation?

- **Assessment of Risk:** Higher prevalence and severity of dental caries are found among specific racial and ethnic (e.g., Black and Mexican American) populations. Social determinants of health associated with increased caries risk include lack of access to dental care, low socioeconomic status, personal and family oral health history, dietary habits (especially frequent intake of dietary sugars in foods and beverages), fluoride exposure, and oral hygiene practices.

The USPSTF determined there was insufficient evidence to assess the balance of benefits and harms of performing **routine screening** examinations. In deciding whether to routinely perform screening examinations, clinicians may consider the following:

- **Potential preventable burden:** Dental caries is the most common chronic disease in children in the US and can cause pain and diminished quality of life. Of children living below the poverty threshold, 17% had untreated caries in 2011 to 2014. As soon as teeth erupt, all children are susceptible to dental caries.
- **Potential harms:** Primary care screening examinations for dental caries in children younger than 5 years are not invasive and unlikely to cause serious harms.
- **Current practice:** About half of pediatricians report examining the teeth of children between birth and age 3 years. Fewer report regularly applying fluoride varnish.

Why is this recommendation and topic important?

Dental caries in early childhood is associated with pain, loss of teeth, impaired growth, decreased weight gain, negative effects on quality of life, poor school performance, and future dental caries. According to the 2011–2016 National Health and Nutrition Examination Survey, approximately 23% of children aged 2 to 5 years have dental caries in their primary teeth. Prevalence is higher in Mexican American children (33%) and non-Hispanic Black children (28%) than in non-Hispanic White children (18%).

What are other relevant USPSTF recommendations?

Information on other oral health recommendations in adults and children older than 5 years from the USPSTF are available on the USPSTF website.

What are additional Tools and Resources?

- The Community Preventive Services Task Force recommends:
  - o Fluoridation of community water sources to reduce dental caries
  - o School-based dental sealant delivery programs to prevent caries
- The Health Resources and Services Administration's website contains various oral health program resources, including the "Bright Futures: Oral Health–Pocket Guide, 3rd edition," an overview of oral health prevention and interventions

The USPSTF recognizes that clinical decisions involve more considerations than evidence alone. Clinicians should understand the evidence but individualize decision making to the specific patient or situation.

U.S. Preventive Services TASK FORCE
www.uspreventiveservicestaskforce.org

Where to read the full recommendation statement?

Visit the USPSTF website or the *JAMA website* to read the full recommendation statement. This includes more details on the rationale of the recommendation, including benefits and harms; supporting evidence; and recommendations of others.

The USPSTF recognizes that clinical decisions involve more considerations than evidence alone. Clinicians should understand the evidence but individualize decision making to the specific patient or situation.

Abbreviations: NAAT, nucleic acid amplification test; STI, sexually transmitted infection, USPSTF, US Preventive Services Task Force.

NOTICE. The version of this article that was online from Oct. 31 until Nov. 26, 2013, contained an error repeated in several places in the text (pages 1279, 1281 and 1288). The article should have indicated that the recommended dosage of a prescription-strength, home-use fluoride gel or paste is 0.5 percent. The erroneous version of the article was removed Nov. 26; below is the corrected version. If you read or downloaded the article between Oct. 31 and Nov. 26, please review this corrected version. The print version of this article contained the same errors, and therefore an itemized notice of corrections appears in the December 2013 issue of JADA.

Topical fluoride for caries prevention

Executive summary of the updated clinical recommendations and supporting systematic review

Robert J. Weyant, DMD, DrPH; Sharon L. Tracy, PhD; Theresa (Tracy) Anselmo, MPH, BSDH, RDH; Eugenio D. Beltrán-Aguilar, DMD, MPH, MS, DrPH; Kevin J. Donly, DDS, MS; William A. Frese, MD; Philippe P. Hujoel, MSD, PhD; Timothy Iafolla, DMD, MPH; William Kohn, DDS; Jayanth Kumar, DDS, MPH; Steven M. Levy, DDS, MPH; Norman Tinanoff, DDS, MS; J. Timothy Wright, DDS, MS; Domenick Zero, DDS, MS; Krishna Aravamudhan, BDS, MS; Julie Frantsve-Hawley RDH, PhD; Daniel M. Meyer, DDS; for the American Dental Association Council on Scientific Affairs Expert Panel on Topical Fluoride Caries Preventive Agents

In 2006, the Council on Scientific Affairs (CSA) of the American Dental Association (ADA) published recommendations for the use of professionally applied topical fluorides for caries prevention.[1] It is ADA policy to start updating the evidence and clinical recommendations at five-year intervals. The objective of this report is to provide an update on professionally applied topical fluorides and address additional questions related to the use of prescription-strength, home-use topical fluorides for caries prevention. The panel evaluated sodium, stannous and acidulated phosphate fluoride (APF) for professional and prescription-strength home-use, including varnishes, gels, foams, mouthrinses and prophylaxis pastes. The panel did not include over-the-counter products, slow-release delivery devices, dental materials that release fluorides and products that contain sodium monofluorophosphate, silver diamine fluoride and titanium tetrafluoride in this report. Sodium monofluorophosphate is primarily a nonprescription, daily-use fluoride product. Silver diamine fluoride and titanium fluoride are not available in any products in the United States. For the remainder of this article, the term "topical fluoride agents" will be used to include professionally applied, as well as prescription-

ABSTRACT

Background. A panel of experts convened by the American Dental Association (ADA) Council on Scientific Affairs presents evidence-based clinical recommendations regarding professionally applied and prescription-strength, home-use topical fluoride agents for caries prevention. These recommendations are an update of the 2006 ADA recommendations regarding professionally applied topical fluoride and were developed by using a new process that includes conducting a systematic review of primary studies.

Types of Studies Reviewed. The authors conducted a search of MEDLINE and the Cochrane Library for clinical trials of professionally applied and prescription-strength topical fluoride agents—including mouthrinses, varnishes, gels, foams and pastes—with caries increment outcomes published in English through October 2012.

Results. The panel included 71 trials from 82 articles in its review and assessed the efficacy of various topical fluoride caries-preventive agents. The panel makes recommendations for further research.

Practical Implications. The panel recommends the following for people at risk of developing dental caries: 2.26 percent fluoride varnish or 1.23 percent fluoride (acidulated phosphate fluoride) gel, or a prescription-strength, home-use 0.5 percent fluoride gel or paste or 0.09 percent fluoride mouthrinse for patients 6 years or older. Only 2.26 percent fluoride varnish is recommended for children younger than 6 years. The strengths of the recommendations for the recommended products varied from "in favor" to "expert opinion for." As part of the evidence-based approach to care, these clinical recommendations should be integrated with the practitioner's professional judgment and the patient's needs and preferences.

Key Words. Caries prevention; caries; evidence-based dentistry; fluoride; practice guidelines; preventive dentistry.
JADA 2013;144(11):1279-1291.

Dental Coding Review

Coverage Question: Should any changes be made in the current placement of various dental codes?

Question source: multiple stakeholders

Background: At the request of multiple stakeholders, OHA convened the Oral Health Forum (OHF), which is a workgroup that reviewed the placement of current CDT codes and their relationship to dental rules. This workgroup has completed their review of codes and has made recommendation for addition of some previously excluded codes and for movement of some currently covered codes.

OHAP input:

HERC staff summary:

HERC staff have compiled the OHA dental code workgroup recommendations for review by OHAP. HERC staff recommend that OHAP provide input on the codes suggested for movement, which are presented in next two code tables. OHAP members may also review all of the codes considered by OHF, which are presented on two additional code tables and suggest any additional codes for movement.

HERC staff recommendation:

1) Review the covered codes review document and the excluded codes review document
2) Additional full review documents included if any member wishes to pull out additional codes to review

OHF recommended changes to covered codes (with HERC staff recommendations)						
Code	**Code description**	**Current Placement**	**HERC Staff Recommended**	**Rationale/Notes from OHA workgroup**	**OAR update, other comments**	**OHAP input**
D0190	Screening of a patient	3 PREVENTION SERVICES WITH EVIDENCE OF EFFECTIVENESS	Diagnostic Procedures File	to align w/CDT groupings; per CDT line is Diagnostic File (align w/D0191 3,53)		
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full	53 PREVENTIVE DENTAL SERVICES	217 DENTAL CONDITIONS (E.G., PERIODONTAL DISEASE)	Periodontal code		
D4355	Full mouth debridement to enable a comprehensive	53	217	Periodontal code		
D9920	Behavior management, by report	53	Ancillary	D9920 - behavior management was established as a means to assure comprehensive oral health care for persons with developmental disabilities (DD). This code allows for additional compensation to a dentist who is treating persons with developmental disabilities due to the increased time, staffing, expertise, and adaptive equipment required for treatment	define in OAR when code is appropriate	
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar	54	265 DENTAL CONDITIONS (TIME SENSITIVE EVENTS) Treatment URGENT			

OHF recommended changes to covered codes (with HERC staff recommendations)						
Code	**Code description**	**Current Placement**	**HERC Staff Recommended**	**Rationale/Notes from OHA workgroup**	**OAR update, other comments**	**OHAP input**
D7962	Lingual frenectomy (frenulectomy)	18 FEEDING PROBLEMS IN NEWBORNS 597 TONGUE TIE AND OTHER ANOMALIES OF TONGUE	OHF recommended; 341 DENTAL CONDITIONS (E.G., SEVERE CARIES, INFECTION) Treatment ORAL SURGERY. See issue summary for HERC staff recommendation	oral surgery, covered benefit on dental	OHF comment: Guideline Note 48 applies only to D7961. See separate issue document.	
D7280	Exposure of an unerupted tooth	254 DEFORMITIES OF HEAD AND HANDICAPPING MALOCCLUSION 611 DENTAL CONDITIONS (E.G., MALOCCLUSION)	254, 341	618 = uncovered by dental; is covered for HCM should also be on a covered dental line 341 (in addition to 256)		
D7283	Placement of device to facilitate eruption of impacted tooth	254,636	254, 341	618 = uncovered by dental; is covered for HCM should also be on a covered dental line 344 (in addition to 254)		

OHF codes recommended for movement from Excluded file to Prioritized List (with HERC staff recommendations)					
Code	**Code description**	**Current placement**	**HERC staff recommended placement**	**Rationale/OHA workgroup Notes/other comments**	**OHAP input**
D0171	Re-evaluation - post-operative office visit	Excluded (Group 1118)	341 DENTAL CONDITIONS (E.G., SEVERE CARIES, INFECTION) Treatment ORAL SURGERY	Possibly "not to be billed separately" as this service is included in treatment/service provided. (410-123-1200 not eligible for separate reimbursement) 1. Exam code, should be moved to be consistent w/OARs. 2.	
D0391	Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report	Excluded (Group 1118)	53 PREVENTIVE DENTAL SERVICES	Possibly "not to be reimbursed separately" as this service is included in treatment/service provided. (410-123-1200 not eligible for separate reimbursement)	
D0460	Pulp vitality tests	Excluded (Group 1118)	54 DENTAL CONDITIONS (E.G., INFECTION, PAIN, TRAUMA)	Diagnostic	
D4921	Gingival irrigation with a medicinal agent - per quadrant	Not open for pymt	217 DENTAL CONDITIONS (E.G., PERIODONTAL DISEASE)	Is this open for encounter data? (update OAR? Can be billed) "not to be billed separately"	

OHF codes recommended for movement from Excluded file to Prioritized List (with HERC staff recommendations)					
Code	**Code description**	**Current placement**	**HERC staff recommended placement**	**Rationale/OHA workgroup Notes/other comments**	**OHAP input**
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	Excluded (Group 1118)	341	Clinical need. Part of procedure, not separately reimbursed. Dr. Geisler input: Used for bleeding, may reduce ED visits and other complications. These materials are	
D7993	Surgical placement of craniofacial implant - extra oral	Excluded (Group 1118)	612 DENTAL CONDITIONS (E.G., MISSING TEETH) Treatment IMPLANTS	implant Dr. Geisler input: May be used for treatment of severe facial trauma or congentital defects that require extensive reconstruction.	
D7994	Surgical placement: zygomatic implant	Excluded (Group 1118)	612	Dr. Geisler input: May be used for creation of substrate for dentures in a person who had all teeth pulled as a young person	
D9210	Local anesthesia not in conjunction with operative or surgical procedures	Excluded (Group 1118)	54	Palliative, could be urgent, or emergent (needs GN). Add situation to 123-1200 re: local anesthesia	

OHF codes recommended for movement from Excluded file to Prioritized List (with HERC staff recommendations)					
Code	**Code description**	**Current placement**	**HERC staff recommended placement**	**Rationale/OHA workgroup Notes/other comments**	**OHAP input**
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	Excluded (Group 1118)	54, 341	add to "not to be reimbursed separately" (bundle w/oral surgery procedures)	
D9613	Infiltration of sustained release therapeutic drug, per quadrant	Excluded (Group 1118)	341	gets billed, but not paid. Should be either "not paid separate" or have a guideline (e.g. Exporel)	

OHF review of covered codes						
Code	**Code description**	**Current placement**	**If rec'd move, line/group destination**	**Rationale/Notes**	**OAR update, other comments**	**Participant Notes**
D0190	Screening of a patient	3	per CDT line is Diagnostic File (align w/D0191 3,53)	to align w/CDT groupings		
D1701	Pfizer-biontech covid-19 vaccine administration - first dose	3		Per CDT line is preventative- stay		
D1702	Pfizer-biontech covid-19 vaccine administration - second dose	3		Per CDT line is preventative- stay		
D1703	Moderna covid-19 vaccine administration - first dose	3		Per CDT line is preventative- stay		
D1704	Moderna covid-19 vaccine administration - second dose	3		Per CDT line is preventative- stay		
D1705	Astrazeneca covid-19 vaccine administration - first dose	3		Per CDT line is preventative- stay		
D1706	Astrazeneca covid-19 vaccine administration - second dose	3		Per CDT line is preventative- stay		
D1707	Janssen COVID-19 vaccine administration	3		Per CDT line is preventative- stay		
D1708	Pfizer-biontech covid-19 vaccine administration - third dose	3		Per CDT line is preventative- stay		
D1709	Pfizer-biontech covid-19 vaccine administration - booster dose	3		Per CDT line is preventative- stay		

OHF review of covered codes						
Code	**Code description**	**Current placement**	**If rec'd move, line/group destination**	**Rationale/Notes**	**OAR update, other comments**	**Participant Notes**
D1710	Moderna covid-19 vaccine administration - third dose	3		Per CDT line is preventative- stay		
D1711	Moderna covid-19 vaccine administration - booster dose	3		Per CDT line is preventative- stay		
D1712	Janssen Covid-19 vaccine administration - booster dose	3		Per CDT line is preventative- stay		
D1713	Pfizer-biontech covid-19 vaccine administration tris-sucrose pediatric - first dose	3		Per CDT line is preventative- stay		
D1714	Pfizer-biontech covid-19 vaccine administration tris-sucrose pediatric - second dose	3		Per CDT line is preventative- stay		
D1781	Vaccine administration - human papillomavirus - dose 1	3		Per CDT line is preventative- stay		
D1782	Vaccine administration - human papillomavirus - dose 2	3		Per CDT line is preventative- stay		
D1783	Vaccine administration - human papillomavirus - dose 3	3		Per CDT line is preventative- stay		
D1320	Tobacco counseling for the control and prevention of oral disease	5		stay		

OHF review of covered codes						
Code	**Code description**	**Current placement**	**If rec'd move, line/group destination**	**Rationale/Notes**	**OAR update, other comments**	**Participant Notes**
D0120	Periodic oral evaluation - established patient	53		stay	align w/ESPDT age limitations	
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	53		stay	align w/ESPDT age limitations	
D0150	Comprehensive oral evaluation - new or established patient	53		stay	align w/ESPDT age limitations	
D0180	Comprehensive periodontal evaluation - new or established patient	53		stay	align w/ESPDT age limitations	
D0601	Caries risk assessment and documentation, with a finding of low risk	53		stay	Codes currently aren't listed in rule	
D0602	Caries risk assessment and documentation, with a finding of moderate risk	53		stay	Codes currently aren't listed in rule	
D0603	Caries risk assessment and documentation, with a finding of high risk	53		stay	Codes currently aren't listed in rule	
D1110	Prophylaxis - adult	53		stay	dentition, not age	
D1120	Prophylaxis - child	53		stay	dentition, not age	
D1208	Topical application of fluoride - excluding varnish	53		stay		
D1310	Nutritional counseling for the control of dental disease	53		stay		

OHF review of covered codes						
Code	**Code description**	**Current placement**	**If rec'd move, line/group destination**	**Rationale/Notes**	**OAR update, other comments**	**Participant Notes**
D1321	Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use	53		stay		
D1330	Oral hygiene instruction	53		stay		
D1351	Sealant-per tooth	53		stay	consider adjusting age to allow for primary dentition and premolars	
D1355	Caries preventive medicament application - per tooth	53		stay		
D1510	Space maintainer - fixed, unilateral - per quadrant	53		stay		
D1516	Space maintainer - fixed - bilateral, maxillary	53		stay		
D1517	Space maintainer - fixed - bilateral, mandibular	53		stay		
D1520	Space maintainer - removable, unilateral - per quadrant	53		stay		
D1526	Space maintainer - removable - bilateral, maxillary	53		stay		
D1527	Space maintainer - removable - bilateral, mandibular	53		stay		

OHF review of covered codes						
Code	**Code description**	**Current placement**	**If rec'd move, line/group destination**	**Rationale/Notes**	**OAR update, other comments**	**Participant Notes**
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	53		stay		
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	53		stay		
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	53		stay		
D1556	Removal of fixed unilateral space maintainer - per quadrant	53		stay		
D1557	Removal of fixed bilateral space maintainer - maxillary	53		stay		
D1558	Removal of fixed bilateral space maintainer - mandibular	53		stay		
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant	53		stay		
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	53	218	Perio code,		

OHF review of covered codes						
Code	**Code description**	**Current placement**	**If rec'd move, line/group destination**	**Rationale/Notes**	**OAR update, other comments**	**Participant Notes**
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	53	218	Perio code,		
D5986	Fluoride gel carrier	53		stay		
D9920	Behavior management, by report	53	(discussion re Ancillary)		define in OAR when code is appropriate	
D0140	Limited oral evaluation - problem focused	54		Stay		
D0160	Detailed and extensive oral evaluation - problem focused, by report	54		Stay		
D0170	Re-evaluation-limited, problem focused (established patient; not post-operative visit)	54		Stay		
D3110	Pulp cap-direct (excluding final restoration)	54		Stay		
D3221	Pulpal debridement, primary and permanent teeth	54		stay		
D7261	Primary closure of a sinus perforation	54		stay		
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	54		Stay		

OHF review of covered codes						
Code	**Code description**	**Current placement**	**If rec'd move, line/group destination**	**Rationale/Notes**	**OAR update, other comments**	**Participant Notes**
D7510	Incision and drainage of abscess-intraoral soft tissue	54		Stay		
D7520	Incision and drainage of abscess-extraoral soft tissue	54		stay		
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	54		stay		
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	54		stay		
D7670	Alveolus - closed reduction, may include stabilization of teeth	54		stay		
D7770	Alveolus - open reduction stabilization of teeth	54		stay		
D7910	Suture of recent small wounds up to 5 cm	54		stay		
D7911	Complicated suture-up to 5 cm	54		stay		
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar	54	move from emergency line to urgent line, 265			
D9110	Palliative treatment of dental pain - per visit	54		stay		
D9410	House/extended care facility call	54		stay		

OHF review of covered codes						
Code	**Code description**	**Current placement**	**If rec'd move, line/group destination**	**Rationale/Notes**	**OAR update, other comments**	**Participant Notes**
D9420	Hospital or ambulatory surgical center call	54		stay		
D9440	Office visit-after regularly scheduled hours	54		stay		
D9610	Therapeutic parenteral drug, single administration	54		stay		
D9612	Therapeutic parenteral drugs, two or more administrations, different medications	54		stay		
D9995	Teledentistry - synchronous; real-time encounter	54		stay		
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review	54		stay		
D5937	Trismus appliance (not for tm treatment)	71		stay		
D5934	Mandibular resection prosthesis with guide flange	200		stay		
D5935	Mandibular resection prosthesis without guide flange	200		stay		
D9947	custom sleep apnea appliance fabrication and placement	202		stay		

OHF review of covered codes						
Code	**Code description**	**Current placement**	**If rec'd move, line/group destination**	**Rationale/Notes**	**OAR update, other comments**	**Participant Notes**
D9948	adjustment of custom sleep apnea appliance	202		stay		
D9949	repair of custom sleep apnea appliance	202		stay		
D9953	reline custom sleep apnea appliance (indirect)	202		stay		
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	218		stay		
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	218		stay		
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	218		stay		
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	218		stay		
D4342	Periodontal scaling and root planing - one to three teeth, per quadrant	218		stay		
D4910	Periodontal maintenance	218		stay		
D5988	Surgical splint	228		stay		

OHF review of covered codes						
Code	**Code description**	**Current placement**	**If rec'd move, line/group destination**	**Rationale/Notes**	**OAR update, other comments**	**Participant Notes**
D0364	Cone beam ct capture and interpretation with limited field of view - less than one whole jaw	254	Review for additional line			
D0365	Cone beam ct capture and interpretation with field of view of one full dental arch - mandible	254	Review for additional line			
D0366	Cone beam ct capture and interpretation with field of view of one full dental arch - maxilla, with or without cranium	254	Review for additional line			
D0367	Cone beam ct capture and interpretation with field of view of both jaws, with or without cranium	254	Review for additional line			
D0801	3d dental surface scan - direct	256		stay		
D0802	3d dental surface scan - indirect	256		stay		
D5919	Facial prosthesis	256		stay		
D5924	Cranial prosthesis	256		stay		
D5925	Facial augmentation implant prosthesis	256		stay		
D5929	Facial prosthesis, replacement	256		stay		
D5931	Obturator prosthesis, surgical	256		stay		

OHF review of covered codes						
Code	**Code description**	**Current placement**	**If rec'd move, line/group destination**	**Rationale/Notes**	**OAR update, other comments**	**Participant Notes**
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	267		Stay		
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	267		Stay		
D2920	Re-cement or re-bond crown	267		Stay		
D2921	Reattachment of tooth fragment, incisal edge or cusp	267		Stay		
D2940	Protective restoration	267		Stay		
D3120	Pulp cap-indirect (excluding final restoration)	267		stay		
D3220	Therapeutic pulpotomy (excluding final restoration) removal of pulp coronal to the dentinocemental junction and application of medicament	265		stay	clarify age and teeth # in rule 1260 (7)	
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	267		Stay		

OHF review of covered codes						
Code	**Code description**	**Current placement**	**If rec'd move, line/group destination**	**Rationale/Notes**	**OAR update, other comments**	**Participant Notes**
D3230	Pulpal therapy (resorbable filling)-anterior, primary tooth (excluding final restoration)	267		Stay		
D3240	Pulpal therapy (resorbable filling)-posterior, primary tooth (excluding final restoration)	267		stay		
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	267		stay		
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	267		stay		
D3353	Apexification/recalcification-final visit (includes completed root canal therapy-apical closure/calcific repair of perforations, root resorption, etc.)	267		stay		

OHF review of covered codes						
Code	**Code description**	**Current placement**	**If rec'd move, line/group destination**	**Rationale/Notes**	**OAR update, other comments**	**Participant Notes**
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)	267		stay		
D5410	Adjust complete denture - maxillary	267		stay		
D5411	Adjust complete denture - mandibular	267		stay		
D5421	Adjust partial denture - maxillary	267		stay		
D5422	Adjust partial denture - mandibular	267		stay		
D5850	Tissue conditioning, maxillary	267		stay		
D5851	Tissue conditioning, mandibular	267		stay		
D6930	Re-cement or re-bond fixed partial denture	267		stay		
D8695	Removal of fixed orthodontic appliances for reasons other than completion of treatment	267		stay		
D9120	Fixed partial denture sectioning	267		stay		
D9951	Occlusal adjustment-limited	267		stay		
D5983	Radiation carrier	287		stay		
D5985	Radiation cone locator	287		stay		
D5932	Obturator prosthesis, definitive	300		stay		

OHF review of covered codes						
Code	**Code description**	**Current placement**	**If rec'd move, line/group destination**	**Rationale/Notes**	**OAR update, other comments**	**Participant Notes**
D5954	Palatal augmentation prosthesis	300		stay		
D5955	Palatal lift prosthesis, definitive	300		stay		
D5958	Palatal lift prosthesis, interim	300		stay		
D5959	Palatal lift prosthesis, modification	300		stay		
D5960	Speech aid prosthesis, modification	300		stay		
D5987	Commissure splint	300		stay		
D7983	Closure of salivary fistula	323		stay		
D1354	Application of caries arresting medicament - per tooth	343		stay		
D2140	Amalgam-one surface, primary or permanent	343		stay		
D2150	Amalgam-two surfaces, primary or permanent	343		stay		
D2160	Amalgam-three surfaces, primary or permanent	343		stay		
D2161	Amalgam-four or more surfaces, primary or permanent	343		stay		
D2330	Resin-one surface, anterior	343		stay		
D2331	Resin-two surfaces, anterior	343		stay		
D2332	Resin-three surfaces, anterior	343		stay		

OHF review of covered codes						
Code	**Code description**	**Current placement**	**If rec'd move, line/group destination**	**Rationale/Notes**	**OAR update, other comments**	**Participant Notes**
D2335	Resin-four or more surfaces or involving incisal angle (anterior)	343		stay		
D2390	Resin-based composite crown, anterior	343		stay		
D2391	Resin-based composite - one surface, posterior	343		stay		
D2392	Resin-based composite - two surfaces, posterior	343		stay		
D2393	Resin-based composite - three surfaces, posterior	343		stay		
D2394	Resin-based composite - four or more surfaces, posterior	343		stay		
D2930	Prefabricated stainless steel crown-primary tooth	343		stay		
D2931	Prefabricated stainless steel crown-permanent tooth	343		stay		
D2932	Prefabricated resin crown	343		stay		
D2933	Prefabricated stainless steel crown with resin window	343		stay		
D2941	Interim therapeutic restoration - primary dentition	343	move to urgent, 265			
D2951	Pin retention-per tooth, in addition to restoration	343		stay		
D2954	Prefabricated post and core in addition to crown	343		stay		

OHF review of covered codes						
Code	**Code description**	**Current placement**	**If rec'd move, line/group destination**	**Rationale/Notes**	**OAR update, other comments**	**Participant Notes**
D2957	Each additional prefabricated post - same tooth	343		stay		
D2980	Crown repair necessitated by restorative material failure	343		stay		
D6980	Fixed partial denture repair necessitated by restorative material failure	343		stay		
D6096	Remove broken implant retaining screw	344		stay		
D7241	Removal of impacted tooth-completely bony, with unusual surgical complications	344		Stay		
D7251	Coronectomy - intentional partial tooth removal, impacted teeth only	344		stay		
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	344		Stay	currently not covered, should stay as not covered. Should be on Not to be billed seperately list.	

OHF review of covered codes						
Code	**Code description**	**Current placement**	**If rec'd move, line/group destination**	**Rationale/Notes**	**OAR update, other comments**	**Participant Notes**
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	344		Stay		
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	344		stay	lots of requests for. Covered for under 21 and preg adults. Budget review if can be available for non-pregnant adults. (oral surgeons may sometimes substitute and submit claim for exostosis) If funded, would need GN similar to GN117 when medically needed for prostetic.	

OHF review of covered codes						
Code	**Code description**	**Current placement**	**If rec'd move, line/group destination**	**Rationale/Notes**	**OAR update, other comments**	**Participant Notes**
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	344		stay	lots of requests for. Covered for under 21 and preg adults. Budget review if can be available for non-pregnant adults. (oral surgeons may sometimes substitute and submit claim for exostosis)	
D7450	Removal of benign odontogenic cyst or tumor-lesion diameter up to 1.25 cm	344		stay		
D7451	Removal of benign odontogenic cyst or tumor-lesion diameter greater than 1.25 cm	344		stay		
D7465	Destruction of lesion(s) by physical or chemical methods, by report	344		stay		
D7471	Removal of lateral exostosis (maxilla or mandible)	344		stay	providers may use this instead of alveloplasty; covered service, used frequently	
D7509	marsupialization of odontogenic cyst	344		stay		

OHF review of covered codes						
Code	**Code description**	**Current placement**	**If rec'd move, line/group destination**	**Rationale/Notes**	**OAR update, other comments**	**Participant Notes**
D7540	Removal of reaction-producing foreign bodies-musculoskeletal system	344		stay		
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	344		stay		
D7963	Frenuloplasty	344		stay	needs more extensive guideline note	
D7971	Excision of pericoronal gingiva	344		stay		
D9930	Treatment of complications (postsurgical) - unusual circumstances, by report	344		stay		
D7810	Open reduction of dislocation	359		stay	(medical line?)	
D7820	Closed reduction of dislocation	359		stay	(medical line?)	
D7830	Manipulation under anesthesia	359		stay	(medical line?)	

OHF review of covered codes						
Code	**Code description**	**Current placement**	**If rec'd move, line/group destination**	**Rationale/Notes**	**OAR update, other comments**	**Participant Notes**
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	384			look at lines, verify why the endodontic therapy treatments are on different line #s. Possibly history of variable benefits.	
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	411			look at lines, verify why the endodontic therapy treatments are on different line #s. Possibly history of variable benefits.	

OHF review of covered codes						
Code	**Code description**	**Current placement**	**If rec'd move, line/group destination**	**Rationale/Notes**	**OAR update, other comments**	**Participant Notes**
D3330	Endodontic therapy, molar tooth (excluding final restoration)	444			look at lines, verify why the endodontic therapy treatments are on different line #s. Possibly history of variable benefits. (confirm clinical criteria for endo in molars, in addition to age/tooth number etc)	
D5110	Complete denture - maxillary	454		stay	review frequency limitation	
D5120	Complete denture - mandibular	454		stay		
D5130	Immediate denture - maxillary	454		stay		
D5140	Immediate denture - mandibular	454		stay		
D5211	Maxillary partial denture - resin base (including, retentive/clasping materials, rests, and teeth)	454		stay		

OHF review of covered codes						
Code	**Code description**	**Current placement**	**If rec'd move, line/group destination**	**Rationale/Notes**	**OAR update, other comments**	**Participant Notes**
D5212	Mandibular partial denture - resin base (including, retentive/clasping materials, rests and teeth)	454		stay		
D5221	Immediate maxillary partial denture - resin base (including retentive/clasping materials, rest and teeth)	454		stay		
D5222	Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth)	454		stay		
D5511	Repair broken complete denture base, mandibular	454		stay		
D5512	Repair broken complete denture base, maxillary	454		stay		
D5520	Replace missing or broken teeth-complete denture (each tooth)	454		stay		
D5611	Repair resin partial denture base, mandibular	454		stay		
D5612	Repair resin partial denture base, maxillary	454		stay		
D5621	Repair cast partial framework, mandibular	454		stay		
D5622	Repair cast partial framework, maxillary	454		stay		

OHF review of covered codes						
Code	**Code description**	**Current placement**	**If rec'd move, line/group destination**	**Rationale/Notes**	**OAR update, other comments**	**Participant Notes**
D5630	Repair or replace broken retentive clasping materials - per tooth	454		stay		
D5640	Replace broken teeth-per tooth	454		stay		
D5650	Add tooth to existing partial denture	454		stay		
D5660	Add clasp to existing partial denture - per tooth	454		stay		
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	454		stay		
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	454		stay		
D5710	Rebase complete maxillary denture	454		stay		
D5711	Rebase complete mandibular denture	454		stay		
D5720	Rebase maxillary partial denture	454		stay		
D5721	Rebase mandibular partial denture	454		stay		
D5730	Reline complete maxillary denture (direct)	454		stay		
D5731	Reline lower complete mandibular denture (direct)	454		stay		
D5740	Reline maxillary partial denture (direct)	454		stay		

OHF review of covered codes						
Code	**Code description**	**Current placement**	**If rec'd move, line/group destination**	**Rationale/Notes**	**OAR update, other comments**	**Participant Notes**
D5741	Reline mandibular partial denture (direct)	454		stay		
D5750	Reline complete maxillary denture (indirect)	454		stay		
D5751	Reline complete mandibular denture (indirect)	454		stay		
D5760	Reline maxillary partial denture (indirect)	454		stay		
D5761	Reline mandibular partial denture (indirect)	454		stay		
D5765	Soft liner for complete or partial removable denture - indirect	454		stay		
D5820	Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary	454		stay		
D5821	Interim partial denture (including retentive/clasping materials, rests, and teeth), mandibular	454		stay		
D5876	add metal substructure to acrylic full denture (per arch)	454		stay		
D7472	Removal of torus palatinus	454		stay		

OHF review of covered codes						
Code	**Code description**	**Current placement**	**If rec'd move, line/group destination**	**Rationale/Notes**	**OAR update, other comments**	**Participant Notes**
D7473	Removal of torus mandibularis	454		stay		
D7970	Excision of hyperplastic tissue-per arch	454		stay		
D3346	Retreatment of previous root canal therapy-anterior	456		stay		
D3410	Apicoectomy - anterior	456		stay		
D2710	Crown - resin-based composite (indirect)	469		stay	Review limitations	
D2712	Crown - 3/4 resin-based composite (indirect)	469		stay	Review limitations	
D2740	Crown - porcelain/ceramic	469		stay	Review limitations	
D2751	Crown-porcelain fused to predominantly base metal	469		stay	Review limitations	
D2752	Crown-porcelain fused to noble metal	469		stay	Review limitations	
D7962	Lingual frenectomy (frenulectomy)	18,597	341	oral surgery, covered benefit on dental	(GN48 currently applies only to D7961)	
D7440	Excision of malignant tumor-lesion diameter up to 1.25 cm	200,287		stay		
D7441	Excision of malignant tumor-lesion diameter greater than 1.25 cm	200,287		stay		
D7912	Complicated suture-greater than 5 cm	207,300		stay		

OHF review of covered codes						
Code	**Code description**	**Current placement**	**If rec'd move, line/group destination**	**Rationale/Notes**	**OAR update, other comments**	**Participant Notes**
D5933	Obturator prosthesis, modification	256,300		stay		
D7220	Removal of impacted tooth-soft tissue	256,344		stay		
D7230	Removal of impacted tooth-partially bony	256,344		stay		
D7240	Removal of impacted tooth-completely bony	256,344		stay		
D5915	Orbital prosthesis	256,484		stay		
D5928	Orbital prosthesis, replacement	256,484		stay		
D7940	Osteoplasty-for orthognathic deformities	256,617		stay		
D7941	Osteotomy - mandibular rami	256,617		stay		
D7943	Osteotomy - mandibular rami with bone graft; includes obtaining the graft	256,617		stay		
D7944	Osteotomy-segmented or subapical	256,617		stay		
D7945	Osteotomy-body of mandible	256,617		stay		
D7946	Lefort i (maxilla-total)	256,617		stay		
D7947	Lefort i (maxilla-segmented)	256,617		stay		

OHF review of covered codes						
Code	**Code description**	**Current placement**	**If rec'd move, line/group destination**	**Rationale/Notes**	**OAR update, other comments**	**Participant Notes**
D7948	Lefort ii or lefort iii (osteoplasty of facial bones for midface hypoplasia or retrusion)-without bone graft	256,617		stay		
D7949	Lefort ii or lefort iii-with bone graft	256,617		stay		
D7280	Exposure of an unerupted tooth	254,618	341	618 = uncovered by dental; is covered for HCM should also be on a covered dental line 344 (in addition to 256)		
D7283	Placement of device to facilitate eruption of impacted tooth	254,618	341	618 = uncovered by dental; is covered for HCM should also be on a covered dental line 344 (in addition to 256)		
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	256,619		stay		
D7952	Sinus augmentation via a vertical approach	256,619		stay		
D7955	Repair of maxillofacial soft and/or hard tissue defect	256,643		Review why this on the TMJ line? (643)		
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report	256,646		review 646 placement, most often in conjunction w/implants (619)		

OHF review of covered codes						
Code	**Code description**	**Current placement**	**If rec'd move, line/group destination**	**Rationale/Notes**	**OAR update, other comments**	**Participant Notes**
D7953	Bone replacement graft for ridge preservation - per site	256,646		Stay; consider adding to implant line (619)		
D2950	Core build-up, including any pins when required	267,343		stay	verify if limitations are correct either in GN or OAR. Only to be used in conjuction w/crown	
D7250	Removal of residual tooth roots (cutting procedure)	300,344		stay	GN 34 is specific to removal of impacted third molars. Review GN 34 and OAR regarding impacted teeth. Should be additional GN to allow for other roots than only third molars.	
D7340	Vestibuloplasty-ridge extension (second epithelialization)	300,586		stay		

OHF review of covered codes						
Code	**Code description**	**Current placement**	**If rec'd move, line/group destination**	**Rationale/Notes**	**OAR update, other comments**	**Participant Notes**
D7350	Vestibuloplasty-ridge extension (including soft tissue grafts, muscle re-attachments, revision of soft tissue attachment, and management of hypertrophied and hyperplastic tissue)	300,586		stay		
D7982	Sialodochoplasty	323,500		stay		
D6100	Surgical removal of implant body	344,619		stay		
D6105	Removal of implant body not requiring bone removal or flap elevation	344,619		stay		
D7961	Buccal / labial frenectomy (frenulectomy)	344,661		stay	review GN 48 to have it also address D7962, D7963	
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	54,256,300		stay		
D7260	Oral antral fistula closure	54,300,577		stay		
D5984	Radiation shield	#########		stay		
D7920	Skin graft (identify defect covered, location, and type of graft)	#########		stay		
D7111	Extraction, coronal remnants - primary tooth	#########		stay		

OHF review of covered codes						
Code	**Code description**	**Current placement**	**If rec'd move, line/group destination**	**Rationale/Notes**	**OAR update, other comments**	**Participant Notes**
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	#########		stay		
D3331	Treatment of root canal obstruction; non-surgical access	#########		stay		
D3333	Internal root repair of perforation defects	#########		stay		
D3430	Retrograde filling-per root	#########		stay		
D7298	removal of temporary anchorage device [screw retained plate], requiring flap	#########		stay	Review: database says "not to be billed separately", but this not stated in OAR. 123-1200	
D7299	removal of temporary anchorage device, requiring flap	#########		stay	Review: database says "not to be billed separately", but this not stated in OAR.	
D7300	removal of temporary anchorage device without flap	#########		stay	Review: database says "not to be billed separately", but this not stated in OAR.	

OHF review of covered codes						
Code	**Code description**	**Current placement**	**If rec'd move, line/group destination**	**Rationale/Notes**	**OAR update, other comments**	**Participant Notes**
D8010	Limited orthodontic treatment of the primary dentition	#########		stay		
D8020	Limited orthodontic treatment of the transitional dentition	#########		stay		
D8030	Limited orthodontic treatment of the adolescent dentition	#########		stay		
D8040	Limited orthodontic treatment of the adult dentition	#########		stay		
D8070	Comprehensive orthodontic treatment of the transitional dentition	#########		stay		
D8080	Comprehensive orthodontic treatment of the adolescent dentition	#########		stay		
D8090	Comprehensive orthodontic treatment of the adult dentition	#########		stay		
D8210	Removable appliance therapy	#########		stay		
D8220	Fixed appliance therapy	#########		stay		
D8660	Pre-orthodontic treatment examination to monitor growth and development	#########		stay		
D8670	Periodic orthodontic treatment visit	#########		stay		

OHF review of covered codes						
Code	**Code description**	**Current placement**	**If rec'd move, line/group destination**	**Rationale/Notes**	**OAR update, other comments**	**Participant Notes**
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	#########		stay		
D8681	Removable orthodontic retainer adjustment	#########		stay		
D8696	Repair of orthodontic appliance - maxillary	#########		stay		
D8697	Repair of orthodontic appliance - mandibular	#########		stay		
D8698	Re-cement or re-bond fixed retainer - maxillary	#########		stay		
D8699	Re-cement or re-bond fixed retainer - mandibular	#########		stay		
D8701	Repair of fixed retainer, includes reattachment - maxillary	#########		stay		
D8702	Repair of fixed retainer, includes reattachment - mandibular	#########		stay		
D8703	Replacement of lost or broken retainer - maxillary	#########		stay		
D8704	Replacement of lost or broken retainer - mandibular	#########		stay		

OHF review of covered codes						
Code	**Code description**	**Current placement**	**If rec'd move, line/group destination**	**Rationale/Notes**	**OAR update, other comments**	**Participant Notes**
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	#########		stay		
D7981	Excision of salivary gland, by report	#########		stay on medical		
D5992	Adjust maxillofacial prosthetic appliance, by report	#########		stay on medical		
D5993	Maintenance and cleaning of a maxillofacial prosthesis (extra- or intra-oral) other than required adjustments, by report	#########		stay on medical		
D3911	intraorifice barrier	384, 411, 444, 456, 507, 538		"not to be billed separately" 123-1200		
D3921	decoronation or submergence of an erupted tooth	384, 411, 444, 456, 507, 538		stay		
D0191	Assessment of a patient	3,53		stay		
D1206	Topical application of fluoride varnish	3,53		stay		

OHF review of excluded codes							
Code	**Code description**	**Current placement**	**If rec'd move, line/group destination**	**Rationale/Notes**	**Applicable OARs/GNs**	**Participant Notes**	**Excluded since**
D0171	Re-evaluation - post-operative office visit	Excluded (Group 1118)	343 (exam line)	possibly "not to be billed separately" as this service is included in treatment/service provided. (410-123-1200 not eligible for separate reimbursement) 1. Exam code, should be moved to be consistent w/OARs. 2. should stay as "not to be reimbursed separately." Add to post-operative rule.	Per OAR 410-120-1200		1/1/2019
D0368	Cone beam ct capture and interpretation for tmj series including two or more exposures	Excluded (Group 1118)		only Cone Beam call out of TMJ . Limited specifications (possibly add GN for cone beams). Possibly revisit, conduct another evidence review. Review the other cone beams, keep this on Excluded.	Per OAR 410-120-1200		1/1/2013

OHF review of excluded codes							
Code	**Code description**	**Current placement**	**If rec'd move, line/group destination**	**Rationale/Notes**	**Applicable OARs/GNs**	**Participant Notes**	**Excluded since**
D0369	Maxillofacial mri capture and interpretation	Excluded (Group 1118)		MRI = medical ? Could be used by oral surgeons but would use medical code. Keep on excluded	Per OAR 410-120-1200		1/1/2013
D0370	Maxillofacial ultrasound capture and interpretation	Excluded (Group 1118)		MRI = medical ? Could be used by oral surgeons but would use medical code. Keep on excluded	Per OAR 410-120-1200		1/1/2013
D0371	Sialoendoscopy capture and interpretation	Excluded (Group 1118)		MRI = medical ? Could be used by oral surgeons but would use medical code. Keep on excluded	Per OAR 410-120-1200		1/1/2013
D0372	Intraoral tomosynthesis - comprehensive series of radiographic images	Excluded (Group 1118)		New technology, inadequate research, (consider putting in re-evaluation cycle)	Per OAR 410-120-1200		1/1/2023
D0373	Intraoral tomosynthesis - bitewing radiographic image	Excluded (Group 1118)		New technology, inadequate research, (consider putting in re-evaluation cycle)	Per OAR 410-120-1200		1/1/2023
D0374	intraoral tomosynthesis - periapical radiographic image	Excluded (Group 1118)		New technology, inadequate research, (consider putting in re-evaluation cycle)	Per OAR 410-120-1200		1/1/2023

OHF review of excluded codes							
Code	**Code description**	**Current placement**	**If rec'd move, line/group destination**	**Rationale/Notes**	**Applicable OARs/GNs**	**Participant Notes**	**Excluded since**
D0380	Cone beam ct image capture with limited field of view - less than one whole jaw	Excluded (Group 1118)		Recommend evidence review	Per OAR 410-120-1200		1/1/2013
D0381	Cone beam ct image capture with field of view of one full dental arch - mandible	Excluded (Group 1118)		Recommend evidence review	Per OAR 410-120-1200		1/1/2013
D0382	Cone beam ct image capture with field of view of one full dental arch - maxilla, with or without cranium	Excluded (Group 1118)		Recommend evidence review	Per OAR 410-120-1200		1/1/2013
D0383	Cone beam ct image capture with field of view of both jaws, with or without cranium	Excluded (Group 1118)		Recommend evidence review	Per OAR 410-120-1200		1/1/2013
D0384	Cone beam ct image capture for tmj series including two or more exposures	Excluded (Group 1118)		Stay on Excluded. (Related to TMJ)	Per OAR 410-120-1200		1/1/2013
D0385	Maxillofacial mri image capture	Excluded (Group 1118)		medical use; keep on excluded. (Check if there's a coordinated CPT code)	Per OAR 410-120-1200		1/1/2013

OHF review of excluded codes							
Code	**Code description**	**Current placement**	**If rec'd move, line/group destination**	**Rationale/Notes**	**Applicable OARs/GNs**	**Participant Notes**	**Excluded since**
D0386	Maxillofacial ultrasound image capture	Excluded (Group 1118)		medical use; keep on excluded. (Check if there's a coordinated CPT code)	Per OAR 410-120-1200		1/1/2013
D0387	Intraoral tomosynthesis - comprehensive series of radiographic images - image capture only	Excluded (Group 1118)		New technology, inadequate research, (consider putting in re-evaluation cycle)	Per OAR 410-120-1200		1/1/2023
D0388	Intraoral tomosynthesis - bitewing radiographic image - image capture only	Excluded (Group 1118)		New technology, inadequate research, (consider putting in re-evaluation cycle)	Per OAR 410-120-1200		1/1/2023
D0389	Intraoral tomosynthesis - periapical radiographic image - image capture only	Excluded (Group 1118)		New technology, inadequate research, (consider putting in re-evaluation cycle)	Per OAR 410-120-1200		1/1/2023
D0391	Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report	Excluded (Group 1118)	53	possibly "not to be reimbursed separately" as this service is included in treatment/service provided. (410-123-1200 not eligible for separate reimbursement)	Per OAR 410-120-1200		1/1/2013
D0416	Viral culture	Excluded (Group 1118)		medical in nature	Per OAR 410-120-1200		1/1/2005

OHF review of excluded codes							
Code	**Code description**	**Current placement**	**If rec'd move, line/group destination**	**Rationale/Notes**	**Applicable OARs/GNs**	**Participant Notes**	**Excluded since**
D0417	Collection and preparation of saliva sample for laboratory diagnostic testing	Excluded (Group 1118)		medical in nature	Per OAR 410-120-1200		1/1/2009
D0418	Analysis of saliva sample	Excluded (Group 1118)		Saliva=dental health-related, medical in nature. Carries risk assessment.	Per OAR 410-120-1200		1/1/2009
D0419	Assessment of salivary flow by measurement	Excluded (Group 1118)		Saliva=dental health-related, medical in nature. Carries risk assessment.	Per OAR 410-120-1200		1/1/2020
D0422	Collection and preparation of genetic sample material for laboratory analysis and report	Excluded (Group 1118)		Stay	GL Note 173		1/1/2019
D0423	Genetic test for susceptibility to diseases – specimen analysis	Excluded (Group 1118)		Stay	GL Note 173		1/1/2019
D0425	Caries susceptibility tests	Excluded (Group 1118)		Stay	Per OAR 410-120-1200		1/1/2000

OHF review of excluded codes							
Code	**Code description**	**Current placement**	**If rec'd move, line/group destination**	**Rationale/Notes**	**Applicable OARs/GNs**	**Participant Notes**	**Excluded since**
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	Excluded (Group 1118)		Stay	Per OAR 410-120-1200		1/1/2005
D0460	Pulp vitality tests	Excluded (Group 1118)	54	Diagnostic	Per OAR 410-120-1200		1/1/2000
D0470	Diagnostic casts	Excluded (Group 1118)		Stay	Per OAR 410-120-1200		1/1/1995
D0475	Decalcification procedure	Excluded (Group 1118)		Stay	Per OAR 410-120-1200		1/1/2005
D0476	Special stains for microorganisms	Excluded (Group 1118)		Stay	Per OAR 410-120-1200		1/1/2005
D0477	Special stains, not for microorganisms	Excluded (Group 1118)		Stay	Per OAR 410-120-1200		1/1/2005
D0478	Immunohistochemical stains	Excluded (Group 1118)		Stay	Per OAR 410-120-1200		1/1/2005
D0479	Tissue in-situ hybridization, including interpretation	Excluded (Group 1118)		Stay	Per OAR 410-120-1200		1/1/2005
D0481	Electron microscopy	Excluded (Group 1118)		Stay	Per OAR 410-120-1200		1/1/2005
D0482	Direct immunofluorescence	Excluded (Group 1118)		Stay	Per OAR 410-120-1200		1/1/2005

OHF review of excluded codes							
Code	**Code description**	**Current placement**	**If rec'd move, line/group destination**	**Rationale/Notes**	**Applicable OARs/GNs**	**Participant Notes**	**Excluded since**
D0483	Indirect immunofluorescence	Excluded (Group 1118)		Stay	Per OAR 410-120-1200		1/1/2005
D0484	Consultation on slides prepared elsewhere	Excluded (Group 1118)		Stay	Per OAR 410-120-1200		1/1/2005
D0485	Consultation, including preparation of slides from biopsy material supplied by referring source	Excluded (Group 1118)		Stay	Per OAR 410-120-1200		1/1/2005
D0600	Non-ionizing diagnostic procedure capable of quantifying, monitoring, and recording changes in structure of enamel, dentin, and cementum	Excluded (Group 1118)		Stay	Per OAR 410-120-1200		1/1/2017
D0605	Antibody testing for a public health related pathogen, including coronavirus	Excluded (Group 1118)		Stay	Per OAR 410-120-1200		1/1/2021
D0803	3d facial surface scan - direct	Excluded (Group 1118)		Stay	Per OAR 410-120-1200		1/1/2023
D0804	3d facial surface scan - indirect	Excluded (Group 1118)		Stay	Per OAR 410-120-1200		1/1/2023
D0999	Unspecified diagnostic procedure, by report	Excluded (Group 1118)		Stay	Per OAR 410-120-1200		1/1/2000

OHF review of excluded codes							
Code	**Code description**	**Current placement**	**If rec'd move, line/group destination**	**Rationale/Notes**	**Applicable OARs/GNs**	**Participant Notes**	**Excluded since**
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth	Excluded (Group 1118)		Public health method, less invasive. What is evidence? (Table for more research, ask Dr. Allen's opinion) could take place of sealants for adults. If covered, what would be the frequency? (if billed, cant bill sealant/composite on same date/same tooth). Some commercial plans cover, w/clinical rules. no age limitation listed. (Possibly offer to ages 16+). Dr. Allen skeptical, some controversy, as decay can be sealed over. (review what overall utilization is). **STAY**	Per OAR 410-120-1200		1/1/2011

OHF review of excluded codes							
Code	**Code description**	**Current placement**	**If rec'd move, line/group destination**	**Rationale/Notes**	**Applicable OARs/GNs**	**Participant Notes**	**Excluded since**
D1353	Sealant repair - per tooth	Excluded (Group 1118)		Some commercial plans cover, w/limitations. Limitations = time since first sealed, if cavitated. (Table for more research, ask Dr. Allen's opinion)	Per OAR 410-120-1200		1/1/2019
D1999	Unspecified preventive procedure, by report	Excluded (Group 1118)		Stay	Per OAR 410-120-1200		1/1/2019
D2975	Coping	Excluded (Group 1118)		Stay	Per OAR 410-120-1200		1/1/2005
D4265	Biologic materials to aid in soft and osseous tissue regeneration, per site	Excluded (Group 1118)		Stay	Per OAR 410-120-1200		1/1/2003
D4266	Guided tissue regeneration, natural teeth - resorbable barrier, per site	Excluded (Group 1118)		Stay	Per OAR 410-120-1200		1/1/2000
D4267	Guided tissue regeneration, natural teeth - non-resorbable barrier, per site	Excluded (Group 1118)		Stay	Per OAR 410-120-1200		1/1/2000

OHF review of excluded codes							
Code	**Code description**	**Current placement**	**If rec'd move, line/group destination**	**Rationale/Notes**	**Applicable OARs/GNs**	**Participant Notes**	**Excluded since**
D4921	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft	Excluded (Group 1118)		Stay	Per OAR 410-120-1200		1/1/2019
D7295	Combined connective tissue and pedicle graft, per tooth	Excluded (Group 1118)		Stay	Per OAR 410-120-1200		1/1/2011
D4921	Gingival irrigation with a medicinal agent - per quadrant	Not open for pymt	Perio procedure, Line 218	Is this open for encounter data? (update OAR? Can be billed) "not to be billed separately"			
D7295	Harvest of bone for use in autogenous grafting procedure	Not open for pymt Excluded		(move to Excluded) Stay			
D7411	Excision of benign lesion greater than 1.25 cm	Excluded (Group 1118)		Stay (consider revising OAR. Not always most appropriate to be limited to medical codes. Coordinating care becomes complex. Could be helpful for oral surgeons to use these codes).	Per OAR 410-120-1200		1/1/2003

OHF review of excluded codes							
Code	**Code description**	**Current placement**	**If rec'd move, line/group destination**	**Rationale/Notes**	**Applicable OARs/GNs**	**Participant Notes**	**Excluded since**
D7412	Excision of benign lesion, complicated	Excluded (Group 1118)		Stay (consider revising OAR. Not always most appropriate to be limited to medical codes. Coordinating care becomes complex. Could be helpful for oral surgeons to use these codes). Bring this to OHAP to discuss medical/dental care coordination. Get oral surgeon input (lived experiences for council on how). OHA guidance could cause confusion, not recommended.	Per OAR 410-120-1200		1/1/2003

OHF review of excluded codes							
Code	**Code description**	**Current placement**	**If rec'd move, line/group destination**	**Rationale/Notes**	**Applicable OARs/GNs**	**Participant Notes**	**Excluded since**
D7413	Excision of malignant lesion up to 1.25 cm	Excluded (Group 1118)		Stay (consider revising OAR. Not always most appropriate to be limited to medical codes. Coordinating care becomes complex. Could be helpful for oral surgeons to use these codes)	Per OAR 410-120-1200		1/1/2003
D7414	Excision of malignant lesion greater than 1.25 cm	Excluded (Group 1118)		Stay (consider revising OAR. Not always most appropriate to be limited to medical codes. Coordinating care becomes complex. Could be helpful for oral surgeons to use these codes)	Per OAR 410-120-1200		1/1/2003

OHF review of excluded codes							
Code	**Code description**	**Current placement**	**If rec'd move, line/group destination**	**Rationale/Notes**	**Applicable OARs/GNs**	**Participant Notes**	**Excluded since**
D7415	Excision of malignant lesion, complicated	Excluded (Group 1118)		Stay (consider revising OAR. Not always most appropriate to be limited to medical codes. Coordinating care becomes complex. Could be helpful for oral surgeons to use these codes)	Per OAR 410-120-1200		1/1/2003
D7485	Reduction of osseous tuberosity	Excluded (Group 1118)		Oral surgery. Stay on excluded	Per OAR 410-120-1200		1/1/2003
D7671	Alveolus - open reduction, may include stabilization of teeth	Excluded (Group 1118)		Trauma-related. Stay	Per OAR 410-120-1200		1/1/2003
D7771	Alveolus, closed reduction stabilization of teeth	Excluded (Group 1118)		Stay	Per OAR 410-120-1200		1/1/2003
D7921	Collection and application of autologous blood concentrate product	Excluded (Group 1118)		Stay, or on non-covered line. Questionable evidence to support	Per OAR 410-120-1200		1/1/2013

OHF review of excluded codes							
Code	**Code description**	**Current placement**	**If rec'd move, line/group destination**	**Rationale/Notes**	**Applicable OARs/GNs**	**Participant Notes**	**Excluded since**
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	Excluded (Group 1118)	move to 344	Clinical need. Part of procedure, not separately reimbursed. Should discuss whether this ought to be reimbursed separately.	Per OAR 410-120-1200		1/1/2020
D7993	Surgical placement of craniofacial implant - extra oral	Excluded (Group 1118)	move to 619	implant	Per OAR 410-120-1200		1/1/2021
D7994	Surgical placement: zygomatic implant	Excluded (Group 1118)	more to 619		Per OAR 410-120-1200		1/1/2021
D8999	Unspecified orthodontic procedure, by report	Excluded (Group 1118)		Stay	Per OAR 410-120-1200		1/1/2012
D9210	Local anesthesia not in conjunction with operative or surgical procedures	Excluded (Group 1118)	54	Palliative, could be urgent, or emergent (needs GN). Add situation to 123-1200 re: local anesthesia	Per OAR 410-120-1200		1/1/2000
D9215	Local anesthesia in conjunction with operative or surgical procedures	Excluded (Group 1118)		Stay	Per OAR 410-120-1200		1/1/2000

OHF review of excluded codes							
Code	**Code description**	**Current placement**	**If rec'd move, line/group destination**	**Rationale/Notes**	**Applicable OARs/GNs**	**Participant Notes**	**Excluded since**
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	Excluded (Group 1118)	54, 344	add to "not to be reimbursed separately" (bundle w/oral surgery procedures)	Per OAR 410-120-1200		1/1/2019
D9450	Case presentation, subsequent to detailed and extensive treatment planning	Excluded (Group 1118)		Stay	Per OAR 410-120-1200		1/1/2003
D9613	Infiltration of sustained release therapeutic drug, per quadrant	Excluded (Group 1118)	344	gets billed, but not paid. Should be either "not paid separate" or have a guideline (eg, Exporel). Discuss if should be paid separately	Per OAR 410-120-1200		1/1/2019
D9932	Cleaning and inspection of the removable complete denture, maxillary	Excluded (Group 1118)		Stay (173 GN) per OHAP in 2019	GL Note 173		1/1/2019
D9933	Cleaning and inspection of the removable complete denture, mandibular	Excluded (Group 1118)		Stay	GL Note 173		1/1/2019
D9934	Cleaning and inspection of the removable complete denture, mandibular	Excluded (Group 1118)		Stay	GL Note 173		1/1/2019

OHF review of excluded codes							
Code	**Code description**	**Current placement**	**If rec'd move, line/group destination**	**Rationale/Notes**	**Applicable OARs/GNs**	**Participant Notes**	**Excluded since**
D9935	Cleaning and inspection of the removable complete denture, mandibular	Excluded (Group 1118)		Stay	GL Note 173		1/1/2019
D9961	duplicate/copy patient's records	Excluded (Group 1118)		Stay	Per OAR 410-120-1200		1/1/2019
D9985	Sales tax	Excluded (Group 1118)		Stay	Per OAR 410-120-1200		1/1/2019
D9986	Missed appointment	Excluded (Group 1118)		Stay	Per OAR 410-120-1200		1/1/2020
D9987	Cancelled appointment	Excluded (Group 1118)		Stay	Per OAR 410-120-1200		1/1/2019