

NATIONAL CLINICAL CRITERIA GUIDELINES AND PRACTICE PARAMETERS

Medicare Dental Programs

Preface

DentaQuest's National Clinical Criteria Guidelines and Practice Parameters are established to promote consistent, evidence-based decision-making for dental services provided under Medicare dental programs. These criteria are intended to serve as clinical guidance for coverage determinations, authorization decisions, and retrospective review; however, for Medicare coverage purposes they must be applied in a manner consistent with applicable CMS statutes, regulations, subregulatory guidance, and Medicare program instructions regarding dental services. These guidelines are developed and reviewed periodically by licensed Dental Directors with input from practicing general dentists and specialists and are informed by ADA Dental Practice Parameters, peer-reviewed clinical literature, and community practice patterns.

The criteria outlined in this document are guidelines and do not replace professional clinical judgment. Coverage determinations are subject to the member's specific benefit plan, contractual provisions, and applicable federal regulations. Where Medicare coverage applies, CMS coverage rules control, including the statutory exclusion of most routine dental services except in limited circumstances recognized by CMS.

For information regarding a member's plan benefits and eligibility status, providers may contact the DentaQuest call center. The call center phone number is available on the back of the member's ID card.

Questions about member coverage and eligibility?



Contact the DentaQuest call center. The phone number is located on the back of the member's ID card.

New Patient Information

Providers are expected to obtain and maintain comprehensive registration, medical, and dental history information for all new patients. Documentation must support diagnosis, treatment planning, and medical necessity.

At a minimum, patient records must include:

- Demographic and emergency contact information
- Comprehensive medical history (reviewed and signed by the treating dentist)
- Dental history including relevant prior treatment

These elements are essential components of high-quality dental care and are expected to be part of routine provider practice.

Dental Records and Documentation

Dental records must be complete, legible, and maintained in compliance with all applicable federal and state laws. Records for active and inactive patients must be retained for the required retention period regardless of provider participation status.

Records must include:

- Medical and dental history as applicable
- Clinical examination findings
- Diagnostic images and interpretations
- Treatment plans and progress notes
- Documentation supporting medical necessity

Entries must be signed and dated by the treating provider. Corrections or amendments must clearly identify the author and date of the change.

Failure to maintain adequate records may result in corrective action.

Need coverage clarification?



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Informed Consent Process

Providers must document that all recommended treatment options have been discussed with the member, including:

- Risks and benefits
- Alternatives
- Likelihood of success
- Financial responsibility

Informed consent must be signed and dated by the member and the provider prior to treatment. Refusal of recommended treatment must be documented.

Private pay agreements for non-covered services must be established prior to treatment and clearly documented. Members must be informed of alternative treatment plans, including for covered procedures.

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Medical Necessity

For purposes of these guidelines, a dental service may be clinically indicated based on the member's oral condition; however, under Original Medicare, most routine dental services remain excluded from coverage. Medicare payment may be available only when the dental service is inextricably linked to, and substantially related and integral to, the clinical success of a Medicare-covered medical service, or when another specific CMS-recognized exception applies.

Services must:

- Be supported by documentation of the diagnosis, symptoms, clinical findings, and treatment rationale
- Be clinically appropriate, not primarily cosmetic, and consistent with accepted standards of care
- When billed to Original Medicare, satisfy applicable CMS coverage requirements, including documentation that the service is integral to a covered medical service when required
- Be furnished in the most appropriate setting with sufficient records to support medical necessity and claim submission

Certain dental services require clinical review to determine coverage and medical necessity. Review criteria must be applied consistently with the member's specific plan benefits, including any Medicare Advantage supplemental dental coverage, and with applicable CMS coverage rules when Medicare coverage standards govern the service. When a provider seeks Medicare payment for a dental service under one of these exceptions, the record should clearly identify the related Medicare-covered medical service, the clinical relationship between the dental service and the success of that medical treatment, the timing of the dental service relative to the medical treatment, and any supporting diagnostic findings. Where applicable, claims submission must follow current CMS billing instructions, including modifier and diagnosis-code requirements effective for applicable claim formats and dates of service.

Providers must submit complete clinical documentation, including, as applicable, clinical notes, diagnostic imaging, treatment rationale, and records identifying the related covered medical service when the dental service is being requested under a CMS-recognized Medicare exception.

Emergency services may be rendered without prior authorization when necessary, with documentation submitted for retrospective review.

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Clinical Oral Evaluation

Clinical oral evaluations must be performed in accordance with CDT definitions and support diagnosis and treatment planning. Frequency limitations and benefit restrictions apply per plan provisions.

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Diagnostic Imaging

Diagnostic imaging must be clinically indicated and of diagnostic quality, following ADA and FDA guidelines for Dental Radiographic Examinations. Images must be labeled and retained as part of the patient record. Any patient refusal of radiographs must be documented in the dental record.

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Preventive Services

Preventive services aim to prevent the development or progression of oral disease and may include prophylaxis, fluoride treatments, sealants, caries risk assessment, and patient education. Under Medicare, these routine preventive dental services are generally excluded from coverage unless furnished under a Medicare Advantage supplemental benefit or another applicable coverage provision.

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Restorative Treatment

Restorative services may be clinically indicated for teeth with documented caries, fracture, or defective restorations. Under Medicare, restorative treatment is generally non-covered unless it qualifies under a specific CMS-recognized dental exception related to a covered medical service or is otherwise available through a Medicare Advantage supplemental dental benefit. Crowns are indicated when more than 50% of tooth structure is compromised, a posterior tooth is endodontically treated, and the tooth has a favorable prognosis.

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Endodontics

Endodontic treatment must be supported by documented pulpal and periapical diagnosis, diagnostic imaging, and evidence of restorability.

Teeth with untreated advanced periodontal disease or poor prognosis are not candidates for endodontic therapy.

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Periodontics

Periodontal evaluation and treatment must be based on probing depths, radiographic evidence of bone loss, and clinical inflammation.

Scaling and root planing, maintenance, and surgical services must follow accepted clinical sequencing and documentation standards.

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Removable Prosthodontics

Removable prosthetic services must restore function and be appropriate based on the condition of remaining dentition and periodontal support.

Replacement is not covered when an appliance is serviceable through repair or reline. Under Medicare, removable prosthetic services such as dentures are generally excluded unless another specific CMS-covered exception applies.

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Dental Implants

Dental Implants are limited benefit and must be appropriate based on condition of remaining dentition, periodontal support, and favorable long term prognosis based on member's medical and dental history. Frequency limitations and benefit restrictions apply per plan provisions.

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Fixed Prosthodontics

Fixed prostheses must be supported by abutment teeth with favorable prognosis and adequate bone support. Untreated periodontal disease contraindicates treatment. Under Medicare, fixed prosthodontic services are generally excluded unless another specific CMS-covered exception applies.

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Oral Surgery

Extractions and surgical procedures must be supported by documented pathology, infection, or functional impairment. Under Medicare, routine or prophylactic dental extractions are generally non-covered; however, extractions or other oral surgical services may be covered when they are medically necessary and integral to the clinical success of a covered medical service recognized by CMS.

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Adjunctive General Services

Adjunctive services such as palliative treatment, sedation, and desensitization must be medically necessary and appropriately documented.

Providers must document anesthesia start and stop times and medical necessity for advanced sedation or general anesthesia.

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Retrospective Review

Both prospective and retrospective reviews require documentation supporting medical necessity. Objective clinical evidence takes precedence over narrative descriptions.

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Professional Judgment Disclaimer

These guidelines are intended as clinical guidance only. Individual treatment decisions must be based on the treating provider's professional judgment and the member's specific clinical circumstances. Coverage is determined under the member's applicable benefit plan and governing law; for Medicare-covered services, CMS statutes, regulations, manuals, and other controlling guidance prevail over any inconsistent statement in these guidelines.

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