

## Dental Clinical Policy: Indirect Fixed Prosthodontic Restorations

Reference Number: CP.DP.37

[Coding Implications](#)

Last Review Date: 12/23

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

### Description

Indirect fixed prosthodontic restorations (retainer crowns, inlays, and onlays) are those that are fabricated outside the mouth. Indirect restorations are made on a replica of the prepared tooth in a dental laboratory or by using computer-aided design/computer-assisted manufacturing (CAD/CAM) either chairside or in the dental laboratory and finally cemented on to the prepared tooth. Local anesthetic, impressions, tooth preparation, temporary restoration, fitting, cementation, adjustment and any liners or bases are inclusive.

### Policy/Criteria

- I. It is the policy of Envolve Dental Inc.® that indirect fixed prosthodontic restorations are **medically necessary** when any of the following conditions are met:
  - A. Molars – extensive caries involving four or more surfaces, undermining or loss of two or more cusps, or 50% loss of clinical crown;
  - B. Premolars – extensive caries involving three or more surfaces, undermining of at least one cusp, or 50% loss of clinical crown;
  - C. Anterior teeth – extensive caries involving four or more surfaces, undermining or loss of at least 50% of the incisal angle, or 50% loss of clinical crown;
  - D. Large, defective restorations on posterior teeth that will require a new restoration involving greater than 50% of the occlusal surface, and that can be seen on the radiographic image or intraoral photograph;
  - E. Fractures that extend to the root surface;
  - F. Endodontically treated posterior teeth;
  - G. Endodontically treated anterior teeth with loss of at least 50% of the clinical crown or 50% of the incisal edge;
  - H. Crown/root ratio must be favorable (at least 1:1);
  - I. Documentation/narrative that the failing existing crown can only be resolved with a new crown, if crown failure and/or recurrent decay is not visible on radiographic image or intraoral photograph;
  - J. Tooth has at least 50% remaining bone support;
  - K. Symptomatic “cracked tooth syndrome” cases require supporting documentation of a clinical diagnosis, including the following:
    1. Chart notes documenting the clinical evaluation of chief complaint, patient symptoms, and results of tests conducted;
    2. Endodontic evaluation of the tooth, including verification that a root fracture does not exist, and that irreversible pulpitis does not exist;
    3. Evidence that either a direct amalgam or bonded resin restoration cannot adequately restore the tooth;
  - L. Full coverage indirect restoration of a primary tooth without a permanent successor (or where a permanent successor cannot erupt) may be considered if the root structure is

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intact and adequate, periodontal support does not show a loss of bone support of more than 25%.

**M. When none of the following contraindications are present:**

1. When the patient is under the age of 15. This is due to incomplete passive eruption of the tooth, which will result in aesthetic failure and the need to replace the crown prior to its serviceable life span;
2. When the tooth restoration can be accomplished with a direct amalgam or bonded resin restoration;
3. When root resorption is present;
4. When solely for cosmetic/aesthetic reasons (peg teeth, diastema closure, discoloration);
5. When the purpose is for alteration of vertical dimension;
6. When the purpose is for preventing future fracture, or to eliminate enamel craze lines (cracked tooth syndrome must be diagnosed with documented diagnostic tests and supported by a narrative; tooth must be symptomatic);
7. When the purpose is to treat non-pathologic wear/abrasion, or abfraction lesions in the absence of decay;
8. When molars exhibit bone loss with a class II or III furcation involvement;
9. When there are periodontally compromised teeth (less than 50% remaining bone support), even with successful endodontics, unless the patient has undergone previous periodontal therapy/surgery and progress notes/periodontal notes indicate the tooth is stable;
10. When there is fracture of porcelain not involving the margin or a functional ridge of an existing crown or onlay is not sufficient for replacement;
11. When there Endodontically treated teeth exhibiting the following conditions:
  - a. Any canal is not filled to within 2.0 mm of the radiographic apex;
  - b. Any canal is overfilled by 2.0 mm or more from the radiographic apex;
  - c. Any canal is incompletely filled;
  - d. A radiolucency remains more than six months after root canal treatment and the tooth is symptomatic (documentation supporting asymptomatic conditions must be submitted).

**N. Required Documentation**

1. Recent (within 12 months) and dated diagnostic quality periapical radiographic image(s) clearing showing the clinical crown and all root apices;
2. Clinical chart notes supporting diagnostic and evaluation determinations;
3. Intra-oral photographs where necessary to support conditions not clearly represented with radiographs;
4. Intra-oral photographs where necessary to support conditions not clearly represented with radiographs;
5. Recent (within six months) and dated six-point periodontal charting and history of previous periodontal therapy is required when radiographic evidence of bone loss exists.

**Coverage Limitation/Exclusions**

- I. **Retainer Onlays are not a covered benefit unless specifically noted by state-specific regulation(s).**

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- a. When a state-regulated benefit, retainer onlays are indicated for posterior teeth only and under the same criteria as crowns;
  - b. When a state-regulated benefit, the required documentation required for review is the same as for crowns.
- II. **Retainer Inlays are not a covered benefit unless specifically noted by state-specific regulation(s).**
- a. Retainer inlays are allowed only when specifically noted by state-specific regulations; however, retainer inlays have not been proven to be superior to direct restorations and thus amalgam or bonded resin restorations are generally recommended instead of inlays.
- III. Retainer crowns, onlays, and inlays are covered once per tooth per 60 months for Medicaid and 84 months for Medicare unless specified otherwise by state Medicaid or federal Medicare regulations.
- IV. Replacement of retainer crowns, onlays, or inlays, if damage or breakage was directly related to provider error, is the responsibility of the dentist.
- V. If replacement is necessary because of patient non-compliance and the patient is deemed capable of compliance, the patient is liable for the cost of replacement.
- VI. Subject to state-specific regulations.

**Coding Implications**

This clinical policy references Current Dental Terminology (CDT®). CDT® is a registered trademark of the American Dental Association. All CDT codes and descriptions are copyrighted 2023, American Dental Association. All rights reserved. CDT codes and CDT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CDT® Codes	Description
D6600	Retainer inlay – porcelain/ceramic, two surfaces
D6601	Retainer inlay – porcelain/ceramic, two surfaces
D6602	Retainer inlay – cast high noble metal, two surfaces
D6603	Retainer inlay – cast high noble metal, three or more surfaces
D6604	Retainer inlay – cast predominantly base metal, two surfaces
D6605	Retainer inlay – cast predominantly base metal, three or more surfaces
D6606	Retainer inlay – cast noble metal, two surfaces
D6607	Retainer inlay – cast noble metal, three or more surfaces
D6624	Retainer inlay - titanium
D6608	Retainer onlay – porcelain/ceramic, two surfaces
D6609	Retainer onlay – porcelain/ceramic, three or more surfaces
D6610	Retainer onlay – cast high noble metal, two surfaces
D6611	Retainer onlay – cast high noble metal, three or more surfaces
D6612	Retainer onlay – cast predominantly base metal, two surfaces
D6613	Retainer onlay – cast predominantly base metal, three or more surfaces

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<b>CDT® Codes</b>	<b>Description</b>
D6614	Retainer onlay – cast noble metal, two surfaces
D6615	Retainer onlay – cast noble metal, two surfaces
D6634	Retainer onlay – titanium
D6710	Retainer crown – resin-based composite (indirect)
D6720	Retainer crown – resin with high noble metal
D6721	Retainer crown – resin with predominantly base metal
D6722	Retainer crown – resin with noble metal
D6740	Retainer crown – porcelain/ceramic
D6750	Retainer crown – porcelain fused to high noble metal
D6751	Retainer crown – porcelain fused to predominantly base metal
D6752	Retainer crown – porcelain fused to noble metal
D6753	Retainer crown – porcelain fused to titanium and titanium alloys
D6780	Retainer crown – ¾ cast high noble metal
D6781	Retainer crown – ¾ cast predominantly base metal
D6782	Retainer crown – ¾ cast noble metal
D6783	Retainer crown – ¾ porcelain/ceramic
D6784	Retainer crown – ¾ titanium and titanium alloys
D6790	Retainer crown – full cast high noble metal
D6791	Retainer crown – full cast predominantly base metal
D6792	Retainer crown – full cast noble metal
D6794	Retainer crown – titanium and titanium alloys
D6793	Interim retainer crown – further treatment or completion of diagnosis necessary prior to final impression

**ICD-10-CM Diagnosis Codes that Support Coverage Criteria**

<b>ICD-10-CM Code</b>	<b>Description</b>
K02.52	Dental caries on pit and fissure surface penetrating into dentin
K02.53	Dental caries on pit and fissure surface penetrating into pulp
K02.62	Dental caries on smooth surface penetrating into dentin
K02.63	Dental caries on smooth surface penetrating into pulp
K02.7	Dental root caries
K02.9	Dental carries, unspecified
K03.2	Erosion of teeth
K03.81	Cracked tooth
K03.89	Other specified diseases of hard tissues of teeth
K03.9	Disease of hard tissues of teeth, unspecified
S02.5XXA	Fracture of tooth (traumatic), initial encounter for closed fracture
S02.5XXB	Fracture of tooth (traumatic), initial encounter for open fracture
S02.5XXD	Fracture of tooth (traumatic), subsequent encounter for fracture with routine healing

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ICD-10-CM Code	Description
S02.5XXG	Fracture of tooth (traumatic), subsequent encounter for fracture with delayed healing
S02.5XXK	Fracture of tooth (traumatic), subsequent encounter for fracture with nonunion
S02.5XXS	Fracture of tooth (traumatic), sequela

Reviews, Revisions, and Approvals	Date	Approval Date
Format changes	06/20	06/20
Update clinical indications and contraindications	05/20	05/20
Update clinical indications and references	04/20	04/20
Revise indications for coverage	10/19	10/19
Annual Review	12/22	12/22
Code modifications to retainers	03/23	03/23
Annual Review	12/23	12/23

**References**

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3. American Dental Association (ADA). Glossary of Clinical and Administrative Terms. Angeletaki F, Gkogkos A, Papazoglou E, Kloukos D. Direct versus indirect inlay/onlay composite restorations in posterior teeth. A systematic review and meta-analysis. J Dent. 2016 Oct; 53:12-21.
4. da Veiga AM, Cunha AC, Ferreira DM, et al. Longevity of direct and indirect resin composite restorations in permanent posterior teeth: A systematic review and meta-analysis. J Dent. 2016 Nov; 54:1-12.
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7. Pallesen U, Qvist, V. Composite fillings and inlays: An 11 year evaluation. Clin Oral Invest.2003; 7:71–79.
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**Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of dental practice; peer-reviewed dental/medical literature; government

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agency/program approval status; evidence-based guidelines and positions of leading national dental and health professional organizations; views of dentists practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. Envolve Dental makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of dental practice current at the time that this clinical policy was approved. “Envolve Dental” means a dental plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Envolve Benefit Options, Inc, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to dental and medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Envolve Dental administrative policies and procedures.

This clinical policy is effective as of the date determined by Envolve Dental. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Envolve Dental retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

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**Note: For Medicaid members,** when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence.

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Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

**Note: For Medicare members,** to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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