# Delta Dental of New Jersey Clinical Policy #2015-04000-00005

<table>
<thead>
<tr>
<th>Subject</th>
<th>Originating Department</th>
<th>Signature Authority</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distal Wedge</td>
<td>Professional Services</td>
<td>Dental Director/Chief Clinical Officer</td>
</tr>
</tbody>
</table>

**Type:** √ New  □ Replacement  □ Revision  □ Clarification

**Date:** 7/14/2014  **Revision Date:** ____________

**Preamble:**

The Clinical Policy Bulletin is an expression of Delta Dental of New Jersey’s (DDNJ) determination regarding whether certain services or supplies are medically or dentally necessary. Its dental consultants also consider their training and experience in determining medical/clinical necessary. Although each source is not necessarily applied in the development of each and every criterion the clinical policies consider the following sources:

- Appropriate peer review dental literature
- Published standards of professional organizations
- Input from dentists and Delta Dental dental directors and dental consultants
- Input from the DeltaUSA Scientific Advisory Committee
- Changes to the CDT (updated annually)
- The DeltaUSA Dental Consultant Manual

The enrollee’s Certificate of Coverage defines covered services as well as other limits. DDNJ advises dentists and enrollees to consult the plan documents to determine if there are exclusions or other benefit limitations applicable to the service request. The conclusion that a particular service is medically or dentally necessary does not constitute an indication or warranty that the service requested is a covered benefit payable by DDNJ. Some plans exclude coverage for services that DDNJ considers either medically or dentally necessary. When there is a discrepancy between DDNJ’s clinical policy and the enrollee’s plan documents, DDNJ will defer to the enrollee’s plan documents as to whether the dental service is a covered benefit.

---

Distal Wedge
| Policy Therapy/Guidelines: | a. Indicated in edentulous areas that are the distal surface of molars if deep pockets persists due to the inaccessibility of patients to keep the area clean \(^{(1)}\).
b. Indicated to allow access for scaling and root planning, and flushing of the area \(^{(1)}\).
c. Indicated if irregular bone deformities exists or distal furcation of maxillary molars are involved and patient cannot keep furcation area clean \(^{(1)}\). |
| --- | --- |