Delta Dental of New Jersey Clinical Policy #2015-03000-00004

Subject
Vital Pulpotomy, Apexification, Reimplantation of Avulsions and Placement of Posts and Cores on Primary Teeth

Originating Department
Professional Services

Signature Authority
Dental Director/Chief Clinical Officer

Type: √ New ☐ Replacement ☐ Revision ☐ Clarification

Date: 1/27/2014

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.
**Policy Therapy/Guidelines:**  

a. Any planned treatment should include consideration of:  
   1. the patient’s medical history;  
   2. the value of each involved tooth in relation to the child’s overall development;  
   3. alternatives to pulp treatment; and  
   4. restorability of the tooth.  

b. The pulpotomy procedure is indicated when caries removal results in pulp exposure in a primary tooth with a normal pulp or reversible pulpitis or after a traumatic pulp exposure. The coronal tissue is amputated, and the remaining radicular tissue is judged to be vital without suppuration, purulence, necrosis, or excessive hemorrhage that cannot be controlled by a damp cotton pellet after several minutes, and there are no radiographic signs of infection or pathologic resorption.  

c. Apexification, reimplantation of avulsions, and placement of prefabricated post and cores are not indicated for primary teeth.  

d. Primary teeth with insufficient root structure, internal resorption, furcal perforation or periradicular pathosis that may jeopardize the permanent successor are not indicated for pulpotomy procedures.  

**References:**  