



Clinical Guideline

Subject: Veneers

Guideline #: 02-902

Status: New

Current Effective Date: 03/24/2017

Last Review Date: 02/08/2017

Description

This document addresses the procedure of placement of a dental veneer.

Note: Please refer to the following documents for additional information concerning related topics:

Crown Build-up – 02-901

Clinical Indications

Medically Necessary: The placement of veneers is a conservative method that restores function and is considered medically necessary when teeth have been damaged as a result of an injury causing significant loss of tooth structure, not minor loss of incisal edge/angle that can be restored by other means of the anterior teeth.

Medically/Dentally Necessary or Medical/Dental Necessity means Medical/Dental Services that are:

(1) Consistent with the Member's diagnosis or condition;

(2) Is rendered:

- (A) In response to a life-threatening condition or pain; or
- (B) To treat an injury, illness or infection related to the dentition; or
- (C) To achieve a level of function to the dentition consistent with prevailing community standards for the diagnosis or condition.

Not Medically Necessary: When the placement of a veneer addresses tooth staining as a result of root canal or drug therapy; uneven or misaligned anterior teeth; teeth with gaps; congenitally malformed teeth or when performed for any condition that addresses cosmetic concerns.

Note: Whether a service is covered by the plan, when any service is performed in conjunction with or in preparation for a non-covered or denied service, all related services are also either not covered or denied.

Criteria

To qualify for veneer restorations, all of the following criteria must be met:

1. Placement of veneers must be necessary, appropriate and meet generally accepted standards of care.
2. Must have a reasonable prognosis for success.
3. Must have fully intact lingual surfaces on anterior teeth that can support veneer placement when there are large areas of decay. When areas of decay are considered too large, a full crown may be the more appropriate restoration.
4. The periodontal health and long term prognosis of the teeth must be considered. Placement of veneers on teeth with uncontrolled or untreated periodontal disease creates a condition that leads to a compromised long term prognosis and is not appropriate. Documentation relative to the history of definitive periodontal treatment is required.
5. To be considered for a labial veneer, a tooth must demonstrate significant loss of tooth structure.
 - a. The degree of tooth breakdown must be documented radiographically, by report, and photographically, when available.
6. Replacement of defective veneers (e.g. – veneers that have become defective after initial placement as a result of normal wear, fracture or caries based on contractual frequency limitations).
7. Placement of veneers are not considered;
 - a. for cosmetic purposes
 - b. for correction of congenital/developmental problems
 - c. for correction of tooth size discrepancies.
8. Restorative procedures for repair of complications from wear, attrition, abrasion, erosion, and abfraction do not meet contractual criteria for treatment.

Note: Veneers are not appropriate restorations for patients who demonstrate severe bruxism or grinding as this condition places undue stress on the restoration compromising long term prognosis of the restoration.

Coding

The following codes for treatments and procedures applicable to this document are included below for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

CDT Including, but not limited to, the following:

D2960	Labial veneer (resin laminate) – CHAIRSIDE
D2961	Labial veneer (resin laminate) – laboratory
D2962	Labial veneer (porcelain laminate)- laboratory

CPT

41899	Unlisted procedure, dentoalveolar structures
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ICD-10 Diagnosis

K00.3	Mottled teeth
K03.6	Deposits (accretions) on teeth
K00.5	Hereditary disturbances in tooth structure, not elsewhere classified
K00.8	Other disorders of tooth development
K02.6	Dental caries on smooth surface
K02.61	Dental caries on smooth surface limited to enamel
K03.0	Excessive attrition of teeth
K03.1	Abrasion of teeth
K03.2	Erosion of teeth
K03.4	Hypercementosis

K03.6	Deposits (accretions) on teeth
K03.7	Posteruptive color changes of dental hard tissues
K04.1	Necrosis of pulp
K08.5	Unsatisfactory restoration of tooth
K08.59	Other unsatisfactory restoration of teeth

Discussion/General Information

Veneers are thin, custom-made shells crafted of tooth-colored materials designed to cover the front side of teeth. They may be used to cosmetically correct stained, fractured, decayed or crooked teeth. Veneers can be made chairside by the dentist or can be created by a dental laboratory technician. The dental laboratory technician creates the veneers working from a model provided by the dentist. The placement of veneers is typically an irreversible process because a small amount of enamel is removed from the facial (front) surface of the tooth to be able to accept the shell.

Veneers are frequently used to fix teeth that can be discolored as a result of a dying nerve causing the tooth to internally change color or from tooth discoloration as a result of root canal therapy as well as stains from drugs such as tetracycline, excessive fluoride ingestion or the presence of large resin fillings that have discolored the tooth. Veneers can also replace missing tooth structure resulting from wear or fracture. Dental veneers can also be considered cosmetic to correct misalignment of or misshapen teeth and can artificially close diastemas (gaps) between teeth.

Due to the cosmetic nature of veneers, dental plans may consider the placement of veneers cosmetic. When replacing missing tooth structure such as occurs when teeth are fractured, a veneer can be considered a more conservative approach to restoring a tooth to functionality.

Note:

A group may define covered dental services under either their dental or medical plan, as well as to define those services that may be subject to dollar caps or other limits. The plan documents outline covered benefits, exclusions and limitations. The health plan 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 the health plan. Some plans exclude coverage for services that the health plan considers either medically or dentally necessary. When there is a discrepancy between the health plan's clinical policy and the group's plan documents, the health plan will defer to the group's plan documents as to whether the dental service is a covered benefit. In addition, if state or federal regulations mandate coverage then the health plan will adhere to the applicable regulatory requirement.

Definitions

Anterior teeth - defined as canine (cuspid) to canine (cuspid)

Attrition – a type of tooth wear caused by incisal end to end contact leading to loss of tooth enamel tissue, usually starting at the incisal or occlusal surfaces.

Abrasion – loss of tooth structure by mechanical forces from a foreign element.

Abfraction – a form of non-carious tooth tissue loss that occurs along the gingival margin

Incisal Angle – the angle formed with edge and side of an anterior tooth

Veneer - a layer of material placed on the labial or cheek surface of a tooth to either improve the esthetics of a tooth or to protect the tooth from additional damage

References

Peer Reviewed Publications:

1. Porcelain veneers: a review of the literature ; Peumans M, Van Meerbeek B, Lambrechts P, Vanherle G; Journal of Dent. 2000 Mar; 28(3):163-77.
2. Guideline on Pediatric Restorative Dentistry; Originating Committee Clinical Affairs Committee – Restorative Dentistry Subcommittee Review Council; American Academy of Pediatric Dentistry (AAPD); Council on Clinical Affairs Adopted 1991 Revised 1998, 2001, 2004, 2008

. Government Agency, Medical Society, and Other Authoritative Publications:

1. Efficacy of E-max porcelain laminate veneer on esthetic restoration for anterior teeth over 2 years; Zhang N1, Tao LS, Zhang XD.; PubMed.gov; 2013 Dec;22(6):705-7.

History

Status	Date	Action
Reviewed	11/09/2016	

Federal and State law, as well as contract language, and Dental Policy take precedence over Clinical UM Guidelines. We reserve the right to review and update Clinical UM Guidelines periodically. Clinical guidelines approved by the Clinical Policy Committee are available for general adoption by plans or lines of business for consistent review of the medical or dental necessity of services related to the clinical guideline when the plan performs utilization review for the subject. Due to variances in utilization patterns, each plan may choose whether to implement a particular Clinical UM Guideline. To determine if review is required for this Clinical UM Guideline, please contact the customer service number on the member's card.

Alternatively, commercial or FEP plans or lines of business which determine there is not a need to adopt the guideline to review services generally across all providers delivering services to Plan's or line of business's members may instead use the clinical guideline for provider education and/or to review the medical or dental necessity of services for any provider who has been notified that his/her/its claims will be reviewed for medical or dental necessity due to billing practices or claims that are not consistent with other providers, in terms of frequency or in some other manner.

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