

Blue Cross Blue Shield Of Arizona Health Choice Dental Clinical Review Criteria

Department	Utilization Management
Policy Number	D0007
Subject	Pulp Therapy, Root Canal Treatment, and Referrals
Attachments	None

Overview:

This clinical policy provides guidance for benefit administration and medical and dental necessity determinations related to pulp therapy and endodontic services. Coverage determinations are subject to the member's benefit plan, applicable state and federal regulations, and do not guarantee payment or clinical outcomes.

Blue Cross Blue Shield of Arizona Health Choice provides coverage for endodontic procedures, including pulp therapy and root canal therapy, for primary and permanent teeth when medically and dentally necessary. Covered indications include the treatment of acute infection or the relief of pain associated with dental caries involving the pulp; restorative procedures that compromise pulpal tissues; failed restorations; tooth fractures; and traumatic dental injuries.

Endodontic treatment for third molars is excluded unless the tooth is functioning in place of a missing second molar.

Vital Pulp Therapy

Direct Pulp Capping

A radiopaque capping material is placed directly onto the surface of vital pulp tissue at the exposure site. The final restoration is placed over the base. The status of the pulp and periradicular tissues should be assessed through periodic recall examinations.

Criteria

Direct pulp capping is considered medically or dentally necessary when all of the following criteria are met:

- A mechanical exposure of a clinically vital pulp is present, and the tooth is asymptomatic.
- Bleeding at the exposure site can be adequately controlled.
- The pulp exposure allows the capping material to be placed in direct contact with the vital pulp tissue.
- The pulp exposure occurs while the tooth is properly isolated.

Indirect Pulp Capping

A procedure performed on a tooth with deep caries near the pulp but without radicular pathology. The deepest caries is left to avoid pulp exposure and covered with a

biocompatible, radiopaque liner to arrest caries and promote reparative dentin formation. The tooth is then restored to ensure a sound seal.

Criteria

Indirect pulp capping is considered medically or dentally necessary under this policy for permanent teeth with immature apices when all of the following criteria are met:

- A deep carious lesion is present, and complete excavation is likely to result in pulp exposure.
- The tooth exhibits a vital pulp with no pretreatment symptoms indicative of irreversible pulpitis.
- There are no radiographic signs of periapical pathology.

Partial Pulpotomy For Apexogenesis

Vital pulp therapy performed to allow continued physiological development and formation of the root. The procedure involves removal of a portion of pulp tissue and placement of a medicament to maintain vitality of the remaining pulp.

Criteria

Apexogenesis is considered medically or dentally necessary for permanent teeth with immature apices when all of the following criteria are met:

- The tooth has a deep carious lesion likely to result in pulp exposure during excavation.
- No pretreatment symptoms were reported.
- No radiographic evidence of periapical pathology.
- Mechanical pulp exposure of a clinically vital, asymptomatic pulp occurs.
- Bleeding at the exposure site can be adequately controlled.

Pulpotomy

Pulpotomy involves removal of the coronal portion of vital pulp tissue, placement of a biologically compatible material in the pulp chamber, and restoration of the tooth to maintain vitality of the remaining healthy pulp tissue.

Criteria

Pulpotomy is considered medically or dentally necessary when any of the following criteria are met:

- Exposed vital pulp or irreversible pulpitis of primary teeth.
- The tooth is clinically determined to be vital.
- Traumatic pulp exposure with no radiographic signs of infection or pathologic resorption.
- As an emergency procedure in a permanent tooth until root canal therapy can be completed.
- Caries extends to or in close proximity to the dental pulp.

Contraindications

- Root resorption (internal or external), including primary teeth with insufficient remaining root structure.

- Inadequate periodontal bone support or insufficient remaining coronal structure to allow restoration.
- Primary teeth with furcal perforation or periapical pathology that may jeopardize the permanent successor.
- Periodontal furcation involvement.
- Unless otherwise stated, pulpotomy is not considered the first stage of root canal therapy.

Pulpal Debridement, Primary Or Permanent Teeth

Pulpal debridement involves complete removal of pulp tissue and is performed as a temporary or emergency procedure.

Criteria

Pulpal debridement is considered medically or dentally necessary when all of the following criteria are met:

- The procedure is performed as a stand-alone emergency service for the relief of acute pain.
- Removal of pulpal tissue is required prior to conventional root canal therapy.
- Complete endodontic treatment cannot be completed at the same visit.
- The member will be subsequently referred for definitive root canal treatment.

Contraindications

- When endodontic treatment is completed on the same date of service.

Non- Surgical Endodontic

Pulpal Therapy (Resorbable Filling) – Primary Teeth

This procedure includes pulpectomy, cleaning of canals, and placement of a resorbable filling material in primary teeth with succedaneous teeth.

Criteria

Pulpal therapy with resorbable filling is considered medically or dentally necessary when all of the following criteria are met:

- A restorable primary tooth with irreversible pulpitis
- Pulpal necrosis with or without evidence of periapical pathology
- Treatment will not jeopardize the permanent successor

Contraindications

- Root resorption (internal or external), including primary teeth with insufficient remaining root structure, is present

Endodontic Therapy (Including Treatment Plan, Clinical Procedures And Follow-Up Care)

Endodontic therapy includes complete root canal treatment for primary teeth without succedaneous teeth and permanent teeth. All appointments and intra-operative radiographs required to complete treatment are included.

Endodontic Therapy – Included Services

Endodontic therapy (root canal treatment) is a comprehensive procedure that includes all steps necessary to access, isolate, clean, shape, disinfect, and obturate the root canal system.

The following services are considered integral components of endodontic therapy and are not separately reimbursable:

- Local anesthesia and pain control
- Placement and use of a rubber dam for isolation
- Access preparation
- Mechanical instrumentation (hand or rotary files)
- Chemical irrigation and canal disinfection
- Intracanal medicaments placed during treatment
- Canal obturation and sealing

Supplies, materials, and adjunctive techniques used to complete the procedure are considered inclusive of the primary endodontic service.

Separate reimbursement is not allowed for services that are routine components of root canal therapy.

Criteria

Endodontic Therapy is considered medically or dentally necessary when any of the following criteria are met:

- Symptomatic or asymptomatic irreversible pulpitis, with or without evidence of periapical pathology.
- Necrotic pulp with or without periapical pathology.
- Teeth where the pulp is at risk of exposure or compromise due to caries removal.
- Cracked or fractured teeth with pulpal involvement.

Additionally, all of the following must apply:

- Apex must be closed.
- The tooth has at least 50 percent remaining alveolar bone support and adequate sound coronal structure for restoration.
- Arch integrity is present, and opposing dentition exists and is in good dental health.

- Arch integrity exists when the following conditions are met:
 - All anterior teeth are present (a fixed appliance replacing one or more anterior teeth is acceptable) and
 - All first and second bicuspid and first molars are present and free of overt periodontal disease and do not require endodontic treatment (a removable or fixed appliance replacing one or more of these teeth is acceptable)
 - Second and third molars may or may not be present
 - Opposing tooth must be present and free of overt periodontal disease and does not require endodontic treatment

Contraindications

- Less than 50 percent alveolar bone support, furcation involvement, or advanced periodontal disease compromising prognosis.
- Caries or structural compromise extending to within 2.0 mm of the crestal bone, below the crestal bone, or into the furcation, rendering the tooth non-restorable
- Compromised arch integrity or absence of functional opposing dentition.
- Third molars, unless fully erupted and functioning in place of a missing second molar.
- Loss of root integrity due to fracture or resorption.
- When a more appropriate alternative treatment is indicated based on professionally accepted standards of care.

Prior authorization requests for root canal treatment on multiple teeth may be subject to alternative treatment when the overall dental condition of the member is such that an alternative treatment plan would be better suited to meet the member's needs.

Retreatment Of Endodontic Therapy

Endodontic retreatment must be performed by an endodontist.

Criteria

Retreatment or further endodontic intervention is considered medically or dentally necessary when any of the following criteria are met:

- Persistent or worsening periapical pathology, with clinical symptoms.
- Inadequate canal obturation, including:
 - Canal fill that terminates more than 2 mm short of the radiographic apex,
 - Canal fill that extends significantly beyond the apex, or
 - Incomplete canal fill
- Ongoing clinical symptoms, including sensitivity to pressure, percussion, or other reported symptoms.
- Radiographic evidence of persistent or enlarging periapical pathology
- Planned restorative or prosthetic treatment where prior endodontic therapy is questionable.

Contraindications

- The presence of both periapical and furcation involvement, rendering the tooth non-restorable

- Evidence of internal or external root resorption.
- Failure of a previously retreated tooth.

Treatment Of Root Canal Obstruction; Non-Surgical Access

A non-surgical approach is used instead of surgical intervention to manage a blocked root canal. A pathway is created to allow achievement of an apical seal in a non-negotiable root canal.

Criteria

- The root canal is obstructed by foreign material, including but not limited to:
 - Separated files or other instruments
 - Broken posts
 - Biological obstructions
 - Iatrogenic ledges
 - Calcification involving 50% or more of the root length

Required Documentation

- Clinical notes with detailed narratives
- Radiographs (properly angled images or CBCT scans) showing canal calcification, instrument fracture or separation, blockage by foreign material, or iatrogenic ledges.

Incomplete Endodontic Therapy; Inoperable Or Fractured Tooth

Considerable clinical time may be required to establish a diagnosis or attempt treatment before it is determined that a tooth is inoperable, non-restorable, or fractured. Endodontic therapy may be discontinued when, during treatment, it is determined that canal access cannot be achieved, the tooth is non-restorable, or a tooth fracture has occurred.

Limitations and Exclusions

- D3332 is not an AHCCCS/Blue Cross Blue Shield of Arizona Health Choice covered service under the adult dental emergency for Medicaid members 21 years of age and older.
- D3332 is not a Health Choice Pathway covered service under the Supplemental dental benefits.

Apexification

The inducement of the root end closure of a non-vital permanent tooth open apex. Apical closure may be considered in cases when endodontic therapy is indicated on permanent with incompletely formed apices. The type of procedure(s) used to induce root end closure will be dictated by the clinical and radiographic presentation. Up to three visits may be allowed for apexification. However, if root end closure is accomplished at the initial or the intermediate visit, then additional apexification visits will not be allowed.

Surgical Endodontic Therapy

Apicoectomy

The excision of the apical portion of the tooth root and attached soft tissue to achieve a flat surface in order to promote repair of soft and hard tissue.

Criteria

Apicoectomy is considered medically or dentally necessary when any of the following criteria are met:

- Failed endodontic retreatment with persistent symptoms and pathology.
- Root canal filling material extending beyond the end of the root (over fill) that interferes with normal healing.
- Inability to fully reach, clean, or seal the tip of the tooth root without surgery due to calcification, infection, or other structural abnormalities.
- Need for direct visualization of the tissues around the root when a root perforation or fracture is suspected.
- Surgical intervention is required to remove infected tissue, obtain a biopsy, or access an additional root that cannot be treated without surgery.

Contraindications

- Asymptomatic non pathologic poorly filled teeth.
- Caries or structural compromise extending to within 2.0 mm of the crestal bone, below the crestal bone, or into the furcation, rendering the tooth non-restorable.
- Less than fifty percent (50%) remaining alveolar bone support, furcation involvement, and/or advanced periodontal disease compromising tooth prognosis.
- Unusual bone or root morphology hindering surgical access.
- Involvement or risk to neurovascular structures (e.g., inferior alveolar nerve, nasopalatine nerve and blood vessels).
- Root resorption is present (external or internal).

Required Documentation

- Current, diagnostic-quality periapical radiographs that clearly display the full clinical crown and all root apices.
- Clinical records and progress notes that support the diagnosis, evaluation, and treatment planning decisions.
- Intraoral photographs, as appropriate, to document clinical conditions not adequately demonstrated on radiographs.
- Cone Beam Computed Tomography (CBCT) imaging, when clinically indicated, to assist with detailed evaluation and treatment planning.

Coding/Billing

The codes listed in this policy are for reference purposes only. Listing of a code in this policy does not imply that the service described by this code is a covered or non-covered health service. Coverage is determined by dental necessity criteria and specific benefit plans or other regulatory conditions. This list of codes may not be all inclusive.

CDT codes

Key:

C = Covered service

N = Non-covered service

Code	Description	Medicaid Under 21	Medicaid 21+	Medicare HCP
D3110	Pulp cap - direct (excluding final restoration)	C	C	C
D3120	Pulp cap – indirect (excluding final restoration)	C	C	N
D3220	Therapeutic pulpotomy (excluding final restoration)	C	C	N
D3221	Pulpal debridement, primary and permanent teeth	C	C	C
D3222	Partial pulpotomy for apexogenesis	C	N	N
D3230	Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)	C	N	N
D3240	Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)	C	N	N

D3310	Endodontic therapy, anterior tooth (excluding final restoration)	C	C	C
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	C	C	C
D3330	Endodontic therapy, molar tooth (excluding final restoration)	C	C	C
D3331	Treatment of root canal obstruction; non-surgical access	C	C	C
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	C	N	N
D3333	Internal root repair of perforation defects; non-surgical	C	C	N
D3346	Retreatment of previous root canal therapy- anterior	C	C	C
D3347	Retreatment of previous root canal therapy - premolar	C	C	C
D3348	Retreatment of previous root canal therapy- molar	C	C	C
D3351	Apexification/recalcification - initial visit	C	N	N
D3352	Apexification/recalcification - interim	C	N	N
D3353	Apexification/recalcification-final visit	C	N	N
D3410	Apicoectomy - anterior	C	C	N
D3421	Apicoectomy - premolar (first root)	C	C	N
D3425	Apicoectomy - molar (first root)	C	C	N
D3426	Apicoectomy (each additional root)	C	C	N
D3430	Retrograde filling-per root	C	C	N
D3450	Root amputation-per root	C	N	N
D3471	Surgical repair of root resorption - anterior	C	C	N
D3472	Surgical repair of root resorption - premolar	C	C	N
D3473	Surgical repair of root resorption - molar	C	C	N
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption- anterior	C	C	N
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption- premolar	C	C	N

D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption-molar	C	C	N
D3920	Hemisection (including any root removal), not including root canal therapy	C	N	N
D3921	Decoronation or submergence of an erupted tooth	C	C	N
D3999	Unspecified endodontic procedure, by report	C	N	N

The following CDT codes are not covered:

Codes	Description
D3355	Pulpal regeneration – initial visit
D3356	Pulpal regeneration – interim medication replacement
D3357	Pulpal regeneration – completion of treatment
D3428	Bone graft in conjunction with periradicular surgery – per tooth, single site
D3429	Bone graft in conjunction with periradicular surgery – each additional contiguous tooth in the same surgical site
D3431	Biologic materials to aid in soft and osseous tissue regeneration in conjunction with periradicular surgery
D3432	Guided tissue regeneration, resorbable barrier, per site, in conjunction with periradicular surgery
D3460	Endodontic endosseous implant
D3470	Intentional reimplantation (including necessary splinting)
D3910	Surgical procedure for isolation of tooth with rubber dam
D3911	Intraorifice barrier
D3950	Canal preparation and fitting of preformed dowel or post

References

- American Dental Association. CDT 2026 Current Dental Procedures (2026).
- American Academy of Pediatric Dentistry. Pulp therapy for primary and immature permanent teeth. The Reference Manual of Pediatric Dentistry. Chicago, IL: American Academy of Pediatric Dentistry; 2025:487-96.
- American Academy of Pediatric Dentistry. Use of Vital Pulp Therapies in Primary Teeth 2024
- American Association of Endodontists (AAE). Glossary of Endodontic Terms. 10th edition. 2020.
- American Association of Endodontists (AAE). Guide to Clinical Endodontics, 6th edition. Updated 2019
- American Association of Endodontists (AAE). Vital Pulp Therapy, 2021.

- AHCCCS Medical Policy Manual Chapter 400 – Maternal and Child Health 431- Oral Health Care for Early and Periodic Screening, Diagnosis and Treatment Aged Members.
- AHCCCS Medical Policy Manual Chapter 300-Covered Services- 310-D1– Dental Services for Members 21Years of Age And Older.
- Health Choice Pathway 2026 CPT and CDT codes for Supplemental Benefits.

Policy History/Review Date:

Developed Date	10/27/2004
Last Review Date	05/2026
Next Review Date	05/2027

This policy will be reviewed on an annual basis.