

Tri-Service Remote Dental Program

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The Tri-Service Remote Dental Program (RDP) provides Department of Defense (DoD) active duty service members (ADSMs) living and working more than 50 miles from active duty dental treatment facilities (DTFs) access to appropriate and needed dental care to establish and maintain dental health to ensure world-wide deployability and maintainability. Service members on continuous active duty orders for more than 30 days and enrolled in TRICARE Prime Remote for medical coverage are automatically eligible for RDP benefits. When a service member separates from active duty they are no longer eligible for RDP benefits, including any treatment that may have been authorized or initiated while on active duty. Therefore, all treatment initiated must be completed (not just initiated for billing purposes) before separation or retirement from continuous active duty service.

The Military Medical Support Office (MMSO) is charged with the administration of the RDP and is responsible to the Services to ensure the assets are used for this purpose. MMSO evaluates treatment plans and dental conditions for fitness for duty as well as appropriateness and necessity of care.

The RDP is not a premium-based insurance program and therefore its operation, like its mission, is slightly different from typical third-party payment dental insurance programs. The purpose of the RDP is to augment, not replace, dental care provided at active duty DTFs. Appropriate treatment needed to establish or maintain dental health to meet worldwide readiness standards will be considered for pre-authorization and processing for payment. Procedures or treatment that will impair worldwide readiness or deployability will be considered but are not likely to be authorized.

ADSMs may contact the Military Medical Support Office Customer Service directly for specific eligibility information related to dental treatment. **DoD service members** may contact the MMSO at 1-888-MHS-MMSO (1-888-647-6676). **USPHS and NOAA members**, call the Beneficiary Medical Program at 1-800-368-2777 option 2. **Coast Guard members**, call 1-800-9HBA HBA (1-800-942-2422).

Members leaving active duty status should investigate their eligibility for TAMP, VA, TRICARE Dental Program for Select Reserves, or Retiree Dental Program benefits.

TAMP: Service members that have separated from active duty service but have Transitional Assistance Management Program (TAMP) health care benefits are not eligible for dental care under the RDP. TAMP authorizes dental care provided directly by active duty DTFs, not RDP supplemental health care benefits provided by civilian dental care providers. Contact your nearest TRICARE Service Center for the latest information on TAMP benefits.

VA benefit: Service members that have served at least 90 days of continuous active duty service may be eligible for dental care to treat or correct a dental condition shown to have been in existence at time of their discharge or release from active service as a Veterans Administration (VA) benefit following separation

from active duty. In order for recently discharged veterans to be eligible for this VA dental care benefit, they must meet the following dental eligibility criteria:

- a. They must have served on active duty for 90 days or longer.
- b. They must apply to the VA for dental care within 90 days of their discharge of release from active military service.
- c. Their certificate of discharge of release from active duty (DD-214) does not bear a certification that the veteran was provided, within the 90-day period immediately before their discharge, a complete dental examination (including x-rays) and all appropriate dental treatment was completed as indicated by the examination.
- d. They were discharged or released under conditions other than dishonorable.

The veteran may contact any VA medical care facility to apply for dental care. (Consult the Government section of a local telephone directory for a telephone number for VA benefits.) The veteran will need to present a copy of their DD-214 along with their completed application. The VA has limited Fee-basis funds to authorize veterans to be treated by civilian dental providers on a limited basis, such as, when dental specialty care is not available at VA facilities or for veterans who may reside in geographically remote areas. To be eligible for this treatment the veteran must receive authorization and approval from the VA prior to contacting a civilian dentist for examination or treatment.

For information concerning the TRICARE dental programs for Select Reserve and Retiree populations, visit the TRICARE web site at <http://www.tricare.osd.mil>.

Tri-Service Remote Dental Program (RDP) General Benefit Information:

The Tri-Service Remote Dental Program does not have a preferred dental provider network but treatment must be provided by a dentist licensed and practicing in one of the fifty United States or District of Columbia. MMSO does not maintain a list of participating dentists. If the service member does not have an established dental provider, they may consider consulting the TRICARE Web site for the name of a TRICARE Dental Program (TDP) participating dentist in their area. Please note that all active-duty dental pre-authorization requests, claims, and other inquiries should be sent to MMSO and not TRICARE.

For all procedures appropriately pre-authorized there is no deductible or co-payment required of the service member. In most cases, the RDP will pay the usual and customary fee the dental provider charges their private-pay patients and other third-party payment programs. The U.S. government reserves the right to establish a maximum allowance for any given procedure. Some procedures are not covered benefits (see sections on covered and non-covered procedures). Therefore pre-authorization of treatment is highly recommended.

Failure to obtain pre-authorization will result in the service member being financially responsible for payment of any non-covered service or care determined to be elective or otherwise not required to establish or maintain dental health status for worldwide deployability. When in doubt, service members should submit the request for care to the MMSO for review prior to initiating treatment.

For extensive or questionable treatment plans, evaluation at an active duty dental treatment facility may be required before an authorization or denial for treatment is made. Every consideration is given to minimize travel and the service member's time away from the unit. Service members and their units share responsibility with the active duty military dental facilities for maintaining dental readiness. Military exams and needed dental care are expected to be kept up-to-date as part of this requirement. Treatment to correct a pre-existing condition (such as a missing tooth or a malocclusion) that is not presenting as an acute condition, nor is likely to create an acute condition, or is not immediately needed to meet occupational requirements or world-wide dental readiness status may be recommended to be delayed until the service member is able to receive this care at an active duty dental treatment facility.

Eligibility:

Service members enrolled in TRICARE Prime Remote (medical) are automatically eligible for the Tri-Service Remote Dental Program (RDP). RDP eligible active duty service members can receive emergency dental care any time they are in an active duty status (see definition and examples of emergency care). To be able to receive routine or specialty dental care through the RDP, the service member must be on

continuous active duty status for more than 30 days. As previously stated, once the service member separates from active duty they are no longer eligible for RDP benefits, including any treatment that may have been authorized or initiated while on active duty.

For more information on eligibility see the Military Medical Support Office information paper concerning Supplemental Health Care and TRICARE Prime Remote programs available on the MMSO Web site.

Emergency Dental Care:

Emergency care, which does not need pre-authorization, includes any treatment necessary to:

- relieve pain*
- treat infection*
- control hemorrhage
- repair broken fillings by placement of temporary or permanent fillings (not crowns)

*Root canal treatment and extractions may be needed to relieve the pain and infection noted above.

Crowns, bridges, and dentures **are not** considered emergency care and require pre-authorization (see below).

For example, root canal therapy required to relieve pain or treat infection can be completed without pre-authorization even if this treatment requires more than one appointment. If a crown is indicated following the root canal therapy, the crown must have pre-authorization before initiating the crown preparation.

If a posterior (molar or premolar) tooth has had root canal therapy and a full coverage restoration (crown) is indicated, the tooth may be prepared for a crown and a temporary crown placed to stabilize the tooth while awaiting written pre-authorization for the permanent crown. A separate charge will be paid for the temporary crown if the dentist (or dental facility) providing the permanent crown is not the same dentist (or dental facility) that provided the temporary crown. The type of temporary crown and cement used should be appropriate for the expected 3-4 weeks required for written pre-authorization. Review the section on covered and non-covered procedures prior to reduction of teeth for crowns.

Other examples: If an anterior tooth fractures or a posterior tooth suffers a cuspal fracture, the tooth should be restored with a direct filling material to cover any exposed dentin and provide temporary treatment while written pre-authorization is obtained for a crown (if indicated).

If a posterior tooth suffers a central groove fracture, a temporary crown should be placed to stabilize the crack and allow follow up evaluation for possible root canal therapy while awaiting written pre-authorization for a crown. Again, a separate charge will be paid for the temporary crown if the dentist providing the permanent crown is not the same dentist (or dental facility) that provided the temporary crown.

Please note that if a service member has an acute condition involving one impacted tooth requiring a surgical extraction, extraction of that tooth can be completed without written pre-authorization. Extraction of other non-emergent teeth requiring the same treatment should be delayed until written authorization is obtained.

Routine Dental Care:

Routine dental treatment can be completed without first obtaining pre-authorization, as long as the treatment meets all of the following requirements:

1. **Routine care** includes diagnostic (exams and X-rays), preventive (cleanings), routine restorations (amalgam or composite fillings), and single tooth extractions. ***Under no circumstances are crowns considered routine care.***
2. The **routine care** total cost of treatment appointment must be less than \$500 to be considered routine care. For example, two or three fillings or extraction of one or two teeth is considered routine care as long as the total cost is less than \$500 for that appointment.

3. Treatment plans that exceed a total of \$1,500 per calendar year require pre-authorization, even if each of the procedures or treatment appointments is less than \$500 per procedure/appointment.
4. The procedures must be covered benefits. (See the section on covered and non-covered procedures.)

Examples: If the total cost of any non-emergency treatment for any one procedure or appointment will exceed \$500 (such as most multiple wisdom tooth extractions) you must have written pre-authorization from MMSO before initiating the treatment.

Note: All prosthodontic procedures, including single unit crowns, require written pre-authorization from MMSO, regardless of cost. All non-emergency surgical procedures are considered specialty care and require pre-authorization, regardless of cost.

Specialty Dental Care:

All specialty care (prosthodontics, periodontics, multiple extractions or other oral surgery) and other dental treatment not considered emergency or routine care requires pre-authorization. Initiating specialty care without written pre-authorization from MMSO may result in the service member being responsible for part or all cost of treatment. If the dental provider initiates specialty care without receiving written pre-authorization from MMSO, the provider has the responsibility to obtain written consent from the service member clearly explaining this financial responsibility and risk.

Crowns requested for root-canal treated teeth require the submission of a post-treatment periapical radiograph showing the completed root canal.

Covered procedures:

All procedures or treatments must meet the requirements of being appropriate and necessary to establish and maintain dental health to meet military worldwide readiness/deployment status.

Diagnostic Services:

Examinations and radiographs are covered as needed to effectively diagnosis and develop appropriate treatment plans. Two routine examinations per year are covered without obtaining pre-authorization. Oral evaluations are considered integral when provided on the same date of service as palliative or surgical procedure(s) by the same dentist. Limited oral evaluations – problem focused, are only covered when performed on an emergency basis.

Additional examinations for specialty evaluations for covered procedures are authorized one per specialty per year. Note: Orthodontic and implant evaluations and related services are not covered.

Preventive Services:

Two routine prophylaxes are covered per year to establish and maintain dental health. If additional prophylaxes are indicated to control periodontal disease, pre-authorization is required. Note: Adult fluoride treatment is not covered unless pre-authorized as part of a specific caries control program. Sealants also require pre-authorization and the need must be provided in the request.

Restorative Services:

Covered restorations not requiring pre-authorization are directly placed amalgam and composite resin restorations, provided they meet the financial limitations for routine care previously described. Multiple restorations performed on a single tooth will be paid as a single restoration reflecting the number of surfaces involved. Note: Following premolar or molar root canal therapy a cuspal coverage amalgam core build up can be placed without pre-authorization (to provide both a core build-up for a future crown and protection from tooth fracture).

Covered materials/procedures also include preformed or cast posts (as appropriate), core build-ups (both with and without retention pins), cast gold crowns, and porcelain-fused-to-metal crowns. Cast posts are limited to root canal treated anterior teeth. Preformed posts may be used in both anterior and posterior root canal treated teeth. (All of these procedures require pre-authorization.)

Substitution of a non-covered procedure for a covered procedure is not allowed. For instance: Pre-authorization is granted for a porcelain-fused-to-metal (PFM) crown. An all-ceramic crown may not be substituted for the PFM even if the cost is equal to, or less than, the cost of the authorized PFM crown. An exception would be the substitution of a direct restorative material for an authorized indirect restoration, but the billing will reflect the procedure actually provided in procedure code, description of code, and fee.

Endodontic Services:

Covered procedures include: pulpotomy (for emergency treatment when provided by a dentist not completing the root canal therapy), root canal therapy and endodontic surgery. Non-emergency endodontic surgery requires pre-authorization. Pulpotomies are considered integral when performed by the same dentist within 45 days prior to the completion of the root canal therapy.

Periodontal Services:

Covered services include: periodontal prophylaxis, scaling and root planning and periodontal surgery. Surgical procedures such as gingival curettage, gingivectomy or gingivoplasty, crown lengthening, grafting (both soft and hard tissue), and guided tissue regeneration require pre-authorization.

Oral Surgery Services:

Covered procedures include: extractions (routine, surgical, and impacted), tooth reimplantation and/or stabilization, alveoloplasty, and surgical treatment of abscesses. Analgesia, sedation, and general anesthesia are covered when used in conjunction with surgical procedures but written pre-authorization must be obtained unless the surgical procedure is for treatment of an emergent condition.

Removable and Fixed Prosthodontics:

Covered services include: repairs, relines and rebases to complete and partial dentures, complete and partial dentures, and fixed bridges. Cast gold and porcelain-fused-to-metal are the only materials/techniques currently authorized. All prosthodontic procedures require pre-authorization (with the exception of repairs to, or recementation of, existing prosthesis).

Again, substitution of one procedure for another is not authorized. The one exception would be the substitution of an all gold crown for an authorized PFM crown (but not vice-versa). All metal restorations are recommended in areas that are not an esthetic concern or where conservation of sound natural tooth structure is indicated.

Crowns requested for root-canal treated teeth require the submission of a post-treatment periapical radiograph showing the completed root canal.

What is not covered:

Experimental drugs or procedures are not covered.

Medications not prescribed in writing by an authorized health care provider are not covered. Over-the-counter prescriptions, even if prescribed in writing by an authorized health care provider, will not be authorized for payment or reimbursement.

Supplies for home use (toothbrushes, mouth rinses, and other over-the-counter personal hygiene supplies), even if recommended by the dentist, are not authorized for payment or reimbursement. These are the personal responsibility of the service member.

Plaque control program, oral hygiene, and dietary instructions are not covered.

Sealants and fluoride treatment for adult patients are not covered unless pre-authorized (see above).

Cosmetic treatment (bleaching, bonding, porcelain veneers, etc.) is not covered.

Porcelain or composite resin inlays/onlays, and gold foil restorations are not covered.

Composite resin or all-porcelain full or partial coverage crowns are not covered.

Duplicate or temporary devices, appliances, and services are not covered.

Civilian orthodontic treatment (braces) is not normally authorized. Exceptions may be granted in unusual circumstances but a general guideline is that correction of previously existing malocclusions is not covered.

Implants and related procedures and elective procedures such as replacement of serviceable crowns, bridges and other prosthesis may be delayed for evaluation and treatment at an active duty dental treatment facility (DTF). Replacement of missing teeth not causing an acute condition and not likely to result in a deterioration of the dentition during the service member's tour at that duty station may also be delayed for evaluation and treatment at a DTF. Exceptions may be granted in unusual circumstances but a guideline is replacement of serviceable prosthodontic restorations or non-essential missing teeth is not covered.

Separate charges for local anesthesia, infection control, bases, liners, indirect pulp cap, diagnostic casts, temporary crowns, photographs, etc., are considered integral to the parent (original and main) procedure, and will not be paid or reimbursed as an additional fee. Nor will these be charged to the service member.

Nitrous oxide analgesia, intravenous sedation, and general anesthesia are not covered in conjunction with routine operative or preventive procedures. Exceptions may be made in unusual circumstances but written pre-authorization is required for payment or reimbursement. Authorization for payment or reimbursement of analgesia, etc., used in conjunction with routine operative or preventive procedures will not be granted after-the-fact.

Charges for failure to keep a scheduled appointment, transportation costs related to outpatient treatment, or charges for completion of a claim form are not covered.

What requires pre-authorization:

Extensive routine dental care or any procedure that does not fit the definition of emergency or routine dental care as previously described to include:

- Surgical extractions of non-emergent impacted third molars (wisdom teeth) and any special surgery care to include non-emergent periodontal and endodontic surgery.
- All crowns, bridges, complete and partial dentures, and other prosthodontic procedures, including all partial coverage or full coverage gold and porcelain-fused-to-metal restorations.
- Nitrous oxide analgesia, intravenous sedation, and general anesthesia in conjunction with non-emergency dental treatment.
- Periodontal treatment and surgery to include scaling and root planing, gingival and osseous surgery, bone or soft tissue grafts, or other adjunctive periodontal care.

Procedure for Requesting Dental Pre-Authorization:

The following three items are required in order for MMSO to process a request for pre-authorization of dental care under the provisions of the Tri-Service Remote Dental Program (RDP):

1. A **Command Request Memorandum** from the service member's unit signed by the unit commander or designated representative. See the MMSO Web site for a sample letter. (This is not the MMSO Dental Information Sheet.) The Memorandum is used for RDP eligibility verification and time remaining on active duty at that location as well as an address for return correspondence.
2. A **Dentist's pre-treatment estimate** from the dental provider indicating (as appropriate): tooth number, ADA procedure code and description of procedure, and an itemized fee for each procedure.
3. Appropriate **current diagnostic-quality radiographs**. All requests for crowns should include both bitewing and periapical radiographs. All requests for bridges, partials and dentures should include current

full mouth radiographs or panoramic x-ray documenting all missing and remaining teeth and appropriate diagnostic-quality periapical radiographs of the proposed abutment teeth identified in the treatment plan.

4. Requests for periodontal care must include **current periodontal charting, current diagnostic-quality full mouth series x-rays including bitewings, any tobacco use including smokeless tobacco,** and any pertinent unique clinical information to justify the need for care.

Please include any additional information (photographs, narrative justification, dates of previous placement of crowns, bridges, or other prosthesis if the request is for replacement of an existing prosthesis) that may be useful to justify the need for the requested treatment. If the need for the treatment is not readily evident on the radiographs a narrative justification should be included. Requests for non-covered procedures will be denied. MMSO's pre-authorization decision will be made on the information supplied. The MMSO return correspondence will provide clear authorization or denial of the requested treatment with the authorized fee and a control number assigned to all authorizations. All denials will be supplied a reason and possibly a recommended alternative treatment.

MMSO does not maintain a hard copy file of documents or x-rays. Each request must contain all of the pertinent information at the same time. Otherwise your request may be delayed and or returned without any action. Unfortunately MMSO does not have the staff or the space to maintain a file for every service member.

All of the information should be mailed (not faxed, x-rays do not fax well) in a single package to:

**The Military Medical Support Office
Attention: Dental Pre-authorizations
P.O. Box 886999
Great Lakes, Illinois 60088-6999**

Return correspondence will be sent to both the dentist submitting the pre-treatment request and the unit address supplied on the Command Memorandum so be certain to provide complete correct mailing information. Dental x-rays (and photographs) will be returned to the dentist that submitted the pre-treatment request. Study models (if sent) will not be returned. Keep a copy of your request information.

Procedure for Filing Claims:

Claims should be submitted within 90 days of date of service. Items required for processing a claim:

1. A completed standard American Dental Association (ADA) Dental Claim Form identifying (as appropriate) the tooth number or area of the mouth, ADA procedure code and description of procedure, date of service, and itemized cost of each procedure performed by the dental provider.
2. A completed MMSO Dental Information Sheet (available on the Web site) signed by the service member or the designated representative of the service member's military unit.

Send this information to:

**The Military Medical Support Office
Attention: Dental Claims
P.O. Box 886999
Great Lakes, Illinois 60088-6999**

Upon receipt of complete claim information, the MMSO will process the claim. If the service member has paid out-of-pocket expenses for dental care, a Claim for Reimbursement for Expenditures on Official Business (SF 1164) signed by the service member accompanied with appropriate proof of payment must be submitted with the forms described above.

The claim will be paid by U.S. Treasury check, usually within 30 days. An Explanation of Benefit (EOB) will be sent to both dental provider and service member at the addresses indicated on the dental claim form or MMSO Dental Information Sheet.

The service member is responsible for notifying his/her command of all dental care received. The service member is also responsible for ensuring that the claim has been properly submitted to MMSO (not TRICARE) with the required information and that the claim has been paid. Failure to ensure the claim has been submitted promptly and appropriately may result in credit problems or even personal financial liability to the service member. If a claim is denied because the MMSO does not yet have eligibility verification or other information required to process the claim, it does not mean these services will not be covered. However, until the required information is supplied, the MMSO will not be able to process the claim. To check on the status of a submitted claim or if assistance is required contact the MMSO at 1-888-647-6676.

Appeal Process:

For complete information on the appeals process, visit the MMSO website. The RDP has two levels of appeal. The first level of appeal is submitted to MMSO for a second review by MMSO. The appeal submission must include all appropriate information (radiographs, charting, properly completed pre-treatment request or claim, additional narrative information, etc.) relevant to the denied pre-authorization request or claim. When all relevant information is provided, the MMSO Dental Department will review the appeal to determine if justification exists to overturn the previous denial.

The second level of appeal is forwarded to the respective ADSM's Surgeon General Dental Consultant via MMSO. The purpose of submitting the appeal via MMSO is to ensure all appropriate information has been included so as not to waste the time of the ADSM or Service Dental Consultant reviewer in reviewing incomplete information.

First Level Appeal: While it is always the ADSM's responsibility to formally submit the appeal, the ADSM's command, the ADSM's health benefits advisor (HBA), or the civilian/VA treatment facility may send additional information to MMSO to support a first level appeal. The ADSM is responsible for ensuring all appropriate radiographs, documentation and information to justify the need for additional review, and appropriate appeal correspondence are included in the appeal submission. First level appeals should be addressed to: Officer in Charge, MMSO, and be mailed to:

Officer in Charge
The Military Medical Support Office
ATTN: Dental Appeals
P.O. Box 886999
Great Lakes, IL 60088-6999

Second Level Appeal: The second level of appeal is used following a denial of first level appeal. The second level of appeal is generated and submitted following the same guidelines as the first level of appeal. Again, the ADSM is responsible for ensuring all appropriate radiographs, documentation and information to justify the need for additional review, and appropriate appeal correspondence are included in the appeal submission. The correspondence from the ADSM should state that this appeal is submitted to challenge a previously denied appeal. Second level appeals should be addressed to: Officer in Charge, MMSO, and be mailed to:

Officer in Charge
The Military Medical Support Office
Attn: Dental Appeals
P.O. Box 886999
Great Lakes, IL 60088-6999.

Once received by the MMSO OIC, the appeal, along with all necessary documents, are routed via normal workflow to the appropriate MMSO Dental Department staff dental officer(s) for review. Once the package has been reviewed for completeness, the appeal information will be forwarded to the appropriate Service (Army, Air Force, or Navy) Surgeon General's (SG) Dental Consultant for final review.

Reply correspondence may be sent directly from the Service Dental Consultant to the Service Member or through MMSO correspondence as deemed appropriate by the Service Dental Consultant.

Contact Information:

Instructions and forms, as well as other information may be found on the MMSO Web site at: <http://mmso.med.navy.mil>. The MMSO may be contacted at 1-888-MHS-MMSO (888-647-6676) for general information or questions pertaining to eligibility, guidelines or status of a pre-authorization submission, claim processing, or status of a claim.