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BUMED INSTRUCTION 6600.18

From: Chief, Bureau of Medicine and Surgery

Subj: IMPLEMENTATION AND STANDARDIZATION OF DENTAL CLASSIFICATION
GUIDELINES

Ref: (a) DoD Instruction 6025.19 of 3 January 2006

Encl: (1) Specialty-Specific Classification Guidelines for Navy Dentistry

1. Purpose. Establish and standardize guidelines for determining dental readiness classification in the Navy Military Health System.
2. Cancellation. BUMED Itr 6600 Ser M3D32/00933 of 8 May 2003.
3. Scope. This instruction applies to all dental personnel ashore and afloat. All naval medical and dental treatment facilities must follow these guidelines when assigning a dental readiness classification for Sailors and Marines.
4. Background. Dental readiness classification guidelines outlined in reference (a) provide the minimal Department of Defense standard for classifying patients as dentally ready for worldwide deployment. Sailors and Marines can be assigned to remote duty such as recruiter or Marine Security Guard and often deploy on submarines and ships without dental clinics, requiring Navy Medicine to establish additional readiness standards. Navy Medicine standards serve to maximize medical readiness and operational effectiveness.
5. Policy. Dental specialty-specific guidelines for assigning dental readiness classification for Sailors and Marines are provided in enclosure (1). Guidelines are provided in list and table format to accommodate provider preference. Strict adherence to this guidance will contribute to a dentally ready force, minimize dental emergencies, and assure standardization of dental readiness classification throughout the Navy and Marine Corps.

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SPECIALTY-SPECIFIC CLASSIFICATION
GUIDELINES FOR NAVY DENTISTRY

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SPECIALTY-SPECIFIC CLASSIFICATION GUIDELINES FOR NAVY DENTISTRY

1. Oral Diagnosis

a. Class 2

(1) Radiographic anomaly or previously diagnosed lesion which requires follow-up or routine management within the next 12 months.

(2) Benign, non-acute oral lesion which requires follow-up or routine treatment within the next 12 months.

(3) Recurrent orofacial lesion which requires follow-up or routine management within the next 12 months.

(4) Lesion with obvious or confirmed etiology such as cheek or tongue chewing or biting lesion; low risk snuff dippers lesion not requiring biopsy; linea alba; leukoedema; edentulous ridge with evidence of traumatic or thermal hyperkeratosis, which requires follow-up or routine treatment within the next 12 months.

(5) Orofacial Pain (Temporomandibular disorders, headache, neuropathy, facial-cervical myofascial conditions, etc.) patients in maintenance therapy. The provider anticipates the patient can perform duties while deployed without modification to ongoing care. For some diagnoses, medication or an appliance may be necessary to establish maintenance therapy that will not interfere with duties.

b. Class 3

(1) Any undiagnosed radiographic lesion.

(2) Acute tissue lesion or condition requiring further evaluation or urgent treatment such as major aphthous stomatitis, erythema multiforme, glossodynia, primary herpetic gingivostomatitis, erythroplakia, mixed red and white or white lesions without obvious etiology.

(3) Chronic oral infection or other pathological lesion:

(a) Pulpal or periapical pathology requiring treatment.

(b) Lesions requiring biopsy or awaiting a biopsy report.

(c) Requiring an endodontic consult or treatment.

(4) Patients who are status post-surgery and in the post-surgery recovery phase requiring follow-up.

(5) Oral condition that requires urgent treatment. Any symptomatic lesion (acute pain, swelling, or bleeding). Includes emergency situations requiring therapy to relieve pain, treat trauma, treat acute oral infections, or provide timely follow-up care (drain or suture removal) until resolved.

(6) Orofacial Pain (Temporomandibular disorders, headache, neuropathy, facial-cervical myofascial conditions, etc.) that interferes with duties and requires active treatment.

c. The table on the following page provides specialty-specific guidelines for oral diagnosis in table format.

Oral Diagnosis	
Class 2	Class 3
Radiographic anomaly or previously diagnosed lesion which requires follow-up or routine management within the next 12 months.	Any undiagnosed radiographic lesion.
Benign, non-acute oral lesion which requires follow-up or routine treatment within the next 12 months. Recurrent orofacial lesion which requires follow-up or routine management within the next 12 months. Lesion with obvious or confirmed etiology such as cheek or tongue chewing or biting lesion; low risk snuff dippers lesion not requiring biopsy; linea alba; leukoedema; edentulous ridge with evidence of traumatic or thermal hyperkeratosis, which requires follow-up or routine treatment within the next 12 months.	Acute tissue lesion or condition requiring further evaluation or urgent treatment such as major aphthous stomatitis, erythema multiforme, glossodynia, primary herpetic gingivostomatitis, erythroplakia, mixed red and white or white lesions without obvious etiology.
	Chronic oral infection or other pathological lesion: (a) Pulpal or periapical pathology requiring treatment. (b) Lesions requiring biopsy or awaiting a biopsy report. (c) Requiring an endodontic consult or treatment.
	Patients who are status post-surgery and in the post-surgery recovery phase requiring follow-up.
	Oral condition that requires urgent treatment. Any symptomatic lesion (acute pain, swelling, or bleeding). Includes emergency situations requiring therapy to relieve pain, treat trauma, treat acute oral infections, or provide timely follow-up care (drain or suture removal) until resolved.
Orofacial Pain (Temporomandibular disorders, headache, neuropathy, facial-cervical myofascial conditions, etc.) patients in maintenance therapy. The provider anticipates the patient can perform duties while deployed without modification to ongoing care. For some diagnoses, medication or an appliance may be necessary to establish maintenance therapy that will not interfere with duties.	Orofacial Pain (Temporomandibular disorders, headache, neuropathy, facial-cervical myofascial conditions, etc.) that interferes with duties and requires active treatment.

2. Operative Dentistry

a. Class 2

(1) Deep retentive pits and fissures requiring sealants.

(2) Asymptomatic lesions in the enamel or dentin (caries limited to lesions that extend less than 0.5 mm radiographically beyond the dentin-enamel junction (DEJ)). Consider remineralization as the treatment of choice.

(3) Interim restorations deemed acceptable for the next 12 months.

(4) Existing restorations that have minor defects, but are non-symptomatic and unlikely to cause damage to the tooth or surrounding tissues in 12 months.

(5) Dental caries for which remineralization is the treatment of choice, such as:

(a) White spot lesions.

(b) Proximal lesions extending less than 0.5mm radiographically into dentin.

b. Class 3 (*) denotes highest priority restorative conditions

(1) *All symptomatic caries lesions and symptomatic defective restorations.

(2) *Symptomatic cracked tooth syndrome.

(3) *Cavitated or non-cavitated caries lesions extending one-third of the way or greater into dentin radiographically.

(4) All cavitated carious lesions.

(5) Non-cavitated carious lesions that extend 0.5 mm or more (radiographically) beyond the DEJ. For non-cavitated lesions, consider remineralization as an option.

(6) Faulty restorations and recurrent caries likely to cause symptoms or tissue damage within 12 months (i.e., open margins, cracked restorations, overhangs compromising periodontal health through asymptomatic bone resorption).

(7) Interim restorations or prostheses that are defective or not maintainable by the patient. This includes endodontically or non-endodontically treated teeth that have been restored with permanent restorative materials but for which cuspal coverage is indicated.

(8) Anterior teeth with completed endodontic treatment but not permanently restored and require full coverage. Access preparations sealed with only a glass ionomer or resin modified glass ionomer (GI or RMGI) or composite resin alone are considered "temporary." A "sandwich-type" permanent restoration with GI or RMGI and composite resin is recommended in the endo access to satisfy both microleakage and esthetic concerns. If significant tooth structure is missing (i.e. – significant marginal ridge involvement), a post core and crown are recommended.

(9) Tooth fractures or defective restoration not maintainable by the patient or with unacceptable esthetics.

c. The table on the following page provides specialty-specific guidelines for operative dentistry in table format.

Operative Dentistry	
Class 2	Class 3
Asymptomatic lesions in the enamel or dentin (caries limited to lesions that extend less than 0.5 mm radiographically beyond the DEJ). Consider remineralization as the treatment of choice.	All cavitated carious lesions. Non-cavitated carious lesions that extend 0.5 mm or more (radiographically) beyond the DEJ. For non-cavitated lesions, consider remineralization as an option.
Interim restorations deemed acceptable for the next 12 months.	Interim restorations or prostheses that are defective or not maintainable by the patient. This includes endodontically or non-endodontically treated teeth that have been restored with permanent restorative materials but for which cuspal coverage is indicated.
Existing restorations that have minor defects, but are non-symptomatic and unlikely to cause damage to the tooth and surrounding tissues in 12 months.	Faulty restorations and recurrent caries likely to cause symptoms or tissue damage within 12 months (i.e., open margins, cracked restorations, overhangs compromising periodontal health through asymptomatic bone resorption).
	Anterior teeth with completed endodontic treatment but not permanently restored and require full coverage. Access preparations sealed with only a glass ionomer or resin modified glass ionomer (GI or RMGI) or composite resin alone are considered "temporary." A "sandwich-type" permanent restoration with GI or RMGI and composite resin is recommended in the endo access to satisfy both microleakage and esthetic concerns. If significant tooth structure is missing (i.e., significant marginal ridge involvement), a post core and crown is recommended.
Deep, retentive pits and fissures requiring sealants.	Tooth fractures and defective restoration not maintainable by the patient or with unacceptable esthetics.
Dental caries for which remineralization is the treatment of choice, such as: (a) White spot lesions. (b) Proximal lesions extending less than 0.5 mm radiographically into dentin.	The highest priority restorative conditions: - All symptomatic caries lesions and symptomatic defective restorations. - Symptomatic cracked tooth syndrome. - Cavitated or non-cavitated carious lesions extending one-third of the way or greater into dentin radiographically.

3. Endodontics

a. Class 2. The following conditions are not expected to result in a dental emergency in 12 months:

(1) Pulp caps, pulpal regeneration techniques, and traumatic injuries that require reevaluation within a year.

(2) Teeth requiring non-vital bleaching.

(3) Endodontically treated teeth with an apical radiolucency that has decreased in size within the previous year. Clinically it is asymptomatic, percussion normal, without soft tissue involvement, and is sealed coronally with permanent restoration.

b. Class 3

(1) Traumatic dental injuries that require treatment, including splints and endodontic therapy.

(2) Teeth with irreversible pulpitis (symptomatic and asymptomatic).

(3) Teeth with a painful response to biting, percussion, or palpation with or without apical radiolucencies (symptomatic apical periodontitis).

(4) Asymptomatic teeth with apical radiolucencies of pulpal origin (asymptomatic apical periodontitis).

(5) Pulp caps and pulpal regeneration techniques that require endodontic therapy.

(6) Pulp necrosis.

(7) Asymptomatic or symptomatic teeth with a chronic apical abscess (presence of a sinus tract).

(8) Acute apical abscess (infection of pulpal origin characterized by rapid onset, spontaneous pain, tenderness of the tooth, pus formation, and swelling of associated tissues).

(9) Previously initiated endodontic therapy.

(10) Symptomatic endodontically treated teeth.

(11) Endodontically treated teeth with evidence that an apical radiolucency has remained unchanged or increased in size within the previous year.

(12) Teeth with completed endodontic treatment but not permanently restored.

(13) Condensing osteitis (diffuse radiopaque lesion representing a localized bony reaction usually seen at the tooth apex; corresponding abnormal response to pulp tests).

c. The table on the following page provides specialty-specific guidelines for endodontics in table format.

Endodontics	
Class 2	Class 3
	Traumatic dental injuries that require treatment, including splints and endodontic therapy.
	Teeth with irreversible pulpitis (symptomatic and asymptomatic).
	Teeth with a painful response to biting, percussion, or palpation with or without apical radiolucencies (symptomatic apical periodontitis).
Pulp caps, pulpal regeneration techniques and traumatic injuries that require reevaluation within a year.	Pulp caps and pulpal regeneration techniques that require endodontic therapy.
Teeth requiring non-vital bleaching.	Asymptomatic teeth with apical radiolucencies of pulpal origin (asymptomatic apical periodontitis).
Endodontically treated teeth with an apical radiolucency that has decreased in size within the previous year. Clinically it is asymptomatic, percussion normal, without soft tissue involvement, and is sealed coronally with permanent restoration.	Endodontically treated teeth with evidence that an apical radiolucency has remained unchanged or increased in size within the previous year.
	Pulp necrosis.
	Asymptomatic or symptomatic teeth with a chronic apical abscess (presence of a sinus tract).
	Acute apical abscess (infection of pulpal origin characterized by rapid onset, spontaneous pain, tenderness of the tooth, pus formation, and swelling of associated tissues).
	Previously initiated endodontic therapy.
	Symptomatic endodontically treated teeth.
	Teeth with completed endodontic treatment but not permanently restored.
	Condensing osteitis (diffuse radiopaque lesion representing a localized bony reaction usually seen at the tooth apex; corresponding abnormal response to pulp tests).

4. Oral Surgery

a. Class 2

(1) Erupted, partially erupted, unerupted, or malposed third molars that are without clinical, historical, or radiographic signs or symptoms of pathosis, but which are recommended for elective or adjunctive removal in conjunction with another specialty treatment plan.

(2) Partially erupted or unerupted teeth that have the potential to erupt and lead to either symptomatic episodes or pathology. Note: Military and clinical judgment may supersede this criterion in individual cases.

b. Class 3

(1) Teeth associated with pathosis. Examples include: follicular cystic changes associated with impacted teeth, distal caries in the lower second molar resulting from position of third molar, periodontal disease contributed by the third molar affecting the second molar, external or internal resorption, and currently symptomatic or recurrent episodes of pericoronitis.

(2) Erupted, partially erupted, unerupted, or malposed teeth with historical, clinical, or radiographic signs or symptoms of pathosis including partially impacted teeth that will never erupt into occlusion and have oral communication. Note: Clinical judgment may supersede these criteria in individual cases.

(3) Unerupted teeth with oral communication or partially erupted teeth that will not erupt into a functioning occlusion and are recommended for removal.

(4) Surgical incision or excision of pathologic lesions for histologic examination.

(5) Conditions requiring surgical repair procedures.

(6) All non-restorable teeth, remaining roots, or parts of teeth that could cause an infection.

(7) Conditions requiring follow-up care, such as suture removal, drain removal, post-op awaiting biopsy report.

(8) Temporomandibular disorders or myofascial pain dysfunction that interferes with duties and requires active treatment.

(9) The post-surgical healing, intermaxillary fixation and follow-up of orthognathic surgery, surgical and adjunctive treatment of disease, injuries and defects of the oral and maxillofacial regions.

(10) Surgical treatment of temporomandibular joint dysfunction following unsuccessful non-surgical management.

c. The table on the following page provides specialty-specific guidelines for oral surgery in table format.

Oral Surgery	
Class 2	Class 3
Erupted, partially erupted, unerupted, or malposed third molars that are without clinical, historical, or radiographic signs or symptoms of pathosis, but which are recommended for elective or adjunctive removal in conjunction with another specialty treatment plan.	Teeth associated with pathosis. Examples include: follicular cystic changes associated with impacted teeth, distal caries in the lower second molar resulting from position of third molar, periodontal disease contributed by the third molar affecting the second molar, external or internal resorption, and currently symptomatic or recurrent episodes of pericoronitis.
Partially erupted or unerupted teeth that have the potential to erupt and lead to either symptomatic episodes or pathology. Note: Military and clinical judgment may supersede this criterion in individual cases.	Erupted, partially erupted, unerupted, or malposed teeth with historical, clinical, or radiographic signs or symptoms of pathosis including partially impacted teeth that will never erupt into occlusion and have oral communication. Note: Clinical judgment may supersede these criteria in individual cases.
	Unerupted teeth with oral communication or partially erupted teeth that will not erupt into a functioning occlusion and are recommended for removal.
	Surgical incision or excision of pathologic lesions for histologic examination.
	Conditions requiring surgical repair procedures.
	All non-restorable teeth, remaining roots, or parts of teeth that could cause an infection.
	Conditions requiring follow-up care, such as suture removal, drain removal, post-op awaiting biopsy report.
	The post-surgical healing, intermaxillary fixation and follow-up of orthognathic surgery, surgical and adjunctive treatment of disease, injuries and defects of the oral and maxillofacial regions.
	Surgical treatment of temporomandibular joint dysfunction following unsuccessful non-surgical management. Temporomandibular disorders or myofascial pain dysfunction that interferes with duties and requires active treatment.

5. Periodontics

a. Class 2. Chronic diseases of the periodontium not projected to become acute within 12 months.

(1) Non-acute gingivitis.

(2) Periodontal diseases as defined by 5 mm or greater probing attachment loss, with bleeding or purulence on probing, *without* excessive mobility or pain upon mastication.

(3) Non-progressive mucogingival conditions.

(4) Patients in active periodontal therapy for a condition not expected to result in a dental emergency within the next 12 months.

(5) Patients in maintenance therapy, or with stable or non-progressive mucogingival conditions requiring periodic evaluation.

(6) Patients requiring removal of supragingival or mild to moderate (localized: less than 30 percent) subgingival calculus.

(7) Patients requiring oral prophylaxis.

b. Class 3 Acute. Periodontal diseases or periodontium exhibiting:

(1) Acute pericoronitis, acute gingivitis, or acute periodontal disease.

(2) Periodontal abscess.

(3) Progressive mucogingival conditions.

(4) Acute periodontal manifestations of systemic disease or hormonal disturbances.

(5) Generalized moderate (greater than 30 percent) to heavy subgingival calculus.

(6) Moderate to severe periodontitis.

c. Class 3 Chronic

(1) Chronic diseases of the periodontium that are likely to become acute within 12 months.

(2) Periodontal diseases as defined by 5 mm or greater probing attachment loss, with bleeding or purulence on probing, **and** excessive mobility **or** pain upon mastication, **or** any previous history of periodontal abscess formation.

d. The table on the following page provides specialty-specific guidelines for periodontics in table format.

Periodontics	
Class 2	Class 3
<p>Chronic diseases of the periodontium not projected to become acute within 12 months.</p> <p>Non-acute gingivitis.</p> <p>Periodontal diseases as defined by 5 mm or greater probing attachment loss, with bleeding or purulence on probing, <i>without</i> excessive mobility or pain upon mastication.</p> <p>Non-progressive mucogingival conditions.</p> <p>Patients in active periodontal therapy for a condition not expected to result in a dental emergency within the next 12 months.</p> <p>Patients in maintenance therapy, or with stable or non-progressive mucogingival conditions requiring periodic evaluation.</p>	<p>Acute periodontal diseases or periodontium exhibiting:</p> <p>(1) Acute pericoronitis, acute gingivitis or acute periodontal disease.</p> <p>(2) Periodontal abscess.</p> <p>(3) Progressive mucogingival conditions.</p> <p>(4) Acute periodontal manifestations of systemic disease or hormonal disturbances.</p> <p>(5) Generalized moderate (greater than 30 percent) to heavy subgingival calculus</p> <p>(6) Moderate to severe periodontitis.</p>
<p>Patients requiring removal of supragingival or mild to moderate (localized: less than 30 percent) subgingival calculus.</p>	
<p>Patients requiring oral prophylaxis.</p>	<p>Chronic diseases of the periodontium that are likely to become acute within 12 months.</p> <p>Periodontal diseases as defined by 5 mm or greater probing attachment loss, with bleeding or purulence on probing, <i>and</i> excessive mobility <i>or</i> pain upon mastication, <i>or</i> any previous history of periodontal abscess formation.</p>

6. Dental Hygiene

a. Class 2

- (1) Non-specific or non-acute gingivitis.
- (2) Requirement for oral prophylaxis to remove stain, supragingival, and subgingival deposits.
- (3) Preventive and maintenance care.
- (4) Sealants.
- (5) Root planing and scaling procedures to support Class 2 periodontal treatment.

b. Class 3

- (1) Chronic diseases of the periodontium that are likely to become acute within 12 months.
- (2) Periodontal diseases as defined by 0.5 mm or greater probing attachment loss, with bleeding or purulence on probing, and excessive mobility or pain upon mastication, or any previous history of periodontal abscess formation.
- (3) Acute gingivitis, independent of periodontal screening and recording (PSR) scores.
- (4) Treatment to facilitate Class 3 procedures.

c. The following table provides specialty-specific guidelines for dental hygiene in table format.

Dental Hygiene	
Class 2	Class 3
	<p>CHRONIC diseases of the periodontium that are likely to become acute within 12 months.</p> <p>Periodontal diseases as defined by 0.5 mm or greater probing attachment loss, with bleeding or purulence on probing, and excessive mobility or pain upon mastication, or any previous history of periodontal abscess formation.</p>
<p>Non-specific or non-acute gingivitis.</p> <p>Requirement for oral prophylaxis to remove stain, supragingival, and subgingival deposits.</p>	<p>Acute gingivitis, independent of periodontal screening and recording (PSR) scores.</p>
<p>Root planing and scaling procedures to support Class 2 periodontal treatment.</p>	<p>Treatment to facilitate Class 3 procedures.</p>
<p>Preventive and maintenance care.</p> <p>Sealants.</p>	

7. Prosthodontics

a. Class 2

- (1) Restoration of teeth or edentulous areas with prosthetic restorations or appliances (fixed or removable), but not on an immediate basis.
- (2) Routine esthetic replacement of missing anterior teeth, but not on an immediate basis.
- (3) Any covered or uncovered dental implants with provisional restorations or other type of space maintenance.

b. Class 3

- (1) Edentulous areas or teeth requiring immediate prosthodontic treatment for adequate mastication, communication, esthetics, or military function.
- (2) Ill-fitting or unserviceable prostheses, castings or computer aided design and computer aided manufacturing (CAD CAM) restorations associated with recurrent caries.
- (3) Any fixed partial denture with loose abutments; any loose implant retained restoration (fixed), or any loose implant abutments (removable).
- (4) Any implant fixture that becomes loose or painful.

c. The following table provides specialty-specific guidelines for prosthodontics in table format.

Prosthodontics	
Class 2	Class 3
Restoration of teeth or edentulous areas with prosthetic restorations or appliances (fixed or removable), but not on an immediate basis.	Edentulous areas or teeth requiring immediate prosthodontic treatment for adequate mastication, communication, esthetics, or military function.
Routine esthetic replacement of missing anterior teeth, but not on an immediate basis.	Ill-fitting or unserviceable prostheses, castings or computer aided design and computer aided manufacturing (CAD CAM) restorations associated with recurrent caries.
	Any fixed partial denture with loose abutments; any loose implant retained restoration (fixed) or any loose implant abutments (removable).
Any covered or uncovered dental implants with provisional restorations or other type of space maintenance.	Any implant fixture that becomes loose or painful.