DEPARTMENT OF THE NAVY
BUREAU OF MEDICINE AND SURGERY
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IN REPLY REFER TO
BUMEDINST 6600.18A
BUMED-M3
28 Sep 2021

BUMED INSTRUCTION 6600.18A

From: Chief, Bureau of Medicine and Surgery

Subj: DENTAL READINESS CLASSIFICATION GUIDELINES

Ref: (a) DoD Instruction 6025.19 of 9 June 2014
(b) SECNAVINST 6120.3A

Encl: (1) Specialty-Specific Dental Readiness Classification Guideline Lists
(2) Specialty-Specific Dental Readiness Classification Guideline Tables

1. Purpose. To establish guidelines for determining dental readiness classification (DRC) of Service members under the care of Navy dentistry. This instruction is a complete revision and should be reviewed in its entirety.

2. Cancellation. BUMEDINST 6600.18.

3. Scope and Applicability. This instruction applies to all budget submitting office (BSO) 18 dental commands, units, and operational activities. These guidelines must be followed when assigning a DRC to Service members under the care of Navy dentistry.

4. Background. References (a) and (b) provide DRC guidelines for classifying Service members as dentally ready for worldwide deployment. This instruction establishes additional readiness standards for Service members assigned to remote duty locations or on submarines and ships without dental clinics. These standards serve to maximize medical readiness and operational effectiveness.

5. Policy. Specialty-specific guidelines for assigning DRC are provided in enclosures (1) and (2). Guidelines are provided in list and table format to accommodate provider preference. Adherence to the guidelines will assure standardization of DRC, contribute to a dentally ready force, and minimize dental emergencies. Directors of dental services and senior dental executives must ensure all dental providers within their local command are provided annual training and calibration on the contents of this instruction.

6. Records Management

a. Records created as a result of this instruction, regardless of format or media, must be maintained and dispositioned per the records disposition schedules located on the Department of the Navy Directorate for Administration, Logistics, and Operations, Directives and Records Management Division portal page at https://portal.secnav.navy.mil/orgs/DUSNM/DONAA/DRM/Records-and-Information-Management/Approved%20Record%20Schedules/Forms/AllItems.aspx.

b. For questions concerning the management of records related to this instruction or the records disposition schedules, please contact the local records manager or the Department of the Navy Directorate for Administration, Logistics, and Operations, Directives and Records Management Division program office.

7. Review and Effective Date. Per OPNAVINST 5215.17A, Medical Operations (BUMED-M3) will review this instruction annually around the anniversary of its issuance date to ensure applicability, currency, and consistency with Federal, DoD, Secretary of the Navy, and Navy policy and statutory authority using OPNAV 5215/40 Review of Instruction. This instruction will be in effect for 10 years, unless revised or cancelled in the interim, and will be reissued by the 10-year anniversary date if it is still required, unless it meets one of the exceptions in OPNAVINST 5215.17A, paragraph 9. Otherwise, if the instruction is no longer required, it will be processed for cancellation as soon as the need for cancellation is known following the guidance in OPNAV Manual 5215.1 of May 2016.

G. D. SHAFFER
Acting

Releasability and distribution:
This instruction is cleared for public release and is available electronically only via the Navy Medicine Web site at, https://www.med.navy.mil/Directives

SPECIALTY-SPECIFIC DENTAL READINESS CLASSIFICATION GUIDELINE LISTS

1. Oral Diagnosis

a. DRC 2

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

(2) Benign, non-acute or previously diagnosed 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.

b. DRC 3

(1) Any undiagnosed radiographic lesion.

(2) Acute tissue lesion or condition requiring further evaluation or urgent treatment such as oral cancer, mucous membrane pemphigoid, symptomatic lichen planus, major aphthous stomatitis, symptomatic minor aphthous stomatitis, erythema multiforme, glossodynia, primary herpetic gingivo-stomatitis, erythroplakia, mixed red and white or white lesions without obvious etiology.

(3) Chronic oral infection or other pathological lesion:

(a) Pulpal or periapical pathosis 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.

c. The oral diagnosis table in enclosure (2) provides specialty-specific guidelines for oral diagnosis in table format.

2. Operative Dentistry

a. DRC 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 one-third of the way radiographically beyond the dentin-enamel junction).

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

(4) Existing restorations that have minor defects, but are asymptomatic 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) Non-cavitated proximal lesions extending less than one-third of the way radiographically into dentin.

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

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

(2) *Symptomatic cracked tooth syndrome.

(3) *Non-cavitated carious lesions extending one-third of the way or greater into dentin radiographically.

(4) All cavitated carious lesions.

(5) 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).

(6) 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.

(7) Anterior teeth with completed endodontic treatment, but not permanently restored and require full coverage. Access preparations sealed with only a glass ionomer (GI) or resin modified glass ionomer (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.

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

c. The operative dentistry table in enclosure (2) provides specialty-specific guidelines for operative dentistry in table format.

3. Endodontics

a. DRC 2. The conditions in subparagraphs 3a(1) through 3a(3) of this enclosure 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. DRC 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) Pulpal 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 endodontics table in enclosure (2) provides specialty-specific guidelines for endodontics in table format.

4. Oral Surgery

a. DRC 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 pathosis. Note: Military and clinical judgment may supersede this criterion in individual cases.

b. DRC 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: Military and 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 oral surgery table in enclosure (2) provides specialty-specific guidelines for oral surgery in table format.

5. Periodontics

a. DRC 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 millimeter (mm) or greater probing attachment loss, with bleeding or purulence on probing, without excessive mobility or pain upon mastication.

(3) Non-acute peri-implant mucositis.

(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. DRC 3. Acute periodontal diseases or periodontium exhibiting:

(1) Pericornitis, gingivitis, periodontal disease, or peri-implant mucositis with sudden onset or exacerbation of infection characterized by pain, swelling, or purulent exudate.

(2) Periodontal abscess.

(3) Progressive mucogingival conditions.

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

(5) Localized (less than 30 percent) heavy or generalized (greater than 30 percent) mild, moderate, or heavy subgingival calculus.

c. DRC 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 periodontics table in enclosure (2) provides specialty-specific guidelines for periodontics in table format.

6. Dental Hygiene

a. DRC 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 planning and scaling procedures to support DRC 2 periodontal treatment.

b. DRC 3

(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.

(3) Acute gingivitis, independent of periodontal screening and recording scores.

(4) Treatment to facilitate DRC 3 procedures.

c. The dental hygiene table in enclosure (2) provides specialty-specific guidelines for dental hygiene in table format.

7. Prosthodontics

a. DRC 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 any transmucosal attachment.

b. DRC 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 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 prosthodontics table in enclosure (2) provides specialty-specific guidelines for prosthodontics in table format.

8. Orofacial Pain

a. DRC 2. 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. DRC 3. Orofacial pain (Temporomandibular disorders, headache, neuropathy, facial-cervical myofascial conditions, etc.) that interferes with duties and requires active treatment.

c. The orofacial pain table in enclosure (2) provides specialty-specific guidelines for orofacial pain in table format.

SPECIALTY-SPECIFIC DENTAL READINESS CLASSIFICATION
GUIDELINE TABLES

ORAL DIAGNOSIS	
DRC 2	DRC 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 or previously diagnosed 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 oral cancer, mucous membrane pemphigoid, symptomatic lichen planus, major aphthous stomatitis, symptomatic minor aphthous stomatitis, erythema multiforme, glossodynia, primary herpetic gingivo-stomatitis, erythroplakia, mixed red and white or white lesions without obvious etiology.
	Chronic oral infection or other pathological lesion: (a) Pulpal or periapical pathosis 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.

OPERATIVE DENTISTRY	
DRC 2	DRC 3
Asymptomatic lesions in the enamel or dentin (caries limited to lesions that extend less than one-third of the way radio-graphically beyond the dentin-enamel junction).	All cavitated carious lesions. Non-cavitated carious lesions extending one-third of the way or greater into dentin radiographically.
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 asymptomatic 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 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) Non-cavitated proximal lesions extending less than one-third of the way radio-graphically into dentin.	<u>The highest priority restorative conditions</u>: - All symptomatic carious lesions and symptomatic defective restorations. - Symptomatic cracked tooth syndrome. - Non-cavitated carious lesions extending one-third of the way or greater into dentin radiographically.

ENDODONTICS	
DRC 2	DRC 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 radio-lucencies 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.
	Pulpal 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).

ORAL SURGERY	
DRC 2	DRC 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 pathosis. 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.

PERIODONTICS	
DRC 2	DRC 3
Chronic diseases of the periodontium not projected to become acute within 12 months. Non-acute gingivitis. 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. Non-acute peri-implant mucositis. Patients in active periodontal therapy for a condition not expected to result in a dental emergency within the next 12 months. Patients in maintenance therapy, or with stable or non-progressive mucogingival conditions requiring periodic evaluation.	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) Localized (less than 30 percent) heavy, or generalized (greater than 30 percent) mild, moderate or heavy subgingival calculus.
Patients requiring removal of supragingival or mild to moderate localized (less than 30 percent) subgingival calculus.	
Patients requiring oral prophylaxis.	Chronic diseases of the periodontium that are likely to become acute within 12 months. 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.

DENTAL HYGIENE	
DRC 2	DRC 3
	Chronic diseases of the periodontium that are likely to become acute within 12 months. 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.
Non-specific or non-acute gingivitis. Requirement for oral prophylaxis to remove stain, supragingival, and subgingival deposits.	Acute gingivitis, independent of periodontal screening and recording scores.
Root planing and scaling procedures to support DRC 2 periodontal treatment.	Treatment to facilitate DRC 3 procedures.
Preventive and maintenance care. Sealants.	

PROSTHODONTICS	
DRC 2	DRC 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 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 any transmucosal attachment.	Any implant fixture that becomes loose or painful.

OROFACIAL PAIN	
DRC 2	DRC 3
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.