January 2019

policy update bulletin

Dental Clinical Policy & Coverage Guideline Updates

UnitedHealthcare respects the expertise of the physicians, health care professionals, and their staff who participate in our network. Our goal is to support you and your patients in making the most informed decisions regarding the choice of quality and cost-effective care, and to support practice staff with a simple and predictable administrative experience. The Policy Update Bulletin was developed to share important information regarding UnitedHealthcare Dental Clinical Policy and Coverage Guideline updates.*

*Where information in this bulletin conflicts with applicable state and/or federal law, UnitedHealthcare follows such applicable federal and/or state law

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Dental Clinical Policy & Coverage Guideline Updates

Overview

This bulletin provides complete details on UnitedHealthcare Dental Clinical Policy, Coverage Guideline, and Utilization Review Guideline (URG) updates. The inclusion of a dental service (e.g., procedure or technology) in this bulletin indicates only that UnitedHealthcare has recently adopted a new policy and/or updated, revised, replaced or retired an existing policy; it does not imply that UnitedHealthcare provides coverage for the dental service. In the event of an inconsistency or conflict between the information provided in this bulletin and the posted policy, the provisions of the posted policy will prevail. Note that most benefit plan documents exclude from benefit coverage health services identified as investigational or unproven/not medically necessary. Physicians and other health care professionals may not seek or collect payment from a member for services not covered by the applicable benefit plan unless first obtaining the member's written consent, acknowledging that the service is not covered by the benefit plan and that they will be billed directly for the service.

A complete library of Dental Clinical Policies & Coverage Guidelines is available at **UHCprovider.com** > *Policies and Protocols > Dental Clinical Policies and Coverage Guidelines.*

Tips for using the Policy Update Bulletin:

- From the table of contents, click the policy title to be directed to the corresponding policy update summary.
- From the policy updates table, click the policy title to view a complete copy of a new, updated, or revised policy.

Policy Update Classifications

New

New clinical coverage criteria and/or documentation review requirements have been adopted for a health service (e.g., test, drug, device or procedure)

Updated

An existing policy has been reviewed and changes have not been made to the clinical coverage criteria or documentation review requirements; however, items such as the clinical evidence, FDA information, and/or list(s) of applicable codes may have been updated

Revised

An existing policy has been reviewed and revisions have been made to the clinical coverage criteria and/or documentation review requirements

Replaced

An existing policy has been replaced with a new or different policy

Retired

The health service(s) addressed in the policy are no longer being managed or are considered to be proven/medically necessary and are therefore not excluded as unproven/not medically necessary services, unless coverage guidelines or criteria are otherwise documented in another policy

Note: The absence of a policy does not automatically indicate or imply coverage. As always, coverage for a health service must be determined in accordance with the member's benefit plan and any applicable federal or state regulatory requirements. Additionally, UnitedHealthcare reserves the right to review the clinical evidence supporting the safety and effectiveness of a medical technology prior to rendering a coverage determination.

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Take Note

ANNUAL CDT® CODE UPDATES

Effective Jan. 1, 2019, the following Dental Clinical Policies, Coverage Guidelines, and Utilization Review Guidelines will be modified to reflect the 2019 Current Dental Terminology (CDT®) code additions, revisions, and deletions. Refer to the following source for information on the 2019 code updates:

American Dental Association®. Current Dental Terminology: CDT®

Policy Title	Policy Type	Summary of Changes
General Anesthesia and Conscious Sedation Services	Coverage Guideline	• Revised description for D9219
Miscellaneous Diagnostic Procedures	Clinical Policy	• Added D0412
National Standardized Dental Claim Utilization Review Criteria	Utilization Review Guideline	• Added D0412, D1516, D1517, D1526, D1527, D5282, D5283, D5876, D9613, D9944, D9945, and D9946 • Removed D1515, D1525, D5281, and D9940
Occlusal Guards	Coverage Guideline	• Added D9944, D9945, and D9946 • Removed D9940
Removable Prosthodontics	Coverage Guideline	• Added D5282, D5283, and D5876 • Removed D5281 • Revised description for D5211, D5212, and D5630
Space Maintenance	Coverage Guideline	• Added D1516, D1517, D1526, and D1527 • Removed D1515 and D1525
Therapeutic Parenteral Drug Administration and In-Office Dispensing of Medications	Clinical Policy	• Added D9613

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Clinical Policy Updates

Policy Title	Effective Date	Summary of Changes
UPDATED		
Salivary Testing	Jan. 1, 2019	• Updated supporting information to reflect the most current description of services, clinical evidence, and references; no change to coverage rationale or list of applicable codes

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
REVISED			
Genetic Testing for Oral Disease	Feb. 1, 2019	• Revised coverage rationale; replaced language indicating: ○ "The collection, preparation and testing of genetic samples *are* indicated for patients who have known human papilloma virus (HPV) infection, or have other related risk factors, to identify if the strain of HPV known to be related to oral and oropharyngeal cancers is present" with "the collection, preparation and testing of genetic samples *may be* indicated for patients who have known human papilloma virus (HPV) infection, or have other related risk factors, to identify if the strain of HPV *(HPV16)* known to be related to oral and oropharyngeal cancers is present" ○ "*The clinical utility of* genetic testing for susceptibility to periodontal diseases *has not been established; additionally, there is a lack of objective, high quality clinical evidence to support these tests*" with "genetic testing for susceptibility to	**<u>Collection and Preparation of Genetic Sample Material for Laboratory Analysis and Report</u>** ***Genetic Test for Susceptibility to Diseases – Specimen Analysis*** The collection, preparation and testing of genetic samples may be indicated for patients who have known human papilloma virus (HPV) infection, or have other related risk factors, to identify if the strain of HPV (HPV16) known to be related to oral and oropharyngeal cancers is present. Genetic testing for susceptibility to periodontal diseases and caries is not indicated due to insufficient evidence of efficacy.

Clinical Policy Updates

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
REVISED			
Genetic Testing for Oral Disease *(continued)*	Feb. 1, 2019	periodontal diseases *and caries is not indicated due to insufficient evidence of efficacy"* • Updated supporting information to reflect the most current clinical evidence and references	

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Coverage Guideline Updates

Policy Title	Effective Date	Summary of Changes
UPDATED		
Non-Ionizing Diagnostic Procedures	Jan. 1, 2019	• Updated supporting information to reflect the most current clinical evidence and references; no change to coverage rationale or list of applicable codes
Non-Surgical Endodontics	Jan. 1, 2019	• Updated supporting information to reflect the most current references; no change to coverage rationale or list of applicable codes

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
REVISED			
Provisional Splinting	Feb. 1, 2019	• Revised coverage rationale; removed language pertaining to coverage limitations and exclusions • Updated supporting information to reflect the most current references	**Provisional Splinting using these codes is indicated for the following**: • Multiple teeth that have become mobile due to loss of alveolar bone loss and periodontium • During surgical and healing phases of regenerative periodontal therapy **Provisional Splinting using these codes is not indicated for the following**: • Tooth transplantation • Trauma resulting in the reimplantation of completely avulsed tooth/teeth • Trauma resulting in displacement or fracture of tooth/teeth
Single Tooth Indirect Restorations	Feb. 1, 2019	• Revised coverage rationale; removed language pertaining to coverage limitations and exclusions • Updated supporting information to reflect the most current description of services, clinical evidence, and references	**Indications for Coverage** For indirect restorations, the following clinical parameters apply: • Five-year longevity should be evident, periodontium must be healthy or have documentation the member has periodontal disease under control for a period of at least 6 months, and no evidence of endodontic pathology or potential endodontic issues on the radiographic image. ***Crowns*** **Crowns are indicated for the following**: • Extensive caries on three or more surfaces or 50% loss of clinical Crown • Large, >50% of the tooth, defective restoration that can be seen on the radiographic image or intraoral photograph • Fracture of cusps • Endodontically treated teeth, unless minimal access opening on anterior tooth • Documentation that a direct restoration is not possible • Crown/root ratio must be favorable • Documentation/narrative that the failing existing Crown can only be

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Coverage Guideline Updates

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
REVISED			
Single Tooth Indirect Restorations *(continued)*	Feb. 1, 2019		resolved with a new Crown if not visible on radiographic image or intraoral photograph • 50% bone support with no ligament or root pathology unless patient has undergone periodontal therapy/surgery • Anterior teeth: at least 50% involvement of incisal portion • Bicuspids and molars: 3 or more surfaces and/or one or more cusps involved • Symptomatic "cracked tooth syndrome" (not enamel craze lines) • Full coverage restoration of a primary tooth without a permanent successor **Crowns are not indicated for the following**: • If a lesser means of restoration is acceptable • If root resorption is present • Solely for cosmetic/aesthetic reasons (peg teeth, diastema closure, discoloration) • For alteration of vertical dimension • For purposes of preventing future fracture, or to eliminate enamel craze lines (cracked tooth syndrome must be diagnosed with documented diagnostic tests and supported by a narrative; tooth must be symptomatic) • To treat non-pathologic wear/abrasion, or abfraction lesions in the absence of decay • For molars exhibiting bone loss with a class III furcation involvement • Periodontally compromised teeth, even with successful endodontics, unless the patient has undergone previous periodontal therapy/surgery and progress notes/periodontal notes indicate the tooth is stable • Fracture of porcelain not involving the margin or a functional ridge is not sufficient for replacement ***Onlays*** **Onlays are indicated for the following**: • Extensive caries on three or more surfaces or 50% loss of clinical Crown • Large, >50% of the tooth, defective restoration that can be seen on the radiographic image or intraoral photograph • Fracture of cusps • Endodontically treated teeth, unless minimal access opening on anterior tooth • Documentation that a direct restoration is not possible

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Coverage Guideline Updates

<table>
<tr><th>Policy Title</th><th>Effective Date</th><th>Summary of Changes</th><th>Coverage Rationale</th></tr>
<tr><td colspan="4">REVISED</td></tr>
<tr><td>Single Tooth Indirect Restorations (continued)</td><td>Feb. 1, 2019</td><td></td><td>

Crown/root ratio must be favorable
Documentation/narrative that the failing existing Onlay can only be resolved with a new Onlay if not visible on radiographic image or intraoral photograph
50% bone support with no ligament or root pathology unless patient has undergone periodontal therapy/surgery
Anterior teeth: at least 50% involvement of incisal portion
Bicuspids and molars: 3 or more surfaces and/or one or more cusps involved
Benefitted for primary teeth without permanent successor
Bicuspids and molars: 3 or more surfaces and one or more cusps involved
Symptomatic “cracked tooth syndrome”

Onlays are not indicated for the following:

If a lesser means of restoration is acceptable
If root resorption is present
Solely for cosmetic/aesthetic reasons (peg teeth, diastema closure, discoloration)
For alteration of vertical dimension
For purposes of preventing future fracture, or to eliminate enamel craze lines (cracked tooth syndrome must be diagnosed with documented diagnostic tests and supported by a narrative; tooth must be symptomatic)
To treat non-pathologic wear/abrasion, or abfraction lesions in the absence of decay
For molars exhibiting bone loss with a class III furcation involvement
Periodontally compromised teeth, even with successful endodontics, unless the patient has undergone previous periodontal therapy/surgery and progress notes/periodontal notes indicate the tooth is stable
Fracture of porcelain not involving the margin or a functional ridge is not sufficient for replacement

Inlays
Inlays are unproven.
Inlays have not been proven superior over direct restorations and are alternative benefitted to amalgam restorations.
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