March 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

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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UPDATED		
Oral Surgery: Miscellaneous Surgical Procedures	Mar. 1, 2019	• Updated list of applicable CDT codes; added D7295
Prefabricated Crowns	Mar. 1, 2019	• Updated supporting information to reflect the most current references; no change to coverage rationale or list of applicable codes

Surgical Endodontics	Mar. 1, 2019	• Simplified coverage rationale (no change to guidelines)
		• Updated definition of:
		  ○ Periradicular
		  ○ *Root End Resection/*Apicoectomy
		• Updated supporting information to reflect the most current description of services, clinical evidence, and references

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
REVISED			

Surgical Periodontics: Mucogingival Procedures	Apr. 1, 2019	• Revised coverage rationale:
		Tissue Graft Procedures
		  ○ Simplified/reorganized content
		  ○ Revised list of indications for free soft tissue graft procedure (including donor site surgery); added:
		    ▪ Areas with less than 2 mm of attached gingiva
		    ▪ Ridge augmentation
		Biologic Materials to Aid in Soft and Osseous Tissue Regeneration
		  ○ Replaced language indicating "biologic materials to aid in soft and osseous tissue regeneration *are intended* to enhance periodontal tissue regeneration and healing *for mucogingival defects* in conjunction with
			Tissue Graft Procedures
			Pedicle soft tissue Graft, Autogenous connective tissue Graft, non-Autogenous connective tissue Graft and combined connective tissue and double pedicle Graft procedures are indicated for the following:
			• Areas with less than 2 mm of attached gingiva
			• Unresolved sensitivity in areas of Recession
			• Progressive Recession or chronic inflammation
			• For teeth with subgingival restorations where there is little or no attached gingiva to improve plaque control
			• Ridge augmentation
			• To increase vestibular depth for the correct fit of prosthesis
			• To widen zone of attached gingiva for prosthetic abutment teeth
			• To increase vestibular depth to allow proper oral hygiene techniques
			• Gingival clefting
			
			Pedicle soft tissue Graft, Autogenous connective tissue Graft, non-Autogenous connective tissue Graft and combined connective tissue and double pedicle Graft procedures are not indicated for the following:
			• Roots covered with thin bony plates
			• Individuals with an untreated medical condition
			• Autogenous connective tissue Graft is not indicated when there is a

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
REVISED			
[Surgical Periodontics: Mucogingival Procedures](#) *(continued)*	Apr. 1, 2019	mucogingival surgeries; there is *inconclusive clinical* evidence demonstrating the *benefit* of these materials in published peer-reviewed literature and further clinical studies are needed" with "biologic materials to aid in soft and osseous tissue regeneration *may be indicated* to enhance periodontal tissue regeneration and healing in conjunction with mucogingival surgeries; there is *a lack of* evidence demonstrating the *efficacy* of these materials in published peer-reviewed literature and further *high quality* clinical studies are needed" **Guided Tissue Regeneration – Resorbable and Non-Resorbable Barrier (Includes Membrane Removal)** ○ Updated coverage statement to indicate Guided Tissue Regeneration *may* be indicated *to enhance periodontal tissue regeneration and healing for mucogingival defects in conjunction with mucogingival surgeries; there is a lack of evidence in the published peer-reviewed literature demonstrating the clinical superiority of these materials over grafting*	broad, shallow palatal donor site, or excessively glandular or fatty submucosal tissue in donor site **Free soft tissue Graft procedure (including donor site surgery) is indicated for the following**: • Unresolved sensitivity in areas of Recession • Progressive Recession or chronic inflammation • For teeth with subgingival restorations where there is little or no attached gingiva to improve plaque control • To increase vestibular depth for the correct fit of prosthesis • To widen zone of attached gingiva for prosthetic abutment teeth • To increase vestibular depth to allow proper oral hygiene techniques • Gingival clefting • Areas with less than 2 mm of attached gingiva • Ridge augmentation **Free soft tissue Graft procedure is not indicated for the following**: • Broad, shallow palatal donor site • Excessively glandular or fatty submucosal tissue in donor site • A donor site with roots covered with thin bony plates • Individuals with an untreated medical condition **<u>Biologic Materials to Aid in Soft and Osseous Tissue Regeneration</u>** **Biologic Materials to aid in soft and osseous tissue regeneration may be indicated to enhance periodontal tissue regeneration and healing in conjunction with mucogingival surgeries**. There is a lack of evidence demonstrating the efficacy of these materials in published peer-reviewed literature and further high quality clinical studies are needed. **<u>Guided Tissue Regeneration – Resorbable and Non-Resorbable Barrier (Includes Membrane Removal)</u>** **Guided Tissue Regeneration may be indicated to enhance periodontal tissue regeneration and healing for mucogingival defects in conjunction with mucogingival surgeries**. There is a lack of evidence in the published peer-reviewed literature demonstrating the clinical superiority of these materials over grafting procedures.

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
REVISED			
Surgical Periodontics: Mucogingival Procedures *(continued)*	Apr. 1, 2019	*procedures* ○ Removed lists of conditions for which Guided Tissue Regeneration is/is not indicated • Updated definitions: ○ Modified definition of "Biologic Materials/*Biologic Response Modifiers*" ○ Removed definition of "Site" • Updated supporting information to reflect the most current description of services, clinical evidence, FDA information, and references	
Surgical Periodontics: Regenerative Procedures	Apr. 1, 2019	• Revised coverage rationale: **Biologic Materials to Aid in Soft and Osseous Tissue Regeneration** ○ Updated coverage statement to indicate there is *a lack of high quality* evidence demonstrating the *efficacy* of these materials in published peer-reviewed literature and further clinical studies are needed ○ Removed description of service and list of conditions for which Biologic Materials to aid in soft and osseous tissue regeneration are not indicated **Guided Tissue Regeneration – Resorbable and Non-Resorbable Barrier (Includes Membrane Removal)** ○ Replaced language indicating	**Bone Replacement Grafts** **Bone Replacement Grafts are indicated for the following**: • Infrabony/Intrabony vertical defects • Class II Furcation involvements **Bone Replacement Grafts are not indicated for the following**: • Class I Furcation involvement • Class III or higher Furcation involvement • Non-vertical defects • Individuals with an uncontrolled underlying medical condition • Individuals who have been non-compliant with previous periodontal therapies • Individuals with poor oral hygiene • Teeth with a hopeless prognosis (more than 75% bone loss and Class 3 or higher Mobility) **Biologic Materials to Aid in Soft and Osseous Tissue Regeneration** There is a lack of high quality evidence demonstrating the efficacy of these materials in published peer-reviewed literature and further clinical studies are needed. **Guided Tissue Regeneration – Resorbable and Non-Resorbable Barrier (Includes Membrane Removal)**

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
REVISED			
Surgical Periodontics: Regenerative Procedures *(continued)*	Apr. 1, 2019	"guided tissue regeneration *is* indicated for the [listed conditions]" with "guided tissue regeneration *may be* indicated for the [listed conditions]" **Surgical Revision Procedure (per Tooth)** ○ Replaced language indicating "a surgical revision procedure *is* indicated to correct an abnormal healing response that interferes with the therapeutic goals of the original regenerative surgical procedure" with "a surgical revision procedure *may be* indicated to correct an abnormal healing response that interferes with the therapeutic goals of the original regenerative surgical procedure" • Updated definitions: ○ Modified definition of "Biologic Materials/*Biologic Response Modifiers*" ○ Removed definition of "Site" • Updated supporting information to reflect the most current description of services, clinical evidence, FDA information, and references	**Guided Tissue Regeneration may be indicated for the following**: • Intrabony/infrabony vertical defects • Class II Furcation involvements **Guided Tissue Regeneration is not indicated for the following**: • Teeth with a hopeless prognosis (more than 75% bone loss and Class 3 or higher Mobility) • Class I Furcation involvement • Class III or higher Furcation involvement • Horizontal bone loss • Non-vertical defects • Individuals with an uncontrolled underlying medical condition • Individuals who have been non-compliant with previous periodontal therapies • Individuals with poor oral hygiene • Crater defects **Surgical Revision Procedure (per Tooth)** **A surgical revision procedure may be indicated to correct an abnormal healing response that interferes with the therapeutic goals of the original regenerative surgical procedure**. **A surgical revision procedure is not indicated solely for cosmetic/aesthetic purposes**.
Surgical Periodontics: Resective Procedures	Apr. 1, 2019	• Revised coverage rationale: ○ Simplified/reorganized content ○ Added language to indicate clinical crown lengthening-	**Gingivectomy/Gingivoplasty** **Gingivectomy/Gingivoplasty is indicated for the following**: • Elimination of suprabony pockets, exceeding 3mm, if the pocket wall is fibrous and firm and there is an adequate zone of keratinized tissue • Elimination of gingival enlargements/overgrowth due to medications,

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
REVISED			
Surgical Periodontics: Resective Procedures *(continued)*	Apr. 1, 2019	hard tissue is indicated to allow preservation of the biological width for restorative procedures • Removed definition of "Site" • Updated supporting information to reflect the most current references	medical conditions or tooth position • Elimination of suprabony periodontal abscesses • For exposure of soft tissue impacted teeth to aid in eruption • To reestablish gingival contour following an episode of acute necrotizing ulcerative gingivitis • To allow restorative access, including root surface caries **Gingivectomy/Gingivoplasty is not indicated for the following**: • When bone surgery is required for infrabony defects, or for the purpose of examining bone shape and morphology • Situations in which the bottom of the pocket is apical to the mucogingival junction • Areas where aesthetics are a concern (particularly in the anterior maxilla) • In areas with a shallow palatal vault or prominent external oblique ridge • Severely edematous or inflamed tissue • Individuals with poor plaque control or non-compliance with non-surgical procedures • Individuals with an uncontrolled underlying medical condition • Solely for cosmetic/aesthetic purposes **Anatomical Crown Exposure** **Anatomical Crown exposure is indicated in a periodontally healthy area for the following**: • Facilitate the restoration of subgingival caries • Allow proper contour of restoration • Allow management of a fractured tooth in which the fracture extends subgingivally **Anatomical Crown exposure is not indicated for the following**: • Solely for cosmetic/aesthetic purposes • Individuals with an uncontrolled underlying medical condition **Flap Procedures** **Gingival Flap and Apically Positioned Flap procedures are indicated for the following (includes root planing)**: • The presence of moderate to deep probing depths • Loss of attachment • The need for increased access to root surface and/or alveolar bone when

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
REVISED			
Surgical Periodontics: Resective Procedures *(continued)*	Apr. 1, 2019		previous non-surgical attempts have been unsuccessful • The diagnosis of a cracked tooth, fractured root or external root resorption when this cannot be accomplished by non-invasive methods • To preserve keratinized tissue in conjunction with osseous surgery **Flap procedures are not indicated for the following**: • Solely for cosmetic/aesthetic purposes • Individuals with an uncontrolled underlying medical condition • Individuals who have been non-compliant with previous periodontal therapies **<u>Clinical Crown Lengthening-Hard Tissue</u>** **Clinical crown lengthening-hard tissue is indicated for the following**: • In an otherwise periodontally healthy area to allow a restorative procedure on a tooth with little to no crown exposure • To allow preservation of the biological width for restorative procedures **Clinical crown lengthening-hard tissue is not indicated for the following**: • As treatment for periodontal disease • Solely for cosmetic/aesthetic purposes • Individuals with an uncontrolled underlying medical condition **<u>Osseous Surgery</u>** **Osseous Surgery is indicated for the following**: • Patients with a diagnosis of moderate to advanced periodontal disease • For cases of Refractory periodontal disease • When less invasive therapy (i.e., non-surgical periodontal therapy, Flap procedures) has failed to eliminate disease **Osseous Surgery is not indicated for the following**: • Individuals with a diagnosis of mild periodontal disease • For teeth with a hopeless prognosis (more than 80% bone loss and Class 3 or higher Mobility) • Individuals with an uncontrolled underlying medical condition • Individuals who have been non-compliant with previous periodontal therapies **<u>Distal or Proximal Wedge (When Not Performed in Conjunction with</u>**

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
REVISED			
Surgical Periodontics: Resective Procedures *(continued)*	Apr. 1, 2019		**Surgical Procedures in the Same Anatomical Area)** **Distal or proximal wedge procedure is indicated for the following**: • The presence of moderate to deep probing depths (greater than 5mm) on a surface adjacent to an edentulous/terminal tooth area • The need for increased access to root surface and/or alveolar bone when previous non-surgical attempts have been unsuccessful on a surface adjacent to an edentulous/terminal tooth area • The diagnosis of a cracked tooth, fractured root or external root resorption on a surface adjacent to an edentulous/terminal tooth area, when this cannot be accomplished by non-invasive methods **Distal or proximal wedge procedure is not indicated for the following**: • Solely for cosmetic/aesthetic purposes • Individuals with an uncontrolled underlying medical condition • Individuals who have been non-compliant with previous periodontal therapies • In areas in which there are teeth with proximal contact

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Coverage Guideline Updates

Policy Title	Effective Date	Summary of Changes
UPDATED		
Dental Care Services in an Operating Room or Ambulatory Surgery Center	Mar. 1, 2019	• Updated coverage rationale: ○ Modified language to clarify prior authorization documentation requirements apply only to plans that require authorization • Updated benefit considerations: ○ Replaced language indicating "prior authorization requirements apply to UnitedHealthcare *commercial* plans that require services to be *medically* necessary, including being cost-effective; refer to the member specific benefit plan document to determine if *medical* necessity applies" with "prior authorization requirements apply to UnitedHealthcare plans that require services to be necessary, including being cost-effective; refer to the member specific benefit plan document to determine if necessity applies"

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
REVISED			
General Anesthesia and Conscious Sedation Services	Apr. 1, 2019	• Revised coverage rationale: ○ Replaced references to services/procedures being indicated or contraindicated "*for* the [listed situations]" with "*in* the [listed] *situations*" ○ Removed language pertaining to coverage limitations and exclusions ○ Revised list of situations in which moderate/conscious sedation administered intravenously may be indicated: ▪ Replaced: - "Anxiety and fear" with "anxiety and fear *when other techniques have proven inadequate"* - "Pain control" with "pain control *when other techniques have proven inadequate"*	Different types of sedation are used in dentistry and are proven to decrease anxiety, diminish fear and increase tolerance for dental procedures. It may also be the only way to provide safe and comprehensive dental treatment for individuals of certain criteria. Local Anesthesia is not covered in conjunction with operative or surgical procedures. It is considered an inclusive component of any dental procedure unless used for pain relief or if pain relief is required to make an accurate diagnosis. Nerve blocks are not addressed in this Dental Coverage Guideline; please refer to the appropriate Medical Policy. Regional and trigeminal block anesthesia is not a covered service. **Nitrous Oxide** **Nitrous oxide may be indicated in the following**: • Ineffective Local Anesthesia • Anxiety • Individuals with special needs • Extensive and/or complex services for individuals • Behaviorally challenged or uncooperative individuals • Management of a severe gag reflex **Nitrous oxide is contraindicated in, but not limited to, the following situations**: • Severe underlying medical conditions (e.g., severe chronic obstructive

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
REVISED			
General Anesthesia and Conscious Sedation Services *(continued)*	Apr. 1, 2019	- "Management of gag reflex if nitrous oxide is not suitable" with "management of gag reflex if nitrous oxide is *ineffective or* not suitable" ▪ Removed "oral surgery" ○ Removed language indicating moderate/ conscious sedation administered intravenously is contraindicated for certain prescribed pharmaceuticals • Updated definitions: ○ Removed definition of "Conscious Sedation" ○ Modified definition of "Moderate Sedation *("Conscious Sedation")*" • Updated supporting information to reflect the most current references	pulmonary diseases, congestive heart failure, sickle cell anemia, acute otitis media, recent tympanic membrane graft, acute severe head injury) • Upper respiratory tract infections or other acute respiratory conditions • Severe emotional disturbances • Severe behavioral disorders • Drug related dependencies • Claustrophobic individuals • Pregnancy – first trimester • Treatment with bleomycin sulfate (injection used in cancer patients) • Methlenetetrahydropfolate reductase (MTHFR) deficiency • Vitamin B12 deficiency **Moderate/Conscious Sedation** **Moderate/Conscious Sedation administered intravenously may be indicated in the following situations**: • Anxiety and fear when other techniques have proven inadequate • Pain control when other techniques have proven inadequate • Management of gag reflex if nitrous oxide is ineffective or not suitable • Individuals that are medically compromised or those with special needs **Moderate/Conscious Sedation administered intravenously is contraindicated for, but not limited to, the following**: • Allergy to intravenous medications • In any individual where intravenous sedation presents increased risk of adverse outcome or complications **Non-Intravenous Sedation** **Non-intravenous sedation may be indicated in the following situations**: • Anxiety • Individuals that are uncooperative or unmanageable **Non-intravenous sedation is contraindicated for individuals with, but not limited to, the following**: • Member or dentist convenience **Nerve Blocks** Nerve blocks are not covered for dental services. Please refer to the appropriate Medical Policy for specifics regarding coverage for nerve blocks.

Coverage Guideline Updates

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<tr><td colspan="4">REVISED</td></tr>
<tr><td>General Anesthesia and Conscious Sedation Services (continued)</td><td>Apr. 1, 2019</td><td></td><td><u>Deep Sedation/General Anesthesia</u>
Deep Sedation/General Anesthesia is a proven and effective form of sedation. However, the decision to administer Deep Sedation/General Anesthesia should be made on an individual basis.

Deep Sedation/General Anesthesia may be indicated in the following situations:
• Clinical procedures of extensiveness or complexity or situations that require more than a local anesthetic
• Uncooperative or unmanageable individuals for which other behavior management techniques are inappropriate or inadequate
• Physical, cognitive or developmental disabilities
• Significant underlying medical condition
• Allergy or sensitivity to Local Anesthesia
• Lengthy restoration procedures for pediatric members
• Individuals with extreme anxiety or fear

Deep Sedation/General Anesthesia is contraindicated in, but not limited to, the following situations:
• Individuals with predisposing medical and/or physical conditions that potentially make Deep Sedation/General Anesthesia unsafe
• Cooperative individuals with minimal dental needs
• Choice of an alternative option for treatment
• Language or cultural barriers
• Parental objection</td></tr>
<tr><td>Occlusal Guards</td><td>Apr. 1, 2019</td><td>• Revised coverage rationale; removed language pertaining to coverage limitations and exclusions
• Added definition of "Bruxism"
• Updated supporting information to reflect the most current references</td><td><u>Occlusal Guards</u>
Occlusal guards are indicated for the following:
• Bruxism or clenching either as a nocturnal parasomnia or during waking hours, resulting in excessive wear or fractures of natural teeth or restorations
• To protect natural teeth when the opposing dentition has the potential to cause enamel wear such as the presence of porcelain or ceramic restorations
• When nocturnal clenching or Bruxism results in tooth sensitivity

Occlusal guards are not indicated for the following:
• For treatment of temporomandibular disorders or myofacial pain disfunction</td></tr>
</table>

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
REVISED			
Occlusal Guards *(continued)*	Apr. 1, 2019		• As an athletic Mouthguard • As an appliance intended for orthodontic tooth movement **Fabrication of Athletic Mouthguard** Athletic Mouthguards are intended to protect the dentition during athletic activities and not a covered service. **Occlusal Orthotic Devices** Occlusal Orthotic Devices are appliances intended for the management of orofacial pain or to reposition or stabilize the jaw for the treatment of temporomandibular disorders (TMD) and not a covered service under the dental plan. TMD and these appliances are considered to be medical in nature and are typically covered under the medical plans. Please see the appropriate medical policy for information.

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Utilization Review Guideline (URG) Updates

Policy Title	Effective Date	Summary of Changes
UPDATED		
National Standardized Dental Claim Utilization Review Criteria	Mar. 1, 2019	• Updated list of related policies for CDT code D7295; added reference link to the Dental Clinical Policy titled Oral Surgery: Miscellaneous Surgical Procedures