MEDICALLY NECESSARY ORTHODONTIC TREATMENT

Guideline Number: DCG003.06  Effective Date: November 1, 2018

Table of Contents

COVERAGE RATIONALE ........................................... 1
DEFINITIONS ..................................................... 1
APPLICABLE CODES ............................................. 2
DESCRIPTION OF SERVICES ....................................... 3
REFERENCES ....................................................... 3
GUIDELINE HISTORY/REVISION INFORMATION ................. 4
INSTRUCTIONS FOR USE .......................................... 4

COVERAGE RATIONALE

Indications for Coverage

Orthodontic Treatment

Orthodontic treatment is a covered dental service and Medically Necessary when the following criteria have been met:

- All services must be approved by the plan; and
- The member is under the age 19 (through age 18, unless the member specific benefit plan document indicates a different age); and
- Services are related to the treatment of a severe craniofacial deformity that results in a physically Handicapping Malocclusion, including but not limited to the following conditions:
  - Cleft Lip and/or Cleft Palate;
  - Crouzon Syndrome/Craniofacial Dysostosis;
  - Hemifacial Hypertrophy/Congenital Hemifacial Hyperplasia;
  - Parry-Romberg Syndrome/Progressive Hemifacial Atrophy;
  - Pierre-Robin Sequence/Complex;
  - Treacher-Collins Syndrome/Mandibulofacial Dysostosis; or
  - Other clinical criteria based on the member specific benefit plan document and any federal or state mandates.

Removal of Fixed Orthodontics Appliances for Reasons Other Than Completion of Treatment

Removal of fixed orthodontics appliances for reasons other than completion of treatment is a decision to be made by the treating provider based on an individual patient basis. Reasons include, but are not limited to:

- Patient non-compliance (AAOMS)
- Military deployment (Department of the Army)
- Prior to radiation therapy to the head or neck if the appliances will be in the radiation field (NIH, AAPD)
- Prior to highly stomatotic chemotherapy (NIH, AAPD)
- Complications related to IV bisphosphonates and other medical conditions (AAOMS)

DEFINITIONS

Cleft Lip: A congenital facial defect of the lip due to failure of fusion of the medial and lateral nasal prominences and maxillary prominence. (American Cleft Palate-Craniofacial Association)

Cleft Palate: A congenital fissure in the medial line of the palate. (American Cleft Palate-Craniofacial Association)

Comprehensive Orthodontic Treatment: A coordinated diagnosis and treatment leading to the improvement of a patient's craniofacial dysfunction and/or dentofacial deformity which may include anatomical, functional and/or esthetic relationships. Treatment may utilize fixed and/or removable orthodontic appliances and may also include functional and/or orthopedic appliances in growing and non-growing patients. Adjunctive procedures to facilitate care may be required. Comprehensive orthodontics may incorporate treatment phases focusing on specific objectives at various stages of dentofacial development. (AAO)
**Craniofacial Anomaly**: A structural or functional abnormality that affects the cranium or face. (American Cleft Palate-Craniofacial Association)

**Crouzon Syndrome/Craniofacial Dysostosis**: One of a large group of facial birth defects in which there is abnormal craniofacial fusion. This fusion does not allow the bones to grow normally, affecting the shape of the head, appearance of the face and the relationship of the teeth. (American Cleft Palate-Craniofacial Association)

**Handicap (as related to Handicapping Malocclusion)**: A physical, mental, or emotional condition that interferes with one's normal functioning. (Farlex Partner Medical Dictionary)

**Hemifacial Hypertrophy/Congenital Hemifacial Hyperplasia**: A rare developmental anomaly characterized by asymmetric overgrowth. Hemihyperplasia can be an isolated finding, but it also may be associated with a variety of malformation syndromes. (Neville 2016)

**Malocclusion (as related to Handicapping Malocclusion)**: A deviation in intramaxillary and/or intermaxillary relations of teeth from normal occlusion. Often associated with other dentofacial deformities. (AAO)

**Medically Necessary**: The health care services provided for the purpose of preventing, evaluating, diagnosing or treating a sickness, injury, mental illness, substance use disorder, condition, disease or its symptoms, that are all of the following as determined by us or our designee, within our sole discretion.
- In accordance with Generally Accepted Standards of Medical Practice.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your sickness, injury, mental illness, substance use disorder, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

*Generally Accepted Standards of Medical Practice* are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within our sole discretion.

We develop and maintain clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by us and revised from time to time), are available to Covered Persons on [www.myuhc.com](http://www.myuhc.com) or by calling Customer Care at the telephone number on your ID card, and to Physicians and other health care professionals on [www.UHCprovider.com](http://www.UHCprovider.com). (COC, 2011, 2017)

**Parry-Romberg Syndrome/Progressive Hemifacial Atrophy**: A rare disorder characterized by slowly progressive deterioration (atrophy) of the skin and soft tissues of half of the face (hemifacial atrophy), usually the left side. (National Institutes of Health)

**Pierre-Robin Sequence/Complex**: A complex of congenital anomalies including micrognathia and abnormal smallness of the tongue, often with cleft palate, severe myopia, congenital glaucoma, and retinal detachment. (American Cleft Palate-Craniofacial Association)

**Treacher-Collins Syndrome/Mandibulofacial Dysostosis**: The name given to a birth defect which may affect the size and shape of the ears, eyelids, cheek bones, and upper and lower jaws. The extent of facial deformity varies from one affected individual to another. (American Cleft Palate-Craniofacial Association)

**APPLICABLE CODES**

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Clinical Policies and Coverage Guidelines may apply.
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<tr>
<th>CDT Code</th>
<th>Description</th>
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<tr>
<td>D8010</td>
<td>Limited orthodontic treatment of the primary dentition</td>
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<td>D8020</td>
<td>Limited orthodontic treatment of the transitional dentition</td>
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<td>Limited orthodontic treatment of the adolescent dentition</td>
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<td>D8040</td>
<td>Limited orthodontic treatment of the adult dentition</td>
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<td>D8050</td>
<td>Interceptive orthodontic treatment of the primary dentition</td>
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<td>Comprehensive orthodontic treatment of the transitional dentition</td>
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<td>Comprehensive orthodontic treatment of the adolescent dentition</td>
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<td>D8090</td>
<td>Comprehensive orthodontic treatment of the adult dentition</td>
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<td>D8220</td>
<td>Fixed appliance therapy</td>
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<td>D8660</td>
<td>Pre-orthodontic treatment examination to monitor growth and development</td>
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<td>D8670</td>
<td>Periodic orthodontic treatment visit</td>
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<td>D8680</td>
<td>Orthodontic retention [removal of appliances, construction and placement of retainer(s)]</td>
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<td>D8690</td>
<td>Orthodontic treatment (alternative billing to a contract fee)</td>
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<td>D8691</td>
<td>Repair of orthodontic appliance</td>
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<td>D8695</td>
<td>Removal of fixed orthodontic appliances for reasons other than completion of treatment</td>
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<tr>
<td>D8999</td>
<td>Unspecified orthodontic procedure, by report</td>
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**DESCRIPTION OF SERVICES**

Medically necessary orthodontic treatment involves the correction of the dental component of a craniofacial abnormality that results in a handicapping malocclusion, and is intended to restore a functional dentition. It is not for orthodontic services for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or horizontal/vertical discrepancies (overjet/overbite).

**REFERENCES**


American Cleft Palate – Craniofacial Association.

Department of the Army. U.S. Army Dental Command Policy 07-08, Orthodontic Care Policy. 2007.


GUIDELINE HISTORY/REVISION INFORMATION

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<td>o Simplified and relocated Instructions for Use</td>
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<td>o Removed Benefit Considerations section</td>
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<td>11/01/2018</td>
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INSTRUCTIONS FOR USE

This Dental Coverage Guideline provides assistance in interpreting UnitedHealthcare standard dental benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plan may differ from the standard dental plan. In the event of a conflict, the member specific benefit plan document governs. Before using this guideline, please check the member specific benefit plan document and any applicable federal or state mandates. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Dental Coverage Guideline is provided for informational purposes. It does not constitute medical advice.