UnitedHealthcare

UnitedHealthcare® Dental
Coverage Guideline

MEDICALLY NECESSARY ORTHODONTIC TREATMENT

Guideline Number: DCG003.08 **Effective Date**: November 1, 2020

Instructions for Use

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Related Medical Policy

- Orthognathic (Jaw) Surgery

COVERAGE RATIONALE

Orthodontic treatment is 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.

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.

CDT Code	Description
D8010	Limited orthodontic treatment of the primary dentition
D8020	Limited orthodontic treatment of the transitional dentition
D8030	Limited orthodontic treatment of the adolescent dentition
D8040	Limited orthodontic treatment of the adult dentition
D8050	Interceptive orthodontic treatment of the primary dentition
D8060	Interceptive orthodontic treatment of the transitional dentition
D8070	Comprehensive orthodontic treatment of the transitional dentition
D8080	Comprehensive orthodontic treatment of the adolescent dentition

CDT Code	Description
D8090	Comprehensive orthodontic treatment of the adult dentition
D8220	Fixed appliance therapy
D8660	Pre-orthodontic treatment examination to monitor growth and development
D8670	Periodic orthodontic treatment visit
D8680	Orthodontic retention [removal of appliances, construction and placement of retainer(s)]
D8690	Orthodontic treatment (alternative billing to a contract fee)
D8695	Removal of fixed orthodontic appliances for reasons other than completion of treatment
D8696	repair of orthodontic appliance – maxillary
D8697	repair of orthodontic appliance – mandibular
D8698	re-cement or re-bond fixed retainer – maxillary
D8699	re-cement or re-bond fixed retainer – mandibular
D8701	repair of fixed retainer, includes reattachment – maxillary
D8702	repair of fixed retainer, includes reattachment – mandibular
D8703	replacement of lost or broken retainer – maxillary
D8704	replacement of lost or broken retainer – mandibular
D8999	Unspecified orthodontic procedure, by report

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 Dental Association (ADA); CDT 2021 Dental Procedure Code Book.

American Academy of Pediatric Dentistry Guideline on Dental Management of Pediatric Patients Receiving Chemotherapy, Hematopoietic Cell Transplantation, and/or Radiation Therapy. Revised 2013.

American Association of Orthodontists Clinical Practice Guidelines for Orthodontics and Dentofacial Orthopedics 2014.

American Association of Orthodontists Glossary 2017.

American Cleft Palate – Craniofacial Association.

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

Information on Essential Health Benefits (EHB) Benchmark Plans (links to States plans). Available at: https://www.cms.gov/cciio/resources/data-resources/ehb.html. Accessed September 1, 2020.

National Institutes of Health, National Institute of Neurological Disorders and Stroke. Parry-Romberg Information Page. 2017.

Neville B, Damm D, Allen C et al. Oral and Maxillofacial Pathology, 4th ed. St. Louis, MO: Elsevier c2016. Chapter 1, Developmental Defects of the Oral and Maxillofacial Region; p. 1-48.

U.S. Department of Health and Human Services, National Institutes of Health, National Institute of Dental and Craniofacial Research. Oral Complications of Cancer Treatment: What the Dental Team Can Do. 2009.

UnitedHealthcare Company Generic Certificate of Coverage 2011.

UnitedHealthcare Company Generic Certificate of Coverage 2018.

GUIDELINE HISTORY/REVISION INFORMATION

Date	Action/Description
11/01/2020	• Routine review; no content changes • Archived previous policy version DCG003.07

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.