# Coverage Summary

## Dental Services, Oral Surgery and Treatment of Temporomandibular Joint (TMJ)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Approved by:</td>
<td>UnitedHealthcare Medicare Benefit Interpretation Committee</td>
<td>Last Review Date: 10/15/2019</td>
<td></td>
</tr>
</tbody>
</table>

**Related Medicare Advantage Policy Guidelines:**
- [Dental Examination Prior to Kidney Transplantation (NCD 260.6)]
- [Manipulation (NCD 150.1)]
- [Dental Services]

---

This information is being distributed to you for personal reference. The information belongs to UnitedHealthcare and unauthorized copying, use, and distribution are prohibited. This information is intended to serve only as a general reference resource and is not intended to address every aspect of a clinical situation. Physicians and patients should not rely on this information in making health care decisions. Physicians and patients must exercise their independent clinical discretion and judgment in determining care. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the Member’s Evidence of Coverage (EOC)/Summary of Benefits (SB). If there is a discrepancy between this policy and the member’s EOC/SB, the member’s EOC/SB provision will govern. The information contained in this document is believed to be current as of the date noted.

The benefit information in this Coverage Summary is based on existing national coverage policy, however, Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable.

There are instances where this document may direct readers to a UnitedHealthcare Commercial Medical Policy, Medical Benefit Drug Policy, and/or Coverage Determination Guideline (CDG). In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence (Medicare IOM Pub. No. 100-16, Ch. 4, §90.5).

---

# INDEX TO COVERAGE SUMMARY

<table>
<thead>
<tr>
<th>I.</th>
<th>COVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Dental Services or Oral Surgery</td>
</tr>
<tr>
<td>2.</td>
<td>Temporomandibular Joint (TMJ)</td>
</tr>
<tr>
<td>3.</td>
<td>Orthognathic Surgery</td>
</tr>
<tr>
<td>4.</td>
<td>Dental services and oral surgery services that are not covered</td>
</tr>
</tbody>
</table>

| II. | DEFINITIONS |
| III. | REFERENCES |
| IV. | REVISION HISTORY |
| V.  | ATTACHMENTS |

---

## I. COVERAGE

**Coverage Statement:** Dental and oral surgery service are covered when Medicare Coverage criteria are met.

**Guidelines/Notes:**

1. **Dental Services or Oral Surgery**

   Dental services or oral surgery, rendered by a physician or dental professional, for treatment of primary medical conditions are covered. The dental procedures are not covered. Examples of
these non-covered services are items and services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth.

Notes:

- **Outpatient (Part B) Services including Ambulatory Surgery Center Procedures**
  Whether services such as the administration of anesthesia, diagnostic x-rays, and other related procedures are covered depends upon whether the primary procedure being performed by the dentist is itself covered. Thus, an x-ray taken in connection with the reduction of a fracture of the jaw or facial bone is covered. However, a single x-ray or x-ray survey taken in connection with the care or treatment of teeth or the periodontium is not covered.

  *For coverage of inpatient (Part A) facilities and anesthesia charges, refer to [Guideline #1.g](#) below.*

- **Place of Service**
  Medicare makes payment for a covered dental procedure no matter where the service is performed. The hospitalization or nonhospitalization of a patient has no direct bearing on the coverage or exclusion of a given dental procedure.

- **Services Performed by a Dentist**
  If an otherwise noncovered procedure or service is performed by a dentist as incident to and as an integral part of a covered procedure or service performed by the dentist, the total service performed by the dentist on such an occasion is covered.

  Because the general exclusion of payment for dental services has not been withdrawn, payment for the services of dentists is also limited to those procedures which are not primarily provided for the care, treatment, removal, or replacement of teeth or structures directly supporting the teeth.

  A dentist qualifies as a physician if he/she is a doctor of dental surgery or of dental medicine who is legally authorized to practice dentistry by the State in which he/she performs such function and who is acting within the scope of his/her license when he/she performs such functions. Such services include any otherwise covered service that may legally and alternatively be performed by doctors of medicine, osteopathic medicine and dentistry; e.g., dental examinations to detect infections prior to certain surgical procedures, treatment of oral infections and interpretations of diagnostic X-ray examinations in connection with covered services. The coverage of any given dental service is not affected by the professional designation of the physician rendering the service; i.e., an excluded dental service remains excluded and a covered dental service is still covered whether furnished by a dentist or a doctor of medicine or osteopathy.

  See the [Medicare Benefit Policy Manual, Chapter 15, §150 - Dental Services](#).

  Also see the following:
  - [Medicare Benefit Policy Manual, Chapter 15, §140 - Dental Services Exclusion](#)
  - [Medicare Benefit Policy Manual, Chapter 15, §260.5 - List of Covered Ambulatory Surgical Center Procedures](#)
  - [Medicare General Information, Eligibility, and Entitlement, Chapter 5, §70.2 - Dentists.](#)
  - [Medicare Benefit Policy Manual, Chapter 1, §70 - 70 - Inpatient Services in Connection With Dental Services](#)

  *(Accessed July 30, 2019)*

Examples of covered services include, but are not limited to:

a. Setting of the jaw or facial bones (includes wiring of the teeth when performed in connection with the reduction of a jaw fracture).
Splints and casts, and other devices used for reductions of fractures and dislocations are covered under Part B of Medicare. This includes dental splints.

Dental splints used to treat a dental condition are excluded from coverage under 1862(a)(12) of the Act. On the other hand, if the treatment is determined to be a covered medical condition (i.e., dislocated upper/lower jaw joints), then the splint can be covered.

See the Medicare Benefit Policy Manual, Chapter 15, §150 - Dental Services. Also see the Medicare Benefit Policy Manual, Chapter 1, §100 - Surgical Dressings, Splints, Casts, and Other Devices Used for Reductions of Fractures and Dislocations. (Accessed July 30, 2019)

b. Reconstruction of a ridge that is performed as a result of and at the same time as the surgical removal of a tumor (for other than dental purposes). See the Medicare Benefit Policy Manual, Chapter 15, §150 - Dental Services. (Accessed July 30, 2019)

c. Extraction of teeth to prepare the jaw for radiation treatments of neo-plastic disease is covered. See the Medicare Benefit Policy Manual, Chapter 15, §150 - Dental Services. Also see the Medicare Benefit Policy Manual, Chapter 16, §140 - Dental Services Exclusion. (Accessed July 30, 2019)

d. Payment may be made under part A in the case of inpatient hospital services in connection with the provision of dental services if the individual, because of his underlying medical condition and clinical status or because of the severity of the dental procedure, requires hospitalization in connection with the provision of such services. See the Statutory Dental Exclusion section of the Medicare Dental Coverage Overview at http://www.cms.hhs.gov/MedicareDentalCoverage/ and the Medicare Benefit Policy Manual, Chapter 1, §70 - 70 - Inpatient Services in Connection With Dental Services. (Accessed July 30, 2019)

e. Insertion of Metallic Implants

- Medicare does not have a National Coverage Determination for insertion of metallic dental implants.
- Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For state-specific LCDs/LCAs, refer to the LCD Availability Grid (Attachment B).
- For states with no LCDs/LCAs, refer to the Palmetto LCD for Dental Services (L34574).
  (IMPORTANT NOTE: After searching the Medicare Coverage Database, if no state LCD/LCA is found, then use the above referenced policy.)
- Committee approval date: August 20, 2019
- Accessed November 18, 2019

Note: Crowns, dentures, and other dental prostheses are not covered even if supported by the implants. See the Medicare Dental Coverage Overview - Services Excluded under Part B. (Accessed July 30, 2019)

f. Oral or dental examinations Prior to Kidney Transplantation or Heart Valve Replacement.

Oral or dental examinations, but not treatment, performed inpatient as part of a comprehensive workup prior to kidney/renal transplantation surgery or heart valve replacement. Such a dental or oral examination would be covered under Part A of the program if performed by a dentist on the hospital's staff, or under Part B if performed by a physician. See the NCD for Dental Examination Prior to Kidney Transplantation (260.6). Also see the Medicare Dental Coverage Overview. (Accessed July 30, 2019)

g. Inpatient (Part A) Facilities and Anesthesia Charges (For anesthesia coverage for Part B services, see Guideline 1 Note above.)
Facilities and anesthesia charges in an inpatient facility when a dental procedure cannot be
performed in a dental office due to an underlying medical condition and clinical status or
the severity of a non-covered dental procedure, are covered.

When a patient is hospitalized for a dental procedure and the dentist's service is covered
under Part B, the inpatient hospital services furnished are covered under Part A. For
example, both the professional services of the dentist and the inpatient hospital expenses
are covered when the dentist reduces a jaw fracture of an inpatient at a participating
hospital.

When the hospital services are covered, all ancillary services such as x-rays, administration of anesthesia, use of the operating room, etc., are covered.

Regardless of whether the inpatient hospital services are covered, the medical services of
physicians furnished in connection with the non-covered dental procedures are not
covered. Examples of these non-covered services are items and services of an
anesthesiologist, radiologist, or pathologist in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth.

See the Medicare Benefit Policy Manual, Chapter 1, §70 - Inpatient Services in
Connection With Dental Services Covered Under Part A. Also see the Medicare Benefit

The attending doctor of dental surgery or of dental medicine is authorized to certify that
the patient's underlying medical condition and clinical status or the severity of the dental
procedure requires the patient to be admitted to the hospital for the performance of the
dental procedure; and to recertify the patient's continuing need for hospitalization when
required. This applies even if the dental procedure is not covered. See the Medicare
General Information, Eligibility, and Entitlement, Chapter 4, §10.3 - Certification for
Hospital Admissions for Dental Services. (Accessed July 30, 2019)

h. Denture as part of the prosthesis when the denture or a portion of denture is an integral part
(built-in) of a covered prosthesis (e.g., an obturator which fills an opening in the palate. See the Medicare Benefit Policy Manual, Chapter 15, §120 - Prosthetic Devices, C - Dentures.
(Accessed July 30, 2019)

Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) for Dental Services
exist. Compliance with these policies is required where applicable. These LCDs are available
(Accessed July 31, 2019)

2. Temporomandibular Joint (TMJ)

There are a wide variety of conditions that can be characterized as TMJ, and an equally wide
variety of methods for treating these conditions. Many of the procedures fall within the
Medicare program’s statutory exclusion that prohibits payment for items and services that have
not been demonstrated to be reasonable and necessary for the diagnosis and treatment of illness
or injury (§1862(a)(1) of the Act). Other services and appliances used to treat TMJ fall within
the Medicare program’s statutory exclusion at 1862(a)(12), which prohibits payment “for
services in connection with the care, treatment, filling, removal, or replacement of teeth or
structures directly supporting teeth... ” For these reasons, a diagnosis of TMJ on a claim is
insufficient. The actual condition or symptom must be determined. See the Medicare Benefit
(Accessed July 30, 2019)

Treatment of TMJ may include:

a. Oral medications (May be available for coverage under the member’s Part D plan
b. Botulinum Toxins A & B
   • Medicare does not have a National Coverage Determination for Botulinum Toxins A & B for treatment of TMJ.
   • Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For state-specific LCDs/LCAs, refer to the LCD Availability Grid (Attachment A).
   • For states with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Benefit Drug Policy for Botulinum Toxins A and B. (IMPORTANT NOTE: After searching the Medicare Coverage Database, if no state LCD/LCA is found, then use the above referenced policy.)
   • Committee approval date: October 15, 2019
   • Accessed November 18, 2019

c. Manipulation of the head. See the NCD for Manipulation (150.1). (Accessed July 31, 2019)

d. TMJ devices and supplies
   • For jaw motion rehabilitation system (HCPCS codes E1700 - E1702), refer to the Coverage Summary for Durable Medical Equipment (DME), Prosthetics, Corrective Appliances/Orthotics (Non-Foot Orthotics) and Medical Supplies Grid (Jaw Motion Rehabilitation System).
   • For traction equipment (E0849 or E0855) for the treatment of TMJ, see the Coverage Summary for Durable Medical Equipment (DME), Prosthetics, Corrective Appliances/Orthotics (Non-Foot Orthotics) and Medical Supplies Grid (Traction Equipment).

e. Arthrocentesis
   • Medicare does not have a National Coverage Determination for Arthrocentesis for treatment of TMJ.
   • Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist at this time.
   • For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy for Temporomandibular Joint Disorders. (IMPORTANT NOTE: After searching the Medicare Coverage Database, if no state LCD/LCA is found, then use the above referenced policy.)
   • Committee approval date: August 20, 2019
   • Accessed July 31, 2019

f. Treatments such as the injection of corticosteroid, physical therapy, arthroscopy, or arthroplasty
   • Medicare does not have a National Coverage Determination (NCD) for corticosteroid injections, physical therapy, arthroscopy or arthroplasty used in treatment of TMJ.
   • Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist at this time.
   • For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy for Temporomandibular Joint Disorders. (IMPORTANT NOTE: After searching the Medicare Coverage Database, if no state LCD/LCA is found, then use the above referenced policy.)
   • Committee approval date: August 20, 2019
   • Accessed August 2, 2019
g. Sodium Hyaluronate Injections
   - Medicare does not have a National Coverage Determination (NCD) for sodium
     hyaluronate injections used in treatment of TMJ.
   - Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist
     at this time.
   - For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy
     for Sodium Hyaluronate.
     (IMPORTANT NOTE: After searching the Medicare Coverage Database, if no state
     LCD/LCA is found, then use the above referenced policy.)
   - Committee approval date: August 20, 2019
   - Accessed August 2, 2019

3. Orthognathic Surgery
   - Medicare does not have a National Coverage Determination (NCD) for orthognathic
     surgery.
   - Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and
     compliance with these policies is required where applicable. For state-specific LCDs/LCAs,
     refer to the LCD Availability Grid (Attachment C).
   - For states with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Coverage
     Determination Guideline for Orthognathic (Jaw) Surgery.
     (IMPORTANT NOTE: After searching the Medicare Coverage Database, if no state
     LCD/LCA is found, then use the above referenced policy.)
   - Committee approval date: October 15, 2019
   - Accessed November 18, 2019

4. The following dental services and oral surgery services are not covered:
   a. Items and services in connection with the care, treatment, filling, removal, or replacement
      of teeth or structures directly supporting the teeth are not covered. “Structures directly
      supporting the teeth” means the periodontium, which includes the gingivae, dentogingival
      junction, periodontal membrane, cementum of the teeth, and alveolar process.
      - See the Medicare Benefit Policy Manual, Chapter 15, §150 - Dental Services.
        (Accessed August 5, 2019)
      - Also see the Medicare Benefit Policy Manual, Chapter 16, §140 - Dental Services
        Exclusion. (Accessed August 5, 2019)
   b. Cosmetic surgery or treatment provided solely to improve the member’s appearance and
      not intended to improve the physical functioning of a malformed body part(s). See the
      5, 2019)
   c. Application of dental/orthodontic devices/appliances whether or not it accompanies oral
      and/or orthognathic surgery, except for the treatment of Temporomandibular Joint (TMJ)
      Disorders. See the Medicare Benefit Policy Manual, Chapter 15, §150.1 - Treatment of
      Temporomandibular Joint (TMJ) Syndrome. (Accessed August 5, 2019)
      For coverage guideline for the treatment of TMJ, refer to Guideline 2
      (Temporomandibular Joint (TMJ)) above.

Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) for Dental Services
exist. Compliance with these policies is required where applicable. These LCDs/LCAs are
II. DEFINITIONS

Cosmetic Surgery: Cosmetic or reconstructive surgery used to alter and improve the member's physical appearance or to improve the member's self-esteem and which provides no improvement to a functional impairment. *Medicare Benefit Policy Manual, Chapter 16, § 120 - Cosmetic Surgery.* (Accessed August 5, 2019)


III. REFERENCES

See above.
IV. REVISION HISTORY

10/15/2019  Guideline 2.b (Botulinum Toxins A & B)
- Updated language to clarify Medicare does not have a National Coverage Determination (NCD) for Botulinum Toxins A & B for treatment of TMJ

Guideline 2.e (Arthrocentesis)
- Updated language to clarify Medicare does not have a NCD for Arthrocentesis for treatment of TMJ

Guideline 3 (Orthognathic Surgery)
- Revised language pertaining to applicable Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) to indicate:
  - LCDs/LCAs exist and compliance with these policies is required, where applicable
    - For state-specific LCDs/LCAs, see Attachment C: LCD Availability Grid Orthognathic Surgery
    - For states with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Coverage Determination Guideline titled Orthognathic (Jaw) Surgery

Attachments
- Added Attachment C: LCD Availability Grid (Orthognathic Surgery)
- Updated LCD Availability Grids to reflect the most current reference links

V. ATTACHMENT(S)

Attachment A - LCD Availability Grid
Botulinum Toxin Types A & B

<table>
<thead>
<tr>
<th>LCD ID</th>
<th>LCD Title</th>
<th>Contractor Type</th>
<th>Contractor Name</th>
<th>States</th>
</tr>
</thead>
<tbody>
<tr>
<td>L35172</td>
<td>Botulinum Toxin Types A and B</td>
<td>A and B MAC</td>
<td>Noridian Healthcare Solutions, LLC</td>
<td>AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY</td>
</tr>
<tr>
<td>(A57186)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>L35170</td>
<td>Botulinum Toxin Types A and B Policy</td>
<td>A and B MAC</td>
<td>Noridian Healthcare Solutions, LLC</td>
<td>CA-Northern, CA-Southern, AS, GU, HI, MP, NV</td>
</tr>
<tr>
<td>(A57185)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

End of Attachment A

Attachment B - LCD Availability Grid
Insertion of Metallic Implant

<table>
<thead>
<tr>
<th>LCD ID</th>
<th>LCD Title</th>
<th>Contractor Type</th>
<th>Contractor Name</th>
<th>States</th>
</tr>
</thead>
<tbody>
<tr>
<td>L34574</td>
<td>Dental Services</td>
<td>A and B MAC</td>
<td>Palmetto GBA</td>
<td>AL, GA, NC, VA, WV, SC, TN</td>
</tr>
</tbody>
</table>

End of Attachment B

Attachment C - LCD Availability Grid
Orthognathic Surgery

<table>
<thead>
<tr>
<th>LCD ID</th>
<th>LCD Title</th>
<th>Contractor Type</th>
<th>Contractor Name</th>
<th>States</th>
</tr>
</thead>
<tbody>
<tr>
<td>L33428</td>
<td>Cosmetic and Reconstructive Surgery</td>
<td>A and B MAC</td>
<td>Palmetto GBA</td>
<td>AL, GA, NC, VA, WV, SC, TN</td>
</tr>
<tr>
<td>(A56658)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A53793</td>
<td>Billing and Coding: Gender Reassignment Services for Gender Dysphoria</td>
<td>A and B MAC</td>
<td>Palmetto GBA</td>
<td>AL, GA, NC, VA, WV, SC, TN</td>
</tr>
<tr>
<td>L34526</td>
<td>Surgical Treatment of</td>
<td>MAC - Part A and B</td>
<td>Wisconsin Physicians Service</td>
<td>IN, IA, KS, MI, MO, NE</td>
</tr>
</tbody>
</table>
**Attachment C - LCD Availability Grid**

**Orthognathic Surgery**

CMS website accessed November 18, 2019

<table>
<thead>
<tr>
<th>LCD ID</th>
<th>LCD Title</th>
<th>Contractor Type</th>
<th>Contractor Name</th>
<th>States</th>
</tr>
</thead>
<tbody>
<tr>
<td>(A56905)</td>
<td>Obstructive Sleep Apnea (OSA)</td>
<td></td>
<td>Insurance Corporation</td>
<td></td>
</tr>
<tr>
<td>L34526</td>
<td>Surgical Treatment of Obstructive Sleep Apnea (OSA)</td>
<td>MAC - Part A</td>
<td>Wisconsin Physicians Service Insurance Corporation</td>
<td>AK, AL, AR, AZ, CA, CO, CT, DE, FL, GA, HI, IA, ID, IL, IN, KS, KY,</td>
</tr>
<tr>
<td>(A56905)</td>
<td></td>
<td></td>
<td></td>
<td>LA, MA, MD, ME, MI, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, OH, OK,</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>OR, PA, RI, SC, SD, TN, TX, UT, VA, VT, WA, WY, WY</td>
</tr>
</tbody>
</table>

End of Attachment C