Coverage Summary

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

Policy Number: D-007  Products: UnitedHealthcare Medicare Advantage Plans  
Original Approval Date: 09/25/2008  
Approved by: UnitedHealthcare Medicare Benefit Interpretation Committee  
Last Review Date: 09/18/2018

Related Medicare Advantage Policy Guidelines:

- Dental Examination Prior to Kidney Transplantation (NCD 260.6)
- Dental Services
- Manipulation (NCD 150.1)

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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).

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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** 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 16, §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**.

(Accessed August 15, 2018)

**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 August 15, 2018)

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 August 15, 2018)

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 August 15, 2018)

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/. (Accessed August 15, 2018)

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, 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 21, 2018
- Accessed December 13, 2018

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 August 15, 2018)

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
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 Policy Manual, Chapter 15, §150 – Dental Services. (Accessed August 15, 2018)*

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 August 15, 2018)*

**Denture as part of the prosthesis when the denture or a portion of denture is an integral part (built-in) of a covered prothesis (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 August 15, 2018)*

Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) for Dental Services exist. Compliance with these policies is required where applicable. These LCDs are available at [http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx](http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx). (Accessed December 13, 2018)

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 Policy Manual, Chapter 15, §150.1 – Treatment of Temporomandibular Joint Syndrome. (Accessed August 15, 2018)

**Treatment of TMJ may include:**

a. Oral medications *(May be available for coverage under the member’s Part D plan benefit; contact the Prescription Solutions Customer Service Department to determine coverage eligibility for UnitedHealthcare Part D prescription drug plan benefit.)*

b. **Botulinum Toxins A & B**

   - Medicare does not have a National Coverage Determination for Botulinum Toxins A & B
   - 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,** 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:** August 21, 2018
   - **Accessed December 13, 2018**

c. Manipulation of the head. See the NCD for Manipulation (150.1) (Accessed August 15, 2018)

d. TMJ devices and supplies

   - For jaw motion rehabilitation system (HCPCS codes E1700 - E1702), refer to the 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 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
   - Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist at this time.
   - **For states with no LCDs,** 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 21, 2018
   - **Accessed July 26, 2018**

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 21, 2018**
- **Accessed July 26, 2018**

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) that specifically address the use of sodium hyaluronate in the treatment of TMJ 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 21, 2018**
- **Accessed July 26, 2018**

3. **Orthognathic Surgery**

- Medicare does not have a National Coverage Determination (NCD) for orthognathic surgery.
- Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist at this time
- **For coverage guidelines**, refer to the UnitedHealthcare Commercial Coverage Determination Guideline (CDG) 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: August 21, 2018**
- **Accessed July 26, 2018**

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 15, 2018)*

   *Also see the Medicare Benefit Policy Manual, Chapter 16, §140 - Dental Services Exclusion.* *(Accessed August 15, 2018)*

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 Medicare Benefit Policy Manual, Chapter 16, § 120 - Cosmetic Surgery.* *(Accessed August 15, 2018)*

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)

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 are available at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. (Accessed December 13, 2018)

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 15, 2018)


Dental Implant: A device specially designed to be placed surgically within or on the mandibular or maxillary bone as a means of providing for dental replacement; endosteal (endosseous); eposteal (subperiosteal); transosteal (transosseous). American Dental Association Glossary at http://www.ada.org/en/publications/cdt/glossary-of-dental-clinical-and-administrative-ter. (Accessed August 15, 2018)

III. REFERENCES

See above.

IV. REVISION HISTORY

04/01/2019 • Updated policy introduction; added language to clarify:
  o There are instances where [the Coverage Summary] may direct readers to a UnitedHealthcare Commercial Medical Policy, Medical Benefit Drug Policy, and/or Coverage Determination Guideline (CDG)
  o 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)
  • Retitled reference links that direct users to UnitedHealthcare Commercial policies

09/18/2018 Updated Local Coverage Determination (LCD) Availability Grids; removed instruction to “use the applicable LCD based on member’s residence/place and type of service” (this note only applies when selecting the appropriate DME LCD Policy)

08/21/2018 Annual review; no updates

08/15/2017 Annual review with the following updates:
  Guideline 1 (Dental Services or Oral Surgery)
  • Added notes for the following:
• **Place of Services**
  
• **Services Performed by a Dentist**
  
- Added reference link to the Medicare General Information, Eligibility, and Entitlement, Chapter 5, §70.2 – Dentists.

**Guideline 1 (Examples of covered services)**

- Deleted the following (language not in any of the Medicare manuals or LCDs):
  
  Reconstruction of the jaw when medically necessary (e.g., radical neck or removal of mandibular bone for cancer or tumor).

- Deleted the following; language not in any of the Medicare manuals; only addressed in the LCD for Palmetto LCD for Dental Services (L34574).
  
  Insertion of metallic implants if the implants are used to assist in or enhance the retention of a dental prosthetic as a result of a covered service under the member’s medical plan. See the Local Coverage Determinations (LCDs) for Dental Services

- Added new guideline for insertion of metallic implants with default to the Palmetto LCD for Dental Services (L34574) for states with no LCD

- Deleted the following (language not in any of the Medicare manuals or LCDs): Biopsy of gums or soft palate (e.g., for the diagnosis of a suspicious lesion for cancer). See the Local Coverage Determinations (LCDs) for Dental Services. Compliance with these policies is required where applicable. These LCDs are available at [http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx](http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx).

- Deleted the following (language not in any of the Medicare manuals or LCDs):
  
  Treatment of maxillofacial cysts, including extraction and biopsy. See the Local Coverage Determinations (LCDs) for Dental Services. Compliance with these policies is required where applicable. These LCDs are available at [http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx](http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx).

- Added “of a covered prosthesis” to align with the language in the reference Medicare Manual, to read: Denture as part of the prosthesis when the denture or a portion of denture is an integral part (built-in) of a covered prothesis (e.g., an obturator which fills an opening in the palate.

**Guideline 2.a (Treatment of TMJ) – added language to further clarify Part D coverage eligibility for oral medications.**

**Guideline 2.d (TMJ Devices and Supplies)**

- Added “For jaw Motion rehabilitation system” to the first bullet point

- Added cross reference to the Durable Medical Equipment (DME), Prosthetics, Corrective Appliances/Orthotics (Non-Foot Orthotics) and Medical Supplies Grid (Traction Equipment) for traction equipment (E0849 or E0855) for the treatment of TMJ

**Guideline 4 (Dental Services that are not covered)**

- Deleted the following (language not in any of the Medicare manuals or LCDs):
  
  Reconstruction of the jawbone or supporting tissues to provide a better fit for dentures or other mouth prostheses or reconstruction of the jawbone following services that were originally dental in nature. Example include, but not limited to reconstruction of mandible or maxilla, endosteal implant (CPT codes 21248 and 21249). See the Medicare Benefit Policy Manual, Chapter 16, §140 – Dental
Deleted “Dental Implants”; language not in any of the Medicare manuals or LCDs
Deleted the following (language not in any of the Medicare manuals or LCDs):

Bone grafts for preparation of dental implants. See the Services Excluded Under Part B section of the Medicare Dental Coverage Overview at http://www.cms.hhs.gov/MedicareDentalCoverage.

Definitions

Deleted the following definition; not in any of the Medicare manuals, LCDs, or ADA Glossary:

Dental/Orthodontic Devices/Appliances: Any device used to influence growth or the position of teeth and jaws. (e.g., braces, retainers, night guards, oral splints) American Dental Association Glossary at http://www.ada.org/glossaryforprofessionals.aspx#i.

Updated the reference link of the following definitions:

- Dental Prosthesis
- Dental Implant

03/21/2017 Re-review with the following updates to clarify coverage of anesthesia for dental procedures in a facility:

Guideline 1 (Dental Services and Oral Surgery)

- Note – added “Outpatient (Part B) Services including Ambulatory Surgery Center Procedures”

- Add reference links to the following:
  - Medicare Benefit Policy Manual, Chapter 16 General Exclusions From Coverage, §140 Dental Services Exclusion
  - Medicare Benefit Policy Manual (Pub 100-2), Ch 15, Covered Medical and Other Health Services, §260.5 - List of Covered Ambulatory Surgical Center Procedures.

- Revised the language “For coverage of facilities and anesthesia charges, refer to Guideline #1.j below” to “For coverage of inpatient (Part A) facilities and anesthesia charges, refer to Guideline #1.j below.”

Guideline 1.j (Facilities and anesthesia charges) - based on the Medicare Benefit Policy Manual, Chapter 1 - Inpatient Hospital Services, Section 70 - Inpatient Services in Connection With Dental Services Covered Under Part A:

- Revised the first paragraph. to read:

  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**

- Added the following language:

  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**.

- Revised the 4th paragraph, to read:
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.

08/16/2016  Annual review; no updates

02/16/2016  Guideline 2.e (Arthrocentesis) - deleted the following language “LCDs exist and replaced with the statement that LCDs do not exist at this time.”

Updated reference link(s) of the applicable LCDs to reflect the condensed link.

11/17/2015  Guideline 4.c (Dental services and oral surgery services that are not covered; reconstruction of the jawbone or supporting tissues) – added language to state:

Example include, but not limited to reconstruction of mandible or maxilla, endosteal implant (CPT codes 21248 and 21249)

09/15/2015  Annual review with the following updates:

Guideline #1.g [Biopsy of gums or soft palate (e.g., for the diagnosis of a suspicious lesion for cancer)] - Added reference link to the Local Coverage Determinations (LCDs) for Dental Services.

Guideline #1.h (Treatment of maxillofacial cysts, including extraction and biopsy) - Added reference link to the Local Coverage Determinations (LCDs) for Dental Services.

Guideline #2.e (Arthrocentesis) – Changed default from UnitedHealthcare Medical Policy for Mandibular Disorder (archived 7/15) to the UnitedHealthcare Medical Policy for Temporomandibular Joint Disorders.

Guideline #2.f (Treatments such as the injection of corticosteroid, physical therapy, arthroscopy, or arthroplasty) - Changed default from UnitedHealthcare Medical Policy for Mandibular Disorder (archived 7/15) to the UnitedHealthcare Medical Policy for Temporomandibular Joint Disorders.

Guideline #2.g (Sodium Hyaluronate Injections) – Added “for sodium hyaluronate injections used in treatment of TMJ” to first bullet point of guideline.

Guideline #4.e (Dental Implants) – Added reference and link to the Services Excluded Under Part B section of the Medicare Dental Coverage Overview.

Guideline #4.f (Bone grafts for preparation of dental implants) - Added reference and link to the Services Excluded Under Part B section of the Medicare Dental Coverage Overview.

Guideline #4.g [Fluoride trays and/or bite guards used to protect teeth from caries and possible infection during radiation. (HCPCS code D5986-Noncovered by Medicare)] – Deleted, unable to find appropriate CMS reference.

Guideline #4 (The following dental services and oral surgery services are not covered) – Added reference and link to the Local Coverage Determinations (LCDs) for Dental Services at end of this section.

06/16/2015  Guideline 1.i (Oral or dental examinations Prior to Kidney Transplantation or Heart Valve Replacement) - Revised language to indicate:
Oral or dental examinations, but not treatment, performed on an 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.

10/21/2014 Annual review with the following updates:

- Updated the definition of:
  - Cosmetic Surgery: Added reference link to the Medicare Benefit Policy Manual Chapter 16, §120 - Cosmetic Surgery
- Deleted the definition of:
  - Malocclusion (not used in the body of the Coverage Summary)
  - Orthognathic Surgery (definition in the default UnitedHealthcare Coverage Determination Guidelines for Orthognathic/Jaw Surgery)

02/18/2013

- Guideline #2.b (Botulinum Toxins A & B) - Changed default guideline for states without Local Coverage Determinations (LCDs) from UnitedHealthcare Medical Policy for Mandibular Disorders to UnitedHealthcare Medical Policy for Botulinum Toxins A and B
- Guidelines #2.g (Sodium Hyaluronate Injections)-added applicable guideline

10/24/2013 Annual review; no updates

08/20/2013

- Guidelines #1 (Dental Services or Oral Surgery) - Added noncoverage language for dental procedures and examples based on the Medicare Benefit Policy Manual
- Added a reference to Guidelines #1.j for coverage of facilities and anesthesia charges in a contracted facility
- Guidelines #1.j (Facilities and anesthesia charges in a contracted facility)- Added noncoverage language for dental procedures and clarification as to who is authorized to certify/recertify member’s underlying medical condition based on the Medicare Benefit Policy Manual

10/31/2012 Annual review; updated the applicable CMS references and links; also with the following updates:

- Guidelines #1.a.-added “Splints and casts, and other devices used for reductions of fractures and dislocations are covered under Part B of Medicare. This includes dental splints.”
- Guidelines #1.a.5 – deleted “Extraction of teeth if medically necessary for members undergoing transplant procedures”; replaced with “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” based on the Statutory Dental Exclusion section of the Medicare Dental Coverage Overview
- Guidelines #1.d (reconstruction of the jaw when medically necessary); #1.g (biopsy of gums or soft palate; and #1.h (treatment of maxillofacial cysts, including extraction and biopsy) were reviewed and confirmed by UMBIC as covered; no CMS reference found
- Guidelines #3.e (dental implants) and #3.f (bone grafts for preparation of dental implants) were reviewed and confirmed by UMBIC not as covered; no CMS
10/13/2011  Guidelines #2.b (Botulinum Toxins A & B) - updated to include the Trailblazer, Noridian and Palmetto LCD coverage determination for Botulinum Toxins Type A&B

09/07/2010  Policy updated to include the applicable Medicare references and link

V. ATTACHMENT(S)

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

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<th>LCD ID</th>
<th>LCD Title</th>
<th>Contractor Type</th>
<th>Contractor Name</th>
<th>States</th>
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<td>Botulinum Toxin Types A and B</td>
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<td>Noridian Healthcare Solutions, LLC</td>
<td>CA-Northern, CA-Southern, AS, GU, HI, MP, NV</td>
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End of Attachment A

### Attachment B - LCD Availability Grid
**Insertion of Metallic Implant**

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<thead>
<tr>
<th>LCD ID</th>
<th>LCD Title</th>
<th>Contractor Type</th>
<th>Contractor Name</th>
<th>States</th>
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<tbody>
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<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