DENTAL CARE AND ORAL SURGERY

Policy Number: BIP033.F
Effective Date: December 1, 2018

Related Benefit Interpretation Policies:
- Cosmetic, Reconstructive or Plastic Surgery
- Medical Necessity

Related Medical Management Guidelines:
- Orthognathic (Jaw) Surgery
- Preventive Care Services
- Temporomandibular Joint Disorders

Covered benefits are listed in three (3) Sections - A, B and C. All services must be medically necessary. Each benefit plan contains its own specific provisions for coverage, limitations and exclusions as stated in the member's Evidence of Coverage (EOC)/Schedule of Benefits (SOB). If there is a discrepancy between this policy and the member's EOC/SOB, the member's EOC/SOB provision will govern.

Essential Health Benefits for Individual and Small Group
For plan years beginning on or after January 1, 2014, the Affordable Care Act of 2010 (ACA) requires fully insured non-grandfathered individual and small group plans (inside and outside of Exchanges) to provide coverage for ten categories of Essential Health Benefits (“EHBs”). Large group plans (both self-funded and fully insured), and small group ASO plans, are not subject to the requirement to offer coverage for EHBs. However, if such plans choose to provide coverage for benefits which are deemed EHBs (such as maternity benefits), the ACA requires all dollar limits on those benefits to be removed on all Grandfathered and Non-Grandfathered plans. The determination of which benefits constitute EHBs is made on a state by state basis. As such, when using this guideline, it is important to refer to the member specific benefit document to determine benefit coverage.

A. FEDERAL/STATE MANDATED REGULATIONS

1. California Health and Safety Code Section 1367.71 (effective 1/1/2000) Dental Anesthesia:
   (a) Every health care service plan contract, other than a specialized health care service plan contract, that is issued, amended, renewed, or delivered on or after January 1, 2000, shall be deemed to cover general anesthesia and associated facility charges for dental procedures rendered in a hospital or surgery center setting, when the clinical status or underlying medical condition of the patient requires dental procedures that ordinarily would not require general anesthesia to be rendered in a hospital or surgery center setting. The health care service plan may require prior authorization of general anesthesia and associated charges required for dental care procedures in the same manner that prior authorization is required for other covered diseases or conditions.
(b) This section shall apply only to general anesthesia and associated facility charges for only the following enrollees, and only if the enrollees meet the criteria in subdivision (a):
   (1) Enrollees who are under seven years of age.
   (2) Enrollees who are developmentally disabled, regardless of age.
   (3) Enrollees whose health is compromised and for whom general anesthesia is medically necessary, regardless of age.

(c) Nothing in this section shall require the health care service plan to cover the charges for the dental procedure itself, including, but not limited to, the professional fees of the dentist. Coverage for anesthesia and associated facility charges pursuant to this section shall be subject to all other terms and conditions of the plan that applies generally to other benefits.

(d) Nothing in this section shall be construed to allow a health care service plan to deny coverage for basic health care services as defined in Section 1345 (Health and Safety Code).

(e) A health care service plan may include coverage specified in subdivision (a) at any time prior to January 1, 2000.

2. California Health & Safety Code 1367.68 Coverage for Surgical Conditions Affecting Upper and Lower Jawbone:
   (a) Any provision in a health care service plan contract entered into, amended, or renewed in this state on or after July 1, 1995, that excludes coverage for any surgical procedure for any condition directly affecting the upper or lower jawbone, or associated bone joints, shall have no force or effect as to any enrollee if that provision results in any failure to provide medically-necessary basic health care services to the enrollee pursuant to the plan’s definition of medical necessity.
   (b) For purposes of this section, “plan contract” means every plan contract, except a specialized health care service plan contract, that covers hospital, medical, or surgical expenses.
   (c) Nothing in this section shall be construed to prohibit a plan from excluding coverage for dental services provided that any exclusion does not result in any failure to provide medically-necessary basic health care services.

   (a) Every health care service plan contract, except a specialized health care service plan contract, that is issued, amended, renewed, or delivered in this state on or after July 1, 1999, shall cover reconstructive surgery, as defined in subdivision (c) that is necessary to achieve the purposes specified in paragraphs (A) or (B) of subdivision (c). Nothing in this section shall be construed to require coverage for cosmetic surgery, as defined in subdivision (d).
   (b) No individual, other than a licensed physician competent to evaluate the specific clinical issues involved in the care requested, may deny initial requests for authorization of coverage for treatment pursuant to this section. For a treatment authorization request submitted by a podiatrist or an oral and maxillofacial surgeon, the request may be reviewed by a similarly licensed individual competent to evaluate the specific clinical issues involved in the care requested.
   (Bolded areas below are Subsections C and D referenced in the above text of the law).
   (c) "Reconstructive surgery" means surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following:
   A. To improve function.
   B. To create a normal appearance to the extent possible.
(2) As of July 1, 2010, “reconstructive surgery” shall include medically necessary
dental or orthodontic services that are an integral part of reconstructive surgery,
as defined in paragraph (1), for cleft palate procedures.

(3) For purposes of this section, “cleft palate” means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate.

(d) "Cosmetic surgery" means surgery that is performed to alter or reshape normal structures of the body in order to improve appearance.

(e) In interpreting the definition of reconstructive surgery, a health plan may utilize prior authorization and utilization review that may include, but need not be limited to, any of the following:
   1. Denial of proposed surgery if there is another more appropriate surgical procedure that will be approved for the enrollee.
   2. Denial of the proposed surgery or surgeries if the procedure or procedures, in accordance with the standard of care as practiced by physicians specializing in reconstructive surgery, offer minimal improvement in the appearance of the enrollee.
   3. Denial of payment for procedures performed without prior authorization.
   4. For services provided under Medi-Cal (Chapter 7 (commencing with section 1400) of Part 3 of Division 9 of the Welfare and Institutional Code), denial of the proposed surgery if the procedure offers only a minimal improvement in the appearance of the enrollee, as may be defined in any regulations that may be promulgated by the State Department of Health Services.

(f) As applied to services described in paragraph (2) of subdivision (c) only, this section shall not apply to Medi-Cal managed care plans that contract with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) of, Chapter 8 (commencing with Section 14200) of, or Chapter 8.75 (commencing with Section 14591) of, Part 3 of Division 9 of the Welfare and Institutions Code, where such contracts do not provide coverage for California Children’s Services (CCS) or dental services.

B. STATE MARKET PLAN ENHANCEMENTS

For California Small Groups and UnitedHealthcare Benefits Plan of California: Please refer to the Pediatric Dental Addendum in the Combined Evidence of Coverage and Disclosure Form for additional pediatric Dental benefits for Members who are covered until at least the end of the month in which the Member turns 19 years of age.

C. COVERED BENEFITS

**IMPORTANT NOTE:** Covered benefits are listed in Sections A, B and C. Always refer to Sections A and B for additional covered benefits not listed in this Section.

**Note:** Refer to the member’s Evidence of Coverage (EOC)/Schedule of Benefit (SOB) to determine the coverage eligibility. Member may have Supplemental Dental Coverage.

Reconstructive procedures require preauthorization by the Member’s Network Medical Group or UnitedHealthcare in accordance with standards of care as practiced by physicians specializing in Reconstructive Surgery.

Oral Surgery or Dental Services, provided by a physician or Dental professional for treatment of primary medical conditions; examples include, but are not limited to:

1. Setting of the jaw or facial bones (includes wiring of teeth when performed in connection with the reduction of the jaw fracture)
2. Reconstruction of the jaw when Medically Necessary (e.g., radical neck or removal of mandibular bone for cancer or tumor)
3. 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)
4. 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. **Note:**
Crowns, dentures, and other Dental prostheses are not covered even if supported by the implants.

5. Oral or Dental exam performed on an inpatient or outpatient basis as part of a comprehensive workup prior to transplantation surgery

6. Extraction of teeth if Medically Necessary for members undergoing transplant procedures

7. Extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease to the head or neck

8. Emergency Health Care Services for stabilizing an acute injury to sound natural teeth, the jawbone, or the surrounding structures and tissues. Coverage is limited to treatment provided within 48 hours of the injury or as soon as the member is medically stable.

9. Biopsy of gums or soft palate

10. Treatment of maxillofacial cysts, including extraction and biopsy

11. Anesthesia and related Facility charges for Dental procedures provided in a Contracted Hospital or Outpatient surgery center are covered when:
   - the Member’s clinical status or underlying medical condition requires use of an Outpatient surgery center or Inpatient setting for the provision of the anesthesia for a Dental procedure(s) that ordinarily would not require anesthesia in a hospital or outpatient surgery center setting;
   - and (b) one of the following criteria is met:
     o The Member is under seven years of age;
     o The Member is developmentally disabled, regardless of age; or
     o The Member’s health is compromised and general anesthesia is Medically Necessary, regardless of age.
   - Member’s dentist must get prior-authorization from the Member’s Network Medical Group or UnitedHealthcare before the Dental procedure is provided.

12. Fluoride trays and/or bite guards used to protect teeth from caries and possible infection during radiation therapy

13. Denture as part of the prosthesis when the denture or a portion of denture is an integral part (built-in) of an obturator which fills an opening in the palate

14. Biopsy and excision of cysts or tumors of the jaw, treatment of malignant neoplastic disease and treatment of Temporomandibular joint syndrome (TMJ)

15. Preventive fluoride treatment prior to an aggressive chemotherapeutic or radiation therapy protocol

16. Reconstructive surgery due to congenital defect such as cleft lip and cleft palate. Refer to “Reconstructive surgery” procedure

17. Ridge augmentation or Alveoplasty are covered when determined to be Medically Necessary based on state Cosmetic Reconstructive Surgery Law and Jawbone Surgery Law

D. NOT COVERED

1. Services related to Routine Dental Care (see Section E), unless member has supplemental Dental coverage

2. Dental Services beyond the emergency treatment required to stabilize acute accidental injuries to sound natural teeth, jawbone or surrounding tissues (Review Sections A & B above for mandates and coverage)

3. Cosmetic surgery or treatment

4. Inpatient or outpatient hospitalization due to age and/or behavioral problems when no medical problem exists that would require the continuous monitoring by an anesthesiologist

5. Extraction of an impacted tooth, except as addressed above

6. 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

7. Removal of teeth for the main purpose of fitting for dentures

8. Alveoplasty when performed in connection with an excluded service, such as preparation of the mouth for dentures

9. Application of Dental/Orthodontic Devices/Appliances, whether or not it accompanies Oral and/or Orthognathic Surgery, except as addressed in the Treatment of Temporomandibular Joint (TMJ) Disorders policy. (Review Sections A & B above for mandates and coverage).

10. Physician services provided in connection with non-covered dental services
11. Dental Implants
12. Bone grafts for preparation of Dental Implants
13. Crowns, fillings, caps, dentures, braces, gold inlays, and other dental prosthesis are not covered unless specifically provided for under Section C.
14. Dental anesthesia in a Dental office or dental clinic is not covered.

E. DEFINITIONS

1. **Alveoplasty**: Conservative contouring of the alveolar process in preparation for immediate or future denture construction.

2. **Cosmetic Services and Surgery: (California only)**: Cosmetic surgery and cosmetic services are not covered. Cosmetic surgery and cosmetic services are defined as surgery and services performed to alter or reshape normal structures of the body in order to improve appearance. Drugs, devices and procedures related to cosmetic surgery or cosmetic services are not covered. Surgeries or services that would ordinarily be classified as cosmetic will not be reclassified as reconstructive, based on a Member’s dissatisfaction with his or her appearance.

3. **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)

4. **Dental Implant**: 1. Any object or material, such as an alloplastic substance or other tissue, which is partially or completely inserted or grafted into the body for therapeutic, diagnostic, prosthetic, or experimental purposes. 2. Generally an artificial structure placed into bone which provides for prosthetic replacement of some missing structure.

5. **Routine Dental Care**: Services in connection with care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth. Services include those for crowns, root canals, replacement of teeth, complete dentures, gold inlays, fillings, and other dental services specific to the treatment of the teeth.

6. **Reconstructive Surgery: (California only)**: Reconstructive procedures to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance for cosmetic purposes only, but rather to improve function and/or to create a normal appearance, to the extent possible.

F. POLICY HISTORY/REVISION INFORMATION

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<th>Date</th>
<th>State Market Plan Enhancements</th>
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<td>12/01/2018</td>
<td>- Revised language pertaining to California Small Groups and UnitedHealthcare Benefits Plan of California; replaced instruction to “refer to the Pediatric Dental Addendum in the Combined Evidence of Coverage and Disclosure Form for additional pediatric Dental benefits for Members under the age of 19” with “refer to the Pediatric Dental Addendum in the Combined Evidence of Coverage and Disclosure Form for additional pediatric Dental benefits for Members who are covered until at least the end of the month in which the Member turns 19 years of age”</td>
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**Covered Benefits**

- Replaced references to:
  - "Member’s Participating Medical Group” with “Member’s Network Medical Group”
  - “Emergency Services” with “Emergency Health Care"
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<tr>
<td><strong>Definitions</strong></td>
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<tr>
<td>• Removed definition of “Skeletal Facial Deformities”</td>
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<td>• Archived previous policy version BIP033.E</td>
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