

Policy: MP038

Section: Medical Benefit Policy

Subject: Oral Health

Applicable line of business:

Commercial	x	Medicaid	x
Medicare	x	ACA	x
CHIP	x		

I. Policy: Oral Health

II. Purpose/Objective:

To provide a policy of coverage regarding Oral Health

III. Responsibility:

- A. Medical Directors
- B. Medical Management

IV. Required Definitions

1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – the date the policy was implemented.
4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

Commercial

Geisinger Health Plan may refer collectively to health care coverage sponsors Geisinger Health Plan, Geisinger Quality Options, Inc., and Geisinger Indemnity Insurance Company, unless otherwise noted. Geisinger Health Plan is part of Geisinger, an integrated health care delivery and coverage organization.

Medicare

Geisinger Gold Medicare Advantage HMO, PPO, and HMO D-SNP plans are offered by Geisinger Health Plan/Geisinger Indemnity Insurance Company, health plans with a Medicare contract. Continued enrollment in Geisinger Gold depends on contract renewal. Geisinger Health Plan/Geisinger Indemnity Insurance Company are part of Geisinger, an integrated health care delivery and coverage organization.

CHIP

Geisinger Health Plan Kids (GHP Kids) is a Children’s Health Insurance Program (CHIP) offered by Geisinger Health Plan in conjunction with the Pennsylvania Department of Human Services (DHS). Geisinger Health Plan is part of Geisinger, an integrated health care delivery and coverage organization.

Medicaid

Geisinger Health Plan Family (GHP Family) is a Medical Assistance (Medicaid) insurance program offered by Geisinger Health Plan in conjunction with the Pennsylvania Department of Human Services (DHS). Geisinger Health Plan is part of Geisinger, an integrated health care delivery and coverage organization.

V. Additional Definitions

Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

- a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
- b. provided for the diagnosis, and the direct care and treatment of the Member's condition, illness disease or injury;
- c. in accordance with current standards of good medical treatment practiced by the general medical community.
- d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and
- e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

Medicaid Business Segment

Medically Necessary — A service, item, procedure, or level of care that is necessary for the proper treatment or management of an illness, injury, or disability is one that:

- Will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability.
- Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.
- Will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age

This definition of medical necessity will apply to all decisions made under the Health Choices program.

• **Impacted Wisdom Teeth**

For members in which applicable benefit documents include the Impacted Wisdom Tooth rider, the benefit is limited to those services that are expressly outlined in the applicable benefit document.

CHIP and Medicaid Business Segment: REQUIRES PRIOR AUTHORIZATION BY A PLAN MEDICAL DIRECTOR OR DESIGNEE

Coverage of extraction of impacted third molars is considered among the medically necessary services available under PA Medical Assistance benefits for both adults and children (less than 21 yrs. of age) when any of the following conditions are present:

Group A

- Symptoms such as severe pain, edema or trismus; and
- Physical and radiographic examination findings of acute pericoronitis, or dental caries or localized or spreading fascial space infection

Group B

- Absence of disease and one of the following:
- Symptoms including vague posterior quadrant pain from impending eruption in the setting of adequate space for the third molar to erupt into a useful, functional position ; or
- Other third molars located in quadrants in which there is referred myofascial or deafferentiated (atypical) pain.

Group C

- Absence of symptoms; and
- Physical and radiographic examination findings of periodontitis, non-restorable caries, or odontogenic cysts and tumors associated with the third molar.

• **Orthognathic Surgery - REQUIRES PRIOR AUTHORIZATION BY A PLAN MEDICAL DIRECTOR OR DESIGNEE**

Orthognathic surgery may be considered medically necessary to correct deformities of the maxilla and/or mandible secondary to congenital deformities, cleft lip or palate, or trauma when any of the following conditions are present:

1. Masticatory malocclusion, as defined by the American Association of Oral and Maxillofacial Surgeons (AAOMS) that results in dysfunction in chewing, swallowing, articulation or respiration and evidenced by one or more of the following measurements that represent two or more standard deviations from published norm:
 - Anteroposterior discrepancies

- i. Maxillary/mandibular incisor relationship: overjet of 5 millimeters (mm) or more, or a 0 to a negative value (norm 2 mm); or
 - ii. Maxillary/mandibular anteroposterior molar relationship discrepancy of 4 mm or more (norm 0-1 mm)
 - Vertical discrepancies defined as any of the following:
 - i. Presence of a vertical facial skeletal deformity which is two or more standard deviations from published norms for accepted skeletal landmarks
 - ii. Open bite
 - iii. Absence of vertical overlap of anterior teeth greater than 2 mm
 - iv. Unilateral or bilateral posterior open bite greater than 2 mm
 - v. Deep overbite with impingement or irritation of buccal or lingual soft tissues of the opposing arch
 - vi. Supraeruption of a dentialveolar segment due to a lack of opposing occlusion creating dysfunction not amenable to conventional prosthetics.
 - Transverse discrepancies
 - i. Presence of a transverse skeletal discrepancy which is two or more standard deviations from published norms; or
 - ii. Total bilateral maxillary palatal cusp to mandibular fossa discrepancy of 4 mm or greater, or a unilateral discrepancy of 3 mm or greater, given normal axial inclination of the posterior teeth
 - Asymmetries
 - i. Anteroposterior, transverse or lateral asymmetries greater than 3 mm with concomitant occlusal asymmetry
2. Facial skeletal deformities associated with documented sleep apnea or airway defects evidenced by moderate to severe obstructive sleep apnea confirmed by a sleep study, that occurs because of skeletal deformities that can only be corrected by surgical repositioning of the jaws
 3. To restore physiologic function after accidental injury or trauma
 4. Severe congenital defects (eg, cleft deformity) resulting in speech impairment.

• **Temporomandibular Joint (TMJ) Dysfunction**

Unless a specific contractual exclusion exists for treatment of TM dysfunction, members with orthotic benefits have coverage for occlusal splints, mandibular occlusal repositioning appliances or bite planes/splints for the treatment of TM joint disease.

Coverage is subject to the limitations of the member's applicable benefit document specific to the orthotic benefit.

- **Temporomandibular Joint Surgery** including arthrocentesis, arthroscopy, arthroplasty, condylotomy, and joint reconstruction is considered medically necessary for the treatment of a dislocation or complete degeneration of the TM joint in which severe pain or functional disability due to an intracapsular condition is confirmed by an imaging study or arthroscopy and non-surgical modalities of treatment have failed. Consultations to determine the need for surgery and radiologic determinations of pathology are covered.

• **Extraction of Teeth, Alveoplasty– REQUIRES PRIOR AUTHORIZATION BY A PLAN MEDICAL DIRECTOR OR DESIGNEE**

Although extraction of erupted teeth is generally excluded as a dental service in the applicable benefit documents, in some instances requests for extractions limited to the following situations when performed by a dentist or oral surgeon, may be considered for medical necessity

1. Cardiac surgery
2. Radiation therapy
3. Transplant procedures
4. Joint replacements

Dental reconstruction to replace the extracted teeth following the services listed above is **NOT COVERED**.

• **Fluoride gel tray**

Although Fluoride Gel Trays are generally considered a dental service and are excluded, in some instances coverage may be extended to members receiving radiotherapy for head and neck cancer. The Plan has determined that the use of fluoride gel trays is not separately reimbursable when provided by the same provider that is doing the radiation therapy. Fluoride gel trays (including the fluoride gel) for use in head and neck radiotherapy, provided by a specialty other than the radiation therapy provider, is a payable service.

- **Traumatic injury to teeth**

Coverage is limited to services and supplies necessary for the emergency treatment of dental trauma including but not limited to stabilization or reimplantation of accidentally avulsed or displaced sound, natural teeth, resulting from accidental injury (not chewing or biting). Medically necessary endodontics to the injured teeth will be considered for coverage within 6 months of the date of injury.

- **Treatment of fractures of the jaws or facial bones**

Note: Removal of broken teeth to accomplish a reduction of a jaw fracture is considered to be integral to the medical procedure and covered.

- **Frenulectomy**

Coverage is limited to treatment for ankyloglossia:

- when newborn feeding difficulties or childhood articulation problems exist; or
- to treat congenital defects interfering with physiologic function

- **Excision of tumors**

Coverage is limited to non-dental treatment related to medically diagnosed tumors.

- **Services Related to Maxillofacial Prosthetics -- REQUIRES PRIOR AUTHORIZATION BY A PLAN MEDICAL DIRECTOR OR DESIGNEE**

Medically necessary dental and oral cavity treatment related to the support and retention of maxillofacial prosthetics and obturators may be considered for coverage when required following surgical resection of head and neck tumors. The treatment plan must include detail of all required services and must be approved by a Plan medical director.

Hospital/ambulatory surgical center services - REQUIRES PRIOR AUTHORIZATION BY A PLAN MEDICAL DIRECTOR OR DESIGNEE

The Plan considers the following indications on a "per case" basis as being medically necessary for deep sedation or general anesthesia to perform an oral or dental surgery procedure:

- When deemed medically necessary for members aged 7 years or younger; **or**
- members who require multiple procedures in more than one quadrant of the mouth and there is an inability to perform the necessary services in a staged, "in-office" procedure or over multiple visits; **or**
- members who require complex procedures that have a documented failure of at least one attempt to perform the required procedure in an office setting (**NOTE: This criteria not applicable to Medicaid Business Segment**); **or**
- the member has a medical condition that precludes the use of in-office anesthesia methods or in whom in-office anesthesia methods are ineffective (due to acute local infection, anatomic variation or allergy); **or**
- When deemed medically necessary for individuals with certain physical, mental, or medically compromising conditions including, but not limited to, intellectual or developmental disability, cerebral palsy, or autism; **or**
- Patients who have sustained extensive orofacial or dental trauma and for whom in-office anesthesia methods would be ineffective

Coverage for anesthesia and related services is limited to services provided in connection with a covered or non-covered oral surgery procedure, provided on an inpatient or outpatient basis only when authorized in advance by a Plan Medical Director.

EXCLUSIONS:

- Passive jaw rehabilitation devices such as, but not limited to the TheraBite® system for the treatment of jaw hypomobility are considered investigational and are **NOT COVERED**. There is insufficient evidence to conclude that this device is effective for mandibular hypomobility.
- Chin implant (genioplasty, mentoplasty) performed to improve appearance and without evidence of physiologic functional deficit.
- Orthognathic surgery for correction of unaesthetic facial features regardless of whether they are associated with psychological disorders
- Orthognathic surgery for correction of temporomandibular joint disease or myofascial pain disorder.
- Oral brush biopsy for screening of cancerous or pre-cancerous lesions.
- Intra-oral appliances such as Nociceptive Trigeminal Inhibition-Tension Suppression for the treatment of TMJ and the treatment of headaches
- Any procedures performed for the preparation of the mouth for dentures including, but not limited to:
 - Removal of the torus mandibularis or maxillary torus palatines,
 - Conditioning of the gum and surrounding tissue
 - Dental implants and/or bone grafting

Medicaid Business Segment:

Any requests for services, that do not meet criteria set in the PARP, may be evaluated on a case by case basis.

Note: A complete description of the process by which a given technology or service is evaluated and determined to be experimental, investigational or unproven is outlined in MP 15 - Experimental Investigational or Unproven Services or Treatment.

LINE OF BUSINESS:

Eligibility and contract specific benefits, limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy. For Medicare, applicable LCD's and NCD's will supersede this policy. For PA Medicaid Business segment, this policy applies as written.

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TheraBite® Jaw Motion Rehabilitation System. http://www.therabite.com/study_trismus.html;
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Department of Health and Human Services Centers for Medicare & Medicaid Services 45 CFR Parts 144 and 146 Final Regulations for Health Coverage Portability for Group Health Plans and Group Health Insurance Issuers Under HIPAA Titles I & IV

Department of Labor, Employee Benefits Security Administration 29 CFR Part 2590

Department of the Treasury, Internal Revenue Service 26 CFR Parts 54 and 602

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American Academy of Pediatric Dentistry. Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures: An Update
http://www.aapd.org/media/Policies_Guidelines/G_Sedation.pdf

American Academy of Pediatric Dentistry. Behavior Guidance for the Pediatric Dental Patient
http://www.aapd.org/media/Policies_Guidelines/G_BehavGuide.pdf

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This policy will be revised as necessary and reviewed no less than annually.

Devised: 4/03

Revised: 1/04(clarification of criteria); 5/05; 7/05 (HIPPA regulations);7/06; 12/07(add coverage and exclusion clarification); 1/09 (wording); 12/09 (coverage clarifications); 4/10 (coverage clarification), 4/12 (updated anesthesia criteria), 4/13; 7/14 (coverage revisions); 12/15 (exclusion clarification) 2/18 (Clarify auth requirement for IWT), 10/19 (Added Maxillofacial Prosthetics and P/A, Remove Group D IWT criteria per DHS reviewer); 10/24 (revise TMJ orthotic language)

Reviewed: 7/07 (wording); 4/11, 1/17, 11/17, 10/20, 10/21, 10/22, 10/23

CMS UM Oversight Committee Approval: 12/23

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Coverage for experimental or investigational treatments, services and procedures is specifically excluded under the member's certificate with Geisinger Health Plan. Unproven services outside of an approved clinical trial are also specifically excluded under the member's certificate with Geisinger Health Plan. This policy does not expand coverage to services or items specifically excluded from coverage in the member's certificate with Geisinger Health Plan. Additional information can be found in MP015 Experimental, Investigational or Unproven Services.

Prior authorization and/or pre-certification requirements for services or items may apply. Pre-certification lists may be found in the member's contract specific benefit document. Prior authorization requirements can be found at <https://www.geisinger.org/health-plan/providers/ghp-clinical-policies>

Please be advised that the use of the logos, service marks or names of Geisinger Health Plan, Geisinger Quality Options, Inc. and Geisinger Indemnity Insurance Company on a marketing, press releases or any communication piece regarding the contents of this medical policy is strictly prohibited without the prior written consent of Geisinger Health Plan. Additionally, the above medical policy does not confer any endorsement by Geisinger Health Plan, Geisinger Quality Options, Inc. and Geisinger Indemnity Insurance Company regarding the medical service, medical device or medical lab test described under this medical policy.