Health Alliance™

Policy & Procedure

Policy Name:	Medical Policy: Dental Services	Policy #:	MP-171

Policy Information

Owner Department:	Medical UM & Systems Department
Owner:	Assigned Medical Director

If there is a discrepancy between a medical policy and a patient's policy or plan document/summary plan description, the policy or plan document/summary plan descriptions provisions and limitations will govern the determination of benefits.

Purpose of the Policy

To make utilization decisions, Health Alliance uses written criteria based on sound clinical evidence for appropriately applying the criteria.

Statement of the Policy

To apply objective and evidence-based criteria when determining the medical appropriateness of health care services.

Essential Health Benefits

APPLIES TO ILLINOIS and IOWA:
The Affordable Care Act (ACA) requires coverage of a minimal set of benefits known as Essential Health Benefits (EHB). The Illinois and Iowa Departments of Insurance (DOI) require coverage for extraction of completely bony impacted wisdom teeth as an EHB. Extraction of bony impacted wisdom teeth services are included and coverage is subject to the limitations of oral surgery/medical benefits for members who are enrolled in Illinois or Iowa Small Group Plans that renew on or after January 1, 2014 or Illinois Individual Plans. Plans that do not currently include this coverage are Small Group Plans renewing prior to January 1, 2014, Large Group Plans, and members renewing on 2013 Individual Plans.
APPLIES TO STATE of WASHINGTON:
Essential Health Benefits (EHB) for pediatric dental services in the State of Washington are not covered benefits, as they would be accessed separately through a dental plan in the marketplace.

NOTE: Please refer to the member's Plan File to determine eligibility for this requirement and Sections 1.2–1.3.

Interpretations

1. Dental service would encompass management of conditions involving the tooth or teeth and their supporting structures, including the gingivae, and are not generally covered under the medical benefit.

1.1 Dental services may include tooth extraction, root canals, filings, crowns, bridges, management of dental implants and tooth-related conditions (such as apical odontogenic cysts).

1.2 Dental care is not covered unless the member has dental coverage with Health Alliance or the member has individual or small-group EHB coverage specifically for completely bony impacted wisdom teeth extraction, and in that case, coverage would be subject to the Plan File dental benefits.

1.3 Members with individual or small group EHB coverage for extraction of bony impacted wisdom teeth are covered at any age and include coverage for anesthesia and facility charges as part of the procedure. Coverage is limited to dental codes D7240-removal of completely bony impacted tooth and D7241-removal of completely bony impacted tooth with unusual surgical complications (unusually difficult or complicated

due to factors such as nerve dissection required, separate closure of maxillary sinus required or aberrant tooth position).

1.4 Medical services associated with dental conditions may include Emergency Room services for severe tooth-related problems (see below), dental devices fabricated for cleft palate or sleep apnea, oral soft tissue biopsy unrelated to the gums, and maxilla or mandible biopsy for bone tumor or cysts.

1.5 Tooth extraction required for cyst/tumor biopsy is covered if the provider has any concern that it is a non-odontogenic cyst or an odontogenic tumor.

1.6 Excision of a non-odontogenic cyst or tumor would be covered under the medical benefit, as would a large developmental odontogenic cyst or tumor with significant bone erosion to the extent that there may be risk for pathologic fracture. Necessary bone grafting to maintain the bony integrity of the mandible or maxilla is covered, in addition to reconstruction and temporary splinting of a dental ridge distorted as a result of tumor excision. Bone grafting solely in preparation for dental implants or the implants themselves is not covered under the medical benefit. Restorative dental procedures after reconstruction of the dental alveolar ridge are considered dental and not covered.

1.7 Additional dental services that are part of a medical procedure are considered medically necessary, and are covered as a medical benefit include:

- 1.7.1 Teeth extraction including alveoplasty prior to radiation therapy to the head or neck (follow-up reconstruction or tooth replacement is not considered medically necessary and thus is not covered),
- 1.7.2 Broken tooth removal required to reduce mandible fracture.

1.8 ***NOTE:*** Dental services do not become eligible for medical coverage merely by virtue of their being caused by a medical condition or being performed prior to or following a covered medical procedure, even if the medical service makes the dental service medically necessary. Non-covered dental services includes, but are not limited to:

- 1.8.1 Teeth extraction when there is a risk for infection,
- 1.8.2 Teeth extraction or fillings/treatment for radiation-induced dental caries,
- 1.8.3 Teeth extraction or fillings/treatment due to side effects from drugs or medications.
- 1.8.4 Teeth extraction of fillings/treatment resulting from systemic disease effects (e.g. Sjogren's syndrome, Crohn's disease, osteoporosis, malabsorption syndromes).
- 1.8.5 Periodontal (gum tissue surrounding teeth) therapy,
- 1.8.6 Orthodontic treatment. Whereas, Orthodontic treatment is not covered, some medical plans cover Orthognathic Surgery (Corrective Jaw Surgery)- A mandibular or maxillary osteotomy is covered only if you have significant functional problems that have not been corrected with Dental and/or orthodontic treatment. See plan documents.
- 1.8.7 Endodontal treatment (Root Canal) except for coverage under 4. Traumatic injury to sound natural teeth.
- 1.8.8 Oral rehabilitation and reconstruction,
- 1.8.9 Other dental services that may be related to major surgical procedures (e.g., joint reconstruction, organ transplant, cardiac surgery, etc.) or other medically necessary treatments.

1.9 Alveoplasty to accommodate a dental prosthesis is not covered under Health Alliance medical benefits. Alveoplasty is covered under outpatient medical benefits after the removal of teeth prior to radiation therapy.

1.10 Excision of a lingual (under tongue) (CPT 41010) or maxillary (under upper lip) (CPT 40806) frenulum is covered only if there is clear documentation of a functional speech or feeding problem.

1.11 Removal of oral exostoses, including palatal (CPT 21032) and mandibular (CPT 21031) tori, are not covered.

2. Repair of cleft palate in children may include services normally considered as dental care but that would be covered in the following situations:

2.1 As part of cleft palate repair, alveolar ridge closure would be covered.

2.2 To prepare for bone graft surgery of the alveolar cleft, palatial expansion appliances may be covered for primary or mixed dentitions in the pre or post-operative period. (Later orthodontic care is not covered.)

2.3 If the cleft palate and/or treatment of it causes functional impairment, orthognathic surgery would be covered for correction of this impairment.

3. General anesthesia and/or inpatient/outpatient hospitalization associated with dental treatment is covered under the medical benefit when:

3.1 A patient has an existing medical condition, such as (including, but not limited to) hemophilia, or malignant hyperthermia which makes dental treatment in an office setting contraindicated.

3.2 Anesthesia payments to an Anesthesiologist and the facility are **mandated by the State of Illinois** if any of the following applies:

- 3.2.1 Member is a child age 6 years of age or under, or
- 3.2.2 Member has a medical condition that requires hospitalization or general anesthesia for dental care, or
- 3.2.3 A member chronically disabled of any age who meets all the following criteria:
  - 3.2.3.1 The disability is attributable to a mental or physical impairment or a combination of mental and physical impairment
  - 3.2.3.2 The condition is likely to continue
  - 3.2.3.3 It results in substantial functional limitations in one or more of the following areas of major life activities: self-care, receptive and expressive language, learning, mobility, capacity for independent, and/or economic self-sufficiency

3.3 Anesthesia payments to a Dentist and the facility. Additionally **Mandated coverage by the State of Illinois** effective 1/1/2020 covers "anesthetics provided by a dentist with a permit provided under Section 8.1 of the Illinois Dental Practice Act, in conjunction with dental care that is provided to a covered individual in a dental office, oral surgeon's office, hospital, or ambulatory surgical treatment center if the individual is under the age of 26 and":

- 3.3.1 Has been diagnosed with an autism spectrum disorder as defined in Section 10 of the Autism Spectrum Disorders Reporting Act, OR
- 3.3.2 Has been diagnosed with a developmental disability. A covered individual shall be required to make 2 visits to the dental care provider prior to accessing other coverage.
  - 3.3.2.1 “Developmental disability" means a disability that is attributable to an intellectual disability or related condition, if the related condition meets all of the following conditions:
    - 3.3.2.1.1 "It is attributable to cerebral palsy, epilepsy, or any other condition, other than mental illness, found to be closely related to an intellectual disability because that condition results in impairment of general intellectual functioning or adaptive behavior similar to that of individuals with an intellectual disability and requires treatment or services similar to those required for those individuals; for purposes of this definition, autism is considered a related condition;
    - 3.3.2.1.2 It is manifested before the individual reaches age 22;
    - 3.3.2.1.3 It is likely to continue indefinitely; and
    - 3.3.2.1.4 It results in substantial functional limitations in or more of the following areas of major life activity: self-care, language, learning, mobility, self-direction, and capacity for independent living."
- 3.3.3 "Nothing in this Section requires that the dental services be covered" and the dentist would not be paid for anesthesia unless meeting criteria above.

3.4 **Mandated coverage by the State of Iowa:**

- 3.4.1 Cover an Iowa member/child under five years of age when: A licensed dentist and the treating physician determine that the necessary dental treatment must be performed in a hospital or ambulatory surgical center due to a dental condition or a developmental disability for which patient management in a dental office has proven ineffective.
- 3.4.2 Cover any Iowa member when: A licensed dentist and the treating physician determine that the patient has one or more medical conditions which would create significant or undue medical risk if the treatment or surgery was not rendered in a hospital or ambulatory surgical center.

3.5 **Mandated coverage by the State of Washington** if any of the following applies:

3.5.1 Member is under the age of seven, or physically or developmentally disabled, with a dental condition that cannot be safely and effectively treated in a dental office; or

3.5.2 Member has a medical condition that the person's physician determines would place the person at undue risk if the dental procedure were performed in a dental office. The procedure must be approved by the member's physician.

4. Dental Services required due to traumatic injury of sound natural teeth are covered when:

4.1 Standard coverage is limited to medically necessary, emergent, non-restorative services to sound natural teeth (teeth without evidence of current decay or other pathology and not involving the act of chewing) and includes:

4.1.1 The initial evaluation of the injury, x-rays, and emergency initial stabilization of dental structures

4.1.2 Treatment of the injured teeth is limited to initial emergency stabilization, a root canal if directly related to the trauma, and tooth re-implantation.

4.1.3 Root canals delayed for medical reasons but directly related to the preceding trauma are covered within 90 days of the injury.

4.1.4 There is no coverage for restorations, delayed tooth stabilization, interim partials or gap fillers, dental implants, or implant crowns.

4.2 Coverage is provided in some policies (such as the Federal group plan) for repair of sound natural teeth that would include bonding (including use of composite resins or acid etching) or capping if the tooth is unable to be otherwise repaired. Please refer to each plan's specific brochure language

4.3 Coverage is not available for replacement of lost natural teeth, including but not limited to the use of bridges or dental implants

4.4 Emergency treatment of dental infections and dental abscesses is a provisionally covered benefit if the following criteria are met:

4.4.1 The care provided is medically necessary and performed by a physician or oral surgeon. Health Alliance providers must be used if available.

4.4.2 The dental-related infection or abscess has the potential to jeopardize the patient's health and requires immediate incision and drainage.

4.5 Coverage will be provided per the member's health plan emergency benefit. HMO members may receive emergency services at the nearest facility or dentist of choice if a Health Alliance participating facility is more distant. For members with an out-of-network benefit, they may use non-participating facilities and if an emergency receive coverage at the in-network rate.

5. Medicare Advantage Criteria details:

Health Alliance Medicare Advantage members have additional Supplemental Dental Benefits available beyond Traditional Medicare which have maximal dollar limits per plan year. Please see plan materials/evidence of coverage for dental coverage details.

- *For specific criteria and coverage information please refer to the appropriate Medicare Benefit Policy Manual Chapter 16, 100-02, Section 140.*
- *Additional Medicare coverage/non-coverage information*

Codes

*Codes listed are for informational purposes only and do not necessarily indicate prior authorization is or is not required or coverage is guaranteed.

Providers are required to indicate the diagnosis and procedure codes when requesting review of coverage.

References

1. Public Act 99-0141 – Dental Anesthesia. HB 235 – Illinois – 2015. Effective 1/1/2016.
2. Health Alliance Medical Plans HMO Member Subscription Certificate.
3. Illinois HB 1889 (2002) Hospitalization for Dental Care
4. House File 754 (Iowa, 2005) – Anesthesia and Hospital Charges Associated with Dental Care Services
5. State of Illinois Mandate - Illinois General Assembly - Illinois Compiled Statutes (ilga.gov)

History			
Created Date:	01/09/08		
Effective Date:	01/09/08		
Next Review Date:	12/15/2026		
Revision Date:	02/11/09	09/09/09	05/12/10
	03/23/11	10/28/11	02/08/12
	12/05/12	12/18/13 – Revised to cover repair cleft palate in children and extraction of bony impacted wisdom teeth coverage for EHB-mandated beneficiaries.	
	11/07/14	12/04/15 – MDC-Added EHB language for State of WA.	
	02/10/16 – MDC-Revision added State-Mandated coverage for anesthesia provided by permitted dentists to select members under age 19 years.		
	03/08/17	03/14/18 – MDC-Revision to add language to 1.6 related to restoration of dental ridge post mandibular resection	
	01/15/19 – MDC-Annual review, no changes.		
	12/17/19 – MDC-Annual review; revision to comply with updated Illinois Dental Mandate.		
	12/15/20 – MDC-Annual review, no changes.		
	12/21/21 – MDC-Annual review, added language, no orthodontic coverage.		
	12/20/22 – MDC-Annual review, CPT codes in 1.10 and 1.11 for clarification only, no other changes.		
	05/21/24 – MDC-Annual review, **Commercial**: No changes, **Medicare Advantage:** Language added in section 5 regarding supplemental benefits and checking plan documents for coverage details.		
	02/18/25 – MDC-Annual review, Commercial: Root canals delayed for medical reasons but directly related to the preceding trauma are covered now to within 90 days instead of 30 and Medical Advantage: no changes.		
	08/18/25 – MDC-Annual review, Commercial: no changes and Medicare Advantage: no changes.		
	12/08/25 – MDC-Annual review, Commercial: no changes and Medicare Advantage: no changes.		