Dental Care and Oral Surgery

Policy Number: BIP033.K
Effective Date: November 1, 2023

Instructions for Use

Table of Contents **Page**

Related Benefit Interpretation Policies

- Cosmetic, Reconstructive or Plastic Surgery
- Medical Necessity

Related Medical Management Guidelines

- Cosmetic and Reconstructive Procedures
- Orthognathic (Jaw) Surgery
- Preventive Care Services
- Temporomandibular Joint Disorders

Federal/State Mandated Regulations

Note: The most current federal/state mandated regulations for each state can be found in the links below.

California Health and Safety Code Section 1367.71 (effective 01/01/2000) Dental Anesthesia

http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1367.71&lawCode=HSC

(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.

California Health and Safety Code 1367.68 Coverage for Surgical Conditions Affecting Upper and Lower Jawbone

http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1367.68&lawCode=HSC

(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.

California Health and Safety Code §1367.63 Cosmetic Reconstructive Surgery

http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1367.63&lawCode=HSC

(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) **(1) "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.

State Market Plan Enhancements

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.

Covered Benefits

Important Note: Covered benefits are listed in *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits* sections. Always refer to the *Federal/State Mandated Regulations* and *State Market Plan Enhancements* sections for additional covered services/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 prior authorization by the member's network medical group or UnitedHealthcare in agreement 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:

- Anesthesia and related facility charges for dental procedures provided in a 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
  - One of the following criteria is met:
    - The member is under seven years of age;
    - The member is developmentally disabled, regardless of age; or
    - The member's health is compromised and general anesthesia is medically necessary, regardless of age.

  Note: Member's dentist must get prior authorization from the member's network medical group or UnitedHealthcare before the dental procedure is provided.
- Biopsy and excision of cysts or tumors of the jaw, treatment of malignant neoplastic disease(s) and treatment of temporomandibular joint syndrome (TMJ)
- Biopsy of gums or soft palate
- 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.
- 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
- Oral or dental exam performed on an inpatient or outpatient basis as part of a comprehensive work-up prior to transplantation surgery
- Preventive fluoride treatment prior to an aggressive chemotherapeutic or radiation therapy protocol. Fluoride trays and/or bite guards used to protect the teeth from caries and possible infection during radiation therapy
- 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)
- Reconstruction of the jaw when medically necessary (e.g., radical neck or removal of mandibular bone for cancer or tumor)
- Reconstructive surgery due to congenital defect such as cleft lip and cleft palate
- Ridge augmentation or alveoplasty are covered when determined to be medically necessary based on state cosmetic reconstructive surgery law and jawbone surgery law
- Setting of the jaw or facial bones
- Tooth extraction prior to a major organ transplant or radiation therapy of neoplastic disease to the head or neck
- Treatment of maxillofacial cysts, including extraction and biopsy

Not Covered

- Alveoplasty when performed in connection with an excluded service, such as preparation of the mouth for dentures.
- Application of dental/orthodontic devices/appliances, whether or not it accompanies oral and/or orthognathic surgery, except as addressed in the Benefit Interpretation Policy titled Treatment of Temporomandibular Joint (TMJ) Disorders. (Review *Federal/State Mandated Regulations* and *State Market Plan Enhancements* sections for mandates and coverage).
- Bone grafts for preparation of dental Implants.
- Cosmetic surgery or treatment.
- Crowns, fillings, caps, dentures, braces, gold inlays, and other dental prosthesis are not covered unless specifically provided for under the *Covered Benefits* section.
- Dental anesthesia in a dental office or dental clinic.
- Dental implants.
- Dental services beyond the emergency treatment required to stabilize acute accidental injuries to sound natural teeth, jawbone or surrounding tissues. (Review *Federal/State Mandated Regulations* and *State Market Plan Enhancements* sections for mandates and coverage)
- Extraction of an impacted tooth, except as noted in the *Covered Benefits* section.
- 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.
- Physician services provided in connection with non-covered dental services.
- 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.
- Removal of teeth for the main purpose of fitting for dentures.
- Services related to routine dental care, unless member has supplemental dental coverage.

Policy History/Revision Information

Date	Summary of Changes
11/01/2023	**Supporting Information** • Removed *Definitions* section • Archived previous policy version BIP033.J

Instructions for Use

Covered benefits are listed in three (3) sections: *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits*. 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.