# Dental Care and Oral Surgery

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Instructions for Use

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## Federal/State Mandated Regulations

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

### Oklahoma

#### *Oklahoma Department of Insurance Title 36, Section 6060.6*

https://www.oscn.net/applications/oscn/deliverdocument.asp?id=103738&hits=

A. Any health benefit plan that is offered, issued or renewed in this state on or after January 1, 1999, that provides hospitalization benefits shall provide coverage for anesthesia expenses including anesthesia practitioner expenses for the administration of the anesthesia, and hospital and ambulatory surgical center expenses associated with any medically necessary dental procedure when provided to a covered person who is:
   1. Severely disabled; or
   2. a. A minor eight (8) years of age or under, and who has a medical or emotional condition which requires hospitalization or general anesthesia for dental care, or
      b. A minor four (4) years of age or under, who in the judgment of the practitioner treating the child, is not of sufficient emotional development to undergo a medically necessary dental procedure without the use of anesthesia.

B. A health benefit plan may require prior authorization for either inpatient or outpatient hospitalization for dental care in the same manner that prior authorization is required for hospitalization for other covered diseases or conditions.

C. Coverage provided for in subsection A of this section shall be subject to the same annual deductibles, copayments or coinsurance limits as established for all other covered benefits under the health benefit plan.

D. As used in this section, "health benefit plan" means any plan or arrangement as defined in subsection C of Section 6060.4 of this title.

#### *Oklahoma Administrative Code 365:40-5-20 (12)*

Oklahoma Administrative Code, Part 5, 365:40-5-20 - Basic health care services | Oklahoma Administrative Code | Justia

Basic health care services shall include:

(12) Inpatient and outpatient care for treatment of the birth defect known as cleft lip or cleft palate or both including medically necessary oral surgery, orthodontics and otologic, audiological and speech/language treatment.

## Oregon

### *ORS 743A.032 Surgical Services Provided by Dentists*

https://www.oregonlaws.org/ors/743A.032

Notwithstanding any provision of a policy of health insurance, whenever the policy provides for payment of a surgical service, the performance for the insured of such surgical service by any dentist acting within the scope of the dentist's license is compensable if performance of that service by a physician acting within the scope of the physician's license would be compensable.

### *ORS 743A.028 Services Provided by a Denturist*

https://www.oregonlaws.org/ors/743A.028

Notwithstanding any provisions of any policy of insurance covering dental health, whenever such policy provides for reimbursement for any service which is within the lawful scope of practice of a denturist, the insured under such policy shall be entitled to reimbursement for such service, whether the service is performed by a licensed dentist or a licensed denturist as defined in ORS 680.500.

**Note:** 743A.028 was added to and made a part of the Insurance Code by the law but was not added to ORS chapter 743A or any series therein. See Preface to Oregon Revised Statutes for further explanation.

### *Oregon 743A.150 Treatment of Craniofacial Anomaly*

https://www.oregonlaws.org/ors/743A.150

1. As used in this section, "craniofacial anomaly" means a physical disorder identifiable at birth that affects the bony structures of the face or head, including but not limited to cleft palate, cleft lip, craniosynostosis, craniofacial microsomia and Treacher Collins syndrome.
2. All health benefit plans, as defined in ORS 743B.005, providing coverage of hospital, surgical or dental services, shall provide coverage for dental and orthodontic services for the treatment of craniofacial anomalies if the services are medically necessary to restore function.
3. This section does not require coverage for the treatment of:
    a. Developmental maxillofacial conditions that result in overbite, crossbite, malocclusion or similar developmental irregularities of the teeth; or
    b. Temporomandibular joint disorder.
4. Coverage required by this section may be subject to copayments, deductibles and coinsurance imposed on similar services by the terms of the plan.
5. This section does not limit or supersede any coverage required by ORS 743A.028, 743A.032 or 743A.148.
6. This section is exempt from ORS 743A.001. [2012 c.21 §2]

**Note:** 743A.150 was added to and made a part of the Insurance Code by legislative action but was not added to ORS chapter 743A or any series therein. See Preface to Oregon Revised Statutes for further explanation.

### *Oregon 743A.034 Services Provided by Expanded Practice Dental Hygienist*

https://www.oregonlaws.org/ors/743A.034

1. If a policy of insurance covering dental health provides for coverage for services performed by a dentist licensed under ORS chapter 679, the policy must also cover the services when they are performed by an expanded practice dental hygienist as defined in ORS 679.010, who has entered into a provider contract with the insurer.
2. The provisions of ORS 743A.001 (Automatic repeal of certain statutes on individual and group health insurance) do not apply to this section. [2011 c.716 §11]

## Texas

### *Texas Insurance Code 1367.153 Reconstructive Surgery for Craniofacial Abnormalities; Definition Required*

https://statutes.capitol.texas.gov/DocViewer.aspx?DocKey=IN%2fIN.1367&Phrases=1367.153&HighlightType=1&ExactPhrase=False&QueryText=1367.153

A health benefit plan that provides benefits to a child who is younger than 18 years of age must define “reconstructive surgery for craniofacial abnormalities” under the plan to mean surgery to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease. [applies to individual and large group]

### Washington

#### *RCW 48.43.185 General Anesthesia Services for Dental Procedures*

https://app.leg.wa.gov/rcw/default.aspx?cite=48.43.185

1. Each **group health benefit plan** that provides coverage for hospital, medical, or ambulatory surgery center services **must cover general anesthesia services and related facility charges in conjunction with any dental procedure performed in a hospital or ambulatory surgical center if such anesthesia services and related facility charges are medically necessary because the covered person:**
    a. 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**
    b. 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 person's physician.
2. Each group health benefit plan or group dental plan that provides coverage for dental services **must cover medically necessary general anesthesia services in conjunction with any covered dental procedure performed in a dental office if the general anesthesia services are medically necessary because the covered person is under the age of seven or physically or developmentally disabled.**
3. This section does not prohibit a group health benefit plan or group dental plan from:
    a. Applying cost-sharing requirements, maximum annual benefit limitations, and prior authorization requirements to the services required under this section; or
    b. Covering only those services performed by a health care provider, or in a health care facility, that is part of its provider network; nor does it limit the health carrier in negotiating rates and contracts with specific providers.
4. This section does not apply to medicare supplement policies, or supplemental contracts covering a specified disease or other limited benefits.
5. For the purpose of this section, "general anesthesia services" means services to induce a state of unconsciousness accompanied by a loss of protective reflexes, including the ability to maintain an airway independently and respond purposefully to physical stimulation or verbal command.
6. This section applies to group health benefit plans and group dental plans issued or renewed on or after January 1, 2002.

## 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.

### Washington

#### *For Washington PEBB Active Plan Members Only*

The services of a licensed dentist will be covered subject to an office visit copayment for repair of accidental injury to natural teeth. Evaluation of the injury and development of a treatment plan must be completed within 30 days of the injury. The member must be continuously covered by a PEBB medical plan from the date of injury through the date services are provided. Injuries caused by biting or chewing; malocclusion resulting from an accidental injury, orthodontic treatment; and dental implants are not covered.

### Oregon

Treatment of temporomandibular joint syndrome (TMJ) benefits must be selected by the group. Refer to the member’s Schedule of Benefits for additional information.

# 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.

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:

- **Oklahoma:** Anesthesia, anesthesia practitioner expenses, hospital and ambulatory surgical center expenses are covered for a member who is:
  - Four years of age or under, who in the judgment of the practitioner treating the child, is not of sufficient emotional development to undergo a medically necessary dental procedure without the use of anesthesia, or
  - A minor eight years of age or younger, who has a medical or emotional condition which requires hospitalization or general anesthesia for dental care, or
  - Severely disabled.

  **Note**: The member's dentist must get preauthorization from the member's network medical group or UnitedHealthcare before the dental procedure is provided.
- **Oregon and Washington:** Anesthesia and associated 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:
  - 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 preauthorization from the member's network medical group or UnitedHealthcare before the dental procedure is provided.
- **Oklahoma, Texas, and Washington:** Biopsy and excision of cysts or tumors of the jaw, treatment of malignant neoplastic disease and treatment of temporomandibular joint syndrome (TMJ).
- Emergency treatment for the stabilization of acute accidental injuries to sound natural teeth, jawbone or surrounding tissues immediately following injury or as soon as the member is medically stable.
  **Oklahoma, Oregon, and Texas:** Coverage is limited to treatment provided within 48 hours of injury.
- **Oregon and Washington:** Extraction of teeth if medically necessary for members undergoing transplant procedures.
- Extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease to the head or neck.
- Facilities and anesthesia charges in a contracted facility when a dental procedure cannot be performed in a dental office due to an underlying medical condition and/or clinical status. Review the *Federal/State Mandated Regulations* and *State Market Plan Enhancements* sections for mandates and coverage. Preventive fluoride trays and/or bite guards used to protect teeth from caries and possible infection during radiation therapy.
- 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.
- **Oregon and Washington:** Oral or dental examinations performed on an inpatient or outpatient basis as part of a comprehensive workup prior to transplantation surgery.
- 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).

- Setting of the jaw or facial bones (includes wiring of teeth when performed in connection with the reduction of the jaw fracture).
- 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 the *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 in the *Covered Benefits* section.
- Dental anesthesia in a dental office or dental clinic is not covered.
- Dental implants.
- Dental services beyond the emergency treatment required to stabilize acute accidental injuries to sound natural teeth, jawbone or surrounding tissues. (Review the *Federal/State Mandated Regulations* and *State Market Plan Enhancements* sections for mandates and coverage)
- Extraction of an impacted tooth, except as addressed above.
- 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 service.
- 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 | State(s) Affected | Summary of Changes |
|---|---|---|
| 11/01/2023 | All | **Supporting Information**<br>• Removed *Definitions* section<br>• Archived previous policy version BIP034.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.