BlueCross BlueShield of North Carolina

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Corporate Medical Policy

Dental Reconstructive Services

File Name:	dental_reconstructive_services
Origination:	3/1998
Last CAP Review:	10/2021
Next CAP Review:	10/2022
Last Review:	10/2021

Description of Procedure or Service

Reconstructive dental services may include numerous procedures from teeth removal to orthodontic, endodontic or periodontic services for fractured teeth. The term may also apply to reconstruction of crowns and/or bridges, impacted wisdom teeth, oral surgery to repair an injury, removal of a tumor of the jaw or palate, and treatment for temporomandibular joint disease. It may even include cosmetic dentistry.

Note: Criteria for coverage in this medical policy do not apply to reconstructive services for cleft lip and cleft palate. Coverage of reconstructive services for cleft lip and cleft palate is described under the Orthognathic Surgery policy.

Related Policies:
Orthodontics for Pediatric Patients

******Note: This Medical Policy is complex and technical. For questions concerning the technical language and/or specific clinical indications for its use, please consult your physician.***

Policy

BCBSNC will provide coverage for Reconstructive Dental Services when it is determined to be medically necessary because the medical criteria and guidelines shown below are met

Benefits Application

This medical policy relates only to the services or supplies described herein. Please refer to the Member's Benefit Booklet for availability of benefits. Member's benefits may vary according to benefit design; therefore member benefit language should be reviewed before applying the terms of this medical policy.

This medical policy does NOT apply to pediatric dental services related to the Essential Health Benefits (EHB) under the Patient Protection and Affordable Care Act (PPACA) requirements**.** Please, see Corporate Medial Policy titled "Orthodontics for Pediatric Patients" and refer to the member benefit booklet for additional information.

When Reconstructive Dental Services are covered

Reconstructive dental services are covered when they are determined to be medically necessary.

Reconstructive dental services may be considered medically necessary:

- When the procedure is intended primarily to improve/restore bodily function or to correct significant deformity resulting from accidental injury, trauma, or previous therapeutic process; or
- The procedure is intended to correct congenital defects and anomalies when they result in a functional impairment.

I. Reconstructive Dental Services may be considered medically necessary for the following indications:

A. Accidental external traumatic injury to a sound tooth. Benefits include extractions, fillings, crowns, bridges, or other necessary therapeutic techniques and appliances, and are limited to those services necessary to restore condition and function to that which existed immediately prior to the accident. It does not include the repair or replacement of dentures.

B. Dental and orthodontic care that is directly related to and an integral part of the medical and surgical correction of a functional impairment resulting from a congenital defect or anomaly.

1. Depending on the degree of involvement of the congenital defect or anomaly, the patient may require adjunctive dental or orthodontic support from birth until the medical/surgical treatment of the defect or anomaly has been completed (i.e., until the dentoalveolar arch discrepancies and/or maxillomandibular disharmonies are corrected). Treatment may include the fabrication of obturators early in life, and splints at the time of surgical treatment for stabilization of the maxilla and mandible. As the arches develop and teeth erupt, orthodontic treatment may be required to establish a functional relationship of the dental arches. When the deformity causes the function to be greatly impaired, obturators and pharyngeal bulb appliances may be required to assure proper nutrition, deglutition and to avoid aspiration of foreign matter during the intake of food.
2. Orthodontics may be considered medically necessary in congenital defects or anomalies when they:
   a) Correct dentoalveolar arch discrepancies that are part of or the result of, the congenital defect or anomaly and prevent the usual and normal action of mastication and ingestion of normally solid foods.
   b) Correct dentoalveolar arch discrepancies, the correction of which is necessary to satisfactorily correct other aspects of the general deformity which results in a functional impairment, or to prevent relapse of such treatment.
3. The following are examples of congenital defects or anomalies that affect the face and possibly the dentoalveolar arches, or their relationships to each other and may be medically necessary depending on the functional impairment:
   a) Hemifacial macrosomia,
   b) Craniofacial dysostosis (Crouzon's Syndrome),
   c) Apert syndrome

C. For oral reconstruction following acute trauma to jaws, cheeks, lips, tongue, roof and floor of mouth. Trauma may involve soft tissue injuries (skin and gums), bone injuries (fractures), or injuries to nerves (such as the lingual, inferior alveolar or mental nerves).

D. For oral reconstruction following excision of cancer or invasive tumors of the oral structures. For example, reconstruction of the alveolar ridge if distorted as a result of the surgical removal of a tumor.

E. For oral reconstruction using dental implants and related procedures, such as bone grafting if related to conditions specified as covered under medical benefits in the member's benefit booklet and the condition results in functional impairment.

II. There are various dental services that may not be reconstructive, but may be considered medically necessary for the following indications if specified as covered under medical benefits in the member's benefit booklet and the condition results in functional impairment:

A. Removal of exostoses, for reasons other than for preparation for dentures , that due to their extreme size are causing functional impairment (soft tissue trauma with mastication or speech interference).
B. Removal of cysts that are not related to teeth or associated dental procedures:
    - Thyroglossal duct,
    - Branchiogenic,
    - Dermoid,
    - Nasoalveolar,
    - Mucoceles,
    - Median and incisive canal,
    - Ranulas,
    - Keratocystic or other odontogenic tumor
C. Lingual frenectomy for total or complete ankyloglossia (tongue-tie) if causing speech impediment or difficulty with feeding/eating/swallowing.

When Reconstructive Dental Services are not covered

Reconstructive dental services are **not** covered when:

- the procedure is **not** intended primarily to improve/restore bodily function or to correct significant deformity that resulted from accidental injury, trauma, or previous therapeutic process; or
- the procedure is **not** for the correction of functional impairment related to congenital defects and anomalies.

For injuries that occur while in the act of chewing or biting.

For cleaning, maintenance, and subsequent repair or replacement of completed dental reconstruction.

Policy Guidelines

There are a variety of dental services that are not considered reconstructive services and would <u>not</u> be covered under MEDICAL benefits, including, but not limited to:

1. The treatment of generally poor dental health (dental caries/dental erosion) due to certain systemic causes (e.g., Sjogren's syndrome, Crohn's disease, malabsorption syndromes, rickets, etc.)
2. The treatment of side effects medications (e.g., drug associated gingival hyperplasia).
3. Any procedures performed for the preparation of the mouth for dentures such as:
    - Alveoplasty, (the surgical improvement of the shape and condition of the alveolar process),
    - Removal of the torus mandibularis or maxillary torus palatines,
    - Vestibuloplasty procedures,
    - Tissue conditioning,
    - Frenulectomy for treatment of diastema, facial, labial or buccal frenectomy; frenotomy, frenuloplasty
    - Placement of dental implants and/or bone grafting to support a dental prosthesis
4. The treatment of natural cysts of dental root origin (performed in conjunction with extraction of teeth):
    - Periodontal
    - Periapical
    - Primordial
    - Dentigerous (intrabony <= 2.5 cm)

5. Dental care required in preparation for or as a result of radiation therapy for oral or facial cancer. Without the necessary care, patients who undergo radiation therapy about the head may be at risk for development of osteonecrosis. Extraction of teeth prior to radiation therapy of the mandibular and maxillary area for malignant tumor is not considered "reconstructive dental services" and therefore not covered under MEDICAL benefits. (This service may be covered under the member's dental benefit.)
6. Dental extractions prior to the initiation of cardiac surgery (when there is risk for bacterial endocarditis from procedures such as valve replacement or surgical correction of tetralogy of Fallot) or transplant surgery to prevent medical complications or infections. These services are not considered "reconstructive dental services" and therefore not covered under MEDICAL benefits. (This service may be covered under the member's dental benefit.)
7. Treatment for the following conditions: Preventative dental care, diagnosis or treatment of or related to teeth or gums; periodontal disease or cavities and disease due to infection or tumor. These services are not considered "reconstructive dental services" and therefore not covered under MEDICAL benefits. (This service may be covered under the member's dental benefit.)

Billing/Coding/Physician Documentation Information

This policy may apply to the following codes. Inclusion of a code in this section does not guarantee that it will be reimbursed. For further information on reimbursement guidelines, please see Administrative Policies on the Blue Cross Blue Shield of North Carolina web site at www.bcbsnc.com. They are listed in the Category Search on the Medical Policy search page.

Applicable service codes: D0140, D0150, D0160, D0170, D0180, D0210, D0220, D0230, D0240, D0250, D0260, D0270, D0272, D0274, D0277, D0290, D0310, D0320, D0321, D0322, D0330, D0340. D0470, D0472, D0473, D0474, D0480, D0502, D0999, D6011, D6013, , D7111-D7999, D8999, D9210, D9211, D9212, D9215, D9220, D9221, D9230, D9241, D9242, D9248, D9310, D9410, D9420, D9430, D9440, D9450, D9610, D99630, D9910, D9911, D9920, D9930, D9940. D9950, D9951, D9952, D9970, D9973, D9974, D9999. 21025, 21031, 21032, 21040, 21044, 21045, 21046, 21047, 21048, 21049, 21050, 21060, 21070. 21081, 21082, 21083, 21084, 21085. 21089, 21141, 21142, 21143, 21145, 21146, 21147, 21150, 21151, 21154, 21155. 21193, 21194, 21195, 21196, 21198, 21199, 21206. 21210, 21215, 21240, 21242, 21243, 21244, 21245, 21246, 21247. 21345, 21346, 21347, 21348. 21421, 21422, 21423, 21431. 21440, 21445, 21450, 21451, 21452, 21453, 21454, 21461, 21462, 21465, 21470, 21480, 21485, 21490, 21497

Note: For dentigerous cysts, the operative report is needed for review to confirm size.

BCBSNC may request medical records for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often useful, but are not sufficient documentation unless all specific information needed to make a medical necessity determination is included.

Scientific Background and Reference Sources

Dental Advisory Group

CMS601A Manual

Medical Policy Advisory Group 12/2/1999

Specialty Matched Consultant Advisory Panel - 5/2001

Specialty Matched Consultant Advisory Panel - 5/2003

Specialty Matched Consultant Advisory Panel - 5/2005

Specialty Matched Consultant Advisory Panel - 5/2007

Senior Medical Director Review - 11/2009

Specialty Matched Consultant Advisory Panel – 11/2009

Specialty Matched Consultant Advisory Panel- 10/2011

Specialty Matched Consultant Advisory Panel- 10/2012

Specialty Matched Consultant Advisory Panel- 10/2013

Medical Director Review- 10/2014

Specialty Matched Consultant Advisory Panel- 10/2014

Specialty Matched Consultant Advisory Panel 10/2015

Medical Director Review 10/2015
Specialty Matched Consultant Advisory Panel 10/2020

Specialty Matched Consultant Advisory Panel 10/2021

Medical Director Review 10/2021

Policy Implementation/Update Information

3/98	Original policy
7/99	Reformatted, Description of Procedure or Service changed, Medical Term Definitions added.
12/99	Reaffirmed, Medical Policy Advisory Group
3/00	Corrected typographical errors. No change in policy content. Coding added.
5/01	Specialty Matched Consultant Advisory Panel review (5/2001). No change in policy. Changes in formatting.
6/03	Specialty Matched Consultant Advisory Panel review (5/30/2003). No change in criteria. Benefits Application section revised. Policy name changed from Reconstructive Dental Services to Dental, Reconstructive Services for ease in locating policy.
8/12/04	Billing/Coding section updated for consistency. Individual CPT codes listed for CPT code ranges, D0140-D0340; D0470-D0999;D7111-D7999; D9210-D9940; D9950-D9999; 21040-21070; 21081-21085; 21141-21155; 21193-21206; 21240-21247; 21345-21348; 21421-21431; 21440-21490, under Billing/Coding section. Code D7110 removed from Policy.
6/2/05	Specialty Matched Consultant Advisory Panel review - 5/13/05. No changes to criteria at this time.
6/18/07	Under "When Covered" section, removed 4th bullet "For augmentation of severely resorbed mandible. A lateral cephalometric film should document 12 mm. or less of bone height as measured in the mid-line anterior mandible." Under "When not Covered" section, clarified information in bullets 1, 6 & 7. Medical term definition added. Reference sources added. (pmo)
12/21/09	Policy reformatted. Under "When Covered" section, added another bullet: "For dental implants and related procedures such as bone grafting. (Refer to certificate language for

specific conditions that are covered.) Under "When not Covered" section, removed last two bullets re: dental implants and bone grafting. System Application Guidelines not updated due to conversion to the QMP real time database. (pmo)

6/22/10 Policy Number(s) removed (amw)

9/28/10 Policy extensively revised to include additional indications based on updated benefit language. Extensively expanded the "When Covered" section for clarity. Removed the following statement previously stated as a covered indication; "For dental extraction related to radiation therapy." This is not considered reconstructive services. Removed the following statement under the "When Not Covered" section; "For reconstructive procedures delayed without medical cause beyond the immediate post-injury period (2 years)." "Policy Guidelines" section revised to discuss dental services that are not considered reconstructive. Specialty Matched Consultant Advisory Panel review 1/2010. Senior Medical Director review 6/2010 and 8/2010. References added. Notification given 9/28/2010. Effective date 1/4/2011. (lpr)

11/8/11 Specialty Matched Consultant Advisory Panel review 10/26/2011. No changes to policy statement. (lpr)

11/13/12 Specialty Matched Consultant Advisory Panel review 10/17/2012. No change to policy statement or intent. Under Policy Guidelines: 1) revised page 3 II B #8 from "Non-odontogenic keratocysts to non-keratocystic odontogenic tumor"; 2) revised page 4 IV 4th bullet to add "Keratocystic Odontogenic tumor with parenthetical (Odontogenic keratocysts). (lpr)

7/16/13 Under "Policy Guidelines" section: IV. 3rd bullet Dentigerous, added (intrabony <= 2.5cm); and 4th bullet was deleted (Keratocystic Odontogenic tumor (Odontogenic keratocysts). Under "When Covered" section: II. B. 8 deleted non-keratocystic and kept keratocystic, then added "or other" to the statement. Also deleted (non-odontogenic keratocysts). Under "When Covered" section: II. A. added "for reasons other than for preparation for dentures" to the statement. Medical director review 6/27/13. (lpr).

11/12/13 Specialty Matched Consultant Advisory panel review 10/21/2013. No change to policy statement. (lpr)

12/31/13 Added Dental codes D6011, D6013, D6052 to Billing/Coding section for 2014 code update. (lpr)

4/1/14 Under Description section, changed related policy from Cosmetic and Reconstructive Services to Orthognathic Surgery. (lpr)

11/11/14 Added Related Policy and Benefit Application Language 10/2014. Medical Director Review 10/2014. Specialty Matched Consultant Advisory panel review 10/2014. No change to policy statement. (td)

11/24/15 Specialty Matched Consultant Advisory Panel review 10/29/2015. Medical Director Review 10/2015. Policy intent unchanged. (td)

12/30/16 Added the statement "This service may be covered under the member's dental benefit" to Items 5 and 6 in the Policy Guidelines section. Specialty Matched Consultant Advisory Panel review 10/26/2016. No change to policy statement. (an)

11/10/17 Specialty Matched Consultant Advisory Panel review 10/25/2017. No change to policy statement. (an)

11/9/18	The following statement added to Billing/Coding section: ***For dentigerous cysts, the operative report is needed for review to confirm size.*** Specialty Matched Consultant Advisory Panel review 10/24/2018. No change to policy statement. (an)
10/29/19	Specialty Matched Consultant Advisory Panel review 10/16/2019. No change to policy statement. (eel)
11/10/20	Specialty Matched Consultant Advisory Panel review 10/21/2020. No change to policy statement. (eel)
12/31/20	Code D6052 deleted from the Billing/Coding section effective 1/1/21. (bb)
5/4/21	Updated Policy Guidelines item 4 for clarification and added item 7. No change to policy statement. (bb)
6/15/21	Updated Policy Guidelines item 3 for clarification by adding "labial or buccal frenectomy, frenotomy, frenuloplasty". No change to policy statement. (bb)
11/2/21	Specialty Matched Consultant Advisory Panel review 10/2021. Medical Director Review 10/2021. No change to policy statement. (tt)