



Dental Policy

Subject: Medically Necessary Orthodontia Care

Guideline #: #08-001

Publish Date: 03/15/2018

Status: Revised

Last Review Date: 02/19/2018

Description

This document addresses the medical necessity and appropriateness for medically necessary orthodontia.

Note: Please refer to the following documents for additional information concerning related topics:

- 08-002 Non-Medically Necessary Orthodontic Care

Clinical Indications

Orthodontia includes those **dental services that a licensed dentist or orthodontist**, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating orthodontic problems.

Medically Necessary Orthodontia Care (MNOC) is considered appropriate for the treatment of mild to severe occlusal functional discrepancies. A “medically necessary” situation as it relates to dental therapies is one where failure to provide the dental services would result in deleterious effects to one’s overall health status or are necessary to sustain life. MNOC is:

1. A demanding and time-consuming procedure that is indicated for severe malocclusions (situations where the upper and lower teeth do not occlude and function properly as a result of an underlying craniofacial abnormality.
2. Used to treat dysfunctional occlusions.
3. A procedure that can be pre-surgical in nature which often creates a more dysfunctional occlusion while in preparation for surgery.
4. Performed by an actively licensed dentist or orthodontist.
5. Not a cosmetic procedure.

As it applies to appropriateness of care, dental services are:

- **provided by** a Dentist, exercising prudent clinical judgment
- **provided to** a patient for the purpose of evaluating, diagnosing and/or treating a dental injury or disease or its symptoms
- in accordance with the generally accepted standards of dental practice which means:
 - standards that are based on credible scientific evidence published in peer-reviewed, dental literature generally recognized by the practicing dental community
 - specialty society recommendations/criteria
 - any other relevant factors
- clinically appropriate, in terms of type, frequency and extent
- considered effective for the patient's dental injury or disease
- not primarily performed for the convenience of the patient or Dentist
- Not more costly than an alternative service.

- Dependent on group contract provisions, cosmetic services may not qualify for benefit coverage even though the services may be clinically appropriate.

Not Medically Necessary:

Orthodontic treatment can solve problems that include crooked or crowded teeth, teeth that are in cross bite, prognathic and retrognathic jaw appearance as a result of malposition of the teeth as well as for the control of harmful habits. Cosmetic orthodontia care is not considered medically or dentally necessary treatment. However cosmetic orthodontia can be used and is appropriate for the treatment of mild to moderate malocclusion while addressing minor dysfunctional occlusal discrepancies. The goal of treatment for non-medically necessary orthodontic care is to achieve an improved level of function and cosmetic appearance to the dentition consistent with supporting overall health status which can decrease the risk of tooth decay, gingival disease, periodontal disease, loss of teeth, and TMJ/TMD problems.

NOTE:

Benefit coverage for medically necessary orthodontic therapy is based upon group language as well as dental or medical necessity criteria. There are four specific types of orthodontic coverage.

1. State mandated treatment for medically necessary orthodontia according to the essential health benefit
2. Orthodontia considered medically necessary according to plan guidelines
3. State mandated orthodontic coverage for severe craniofacial deformities
4. Cosmetic orthodontia

For specific benefit coverage, refer to the group contract.

Angle classification is a manner in which malocclusion is classified by the dental profession. The classification is based upon the position of the upper first molar and specifically the alignment of the mesiobuccal cusp of the upper first molar with the buccal groove of the lower first molar. The teeth should fit on a line of occlusion which, in the upper arch, is a smooth curve through the central fossae of the posterior teeth and cingulum of the canines and incisor teeth, and in the lower arch, is a smooth curve through the buccal cusps of the posterior teeth and incisal edges of the anterior teeth. Any variations from this normocentric or neutrocentric occlusion define the classification of the malocclusion. It is possible to have different classifications of malocclusion that are side dependent, right or left. Variations in occlusion classifications can be associated with craniofacial relationships.

- **Class I: Neutroclusion** - the molar relationship of the occlusion is normal where the mesiobuccal cusp of the upper first molar occludes with the buccal groove of the lower first molar. However, it is possible for the remaining teeth to encounter problems such as spacing, crowding, over or under eruption, etc.
- **Class II: Distocclusion** (also associated or defined as retrognathism – may note lower incisor teeth in a destructive occlusion with the soft tissues of the palate) the mesiobuccal cusp of the upper first molar is not aligned with the buccal groove of the lower first molar as it is anterior to it. A typical finding is to have the upper first molar mesiobuccal cusp occluding between the first mandibular molars and second premolars. There are two subtypes:
 - **Class II Division 1:** The molar relationships are defined as Class II with the anterior teeth protruded.
 - **Class II Division 2:** The molar relationships are defined as Class II but the central incisors are retroclined with the lateral incisor teeth overlapping the central incisors.
- **Class III: Mesioclusion** (also known as prognathism –in this situation, the lower incisor teeth are forward of the upper incisor teeth creating an underbite) the mesiobuccal cusp of the upper first molars are not within the mesiobuccal groove of the lower first molar, but posterior to it. The lower front teeth are more prominent than the upper front teeth. Quite often, this situation involves an overdeveloped lower jaw and/or an undersized or short upper jaw.

Causes of tooth crowding include, but are not limited to: extra teeth, early loss of teeth, impacted teeth, or abnormally shaped teeth. A small underdeveloped jaw, caused by lack of masticatory stress during childhood, can cause tooth

overcrowding as well. Ill-fitting dental fillings, crowns, appliances, retainers, or braces as well as misalignment of jaw fractures after a severe injury may be additional causes. Tumors of the mouth and jaw, thumb sucking, tongue thrusting, pacifier use beyond age 3, and prolonged use of a bottle have also been identified as potential causes.

NOTE:

Dental/Medical necessity includes those dental services that a dentist or physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an injury, disease, anatomical defect or its symptoms. These dental services are (a) in accordance with generally accepted standards of dental practice (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's injury and/or disease, and (c) are not primarily performed for the convenience of the patient, dentist or other health care provider and is likely to improve function as it relates to the diagnosis or treatment of the patient's injury or disease. "Dental Necessity" includes, but is not limited to, treatments involving dental structures and pathology which, while rarely "medically" necessary, are essential to resolve the condition of dental disease or pathosis.

A "medically necessary" situation as it relates to dental therapies is one where failure to provide the dental services would result in deleterious effects to one's overall health status or are necessary to sustain life.

For these purposes, "generally accepted standards of dental practice" means standards that are credible, scientific, evidence based and published in peer-reviewed dental literature generally recognized by the relevant dental community, or otherwise consistent with Dental Specialty Associations recommendations and the views of dentists practicing in those relevant clinical areas." For orthodontic purposes, a severe handicapping malocclusion may qualify for benefits.

Malocclusion is defined as the misalignment of the upper and lower teeth when biting or chewing. Malocclusion can also be defined as a bad bite and is quite often hereditary. Malocclusion is the most common reason for referral to an orthodontist. Most problems are minor and do not require treatment.

Malocclusion may be referred to as an irregular bite, crossbite, underbite or overbite. A handicapping malocclusion can be defined as one that severely interferes with function (proper mastication, speech, ability to maintain good oral hygiene) that typically includes crooked, crowded, or protruding teeth that affect appearance, speech, and/or the ability to eat. Many handicapping malocclusions require a combination of pre-surgical orthodontics and surgery for correction and improved function of the masticatory arches and therefore occlusion. Severe cases are typically those where orthodontic services alone cannot solely treat the handicapping malocclusion. Diagnoses include, but are not limited to: cleft palate, severe lateral or anterior open bite deformities, severe class II malocclusion with impingement of the lower incisors into the palatal tissues/mucosa (deep, destructive bite), and class III malocclusions (severe underbite or lower jaw protrusion).

There are certain handicapping malocclusions that are associated with severe craniofacial deformities and include, but are not limited to: cleft lip/cleft palate, Treacher Collins Syndrome, severe dento-facial trauma. Documented craniofacial deformities that create a handicapping malocclusion and require MNOC are considered medically necessary and an automatic qualifier.

Medically/Dentally Necessary or Medical/Dental Necessity means Medical/Dental Services that are:

- (1) Consistent with the Member's diagnosis or condition;
- (2) Is rendered:
 - (A) In response to a life-threatening condition or pain; or
 - (B) To treat an injury, illness or infection related to the dentition; or
 - (C) To achieve a level of function to the dentition consistent with prevailing community standards for the diagnosis or condition.

Not Medically Necessary or Contraindications include:

1. Malocclusion is abnormal contact between the maxillary and mandibular teeth. Orthodontic services to correct malocclusion that is not considered dysfunctional is not medically necessary.
2. Minor corrections of malocclusion are considered cosmetic.

NOTE: A group may define covered dental services under either their dental or medical plan, as well as to define those services that may be subject to dollar caps or other limits. The plan documents outline covered benefits, exclusions and limitations. The health plan advises dentists and enrollees to consult the plan documents to determine if there are exclusions or other benefit limitations applicable to the service request. The conclusion that a particular service is medically or dentally necessary does not constitute an indication or warranty that the service requested is a covered benefit payable by the health plan. Some plans exclude coverage for services that the health plan considers either medically or dentally necessary. When there is a discrepancy between the health plan's clinical policy and the group's plan documents, the health plan will defer to the group's plan documents as to whether the dental service is a covered benefit. In addition, if state or federal regulations mandate coverage then the health plan will adhere to the applicable regulatory requirement.

Criteria for MEDICALLY Necessary Orthodontia

1. Orthodontia and **dental services must be provided by a licensed dentist or orthodontist**, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating orthodontic problems.
2. MNOC services **require pre authorization** prior to the initiation of any services.
3. The patient must present with fully erupted permanent teeth. In clinical situations that demonstrate partially erupted/impacted teeth as a result of severe crowding, the partially erupted/impacted teeth must present showing exposure of at least $\frac{3}{4}$ of the clinical crown.
4. **In order to qualify for treatment, validated, recognized Index criteria will be used to determine dental/medical necessity. In order to qualify, a subscriber must achieve a HLD (Handicapping Labio-Lingual Deviation) Index minimum score of 26 points. Handicapping esthetic diagnoses are not considered part of the determination.**

Note: The initiation and billing date for orthodontic services is defined as the date when the bands, brackets, or appliances are placed. The subscriber must be eligible on the date of service. If the subscriber becomes ineligible during treatment and prior to full payment of services, it is imperative for the subscriber to understand the plan and their responsibility to pay any remaining balance for the orthodontic therapy.

Requirements (clinical information) for pre authorization include:

- Completed HLD Scoring Index
- Orthodontic Treatment Plan
- Narrative describing nature of the severe physically handicapping malocclusion
- Panoramic and/or mounted full mouth radiographic images
- Cephalometric x-ray with teeth in centric occlusion and cephalometric tracing
- Facial photographs of frontal and profile views
- Intra-oral photographs depicting right and left occlusal relationships and an anterior view
- Maxillary and mandibular occlusal photographs
- Photographs of articulated study models or ortho cadcam electronic equivalent including all views (lateral, anterior, and posterior)
- When surgery is treatment planned, please include the surgical treatment plan and a letter of medical necessity

Guidelines:

- a. To qualify for benefits, the diagnosis, treatment planning, and hands on treatment of medically necessary orthodontia may only be performed under the direct supervision of an actively licensed dentist or orthodontist. Orthodontic procedures are benefits for a medically necessary handicapping malocclusion such as cleft lip/cleft palate (an automatic qualification) and severe facial growth and developmental discrepancy patients under the age of 19.
- b. Only those individuals with a permanent dentition shall be considered for medically necessary handicapping malocclusion, unless the patient is age 13 or older with primary teeth remaining resulting from the craniofacial condition. Cleft palate and craniofacial anomaly members qualify for a benefit with primary, mixed and permanent dentitions.

- c. All necessary dental procedures that may affect orthodontic treatment must be completed prior to the initiation of orthodontic therapy.
- d. Medically Necessary Orthodontic procedures are a benefit only when the diagnostic casts verify a minimum score of 42 points on the Handicapping Labio-Lingual Deviation (HLD) Index.

Coding

The following codes for treatments and procedures applicable to this document are included below for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

CDT

	<i>Including, but not limited to, the following:</i>
D8660	Pre-orthodontic treatment examination to monitor growth and development
D8030	Limited orthodontic treatment of the adolescent dentition
D8040	Limited orthodontic treatment of the adult dentition
D8080	Comprehensive treatment of the adolescent dentition
D8090	Comprehensive treatment of the adult dentition
D8670	Periodic orthodontic treatment visit
D8693	Re-cement or re-bond fixed retainer
D7280	Surgical access of an unerupted tooth
D7283	Placement of device to facilitate eruption of impacted tooth

CPT

No procedural codes

ICD10	
K00.0	Anodontia
K00.1	Supernumerary teeth
K00.2	Abnormalities of size and form of teeth
K00.5	Hereditary disturbances in tooth structure, not elsewhere classified
K00.6	Disturbances in tooth eruption
K00.9	Disturbances of tooth development, unspecified
K08.11	Complete loss of teeth
K08.111	Complete loss of teeth due to trauma, Class I
K08.112	Complete loss of teeth due to trauma, Class II
K08.113	Complete loss of teeth due to trauma, Class III
K08.114	Complete loss of teeth due to trauma, Class IV
K08.119	Complete loss of teeth due to trauma, unspecified class
K08.4	Partial loss of teeth (acquired loss of teeth)
Q75.1	Crouzon's disease
Q87.9	Apert's Syndrome
Q36.9	Cleft lip
Q37.9	Cleft lip with cleft palate
Q35.9	Cleft palate
Q35.1	Hard palate
Q75.4	Treacher Collins Syndrome
Q87.0	Pierre Robin Syndrome
Q87.0	Goldenhar Syndrome

Discussion/General Information

Orthodontics is the dental science concerned with the prevention, correction and management of irregularities and anomalies of the bite or occlusion. Orthodontic therapy attempts to correct occlusal or bite problems with fixed or removable appliance therapy that may involve other dental disciplines that include, but are not limited to, procedures such as extraction of teeth, fixed prosthodontic treatment, maxillofacial surgery, periodontal therapy, speech therapy, etc. Malocclusion may make it difficult to keep the teeth clean and therefore increases the risk for caries and periodontal disease development.

Definitive orthodontic therapy is generally divided into three main subtypes:

1. Limited orthodontics
2. Interceptive orthodontics
3. Comprehensive orthodontics

Limited orthodontics is defined as treatment with a limited objective which does not involve the entire dentition. Limited treatment may be directed toward a single existing problem, or one aspect of a larger problem about which a decision is made to defer or forego more comprehensive therapy. Examples of limited therapy would be treatment in a single arch to correct tooth crowding, closure of spaces, or to upright a tooth.

Interceptive orthodontics includes procedures used to eliminate, manage and/or reduce the severity of future effects of an occlusal anomaly. Interceptive treatment may involve primary or transitional dentitions, and may include procedures for management of such problems as ectopically erupting teeth, isolated cross bites, and recovery of lost spacing required for the proper eruption of permanent teeth.

Comprehensive orthodontics may involve multiple phases of treatment at different stages of dentofacial development. For example, placement of an orthodontic activator is generally considered the first phase of multistage treatment with subsequent placement of a fixed appliance considered as phase two. Both phases should be considered as comprehensive treatment modified by the appropriate stage of dental development. The comprehensive designation is used to report coordinated diagnoses and treatment leading to improvement of the patient's craniofacial and/or dentofacial discrepancy or dysfunction. Comprehensive treatment may utilize fixed or removable appliances.

Definitions

Biofilm: any group of bacteria that stick to each other and often adhere to a surface, such as a tooth. These "sticky" cells are frequently embedded within a self-produced matrix of cells.

Calculus: Also known as **tartar** on the teeth is a form of hardened dental plaque caused by the collection of minerals from saliva and gingival crevicular fluid (GCF). The process of precipitation kills the bacterial cells within dental plaque, but the rough and hardened surface that is formed provides an ideal surface for further plaque formation. This leads to calculus buildup, which compromises the health of the gingiva (gums). Calculus can form both along the gum line, where it is referred to as supragingival ("above the gum"), and within the narrow space that exists between the teeth and the gingiva, where it is referred to as subgingival ("below the gum"). Calculus formation is associated with a number of signs and symptoms including bad breath, receding gums and inflamed gingiva. Brushing and flossing can remove plaque from which calculus forms; however, once formed, it is too hard and firmly attached to be removed with a toothbrush requiring removal at the dentist's office.

Dental plaque: is a biofilm or mass of bacteria that grows on surfaces within the mouth. It is a sticky colorless deposit at first, but when it forms tartar it is brown or pale yellow and is commonly found between the teeth, on the front of teeth, behind the teeth, on chewing surface, along the gum line, and below the gum line. Dental plaque is also known as microbial plaque, oral biofilm, dental biofilm, dental plaque biofilm or bacterial plaque biofilm. While plaque is commonly associated with oral diseases such as caries (cavities) and periodontal disease (gum diseases), its formation is a normal process that cannot be prevented.

Direct Supervision: means the directing of the authorized activities and treatment of a **dental** hygienist or **dental** assistant by an actively licensed **dentist** requiring the physical presence of the dentist and patient.

Gingiva: the clinical term for gums. The gums are found in the oral cavity or mouth. They consist of mucosal (soft, pink) tissue that covers the alveolar processes (bone) of the maxilla (upper jaw) and mandible (lower jaw) and finish at the neck of each tooth. **Malocclusion:** is defined as the misalignment of the upper and lower teeth when biting or chewing. Malocclusion can also be defined as a bad bite and is quite often hereditary. Malocclusion is the most common reason for referral to an orthodontist. Most problems are minor and do not require treatment

Orthodontia: the branch of dentistry that deals with abnormalities of the teeth and jaw. Orthodontic care involves the use of devices, such as braces to straighten teeth and to correct problems with the bite.

Periodontal Disease: can affect one or more of the tissue/structures associated with teeth {e.g. bone, the ligament that attaches the tooth to bone and gingiva (gums)}. While there are many different periodontal diseases that can affect these tooth-supporting tissues/structures, by far the most common ones are plaque-induced inflammatory conditions, such as gingivitis and periodontitis.

Periodontium: refers to the specialized tissues that surround and support the teeth and maintain the teeth in the upper and lower jaw bones.

Saliva: a watery substance located in the mouth, secreted by salivary glands. Human saliva is 99.5% water with the remainder consisting of several things such as minerals, mucus, protein, enzymes, and bacterial compounds.

Tooth bounded space: a space created by one or more missing teeth that have a tooth on each side.

References

Peer Reviewed Publications:

1. dentistrydig.com/g/orthodontics.html
2. <http://ada.org/2555.aspx#odo>
3. Salzmann, JA 91968). Handicapping malocclusion assessment to establish treatment priority. American Journal of Orthodontics, Vol. 54, pp. 749-765.
4. www.nih.nih.gov/medlineplus/orthodontia.html

Government Agency, Medical Society, and Other Authoritative Publications:

1. For further information on orthodontics please see the following text: Contemporary Orthodontics. Fields, H.W. and Proffitt, W. R. 5th edition. 2012. Mosby, Inc.

History

Revision History	Version	Date	Nature of Change	SME
	Initial	3/23/14		Koumaras and Kahn
	Revision	9/21/15	posting	Koumaras and Kahn
	Revision	2/8/17	Criteria, Coding, definitions	Rosen
	Revision	1/26/18	Related Dental Policies, HLD Index Threshold, Direct Supervision, Requirement for pre-authorization, Definitions	M Kahn
	Revision	2/6/18	Related Dental Policies, Appropriateness and medical necessity	M Kahn
	Revision	2/19/18	Direct supervision	G Koumaras M Kahn

Federal and State law, as well as contract language, and Dental Policy take precedence over Clinical UM Guidelines. We reserve the right to review and update Clinical UM Guidelines periodically. Clinical guidelines approved by the Clinical Policy Committee are available for general adoption by plans or lines of business for consistent review of the medical or dental necessity of services related to the clinical guideline when the plan performs utilization review for the subject. Due to variances in utilization patterns, each plan may choose whether to implement a particular Clinical UM Guideline. To determine if review is required for this Clinical UM Guideline, please contact the customer service number on the member's card.

Alternatively, commercial or FEP plans or lines of business which determine there is not a need to adopt the guideline

to review services generally across all providers delivering services to Plan's or line of business's members may instead use the clinical guideline for provider education and/or to review the medical or dental necessity of services for any provider who has been notified that his/her/its claims will be reviewed for medical or dental necessity due to billing practices or claims that are not consistent with other providers, in terms of frequency or in some other manner.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

Current Procedural Terminology - CPT® 2017 Professional Edition – American Medical Association. All rights reserved.

Current Dental Terminology - CDT © 2018 American Dental Association. All rights reserved.

ICD-10-CM 2017: The Complete Official Codebook. All rights reserved.