Medical Coverage Policy | Pediatric Dental Services - Essential Health Benefit

EFFECTIVE DATE: 1/1/2014
POLICY LAST UPDATED: 1/1/2014

OVERVIEW

Effective January 1, 2014, Pediatric Services including oral care has been defined as an Essential Health Benefit. For those plans that have coverage for essential health benefits, this policy defines the oral care services that will be covered for children from the ages of 0 up to the child's 19th birthday.

PRIOR AUTHORIZATION

Dental Consultant review required.

POLICY STATEMENT

Pediatric oral care services listed in this policy are covered as part of the members medical coverage for children from the ages of 0 up to child's 19th birthday when the benefit plan includes coverage for essential health benefits

No coverage is available under the member's medical coverage for services not listed in this policy. These procedures would be considered not covered and are the member's responsibility up to the dentist's charge.

Orthodontic Services

Orthodontic services are not covered for:

- Repair of damaged orthodontic appliances
- Replacement of lost or missing appliances
- Services to alter vertical dimension and/or restore or maintain the occlusion, such as procedures that include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation and restoration for misalignment of teeth.

If a member has started orthodontic treatment with coverage by another carrier, or no insurance coverage at all, and the treatment meets BCBSRI medical criteria for coverage, the benefit maximum for orthodontic services will be prorated according to the length of time remaining in the treatment plan. *Example:* The member has completed 12 months of a 24 month orthodontic treatment plan before becoming enrolled. BCBSRI will pay 50% (12 months remaining/24 month total) of the allowable fee towards the orthodontic treatment.

For members who began orthodontic treatment with coverage under a BCBSRI dental plan and transitioned to the Pediatric Dental Benefit without coverage disruption, orthodontic payments will be made in accordance with the terms of the plan that was in place when treatment began. Should additional orthodontic benefits be requested, the dental necessity criteria for coverage under the EHB-Pediatric Dental Benefit must be met. Payment will never exceed the Blue Cross Dental allowance for treatment rendered.

DENTAL CRITERIA

Please refer to the coding section for the specific service that requires dental consultant review. If review is required, refer to the corresponding category of service below for the documentation requirements.

Major Restorative Services
Criteria:

- Periodontically and endodontically sound permanent tooth
- Sufficient breakdown as demonstrated on a radiograph

  or
- Documented evidence of cracked tooth syndrome

Required documentation:
- Pre-operative periapical xray
- Intra-oral photo (if available)
- Detailed narrative (if applicable)

Endodontic Services
Criteria:
- Sound periodontal prognosis
- If post service review:
  - Complete fill to the apex of each canal or calcification that prevent complete fill
  - No paste type fill material

Required documentation:
- Pre-operative and post-operative periapical xrays.
- A working film may not be substituted for a post-operative film.

Periodontal Services
Criteria:
- Scaling and root planning – Pocket depths of 4mm or more or radiographic evidence of calculus and interproximal bone loss (the number of teeth with qualifying pocket depths determine the appropriate code D4341; D4342)
- Osseous surgery - Pocket depths of 5mm or more and radiographic evidence of interproximal bone loss (the number of teeth with qualifying pocket depths determine the appropriate code D4260; D4261)
- Tissue grafts – 2mm of less of attached gingiva per treatment site

Required documentation:
- Periapical xrays of treatment area
- Full mouth periodontal chart
- Detailed narrative (if applicable)

Removable Prosthodontic Services
Required documentation:
- Detailed narrative.

Implant Services
Criteria:
- If an arch can be restored with a standard prosthesis or restoration, no benefits will be allowed for the implant or implant related services.

Required documentation:
- Pre-operative panorex or intraoral complete series
- Detailed narrative.
- If payment of claim: Post-operative film of implant, with above documentation is required for review.

Fixed Prosthodontics

Criteria:
- Periodontically and endodontically sound permanent abutment teeth

Required documentation:
- Pre-operative periapical xrays of entire treatment site

- If there are special circumstances related to the treatment, a detailed narrative is recommended.

Oral Surgery

Required documentation:

- Pre-operative xray of treatment site
- Narrative (if applicable)

Orthodontic Services

One of the following criteria must be met for services to be covered under this benefit:

- Maxillary/Mandibular incisor relationship: overjet of 5 mm or more, or 0 to a negative value
- Maxillary/Mandibular anteroposterior molar relationship discrepancy of 4mm or more
- No overlap of anterior teeth
- Unilateral or posterior bilateral open bite of 2mm or more
- Deep overbite with impingement or irritation of soft tissues of the opposing arch
- Supraeruption of a dentoalveolar segment due to lack of occlusion
- Total bilateral maxillary cusp to mandibular fossa discrepancy of 4mm or greater, or a unilateral discrepancy of 3mm or greater, given normal axial inclination of posterior teeth

Required Documentation for dental consultant review:

- Photos frontal and profile (smiling)
- Lateral cephalometric films
  - Frontal cephalometric film for asymmetries greater than 4mm
- Panoramic film
- Consultation letter with diagnosis and treatment plan

Major Restorative Services-

- The following services are limited to 1 tooth per 60 months
- inlay and onlay metallic
- core buildup
- prefabricated post and core
- crowns

Endodontic Services-

- Therapeutic pulpotomy (excluding final restoration) – If a root canal is performed within 45 days of the pulpotomy, the pulpotomy is not a covered service and will be considered part of the root canal procedure
- Parital pulpotomy for apexogenesis – permanent tooth with incomplete root formation- If a root canal is performed within 45 days of the pulpotomy, the pulpotomy is not a covered service and will be considered part of the root canal procedure
- Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration) – Up to age 6 for primary incisiors, Up to age 11 for primary canines- Limited to once per tooth per lifetime
- Pulpal therapy (resorabable filling) – posterior, primary tooth (excluding final restoration) – Up to age 11 for primary molars – Limited to once per tooth per lifetime

Periodontal Services -

- Gingivectomy or gingivoplasty – four or more teeth
- Gingivectomy or gingivoplasty – one to three teeth
- Gingival flap procedure, including root planing, four or more teeth

- o Clinical crown lengthening-hard tissue
- o Osseous surgery (including flap entry and closure), four or more contiguous teeth or bounded teeth spaces per quadrant
- o Pedicle soft tissue graft – Limited to once, per site, per 24 months
- o Subepithelial connective tissue graft procedures
- o Periodontal scaling and root planning-four or more teeth per quadrant-
- o Periodontal scaling and root planning-one to three teeth per quadrant
- o Full mouth debridement to enable comprehensive evaluation and diagnosis
- o Periodontal maintenance

Implant Services-

o Implants and related services are allowed once, per type of service (i.e. endosteal OR eposteal, porcelain OR metal crown), per treatment site per 60 months.

Fixed Prosthodontics -

o One fixed partial denture per treatment area per 60 months.

Oral Surgery -

Orthodontic Services -

oOrthodontic services are not covered for:
oRepair of damaged orthodontic appliances
oReplacement of lost or missing appliances
oServices to alter vertical dimension and/or restore or maintain the occlusion, such as procedures that include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation and restoration for misalignment of teeth.

BACKGROUND

Effective January 1, 2014, Qualified Health Plans (QHPs) are required to cover Essential Health Benefits (EHBs), as defined in Section 1302(b) of the Patient Protection and Affordable Care Act. Pediatric Services including oral and vision care has been defined as essential Health Benefits. This policy defines the oral care services that will be covered for members from the ages of 0 up to the members 19th birthday.

COVERAGE

Benefits may vary between groups/contracts. Please refer to the appropriate Subscriber Agreement for applicable pediatric dental benefits/coverage.

CODING

Claims are filed on CDT forms and if approved, will be processed under the members medical benefit.

DIAGNOSTIC SERVICES

- o D0120 Periodic oral evaluation
- o D0140 Limited oral evaluation
- o D0150 Comprehensive oral evaluation
- o D0160 Detailed and extensive oral evaluation, problem focused, by report
- o D0180 Comprehensive periodontal evaluation
- o D0210 Intraoral – complete series of radiographic images
- o D0220 Intraoral – periapical first radiographic image
- o D0230 Intraoral – periapical each additional radiographic image
- o D0240 Intraoral – occlusal film

- D0270 Bitewing – single radiographic image
- D0272 Bitewings – two radiographic images
- D0274 Bitewings – four radiographic images
- D0277 Vertical Bitewings – 7 to8 radiographic images
- D0330 Panoramic radiographic image
- D0340 Cephalometric radiographic image
- D0350 Oral/Facial photographic images
- D0470 Diagnostic casts

PREVENTIVE SERVICES

- D1110 Prophylaxis – Adult (age 13 or older)
- D1120 Prophylaxis – Child
- D1208 Topical application of fluoride
- D1351 Sealant-per tooth – unrestored permanent molars
- D1352 Preventive resin restoration in a moderate to high caries risk patient – permanent tooth
- D1510 Space maintainer –fixed- unilateral
- D1515 Space maintainer-fixed-bilateral
- D1520 Space maintainer-removable-unilateral
- D1525 Space maintainer-removable-bilateral
- D1550 Re-cementation of fixed space maintainer

MINOR RESTORATIVE SERVICES

- D2140 Amalgam-one surface, primary or permanent
- D2150 Amalgam-two surface, primary or permanent
- D2160 Amalgam-three surface, primary or permanent
- D2161 Amalgam-four or more surfaces, primary or permanent
- D2330 Resin-based composite-one surface, anterior
- D2331 Resin-based composite-two surface, anterior
- D2332 Resin-based composite-three surface anterior
- D2335 Resin-based composite-four or more surfaces or involving incisal angle (anterior)
- D2910 Re-cement inlay
- D2920 Re-cement crown
- D2930 Pre-fabricated stainless steel crown-primary tooth-Under age 15 (Dental Consultant review required)
- D2931 Pre-fabricated stainless steel crown-permanent tooth-Under age 15 (Dental Consultant review required)
- D2940 Protective resoration
- D2951 Pin retention-per tooth, in addition to restoration

MAJOR RESTORATIVE SERVICES (Dental Consultant review required)

- D2510 Inlay-metallic-one surface
- D2520 Inlay-metallic-two surfaces
- D2530 Inlay-metallic-three surfaces
- D2542 Onlay-metallic-two surfaces
- D2543 Onlay-metallic-three surfaces
- D2544 Onlay-metallic-four or more surfaces
- D2740 Crown-porcelain/ceramic substrate
- D2750 Crown-porcelain fused to high noble metal
- D2751 Crown-porcelain fused to predominantly base metal
- D2752 Crown-porcelain fused to noble metal

- D2780 Crown-3/4 cast high noble metal
- D2781 Crown-3/4 cast predominantly base metal
- D2783 Crown-3/4 porcelain/ceramic
- D2790 Crown-full cast high noble metal
- D2791 Crown-full cast predominantly base metal
- D2792 Crown-full cast noble metal
- D2794 Crown-titanium
- D2950 Core buildup, including any pins
- D2954 Prefabricated post and core, in addition to crown
- D2980 Crown repair necessitated by restorative material failure

ENDODONTIC SERVICES

- D3220 Therapeutic pulpotomy (excluding final restoration)
- D3222 Parital pulpotomy for apexogenesis – permanent tooth with incomplete root formation)
- D3230 Pulpal therapy (resorbable filling) – anterior, primary tooth
- D3240 Pulpal therapy (resorabable filling) – posterior, primary tooth (excluding final restoration)
- D3310 Endodontic therapy, anterior tooth (excluding final restoration) (Dental Consultant review required)
- D3320 Endodontic therapy, bicuspid tooth (excluding final restoration) (Dental Consultant review required)
- D3330 Endodontic therapy, molar (excluding final restoration) (Dental Consultant review required)
- D3346 Retreatment of previous root canal therapy-anterior (Dental Consultant review required)
- D3347 Retreatment of previous root canal therapy-bicuspid (Dental Consultant review required)
- D3348 Retreatment of previous root canal therapy-molar (Dental Consultant review required)
- D3351 Apexification/recalcification/pulpal regeneration –initial visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)
- D3352 Apexification/recalcification/pulpal regeneration –interim medication replacement
- D3353 Apexification/recalcification/pulpal regeneration –final visit (includes completed root canal therapy- apical closure/ calcific repair of perforations, root resorption,etc)
- D3354 Pulpal regeneration (completion of regenerative treatment in an immature permanent tooth with necrotic pulp); does not include final restoration)
- D3410 Apicoectomy/periradicular surgery –anterior (Dental Consultant review required)
- D3421 Apicoectomy/periradicular surgery –bicuspid (first root) (Dental Consultant review required)
- D3425 Apicoectomy/periradicular surgery –molar (first foot) (Dental Consultant review required)
- D3426 Apicoectomy/periradicular surgery –(each additional root) (Dental Consultant review required)
- D3450 Root amputation-per root (Dental Consultant review required)
- D3920 Hemisection (including any root removal)-not including root canal therapy (Dental Consultant review required)

PERIODONTAL SERVICES

- D4210 Gingivectomy or gingivoplasty – four or more teeth (Dental Consultant review required)
- D4211 Gingivectomy or gingivoplasty – one to three teeth (Dental Consultant review required)
- D4240 Gingival flap procedure, including root planing, four or more teeth
- D4249 Clinical crown lengthening-hard tissue (Dental Consultant review required)
- D4260 Osseous surgery (including flap entry and closure), four or more contiguous teeth or bounded teeth spaces per quadrant) (Dental Consultant review required)
- D4270 Pedicle soft tissue graft
- D4273 Subepithelial connective tissue graft procedures
- D4341 Periodontal scaling and root planning-four or more teeth per quadrant (Dental Consultant review required)
- D4342 Periodontal scaling and root planning-one to three teeth per quadrant (Dental Consultant review required)
- D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis
- D4910 Periodontal maintenance

PROSTHODONTIC SERVICES

- D5110 Complete denture-maxillary
- D5120 Complete denture-mandibular
- D5130 Immediate denture-maxillary
- D5140 Immediate denture-mandibular
- D5211 Maxillary partial denture-resin base (including any conventional clasps, rests and teeth)
- D5212 Mandibular partial denture-resin base (including any conventional clasps, rests and teeth)
- D5213 Maxillary partial denture-cast metal framework with resin denture base (including any conventional clasps, rests and teeth)
- D5214 Mandibular partial denture-cast metal framework with resin denture base (including any conventional clasps, rests and teeth)
- D5281 Removable unilateral partial denture-one piece cast metal (including clasps and teeth)
- D5410 Adjust complete denture-maxillary
- D5411 Adjust complete denture-mandibular
- D5421 Adjust parital denture-maxillary
- D5422 Adjust partial denture-mandibular
- D5510 Repair broken complete denture base
- D5520 Replace missing or broken teeth-complete denture (each tooth)
- D5610 Repair resin denture base
- D5620 Repair cast framework
- D5630 Repair or replace broken clasp
- D5640 Replace broken teeth-per tooth
- D5650 Add tooth to existing partial denture
- D5660 Add clasp to existing partial denture
- D5710 Rebase complete maxillary denture-Limited to once per 36 months
- D5711 Rebase complete mandibular denture-Limited to once per 36 months
- D5720 Rebase maxillary partial denture
- D5721 Rebase mandibular parital denture
- D5730 Reline complete maxillary denture (chairside)

- D5731 Reline complete mandibular denture (chairside)
- D5740 Reline maxillary partial denture (chairside)
- D5741 Reline mandibular partial denture (chairside)
- D5750 Reline complete maxillary denture (laboratory)
- D5751 Reline complete mandibular denture (laboratory)
- D5760 Reline maxillary partial denture (laboratory)
- D5761 Reline manidbular partial denture (laboratory)
- D5850 Tissue conditioning, maxillary
- D5851 Tissue conditioning, mandibular

IMPLANT SERVICES (Dental Consultant review required)

- D6010 Endosteal implant
- D6012 Surgical Placement of Interim Implant Body
- D6040 Eposteal Implant
- D6050 Transosteal Implant, including hardware
- D6053 Implant supported complete denture
- D6054 Implant supported partial denture
- D6055 Connecting bar – implant or abutment supported
- D6056 Prefabricated abutment
- D6058 Abutment supported porcelain ceramic crown
- D6059 Abutment supported porcelain fused to high noble metal crown
- D6060 Abutment supported porcelain fused to predominantly base metal crown
- D6061 Abutment supported porcelain fused to noble metal crown
- D6062 Abutment supported cast high noble metal crown
- D6063 Abutment supported cast predominantly base metal crown
- D6064 Abutment supported cast noble metal crown
- D6065 Implant supported porcelain ceramic crown
- D6066 Implant supported porcelain fused to high noble metal crown
- D6067 Implant supported metal crown
- D6068 Abutment supported retainer for porcelain /ceramic fixed partial denture
- D6069 Abutment supported retainer for porcelain fused to high noble metal fixed partial denture
- D6070 Abutment supported retainer for porcelain fused to predominantly base metal fixed partial denture
- D6071 Abutment supported retainer for porcelain fused to noble metal fixed partial denture
- D6072 Abutment supported retainer for cast high noble metal fixed partial denture
- D6073 Abutment supported retainer for cast predominantly base metal fixed partial denture
- D6074 Abutment supported retainer for cast noble metal fixed partial denture
- D6075 Implant supported retainer for ceramic fixed partial denture
- D6076 Implant supported retainer for porcelain fused to high noble metal fixed partial denture
- D6077 Implant supported retainer for cast metal fixed partial denture
- D6078 Implant/abutment supported fixed denture for completely edentulous arch
- D6080 Implant maintenance procedures
- D6090 Repair implant supported prosthesis
- D6091 Replacement of semi-precision or precision attachment
- D6095 Repair implant abutment
- D6100 Implant removal

FIXED PROSTHODONTICS (Dental Consultant review required)

- D6210 Pontic-cast high noble metal
- D6211 Pontic-cast predominantly base metal
- D6212 Pontic-cast noble metal
- D6214 Pontic-titanium
- D6240 Pontic-porcelain fused to high noble metal
- D6241 Pontic-porcelain fused to predominantly base metal
- D6242 Pontic-porcelain fused to noble metal
- D6245 Pontic-porcelain/ceramic
- D6545 Retainer-cast metal for resin bonded fixed prosthesis
- D6548 Retainer-porcelain/ceramic for resin bonded fixed prosthesis
- D6740 Crown-porcelain/ceramic
- D6750 Crown-porcelain fused to high noble metal
- D6751 Crown-porcelain fused to predominantly base metal
- D6752 Crown-porcelain fused to noble metal
- D6780 Crown-3/4 cast high noble metal
- D6781 Crown-3/4 cast predominantly base metal
- D6782 Crown-3/4 cast noble metal
- D6783 Crown-3/4 porcelain/ceramic
- D6790 Crown-full cast high noble metal
- D6791 Crown-full cast predominantly metal
- D6792 Crown-full cast noble metal
- D6930 Recement fixed partial denture
- D6980 Fixed partial denture repair necessitated by restorative material failure

ORAL SURGERY (Dental Consultant review required)

- D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
- D7210 Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
- D7220 Removal of impacted tooth-soft tissue
- D7230 Removal of impacted tooth-partially bony
- D7240 Removal of impacted tooth-completely bony
- D7241 Removal of impacted tooth-completely bony with unusual surgical complications
- D7250 Surgical removal of residual tooth roots (cutting procedure)
- D7251 Coronectomy-intentional partial tooth removal
- D7270 Tooth reimplantation and/or stabilization of accidentally avulsed or displaced tooth
- D7280 Surgical access of an unerupted tooth
- D7310 Alveoloplasty in conjunction with extractions-per quadrant
- D7311 Alveoloplasty in conjunction with extractions-one to three teeth or tooth spaces, per quadrant
- D7320 Alveoloplasty not in conjunction with extractions-per quadrant
- D7321 Alveoloplasty not in conjunction with extractions-one to three teeth or tooth spaces, per quadrant
- D7471 Removal of lateral exostosis (maxilla or mandible)
- D7510 Incision and drainage of abscess- intraoral soft tissue
- D7910 Suture of recent small wounds-up to 5 cm
- D7971 Excision of pericoronal gingival

ADJUNCTIVE SERVICES

- o D9110 Palliative (emergency) treatment of dental pain-minor procedure
- o D9220 Deep sedation/general anesthesia – first 30 minutes
- o D9221 Deep sedation/general anesthesia-each additional 15 minutes
- o D9241 Intravenous conscious sedation/analgesia-first 30 minutes
- o D9242 Intravenous conscious sedation/analgesia-each additional 15 minutes
- o D9310 Consultation- diagnostic service provided by a dentist or physician other than requesting dentist or physician
- o D9610 Therapeutic drug injection, by report
- o D9930 Treatment of complications (post-surgical)-unusual circumstances, by report (Dental Consultant review required)
- o D9940 Occlusal guard, by report

ORTHODONTIC SERVICES (Dental Consultant review required)
The following services are covered under medical only when the services meet the criteria for coverage in this policy (see above)

- o D8010 Limited orthodontic treatment of the primary dentition
- o D8020 Limited orthodontic treatment of the transitional dentition
- o D8030 Limited orthodontic treatment of the adolescent dentition
- o D8040 Limited orthodontic treatment of the adult dentition
- o D8050 Interceptive orthodontic treatment of the primary dentition
- o D8060 Interceptive orthodontic treatment of the transitional dentition
- o D8070 Comprehensive orthodontic treatment of the transitional dentition
- o D8080 Comprehensive orthodontic treatment of the adolescent dentition
- o D8090 Comprehensive orthodontic treatment of the adult dentition
- o D8210 Removable appliance therapy
- o D8220 Fixed appliance therapy
- o D8660 Pre-orthodontic treatment visit*
- o D8670 Periodic orthodontic treatment visit *
- o D8680 Orthodontic retention (removal of appliances, construction and placement of retainer(s)
- o D8999 Unspecified orthodontic procedure, by report

* these services are typically reimbursed as part of the global services

RELATED POLICIES

Not applicable

PUBLISHED

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REFERENCES

http://www.ncsl.org/issues-research/health/state-ins-mandates-and-aca-essential-benefits.aspx

http://ebn.benefitnews.com/news/hhs-defines-essential-health-benefits-ppaca-2729494-1.html.

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