Coverage Summary

Dental Services, Oral Surgery and Treatment of Temporomandibular Joint (TMJ)

Approved by: UnitedHealthcare Medicare Benefit Interpretation Committee  Last Review Date: 03/21/2017

Related Medicare Advantage Policy Guidelines:
- Dental Examination Prior to Kidney Transplantation (NCD 260.6)
- Manipulation (NCD 150.1)

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The benefit information in this Coverage Summary is based on existing national coverage policy, however, Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable.

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I. COVERAGE

Coverage Statement: Dental and oral surgery service are covered when Medicare Coverage criteria are met.

Guidelines/Notes:
1. Dental Services or Oral Surgery
   Dental services or oral surgery, rendered by a physician or dental professional, for treatment of primary medical conditions are covered. The dental procedures are not covered. Examples of these non-covered services are items and services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth.

   Note: Outpatient (Part B) Services including Ambulatory Surgery Center Procedures
   Whether services such as the administration of anesthesia, diagnostic x-rays, and other related
procedures are covered depends upon whether the primary procedure being performed by the dentist is itself covered. Thus, an x-ray taken in connection with the reduction of a fracture of the jaw or facial bone is covered. However, a single x-ray or x-ray survey taken in connection with the care or treatment of teeth or the periodontium is not covered.


Also see the Medicare Benefit Policy Manual, Chapter 16, §140 - Dental Services Exclusion. (Accessed March 14, 2017)

Also see the Medicare Benefit Policy Manual, Chapter 15, §260.5 - List of Covered Ambulatory Surgical Center Procedures. (Accessed March 14, 2017)

For coverage of inpatient (Part A) facilities and anesthesia charges, refer to Guideline #1.j below.

Examples of covered services include, but are not limited to:

a. Setting of the jaw or facial bones (includes wiring of the teeth when performed in connection with the reduction of a jaw fracture).
   Splints and casts, and other devices used for reductions of fractures and dislocations are covered under Part B of Medicare. This includes dental splints. Dental splints used to treat a dental condition are excluded from coverage under 1862(a)(12) of the Act. On the other hand, if the treatment is determined to be a covered medical condition (i.e., dislocated upper/lower jaw joints), then the splint can be covered.


b. 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).


c. Extraction of teeth to prepare the jaw for radiation treatments of neo-plastic disease is covered.


Also see the Medicare Benefit Policy Manual, Chapter 16, §140 - Dental Services Exclusion. (Accessed July 29, 2016)

d. Reconstruction of the jaw when medically necessary (e.g., radical neck or removal of mandibular bone for cancer or tumor).

e. Payment may be made under part A in the case of inpatient hospital services in connection with the provision of dental services if the individual, because of his underlying medical condition and clinical status or because of the severity of the dental procedure, requires hospitalization in connection with the provision of such services.

See the Statutory Dental Exclusion section of the Medicare Dental Coverage Overview at...

f. Insertion of metallic implants if the implants are used to assist in or enhance the retention of a dental prosthesis as a result of a covered service under the member’s medical plan.

See the Local Coverage Determinations (LCDs) for Dental Services

**Note:** Crowns, dentures, and other dental prostheses are not covered even if supported by the implants. See the Services Excluded Under Part B section of the Medicare Dental Coverage Overview at http://www.cms.hhs.gov/MedicareDentalCoverage. (Accessed July 29, 2016)

g. Biopsy of gums or soft palate (e.g., for the diagnosis of a suspicious lesion for cancer).

See the Local Coverage Determinations (LCDs) for Dental Services. Compliance with these policies is required where applicable. These LCDs are available at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. (Accessed July 29, 2016)

h. Treatment of maxillofacial cysts, including extraction and biopsy.

See the Local Coverage Determinations (LCDs) for Dental Services. Compliance with these policies is required where applicable. These LCDs are available at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. (Accessed July 29, 2016)

i. Oral or dental examinations Prior to Kidney Transplantation or Heart Valve Replacement.

Oral or dental examinations, but not treatment, performed inpatient as part of a comprehensive workup prior to kidney/renal transplantation surgery or heart valve replacement. Such a dental or oral examination would be covered under Part A of the program if performed by a dentist on the hospital's staff, or under Part B if performed by a physician.

See the NCD for Dental Examination Prior to Kidney Transplantation (260.6). (Accessed July 29, 2016)


j. Inpatient (Part A) Facilities and Anesthesia Charges (For anesthesia coverage for Part B services, see Guideline 1 Note, above.)

Facilities and anesthesia charges in an inpatient facility when a dental procedure cannot be performed in a dental office due to an underlying medical condition and clinical status or the severity of a non-covered dental procedure, **are covered.**

When a patient is hospitalized for a dental procedure and the dentist's service is covered under Part B, the inpatient hospital services furnished are covered under Part A. For example, both the professional services of the dentist and the inpatient hospital expenses are covered when the dentist reduces a jaw fracture of an inpatient at a participating hospital.

When the hospital services are covered, all ancillary services such as x-rays, administration of anesthesia, use of the operating room, etc., are covered.

Regardless of whether the inpatient hospital services are covered, the medical services of physicians furnished in connection with the non-covered dental procedures **are not**
covered. Examples of these non-covered services are items and services of an anesthesiologist, radiologist, or pathologist in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth.


Also see see the Medicare Benefit Policy Manual, Chapter 15, §150 – Dental Services. (Accessed March 14, 2017)

The attending doctor of dental surgery or of dental medicine is authorized to certify that the patient's underlying medical condition and clinical status or the severity of the dental procedure requires the patient to be admitted to the hospital for the performance of the dental procedure; and to recertify the patient's continuing need for hospitalization when required. This applies even if the dental procedure is not covered. See the Medicare General Information, Eligibility, and Entitlement, Chapter 4, §10.3 - Certification for Hospital Admissions for Dental Services. (Accessed March 14, 2017)

k. Denture as part of the prosthesis when the denture or a portion of denture is an integral part (built-in) of an obturator which fills an opening in the palate. See the Medicare Benefit Policy Manual, Chapter 15, §120 - Prosthetic Devices, C - Dentures. (Accessed July 29, 2016)

Local Coverage Determinations (LCDs) for Dental Services exist. Compliance with these policies is required where applicable. These LCDs are available at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. (Accessed July 29, 2016)

2. Temporomandibular Joint (TMJ)

There are a wide variety of conditions that can be characterized as TMJ, and an equally wide variety of methods for treating these conditions. Many of the procedures fall within the Medicare program’s statutory exclusion that prohibits payment for items and services that have not been demonstrated to be reasonable and necessary for the diagnosis and treatment of illness or injury (§1862(a)(1) of the Act). Other services and appliances used to treat TMJ fall within the Medicare program’s statutory exclusion at 1862(a)(12), which prohibits payment “for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth...”. For these reasons, a diagnosis of TMJ on a claim is insufficient. The actual condition or symptom must be determined. See the Medicare Benefit Policy Manual, Chapter 15, §150.1 – Treatment of Temporomandibular Joint Syndrome. (Accessed July 29, 2016)

Treatment of TMJ may include:

a. Oral medications (Member must have Part D plan coverage)

b. Botulinum Toxins A & B

- Medicare does not have a National Coverage Determination for Botulinum Toxins A & B
- Local Coverage Determinations (LCDs) exists and compliance with these LCDs is required where applicable. For state-specific LCDs, see the LCD Availability Grid (Attachment A).
- For states with no LCDs, refer to the UnitedHealthcare Drug Policy for Botulinum Toxins A and B. (IMPORTANT NOTE: After searching the Medicare Coverage Database, if no state LCD or Local Article is found, then use the above referenced
3. Orthognathic Surgery
   - Medicare does not have a National Coverage Determination (NCD) for orthognathic surgery
   - Local Coverage Determinations (LCDs) do not exist at this time
   - For coverage guidelines, refer to the UnitedHealthcare Coverage Determination Guidelines

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4. The following dental services and oral surgery services are not covered:

   a. Items and services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth are not covered. “Structures directly supporting the teeth” means the periodontium, which includes the gingivae, dentogingival junction, periodontal membrane, cementum of the teeth, and alveolar process.


   Also see the Medicare Benefit Policy Manual, Chapter 16, §140 - Dental Services Exclusion. (Accessed August 3, 2016)

   b. Cosmetic surgery or treatment provided solely to improve the member’s appearance and not intended to improve the physical functioning of a malformed body part(s). See the Medicare Benefit Policy Manual, Chapter 16, § 120 - Cosmetic Surgery. (Accessed August 3, 2016)

   c. 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. Example include, but not limited to reconstruction of mandible or maxilla, endosteal implant (CPT codes 21248 and 21249). See the Medicare Benefit Policy Manual, Chapter 16, §140 - Dental Services Exclusion. (Accessed August 3, 2016)


   See the Local Coverage Determinations (LCDs) for Dental Services. Compliance with these policies is required where applicable. These LCDs are available at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. (Accessed August 3, 2016)

II. DEFINITIONS

Cosmetic Surgery: Cosmetic or reconstructive surgery used to alter and improve the member's physical appearance or to improve the member's self-esteem and which provides no improvement to a functional impairment. Medicare Benefit Policy Manual, Chapter 16, § 120 - Cosmetic Surgery. (Accessed August 3, 2016)
**Dental/Orthodontic Devices/Appliances:** Any device used to influence growth or the position of teeth and jaws. (e.g., braces, retainers, night guards, oral splints) American Dental Association Glossary at [http://www.ada.org/glossaryforprofessionals.aspx#i](http://www.ada.org/glossaryforprofessionals.aspx#i). (Accessed August 3, 2016)

**Dental Prosthesis:** An artificial device that replaces one or more missing teeth. American Dental Association Glossary at [http://www.ada.org/glossaryforprofessionals.aspx#i](http://www.ada.org/glossaryforprofessionals.aspx#i). (Accessed August 3, 2016)

**Dental Implant:** A device specially designed to be placed surgically within or on the mandibular or maxillary bone as a means of providing for dental replacement; endosteal (endosseous); eposteal (subperiosteal); transosteal (transosseous). American Dental Association Glossary at [http://www.ada.org/glossaryforprofessionals.aspx#i](http://www.ada.org/glossaryforprofessionals.aspx#i). (Accessed August 3, 2016)

### III. REFERENCES

See above.

### IV. REVISION HISTORY

03/21/2017 Re-review with the following updates to clarify coverage of anesthesia for dental procedures in a facility:

- Guideline 1 (Dental Services and Oral Surgery)
  - Note – added “Outpatient (Part B) Services including Ambulatory Surgery Center Procedures”
  - Add reference links to the following:
    - Medicare Benefit Policy Manual, Chapter 16 General Exclusions From Coverage, §140 Dental Services Exclusion
    - Medicare Benefit Policy Manual (Pub 100-2), Ch 15, Covered Medical and Other Health Services, §260.5 - List of Covered Ambulatory Surgical Center Procedures.
  - Revised the language “For coverage of facilities and anesthesia charges, refer to Guideline #1,j below” to “For coverage of inpatient (Part A) facilities and anesthesia charges, refer to Guideline #1,j below.”
  - Guideline 1,j (Facilities and anesthesia charges) - based on the Medicare Benefit Policy Manual, Chapter 1 - Inpatient Hospital Services, Section 70 - Inpatient Services in Connection With Dental Services Covered Under Part A:
    - Revised the first paragraph, to read:
      Facilities and anesthesia charges in an inpatient facility when a dental procedure cannot be performed in a dental office due to an underlying medical condition and clinical status or the severity of a non-covered dental procedure, are covered
    - Added the following language:
      When a patient is hospitalized for a dental procedure and the dentist's service is covered under Part B, the inpatient hospital services furnished are covered under Part A. For example, both the professional services of the dentist and the inpatient hospital expenses are covered when the dentist reduces a jaw fracture of an inpatient at a participating hospital
      When the hospital services are covered, all ancillary services such as x-rays, administration of anesthesia, use of the operating room, etc., are covered.
    - Revised the 4th paragraph, to read:
Regardless of whether the inpatient hospital services are covered, the medical services of physicians furnished in connection with the non-covered dental procedures are not covered. Examples of these non-covered services are items and services of an anesthesiologist, radiologist, or pathologist in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth.

08/16/2016 Annual review; no updates

02/16/2016 Guideline 2.e (Arthrocentesis) - deleted the following language “LCDs exist and replaced with the statement that LCDs do not exist at this time.”

Updated reference link(s) of the applicable LCDs to reflect the condensed link.

11/17/2015 Guideline 4.c (Dental services and oral surgery services that are not covered; reconstruction of the jawbone or supporting tissues) – added language to state:

Example include, but not limited to reconstruction of mandible or maxilla, endosteal implant (CPT codes 21248 and 21249)

09/15/2015 Annual review with the following updates:

- Guideline #1.g [Biopsy of gums or soft palate (e.g., for the diagnosis of a suspicious lesion for cancer)] - Added reference link to the Local Coverage Determinations (LCDs) for Dental Services.
- Guideline #1.h (Treatment of maxillofacial cysts, including extraction and biopsy) - Added reference link to the Local Coverage Determinations (LCDs) for Dental Services.
- Guideline #2.e (Arthrocentesis) – Changed default from UnitedHealthcare Medical Policy for Mandibular Disorder (archived 7/15) to the UnitedHealthcare Medical Policy for Temporomandibular Joint Disorders.
- Guideline #2.f (Treatments such as the injection of corticosteroid, physical therapy, arthroscopy, or arthroplasty) - Changed default from UnitedHealthcare Medical Policy for Mandibular Disorder (archived 7/15) to the UnitedHealthcare Medical Policy for Temporomandibular Joint Disorders.
- Guideline #2.g (Sodium Hyaluronate Injections) – Added “for sodium hyaluronate injections used in treatment of TMJ” to first bullet point of guideline.
- Guideline #4.e (Dental Implants) – Added reference and link to the Services Excluded Under Part B section of the Medicare Dental Coverage Overview.
- Guideline #4.f (Bone grafts for preparation of dental implants) - Added reference and link to the Services Excluded Under Part B section of the Medicare Dental Coverage Overview.
- Guideline #4.g [Fluoride trays and/or bite guards used to protect teeth from caries and possible infection during radiation. (HCPCS code D5986-Noncovered by Medicare)] – Deleted, unable to find appropriate CMS reference.
- Guideline #4 (The following dental services and oral surgery services are not covered) – Added reference and link to the Local Coverage Determinations (LCDs) for Dental Services at end of this section.

06/16/2015 Guideline 1.i (Oral or dental examinations Prior to Kidney Transplantation or Heart Valve Replacement) - Revised language to indicate:

Oral or dental examinations, but not treatment, performed on an inpatient as part of a comprehensive workup prior to kidney/renal transplantation surgery or heart valve
replacement. Such a dental or oral examination would be covered under Part A of the program if performed by a dentist on the hospital’s staff, or under Part B if performed by a physician.

10/21/2014 Annual review with the following updates:
- Updated the definition of:
  - Cosmetic Surgery: Added reference link to the Medicare Benefit Policy Manual Chapter 16, §120 - Cosmetic Surgery
- Deleted the definition of:
  - Malocclusion (not used in the body of the Coverage Summary)
  - Orthognathic Surgery (definition in the default UnitedHealthcare Coverage Determination Guidelines for Orthognathic/Jaw Surgery)

02/18/2013 Guideline #2.b (Botulinum Toxins A & B) - Changed default guideline for states without Local Coverage Determinations (LCDs) from UnitedHealthcare Medical Policy for Mandibular Disorders to UnitedHealthcare Medical Policy for Botulinum Toxins A and B
- Guidelines #2.g (Sodium Hyaluronate Injections)-added applicable guideline

10/24/2013 Annual review; no updates

08/20/2013
- Guidelines #1 (Dental Services or Oral Surgery) - Added noncoverage language for dental procedures and examples based on the Medicare Benefit Policy Manual
- Added a reference to Guidelines #1.j for coverage of facilities and anesthesia charges in a contracted facility
- Guidelines #1.j (Facilities and anesthesia charges in a contracted facility)- Added noncoverage language for dental procedures and clarification as to who is authorized to certify/recertify member’s underlying medical condition based on the Medicare Benefit Policy Manual

10/31/2012 Annual review; updated the applicable CMS references and links; also with the following updates:
- Guidelines #1.a.-added “Splints and casts, and other devices used for reductions of fractures and dislocations are covered under Part B of Medicare. This includes dental splints.”
- Guidelines #1.a.5 – deleted “Extraction of teeth if medically necessary for members undergoing transplant procedures”; replaced with “Payment may be made under part A in the case of inpatient hospital services in connection with the provision of dental services if the individual, because of his underlying medical condition and clinical status or because of the severity of the dental procedure, requires hospitalization in connection with the provision of such services” based on the Statutory Dental Exclusion section of the Medicare Dental Coverage Overview
- Guidelines #1.d (reconstruction of the jaw when medically necessary); #1.g (biopsy of gums or soft palate; and #1.h (treatment of maxillofacial cysts, including extraction and biopsy) were reviewed and confirmed by UMBIC as covered; no CMS reference found
- Guidelines #3.e (dental implants) and #3.f (bone grafts for preparation of dental implants) were reviewed and confirmed by UMBIC not as covered; no CMS reference found

10/13/2011 Guidelines #2.b (Botulinum Toxins A & B) - updated to include the Trailblazer,
V. ATTACHMENT(S)

Attachment A - LCD Availability Grid

<table>
<thead>
<tr>
<th>LCD ID</th>
<th>LCD Title</th>
<th>Contractor Type</th>
<th>Contractor Name</th>
<th>States</th>
</tr>
</thead>
<tbody>
<tr>
<td>L35172</td>
<td>Botulinum Toxin Types A and B</td>
<td>A and B MAC</td>
<td>Noridian Healthcare Solutions, LLC</td>
<td>AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY</td>
</tr>
<tr>
<td>L35170</td>
<td>Botulinum Toxin Types A and B Policy</td>
<td>A and B MAC</td>
<td>Noridian Healthcare Solutions, LLC</td>
<td>CA-Northern, CA-Southern, AS, GU, HI, MP, NV</td>
</tr>
</tbody>
</table>

IMPORTANT NOTE: Use the applicable LCD based on member’s residence/place of service AND type of service.

CMS website accessed May 2, 2017

End of Attachment A