ORAL SURGERY: ORTHODONTIC RELATED PROCEDURES

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Table of Contents

INSTRUCTIONS FOR USE .......................................................... 1
BENEFIT CONSIDERATIONS .............................................. 1
COVERAGE RATIONALE ..................................................... 2
DEFINITIONS ..................................................................... 2
APPLICABLE CODES ............................................................. 3
DESCRIPTION OF SERVICES ............................................ 3
CLINICAL EVIDENCE ............................................................ 4
U.S. FOOD AND DRUG ADMINISTRATION ....................... 5
REFERENCES ..................................................................... 5
POLICY HISTORY/REVISION INFORMATION ...................... 6

INSTRUCTIONS FOR USE

This Dental Coverage Policy provides assistance in interpreting UnitedHealthcare dental benefit plans. When deciding coverage, the member specific benefit plan document must be referenced. The terms of the member specific benefit plan document (e.g., Certificate of Coverage (COC), Schedule of Benefits (SOB), and/or Summary Plan Description (SPD)) may differ greatly from the standard benefit plan upon which this Dental Coverage Policy is based. In the event of a conflict, the member specific benefit plan document supersedes this Dental Coverage Policy. All reviewers must first identify member eligibility, any federal or state regulatory requirements, and the member specific benefit plan coverage prior to use of this Dental Coverage Policy. Other Clinical Policies and Coverage Guidelines may apply. UnitedHealthcare reserves the right, in its sole discretion, to modify its Policies and Guidelines as necessary. This Dental Coverage Policy is provided for informational purposes. It does not constitute medical advice.

BENEFIT CONSIDERATIONS

Before using this policy, please check the member specific benefit plan document and any federal or state mandates, if applicable.

Essential Health Benefits for Individual and Small Group

For plan years beginning on or after January 1, 2014, the Affordable Care Act of 2010 (ACA) requires fully insured non-grandfathered individual and small group health plans (inside and outside of Exchanges) to provide coverage for Pediatric Dental Essential Health Benefits ("EHBs"). Large group plans (both self-funded and fully insured), and small group ASO plans, are not subject to the requirement to offer coverage for Pediatric Dental EHBs. However, if such plans choose to provide coverage for benefits which are deemed Pediatric Dental EHBs, the ACA requires all dollar limits on those benefits to be removed on all Grandfathered and Non-Grandfathered plans. The determination of which benefits constitute Pediatric Dental EHBs is made on a state by state basis. As such, when using this policy, it is important to refer to the member specific benefit plan document to determine benefit coverage.

COVERAGE RATIONALE

For plans that have comprehensive orthodontic coverage, the following identify guidelines for the use of related oral surgery procedures.

Surgical Placement of Temporary Anchorage Device (Not Related to Distraction Osteogenesis or Orthognathic Surgery)

The surgical placement of temporary anchorage devices are used in conjunction with orthodontic treatment and are indicated for patients aged 12 and over for the following:

- Intrusion of maxillary teeth
- Molar distalization
- Canine retraction and intrusion retraction mechanics
- Correction of anterior open bite and deep overbite
- Correction of canted occlusal planes
The surgical placement of a temporary anchorage device is not indicated for the following:

- Patients with a known allergy to titanium alloy
- Patients with a history of heavy tobacco use
- Patients with advanced osteoporosis
- Patients with uncontrolled immune or metabolic bone disorders
- Patients with unmanaged medical conditions that result in excessive bleeding, reduced resistance to infection, or poor healing response
- Patients with poor oral hygiene
- In areas with poor quality cortical bone density and volume
- For ankylosed teeth

**Surgical Access of Unerupted Tooth**

Surgical access of unerupted tooth is indicated for the following:

- When a tooth is in such a position that it is unable to erupt into a functional position within the dental arch
- Tooth developing normally and appears to be in a good position to be moved into position orthodontically, or spontaneously
- Only for labially impacted teeth when there will be 2-3 mm of gingival cuff present after eruption

Surgical access of unerupted tooth is not indicated for the following:

- Teeth with abnormal development or positioning
- For supernumerary teeth and third molars
- For primary teeth
- For ankylosed permanent teeth
- When surgical access of impacted tooth would threaten vital structures
- Patients with unmanaged medical conditions that result in excessive bleeding, reduced resistance to infection, or poor healing response

**Placement of Device to Facilitate Eruption of Impacted Tooth**

This is the placement of an orthodontic bracket, band or other device and attached with a chain, on an unerupted tooth, after surgical exposure, to aid in its eruption. This procedure is done following the surgical access of an unerupted tooth.

**Mobilization of Erupted or Malpositioned Tooth to Aid Eruption**

Mobilization of erupted or malpositioned tooth to aid eruption is indicated for the treatment of ankylosed permanent teeth.

Mobilization of erupted or malpositioned tooth to aid eruption is not indicated for primary teeth.

**DEFINITIONS**

**Anchorage**: Resistance to force. Anchorage may come from any of the following sources: intraoral (teeth, bone, soft tissue, implants), or extraoral (cervical, occipital, cranial) (AAO).

**Angle’s Classification of Malocclusion**: A classification of malocclusion introduced by Edward H. Angle. The governing criterion is the anteroposterior relationship of maxillary and mandibular first molars (AAO).

- **Class I Malocclusion (Neutroclusion)**: A malocclusion in which the mesiobuccal cusp of the maxillary first molar occludes in the buccal groove of the mandibular first molar. “Class I” is sometimes incorrectly used as a synonym for normal occlusion, whereas it signifies only a normal sagittal relationship of maxillary and mandibular posterior teeth as they meet.
- **Class II Malocclusion (Distoclusion)**: A distal (posterior) placement of the mandibular (lower) molar, a mesial (anterior) relationship of the maxillary (upper), or a combination of the two. The mesiobuccal cusp of the mandibular first molar occludes mesial to the buccal groove of the mandibular first molar, usually near the embrasure between the mandibular molar and second premolar.
  - **Division 1**: A Class II molar relationship with proclined maxillary incisors.
  - **Division 2**: A Class II molar relationship, usually with the maxillary central incisors tipped lingually, the maxillary lateral incisors tipped labially. This malocclusion, in many instances, has an excessive overbite.
  - **Subdivision**: Subdivision of any malocclusion category denotes a unilateral malocclusion classification (e.g., Class II, division 2, subdivision).
- **Class III Malocclusion (Mesioclusion)**: Mesial (anterior) relationship of the mandibular first molar to the maxillary first molar, a retruded relationship of the maxillary first molar to the mandibular, or a combination of the two. The mesiobuccal cusp of the maxillary first molar will typically occlude near the embrasure between the mandibular first and second molars.
**Ankylosis**: Abnormal immobility, union or fusion. It may occur between two bones at their articulation (e.g., TMJ) or between teeth and alveolar bone (AAO).

**Distalization**: A common descriptor for the biomechanics involved in moving maxillary first and second molars distally and into a Class I molar relationship.

**Intrusion**: A translational form of tooth movement directed apically and parallel to the long axis of a tooth (AAO).

**Occlusal Plane**: The imaginary surface on which upper and lower teeth meet in occlusion. It is actually a compound curved surface, but is commonly approximated by a plane (straight line in the lateral view) based on specific reference points within the dental arches (AAO).

**Open Bite**: Lack of tooth contact in an occluding position (AAO).

**Orthognathic Surgery**: Orthognathic surgery is the surgical correction of abnormalities of the mandible, maxilla, or both. The underlying abnormality may be present at birth or may become evident as the patient grows and develops or may be the result of traumatic injuries. The severity of these deformities precludes adequate treatment through dental treatment alone (AAOMS).

**Overbite**: Vertical overlap of maxillary teeth over mandibular anterior teeth, usually measured perpendicular to the occlusal plane (AAO).

**Retraction**: Pertaining to desired posteriorly directed, orthodontic or orthopedic displacements of teeth or of bones of the face (AAO).

**APPLICABLE CODES**

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Clinical Policies and Coverage Guidelines may apply.

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<tr>
<th>CDT Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>D7280</td>
<td>exposure of an unerupted tooth</td>
</tr>
<tr>
<td>D7282</td>
<td>mobilization of erupted or malpositioned tooth to aid eruption</td>
</tr>
<tr>
<td>D7283</td>
<td>placement of device to facilitate eruption of impacted tooth</td>
</tr>
<tr>
<td>D7292</td>
<td>placement of temporary anchorage device [screw retained plate] requiring flap; includes device removal</td>
</tr>
<tr>
<td>D7293</td>
<td>placement of temporary anchorage device requiring flap; includes device removal</td>
</tr>
<tr>
<td>D7294</td>
<td>placement of temporary anchorage device without flap; includes device removal</td>
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<tr>
<td>D7997</td>
<td>appliance removal (not by dentist who placed appliance), includes removal of archbar</td>
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*CDT® is a registered trademark of the American Dental Association*

<table>
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<th>CPT Code</th>
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*CPT® is a registered trademark of the American Medical Association*

**DESCRIPTION OF SERVICES**

Temporary anchorage devices (TADs) are used to improve anchorage during routine orthodontic therapy. They are gaining popularity, and can allow better anchorage than extraoral headgear which relies on significant patient compliance for success. TAD’s may also be used for distraction osteogenesis of the mandible and this use is medical in nature and typically covered under the member’s medical plan. Impacted teeth are those that are not expected to erupt into their normal position within the dental arch. The most common impactions occur with third molars and maxillary canine teeth, but may involve any teeth. If impacted teeth (other than third molars, primary or supernumerary teeth) are exposed early and there is no tooth size or arch length discrepancies, these teeth will often erupt on their own. However, these teeth may require surgery to expose the tooth and place a bracket, band or other device on the unerupted tooth, after its exposure, to aid eruption. Some oral surgery procedures may be covered under the member’s medical benefit when determined to be medical in nature. Refer to the member’s Certificate of Coverage and/or health plan documentation for specific coverage guidelines.
Bechtold et al (2013) conducted a study to determine the effects of linear force vector(s) from interradicular miniscrews on the distalization pattern of the maxillary arch in adult Class II patients. Twenty-five adult patients with mild to moderate Class II dentition and minimal crowding were collected. Either single (group A) or dual (group B) miniscrews were inserted on the posterior interradicular area to deliver a distalizing force to the main archwire. The displacement patterns of maxillary incisors and molars were measured and compared. Significant distalization in the molars and incisors was shown in both groups. Significantly greater distalization and intrusion of the first molar and intrusive displacement of the incisor, together with significant reduction of the mandibular plane, were noted in group B, in contrast to the rotation of the occlusal plane in group A. The authors concluded that interradicular miniscrews predictably induced total arch distalization, leading to the correction of Class II. Additional miniscrews in the premolar area appear to facilitate intrusion and distalization of the entire arch according to the position of the force vectors.

Cheng et al (2004) conducted a prospective clinical study to assess the risk factors associated with failure of mini-implants used for orthodontic anchorage. A total of 140 mini-implants in 44 patients, including 48 miniplates and 92 freestanding miniscrews, were examined in the study. A variety of orthodontic loads were applied. The majority of implants were placed in the posterior maxilla, and the next most common location was the posterior mandible. A cumulative survival rate of 89% (125/140) was found by Kaplan-Meier analysis. There was no significant difference in the survival rate between miniplates and freestanding miniscrews, but miniplates were used in more hazardous situations. The Cox proportional-hazards regression model identified anatomic location and peri-implant soft tissue character as 2 independent prognostic indicators. The results of this study confirmed the effectiveness of orthodontic mini-implants, but in certain situations adjustment of the treatment plan or modifications in the technique of implant placement may lead to improved success rates.

Heravi et al (2016) conducted a study evaluating the movement of impacted canines away from the roots of neighboring teeth before full-mouth bracket placement, performed by means of TADs to decrease undesired side effects on adjacent teeth. The study sample consisted of 34 palatally impacted canines, 19 in the experimental group and 15 in the control group. In the experimental group, before placement of brackets, the impacted canine was erupted by means of miniscrews. In the control group, after initiation of comprehensive orthodontics, canine disimpaction was performed by means of a cantilever spring soldered to a palatal bar. At the end of treatment, volume of lateral incisors and canine root resorption were measured and compared by means of a CBCT-derived tridimensional model. Visual Analogue Scale (VAS) score, bleeding on probing (BOP) and gingival index (GI) were recorded. Clinical success rate was also calculated. The volume of root resorption of lateral teeth in the control group was significantly greater than in the experimental group (p < 0.001). At the end of treatment, VAS score, GI and BOP were not significantly different between the two groups. From this study, the authors concluded that disimpaction of canines and moving them to the arch can be done successfully carried out with minimal side effects by means of skeletal anchorage.

Karagkiolidou et al (2013) conducted a study to examine the overall success of miniscrews inserted in the paramedian palatal region for support of various appliances during orthodontic treatment. The patients received 1 or 2 miniscrews in the paramedian anterior palate of 8.0-mm length and 1.6-mm diameter placed during orthodontic treatment by the same experienced orthodontist. In total, 196 patients who received 384 miniscrews were evaluated. Two hundred four miniscrews were used with rapid palatal expansion appliances, 136 with appliances for distalization of posterior teeth, and 44 with other appliances, such as transpalatal arches for tooth stabilization. The overall survival of the miniscrews was excellent (97.9%) in the cases examined. Cox regression analysis showed no difference in the overall survival rates of miniscrews loaded with different appliances for sex (hazard ratio, 0.95; 95% confidence interval, 0.71-1.27; P = 0.73) after adjusting for appliance and age. This study shows that miniscrews placed in the paramedian anterior palate for supporting various orthodontic appliances have excellent survival.

Lee et al (2015) conducted a clinical study to compare the treatment duration and dento-skeletal changes between two different anchorage systems used to treat maxillary dentoalveolar protrusion and to examine the effectiveness of en-masse retraction using two miniscrews placed in the midpalatal suture. Fifty-seven patients were divided into two groups according to the method of maxillary posterior anchorage reinforcement: midpalatal miniscrews (25 patients, mean age 22 years) and conventional anchorage (32 patients, mean age 19 years). The en-masse retraction period, overall treatment duration, pre-treatment effective ANB angle, and change in the effective ANB angle were compared with an independent-samples t-test. Compared to the headgear group, the duration of en-masse retraction was longer by approximately 4 months in the miniscrew group (p < 0.001). However, we found no significant difference in the total treatment duration between the groups. Moreover, a greater change in the effective ANB angle was observed in patients treated with miniscrews than in those treated with the conventional method (p < 0.05). The authors concluded that treatment using miniscrews placed in the midpalatal area will allow orthodontists more time to control the anterior teeth during en-masse retraction, without increasing the total treatment duration. Furthermore, it
achieves better dentoskeletal control than does the conventional anchorage method, thereby improving the quality of the treatment results.

Manni et al (2016) conducted a study with the aim of evaluating the effectiveness of the treatment of skeletal Class II malocclusions with an acrylic splint Herbst appliance anchored to miniscrews with 2 types of ligation. Sixty patients (mean age, 11.6 years; SD, 1.9) with a bilateral Angle Class II Division 1 malocclusion were retrospectively selected and divided into 3 homogeneous and balanced groups on the basis of the Herbst anchorage used: without anchorage, miniscrews with elastic chains, and miniscrews with metallic ligatures. A cephalometric sagittal occlusion analysis merged with mandibular incisor proclination and skeletal divergence was carried out before and after treatment. To compare the absolute variations within and among the groups, we performed the 1-sample t test for repeated measures and 1-way analysis of variance, respectively. The results showed overjet was reduced similarly in all groups, the mandibular bone base length increased in the group with elastic chains only, and the change in the distance between Point A and pogonion showed the most reduction in the group with elastic chains (P < 0.05). Incisive flaring was more pronounced in the group with no anchorage than in the group with elastic chains (P < 0.001) and the group with metallic ligatures (P = 0.003). The authors concluded that anchorage to miniscrews with elastic chains increases the orthopedic effect of the acrylic splint Herbst appliance and confirmed that skeletal anchorage reduces incisor flaring.

Wehrbein et al (2009) conducted a study to determine the positional stability and success rate of palatally placed length-reduced temporary anchorage devices (LRTADs) (length, 4 or 6 mm). Twenty-two patients (ages, 21-62 years; 14 women, 8 men) were enrolled in the study. Each received 1 LRTAD placed in the midsagittal palate for multifunctional anchorage tasks. Standardized cephalograms were taken directly after implant placement and at the end of treatment to analyze any implant movements. The cephalometric tracings were superimposed on anterior nasal spine to posterior nasal spine in posterior nasal spine to analyze changes in implant angulation and position during treatment. The LRTADs were also evaluated clinically for mobility. Two of 22 implants showed mobility during the healing period (first 10-12 weeks after placement). Thus, the success rate was 91%. The remaining 20 palatally placed LRTADs had no mobility during healing (10-12 weeks) or the loading period (18 months 1 week) and were evaluated radiographically. The mean differences between the initial and final cephalometric evaluations were 0.5 degrees for changes in implant angulation and -0.6 mm for changes in implant position. (These changes were most likely due to inaccuracies in cephalometric landmark identification rather than to LRTAD movements because no mobility was recorded). The authors concluded that one palatally placed LRTAD was sufficient for multifunctional stationary anchorage tasks in the maxilla under clinical loading conditions. The success rate was 91%. Implant loss occurred during the healing period.

Xun et al (2013) The aim of this retrospective study was to quantitatively evaluate the treatment effects of intrusion of overerupted maxillary molars using miniscrew implant anchorage and to investigate the apical root resorption after molar intrusion. The subjects included 30 patients whose average ages were 35.5±9.0 years. All patients had received intrusion treatments for overerupted maxillary molars with miniscrew anchorage. There were 38 maxillary first molars and 26 maxillary second molars to be intruded. Two miniscrews were inserted in the buccal and palatal alveolar bone mesial to the overerupted molar. Force of 100-150 g was applied by the elastic chains between screw head and attachment on each side. Lateral cephalograms and panoramic radiographs taken before and after intrusion were used to evaluate dental changes and root resorption of molars. Only 6 of the 128 miniscrews failed. The first and second molars were significantly intruded by averages of 3.4 mm and 3.1 mm respectively (P<0.001). The average intrusion time was more than 6 months. The crown of the molars mesially tilted by averages of 3.1 degrees and 3.3 degrees (P<0.001) for first and second molars. The amounts of root resorption were 0.2-0.4 mm on average. The intrusion treatment of overerupted molars with miniscrew anchorages could be used as an efficient and reliable method to recover lost restoration space for prosthesis. Radiographically speaking, root resorption of molars was not clinically significant after application of intrusive forces of 200 to 300 g.

**U.S. FOOD AND DRUG ADMINISTRATION (FDA)**

Temporary anchorage devices are FDA approved for use in patients aged 12 years and older. There are an extensive number of manufacturers of these devices. See the following website for more information and search by specific product name: [http://www.fda.gov/MedicalDevices/default.htm](http://www.fda.gov/MedicalDevices/default.htm) (Accessed June 8, 2016)

**REFERENCES**


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**POLICY HISTORY/REVISION INFORMATION**

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<tr>
<td>01/01/2017</td>
<td>Updated list of applicable CDT codes to reflect annual code edits; revised description for D7280, D7292, D7293 and D7294</td>
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