



MEDICAL COVERAGE POLICY

SERVICE: Dental Services and Anesthesia for Dental Services

Policy Number: 026

Effective Date: 05/01/2024

Last Review: 03/11/2024

Next Review: 03/11/2025

Important note: Unless otherwise indicated, medical policies will apply to all lines of business. Medical necessity as defined by this policy does not ensure the benefit is covered. This medical policy does not replace existing federal or state rules and regulations for the applicable service or supply. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan documents. See the member plan specific benefit plan document for a complete description of plan benefits, exclusions, limitations, and conditions of coverage. In the event of a discrepancy, the plan document always supersedes the information in this policy.

SERVICE: Dental Services and Anesthesia for Dental Services

PRIOR AUTHORIZATION: Required.

POLICY: Please review the plan's EOC (Evidence of Coverage) or Summary Plan Description (SPD) for details.

Dental services provided for the routine care, treatment, or replacement of teeth or structures (e.g., root canals, fillings, crowns, bridges, dental prophylaxis, fluoride treatment, and extensive dental restoration) or structures directly supporting the teeth are generally excluded from coverage under BSWHP medical plans, except under limited circumstances. Certain dental or oromaxillary procedures may be covered under a member's medical benefits if specific criteria are met. This policy delineates the coverage criteria used to make authorization or denial decisions regarding dental and oral surgery services.

This policy also addresses the use of hospital facilities or ambulatory surgical centers (ASC) and general anesthesia for dental procedures or oromaxillary facial surgery procedures which do not ordinarily require that setting or service.

Note: Unless otherwise indicated (see below), this policy will apply to all lines of business.

For Medicare plans, please refer to appropriate Medicare documents ([Medicare Benefit Policy Manual, Chapter 16, 140 Dental Services Exclusion](#)), NCD (National Coverage Determination) [NCD 260.6 - Dental Examination Prior to Kidney Transplantation](#), or LCD (Local Coverage Determination). Medicare NCD or LCD specific InterQual criteria may be used when available. If there are no applicable NCD or LCD criteria, use the criteria set forth below.

For Medicaid plans, please confirm coverage as outlined in the [Texas Medicaid Provider Procedures Manual | TMHP](#) (TMPPM), 3.2.28.2 General Anesthesia for Dental Treatment. If there are no applicable criteria to guide medical necessity decision making in the TMPPM, use the criteria set forth below.

A dental service that would otherwise be excluded from coverage may be a covered medical expense if the dental service is medically necessary and is incident to and an integral part of a service covered under the medical plan. Coverage requires prior authorization. Examples of dental services that are



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integral to medical procedures include the following:

Requested Service	Required Documentation	Authorized When
Periodontal surgery for the treatment of drug-induced gingival hyperplasia	<ol style="list-style-type: none"> 1. Periodontal charting 2. Photographs 3. Relevant medication (e.g., Dilantin, Calcium Channel Blockers) history including dosages. 	<p>Clinical information supports the presence of drug-induced gingival hyperplasia with:</p> <ol style="list-style-type: none"> 1. Pocket depths > 5mm; or 2. Difficulty with hygiene due to orthodontic brackets impinging on the gingiva.
<p>Medical/Surgical care for osteonecrosis of the jaw secondary to IV bisphosphonate therapy, chemotherapy, bone marrow or solid organ transplant, or immunodeficiency related to HIV.</p> <p>Medical/Surgical care for osteoradionecrosis of the jaw secondary to head and neck, or mantle field irradiation</p>	<p>Narrative description of the clinical findings, X-rays and/or CT scan and photographs demonstrating bone involvement.</p>	<p>Clinical information supports diagnosis of osteonecrosis, or osteoradionecrosis of the jaw is present and secondary to conditions listed under requested service.</p>
<p>Tooth Extraction</p> <p>Note: Dental reconstruction for the replacement of extracted teeth is NOT covered by the medical plan.</p>	<ol style="list-style-type: none"> 1. Narrative description of the clinical history and findings. 2. X-rays and/or CT scan and photographs demonstrating bone involvement 	<p>Member ...</p> <ol style="list-style-type: none"> 1. Is pre-or post-head and neck/mantle field radiation therapy, pre-chemotherapy, or pre bone marrow or solid organ transplant; or 2. Has severe immunodeficiency (e.g., post organ transplant, peri-chemotherapy); or 3. Has osteonecrosis of the jaw related to chemotherapy, bone marrow or solid organ transplant, HIV immunodeficiency, or IV bisphosphonate therapy; or 4. Has osteoradionecrosis due to head and neck, or mantle field radiation. 5. Removal of broken teeth necessary to reduce a jaw fracture.

* In these examples, the dental service is either a part of the medical procedure or is done in



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conjunction with and made necessary solely because of the medical procedure.

Certain **oral excisions** are allowed under the medical plan the same as any other illness. This includes **biopsies of oral tissue (soft and/or hard tissue), surgical excisions of lesions, tumors, neoplasms, and non-periapical cysts:**

21030 – Excision of benign tumor or cyst of maxilla or zygoma by enucleation and curettage.
21040 – Excision of benign tumor or cyst of mandible by enucleation and/or curettage.
21046 – Excision of benign tumor or cyst of mandible; requiring intra-oral osteotomy (e.g., locally aggressive or destructive lesion(s))
21047– Excision of benign tumor or cyst of mandible; requiring extra-oral osteotomy and partial mandibulectomy (e.g., locally aggressive or destructive lesion(s))
21048 – Excision of benign tumor or cyst of maxilla; requiring intra-oral osteotomy (e.g., locally aggressive or destructive lesion(s))
21049 – Excision of benign tumor or cyst of maxilla; requiring extra-oral osteotomy and partial maxillectomy (e.g., locally aggressive or destructive lesion(s))
*These codes are covered if NOT dental related. They are NOT covered if done in conjunction with third molar removal or with endodontic surgery.

The following codes are generally covered when performed for a medical indication.

Service	Not Covered Indication
40810 – Excision of lesion of mucosa and submucosa, vestibule of mouth; without repair	Preparation for dentures
40812 – Excision of lesion of mucosa and submucosa, vestibule of mouth; with simple repair	Preparation for dentures
40814 – Excision of lesion of mucosa and submucosa, vestibule of mouth; with complex repair	Preparation for dentures
40816 – Excision of lesion of mucosa and submucosa, vestibule of mouth; complex, with excision of underlying muscle	Preparation for dentures
41825 – Excision of lesion or tumor (except listed above), dentoalveolar structure, without repair.	<ol style="list-style-type: none"> 1. Removal of tori exostoses, fibrous tuberosity (preparation for dentures) 2. Periodontal abscess, endodontic cyst (generally dental)

Torus mandibularis or maxillary torus are bony sublingual protuberances, typically near the canine and premolar teeth. These are almost always benign lesions and excision is not medically



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necessary. The most common reason for requesting removal of a torus is in preparation for dentures, and thus not a benefit under a medical plan. Excision can be covered with diagnosis of head/neck cancer.

BSWHP covers the use of **hospital facility or Ambulatory Surgical Center (ASC)** when those settings are **medically necessary for the safe delivery of dental and/or oral surgery services**, or there are serious medical issues. **Prior authorization is required for these services.** Routine dental services are **NOT** covered, **neither** is dental office-based anesthesia.

- A. Authorization Criteria - Prior authorization is required for elective (non-emergent) dental and oral surgery services provided to members who have this coverage in inpatient hospital or ASC settings. Prior authorization does NOT include coverage for restorative dental/oral surgery services that are not covered under the member's benefit plan (EOC or SPD).
- B. Using relevant clinical information, the criteria below are used to review requests for services to be provided at inpatient or ASC settings.

Use of inpatient or ASC settings, including anesthesia by contracted providers, is authorized with submission of relevant clinical information to establish medical necessity for the following services:

Requested Service: Dental Anesthesia	Authorized When
<p>For Medicaid plans, general anesthesia is available for members who are six years of age or younger</p> <p>All level 4 sedation/general anesthesia services (CPT 00170) require PA</p>	<p>For Medicaid plans ALL of the following documentation/criteria must be provided/met:</p> <ul style="list-style-type: none"> • A completed Criteria for Dental Therapy under general anesthesia with a score of 22 or higher • Proof of approval for dental services from the DMO (for age 6 and below) • The location where the procedure (s) will be performed • The narrative/clinical records unique to the member
<p>Section below is for non-Medicaid plans</p>	
<p>Dental Rehabilitation services for children up to 48 months old</p>	<p>Following criteria must be met:</p> <ul style="list-style-type: none"> • The member has rampant decay, AND • There is documentation of at least one unsuccessful attempt to treat the member in the office setting



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<p>Dental Rehabilitation for members with functional or behavioral impairment due to medical/behavioral conditions (e.g., autism, developmental delay, mental retardation) manifesting as severe oppositional and uncooperative behavior</p>	<ol style="list-style-type: none"> 1. The member has rampant decay or dental needs of high complexity, OR 2. There is documentation of EITHER: <ol style="list-style-type: none"> a. Two unsuccessful attempts to treat in the office setting, OR b. The PCP or attending practitioner documents why the member's functional or behavioral impairment inhibits the safe delivery of care in an office setting considering the level of dental needs
<p>Members with extreme apprehension and anxiety manifesting as significant oppositional and uncooperative behavior during treatment</p>	<ol style="list-style-type: none"> 1. The member has rampant decay or dental needs of high complexity; AND 2. There is documentation of two unsuccessful attempts to treat in the office setting; AND 3. The PCP or attending practitioner delineates why the member's functional or behavioral impairment inhibits the safe delivery of care in an office setting
<p>Dental/Oral Surgery procedures for members with dental pathology and a co-existing medical condition, co-morbidity, or mental or physical handicap that might inhibit the safe delivery of care in an office setting</p>	<p>There is documentation of one or more of the following:</p> <ol style="list-style-type: none"> 1. Abnormal pulmonary function measurements (i.e., FEV1 < 60% of predicted) 2. History of serious blood dyscrasia or bleeding disorder which required medical preoperative care not available in the office setting 3. Evidence of acute cardiac disease, current angina, patterns of CHF (class III or IV), or an MI within 90 days of the anticipated admission 4. History of immunodeficiency diagnosis 5. Difficulty regulating endocrine diseases (e.g., diabetes, Addison's disease), hypertension, bronchospastic lung disease, or seizures 6. History of adverse reaction to anesthesia or sedation 7. Previous unsuccessful attempts to provide care in the office setting, and/or significant functional or behavioral impairment.

BACKGROUND:

Most routine dental procedures can be safely provided in an office setting with local anesthesia. However, pediatric patients, individuals with special needs or intellectual limitations may require both a different setting and deep sedation / anesthesia. Deep sedation or general anesthesia, however, is not without risks and should not be used without appropriate equipment and staffing. Consistent with the American Academy of Pediatric Dentistry (AAPD) *Behavior Guidance*, the goals of sedation include:



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- Guarding the patient's safety and welfare
- Minimizing physical discomfort and pain
- Managing anxiety
- Minimizing psychological trauma
- Manage behavior

Sedation should not be used for healthy, cooperative patients with minimal dental needs, patient/practitioner convenience; or predisposing medical conditions which would make general anesthesia inadvisable.

CODES:

Important note: Due to the wide range of applicable diagnosis codes and potential changes to codes, an inclusive list may not be presented, but the following codes may apply. Inclusion of a code in this section does not guarantee that it will be reimbursed, and patient must meet the criteria set forth in the policy language.

CPT Codes	<p>21030 – Excision of benign tumor or cyst of maxilla or zygoma by enucleation and curettage</p> <p>21040 – Excision of benign tumor or cyst of mandible by enucleation and/or curettage</p> <p>21046 – Excision of benign tumor or cyst of mandible; requiring intra-oral osteotomy (eg, locally aggressive or destructive lesion(s))</p> <p>21047– Excision of benign tumor or cyst of mandible; requiring extra-oral osteotomy and partial mandibulectomy (eg, locally aggressive or destructive lesion(s))</p> <p>21048 – Excision of benign tumor or cyst of maxilla; requiring intra-oral osteotomy (eg, locally aggressive or destructive lesion(s))</p> <p>21049 – Excision of benign tumor or cyst of maxilla; requiring extra-oral osteotomy and partial maxillectomy (eg, locally aggressive or destructive lesion(s))</p> <p>40810 – Excision of lesion of mucosa and submucosa, vestibule of mouth; without repair</p> <p>40812 – Excision of lesion of mucosa and submucosa, vestibule of mouth; with simple repair</p> <p>40814 – Excision of lesion of mucosa and submucosa, vestibule of mouth; with complex repair</p> <p>40816 – Excision of lesion of mucosa and submucosa, vestibule of mouth; complex, with excision of underlying muscle</p> <p>41825 – Excision of lesion or tumor (except listed above), dentoalveolar structure; without repair</p>
CPT Codes Not Covered	<p>21031 - Excision of torus mandibularis: COVERED only with diagnosis of head/neck cancer</p> <p>21032 - Excision of maxillary torus palatinus: COVERED only with diagnosis of head/neck cancer</p>
ICD10 Codes	<p>C03.X - Malignant neoplasm of gum</p> <p>C41.X - Malignant neoplasm of skull, face, jaw</p> <p>C04.X - Malignant neoplasm of floor of mouth</p> <p>C05.X - Malignant neoplasm of palate</p> <p>C76.X - Malignant neoplasm of head, face, neck</p> <p>D00.XX - Carcinoma in situ of oral cavity, gingiva, palate, mouth, tongue, etc.</p> <p>Q37.X - Cleft palate</p> <p>S02.4XXX - Fracture- zygomatic, maxilla, Le Forte</p> <p>S02.6XXX - Fracture of mandible</p>



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	S02.8XXX - Fractures of skull and facial bones S02.9XXX - Fractures of facial bones K03.89 - K03.9 - Diseases of hard tissues of teeth S01.502S - Sequelae - open wound of oral cavity
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POLICY HISTORY:

Status	Date	Action
New	8/1/2010	New policy
Reviewed	10/18/2011	Reviewed.
Reviewed	8/30/2012	Reviewed and revised
Reviewed	4/25/2013	No changes
Reviewed	3/27/2014	No changes
Reviewed	4/9/2015	No changes
Reviewed	4/14/2016	Reviewed – no changes
Reviewed	3/28/2017	Several minor changes to improve coverage details.
Reviewed	2/20/2018	No changes
Updated	9/04/2018	Updated Medicaid general anesthesia and sedation requirements
Reviewed	11/26/2019	Added exclusion of coverage for removal of tori
Reviewed	04/22/2020	Rationalized code list
Reviewed	05/27/2021	Torus mandibularis or maxillary torus set to pay with head/neck cancer
Reviewed	06/23/2022	Updated Medicaid anesthesia for dental procedures section
Reviewed	03/30/2023	No changes
Updated	03/11/2024	Added “Background” section, formatting changes, added hyperlinks to Medicare / NCD documents and TMPPM, beginning and ending note sections updated to align with CMS requirements and business entity changes.

REFERENCES:

The following scientific references were utilized in the formulation of this medical policy. BSWHP will continue to review clinical evidence related to this policy and may modify it at a later date based upon the evolution of the published clinical evidence. Should additional scientific studies become available, and they are not included in the list, please forward the reference(s) to BSWHP so the information can be reviewed by the Medical Coverage Policy Committee (MCPC) and the Quality Improvement Committee (QIC) to determine if a modification of the policy is in order.



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Health Maintenance Organization (HMO) products are offered through Scott and White Health Plan dba Baylor Scott & White Health Plan, and Scott & White Care Plans dba Baylor Scott & White Care Plan. Insured PPO and EPO products are offered through Baylor Scott & White Insurance Company. Scott and White Health Plan dba Baylor Scott & White Health Plan serves as a third-party administrator for self-funded employer-sponsored plans. Baylor Scott & White Care Plan and Baylor Scott & White Insurance Company are wholly owned subsidiaries of Scott and White Health Plan. These companies are referred to collectively in this document as Baylor Scott & White Health Plan.

RightCare STAR Medicaid plans are offered through Scott and White Health Plan in the Central Managed Care Service Area (MRSA) and STAR and CHIP plans are offered through SHA LLC dba FirstCare Health Plans (FirstCare) in the Lubbock and West MRSAs.