DENTAL AND ORAL SURGICAL PROCEDURES

Policy Number: DENTAL 002.28 T2 **Effective Date**: March 1, 2017

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Related Policy

- Temporomandibular Joint Disorders

INSTRUCTIONS FOR USE

The services described in Oxford policies are subject to the terms, conditions and limitations of the member's contract or certificate. Unless otherwise stated, Oxford policies do not apply to Medicare Advantage members. Oxford reserves the right, in its sole discretion, to modify policies as necessary without prior written notice unless otherwise required by Oxford's administrative procedures or applicable state law. The term Oxford includes Oxford Health Plans, LLC and all of its subsidiaries as appropriate for these policies.

Certain policies may not be applicable to Self-Funded members and certain insured products. Refer to the member specific benefit plan document or Certificate of Coverage to determine whether coverage is provided or if there are any exclusions or benefit limitations applicable to any of these policies. If there is a difference between any policy and the member specific benefit plan document or Certificate of Coverage, the member specific benefit plan document or Certificate of Coverage will govern.

Applicable Lines of Business/ Products	This policy applies to Oxford Commercial plan membership and Oxford USA membership.
Benefit Type	General benefits package
Referral Required (Does not apply to non-gatekeeper products)	No
Authorization Required (Precertification always required for inpatient admission)	Yes[1,2,3]
Precertification with Medical Director Review Required	Yes[1,2,3]
Applicable Site(s) of Service (If site of service is not listed, Medical Director review is required)	Outpatient, Office, Inpatient[1,2,3]
Special Considerations	[1]Specialty review of all dental and oral surgical services is required when services are to be rendered by practitioners of the following specialties: oral surgery, oral/maxillofacial surgery, general or pediatric dentistry, endodontics, periodontics, and orthodontics. Services rendered by providers with any other specialty require review through Oxford's Clinical Services Department. [2]Precertification with review by a Medical Director or their designee is required. [3]Precertification is required for services covered under the Member's General Benefits package when performed in the office of a participating provider. For Commercial plans, precertification is not required, but is encouraged

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Special Considerations *(continued)*	for out-of-network services performed in the office that are covered under the Member's General Benefits package. If precertification is not obtained, Oxford may review for medical necessity after the service is rendered.

BENEFIT CONSIDERATIONS

Before using this policy, please check the member specific benefit plan document and any federal or state mandates, if applicable. If there is a difference between this policy and the member specific benefit plan document, the member specific benefit plan document will govern.

Procedures that are deemed dental in nature rather than medical will not be covered unless the Member has dental coverage as part of their benefit plan. Except for the conditions listed in the policy below, dental and oral surgical treatment needed directly or indirectly because of systemic disease or surgery is excluded from coverage. This includes (but is not limited to):

- Dental care needed due to radiation caries, gastric reflux disease, extractions prior to surgery, etc.
- Dental or oral surgical services needed primarily to prepare the mouth for the replacement of teeth are not covered (including but not limited to; bone grafting, soft tissue grafting, ridge augmentation, sinus lift procedures, barrier membranes, etc.).

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 plans (inside and outside of Exchanges) to provide coverage for ten categories of 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 EHBs. However, if such plans choose to provide coverage for benefits which are deemed 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 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.

Note: Members enrolled on *Essential Health Benefit* plans may have coverage for Pediatric Dental. Pediatric Dental coverage may provide additional coverage beyond what is outlined in this policy. Before using this policy, please check the member specific benefit plan document and any federal or state mandates, if applicable.

PURPOSE

The purpose of this document is to outline the circumstances in which Oxford will reimburse dental or oral surgical services and related anesthesia.

POLICY

Oxford will cover certain oral surgical and dental procedures under the general benefits package when determined to be medical in nature. Refer to the member specific benefit plan document for specific coverage guidelines.

In addition, under certain circumstances, coverage for anesthesia services in conjunction with dental or oral surgical services may be approved. Please check the member specific benefit plan document and any federal or state mandates, if applicable.

PROCEDURES AND RESPONSIBILITIES

The following procedures MAY qualify for coverage under the general benefits package:

- Oral surgical procedures for the correction of a non-dental physiological condition which results in a severe functional impairment.
- Oral surgical procedures for the excision of cysts and tumors of the maxilla, mandible and surrounding tissues (cysts and tumors associated with the teeth are not covered). **Exception**: Please check the member specific benefit plan document for New Jersey (NJ) Small Group plans (excision of cysts and tumors associated with teeth may be covered).
- Dental services for the repair (not replacement) of sound and natural teeth, maxilla, mandible, and surrounding tissues following accidental injury (not including injuries caused by eating, biting, or chewing).
  - Treatment must be rendered within 12 months of the injury. **Exception**: Please check the member specific benefit plan document for NJ Small Group plans for additional coverage limitations.

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    - Accidental injury must be documented.
    - Pre- and post-accident x-rays are required.
    - Teeth were stable and functional immediately prior to the time of the accident without evidence of decay, periodontal disease, or endodontic pathology.
- Surgical removal of bony impacted teeth. **Note**: This benefit is limited to specific lines of business; refer to the member specific benefit plan document.
- Dental services that are medically necessary and incident to a covered medical service including:
    - Extraction of teeth before radiation treatment of the head and neck
    - Extraction of teeth incidental to reducing a fracture of the jaw
    - Dental examination prior to major surgery
    - Reconstructive surgery and grafting procedures in conjunction with oral resective surgery if completed at the same time as resective surgery (not including replacement of teeth.
- Obturators and obturator prosthesis after resective surgery.
- Removal of odontogenic cysts or tumors >1.5 cm in diameter.
- Removal of soft tissue neoplasms of the of lips, tongue, palate, floor of mouth, and vestibule (e.g., fibromas, mucocoeles, etc.).

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 Policies may apply.

CPT Code	Description
21015	Radical resection of tumor (e.g., sarcoma), soft tissue of face or scalp; less than 2 cm
21016	Radical resection of tumor (e.g., sarcoma), soft tissue of face or scalp; 2 cm or greater
21025	Excision of bone (e.g., for osteomyelitis or bone abscess); mandible
21026	Excision of bone (e.g., for osteomyelitis or bone abscess); facial bone(s)
21029	Removal by contouring of benign tumor of facial bone (e.g., fibrous dysplasia)
21030	Excision of benign tumor or cyst of maxilla or zygoma by enucleation and curettage
21031	Excision of torus mandibularis
21032	Excision of maxillary torus palatinus
21034	Excision of malignant tumor of maxilla or zygoma
21040	Excision of benign tumor or cyst of mandible, by enucleation and/or curettage
21044	Excision of malignant tumor of mandible
21045	Excision of malignant tumor of mandible; radical resection
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])
21076	Impression and custom preparation; surgical obturator prosthesis
21077	Impression and custom preparation; orbital prosthesis
21079	Impression and custom preparation; interim obturator prosthesis
21080	Impression and custom preparation; definitive obturator prosthesis
21081	Impression and custom preparation; mandibular resection prosthesis
21082	Impression and custom preparation; palatal augmentation prosthesis
21083	Impression and custom preparation; palatal lift prosthesis
21084	Impression and custom preparation; speech aid prosthesis

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CPT Code	Description
21085	Impression and custom preparation; oral surgical splint
21086	Impression and custom preparation; auricular prosthesis
21087	Impression and custom preparation; nasal prosthesis
21088	Impression and custom preparation; facial prosthesis
21089	Unlisted maxillofacial prosthetic procedure
21100	Application of halo type appliance for maxillofacial fixation, includes removal (separate procedure)
21110	Application of interdental fixation device for conditions other than fracture or dislocation, includes removal
21116	Injection procedure for temporomandibular joint arthrography
21188	Reconstruction midface, osteotomies (other than LeFort type) and bone grafts (includes obtaining autografts)
21206	Osteotomy, maxilla, segmental (e.g., Wassmund or Schuchard)
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)
21209	Osteoplasty, facial bones; reduction
21210	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)
21215	Graft, bone; mandible (includes obtaining graft)
21244	Reconstruction of mandible, extraoral, with transosteal bone plate (e.g., mandibular staple bone plate)
21245	Reconstruction of mandible or maxilla, subperiosteal implant; partial
21246	Reconstruction of mandible or maxilla, subperiosteal implant; complete
21248	Reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder); partial
21249	Reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder); complete
21255	Reconstruction of zygomatic arch and glenoid fossa with bone and cartilage (includes obtaining autografts)
21296	Reduction of masseter muscle and bone (e.g., for treatment of benign masseteric hypertrophy); intraoral approach
21299	Unlisted craniofacial and maxillofacial procedure
21421	Closed treatment of palatal or maxillary fracture (LeFort I type), with interdental wire fixation or fixation of denture or splint
21422	Open treatment of palatal or maxillary fracture (LeFort I type)
21423	Open treatment of palatal or maxillary fracture (LeFort I type); complicated (comminuted or involving cranial nerve foramina), multiple approaches
21431	Closed treatment of craniofacial separation (LeFort III type) using interdental wire fixation of denture or splint
21432	Open treatment of craniofacial separation (LeFort III type); with wiring and/or internal fixation
21433	Open treatment of craniofacial separation (LeFort III type); complicated (e.g., comminuted or involving cranial nerve foramina), multiple surgical approaches
21435	Open treatment of craniofacial separation (LeFort III type); complicated, utilizing internal and/or external fixation techniques (e.g., head cap, halo device, and/or intermaxillary fixation)
21436	Open treatment of craniofacial separation (LeFort III type); complicated, multiple surgical approaches, internal fixation, with bone grafting (includes obtaining graft)
21440	Closed treatment of mandibular or maxillary alveolar ridge fracture (separate procedure)
21445	Open treatment of mandibular or maxillary alveolar ridge fracture (separate procedure)
21450	Closed treatment of mandibular fracture; without manipulation

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CPT Code	Description
21451	Closed treatment of mandibular fracture; with manipulation
21452	Percutaneous treatment of mandibular fracture, with external fixation
21453	Closed treatment of mandibular fracture with interdental fixation
21454	Open treatment of mandibular fracture with external fixation
21461	Open treatment of mandibular fracture; without interdental fixation
21462	Open treatment of mandibular fracture; with interdental fixation
21465	Open treatment of mandibular condylar fracture
21470	Open treatment of complicated mandibular fracture by multiple surgical approaches including internal fixation, interdental fixation, and/or wiring of dentures or splints
21480	Closed treatment of temporomandibular dislocation; initial or subsequent
21485	Closed treatment of temporomandibular dislocation; complicated (e.g., recurrent requiring intermaxillary fixation or splinting), initial or subsequent
21490	Open treatment of temporomandibular dislocation
21497	Interdental wiring, for condition other than fracture
21499	Unlisted musculoskeletal procedure, head
40530	Resection of lip, more than one-fourth, without reconstruction
40654	Repair lip, full thickness; over one-half vertical height, or complex
40700	Plastic repair of cleft lip/nasal deformity; primary, partial or complete, unilateral
40701	Plastic repair of cleft lip/nasal deformity; primary bilateral, 1 stage procedure
40702	Plastic repair of cleft lip/nasal deformity; primary bilateral, 1 of 2 stages
40720	Plastic repair of cleft lip/nasal deformity; secondary, by recreation of defect and reclosure
40761	Plastic repair of cleft lip/nasal deformity; with cross lip pedicle flap (Abbe-Estlander type), including sectioning and inserting of pedicle
40799	Unlisted procedure, lips
40800	Drainage of abscess, cyst, hematoma, vestibule of mouth; simple
40801	Drainage of abscess, cyst, hematoma, vestibule of mouth; complicated
40804	Removal of embedded foreign body, vestibule of mouth; simple
40805	Removal of embedded foreign body, vestibule of mouth; complicated
40806	Incision of labial frenum (frenotomy)
40814	Excision of lesion of mucosa and submucosa, vestibule of mouth; with complex repair
40816	Excision of lesion of mucosa and submucosa, vestibule of mouth; complex, with excision of underlying muscle
40818	Excision of mucosa of vestibule of mouth as donor graft
40819	Excision of frenum, labial or buccal (frenumectomy, frenulectomy, frenectomy)
40820	Destruction of lesion or scar of vestibule of mouth by physical methods (e.g., laser, thermal, cryo, chemical)
40840	Vestibuloplasty; anterior
40842	Vestibuloplasty; posterior, unilateral
40843	Vestibuloplasty; posterior, bilateral
40844	Vestibuloplasty; entire arch
40845	Vestibuloplasty; complex (including ridge extension, muscle repositioning)
40899	Unlisted procedure, vestibule of mouth
41000	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; lingual
41005	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; sublingual, superficial
41006	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; sublingual, deep, supramylohyoid

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CPT Code	Description
41007	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; submental space
41008	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; submandibular space
41009	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; masticator space
41010	Incision of lingual frenum (frenotomy)
41015	Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; sublingual
41016	Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; submental
41017	Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; submandibular
41018	Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; masticator space
41114	Excision of lesion of tongue with closure; with local tongue flap
41115	Excision of lingual frenum (frenectomy)
41120	Glossectomy; less than one-half tongue
41130	Glossectomy; hemiglossectomy
41252	Repair of laceration of tongue, floor of mouth, over 2.6 cm or complex
41500	Fixation of tongue, mechanical, other than suture (e.g., K-wire)
41512	Tongue base suspension, permanent suture technique
41520	Frenoplasty (surgical revision of frenum, e.g., with Z-plasty)
41530	Submucosal ablation of the tongue base, radiofrequency, 1 or more sites, per session
41800	Drainage of abscess, cyst, hematoma from dentoalveolar structures
41805	Removal of embedded foreign body from dentoalveolar structures; soft tissues
41806	Removal of embedded foreign body from dentoalveolar structures; bone
41820	Gingivectomy, excision gingiva, each quadrant
41821	Operculectomy, excision pericoronal tissues
41822	Excision of fibrous tuberosities, dentoalveolar structures
41823	Excision of osseous tuberosities, dentoalveolar structures
41825	Excision of lesion or tumor (except listed above), dentoalveolar structures; without repair
41826	Excision of lesion or tumor (except listed above), dentoalveolar structures; with simple repair
41827	Excision of lesion or tumor (except listed above), dentoalveolar structures; with complex repair
41828	Excision of hyperplastic alveolar mucosa, each quadrant (specify)
41830	Alveolectomy, including curettage of osteitis or sequestrectomy
41850	Destruction of lesion (except excision), dentoalveolar structures
41870	Periodontal mucosal grafting
41872	Gingivoplasty, each quadrant (specify)
41874	Alveoloplasty, each quadrant (specify)
41899	Unlisted procedure, dentoalveolar structures
42000	Drainage of abscess of palate, uvula
42107	Excision, lesion of palate, uvula; with local flap closure
42120	Resection of palate or extensive resection of lesion
42140	Uvulectomy, excision of uvula
42145	Palatopharyngoplasty (e.g., uvulopalatopharyngoplasty, uvulopharyngoplasty)

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CPT Code	Description
42182	Repair, laceration of palate; over 2 cm or complex
42200	Palatoplasty for cleft palate, soft and/or hard palate only
42205	Palatoplasty for cleft palate, with closure of alveolar ridge; soft tissue only
42210	Palatoplasty for cleft palate, with closure of alveolar ridge; with bone graft to alveolar ridge (includes obtaining graft)
42215	Palatoplasty for cleft palate; major revision
42220	Palatoplasty for cleft palate; secondary lengthening procedure
42225	Palatoplasty for cleft palate; attachment pharyngeal flap
42226	Lengthening of palate, and pharyngeal flap
42227	Lengthening of palate, with island flap
42235	Repair of anterior palate, including vomer flap
42280	Maxillary impression for palatal prosthesis
42281	Insertion of pin-retained palatal prosthesis
42299	Unlisted procedure, palate, uvula

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REFERENCES

American Medical Association. Current Procedural Terminology: CPT, Professional Edition.

Oxford Certificate of Coverage and Member Handbook.

POLICY HISTORY/REVISION INFORMATION

Date	Action/Description

03/01/2017	• Reformatted and reorganized policy content; changed policy type classification from "Clinical" to "Administrative"
	• Removed language pertaining to New Jersey (NJ) Individual Plans *(NJ individual benefit plans transitioned to UnitedHealthcare Oxford Navigate effective Jan. 1, 2017)*
	• Updated conditions of coverage/authorization requirements:
	  ○ Replaced language indicating "*Oxford's Dental Department will review requests for* services to be rendered by practitioners of the following specialties: oral surgery, oral/maxillofacial surgery, general or pediatric dentistry, endodontics, periodontics, and orthodontics; *all* other specialties require *Medical Director* review through Oxford's *Medical Management Department*" with "*specialty review of all dental and oral surgical services is required when* services *are* to be rendered by practitioners of the following specialties: oral surgery, oral/maxillofacial surgery, general or pediatric dentistry, endodontics, periodontics and orthodontics; *services rendered by providers with any* other specialties require review through Oxford's *Clinical Services* Department"
	  ○ Added language to indicate precertification is required for services covered under the Member's General Benefits package when performed in the office of a participating provider
	    ▪ For Commercial plans, precertification is not required, but is encouraged for out-of-network services performed in the office that are covered under the Member's General Benefits package
	    ▪ If precertification is not obtained, Oxford may review for medical necessity after the service is rendered
	• Updated benefit considerations; added language to indicate:
	  ○ If there is a difference between this policy and the member specific benefit plan document, the member specific benefit plan document will govern
	  ○ Members enrolled on *Essential Health Benefit* plans may have coverage for pediatric dental which may provide additional coverage beyond this policy
	• Added policy "purpose" statement to indicate this document outlines the circumstances in which Oxford will reimburse dental or oral surgical services and related anesthesia
	• Revised "policy" guidelines:

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	○ Replaced language indicating "under certain circumstances, coverage for anesthesia services in conjunction with dental or oral surgical services may be *certified if any of the [listed] conditions apply*" with "under certain circumstances, coverage for anesthesia services in conjunction with dental or oral surgical services may be *approved; check the member specific benefit plan document and any federal or state mandates, if applicable*" ○ Removed list of circumstances in which anesthesia services may be covered in conjunction with dental or oral surgical services ○ Removed notation indicating analgesia and anxiolytic services (including oral sedation and nitrous oxide sedation) are considered inclusive to the surgical procedure • Revised procedures and responsibilities: ○ Replaced language indicating "the listed procedures may qualify for coverage under the *medical plan*" with "the listed procedures may qualify for coverage under the *general benefits package*" ○ Updated list of procedures that may be covered under the general benefits package; modified language pertaining to: ▪ Oral surgical procedures for the correction of a non-dental physiological condition which results in a severe functional impairment - Removed language indicating diagnostic radiographs, study models, photographs, and treatment record/consultation notes are required ▪ Oral surgical procedures for the excision of cysts and tumors of the maxilla, mandible and surrounding tissues - Removed language indicating: • Diagnostic radiographs, treatment record/consultation notes/operative report, and pathology report are required • Bone grafting of surgical sites is generally not medically necessary - Added instruction to check the member specific benefit plan document for NJ Small Group plans (excision of cysts and tumors associated with teeth may be covered) ▪ Dental services for the repair (not replacement) of sound and natural teeth, maxilla, mandible, and surrounding tissues following accidental injury - Removed language indicating NJ Small Group Commercial plans cover replacement of teeth following accidental injury and require completion of treatment within 6 months of injury - Added instruction to check the member specific benefit plan document for coverage limitations for NJ Small Group plans ○ Removed language detailing state specific coverage requirements • Updated list of applicable codes; removed 21010, 21050, 21060, 21070, 21240, 21242, 21243, 29800, and 29804 • Updated supporting information to reflect the most current references • Archived previous policy version DENTAL 002.27 T2

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