MEDICAL MUTUAL®

Medically Necessary Orthodontic Treatment (March 28, 2014)

Medically Necessary Orthodontic Treatment is not currently defined in detail by the American Association of Orthodontists. For the purposes of this policy it will be described as follows. (Note: This description is subject to change.)

Medically necessary orthodontic treatment is orthodontic treatment that is rendered by an orthodontist or pediatric dentist to satisfy a demonstrated need for *significant* functional improvement of the teeth, jaws or related anatomy and is not rendered primarily for esthetic improvement.

In order to demonstrate need for *significant* functional improvement, a patient must present with one or more of the following general conditions that can be definitively diagnosed (using generally accepted clinical standards) to be directly related to their malocclusion or jaw relationship:

- Severe impairment of oral function
- Chronic moderate pain or chronic severe pain that cannot be adequately managed through alternative treatments.
- Traumatic injury to the orofacial structures that requires reparative treatment with orthodontic appliances.
- Craniofacial anomaly or systemic disorder involving the dentition (see list).
- A malocclusion which, if left untreated, substantiates a prognosis of:
    - Premature loss and/or severe debilitation of an essential tooth or teeth
    - Severe debilitation of the dentition, periodontium, and/or temporomandibular joint(s).
    - A sustained or deteriorating condition that in an advanced state will no longer be treatable through orthodontic means alone and that, in an advanced state, will require more invasive or complicated treatment such as orthognathic surgery.

Furthermore, medically necessary orthodontic treatment should be prescribed within generally accepted standards of orthodontic practice (evidence-based when possible).

In addition, orthodontic treatment prescribed for the convenience of a patient does not constitute medically necessary orthodontic treatment. If a less costly alternative therapy to orthodontic treatment will satisfy the need for functional improvement or resolve one of the qualifying conditions described above, orthodontic treatment will not be considered to be medically necessary.

For example, a patient may present with severe attrition of mandibular incisors secondary to a severe overbite with nocturnal bruxing. If an occlusal guard (removable bruxing appliance) can prescribed for adequate prevention of further attrition, orthodontic treatment would not be considered as medically necessary.

Finally, the scope of any medically necessary orthodontic treatment plan should be limited, whenever possible, to prescription of appliances and therapy to the extent necessary to correct the condition that qualifies the patient for such treatment.

For example, a patient presents with an isolated cross bite of tooth #9 in traumatic occlusion and no other significant orthodontic problems. If the isolated cross bite can be treated successfully with a partial fixed orthodontic appliance limited to one arch or removable orthodontic appliance without creating additional malocclusion, comprehensive orthodontic treatment of both arches should not be prescribed.

SPECIAL CASES

If a provider identifies a case that is compelling in its need for medically necessary orthodontic treatment but it does not meet the criteria described above, the provider may submit diagnostic records with narrative (see requirements described in this policy) to be reviewed for consideration.

WE ARE PROVIDING THE FOLLOWING LISTS OF CONDITIONS THAT MAY OR MAY NOT QUALIFY FOR MEDICALLY NECESSARY ORTHODONTIC TREATMENT FOR GUIDANCE IN DETERMINING HOW CERTAIN CASES MAY BE CLASSIFIED. THESE EXAMPLES ARE NOT INTENDED TO REPRESENT ALL POSSIBLE ORTHODONTIC CONDITIONS.

Examples of conditions that *do not* qualify for "medically necessary" orthodontic treatment include, but are not limited to:

- Generalized interdental spacing and/or diastemas in one or both arches
- Minor to moderate dental crowding
- Dental crowding which makes caries prevention more difficult, but not impossible
- Severe dental crowding with adequate eruption of first molars, premolars and anterior teeth
- Temporomandibular joint (TMJ) dysfunction with no obvious correlation between the patient's occlusion and the dysfunction
- TMJ dysfunction with no associated traumatic injury in which symptoms have been present for less than six months
- TMJ clicking, popping or crepitus with no other symptoms
- Thumb habit
- Minor to moderate Class II or Class III malocclusion
- Severe Class II or Class III malocclusion, aperognathia or overbite with no functional impairment or other significant pathology secondary to the malocclusion, and with low expectation for any future significant pathology secondary to the malocclusion
- Unilateral or posterior cross bite that is not due to a transverse skeletal discrepancy between the maxilla and mandible and that will not require surgical treatment at a later date if not treated with orthopedic maxillary expansion in the pediatric or adolescent patient
- Fully impacted tooth (or teeth) that can be extracted without any detrimental impact on the occlusion, thus eliminating the need for orthodontic intervention
- A patient presenting for "Phase II" treatment that has completed a "Phase I" medically necessary orthodontic treatment that resulted in elimination of all conditions which qualify for medically necessary orthodontic treatment

Examples of conditions that *may* (but not necessarily) qualify for "medically necessary" orthodontic treatment include, but are not limited to:

- Dental crowding that has been demonstrated to make caries prevention impossible
- Craniofacial anomalies and other systemic disorders involving the dentition, including but not limited to: Hemifacial Microsomia, Craniosynostosis, Cleidocranial Dysplasia, Marfan Syndrome, Pierre Robin Syndrome, Clefting, Treacher Collins Syndrome, Gigantism and other pituitary diseases. Other rare disorders involving the dentition may be may be considered for coverage on an individual basis through prior authorization
- Cleft palate
- Cleft lip with alveolar process deformity
- Traumatic injury involving the dentition
- Anterior cross bite with traumatic occlusion and/or severe functional shift that contributes to significant functional impairment
- Severe Class II or Class III malocclusion or aperognathia that requires orthognathic surgery in conjunction with orthodontic treatment for correction. Additionally, the patient must exhibit significant functional impairment
- Unilateral or posterior cross bite due to a transverse skeletal discrepancy between the maxilla and mandible and that will require surgical treatment at a later date if not treated with orthopedic maxillary expansion in the pediatric or adolescent patient
- Fully impacted tooth (or teeth) that cannot be extracted without any detrimental impact on the occlusion and that requires orthodontic intervention to facilitate eruption of the tooth into the dental arch
- Traumatic occlusion causing (or posing significant risk of) damage to associated hard and/or soft tissue
- Ectopic eruption of a tooth or teeth that may lead to loss of tooth/teeth or severe damage to tooth/teeth

SPECIAL CATEGORIES

Posterior cross bite (unilateral or bilateral) and treatments with palatal expansion appliances

Treatment of a posterior cross bite that is due to a transverse skeletal discrepancy between the maxilla and mandible using an orthopedic palatal expansion appliance may be considered to be a medically necessary orthodontic treatment insofar as it is prescribed to prevent the need for a maxillary osteotomy to correct the same cross bite when the patient becomes more mature.

When cross bite correction is performed as a "Phase I" treatment, limited alignment with a fixed appliance to complete the cross bite correction can be considered to be part of the same medically necessary orthodontic treatment if necessary. If palatal expansion is performed as a "Phase I" treatment and results in elimination of all aspects of the patient's condition that qualify for medically necessary orthodontic treatment, a "Phase II" treatment would not be considered to be a medically necessary orthodontic treatment.

When cross bite correction with an orthopedic palatal expansion appliance is performed as a treatment that is not "Phase I" and no other conditions qualifying for medically necessary orthodontic treatment will persist after cross bite correction, limited alignment with a fixed

appliance to complete the cross bite correction can be considered to be part of the same medically necessary orthodontic treatment if required to properly correct the cross bite. However, other aspects of malocclusion that persist but do not require medically necessary orthodontic treatment will not qualify for reimbursement.

Special circumstances that will disqualify a patient for reimbursement associated with medically necessary orthodontic treatment:

- Appliance replacement due to patient non-compliance or neglect
- Cases that were previously diagnosed and treated as "medically necessary" but which require retreatment due to patient non-compliance
- Surcharges due to patient non-compliance

Retention

If retainer appliances are billed separately from treatment, reimbursement will be limited to one retainer per arch in a lifetime.

Post-treatment monitoring (retention phase) is limited to two years or less (not applicable to Phase I treatments). If special conditions warrant a longer period for post-treatment visits, the provider must submit a narrative explaining these special conditions for prior approval.

WRITTEN NARRATIVE NECESSARY FOR PREAUTHORIZATION

Providers must present a written narrative that includes:

1. A diagnostic summary of the patient's orthodontic condition
2. An explanation of how the orthodontic diagnosis relates to the condition(s) that is (are) considered to require medically necessary orthodontic treatment. (In cases when subjective symptoms such as pain qualify the patient for medically necessary orthodontic treatment, please be specific as to how a definitive diagnosis was made (for example; Have any other non-orthodontic treatments been rendered in an attempt to rule out other sources of pain? Has a general dentist documented efforts to alleviate the pain without success? Is this type of pain recognized to be typically associated with this particular malocclusion, etc.?)
3. When applicable, a report on why a less costly alternative (non-orthodontic) therapy is not appropriate for the case
4. An orthodontic treatment plan with an explanation of how the treatment plan will specifically eliminate the patient's condition(s) that qualifies for medically necessary orthodontic treatment

DIAGNOSTIC RECORDS NECESSARY FOR PRIOR APPROVAL

The following unaltered records of sufficient diagnostic quality are required. The date of record production must be sufficiently recent so as to permit accurate diagnosis of the patient's condition at the time when the preauthorization submission is made. The date of record production must be sufficiently recent to accurately represent the patient's condition and state of development at the time when the preauthorization request is made.

1. Panoramic radiograph or full-mouth series of radiographs
2. Cephalometric radiograph
3. A 3-dimensional (cone-beam) image may be submitted in place of 1 and/or 2 above
4. A digital photographic series of eight images as described below. Photographs should be made according to the specifications recommended by the American Board of Orthodontics*. Additional photographs may be submitted if they are relevant to the case but may not serve as a substitute for any of the images described below.
    - Full Facial Image, Repose
    - Full Facial Image, Smiling
    - Later Facial Image, Repose
    - Centric Occlusion
    - Right Lateral Occlusion
    - Left Lateral Occlusion
    - Maxillary Occlusal View
    - Mandibular Occlusal View
5. Digital or Plaster Models of both arches, trimmed or formatted to the recommendations of the American Board of Orthodontics*. Plaster models must include a bite registration.

Note: The American Board of Orthodontists has examples of required photographs and trimmed models at www.americanboardortho.com/professionals/downloads/Example_Case_Madelaine.pdf

INCOMPLETE RECORDS

If a patient condition or disability prohibits production of any component of the required diagnostic records, a detailed explanation of the circumstances should accompany the records submission. Otherwise, when any component of the required diagnostic records is not submitted, the case will not be authorized until all required records are submitted and received.

GLOSSARY

Apertognathia: Condition in which either the anterior or posterior teeth of opposing arch do not contact. This is also referred to as “open bite.”

Bruxism: 1. The parafunctional grinding of teeth. 2. An oral habit consisting of involuntary rhythmic or spasmodic nonfunctional gnashing, grinding or clenching of teeth, in other than chewing movements of the mandible, which may lead to occlusal trauma, attrition of the teeth, muscle ischemia, pain and damage to the supporting tissues. It is also called tooth grinding or occlusal neurosis.

Caries (dental): The disease involving decay of tooth structure.

Chronic Pain: Specific and consistent pain of at least six months in duration.

Class I malocclusion: A malocclusion in which the mesiobuccal cusp of the maxillary first molar occludes in the buccal groove of the mandibular first molar. Upper and lower arches are coordinated well with each other in respect to their anterior-posterior direction.

Class II malocclusion: A distal relationship of the mandibular first molar to the maxillary first molar, a mesial relationship of the maxillary first molar to the mandibular first molar, or a combination of the two. The mesiobuccal cusp of the maxillary first molar occludes mesial to the buccal groove of the mandibular first molar. The upper arch is protrusive in relation to the lower arch. It is typically associated with excessive overjet.

Class III malocclusion: A mesial relationship of the mandibular first molar to the maxillary first molar, a distal relationship of the maxillary first molar to the mandibular first molar, or a combination of the two. The mesiobuccal cusp of the maxillary first molar occludes distal to the buccal groove of the mandibular first molar. The lower arch is protrusive in relation to the upper arch. It is typically associated with underjet.

Comprehensive Orthodontic Treatment: Orthodontic treatment of all or most teeth in both dental arches usually accomplished, at least in part, with a fixed appliance to provide ideal occlusion in as many aspects as possible.

Craniofacial Anomaly: Deformity of the cranial and facial bones and associated structures linked to unusual growth and development of the craniofacial complex.

Crepitus: A grating or grinding sound in a moving joint or fracture.

Cross bite: An abnormal relationship of a tooth or teeth to the opposing teeth, in which normal buccolingual or labiolingual relationships are reversed.

Crowding: Dental malalignment caused by inadequate space for the teeth.

Debilitation: Significant weakening.

Dentition:

Primary dentition: Teeth that develop and erupt first in order of time and are normally shed and replaced by permanent (succedaneous) teeth.

Transitional dentition: A phase in the change from primary to permanent dentition, in which the primary molars and canines are in the process of exfoliating and the permanent successors are emerging.

Adolescent dentition: The dentition that is present after the normal loss of primary teeth and prior to cessation of growth that could affect orthodontic treatment.

Adult dentition: The dentition that is present after the cessation of growth that could affect orthodontic treatment.

Permanent dentition: Either the adolescent or adult dentition.

Diastema: A space between two adjacent teeth in the same dental arch.

Eruption: Movement of teeth in an incisal or occlusal direction into the oral cavity through the supporting bone and gingival tissue.

Esthetic Improvement: Improvement in appearance.

Fixed Appliance: An orthodontic appliance that is bonded or cemented to the teeth and cannot be removed by the patient. The most common fixed appliance is often referred to as “braces.”

Functional Improvement: Improvement in the capacity of anatomical structures to correctly and efficiently perform their intended physiologic purpose.

Functional Shift: Mandibular deviation that occurs just after initial contact of the teeth during closure. The deviation may be anterior, posterior, or lateral.

Impaction (tooth): A condition that describes the total or partial lack of eruption of a tooth well after the normal age for eruption.

Impaired of Oral Function: A condition in which orofacial anatomy, in part or in whole, is compromised so that it does not adequately perform a physiologic function for which it is intended. Severely Impaired Oral Function is a state of impaired oral function in which an individual is unable to adapt or compensate to adequately satisfy a basic physiologic need. Example: an individual who only contacts on two posterior teeth upon full closure and is unable to sufficiently chew food without severe pain.

Intermaxillary: Between the upper and lower jaws.

Intramaxillary: Within one dental arch.

Jaw Relationship: the position of the upper jaw in relationship to the lower jaw; usually an anteroposterior or transverse assessment.

Malocclusion: A deviation in intramaxillary and/or intermaxillary relations of teeth from normal occlusion.

Moderate Pain: Pain that a patient describes as a “5” or “6” on a numerical rating scale of 1 to 10.

Occlusion: The relationship of the maxillary and mandibular teeth as they are brought into functional contact.

Orthodontic: Relating to correction of abnormal dental relationships, including facial structures and neuromuscular abnormalities.

Orthodontics: The branch of dentistry that includes the diagnosis, prevention, interception, and correction of imperfections in tooth alignment and bite function (malocclusion), as well as neuromuscular and skeletal abnormalities of the developing or mature orofacial structures. Orthodontic treatment often utilizes appliances such as braces, retainers, and expanders. Formally, this specialty is known as “Orthodontics and Dentofacial Orthopedics.”

Orthodontist: A dental specialist who has completed an advanced post-doctoral course in orthodontics which is accredited by the American Dental Association, also referred to as “Specialist in Orthodontics and Dentofacial Orthopedics.”

Orthognathic Surgery: Surgery to alter relationships of teeth and/or supporting bones, usually accomplished in conjunction with orthodontic therapy.

Orthopedic: Correction of abnormal form or relationship of bone structures. May be accomplished surgically (orthopedic surgery) or by the application of appliances to stimulate changes in the bone structure by natural physiologic response (orthopedic therapy).

Osteotomy: Surgical procedure that involves the cutting of bone.

Overjet: the distance between the incisal edges of the upper incisors and the labial surface of the lower incisors.

Pediatric Dentist: A dental specialist who has completed an advanced post-doctoral course in pediatric dentistry which is accredited by the American Dental Association.

Periodontium: The investing and supporting tissues of the teeth; the periodontal membrane and alveolar process.

Phase I Orthodontic Treatment: Orthodontic treatment provided in the transitional dentition to accomplish a specific limited treatment goal with an expectation that ideal occlusion and alignment will likely require a second phase (“Phase II”) of treatment in the late-transitional or permanent dentition.

Phase II Orthodontic Treatment: Orthodontic treatment usually provided in the late transitional, adolescent or adult dentition for a patient that has previously completed a Phase I orthodontic treatment.

Retainer: Any orthodontic appliance, fixed or removable, that is used to maintain the position of the teeth following corrective treatment.

Retention: The passive treatment period following active orthodontic correction during which retaining appliances may be used.

Severe Impairment of Oral Function: a state of impaired oral function in which an individual is unable to adapt or compensate to adequately satisfy a basic physiologic need. Example: an individual who only contacts on two posterior teeth upon full closure and is unable to sufficiently chew food without severe pain. SEE ALSO: IMPAIRED ORAL FUNCTION

Severe Pain: Pain that a patient describes as a “7,” “8,” “9,” or “10” on a numerical rating scale of 1 to 10.

Temporomandibular Joint: One of the two paired articulations between the temporal bones of the skull and the mandible; the condylar process of the mandible articulates on the eminence of the glenoid fossa of the temporal bone.

TMJ: Temporomandibular joint.

Traumatic Occlusion: Malocclusion which results in excessive force being applied to a tooth or teeth (or periodontal tissue) during closure that can be associated with tooth mobility, attrition of the hard tissue of a tooth or teeth, and periodontal tissue damage.

Overjet: the distance between the incisal edges of the lower incisors and the labial surface of the upper incisors.

Refrain from using the term *"Orthodontia";* it is not used prevalently in literature and is not in the AAO glossary

REFERENCES FOR POLICY REVISIONS MADE JANUARY 2014

Chronic Pain
http://www.nlm.nih.gov/medlineplus/magazine/issues/spring11/articles/spring11pg5-6.html

PAIN SCALE
http://www.ncbi.nlm.nih.gov/pubmed/16000093
http://www.ncbi.nlm.nih.gov/pubmed/22925457
http://www.ncbi.nlm.nih.gov/pubmed/18095813

ABO Subjective complexity Index
http://www.americanboardortho.com/about/articles/DiscrepancyIndexAMeasureOfCaseComplexity.pdf

ABO IMAGES AND MODELS
http://www.americanboardortho.com/professionals/downloads/Example_Case_Madelaine.pdf