

Clinical Policy: Pediatric Dental Coverage



Reference Number: QCP.PP.036

Effective Date: 01/01/2014

Date of Last Revision: 01/01/2017

CPT Codes: 00170; D0120-D9243

Document: BI432:00

Public Statement

Effective Date:

- a) This policy will apply to all services performed on or after the above revision date which will become the new effective date.
- b) For all services referred to in this policy that were performed before the revision date, contact customer service for the rules that would apply.

This benefit does not apply to all plans issued by QualChoice.

This policy addresses the application of pediatric dental benefits in those metallic level plans that have a pediatric dental benefit. Please refer to your Evidence of Coverage and your Benefit Summary to determine if this policy applies to you.

1. Pediatric dental benefits are available only to individuals under the age of 19.
2. General anesthesia for dental procedures requires preauthorization; see BI104.
3. The following covered dental benefits are subject to prepayment review, and will only be covered if the medical policy criteria are met:
 - a. Space maintainers
 - b. Crowns other than prefabricated stainless steel crowns on deciduous (baby) teeth
 - c. Periodontal therapy
 - d. Dentures, partial and complete with repairs.
 - e. Frenectomy
4. Dental screening exams are covered twice every six months.
5. Prophylaxis and fluoride treatment are limited to once per six months.
6. Silver amalgam fillings are covered for all teeth. Composite (tooth-colored) fillings are covered only for the front teeth.
7. Pulpotomies and root canals are covered once per tooth.
8. Orthodontia is not covered.

Medical Statement

For those plans with a pediatric dental benefit, the following services will be covered:

1. Preventive Services
 - a. Two screening exams every six months
 - b. Complete dental x-rays every five years, and bitewings every six months
 - c. Prophylaxis (cleaning) and fluoride treatment every six months
 - d. Sealant on first and second permanent molars (once per lifetime)
2. Space Maintainers
 - a. Subject to pre-payment review
 - b. Authorization will only be provided when a deciduous tooth is lost earlier than expected, where there is likely to be a significant shift in tooth spacing as a result, and where a permanent tooth is going to fill the space.
3. Restorations
 - a. Amalgam restorations are covered for all teeth
 - b. Composite restorations are only covered for anterior teeth. Composites posterior to the cuspids will be paid at the same rate as amalgam.
 - c. Fillings are not covered on teeth with crowns within one year of crown placement.
4. Crowns
 - a. Prefabricated stainless steel crowns are covered for deciduous teeth.
 - b. All of the following are subject to prepayment review:
 - i. Prefabricated stainless steel crowns are only covered for posterior permanent teeth for loss of cuspal function.
 - ii. Prefabricated stainless steel or resin crowns may be covered for anterior teeth in members below 14 for:
 - iii. Teeth with dental caries where a significant amount of tooth structure has been destroyed by decay and cannot be reasonably restored with a direct restorative material; OR
 - iv. Teeth with fractured off or broken off tooth structure that is not presently replaced with an existing restoration and cannot be reasonably restored with a direct restorative material; OR
 - (1) Teeth with a fractured or broken existing restoration that cannot reasonably be replaced with a direct restoration.
5. Endodontic Care
 - a. Pulpotomies are covered for deciduous teeth.
 - b. Pulpal debridement for pain control, without completion of endodontic treatment on the same day, is subject to pre-payment review. Such therapy will be covered only if there is documentation of clinical reasons for delaying definitive therapy.
 - c. Root canals are covered one per tooth per lifetime.

6. Periodontal Therapy
 - a. Periodontal therapy is subject to prepayment review. Coverage will require a report, a perio-chart, and a complete series of radiographs that reflects evidence of bone loss, numerous 4-5 mm pockets and obvious calculus.
7. Removable Prosthetic Services
 - a. All dentures, including repairs, are subject to prepayment review.
 - b. A complete series of x-rays and a complete treatment plan, including tooth numbers to be replaced by partial dentures, must be submitted with the claim.
 - c. Dentures must be manufactured by a QualChoice contracted dental lab.
8. Extractions
 - a. Simple extractions and simple surgical extractions are covered.
 - b. Complex surgical extractions (with unusual surgical complications or cutting procedure to remove residual roots) require submission of records prior to payment.
9. Frenectomy will rarely be covered. Coverage will only be provided in documented cases where the frenum causes significant, objective functional problems.
10. Anesthesia and Analgesia
 - a. General anesthesia requires preauthorization for members over age 6, and is only covered when provided by an anesthesiologist or a certified registered nurse anesthetist. Codes D9220 and D9221 are not accepted by QualChoice; the appropriate billing code is 00170, anesthesia for intra-oral procedures.
 - b. Intravenous conscious sedation is covered when medically necessary. Preauthorization is not required, but post payment review may be performed.
 - c. Use of inhaled nitrous oxide for analgesia is covered, one unit per day.

Codes Used In This BI: N/A

Limits

- 1) The following dental services for members under the age of 19 have frequency limitations:
 - a) Dental screening exams, twice every six months
 - b) Dental x-rays:
 - i) Complete intraoral series, once every five years
 - ii) Panogram (six years old or older only), once every five years
 - iii) Bitewings, once every six months
 - c) Prophylaxis, once every six months
 - d) Topical application of fluoride, once every six months
 - e) Sealant, applied to 1st and 2nd permanent molars only, once per tooth per lifetime
 - f) Pulpotomies and root canals, once per tooth
 - g) Analgesia with nitrous oxide one unit daily

Clinical Policy: Pediatric Dental Coverage



- 2) General anesthesia will only be covered when provided by a network anesthesiologist other than the performing dentist
- 3) Composite restoration is not covered behind the cuspids. If a dental provider chooses to use posterior composites, payment will be provided at the amalgam rate.
- 4) Orthodontia is not covered.
- 5) Any dental procedures not listed above are not covered.

Background

Reference

Addendums:

Application to Products

This policy applies to all health plans and products administered by QualChoice, both those insured by QualChoice and those that are self-funded by the sponsoring employer, unless there is indication in this policy otherwise or a stated exclusion in your medical plan booklet. Consult the specific Evidence of Coverage (EOC) or Certificate of Coverage (COC) for those plans or products insured by QualChoice. In the event of a discrepancy between this policy and a self-insured customer's SPD or the specific QualChoice EOC or COC, the SPD, EOC, or COC, as applicable, will prevail. State and federal mandates will be followed as they apply.

Changes: QualChoice reserves the right to alter, amend, change or supplement benefit interpretations as needed.