Payment Policy: Pediatric Dental

Reference Number: QCP.PP.036
Last Review Date: 12/1/2025

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

This policy addresses the application of pediatric dental benefits in those metallic level plans that have a pediatric dental benefit.

Policy/Criteria

I. 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 CP.MP.61
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.

II. Medical Statement

1. For those plans with a pediatric dental benefit, the following services will be covered:
    a. Preventive Services
        i. Two screening exams every six months
        ii. Complete dental x-rays every five years, and bitewings every six months
        iii. Prophylaxis (cleaning) and fluoride treatment every six months
        iv. Sealant on first and second permanent molars (once per lifetime)
    b. Space Maintainers
        i. Subject to pre-payment review
        ii. 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.
    c. Restorations

i. Amalgam restorations are covered for all teeth
ii. Composite restorations are only covered for anterior teeth. Composites posterior to the cuspids will be paid at the same rate as amalgam.
iii. Fillings are not covered on teeth with crowns within one year of crown placement.

d. Crowns
   i. Prefabricated stainless steel crowns are covered for deciduous teeth.
   ii. All of the following are subject to prepayment review:
      a) Prefabricated stainless steel crowns are only covered for posterior permanent teeth for loss of cuspal function.
      b) Prefabricated stainless steel or resin crowns may be covered for anterior teeth in members below 14 for:
      c) 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
      d) 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 Teeth with a fractured or broken existing restoration that cannot reasonably be replaced with a direct restoration.
   iii. All of the following are subject to prepayment review
e. Endodontic Care
   i. Pulpotomies are covered for deciduous teeth.
   ii. 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.
   iii. Root canals are covered one per tooth per lifetime.
f. Periodontal Therapy
   i. 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.
g. Removable Prosthetic Services
   i. All dentures, including repairs, are subject to prepayment review.
   ii. 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.
   iii. Dentures must be manufactured by a QualChoice contracted dental lab.
h. Extractions
   i. Simple extractions and simple surgical extractions are covered.
   ii. Complex surgical extractions (with unusual surgical complications or cutting procedure to remove residual roots) require submission of records prior to payment.

i. Frenectomy will rarely be covered. Coverage will only be provided in documented cases where the frenum causes significant, objective functional problems.

j. Anesthesia and Analgesia
   i. 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.
   ii. Intravenous conscious sedation is covered when medically necessary. Preauthorization is not required, but post payment review may be performed.
   iii. Use of inhaled nitrous oxide for analgesia is covered, one unit per day

III. 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
2. General anesthesia will only be covered when provided by a network anesthetist 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.

Reviews, Revisions, and Approvals	Date	Approval Date
Original approval date	1/1/2014	1/1/2014

Important Reminder

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 selfinsured 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.

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to

recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.

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