

	<h2>Oral Surgery Guidelines</h2>	
	<p><b>Categories</b></p> <p>Clinical <input type="checkbox"/> Care Coordination, Care Coordination – Utilization management , TCHP Guidelines</p>	<p><b>This Guideline Applies To:</b></p> <p>Texas Children's Health Plan</p> <hr/> <p><b>Document Owner</b></p> <p>Lisa Fuller</p>

**GUIDELINE STATEMENT:**

Texas Children's Health Plan (TCHP) performs authorization of all Oral Surgery Procedures with the exception of surgical procedures to correct cleft lip and palate.

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In addition to this guideline, TCHP follows the criteria and requirements of the Texas Medicaid Provider Procedures Manual.

**DEFINITIONS:**

**Sound tooth** is one sufficiently supported by its natural structure (bone and gum tissue) and one that is formed by the human body and is not decayed or weakened by previous dental work at the injury site. For example, a tooth with no crowns, root canals, periodontal condition and no fractures and one that is not in need of treatment for any reason other than the accidental injury.

**Congenital anomaly or disease:** An abnormality of structure or function that was present at birth (e.g., cleft palate, ectodermal dysplasia). A clinical condition that develops after birth but is based on inherited factors (e.g., diabetes) is not considered congenital.

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## PRIOR AUTHORIZATION GUIDELINES

1. All requests for prior authorization for oral surgery are received via online submission, fax, phone or mail by the Utilization Management Department and processed during normal business hours.
2. The Utilization Management professional receiving the request evaluates the submitted information to determine if the documentation supports the oral surgery procedure as an eligible service.
3. Texas Children’s Health Plan follows the criteria and requirements of the Texas Medicaid Provider Procedures Manual.

4. To request prior authorization for oral surgery, the requesting provider must supply:
  - 3.1 Documentation supporting the medical necessity of the procedure requested
  - 3.2 Identify the location or facility where the services will be provided
5. TCHP covers medically necessary oral surgery procedures in the following clinical situations:
  - 5.1 Developmental cysts of epithelial remnants (e.g., globulomaxillary cysts, median alveolar cysts, median palatine cysts, nasopalatine cysts). These cysts are not tooth related. Removal is considered medically appropriate.
  - 5.2 Biopsy of the buccal mucosa, tongue or palate
  - 5.3 Biopsy of the gingiva or supporting structures of the teeth except when tissue is obtained as part of a routine tooth extraction or a routine periodontal procedure.
    - 5.3.1 Subsequent care or treatment of dental conditions are ineligible for coverage under medical/ surgical contracts.
  - 5.4 Services for the treatment of accidental injury caused by a force outside of the body or oral cavity to sound and natural teeth when:
    - 5.4.1 Initial treatment is rendered within 90 days from the date of injury
    - 5.4.2 The affected tooth is sound and natural with no restorative treatment or disease prior to the injury
  - 5.5 The services are for the treatment of an underlying congenital anomaly or disease that was present at birth and medical documentation of the anomaly is provided
    - 5.5.1 Medical documentation includes provider documentation, genetic testing records, birth records
6. TCHP covers medically necessary mandibular/maxillary (orthognathic) surgery when necessary for medical reasons or when necessary as part of an approved plan of care in the Texas Medicaid Dental Program. Orthognathic surgery may be considered medically necessary for the following conditions:
  - 6.1 Producing signs or symptoms of masticatory dysfunction
  - 6.2 Facial skeletal discrepancies associated with documented sleep apnea, airway defects, and soft tissue discrepancies

- 6.3 Facial skeletal discrepancies associated with documented speech impairments when determined by a speech pathologist or therapist to be due to a malocclusion AND not helped by orthodontia or at least 6 months of speech therapy.
- 6.4 Structural abnormalities of the jaws secondary to infection, trauma, neoplasia, or congenital anomalies
7. Orthognathic surgery is medically necessary for masticatory dysfunction or dysphagia when **ALL** of the following criteria are met:
- 7.1 Symptoms related to difficulty chewing such as choking due to incomplete mastication, difficulty swallowing chewed solid food, ability to chew only soft food or reliance on liquid food; Intra-oral trauma while chewing related to malocclusion (e.g., loss of food through the lips during mastication, causing recurrent damage to the soft tissues of the mouth during mastication) **AND**
- 7.2 Symptoms must be documented in the medical record, must be significant and must persist for at least 4 months; **AND**
- 7.3 Other causes of swallowing or choking problems have been ruled out by history, physical exam and appropriate diagnostic studies.
8. Orthognathic surgery is medically necessary for masticatory dysfunction or malocclusion when criteria in Section 7 are met **OR**:
- 8.1 Completion of skeletal growth with long bone x-ray or serial cephalometrics showing no change in facial bone relationships over the last 3- to 6-month period (Class II malocclusions and individuals age 18 and over do not require this documentation); **AND**
- 8.2 Documentation of malocclusion with either intra-oral casts (if applicable), bilateral lateral x-rays, cephalometric radiograph with measurements, panoramic radiograph or tomograms; **AND** any one of the following is documented:
- 8.2.1 Anteroposterior discrepancies defined as **either** of the following:
- 8.2.1.2 Maxillary/Mandibular incisor relationship (established norm = 2 mm) defined as **one** of the following:
- 8.2.1.2.1 Horizontal overjet of 5mm or more, **Or**
- 8.2.1.2.2 Horizontal overjet of zero to a negative value. (*Note: Overjet up to 5mm may be treatable with routine orthodontic therapy*); **Or**
- 8.2.1.3 Maxillary/Mandibular anteroposterior molar relationship discrepancy of 4mm or more (norm 0 to 1mm).

8.2.2 Vertical discrepancies defined as **any** of the following:

8.2.2.1 Presence of a vertical facial skeletal deformity which is two or more standard deviations from published norms for accepted skeletal landmarks; **Or**

8.2.2.2 Open bite (defined as **one** of the following):

1. No vertical overlap of anterior teeth; **Or**

2. Unilateral or bilateral posterior open bite greater than 2mm; **Or**

8.2.2.3 Deep overbite with impingement or irritation of buccal or lingual soft tissues of the opposing arch; **Or**

8.2.2.4 Supra-eruption of a dentoalveolar segment due to lack of occlusion.

8.2.3 Transverse discrepancies defined as **either** of the following:

8.2.3.1 Presence of a transverse skeletal discrepancy which is two or more standard deviations from published norms; **Or**

8.2.3.2 Total bilateral maxillary palatal cusp to mandibular fossa discrepancy of 4 mm or greater, or a unilateral discrepancy of 3 mm or greater, given normal axial inclination of the posterior teeth.

8.2.4 Asymmetries defined as the following:

8.2.4.1 Anteroposterior, transverse or lateral asymmetries greater than 3 mm with concomitant occlusal asymmetry.

6. TCHP does not cover oral surgical procedures unless otherwise stated in this guideline and/or the Texas Medicaid Provider Procedures Manual. Non-covered services include, but are not limited to:

6.1. Single arch comprehensive orthodontic services

6.2. Orthodontic services performed solely for cosmetic purposes

6.3. Routine Dental extractions

6.4. Biopsies for dental related cysts or tissue of dental origin (e.g. amalgam tattoo, fibroma, or hyperkeratoses)

6.5. Removal of tooth-related cysts (e.g. including but not limited to follicular-dentigerous, primordial, or multilocular-cysts, cysts of Malassez, radicular cysts, residual cysts and odontomas)

7. This Guideline does not apply to the diagnosis and treatment of temporomandibular joint disorders (TMJ).

8. Requests for Oral surgery procedures that do not meet the guidelines referenced here will be referred to a TCHP Medical Director/Physician Reviewer for review and the Denial Policy will be followed.

9. Preauthorization is based on medical necessity and not a guarantee of benefits or eligibility. Even if preauthorization is approved for treatment or a particular service, that authorization applies only to the medical necessity of treatment or service. All services are subject to benefit limitations and exclusions. Providers are subject to State and Federal Regulatory compliance and failure to comply may result in retrospective audit and potential financial recoupment.

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