Title: Immediate Repair of Trauma to Natural Teeth

Description/Background

Trauma to natural teeth (dental trauma) means injury sustained from an external force to natural teeth. Immediate repair of trauma to natural teeth includes the evaluation and treatment, including restoration, performed on the injured teeth within seventy-two hours of the traumatic occurrence (e.g., care is sought from an emergency room (ER)/urgent care center (UCC), dentist, etc.).

Traumatic dental injuries occur frequently in children and young adults, with the majority of injuries occurring before age 19. The most common injuries to permanent teeth occur secondary to falls, followed by traffic accidents, violence and sports. All sporting activities have an associated risk of orofacial injuries due to falls, collisions and contact with hard surfaces. Dental trauma most frequently occurs in pre-teens or young teens in whom the teeth have not yet fully developed and root development will cease without a vital pulp. Every effort should be made to preserve pulpal vitality in the immature permanent tooth to ensure continuous root development. The immature permanent tooth has considerable capacity for healing after traumatic pulp exposure, luxation injury and root fractures. The aim of treating dental trauma should be to either maintain or regain pulpal vitality in traumatized teeth.

Immediate repair of trauma is defined as care and treatment administered to the natural teeth within 72 hours of the initial injury.

Regulatory Status:

N/A
Medical Policy Statement

Coverage is provided under the BCN medical certificate for immediate (within 72 hours) repair to natural teeth that have sustained traumatic injury and remain in the mouth or need to be/have been re-implanted into the mouth.

Inclusionary and Exclusionary Guidelines (Clinically based guidelines that may support individual consideration and pre-authorization decisions)

Inclusions:
- Examination and diagnostic procedures necessary to determine the nature and extent of injury.
- Routine dental radiographs of the injured dentition and/or surrounding support structure.
- Panoramic films only when the extent of the injury cannot be determined or hidden trauma is suspected and can be documented by the provider.
- Services under this benefit are secondary to any dental insurance the member may have.
- All services rendered within the first 72 hours, except for initial emergency care, must have prior authorization by BCN.

Exclusions:
- Prosthetic replacement of teeth that had been avulsed or extracted as a result of the trauma.
- Repair of damage to fixed or removable bridges, dentures, veneers, bondings, laminates or any other appliance or prosthesis placed in the mouth or on or about the teeth.
- Initial evaluation and services when obtained later than 72 hours after the traumatic occurrence.
- Services for the repair of injuries that are not the result of an external force. An example of this exclusion includes injury to teeth resulting from biting and chewing functions.
- All cast metal, porcelain and resin crowns and inlay restorations.

CPT/HCPCS Level II Codes (Note: The inclusion of a code in this list is not a guarantee of coverage. Please refer to the medical policy statement to determine the status of a given procedure)

Pre-service review coordinators identify the dental procedure codes in the body of the clinical notes of the CareAdvance case for claims referral. Covered dental procedures may include, but are not limited to:

D0120-D0180  D2330-D2394  D5110-D5899
D0210-D0321  D2410-D2430  D8010-D6199
D0322       D2510-D2664  D6720-D6999
Immediate repair refers to the services to the natural teeth provided within the first 72 hours after the initial trauma to the natural teeth. It does not refer to services that will be completed much later or in the future. It is not uncommon for there to be no response to vitality tests for up to three months, especially in young and immature teeth. Signs of pulpal necrosis may take time to become evident, thus continued monitoring of the patient at regular intervals, up to one year, is recommended. For example, BCN would cover a temporary crown provided within the first 72 hours, but would not cover the permanent crown which may need to be delayed until the tooth/teeth involved can be accessed for adequate vitality or swelling from the trauma has time to resolve, which would be well past the 72-hour time frame.

Government Regulations
NCD: CMS Publication 100-2 Medicare Benefit Policy Manual:

Chapter 15 – Covered Medical and Other Health Services (Rev. 259, 07-12-19)

Section 10 - Supplementary Medical Insurance (SMI) Provisions (Rev. 37, Issued: 08-12-05; Effective/Implementation: 09-12-05)

The supplementary medical insurance plan covers expenses incurred for the following medical and other health services under Part B of Medicare:

- Prosthetic devices, other than dental, which replace all or part of an internal body organ
**Section 100 – Surgical Dressings, Splints, Casts and Other Devices Used for Reductions of Fractures and Dislocations** (Rev. 1, 10-01-03)

Splints and casts, and other devices used for reductions of fractures and dislocations are covered under Part B of Medicare. This includes dental splints.

**Section 150: Dental Services** (Rev. 1, 10-01-03)

As indicated under the general exclusions from coverage, items and services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth are not covered. “Structures directly supporting the teeth” means the periodontium, which includes the gingivae, dentogingival junction, periodontal membrane, cementum of the teeth, and alveolar process.

If an otherwise non-covered service is performed by a dentist as incident to, and as an integral part of, a covered procedure or service performed by him/her, the total services performed by the dentist on such an occasion are covered.

**Example 1:** The reconstruction of a ridge performed primarily to prepare the mouth for dentures is a non-covered procedure. However, when the reconstruction of a ridge is performed as a result of, and at the same time as the surgical removal of a tumor (for other than dental purposes) the totality of surgical procedures are a covered service.

When an excluded service is the primary procedure involved, it is not covered, regardless of its complexity or difficulty. For example, the extraction of an impacted tooth is not covered. Similarly, an alveoplasty (the surgical improvement of the shape and condition of the alveolar process) and a frenectomy are excluded from coverage when either of these procedures is performed in connection with an excluded service, e.g., the preparation of the mouth for dentures. In a like manner, the removal of a torus palatinus (a bony protuberance of the hard palate) may be a covered service. However, with rare exception, this surgery is performed in connection with an excluded service, i.e., the preparation of the mouth for dentures. Under such circumstances, Medicare does not pay for this procedure.

Dental splints used to treat a dental condition are excluded from coverage under 1862(a)(12) of the Act. On the other hand, if the treatment is determined to be a covered medical condition (i.e., dislocated upper/lower jaw joints), then the splint can be covered.

Whether such services as the administration of anesthesia, diagnostic x-rays, and other related procedures are covered depends upon whether the primary procedure being performed by the dentist is itself covered. Thus, an x-ray taken in connection with the reduction of a fracture of the jaw or facial bone is covered. However, a single x-ray or x-ray survey taken in connection with the care or treatment of teeth or the periodontium is not covered.
Medicare makes payment for a covered dental procedure no matter where the service is performed. The hospitalization or non-hospitalization of a patient has no direct bearing on the coverage or exclusion of a given dental procedure.

Payment may also be made for services and supplies furnished incident to covered dental services. For example, the services of a dental technician or nurse who is under the direct supervision of the dentist or physician are covered if the services are included in the dentist's or physician's bill.

Chapter 16 - General Exclusions from Coverage (Rev. 198, Issued: 11-06-14, Effective: 01-01-15, Implementation: 01-05-15)

Section 10: General Exclusions from Coverage
No payment can be made under either the hospital insurance or supplementary medical insurance program for certain items and services, when the following conditions exist:
- Dental services (§140)

Section 140: Dental Services Exclusion
Items and services in connection with the care, treatment, filling, removal, or replacement of teeth, or structures directly supporting the teeth are not covered. Structures directly supporting the teeth mean the periodontium, which includes the gingivae, dento-gingival junction, periodontal membrane, cementum, and alveolar process.

The hospitalization or non-hospitalization of a patient has no direct bearing on the coverage or exclusion of a given dental procedure.

(The above Medicare information is current as of the review date for this policy. However, the coverage issues and policies maintained by the Centers for Medicare & Medicare Services [CMS, formerly HCFA] are updated and/or revised periodically. Therefore, the most current CMS information may not be contained in this document. For the most current information, the reader should contact an official Medicare source.)

Related Policies
- Oral Surgery
- Orthognathic Surgery

References
3. BCN certificate language.


The articles reviewed in this research include those obtained in an Internet based literature search for relevant medical references through 8/27/19, the date the research was completed.
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<th>Date</th>
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Next Review: 3\textsuperscript{rd} Qtr, 2020
I. Coverage Determination

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<tr>
<th>Commercial HMO (includes Self-Funded groups unless otherwise specified)</th>
<th>Covered; criteria apply</th>
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<tr>
<td>BCNA (Medicare Advantage)</td>
<td>Refer to the Medicare information under the Government Regulations section of this policy.</td>
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<tr>
<td>BCN65 (Medicare Complementary)</td>
<td>Routine dental services are not covered by Medicare. If an otherwise noncovered service is performed by a dentist as incident to, and as an integral part of, a covered procedure or service performed by him/her, the total services performed by the dentist on such an occasion are covered. BCN will cover coinsurance amounts for any of the services that Medicare covers.</td>
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II. Administrative Guidelines

- The member’s contract must be active at the time the service is rendered.
- Coverage is based on each member’s certificate and is not guaranteed. Please consult the member’s certificate for details. Additional information regarding coverage or benefits may also be obtained through customer or provider inquiry services at BCN.
- The service must be authorized by the member’s PCP except for Self-Referral Option (SRO) members seeking Tier 2 coverage.
- Services must be performed by a BCN-contracted provider, if available, except for Self-Referral Option (SRO) members seeking Tier 2 coverage.
- Payment is based on BCN payment rules, individual certificate and certificate riders.
- Appropriate copayments will apply. Refer to certificate and applicable riders for detailed information.
- CPT - HCPCS codes are used for descriptive purposes only and are not a guarantee of coverage.