

Policy on Third-party Reimbursement for Oral Health Care Services Related to Congenital Orofacial Anomalies

Originating Committee

Clinical Affairs Committee

Review Council

Council on Clinical Affairs

Adopted

1996

Revised

2000, 2003, 2006, 2011

Purpose

The American Academy of Pediatric Dentistry (AAPD), recognizing that patients with craniofacial anomalies require oral health care as a direct result of their craniofacial condition and that these services are an integral part of the rehabilitative process,¹ advocates compensation for provision of comprehensive oral health care services throughout life.

Methods

This policy is an update of the document previously revised in 2006. It is based on review of current dental and medical literature, including a systematic literature search of the PubMed[®] electronic database with the following search parameters: Terms: “orofacial anomalies OR cleft OR anodontia OR oligodontia OR ectodermal dysplasia” AND “insurance OR third party OR reimbursement”; Fields: all; Limits: within the last 10 years, human, English. Twenty-six articles matched these criteria. Papers for review were chosen from this list and from the references within selected articles. When data did not appear sufficient or were inconclusive, recommendations were based upon expert and/or consensus opinion by experienced researchers and clinicians.

Background

Congenital orofacial anomalies that result in malformed or missing teeth, such as but not limited to ectodermal dysplasia and cleft defects, can have significant negative functional, esthetic, and psychological effects on individuals and their families.¹⁻³ Patients with craniofacial anomalies often require specialized oral health care as a direct result of their condition. These services are medically necessary and an integral part of the rehabilitative process.⁴ Young children benefit from esthetic and functional restorative techniques and readily adapt to appliances that replace missing teeth and improve function,

appearance, and self-image. During the period of facial and oral growth, appliances require frequent adjustment and have to be remade as the individual grows.

These patients often are denied coverage for initial appliance construction and, more frequently, replacement of appliances as the child grows. Third-party payors legally may control the coverage of these services by limiting contractual benefits. The distinction between congenital anomalies involving the orofacial complex and those involving other parts of the body is often arbitrary and unfair. For instance, health care policies may provide reimbursement for the necessary prosthesis required for congenitally missing extremities and its replacement as the individual grows, but deny benefits for the initial prosthesis and the necessary periodic replacement for congenitally missing teeth. Third-party payors frequently will refuse to pay for oral health care services even when they clearly are associated with the complete rehabilitation of the craniofacial condition.⁵

Furthermore, clerical personnel and professional consultants employed by third-party payors often make benefit determinations based on arbitrary distinction between medical versus dental anomalies, ignoring important functional and medical relationships. Evaluation and care provided for an infant, child, or adolescent by a cleft lip/palate, orofacial, or craniofacial deformities team have been described as the optimal way to coordinate and deliver complex services.⁵ This approach may provide additional documentation to facilitate “medical necessity” of dental rehabilitation.⁶

Policy statement

The AAPD strongly believes that the dentist providing the oral health care for the patient determines the medical indication and justification for treatment in these cases.

The AAPD encourages third party payors to:

1. recognize that malformed and missing teeth and resultant anomalies of facial development seen in orofacial anomalies are congenital defects, just as the congenital absence of other body parts, requiring care over the lifetime of the patient;
2. include oral health care services related to these facial and dental anomalies as benefits of health insurance without discrimination between the medical and dental nature of the congenital defect. These services, optimally provided by the craniofacial team, include, but are not limited to, initial appliance construction, periodic examinations, and replacement of appliances;
3. end arbitrary and unfair refusal of compensation for oral health care services related to these facial and dental anomalies;
4. regularly consult the AAPD with respect to the development of benefit plans that best serve the oral health interests of infants, children, and adolescents with craniofacial anomalies.

References

1. American Cleft Palate-Craniofacial Association. Parameters for evaluation and treatment of patients with cleft lip/palate or other craniofacial anomalies. Revised ed. Chapel Hill, NC: American Cleft Palate-Craniofacial Association; November 2007.
2. Murdock S, Lee JY, Guckes A, Wright JT. A cost analysis of dental treatment for ectodermal dysplasia. *J Am Dent Assoc* 2005;136(9):1273-5.
3. National Foundation for Ectodermal Dysplasias. Parameters of oral health care for individuals affected by ectodermal dysplasias. National Foundation for Ectodermal Dysplasias. Mascoutah, Ill; 2003:9.
4. American Academy of Pediatric Dentistry. Policy on medically necessary care. *Pediatr Dent* 2011;33(special issue): 18-22.
5. Strauss RP. The organization and delivery of craniofacial services: The state of the art. *Cleft Palate Craniofac J* 1999;36(3):189-95.
6. American Academy of Pediatrics. Policy statement: Model contractual language for medical necessity for children. *Pediatr* 2005;116(1):261-2.