

Policy on Medically Necessary Care

Originating Council

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Purpose

The American Academy of Pediatric Dentistry (AAPD) recognizes that dental care is medically necessary for the purpose of preventing and eliminating orofacial disease, infection, and pain, restoring the form and function of the dentition, and correcting facial disfigurement or dysfunction.

Methods

This policy is based upon a review of the current dental and medical literature related to the concept of medically necessary care. A MEDLINE search was performed using the terms “medically necessary care”, “systemic disease and oral disease”, “dentistry as medically necessary care”, “periodontal disease and cardiovascular disease”, “maternal oral disease and pregnancy”, and “oral disease and respiratory illness”.

Background

The AAPD defines medically necessary care (MNC) as the reasonable and appropriate diagnostic, preventive, and treatment services (including supplies, appliances, and devices) and follow-up care as determined by qualified, appropriate health care providers in treating any condition, disease, injury, or congenital or developmental malformation. MNC includes all supportive health care services that, in the judgment of the attending dentist, are necessary for the provision of optimal quality therapeutic and preventive oral care. These services include, but are not limited to, sedation, general anesthesia, and utilization of surgical facilities. MNC must take into account the patient’s age, developmental status, and psychosocial well-being, in addition to the setting appropriate to the needs of the child and family.¹

MNC is based upon current preventive and therapeutic practice guidelines formulated by professional organizations with recognized clinical expertise. Such recommendations ideally are evidence based but, in the absence of conclusive evidence, may rely on expert opinion and clinical observations. Expected benefits of care should outweigh potential risks. MNC increases the probability of good health and well-being and decreases the likelihood of an unfavorable outcome. Value of services is an important consideration, and all stakeholders should recognize that cost-effective care is not necessarily the least expensive treatment.²

Dental care is medically necessary to prevent and eliminate orofacial disease, infection, and pain, to restore the

form and function of the dentition, and to correct facial disfigurement or dysfunction. Following the US Surgeon General’s report³ emphasizing that oral health is integral to general health, the US Department of Health and Human Services recommended changing perceptions of the public, policy makers, and healthcare providers so that oral health becomes an accepted component of general health.⁴ Oral diseases can have a direct and devastating impact on overall health, especially for those with certain systemic health problems or conditions.

Caries is the most common chronic disease of childhood.³ Approximately 60% of children experience caries in their primary teeth by age 5.⁵ Between 1988-1994 and 1999-2004, prevalence of caries in primary teeth increased for youths aged 2 to 11 years, with a significant increase noted for those in the 2-5 year age range.⁶ By 17 years of age, 78% of children in the US have experienced caries.⁴ As much as 90% of all caries in school-aged children occurs in pits and fissures. Caries, periodontal diseases, and other oral conditions, if left untreated, can lead to pain, infection, and loss of function. These undesirable outcomes can adversely affect learning, communication, nutrition, and other activities necessary for normal growth and development.⁷ Rampant caries is one of the factors causing insufficient development in children who have no other medical problems.⁸ Children with early childhood caries (ECC) may be severely underweight because of the associated pain and disinclination to eat. Nutritional deficiencies during childhood can impact cognitive development.⁹

Other oral conditions also can impact general health and well-being. Gingivitis is nearly universal in children and adolescents, and children can develop severe forms of periodontitis.¹⁰ There exists a relationship between periodontal disease and cardiovascular disease^{11,12} and periodontal disease and adverse pregnancy outcomes.^{13,14} An association between oral health and respiratory diseases has been recognized.^{15,16} Oral health, oral microflora, and bacterial pneumonia, especially in populations at high risk for respiratory disease, have been linked. The mouth can harbor respiratory pathogens that subsequently are aspirated, resulting in airway infections.¹⁶ Problems of esthetics, form, and function can affect the developing psyche of children, with life-long consequences in social, educational, and occupational environments.¹⁷ Self-image, self-esteem, and self-confidence are unavoidable issues in society, and an acceptable orofacial presentation is a necessary component of these psychological concepts.¹⁸

Congenital orofacial anomalies (eg, ectodermal dysplasia, cleft defects) that result in malformed or missing teeth can have significant negative functional, esthetic, and psychological effects on individuals and their families.^{19,20} Patients with craniofacial anomalies often require oral health care as a direct result of their craniofacial condition. These services are an integral part of the rehabilitative process.¹⁹ 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.

Professional care is necessary to maintain oral health,³ and risk assessment is an integral element of contemporary preventive care for infants, children, adolescents, and persons with special health care needs.²¹ The goal of caries risk assessment is to prevent disease by identifying and minimizing causative factors (eg, microbial burden, dietary habits, dental morphology) and optimizing protective factors (eg, fluoride exposure, personal oral hygiene, sealants).²² Ideally, risk assessment and implementation of preventive strategies would occur before the disease process has been initiated.

Infants and young children have unique caries-risk factors such as ongoing establishment of oral flora and host defense systems, susceptibility of newly erupted teeth, and development of dietary habits and childhood food preferences. Children are most likely to develop caries if mutans streptococci is acquired at an early age.²³ High-risk dietary practices appear to be established early, probably by 12 months of age, and are maintained throughout early childhood.²⁴ Adolescence can be a time of heightened caries activity and periodontal disease due to an increased intake of cariogenic substances and inattention to oral hygiene procedures.^{25,26}

An analysis of caries risk includes determination of protective factors, such as fluoride exposure. More than one-third of the US population does not benefit from community water fluoridation.³ Fluoride contributes to the prevention, inhibition, and reversal of caries.²⁷ Therefore, early determination of a child's systemic and topical fluoride exposure is important.

Children experiencing caries as infants and toddlers have a much greater probability of subsequent caries in both the primary and permanent dentitions.⁹ An individualized preventive plan based on the Caries-risk Assessment Tool (CAT)²¹ is the key component of caries prevention. Because any risk assessment tool may fail to identify all infants at risk for developing ECC, early establishment of the dental home is the ideal approach for disease prevention.²⁸ Early diagnosis and timely intervention, including appropriate referrals, can prevent the need for more extensive and expensive care often required when problems have gone unrecognized and/or untreated.²⁹

When very young children have not been the beneficiaries of adequate preventive care and subsequently develop ECC, therapeutic intervention should be provided by a practitioner with the training, experience, and expertise to manage both the child and the disease process. Because of the aggressive nature

of ECC, treatment should be definitive yet specific for each individual patient. Conventional restorative approaches may not arrest the disease.³⁰ Areas of decalcification and hypoplasia can develop cavitation rapidly. The placement of stainless steel crowns may be necessary to inhibit the caries process. Stainless steel crowns decrease the number of tooth surfaces at risk for new or secondary caries and are less likely than other restorations to require retreatment.^{31,32} Low levels of compliance with follow-up care and a high recidivism rate of children requiring additional treatment also can influence a practitioner's decisions for management of ECC.³³

Sealants are particularly effective in preventing pit and fissure caries and providing cost savings if placed on patients during periods of greatest risk.³⁴ Children with multiple risk factors and tooth morphology predisposed to plaque retention (ie, developmental defects, pits and fissures) benefit from having such teeth sealed prophylactically. A child who receives sealants is 72% less likely to receive restorative services over the next 3 years than children who do not.³⁵ Although sealant retention rates initially are high, sealant loss does occur.³⁶ It is in the patient's interest to receive periodic evaluation of sealants. With follow-up care, the success rate of sealants may be 80 to 90%, even after a decade.³⁶

The extent of the disease process, as well as the patient's developmental level and comprehension skills, affect the practitioner's behavior guidance approaches. To perform treatment effectively and efficiently while instilling a positive dental attitude, the practitioner caring for a pediatric patient may employ advanced behavior guidance techniques such as protective stabilization and/or sedation or general anesthesia.³⁶ The patient's age, dental needs, disabilities, medical conditions, and/or acute situational anxiety may preclude the patient's being treated safely in a traditional outpatient setting.³⁷

For some infants, children, adolescents, and persons with special health care needs, treatment under sedation/general anesthesia in a hospital, outpatient facility, or dental office or clinic represents the only appropriate method to deliver necessary oral health care.³⁷ The success of restorations may be influenced by the child's response to the chosen behavior guidance technique. Although general anesthesia may provide optimal conditions to perform restorative procedures, it can add significantly to the cost of care. General anesthesia, under certain circumstances, may offer a cost-saving alternative to sedation for children with ECC.^{9,38}

Reimbursement issues defined by the concept of MNC have been a complicated topic for dentistry. Pediatric dental patients may be denied access to oral health care when insurance companies refuse to provide reimbursement for sedation/general anesthesia and related facility services. Most denials cite the procedure as "not medically necessary". This determination appears to be based on arbitrary and inconsistent criteria.³⁹⁻⁴⁴ For instance, medical policies often provide reimbursement for sedation/general anesthesia or facility fees related to myringotomy for a 3-year-old child, but deny these benefits when related to treatment of dental disease and/or infection for the same patient. American Dental Association Resolution

1989-546 states that insurance companies should not deny benefits that would otherwise be payable “solely on the basis of the professional degree and licensure of the dentist or physician providing treatment, if that treatment is provided by a legally qualified dentist or physician operating within the scope of his or her training and licensure.”⁴⁴

Patients with craniofacial anomalies often are denied third party coverage for initial appliance construction and, more frequently, replacement of appliances as the child grows. 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 prosthesis required for a congenitally missing extremity and its replacement as the individual grows, but deny benefits for the initial prosthesis and 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.⁴⁵

Although sealants are safe and effective, their use continues to be low.⁴⁶ Initial insurance coverage for sealants often is denied, and insurance coverage for repair and/or replacement may be limited.^{47,48} Although some third party carriers restrict reimbursement for sealants to patients of certain ages, it is important to consider that timing of dental eruption can vary widely. Furthermore, caries risk may increase at any time during a patient’s life due to changes in habits (eg, dietary, home care), oral microflora, or physical condition, and previously unsealed teeth subsequently might benefit from sealant application.³⁶

Policy statement

Dental care is medically necessary to prevent and eliminate orofacial disease, infection, and pain, to restore the form and function of the dentition, and to correct facial disfiguration or dysfunction. MNC is based upon current preventive and therapeutic practice guidelines formulated by professional organizations with recognized clinical expertise. Expected benefits of MNC outweigh potential risks of treatment or no treatment. Early detection and management of oral conditions can improve a child’s oral health, general health and well-being, school readiness, and self-esteem. Early recognition, prevention, and intervention could result in savings of health care dollars for individuals, community health care programs, and third party payors. Because a child’s risk for developing dental disease can change over time, continual professional reevaluation and preventive maintenance are essential for good oral health. Value of services is an important consideration, and all stakeholders should recognize that cost-effective care is not necessarily the least expensive treatment.

The AAPD:

1. recommends oral health care be included in the design and provision of individual and community-based health care programs to achieve comprehensive health care.

2. encourages establishment of a dental home for all children by 12 months of age in order to institute an individualized preventive oral health program based upon each patient’s unique caries risk assessment.
3. recommends that health care providers who diagnose oral disease either provide therapy or refer the patient to an appropriately trained individual for treatment. Immediate intervention is necessary to prevent further dental destruction, as well as more widespread health problems.
4. recognizes evaluation and care provided for an infant, child, or adolescent by a cleft lip/palate, orofacial, or craniofacial deformities team as the optimal way to coordinate and deliver complex services.
5. believes that the dentist providing the oral health care for the patient determines the medical indication and justification for treatment. The dental care provider must assess the patient’s developmental level and comprehension skills, as well as the extent of the disease process, to determine the need for advanced behavior guidance techniques such as sedation or general anesthesia.

Furthermore, 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 orofacial and dental anomalies;
4. recognize the oral health benefits of dental sealants and not base coverage for sealants on a patient’s age;
5. ensure that all children have access to the full range of oral health delivery systems. If sedation or general anesthesia and related facility fees are payable benefits of a health care plan, these same benefits shall apply for the delivery of oral health services; and
6. regularly consult the AAPD with respect to the development of benefit plans that best serve the oral health interests of infants, children, adolescents, and persons with special health care needs, especially those with craniofacial anomalies.

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