

Policy on Third-Party Reimbursement for Oral Health Care Services Related to Congenital and Acquired Orofacial Anomalies

Latest Revision

2016

Purpose

The American Academy of Pediatric Dentistry (AAPD) values the unique qualities of each person and the need to ensure maximal health attainment for all, regardless of developmental anomalies or other special health care needs. 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 AAPD advocates providing benefits for provision of comprehensive oral health care services throughout life.

Methods

This policy was developed by the Clinical Affairs Committee and adopted in 1996, and was revised by the Council of Clinical Affairs. This document is an update of the previous version, revised in 2011. It is based on review of current dental and medical literature, including a search of the PubMed®/MEDLINE database using the terms: orofacial anomalies and 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. Seventy-two 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, policies were based upon expert and/or consensus opinion by experienced researchers and clinicians.

Background

Congenital and acquired orofacial anomalies (e.g., ectodermal dysplasia, cleft defects, oral cancer) can have significant negative functional, esthetic, and psychological effects on individuals and impose a financial burden to their families.¹⁻⁴ The oral health care needs of these patients are unique, impact their overall health, and necessitate special considerations.⁵ Patients with craniofacial anomalies often require specialized oral health care as a direct result of their condition to promote normal function and development. These services are medically necessary and an integral part of the rehabilitative process.⁶ 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 and acquired anomalies involving the orofacial complex and those involving other parts of the body often seems 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 services even when they clearly are associated with the complete rehabilitation of the craniofacial condition.⁷

The Patient Protection and Affordable Care Act of 2010⁸ “is silent on the features of what might constitute a fair and acceptable medical necessity standard in qualified health plans”.⁹ Despite being included as one of the essential health benefits in all qualified plans, federal regulations allow significant flexibility to plans that include dental care, and these services often are restricted. The restriction of these benefits largely affects children with multiple chronic conditions who have complex developmental needs and use specialty care.⁹ 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.⁷ This approach may provide additional documentation to facilitate medical necessity of dental rehabilitation.

ABBREVIATION

AAPD: American Academy Pediatric Dentistry.

Policy statement

The AAPD encourages all policy makers and third-party payors to consult the AAPD in the development of benefit plans that best serve the oral health interests of infants, children, adolescents, and individuals with special health care needs.

The AAPD strongly believes that the dentist providing the oral health care for the patient determines the medical indication and justification for treatment for patients with congenital and acquired orofacial anomalies.

The AAPD encourages third-party payors to:

- recognize that congenital and acquired orofacial anomalies require care over the life-time of the patient.
- include oral health services related to these facial and dental anomalies as benefits of health insurance without discrimination between the medical and dental nature of the defect. These services, optimally provided by the craniofacial team, include, but are not limited to, initial appliance construction, periodic examinations, and replacement of appliances.
- provide payable benefits for oral health services related to these facial and dental anomalies.

References

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