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

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Abbreviations
AAPD: American Academy of Pediatric Dentistry.
DHMO: Dental health maintenance organization.
HMO: Health maintenance organization.
Majr: Medical subject headings major topic.
PPO: Preferred provider organization.
Tiab: Title and abstract.

* *Used in the PubMed search to identify all terms that begin with this truncated base.*

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 differences, referred to in this document as 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,[1p18] the AAPD advocates for the provision of comprehensive oral health care throughout the lifespan. This document provides background information to assist pediatric dentists to continue working with and encouraging third-party payors to provide comprehensive oral health care benefits for individuals with craniofacial anomalies that meet their specific needs.

Methods
This policy was developed by the Clinical Affairs Committee, adopted in 1996 ,[2] and last revised by the Council of Clinical Affairs in 2021.[3] This update is based on review of current dental and medical literature, including a search of the PubMed/MEDLINE database using the terms: (*evidence based dentistry* [**Majr**] OR *pediatric dentistry* [Majr] OR *dental care for children* [Majr] OR *dental health services*[Majr] OR *dentistry* [Majr]) AND ((*insurance, health, reimbursement* [Majr] OR *insurance coverage* [Majr] OR *dental insurance* [**Tiab**] OR *insurance, health, reimbursement* [Majr] OR *cost sharing* [Majr] OR *costs and cost analysis* [Majr] OR *third party pay** [Tiab] OR *third party reimburse** [Tiab] OR *health care costs* [Majr] OR *health expenditures* [Majr] OR *reimbursement, incentive* [Majr] OR *economics, dental* [Majr] OR *health policy* [Majr] OR *PPO* [Tiab] OR *HPO* [Tiab] OR *dental HMO* [Tiab] OR *DHMO* [Tiab]) AND (*orofacial anomalies* [Tiab] OR *cleft palate* [Majr] OR *anodontia* [Majr] OR *oligodontia* [Tiab] OR *ectodermal dysplasia* [Majr] OR *cleft lip* [Tiab] OR *cleft palate* [Tiab] OR *craniofacial abnormalities* [Majr] OR *craniofacial* [Tiab] OR *ectodermal dysplasia* [Majr] OR *oligodontia* [Tiab] OR *hypodontia* [Tiab] OR *pediatric prosthetic** [Tiab] OR *congenital abnormalities* [Majr])); fields: all; limits: within the last 10 years, human, English. Twenty-four articles were identified. Papers for review were chosen from the resultant list of articles and from the references within selected articles. Recent federal policies relevant to orofacial differences also were reviewed. When data did not appear sufficient or were inconclusive, policies were based upon expert or consensus opinion by experienced researchers and clinicians.

Background

There exists a large and diverse group of congenital and acquired orofacial anomalies that can have significant negative functional, esthetic, and psychosocial effects on individuals and impose a significant financial burden on their families.[1p18,4-9] 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.[1p18,10] Young children will benefit from early dental interventions (eg, prosthetics to replace missing teeth) to improve function, esthetics, and self-image and will readily adapt to oral appliances. During the period of facial and oral growth, appliances require frequent adjustment and must be remade as the individual grows.

Patients with craniofacial anomalies should not be denied coverage for initial appliance construction, rehabilitative therapies, replacement of appliances, and other services necessary for craniofacial form and function throughout their lifespan. Unfortunately, as insurance law exists today, third-party payors in the commercial market legally may control the coverage of these services by limiting contractual benefits. Conversely, in public programs such as Medicaid and Children's Health Insurance Program (CHIP), these services would be deemed necessary for coverage due to the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)[11] provision. The distinction between congenital and acquired anomalies involving the orofacial complex and those involving other parts of the body seems arbitrary and unfair. For instance, health care policies may provide reimbursement for the necessary prosthesis required for a congenitally missing extremity 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.[12,13]

Coverage for orthodontic services for individuals with orofacial anomalies or cleft palate is at the discretion of individual state mandates,[12,14] leaving room for states to exclude coverage for crucial treatment. Private health insurance plans may demand clear indications of medical necessity to improve function[15] and specific referral systems while denying coverage for services deemed elective or cosmetic in nature.[16] Subjective and indiscriminate denials by insurance companies hinder the ability of individuals to obtain comprehensive and timely care that can significantly improve their appearance, function, and quality of life.[17,18]

The Patient Protection and Affordable Care Act of 2010[19] "is silent on the features of what might constitute a fair and acceptable medical necessity standard in qualified health plans".[20] Despite being included as one of the essential health benefits in all qualified plans, federal regulations allow significant flexibility to plans that include pediatric dental care, and these services often are restricted.[9,12,14,21] The restriction of these benefits largely affects children with multiple chronic conditions who have complex developmental needs and use specialty care.[20] Additionally, limitations on allowable services and reimbursement inequitably affect those with public health insurance, amplifying the vulnerability of those requiring complex treatment.[22] Clerical personnel and professional consultants employed by third-party payors sometimes make benefit determinations based on arbitrary distinction between medical versus dental anomalies, ignoring important functional and medical relationships. Recent legislation has been re-introduced to address insurance gaps in the private, group, and individual health-plan markets for services related to the treatment and management of craniofacial anomalies.[23] This legislation also corrects for the past disconnect between coverage for preliminary surgeries and denials of corrective or follow-up procedures, including necessary dental services as well as services for hearing and vision.[14,24] Evaluation and care provided for an infant, child, or adolescent by a cleft lip/palate, orofacial, or craniofacial anomalies team have been described as the optimal way to coordinate and deliver complex services.[13,25p6] This approach may provide additional documentation to facilitate medical necessity of dental rehabilitation.

Policy statement

The AAPD encourages all third-party payors to design fair benefit plans that accommodate the specific oral health needs of individuals with craniofacial differences. The AAPD encourages policymakers to require and enforce coverage for these medically necessary services.

The AAPD strongly believes in the sanctity of the patient-provider relationship, and the dentist providing the oral health services for the patient determines the medical indication, necessity, 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 lifetime 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, rehabilitative therapy, periodic examinations, and replacement of appliances.
- provide payable benefits for oral health services related to these facial and dental anomalies.

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