Policy on Medically-Necessary Care

Latest Revision

2024

How to Cite: American Academy of Pediatric Dentistry. Policy on medically-necessary care. The Reference Manual of Pediatric Dentistry. Chicago, IL: American Academy of Pediatric Dentistry; 2025:71-5.

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 disfiguration or dysfunction.

Methods

This document was developed by the Council on Clinical Affairs, adopted in 2007,[1] and last revised in 2019.[2] This revision included an electronic search with PubMed/MEDLINE using the terms: *dentistry* AND *medically-necessary care*, *oral health* AND *medically-necessary care*, *and dentistry* AND *COVID* OR *pandemic*; fields: all; limits: within the last 15 years, human, English. Three hundred ninety-two articles were identified.

Background

The AAPD defines medically-necessary care (**MNC**) as "the reasonable and essential diagnostic, preventive, and treatment services (including supplies, appliances, and devices) and follow-up care as determined by qualified health care providers in treating any condition, disease, injury, or congenital or developmental malformation to promote optimal health, growth, and development. 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 clinical setting appropriate to meet the needs of the patient and family."[3]

MNC benefits patients by increasing the probability of good health and well-being while decreasing the likelihood of potentials risks and unfavorable outcomes. Value of services is an important consideration, and cost-effective care is not necessarily the least expensive treatment.[4] For example, a very young patient may require a stainless steel crown as an alternative to an intracoronal restoration due to high caries risk and the durability of the tooth.[5,6]

Oral health plays a vital role in the physical, mental, social, and economic well-being of individuals and populations.[7] Following the US Surgeon General's *National Call to Action*,[8] the US Department of Health and Human Services recommended changing perceptions of the public, policy makers, and health care providers to emphasize that oral health is an integral component of general health.[9]

Caries is the most common chronic disease of childhood.[10,11] More than one half of children aged 6 to 8 have had a cavity in at least 1 primary tooth, and more than one half of adolescents aged 12 to 19 have had a cavity in at least 1 permanent tooth.[10] "Dental 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."[12] Children with early childhood caries (**ECC**) may be severely underweight because of the associated pain and disinclination to eat.[13] Nutritional deficiencies during childhood can impact cognitive development.[14,15]

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.[16] A relationship has been established between periodontal disease and cardiovascular disease, as well as periodontal disease and adverse pregnancy outcomes, through several cross-sectional, case-control, and longitudinal studies.[17] As the evidence describing the nature of the relationship continues to evolve, it has become apparent that a common link is the heightened inflammatory state attributed to these conditions.[17-19] An association between oral health and respiratory diseases has been recognized.[20-22] Oral health, oral microflora, and bacterial pneumonia, especially in populations at high risk for respiratory disease, have been linked.[21] The mouth can harbor respiratory pathogens that may be aspirated, resulting in airway infections.[23] Furthermore, dental plaque may serve as a reservoir for respiratory pathogens in patients who are undergoing mechanical ventilation.[24] Problems of esthetics, form, and function can affect the developing psyche of children and adolescents, with lifelong consequences in social, educational, and occupational environments.[25,26] 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.[27]

Congenital or acquired orofacial anomalies (eg, ectodermal dysplasia, cleft defects, cysts, tumors) and malformed or missing teeth can have significant negative functional,

ABBREVIATIONS

AAPD: American Academy of Pediatric Dentistry. **ECC:** Early childhood caries. **MNC:** Medically-necessary care. **SHCN:** Special health care needs.

esthetic, and psychological effects on individuals and their families.[28,29] Patients with craniofacial anomalies often require specialized oral health care as a direct result of their medical condition. Pre- and postsurgical services are an integral part of the rehabilitative process.[28] Young children benefit from esthetic and functional restorative or surgical 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 must be remade as the individual grows.

Professional care is necessary to maintain oral health,[9,30] and risk assessment is an integral element of contemporary preventive care for infants, children, adolescents, and persons with special health care needs (**SHCN**).[15,31] Ideally, risk assessment and implementation of preventive strategies would occur before the disease process has been initiated. An individualized preventive plan based on a caries-risk assessment 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.[32] Early diagnosis and timely intervention, including necessary referrals, can prevent the need for more extensive and expensive care often required when problems have gone unrecognized and/or untreated.[33-35]

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, restorative treatment should be definitive yet specific for each individual patient. Conventional restorative approaches may not arrest the disease.[36] Areas of demineralization and hypoplasia can cavitate rapidly. The placement of stainless steel crowns may be necessary to decrease the number of tooth surfaces at risk for new or secondary caries. Stainless steel crowns are less likely than other restorations to require retreatment.[36,37] 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[38] and may decrease success of a disease management approach to ECC.[39]

Sealants are particularly effective in preventing pit and fissure caries and providing cost savings if placed on the teeth of patients during periods of greatest risk.[40-42] While 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.[43]

The extent of the oral disease process is not the lone determinant of the practitioner's behavior guidance approach to care for infants, children, adolescents, and individuals with SHCN. To perform treatment safely, effectively, and efficiently, especially for those unable to cooperate due to lack of psychological or emotional maturity and/or mental, physical, or medical conditions, the practitioner caring for a pediatric patient may employ advanced behavior guidance techniques.[44] For some patients, treatment under sedation or general anesthesia in a hospital, outpatient facility, or dental office/clinic may improve safety and outcomes in the delivery of necessary oral health care.[45]

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.[46,47] These procedures often are a medical necessity for patients with SHCN or comprised immunity.[48,49] Historically, most denials cite the procedure as "not medically necessary".[50] This determination appears to be based on arbitrary and inconsistent criteria.[51,52] 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 dental infection for the same patient. The 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."[53] Operating room access for dental procedures decreased over the last decade even though third-party coverage may be mandated.[54,55] Failure by third-party payors to cover general anesthesia costs, hospital fees, and/or sedation costs can expose the patient to multiple ineffective, potentially unsafe, and/or psychologically-traumatic in-office experiences.

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. Often, medical insurance companies interpret dental appliance construction to be solely esthetic, without taking into consideration the restorative function. 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.[56,57]

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 or recommendations formulated by professional organizations with recognized clinical expertise. 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, academic performance, 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 optimal oral health. The 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 encourages

- oral health care to be included in the design and provision of individual and community-based health care programs to achieve comprehensive health care.
- 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 and periodontal disease risk assessments.
- health care providers who diagnose oral disease to either provide therapy or refer the patient to a dentist or dental/medical specialist as dictated by the nature and complexity of the condition. Immediate intervention is necessary to prevent further dental destruction, as well as more widespread health problems.
- evaluation and care provided for an infant, child, or adolescent by a cleft lip/palate, orofacial, or craniofacial team as the optimal way to coordinate and deliver such complex services.
- the dentist providing oral health care for a patient to determine 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

- recognize malformed and missing teeth are resultant anomalies of facial development seen in orofacial anomalies and may be from congenital defects. Just as the congenital absence of other body parts requires care over the lifetime of the patient, so will these.
- 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.
- end arbitrary and unfair refusal of compensation for oral health care services related to orofacial and dental anomalies.
- recognize the need for preventive, restorative, and surgical oral health care services to be regarded as a medically necessary benefit.
- 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.
- regularly consult the AAPD with respect to the development of benefit plans that best serve the oral health interests of infants, children, adolescents, and individuals with SHCN, especially those with craniofacial or acquired orofacial anomalies.

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