Oral Surgery

Policy

Harvard Pilgrim reimburses contracted providers for the provision of contracted oral surgery services.

Policy Definition

Oral Surgery is the specialty of dentistry that is concerned with the diagnosis, surgical and adjunctive treatment of diseases, injuries and deformities of the oral and maxillofacial region.

Prerequisite(s)

Applicable Harvard Pilgrim referral, notification and authorization policies and procedures apply.
Refer to *Referral, Notification and Authorization* for more information.

HMO/POS/PPO

- A referral is required for specialist services for HMO and in-network POS members, except for tooth extraction or removal of impactions in an office setting.

Open Access HMO and POS

For *Open Access HMO and Open Access POS* products, no referral is required to see a contracted specialist.

- Authorization required for some dental procedures, including odontectomy, oral surgery in a surgical day care setting, and TMJ surgery. (Refer to *Dental Benefit Clinical Review* for specific requirements.)

Harvard Pilgrim Reimburses[1]

HMO/POS/PPO

- Office examinations for covered services
- TMD/TMJ initial consultation only (one consultation per lifetime, including exam and panoramic x-ray) by an oral surgeon to evaluate symptoms
- Surgery for the treatment of TMD/TMJ
- Orthognathic surgery for the correction of handicapping functional malocclusion, including post-operative follow-up visits
- Orthodontic treatment of cleft palate
- Removal of benign or malignant tumors or cysts of the mouth
- Surgical treatment of jaw injury or disease
- Biopsy of mouth or jaw oral lesions
- Incision and drainage of significant odontogenic infection, including antibiotic management (if member has drug benefit)
- Alveoplasty, only to prepare the mouth for prostheses
- More than one oral surgery procedure performed during the same session, subject to the multiple surgery discount
- An assistant surgeon for those procedures included on the CMS-approved assistant surgeon list
- Treatment of cleft palate and cleft lip in compliance with the MA state mandate
- Extractions
  - Removal of impacted teeth fully or partially impacted in bone including pre- and post-operative care, x-rays and anesthesia (when the member's group has selected the coverage)
  - Removal of non-impacted teeth for members at significant risk because of medical conditions (e.g., immunodeficiency due to AIDS, suppressant drugs for organ transplant, due to chemotherapy or osteoradionecrosis due to neck and head radiation treatment)
- Periodontal surgery required for treatment of drug-induced hyperplasia only

Harvard Pilgrim Does *Not* Reimburse

HMO/POS/PPO

- Alveoloplasty, except to prep the mouth for prostheses
- Activities considered part of the sedation/general anesthesia service:
  - All usual pre-and post-operative services;
  - Induction of anesthesia during the procedure
  - Incidental administration of IV fluids, injections, or drug administrations (CPT 96365-96376)
- Charges for restorative dental care or non-covered oral surgery when anesthesia and/or hospital care is authorized for members with special needs
- Dental prostheses designed to replace teeth lost through infection, disease, decay or the treatment of these conditions
- Endodontic care (root canals)
- Extraction of teeth to prepare for, or support, orthodontic, prosthodontic or periodontal procedures
- Extraction of non-impacted teeth, except for members at significant risk because of medical conditions
- Oral surgical or dental services associated with the removal of teeth for the treatment of baby bottle syndrome
- Hospital or other ancillary costs associated with non-covered services
- Oral surgery services, other than described above
- Periodontal care (treatment of gums and/or gum diseases), except as described above
- Palatal restoration with implants (Pillar Palatal Implant System)
- Prosthodontic services or devices including bridges, dentures, crowns, etc.
- Repair of dentures, crowns, bridges or other dental appliances damaged as a result of accidental injury
- Replacement of teeth lost during intubation
- Restorative treatment including fillings, bonding, caps and/or amalgam
- The work-up necessary to develop the surgical treatment plan for orthognathic surgery when billed with a non-covered diagnosis (Refer to “Provider Billing Guidelines and Documentation” for non-covered conditions.)

Member Cost-Sharing

Services are subject to applicable member out-of-pocket cost (e.g., copayment, coinsurance, deductible).

Provider Billing Guidelines and Documentation

Coding[2]

Code	Description	Comment
21073	Manipulation of temporomandibular joint(s) (TMJ), therapeutic, requiring an anesthesia service (i.e., general or monitored anesthesia care)	Not reimbursed
29800	Arthroscopy, temporomandibular joint, diagnostic, with or without synovial biopsy (separate procedure)	Not reimbursed
42299	Unlisted procedure, palate, uvula	When used to bill for palatal restoration with implants, not a reimbursed service
70355, 70350, or D0340	The work-up necessary to develop the surgical treatment plan for orthognathic surgery	Denies, not a covered benefit, when billed with the following diagnoses codes: **ICD-10**
D7230	Removal of impacted tooth, partially bony	Bill total # of teeth removed on one line with a count
D7240	Removal of impacted tooth, completely bony	

Code	Description	Comment
D8060	Interceptive orthodontic treatment of the transitional dentation	Reimbursed only with the following diagnosis codes in the primary position: **ICD-10 Covered Indications**
D8070	Comprehensive orthodontic treatment of the transitional dentition	
D9222/D9223	Deep sedation/general anesthesia	Bill on one line with a count for the total amount of time.
D9239/D9243	Intravenous moderate (conscious) sedation/analgesia	Bill on one line with a count for the total amount of time

Cleft Palate Treatment

Harvard Pilgrim reimburses cleft palate procedures in compliance with the MA state mandates up to the age of 18 when
one of the following diagnoses are submitted in the primary position:
ICD-10 Covered Indications

Other Information

- Use CPT codes when available or, in the absence of CPT codes, use the most current version of CDT codes
- Bill the same procedure performed multiple times at the same session on one line with a count
- The global surgical period is determined using the CMS designation and guidelines

Related Policies

Payment Policies

- Bilateral Services and CPT Modifier 50
- Certified Midwives, Nurse Practitioners and Physician Assistants
- Cosmetic and Reconstructive Surgery
- CPT & HCPCS Level II Modifiers
- Dental Care
- Evaluation and Management
- Non-Covered Services
- Surgery
- Unlisted/Unspecified Procedure Codes

Clinical/Authorization Policies

- Dental Benefit Clinical Review

Authorization/Notification Policies

- Prior Authorization Policy

PUBLICATION HISTORY

11/01/01	original documentation
01/01/03	added prior authorization note and additional First Seniority information
01/01/04	annual review; orthognathic work-up not reimbursed
10/31/04	annual review
01/31/06	annual review; added palatal implants are not reimbursed
01/31/07	annual review, no changes
01/31/08	annual review; added “orthodontic treatment of cleft palate” under HP Reimburses; other minor edits for clarity
07/31/08	bilateral billing update added
01/31/09	annual review; no changes
11/15/09	annual review; no changes
11/15/10	annual review; update to coding grid

12/15/11	annual review; added TMJ codes to coding grid
01/01/12	removed First Seniority Freedom information from header
11/15/12	annual review; added cleft palate mandate information
11/15/13	annual review; no changes
06/15/14	added *Connecticut Open Access HMO* referral information to prerequisites
11/15/14	annual review; no changes
01/15/15	annual coding update
07/30/15	ICD-10 coding update
11/15/15	annual review; no changes
01/15/16	annual coding update
11/15/16	annual review; administrative edit
11/15/17	annual review; added “Unlisted/Unspecified Procedure Codes” to related policies
02/01/18	annual coding update; updated Open Access Product referral information under prerequisites
12/03/18	annual review; remove ICD-9 diagnosis codes; update to related policies
04/01/19	added Harvard Pilgrim does not reimburse incidental services that are part of sedation/general anesthesia
05/01/19	added CNM, CPM, NP and PA to related policies
12/02/19	annual review; no changes
12/01/20	annual review; updated Provider Billing Guidelines and Documentation
12/01/221	annual review; removed modifier grid; added CPT & HCPCS Level II Modifier Policy to Related Policies

[1]This policy applies to the products of Harvard Pilgrim Health Care and its affiliates—Harvard Pilgrim Health Care of Connecticut, Harvard Pilgrim Health Care of New England, and HPHC Insurance Company—for services performed by contracted providers. Payment is based on member benefits and eligibility, medical necessity review, where applicable, and provider contractual agreement. Payment for covered services rendered by contracted providers will be reimbursed at the lesser of charges or the contracted rate. (Does not apply to inpatient per diem, DRG, or case rates.) HPHC reserves the right to amend a payment policy at its discretion. CPT and HCPCS codes are updated annually. Always use the most recent CPT and HCPCS coding guidelines.

[2]The table may not include all provider claim codes related to oral surgery.