

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

## Latest Revision

2021

**How to Cite:** American Academy of Pediatric Dentistry. Policy on third-party reimbursement for oral health care services related to congenital and acquired orofacial differences. The Reference Manual of Pediatric Dentistry. Chicago, Ill.: American Academy of Pediatric Dentistry; 2022:160-2.

## 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,<sup>1</sup> AAPD advocates for the provision of comprehensive oral health care throughout life. This document provides background information to assist pediatric dentists to continue working with and encouraging third-party payors to provide oral health care benefits for individuals with craniofacial anomalies.

## Methods

This policy was developed by the Clinical Affairs Committee, adopted in 1996<sup>2</sup>, and last revised by the Council of Clinical Affairs in 2016<sup>3</sup>. This update 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 cleft palate OR anodontia OR oligodontia OR ectodermal dysplasia AND insurance OR third-party OR reimbursement; fields: all; limits: within the last 10 years, human, English. Papers for review were chosen from the resultant list of articles and from the references within selected articles. 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 psychological effects on individuals and impose a financial burden on their families.<sup>1,4-9</sup> The oral health care needs of these patients are unique, impact their overall health, and necessitate special considerations.<sup>10</sup> 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.<sup>1,11</sup> 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 must be remade as the individual grows.

These patients should not be denied coverage for initial appliance construction or replacement of appliances as the child grows. Unfortunately, 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 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.<sup>12,13</sup>

Coverage for orthodontic services for individuals with orofacial anomalies or cleft palate is at the discretion of individual state mandates,<sup>13,14</sup> leaving room for states to exclude coverage for crucial treatment. Private health insurance plans may demand clear indications of medical necessity to improve function<sup>15</sup> and documented agreement among an interdisciplinary team<sup>16,17</sup> while denying coverage for services deemed elective or cosmetic in nature. 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.<sup>18,19</sup>

## ABBREVIATION

**AAPD:** American Academy Pediatric Dentistry.

The Patient Protection and Affordable Care Act of 2010<sup>20</sup> “is silent on the features of what might constitute a fair and acceptable medical necessity standard in qualified health plans”<sup>21</sup>. 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.<sup>9,13,14,22</sup> The restriction of these benefits largely affects children with multiple chronic conditions who have complex developmental needs and use specialty care.<sup>21</sup> Additionally, limitations on allowable services and reimbursement inequitably affect those with public health insurance, amplifying the vulnerability of those requiring complex treatment.<sup>23</sup> 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 introduced to address the disconnect between coverage for preliminary surgeries and denials of corrective or follow-up procedures, including necessary dental services.<sup>13,24</sup> 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.<sup>1,12</sup> This approach may provide additional documentation to facilitate medical necessity of dental rehabilitation.

### 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.

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