

Adjunctive Dental Care

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1.0 DESCRIPTION

Adjunctive dental care is that dental care which is medically necessary in the treatment of an otherwise covered medical (not dental) condition, is an integral part of the treatment of such medical condition; or is required in preparation for, or as the result of, dental trauma which may be or is caused by medically necessary treatment of an injury or disease.

2.0 POLICY

2.1 Adjunctive dental care requires preauthorization. However, if a beneficiary fails to obtain preauthorization before receiving the services, the contractor shall extend benefits if the services or supplies qualify for benefits. Where adjunctive dental care involves a medical (not dental) emergency (such as facial injuries resulting from an accident), the requirement for preauthorization is waived. Such waiver is limited to the essential adjunctive dental care related to the medical condition requiring the immediate emergency treatment.

2.2 Hospital services and supplies will be covered for a patient who requires a hospital setting for noncovered, nonadjunctive dental care when medically necessary to safeguard the life of the patient from the effects of dentistry on an underlying nondental organic condition. Professional services related to the noncovered dental care are not covered; professional services related to the medical condition (excluding the dentist and anesthesiologist) are covered.

2.3 Benefits may be cost-shared for the treatment of the following conditions:

2.3.1 Intraoral Abscesses

An intraoral abscess should be considered a medical condition only when it extends beyond the dental alveolus. These abscesses may require immediate attention in an acute phase which would preclude preauthorization.

2.3.2 Extraoral Abscesses

In some cases, it is necessary to incise and treat abscesses extraorally; e.g., when the infection follows the facial planes.

2.3.3 Cellulitis and Osteitis

Elimination of a non-local infection which is clearly exacerbating and directly affecting a medical condition currently under treatment.

2.3.4 Facial Trauma Requiring Removal of Teeth or Tooth Fragments

2.3.4.1 Removal of teeth and tooth fragments in order to treat and repair facial trauma resulting from an accidental injury.

2.3.4.2 Removal of an impacted tooth in the line of a fracture may be required in order to treat the fracture.

2.3.5 Myofacial Pain Dysfunction Syndrome

2.3.5.1 Treatment of this syndrome may be considered a medical problem only when it involves immediate relief of pain.

2.3.5.2 Emergency treatment may include initial radiographs, up to four office visits and the construction of an occlusal splint, if necessary to relieve pain and discomfort.

2.3.5.3 Treatment beyond four visits, or any repeat episodes of care within a six (6) month period, must receive individual consideration and be documented by the provider of services.

Note: Occlusal equilibration and restorative occlusal rehabilitation are specifically excluded for myofacial pain dysfunction syndrome.

2.3.6 Total or Complete Ankyloglossia

This condition is commonly known as tongue-tie. It involves the lingual frenum resulting in fixation of the tip of the tongue to the degree that it interferes with swallowing and speech. Surgery for partial ankyloglossia is considered unnecessary, and of no medical value.

2.3.7 Severe Congenital Anomaly

Adjunctive dental and orthodontia is covered when directly related to, and an integral part of, the medical and surgical correction of a severe congenital anomaly.

2.3.7.1 Coverage Guidelines

Depending on the severity or degree of involvement of the congenital anomaly, the patient may require adjunctive dental or orthodontic support from birth until the medical/surgical treatment of the anomaly has been completed; i.e., until the dentoalveolar arch discrepancies and/or maxillomandibular disharmonies are corrected through a combined effort of the surgeon and orthodontist. Treatment may include the fabrication of obturators early in life, and splints at the time of surgical treatment for stabilization of the maxilla and mandible. As the arches develop and teeth erupt, orthodontic treatment may be required to establish a functional relationship of the dental arches. When the deformity is severe and function is greatly impaired, obturators and pharyngeal bulb appliances may be required to assure proper nutrition, deglutition and to avoid

aspiration of foreign matter during the intake of food.

2.3.7.1.1 Vestibuloplasty (CPT¹ procedure codes 40840 - 40845) may be considered adjunctive dental when it is determined to be an appropriate and medical necessary surgical procedure for correction of a severe cleft lip/cleft palate.

Note: Vestibuloplasty is EXCLUDED when performed to prepare the mouth for dentures.

2.3.7.1.2 Orthodontics should be a covered treatment in any congenital deformity of the head and neck, wherein the orthodontia:

2.3.7.1.2.1 Corrects dentoalveolar arch discrepancies that are part of, or the result of, the congenital anomaly and are severe enough to prevent the usual and normal action of mastication and ingestion of normally solid foods.

2.3.7.1.2.2 Corrects dentoalveolar arch discrepancies, the correction of which is necessary to satisfactorily correct other aspects of the general deformity, or to prevent relapse of such treatment.

2.3.7.1.2.3 Corrects dentoalveolar arch discrepancies that are, in themselves, severe enough to obviously disfigure the face.

2.3.7.1.2.4 The following is a listing of congenital anomalies that affect the face and possibly the dentoalveolar arches, or their relationships to each other:

- Cleft palate isolated.
- Lateral or oblique facial clefting.
- Cleft mandible.
- Klippel-Fiel Syndrome.
- Pierre Robin Syndrome.
- Trisomies 18, 21, 13 - 15.
- Chondroectodermal dysplasia (Ellis-van Creveld Syndrome).
- Bird headed dwarfism (Nanocephalic or primordial dwarfism).
- Turner's Syndrome (X-0 Syndrome).
- Klinefelter's Syndrome.
- Craniofacial dysostosis (Crouzon's Syndrome).
- Occuloauriculovertebral dysplasia (Goldenhar's Syndrome).
- Occulamandibulofacial Syndrome (Hallerman Striff Syndrome, Ullrich et al Syndrome).
- Treacher Collins Syndrome.
- Hemifacial microsomia.
- Hemifacial hyperplasia.

2.3.7.1.2.5 Coverage of orthodontia for congenital anomalies of the head and/or neck which do not appear in the above listing must be evaluated to assess the significance of their functional impairments related to the dentoalveolar arch discrepancies described in [paragraphs 2.3.7.1.2.1](#)

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and 2.3.7.1.2.2; i.e., the dentoalveolar arch discrepancies of an unlisted congenital anomaly must impose a significant functional impairment in order for coverage of orthodontia under TRICARE.

2.3.7.1.2.6 The severity and functional impairment of a given congenital anomaly must be assessed on a case-by-case basis from a series of medical records over a period of time. The congenital impairment of the head and/or neck must be at a level resulting in an inability of a beneficiary to perform normal bodily functions (e.g., the inability to eat, breathe, and/or speak normally) in order for coverage to be extended. The functional impairment must be disabling and ongoing.

2.3.7.2 Preauthorization Requirements

2.3.7.3 Preauthorization is required for all adjunctive dental and orthodontia directly related to, and an integral part of, the medical and surgical correction of a severe congenital anomaly.

2.3.7.4 Orthodontia benefits for severe congenital anomalies of the head and neck will be continued as long as the primary physician requires support of his/her treatment or until the best reasonably attainable results have been achieved by the orthodontist. Once active orthodontic treatment has been completed and the patient is placed in the retention phase of treatment, benefit payment ends. If the primary physician or dentist subsequently determines that additional orthodontia work is required, a new preauthorization is required.

2.3.8 Iatrogenic Dental Trauma

Dental care which is prophylactic, restorative, prosthodontic (e.g., dentures and bridge work) and/or periodontic qualifies as adjunctive dental care when performed in preparation for, or as a result of, trauma to the teeth and supporting structures caused by medically necessary treatment of an injury or disease. There must be a direct cause-effect relationship between the otherwise covered medical treatment and the ensuing dental trauma, and the ensuing dental trauma must be functionally associated (adjunct) with the treatment of the physician induced trauma. This must be based on sound medical practice and substantiated in the current medical literature. The following are examples of conditions which are eligible for payment under the iatrogenic dental trauma provision. Because these examples are not meant to be all-inclusive, similar conditions or circumstances may be brought to the attention of the Deputy Director, TRICARE Management Activity (TMA), or designee, for consideration.

2.3.8.1 Radiation Therapy for Oral or Facial Cancer

2.3.8.1.1 It is generally recognized that certain dental care may be required in preparation for or as a result of in-line radiation therapy for oral or facial cancer.

2.3.8.1.2 Treatment may include dental prophylactic, restorative, periodontic and/or orthodontic procedures. Without this necessary care, patients who undergo radiation therapy about the head may be at risk for development of osteonecrosis because their dental needs were not met either prior to, or in conjunction with, radiation therapy. Since the problem here deals with cancer, it may not be possible to wait for prior authorization before beginning radiation therapy. Out of necessity, dental care may have to be initiated before benefit authorization is granted. Extraction of affected teeth due to poor dental health (e.g., multiple dental caries and/or periodontal disease) may necessitate the coverage of dentures or bridge work.

2.3.8.2 Gingival Hyperplasia

2.3.8.2.1 Gingival hyperplasia, or overgrowth of the gingival tissues, occurs frequently in patients who have undergone prolonged Dilantin therapy for epilepsy or seizure disorders. The incidence of this problem can be reduced by good oral hygiene and prophylactic gum care. Severe cases of gingival overgrowth may require surgical intervention to reduce the excessive fibrous tissue growth. The problem is more prevalent among young children, as the older population is not prone to the condition. Also, there is an important difference in the character of tissue between gingival hyperplasia and periodontal disease. Because of this, care needs to be taken in differentiating true gingival hyperplasia from periodontally diseased tissue.

2.3.8.2.2 Treatment usually entails excision of the hyperplastic tissue; however, in some severe cases, free soft tissue grafts may be required.

2.3.8.3 Preauthorization Requirements

The preauthorization criteria for dental care required in preparation for, or as a result of, trauma to the teeth and supporting structures caused by medically necessary treatment of an injury or disease are the same as those described in [paragraphs 2.3.7.3](#) and [2.3.7.4](#).

2.3.9 Dental Metal Amalgam/Alloy Hypersensitivity

The removal of dental metal amalgam/alloy source may be cost-shared for procedures rendered after April 18, 1983, under the following conditions:

2.3.9.1 Independent diagnosis by a physician allergist based upon generally accepted test(s) for any dental metal amalgam/alloy hypersensitivity, and

2.3.9.2 Contemporary clinical record documentation which reasonably rules out sources of metal exposure other than the dental amalgam/alloy.

3.0 POLICY CONSIDERATIONS

3.1 Dental care which is routine, preventive, restorative, prosthodontic (adding or modifying of bridge work and dentures), periodontic or emergency does not qualify as adjunctive dental care except when performed in preparation for, or as a result of, dental trauma caused by medically necessary treatment of an injury or disease.

3.2 Orthodontia is only covered when it is an integral part of the medical or surgical correction of a severe congenital anomaly or when required in preparation for, or as a result of, physician induced dental trauma.

3.3 Clinical oral examinations, radiographs and laboratory tests and examinations may be payable only when necessary in conjunction with the diagnosis and treatment of covered adjunctive dental or oral surgery procedures.

3.4 The Frankel Dental Appliance is categorized as orthodontia and must be denied unless adjunctive to the surgical correction of a cleft palate.

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3.5 The treatment of generally poor dental health (dental caries) due to certain systemic causes (e.g., congenital syphilis, malabsorption syndromes, rickets, etc.) is excluded from coverage.

3.6 American Dental Association (ADA) claim forms and procedure codes may be used in the processing and payment of adjunctive dental claims.

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