Oral Surgery Payment Policy

Applies to the following Tufts Health Plan products:

☒ Tufts Health Plan Commercial (including Tufts Health Freedom Plan)\(^1\)
☐ Tufts Medicare Preferred HMO (a Medicare Advantage product)
☐ Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)

The following payment policy applies to Tufts Health Plan contracting oral surgery providers.

In addition to the specific information contained in this policy, providers must adhere to the information outlined in the Professional Services and Facilities Payment Policy.

**Note:** Audit and disclaimer information is located at the end of this document.

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**POLICY**

Tufts Health Plan covers medically necessary oral surgery services, whether in an inpatient or surgical day care setting, as described below.

**GENERAL BENEFIT INFORMATION**

Services and subsequent payment are pursuant to the member's benefit plan document. Member eligibility and benefit specifics should be verified prior to initiating services by logging on to the secure Provider website or by contacting Commercial Provider Services.

**Massachusetts and Rhode Island fully insured groups:** Coverage for services related to teeth is limited to the emergency treatment of accidental injury to sound and natural teeth by a source external to the mouth. Treatment must be rendered within 48 hours of the injury and is limited to x-rays and emergency oral surgery to temporarily stabilize tissue and/or repositioning of the fractured teeth. Restorative services including crowns, fillings, and root canals are not covered.

**New Hampshire fully insured groups:** Coverage is provided for medically necessary dental services resulting from an accidental injury to sound natural teeth and gums when the course of treatment for the accidental injury is received/authorized within 3 months of the date of the injury. Treatment required due to injury to the jaw and oral structures other than teeth is not subject to a time limit.\(^2\)

**AUTHORIZATION REQUIREMENTS**

Referrals are not required for any oral surgery services; however, members must see a contracting oral surgeon for services to be considered for coverage. If a member is in need of inpatient services, an inpatient notification is required. Prior authorization may be required for certain procedures. Refer to the medical necessity guidelines on the Tufts Health Plan and Tufts Health Freedom Plan websites to determine prior authorization requirements for specific procedures.

**Temporomandibular Joint Disorder Treatment**

Coverage is provided for the cost of certain diagnostic studies and for nondental treatment for temporomandibular joint (TMJ) disorder treatment. Refer to the Temporomandibular Joint (TMJ) Disorder Treatment medical necessity guidelines for additional information.

**Note:** TMJ appliances, occlusal adjustment, or other TMJ appliance-related therapies are not covered.

**Extractions**

Extractions/removal of teeth, and related charges, are generally not covered in an office setting; however some member specific benefit plans may indicate otherwise. Coverage of extractions/removal of teeth is limited and requires prior authorization when performed in an inpatient or surgical day care setting.

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\(^1\)Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLink™ when Tufts Health Plan is the primary administrator.

\(^2\)In accordance with NH RSA 420-G:5.
setting. Refer to the following medical necessity guidelines for additional information, including coverage criteria and limitations:

- Dental Procedures Requiring Hospitalization or Anesthesia in the Office Setting
- Dental Procedures Requiring Hospitalization or Anesthesia in the Office Setting: New Hampshire Products

**Dental Implants**
Tufts Health Plan may authorize the coverage of dental implants when the member has had major jaw resection or traumatic jaw avulsion. Refer to the Dental Implants Medical Necessity Guidelines for additional information, including coverage criteria and limitations.

**Sleep Apnea**
Coverage is provided for an FDA-approved oral appliance (OA) for members with sleep apnea when certain criteria are met. For details about coverage criteria, refer to the Medical Necessity Guidelines for Oral Appliances for Treatment of Obstructive Sleep Apnea for additional information, including coverage criteria and limitations.

**Orthognathic Surgery**
Tufts Health Plan may authorize surgery to correct conditions of the jaw and face related to structure, growth, or sleep apnea. Refer to the Orthognathic Surgery for Severe Oral-Maxillofacial Functional Disorders Medical Necessity Guidelines for additional information, including coverage criteria and limitations.

**Cysts**
The removal of most lesions and cysts may be covered in an office setting when included in the member’s benefit; however prior authorization may be required.

**Note:** Tufts Health Plan does not cover the removal of radicular cysts.

**BILLING INSTRUCTIONS**

**Office Consultations**
Office consultations are included in the member’s coverage and are subject to global periods and other payment edits. Refer to the Evaluation and Management Payment Policy for additional information.

**COMPENSATION/REIMBURSEMENT INFORMATION**
Tufts Health Plan does not routinely compensate for oral appliances used to reduce upper airway collapsibility (E0485, E0486) if a claim for the device is submitted without appropriate documentation (e.g., an invoice) indicating the cost of the device. Prior authorization will continue to be required, as described in the Medical Necessity Guidelines for Oral Appliances for Treatment of Obstructive Sleep Apnea.

**Anesthesia**
Tufts Health Plan does not routinely compensate for the following HCPCS codes in Table 1 when billed with the HCPCS codes in Table 2, as the procedures in Table 1 are included in the primary procedure. Refer to the current HCPCS Level II Manual for additional information.

**Table 1**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D9210</td>
<td>Local anesthesia not in conjunction with operative or surgical procedures</td>
</tr>
<tr>
<td>D9211</td>
<td>Regional block anesthesia</td>
</tr>
<tr>
<td>D9212</td>
<td>Trigeminal division block anesthesia</td>
</tr>
<tr>
<td>D9215</td>
<td>Local anesthesia</td>
</tr>
</tbody>
</table>

**Table 2**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D7220-D7241</td>
<td>Removal of impacted tooth</td>
</tr>
<tr>
<td>D7250</td>
<td>Surgical removal of residual tooth roots cutting procedure</td>
</tr>
</tbody>
</table>
**Assistant Surgeons/Co-Surgeons and Team Surgery**

In alignment with CMS and the American College of Surgeons, Tufts Health Plan will consider compensation for services requiring multiple physicians when the procedure warrants. The appropriate modifier must be appended to compensate the claim according to the services rendered.

**Surgical Global Day Period**

Surgical procedures are assigned a global day period of 0, 10 or 90 day(s) by CMS based on the complexity of the procedure. Services rendered within the assigned specified numbers of global days, including evaluation and management services, are considered inclusive to the primary procedure.

**DOCUMENT HISTORY**

- November 2018: Added link to existing Tufts Health Freedom Plan-specific medical necessity guidelines for dental procedures requiring hospitalization or anesthesia in an office setting; clarified coverage for Tufts Health Freedom Plan members
- June 2018: Template updates
- May 2017: Policy reviewed by committee; reworded anesthesia language for clarity
- January 2017: Template updates
- September 2015: Template conversion, template updates
- December 2014: Moved information about unlisted procedure codes to the Claims Submission payment policy, template updates
- October 2013: Policy reviewed, minor content and formatting changes, template updates
- September 2013: Template conversion
- July 2012: Removed reference indicating all services require prior authorization.
- April 2012: Template updates.
- March 2012: Updated CareLink disclaimer language
- October 2011: Policy reviewed, added information regarding sleep apnea, template changes
- November 2009: Added CPT/HCPCS codes and information on unlisted codes, add-on codes, assistant surgeons and surgical global day period
- February 2008: Revised general benefit information to include self-service channels information

**AUDIT AND DISCLAIMER INFORMATION**

Tufts Health Plan reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that an office/facility did not comply with this payment policy, Tufts Health Plan will expect the office/facility to refund all payments related to noncompliance. For more information about Tufts Health Plan’s audit policies, refer to the Provider website.

This policy provides information on Tufts Health Plan claims adjudication processes. As every claim is unique, this policy is neither a guarantee of payment, nor a final indication of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management requirements (when applicable), adherence to plan policies and procedures, and claims editing logic. An authorization is not a guarantee of payment. Claims for services subject to authorization may be reviewed for accuracy and compliance with payment policies.

This policy applies to the Tufts Health Plan products, as identified in the checkboxes on the first page, and to CareLinkSM for providers in Massachusetts and Rhode Island service areas. Providers in the New Hampshire service area are subject to Cigna’s provider agreements with respect to CareLink members. This policy does not apply to the Private Health Care Systems (PHCS) network (also known as Multiplan). Tufts Health Plan reserves the right to amend a payment policy at its discretion.