

Dental Clinical Policy: Removable & Fixed Appliance Therapy

Reference Number: CP.DP.36

Last Review Date: 12/23

[Coding Implications](#)[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

Removable or fixed appliance therapy procedures are typically used to control harmful habits such as thumb sucking or tongue thrusting. These habits frequently result in open anterior bites and protruding anterior teeth.

Policy/Criteria

- I. It is the policy of Envolve Dental Inc.® that removable appliance therapy is **medically necessary** when any of the following conditions are met:
 - A. When psychological methods to control finger in mouth habits are ineffective;
 - B. When speech and myotherapy to control tongue habits are ineffective;
 - C. When psychological methods to control accessory dental habits (chewing or sucking on items such as pens, pencils, or necklaces) are ineffective;
 - D. When psychological methods to control fingernail biting are ineffective.
 - E. In all of the above, the patient must be willing to wear a removable appliance and be mentally ready/capable to stop their habit. Forcing an appliance onto patients without their willingness to cooperate most often guarantees failure of intervention.
 - F. When none of the following contraindications are present:
 1. When a patient cannot be trusted to wear the appliance (usually age, maturity, or even willingness to cooperate are contributing factors);
 2. When member age and/or growth stage is beyond the ability of appliance correction.
- II. It is the policy of Envolve Dental Inc.® that fixed appliance therapy is **medically necessary** when any of the following conditions are met:
 - A. When any or all of the indications for removable appliance therapy are present and the patient cannot be reasonably expected to wear a removable appliance.
 - B. When none of the following contraindications are present:
 1. When a patient is not psychologically prepared to accept a fixed appliance;
 2. When the primary dentition is not appropriate for treatment;
 3. When member age and/or growth stage is beyond the ability of appliance correction.
 - C. Required documentation to support medical necessity include the following:
 1. Clinical chart and treatment notes documenting conditions listed in the indications for use of Removable or Fixed Appliance Therapy;
 2. Diagnostic-quality panoramic, occlusal, or periapical radiographic images to determine extent of possible root damage prior to therapy;
 3. Photographic images documenting the clinical condition necessitating the use of Removable or Fixed Appliance Therapy.

III. Coverage Limitation/Exclusions

1. One removable or fixed appliance therapy procedure per lifetime
2. Subject to state-specific regulations.

DENTAL CLINICAL POLICY
Removable & Fixed Appliance Therapy

Coding Implications

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CDT® Codes	Description
D8210	Removable appliance therapy
D8220	Fixed appliance therapy

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
F98.8	Other specified behavioral and emotional disorders with onset usually occurring in childhood and adolescence
K00.6	Disturbances in tooth eruption
K00.7	Teething syndrome
K00.8	Other disorders of tooth development
K00.9	Disorder of tooth development, unspecified
K08.81	Primary occlusal trauma
K08.82	Secondary occlusal trauma
K08.89	Other specified disorders of teeth and supporting structures
K08.9	Disorder of teeth and supporting structures, unspecified
K14.8	Other diseases of tongue
M26.220	Open anterior occlusal relationship
M26.25	Anomalies of interarch distance
M26.29	Other anomalies of dental arch relationship
M26.30	Unspecified anomaly of tooth position of fully erupted tooth or teeth
M26.31	Crowding of fully erupted teeth
M26.32	Excessive spacing of fully erupted teeth
M26.33	Horizontal displacement of fully erupted tooth or teeth
M26.34	Vertical displacement of fully erupted tooth or teeth
M26.37	Excessive interocclusal distance of fully erupted teeth
M26.39	Other anomalies of tooth position of fully erupted tooth or teeth
M26.4	Malocclusion, unspecified

Reviews, Revisions, and Approvals	Date	Approval Date
Policy developed	6/20	6/20

DENTAL CLINICAL POLICY
Removable & Fixed Appliance Therapy

Reviews, Revisions, and Approvals	Date	Approval Date
Annual Review	12/22	12/22
Annual Review and Format Change	12/23	12/23

References

1. American Dental Association. CDT 2023: Dental Procedure Codes. American Dental Association, 2023.
2. Abraham R, Kamath G, Sodhi JS, Sodhi S, Rita C, Sai Kalyan S. Habit breaking appliance for multiple corrections. *Case Rep Dent.* 2013;2013:647649. doi:10.1155/2013/647649.
3. Tanaka O, Oliveira W, Galarza M, Aoki V, Bertaiolli B. Breaking the Thumb Sucking Habit: When Compliance Is Essential. *Case Rep Dent.* 2016;2016:6010615. doi:10.1155/2016/6010615.
4. Yemitan TA, daCosta OO, Sanu OO, Isiekwe MC. Effects of digit sucking on dental arch dimensions in the primary dentition. *Afr J Med Med Sci.* 2010;39(1):55-61.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of dental practice; peer-reviewed dental/medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national dental and health professional organizations; views of dentists practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. Envolve Dental makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of dental practice current at the time that this clinical policy was approved. “Envolve Dental” means a dental plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Envolve Benefit Options, Inc, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to dental and medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Envolve Dental administrative policies and procedures.

This clinical policy is effective as of the date determined by Envolve Dental. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Envolve Dental

DENTAL CLINICAL POLICY
Removable & Fixed Appliance Therapy

retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute dental or medical advice, dental treatment or dental care. It is not intended to dictate to providers how to practice dentistry. Providers are expected to exercise professional dental and medical judgment in providing the most appropriate care, and are solely responsible for the dental and medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating dentist in connection with diagnosis and treatment decisions.

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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