October 15, 2021

Subject: **Notification of January 2022 Updates to the Blue Shield *HMO Benefit Guidelines***

Dear IPA/medical group:

We have revised our *HMO Benefit Guidelines.* The changes listed in the following benefit guidelines sections are effective January 1, 2022.

On that date, you can search and download the revised manual on Provider Connection at www.blueshieldca.com/provider in the *Provider Manuals* section under the *Guidelines & Resources* tab.

You may also request a PDF version of the revised *HMO Benefit Guidelines* be emailed to you or mailed to you in CD format, once it is published, by emailing providermanuals@blueshieldca.com.

The *HMO Benefit Guidelines* is referenced in the agreement between Blue Shield of California (Blue Shield) and those IPAs and medical groups contracted with Blue Shield. If a conflict arises between the *HMO Benefit Guidelines* and the agreement held by the IPA or medical group and Blue Shield, the agreement prevails.

If you have any questions regarding this notice about the revisions that will be published in the January 2022 version of this manual, please contact your Blue Shield Provider Relations Coordinator.

Sincerely,

Aliza Arjoyan
Senior Vice President
Provider Partnerships and Network Management

T12062 (10/21)

UPDATES TO THE JANUARY 2022
HMO BENEFIT GUIDELINES

Accidental Injury to Natural Teeth – Basic Plan

Added *language in the Benefit Coverage section in boldface type below:*

NOTE: For the purposes of this policy, the definition of "emergency palliative" is the immediate **and initial** treatment to dentally or medically stabilize the teeth or oral structures and/or to manage or treat acute, intractable (severe) oral pain **to prevent a more serious medical condition from occurring;** it is not necessarily the definitive restoration of the teeth or oral structures. Covered services are limited to the immediate, medically necessary services for the initial, palliative medical stabilization ("first aid") of the teeth and associated oral structures. Submission of pre- and post-accident radiographs of the site **and medical quality photographs of the mouth and teeth** will be required when requesting services.

Added *the following in the Benefit Exclusions section in boldface type below:*

- Replacement, repair, or restoration of dentures, fixed dental bridges, crowns, fillings, dental implants, removable oral appliances, dental retainers, dental veneers, etc. as the result of accidents, lost, thief, or damage following a medical **or dental** clinic visit, a hospital visit, **visit to an urgent care or emergency room**, or the use of an ambulance service.
- Orthodontia (dental services to correct irregularities or malocclusion of the teeth) for any reason, including treatment to alleviate symptoms as a result of TMJ conditions or abnormalities or because of an accident or trauma. Any dental or medical emergency treatment as a result of loose orthodontic arch wires, broken orthodontic brackets, and broken **or lost** orthodontic retainers.
- **The services of dental pathologists, dental anesthesiologists, oral-facial pain specialists, dental radiologists, and dental medicine specialists.**

Updated *language in the Examples of Covered Services section.*

Allergy

Renamed *the guideline to* **Allergy Testing and Immunotherapy** *and* ***updated*** *language from Examples of Covered Services.*

Ambulatory Surgeries and Procedures

Deleted *the following procedure codes:*

0228T	Njx tfrml eprl w/us cer/thor
0230T	Njx tfrml eprl w/us lumb/sac
0295T	Ext ecg complete
0296T	Ext ecg recording
0297T	Ext ecg scan w/report
0298T	Ext ecg review and interp
0525T	Insj/rplcmt compl iims

Consultations

Added *telehealth to list of covered benefits.*

***Updated** in boldface type and **added** to the Benefit Coverage section below:*

- Help the member to decide on actions to maintain and improve dental health **by providing written treatment plans that address the member's dental requirements and needs to include alternative treatment options that better address the member's dental desires and treatment outcomes.**

NOTE: Modern dental treatment spans a board continuum from purely dental treatment (fillings, dentures, etc.) to major surgical procedures. In the event there is a question whether or not a specific procedure or treatment falls into the "dental" category or "medical" category, the DPA will be the final arbiter (the person who makes the final decision) on what category (dental or medical) the treatment best fits based on the information provided to the DPA from the attending dentist.

NOTE: *Evidence of Coverage, DHMO Benefit Guidelines,* and *Summary of Benefits* are not designed to cover ALL of the various specific Plan benefits, exclusions, limitations, medical-dental treatment rationale and restrictions. In the event there is a question if a particular dental treatment or service is a benefit, Blue Shield recommends the member instruct their dental provider to request a "pre-authorization" for any anticipated dental treatments from the DPA before beginning any course of expensive dental treatment.

***Updated** the Benefit Exclusions, General Exclusions section in boldface type below:*

- Dental treatment previously started under a Dental Plan other than Blue Shield prior to the Member's eligibility to receive benefits under this Plan (e.g., an unfinished crown or partially completed root canal, **incomplete dental implant services**, and etc.).
- Treatment from dentists outside the United States of America except when emergency services are necessary to **initially and immediately** medically stabilize the oral or dental structures due to accidental injury or trauma to the mouth and associated structures. Pre-accident or pre-trauma radiographs MUST be submitted for review when making a dental claim of this nature (there are no exceptions to this policy).
- Any self- administered, self-prescribed dental treatment, dental therapies, or oral treatments (drug store purchased "nightguards, teething medications, self-administered teeth bleaching kits, self-administered orthodontic appliances, snore guards, appliances for obstructive sleep apnea, dental restoration kits, medications prescribed by a medical doctor for a dental problem, etc.) **unless written prior approval has been obtained from the DPA.**
- **Any self-prescribed orthodontic treatment (orthodontic aligners that can be purchased from the Internet or a pharmacy) unless prior approval has been obtained from the DPA.**

***Deleted** the following from Benefit Exclusions:*

- Orthodontic consultations via the Internet, social media, telephone, cellphone, etc. (sometimes referred to as "tele-dentistry") in conjunction with non-doctor prescribed orthodontic aligners. This exclusion extends to the taking of and sending of photographs, x-rays, models and impressions, orthodontic and dental records via a mail delivery service in conjunction with non-doctor prescribed orthodontic aligners.

***Added** the following to the Benefit Limitations section:*

NOTE: Preparing asymptomatic teeth to support a dental prosthesis is not a benefit. For example, preparing two asymptomatic teeth for crowns to support a fixed dental bridge is not a benefit. In this example, the DPA will authorize a "pontic" to restore the empty space and the Member will be responsible for paying the cost of the two abutment crowns if a fixed bridge

solution is pursued. Alternatively, an appropriate partial denture to restore the empty tooth space will be approved.

Orthodontic Services: If a particular Dental Plan provides for "medically necessary" orthodontics, the Member must score "26" on the State of California HANDICAPPING LABIO-LINGUAL DEVIATION (HLD) INDEX CALIFORNIA MODIFICATION SCORE SHEET (DC016) or have an "automatically qualifying" condition (clinical documentation to include radiographs and photographs must be provided for review) to be eligible for orthodontic care.

***Updated** the Benefit Limitation in boldface type below:*

Waiting Period: A request to waive the mandatory "waiting period" for a bonified dental emergency and/or when there is acute, intractable (severe) dental or oral pain may be requested when the provider submits clinical information as to the nature of the dental or oral problem (clinical note written on office letterhead, radiographs, intra-oral photographs, etc.) and the reason why such a treatment waiver is justified. A member calling a "customer service representative" stating that they are "in pain," is insufficient clinical information to consider waiving the mandatory "waiting period" for a particular dental service. The treatment goal, when waiving the mandatory "waiting period" for a particular dental procedure, is the immediate relief of pain or to provide emergency dental services to medically or dentally stabilize an emergency condition; it is not necessarily to restore the dentition or to provide definitive treatment. **Requests to waive the waiting period for crowns, fillings, gum surgery, orthodontic care, and etc. will be denied**.

Dental – Blue Shield Smile Basic Dental Plan (DPPO)

***Updated** in boldface type and **added** to the Benefit Coverage section below:*

Principal Benefits and Coverages

NOTE: *Evidence of Coverage, DHMO Benefit Guidelines,* and *Summary of Benefits* are not designed to cover ALL the various specific Plan benefits, exclusions, limitations, medical-dental treatment rationale and restrictions. In the event there is a question if a particular dental treatment or service is a benefit, Blue Shield recommends the member instruct their dental provider to request a "pre-authorization" for any anticipated dental treatments from the DPA before beginning any course of expensive dental treatment.

NOTE: Modern dental treatment spans a board continuum from purely dental treatment (fillings, dentures, etc.) to major surgical procedures. In the event there is a question as to whether or not a specific procedure or treatment falls into the "dental" category or "medical" category, the DPA will be the final arbiter (the person who makes the final decision) on what category (dental or medical) the treatment best fits based on the information provided to the DPA from the attending dentist.

- X-rays:
    - X-rays required to diagnose a specific condition that needs treatment are not subject to limitations stated above. **Multiple x-rays of the same tooth (or teeth) taken on the same day or over a period of several days may be subject to frequency limitations.**
- Restorative Dentistry: Amalgam restorations and synthetic restorations (e.g., porcelain filling, plastic filling, and composite filling). Stainless steel crowns are used when the deciduous tooth cannot be restored with a direct filling material (stainless steel crowns, when properly prepared, are considered permanent restorations per the United States Department of Veterans Administration and subject to the 5 (five) year frequency limitations. **The use of "tooth-colored facings" on stainless steel crowns, prefabricated ceramic crowns, and resin**

crowns will be reimbursed at the equivalent rate for a stainless steel crown with no facings or coverings.

- Waiting Period: A request to waive the mandatory "waiting period" for a bonified dental emergency and/or when there is acute, intractable (SEVERE) dental or oral pain is available when the provider submits clinical information as to the nature of the dental or oral problem (clinical note written on office letterhead, radiographs, intra-oral photographs, etc.) and the reason why such a treatment WAIVER is justified. A member calling a "customer service representative" stating that they are "in pain," is INSUFFICENT clinical information to consider waiving the mandatory "waiting period" for a particular dental service. The treatment goal, when waiving the mandatory "waiting period" for a particular dental procedure, is the immediate relief of pain or to provide emergency dental services to medically or dentally stabilize an emergency condition; it is not necessarily to restore the dentition or to provide definitive treatment. **Generally requests to waive the waiting period for crowns, fillings, gum surgery, deep cleanings, orthodontic extractions of teeth, and etc. will be denied.**

Major Services:

- Cast Restorations: Cast or other laboratory prepared restorations and crowns are covered only when teeth cannot be restored with a direct filling material **(generally the tooth must be missing a cusp and have three sides of the tooth decayed or restored with a filling).** If the DPA determines a tooth can be restored with a direct filling material, the request for a cast restoration will be denied as not dentally necessary. Cast restorations consists of full cast metal crowns, inlays, veneers or onlays constructed of precious metal, dental casting metal, acrylic, composite-glass, porcelain, and porcelain-fused to metal **crowns**. Post-cores and crown build-ups are used on vital or non-vital teeth when functionally necessary to help to retain a crown. There is no coverage for replacement of an existing crown, inlay or onlay, or other cast restoration which is less than 5 years old and/or can be repaired. Repair or re-cementing on inlays, onlays and crowns is covered for 6 months after installation.

- **NOTE: Although an existing crown is eligible for replacement after 5 years, the replacement of the crown must be dentally necessary. If the DPA determines the existing crown is serviceable and the rationale for replacement of an existing crown is primarily for esthetic (cosmetic) reasons, the request to replace the crown will be denied.**

- NOTE: Preparing asymptomatic teeth to support a dental prosthesis is not a benefit. For example, preparing two asymptomatic teeth for crowns to support a fixed dental bridge is not a benefit. In this example, the DPA will authorize a "pontic" to restore the empty space **and the Member will be responsible for paying the cost of the two abutment crowns if a fixed bridge solution is pursued**. Alternatively an appropriate partial denture to restore the empty tooth space **will be approved**.

- Dental Implants: Depending on the Plan, dental implants may be a benefit; if a Plan authorizes implants as a benefit, strict adherence to Plan utilization management guidelines and criteria must be met **(pre-authorization is highly recommended)**. Restoration of an implant body not pre-approved or authorized by Blue Shield is not a benefit. If the DPA believes an implant will be used to support a denture or a fixed dental bridge, the implant will be denied.

- Orthodontic Services: If a particular Dental Plan provides for "medically necessary" orthodontics, the Member must score "26" on the State of California HANDICAPPING LABIO-LINGUAL DEVIATION (HLD) INDEX CALIFORNIA MODIFICATION SCORE SHEET (DC016) or have an "automatically qualifying" condition (clinical documentation to include radiographs and photographs must be provided for review) to be eligible for orthodontic care.

Copayment and Deductible Amounts

In general, the Blue Shield Smile Basic Dental Plan pays up to a maximum of $1000 per person each calendar year for covered services and supplies provided by participating dentists, and a maximum of $750 per person per calendar year for covered services and supplies provided by non-participating dentists. The maximum payment each calendar year for covered services and supplies by any combination of participating and non-participating dentists is $1000 per person. (This maximum is not applicable to Orthodontic Services if a benefit.). **The co-pays, deductibles and yearly maximum amounts may vary from Plan to Plan and calendar year. It is best to call the Blue Shield Customer Service center for further information**.

Diabetes Care

Updated *language in the Examples of Covered Services section.*

Durable Medical Equipment (DME)

Added *the following Benefit Exclusion:*

- Assisted Listening Devices

Added *to Exceptions language:*

NOTE: For oral appliances (mouthpieces) used to manage "obstructive sleep apnea (OSA)" and the symptoms of temporomandibular dysfunction (TMD), the provider must provide photographic documentation of the current (non-useable) appliance, written clinical documentation as to the reason(s) why the oral appliance is no longer functional, documentation the appliance is effective in managing the symptoms of the medical issue, and whether or not the Member was compliant in the use of the oral appliance.

Updated *language in the Examples of Covered and Non-Covered Services sections.*

Emergency Benefits

Added *the following language to the Benefit Exclusion section:*

Any dental treatment to restore the oral cavity following the initial, immediate, emergency, first aid care of teeth, gums, lips, tongue, bone ridge, and jaws as a result of an accident. Examples of emergency, initial and immediate first aid care to the mouth following an accident are: the removal of tooth-teeth fragments, the reduction of avulsed-loose teeth to prevent aspirations of foreign bodies into the lungs, the immediate temporary reduction of luxated teeth or tooth, to stabilize a fractured alveolus, to stabilize a fractured jaw, the immediate temporary stabilization of mobile teeth, the reduction of jaw displacement, the relieving pain/swelling, the suturing soft tissues to include the tongue and to stop bleeding. The services *of d*entists and oral surgeons (including hospitalization related to the services), are not a benefit of the **medical** plan. If a member has dental coverage, these services may be covered under the **dental** plan. Please refer to the benefits section of the *Evidence of Coverage* (EOC) for more information.

Updated *language in the Examples of Non-Covered Services section.*

Family Planning Counseling

Updated *language in the Examples of Covered Services section.*

Home Health Care (HHC) Services – CalPERS and Home Health Care (HHC) Services

Added/updated *language in Benefit Coverage in boldface type below:*

2. In conjunction with the professional services rendered by a home health care or home infusion agency, medical supplies, disposable medical supplies, **limited durable medical equipment required for medication delivery**, and medications administered by the home infusion agency necessary for the home health treatment plan are also a covered benefit. Benefits are also provided for infusion therapy provided in infusion suites associated with a Participating Home Health Care and Home Infusion agency.

6. Medically necessary FDA-approved self-injectable medications when prescribed by the Primary Care Physician **or Specialist** and prior authorized by Blue Shield. Self-injectable medications may be obtained from a Blue Shield participating Specialty Pharmacy under their outpatient prescription benefit. **Specialty drugs that require a clinician to monitor the patient during the administration of a drug or cannot be self-administered are covered under the medical benefit and can be obtained from a home infusion pharmacy for home administration or from the physician if the drug is being given in the office.**

Specialty Drugs are defined as specific drugs used to treat complex or chronic conditions that usually require close monitoring. Specialty Drugs may be self-administered by injection, inhalation, orally or topically. These drugs may also require special handing, special manufacturing processes, have limited prescribing or limited pharmacy availability. Specialty Drugs must be considered safe for self-administration by Blue Shield's Pharmacy & Therapeutics Committee, prior authorized for medical necessity by Blue Shield and obtained from a Blue Shield Specialty Pharmacy. Specialty Drugs are listed in the Blue Shield Outpatient Drug Formulary.

Updated *language in the Examples of Covered Services section.*

Hospice Care

Updated *Benefit Limitations in boldface type below:*

Members are allowed to change their participating hospice agency only once during each period of care. Members may receive care for 30/60/**90-day** period, depending on their diagnosis. The care continues through another period of care if the Primary Care Physician recertifies that the member is terminally ill.

Hospital Services – Inpatient Care

Added *the following to Benefit Exclusions:*

- Routine dental services.

Updated *language in the Examples of Covered and Non-Covered Services sections.*

Hospital Outpatient Care

Updated *language in the Examples of Non-Covered Services section.*

Infertility – Additional Benefits

*The definition of infertility has been **deleted and replaced** with the following:*

1. Demonstrated condition recognized by a licensed physician and surgeon as a cause for infertility.
2. The inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year of regular sexual relations without contraception.

Infertility – Basic Plan

***Renamed** the guideline to* **Infertility – Diagnosis and Treatment of the Cause** *and **updated** infertility definition as described above.*

***Updated** language in the Examples of Covered Services section.*

Maternity Care

***Updated** language in the Examples of Covered and Non-Covered Services sections.*

Mental Health and Substance Use Disorder

***Added** the following language to the Benefit Coverage section:*

HMO IPA/Medical Groups are responsible for decisions related to delegated medical services. As such, medical services for the treatment of gender dysphoria, eating disorder or substance use disorder are the responsibility of the IPA/Medical Group.

***Removed** from Benefit Coverage section the following list of services that require prior authorization by Blue Shield's MHSA:*

- Office-based Opioid Treatment – Substance use disorder maintenance therapy, including methadone maintenance treatment
- Psychological Testing to diagnose a Mental Health Condition

***Added** to Benefit Coverage section the following services requiring prior authorization by Blue Shield's MHSA:*

- Neuropsychological Testing – testing used to measure a psychological function known to be linked to a particular brain structure or pathway. Neuropsychological testing should be considered for coverage through the patient's mental health benefit when:
  - After completion of a comprehensive Behavioral Health evaluation and neurological evaluation, if the Behavioral Health provider or neurologist determines the neuropsychological testing is required, the provider will request authorization and coordinate the request. Blue Shield MHSA will cover Neuropsychological testing when the purpose of testing is to clarify whether there is a psychiatric diagnosis (even when medical conditions are present).

***Added** language in Benefit Limitations section.*

- Neuropsychological testing should be considered for coverage through the patient's medical benefit when:
  - After completion of a comprehensive Behavioral Health evaluation and neurological evaluation, if the Behavioral Health provider or neurologist determines the

neuropsychological testing is required, the provider will request authorization and coordinate the request. Blue Shield MHSA will cover Neuropsychological testing when the purpose of testing is to clarify whether there is a psychiatric diagnosis (even when medical conditions are present).

Out of Area Services

Updated *language in the Examples of Covered and Non-Covered Services sections.*

Physician Services

Updated *language to Outpatient Services in boldface type below.*

Professional office visits for examination, diagnosis, and treatment of a medical condition, disease, or injury including specialist office visits, consultations, **counseling, education, urgent care visits, second medical opinions**, diabetic counseling, asthma self-management training, **administration of injectable medications**, office surgery, outpatient chemotherapy, and radiation therapy are covered. This benefit includes services delivered via telehealth.

Updated *language to Inpatient Services in boldface type below.*

Physician services in a hospital, **residential treatment center, emergency room**, or skilled nursing facility for examination, diagnosis, treatment, and consultation including the services of a specialist, surgeon, assistant surgeon, anesthesiologist, pathologist, and radiologist are covered when the inpatient stay has been authorized by the Blue Shield HMO. Physician services must either be provided by, or referred by, the member's Primary Care Physician (PCP), including services for members who are admitted for detoxification

Added *to language in Benefit Exclusion section.*

- Includes dental and oral surgery services of any kind

Preventive Health Services Grandfathered Plans

This guideline has been ***removed.*** *Please refer to Provider Connection at blueshieldca.com/provider under* Guidelines & resources*, then* Preventive Health Guidelines*.*

Prosthesis

Added *the following language to Benefit Exclusions:*

- Lost or broken: Dentures (full or partial), orthodontic retainers, removable orthodontic aligners, Obstructive Sleep Apnea oral appliances, TMJ appliances, and oral obturators.
- Dentures (full or partial), orthodontic retainers, removable orthodontic aligners, Obstructive Sleep Apnea oral appliances, TMJ appliances, radiation shields used to cover the jaws and face, oral medicament carriers, and oral obturators.

Updated *language in the Examples of Covered and Non-Covered Services sections.*

Renal Dialysis

Renamed *the guideline to* **Dialysis Benefits**. ***Added*** *the following to the Benefit Exclusion section:*

- Comfort, convenience, or luxury equipment
- Non-medical items, such as, generators or accessories to make home dialysis equipment portable.

Updated *language in the Examples of Non-Covered Services section.*

Skilled Nursing Facility

Added *the following language to the Benefit Exclusions section:*

- Lost dental appliances, routine dental services, oral surgery services (for example extractions of teeth), dental cleanings, broken dental appliances, and any dental palliative treatments.
- Any and dental services provided by itinerant dentists and dental hygienists who visit the SNF on an "on-call" basis or have a regular schedule in the SNF.

Teeth, Jaw and Jawbones

Updated *language to the Benefit Coverage section in boldface type below:*

- NOTE: Surgical removal of lesions in the soft and hard tissues of the mouth as a direct or indirect result of **poor oral hygiene**, dental caries, teeth, or pulpal necrosis (e.g., "periapical lesions," **dental** cysts, **dental** abscesses, **gum abscesses**,) are not a benefit under this Plan. Pathology reports **and biopsies of tissues from the mouth by** "dental pathologists" for non-malignant, **malignant**, or pre-malignant lesions are not a benefit of this medical plan as these are covered under a member's dental plan.
- Emergency palliative treatment or damage to the natural teeth and adjacent structures caused **directly** (solely) by an accidental injury or **trauma to the mouth.**
- NOTE: The goal and definition of "emergency palliative" is the immediate treatment to dentally or medically stabilize the teeth or oral structures and/or to manage or treat acute, intractable (severe) oral pain; it is not necessarily the definitive restoration of teeth or oral structures. This benefit does not include services for damage to the natural teeth that are/is not accidental (for example resulting from chewing or biting). Covered services are limited to the immediate, medically necessary services for the initial, palliative medical stabilization ("first aid") of the member' teeth and associated oral structures **to prevent a more serious medical condition from occurring**. Submission of pre- and post-accident radiographs of the site will be required when requesting services. For additional information, see the *HMO Benefit Guideline* for *Accidental Injury to Natural Teeth-Basic Plan*.
- Medically necessary, non-surgical, treatment of Temporomandibular Joint Syndrome (TMJ or TMD) dysfunction (for example splint and physical therapy). The treatment is a benefit when clinical evidence is provided showing there is **definitive** pathology/disease to the TMJ articulating disk, **condyles, and fossa** and not just secondary pain or discomfort ("soreness" or "tenderness") to the joint or the myo-facial tissues surrounding the joint from bruxism or clenching of the teeth (the mere presence of **jaw joint** "clicking," **pain to the muscles of mastication, pain-tenderness to the area of the jaw joints, clenching, nocturnal teeth grinding, limited jaw opening, pain to the face, headaches, neck aches**, is, in-of-itself, not sufficient clinical documentation to arrive at a diagnosis of "TMJ" pathology or disease). The

Provider must provide **unambiguous** clinical documentation, **to include x-rays showing the condition of the teeth and the TMJ joint complex**, distinguishing actual pathology/disease to the jaw joint articulating disk (**for example arthritis, displacement of the articulate disc, changes to the morphology of the jaw condyles, etc**.) versus pain/discomfort secondary to parafunctional oral habits.

Added *the following language to the Benefit Coverage section.*

- NOTE: When a TMJ/TMD appliance is medically necessary to address a jaw joint problem, only one oral appliance is needed to manage the TMJ discomfort because the vast majority of TMJ problems occur at night while the patient is sleeping. If desired, the approved TMJ appliance can also be worn during the day as well. If the TMJ appliance gets in the way when speaking during the day, simply remove the appliance and put it back in your mouth when you are done speaking. The need for a "daytime" TMJ appliance is therefore not needed.

- NOTE: A "flat plane" TMJ oral appliance to "maintain" the jaw condyles in a specific location in the TMJ joint space (fossa) AFTER the acute TMJ pain subsides is essentially an oral appliance used to separate the teeth to minimize the effects from clenching or grinding (usually at night) and viewed as a dental appliance and not a benefit of the medical Plan. In the event the TMJ returns, simply put the TMJ appliance back in the mouth and wear it until the TMJ pain subsides. The current literature suggests that wearing an oral appliance AFTER the TMJ discomfort resolves for long periods of time is not recommended as it can lead to changes to the bite (occlusion).

Updated *the following documentation the dentist must submit for review to Blue Shield for an oral appliance:*

- A report on the periodontal condition of the member **to include the submission of a current periodontal pocket depth charting of the dentition and submission of current full mouth radiographs when requested.**

- A report on the temporomandibular joint (TMJ) of the member. **The member must be FREE of any TMJ symptoms BEFORE an oral appliance is provided not AFTER an oral appliance is provided. Upon request, the provider must provide radiographs of the jaw joints for review. For the purpose of this *HMO Benefit Guidelines*, bruxism and clenching causing discomfort to the jaw joints fall under this TMJ criteria.**

- Completion of the Oral Appliance Therapy Worksheet form. The form must be signed by the attending dentist who certifies the information provided to Blue Shield is TRUE.

  NOTE: Replacement of oral Appliances for TMJ and Obstructive Sleep Apnea (OSA): Generally, replacement of an oral appliance, whether for OSA or TMJ is not a benefit of the Medical Plan during the warranty period of the appliance (generally 5 calendar years after initial delivery of the appliance). After the warranty period, the provider must submit photographs of the appliance, a letter of medical necessity explaining WHY the appliance is no longer useable for review. For OSA, the provider must also provide documentation of the Member's compliance with the oral appliance, a new sleep study if the previous sleep study is older than 5 years old, the current status of the periodontium and status of the TMJ, a sleep study showing the oral appliance is effective in managing the Member's OSA symptoms.

Updated/added *the following language in the Benefit Coverage section regarding Orthognathic surgery:*

- Orthognathic surgery (surgery to reposition the upper and/or lower jaw) which is medically necessary to correct skeletal deformity **and function and not for cosmetic reasons or to**

"balance" the appearance of the face with the jaws (e.g., chin surgery). Refer to the Blue Shield Medical Policy on *Orthognathic Surgery* on necessary documentation when requesting services.

- NOTE: Surgery for the management of "Obstructive Sleep Apnea" (OSA) is a benefit of the medical Plan. The criteria to qualify for surgical correction of OSA requires documentation the Member attempted to use and failed Continuous Positive Airway Pressure (CPAP) therapy to manage their OSA symptoms (or the member refused CPAP) AND also attempted to use and failed a custom-made oral appliance to manage their OSA. The Member cannot simply refuse CPAP AND an oral appliance to qualify for surgery for OSA. Unacceptable medical documentation an oral appliance failed to manage symptoms of OSA include the following: 1) Movement of teeth by the oral appliance, 2) jaw joints are "sore" after using the oral appliance, 3) the Member unconsciously removes the oral appliance during the night, 4) the member drools excessive amounts of saliva during the night, 5) the Member's teeth hurt when using an oral appliance, 6) the oral appliance failed to control snoring.

Expanded *the list of Benefit Exclusions.*

Updated *language in the Examples of Covered and Non-Covered Services sections.*

Urgent Care

Added *the following language to the Benefit Exclusion section:*

- Any dental services and treatments except the initial, emergency, palliative first aid care to medically stabilize the mouth, jaws, teeth, soft tissues of the mouth immediately following an accident. Dental treatment at an Urgent Care facility for toothaches, gum bleeding, gum pain/infections, chipped teeth, orthodontic problems, mouth swelling due to a dental problem are not a benefit at an Urgent Care facility.