

The clinical criteria outlined is generalized. Services described may not be covered for a particular plan type. In addition, there may be additional plan specific criteria regarding treatment. Therefore, it is essential dental providers review the Benefits Covered Section of the Office Reference Manual (ORM) before providing any treatment.

## OVERVIEW

The criteria outlined is based on procedure codes as defined in the American Dental Association's Code Manuals<sup>1</sup>. Documentation requests for information regarding treatment using these codes are determined by generally accepted dental standards for review, such as radiographs, periodontal charting, treatment plans, or descriptive narratives. In some instances, the State legislature will define the requirements for dental procedures.

These criteria were formulated from information gathered from practicing dentists, dental schools, ADA clinical articles and guidelines, insurance companies, as well as other dental related organizations. These criteria and policies must meet and satisfy specific State and Health Plan requirements as well. They are designed as guidelines for review and payment decisions and are not intended to be all-inclusive or absolute.

It is also recognized that "local community standards of care" may vary from region to region and incorporate generally accepted criteria that will be consistent with both the concept of local community standards and the current ADA concept of national community standards.

Prior authorization and post-service review prior to payment are common methods of ensuring medical necessity for payment. Prior Authorization and post-service review are more effective than pay-and-chase processes and preferable to recoupment.

Clinical review (prior authorization or post-service) is necessary for oral and maxillofacial surgery to protect the program and members by confirming the necessity, prognosis, and appropriateness of the procedure. There is an increased potential for abuse for oral and maxillofacial surgery services due to lack of medical necessity or improper coding. Oral and maxillofacial surgery services are commonly reviewed by other Medicaid dental insurance programs for necessity/adherence to clinical criteria.

This policy ensures services are medically necessary, clinically appropriate, and consistent with evidence-based standards while preventing unbundling, overutilization, and misuse of surgical dental codes.

## COVERAGE POLICY

Not all procedures require review.

Documentation needed for review procedure:

- Appropriate radiographs showing clearly the adjacent teeth should be submitted for review: bitewings, periapicals or panorex.
- Treatment rendered under emergency conditions, when review is not possible, will still require that appropriate radiographs showing clearly the adjacent and opposing teeth be submitted with the claim for review for payment.
- Narrative demonstrating medical necessity.

### Criteria

The prophylactic removal of asymptomatic teeth (i.e. third molars) or teeth exhibiting no overt clinical pathology (except for orthodontics) is not a covered service. SKYGEN will not reimburse for any surgical extraction of third molars that are asymptomatic, do not exhibit any evidence of pathology, or were extracted for prophylactic

**Molina Clinical Policy**  
**Criteria for Oral and Maxillofacial**  
**Surgery**  
**Policy No. 16.01**



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reasons only.

1. GP, pedo or ortho determines patient may need 3rd molars extracted - no referral is necessary
  - a. Can refer patient directly to SKYGEN oral surgeon.
  - b. Provider or member can call SKYGEN – (800) 578-0603. SKYGEN will assist member in finding an oral surgeon.
  
2. Oral Surgeon - Submission of treatment for approval
  - a. Non-emergency
    - i. Pre-payment review – performs treatment and submits documentation with claim – no guarantee provider will get paid for service – procedure must meet medical necessity guidelines for SKYGEN to pay.
    - ii. Prior authorization – submit documentation prior to performing treatment. If SKYGEN approves, provider is guaranteed payment as long as patient is eligible on date of service.
  - b. Emergency (treatment necessary within 24 hours) – if want prior approval - send request. through the [SKYGEN](#) portal. Requests must still include documentation when required.

**Documentation of medical necessity for oral surgery - evidence of Microsoft Teams**

3. diagnosed pathology or demonstrable need (including ortho), rather than anticipated future pathology.
  - a. Pathology
    - i. Provider must submit narrative and x-rays or photos describing pathology
    - ii. Each tooth must show pathology
    - iii. Symptomology or impactions without pathology may not be enough
  - b. Demonstrable need
    - i. Narrative describing need
    - ii. Supporting documentation (e.g. x-rays, photos, hospital admissions, etc.)
  - c. Extractions in conjunction with approved orthodontic treatment
    - i. Provider must submit request for extractions from orthodontist
    - ii. Needs to be an approved orthodontic case
    - iii. To expedite process, provider may also want to submit orthodontic approval
  
4. General Approval vs. Denial Guidelines
  - a. Probable Approval
    - i. Pathology =
      1. Non-restorable Decay
      2. Tooth erupting on an angle and impinging on 2nd molars
      3. Recurrent Pericoronitis
      4. Dentigerous Cyst or other growth
      5. Internal or External Root Resorption
      6. 3rd molar has over-erupted due to lack of opposing tooth contact
    - ii. Demonstrable need =
      1. **In conjunction with approved orthodontics** where orthodontist requests the 3rd molars be removed to guarantee the success of the orthodontic case (provide referral from ortho and prior auth approval of ortho if possible)
      2. **Pain with no pathology** – On a per tooth basis, provider must furnish a narrative that describes pain that is more than normal eruption pain – for example: a description of duration, intensity, medications, or other factors that are more than normal eruption pain – the description of such factors is necessary to demonstrate need

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- b. Probable Denial
  - i. Impaction or Symptomology =
    - 1. Impaction with no other pathology
    - 2. Pain or discomfort with unknown pathology
  - ii. Other 3rd molars have pathology (if one, two, or three teeth show pathology, SKYGEN will not automatically approve the extraction of the remaining non-pathologic teeth)
- 5. Denials
  - a. If administrative denial (e.g. lack of documentation) - Resubmit according to deficiencies noted in EOB
  - b. If clinical denial:
    - i. Resubmit with documentation showing additional clinical evidence for extraction
    - ii. Advise members that the service is not covered
      - 1. Member can appeal following appeal process in member handbook
      - 2. Provider and member may work out an out-of-pocket arrangement – Member must sign consent for financial responsibility

The removal of primary teeth whose exfoliation is imminent does not meet criteria. Reimbursement includes local anesthesia and routine postoperative care. Any reimbursement already made for inadequate service may be recouped after the circumstances are reviewed.

**CODING & BILLING INFORMATION**

**CDT (Current Dental Terminology) Codes**

Code	Description	Authorization Required	Frequency Limitations
D7220	removal of impacted tooth-soft tissue	Prior Auth or Post-Service	One per Lifetime Per Patient Same tooth.
D7230	removal of impacted tooth-partially bony	Prior Auth or Post-Service	
D7240	removal of impacted tooth-completely bony	Prior Auth or Post-Service	
D7241	removal of impacted tooth-completely bony, with unusual surgical complications	Prior Auth or Post-Service	
D7283	placement of device to facilitate eruption of impacted tooth	Prior Auth or Post-Service	
D7280	Surgical access of an unerupted tooth	Prior Auth or Post-Service	
D7880	occlusal orthotic device, by report	Prior Auth	One of (D7880) per Lifetime Per patient.

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**APPROVAL HISTORY**

- 04/02/2025 Policy reviewed and approved.
- 05/23/2025 Updated policy reviewed and approved.
- 04/13/2026 Updated policy reviewed and approved.

**REFERENCES**

- 1. American Dental Association's Code Manuals (<https://www.ada.org/publications/cdt>)