Harvard Pilgrim Health Care | TUFTS Health Plan

Medical Necessity Guidelines:

Clinical Review of Dental Services in Medical Benefit

Effective: September 15, 2023

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request to the FAX numbers below	Yes ☒ No ☐
Notification Required IF REQUIRED, concurrent review may apply	Yes ☐ No ☒

Applies to:

Commercial Products

☒ Harvard Pilgrim Health Care Commercial products; 800-232-0816

☐ Tufts Health Plan Commercial products; 617-972-9409

CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

Public Plans Products

☐ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); 888-415-9055

☐ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; 888-415-9055

☐ Tufts Health RITogether – A Rhode Island Medicaid Plan; 857-304-6404

☐ Tufts Health Unify* – OneCare Plan (a dual-eligible product); 857-304-6304

*The MNG applies to Tufts Health Unify members unless a less restrictive LCD or NCD exists.

Senior Products

☐ Harvard Pilgrim Health Care Stride Medicare Advantage; 866-874-0857

☐ Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product); 617-673-0965

☐ Tufts Medicare Preferred HMO, (a Medicare Advantage product); 617-673-0965

☐ Tufts Medicare Preferred PPO, (a Medicare Advantage product); 617-673-0965

Note: While you may not be the provider responsible for obtaining prior authorization or notifying Point32Health, as a condition of payment you will need to ensure that any necessary prior authorization has been obtained and/or Point32Health has received proper notification. If notification is required, providers may additionally be required to provide updated clinical information to qualify for continued service.

Note: Denials as a result of clinical review of dental services in medical benefit are considered benefit denials

Overview

Adult and pediatric dental and oral surgery services includes emergency dental care, extractions, periodontal surgery, inpatient hospital and surgical day care services, preventive services and surgical treatment of certain mouth/jaw injury or disease based on certain indications.

Clinical Guideline Coverage Criteria

The Plan considers surgical extraction of bony impacted teeth as reasonable and medically necessary and are indicated for **ONE** of the following:

1. Facilitate the management or limit progression of periodontal disease; **or**
2. Ectopic position; **or**
3. Is adjacent to a maxillary sinus at risk of persistent oro-antral fistula; **or**
4. Facilitate prosthetic rehabilitation; **or**

5. Facilitate orthodontic tooth movement and promote dental stability; **or**
6. Tooth interfering with orthognathic and/or reconstructive surgery; **or**
7. Fractured tooth; **or**
8. Removal risks fracture of the mandible; **or**
9. Is adjacent to a neuro-vascular bundle; **or**
10. Non-restorable caries; **or**
11. Internal or external resorption of tooth or adjacent teeth; **or**
12. Tooth involved in tumor resection; **or**
13. Prophylactic removal in patients with certain medical or surgical conditions or treatments (e.g., organ transplants, alloplastic implants, chemotherapy, radiation therapy) ; **or**
14. Non-treatable pulpal lesion; **or**
15. Acute or chronic infection (e.g., cellulitis, abscess) ; **or**
16. Findings of periodontal disease; **or**
17. Findings of periapical pathology; **or**
18. Elective therapeutic removal; **or**
19. Tooth in the line of a jaw fracture complicating fracture management; **or**
20. Pathology associated with tooth follicle (e.g., cysts, tumors) ; **or**
21. Facilitate management in trauma, orthognathic or reconstructive surgery; **or**
22. Insufficient space to accommodate erupting tooth or teeth; **or**
23. Orthodontic abnormalities (e.g., arch length/tooth size discrepancies

Emergency Dental Care

The Plan considers dental services resulting from an accidental injury to sound natural teeth and gums as reasonable and medically necessary when documentation confirms member has received a course of treatment for the accidental injury within three months of the date of injury.

Note: Refer to Schedule of Benefits or Benefit Handbook for state-specific month limits on emergency dental services.

Note: Necessary treatment due to injury to the jaw and oral structures other than teeth are covered without time limit.

Anesthesia and Facility Coverage

The Plan considers the use of general anesthesia and monitored anesthesia care (MAC), including facility charges, as reasonable and medically necessary when **ONE** of the following are met:

1. Member is categorized as certain American Society of Anesthesiologists (ASA) III - individual with severe systemic disease (individual case consideration); **or**
2. Member is categorized as ASA IV (individual with severe systemic disease that is a constant threat to life) severe systemic requiring removal of pathologic wisdom tooth, or multiple pathologic teeth (e.g. caries, periodontal disease, cystic involvement) ; **or**
3. Developmental disability/exceptional medical circumstances; **or**
4. Member is pregnant; **or**
5. Increased risk for airway obstruction due to anatomic variation, such as:
    a. History of stridor
    b. Dysmorphic facial features
    c. Oral abnormalities (e.g., macroglossia)
    d. Neck abnormalities (e.g., neck mass)
    e. Jaw abnormalities (e.g., micrognathia), OR
6. Member has **ONE** of the following:
    a. History of adverse reaction to sedation; **or**
    b. History of inadequate response to sedation; **or**
    c. Obstructive sleep apnea; **or**
    d. Morbid obesity (e.g., BMI >40) ; **or**
    e. Active or history of alcohol or substance abuse
7. For children enrolled in a New Hampshire plan, HPHC considers general anesthesia or MAC as reasonable and

medically necessary when **ALL** the following are met:

a. Child is 13 years old or younger; **and**
b. Primary Care Provider (PCP)/Attending provider confirms through documentation that member has ANY of the following:
    i. Complex dental condition; **or**
    ii. Developmental disability; **or**
    iii. Exceptional medical circumstance(s)

NOTE: Clinical notes must clearly describe the member's condition or exceptional medical circumstances, and how/why the member's condition or circumstance inhibits the safe delivery of care in an office setting.

The Plan considers general anesthesia or monitored anesthesia care (MAC) as reasonable and medically necessary when **ONE** of the following are met:

1. Member with functional or behavioral impairment when documentation confirms the member has an impairment due to a medical or behavioral condition (e.g. autism, developmental delay) manifesting as severe oppositional and uncooperative behavior and **ONE** of the following:
    a. Rampant decay, or dental needs of high complexity; **or**
    b. History of two or more unsuccessful attempts to treat in the office setting and documentation includes an evaluation by an oral maxillofacial surgeon (OMFS) or dentist who is certified in office based procedural sedation and analgesia; **or**
    c. The Primary Care Physician (PCP) or attending practitioner clearly describes how/why the member's functional or behavioral impairment inhibits the safe delivery of care in an office setting considering the level of dental needs.
2. Member with extreme apprehension and anxiety when documentation confirms **ALL** the following:
    a. Member with rampant decay and/or highly complex dental needs has extreme apprehension and anxiety manifesting as significant oppositional and uncooperative behavior during treatment; **and**
    b. History of at least two unsuccessful attempts to treat in the office setting, including an evaluation by an OMFS or dentist who is certified in office based procedural sedation and analgesia; **and**
    c. The PCP or attending practitioner clearly describes why the member's functional or behavioral impairment inhibits the safe delivery of care in an office setting.
3. Member with coexisting medical condition, comorbidity, or physical disability when documentation confirms ALL the following:
    a. Member has **ONE** of the following conditions that might inhibit the safe delivery of care in an office setting:
        i. Medical condition(s) resulting in American Society of Anesthesiology (ASA) physical status classification Class III or higher; **or**
        ii. Pulmonary function measurement of FEV1 < 60% of predicted; **or**
        iii. Moderate to severe asthma that is poorly controlled; **or**
        iv. Acute cardiac disease, current angina, or class III or IV congestive heart failure (CHF) ; **or**
        v. Moderate to severe aortic stenosis, or symptomatic mitral stenosis; **or**
        vi. Myocardial Infarction (MI) within past six months; **or**
        vii. Poorly controlled hypertension; **or**
        viii. Poorly controlled diabetes, or diabetes with vascular complications; **or**
        ix. Morbid Obesity (BMI > 40) ; **or**
        x. Bleeding disorder that cannot be improved sufficiently to safely perform the procedure in an office setting; **or**
        xi. Uncontrolled seizures; **or**
        xii. Potential for difficult airway management (i.e., history of difficult intubation, neuromuscular disease, significant cervical spinal disease, deformities of the mouth or jaw impeding airway) ; **or**
        xiii. History of adverse reaction to anesthesia or sedation; Other medical conditions felt to inhibit the safe delivery of care in an office setting
    b. Member has dental needs, and treatment cannot be safely delayed in order to try to stabilize the member's medical condition; **or**
    c. Primary care provider (PCP) or appropriate specialist consultant clearly documents why the dental procedure cannot be safely and effectively performed in an office setting.

NOTE: This medical policy does not address coverage under the dental benefit. However, associated charges, such as

general and MAC anesthesia, may be covered on individual consideration if above criteria are met.

NOTE: When a child is enrolled in a New Hampshire plan, HPHC considers inpatient hospital or Surgical Day Care (SDC) facility charges and administration of general anesthesia as medically necessary for children under the age of 13 with a dental condition of significant dental complexity, exceptional medical circumstances or a developmental disability.

Cleft Lip/Cleft Palate Procedures

The Plan considers the treatment of cleft lip and cleft palate for children under the age of 18 as reasonable and medically necessary for **ONE** of the following:

1. Medical, dental, oral and facial surgery, including surgery performed by oral and plastic surgeons and surgical management and follow-up care related to such surgery, **or**
2. Orthodontic treatment, **or**
3. Preventative and restorative dentistry to ensure good health and adequate dental structures to support orthodontic treatment or prosthetic management therapy, **or**
4. Speech therapy, **or**
5. Audiology services, **or**
6. Nutrition services

Pediatric Oral Health Services

Under the Affordable Care Act (ACA), The Plan considers the following pediatric oral health services as medically necessary:

1. Exams, cleanings, fluoride, sealants, X-rays

Periodontal Surgery

The Plan considers periodontal surgery for drug-induced gingival hyperplasia as reasonable and medically necessary when documentation confirms the presence of drug-induced gingival hyperplasia with **ONE** of the following:

1. Pocket depths > 5mm,
2. Difficulty with hygiene due to orthodontic brackets impinging on the gingiva,
3. A medication history including dosages of relevant drugs (e.g., Dilantin, Calcium Channel Blockers).

NOTE: Required documentation must represent the member's current pre-operative condition and must include medication history including dosages or relevant drugs (e.g., Dilantin, Calcium channel blockers), periodontal charting, and photographs

Members with Serious Medical Conditions

Medical/Surgical Care for Osteonecrosis or Osteoradionecrosis

The Plan considers medical/surgical care for osteonecrosis or osteoradionecrosis of the jaw as reasonable and medically necessary when documentation confirms the presence of **EITHER** of the following:

1. Osteonecrosis of the jaw secondary due to **ONE** of the following:
    a. Chemotherapy
    b. Bone marrow or solid organ transplant
    c. HIV immunodeficiency
    d. IV bisphosphonate therapy, or
2. Osteoradionecrosis due to either head and neck, or mantle field radiation.

NOTE: Required documentation must represent the member's current pre-operative condition and must include narrative description of relevant clinical findings, x-rays and/or CT scan reports, and photographs demonstrating bone involvement (when applicable).

Tooth extraction

The Plan considers tooth extraction as reasonable and medically necessary when documentation confirms **ONE** of the following:

1. Member is pre-or post-head and neck/mantle field radiation therapy, pre-chemotherapy, **or**
2. Member is pre-bone marrow or solid organ transplant, **or**
3. Member has severe immunodeficiency (e.g., post organ transplant, peri-chemotherapy), **or**

4. Member has osteonecrosis of the jaw related to chemotherapy, bone marrow or solid organ transplant, HIV immunodeficiency, or IV bisphosphonate therapy, **or**
5. Member has osteoradionecrosis due to head and neck, or mantle field radiation.

NOTE: Required documentation must represent the member's current pre-operative condition and must include narrative description of relevant clinical findings, x-rays and/or Computed tomography (CT) scan reports, and photographs demonstrating bone involvement (when applicable).

Limitations

The Plan considers all other dental services as a benefit contract exclusion. In addition, The Plan does not cover:

1. Alveoloplasty and/or alveolectomy, for preparation of dentures or bridges, except as described above
2. Cosmetic tooth implants
3. Apicoectomy
4. Bone grafting in conjunction with preparation for dental implants and/or dentures
5. Brush biopsy – transepithelial sample collection
6. Charges for restorative dental care or non-covered oral surgery when anesthesia and/or hospital care is authorized for members with special needs
7. Dental treatment/consultation for temporomandibular joint disorders (TMD/TMJ)
8. Endodontic care (i.e., root canals)
9. Extraction of impacted teeth to prepare for or support orthodontic, prosthodontic, or periodontal procedures (except for cleft palate repair)
10. Extraction of non-impacted teeth, except for high-risk members with serious immunodeficiency due to medical conditions (i.e., AIDS, human organ transplant, chemotherapy) or osteoradionecrosis due to head or neck radiation
11. Cosmetic genioplasty
12. Hospital or other ancillary costs associated with non-covered services
13. Cosmetic labial frenectomies
14. Operculectomy
15. Oral surgery services
16. General periodontal care, except as described above
17. All services of a dentist for temporomandibular joint dysfunction (TMD/TMJ)

Codes

The following code(s) require prior authorization:

Table 1: CPT/HCPCS Codes

Code	Description
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated
D7230	Removal of impacted tooth - partially bony
D7240	Removal of impacted tooth - complete bony
D7241	Removal of impacted tooth - complete bony, with unusual surgical complications
D7292	Surgical Placement of Temporary Anchorage Device (Screw Retained Plate) Requiring Flap; Includes Device Removal
D7293	Surgical Placement of Temporary Anchorage Device Requiring Flap; Includes Device Removal
D7294	Surgical Placement of Temporary Anchorage Device Without Flap; Includes Device Removal
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant
D7340	Vestibuloplasty ridge extension (secondary epithelization)
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)
D7850	Surgical discectomy, with/without implant
D7860	Arthrotomy - Cutting into joint (separate procedure)
D7865	Arthroplasty - Reduction of osseous components of the joint to create a pseudarthrosis or eliminate

Code	Description
	an irregular remodeling pattern (osteophytes)
D7871	Non-arthroscopic lysis and lavage
D7872	Arthroscopy- diagnosis, with or without biopsy
D7873	Arthroscopy- surgical lavage and lysis of adhesions - Removal of adhesions using the arthroscope and lavage of the joint cavities
D7874	Arthroscopy - surgical disc repositioning and stabilization - Repositioning and stabilization of disc using arthroscopic techniques
D7875	Arthroscopy - surgical: synovectomy - Removal of inflamed and hyperplastic synovium (partial/complete) via an arthroscopic technique
D7876	Arthroscopy - surgical: discectomy - Removal of disc and remodeled posterior attachment via the arthroscope
D7877	Arthroscopy - surgical: debridement - Removal of pathologic hard and/or soft tissue using the arthroscope

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Approval And Revision History

November 24, 2020: Reviewed by the Medical Policy Clinical Committee; renewed without changes

Subsequent endorsement date(s) and changes made:

- February 16, 2021: Review by Medical Policy Clinical Committee; coding updated
- December 21, 2022: Reviewed by Medical Policy Approval Committee; renewed without changes
- June 21, 2023: Reviewed by MPAC; renewed without changes

Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven

effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.