Harvard Pilgrim Health Care | TUFTS Health Plan

Point32Health companies

Medical Necessity Guidelines:

Clinical Review of Dental Services in Medical Benefit

Effective: October 1, 2026

Prior Authorization Required If REQUIRED, submit supporting clinical documentation (electronically recommended or by fax)	Yes ☒ No ☐
Notification Required	Yes ☐ No ☒

Applies to:

- Harvard Pilgrim Health Care Commercial products

We recommend submitting prior authorization electronically. If you opt to submit prior authorization requests via fax, please refer to this reference chart for the appropriate fax number (varies by product).
For details on all our products, please visit the Our Plans page on our provider website. For additional Prior Authorization and Notification details on other lines of business not listed on our Medical Necessity Guidelines page, please also reference our Prior Authorization Resources page.

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 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. Emergency care is defined as care provided in an ER, urgent care facility, or dental office to stabilize emergent issues.

Note:

- Refer to Schedule of Benefits or Benefit Handbook for state-specific month limits on emergency dental services.
- Necessary treatment due to injury to the jaw and oral structures other than teeth are covered without time limit.

Anesthesia and Facility Coverage

Anesthesia and associated facility charges are considered not medically necessary if the primary procedure is not covered by the Plan for Massachusetts and Rhode Island Products. Please refer to the member materials for coverage details.

The Plan considers the use of general anesthesia and monitored anesthesia care (MAC), including facility charges, as reasonable and medically necessary for surgical procedures of high complexity or increased risk of patient injury, complication, or adverse outcomes when **BOTH** of the following are met:

1. The general dentist, pediatric dentist, or oral surgeon has documented the Member's condition cannot be safely performed in a traditional dental office setting and treatment requires immediate access to hospital services; **and**
2. Medical record documentation supports **ONE** of the following indications:
    a. Member with coexisting medical condition, comorbidity, or physical disability, **ONE**:
        i. Member is categorized as certain American Society of Anesthesiologists (ASA) III[1] - individual with severe systemic disease (individual case consideration); **or**
        ii. Member is categorized as ASA IV[1] (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**
        iii. Developmental disability/exceptional medical circumstances; **or**
        iv. Pulmonary function measurement of FEV1 < 60% of predicted; **or**
        v. Moderate to severe asthma that is poorly controlled; **or**
        vi. Obstructive sleep apnea; **or**
        vii. Acute cardiac disease, current angina, or class III or IV congestive heart failure (CHF); **or**
        viii. Moderate to severe aortic stenosis, or symptomatic mitral stenosis; **or**
        ix. Myocardial Infarction (MI) within past six months; **or**
        x. Poorly controlled hypertension; **or**
        xi. Poorly controlled diabetes, or diabetes with vascular complications; **or**
        xii. Morbid Obesity (BMI > 40); **or**
        xiii. Bleeding disorder that cannot be improved sufficiently to safely perform the procedure in an office setting; **or**
        xiv. History of malignant hyperthermia; **or**
        xv. Infection that compromises nutrition or hydration (e.g., severe herpetic stomatitis in young children) or infection that involves secondary soft tissue planes that drain or traverse areas of the throat or skull (e.g., retropharyngeal or infratemporal abscesses); **or**
        xvi. Uncontrolled seizures; **or**
        xvii. Potential for difficult airway management or increased risk for airway obstruction due to anatomic

variation, **ONE**:

1. Dysmorphic facial features; **or**
2. History of stridor; **or**
3. History of difficult intubation; **or**
4. Neuromuscular disease; **or**
5. Oral, Jaw, or neck abnormalities (e.g., macroglossia, neck mass, micrognathia); **or**
6. Significant spinal disease; **or**

xviii. History of adverse reaction or inadequate response to sedation to anesthesia or sedation; **or**

xix. Member is pregnant; **or**

xx. Active or history of alcohol or substance abuse

xxi. Other medical conditions felt to inhibit the safe delivery of care in an office setting.

b. 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:

i. Rampant decay, or dental needs of high complexity; **or**

ii. 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**

iii. 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.

c. Member with extreme apprehension and anxiety when documentation confirms **ALL** the following:

i. 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**

ii. 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**

iii. 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.

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.

For members enrolled in a New Hampshire plan, the Plan considers general anesthesia or MAC as reasonable and medically necessary when **ONE** the following are met:

1. Member is less than 13 years of age and a Licensed Dentist in conjunction with Primary Care Provider (PCP)/Attending provider confirms through documentation that the member has a dental condition of significant dental complexity; **or**
2. Member is determined by his or her PCP to require dental treatment in a hospital or surgical day care facility due to exceptional medical circumstances or a developmental disability, which places the Member at serious risk.

For members enrolled in a Maine plan, the Plan considers general anesthesia or MAC and associated facility charges when rendered in a Hospital as reasonable and medically necessary when **ONE** of the following are met:

1. Members with physical, intellectual, or medically compromising condition for which anesthesia is required for dental services; **or**
2. Members for which local anesthesia is ineffective due to acute infection, anatomic variation or allergy, **or**
3. Members under the age of 19 who are extremely uncooperative, fearful, anxious, or uncommunicative with dental needs that cannot be postponed and for whom lack of treatment may result in dental or oral pain, or infection, loss of teeth, or other increased oral or dental morbidity; **or**
4. Members with extensive oral-facial or dental trauma for which local anesthesia would be ineffective or compromised

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 an individual consideration when the above criteria are met.

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 > 5m; **or**
2. Difficulty with hygiene due to orthodontic brackets impinging on the gingiva; **or**
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 **ONE** of the following:

1. Osteonecrosis of the jaw is 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).

In accordance with the Maine Act to Promote Better Dental Care for Cancer Survivors (2024) medical/surgical care is considered medically necessary to reduce the risk of infection or eliminate infection or to treat tooth loss or decay due to cancer treatment including chemotherapy, biological therapy, or radiation therapy treatment.

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. Required to facilitate management in trauma, orthognathic or reconstructive surgery; **or**
6. 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 an irregular remodeling pattern (osteophytes)
D7871	Non-arthroscopic lysis and lavage

Code	Description
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
41899	Unlisted procedure, dentoalveolar structures

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14. Parameters of Care: Clinical Practice Guidelines for Oral and Maxillofacial Surgery; Anesthesia in Outpatient Facilities (AAOMS ParCare 2023) Seventh Edition. doi:10.1016/j.joms.2023.06.017, AAOMS, Rosemont, IL.

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

- July 19, 2023: Reviewed by MPAC; references updated to reflect Maine An Act to Promote Better Dental Care for Cancer Survivors effective 1/1/23
- September 20, 2023: Reviewed by MPAC; annual review language clarified regarding emergency dental care
- November 2023: Rebranded Unify to One Care effective January 1, 2024
- November 21, 2024: Reviewed by MPAC, renewed without changes, effective January 1, 2025
- February 19, 2025: Reviewed by MPAC, code 41899 added to require PA effective March 1, 2025
- June 18, 2025: Reviewed by MPAC, language regarding anesthesia for members undergoing non-covered services clarified effective August 1, 2025
- August 20, 2025: Reviewed by MPAC for annual review; criteria restructured and redundant content removed; inclusion of language from Maine and New Hampshire mandates, effective October 1, 2025
- August 19, 2026: Reviewed by MPAC, administrative update to guideline template and renewed without changes effective October 1, 2026

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.