Harvard Pilgrim Health Care | TUFTS Health Plan

Point32Health companies

Medical Necessity Guidelines:

Dental Implants

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:

- Tufts Health Plan Commercial

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.

Overview

A dental implant is an artificial tooth root that is placed in the jaw to hold a prosthetic tooth or bridge.[1]

Clinical Guideline Coverage Criteria

Tufts Health Plan may consider authorizing the coverage of dental implants when the Member has had major jaw resection (resulting from pathology, or infection, or osteonecrosis) involving the loss of multiple teeth, or traumatic jaw avulsion (resulting from ablative surgery or traumatic injury) and the remaining teeth or jaw are unable to support a functional prosthesis.

Limitations

The Plan will not authorize coverage of dental implants for cosmetic reasons (for example: to improve the Member's appearance).

Codes

The following code(s) require prior authorization:

Table 1: CPT/HCPCS Codes

Code	Description
D6010 – D6199	Implant services

References:

1. American Academy of Periodontology. Dental Implant Procedures. perio.org/consumer/dental-implants. Accessed July 8, 2026.

Approval And Revision History

October 21, 2020: Reviewed by IMPAC, renewed without changes

Subsequent endorsement date(s) and changes made:

- November 24, 2020: Fax number for Unify updated
- December 21, 2021: Reviewed by Medical Policy Approval Committee (MPAC), renewed without changes
- April 5, 2022: Template updated
- December 1, 2022: Reviewed by MPAC, renewed without changes for March 1, 2023, effective date
- June 21, 2023: Reviewed by MPAC, renewed without changes
- September 20, 2023: Reviewed by MPAC, updated clinical coverage criteria
- November 2023: Rebranded Unify to One Care effective January 1, 2024
- November 21, 2024: Reviewed by MPAC, renewed without changes, effective January 1, 2025
- August 20, 2025: Reviewed by MPAC for annual review, renewed without changes 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.