Harvard Pilgrim Health Care | TUFTS Health Plan

Point32Health companies

Medical Necessity Guidelines:

Dental Procedures Requiring Hospital/Facility-Based Care

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:

Commercial Products

- Tufts Health Plan 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.

Overview

Treatment under sedation or general anesthesia in a hospital setting may be medically necessary for some infants, children, adolescents, and adults with compromising medical conditions and special health care needs. Consideration for treatment in this setting is based on the Member's medical condition, age, behavioral/cognitive status, and complexity of the dental procedures.

The Plan may cover certain costs associated with dental procedures that are performed in an acute care inpatient facility or ambulatory surgery center. This coverage may include all medically necessary hospital or surgical day care facility charges, as well as the administration of general anesthesia by a licensed anesthesiologist or anesthetist for dental procedures for members who meet the criteria described below.

Clinical Guideline Coverage Criteria

The Plan considers hospital or facility-based care for the administration of general anesthesia as reasonable and medically necessary for Members requiring extensive dental procedures when **ALL** of the following indications 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 has a serious significant cognitive or behavioral health impairment, and/or psychological symptoms (e.g., psychiatric disorder, intellectual impairment, immature cognitive functioning, extreme apprehension and anxiety, autism, down syndrome) which significantly impairs the Members ability to safely cooperate with dental care in a traditional dental office setting*, **BOTH**:
        i. The member requires medically necessary treatment for extensive or complex dental surgical procedures**; **and**
        ii. At least one attempt at office-based dental intervention demonstrates Member is extremely fearful, anxious or uncooperative or has demonstrated the inability to respond to other behavior guidance techniques and safe, effective dental intervention is not possible without hospital-based anesthesia

services; **or**

b. Member has one or more moderate to severe comorbid conditions that the physician determines would place the Member at undue risk if the procedure is performed at a dental office (e.g., risk for life threatening complications such as airway obstruction or bleeding requiring appropriate cardiorespiratory monitoring during treatment) and includes any **ONE** of the following factors:
    i. American Society of Anesthesiology (ASA) physical status classification Class III or greater; defined as a patient with severe systemic disease[8]; **or**
    ii. Hematological disease such as hemophilia, von Willebrand's Disease, and other inherited coagulation defects; **or**
    iii. Member on direct oral anticoagulants (DOACs) or antiplatelet medication and with a high risk of bleeding and undergoing procedures with a high risk of increased bleeding; **or**
    iv. Cardiac conditions, such as uncontrolled hypertension, current angina, cardiac arrhythmia such as SVT, or refractory atrial fibrillation, CHF class III or IV, moderate to severe aortic stenosis, symptomatic mitral stenosis, or an MI within 6 months); **or**
    v. Chronic pulmonary disease, such as emphysema, asthma, or COPD and poorly controlled; **or**
    vi. History of malignant hyperthermia; **or**
    vii. Presence of allergies that contraindicate local anesthesia; **or**
    viii. History of adverse reaction to anesthesia or sedation; **or**
    ix. Potential for or history of difficult airway management (e.g., significant neuromuscular disease or cervical spinal disease, history of difficult intubation, craniofacial abnormality/anatomic abnormality with deformities of the mouth or jaw impeding airway, moderate to severe tonsillar hyper-trophy); **or**
    x. 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. retropharynegeal or infratemporal abscesses); **or**
    xi. Obesity and BMI ≥ 40; **or**
    xii. Other medical conditions that prevent safe delivery of care in a dental office setting with documentation provided from the PCP and appropriate specialist; **or**
c. Prolonged and extensive oral surgery and/or maxillofacial surgery requiring a longer period of sedation and anesthesia complexity that cannot be provided safely in an office setting; **or**
d. Member is 6 years of age or less and has a need for complex dental surgery and/or a large number of dental procedures (e.g., severe early childhood caries requiring extensive or complex restorative oral rehabilitation treatment)*** and at least one attempt at office-based treatment has been unsuccessful; **or**
e. Member requires immediate, comprehensive dental surgery due to dental abscess or infection threatening patency of the airway or other anatomical structures; **or**
f. Member has sustained extensive oral-facial and/or dental trauma and treatment under local anesthesia would be ineffective or compromised; **or**
g. Postoperative complications following outpatient dental surgery.

*Members who cannot cooperate due to a lack of psychological or emotional maturity and/or mental, physical or medical disability or those who are verbally uncommunicative because of psychosocial or medical conditions, or those who have demonstrated the inability to respond to other available behavior guidance techniques may also require general anesthesia in a hospital or facility-based setting.

**Examples of extensive or complex dental procedures include: serial extractions, periodontal surgeries (greater than 3 non-cosmetic restorations, greater than 3 extractions of teeth other than primary incisors (tooth extractions for entangled roots, impacted teeth), greater than 3 endodontic procedures on posterior teeth (pulpotomies), stainless steel crowns and or multiple restorations on primary molar teeth).

***The American Dental Association defines Early Childhood Caries (ECC) as severe early childhood caries (S-ECC) is any sign of smooth-surface caries in a child younger than three years of age, and from ages three through five, one or more cavitated, missing (due to caries), or filled smooth surfaces in primary maxillary anterior teeth or a decayed, missing, or filled score of greater than or equal to four (age 3), greater than or equal to five (age 4), or greater than or equal to six (age 5)[1,2].

Note: The presence of co-morbidity in itself does not guarantee approval.

Limitations

The Plan will not cover hospitalization for Members:

1. Receiving discretionary dental procedures, such as tooth extraction prior to elective orthodontia.
2. Members who are healthy, cooperative, and who have minimal dental needs

Codes

The following code(s) require prior authorization:

Table 1: CPT/HCPCS Codes

Code	Description
D0120–D9999	Dental procedures
41899	Unlisted procedure, dentoalveolar structures

References:

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Approval And Revision History

October 21, 2020: Reviewed by IMPAC. For clinical coverage criteria, revised office-based dental interventions from two attempts to at least one attempt

Subsequent endorsement date(s) and changes made:

- October 26, 2020: Fax number for Unify updated
- December 21, 2021: Reviewed by Medical Policy Approval Committee (MPAC), renewed without changes
- May 26, 2022: Reviewed by MPAC for removal of prior authorization for Tufts Health plan Public Products with effective date of May 26, 2022
- December 1, 2022: Reviewed by MPAC for an effective date of March 1, 2023. Added criteria for “Medical condition(s) resulting in American Society of Anesthesiology (ASA) physical status classification Class III or higher”. Added code 41899
- September 20, 2023: Reviewed at MPAC, renewed with no changed
- November 2023: Rebranded Unify to One Care effective January 1, 2024
- November 21, 2024: Reviewed at MPAC, policy name change to Dental Procedures Requiring Hospital/Facility-Based care; criteria revised to include additional comorbid conditions appropriate for hospital/facility-based care, effective date of 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.