Medical Necessity Guidelines:
Dental Procedures Requiring Hospitalization

Effective: October 21, 2020

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request.	**Yes ☒ No ☐**

Applies to:

COMMERCIAL Products

☒ Tufts Health Plan Commercial products; Fax: 617.972.9409

☐ Tufts Health Freedom Plan products; Fax: 617.972.9409

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

TUFTS HEALTH PUBLIC PLANS Products

☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax:888.415.9055

☒ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax: 888.415.9055

☒ Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax: 857.304.6404

☒ Tufts Health Unify* – OneCare Plan (a dual-eligible product); Fax: 857.304.6304

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

SENIOR Products

- Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product) – Refer to the Tufts Health Plan SCO Prior Authorization List
- Tufts Medicare Preferred HMO, (a Medicare Advantage product) – Refer to the Tufts Medicare Preferred HMO Prior Authorization and Inpatient Notification List

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to make sure that prior authorization has been obtained.

OVERVIEW

Tufts Health 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 COVERAGE CRITERIA

Tufts Health Plan may provide coverage for services related to anesthesia and hospitalization for nondiscretionary dental procedures for Members meeting the criteria in **either one** of the categories below:

1.) Members meeting the following clinical criteria:

- Member requires complex dental work.
  Examples of "complex" dental procedures include the following:
  - Greater than 3 non-cosmetic restorations
  - Greater than 3 extractions of teeth other than primary incisors
  - Greater than 3 endodontic procedures on posterior teeth (pulpotomies)
  - Stainless steel crowns and or multiple restorations on primary molar teeth

AND

- At least one attempt at office-based dental intervention demonstrate member is extremely fearful, anxious or uncooperative, and safe, effective dental intervention is not possible without hospital-based anesthesia services.

OR

2.) Member has a medical co-morbidity or developmental disability, as determined by a licensed physician, which places the member at serious risk for peri-operative complications. Co-morbidities or disabilities may include, but are not limited to:

- Autism
- Down Syndrome
- Cerebral Palsy
- Cardiopulmonary problems
- Hemophilia

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

LIMITATIONS

Tufts Health Plan will not cover hospitalization for members receiving discretionary dental procedures, such as tooth extraction prior to elective orthodontia.

CODES

The following HCPCS codes require prior authorization:

Code	Description
D0120–D9999	Dental procedures

REFERENCES

1. Policy on Model Dental Benefits for Infants, Children, Adolescents, and Individuals with Special Health Care Needs. Pediatr Dent. 2018;40(6):110-112.
2. Policy on Hospitalization and Operating Room Access for Oral Care of Infants, Children, Adolescents, and Individuals with Special Health Care Needs. Pediatr Dent. 2017;39(6):104-105.
3. Clinical Affairs Committee-Behavior Management Subcommittee, American Academy of Pediatric Dentistry. Guideline on Behavior Guidance for the Pediatric Dental Patient. Pediatr Dent. 2015;37(5):57-70.
4. American Academy of Pediatric Dentistry. Guideline on behavior guidance for the pediatric dental patient. Reference Manual V37/NO 6 15/16. Accessed August 1, 2018.
5. American Academy of Pediatric Dentistry. Guideline on use of local anesthesia for pediatric dental patients. Pediatr Dent 2015; 37(special issue):199-205.
6. Corcuera-Flores JR, Delgado-Muñoz JM, Ruiz-Villandiego JC, Maura-Solivellas I, Machuca-Portillo G. Dental treatment for handicapped patients; sedation vs general anesthesia and update of dental treatment in patients with different diseases. Med Oral Patol Oral Cir Bucal. 2014;19(2):e170-e176. Published 2014 Mar 1. doi:10.4317/medoral.19555.
7. Commonwealth of Massachusetts. Mass Health Provider Manual Series; Dental Manual 130 CMR 420.000). Published 4/22/2019. mass.gov/doc/dental-providers-regulation/download.

APPROVAL HISTORY

February 1999: Reviewed by the Clinical Coverage Criteria Committee

Subsequent endorsement date(s) and changes made:

- October 2000: Renewed, no changes
- October 2001: Renewed, no changes
- February 2002: Renewed, no changes
- July 23, 2003: Renewed, updated to new format, term 'non-discretionary' added as a description of the type of dental procedures referred to by the guidelines.
- August 20, 2004: Reviewed and renewed
- October 14, 2005: Definition of 'young age' clarified as under age 48 months.
- October 16, 2006: Reviewed and renewed without changes
- October 1, 2007: Reviewed and renewed without changes
- October 15, 2008: Reviewed and renewed without changes
- May 4, 2009: Age requirement changed from under 48 months to under 84 months of age
- November 19, 2009: Administrative process updated
- April 14, 2010: Deleted (Examples of severe medical co-morbidities include the following), added e.g., after outpatient setting, deleted "severe" before medical co-morbidities.
- August 2011: Reviewed by Medical Affairs, Medical Policy. "Including but not limited to" added to co-morbidity language. In addition a note explaining that the presence of co-morbidity does not guarantee approval was added.
- December 28, 2012: Reviewed by the Integrated Medical Policy Advisory Committee (IMPAC), no changes
- December 11, 2013: Reviewed by IMPAC, renewed without changes

- November 20, 2014: Adopted by Tufts Health Plan – Network Health Commercial Plans and Tufts Health Plan – Network Health Medicaid Plans.
- December 10, 2014: Reviewed by IMPAC. First bullet: the age requirement changed from 84 months to 7 years of age or less.
- August 12, 2015: Reviewed by IMPAC, renewed without changes
- September 2015: Branding and template change to distinguish Tufts Health Plan products in "Applies to" section. Added Tufts Health Freedom Plan products, effective January 1, 2016.
- July 20, 2016: Reviewed by IMPAC. Removed criteria that complex dental work be performed on non-anterior teeth only.
- August 10, 2016: Reviewed at IMPAC. For effective date January 1, 2017, change to criteria for complex dental work; age limit removed and addition to criteria for attempts at office based intervention.
- April 2017: Added RITogether Plan product to template. For MNGs applicable to RITogether, effective date is August 1, 2017
- July 20, 2017: Reviewed by IMPAC, renewed without changes
- August 22, 2018: Reviewed at IMPAC. For effective date January 1, 2019, "multiple" non-cosmetic restorations, extractions of teeth other than primary incisors and endodontic procedures on posterior teeth (pulpotomies) changed to "greater than 3".
- October, 2018: Template and disclaimer updated
- October 16, 2019: Reviewed by IMPAC, renewed without changes
- November 14, 2019: Admin update
- July 20, 2020: References updated
- October 21, 2020: Reviewed by IMPAC. For clinical coverage criteria, revised office-based dental interventions from two attempts to at least one attempt
- October 26, 2020: Fax number for Unify updated

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.

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.