Medical Necessity Guidelines: Dental Implants

Effective: August 22, 2018

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
• CareLinkSM – 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 Uniﬁ* – OneCare Plan (a dual-eligible product); Fax: 781.393.2607
*The MNG applies to Tufts Health Uniﬁ 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
A dental implant is a tooth root that is placed in the jaw so that a replacement tooth can be attached (American Academy of Periodontology, 2003).

CLINICAL COVERAGE CRITERIA
Tufts Health Plan may authorize the coverage of dental implants when the Member has had major jaw resection or traumatic jaw avulsion and the remaining teeth are unable to support a functional prosthesis.

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

CODES
The following HCPCS codes require prior authorization:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>D6010 – D6199</td>
<td>Implant services</td>
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REFERENCES

APPROVAL HISTORY
July 23, 2003: Reviewed by the Clinical Coverage Criteria Committee

Subsequent endorsement date(s) and changes made:
• August 20, 2004: Reviewed and renewed.
• October 21, 2005: Reviewed and renewed.
• October 16, 2006: Reviewed and renewed, additional definitions and examples added.
October 1, 2007: Reviewed, no substantive changes made.
October 15, 2008: Reviewed and renewed without changes.
December 2009: Reviewed by Medical Policy, no changes
April 14, 2010: Deleted paragraph (the Member has severe alveolar ridge atrophy that results in
an inability to fabricate a functional prosthesis and the lack of such a prosthesis is materially
affecting the Member’s health, i.e., severe gastrointestinal problems, alarming weight loss solely
attributable to the lack of teeth, and/or other associated co morbidities).
December 2010: Admin Process changed to RN/LPN.
August 2011: Reviewed by Medical Affairs, Medical Policy. “Full documentation of the Member’s
condition, including appropriate radiographs and intra-oral photographs, must be submitted to
Tufts Health Plan for review” statement removed from MNG.
December 28, 2012: Reviewed by the Integrated Medical Policy Advisory Committee (IMPAC),
no changes
December 11, 2013: Reviewed by IMPAC, renewed without changes
December 10, 2014: Reviewed by IMPAC, renewed without changes
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, renewed without changes
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 by IMPAC, renewed without changes
October, 2018: Template and disclaimer 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.