

130 CMR 420.000: DENTAL SERVICES

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420.401: Introduction

(A) 130 CMR 420.000 contains the regulations governing dental services under MassHealth. All dental providers participating in MassHealth must comply with MassHealth regulations, including but not limited to 130 CMR 420.000 and 450.000.

(B) As described in 130 CMR 420.000 and in 450.000, covered dental services are more extensive for members under age 21 than for members aged 21 and older.

(C) Subchapter 6 of the *Dental Manual* lists the Current Dental Terminology (CDT) codes for dentists and Current Procedural Terminology (CPT) codes for specialists in Oral surgery that the MassHealth agency pays for, a description of those codes, and where indicated, prior-authorization requirements.

420.402: Definitions

The following terms used in 130 CMR 420.000 have the meanings given in 130 CMR 420.402, unless the context clearly requires a different meaning. The reimbursability of services defined in 130 CMR 420.000 is not determined by these definitions, but by application of regulations elsewhere in 130 CMR 420.000 and 450.000.

Caseload Capacity - a MassHealth dental provider's good-faith determination of the number of MassHealth members to whom the provider is able to provide dental services.

CODA - the Commission on Dental Accreditation of the American Dental Association

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Department of Developmental Services (DDS) - the state agency organized under M.G.L. c. 19B.

DDS Clients - MassHealth members aged 21 and over who have been determined by DDS to be eligible for adult DDS services, pursuant to 115 CMR 6.00.

EPSDT - Early and Periodic Screening, Diagnosis and Treatment Services as described in federal law at 42 U.S.C. § 1396d(a)(4)(B) and (R) and 42 CFR 441 Subpart B. In Massachusetts, EPSDT-eligible members are in MassHealth Standard or MassHealth CommonHealth categories of assistance, and are under age 21.

Pre-orthodontic Work-up - includes the treatment plan, radiographs, diagnostic prints and photographs, orthodontic records, diagnosis and diagnostic models.

420.403: Eligible Members

(A) MassHealth Members. 130 CMR 405.105 specifically states for each MassHealth coverage type, which members are eligible to receive dental services. The MassHealth agency pays for dental services described in 130 CMR 420.000, provided to eligible MassHealth members.

(B) Recipients of Emergency Aid to the Elderly, Disabled and Children Program. 130 CMR 450.106 provides information on services available to recipients of the Emergency Aid to the Elderly, Disabled and Children Program (EAEDC).

(C) Member Eligibility and Coverage Type. 130 CMR 450.107 provides information on verifying member eligibility and coverage type.

420.404: Provider Eligibility: Participating Providers

The MassHealth agency pays for services described in 130 CMR 420.000 only to providers of dental services who are participating in MassHealth on the date of service. The participating provider is responsible for the quality of all services for which payment is claimed, the accuracy of such claims, and compliance with all regulations applicable to dental services under MassHealth. In order to claim payment, the participating provider must be the dentist who actually performed the service, except as described in 130 CMR 420.404(A) through (D).

(A) A dentist who is a member of a group practice can direct payment to the group practice under the provisions of the MassHealth regulations governing billing intermediaries in 130 CMR 450.000. The dentist providing the services must be enrolled as an individual provider, and must be identified on claims for his or her services.

(B) A dental school may claim payment for services provided in its dental clinic.

(C) A dental clinic may claim payment for services provided in its dental clinic.

(D) A community health center, hospital-licensed health center, or hospital outpatient department may claim payment for services provided in its dental clinic.

420.405: Provider Eligibility

(A) In-state Providers. The following requirements apply when the dental provider's practice is located in Massachusetts.

(1) Practitioner. A dentist engaged in private practice is eligible to participate in MassHealth as a dental provider if licensed to practice by the Massachusetts Board of Registration in Dentistry. Private practices may include, but are not limited to, solo, partnership, or group practices.

(2) Community Health Center. A licensed community health center with a dental clinic is eligible to participate in MassHealth as a provider of dental services.

(3) Dental School. A teaching clinic of a dental school accredited by CODA is eligible to participate in MassHealth as a provider of dental services.

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(4) Acute Hospital Outpatient Department, Hospital-licensed Health Center or Other Satellite Clinic. An acute hospital's outpatient department, hospital-licensed health center, or other satellite clinic that participates in MassHealth pursuant to the Executive Office of Health and Human Services (EOHHS) Acute Hospital Request for Applications (RFA) and contract is eligible to provide services designated as dental clinic services in Subchapter 6 of the MassHealth *Dental Manual* for providers under 130 CMR 420.000.

(5) Dental Clinic. A dental clinic must be licensed by the Massachusetts Department of Public Health (DPH) to be eligible to participate in MassHealth as a dental provider. A DPH license is not required for a state owned and operated dental clinic. A dental clinic that limits its services to education and diagnostic screening is not eligible to participate in MassHealth as a dental provider.

(6) Specialist in Orthodontics. A dentist who is a specialist in orthodontics must have completed a minimum of two years' training in a CODA advanced-education program in orthodontics that fulfills all educational requirements for eligibility for the examination by the American Board of Orthodontists.

(7) Specialist in Oral Surgery. A dentist who is a specialist in oral surgery must have completed a minimum of four years' training in an oral and maxillofacial surgery advanced-education program, fulfilling the requirements for advanced training in oral and maxillofacial surgery as outlined by CODA and leading to a Certificate in Advanced Graduate Studies (CAGS).

(8) Other Dental Specialists. A dentist who is a specialist in any other area of dentistry (for example, pedodontics, endodontics, periodontics, prosthodontics, or maxillofacial prosthetics) must have completed the appropriate CODA certificate program that satisfies eligibility requirements for the specific specialty board.

(B) Out-of-state Providers. A dental provider whose practice is located outside of Massachusetts is eligible to participate in MassHealth as a dental provider and to be paid for dental services provided to MassHealth members only if the provider is licensed or certified by the state in which the provider practices, meets the specific provider eligibility requirements listed in 130 CMR 420.404, and meets the conditions set forth in 130 CMR 450.109.

(C) Enhancement Fee for Community Health Centers and Hospital-licensed Health Centers. To qualify for an enhancement fee for dental services:

(1) Community health centers and hospital-licensed health centers must commit to undertaking efforts that include, but are not limited to, increasing access to dental covered services by implementing and reporting on measures to increase the capacity and volume of dental services they deliver, either directly or through subcontracts with private dental providers.

(2) The dental enhancement fee is set by the Massachusetts Division of Health Care Finance and Policy (*see* 114.3 CMR 4.05(1)).

420.406: Caseload Capacity

(A) A provider must immediately notify the MassHealth agency when its individual, group, or facility practice has reached the maximum number of MassHealth members it can accept and also when its practice is accepting new MassHealth members.

(B) Group practices, community health centers, hospital-licensed health centers, and acute hospital outpatient departments that choose to establish a caseload capacity must establish a single caseload capacity for the entire group or facility.

420.407: Maximum Allowable Fees

The Division of Health Care Finance and Policy (DHCFP) determines the maximum allowable fees for dental services. Payment is always subject to the conditions, exclusions, and limitations set forth in 130 CMR 420.000. Payment by the MassHealth agency is the lower of the following:

(A) the provider's usual charge to the general public for the same or a similar service; or

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- (B) the maximum allowable fee listed in the applicable DHCFP fee schedule.

420.408: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services

The MassHealth agency pays for all medically necessary dental services for EPSDT-eligible members in accordance with 130 CMR 450.140 *et seq.*, without regard to service limitations described in 130 CMR 420.000, and with prior authorization.

420.409: Noncovered Circumstances

(A) Conditions. The MassHealth agency does not pay for dental services under any of the following conditions:

- (1) services provided in a state institution by a state-employed dentist or a dental consultant;
- (2) services provided by a provider whose salary includes compensation for professional services;
- (3) if, under comparable circumstances, the provider does not customarily bill individuals who do not have health insurance; or
- (4) if the member is not an eligible MassHealth member on the date of service. The provider must verify the member's eligibility for MassHealth on the date of service even if the provider has obtained prior authorization for the service.

(B) Substitutions.

- (1) If a member desires a substitute for, or a modification of, a covered service, the member must pay for the entire cost of the service. The MassHealth agency does not pay for any portion of the cost of a substitute for a covered service. In all such instances, before performing services not covered for the member, the provider must inform the member both of the availability of covered services and of the member's obligation to pay for those that are not covered services.
- (2) It is unlawful (M.G.L. c. 6A, § 35) for a provider to accept any payment from a member for a service or item for which payment is available under MassHealth. If a member claims to have been misinformed about the availability of covered services, it will be the responsibility of the provider to prove that the member was offered a covered service, refused it, and chose instead to accept and pay for a service that MassHealth does not pay for.
- (3) Providers may upgrade medically necessary services at no additional cost to the MassHealth agency or the member.

420.410: Prior Authorization

(A) Introduction.

- (1) The MassHealth agency pays only for medically necessary services to eligible MassHealth members and may require that medical necessity be established through the prior authorization process. In some instances, prior authorization is required for members aged 21 and older when it is not required for members under age 21.
- (2) Services requiring prior authorization are identified in Subchapter 6 of the *Dental Manual*, and may also be identified in billing instructions, program regulations, associated lists of service codes and service descriptions, provider bulletins, and other written issuances. The MassHealth agency only reviews requests for prior authorization where prior authorization is required or permitted (*See* 130 CMR 420.410(B)).
- (3) The provider must not begin to furnish a service that requires prior authorization, until the provider has requested and received written prior authorization from the MassHealth agency. The MassHealth agency may grant prior authorization after a procedure has begun if, in the judgment of the MassHealth agency:
 - (a) the treatment was medically necessary;
 - (b) the provider discovers the need for additional services while the member is in the office and undergoing a procedure, and
 - (c) it would not be clinically appropriate to delay the provision of the service.

(B) Services Requiring Prior Authorization. The MassHealth agency requires prior authorization for the following:

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- (1) those services listed in Subchapter 6 of the *Dental Manual* with the abbreviation "P.A" or otherwise identified in billing instructions, program regulations, associated lists of service codes and service descriptions, provider bulletins, and other written issuances;
- (2) any service not listed in Subchapter 6 for an EPSDT-eligible member; and
- (3) any exception to a limitation on a service otherwise covered for that member as described in 130 CMR 420.421 through 420.456. (For example, MassHealth limits prophylaxis to two per member per calendar year, but pays for additional prophylaxis for a member within a calendar year if medically necessary.)

(C) Submission Requirements.

- (1) The provider is responsible for including with the request for prior authorization appropriate and sufficient documentation to justify the medical necessity for the service. Refer to Subchapter 6 of the *Dental Manual* for prior authorization requirements.
- (2) Instructions for submitting a request for prior authorization for Current Dental Terminology (CDT) codes are described in the MassHealth *Dental Program Office Reference Manual*. Dental providers requesting prior authorization for services listed with a CDT code must use the ADA-2006 form.

(D) Other Requirements for Payment.

- (1) Prior authorization determines only the medical necessity of the authorized service and does not establish or waive any other prerequisites for payment such as member eligibility, the availability of other health-insurance payment or whether the service is a covered service.
- (2) The MassHealth agency does not pay for a prior-authorized service when the member's MassHealth eligibility is terminated on or before the date of service.
- (3) When the member's MassHealth eligibility is terminated before delivery of a special-order good, such as a denture, the provider may claim payment in accordance with the provisions of 130 CMR 450.231(B). Refer to 130 CMR 450.231(B) for special procedures in documenting member eligibility for special-order goods.

420.411: Pretreatment Review

When the MassHealth agency identifies an unusual pattern of practice of a given provider, the MassHealth agency, at its discretion and pursuant to written notice, may require the provider to submit any proposed treatments identified by the MassHealth agency, including those not otherwise subject to prior authorization, for the MassHealth agency's review and approval before treatment.

420.412: Individual Consideration

(A) Certain services, including unspecified procedures, are designated "I.C." (individual consideration) in Subchapter 6 of the *Dental Manual*. This means that a fee could not be established for these services. The MassHealth agency determines appropriate payment for individual-consideration services from the provider's detailed report of services provided (*See* Subchapter 6 of the *Dental Manual* for report requirements). The MassHealth agency does not pay claims for "I.C." services without a complete report (*see* 130 CMR 420.415). If the documentation is illegible or incomplete, the MassHealth agency denies the claim.

(B) The MassHealth agency determines the appropriate payment for an individual-consideration service in accordance with the following standards and criteria:

- (1) the amount of time required to perform the service;
- (2) the degree of skill required to perform the service;
- (3) the severity and complexity of the member's disease, disorder, or disability; and
- (4) any extenuating circumstances or complications.

420.413: Separate Procedures

Certain procedures are designated "S.P." (separate procedure) in the service descriptions in Subchapter 6 of the *Dental Manual*. A separate procedure is one that is commonly performed as an integral part of a total service and therefore does not warrant a separate payment, but that commands a separate payment when performed as a separate procedure not immediately related to other services. (For example, the MassHealth agency does not pay for a frenulectomy when it is performed as part of a vestibuloplasty, and full-study models are not payable separately when performed as part of orthodontic treatment or diagnosis. Nevertheless, the MassHealth agency does pay for frenulectomy as a separate procedure when medically necessary; and full-study models separately when the MassHealth agency requests them.)

420.414: Recordkeeping Requirements

(A) Record Retention. Federal and state regulations require that all MassHealth providers maintain complete written records of patients who are members. All records, including radiographs, must be kept for a minimum of four years after the date of service. Records for members who are residents of long-term-care facilities must be retained by the dentist as part of the member's dental record and by the nursing facility as part of the member's record at the facility.

(B) Dental Record. Payment by the MassHealth agency for dental services listed in 130 CMR 420.000 includes payment for preparation of the member's dental record. Services for which payment is claimed must be substantiated by clear evidence of the nature, extent, and necessity of care provided to the member. For all claims under review, the member's medical and dental records determine the appropriateness of services provided to members. The written dental record corresponding to the services claimed must include, but is not limited to, the following:

- (1) the member's name, date of birth, and sex;
- (2) the member's identification number;
- (3) the date of each service;
- (4) the name and title of the individual servicing provider furnishing each service, if the dental provider claiming payment is not a solo practitioner;
- (5) pertinent findings on examination and in medical history;
- (6) a description of any medications administered or prescribed and the dosage given or prescribed;
- (7) a description of any anesthetic agent administered, the dosage given, and the anesthesia flowsheet;
- (8) a complete identification of treatment, including, when applicable, the arch, quadrant, tooth number, and tooth surface;
- (9) dated digital or mounted radiographs, if applicable; and
- (10) copies of all approved prior-authorization requests or the prior-authorization number.

420.415: Report Required with Certain Claims

(A) The provider must submit with the claim for payment, a written description of the service provided in accordance with the requirements described in Subchapter 6 of the *Dental Manual* when the service description in Subchapter 6 stipulates "by report;" or the service is designated in Subchapter 6 as "I.C."

(B) The report must be sufficiently detailed to enable the MassHealth agency to assess the extent and nature of services provided.

420.416: Pharmacy Services: Prescription Requirements

For information on pharmacy services refer to 130 CMR 406.000.

420.421: Covered Services: Introduction

(A) Medically Necessary Services. The MassHealth agency pays for the following dental services when medically necessary:

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- (1) the services with codes listed in Subchapter 6 of the *Dental Manual*, in accordance with the service descriptions and limitations described in 130 CMR 420.422 through 420.456; and
- (2) all services for EPSDT-eligible members, in accordance with 130 CMR 450.140 through 450.149, without regard for the service limitations described in 130 CMR 420.422 through 420.456, or the listing of a code in Subchapter 6. All such services are available to EPSDT-eligible members, with prior authorization, even if the limitation specifically applies to other members younger than 21 years old.

(B) Noncovered Services. The MassHealth agency does not pay for the following services for any member, except when medically necessary for members younger than 21 years old with prior authorization.

- (1) cosmetic services;
- (2) certain dentures including unilateral partials, overdentures and their attachments temporary dentures, CuSil-type dentures, other dentures of specialized designs or techniques, and preformed dentures with mounted teeth (teeth that have been set in acrylic before the initial impressions);
- (3) chair-side relines;
- (4) counseling or member-education services;
- (5) habit-breaking appliances;
- (6) implants of any type or description;
- (7) laminate veneers;
- (8) oral hygiene devices and appliances, dentifrices, and mouth rinses;
- (9) orthotic splints, including mandibular orthopedic repositioning appliances;
- (10) panoramic films for crowns, endodontics, periodontics, and interproximal caries;
- (11) root canals filled by silver point technique, or paste only;
- (12) tooth splinting for periodontal purposes; and
- (13) any other service not listed in Subchapter 6 of the *Dental Manual*.

(C) Covered Services for All Members 21 Years of Age or Older. The MassHealth agency pays for the services listed in the following sections for all members 21 years of age or older in accordance with the service descriptions and limitations set forth in 130 CMR 420.422 through 420.456:

- (1) diagnostic services as described in 130 CMR 420.422;
- (2) radiographs as described in 130 CMR 420.423;
- (3) preventive services as described in 130 CMR 420.424;
- (4) restorative services as described in 130 CMR 420.425;
- (5) exodontic services as described in 130 CMR 420.430, except for the following:
 - (a) alveoplasty;
 - (b) vestibuloplasty;
 - (c) frenulectomy;
 - (d) excision of hyperplastic tissue;
 - (e) excision of benign lesion; and
 - (f) tooth reimplantation and stabilization;
- (6) anesthesia services as described in 130 CMR 420.452;
- (7) oral and maxillofacial surgery services as described in 130 CMR 420.453;
- (8) behavior management services as described in 130 CMR 420.456(C);
- (9) palliative treatment of dental pain or infection services as described in 130 CMR 420.456(D); and
- (10) house/facility call as described in 130 CMR 420.456(G).

(D) Noncovered Services for All Members 21 Years of Age or Older. The MassHealth agency does not pay for the following services for all members 21 years of age or older:

- (1) preventive services as described in 130 CMR 420.424(C);
- (2) prosthodontic services (fixed) as described in 130 CMR 420.429; and
- (3) other services as described in 130 CMR 420.456(A), (B), (E), and (F).

(E) Additional Covered Services for DDS Clients Aged 21 and Older. The MassHealth agency pays for the following additional services for DDS clients 21 years of age or older:

- (1) endodontic services as described in 130 CMR 420.426;
- (2) periodontic services as described in 130 CMR 420.427; and

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- (3) the following additional exodontic services as described in 130 CMR 420.430
 - (a) alveoplasty;
 - (b) vestibuloplasty;
 - (c) frenulectomy;
 - (d) excision of hyperplastic tissue; and
 - (e) excision of benign lesion;
- (4) prosthodontic services (removable) as described in 130 CMR 420.428; and
- (5) maxillofacial prosthetics as described in 130 CMR 420.455.

420.422: Service Descriptions and Limitations: Diagnostic Services

(A) Comprehensive Oral Evaluation. The MassHealth agency pays for a comprehensive oral evaluation once per member per provider. A comprehensive oral evaluation is more thorough than a periodic oral evaluation, and includes a written review of the member's medical and dental history, the examination and charting of the member's dentition and associated structures, periodontal charting if applicable, the diagnosis, and the preparation of treatment plans and reporting forms.

(B) Periodic Oral Evaluation. The MassHealth agency pays for a periodic oral evaluation twice per member per calendar year. A periodic oral evaluation includes an update of the member's medical and dental history, the examination and charting of the member's dentition and associated structures, periodontal charting if applicable, diagnosis, and the preparation of treatment plans and reporting forms. This service is not covered on the same date of service as an emergency treatment visit.

(C) Limited Oral Evaluation. The MassHealth agency pays for a limited oral evaluation twice per member per calendar year. A limited oral evaluation may necessitate further diagnostic procedures (such as radiographs) to help the provider formulate a differential diagnosis about the member's specific problem. A limited oral evaluation is not covered on the same date of service as an emergency treatment visit.

(D) Detailed and Extensive Oral Evaluation. The MassHealth agency pays for a detailed and extensive, problem-focused evaluation twice per member per calendar year. A detailed and extensive oral evaluation entails extensive diagnostic and cognitive modalities based on the findings of a more comprehensive oral evaluation. Integration of more extensive diagnostic modalities to develop a treatment plan for a specific problem is required. The condition requiring this type of evaluation must be described and documented. A detailed and extensive oral evaluation is not covered on the same date of service as an emergency treatment visit.

420.423: Service Descriptions and Limitations: Radiographs

(A) Introduction. The MassHealth agency pays for radiographs/diagnostic imaging taken as an integral part of diagnosis and treatment planning. The intent is to confine radiation exposure of members to the minimum necessary to achieve satisfactory diagnosis. The provider must document efforts to obtain any previous radiographs/diagnostic imaging before prescribing more. When radiographs and diagnostic imaging submitted to the MassHealth agency are not of good diagnostic quality, the provider may not claim payment for any retake of radiographs/diagnostic imaging requested by the MassHealth agency.

(B) Intraoral Conventional or Direct Digital Radiographs.

- (1) Full-mouth Radiographs. The MassHealth agency pays for full mouth radiographs only for members aged six years and older and only once per member every three calendar years. Full mouth radiographs must consist either of a minimum of ten periapical films and two posterior bitewing films, or two-to-four bitewing films and two periapical films taken with a panoramic film. However, panoramic films cannot be substituted for full mouth radiographs if full mouth radiographs are required for a prior-authorization request, unless the member has complete bony impacted teeth and other surgical conditions listed under 130 CMR 420.423(C)(1). The MassHealth agency does not pay more for individual periapical films (with or without bitewings) than it would for a full-mouth series.

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(2) Bitewing Radiographs. The MassHealth agency pays for up to four bitewing films as separate procedures no more than twice per calendar year. The MassHealth agency does not pay separately for bitewing films taken as part of a full-mouth series.

(3) Periapical Films. Periapical films may be taken for specific areas where extraction is anticipated when infection, periapical change, or an anomaly is suspected, or when otherwise directed by the MassHealth agency. A maximum of four periapical films is allowed per member per visit.

(C) Panoramic Films. The MassHealth agency pays for panoramic films for surgical and nonsurgical conditions as described in 130 CMR 420.423(C)(1) and (2). The MassHealth agency does not pay for panoramic films for crowns, endodontics, periodontics, and interproximal caries.

(1) Surgical Conditions. The MassHealth agency pays for panoramic films when used as a diagnostic tool for surgical conditions, whether or not the film is taken prior to the procedure or on the same date as the surgical procedure. Surgical conditions include, but are not limited to

- (a) impactions;
- (b) teeth requiring extractions in more than one quadrant;
- (c) large cysts or tumors that are not fully visualized by intraoral films or clinical examination;
- (d) salivary-gland disease;
- (e) maxillary-sinus disease;
- (f) facial trauma;
- (g) trismus where an intraoral film placement is impossible; and
- (h) orthognatic surgery.

(2) Nonsurgical Conditions.

(a) Members Younger than 21 Years Old. The MassHealth agency pays for only one panoramic film per member per three-year period for nonsurgical conditions, to monitor the growth and development of permanent dentition.

(b) Members 21 Years of Age or Older. The MassHealth agency pays for only one panoramic film per member per three year period in *lieu* of a full-mouth series only for those members who are unable to cooperate with the process for obtaining a full-mouth series. The provider must document in the member's dental record the reasons why the member cannot cooperate with the process for obtaining a full-mouth series.

(D) Cephalometric Film. The MassHealth agency pays for cephalometric films in conjunction with surgical conditions. Surgical conditions include, but are not limited to status post-facial trauma, mandibular fractures, dentoalveolar fractures, mandibular atrophy, and jaw dislocations. Payment for cephalometric film, or other radiographs, in conjunction with orthodontic diagnosis is included in the payment for orthodontic services. The MassHealth agency does not pay separately for additional radiographs when required for orthodontic diagnosis.

(E) Oral/Facial Photographic Images.

(1) The MassHealth agency pays for digital or photographic prints, not slides, only to support prior-authorization requests for orthodontic treatment.

(2) Payment for digital or photographic prints is included in the payment for orthodontic services. The MassHealth agency does not pay for digital or photographic prints as a separate procedure (*see* 130 CMR 420.413). Payment for orthodontic treatment includes payment for services provided as part of the pre-orthodontic work-up, except if the MassHealth agency denies the orthodontic treatment. In that case, the MassHealth agency pays for the pre-orthodontic work-up.

(3) The MassHealth agency may request digital or diagnostic photographic prints for other services that require prior-authorization.

(F) Diagnostic Casts. The MassHealth agency pays for diagnostic casts where medically necessary.

420.424: Service Descriptions and Limitations: Preventive Services

(A) Prophylaxis. The MassHealth agency pays for prophylaxis twice per member per calendar year. The prophylaxis must include a scaling of natural teeth, removal of acquired stains, and polishing of the teeth. As part of the prophylaxis, the practitioner must review with the member oral-hygiene methods including toothbrush instruction and flossing methods.

(B) Fluoride.

(1) Topical Fluoride Treatment.

(a) Members Younger than 21 Years Old. The MassHealth agency pays for topical fluoride treatment. Topical fluoride treatment consists of continuous topical application of an approved fluoride agent such as gels, foams, and varnishes, for a period shown to be effective for the agent. The MassHealth agency pays for treatment that incorporates fluoride with the polishing compound as part of the prophylaxis. The MassHealth agency does not pay for treatment that incorporates fluoride with the polishing compound as a separate procedure.

(b) Members 21 Years of Age or Older. The MassHealth agency pays for topical fluoride only for members who have medical or dental conditions that significantly interrupt the flow of saliva.

(2) Fluoride Supplements. The MassHealth agency pays for fluoride supplements only for members Younger than 21 Years Old and through the pharmacy program (*see* 130 CMR 406.000: *Pharmacy Services*).

(C) Sealants.

(1) The MassHealth agency pays for sealants, which includes proper preparation of the enamel surface, etching, placement and finishing of the sealant, and reapplication if the process fails within three years. The MassHealth agency does not pay to replace sealants lost or damaged during the three-year period when reapplied by the same provider. The MassHealth agency does not pay for sealants applied to any tooth that has been restored or for sealants for primary (deciduous) molars.

(2) The MassHealth agency pays only for sealants that meet all of the following requirements:

- (a) for permanent noncarious nonrestored molars;
- (b) for members who are younger than 17 years old; and
- (c) only once every three years per noncarious nonrestored molar.

(D) Space Maintainers. The MassHealth agency pays for space maintainers and replacement space maintainers. Space maintainers are indicated when there is premature loss of teeth that may lead to loss of arch integrity. For primary cuspids, space maintainers prevent midline deviation and loss of arch length and circumference. Premature loss of primary molars also indicates the use of space maintainers to prevent the migration of adjacent teeth. The loss of primary incisors usually does not require the use of a space maintainer. An initial diagnostically acceptable radiograph must be maintained in the member's record, demonstrating that the tooth has not begun to erupt or that migration of the adjacent tooth has already occurred. The provider must maintain in the member's record, diagnostic-quality radiographs that support the need for space maintainers whether initial or replacement. Payment for subsequent visits to adjust space maintainers is included in the original payment.

420.425: Service Descriptions and Limitations: Restorative Services

The MassHealth agency pays for restorative services in accordance with the service descriptions and limitations in 130 CMR 420.425(A) through (E). The MassHealth agency considers all of the following to be components of a completed restoration and includes them in the payment for this service: tooth and soft-tissue preparation, cement bases, etching and bonding agents, pulp capping, impression, local anesthesia, and polishing. The MassHealth agency does not pay for restorations replaced within one year of the date of completion of the original restoration when replaced by the same provider. The initial payment includes all restorations replaced due to defects or failure less than one year from the original placement.

(A) Amalgam Restorations.

(1) The MassHealth agency does not pay for restorations attempted on primary teeth when early exfoliation (more than $\frac{2}{3}$ of the root structure resorbed) is expected.

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(2) The MassHealth agency pays for only one amalgam restoration per member per tooth surface per year. Occlusal surface restorations, including all occlusal pits and fissures, are payable as a one surface restoration whether or not the transverse ridge on an upper molar is left intact.

(B) Resin-based Composite Restorations.

(1) The MassHealth agency pays for the following:

- (a) all resin-based composite restorations for all surfaces of anterior and posterior teeth;
- (b) full-coverage composite crowns only for members younger than 21 years old, only for anterior primary teeth; and
- (c) preventive resin restorations only for members younger than 21 years old, only on occlusal surfaces, and only as a single-surface posterior composite. Preventive resin restorations include instrumentation of the occlusal surfaces of grooves.

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(2) For anterior teeth, the MassHealth agency pays no more than the maximum allowable payment for four-or-more-surface resin-based composite restorations on the same tooth, except for reinforcing pins and commercial amalgam bonding systems.

(3) The MassHealth agency pays for only one resin-based composite restoration per member per tooth surface per year.

(4) The MassHealth agency does not pay more for a composite restoration on a posterior deciduous (primary) tooth than it would for an amalgam restoration.

(C) Crowns, Posts and Cores and Fixed Partial Dentures (Bridgework).

(1) Members Younger than 21 Years Old. The MassHealth agency pays for the following:

(a) crowns made from resin-based composite (indirect);

(b) crowns porcelain fused to predominantly base metal, posts and cores on permanent incisors, cuspids, bicuspid, and first and second molars; and

(c) prefabricated stainless-steel crowns for primary and permanent posterior teeth or prefabricated resin crowns for primary and permanent anterior teeth. Stainless-steel or prefabricated resin crowns are limited to instances where the prognosis is favorable and must not be placed on primary teeth that are mobile or show advanced resorption of roots. The MassHealth agency pays for no more than four stainless-steel or prefabricated resin crowns per member per date of service in an office setting.

(2) DDS Clients 21 Years of Age or Older. The MassHealth agency pays for crown porcelain fused to predominantly base metal, prefabricated posts and cores on anterior teeth only. The MassHealth agency pays for porcelain fused to predominantly base metal and stainless steel crowns for posterior teeth only if extraction (the alternative treatment) would cause undue medical risk for a member with one or more medical conditions that include, but are not limited to

(a) hemophilia;

(b) history of radiation therapy;

(c) acquired or congenital immune disorder;

(d) severe physical disabilities such as quadriplegia;

(e) profound mental retardation; and

(f) profound mental illness.

(D) Reinforcing Pins. The MassHealth agency pays for reinforcing pins only when used in conjunction with a two-or-more-surface restoration on a permanent tooth. Commercial amalgam bonding systems are included in this category.

(E) Crown Repair. The MassHealth agency pays for chairside crown repair and fixed partial denture repair. A description of the repair must be documented in the member's dental record. The MassHealth agency pays for unspecified restoration procedures for crown repair by an outside laboratory only if the repair is extensive and cannot be done chairside.

420.426: Service Descriptions and Limitations: Endodontic Services

Payment by the MassHealth agency for endodontic services includes payment for all radiographs performed during the treatment session. The MassHealth agency pays for endodontic services for members younger than 21 years of age and DDS clients only in accordance with the service descriptions and limitations described in 130 CMR 420.426.

(A) Pulpotomy.

(1) The MassHealth agency pays for a therapeutic pulpotomy for members younger than 21 years of age only. Pulpotomy consists of the complete removal of the coronal portion of the pulp to maintain the vitality of the remaining tissue by means of an adequate dressing. It is limited to instances when the prognosis is favorable, and must not be performed on primary teeth that are ready to exfoliate or permanent teeth with advanced periodontal disease.

(2) The MassHealth agency does not pay for pulpotomy on deciduous teeth that are ready to exfoliate.

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(3) The MassHealth agency does not pay for a pulpotomy performed on the same date of service as root-canal therapy. (See 130 CMR 420.456(D) regarding palliative treatment.)

(B) Root-canal Therapy.(1) General Conditions.

(a) Payment by the MassHealth agency for root-canal therapy includes payment for all preoperative and postoperative treatment; diagnostic (for example, pulp vitality) tests; and pretreatment, treatment, and post-treatment radiographs.

(b) The provider must maintain a radiograph of the completed root canal in the member's dental record.

(2) Members Under Age 21.

(a) The MassHealth agency pays for root-canal therapy on anterior teeth, bicuspid, and first and second molars but does not pay for root-canal therapy on third molars. Root-canal therapy is limited to the permanent dentition and then only when there is a favorable prognosis for the continued good health of both the tooth and the remaining dentition.

(b) The MassHealth agency pays for retreatment of previously root-canaled teeth for all permanent teeth with the exception of third molars.

(3) DDS Clients Aged 21 and Older.

(a) The MassHealth agency pays for root-canal therapy only on anterior teeth and then only when there is a favorable prognosis for the continued good health of both the tooth and the remaining dentition.

(b) The MassHealth agency does not pay for root-canal therapy on a posterior tooth unless extractions and/or removable prosthodontics (the alternate treatment) would cause undue medical risk for a member with one or more of the medical conditions that include but are not limited to those listed under 130 CMR 420.425(C)(2).

(C) Endodontic Retreatment.

(1) The MassHealth agency pays for endodontic retreatment of previous root-canal therapy on anterior, bicuspid, and molar teeth for members under age 21 only and endodontic retreatment of previous root-canal therapy only on anterior teeth for DDS clients aged 21 and older. This procedure may include the removal of a post, pins, old root-canal filling material, and the procedures necessary to prepare the canals and place the canal filling.

(2) The MassHealth agency pays for endodontic retreatment of previous root-canal therapy on a posterior tooth for DDS clients aged 21 and older only if the alternate treatment would cause undue medical risk for such member with one or more of the medical conditions that include but are not limited to those listed under 130 CMR 420.425(C)(2).

(3) Payment to the original provider includes all retreatments within 24 months of the original root canal.

(D) Apicoectomy/Periradicular Surgery.

(1) The MassHealth agency pays for an apicoectomy as a separate procedure for members under age 21 and DDS clients only following root canal therapy when the canal cannot be retreated through instrumentation.

(2) Payment by the MassHealth agency for an apicoectomy with root canal filling includes payment for the filling of the canal or canals and removing the pathological periapical tissue and any retrograde filling in the same period of treatment.

420.427: Service Descriptions and Limitations: Periodontic Services

(A) Gingivectomies and Gingivoplasties. The MassHealth agency pays for gingivectomies and gingivoplasties once per member per quadrant every three years for members under age 21 and DDS clients only. The MassHealth agency does not pay for a gingivectomy performed on the same day as a prophylaxis or periodontal scaling and root planing, or as a separate procedure with an extraction. The MassHealth agency pays only for the gingivectomy or gingivoplasty for a maximum of two quadrants on the same date of service in an office setting.

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(B) Periodontal Scaling and Root Planing. The MassHealth agency pays for periodontal scaling and root planing once per member per quadrant every three years for members under age 21 and DDS clients only. The MassHealth agency does not pay separately for prophylaxis provided on the same day as periodontal scaling and root planing or on the same day as a gingivectomy or a gingivoplasty. The MassHealth agency pays only for periodontal scaling and root planing for a maximum of two quadrants on the same date of service in an office setting.

420.428: Service Descriptions and Limitations: Prosthodontic Services (Removable)

(A) Dentures: General Conditions.

- (1) Members Under Age 21. The MassHealth agency pays for the following dentures only:
 - (a) complete dentures;
 - (b) immediate dentures; and
 - (c) removable partial-upper and partial lower cast dentures including conventional clasps and rests.
- (2) DDS Clients Aged 21 and Older.
 - (a) The MassHealth agency pays for the following dentures only:
 1. complete dentures (complete dentures following multiple extractions generally require a period of two months between the time the first impressions are taken); and
 2. removable resin-based partial-upper and partial-lower dentures, including conventional clasps and rests.
 - (b) The MassHealth agency does not pay for full dentures when contraindications include the presence of a physical or mental illness that affects the patient's ability to cooperate during the fabrication of the denture and to accept or function with the denture, or if the patient is not interested in the replacement of their missing teeth.
- (3) Denture Procedures.
 - (a) As part of the denture fabrication technique, the member must approve the teeth and set up in wax before the dentures are processed.
 - (b) The member's identification must be on each denture.
 - (c) All dentures must be initially inserted and subsequently examined and adjusted by the dentist at reasonable intervals consistent with practice in the community or at the member's request.

(B) Complete Dentures. Payment by the MassHealth agency for complete dentures includes payment for all necessary adjustments, including relines, as described in 130 CMR 420.428(E).

(C) Removable Partial Dentures. The MassHealth agency pays for removable partial dentures for members under age 21 and DDS clients only if there are two or more missing posterior teeth or one or more missing anterior teeth, the remaining dentition is sound and there is a good prognosis. A tooth is considered missing whether it is a natural tooth or a prosthetic tooth missing from a fixed prosthesis. Payment for a partial denture includes payment for all necessary clasps and rests.

(D) Replacement of Dentures. The MassHealth agency pays for the necessary replacement of dentures for members under age 21 and DDS clients only. The member is responsible for denture care and maintenance. The member, or persons responsible for the member's custodial care, must take all possible steps to prevent the loss of the member's dentures. The provider must inform the member of the MassHealth agency's policy on replacing dentures and the member's responsibility for denture care. The MassHealth agency does not pay for the replacement of dentures if the member's denture history reveals any of the following:

- (1) repair or reline will make the existing denture usable;
- (2) any of the dentures made previously have been unsatisfactory due to physiological causes that cannot be remedied;
- (3) a clinical evaluation suggests that the member will not adapt satisfactorily to the new denture;
- (4) no medical or surgical condition in the member necessitates a change in the denture or a requirement for a new denture;
- (5) the existing denture is less than seven years old and no other condition in this list applies;

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- (6) the denture has been relined within the previous two years, unless the existing denture is at least seven years old, or due to a marked physiological change in the member's oral cavity, any further reline has a poor prognosis for success; or
- (7) the loss of the denture was not due to extraordinary circumstances such as a fire in the home.

(E) Complete Denture Relines and Rebases. The MassHealth agency pays only for complete denture relines and rebases that are laboratory processed.

(1) Members Under Age 21. Payment for dentures for members under age 21 only includes any relines or rebases necessary within six months of the insertion date of the denture. The MassHealth agency pays for subsequent relines or rebases once every two years.

(2) DDS Clients Aged 21 and Older. Payment for dentures for DDS clients aged 21 and older only includes any relines necessary within 12 months of the insertion date of the denture. The MassHealth agency pays for subsequent relines and rebases once every three years.

420.429: Service Descriptions and Limitations: Prosthodontic Services (Fixed)

(A) Fixed Partial Dentures. The MassHealth agency pays for fixed partial dentures (bridgework) for anterior teeth only for members under age 21 only with fully matured teeth. The member's oral health must be excellent and the prognosis for the life of the bridge and remaining dentition must be excellent.

(B) Fixed Partial Denture Repair.

(1) The MassHealth agency pays for chairside fixed partial denture repair. A description of the repair must be documented in the member's dental record.

(2) The MassHealth agency pays for unspecified, fixed prosthodontic procedure by an outside laboratory only if the repair is extensive and cannot be done chairside.

420.430: Covered Service Descriptions and Limitations: Exodontic Services

(A) General Conditions.

(1) The MassHealth agency pays for exodontic services for all members, regardless of age, subject to the service descriptions and limitations described in 130 CMR 420.430 and including payment for local anesthesia, suture removal, irrigations, spicule removal, apical curettage of associated cysts and granulomas, enucleation of associated follicles, and routine preoperative and postoperative care.

(2) The MassHealth agency pays for routine extractions provided in an office, hospital, or freestanding ambulatory surgery center. Use of a hospital or freestanding ambulatory surgery center for extractions is limited to those members whose health, because of a medical condition, would be at risk if these procedures were performed in the provider's office. Member apprehension alone is not sufficient justification for use of a hospital or freestanding ambulatory surgery center. Lack of facilities for the administration of general anesthesia when the procedure can be routinely performed with local anesthesia does not justify the use of a hospital or a freestanding ambulatory surgery center.

(B) Extraction. The MassHealth agency pays for extractions. An extraction can be either the removal of soft tissue-retained coronal remnants of a deciduous tooth or the removal of an erupted tooth or exposed root by elevation and/or forceps including routine removal of tooth structure, minor smoothing of socket bone, and closure. The removal of root tips whose main retention is soft tissue is considered a simple extraction. All simple extractions may be performed as necessary. The MassHealth agency pays for incision and drainage as a separate procedure from an extraction performed on a different tooth on the same day.

(C) Surgical Removal of Erupted Tooth. The MassHealth agency pays for the surgical removal of an erupted tooth. Surgical removal of an erupted tooth is the removal of any erupted tooth that includes the retraction of a mucoperiosteal flap and the removal of alveolar bone in order to aid in the extraction or the sectioning of a tooth. The provider must maintain clinical documentation demonstrating medical necessity and a preoperative radiograph of the erupted tooth in the member's dental record to substantiate the service performed.

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(D) Surgical Removal of Impacted Tooth. The MassHealth agency pays for the surgical removal of an impacted tooth in a hospital or freestanding ambulatory surgery center, when medically necessary. Member apprehension alone is not sufficient justification for the use of a hospital or freestanding ambulatory surgery center. Lack of facilities for administering general anesthesia in the office setting when the procedure can be routinely performed with local anesthesia does not justify use of a hospital or freestanding ambulatory surgery center.

(1) Circumstances under which the MassHealth agency pays for surgical removal of impacted teeth include but are not limited to

- (a) full bony impacted supernumerary teeth, mesiodens, or teeth unerupted because of lack of alveolar ridge length;
- (b) teeth involving a cyst, tumor, or other neoplasm;
- (c) unerupted teeth causing the resorption of roots of other teeth;
- (d) partially erupted teeth that cause intermittent gingival inflammation; and
- (e) perceptive radiologic pathology that fails to elicit symptoms.

(2) The provider must maintain a preoperative radiograph of the impacted tooth in the member's dental record to substantiate the service performed. The radiograph must clearly define the category of impaction.

(3) A root tip is not considered an impacted tooth.

(4) Surgical removal of a whole tooth with soft-tissue impaction is the removal of a tooth in which the occlusal surface of the tooth is covered by soft tissue requiring mucoperiosteal flap elevation for removal.

(5) Surgical removal of a whole tooth with partial bony impaction is the removal of a tooth in which part of the crown is covered by bone and requires mucoperiosteal flap elevation and bone excision for removal. Segmentalization of the tooth may be required.

(6) Surgical removal of a whole tooth with complete bony impaction is the removal of a tooth in which most or all of the crown is covered by bone and requires mucoperiosteal flap elevation, bone removal, and possible segmentalization for removal.

(7) The MassHealth agency pays for surgical exposure of impacted or unerupted teeth to aid eruption only for members under age 21 for orthodontic reasons. MassHealth agency payment for surgical exposure includes reexposure due to tissue overgrowth or lack of orthodontic intervention.

(E) Alveoplasty. The MassHealth agency pays for alveoplasty for members under age 21 and DDS clients only.

(1) The MassHealth agency pays for alveoplasty procedures performed in conjunction with the extraction of teeth.

(2) MassHealth agency payment for a quadrant alveoplasty (dentulous or edentulous) includes any additional alveoplasty of the same quadrant performed within six months of initial alveoplasty.

(F) Vestibuloplasty. The MassHealth agency pays for vestibuloplasty ridge extension by report for members under age 21 and DDS clients only.

(G) Frenulectomy. The MassHealth agency pays for frenulectomy procedures for members under age 21 and DDS clients only. Frenulectomies may be performed to excise the frenum when the tongue has limited mobility, to aid in the closure of diastemas, and as a preparation for prosthetic surgery. If the purpose of the frenulectomy is to release a tongue, a written statement by a physician or primary care clinician and a speech pathologist clearly stating the problem must be maintained in the member's dental record. The MassHealth agency does not pay for labial frenulectomies performed before the eruption of the permanent cuspids, unless orthodontic documentation that clearly justifies the medical necessity for the procedure is maintained in the member's dental record.

(H) Excision of Hyperplastic Tissue. The MassHealth agency pays for excision of hyperplastic tissue by report for members under age 21 and DDS clients only. The MassHealth agency does not pay separately for the excision of hyperplastic tissue when performed in conjunction with an extraction. This procedure is generally reserved for the preprosthetic removal of such lesions as fibrous epuli or benign palatal hyperplasia.

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(I) Excision of Benign Lesion. The MassHealth agency pays for excision of soft-tissue lesions for members under age 21 and DDS clients only.

(J) Tooth Reimplantation and Stabilization of Accidentally Evulsed or Displaced Tooth. The MassHealth agency pays for tooth reimplantation and stabilization of an accidentally evulsed or displaced tooth. The procedure includes splinting and stabilization.

(K) Treatment of Complications (Post-surgical). The MassHealth agency pays for nonroutine postoperative follow-up in the office as an individual-consideration service only for unusual services and only to ensure the safety and comfort of a postsurgical member. This nonroutine postoperative visit may include drain removal or packing change. The provider must include a detailed report for individual consideration in conjunction with the claim form for postoperative visit. The report must at a minimum include the date, the location of the original surgery, and the type of procedure.

420.431: Service Descriptions and Limitations: Orthodontic Services

(A) General Requirements.

(1) The MassHealth agency pays for orthodontic treatment only for members under age 21 and only once per member per lifetime. The provider must begin initial fabrication and insertion of orthodontic appliances (initial treatment) before a member is 21 years of age. The MassHealth agency pays for the continuation of full orthodontic treatment as long as the member remains eligible for MassHealth, provided that initial treatment started before the member reached age 21. This payment limitation also applies to any pre- or post-orthognathic surgical case.

(2) The MassHealth agency pays for pre orthodontic work up (alternative billing to a contract fee) when the MassHealth agency denies a request for prior authorization for comprehensive orthodontic treatment and when the member fails to receive further treatment.

(B) Orthodontic Consultation. The MassHealth agency pays for an orthodontic consultation only for members under age 21 and only for the purpose of determining whether orthodontic treatment is necessary, and if so, when treatment should begin. The MassHealth agency pays for an orthodontic consultation as a separate procedure (*see* 130 CMR 420.413) only once per six-month period. The MassHealth agency does not pay for an orthodontic consultation as a separate procedure when used in conjunction with ongoing or planned (within six months) orthodontic treatment. The payment for an orthodontic consultation as a separate procedure does not include models or photographic prints. The MassHealth agency may request additional consultation for any orthodontic procedure.

(C) Orthodontic Radiographs. The MassHealth agency pays for radiographs as a separate procedure for orthodontic diagnostic purposes only for members under age 21, and only if requested by the MassHealth agency. Cephalometric films are to be used in conjunction with orthodontic diagnosis and are included in the payment for comprehensive orthodontic treatment (*see* 130 CMR 420.423(D)). Payment for radiographs in conjunction with orthodontic diagnosis is included in the payment for orthodontic services. If the MassHealth agency denies the request for comprehensive orthodontic treatment, the MassHealth agency pays for pre-orthodontic work-up that includes payment for radiographs.

(D) Interceptive Orthodontic-treatment Visits. The goal of preventive or interceptive orthodontics is to prevent or minimize a developing malocclusion with primary or mixed dentition. Use of this treatment precludes or minimizes the need for additional orthodontic treatment.

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(E) Comprehensive Orthodontic Treatment.

(1) The MassHealth agency pays for comprehensive orthodontic treatment only once per member under age 21 per lifetime and only when the member has a severe and handicapping malocclusion. The MassHealth agency determines whether a malocclusion is severe and handicapping based on the clinical standards described in Appendix D of the *Dental Manual*. The permanent dentition must be reasonably complete (usually by age 11). Payment covers a maximum period of two and one-half years of orthodontic treatment visits. Upon the completion of orthodontic treatment, the provider must take photographic prints and maintain them in the member's dental record.

(2) Payment for initial fabrication and insertion of the orthodontic appliance, which includes payment for records and all appliances associated with treatment: fixed and removable (for example, rapid palatal expansion (RPE) or head gear) is included in the payment for comprehensive orthodontic treatment.

(F) Orthodontic Treatment Visits. The MassHealth agency pays for ongoing orthodontic treatment visits on a quarterly basis (each quarter is billed as one unit of service). If a member becomes inactive for any period of time, prior authorization is not required to resume orthodontic treatment visits and subsequent billing unless the prior-authorization time limit has expired. Orthodontists should see members every four-to-six weeks. The provider may bill the MassHealth agency for a quarterly visit if the MassHealth member was seen at least once in that quarter. The provider must document the number and dates of visits in the member's orthodontic record.

(G) Replacement Retainers. The MassHealth agency pays for a replacement retainer only during the two-year retention period following orthodontic treatment.

(H) Orthodontic Retention. The MassHealth agency pays separately for orthodontic retention (removal of appliances, construction and placement of retainers). Retention includes the fabrication and delivery of the initial retainers and follow-up visits. The MassHealth agency pays for a maximum of five retention visits (post-treatment stabilization).

(I) Patient Noncooperation. If the provider determines that continued orthodontic treatment is not indicated because of lack of member cooperation, the provider may request individual consideration for appliance removal and the placement of retainers, if indicated.

420.452: Service Descriptions and Limitations: Anesthesia

(A) General Anesthesia and IV Sedation. The MassHealth agency pays for general anesthesia and IV sedation subject to the service descriptions and limitations described in 130 CMR 420.452.

(1) General Anesthesia. General anesthesia, when administered in the office, must be administered only by a provider who possesses both an anesthesia administration permit and an anesthesia facility permit issued by the Massachusetts Board of Registration in Dentistry and when a member is eligible for oral-surgery services. All rules, regulations, and requirements set forth by the Massachusetts Board of Registration in Dentistry and by the Massachusetts Society of Oral and Maxillofacial Surgeons that apply to office general anesthesia, intravenous sedation, and the various forms of analgesia must be followed without exception. In most circumstances general anesthesia is used for oral surgery and maxillofacial procedures. The MassHealth agency pays for general anesthesia services for the first 30 minutes and in 15-minute increments thereafter, as set forth in the service descriptions in Subchapter 6 of the *Dental Manual*. Payment for general anesthesia in the office setting is limited to a maximum of 90 minutes.

(2) IV Sedation. The MassHealth agency pays for IV sedation when administered in the office, and when a member is eligible for oral-surgery services, only when administered by a provider who possesses both an anesthesia-administration permit and an anesthesia-facility permit issued by the Massachusetts Board of Registration in Dentistry. IV sedation may only be used for oral surgery and maxillofacial procedures. The MassHealth agency pays for IV sedation services for the first 30 minutes and in 15-minute increments thereafter, as set forth in the service descriptions in Subchapter 6 of the *Dental Manual*. Payment for IV sedation in the office setting is limited to a maximum of 90 minutes.

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- (B) Analgnesia. The MassHealth agency pays for analgesia as follows.
- (1) The MassHealth agency pays for the administration of analgesia, both orally (PO), and rectally (PR), as part of an operative procedure. The MassHealth agency does not pay for the administration of non-inhalation analgesia, as a separate procedure (*see* 130 CMR 420.413).
 - (2) The MassHealth agency pays for the administration of inhalation analgesia (nitrous oxide (N₂O/O₂)) as a separate procedure.
- (C) Local Anesthesia. The MassHealth agency pays for the administration of local anesthesia as part of an operative procedure. The MassHealth agency does not pay for local anesthesia as a separate procedure (*see* 130 CMR 420.413).
- (D) Documentation. The provider must maintain a completed anesthesia flowsheet in the member's dental record. In addition, the provider must document the following in the member's dental record:
- (1) the beginning and ending times of any general anesthesia or analgesia;
 - (2) preoperative, intraoperative, and postoperative vital signs;
 - (3) medications administered including their dosages and routes of administration;
 - (4) monitoring equipment used; and
 - (5) a statement of the member's response to the analgesic or anesthetic used including any complication or adverse reaction.

420.453: Service Descriptions and Limitations: Oral and Maxillofacial Surgery Services

The MassHealth agency pays for oral and maxillofacial surgery services subject to the service descriptions and limitations described in 130 CMR 420.453. Payment for oral and maxillofacial surgery services includes payment for routine inpatient preoperative and postoperative care as well as for any related administrative or supervisory duties in connection with member care.

- (A) Introduction. Oral and maxillofacial surgery services consist of those basic surgical services essential for the prevention and control of diseases of the oral cavity and supporting structures and for the maintenance of oral health. The MassHealth agency pays for maxillofacial surgery services only for the purpose of anatomic and functional reconstruction of structures that are missing, defective, or deformed because of surgical intervention, trauma, pathology, or developmental or congenital malformations. Cosmetic benefit may result from such surgical services but cannot be the primary reason for those services.
- (B) General Conditions. The MassHealth agency pays only a dentist who is a specialist in oral surgery for the services listed in Subchapter 6 of the *Dental Manual* designated as current procedural terminology (CPT) codes. Oral and maxillofacial surgery services should be performed in the office location where technically feasible and safe for the member. The MassHealth agency pays for the use of such settings when it is justified by the difficulty of the surgery (for example, four deep bony impactions) and the medical health of the member (for example, asthmatic on multiple medications, alcoholism, or drug history, seizure disorder, or developmentally disabled). Member fear or apprehension does not justify the use of a hospital or freestanding ambulatory surgery center.
- (C) Surgical Assistants. The MassHealth agency pays a surgical assistant 15% of the allowable fee for the procedure performed.
- (D) Preoperative Diagnosis and Postoperative Care. Payment for surgery procedures performed in a hospital or freestanding ambulatory surgery center includes payment for preoperative diagnosis and postoperative care during the member's stay.
- (E) Inpatient Visits. The MassHealth agency pays providers for visits to hospitalized members except for routine preoperative and postoperative care to members who have undergone or who are expected to undergo surgery. Inpatient visits are payable only under exceptional circumstances, such as with preoperative or postoperative complications or the need for extended care, prolonged attention, intensive-care services, or consultation services. The provider must substantiate the need for this service in the member's hospital medical record.

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(F) Multiple Procedures.

- (1) The MassHealth agency does not pay separately for the component parts of a major, more comprehensive service when they are performed on the same date as the comprehensive service. Payment for a comprehensive service includes any separately identified component parts of the comprehensive service, even when separate service codes exist for the component parts. (For example, the provider may not claim payment for a frenulectomy performed at the time of a full vestibuloplasty with graft.)
- (2) Where two or more individual procedures are performed in the same operative session, the MassHealth agency pays the full amount for the procedure with the highest payment rate, and each additional procedure is payable at 50% of the amount that would have been paid if performed alone. This requires the use of modifiers and applies only to those oral-surgery codes listed in Subchapter 6 of the *Dental Manual* designated as current procedural terminology (CPT) codes.

(G) Orthognathic Surgery.

- (1) The MassHealth agency pays for orthognathic surgery.
- (2) Any proposed orthodontic treatment must meet all the criteria described at 130 CMR 420.431.

420.455: Service Descriptions and Limitations: Maxillofacial Prosthetics

- (A) The MassHealth agency pays for maxillofacial prosthetics by providers who have completed a CODA certificate program in maxillofacial prosthetics (as described in 130 CMR 420.405(A)(8)) and only where the maxillofacial prosthetic device will be constructed for the treatment of a member with congenital, developmental, or acquired defects of the mandible or maxilla and associated structures.
- (B) The MassHealth agency pays for opposing appliances only when they are necessary for the balance or retention of the primary maxillofacial prosthetic device.

420.456: Service Descriptions and Limitations: Other Services

(A) Hospital or Freestanding Ambulatory Surgical Center: Admission of Members with Certain Disabilities or Age-related Behavior for Restorative, Endodontic, or Exodontic Dentistry.

- (1) The MassHealth agency pays for a member who is severely and chronically mentally and physically impaired, under certain circumstances, to undergo restorative, endodontic, or exodontic dental procedures for which they are eligible in a hospital or freestanding ambulatory surgery center. Use of these facilities may be indicated for a member who
 - (a) has a condition that is reasonably likely to place the member at risk of medical complications that require medical resources that are not available in an office setting;
 - (b) is extraordinarily uncooperative, fearful, or anxious;
 - (c) has dental needs but for which local anesthesia is ineffective due to acute infection, idiosyncratic anatomy, or allergy; or
 - (d) has sustained orofacial or dental trauma, or both, so extensive that treatment cannot be provided safely and effectively in an office setting.
- (2) The member's medical record must include the following:
 - (a) a detailed description of the member's illness or disability;
 - (b) a history of previous treatment or attempts at treatment;
 - (c) a treatment plan listing all procedures and the teeth involved;
 - (d) radiographs (if radiographs are not available, an explanation is required);
 - (e) photographs to indicate the condition of the mouth if radiographs are not available; and
 - (f) documentation that there is no other suitable site of service for the member that would be less costly to the MassHealth agency.

(B) Oral Screenings for Members Undergoing Radiation Treatment or Chemotherapy.

- (1) The MassHealth agency pays for oral screenings for members undergoing radiation, chemotherapy, or both, or who are on long-term immunosuppressive therapy.

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(2) The MassHealth agency pays for a global fee for oral screenings that include payment for

- (a) comprehensive oral examination;
- (b) consultation;
- (c) salivary flow measurements;
- (d) oral hygiene evaluations and instructions;
- (e) fluoride treatments;
- (f) construction of fluoride trays;
- (g) follow-up examination; and
- (h) follow-up salivary evaluations.

(C) Behavioral Management. The MassHealth agency pays an additional payment once per member per day for management of a severely and chronically mentally, physically and/or developmentally impaired member in the office. The provider must document a history of treatment or previous attempts at treatment in the member's medical record.

(D) Palliative Treatment of Dental Pain or Infection. The MassHealth agency pays for palliative treatment to alleviate dental pain or infection in an emergency. Palliative treatment includes those services minimally required to address the immediate emergency including, but not limited to, draining of an abscess, prescribing pain medication or antibiotics, or other treatment that addresses the member's chief complaint. The provider must maintain in the member's dental record a description of the treatment provided and must document the emergent nature of the condition. The MassHealth agency pays separately for medically necessary covered services provided during the same visit.

(E) Occlusal Guard. The MassHealth agency pays for occlusal guards only for members under age 21 and only once per calendar year. The MassHealth agency pays for only custom-fitted laboratory-processed occlusal guards designed to minimize the effects of bruxism (grinding) and other occlusal factors. All follow-up care is included in the payment.

(F) Mouth Guard for Sports. The MassHealth agency pays for custom-fitted mouth guards where medically necessary, only for members under age 21. The member must be engaged in a contact sport, and there must be no other provision for the purchase of mouth guards for the sport's participants. Examples of contact sports include but are not limited to basketball, football, hockey, lacrosse, and soccer.

(G) House/Facility Call. The MassHealth agency pays for visits to nursing facilities, chronic disease and rehabilitation hospitals, hospice facilities, schools, and other licensed educational facilities, once per facility per day, in addition to any medically necessary MassHealth-covered service provided during the same visit.

REGULATORY AUTHORITY

130 CMR 420.000: M.G.L. c. 118E, §§ 7 and 12.

(PAGES 333 THROUGH 336 ARE RESERVED FOR FUTURE USE.)