Office of Medicaid
BOARD OF HEARINGS

Appellant Name and Address:

[redacted]

Appeal Decision:	Denied in part; Approved in part	**Appeal Number:**	2405985
Decision Date:	10/29/2024	**Hearing Date:**	07/24/2024
Hearing Officer:	Emily Sabo	**Record Open to:**	08/29/2024

Appearance for Appellant:

[redacted]

Appearances for Molina/Senior Whole Health:
Dr. Robert Thielen, Dental Director; Trenisha Kunzi, Appeals & Grievance Manager; Dr. Christopher Post, Chief Medical Officer; Ann Dupre, Senior Process Specialist for Senior Whole Health

Interpreter:
[redacted]

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
Board of Hearings
100 Hancock Street, Quincy, Massachusetts 02171

APPEAL DECISION

Appeal Decision:	Denied in part; Approved in part	**Issue:**	Dental Services; Prior Authorization; Senior Care Organizations (SCOs)
Decision Date:	10/29/2024	**Hearing Date:**	07/24/2024
Molina's Reps.:	Robert Thielen; Trenisha Kunzi; Christopher Post; Ann Dupre	**Appellant's Rep.:**	Pro se
Hearing Location:	Quincy Harbor South 4	**Aid Pending:**	No

Authority

This hearing was conducted pursuant to Massachusetts General Laws Chapter 118E, Chapter 30A, and the rules and regulations promulgated thereunder.

Jurisdiction

Through a notice dated December 27, 2023, Molina Senior Whole Health, a MassHealth Senior Care Organization (SCO)[1] and MassHealth's agent, denied the Appellant's appeal of a denial for certain dental procedures.[2] Exhibit 1. The Appellant filed this appeal in a timely manner on April 15, 2024. 130 CMR 610.015(B)(7)(a) and Exhibit 2. Denial of assistance is valid grounds for appeal.[3]

[1] In 130 CMR 501.001, SCO is defined as "an organization that participates in MassHealth under a contract with the MassHealth agency and the Centers for Medicare & Medicaid Services to provide a comprehensive network of medical, health care, and social service providers that integrates all components of care, either directly or through subcontracts. SCOs are responsible for providing enrollees with the full continuum of Medicare- and MassHealth-covered services."

[2] The Appellant's request for services was denied on November 16, 2023, and the Appellant appealed that denial on December 8, 2023. Exhibit 7.

[3] On March 5, 2024, Molina approved procedures D6010, D6057, D6058 for tooth 20, which were initially denied in the December 27, 2023, appeal. Exhibit 5. Because those were resolved prior to the hearing, they will not be discussed further in this decision.

130 CMR 610.032.

Action Taken by Molina Senior Whole Health

Molina Senior Whole Health denied the Appellant's request for procedures D7953 (bone grafts at time of tooth removal) for teeth #7, 10, 11, and 14; D2740 (all white glass crown) for tooth #4; D5820 (temporary (interim) partial denture); D0367 (cone beam CT scan); and D5982 (surgical stent material) for tooth #7.

Issue

The appeal issue is whether Molina Senior Whole Health was correct, in denying the Appellant's request for procedures D7953 (bone grafts at time of tooth removal) for teeth #7, 10, 11, and 14; D2740 (all white glass crown) for tooth #4; D5820 (temporary (interim) partial denture); D0367 (cone beam CT scan); and D5982 (surgical stent material) for tooth #7.

Summary of Evidence

The Appellant and hearing officer appeared in person at the Board of Hearings' Quincy office for the hearing, and the Molina Senior Whole Health representatives appeared for the hearing by phone. The Appellant testified through an interpreter and verified her identity.

Molina Senior Whole Health was represented by its Dental Director who testified that the Appellant's condition is complex, and that she has already had a lot of restorative dental work performed, including implants and crowns. The Dental Director testified that procedure D2740 (all white glass crown) for tooth #4 was denied because it exceeded the benefit limitation because the member had had the service within the last 60 months. When the hearing officer asked when procedure D2740 had been performed on tooth #4, the Dental Director stated that he was not sure when it was last done and that based on the Appellant's claim history, she has had a number of procedures done since 2019. The Dental Director explained that procedures D7953 (bone grafts at time of tooth removal) for teeth #7, 10, 11, and 14; D5820 (temporary (interim) partial denture); D0367 (cone beam CT scan); and D5982 (surgical stent material) for tooth #7 were denied because they are not covered services.

The Appellant shared her appeal letter for the record:

> I'm an [redacted] with chronic medical conditions and a history of neck cancer . . . I currently have a loose dental bridge on my upper front teeth that is close to falling out because of broken and infected teeth. It is affecting my quality of life because I can't eat as it moves up and down. To fix this problem, my dentists need to do a

> bone graft in the area, do a 3D scan and make a surgical guide to help with implant placement, which are procedures that were denied. I got approved for the actual implants and their respective crowns, however, I cannot get these implants without the denied procedures, which are pre-requisites for the treatment. I cannot afford any of the non-covered procedures, [I have] no income. The option for me to get a removable prosthesis beyond temporary measures will be devastating to my quality of life as with my cancer history my mouth is dry and I was told it would not fit well and will not be comfortable. I would greatly appreciate it if you could reconsider approving the denied procedures.

Exhibit 2 at 2.

At the hearing, the Appellant visually demonstrated that her upper bridge does not fit to her gum, such that there is a sizable gap between the bridge and her gums. The Appellant also testified that she cannot eat for that reason.

The record was held open until August 15, 2024, for the Appellant to submit a narrative and supporting medical records from her dentist as to why the procedure was medically necessary. The record was held open until August 29, 2024, for Molina Senior Whole Health to respond.

The Appellant's dentist wrote:

> [The Appellant] is an [redacted] with controlled chronic medical conditions. She lives on a limited income and has limited means when she comes to her dental treatments. Since 2022, she's been suffering with a loose bridge on her upper front left side with fractured teeth and chronic infections that are hindering her ability to eat and chew as well. The bridge extends from teeth #7-13.
>
> [The Appellant] is not able to tolerate a removable prosthesis at this time due to chronic dryness of her mucosa, therefore, our efforts are focused on an implant replacement for her. She is planned for implants in sites #7, 10, 11, and 13 and implant supported bridges which were previously approved by her insurance. However, in order for us to continue with this treatment option, we require a CBCT (cone beam CT-scan) be taken and surgical planning for a surgical guide to ensure proper placement of the implants in the best possible restorative position. Those services have been denied by her insurance unfortunately, but due to her limited income, she is unable to come up with funds for those services.
>
> Please find attached to this request copies of more recent x-rays that were taken over the past year, as well as pictures of her intraoral scans that show the current condition of her bridge. The patient is in desperate need for these treatments as it [i]s affecting her ability to eat and function which ultimately is affecting her quality

> of life. Please consider giving the patient the coverage she needs so she can get her treatments done.

Exhibit 10 at 2. The submission also included scans showing the damaged bridge. *Id.* at 4-6.

In response, Molina Senior Whole Health's Dental Director wrote:

> [redacted] member with failing prior full mouth rehabilitation including multiple implants, crowns, restorative therapy. Extensive secondary full mouth rehabilitation is being requested. There is no comprehensive long-term treatment plan submitted for this member to support the medical necessity of the requests for bone grafts, temporary partial denture services, etc. The[re] is no medical health status documentation of the member to determine the success of future rehabilitative care. . . Documentation submitted and reviewed does not support the medical necessity for providing the following services and/or considering services not offered under member's Plan benefits. Molina therefore respectively supports upholding the denial. *Id.* at 1.

Findings of Fact

Based on a preponderance of the evidence, I find the following:

1. The Appellant is [redacted]. Testimony, Exhibit 6.

2. The Appellant is eligible for MassHealth Standard and is enrolled in a SCO, Molina Senior Whole Health. Testimony, Exhibit 6.

3. On November 16, 2023, Molina Senior Whole Health denied the Appellant's request for dental services. Exhibit 7.

4. On December 8, 2023, the Appellant appealed that denial internally with Molina Senior Whole Health. Exhibit 7.

5. On December 27, 2023, Molina Senior Whole Health denied the Appellant's Level I internal appeal. Exhibit 1.

6. On April 15, 2024, the Appellant timely filed an external appeal with the Board of Hearings. Exhibit 2.

Analysis and Conclusions of Law

As a rule, the MassHealth agency and its dental program only pay for medically necessary

services to eligible MassHealth members and may require that such medical necessity be established through a prior authorization process. 130 CMR 450.204; 130 CMR 420.410. In addition to complying with the prior authorization requirements at 130 CMR 420.410 et seq.,[4] covered services for certain dental treatments are subject to the relevant limitations of 130 CMR 420.421 through 420.456. 130 CMR 420.421 provides the relevant introduction to service limitations for members over the age of 21:

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

> (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 MassHealth determines the service to be medically necessary and the member is younger than 21 years old. Prior authorization must be submitted for any medically necessary noncovered services for members younger than 21 years old.*

(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 crylic before the initial impressions);
(3) counseling or member education services;
(4) habit-breaking appliances;
(5) implants of any type or description;
(6) laminate veneers;
(7) oral hygiene devices and appliances, dentifrices, and mouth rinses;
(8) orthotic splints, including mandibular orthopedic repositioning appliances;
(9) panoramic films for crowns, endodontics, periodontics, and interproximal caries;
(10) root canals filled by silver point technique, or paste only;
(11) tooth splinting for periodontal purposes; and

[4] 130 CMR 420.410(C) also references and incorporates the MassHealth Dental Program Office Reference Manual as a source of additional explanatory guidance beyond the Regulations. It is noted that references in the Regulations to the Dental Manual include the pertinent state Regulations, the administrative and billing instructions, and service codes found in related subchapters and appendices.

(12) *any other service not listed in Subchapter 6 of the Dental Manual.*

130 CMR 420.421(A), (B) (emphasis added).

130 CMR 508.008 provides:

508.008: Senior Care Organizations

(A) Enrollment Requirements. In order to voluntarily enroll in a senior care organization, a MassHealth Standard member must meet all of the following criteria:

(1) be 65 years of age or older;
(2) live in a designated service area of a senior care organization;
(3) not be diagnosed as having end-stage renal disease;
(4) not be subject to a six-month deductible period under 130 CMR 520.028: *Eligibility for a Deductible*;
(5) not be a resident of an intermediate care facility for individuals with intellectual disabilities (ICF/ID); and
(6) not be an inpatient in a chronic or rehabilitation hospital.

(B) Selection Procedure. The MassHealth agency will notify members of the availability of a senior care organization (SCO) in their service area and of the procedures for enrollment. An eligible member may voluntarily enroll in any SCO in the member's service area. A service area is the specific geographical area of Massachusetts in which a SCO agrees to serve its contract with the MassHealth agency and the Centers for Medicare & Medicaid Services. Service area listings may be obtained from the MassHealth agency or its designee. The list of senior care organizations (SCOs) that the MassHealth agency will make available to members will include those SCOs that contract with the MassHealth agency and provide services within the member's service area.

(C) Obtaining Services When Enrolled in a SCO. When a member chooses to enroll in a senior care organization (SCO) in accordance with the requirements under 130 CMR 508.008, the SCO will deliver the member's primary care and will authorize, arrange, integrate, and coordinate the provision of all covered services for the member. Upon enrollment, each SCO is required to provide evidence of its coverage, including a complete list of participating providers, the range of available covered services, what to do for emergency conditions and urgent care needs, and how to obtain access to covered services such as specialty, behavioral health, and long-term-care services.

(D) Disenrollment from a Senior Care Organization. A member may disenroll from a SCO at any time by submitting a notice of disenrollment to the MassHealth agency or its designee. Disenrollment notices received by the MassHealth agency or its designee by the 20th day of the month will be effective the first day of the following month.

(E) Discharge or Transfer. The MassHealth agency may discharge or transfer a member from a SCO

where the SCO demonstrates to the MassHealth agency's satisfaction a pattern of noncompliant or disruptive behavior by the member or for other good cause. In each case, the MassHealth agency will state the good cause basis for discharge or transfer in a notice to the member.

(F) Other Programs. While voluntarily enrolled in a senior care organization (SCO) under 130 CMR 508.008, a member may not concurrently participate in

(1) any program described in 130 CMR 519.007: *Individuals Who Would be Institutionalized*, except the Home- and Community-based Services Waiver-Frail Elder described in 130 CMR 519.007(B): *Home- and Community-based Services Waiver-Frail Elder*;

(2) any Medicare demonstration program or Medicare Advantage plan, except for Medicare Advantage Special Needs Plan for Dual Eligibles contracted as a SCO; or

(3) an ICO described in 130 CMR 508.007.

(G) Copayments. Members who are enrolled in a SCO must make copayments in accordance with the SCO's MassHealth copayment policy. Those SCO copayment policies must

(1) be approved by MassHealth;

(2) exclude the persons and services listed in 130 CMR 506.014: *Copayments Required by MassHealth* and 520.037: *Copayment and Cost Sharing Requirement Exclusions*;

(3) not exceed the MassHealth copayment amounts set forth in 130 CMR 506.015: *Copayment and Cost Sharing Requirement Exclusions* and 520.038: *Services Subject to Copayments*; and

(4) include the copayment maximums set forth in 130 CMR 506.018: *Maximum Cost Sharing* and 520.040: *Maximum Cost Sharing*. (See also 130 CMR 450.130: *Copayments Required by the MassHealth Agency*.)

130 CMR 508.008.

130 CMR 450.105(A) provides:

450.105: Coverage Types

A member is eligible for services and benefits according to the member's coverage type. Each coverage type is described below. Payment for the covered services listed in 130 CMR 450.105 is subject to all conditions and restrictions of MassHealth, including all applicable prerequisites for payment. See individual program regulations for information on covered services and specific service limitations, including age restrictions applicable to certain services.

(A) MassHealth Standard.

(1) Covered Services. The following services are covered for MassHealth Standard members (see 130 CMR 505.002: *MassHealth Standard* and 130 CMR 519.002: *MassHealth Standard*).

(a) abortion services;

(b) acupuncture services;

(c) adult day health services;
(d) adult foster care services;
(e) ambulance services;
(f) ambulatory surgery services;
(g) audiologist services;
(h) behavioral health services;
(i) certified nurse midwife services
(j) certified nurse practitioner services;
(k) certified registered nurse anesthetist services;
(l) Chapter 766: home assessments and participation in team meetings;
(m) chiropractor services;
(n) clinical nurse specialist services;
(o) community health center services;
(p) day habilitation services;
(q) dental services;
(r) durable medical equipment and supplies;
(s) early intervention services;
(t) family planning services;
(u) hearing aid services;
(v) home health services;
(w) hospice services;
(x) independent nurse (private duty nursing) services;
(y) inpatient hospital services;
(z) laboratory services;
(aa) nursing facility services;
(bb) orthotic services;
(cc) outpatient hospital services;
(dd) oxygen and respiratory therapy equipment;
(ee) personal care services;
(ff) pharmacy services;
(gg) physician services;
(hh) physician assistant services;
(ii) podiatrist services;
(jj) prosthetic services;
(kk) psychiatric clinical nurse specialist services;
(ll) rehabilitation services;
(mm) renal dialysis services;
(nn) speech and hearing services;
(oo) therapy services: physical, occupational, and speech/language;
(pp) transportation services;
(qq) urgent care clinic services;
(rr) vision care; and

(ss) X-ray/radiology services.

(2) Managed Care Member Participation. MassHealth Standard members must enroll with a MassHealth managed care provider unless excluded from enrollment with a MassHealth managed care provider. (See 130 CMR 450.117, and 130 CMR 508.000: *MassHealth: Managed Care Requirements*.) MassHealth members who are enrolled in the Kaileigh Mulligan Program, described in 130 CMR 519.007(A): *The Kaileigh Mulligan Program*, or who are enrolled in a home- and community-based services waiver may choose to enroll in the PCC Plan or a MassHealth-contracted MCO. Such members who do not choose to enroll in the PCC Plan or a MassHealth-contracted MCO are enrolled with the MassHealth behavioral health contractor. Such members may choose to receive all services on a fee-for-service basis.

(3) MCOs, Accountable Care Partnership Plans, SCOs, and ICOs. For MassHealth Standard members who are enrolled in an MCO, Accountable Care Partnership Plan, SCO, or ICO, 130 CMR 450.105(A)(3)(a) and (b) apply.

(a) The MassHealth agency does not pay a provider other than the MCO, Accountable Care Partnership Plan, SCO, or ICO for any services that are covered by the MassHealth agency's contract with the MCO, Accountable Care Partnership Plan, SCO, or ICO except for family planning services that were not provided or arranged for by the MCO, Accountable Care Partnership Plan, SCO, or ICO. It is the responsibility of the provider to verify the scope of services covered by the MassHealth agency's contract with the MCO, Accountable Care Partnership Plan, SCO, or ICO.

(b) The MassHealth agency pays providers other than the MCO, Accountable Care Partnership Plan, SCO, or ICO for those services listed in 130 CMR 450.105(A)(1) that are not covered by the MassHealth agency's contract with the MCO, Accountable Care Partnership Plan, SCO, or ICO. Such payment is subject to all conditions and restrictions of MassHealth, including all applicable prerequisites for payment.

(4) Behavioral Health Services.

(a) MassHealth Standard members enrolled in the PCC Plan or a Primary Care ACO receive behavioral health services only through the MassHealth behavioral health contractor. (See 130 CMR 450.124.)

(b) MassHealth Standard members enrolled in an MCO, Accountable Care Partnership Plan, SCO, or ICO receive behavioral health services only through the MCO, Accountable Care Partnership Plan, SCO, or ICO. (See 130 CMR 450.117.)

(c) MassHealth Standard members who are not enrolled in an MCO, Accountable Care Partnership Plan, SCO, ICO, or with the behavioral health contractor may receive behavioral health services from any participating MassHealth provider of such services.

(d) MassHealth Standard members who are younger than 21 years old and who are excluded from participating with a MassHealth managed care provider under 130 CMR 508.002(A)(1) or (2) must enroll with the MassHealth behavioral health contractor.

(e) MassHealth members who are enrolled in the Kaileigh Mulligan Program, described in 130 CMR 519.007(A): *The Kaileigh Mulligan Program*, may choose to enroll with a MassHealth managed care provider. Such members who do not choose to enroll with a

MassHealth managed care provider are enrolled with the MassHealth behavioral health contractor. Such members may choose to receive all services on a fee-for-service basis.

(f) MassHealth members who are receiving services from the Department of Children and Families (DCF) or the Department of Youth Services (DYS) may choose to enroll with a MassHealth managed care provider. Such members who do not choose to enroll with a MassHealth managed care provider must enroll with the MassHealth behavioral health contractor.

(g) MassHealth members who receive Title IV-E adoption assistance, described in 130 CMR 522.003: *Adoption Assistance and Foster Care Maintenance*, may choose to enroll with a MassHealth managed care provider. Such members who do not choose to enroll with a MassHealth managed care provider are enrolled with the MassHealth behavioral health contractor. Such members may choose to receive all services on a fee-for-service basis.

(h) MassHealth members who participate in one of the Money Follows the Person home- and community-based services waivers who are not enrolled with a MassHealth managed care provider or not otherwise enrolled with the behavioral health contractor must enroll with the behavioral health contractor.

(5) Purchase of Health Insurance. The MassHealth agency may purchase third-party health insurance for MassHealth Standard members, with the exception of members described at 130 CMR 505.002(F): *Individuals with Breast or Cervical Cancer*, if the MassHealth agency determines such premium payment is cost effective. Under such circumstances, the MassHealth agency pays a provider only for those services listed in 130 CMR 450.105(A)(1) that are not available through the member's third-party health insurer.

(6) Senior Care Organizations. MassHealth Standard members 65 years of age or older may voluntarily enroll in a senior care organization (SCO) in accordance with the requirements under 130 CMR 508.008: *Senior Care Organizations*. The MassHealth agency does not pay a provider other than a SCO for any services that are provided to the MassHealth member while the member is enrolled in a SCO.

(7) Integrated Care Organizations. MassHealth Standard members 21 through 64 years of age who are enrolled in Medicare Parts A and B, are eligible for Medicare Part D, and have no other health insurance that meets the basic benefit level defined in 130 CMR 501.001: *Definition of Terms* may voluntarily enroll in integrated care organization (ICO) in accordance with the requirements at 130 CMR 508.007: Integrated Care Organizations. While enrolled in an ICO, MassHealth members who turn 65 years of age and are eligible for MassHealth CommonHealth may remain in One Care after 65 years of age. The MassHealth agency does not pay a provider other than the ICO for any services that are provided by an ICO while the member is enrolled in the ICO, except for family planning services that were not provided or arranged for by the ICO. It is the responsibility of the provider of services to determine if a MassHealth member is enrolled in an ICO. Upon request, the ICO must inform providers and enrolled members of ICO covered benefits. ICOs are responsible for providing enrolled members with the full continuum of Medicare and MassHealth covered services.

130 CMR 450.105(A).

130 CMR 450.204 provides:

450.204: Medical Necessity

The MassHealth agency does not pay a provider for services that are not medically necessary and may impose sanctions on a provider for providing or prescribing a service or for admitting a member to an inpatient facility where such service or admission is not medically necessary.

(A) A service is medically necessary if

(1) it is reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity; and

(2) there is no other medical service or site of service, comparable in effect, available, and suitable for the member requesting the service, that is more conservative or less costly to the MassHealth agency. Services that are less costly to the MassHealth agency include, but are not limited to, health care reasonably known by the provider, or identified by the MassHealth agency pursuant to a prior-authorization request, to be available to the member through sources described in 130 CMR 450.317(C), 503.007: *Potential Sources of Health Care*, or 517.007: *Utilization of Potential Benefits*.

(B) Medically necessary services must be of a quality that meets professionally recognized standards of health care, and must be substantiated by records including evidence of such medical necessity and quality. A provider must make those records, including medical records, available to the MassHealth agency upon request. (See 42 U.S.C. 1396a(a)(30) and 42 CFR 440.230 and 440.260.)

(C) A provider's opinion or clinical determination that a service is not medically necessary does not constitute an action by the MassHealth agency.

(D) Additional requirements about the medical necessity of MassHealth services are contained in other MassHealth regulations and medical necessity and coverage guidelines.

(E) Any regulatory or contractual exclusion from payment of experimental or unproven services refers to any service for which there is insufficient authoritative evidence that such service is reasonably calculated to have the effect described in 130 CMR 450.204(A)(1).

130 CMR 450.204.

Molina Senior Whole Health's Evidence of Coverage provides the following:

Services that are covered for you	What you must pay when you get these services
Dental services In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. We cover the following services under your MassHealth (Medicaid) benefit: • Diagnostic services (x-rays and exams) • Emergency care visits • Preventive services (teeth cleaning, fluoride treatment) • Restorative care (silver and tooth-colored fillings) • Periodontal (gum) care including deep scaling • Dental implants (limited to 4 implants per year) • Crowns • Dentures (full and partial) • Oral surgery including tooth extractions • Endodontic care (root canal treatment) *This list is not a guarantee of coverage. Must use a network provider.	There is no coinsurance, copayment, or deductible for members eligible for this benefit. Your dentist will submit documentation such as x- rays and a narrative to support the procedures are medically necessary and meet acceptable clinical guidelines for a favorable prognosis. **Certain procedures may require prior authorization.**

Exhibit 8 at 57.

Molina Senior Whole Health denied procedures D7953 (bone grafts at time of tooth removal) for teeth #7, 10, 11, and 14; D5820 (temporary (interim) partial denture); D0367 (cone beam CT scan); and D5982 (surgical stent material) for tooth #7 on the grounds that they are not covered services. Molina's Dental Director also stated that the Appellant's provider did not submit a comprehensive long-term treatment plan.

MassHealth does not pay for services not listed in Subchapter 6 of the Dental Manual. 130 CMR

420.421(B)(12). Codes D7953, D5820, D0367, and D5982 are not listed in Subchapter 6 of the Dental Manual.[5] Appendix D of the MassHealth Dental Office Reference Manual states that the MassHealth Dental Program claim system will only process claims with the codes described in 130 CMR 420.000 et seq. and listed in the tables in Appendix D. It further states that all claims with codes not listed in the tables at Appendix D will be rejected.[6] Exhibit B in Appendix D contains dental benefits covered for MassHealth members aged 21 and older. Codes D7953, D5820, D0367, and D5982 do not appear in the table of dental benefits covered for MassHealth members aged 21 and older.[7] Additionally, the requested procedures are not listed in Molina Senior Whole Health's Evidence of Coverage. Exhibit 8 at 57.

I credit the Appellant's testimony and am very sorry for her situation. However, Molina Senior Whole Health did not err in denying the request for procedures D7953, D5820, D0367, and D5982, as they are not listed within Subchapter 6 or Appendix D. Based on the MassHealth regulations, MassHealth Dental Office Reference Manual, and the Evidence of Coverage, Molina Senior Whole Health's determination that procedures D7953, D5820, D0367, and D5982 procedure are not covered services is upheld.[8]

Molina Senior Whole Health also denied procedure D2740 (all white glass crown) for tooth #4 on the grounds that the service exceeded the benefit limitation because it had been provided within the last 60 months. However, Molina Senior Whole Health did not offer specific testimony or other evidence into the record concerning when the procedure occurred, beyond that the Appellant has had a number of treatments since 2019. If the procedure occurred prior to October 2019, more than 60 months have elapsed since then. Accordingly, the appeal regarding procedure D2740 is approved. 130 CMR 420.425(C)(2); Exhibit 8 at 57.

In conclusion, the appeal is approved for procedure D2740, and denied regarding procedures D7953, D5820, D0367, and D5982.

Order for Molina Senior Whole Health

Approve the Appellant's request for procedure D2740 (all white glass crown) for tooth #4.

Notification of Your Right to Appeal to Court

[5] Subchapter 6 can be found online at: https://www.mass.gov/files/documents/2024/06/27/sub6-den.pdf.

[6] The MassHealth Dental Office Reference Manual can be found online at: https://masshealth dental.net/MassHealth/media/Docs/MassHealth-ORM.pdf.

[7] I note that the Dental Manual does include code D2999 "unspecified restorative procedure, by report" for members 21 and older, requiring prior authorization. It also includes D6999 "fixed prosthodontic procedure" for members 21 and older, requiring prior authorization and a narrative demonstrating medical necessity.

[8] While outside the scope of this decision, and my jurisdiction, I would hope that Molina Senior Whole Health would work with the Appellant and her provider to find alternative covered treatment options that would address the Appellant's dental pain and inability to eat.

If you disagree with this decision, you have the right to appeal to Court in accordance with Chapter 30A of the Massachusetts General Laws. To appeal, you must file a complaint with the Superior Court for the county where you reside, or Suffolk County Superior Court, within 30 days of your receipt of this decision.

Implementation of this Decision

If this decision is not implemented within 30 days after the date of this decision, you should contact your MassHealth Enrollment Center. If you experience problems with the implementation of this decision, you should report this in writing to the Director of the Board of Hearings, at the address on the first page of this decision.

Emily Sabo
Hearing Officer
Board of Hearings

MassHealth Representative: Senior Whole Health - Molina Healthcare, Attn: Jenny DeMusis, P.O. Box 22816, Long Beach, CA 90801-9973