Office of Medicaid
BOARD OF HEARINGS

Appellant Name and Address:

[redacted]

Appeal Decision:	Denied	**Appeal Number:**	2501555
Decision Date:	4/14/2025	**Hearing Date:**	02/28/2025
Hearing Officer:	Emily Sabo		

Appearances for Appellant:
[redacted]

Appearance for MassHealth:
Dr. Sheldon Sullaway, DentaQuest

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	**Issue:**	Dental Services; Prior Authorization
Decision Date:	4/14/2025	**Hearing Date:**	02/28/2025
MassHealth's Rep.:	Sheldon Sullaway	**Appellant's Reps.:**	Pro se & Therapist
Hearing Location:	Quincy Harbor South (Telephone)	**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 January 8, 2025, MassHealth denied the Appellant's request for procedures D7310 (alveoloplasty in the upper and lower arches), D6104 (bone grafts for teeth 5, 10, 22, and 27), D6010 (surgical implants for teeth 5, 10, 22, and 27), and D9612 (therapeutic drug injection), on the grounds that alveoloplasty is not valid for an arch and that bone grafts and implants are not covered. Exhibit 1. The Appellant filed this appeal in a timely manner on January 24, 2025. 130 CMR 610.015(B) and Exhibit 2. Denial of assistance is valid grounds for appeal. 130 CMR 610.032.

Action Taken by MassHealth

MassHealth denied the Appellant's request for procedures D7310 (alveoloplasty in the upper and lower arches), D6104 (bone grafts for teeth 5, 10, 22, and 27), D6010 (surgical implants for teeth 5, 10, 22, and 27), and D9612 (therapeutic drug injection).

Issue

The appeal issue is whether MassHealth was correct, in denying the Appellant's request for procedures D7310 (alveoloplasty in the upper and lower arches), D6104 (bone grafts for teeth 5, 10, 22, and 27), D6010 (surgical implants for teeth 5, 10, 22, and 27) and D9612 (therapeutic drug injection).

Summary of Evidence

As part of her request for a fair hearing, the Appellant submitted letters from her different medical providers. Her therapist stated that the Appellant is diagnosed with post-traumatic stress disorder and chronic, generalized anxiety disorder. And that "[m]issing many teeth has exacerbated her symptoms of low self-esteem, social anxiety and social avoidance, and depression. She would benefit from dental implants." Exhibit 2 at 2. A letter from her primary care provider stated that the Appellant "has been having trouble eating proteins since she had her teeth removed." *Id.* at 3. It also stated that the Appellant has anxiety and depression "which are exacerbated by her lack of teeth." *Id.*

The hearing was held by telephone. The Appellant verified her identity and was also represented by her therapist. The Appellant is over the age of 21 and a MassHealth CarePlus member. MassHealth was represented by a licensed dentist, a consultant with DentaQuest, which denied the prior authorization request as the agent of MassHealth.

On January 8, 2025, the Appellant's dental provider submitted a request for prior authorization for procedure codes D7310 (alveoloplasty in the upper and lower arches), D6104 (bone grafts for teeth 5, 10, 22, and 27), D6010 (surgical implants for teeth 5, 10, 22, and 27), and D9612 (therapeutic drug injection). The MassHealth representative testified that MassHealth denied the request for procedure D7310 because the tooth ID listing upper and lower arch is invalid. The MassHealth representative explained that the provider would need to specify which specific teeth the procedure was requested for, not just the upper or lower arch. The MassHealth representative testified that MassHealth denied the request for procedures D6104, D6010, and D9612 because they are not covered procedures. The MassHealth representative explained that because the Appellant is over the age of 21, it does not matter if the procedures are medically necessary and cited 130 CMR 420.421(B).

The Appellant testified that she is very self-conscious about her teeth and that it is debilitating. She feels that everyone is staring at her. The Appellant testified that she has a lisp and severe anxiety and that it connects to experiences that she had as a six-year-old child. The Appellant testified that she was told that she has to have ridge surgery and that she would rather have four implants and a partial denture. The Appellant testified that her teeth were damaged in a domestic dispute and that she has severe anxiety and post-traumatic stress related to that incident. The Appellant testified that she does not leave her house unless she is going to work, for groceries, or to bring

her dog to the vet. The Appellant stated that it was unclear whether it made sense to have alveoloplasty without implants. The Appellant also shared complaints that she had about an earlier dental provider who removed her teeth. The Appellant expressed that she is trying to make herself look and feel better.

Findings of Fact

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

1. The Appellant is a CarePlus member over the age of 21. Testimony; Exhibit 4.

2. On January 8, 2025, the Appellant, through her dental provider, sought preauthorization for procedure codes D7310 (alveoloplasty in the upper and lower arches), D6104 (bone grafts for teeth 5, 10, 22, and 27), D6010 (surgical implants for teeth 5, 10, 22, and 27), and D9612 (therapeutic drug injection). Testimony; Exhibit 5.

3. On January 8, 2025, MassHealth denied authorization for procedures D7310, D6104, D6010, and D9612. Testimony; Exhibit 5.

4. On January 24, 2025, the Appellant filed a timely 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. See 130 CMR 450.204; 130 CMR 420.410. In addition to complying with the prior authorization requirements at 130 CMR 420.410 et seq., covered services for certain dental treatments are subject to the relevant limitations of 130 CMR 420.421 through 420.456.

420.421: Covered and Non-covered Services: Introduction

(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) Non-covered 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 non-covered 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 acrylic 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
(12) any other service not listed in Subchapter 6 of the Dental Manual.

. . . .

(D) Non-covered Services for Members 21 Years of Age or Older. The MassHealth agency does not pay for the following services for 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).

130 CMR 420.421(A), (B), (D).

420.430: Covered Service Descriptions and Limitations: Oral and Maxillofacial Surgery Services

(A) General Requirements.

(1) The MassHealth agency pays for oral and maxillofacial surgery services for all members, regardless of age, subject to the service descriptions and limitations as described in 130 CMR 420.430. Payment for oral and maxillofacial surgery includes payment for local anesthesia, suture removal, irrigations, bony 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 or forceps, or both, 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 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.

(D) Surgical Removal of Impacted Teeth. The MassHealth agency pays for the surgical removal of an impacted tooth/teeth 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; or

(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 extraction of an erupted tooth is the removal of bone and/or sectioning of the tooth, and including elevation of mucoperiosteal flap if indicated.

(5) Surgical extraction with soft tissue 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.

(6) Surgical extraction 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 removal.

(7) Surgical extraction with complete bony impaction is the removal of a tooth in which most or the entire crown is covered by bone and requires mucoperiosteal flap elevation and bone removal.

(8) The MassHealth agency pays for surgical exposure of impacted or unerupted teeth to aid eruption only for members younger than 21 years old for orthodontic reasons. MassHealth agency payment for surgical exposure includes reexposure due to tissue overgrowth or lack of orthodontic intervention.

(E) Alveoloplasty.

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

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

130 CMR 420.430(A), (B), (C), (D), (E).

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.

Exhibit B in Appendix D contains dental benefits covered for MassHealth members aged 21 and older and states the following:

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7310	alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D7310) per 6 Month(s) Per patient per quadrant. One of (D7310, D7311) per 1 Lifetime Per patient per quadrant. Limited to one per quadrant when	

					performed within 6 months of initial alveoloplasty.	

Dental Office Reference Manual at 122.[1]

Regarding the Appellant's request for procedure D7310 (alveoloplasty), based on the instructions in the Dental Office Reference Manual, prior authorization is not required, subject to the benefit limitations. However, the procedure is covered per quadrant, not by upper or lower arch as requested by the Appellant's provider. Dental Office Reference Manual at 122; Exhibit 5. Therefore, MassHealth did not err in denying the request for procedure 7310.

Implants of any type or description are a non-covered service. 130 CMR 420.421(B)(5). Additionally, MassHealth does not pay for services not listed in Subchapter 6 of the Dental Manual. 130 CMR 420.421(B)(12). Codes D6104, D6010, D9612 are not listed in Subchapter 6 of the Dental Manual.[2] 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. Exhibit B in Appendix D contains dental benefits covered for MassHealth members aged 21 and older. Codes D6104, D6010, and D9612 do not appear in the table of dental benefits covered for MassHealth members aged 21 and older.[3]

I credit the Appellant's testimony and that of her medical providers regarding her anxiety and believe that she is suffering. However, MassHealth did not err in denying the request for procedures D6104, D6010, and D9612, as they are not listed within Subchapter 6 or Appendix D. Based on the MassHealth regulations and MassHealth Dental Office Reference Manual, MassHealth's determination that procedures D6104, D6010, and D9612 are not covered services is upheld. 130 CMR 420.421(B)(5), (B)(12).[4]

Accordingly, the appeal is denied.

[1] Available at https://www.masshealth-dental.net/MassHealth/media/Docs/MassHealth-ORM.pdf.
[2] Subchapter 6 can be found online at: https://www.mass.gov/files/documents/2024/06/27/sub6-den.pdf.
[3] 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.
[4] I hope that the Appellant and her provider can work with MassHealth to find alternative covered treatment options that would address the Appellant's needs.

Order for MassHealth

None.

Notification of Your Right to Appeal to Court

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.

Emily Sabo
Hearing Officer
Board of Hearings

[redacted]