Office of Medicaid
BOARD OF HEARINGS

Appellant Name and Address:

[redacted]

Appeal Decision:	Denied	**Appeal Number:**	2509644
Decision Date:	09/19/2025	**Hearing Date:**	07/29/2025
Hearing Officer:	Emily Sabo	**Record Open to:**	08/08/2025

Appearance for Appellant:

Pro se

Appearances for Commonwealth Care Alliance (CCA):

Cassandra Horne, Operations Manager for Appeals and Grievances Unit; [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	**Issue:**	Managed Care Organization—Denial of Internal Appeal; Prior Authorization; Dental Services
Decision Date:	09/19/2025	**Hearing Date:**	07/29/2025
CCA's Reps.:	Cassandra Horne; [redacted]	**Appellant's Rep.:**	Pro se
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 June 20, 2025, Commonwealth Care Alliance (CCA), a MassHealth Integrated Care Organization (ICO) and MassHealth's agent, denied the Appellant's level one appeal of a denial of service for codes D6010, D6057, and D6058 for teeth 5 and 12. Exhibit 1.[1] The Appellant filed this external appeal with the Board of Hearings in a timely manner on June 27, 2025. 130 CMR 610.015 and Exhibit 2. Denial of a level one internal appeal by a managed care organization is a valid ground for appeal to the Board of Hearings. 130 CMR 610.032(B).

Action Taken by CCA

[1] An Integrated Care Organization is defined at 130 CMR 501.001 as "an organization with a comprehensive network of medical, behavioral-health care, and long-term services and supports providers that integrates all components of care, either directly or through subcontracts, and has contracted with the Executive Office of Health and Human Services (EOHHS) and the Centers for Medicare & Medicaid Services (CMS) and been designated as an ICO to provide services to dual eligible individuals under M.G.L. c. 118E. ICOs are responsible for providing enrollees with the full continuum of Medicare- and MassHealth-covered services."

CCA denied the Appellant's request for procedures D6010 (surgical placement of implant body: endosteal implant), D6057 (custom fabricated abutment—includes placement), and D6058 (abutment supported porcelain/ceramic crown) for teeth 5 and 12. CCA denied code D6058 on the grounds that it is not a covered code. CCA denied codes 6010 and 6057 as not medically necessary and "[a]n implant may be covered if records sent by your provider show two (2) front tooth implants will be done to help hold in a denture or one (1) implant for a front tooth when no other front teeth are missing. The records sent do not show one of these." Exhibit 5 at 8.

Issue

The appeal issue is whether CCA was correct, in denying the Appellant's request for procedures D6010 (surgical placement of implant body: endosteal implant), D6057 (custom fabricated abutment—includes placement), and D6058 (abutment supported porcelain/ceramic crown) for teeth 5 and 12.

Summary of Evidence

The hearing was held by telephone. CCA was represented by its operations manager for appeals and grievances and a dental consultant. CCA testified that the Appellant is an adult between the ages of 21-64 and has been a CCA OneCare member since April 1, 2017. CCA's dental consultant testified that the Appellant's request for procedures D6010, D6057, and D6058 were initially denied on May 29, 2025. The dental consultant testified that CCA denied code D6058 on the grounds that it is not a covered code, and denied codes 6010 and 6057 as not medically necessary and can only be authorized if it is for two front tooth implants to help hold in a denture or one implant for a front tooth when no other front teeth are missing. The dental consultant explained that teeth 5 and 12 are upper teeth behind the right and left canines and are not the two front teeth. The dental consultant testified that CCA is one of the few insurers that covers dental implants and MassHealth does not cover them. The dental consultant testified that with her remaining teeth, the Appellant has adequate mastication (chewing) and functionality.

The Appellant verified her identity. The Appellant testified that she has lost teeth but since being enrolled in CCA, she has been receiving better dental care. The Appellant testified that she feels ugly and disgusting due to her teeth and that she has a history of self-harm and borderline personality disorder. The Appellant testified that she finds it sad that she would need to lose teeth in order to get cared for. The Appellant testified that she does not want to be hospitalized.

As part of her fair hearing request and as exhibits submitted prior to the hearing, the Appellant submitted a self-written statement and letters from her medical providers. At the hearing, CCA stated that they had not received these. The record was held open until August 8, 2025 for CCA to review and respond. Exhibit 11. CCA did not respond. The hearing officer sent a follow up message

to CCA and did not receive a response. *Id.*

The Appellant's written statement follows:

> [P]lease consider granting my request for dental implants. It means much to me. I am going through a lot of body changes that play a number on my emotional stability. I take care of my overall health to the best of capacity. I follow my treatment drugs, smoke free. I lost my teeth because I had no insurance (on free care) flossing pulled filling out by the time I got service it was too late not because I was careless or neglected. I work at keeping sane, independent, functioning, staying out of hospital a great challenge. Coping with grief, hair loss, lithium toxicity but working together with mental health provider in avoiding my situation to get worse minimizing long term complications I believe I reduce medical cost to minimal. This situation is playing a number on my self esteem, feelings of shame, isolation, rejection, hallucination medication cost to a minimum by working diligent with health provider care treatment for individuals case.

Exhibit 2 at 7.

The Appellant's treatment team provided the following letters:

From her case manager:

> [The Appellant] has been a client of the Department of Mental Health for numerous years. In this time she has made great strides to improve herself. She is diligent in her care of herself, a non smoker, follows treatment plans, and is a good tenant. She suffers from [redacted]r, among other distresses in her life. In light of this and her poor dentition, dental implants would greatly improve her quality of life. She has undergone numerous challenges and is now a candidate for dental implants. She is mindful of the care needed and a responsible person. Please accept this letter of advocacy for [Appellant] to be approved and receive dental implants.

Id. at 6.

From her psychiatric mental health nurse practitioner and registered nurse:

> [Appellant] has been getting psychiatric care at [redacted] for many years. She has a poor body image which worsens her depressive symptoms and causes her to think of unhealthy ways of relieving that depression such as by cutting her skin. One of her main concerns about her image is poor dentition. This keeps her from looking in reflective surfaces and makes it difficult for her to leave her apartment and interact with others. This has a negative impact on her

> depressive symptoms. Her mental health would benefit from dental implants. She feels hopeful that with implants, she would feel much better and be able to decrease the number of medications she takes to manage her depression.

Id. at 5.

From her primary care physician: "She has several psychiatric diagnose [redacted]) and is actively working with her behavioral health team. She is reporting that poor dentition is worsening her body image and depressive symptoms. She would medically benefit from dental implants." *Id.* at 4.

From her dentist: The Appellant "requires an implant supported denture for the upper arch for three reasons: 1. Distortion of the occlusal plane. 2. Crowding and malocclusion. 3. Improper eccentric masticatory movements. Please consider overturning this denial." Exhibit 9 at 2.

From her surgeon: The Appellant "is post op [redacted] [The Appellant] has been effected by the weight loss from this surgery and associated body changes. Receiving dental implants and fixing her teeth will improve her self-esteem and self acceptance." Exhibit 10 at 2.

CCA also submitted the Appellant's case file, MassHealth's covered Dental Codes, the 2025 CCA Member Handbook, and the CCA Provider Manual into the record. Exhibits 5-8. Codes D6010, D6057, and D6058 do not appear in the MassHealth Office Reference Manual with covered Dental Codes. Exhibit 6. The CCA Provider Manual states

> CCA's clinical criteria used by SKYGEN for determining medical necessity were developed from information collected from American Dental Association's Code Manuals, clinical articles and guidelines, as well as dental schools, practicing dentists, insurance companies, other dental-related organizations, and local state or health plan requirements. SKYGEN reviewers use and apply the following clinical criteria to approve authorization requests.
> . . . .
> Implant, surgical placement (D6010, D6191, D6192)
> - Documentation shows healthy bone and periodontium
> - Free from presence of periodontal disease
>
> Implant, supporting structures (D6056, D6057, D6058, D6082, D6083, D6084, D6086, D6087, D6088,
> D6097)
> - Documentation shows fully integrated surgical implant with good crown / root ratio
> - Healthy bone and periodontium surrounding surgical implant
> - Free from presence of periodontal disease

Exhibit 8 at 48, 51.

The CCA Provider Manual for OneCare members does not include code D6058. *Id.* at 99. For codes D6010 and D6057 the Manual states:

Code	Code Description	Age Limitation	Teeth Covered	Auth Req	Benefit Limitation	Required Docs
D6010	Surgical Placement of Implant Body: Endosteal Implant	21 and Older	Teeth 6-11, 22-27	Yes	Maximum of 2 mandibular or maxillary anterior implants or 4 mini implants per arch, for the purpose of supporting a complete denture where there is minimal ridge present 1 per site per lifetime	FMX or panoramic and narrative of medical necessity
D6057	Custom Fabricated Abutment—Includes Modification and Placement	21 and Older	Teeth 6-11, 22-27	Yes	Maximum of 2 mandibular or maxillary anterior implants or 4 mini implants per arch, for the purpose of supporting a complete	FMX or panoramic and narrative of medical necessity

					denture where there is minimal ridge present 1 per site per lifetime	

Id. at 99.

The Appellant's case file includes an x-ray of the Appellant's teeth, which shows she is missing teeth 5 and 12 and has crowns on two front teeth. Exhibit 5 at 4. The CCA Member Handbook states that it covers:

Dental services

The plan covers preventive, restorative, and emergency oral health care. We pay for some dental services when the service is an integral part of specific treatment of a beneficiary's primary medical condition. Some examples include reconstruction of the jaw following fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams preceding kidney transplantation.

We cover these services under the MassHealth benefit:
Preventive/Diagnostic:
- Preventive such as cleanings
- Routine exams
- X-rays

Restorative:
- Fillings
- Crown
- Replacement crown
- Endodontic therapy (root canals)

Periodontics:
- Scaling and root planning
- Periodontal maintenance

Prosthodontics (removable):
- Complete dentures
- Partial dentures
- Immediate dentures (once per lifetime)
- Relines and adjustments of complete dentures

Prosthodontics (fixed):

- Implants, limited to 2 anterior implants per arch when needed to support a complete denture. Requires healthy bone to support the implants.

Oral and Maxillofacial Surgery:

- Extractions (removal of teeth)
- Biopsy and soft tissue surgery
- Alveoplasty Bone grafting

These services are covered without prior authorization:

- Crowns
- Routine exams and x-rays
- Preventive services including cleanings
- Restorative fillings
- Non-surgical periodontal services (cleanings and maintenance)
- Complete dentures and relines (after 6 months of initial placement)
- Partial dentures and relines (after 6 months of initial placement)
- Non-surgical extractions
- Emergency care

Members must use a CCA network dental provider. Services requiring authorization must be sent directly by your treating network dental provider to the plan's dental benefit administrator, Skygen, for review. In the event that clinical input is necessary to determine whether a course of treatment is appropriate, CCA One Care reserves the right to have a dental expert review the treatment plan your dentist has proposed. Benefit limitations apply for certain dental services. For more information, please call Member Services.

Exhibit 7 at 64-65.

Findings of Fact

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

1. The Appellant is an adult between the ages of 21-64. Exhibit 4.

2. The Appellant is eligible for MassHealth Standard and is enrolled in an ICO, CCA. The Appellant has been a CCA One Care member since April 1, 2017. Testimony, Exhibit 4.

3. On May 29, 2025, the Appellant requested prior authorization from CCA for procedures D6010 (surgical placement of implant body: endosteal implant), D6057 (custom fabricated abutment—includes placement), and D6058 (abutment supported porcelain/ceramic crown) for teeth 5 and 12. Testimony, Exhibit 5.

4. On May 29, 2025, CCA denied the request. Exhibit 5.

5. On June 12, 2025, the Appellant internally appealed CCA's denial. Exhibit 5.

6. On June 20, 2025, CCA denied the Appellant's Level I appeal. Exhibits 1 and 5.

7. On June 27, 2025, the Appellant timely filed an appeal with the Board of Hearings. Exhibit 2.

8. The Appellant is missing teeth 5 and 12, which are the upper teeth behind her right and left canines. They are not her two front teeth. Testimony and Exhibit 5.

9. CCA's Provider Manual states that in considering authorization requests, reviewers use and apply the following clinical criteria when reviewing code D6010: Documentation shows healthy bone and periodontium; Free from presence of periodontal disease and for codes D6057 and D6058: Documentation shows fully integrated surgical implant with good crown / root ratio; Healthy bone and periodontium surrounding surgical implant; Free from presence of periodontal disease. Exhibit 8.

10. The CCA Provider Manual for OneCare members does not include code D6058. *Id.* at 99. For codes D6010 and D6057 it states:

Code	Code Description	Age Limitation	Teeth Covered	Auth Req	Benefit Limitation	Required Docs
D6010	Surgical Placement of Implant Body: Endosteal Implant	21 and Older	Teeth 6-11, 22-27	Yes	Maximum of 2 mandibular or maxillary anterior implants or 4 mini implants per arch, for the purpose of supporting a complete denture where there is minimal ridge	FMX or panoramic and narrative of medical necessity

					present 1 per site per lifetime	
D6057	Custom Fabricated Abutment—Includes Modification and Placement	21 and Older	Teeth 6-11, 22-27	Yes	Maximum of 2 mandibular or maxillary anterior implants or 4 mini implants per arch, for the purpose of supporting a complete denture where there is minimal ridge present 1 per site per lifetime	FMX or panoramic and narrative of medical necessity

Exhibit 8.

11. Codes D6010, D6057, and D6058 do not appear in the MassHealth Office Reference Manual with covered Dental Codes. Exhibit 7.

12. The CCA Member Handbook states that it covers: "Implants, limited to 2 anterior implants per arch when needed to support a complete denture. Requires healthy bone to support the implants." Exhibit 6.

13. CCA denied the Appellant's request for procedures D6010 and D6057 for teeth 5 and 12 on the grounds that it is not medically necessary and "[a]n implant may be covered if records sent by your provider show two (2) front tooth implants will be done to help hold in a denture or one (1) implant for a front tooth when no other front teeth are missing. The records sent do not show one of these." CCA denied the request for procedure D6058 on the grounds that it is not a covered code. Testimony, Exhibits 1 and 5.

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*.,[2] 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;

[2] 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.

(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.*

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

130 CMR 508.007 provides:

508.007: Integrated Care Organizations

(A) Eligibility.
(1) In order to be eligible to enroll in an integrated care organization (ICO), a MassHealth member must meet all of the following criteria, and may not be enrolled or concurrently participate in any of the programs or plans listed in 130 CMR 508.007(F):
(a) be 21 through 64 years of age at the time of enrollment;
(b) be eligible for MassHealth Standard as defined in 130 CMR 450.105(A): *MassHealth Standard* or MassHealth CommonHealth as defined in 130 CMR 450.105(E): *MassHealth CommonHealth*;
(c) be enrolled in Medicare Parts A and B, be eligible for Medicare Part D, and have no other health insurance that meets the basic-benefit level as defined in 130 CMR 501.001: *Definition of Terms*; and
(d) live in a designated service area of an ICO.
(2) If a member is enrolled in an ICO and turns 65 years old and is eligible for MassHealth Standard or MassHealth CommonHealth, he or she may elect to remain in the ICO beyond 65 years of age.

(B) Selection Procedure and Assignment to an ICO.
(1) The MassHealth agency will notify members
(a) of the availability of an ICO in their service area and how to enroll in an ICO;
(b) that, in any service area with a choice of at least two ICOs, MassHealth will assign eligible members who do not choose an ICO but have not opted out the Duals Demonstration; and
(c) how to opt out of the Duals Demonstration.
(2) An eligible member may enroll in any ICO in the member's service area by making a written or verbal request to MassHealth or its designee. A service area is the specific geographical area of Massachusetts in which an ICO agrees to provide ICO services. Service listings can be obtained from the MassHealth agency or its designee. The list of integrated care organizations (ICOs) that the MassHealth agency will make available to members will include those ICOs that contract with the MassHealth agency and provide services within the member's service area.

(3) MassHealth provides written notice at least 60 days in advance of its assignment of any eligible members to an ICO. The notice includes the ICO to which the member is being assigned, information about how to enroll in a different ICO, and information about how to opt out of the Duals Demonstration.

(C) Obtaining Services When Enrolled in an ICO. When a member is enrolled in an ICO in accordance with the requirements under 130 CMR 508.007(A), the ICO will authorize, arrange, integrate, and coordinate the provision of all covered services for the member. Upon enrollment, the ICO is required to provide evidence of its coverage, the range of available covered services, what to do for emergency conditions and urgent care needs, and how to obtain access to specialty, behavioral health, and long-term services and supports.

(D) Disenrollment from an Integrated Care Organization. A member may disenroll from an ICO at any time by notifying the MassHealth agency or its designee verbally or in writing. A member who disenrolls from an ICO, but does not select another ICO or opt out of the Duals Demonstration, may be automatically assigned another ICO provided that MassHealth provides a written notice at least 60 days in advance of any auto assignment. The notice includes the ICO to which the member is assigned, information about how to enroll in a different ICO, if available, and information about how to opt out of the Duals Demonstration. Disenrollment requests that are received by the MassHealth agency on the last calendar day of the month will be effective on the first day of the following month.

(E) Disenrollment from the Duals Demonstration. A member may opt out of the Duals Demonstration at any time by notifying the MassHealth agency or its designee verbally or in writing. Requests that are received by the MassHealth agency on the last calendar day of the month will be effective on the first day of the following month.

(F) Other Programs. A member may not be enrolled in an ICO and concurrently participate or be enrolled in any of the following programs or plans:

(1) programs described at 130 CMR 519.007: *Individuals Who Would Be Institutionalized*;

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

(3) any Medicare Demonstrations wherein concurrent participation in the Duals Demonstration is prohibited;

(4) Employer Group Waiver Plans or other employer-sponsored plans; or

(5) plans receiving a retiree drug subsidy.

(G) Copayments. Members who are enrolled in an ICO must make copayments in accordance with the ICO's MassHealth copayment policy. Those ICO 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 508.007.

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 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 behavioral health center services;
(p) community health center services;
(q) community support program services;
(r) day habilitation services;
(s) dental services;
(t) doula services;
(u) durable medical equipment and supplies;

(v) early intervention services;
(w) family planning services;
(x) freestanding birth center services;
(y) hearing aid services;
(z) home health services;
(aa) homeless medical respite services;
(bb) hospice services;
(cc) independent nurse (private duty nursing) services;
(dd) inpatient hospital services;
(ee) laboratory services;
(ff) licensed independent clinical social work services;
(gg) nursing facility services;
(hh) orthotic services;
(ii) outpatient hospital services;
(jj) oxygen and respiratory therapy equipment;
(kk) personal care services;
(ll) pharmacy services;
(mm) physician services;
(nn) physician assistant services;
(oo) podiatrist services;
(pp) prosthetic services;
(qq) psychiatric clinical nurse specialist services;
(rr) rehabilitation services;
(ss) renal dialysis services;
(tt) speech and hearing services;
(uu) therapy services: physical, occupational, and speech/language;
(vv) transportation services;
(ww) urgent care clinic services;
(xx) vision care; and
(yy) 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 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 old and are eligible for MassHealth CommonHealth may remain in One Care after the age of 65. 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.

CCA denied the Appellant's request for D6058 for teeth 5 and 12 on the grounds that it is not a covered code. Code D6058 does not appear in the MassHealth Office Reference Manual with covered Dental Codes. Exhibit 6. Code D6058 also does not appear in the CCA Provider Manual for OneCare Members. Exhibit 8. Accordingly, CCA did not err in denying the request for procedure D6058, and this portion of the appeal is denied. *See also* 130 CMR 420.421(B)(12).

Turning to the Appellant's request for D6010 and D6057 for teeth 5 and 12, these codes do not appear in the MassHealth Office Reference Manual with covered Dental Codes. Exhibit 6. They do, however, appear as covered codes in the CCA Provider Manual for OneCare Members. Exhibit 8. CCA denied this authorization request on the grounds that it is not medically necessary. Based on the denial notice and the testimony at hearing, these requests were denied because the procedures are only authorized for two front tooth implants to help hold in a denture, or for one implant for a front tooth when no other front teeth are missing. The record evidence shows that teeth 5 and 12 are upper teeth behind the right and left canines, and are not the two front teeth. Based on this testimony, the Appellant has not met her burden in showing that CCA erred, and this

portion of the appeal is also denied.

Order for CCA

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

cc: MassHealth Representative: ICO Commonwealth Care Alliance, Attn: Nayelis Guerrero, 30 Winter Street, Boston, MA 02108