Office of Medicaid
BOARD OF HEARINGS

Appellant Name and Address:

[redacted]

Appeal Decision:	Denied	**Appeal Number:**	2509678
Decision Date:	09/19/2025	**Hearing Date:**	07/29/2025
Hearing Officer:	Emily Sabo		

Appearance for Appellant:

Pro se

Appearances for Commonwealth Care Alliance (CCA):

Cassandra Horne, Operations Manager for Appeals and Grievances Unit; [redacted], Dental Consultant

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 4, 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 D6057 and D6058 for teeth 8 and 9. 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 D6057 (custom fabricated abutment—includes placement) for teeth 8 and 9 on the grounds that it is not medically necessary and D6058 (abutment supported porcelain/ceramic crown) for teeth 8 and 9 on the grounds that it is not a covered code.

Issue

The appeal issue is whether CCA was correct, in denying the Appellant's request for procedures D6057 (custom fabricated abutment—includes placement) for teeth 8 and 9 and D6058 (abutment supported porcelain/ceramic crown) for teeth 8 and 9.

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, is eligible for MassHealth CommonHealth, and has been a CCA OneCare member since December 1, 2021. CCA's dental consultant testified that the Appellant's request for procedures D6057 (custom fabricated abutment—includes placement) for teeth 8 and 9 and D6058 (abutment supported porcelain/ceramic crown) for teeth 8 and 9 were denied because the requested treatment is beyond the scope of coverage and not medically necessary. The dental consultant testified that MassHealth does not cover dental implants and that CCA has more extensive coverage than MassHealth, but only covers implants in support of full dentures. The dental consultant testified that the Appellant has two implants which were not approved by CCA. The dental consultant testified that CCA denied a request for implants for teeth and 8 and 9 on December 10, 2024. The dental consultant explained that a partial denture may be covered by CCA.

The Appellant verified his identity. The Appellant testified that he paid for his implants out of his own pocket. The Appellant explained that he had an infection and bone graft. The Appellant testified that he called CCA and was told that his treatment would be paid for if it was medically necessary. The Appellant testified that his dentist told him that dentures would not work for him and will not "hold" in the front. The Appellant testified that his providers are the experts on his condition and know what is necessary for his health. The Appellant explained that he lives on his disability income and has had to pay for his treatment on a credit card.

As part of the hearing record, the Appellant submitted two letters from his dental providers:

> The patient presents with missing maxillary central incisors (#8 and #9) due to failed endodontic treatment, severe periodontal disease and sever[e] mobility. Clinical and radiographic assessments, including CBCT imaging, demonstrate

significant vertical and horizontal bone loss in the anterior maxilla. Notably, the bone height in the region of #8 and #9 is severely compromised due to pneumatization of the maxillary sinus and proximity of the sinus floor, rendering the area unsuitable for implant placement without augmentation.

Whether or not an implant was placed or not[,] a bone graft is medically necessary to restore sufficient bone volume and distance from the sinus cavity, thereby preventing sinus membrane perforation and ensuring the stability of the implants. Sinus floor involvement adds a critical anatomical limitation, increasing the complexity of the case and further underscoring the need for regenerative procedures prior to implant placement.

Implants in the esthetic and functional zone are required to restore mastication, phonetics, and facial support. Alternative options, such as removable prosthesis, are contraindicated due to poor fit, patient intolerance, and inferior long-term outcomes. A fixed bridge is also not feasible for this particular patient.

The proposed treatment plan includes bone grafting to reconstruct the atrophic ridge and elevate the sinus floor, followed by implant placement for teeth #8 and #9. This treatment is not cosmetic—it is medically necessary to restore function, stabilize the surrounding dentition, and prevent further resorption and sinus complications.

Attached are the radiographs (including CBCT), clinical photos, and treatment notes supporting this claim. We respectfully request preauthorization and coverage for the medically necessary procedures outlined.

Thank you.

[redacted] DMD

Dear Claims Review Committee,

I am writing to appeal for the denial of coverage for the implant-supported crowns for teeth #8 and #9. While implant placement and bone grafting were approved based on documentation submitted by [redacted] the final restorative phase—implant customed abutment and crowns—was not. I request reconsideration as the crowns are medically necessary to complete the treatment.

As detailed by [redacted], the patient has severe bone loss and anatomical limitations that required grafting and implants to restore oral function. The crowns are a critical part of that medically necessary plan. Without them, the implants

> cannot restore chewing, speaking, or maintain oral-facial integrity, and may lead to complications such as implant failure, bone loss, and diminished quality of life. These outcomes run counter to the intent of the original medical necessity determination.
>
> We urge you to consider the implant abutments and crowns as an inseparable and medically required component of the treatment plan your office has already partially approved. Thank you for your reconsideration.
>
> [redacted]

Exhibit 5 at 1-2.

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 6-9. Codes D6057 and D6058 do not appear in the MassHealth Office Reference Manual with covered Dental Codes. Exhibit 7. 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, 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 9 at 48, 51.

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

Code	Code Description	Age Limitation	Teeth Covered	Auth Req	Benefit Limitation	Required Docs
D6057	Custom Fabricated Abutment—	21 and Older	Teeth 6-11, 22-27	Yes	Maximum of 2 mandibular	FMX or panoramic and

	Includes Modification and Placement				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	narrative of medical necessity

Id. at 99.

The Appellant's case file includes an x-ray of the Appellant's teeth, which shows multiple missing teeth and bone loss. Exhibit 6 at 9. 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 8 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 CommonHealth and is enrolled in a MassHealth ICO, CCA. The Appellant has been a CCA One Care member since December 1, 2021. Testimony, Exhibit 4.

3. On May 7, 2025, the Appellant requested prior authorization from CCA for procedures D6057 (custom fabricated abutment—includes placement) for teeth 8 and 9 and D6058 (abutment supported porcelain/ceramic crown) for teeth 8 and 9. Testimony, Exhibit 6.

4. On May 18, 2025, CCA denied the request. Exhibit 6.

5. On May 27, 2025, the Appellant internally appealed CCA's denial. Exhibit 6.

6. On June 4, 2025, CCA denied the Appellant's Level I appeal. Exhibits 1 and 6.

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

8. The Appellant's case file includes an x-ray of the Appellant's teeth, which shows multiple missing teeth and bone loss. His dental providers also reference bone loss. Exhibit 5 and Exhibit 6 at 9.

9. CCA's Provider Manual states that in considering authorization requests, reviewers use and apply the following clinical criteria when reviewing 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 9.

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

Code	Code Description	Age Limitation	Teeth Covered	Auth Req	Benefit Limitation	Required Docs
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	FMX or panoramic and narrative of medical necessity

					supporting a complete denture where there is minimal ridge present 1 per site per lifetime	

Exhibit 9.

11. Codes 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 8.

13. CCA denied the Appellant's request for procedures D6057 (custom fabricated abutment—includes placement) for teeth 8 and 9 on the grounds that it is not medically necessary and D6058 (abutment supported porcelain/ceramic crown) for teeth 8 and 9 on the grounds that it is not a covered code. Testimony, Exhibits 1 and 6.

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:

[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.

(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
(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(E) 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.

. . . .

(E) MassHealth CommonHealth.

(1) Covered Services. The following services are covered for MassHealth CommonHealth members (*see* 130 CMR 505.004: *MassHealth CommonHealth* and 519.012: *MassHealth CommonHealth*):

(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) freestanding birth center services;
(x) family planning 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) licensed independent clinical social work services;
(ff) laboratory 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 CommonHealth members must enroll with a MassHealth managed care provider or ICO unless excluded from participation in a MassHealth managed care provider. (*See* 130 CMR 450.117 and 508.000: *Managed Care Requirements*.)

(3) MCOs, Accountable Care Partnership Plans, and ICOs. For MassHealth CommonHealth members who are enrolled in an MCO, Accountable Care Partnership Plan, or ICO, 130 CMR 450.05(E)(3)(a) and (b) apply.

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

(b) The MassHealth agency pays providers other than the MCO, Accountable Care Partnership Plan, or ICO for those services listed in 130 CMR 450.105(E)(1) that are not covered by the MassHealth agency's contract with the MCO, Accountable Care Partnership Plan, 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 CommonHealth 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 CommonHealth members enrolled in an MCO, Accountable Care Partnership Plan, or ICO receive behavioral health services only through the MCO, Accountable Care Partnership Plan, or ICO. (*See* 130 CMR 450.117.)

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

(d) MassHealth CommonHealth members who are younger than 21 years of age and who are excluded from participation in a MassHealth managed care provider or ICO under 130 CMR 508.002(A)(1) or (2) must enroll with the MassHealth behavioral health contractor.

(5) Purchase of Health Insurance. The MassHealth agency may purchase third-party health insurance for any MassHealth CommonHealth member 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(E)(1) that are not available through the member's third-party health insurer.

(6) Integrated Care Organizations. MassHealth CommonHealth 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 an integrated care organization (ICO) in accordance with the requirements at 130 CMR 508.007: *Integrated Care Organizations*. 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(E).

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 (abutment supported porcelain/ceramic crown) for teeth 8 and 9 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 7. Code D6058 also does not appear in the CCA Provider Manual for OneCare Members. Exhibit 9. Accordingly, CCA did not err in denying the request for procedure D6058, and the appeal is denied. *See also* 130 CMR 420.421(B)(12).

Turning to the Appellant's request for D6057 for teeth 8 and 9, code 6057 does not appear in the MassHealth Office Reference Manual with covered Dental Codes. Exhibit 7. It does, however, appear as a covered code in the CCA Provider Manual for OneCare Members. Exhibit 9. CCA denied this authorization request on the grounds that it is not medically necessary. Further guidelines within the CCA Provider Manual and the CCA Member Handbook indicate that in order to authorize D6057, documentation must show healthy bone to support a complete denture, including "fully integrated surgical implant with good crown / root ratio; Healthy bone and periodontium surrounding surgical implant; Free from presence of periodontal disease." Exhibit 9 at 51; Exhibit 8 at 64-65. The Appellant's x-ray and the descriptions from his providers show that the Appellant has missing teeth and bone loss, which would otherwise be required in order for CCA to authorize the treatment based on the CCA Member Handbook and Provider Manual. The Appellant's missing teeth and bone loss seem to indicate that the treatment may not succeed and would not be able to support a complete denture. I am sorry for the Appellant's situation and hope that he and his providers can work with CCA to find an alternative, covered treatment plan.

However, based on the guidance provided in the CCA Provider Manual and Member Handbook, CCA did not err in denying the prior authorization request and the appeal is 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

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