Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
www.mass.gov/masshealth

MassHealth
Transmittal Letter DEN-111
October 2021

TO: Dental Providers Participating in MassHealth

FROM: Amanda Cassel Kraft, Acting Assistant Secretary for MassHealth

RE: *Dental Manual* (Updates to 130 CMR 420.000, Subchapter 6, Appendix D, and Appendix F)

This letter transmits changes to the dental program regulation 130 CMR 420.000, as well as updates to the Subchapter 6 and Appendices D and F in the MassHealth *Dental Manual*. Updates to these regulations, Subchapter 6, and appendices are effective October 15, 2021. Changes are summarized below; please review the referenced documents to see all changes.

Updates to 130 CMR 420.000 and Subchapter 6

130 CMR 420.000 and Subchapter 6 of the *Dental Manual* have been updated to allow coverage for indirect pulp cap treatment for primary and permanent teeth to better preserve tooth vitality, and provide coverage for ceramic or porcelain crowns for permanent teeth and prefabricated porcelain crown for primary teeth. The amendments also provide instructions on orthodontia for cleft lip & cleft palate and class III malocclusions, as well as providing that comprehensive orthodontic care should only commence when the first premolars and first permanent molars have erupted.

The following is a summary of the changes in Subchapter 6 for the effective date of October 15, 2021. Please see Subchapter 6 for limitations, documentation requirements, and notations.

Code	Description
D2929	Zirconia crown for primary teeth
D2740	Ceramic crowns
D3120	Indirect pulp cap
D7251	Coronectomy, intentional partial tooth removal

Updates to Appendix D

Appendix D has been updated to provide clarifications for orthodontia prior authorization and to make certain changes to improve the accuracy of the prior authorization process, including requiring cephalometric radiographs or photographs with measurement device with every case and updating the definition of impinging overbite. Updates have been made both to autoqualifiers and scoring.

Updates to Appendix F

Appendix F has been updated to remove the requirement that crossbite be bilateral and update the non-exclusive medical condition that may be considered in support of a prior authorization for interceptive orthodontics.

MassHealth Website

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Questions

If you have any questions about the information in this transmittal letter, please contact the MassHealth Customer Service Center at (800) 841-2900, email your inquiry to providersupport@mahealth.net, or fax your inquiry to (617) 988-8974.

NEW MATERIAL

(The pages listed here contain new or revised language.)

Dental Manual

Pages iv, 4-1 through 4-30

Pages 6-1 through 6-28

Pages D-1 through D-6

Pages F-1 through F-4

OBSOLETE MATERIAL

(The pages listed here are no longer in effect.)

Dental Manual

Pages iv, 4-9 through 4-30 — transmitted by Transmittal Letter DEN-102

Pages 4-1 through 4-8 and pages F-1 through F-4 — transmitted by Transmittal Letter DEN-97

Pages 6-1 through 6-28 — transmitted by Transmittal Letter DEN-110

Pages D-1 through D-6 — transmitted by Transmittal Letter DEN-108

4. Program Regulations: *Dental Services*

420.401: Introduction

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

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

(C) Subchapter 6 of the *Dental Manual* lists the Current Dental Terminology (CDT) codes for dentists and public health dental hygienists and Current Procedural Terminology (CPT) codes for specialists in oral surgery that the MassHealth agency pays for, a description of those codes, and where indicated, prior-authorization requirements. Oral and maxillofacial surgeons must submit all claims containing CPT codes directly to MassHealth.

420.402: Definitions

The following terms used in 130 CMR 420.000 have the meanings given in 130 CMR 420.402, unless the context clearly requires a different meaning. The reimbursability of services defined in 130 CMR 420.000 is not determined by these definitions, but by application of 130 CMR 420.000 and 450.000: *Administrative and Billing Regulations*. Definitions specific to radiographs are set forth at 130 CMR 420.423.

Adult Dentition (Permanent Dentition) – permanent teeth that have erupted and replaced deciduous teeth.

BORID – the Board of Registration in Dentistry, or any committee or subcommittee thereof, established in the Massachusetts Department of Public Health (DPH) pursuant to the provisions of M.G.L. c. 13, §19 and c. 112 §§1, 12CC, 43 through 53, and 61 through 65E.

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

CODA – the Commission on Dental Accreditation of the American Dental Association.

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

DDS Clients – MassHealth members 21 years of age or older who have been determined by DDS to be eligible for adult DDS services, pursuant to 115 CMR 6.00: *Standards to Promote Dignity*.

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

Mobile Dental Facility (MDF) – any self-contained facility where dentistry will be practiced that may be driven, moved, towed, or transported from one location to another.

Portable Dental Operation (PDO) – any dental practice where a portable dental unit is transported to and utilized on a temporary basis at an out-of-office location.

Primary Dentition (Deciduous Dentition) – deciduous teeth developed and erupted first in order of time.

Public Health Setting – includes, but is not limited to, residences of the homebound; schools; Head Start programs; nursing homes and long-term care facilities licensed pursuant to M.G.L. c. 111, § 71; clinics, community health centers, and hospitals licensed pursuant to M.G.L. c. 111, § 51; medical facilities; residential treatment facilities; federal, state or local public health programs; MDFs and portable dental programs which are permitted by BORID pursuant to 234 CMR 7.00: *Mobile and Portable Dentistry* or licensed or certified by DPH pursuant to M.G.L. c. 111, § 51; and other facilities or programs deemed appropriate by BORID or DPH.

Transitional Dentition (Mixed Dentition) – the phase of the transition from Primary Dentition to Permanent Dentition, in which growth has not ceased and the deciduous teeth are in the process of shedding and the permanent successors are emerging.

420.403: Eligible Members

(A) MassHealth Members. 130 CMR 450.105: *Coverage Types* specifically states for each MassHealth coverage type, which members are eligible to receive dental services. The MassHealth agency pays for dental services described in 130 CMR 420.000, provided to eligible MassHealth members.

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

(C) Member Eligibility and Coverage Type. 130 CMR 450.107: Eligible Members and the MassHealth Card provides information on verifying member eligibility and coverage type.

420.404: Provider Eligibility: Participating Providers

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

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

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

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

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

420.405: Provider Eligibility In-state and Out-of-state

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

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

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

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

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

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

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

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

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

(9) Public Health Dental Hygienist. A dental hygienist engaged in private practice is eligible to participate in MassHealth as a dental provider and claim payment for certain services without the direct supervision of a dentist if he or she is licensed to practice as a registered dental hygienist by BORID and also meets the board's requirements to practice in a public health setting pursuant to 234 CMR 2.00: *General Rules and Requirements* et seq. Private practices may include, but are not limited to, solo, partnership, or group practices.

(10) Mobile Dental Facility (MDF) or Portable Dental Operation (PDO). A dentist or public health dental hygienist is eligible to participate in MassHealth as a dental provider and claim payment for certain services provided through a MDF or PDO only if the provider satisfies the requirements of 234 CMR 7.00: *Mobile and Portable Dentistry* and has obtained a valid permit as a MDF or PDO from BORID.

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

(C) Enhancement Fee for Community Health Centers and Hospital-licensed Health Centers.

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

(2) The dental enhancement fee is set by the Executive Office of Health and Human Services (EOHHS) (*see* 101 CMR 314.00: *Dental Services*).

420.406: Caseload Capacity

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

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

420.407: Maximum Allowable Fees

The MassHealth agency pays for dental services with rates set by the Executive Office of Health and Human Services (EOHHS) at 101 CMR 314.00: *Dental Services*, subject to the conditions, exclusions, and limitations set forth in 130 CMR 420.000 and 450.000: *Administrative and Billing Regulations*.

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

The MassHealth agency pays for all medically necessary dental services for EPSDT-eligible members in accordance with 130 CMR 450.140*: Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services: Introduction*, without regard to service limitations described in 130 CMR 420.000, and with prior authorization.

420.409: Noncovered Circumstances

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

(1) services provided in a state institution by a state-employed dentist, dental consultant, or public health dental hygienist;

(2) services provided by a provider whose salary includes compensation for professional services;

(3) if, under comparable circumstances, the provider does not customarily bill individuals who do not have health insurance; and

(4) if the member is not an eligible MassHealth member on the date of service. The provider must verify the member's eligibility for MassHealth on the date of service even if the provider has obtained prior authorization for the service.

(B) Substitutions.

(1) If a member desires a substitute for, or a modification of, a covered service, the member must pay for the entire cost of the service. The MassHealth agency does not pay for any portion of the cost of a substitute for, or modification of, a covered service. In all such instances, before performing services not covered for the member, the provider must inform the member both of the availability of covered services and of the member's obligation to pay for those that are not covered services.

(2) It is unlawful (M.G.L. c. 6A, § 35) for a provider to accept any payment from a member for a service or item for which payment is available under MassHealth. If a member claims to have been misinformed about the availability of covered services, it will be the responsibility of the provider to prove that the member was offered a covered service, refused it, and chose instead to accept and pay for a service that MassHealth does not pay for.

(3) Providers may upgrade medically necessary services at no additional cost to the MassHealth agency or the member.

420.410: Prior Authorization

(A) Introduction.

(1) The MassHealth agency pays only for medically necessary services to eligible MassHealth members and may require that medical necessity be established through the prior authorization process. In some instances, prior authorization is required for members 21 years of age or older when it is not required for members younger than 21 years old.

(2) Services requiring prior authorization are identified in Subchapter 6 of the *Dental Manual*, and may also be identified in billing instructions, program regulations, associated lists of service codes and service descriptions, provider bulletins, and other written issuances. The MassHealth agency only reviews requests for prior authorization where prior authorization is required or permitted (*see* 130 CMR 420.410(B)).

(3) The provider must not start a service that requires prior authorization until the provider has requested and received written prior authorization from the MassHealth agency. The MassHealth agency may grant prior authorization after a procedure has begun if, in the judgment of the MassHealth agency

(a) the treatment was medically necessary;

(b) the provider discovers the need for additional services while the member is in the office and undergoing a procedure; and

(c) it would not be clinically appropriate to delay the provision of the service.

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

(1) those services listed in Subchapter 6 of the *Dental Manual* with the abbreviation "PA" or otherwise identified in billing instructions, program regulations, associated lists of service codes and service descriptions, provider bulletins, and other written issuances;

(2) any service not listed in Subchapter 6 for an EPSDT-eligible member; and

(3) any exception to a limitation on a service otherwise covered for that member as described in 130 CMR 420.421 through 420.456. (For example, MassHealth limits prophylaxis to two per member per calendar year but pays for additional prophylaxis for a member within a calendar year if medically necessary.)

(C) Submission Requirements.

(1) The provider is responsible for including with the request for prior authorization appropriate and sufficient documentation to justify the medical necessity for the service. Refer to Subchapter 6 of the *Dental Manual* for prior-authorization requirements.

(2) Instructions for submitting a request for prior authorization for Current Dental Terminology (CDT) codes are described in the MassHealth Dental Program Office Reference Manual. Dental providers requesting prior authorization for services listed with a CDT code must use the current American Dental Association (ADA) claim form.

(3) Instructions for submitting a request for prior authorization for CPT codes are described in the administrative and billing instructions (Subchapter 5) in all provider manuals. The provider must submit prior authorization requests for CPT codes to MassHealth in accordance with the instructions in Appendix A of all provider manuals.

(D) Other Requirements for Payment.

(1) Prior authorization determines only the medical necessity of the authorized service and does not establish or waive any other prerequisites for payment such as member eligibility, the availability of other health-insurance payment, or whether the service is a covered service.

(2) The MassHealth agency does not pay for a prior-authorized service when the member's MassHealth eligibility is terminated on or before the date of service.

(3) When the member's MassHealth eligibility is terminated before delivery of a special-order good, such as denture(s) and crown(s), the provider may claim payment in accordance with the provisions of 130 CMR 450.231(B): *General Conditions of Payment*. Refer to 130 CMR 450.231(B) for special procedures in documenting member eligibility for special order goods.

420.411: Pretreatment Review

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

420.412: Individual Consideration

(A) Certain services, including unspecified procedures, are designated "IC" (individual consideration) in Subchapter 6 of the *Dental Manual* and in the EOHHS pricing regulation for dental services, 101 CMR 314.00: *Dental Services*. This means that a fee could not be established for these services. The MassHealth agency determines appropriate payment for individual consideration services from the provider's detailed report of services provided (see Subchapter 6 of the *Dental Manual* for report requirements). The MassHealth agency does not pay claims for "IC" services without a complete report (*see* 130 CMR 420.415). If the documentation is illegible or incomplete, the MassHealth agency denies the claim.

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

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

420.413: Separate Procedures

Certain procedures are designated "SP" (separate procedure) in the service descriptions in Subchapter 6 of the *Dental Manual*. A separate procedure is one that is commonly performed as an integral part of a total service and therefore does not warrant a separate payment, but that commands a separate payment when performed as a separate procedure not immediately related to other services. For example,

(A) the MassHealth agency does not pay for a frenulectomy when it is performed as part of a vestibuloplasty, and full-study models are not payable separately when performed as part of orthodontic treatment or diagnosis. Nevertheless, the MassHealth agency does pay for frenulectomy as a separate procedure when medically necessary; and

(B) the MassHealth agency does not pay for restorations placed on two (2) or more surfaces within 12 months on the same tooth as separate restorations at the one-surface rate. Claims submitted as separate restorations will be paid at the appropriate multi-surface restoration rates set by EOHHS at 101 CMR 314.00: *Dental Services*, subject to the conditions, exclusions, and limitations set forth in 130 CMR 420.000 and 450.000: *Administrative and Billing Regulations*.

420.414: Recordkeeping Requirements

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

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

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

420.415: Report Required with Certain Claims

(A) The provider must submit with the claim for payment, a written description of the service provided in accordance with the requirements described in Subchapter 6 of the *Dental Manual* when

(1) the service description in Subchapter 6 stipulates "by report;" or
(2) the service is designated in Subchapter 6 as "IC". *See* 130 CMR 420.412.

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

420.416: Pharmacy Services: Prescription Requirements

For information on pharmacy services refer to 130 CMR 406.000: *Pharmacy Services*.

(420.417 through 420.420 Reserved)

420.421: Covered and Noncovered 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) 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 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*.

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

(1) diagnostic services as described in 130 CMR 420.422;
(2) radiographs as described in 130 CMR 420.423;
(3) preventive services as described in 130 CMR 420.424;
(4) restorative services as described in 130 CMR 420.425;
(5) endodontic services as described in 130 CMR 420.426;
(6) periodontal services as described in 130 CMR 420.427;
(7) prosthodontic services as described in 130 CMR 420.428;

(8) oral surgery services as described in 130 CMR 420.430;
(9) anesthesia services as described in 130 CMR 420.452;
(10) oral and maxillofacial surgery services as described in 130 CMR 420.453;
(11) maxillofacial prosthetics as described in 130 CMR 420.455;
(12) behavior management services as described in 130 CMR 420.456(B);
(13) palliative treatment of dental pain or infection services as described in 130 CMR 420.456(C); and
(14) house/facility call as described in 130 CMR 420.456(F).

(D) Noncovered 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 and 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).

420.422: Service Descriptions and Limitations: Diagnostic Services

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

(B) Periodic Oral Evaluation. The MassHealth agency pays for a periodic oral evaluation twice per calendar year, per member, per provider or location. This service is not covered on the same date of service as a palliative emergency treatment visit. A periodic oral evaluation is performed on an established patient of record to determine any changes in the member's dental and medical health status since a previous comprehensive or periodic oral evaluation.

(C) Oral Evaluation. The MassHealth agency pays for this service twice per calendar year per provider or location. An oral evaluation is counseling with a primary caregiver (parent/guardian) for members younger than three years old.

(D) Limited Oral Evaluation. The MassHealth agency pays for a limited oral evaluation twice per member per calendar year. A limited oral evaluation is not covered on the same date of service as a palliative emergency treatment visit. A limited oral evaluation is an evaluation limited to a specific oral health problem or complaint. This may require interpretation of information acquired through additional diagnostic procedures. Typically, patients receiving this type of evaluation present with a specific problem and/or dental trauma, pain, or acute infection.

(E) Comprehensive Periodontal Evaluation. The MassHealth agency pays for a comprehensive periodontal evaluation once per calendar year per member, per provider or per location. A comprehensive periodontal evaluation is indicated for members showing signs or symptoms of periodontal disease and for members with risk factors such as smoking or diabetes. A comprehensive periodontal evaluation includes evaluation of periodontal conditions, probing and charting, evaluation and recording of dental caries, missing or unerupted teeth, restorations, occlusal relationships, and oral cancer evaluation.

(F) Oral Screening. The MassHealth agency pays for an oral screening twice per calendar year per member per provider. An oral screening may only be billed by public health dental hygienists. An oral screening includes state or federally mandated screenings to determine a member's need to be seen by a dentist for further diagnosis.

(G) Limited Clinical Assessment. The MassHealth agency pays for a limited clinical assessment once per calendar year per member per provider. A limited clinical assessment may only be billed by public health dental hygienists. A limited clinical assessment includes identification of possible signs of oral or systemic disease, malformation, injury, and/or the potential need for a referral for diagnosis and treatment by a dentist.

420.423: Service Descriptions and Limitations: Radiographs

(A) Introduction and Definitions.

(1) The MassHealth agency pays for radiographs/diagnostic imaging taken as an integral part of diagnosis and treatment planning.

(a) Assessing Extent of Required Radiographs. Providers should conduct a clinical examination; consider the member's oral and medical histories, as well as the member's vulnerability to environmental factors that may affect the oral health before conducting a radiographic examination to determine the type of imaging, frequency, and number of images. Radiographs should be taken only when there is an expectation that the diagnostic yield will affect patient care. The intent is to confine radiation exposure of members to the minimum necessary to achieve satisfactory diagnosis.

(b) The provider must document efforts to obtain any previous radiographs/diagnostic imaging before prescribing more.

(c) When radiographs and diagnostic imaging submitted to the MassHealth agency as part of the prior authorization process or upon other request are not of good diagnostic quality, the provider may not claim payment for any retake of radiographs/diagnostic imaging requested by the MassHealth agency.

(2) Definitions.

(a) Bitewing Radiographs – a bitewing radiograph is a diagnostic image showing the crowns of the upper and lower teeth and alveolar bone simultaneously.

(b) Cephalometric Radiograph – a 2D image of the head made using Cephalostat to standardize anatomic, positioning, and with reproducible x-ray beam geometry.

(c) Intraoral Complete Series of Radiographic Images – intraoral complete series of radiographic images surveys the whole mouth; usually consists of 14 through 22 periapical

and posterior bitewing images, intended to display the crowns and roots of all teeth, periapical areas, and alveolar bone.
(d) Periapical Radiographs – diagnostic intraoral images showing tooth apices and surrounding structures in a particular intraoral area.
(e) Occlusal Radiographs – a supplementary radiograph designed to provide a more extensive view of the maxilla and mandible; highlighting tooth development and placement in children.
(f) Panoramic Radiograph – an extraoral image showing a 2D view of the patients' entire jaw from ear to ear.

(B) Intraoral Conventional or Direct Digital Radiographs.
(1) Intraoral Complete Series of Radiographic Images. The MassHealth agency pays for intraoral complete series of radiographic images once every three calendar years per member; per provider or location. Intraoral complete series of radiographic images are recommended for members with clinical evidence of generalized oral disease or a history of extensive dental treatment. The MassHealth agency allows for substitution of the intraoral complete series of radiographic images with individualized radiographs consisting of posterior bitewings with a panoramic or occlusal radiograph and selected periapicals for members with transitional dentition. Panoramic radiographs cannot be substituted for intraoral complete series of radiographic images if intraoral complete series of radiographic images are required for a prior authorization request, unless the member has complete bony impacted teeth, or other surgical conditions listed under 130 CM 420.423(C)(1), and is edentulous. The MassHealth agency does not pay more for individual periapical radiographs (with or without bitewings) than it would for an intraoral complete series of radiographic images. The MassHealth agency further defines the numbers of radiographs which constitute intraoral complete series of radiographic images based on age limitations described in Appendix E of the *Dental Manual*.
(2) Bitewing Radiographs. The MassHealth agency pays for up to four bitewing radiographs as separate procedures based on the clinical guidelines set forth by the American Dental Association. Providers must document variations from the ADA clinical guidelines in the member's dental record. The MassHealth agency does not pay separately for bitewing radiographs taken as part of an intraoral complete series of radiographic images.
(3) Periapical Radiographs. Periapical radiographs may be taken for specific areas where extraction is anticipated, or when infection, periapical change, or an anomaly is suspected, or when otherwise directed by the MassHealth agency. A maximum of four periapical radiographs is allowed per day per member, per provider, or location.
(4) Occlusal Radiographs. The MassHealth agency pays for two occlusal radiographs per calendar year per member younger than five years old per provider or location.
(5) Panoramic Radiographs. The MassHealth agency pays for panoramic radiographs for surgical and nonsurgical conditions as described in 130 CMR 420.423(C)(1) and (2). The MassHealth agency does not pay for panoramic radiographs for orthodontics, crowns, endodontics, periodontics, and interproximal caries.

(6) Cephalometric Radiographs. The MassHealth agency pays for cephalometric radiographs in conjunction with surgical conditions including, but not limited to, status after facial trauma, mandibular fractures, dentoalveolar fractures, mandibular atrophy, and jaw dislocations. Payment for cephalometric radiographs, or other radiographs, in conjunction with orthodontic diagnosis is included in the payment for orthodontic services (*see* 130 CMR 420.431(C)(9)). The MassHealth agency does not pay separately for additional radiographs when required for orthodontic diagnosis.

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

(1) impactions;
(2) teeth requiring extractions in more than one quadrant;
(3) large cysts or tumors that are not fully visualized by intraoral radiographs or clinical examination;
(4) salivary-gland disease;
(5) maxillary-sinus disease;
(6) facial trauma;
(7) trismus where an intraoral radiographs placement is impossible; and
(8) orthognathic surgery.

(D) Nonsurgical Conditions.

(1) Members Younger than 21 Years Old. The MassHealth agency pays for only one panoramic radiograph every three calendar years per member for nonsurgical conditions, to monitor the growth and development of permanent dentition as a part of an individualized radiograph series for the child member with transitional dentition.

(2) Members 21 Years of Age or Older. The MassHealth agency pays for only one panoramic radiograph every three years per member in lieu of an intraoral complete series of radiographic images only for those members who are unable to cooperate with the process for obtaining an intraoral complete series of radiographic images or are edentulous. The provider must document in the member's dental record the reasons the member cannot cooperate with the process for obtaining an intraoral complete series of radiographic images.

420.424: Service Descriptions and Limitations: Preventive Services

(A) Prophylaxis. The MassHealth agency pays for prophylaxis twice per member per calendar year. The prophylaxis must include the removal of plaque, calculus, and stains from the tooth structures. MassHealth requires the provider to perform as part of this service oral hygiene instruction including but not limited to proper tooth brushing and flossing instructions and use of oral hygiene aids. The MassHealth agency does not pay a separate fee for oral hygiene instruction.

(B) Fluoride.

(1) Topical Fluoride Treatment.

(a) Members Younger than 21 Years Old. The MassHealth agency pays for topical fluoride treatment every 90 days per member, per provider or location. Topical fluoride treatment consists of continuous topical application of an approved fluoride agent such as gels, foams, and varnishes, for a period shown to be effective for the agent. The MassHealth agency pays for treatment that incorporates fluoride with the polishing compound as part of the prophylaxis procedure. The MassHealth agency does not pay for treatment that incorporates fluoride with the polishing compound as a separate procedure.

(b) Members 21 Years of Age or Older. The MassHealth agency pays for topical fluoride only for members who have medical or dental conditions that significantly interrupt the flow of saliva. Providers must submit a prior authorization request for this treatment for members 21 years of age or older.

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

(3) Interim Caries Arresting Medicament Application. The MassHealth agency pays for interim caries arresting medicament such as silver diamine fluoride for all MassHealth members for treatment of asymptomatic and active dental caries only, twice per tooth per lifetime. Providers are required to retain documentation demonstrating medical necessity for interim caries arresting medicament application, including documentation of asymptomatic or active dental caries.

(C) Sealants. The MassHealth agency pays for sealants, for members younger than 17 years old, on the occlusal surface of permanent noncarious nonrestored molars once every three calendar years per member per tooth; per provider or location. Sealants are placed on teeth by mechanically and/or chemically sealing the prepared enamel surface to prevent decay. The MassHealth agency does not pay for reapplication of sealants if the process fails within three calendar years. The MassHealth agency does not pay to replace sealants lost or damaged during the three calendar-year period when reapplied by the same provider or location. The MassHealth agency does not pay for sealants applied to any tooth that has been restored.

(D) Space Maintainers. Space maintainers are indicated when there is premature loss of teeth that may lead to loss of arch integrity. The MassHealth agency pays for two space maintainers per arch per lifetime for members younger than 21 years old, to include recemented or rebonded space maintainers, and replacement space maintainers. These appliances are indicated when there is premature loss of teeth that may lead to loss of arch integrity. The provider must maintain in the

member's record, diagnostic-quality radiographs that support the need for space maintainers whether initial or replacement. Payment for subsequent visits to adjust space maintainers is included in the original payment.

420.425: Service Descriptions and Limitations: Restorative Services

The MassHealth agency pays for restorative services in accordance with the service descriptions and limitations in 130 CMR 420.425(A) through (E). The MassHealth agency considers all of the following to be components of a completed restoration (local anesthesia tooth preparation, acid etching, all adhesives applications, resin bonding agents, amalgam bonding agents, liners, bases, amalgams, resin-based composites, glass ionomers, curing and polishing) and includes them in the payment for this service. The MassHealth agency does not pay for composite or amalgam restorations replaced within one year of the date of completion of the original restoration when replaced by the same provider or dental group. The initial payment includes all restorations replaced due to defects or failure less than one year from the original placement.

(A) Amalgam Restorations. The MassHealth agency does not pay for restorations on primary teeth when early exfoliation (more than 2/3 of the root structure resorbed) is expected.

(B) Resin-based Composite Restorations.
(1) The MassHealth agency pays for:
(a) all resin-based composite restorations for all surfaces of anterior and posterior teeth; and
(b) full-coverage composite crowns only for members younger than 21 years old, only for anterior primary teeth.
(2) For anterior teeth, the MassHealth agency pays no more than the maximum allowable payment for four-or-more-surface resin-based composite restorations on the same tooth, except for reinforcing pins.
(3) The MassHealth agency pays for only one resin-based composite restoration per member per tooth surface per 12 months per provider or provider location.
(4) The MassHealth agency does not pay more for a composite restoration on a posterior (primary or permanent) tooth than it would for an amalgam restoration.

(C) Crowns, Posts and Cores.
(1) Members Younger than 21 Years Old. The MassHealth agency pays for the following crown materials on permanent incisors, cuspids, bicuspids, and first and second molars:
(a) crowns made from resin-based composite (indirect);
(b) crowns porcelain fused to predominantly base metal;
(c) crowns porcelain fused to high noble metal;
(d) crowns made from porcelain or ceramic;
(e) crowns porcelain fused to semi-precious metal;
(f) full case high noble metal;
(g) posts and cores and/or pin retention;
(h) prefabricated porcelain/ceramic crown -primary tooth; and

(i) prefabricated stainless steel crowns for primary and permanent posterior teeth or prefabricated resin crowns for primary and permanent anterior teeth. Stainless steel or prefabricated resin crowns are limited to instances where the prognosis is favorable and must not be placed on primary teeth that are mobile or show advanced resorption of roots. The MassHealth agency pays for no more than four stainless steel or prefabricated resin crowns per member per date of service except in cases that are treated in a hospital operating room or ambulatory care center.

(2) Members 21 Years of Age and Older. The MassHealth agency pays for the following crown materials on permanent incisors, cuspids, bicuspids, and first and second molars:

(a) crowns porcelain fused to predominantly base metal;

(b) crowns made from porcelain or ceramic;

(c) stainless steel crowns only if crown porcelain fused to predominately base metal is unsuitable and extraction (the alternative treatment) would cause undue medical risk for a member with one or more medical conditions that include, but are not limited to

1. hemophilia;
2. history of radiation therapy;
3. acquired or congenital immune disorder;
4. severe physical disabilities such as quadriplegia;
5. profound intellectual or developmental disabilities; or
6. profound mental illness; and

(d) posts and cores and/or pin retention.

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

(E) Crown or Bridge Repair. The MassHealth agency pays for chairside crown repair for all members and fixed partial denture repair only for members younger than 21 years old. A description of the repair must be documented in the member's dental record. The MassHealth agency pays for unspecified restoration procedures for crown repair by an outside laboratory only if the repair is extensive and cannot be done chairside.

420.426: Service Descriptions and Limitations: Endodontic Services

The MassHealth agency pays for endodontic services including all radiographs performed with the exception of panoramic radiographs, during the treatment visit. The MassHealth agency pays for endodontic services for all MassHealth members in accordance with the service descriptions and limitations described in 130 CMR 420.426.

(A) Pulpotomy.

(1) The MassHealth agency pays for a therapeutic pulpotomy for members younger than 21 years old only.

(2) Therapeutic pulpotomy is the surgical removal of a portion of the pulp with the aim of maintaining the vitality of the remaining portion by means of an adequate dressing. This procedure is performed on primary or permanent teeth. It is limited to instances when the prognosis is favorable, and must not be performed on primary teeth that are ready to exfoliate or permanent teeth with advanced periodontal disease or to be used for apexogenesis.
(3) The MassHealth agency does not pay for pulpotomy on deciduous teeth that are ready to exfoliate.
(4) The MassHealth agency does not pay for pulpotomy as the first stage of root canal therapy.
(5) The MassHealth agency does not pay for a pulpotomy performed on the same date of service as root canal therapy. (*See* 130 CMR 420.456(C) regarding palliative treatment.)

(B) Endodontic Root Canal Therapy.
(1) General Conditions.
(a) Payment by the MassHealth agency for root canal therapy includes payment for all preoperative and postoperative treatment; diagnostic (for example, pulp vitality) tests; and pretreatment, treatment, and post-treatment radiographs and anesthesia. MassHealth does not pay for pulpotomy as a separate procedure from root canal therapy.
(b) The provider must maintain a radiograph of the completed root canal in the member's dental record.
(c) The MassHealth agency pays for root canal therapy on permanent anterior teeth, bicuspids, and first and second molars but does not pay for root canal therapy on third molars. Root canal therapy is limited to the permanent dentition only if the periodontal condition of the remaining dentition and soft tissue are stable with a favorable prognosis.

(C) Endodontic Retreatment.
(1) The MassHealth agency pays for endodontic retreatment of permanent anterior, bicuspids, and first and second molar teeth for all MassHealth members. This procedure may include the removal of a post, pins, old root canal filling material, and the procedures necessary to prepare the canals and place the canal filling.
(2) Payment includes all retreatments within 24 months of the original root canal.

(D) Apicoectomy/Periradicular Surgery.
(1) The MassHealth agency pays for an apicoectomy as a separate procedure for all MassHealth members following root canal therapy when the canal cannot be retreated through reinstrumentation.
(2) Payment by the MassHealth agency for an apicoectomy with root canal filling includes payment for the filling of the canal or canals and removing the pathological periapical tissue and any retrograde filling in the same period of treatment.

(E) Pulp Cap. The MassHealth agency pays for indirect pulp cap on primary and permanent tooth to preserve tooth's vitality once per tooth lifetime.

420.427: Service Descriptions and Limitations: Periodontal Services

(A) Surgical Periodontal Procedures. The MassHealth agency pays for gingivectomies and gingivoplasties once per member per quadrant every three calendar years. The MassHealth agency does not pay for a gingivectomy performed on the same day as a prophylaxis, periodontal scaling and root planing, or as a separate procedure with an extraction. The MassHealth agency pays for the gingivectomy or gingivoplasty for a maximum of two quadrants on the same date of service in an office setting. Gingivectomy or gingivoplasty procedure is performed to eliminate suprabony pockets or to restore normal architecture when gingival enlargements or asymmetrical or unaesthetic topography is evident with normal bony configuration. Prior authorization is required for members 21 years of age or older.

(B) Periodontal Scaling and Root Planing. The MassHealth agency pays for periodontal scaling and root planing once per member per quadrant every three calendar years. The MassHealth agency does not pay separately for prophylaxis provided on the same day as periodontal scaling and root planing or on the same day as a gingivectomy or a gingivoplasty. The MassHealth agency pays only for periodontal scaling and root planing for a maximum of two quadrants on the same date of service in an office setting. Periodontal scaling and root planing involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus. It is indicated for members with active periodontal disease, not prophylactic. Root planing is the definitive procedure for the removal of rough cementum and dentin, and/or permeated by calculus or contaminated with toxins or microorganisms. Some soft tissue removal occurs. Local anesthesia is considered an integral part of periodontal procedures and may not be billed separately. Prior authorization is required for members 21 years of age or older.

(C) Non-surgical Scaling in the Presence of Generalized Moderate or Severe Gingival Inflammation - Full Mouth, after Oral Evaluation. The MassHealth agency pays for non-surgical scaling in the presence of generalized moderate or severe gingival inflammation, twice per member per calendar year. The MassHealth agency does not pay for scaling in the presence of generalized moderate or severe gingival inflammation on the same day as a prophylaxis, periodontal scaling and root planing, or surgical periodontal procedure, or as a separate procedure with a full mouth debridement or periodontal maintenance. This procedure includes the removal of plaque, calculus, and stains from supra- and sub-gingival tooth surfaces when there is generalized moderate or severe gingival inflammation in the absence of periodontitis for members who have swollen, inflamed gingiva, generalized suprabony pockets, and moderate to severe bleeding on probing.

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

(A) General Conditions. The MassHealth agency pays for dentures services once per seven calendar years per member, subject to the age limitations specified in 130 CMR 420.428(B). MassHealth payment includes all services associated with the fabrication and delivery process, including all adjustments necessary in the six months following insertion. The member is responsible for all denture care and maintenance following insertion. The MassHealth agency does

not pay for complete dentures when the member's medical record indicates material limitations to the member's ability to cooperate during the fabrication of the denture or to accept or function with the denture, or indications that the member does not intend to utilize the denture.

(B) Prosthodontic Services. The MassHealth agency pays for complete dentures for all members. The MassHealth agency pays for immediate dentures, including relines and post insertion procedures and placement of identification, for members younger than 21 years old.

(C) Denture Procedures.

(1) All denture services require appropriate diagnostic quality radiographs to be taken and stored in the member's chart.

(2) As part of the denture fabrication process, the member must approve the teeth and setup in wax and try on the denture setup at a try-in visit before the dentures are processed.

(3) The member's identification must be on each denture.

(4) All dentures must be initially inserted and subsequently examined and can be adjusted up to six months after the date of insertion by the dentist at reasonable intervals consistent with the community standards.

(5) If a member does not return for the insertion of the completed processed denture, the provider is required to submit to the MassHealth agency written evidence on their office letterhead of at least three attempts to contact the member over a period of one month via certified mail return receipt requested. Upon providing documentation, the provider may be reimbursed a percentage of the denture fee to assist in covering costs. *See* 130 CMR 450.231: *General Conditions of Payment*.

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

(E) Removable Partial Dentures. The MassHealth agency pays for removable partial dentures if there are two or more missing posterior teeth or one or more missing anterior teeth, the remaining dentition does not have active periodontitis, and there is a favorable prognosis for treatment outcome. A tooth is considered missing if it is a natural tooth or a prosthetic tooth missing from a fixed prosthesis. Payment for a partial denture includes payment for all necessary procedures for fabrication including clasps and rest seats.

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

(1) repair or reline will make the existing denture usable;

(2) any of the dentures made previously have been unsatisfactory due to physiological causes that cannot be remedied;

(3) a clinical evaluation suggests that the member will not adapt satisfactorily to the new

denture;
(4) no medical or surgical condition in the member necessitates a change in the denture or a requirement for a new denture;
(5) the existing denture is less than seven years old and no other condition in this list applies;
(6) the denture has been relined within the previous two years, unless the existing denture is at least seven years old;
(7) there has been marked physiological change in the member's oral cavity, and any further reline has a poor prognosis for success; or
(8) the loss of the denture was not due to extraordinary circumstances such as a fire in the home.

(G) Complete Denture Relines. The MassHealth agency pays for chairside and laboratory complete denture relines. Payment for dentures includes any relines or rebases necessary within six months of the insertion date of the denture. The MassHealth agency pays for subsequent relines once every three calendar years per member.

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

(A) Fixed Partial Dentures/Bridges. The MassHealth agency pays for fixed partial dentures/ bridge for anterior teeth only for members younger than 21 years old with two or more missing permanent teeth. The member must not have active periodontal disease, and the prognosis for the life of the bridge and remaining dentition must be excellent.

(B) Fixed Partial Denture/Bridge Repair. The MassHealth agency pays for chairside fixed partial denture/bridge repair. A description of the repair must be documented in the member's dental record.

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 re-exposure 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.

(F) Vestibuloplasty. The MassHealth agency pays for vestibuloplasty ridge extension.

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

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

(I) Excision of Benign Lesion. The MassHealth agency pays for excision of soft tissue lesions.

(J) Removal of Exostosis and Tori. The MassHealth agency pays for removal of exostosis and tori once per arch per member.

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

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

420.431: Service Descriptions and Limitations: Orthodontic Services

(A) General Conditions. The MassHealth agency pays for orthodontic treatment, subject to prior authorization, service descriptions and limitations as described in 130 CMR 420.431. The provider must seek prior authorization for orthodontic treatment and begin initial placement and insertion of orthodontic appliances and partial banding or full banding and brackets prior to the member's 21st birthday.

(B) Definitions.

(1) Pre-orthodontic Treatment Examination – includes the periodic observation of the member's dentition at intervals established by the orthodontist to determine when orthodontic treatment should begin.

(2) Interceptive Orthodontic Treatment – includes treatment of the primary and transitional dentition to prevent or minimize the development of a handicapping malocclusion and therefore, minimize or preclude the need for comprehensive orthodontic treatment.

(3) Comprehensive Orthodontic Treatment – includes a coordinated diagnosis and treatment leading to the improvement of a member's craniofacial dysfunction and/or dentofacial deformity which may include anatomical and/or functional relationship. Treatment may utilize fixed and/or removable orthodontic appliances and may also include functional and/or orthopedic appliances. Comprehensive orthodontics may incorporate treatment phases including adjunctive procedures to facilitate care focusing on specific objectives at various stages of dentofacial development.

(4) Orthodontic Treatment Visits – periodic visits which may include but are not limited to updating wiring, tightening ligatures or otherwise evaluating and updating care while undergoing comprehensive orthodontic treatment.

(C) Service Limitations and Requirements.

(1) Pre-orthodontic Treatment Examination. The MassHealth agency pays for a pre-orthodontic treatment examination for members younger than 21 years old, once per six (6) months per member, and only for the purpose of determining whether orthodontic treatment is medically necessary, and can be initiated before the member's twenty-first birthday. The MassHealth agency pays for a pre-orthodontic treatment examination as a separate procedure (*see* 130 CMR 420.413). The MassHealth agency does not pay for a pre-orthodontic treatment examination as a separate procedure in conjunction with pre-authorized ongoing or planned orthodontic treatment.

(2) Interceptive Orthodontics.

(a) The MassHealth agency pays for interceptive orthodontic treatment once per member per lifetime. The MassHealth agency determines whether the treatment will prevent or minimize a handicapping malocclusion based on the clinical standards described in Appendix F of the *Dental Manual*.

(b) The MassHealth agency limits coverage of interceptive orthodontic treatment to primary and transitional dentition with at least one of the following conditions: constricted palate, deep impinging overbite, Class III malocclusion including skeletal Class III cases as defined in Appendix F of the *Dental Manual* when a protraction facemask/reverse pull headgear is necessary at a young age, craniofacial anomalies, anterior cross bite, or dentition exhibiting results of harmful habits or traumatic interferences between erupting teeth.

(c) When initiated during the early stages of a developing problem, interceptive orthodontics may reduce the severity of the malformation and mitigate its causes. Complicating factors such as skeletal disharmonies, overall space deficiency, or other conditions may require subsequent comprehensive orthodontic treatment. Prior authorization for comprehensive orthodontic treatment may be sought for Class III malocclusions as defined in Appendix F of the *Dental Manual* requiring facemask treatment at the same time that authorization for interceptive orthodontic treatment is sought. For members with craniofacial anomalies, prior authorization may separately be sought for the cost of appliances, including installation.

(3) Comprehensive Orthodontics. The MassHealth agency pays for comprehensive orthodontic treatment, subject to prior authorization, once per member per lifetime for a member younger than 21 years old and only when the member has a handicapping malocclusion. The MassHealth agency determines whether a malocclusion is handicapping based on clinical standards for medical necessity as described in Appendix D of the *Dental Manual*. Upon the completion of orthodontic treatment, the provider must take post treatment photographic prints and maintain them in the member's dental record.

The MassHealth agency pays for the office visit, radiographs and a record fee of the pre-orthodontic treatment examination (alternative billing to a contract fee) when the MassHealth agency denies a request for prior authorization for comprehensive orthodontic treatment or when the member terminates the planned treatment. The payment for a pre-orthodontic treatment consultation as a separate procedure does not include models or photographic prints. The MassHealth agency may request additional consultation for any orthodontic procedure.

Payment for comprehensive orthodontic treatment is inclusive of initial placement, and insertion of the orthodontic fixed and removable appliances (for example: rapid palatal expansion (RPE) or head gear), and records. Comprehensive orthodontic treatment may occur in phases, with the anticipation that full banding must occur during the treatment period. The payment for comprehensive orthodontic treatment covers a maximum period of three (3) calendar years. The MassHealth agency pays for orthodontic treatment as long as the member remains eligible for MassHealth, if initial placement and insertion of fixed or removable orthodontic appliances begins before the member reaches 21 years of age.

Comprehensive orthodontic care should commence when the first premolars and 1st permanent molars have erupted. It should only include the transitional dentition in cases with craniofacial anomalies such as cleft lip or cleft palate. Comprehensive treatment may commence with second deciduous molars present.

Subject to prior authorization, the MassHealth agency will pay for more than one comprehensive orthodontic treatment for members with cleft lip, cleft palate, cleft lip and palate, and other craniofacial anomalies to the extent treatment cannot be completed within three years.

(4) Orthodontic Treatment Visits. The MassHealth agency pays for orthodontic treatment visits on a quarterly (90-days) basis for ongoing orthodontic maintenance and treatment beginning after the initial placement, and insertion of the orthodontic fixed and removable appliances. If a member becomes inactive for any period of time, prior authorization is not required to resume orthodontic treatment visits and subsequent billing, unless the prior authorization time limit has expired. The provider must document the number and dates of orthodontic treatment visits in the member's orthodontic record.

(5) Orthodontic Case Completion. The MassHealth agency pays for orthodontic case completion for comprehensive orthodontic treatment which includes the removal of appliances, construction and placement of retainers and follow-up visits. The MassHealth agency pays for a maximum of five (5) visits for members whose orthodontic treatment begins before their 21st birthday, consistent with 130 CMR 420.431(A). The MassHealth agency pays for the replacement of lost or broken retainers with prior authorization.

(6) Orthodontic Transfer Cases. The MassHealth agency pays for members who transfer from one orthodontic provider to another for orthodontic services subject to prior authorization to determine the number of treatment visits remaining. Payment for transfer cases is limited to the number of treatment visits approved. Providers must submit requests using the form specified by MassHealth.

(7) Orthodontic Terminations. The MassHealth agency requires providers to make all efforts to complete the active phase of treatment before requesting payment for removal of brackets and bands of a noncompliant member. If the provider determines that continued orthodontic treatment is not indicated because of lack of member's cooperation and has obtained the member's consent, the provider must submit a written treatment narrative on office letterhead with supporting documentation, including the case prior authorization number.

(8) Radiographs. Payment for Cephalometric and radiographs used in conjunction with orthodontic diagnosis is included in the payment for comprehensive orthodontic treatment (*see* 130 CMR 420.423(D)). The MassHealth agency pays for radiographs as a separate procedure for orthodontic diagnostic purposes only for members younger than 21 years old if requested by the MassHealth agency.

(9) Oral/Facial Photographic Images. The MassHealth agency pays for digital or photographic prints, not slides, only to support prior-authorization requests for comprehensive orthodontic treatment. Payment for digital or photographic prints is included in the payment for comprehensive orthodontic treatment or orthognathic treatment. The MassHealth agency does not pay for digital or photographic prints as a separate procedure (*see* 130 CMR 420.413). Payment for orthodontic treatment includes payment for services provided as part of the pre-orthodontic treatment examination, unless the MassHealth agency denies the prior authorization request for interceptive or comprehensive orthodontic treatment. The MassHealth agency pays for the pre-orthodontic treatment examination if prior authorization is denied for interceptive or comprehensive orthodontic treatment.

(130 CMR 420.432 through 420.451 Reserved)

420.452: Service Descriptions and Limitations: Anesthesia

(A) General Requirements. The MassHealth agency pays for general anesthesia and intravenous moderate (conscious) sedation/analgesia subject to the service descriptions and limitations described in 130 CMR 420.452 and in accordance with the service description of Subchapter 6 in the *Dental Manual*.

(1) Deep Sedation/General Anesthesia. Deep sedation and general anesthesia, when administered in a dental office, must be administered only by a provider who possesses both an anesthesia-administration permit and an anesthesia-facility permit issued by the Massachusetts Board of Registration in Dentistry (BORID) and when a member is eligible for oral-surgery services. All rules, regulations, and requirements set forth by the Massachusetts BORID and by the Massachusetts Society of Oral and Maxillofacial Surgeons must be followed without exception.

(2) Intravenous Moderate Sedation/Analgesia. The MassHealth agency pays for intravenous moderate sedation/analgesia sedation when administered in a dental office, and when a member is eligible for oral-surgery services, administered by a provider who possesses both an anesthesia-administration permit and an anesthesia-facility permit issued by the Massachusetts BORID.

(3) Inhalation of Nitrous Oxide/Oral Analgesia.

(a) The MassHealth agency pays for the oral administration of analgesia, as part of an operative procedure.

(b) The MassHealth agency pays for the administration of inhalation analgesia (nitrous oxide (N_2O/O_2)) as a separate procedure.

(4) Local Anesthesia. The MassHealth agency pays for the administration of local anesthesia as part of an operative procedure. The MassHealth agency does not pay for local anesthesia as a separate procedure (*See* 130 CMR 420.413).

(B) Documentation. The provider must maintain a completed anesthesia flowsheet in the member's dental record for each procedure requiring the use of anesthesia. In addition, the provider must document the following in the member's dental record:

(1) the beginning and ending times of deep sedation/general anesthesia, IV moderate sedation/analgesia, or inhalation of nitrous oxide analgesia procedure. The anesthesia time begins when the provider administers the anesthetic agent. The provider is required to follow the non-invasive monitoring protocol and remain in continuous attendance of the member. Anesthesia services are considered completed when the member may be safely left under the observation of trained personnel and the provider may safely leave the room. The level of anesthesia is determined by the provider's documentation and consideration of the member's history with anesthesia and anesthetic effects upon the central nervous system and is not dependent upon the route of administration;

(2) preoperative, intraoperative, and postoperative vital signs;

(3) medications administered, including their dosages and routes of administration;

(4) monitoring equipment used;

(5) a statement of the member's response to the analgesic or anesthetic used including any complication or adverse reaction; and

(6) a record of the member's history with anesthesia or analgesics.

420.453: Service Descriptions and Limitations: Oral and Maxillofacial Surgery Services Performed by Specialists in Oral Surgery

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

(A) Introduction. Oral and maxillofacial surgery services consist of those basic surgical services essential for the prevention and control of diseases of the oral cavity and supporting structures and for the maintenance of oral health. The MassHealth agency pays for maxillofacial surgery services only for the purpose of anatomic and functional reconstruction of structures that are missing, defective, or deformed because of surgical intervention, trauma, pathology, or developmental or congenital malformations. Cosmetic benefit may result from such surgical services but cannot be the primary reason for those services.

(B) General Conditions. The MassHealth agency pays only a dentist who is a specialist in oral surgery for the services listed in Subchapter 6 of the *Dental Manual* designated as Current Procedural Terminology (CPT) codes. Oral and maxillofacial surgery services should be performed in the office location where technically feasible and safe for the member. The MassHealth agency pays for the use of such settings when it is justified by the difficulty of the surgery (for example, four deep bony impactions) and the medical health of the member (for example, asthmatic on multiple medications, history of substance use disorder, seizure disorder, or developmentally disabled). Member fear or apprehension does not justify the use of a hospital or freestanding ambulatory surgery center.

(C) Surgical Assistants. The MassHealth agency pays a surgical assistant 15 percent of the allowable fee for the procedure performed.

(D) Preoperative Diagnosis and Postoperative Care. Payment for surgery procedures performed in a hospital or freestanding ambulatory surgery center includes payment for preoperative diagnosis and postoperative care during the member's stay.

(E) Inpatient Visits. The MassHealth agency pays providers for visits to hospitalized members except for routine preoperative and postoperative care to members who have undergone or who are expected to undergo surgery. Inpatient visits are payable only under exceptional circumstances, such as with preoperative or postoperative complications or the need for extended care, prolonged attention, intensive care services, or consultation services. The provider must substantiate the need for this service in the member's hospital medical record.

(F) Multiple Procedures. Where two or more individual procedures are performed in the same operative session, the MassHealth agency pays the full amount for the procedure with the highest payment rate, and each additional procedure is payable at 50 percent of the amount that would have been paid if performed alone. This requires the use of modifiers and applies only to those oral-surgery codes listed in Subchapter 6 of the *Dental Manual* designated as Current Procedural Terminology (CPT) codes.

(G) Orthognathic Surgery.

(1) The MassHealth agency pays for orthognathic surgery including select surgical procedures related to Temporomandibular Joint Disorder or Obstructive Sleep Apnea.

(2) Any proposed orthognathic or orthodontic treatment must meet all the criteria described at 130 CMR 420.431.

(130 CMR 420.454 Reserved)

420.455: Service Descriptions and Limitations: Maxillofacial Prosthetics

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

(B) The MassHealth agency pays for opposing appliances only when they are necessary for the balance or retention of the primary maxillofacial prosthetic device.

420.456: Service Descriptions and Limitations: Other Services

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

(1) The MassHealth agency pays for a member who is severely and chronically mentally and physically impaired, under certain circumstances, to undergo restorative, endodontic, or exodontic dental procedures for which they are eligible in a hospital or freestanding ambulatory surgery center. Use of these facilities may be indicated for a member who

(a) has a condition that is reasonably likely to place the member at risk of medical complications that require medical resources that are not available in an office setting;
(b) is extraordinarily uncooperative, fearful, or anxious;
(c) has dental needs, but local anesthesia is ineffective due to acute infection, idiosyncratic anatomy, or allergy; or
(d) has sustained orofacial or dental trauma, or both, so extensive that treatment cannot be provided safely and effectively in an office setting.

(2) The member's medical record must include:

(a) a detailed description of the member's illness or disability;
(b) a history of previous treatment or attempts at treatment;
(c) a treatment plan listing all procedures and the teeth involved;
(d) radiographs (if radiographs are not available, an explanation is required);
(e) photographs to indicate the condition of the mouth if radiographs are not available; and
(f) documentation that there is no other suitable site of service for the member that would be less costly to the MassHealth agency.

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

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

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

(E) Mouth Guard for Sports. The MassHealth agency pays for custom-fitted mouth guards only for members younger than 21 years old once per calendar year. The provider must document the following information in the member's record: that the member is engaged in a contact sport (including, but not limited to basketball, football, hockey, lacrosse, and soccer) and there must be no other provision for the purchase of mouth guards for the sport's participants.

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

REGULATORY AUTHORITY

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

601 Introduction

Dental providers who bill using Current Dental Terminology (CDT) codes must refer to the current version of the American Dental Association's (ADA) code book for the service descriptions for codes listed in Subchapter 6 of the *Dental Manual*. Dentists who are specialists in oral surgery in accordance with 130 CMR 420.405(A)(7) must refer to the current version of the American Medical Association's (AMA) Current Procedural Terminology (CPT) code book for the service descriptions for codes listed in Subchapter 6 of the *Dental Manual*.

MassHealth pays for dental services as described in MassHealth regulations at 130 CMR 420.000 and 450.000. A dental provider may request prior authorization for any medically necessary service payable in accordance with the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) provisions set forth in 130 CMR 450.144, 42 U.S.C. 1396d(a), and 42 U.S.C. 1396d(r)(5) for a MassHealth Standard or CommonHealth member under the age of 21. This applies even if the service is not listed in Subchapter 6 of the *Dental Manual*. For each dental service code, the description indicates any limitations, such as age and frequency, and if prior authorization is required for the member.

Dentists Who Are Specialists in Oral Surgery

A dentist who is a specialist in oral surgery in accordance with 130 CMR 420.405(A)(7) must submit all requests for prior authorization and claims containing CPT codes directly to MassHealth rather than to any third-party administrator or other MassHealth vendor, as described in 130 CMR 420.000.

When billing for multiple surgeries performed during the same operative session or on the same day, dental providers who are specialists in oral surgery in accordance with 130 CMR 420.405(A)(7), are reminded that Modifier 51 must be added to the second, third, and subsequent lines as appropriate. The primary procedure must be on line 1.

Modifiers

The following modifiers are for Provider Preventable Conditions (PPCs) that are National Coverage Determinations (NDCs).

PA Surgical or other invasive procedure on wrong body part
PB Surgical or other invasive procedure on wrong patient
PC Wrong surgery or other invasive procedure on patient

For more information on the use of these modifiers, see Appendix V of your provider manual.

Public Health Dental Hygienists

Public health dental hygienists may claim payment for service codes D0190, D0191, D0220, D0230, D0272, D0273, D0274, D1110, D1120, D1206, D1208, D1351, D1354, D4341, D4342, D9110, and D9410.

602 Explanation of Abbreviations and Service Code Requirements

The following abbreviations are used in Subchapter 6 with certain services that may require special reporting, as described next.

(A) Prior Authorization.

(1) "PA" indicates that service-specific prior authorization is required (see 130 CMR 420.410). The provider must include in any request for prior authorization sufficiently detailed, clear information documenting the medical necessity of the service requested and, where specified, the information described in this Subchapter 6.

(2) The MassHealth agency may require any additional information it deems necessary. If prior authorization is not required, the provider must maintain in the member's dental record, all information necessary to disclose the medical necessity for the services provided. Pursuant to 130 CMR 420.410(B)(3), prior authorization may be requested for any exception to a limitation on a service otherwise covered for that member. (For example, MassHealth limits prophylaxis to two per member per calendar year, but pays for additional prophylaxis for a member within a calendar year if medically necessary.)

(B) Individual Consideration. "IC" indicates that the claim will receive individual consideration to determine payment. A descriptive report must accompany the claim (see 130 CMR 420.412) and be sufficiently detailed to enable the MassHealth agency to assess the extent and nature of the services provided. The reports must include the following where applicable.

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

603 Service Codes: Diagnostic Services

See 130 CMR 420.422 for service descriptions and limitations.

Service Code and Limitations		Covered Under Age 21?	Covered DDS Clients Aged 21 and Older?	Covered Aged 21 and Older?	Prior-Authorization Requirements, Report Requirements, and Notations
D0120	Twice per calendar year	Yes	Yes	Yes	
D0140	Twice per calendar year	Yes	Yes	Yes	
D0145	Twice per calendar year	Yes (IC)	No	No	See 602(B) above.
D0150	Once per member per dentist	Yes	Yes	Yes	
D0180	Once per calendar year	Yes	Yes	Yes	
D0190	Twice per calendar year	Yes	Yes	Yes	Payable only to a Public Health Hygienist
D0191	Once per calendar year	Yes	Yes	Yes	Payable only to Public Health Hygienist

604 Service Codes: Radiographs

See 130 CMR 420.423 and *Dental Manual* Appendix E for service descriptions and limitations.

Service Code and Limitations		Covered Under Age 21?	Covered DDS Clients Aged 21 and Older?	Covered Aged 21 and Older?	Prior-Authorization Requirements, Report Requirements, and Notations
D0210	Once every three calendar years	Yes	Yes	Yes	
D0220		Yes	Yes	Yes	
D0230		Yes	Yes	Yes	
D0240	Twice per calendar year	Yes	No	No	
D0270	Twice per calendar year	Yes	Yes	Yes	
D0272	Twice per calendar year	Yes	Yes	Yes	
D0273	Twice per calendar year	Yes (IC)	Yes (IC)	Yes (IC)	See 602(B) above.
D0274	Twice per calendar year	Yes	Yes	Yes	
D0330	Once every three calendar years	Yes	Yes	Yes	
D0340		Yes	Yes	Yes	

605 Service Codes: Preventive Services

See 130 CMR 420.424 for service descriptions and limitations.

Service Code and Limitations		Covered Under Age 21?	Covered DDS Clients Aged 21 and Older?	Covered Aged 21 and Older?	Prior-Authorization Requirements, Report Requirements, and Notations
D1110	Twice per calendar year	Yes (Use this code for ages 14-21.)	Yes	Yes	
D1120	Twice per calendar year	Yes (Use this code for ages up to 14.)	No	No	

605 Service Codes: Preventive Services (cont.)

Service Code and Limitations		Covered Under Age 21?	Covered DDS Clients Aged 21 and Older?	Covered Aged 21 and Older?	Prior-Authorization Requirements, Report Requirements, and Notations
D1206		Yes	No*	No*	** Exception for members who have a medical or dental condition that significantly interrupts the flow of saliva (PA required). See 602(A) above and 130 CMR 420.424(B)(1)(b).*
D1208		Yes	No*	No*	** Exception for members who have a medical or dental condition that significantly interrupts the flow of saliva (PA required). See 602(A) above and 130 CMR 420.424(B)(1)(b).*
Other Preventive Services					
D1351	Permanent first, second, and third noncarious, nonrestored molars	Yes	No	No	
Space Maintenance (Passive Appliances)					
D1510	Twice per lifetime	Yes	No	No	
D1354	Twice per tooth's lifetime	Yes	Yes	Yes	
D1516		Yes	No	No	
D1517		Yes	No	No	
D1520	Twice per lifetime	Yes	No	No	
D1526		Yes	No	No	
D1527		Yes	No	No	
D1575		Yes	No	No	
D1701		Yes	Yes	Yes	
D1702		Yes	Yes	Yes	
D1703		Yes	Yes	Yes	
D1704		Yes	Yes	Yes	
D1707		Yes	Yes	Yes	

606 Service Codes: Restorative Services

See 130 CMR 420.425 for service descriptions and limitations.

Service Code and Limitations		Covered Under Age 21?	Covered DDS Clients Aged 21 and Older?	Covered Aged 21 and Older?	Prior-Authorization Requirements, Report Requirements, and Notations
Amalgam Restorations (Including Polishing)					
D2140	Once per calendar year per tooth	Yes	Yes	Yes	
D2150	Once per calendar year per tooth	Yes	Yes	Yes	
D2160	Once per calendar year per tooth	Yes	Yes	Yes	
D2161	Once per calendar year per tooth	Yes	Yes	Yes	
Resin-Based Composite Restorations					
D2330	Once per calendar year per tooth	Yes	Yes	Yes	
D2331	Once per calendar year per tooth	Yes	Yes	Yes	
D2332	Once per calendar year per tooth	Yes	Yes	Yes	
D2335	Once per calendar year per tooth	Yes	Yes	Yes	
D2390	Once per calendar year per tooth	Yes	No	No	
D2391	Once per calendar year per tooth	Yes	Yes	Yes	
D2392	Once per calendar year per tooth	Yes	Yes	Yes	
D2393	Once per calendar year per tooth	Yes	Yes	Yes	
D2394	Once per calendar year per tooth	Yes	Yes	Yes	
Crowns – Single Restoration Only					
D2710	Once per 60 months per tooth	Yes	No	No	
D2740	Once per 60 months per tooth	Yes	Yes	Yes	Maintain pre-treatment and post-treatment film of the tooth.
D2750	Once per 60 months per tooth	Yes	No	No	

606 Service Codes: Restorative Services (cont.)

Service Code and Limitations		Covered Under Age 21?	Covered DDS Clients Aged 21 and Older?	Covered Aged 21 and Older?	Prior-Authorization Requirements, Report Requirements, and Notations
D2751	Once per 60 months per tooth	Yes	Yes	Yes	Maintain pre-treatment and post-treatment film of the tooth.
D2752	Once per 60 months per tooth	Yes	No	No	
D2790	Once per 60 months per tooth	Yes	No	No	
Other Restorative Services					
D2910		Yes	Yes	Yes	
D2920		Yes	Yes	Yes	
D2929	Primary anterior teeth only	Yes	No	No	
D2930		Yes	No	No	
D2931		Yes	No*	No*	** Exception for members with undue medical risk. See 130 CMR 420.425(C)(2).*
D2932	Primary anterior teeth only	Yes	No	No	
D2934		Yes	No	No	
D2950		Yes	Yes	Yes	
D2951		Yes	Yes	Yes	
D2954		Yes	Yes	Yes	Maintain pre-treatment and post-treatment film of the tooth.
D2980	Chairside	Yes	Yes	Yes	
D2999	Outside laboratory	Yes (PA) (IC)	Yes (PA) (IC)	Yes (PA) (IC)	Include documentation to substantiate why the repair could not be done chairside. See 602(A) and (B) above and 130 CMR 420.425(E).

607 Service Codes: Endodontic Services

See 130 CMR 420.426 for service descriptions and limitations.

Service Code and Limitations		Covered Under Age 21?	Covered DDS Clients Aged 21 and Older?	Covered Aged 21 and Older?	Prior-Authorization Requirements, Report Requirements, and Notations
Pulpotomy					
D3120		Yes	Yes	Yes	
D3220		Yes	No	No	
Root Canal Therapy (Including Pre- and Post-Treatment Radiographs and Follow-up Care)					
D3310	Once per lifetime per tooth	Yes	Yes	Yes	
D3320	Once per lifetime per tooth	Yes	Yes	Yes	
D3330	Once per lifetime per tooth	Yes	Yes	Yes	
D3346		Yes	Yes	Yes	
D3347		Yes	Yes	Yes	
Endodontic Retreatment					
D3348		Yes	Yes	Yes	
Apicoectomy/Periradicular Services					
D3410	Per tooth. Includes retrograde filling. Once per lifetime per tooth	Yes	Yes	Yes	Maintain periapical film of the tooth and date of the original root canal treatment.
D3421	Once per lifetime per tooth	Yes	Yes	Yes	Maintain periapical film of the tooth and date of the original root canal treatment.
D3425	First root. Once per lifetime per tooth	Yes	Yes	Yes	Maintain periapical film of the tooth and date of the original root canal treatment.

607 Service Codes: Endodontic Services (cont.)

Service Code and Limitations		Covered Under Age 21?	Covered DDS Clients Aged 21 and Older?	Covered Aged 21 and Older?	Prior-Authorization Requirements, Report Requirements, and Notations
D3426	Each additional root	Yes	Yes	Yes	Maintain periapical film of the tooth and date of the original root canal treatment.

608 Service Codes: Periodontal Services

See 130 CMR 420.427 for service descriptions and limitations.

Service Code and Limitations		Covered Under Age 21?	Covered DDS Clients Aged 21 and Older?	Covered Aged 21 and Older?	Prior-Authorization Requirements, Report Requirements, and Notations
Surgical Services (Including Usual Postoperative Services)					
D4210	Once per quadrant per 3 calendar years	Yes	Yes (PA)	Yes (PA)	Include complete periodontal charting, periapical films, documentation of previous periodontal treatment, and a statement concerning the member's periodontal condition. See 602(A) above and 130 CMR 420.427(A).

608 Service Codes: Periodontal Services (cont.)

Service Code and Limitations		Covered Under Age 21?	Covered DDS Clients Aged 21 and Older?	Covered Aged 21 and Older?	Prior-Authorization Requirements, Report Requirements, and Notations
D4211	Once per quadrant per 3 calendar years	Yes	Yes (PA)	Yes (PA)	Include complete periodontal charting, periapical films, documentation of previous periodontal treatment, and a statement concerning the member's periodontal condition. See 602(A) above and 130 CMR 420.427(A).
D4341	Once per quadrant per 3 calendar years	Yes	Yes (PA)	Yes (PA)	Include complete periodontal charting, periapical films, documentation of previous periodontal treatment, and a statement concerning the member's periodontal condition. See 602(A) above and 130 CMR 420.427(B).

608 Service Codes: Periodontal Services (cont.)

Service Code and Limitations		Covered Under Age 21?	Covered DDS Clients Aged 21 and Older?	Covered Aged 21 and Older?	Prior-Authorization Requirements, Report Requirements, and Notations
D4342	Once per quadrant per 3 calendar years	Yes	Yes (PA)	Yes (PA)	Include complete periodontal charting, periapical films, documentation of previous periodontal treatment, and a statement concerning the member's periodontal condition. See 602(A) above and 130 CMR 420.427(B).
D4346	Twice per calendar year	Yes	Yes	Yes	Include complete periodontal charting, periapical films, documentation of previous periodontal treatment, and a statement concerning the member's periodontal condition. See 602(A) above and 130 CMR 420.427(B).

609 Service Codes: Prosthodontic (Removable) Services

See 130 CMR 420.428 for service descriptions and limitations.

Service Code and Limitations		Covered Under Age 21?	Covered DDS Clients Aged 21 and Older?	Covered Aged 21 and Older?	Prior-Authorization Requirements, Report Requirements, and Notations
Complete Dentures (Including Routine Post-Delivery Care)					
D5110	Once per 84 months	Yes	Yes	Yes	
D5120	Once per 84 months	Yes	Yes	Yes	
D5130		Yes	No	No	
D5140		Yes	No	No	
Partial Dentures (Including Routine Post-Delivery Care)					
D5211	Once per 84 months	Yes	Yes	Yes	
D5212	Once per 84 months	Yes	Yes	Yes	
D5213	Once per 84 months	Yes	No	No	
D5214	Once per 84 months	Yes	No	No	
D5225	Once per 84 months	Yes	No	No	
D5226	Once per 84 months	Yes	No	No	
Repairs to Complete Dentures					
D5511		Yes	Yes	Yes	
D5512		Yes	Yes	Yes	
D5520		Yes	Yes	Yes	
Repairs to Partial Dentures					
D5611		Yes	Yes	Yes	
D5612		Yes	Yes	Yes	
D5621		Yes	Yes	Yes	
D5622		Yes	Yes	Yes	
D5630		Yes	Yes	Yes	
D5640		Yes	Yes	Yes	
D5650		Yes	Yes	Yes	
D5660		Yes	Yes	Yes	
Denture Reline Procedures					
D5730	Once per 24 months per arch	Yes	Yes	Yes	
D5731	Once per 24 months per arch	Yes	Yes	Yes	
D5740	Once per 24 months per arch	Yes	No	No	
D5741	Once per 24 months per arch	Yes	No	No	
D5750	Once per 24 months per arch	Yes	Yes	Yes	
D5751	Once per 24 months per arch	Yes	Yes	Yes	

609 Service Codes: Prosthodontic (Removable) Services (cont.)

Service Code and Limitations		Covered Under Age 21?	Covered DDS Clients Aged 21 and Older?	Covered Aged 21 and Older?	Prior-Authorization Requirements, Report Requirements, and Notations
D5760	Once per 24 months per arch	Yes	No	No	
D5761	Once per 24 months per arch	Yes	No	No	

610 Service Codes: Prosthodontic (Fixed) Services

See 130 CMR 420.429 for service descriptions and limitations.

Service Code and Limitations		Covered Under Age 21?	Covered DDS Clients Aged 21 and Older?	Covered Aged 21 and Older?	Prior-Authorization Requirements, Report Requirements, and Notations
Fixed Partial Denture Pontics					
D6241	Once per 60 months per tooth	Yes	No	No	
D6751	Once per 60 months per tooth	Yes	No	No	
Other Fixed Partial Denture Services					
D6930		Yes	No	No	
D6980		Yes	No	No	

611 Service Codes: Oral Surgery (Exodontic) Services

See 130 CMR 420.430 for service descriptions and limitations.

Service Code and Limitations		Covered Under Age 21?	Covered DDS Clients Aged 21 and Older?	Covered Aged 21 and Older?	Prior-Authorization Requirements, Report Requirements, and Notations
D6999		Yes (PA) (IC)	Yes (PA) (IC)	Yes (PA) (IC)	Include documentation to substantiate why the repair could not be done chairside. See 602(A) and (B) above and 130 CMR 420.429(B).
Extractions (Includes Local Anesthesia and Routine Postoperative Care)					
D7111		Yes	Yes	Yes	
D7140		Yes	Yes	Yes	
D7210		Yes	Yes	Yes	
D7220		Yes	Yes	Yes	
D7230		Yes	Yes	Yes	
D7240		Yes (PA)	Yes (PA)	Yes (PA)	Include Panorex film. See 602(A) above and 130 CMR 420.430(D).
D7250		Yes	Yes	Yes	
D7251		Yes	Yes	Yes	
D7270		Yes	Yes	Yes	
D7280	Including orthodontic attachments	Yes	No	No	
D7283		Yes	No	No	
Surgical Procedures					
D7310	Once per 6 months per quadrant	Yes	Yes	Yes	
D7311	Once per 6 months per quadrant	Yes	Yes	Yes	
D7320	Once per 6 months per quadrant	Yes	Yes	Yes	
D7321	Once per 6 months per quadrant	Yes	Yes	Yes	

611 Service Codes: Exodontic Services (cont.)

Service Code and Limitations		Covered Under Age 21?	Covered DDS Clients Aged 21 and Older?	Covered Aged 21 and Older?	Prior-Authorization Requirements, Report Requirements, and Notations
D7340		Yes (PA)	Yes (PA)	Yes (PA)	Include justification of the surgical procedure designed to increase alveolar ridge height. See 602(A) above and 130 CMR 420.430(F).
D7350†		Yes	Yes (PA)	Yes (PA)	† Payable only to a dental provider with a specialty in oral surgery. In accordance with 130 CMR 420.405(A)(7). See 602(A) above and 130 CMR 420.430(F).
D7410		Yes	Yes	Yes	
D7411		Yes	Yes	Yes	
D7450		Yes	Yes	Yes	
D7451		Yes	Yes	Yes	
D7460		Yes	Yes	Yes	
D7461		Yes	Yes	Yes	

611 Service Codes: Exodontic Services (cont.)

Service Code and Limitations		Covered Under Age 21?	Covered DDS Clients Aged 21 and Older?	Covered Aged 21 and Older?	Prior-Authorization Requirements, Report Requirements, and Notations
D7471†	Once per lifetime per arch	Yes	Yes	Yes	† Payable only to a dental provider with a specialty in oral surgery in accordance with 130 CMR 420.405(A)(7). See 602(A) above.
D7472†	Once per lifetime per arch	Yes	Yes	Yes	† Payable only to a dental provider with a specialty in oral surgery in accordance with 130 CMR 420.405(A)(7). See 602(A) above.
D7473†	Once per lifetime per arch	Yes	Yes	Yes	† Payable only to a dental provider with a specialty in oral surgery in accordance with 130 CMR 420.405(A)(7). See 602(A) above.
D7961		Yes	Yes	Yes	
D7962		Yes	Yes	Yes	
D7963		Yes	Yes	Yes	
D7970		Yes	Yes	Yes	
D7999		Yes (PA) (IC)	Yes (PA) (IC)	Yes (PA)(IC)	See 602(A) and (B) above.

612 Service Codes: Orthodontic Services

See 130 CMR 420.431 for service descriptions and limitations.

Service Code and Limitations		Covered Under Age 21?	Covered DDS Clients Aged 21 and Older?	Covered Aged 21 and Older?	Prior-Authorization Requirements, Report Requirements, and Notations
Orthodontic Diagnosis and Full Orthodontic Treatment					
D8050		Yes (PA) (IC)	No	No	Include the number of adjustment visits required in conjunction with the type of interceptive appliance. See 602(A) and (B) above and 130 CMR 420.431.
D8060†		Yes (PA) (IC)	No	No	Include the number of adjustment visits required in conjunction with the type of interceptive appliance. See 602(A) and (B) above, 130 CMR 420.431, and *Dental Manual* Appendix F. † Payable only to a dental provider who is a specialist in orthodontics in accordance with 130 CMR 420.405(A)(6).

612 Service Codes: Orthodontic Services (cont.)

Service Code and Limitations		Covered Under Age 21?	Covered DDS Clients Aged 21 and Older?	Covered Aged 21 and Older?	Prior-Authorization Requirements, Report Requirements, and Notations
D8070†	Once per lifetime for either D8070, D8080, or D8090.	Yes (PA)	No	No	Include the x-ray, photographic prints, completed copy of the Handicapping Labio-Lingual Deviations (HLD) Form and medical necessity narrative, if applicable. See 602(A) and (B) above,130 CMR 420.431, and Dental Manual Appendix D. † Payable only to a dental provider who is a specialist in orthodontics in accordance with 130 CMR 420.405(A)(6).

612 Service Codes: Orthodontic Services (cont.)

Service Code and Limitations		Covered Under Age 21?	Covered DDS Clients Aged 21 and Older?	Covered Aged 21 and Older?	Prior-Authorization Requirements, Report Requirements, and Notations
D8080†	Once per lifetime for either D8070, D8080, or D8090.	Yes (PA)	No	No	Include the x-ray, photographic prints, a completed copy of the Handicapping Labio-Lingual Deviations (HLD) Form and a medical necessity narrative, if applicable. See 602(A) above and 130 CMR 420.431 and *Dental Manual* Appendix D. † Payable only to a dental provider who is a specialist in orthodontics in accordance with 130 CMR 420.405(A)(6).

612 Service Codes: Orthodontic Services (cont.)

Service Code and Limitations		Covered Under Age 21?	Covered DDS Clients Aged 21 and Older?	Covered Aged 21 and Older?	Prior-Authorization Requirements, Report Requirements, and Notations
D8090†	Once per lifetime for either D8070, D8080 or D8090.	Yes (PA)	No	No	Include the x-ray, photographic prints, a completed copy of the Handicapping Labio-Lingual Deviations (HLD) Form and a medical necessity narrative, if applicable. See 602(A) above and 130 CMR 420.431 and *Dental Manual* Appendix D. † Payable only to a dental provider who is a specialist in orthodontics in accordance with 130 CMR 420.405(A)(6).

612 Service Codes: Orthodontic Services (cont.)

Service Code and Limitations		Covered Under Age 21?	Covered DDS Clients Aged 21 and Older?	Covered Aged 21 and Older?	Prior-Authorization Requirements, Report Requirements, and Notations
D8670†	As part of contract; billed once per quarter (90 days) on the first date of service beginning with the calendar month following the calendar month during which appliance(s) were placed	Yes (PA)	No*	No*	Submit authorization request for the first two years of treatment. Include photographic prints, radiographs (lateral and occlusal views) & HLD Form. ** Exception for members whose comprehensive orthodontic treatment began by age 21.* *See 130 CMR 420.431(A).* † Payable only to a dental provider who is a specialist in orthodontics in accordance with 130 CMR 420.405(A)(6).
D8660†	Consultation - once per 6 months	Yes	No	No	† Payable only to a dental provider who is a specialist in orthodontics in accordance with 130 CMR 420.405(A)(6).

612 Service Codes: Orthodontic Services (cont.)

Service Code and Limitations		Covered Under Age 21?	Covered DDS Clients Aged 21 and Older?	Covered Aged 21 and Older?	Prior-Authorization Requirements, Report Requirements, and Notations
D8680†		Yes	No*	No*	* *Exception for members whose comprehensive orthodontic treatment began by age 21. PA required.* *See 130 CMR 420.431(A)(1).* † Payable only to a dental provider who is a specialist in orthodontics in accordance with 130 CMR 420.405(A)(6). Include the date of the initial banding and a narrative of the reason(s) for removal of the orthodontic appliance. See 602(A) above.
D8690†		Yes (PA)	No	No	† Payable only to a dental provider who is a specialist in orthodontics in accordance with 130 CMR 420.405(A)(6). See 602(A) above.

612 Service: Orthodontic Services (cont.)

Service Code and Limitations		Covered Under Age 21?	Covered DDS Clients Aged 21 and Older?	Covered Aged 21 and Older?	Prior-Authorization Requirements, Report Requirements, and Notations
D8703†		Yes (PA)	No	No	See 602(A) above. See 130 CMR 420.431(C)(5). † Payable only to a dental provider who is a specialist in orthodontics in accordance with 130 CMR 420.405(A)(6).
D8704†		Yes (PA)	No	No	See 602(A) above. See 130 CMR 420.431(C)(5). † Payable only to a dental provider who is a specialist in orthodontics in accordance with 130 CMR 420.405(A)(6).
D8999†		Yes (PA) (IC)	No*	No*	* *Exception for members whose comprehensive orthodontic treatment began by age 21.* PA required. *See 130 CMR 420.431(A).* † Payable only to a dental provider who is a specialist in orthodontics in accordance with 130 CMR 420.405(A)(6). See 602(A) and (B) above.

613 Service Codes: General Anesthesia and IV Sedation Services

See 130 CMR 420.452 for service descriptions and limitations.

Service Code and Limitations		Covered Under Age 21?	Covered DDS Clients Aged 21 and Older?	Covered Aged 21 and Older?	Prior-Authorization Requirements, Report Requirements, and Notations
D9222		Yes	Yes	Yes	
D9223		Yes	Yes	Yes	
D9230		Yes	Yes	Yes	
D9239		Yes	Yes	Yes	
D9243		Yes	Yes	Yes	
D9248		Yes	Yes	Yes	

614 Service Codes: Adjunctive Services

See 130 CMR 420.456 for service descriptions and limitations.

Service Code and Limitations		Covered Under Age 21?	Covered DDS Clients Aged 21 and Older?	Covered Aged 21 and Older?	Prior-Authorization Requirements, Report Requirements, and Notations
Unclassified Treatment					
D9110	Other nonemergency medically necessary treatment may be provided during the same visit; that is, nonemergency codes may be billed in conjunction with D9110.	Yes	Yes	Yes	
Professional Visits					
D9410		Yes	Yes	Yes	A visit to a nursing facility, chronic disease and rehabilitation hospital, hospice facility, school, or other licensed educational facility, once per facility per day. Bill in addition to any medically necessary MassHealth-covered service provided during the same visit. Code may be billed once per facility per day. See 130 CMR 420.456(F).

614 Service Codes: Adjunctive Services (cont.)

Service Code and Limitations		Covered Under Age 21?	Covered DDS Clients Aged 21 and Older?	Covered Aged 21 and Older?	Prior-Authorization Requirements, Report Requirements, and Notations
Treatment of Physically or Developmentally Disabled Members					
D9920	Once per member per day	Yes (PA)	Yes (PA)	Yes (PA)	Include a description of the member's illness or disability, and types of services to be furnished. See 602(A) above and 130 CMR 420.456(B).
Miscellaneous Services					
D9930		Yes (IC)	Yes (IC)	Yes (IC)	Include with the claim the date, the location of the original surgery, and the type of procedure. See 602(A) above.
D9945		Yes (PA)	No	No	Include documented evidence of the need for the appliance. See 602(A) above.
D9941		Yes	No	No	
D9999		Yes (PA), (IC)	Yes (PA), (IC)	Yes (PA) (IC)	See 602(A) and (B) above.

615 Service Codes: Oral and Maxillofacial Surgery Services

See 130 CMR 420.453 and 420.455 for service descriptions and limitations.

The following all-numeric service codes may be used only by dental providers who are specialists in oral surgery, in accordance with 130 CMR 420.405(A)(7).

CPT Service Codes

10060	12002	13152	15574	17273
10061	12004	13153	15576	17274
10120	12005	13160	15610	17276
10121	12006	14000	15620	17280
10140	12007	14001	15630	17281
10160	12011	14020	15730	17282
10180	12013	14021	15731	17283
11010	12014	14040	15733	17284
11011	12015	14041	15734	17286
11012	12016	14060	15740	17999 (IC)
11042	12017	14061	15750	20100
11043	12018	14301	15756	20200
11044	12020	14302	15757	20205
11045	12021	15040	15758	20206
11046	12031	15100	15760	20220
11310	12032	15110	15770	20225
11311	12034	15111	15819	20240
11312	12035	15115	15820 (PA)	20245
11313	12036	15116	15821 (PA)	20520
11440	12037	15120	15822 (PA)	20525
11441	12041	15121	15823 (PA)	20526
11442	12042	15150	15840	20605
11443	12044	15151	15841	20615
11444	12045	15152	15842	20670
11446	12046	15155	15845	20680
11620	12047	15156	15852	20690
11621	12051	15157	15860	20692
11622	12052	15240	16000	20693
11623	12053	15241	17000	20694
11624	12054	15260	17003	20900
11626	12055	15261	17004	20902
11640	12056	15271	17106	20910
11641	12057	15272	17107	20912
11642	13120	15273	17108	20920
11643	13121	15274	17110	20922
11644	13122	15275	17111	20924
11646	13131	15276	17260	20926
11960	13132	15277	17266	20955
11970	13133	15278	17270	20956
11971	13150	15570	17271	20962
12001	13151	15572	17272	20969

615 Service Codes: Oral and Maxillofacial Surgery Services (cont.)

20970	21154 (PA)	21330	21490	31294
20999 (IC)	21155 (PA)	21335	21495	31299 (IC)
21010	21159 (PA)	21336	21497	31420
21015	21160 (PA)	21337	21499 (IC)	31500
21025	21172 (PA)	21338	21685	31502
21026	21175 (PA)	21339	29800 (PA)	31505
21029	21179	21340	29804 (PA)	31510
21030	21180	21343	29999 (IC)	31511
21031	21181	21344	30000	31515
21032	21182	21345	30020	31525
21034	21183	21346	30124	31526
21040	21184	21347	30125	31530
21044	21188 (PA)	21348	30130	31531
21045	21193 (PA)	21355	30140	31535
21046	21194 (PA)	21356	30150	31536
21047	21195 (PA)	21360	30160	31575
21048	21196 (PA)	21365	30462	31600
21049	21198 (PA)	21366	30465	31603
21050	21199 (PA)	21385	30520	31605
21060	21206 (PA)	21386	30580	31610
21070	21208 (PA)	21387	30600	31615
21076	21209 (PA)	21390	30630	31622
21077	21210 (PA)	21395	30901	35500
21079	21215 (PA)	21400	30903	35572
21080	21230 (PA)	21401	30905	35681
21081	21235 (PA)	21406	30906	35682
21082	21240 (PA)	21407	30920	35701
21083	21242 (PA)	21408	30999 (IC)	35800
21084	21243 (PA)	21421	31000	35860
21085	21244 (PA)	21422	31020	35875
21086	21247 (PA)	21423	31030	35876
21087	21255 (PA)	21431	31032	37609
21088 (IC)	21260	21432	31040	38500
21089 (IC)	21261	21433	31200	38505
21100	21263	21435	31201	38510
21110	21267	21436	31205	38542
21116	21268	21440	31225	38550
21120	21270	21445	31230	38555
21137 (PA)	21275	21450	31231	38700
21138 (PA)	21280	21451	31233	38720
21139 (PA)	21282	21452	31237	38724
21141	21295	21453	31238	38790
21142	21296	21454	31239	38792
21143	21299 (PA),(IC)	21461	31240	40490
21145	21310	21462	31256	40500
21146 (PA)	21315	21465	31267	
21147 (PA)	21320	21470	31290	
21150 (PA)	21325	21480	31292	
21151 (PA)		21485	31293	

615 Service Codes: Oral and Maxillofacial Surgery Services (cont.)

40510	41108	42200	42804	62147
40520	41110	42205	42806	62148
40525	41112	42210	42808	64400
40527	41113	42215	42809	64600
40530	41114	42220	42810	64605
40650	41115	42225	42815	64612
40652	41116	42226	42820	64613
40654	41120	42227	42842	64615
40700	41130	42235	42844	64616
40701	41135	42260	42845	64722
40702	41140	42280 (PA)	42860	64727
40720	41145	42281 (PA)	42870	64732
40761	41150	42299 (IC)	42890	64734
40799 (IC)	41153	42300	42894	64736
40800	41155	42305	42900	64738
40801	41250	42310	42950	64740
40804	41251	42320	42953	64864
40805	41252	42330	42955	64865
40806	41510	42335	42960	64868
40808	41520	42340	42961	64872
40810	41599 (IC)	42400	42962	64874
40812	41800	42405	42970	64885
40814	41805	42408	42971	64886
40816	41806	42409	42972	64910
40818	41820 (IC),	42410	42999 (IC)	64911
40819	(PA)	42415	61580	64999 (IC)
40820	41821 (IC)	42420	61581	67715
40830	41822	42425	61582	67840
40831	41823	42426	61583	67916
40840 (PA)	41825	42440	61584	67917
40842 (PA)	41826	42450	61585	68801
40843 (PA)	41827	42500	61586	68810
40844 (PA)	41828	42505	61590	68811
40845 (PA)	41830	42507	61591	69990
40899 (IC)	41850 (IC)	42508	61592	70100
41000	41874	42509	61595	70110
41005	41899 (IC)	42510	61596	70140
41006	42000	42550	61597	70150
41007	42100	42600	61598	70160
41008	42104	42650	61600	70210
41009	42106	42660	61605	70220
41010	42107	42665	61606	70240
41015	42120	42699 (IC)	61607	70328
41016	42140	42700	61608	70330
41017	42145	42720	62142	70360
41018	42160	42725	62143	70380
41100	42180	42800	62145	
41105	42182	42802	62146	

615 Service Codes: Oral and Maxillofacial Surgery Services (cont.)

99202	99213	99220	99226	99236
99203	99214	99221	99231	99281
99204	99215	99222	99232	99282
99205	99217	99223	99233	99283
99211	99218	99224	99234	99284
99212	99219	99225	99235	99285

AUTHORIZATION FORM FOR COMPREHENSIVE ORTHODONTIC TREATMENT

MassHealth Handicapping Labio-Lingual Deviations Index

FOR OFFICE USE ONLY ☐ First Reviewer _____ ☐ Second Reviewer _____ ☐ Third Reviewer _____

The Handicapping Labio-Lingual Deviations Index (HLD) is a quantitative, objective method for evaluating PA requests for comprehensive orthodontic treatment. The HLD allows for the identification of certain autoqualifying conditions and provides a single score, based on a series of measurements, which represent the presence, absence, and degree of handicap. The HLD **must** be submitted with all PA requests for comprehensive orthodontic treatment.

The following documents **must** also be submitted with this form. ☐ x-rays ☐ photos ☐ Lateral Cephalometric radiograph which includes either an embedded measurement device or one added by provider (e.g., ruler, perio probe, measured wire with known length) OR lateral and occlusal photographs with a measurement device. Models are not required. Please include an explanation of the measurement device if it is not marked (e.g. a measured piece of wire).

Cephalometric radiographs OR photographs with a measurement device are required with every case in addition to the standard set of photos. Providers are encouraged to submit a lateral cephalometric radiograph if it will clearly identify the medical necessity of treatment such as for impinging overbite.

Photo(s) with a measurement device (Boley gauge, disposable ruler, or periodontal probe) in the patient's mouth, or on models mounted in centric occlusion should be included. When measuring overjet, reverse overjet, or mandibular protrusion, the measurement device should be placed parallel to the occlusal plane involving two directly opposing incisor teeth with the photo taken on the ipsilateral side (same side) being measured. When measuring open bite, place the measurement device vertically to measure the opening from the incisal edge of the maxillary and mandibular incisors.

A sufficient number of photographs should be submitted with a measurement device, dependent upon the conditions present. The measurement device should be utilized in accordance with the Handicapping Labio-Lingual Deviation Index Scoring Instructions and the guidance provided in the previous paragraph.

Procedure

1. Occlude patient or models in centric occlusion.
2. Record all measurements in the order given and rounded off to the nearest millimeter.
3. **Enter score** "0" **if condition is absent**.
4. Start by measuring **overjet** of the most protruding incisor.
5. Measure **overbite** from the labio-incisal edge of overlapped front tooth (or teeth) to point of maximum coverage.
6. **Ectopic eruption** and **anterior crowding: Do not double score**. Record the more serious condition.
7. Deciduous teeth and teeth not fully erupted should not be scored.
8. Score all other conditions listed, and also check "yes" or "no" for all potential autoqualifiers.

Patient's Name (please print) _____ Member ID_____

Address _____
Street City/County State Zip Code

AUTOQUALIFERS	Condition Observed	
Cleft Lip, Cleft Palate, or other Cranio-Facial Anomaly	Yes ☐ No ☐	
Impinging overbite with evidence of occlusal contact into the opposing soft tissue	Yes ☐ No ☐	
Impactions where eruption is impeded but extraction is not indicated (excluding third molars).	Yes ☐ No ☐	
Severe Traumatic Deviations – This refers to accidents affecting the face and jaw rather than congenital deformity. Do not include traumatic occlusions or crossbites.	Yes ☐ No ☐	
Overjet (greater than 9mm)	Yes ☐ No ☐	
Reverse Overjet (greater than 3.5mm)	Yes ☐ No ☐	
Crowding of 10mm or more, in either the maxillary or mandibular arch (excluding 3rd molars). Includes the normal complement of teeth.	Yes ☐ No ☐	
Spacing of 10mm or more, in either the maxillary or mandibular arch (excluding 3rd molars). Includes the normal complement of teeth.	Yes ☐ No ☐	
Anterior crossbite of 3 or more maxillary teeth per arch.	Yes ☐ No ☐	
Posterior crossbite of 3 or more maxillary teeth per arch.	Yes ☐ No ☐	
Two or more congenitally missing teeth (excluding third molars) of at least one tooth per quadrant	Yes ☐ No ☐	
Lateral open bite: 2mm or more; of 4 or more teeth per arch	Yes ☐ No ☐	
Anterior open bite: 2mm or more; of 4 or more teeth per arch	Yes ☐ No ☐	
HLD SCORING	**Measurement**	**Score**
Overjet (in mm)	# mm X 1	
Overbite (in mm)	# mm X 1	
Mandibular Protrusion (in mm) – See scoring instructions.	# mm X 5	
Anterior Open Bite – Do not count ectopic eruptions; measure the opening between maxillary and mandibular incisors in mm.	# mm X 4	
Ectopic Eruption (number of teeth, excluding third molars) – Refers to an unusual pattern of eruption, such as high labial cuspids. Do not score teeth in this category if they are scored under maxillary or mandibular crowding.	# of teeth X 3	
Anterior Crowding – If crowding exceeds 3.5mm in an arch, score each arch.	Maxilla: 5 points Mandible: 5 points Both: 10 points	
Labio-Lingual Spread (anterior spacing in mm) – See scoring instructions.	# mm X 1	
Posterior Unilateral Crossbite – Must involve 2 or more teeth, one of which must be a molar	4 points	
Posterior impactions or congenitally missing posterior teeth (excluding 3rd molars)	# teeth X 3	
	TOTAL	
Treatment will be authorized for cases with verified autoqualifiers or verified scores of 22 and above.		

Medical Necessity Narrative

MEDICAL NECESSITY NARRATIVE	
Are you submitting a Medical Necessity Narrative?	Yes ☐ No ☐
If yes, are you submitting additional supporting documentation?	Yes ☐ No ☐ The medical necessity determination does not involve any mental, emotional, behavioral or other condition outside the professional expertise of the requesting provider and, therefore, the submitted narrative does not incorporate or rely on the opinion or expertise of anyone other than the requesting provider.

Instructions for Medical Necessity Narrative and Supporting Documentation (if applicable)

Providers may establish that comprehensive orthodontic treatment is medically necessary by submitting a medical necessity narrative and supporting documentation, where applicable. The narrative must establish that comprehensive orthodontic treatment is medically necessary to treat a handicapping malocclusion, including to correct or significantly ameliorate

i. a severe skeletal deviation affecting the patient's mouth and/or underlying dentofacial structures;
ii. a diagnosed mental, emotional, or behavioral condition caused by the patient's malocclusion;
iii. a diagnosed nutritional deficiency and/or a substantiated inability to eat or chew caused by the patient's malocclusion;
iv. a diagnosed speech or language pathology caused by the patient's malocclusion; or
v. a diagnosed condition caused by the overall severity of the patient's malocclusion.

Providers may submit a medical necessity narrative (along with the required completed HLD) in any case where, in the professional judgment of the requesting provider and any other involved clinician(s), comprehensive orthodontic treatment is medically necessary to treat a handicapping malocclusion. Providers must submit this narrative in cases where the patient does not have an autoqualifying condition or meet the threshold score on the HLD, but where, in the professional judgment of the requesting provider and any other involved clinician(s), comprehensive orthodontic treatment is medically necessary to treat a handicapping malocclusion.

The medical necessity narrative must clearly demonstrate why comprehensive orthodontic treatment is medically necessary for the patient. If any part of the requesting provider's justification of medical necessity involves a mental, emotional, or behavioral condition; a nutritional deficiency; a speech or language pathology; or the presence of any other condition that would typically require the diagnosis, opinion, or expertise of a licensed clinician other than the requesting provider, then the narrative and any attached documentation must

i. clearly identify the appropriately qualified and licensed clinician(s) who furnished the diagnosis or opinion substantiating the condition or pathology (e.g., general dentist, oral surgeon, physician, clinical psychologist, clinical dietitian, speech therapist);
ii. describe the nature and extent of the identified clinician(s) involvement and interaction with the patient, including dates of treatment;
iii. state the specific diagnosis or other opinion of the patient's condition furnished by the identified clinician(s);
iv. document the recommendation by the clinician(s) to seek orthodontic evaluation or treatment (if such a recommendation was made);
v. discuss any treatments for the patient's condition (other than comprehensive orthodontic treatment) considered or attempted by the clinician(s); and
vi. provide any other relevant information from the clinician(s) that supports the requesting provider's justification of the medical necessity of comprehensive orthodontic treatment.

The medical necessity narrative must be signed and dated by the requesting provider and submitted on the office letterhead of the provider. If applicable, any supporting documentation from the other involved clinician(s) must also be signed and dated by such clinician(s), and appear on office letterhead of such clinician(s). The requesting provider is responsible for coordinating with the other involved clinician(s) and is responsible for compiling and submitting any supporting documentation furnished by other involved clinician(s) along with the medical necessity narrative.

Attestation

I certify under the pains and penalties of perjury that I am the prescribing provider identified on this form. Any attached statement on my letterhead has been reviewed and signed by me. I certify that the medical necessity information (per 130 CMR 450.204) on this form is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Prescribing provider's signature:

_____

(Signature and date stamps, or the signature of anyone other than the provider, are not acceptable.)

Printed name of prescribing provider _____ Date _____

Handicapping Labio-Lingual Deviation Index Scoring Instructions

1. Occlude patient or models in centric occlusion.
2. Record all measurements in the order given and rounded off to the nearest millimeter.
3. Enter score "0" if condition is absent.
4. Start by measuring overjet of the most protruding incisor.
5. Measure overbite from the labio-incisal edge of overlapped front tooth (or teeth) to point of maximum coverage.
6. Score all other conditions listed.
7. **Ectopic eruption and anterior crowding: Do not double score.** Record the more serious condition.
8. Deciduous teeth and teeth not fully erupted should not be scored.

All measurements are made with a measurement tool scaled in millimeters. Absence of any conditions must be recorded by entering "0."

The following information should help clarify the categories on the HLD Index.

AUTOQUALIFIERS

1. **Cleft Lip, Cleft Palate, or other craniofacial anomalies:** Indicate an "X" on the form. (*This is considered an autoqualifying condition*.)
2. **Impinging Overbite:** Impinging Overbite with evidence of occlusal contact into the opposing soft tissue. Indicate an "X" on the form. (*This is considered an autoqualifying condition*.)
3. **Impactions:** Impactions (excluding third molars) that are impeding eruption in the maxillary and mandibular arches. Indicate an "X" on the form. *(This is considered an autoqualifying condition.)*
4. **Severe Traumatic Deviations:** Traumatic deviations refer to accidents impacting the face, jaws, and teeth rather than congenital deformity. For example, loss of a premaxilla segment by burns or by accident; the result of osteomyelitis; or other gross pathology. Do not include traumatic occlusions or crossbites. Indicate an "X" on the form. *(This is considered an autoqualifying condition.)*
5. **Overjet Greater Than 9mm:** This is recorded with the patient in the centric occlusion and measured from the labial of the lower incisor to the labial of the upper incisor. The measurement could apply to a protruding single tooth as well as to the whole arch. The measurement is read and rounded off to the nearest millimeter and entered on the form. Indicate an "X" on the form. *(This is considered an autoqualifying condition.)*
6. **Reverse Overjet Greater Than 3.5mm**: This is recorded with the patient in the centric occlusion and measured from the labial of the lower incisor to the labial of the upper incisor. Indicate an "X" on the form. *(This is considered an autoqualifying condition.)*
7. **Crowding or spacing of 10 mm or more**, in either the maxillary or mandibular arch (excluding 3rd molars). Includes the normal complement of teeth. Does not include extracted, congenitally missing, or supernumerary teeth. Indicate an "X" on the form. *(This is considered an autoqualifying condition*.)
8. **Anterior or posterior crossbite** of 3 or more teeth per arch. Indicate an "X" on the form. *(This is considered an autoqualifying condition*.)
9. Two or more **congenitally missing teeth** (excluding 3rd molars). Teeth that are missing due to extraction (or other loss) will not be considered under this section. Indicate an "X" on the form. (*This is considered an autoqualifying condition*.)
10. **Lateral or anterior (of incisors) open bite** 2 mm or more; of 4 or more fully erupted teeth per arch. Ectopically erupted teeth are not included. Anterior open bite is defined as absence of vertical overlap of maxillary and mandibular permanent incisors. End to end or edge to edge permanent incisors do not count as an open bite.

Permanent canines are not scored. To be counted, the entire maxillary incisal edge must not have any end to end contact with a mandibular incisor or any vertical overlap of the mandibular incisor. It is measured from the incisal edge of the permanent maxillary incisor to the nearest point of the incisal edge of the permanent mandibular incisor. To be scored as an autoqualifier, the open bite must involve 4 or more fully erupted teeth per arch. Indicate an "X" on the form. (*This is considered an autoqualifying condition*.)

HLD SCORING

1. **Overjet in Millimeters:** This is recorded with the patient in the centric occlusion and measured from the labial of the lower incisor to the labial of the upper incisor. The measurement could apply to a protruding single tooth as well as to the whole arch. The measurement is read and rounded off to the nearest millimeter and entered on the form.
2. **Overbite in Millimeters**: A pencil mark on the tooth indicating the extent of overlap facilitates this measurement. It is measured by rounding off to the nearest millimeter and entered on the form. "Reverse" overbite may exist in certain conditions and should be measured and recorded.
3. **Mandibular Protrusion in Millimeters:** Score exactly as measured from the buccal groove of the first mandibular molar to the MB cusp of the first maxillary molar. The measurement in millimeters is entered on the form and multiplied by 5.
4. **Anterior Open Bite in Millimeters**: This condition is defined as absence of vertical overlap of a maxillary and mandibular permanent incisor. End to end or edge to edge permanent incisors do not count as an open bite. Permanent canines are not scored. To be counted, the entire maxillary incisal edge must not have any end to end contact with a mandibular incisor or any vertical overlap of the mandibular incisor. It is measured from the incisal edge of the permanent maxillary incisor to the nearest point of the incisal edge of the permanent mandibular incisor. This measurement is entered on the form and multiplied by 4.
5. **Ectopic Eruption:** Count each tooth, excluding third molars. Each qualifying tooth must be blocked out of the arch. Enter the number of teeth on the form and multiply by 3. If condition no. 6, anterior crowding, is also present, with an ectopic eruption in the anterior portion of the mouth, score only the most severe condition. Do not score both conditions.
6. **Anterior Crowding:** Arch length insufficiency must exceed 3.5mm. Score only fully erupted incisors and canines. Mild rotations that may react favorably to stripping or mild expansion procedures are not to be scored as crowded. Enter 5 points for maxillary and mandibular anterior crowding. If condition no. 5, ectopic eruption, is also present in the anterior portion of the mouth, score only the most severe condition. Do not score both conditions.
7. **Labio-Lingual Spread:** The measurement tool is used to determine the extent of deviation from a normal arch. Where there is only a protruded or lingually displaced anterior tooth, the measurement should be made from the incisal edge of that tooth to the normal arch line. Otherwise, the total distance between the most protruded tooth and the lingually displaced anterior tooth is measured. The labio-lingual spread approximates a measurement of overall deviation from what would have been a normal arch. If multiple anterior crowding of teeth is observed, all deviations from the normal arch should be measured for labio-lingual spread, but only the most severe individual measurement should be entered on the index.
    - Additionally, anterior spacing may be measured as the total score in mm from the mesial of cuspid to the mesial of cuspid, totaling both arches.
    - Score only the greater score attained by either of these two methods.
8. **Posterior Crossbite**: This condition involves two or more adjacent maxillary permanent teeth, one of which must be a permanent molar. The crossbite must be one in which the maxillary posterior teeth involved may either be both palatal or both completely buccal in relation to the mandibular posterior teeth. The presence of posterior unilateral crossbite is indicated by a score of 4 on the form.
9. **Posterior Impactions or Congenitally Missing Posterior Teeth**: Total the number of posterior teeth, excluding third molars that meet this criterion, and multiply by 3.

Prior Authorization for Interceptive Orthodontic Treatment

MassHealth approves prior authorization (PA) requests for interceptive orthodontic treatment if such treatment will prevent or minimize the development of a handicapping malocclusion or preclude the need for comprehensive orthodontic treatment. 130 CMR 420.431(B)(2). The process for requesting PA for interceptive orthodontic treatment is described below:

(A) Provider performs pre-orthodontic treatment examination (130 CMR 420.431(C)(1)) to determine if orthodontic treatment is necessary.

(B) Provider completes and submits the following:

(1) 2012 ADA Claim form requesting authorization for interceptive orthodontic treatment. The form must include:
   (a) the code for the appliance requested (D8050 or D8060); and
   (b) the code (D8999) for requested adjustments visits; and
   (c) the number of adjustment visits requested, not to exceed five (5).

(2) **Supporting documentation**. Providers ***must*** submit:

a) a medical necessity narrative explaining why, in the professional judgment of the requesting provider and any other involved clinician(s), interceptive orthodontic treatment is medically necessary to prevent or minimize the development of a handicapping malocclusion or will preclude the need for comprehensive orthodontic treatment. The medical necessity narrative must clearly demonstrate why interceptive orthodontic treatment is medically necessary for the patient.

If any part of the requesting provider's justification of medical necessity involves a mental, emotional, or behavioral condition; a nutritional deficiency; a speech or language pathology; or the presence of any other condition that would typically require the diagnosis, opinion, or expertise of a licensed clinician other than the requesting provider, then the medical necessity narrative and any attached documentation must:

i. clearly identify the appropriately qualified and licensed clinician(s) who furnished the diagnosis or opinion substantiating the condition or pathology (e.g., general dentist, oral surgeon, physician, clinical psychologist, clinical dietitian, speech therapist);
ii. describe the nature and extent of the identified clinician(s) involvement and interaction with the patient, including dates of treatment;
iii. state the specific diagnosis or other opinion of the patient's condition furnished by the identified clinician(s);
iv. document the recommendation by the clinician(s) to seek orthodontic evaluation or treatment (if such a recommendation was made);
v. discuss any treatments for the patient's condition (other than interceptive orthodontic treatment) considered or attempted by the clinician(s); and
vi. provide any other relevant information from the clinician(s) that supports the requesting provider's justification of the medical necessity of interceptive orthodontic treatment.

The medical necessity narrative must be signed and dated by the requesting provider and submitted on the office letterhead of the provider. If applicable, any supporting documentation from the other involved clinician(s) must also be signed and dated by such

clinician(s), and appear on office letterhead of such clinician(s). The requesting provider is responsible for coordinating with the other involved clinician(s) and is responsible for compiling and submitting any supporting documentation furnished by other involved clinician(s) along with the medical necessity narrative.

b) The following is a non-exclusive list of medical conditions that may, if documented, be considered in support of a request for PA for interceptive orthodontics:

i. Two or more teeth numbers 6 through 11 in crossbite with photographic evidence documenting 100% of the incisal edge in complete overlap with opposing tooth/teeth;
ii. Crossbite of teeth numbers 3, 14 or 19,30 with photographic evidence documenting cusp overlap completely in fossa, or completely buccal-lingual of opposing tooth;
iii. Crossbite of teeth number A,T or J, K with photographic evidence documenting cusp overlap completely in fossa, or completely buccal or lingual of opposing tooth;
iv. Crowding with radiographic evidence documenting current bony impaction of teeth numbers 6 through 11 or teeth numbers 22 through 27 that requires either serial extraction(s) or surgical exposure and guidance for the impacted tooth to erupt into the arch;
v. Crowding with radiographic evidence documenting resorption of 25% of the root of an adjacent permanent tooth.
vi. Class III malocclusion, as defined by mandibular protrusion of greater than 3.5mm, anterior crossbite of more than 1 tooth/ reverse overjet, or Class III skeletal discrepancy, or hypoplastic maxilla with compensated incisors requiring treatment at an early age with protraction facemask, reverse pull headgear, or other appropriate device.

(3) imaging evidencing the existence of the condition(s) noted in the medical necessity narrative.

(4) a completed Appendix F attestation (found on page F-3 of Appendix F).

Attestation

MassHealth Dental Prior Authorization Request for Interceptive Orthodontics

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Patient's Name (please print) _____ Member ID_____

Address _____
Street City/County State Zip Code

I certify under the pains and penalties of perjury that I am the prescribing provider identified on this form. Any attached statement on my letterhead has been reviewed and signed by me. I certify that the medical necessity information (per 130 CMR 450.204) on the information provided is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Prescribing provider's signature:

_____
(Signature and date stamps, or the signature of anyone other than the provider, are not acceptable.)

Printed name of prescribing provider _____ Date _____

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