Commonwealth of Massachusetts
Executive Office of Health and Human Services
Division of Medical Assistance
600 Washington Street
Boston, MA 02111
www.mass.gov/dma

MASSHEALTH
TRANSMITTAL LETTER DEN-62
December 2002

TO: Dental Providers Participating in MassHealth

FROM: Wendy E. Warring, Commissioner

RE: *Dental Manual* (Age Limitations for Dentures and Revised Regulations and Service Codes and Descriptions)

Beginning January 1, 2003, age restrictions have been added to certain dental services. The Division's current budget appropriation requires these changes, at a minimum, to cover expected deficiencies.

This letter transmits revisions to the MassHealth dental program regulations at 130 CMR 420.000 and Subchapter 6, Service Codes and Descriptions. These revisions are effective January 1, 2003.

I. Elimination of Certain Coverage for Members Aged 21 and Older

Effective January 1, 2003, the Division will no longer cover dentures and related services for MassHealth members aged 21 and older, except for members who meet the special circumstances criteria in 130 CMR 420.410(D). **The changes to the regulations do not alter dental services for members under age 21.**

A. Covered Services – Members Aged 21 and Older

Effective January 1, 2003, the Division will no longer cover dentures (full and partial) and related services for members aged 21 and older, except for members who meet the requirements for Special Circumstances (SC) designation under the Division's regulations at 130 CMR 420.410(D). As of January 1, 2003, you should inform MassHealth members aged 21 and older who do not qualify for SC designation that MassHealth no longer covers these services.

To have a member designated as "Special Circumstances," you need to follow the prior-authorization process that is outlined in Dental Bulletin 26, issued in March 2002.

MassHealth will continue to cover the following dental services for members aged 21 and older who do not qualify for SC designation:

- emergency-care visits, including X rays;
- extractions; and
- oral surgery.

For full service descriptions and limitations for members aged 21 and older, please see 130 CMR 420.442 through 420.449 and 130 CMR 420.452 through 420.457 and also refer to the enclosed Subchapter 6.

B. Service-Specific Prior Authorizations Approved or Appealed Prior to January 1, 2003

If MassHealth approved a prior-authorization (PA) request for a member aged 21 and older on or before October 25, 2002, and the request was for dentures or related services, MassHealth will continue to pay for those services through the authorized period. Until December 31, 2002, MassHealth will approve PA requests for members aged 21 and older for a 90-day period from the date the PA request is approved or changed. After December 31, 2002, MassHealth will no longer approve PA requests for members aged 21 and older for dentures and related services.

If a member appeals any prior-authorization decision made prior to January 1, 2003, the Division will pay for the service if the Board of Hearings or a court does not uphold the Division's decision.

C. Claims for Custom-Made Goods

The Division will pay for custom-made goods in the following circumstances for dates of service after January 1, 2003:

- custom-made goods started before January 1, 2003, but not completed until after; and
- custom-made goods where the prior-authorization expiration date is after January 1, 2003.

As stated in 130 CMR 450.231(B), "the 'date of service' is the date on which a medical service is furnished to a member or, if the medical service consists principally of custom-made goods such as eyeglasses, dentures, or durable medical equipment, the date on which the goods are delivered to a member. If a provider delivers medical goods to a member, which goods had to be ordered, fitted, or altered for the member, and that member ceases to be eligible for such MassHealth services on a date prior to the final delivery of the goods, the Division will reimburse the provider for the goods..."

Providers must submit paper claims for these services with all applicable documentation as outlined in 130 CMR 450.231(B) to the following address.

Division of Medical Assistance
Claims Operations Unit
Attention: After Cancel Unit
600 Washington Street
Boston, MA 02111

D. General Guidelines Chart

Providers may use the revised **Attachment 1**, *MassHealth Dental Services General Guidelines*, as a quick reference for services covered under the MassHealth dental program effective January 1, 2003. Providers should consult the regulations cited in the guidelines for a complete description of conditions, limitations, and possible exceptions that may apply to each service.

II. HIPAA-Related Changes and Other Revisions to the Dental Regulations

A. HIPAA-Related Changes

i. Anesthesia Claims

Effective January 1, 2003, the regulations also reflect the implementation and use of the Healthcare Insurance Portability and Accountability Act (HIPAA), which include a revision to the dental regulations at 130 CMR 420.452(D). Claim payment for general anesthesia or IV sedation services will change from 15-minute increments to an initial 30 minutes followed by 15-minute increments. Payment will continue to be limited to a maximum of 90 minutes.

ii. Revised Subchapter 6

Effective for dates of service on or after January 1, 2003, certain billing codes for dental services and/or service descriptions have changed. The Centers for Medicare and Medicaid Services (CMS) has revised the Healthcare Common Procedure Coding System (HCPCS) for 2002. New national service codes have been added, and MassHealth local codes, which begin with X or Y, have been removed from the *Dental Manual*, Subchapter 6. MassHealth local codes (X and Y codes) that are applicable to dental procedures have been replaced with standard Current Dental Terminology (CDT) codes.

Please see the attached revised Subchapter 6 for complete information on applicable dental service codes. Providers may use **Attachment 2** as a reference to crosswalk from the obsolete MassHealth local service codes to the revised Subchapter 6 service codes.

iii. Prior Authorization Guidelines for New Service Codes

a. Prior Authorization Transition Period

Effective for dates of service on or after January 1, 2003, all requests for prior authorization (PA) must be submitted using the new national service codes from the revised Subchapter 6.

Providers who have already requested PA, and who have received approval for dental services under the old code system, may continue to bill for dates of service on or after January 1, 2003, using the existing PA number under which they have been granted approval.

However, local codes will not be accepted on claims for dates of service on or after January 1, 2003. Providers, therefore, must bill using the new national service codes from the revised Subchapter 6 that correspond to the local code services that have been approved under the existing PA.

Providers are not required to do anything to convert their approved PA numbers due to the MassHealth transition to national service codes.

b. Orthodontics Service Code D8670 and Prior Authorization

The orthodontics Service Code **D8670** is now designated to bill full orthodontic treatment visits in the active first year**,** second year and the first half of the third year, if necessary. These visits were formerly billed to local codes Y9703, Y9704, and X2006. Providers must identify the appropriate service year on Form PA-1 by indicating:

- the Service Code **D8670** with the appropriate year for service in Item 12,
- the number of units in Item 13; and
- the year (1, 2, or 1st half 3) in Item 14.

c. Oral Screening Service Code Change

The Service Code **D9999**, which is used to bill unspecified adjunctive procedures, by report, is now also designated to bill an oral screening for members scheduled for radiation treatment, chemotherapy, bone marrow transplant, or organ transplant. (See 130 CMR 420.410(C)(1)(v) and 420.456(B).) The oral screening requires prior authorization and can be performed in either an inpatient or outpatient hospital setting. Oral screenings were formerly billed to local codes X2098 and X2099.

iv. How to Obtain a Dental Services Fee Schedule with the New Service Codes

Providers who want to obtain a fee schedule with the new service codes may purchase Division of Health Care Finance and Policy regulations from either the Massachusetts Bookstore or from the Division of Health Care Finance and Policy (see addresses and telephone numbers below). Providers must contact them first to find out the price of the publication. The Division of Health Care Finance and Policy also has the regulations on disk. The regulation title is 114.3 CMR 14.00: Dental Services.

Massachusetts State Bookstore
State House, Room 116
Boston, MA 02133
Telephone: 617-727-2834
www.mass.gov/sec/spr

Division of Health Care Finance and Policy
Two Boylston Street
Boston, MA 02116
Telephone: 617-988-3100
www.mass.gov/dhcfp

B. Other Regulation Changes

i. Documentation for Orthodontic Treatment

The regulations also include a revision to the dental regulations at 130 CMR 420.428(G) requiring additional documentation for comprehensive orthodontic treatment when (1) requesting prior authorization for the initial fabrication and insertion of the orthodontic appliance and (2) requesting prior authorizations for each subsequent year of treatment.

When requesting prior authorization for the initial fabrication and insertion of the orthodontic appliance and the first year of orthodontic treatment visits, the provider must submit with the prior-authorization form a **signed** statement **on the provider's letterhead** and include diagnostic X rays demonstrating completion of restorative services. For orthodontic treatment visits subsequent to the first year, the regulations have been revised to require additional documentation for the second, and if necessary, the first half of the third year of treatment. The provider must also submit an updated progress report, with diagnostic X rays and an updated evaluation of anticipated cooperation and hygiene, demonstrating that all restorative services have been completed.

The *Orthodontics Prior Authorization Form, Part IV: Progress* (DEN-002), has been revised to identify year 2 or 3 with the Service Code D8670.

ii. Prior Authorization No Longer Required for Panoramic X Rays

Under the revised regulations at 130 CMR 420.410(C) and 420.423(C), prior authorization is no longer required for panoramic X rays. Note, however, that panoramic X rays for nonsurgical conditions are still only covered for MassHealth members under age 21.

iii. Regulations Corrections/Formatting

Other changes have been made to correct or reformat the regulations in Subchapter 4 to match the official formatting style required by the Secretary of State in the Code of Massachusetts Regulations.

III. Web Site Access and Questions

This transmittal letter and the revised regulations are available on the Division's Web site at www.mass.gov/dma.

If you have any questions, please call MassHealth Provider Services at 617-628-4141 or 1-800-325-5231.

NEW MATERIAL

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

Dental Manual

Pages vi, 4-1 through 4-10, 4-17, 4-18, 4-21, 4-22, 4-29, 4-30, 4-33, 4-34, 4-37 through 4-40, and 6-1 through 6-10

OBSOLETE MATERIAL

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

Dental Manual

Pages 4-1 through 4-10, 4-17, 4-18, 4-21, 4-22, 4-29, 4-30, 4-33, 4-34, and 4-37 through 4-40 — transmitted by Transmittal Letter DEN-59

Pages vi and 6-1 through 6-10 — transmitted by Transmittal Letter DEN-60

6. SERVICE CODES AND DESCRIPTIONS

420.401: Introduction

(A) 130 CMR 420.000 contains regulations governing dental services under MassHealth. All dental providers participating in MassHealth must comply with the regulations of the Division governing MassHealth, including but not limited to Division regulations at 130 CMR 420.000 and 450.000.

(B) In general, and as further described below, coverage of dental services varies for
(1) members under age 21;
(2) members aged 21 and older with special circumstances that meet the criteria in 130 CMR 420.410(D); and
(3) all other members aged 21 and older.

(C) Coverage for members under age 21 includes services essential for the prevention and control of dental diseases and the maintenance of oral health. Coverage for members aged 21 and older with special circumstances that meet the criteria in 130 CMR 420.410(D) is similar, but not identical, to coverage for members under age 21. Coverage for all other members aged 21 and older includes emergency care, exodontic services, oral surgery, and some X-ray services.

(D) The service descriptions and limitations applicable to each group are set forth in the regulations that follow. Where noted, certain service descriptions are the same for all members, regardless of age or circumstances.

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 regulations elsewhere in 130 CMR 420.000 and in 130 CMR 450.000.

Controlled Substance — a drug listed in Schedules II, III, IV, V, or VI of the Massachusetts Controlled Substances Act (M.G.L. c. 94C).

Drug — a substance containing one or more active ingredients in a specified dosage form and strength. Each dosage form and strength is a separate drug.

Federal Upper-Limit Price (FULP) — a price established by the federal Centers for Medicare and Medicaid Services (CMS) pursuant to 42 CFR 447.332 and USC §1396r-8(e). The FULP is equal to 150 percent of the published price for the least costly therapeutic equivalent (using all available national compendia of cost information on drugs) that can be purchased by pharmacists in quantities of 100 tablets or capsules (or, if the drug is not commonly available in quantities of 100, the package size most commonly listed) or, in the case of liquids, the most commonly listed size.

Interchangeable Drug Product — a product containing a drug in the same amounts of the same active ingredients in the same dosage form as another product with the same generic or chemical name, as listed in the current edition of the *Massachusetts List of Interchangeable Drug Products* (105 CMR 720.000) or any supplement thereof.

Legend Drug — any drug for which a prescription is required by applicable federal or state law or regulation.

Massachusetts Upper-Limit Price (MULP) — for multiple-source drugs that do not appear on the federal upper-limit price (FULP) list, an amount equal to 150 percent of the published price for the least costly therapeutic equivalent as listed in national price compendia such as the Red Book and First Data Bank for the most frequently purchased package size.

Most Frequently Purchased Package Size — the package size of a drug most frequently purchased by pharmacy providers based on utilization data compiled by the Division. The National Drug Code (NDC) that is most often paid by the Division and verified by audit, if determined necessary by the Division, will be considered the most frequently purchased package size.

Multiple-Source Drug — a drug marketed or sold by two or more manufacturers or labelers, or a drug marketed or sold by the same manufacturer or labeler under two or more different names.

Nonlegend Drug — any drug for which no prescription is required by federal or state law.

Pharmacy On-Line Processing System (POPS) — the on-line, real-time computer network that adjudicates pharmacy claims, incorporating prospective drug utilization review, prior authorization, and member eligibility verification.

Unit-Dose Distribution System — a means of packaging or distributing drugs, or both, devised by the manufacturer, packager, wholesaler, or retail pharmacist. A unit dose contains an exact dosage of medication and may also indicate the total daily dosage or the times when the medication should be taken.

420.403: Eligible Members

(A) (1) MassHealth Members. The Division pays for dental services provided to MassHealth members, subject to the restrictions and limitations described in the Division's regulations. 130 CMR 450.105 specifically states for each MassHealth coverage type, which services are covered and the members eligible to receive those services.
(2) Recipients of Emergency Aid to the Elderly, Disabled and Children Program. For information on covered services for recipients of the Emergency Aid to the Elderly, Disabled and Children Program, see 130 CMR 450.106.

(B) Member Eligibility and Coverage Type. For information on verifying member eligibility and coverage type, see 130 CMR 450.107.

420.404: Provider Eligibility: Participating Providers

The Division makes payment 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. In order to claim payment, the participating provider must be the dentist who actually performed the service.

(A) A dentist who is a member of a group practice can direct payment to the group practice under the provisions of the Division's regulations governing billing intermediaries in 130 CMR 450.000. The dentist furnishing 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 community health center, hospital-licensed health center, managed care organization, or hospital outpatient department may claim payment for services provided in its dental clinic.

(D) A dental laboratory may claim payment for prosthetic material delivered to a dentist provided that the material was not otherwise provided or paid for by the dentist.

420.405: Provider Eligibility

(A) In-State Providers. The following requirements apply when the dental provider is located in Massachusetts.

(1) Practitioner. A dentist engaged in private practice is eligible to participate in MassHealth if licensed to practice by the Massachusetts Board of Registration in Dentistry. Private practices may include, but are not restricted to, solo, partnership, or group practices.

(2) Managed Care Organization. A managed care organization with a dental clinic is eligible to participate in MassHealth as a provider of dental services.

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

(4) Dental School. A teaching clinic of a dental school accredited by the American Dental Association is eligible to participate in MassHealth as a provider of dental services.

(5) Dental Laboratory. When a dentist's salary from a hospital, state institution, or nursing facility includes compensation for professional services furnished to members in that facility, a dental laboratory is eligible to be a provider and to be paid for the prosthetic materials supplied to a dentist where such materials are not otherwise provided or paid for by the dentist.

(6) Hospital Outpatient Department and Hospital-Licensed Health Center. Dental services provided to members in a hospital outpatient department's dental clinic or a hospital-licensed health center are paid for in accordance with the hospital's signed provider agreement with the Division.

(7) Other Dental Clinic. A dental clinic must be licensed by the Massachusetts Department of Public Health to be eligible to participate in MassHealth. A dental clinic that limits its services to education and diagnostic screening is not eligible to participate.
(8) Specialist in Orthodontics. A dentist is a specialist in orthodontics if the dentist has completed a minimum of two years' training in an accredited postgraduate program leading to board eligibility or board certification as a Diplomate of the American Board of Orthodontists.
(9) Specialist in Oral Surgery. A dentist is a specialist in oral surgery if the dentist has completed a minimum of three years' training in an accredited oral and maxillofacial surgical program leading to board eligibility or certification in oral and maxillofacial surgery as prescribed by the American Board of Oral and Maxillofacial Surgery. An oral surgeon who is also a licensed medical doctor must bill in accordance with the regulations in 130 CMR 420.000 governing the dental program.

(B) Out-of-State Providers. A dental provider located outside of Massachusetts is eligible to be a participating provider in MassHealth 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, the provider meets the specific provider eligibility requirements listed in 130 CMR 420.404, and the provider meets the conditions set forth in 130 CMR 450.109.

(130 CMR 420.406 Reserved)

420.407: Maximum Allowable Fees

(A) Introduction. The Massachusetts Division of Health Care Finance and Policy (DHCFP) determines the maximum allowable fees for all dental services purchased by government agencies. DHCFP publishes a comprehensive listing of dental services and rates. The Division pays for a limited number of the services listed by DHCFP. Refer to Subchapter 6 of the *Dental Manual* for the Division's list of covered services. Payment is always subject to the conditions, exclusions, and limitations set forth in the regulations in 130 CMR 420.000. Payment for a service will be the lower of the following:
(1) the provider's usual charge to the general public for the same or a similar service; or
(2) the maximum allowable fee listed in the applicable DHCFP fee schedule.

(B) Services for Members Under the Age of 21 and for Members Aged 21 and Older. The scope of reimbursable dental services is more extensive for members under the age of 21, and for members aged 21 and older who have special circumstances that meet the criteria for prior authorization set forth in 130 CMR 420.410(D) than for other members aged 21 and older. If the service is reimbursable only for members under the age of 21, or for a more restricted age group, that is noted in the service description in 130 CMR 420.000.

420.408: Noncovered Services

The Division does not cover the following dental services:

(A) cosmetic services;

(B) overdentures and their attachments;

(C) implants of any type or description;

(D) counseling or member-education sessions;

(E) unilateral partials;

(F) laminate veneers;

(G) tooth splinting for periodontal purposes;

(H) medical or dental treatment of temporomandibular joint (TMJ) disease;

(I) habit-breaking appliances;

(J) night guards and orthotic splints, including mandibular orthopedic repositioning appliances (MORAs);

(K) ridge augmentations;

(L) grafts of any nature;

(M) root canals filled by silver point technique, or paste only;

(N) oral-hygiene devices and appliances, dentifrices, and mouth rinses;

(O) procedures and techniques that are considered unproven or experimental, or are not approved by the American Dental Association and its related certifying specialty boards as currently accepted dental practice (for example, genioplasties and facial bone augmentations);

(P) other specialized techniques and associated procedures; and

(Q) all other procedures and services not listed in the *Dental Manual*.

420.409: Noncovered Circumstances

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

(1) the services are provided in a state institution by a state-employed dentist or a dental consultant;

(2) the services are furnished by a provider whose salary includes compensation for professional services;

(3) under comparable circumstances, the provider does not customarily bill private members who do not have health insurance; or

(4) 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 noncovered substitute for, or a modification of, a covered item, the member must pay for the entire cost of the service. The Division does not pay for any portion of the cost of a noncovered service. In all such instances, before performing noncovered services, the provider must inform the member both of the availability of covered services and of the member's obligation to pay for noncovered 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 noncovered service.

420.410: Prior Authorization

(A) Introduction.

(1) In order for certain services (listed in 130 CMR 420.410(C) and (D)) to be payable, the Division requires that the provider obtain prior authorization. The Division pays for these services, which are designated in Subchapter 6 and Appendix E of the *Dental Manual* with the abbreviation "P.A.," only when the provider has obtained prior authorization from the Division. The provider must not begin to furnish the service, except as provided under 130 CMR 420.410(A)(2), until the provider has requested and received written prior authorization from the Division. A prior-authorization request must present the total treatment plan in detail.

(2) The Division may grant prior authorization after a procedure has begun if, in the judgment of the Division, this treatment is medically necessary. When such a prior-authorization request is made, the provider must provide a written justification that the treatment will:

(a) alleviate suffering of the member;

(b) address a dental emergency; or

(c) involve an extenuating circumstance that must be detailed by the dentist.

(3) Requests for prior authorization must be submitted according to the instructions in Subchapter 5 of the *Dental Manual*.

(4) The Division reviews prior-authorization requests with consideration, where applicable, for whether the restoration work requested involves teeth that will be retained for many years and are critical to the member's long-term oral health.
(5) The Division does not consider prior-authorization requests for noncovered services for members aged 21 and older (see 130 CMR 420.408 and service limitations described throughout 130 CMR 420.000.).

(B) 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 or resort to health-insurance payment.
(2) The Division will not pay for a prior-authorized service when the member's MassHealth eligibility is terminated on or before the date of service or a date adjudicated by the Division.
(3) When the member's MassHealth eligibility is terminated prior to delivery of a special-order good, such as a denture, the provider may claim payment in accordance with the provisions of 130 CMR 450.231(B). Refer to 130 CMR 450.231(B) for special procedures in documenting member eligibility for special-order goods.

(C) Services Requiring Prior Authorization.
(1) Services requiring prior authorization include, but are not limited to, the following:
(a) deep scaling and curettage;
(b) gingivectomy or gingivoplasty;
(c) mouth guard;
(d) interceptive orthodontic treatment visits;
(e) orthodontic treatment;
(f) diagnostic casts;
(g) diagnostic photographs;
(h) crowns, posts, cores, and fixed bridgework;
(i) endodontics (root canals and apicoectomies);
(j) prosthodontics (full, partial, and immediate dentures);
(k) rebase of complete upper or lower denture;
(l) reline of complete upper or lower denture;
(m) removal of impacted tooth (soft tissue, partial bony, or complete bony);
(n) surgical exposure of impacted tooth or unerupted tooth to aid eruption (for orthodontic purposes);
(o) vestibuloplasties (ridge extensions);
(p) excision of hyperplastic tissue, per arch;
(q) use of a hospital (inpatient or outpatient) or a freestanding ambulatory surgery center;
(r) certain surgical services performed in a hospital (for example, orthognathic surgery);
(s) additional fee for management of a physically or developmentally disabled member in the office;

(t) maxillofacial prosthetics;
(u) oral screenings of members undergoing radiation treatment, chemotherapy, or organ transplant; and
(v) any other service designated "P.A." in Subchapter 6 or Appendix E of the *Dental Manual*.

(2) The prescription of certain drugs requires prior authorization, as specified in 130 CMR 420.418.

(D) Prior Authorization for Diagnostic, Preventive, Restorative, and Endodontic Services for Members Aged 21 and Older. The Division pays for diagnostic, preventive, restorative, and endodontic services (described in 130 CMR 420.432 through 130 CMR 420.439) for members aged 21 and older only when the provider has obtained prior authorization from the Division that the member meets the special circumstances criteria set forth in 130 CMR 420.410(D)(1).

(1) To demonstrate special circumstances, the member must have
(a) a severe, chronic disability that
(i) is attributable to a mental or physical impairment or combination of mental or physical impairments;
(ii) is likely to continue indefinitely; and
(iii) results in the member's inability to maintain oral hygiene; or
(b) a clinical condition (such as human immunodeficiency virus or cancer) that has advanced to a stage where an infection resulting from oral disease would likely be life-threatening.

(2) The provider's prior-authorization request must contain a clear, written statement signed by the member's physician or primary care clinician (on the clinician's letterhead) describing the member's disability or clinical condition, including but not limited to, the member's specific diagnosis and expected prognosis, and
(a) whether, and specifically why, the member's disability results in the member's inability to maintain oral hygiene; or
(b) whether the member's clinical condition has advanced to a stage where an infection resulting from oral disease would likely be life-threatening, including reference to specific supporting diagnostic evidence.

(3) For purposes of 130 CMR 420.410(D)(1)(a) and (2)(a), "inability to maintain oral hygiene" means that
(a) the member is unable to
(i) independently or with assistance (provided that such assistance actually is available), brush and floss his or her teeth and perform other routine acts of personal oral hygiene; or
(ii) report oral pain; or
(b) the nature of the member's disability is such that routine acts of personal oral hygiene are insufficient to effectively maintain such hygiene.

420.411: Pretreatment Review

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

420.412: Individual Consideration

(A) Certain services are designated "I.C." (indicating individual consideration) in Subchapter 6 and Appendix E of the *Dental Manual*. This means that a fee could not be established for these service codes. Service codes for unlisted or unspecified procedures are also designated as "I.C." The Division determines appropriate payment for individual-consideration services from the provider's detailed report of services furnished. The report must include a narrative summary or operative report, and laboratory, X-ray, and pathology reports. The Division does not pay claims for "I.C." services without a complete report. If the documentation is illegible or incomplete, the Division will deny the claim.

(B) Determination of the appropriate payment for an individual-consideration service is 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;
(4) any applicable relative-value studies; and
(5) any extenuating circumstances or complications.

420.413: Separate Procedures

Certain procedures are designated "S.P." in the service descriptions in Subchapter 6 and Appendix E of the *Dental Manual*. "S.P." is an abbreviation for separate procedure. A separate procedure is one that is commonly performed as an integral part of a total service and therefore does not warrant a separate fee, but that commands a separate fee when performed as a separate procedure not immediately related to other services. (For example, the Division does not pay for a frenectomy when it is performed as part of a vestibuloplasty, and full-study models are not reimbursable separately when performed as part of orthodontic treatment or diagnosis; however, the Division does pay for full-study models separately when they are requested by the Division.) The administration of analgesia and local anesthesia is considered part of an operative procedure and is not reimbursable as a separate procedure.

420.414: Recordkeeping Requirements

Federal and state regulations require that all MassHealth providers maintain complete written records of patients who are members. All records, including X rays, 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. The fees for all dental services listed in 130 CMR 420.000 include payment for preparation of the member's dental record. Services for which payment is claimed must be substantiated by clear evidence of the nature, extent, and necessity of care furnished to the member. Evidence must include examination results, diagnostic charting, description of treatment, X rays, and findings of other diagnostic tests. 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, the following:

(A) the member's name, date of birth, and sex;

(B) the member's identification number;

(C) the date of each service;

(D) the name and title of the individual servicing provider furnishing each service, if the dental provider claiming payment is not a solo practitioner;

(E) pertinent findings on examination and in medical history;

(F) a description of any medications administered or prescribed and the dosage given or prescribed;

(G) a description of any anesthetic agent administered, the dosage given, and the anesthesia flowsheet;

(H) a complete identification of treatment, including, when applicable, the arch, quadrant, tooth number, and tooth surface;

(I) dated and mounted X rays, if applicable; and

(J) copies of all approved prior-authorization requests.

(b) Mixed Dentition: Series of 12 X Rays. A mixed-dentition series of X rays is reimbursable only for members aged six through 12. Such series must consist of 10 intraoral X rays and two posterior bitewing X rays. A panoramic X ray, two bitewing X rays, and necessary periapical X rays may be substituted for a mixed-dentition series. Mixed-dentition series of X rays are reimbursable only once every three calendar years without prior authorization. Prior authorization is required for more frequent X rays.

(2) Bitewing Survey. The Division pays for up to four bitewing X rays as separate procedures no more than twice per calendar year. Bitewing X rays may not be billed separately when taken as part of a full-mouth series. Prior authorization is required for more frequent X rays.

(3) Periapical X Rays. Periapical X rays 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 Division. A maximum of four periapical X rays are allowed per visit. Prior authorization is required for more frequent X rays.

(4) Edentulous Member. X rays are not required and are not reimbursable when the provider is requesting prior authorization for full dentures for an edentulous member.

(C) Panoramic X Rays. Panoramic X rays are not reimbursable for prosthodontics, endodontics, periodontics, and interproximal caries.

(1) Surgical Conditions. Panoramic X rays are reimbursable in conjunction with surgical conditions. Surgical conditions include, but are not limited to:

(a) impactions;

(b) teeth requiring extractions in more than one quadrant;

(c) large cysts or tumors that are not fully visualized by intraoral X rays or clinical examination;

(d) salivary-gland disease;

(e) maxillary-sinus disease;

(f) facial trauma; and

(g) trismus where an intraoral film placement is impossible.

(2) Nonsurgical Conditions.

(a) Panoramic X rays for nonsurgical purposes are reimbursable only for members under age 21. A panoramic X ray, two posterior bitewing X rays, and necessary periapical X rays may be substituted for a mixed dentition series and may be billed as a full-mouth series.

(b) The Division pays for only one panoramic X ray per member for nonsurgical conditions for members between the ages of six and 11 years to monitor the growth and development of permanent dentition.

(D) Diagnostic Photographic Prints.

(1) The Division accepts only photographic prints, not slides, to support prior-authorization requests for orthodontic treatment. In addition, the Division may request models. Seven photographic prints are required for prior authorization both for initial fabrication and insertion of the orthodontic appliance and for first-year orthodontic treatment visits as well as for prior-authorization requests for progress approval. If original photographic prints are not available, photographic prints of the models in the positions required in 130 CMR 420.423(D)(1)(a) through (c) are acceptable. The photographic prints must be a minimum size of three inches by three-and-one-half inches, mounted in clear plastic holders to allow viewing, and include the first molars. In addition, the photographic prints must include

(a) two photographic prints of the member's face (full face and side view);

(b) three photographic prints of teeth in occlusion (front and two side views); and

(c) two photographic prints of the occlusal mirror view of maxillary and mandibular teeth.

(2) Payment for photographic prints is included in the fees for orthodontic services. The Division will not pay for photographic prints as a separate procedure (see 130 CMR 420.413) when prior authorization is granted for orthodontic diagnosis or treatment. An orthodontic specialist must send diagnostic photographic prints to the Division as part of a prior-authorization request for orthodontic treatment. Those members who satisfy conditions for comprehensive orthodontic treatment may have treatment authorized. If such treatment is approved, the Division will grant prior authorization to the provider to bill the treatment. The fee for the orthodontic treatment includes reimbursement for orthodontic diagnosis and records, models, photographic prints, and X rays. However, if the treatment is denied based on the diagnostic photographic prints, the Division will grant prior authorization for the provider to obtain reimbursement for the photographic prints only.

(3) The Division may request diagnostic photographic prints for other prior-authorization services outlined in 130 CMR 420.000.

420.424: Service Descriptions and Limitations: Preventive Services —Members Under Age 21

The following service descriptions and limitations apply to preventive services provided to members under age 21.

(A) Prophylaxis. Prophylaxis is reimbursable only once per six-month period without prior authorization. For example, if the last prophylaxis was performed on February 10th, the next prophylaxis is reimbursable no sooner than August 10th of the same year. The Division may authorize this service up to one additional time per six-month period if, in the Division's opinion, the provider's description of the condition substantiates the need for additional prophylaxis (for example, if a mentally retarded or developmentally disabled individual with gingival disease has a limited ability for self-care). The prophylaxis must include a scaling of natural teeth, removal of acquired stains, and polishing of the teeth. As part of the prophylaxis, the practitioner must review with the member oral-hygiene methods including toothbrush instruction and flossing methods.

(6) Full-coverage composite crowns are reimbursable for anterior primary teeth.
(7) Preventive resin restorations are reimbursable only on occlusal surfaces and only as a single-surface posterior composite. Preventive resin restorations include instrumentation of the occlusal surfaces of grooves.

(C) Reinforcing Pins. Reinforcing pins are reimbursable only when used in conjunction with a two-or-more-surface restoration on a permanent tooth. For teeth where four or more surfaces are restored, either commercial amalgam bonding systems or pins are reimbursable.

(D) Crowns, Posts, and Cores.
(1) Crowns, posts, and cores require prior authorization from the Division. For crowns, posts, and cores, the Division grants prior-authorization requests only when both the prognosis of the tooth and the condition of the remaining dentition is excellent, and then only when the Division determines that conventional restorations cannot be placed due to extensive loss of tooth structure, or when an amalgam or a composite restoration with pins will not withstand the forces of mastication. Acrylic jacket crowns (laboratory processed only) are reimbursable.
(2) The prior-authorization request must be justified by a sufficient number of peripical X rays of good diagnostic quality, dated and suitably mounted, to judge the general dental health. At a minimum, the request must be accompanied by a periapical X ray of the tooth and two posterior bitewing X rays. The Division reserves the right to request current full-mouth X rays or photographs, or both.
(3) Members are eligible for crowns, posts, and cores on permanent incisors, canines, bicuspids, and first molars only.
(4) If root-canal therapy is intended or has been performed previously, the Division grants prior-authorization requests for crowns, posts, and cores only if the loss of coronal tissue precludes a functional occlusion of the tooth. An X ray of the completed root-canal therapy on the tooth must accompany the request. Payment for progress X rays on root canals is included in the fee for root-canal therapy.
(5) Payment is not authorized for crowns provided solely for cosmetic reasons.
(6) When a provider treatment plan includes both root-canal therapy and a post and core with crown, the provider may submit to the Division either a single prior-authorization request for both procedures, or a separate prior-authorization request for each procedure. In either case, each prior-authorization request must contain sufficient information to support the medical need for the procedures requested. An X ray of successful root-canal therapy must be maintained in the member's record.
(7) The Division pays for stainless-steel or prefabricated resin crowns for primary molars or permanent molars. The Division pays for stainless-steel, prefabricated resin crowns for:
(a) primary incisors for members under age six; and
(b) primary canines for members under age nine.
Prior authorization is not required.
(8) Payment for crown repair does not require prior authorization by the Division except where the repair involves laboratory fees or extensive professional time from the dental provider. In these circumstances, providers must submit to the Division for a request for prior authorization and individual consideration. The prior-authorization request must include X rays and documentation of estimated laboratory costs.

(E) Fixed Bridgework.

(1) Fixed bridgework requires prior authorization. The Division only grants prior-authorization requests for fixed bridgework for anterior teeth and only for members aged 16 through 20, with fully matured teeth. The member's oral health must be excellent and the prognosis for the life of the bridge and remaining dentition must be excellent.

(2) The provider must submit with the request for prior authorization X rays of good diagnostic quality, dated and suitably mounted.

(3) Payment for fixed bridgework repair does not require prior authorization by the Division except where the repair requires laboratory fees or extensive professional time from the dental provider. In these circumstances, providers must submit to the Division a request for prior authorization and individual consideration for fixed bridgework repair. The prior-authorization request must include X rays and documentation of estimated laboratory costs.

420.426: Service Descriptions and Limitations: Endodontic Services — Members Under Age 21

The following service descriptions and limitations apply to endodontic services provided to members under age 21. The maximum allowable fee for endodontic services includes payment for all X rays performed during the same treatment session.

(A) Pulpotomy.

(1) A pulpotomy is reimbursable and consists of the complete removal of the coronal portion of the pulp to maintain the vitality of the tooth. It is limited to instances when the prognosis is favorable, and must not be applied to primary teeth that are mobile or that show advanced resorption of roots.

(2) For primary teeth, treatment is limited to cuspids and posterior teeth for members aged 10 or younger, and primary incisor teeth for members aged five or younger. Exceptions to these age limits require prior authorization.

(3) When provided in the same period of treatment, a pulpotomy is not reimbursable in conjunction with root-canal therapy.

(B) Root-Canal Therapy.

(1) Root canal therapy requires prior authorization. This service is limited to the permanent dentition and then only when there is a favorable prognosis for the continued good health of both the tooth and the remaining dentition. Root-canal therapy on second or third molars is not reimbursable. Requests for prior authorization must include a total diagnosis and treatment plan supported by periapical X rays of all remaining teeth. These X rays must be of good diagnostic quality, dated and suitably mounted. The Division authorizes root-canal therapy only when the prior-authorization requirements for a crown (130 CMR 420.425(D)) are met. If the member will subsequently need a crown, the provider may either submit a single prior-authorization request for the combined post, core, crown, and root-canal treatment, or a separate prior-authorization request for each treatment procedure.

(G) Comprehensive Orthodontic Treatment. Comprehensive orthodontic treatment is reimbursable only once per member per lifetime and only when the member has a severe and handicapping malocclusion. The Division determines whether a malocclusion is severe and handicapping based on the clinical standards described in Appendix D of the *Dental Manual*. The permanent dentition must be reasonably complete (usually by age 11).

(1) Reimbursement covers a maximum period of two and one-half years of orthodontic treatment visits. The provider must request prior authorization for initial fabrication and insertion of the orthodontic appliance. Reimbursement for the initial fabrication and insertion of the orthodontic appliance includes payment for retainers. In addition, the provider must request prior authorization separately for each year of treatment (first, second, and, if necessary, first half of the third year).

(2) When requesting prior authorization for the initial fabrication and insertion of the orthodontic appliance and the first year of orthodontic treatment, the provider must submit the following (see the instructions in Subchapter 5 of the *Dental Manual* for obtaining prior authorization forms):

(a) a signed statement on the provider's letterhead that all restorative services have been completed, with diagnostic X rays demonstrating completion of restorative services (see 130 CMR 420.423(A) and (B)), and an evaluation of the anticipated level of member cooperation and hygiene;

(b) seven diagnostic photographic prints, with a minimum size of three inches by three-and-one-half inches, mounted in clear plastic holders, two of which must include frontal and profile facial views and five intraoral views including anterior, left and right lateral views taken at 90 degrees, and occlusal views taken with a mirror;

(c) a completed PAR Index recording form, which provides results of applying the clinical standards described in Appendix D of the *Dental Manual*;

(d) a completed orthodontics prior-authorization form; and

(e) a completed prior-authorization form.

(3) When requesting prior authorization for orthodontic treatment visits subsequent to the first year, for each subsequent year of treatment (the second, and, if necessary, the first half of the third year), the provider must submit the original photographic prints, intraoral progress photographic prints, an updated progress statement for each year of treatment that all restorative services have been completed with diagnostic X rays (see 130 CMR 420.423(A) and (B)), an updated evaluation of anticipated cooperation and hygiene, and a copy of the initially submitted orthodontics prior-authorization form with Part IV completed with progress to date.

(4) Upon the completion of orthodontic treatment, the provider must take photographic prints and maintain them in the member's medical record, subject to review by the Division at its discretion.

(H) Orthodontic Treatment Visits. The provider must request prior authorization for each of the first, second, and, if necessary, first half of the third years of orthodontic treatment visits. The Division pays for ongoing orthodontic treatment visits on a quarterly basis only for members in active orthodontic treatment. The Division considers a member to be in active orthodontic treatment if the member's dental record indicates that orthodontic treatment was provided in the previous 90 days or if the provider includes a justification in the member's dental record for maintaining the member's active status (for example, extended illness). Broken appointments alone do not justify a lapse in service beyond 90 days. 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. Orthodontists should see members every four-to-six weeks. However, the Division recognizes that illness or other extenuating circumstances may cause MassHealth members to occasionally miss appointments. Therefore, the Division requires that MassHealth members receive treatment visits in at least eight out of 12 months in an authorized year of treatment before billing for the next treatment year. The Division requires that three treatment units of one quarter each be billed before requesting prior authorization for the second and third year of treatment. The number and dates of visits must be documented in the member's orthodontic record.

(I) Replacement Retainers. The Division pays for a replacement retainer only during the two-year retention period following orthodontic treatment. The provider must obtain prior authorization and include the date of onset of retention with the request for prior authorization.

(J) Retention Visits. The Division pays separately for up to five retention visits following orthodontic treatment. Prior authorization is not required.

(K) Early Appliance Removal. A prior-authorization request for early appliance removal must include documentation of parent or guardian authorization and an explanation from the orthodontist.

(L) Patient Noncooperation. If the provider determines that continued orthodontic treatment is not indicated because of lack of member cooperation, the provider may request individual consideration for appliance removal. At this time, the provider may also request approval for the placement of retainers.

(M) Additional Consultation. The Division may request additional consultation for any orthodontic procedure requiring prior authorization.

(N) Orthodontic Models and Study Models. Orthodontic models and study models are reimbursable as a separate procedure only when requested by the Division as part of a prior-authorization request for treatment procedures and only when the study models are of good diagnostic quality, properly articulated, well trimmed, and poured in white plaster. Payment for orthodontic models is otherwise included in the fees for orthodontic services. Payment will not be made for an orthodontic model as a separate procedure when prior authorization is granted for orthodontic diagnosis or treatment.

(E) Alveoplasty.

(1) Payment for alveoplasty procedures performed in conjunction with the extraction of teeth is included in the fee for the extraction procedures when six or fewer teeth per jaw are extracted during the same treatment visit.

(2) A provider may claim a separate payment for an alveoplasty only when seven or more teeth per jaw are extracted during the same treatment visit. Edentulous quadrant alveoplasties require prior authorization. The Division pays only once for the same quadrant alveoplasty (dentulous or edentulous) when performed within six months of full or partial denture construction.

(3) The fee for alveoplasty includes payment for tori, tuberosity reductions, and removal of exostoses.

(4) Alveoplasty does not require prior authorization for eligible members.

(F) Frenectomy. Frenectomies may be performed to release tongue ties, to aid in the closure of diastemas, and as a preparation for prosthetic surgery. Frenectomy does not require prior authorization. If the purpose of the frenectomy is to release a tongue tie, 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 Division does not pay for labial frenectomies performed before the eruption of the permanent canines, unless orthodontic documentation that clearly justifies the need for the procedure is maintained in the member's dental record.

(G) Excision of Hyperplastic Tissue. Excision of hyperplastic tissue requires prior authorization. This procedure is for the preprosthetic removal of such lesions as fibrous epuli or benign palatal hyperplasia. The Division may request photographs or models as a result of the review of the request for prior authorization. The photographs and models as well as any related pathology report must be retained in the member's dental record.

(H) Postoperative Visits. Payment for routine postoperative visits is included in the fee for surgical procedures. This includes routine suture removal. Nonroutine postoperative follow-up in the office is an individual-consideration service that is reimbursable 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. A detailed report must be submitted for individual consideration in conjunction with the claim form for postoperative visit. The date, the location of the original surgery, and the type of procedure defines the report.

(130 CMR 420.430 and 420.431 Reserved)

420.432: Service Descriptions and Limitations: Introduction — Members Aged 21 and Older Who Meet the Special Circumstances Criteria

Service descriptions and limitations that are specific to members aged 21 and older who meet the prior-authorization criteria for those with special circumstances set forth in 130 CMR 420.410(D) are set forth in 130 CMR 420.433 through 420.439. Unless otherwise specified below, the service descriptions and limitations for services provided to such members are identical to the coverage for members under age 21 as set forth in 130 CMR 420.422 through 420.429. In addition, services that apply to all members, including members aged 21 and older who meet the prior-authorization criteria for those with special circumstances set forth in 130 CMR 420.410(D), are set forth in 130 CMR 420.452 through 420.457.

420.433: Service Descriptions and Limitations: Diagnostic Services — Members Aged 21 and Older Who Meet the Special Circumstances Criteria

Diagnostic services that are reimbursable when provided to members aged 21 and older who meet the prior-authorization criteria for those with special circumstances set forth in 130 CMR 420.410(D) consist of all services, as described in 130 CMR 420.422(A) through (C), except that the only X rays reimbursable with regard to an emergency care visit are those described and limited in 130 CMR 420.434.

420.434: Service Descriptions and Limitations: X Rays — Members Aged 21 and Older Who Meet the Special Circumstances Criteria

X-ray services that are reimbursable when provided to members aged 21 and older who meet the prior-authorization criteria for those with special circumstances set forth in 130 CMR 420.410(D) consist of all services, as described and limited in 130 CMR 420.423, except as follows.

(A) Mixed Dentition X Rays. The services described in 130 CMR 420.423(B)(1)(b) are not reimbursable.

(B) Panoramic X Rays. The services described in 130 CMR 420.423(C)(2) are not reimbursable.

(C) Diagnostic Photographic Prints. Diagnostic photographic prints are not reimbursable unless otherwise requested by the Division.

420.439: Service Descriptions and Limitations: Exodontic Services — Members Aged 21 and Older Who Meet the Special Circumstances Criteria

Exodontic services that are reimbursable when provided to members aged 21 and older who meet the prior-authorization criteria for those with special circumstances set forth in 130 CMR 420.410(D) consist of all services, as described and limited in 130 CMR 420.429(A) through (H), except that the services described in 130 CMR 420.429(D)(8) are not reimbursable.

(130 CMR 420.440 and 420.441 Reserved)

420.442: Service Descriptions and Limitations: Introduction — Other Members Aged 21 and Older

Service descriptions and limitations that are specific to members aged 21 and older who do not meet the prior-authorization criteria for those with special circumstances set forth in 130 CMR 420.410(D) (other members aged 21 and older) are described in 130 CMR 420.443 through 420.449. In addition, services that apply to all members, including members aged 21 and older who do not meet the prior-authorization criteria for those with special circumstances set forth in 130 CMR 420.410(D), are set forth in 130 CMR 420.452 through 420.457.

420.443: Service Descriptions and Limitations: Diagnostic Services —Other Members Aged 21 and Older

Except for emergency dental care, as described and limited in 130 CMR 420.422(C), diagnostic services are not reimbursable when provided to other members aged 21 and older; except that the only X rays reimbursable with regard to an emergency care visit are those described in 130 CMR 420.444.

420.444: Service Descriptions and Limitations: X Rays — Other Members Aged 21 and Older

X-ray services that are reimbursable when provided to other members aged 21 and older consist of the following.

(A) Intraoral X Rays. The Division pays for intraoral X rays as a separate procedure as related to diagnosing an emergency-care condition, extracting a tooth, or to document a condition for covered treatment related to prior-authorization requirements.

(1) Full-Mouth X Rays. Full-mouth X rays are reimbursable as a separate procedure as related to diagnosing an emergency-care condition, extracting a tooth, or to document a condition for covered treatment related to prior-authorization requirements. All other provisions of 130 CMR 420.423(B)(1)(a) apply.

(2) Bitewing Survey. The Division pays for up to two bitewing X rays as a separate procedure as related to diagnosing an emergency-care condition, extracting a tooth, or to document a condition for covered treatment related to prior-authorization requirements. Bitewing X rays may not be billed separately when taken as part of a full-mouth series.
(3) Periapical X Rays. The Division pays for periapical X rays. A maximum of four periapical X rays may be taken as a separate procedure as related to diagnosing an emergency-care condition, extracting a tooth, or to document a treatment related to prior-authorization requirements. Prior authorization is required for additional X rays.

(B) Panoramic X Rays for Surgical Conditions. The service descriptions and limitations are identical to those set forth in 130 CMR 420.423(C)(1).

(C) Diagnostic Photographic Prints. Diagnostic photographic prints are not reimbursable unless otherwise requested by the Division.

420.445: Service Descriptions and Limitations: Preventive Services— Other Members Aged 21 and Older

Preventive services are not reimbursable when provided to other members aged 21 and older, with the exception of the service as described and limited in 130 CMR 420.435(A).

420.446: Service Descriptions and Limitations: Restorative Services — Other Members Aged 21 and Older

Restorative services are not reimbursable when provided to other members aged 21 and older, with the exception of the service as described and limited in 130 CMR 420.449(B).

420.447: Service Descriptions and Limitations: Endodontic Services — Other Members Aged 21 and Older

(A) Endodontic services are not reimbursable when provided to other members aged 21 and older, with the exception of the service described and limited in 130 CMR 420.447(B).

(B) If an extraction of a tooth would cause undue medical risk for a member with one or more specific medical conditions listed below, the Division will pay for root-canal therapy (the alternative treatment) for a tooth, subject to prior authorization. The prior-authorization request must include documentation of these medical conditions, which 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 mental retardation; and
(6) profound mental illness.

420.448: Service Descriptions and Limitations: Prosthodontic Services — Other Members Aged 21 and Older

Prosthodontic services are not reimbursable when provided to other members aged 21 and older.

420.449: Service Descriptions and Limitations: Exodontic Services — Other Members Aged 21 and Older

(A) Exodontic services that are reimbursable when provided to other members aged 21 and older consist of all services as described and limited in 130 CMR 420.429 (A) through (H), except that the services described in 130 CMR 420.429(D)(8) are not reimbursable.

(B) In addition to the services described in 130 CMR 420.449(A), if an extraction of a tooth would cause undue medical risk for a member with one or more specific medical conditions listed below, with prior authorization the Division will pay for a crown (the alternative treatment). The prior-authorization request must include documentation of these medical conditions, which 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 mental retardation; and
(6) profound mental illness.

(130 CMR 420.450 Reserved)

420.451: Service Descriptions and Limitations: Introduction — All Members

The service descriptions and limitations that apply to all members without exception are set forth in 130 CMR 420.452 through 420.457.

420.452: Service Descriptions and Limitations: General Anesthesia and IV Sedation — All Members

The following service descriptions and limitations apply to all members.

(A) General anesthesia or IV sedation is reimbursable without prior authorization when administered in the office 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 and when a member is eligible for oral surgery services. All rules, regulations, and requirements set forth by the Massachusetts Board of Registration in Dentistry and by the Massachusetts Society of Oral and Maxillofacial Surgeons that apply to office general anesthesia, intravenous sedation, and the various forms of analgesia must be followed without exception. General anesthesia and IV sedation may only be used for oral surgery and maxillofacial procedures.

(B) The administration of analgesia (orally (PO), rectally (PR), inhalation nitrous oxide (N_2O/O_2)) and local anesthesia is considered part of an operative procedure and is not reimbursable as a separate procedure (see 130 CMR 420.413).

(C) A completed anesthesia flowsheet must be retained in the member's dental record. In addition, the provider must document the following in the member's dental record:

(1) the beginning and ending times of any general anesthesia or analgesia;
(2) preoperative, intraoperative, and postoperative vital signs;
(3) medications administered including their dosages and routes of administration;
(4) monitoring equipment utilized; and
(5) a statement of the member's response to the analgesic or anesthetic used including any complication or adverse reaction.

(D) Providers may claim payment for general anesthesia or IV sedation services for the first 30 minutes and then only in 15-minute increments thereafter, as set forth in the service descriptions in Subchapter 6 of the *Dental Manual.* Payment is limited to a maximum of 90 minutes.

420.453: Service Descriptions and Limitations: Oral and Maxillofacial Surgery Services — All Members

The following service descriptions and limitations apply to oral and maxillofacial surgery services provided to all members. Reimbursement for oral and maxillofacial surgery services is full payment for member care and includes payment for routine inpatient preoperative and postoperative care as well as for any related administrative or supervisory duties in connection with member care.

604 Service Codes and Descriptions: Preventive Services (cont.)

Topical Fluoride Treatment (Office Procedure)

D1203 Topical application of fluoride (prophylaxis not included)—child (once per six-month period and no sooner than six months from the date of the last topical fluoride treatment) **(under 21 only) (S.C. and 21 & older — other require P.A.)**

Other Preventive Services

D1351 Sealant—per tooth (permanent first and second molars only) (once per three years per tooth) **(ages 5 through 20 only)**

605 Service Codes and Descriptions: Restorative Services

See 130 CMR 420.425, 420.436, and 420.446 for limitations.

Service Code — Service Description

Amalgam Restorations (Including Polishing)

D2140 Amalgam—one surface, primary or permanent **(primary - under 21 only) (permanent – under 21 and S.C. only)**
D2150 Amalgam—two surfaces, primary or permanent **(primary - under 21 only) (permanent – under 21 and S.C. only)**
D2160 Amalgam—three surfaces, primary or permanent **(primary - under 21 only) (permanent – under 21 and S.C. only)**
D2161 Amalgam—four or more surfaces, primary or permanent **(under 21 and S.C. only)**

Resin Restorations (Composite Restorations)

D2330 Resin-based composite—one surface, anterior **(under 21 and S.C. only)**
D2331 Resin-based composite —two surfaces, anterior **(under 21 and S.C. only)**
D2332 Resin-based composite —three surfaces, anterior **(under 21 only)**
D2335 Resin-based composite —four or more surfaces or involving incisal angle (anterior) (for fractured incisal angle) (includes pins) **(under 21 only)**
D2390 Resin-based composite crown, anterior **(under 21 only)**
D2391 Resin-based composite— one surface, posterior **(primary - under 21 only) (permanent – under 21 and S.C. only)**
D2392 Resin-based composite— two surfaces, posterior **(primary - under 21 only) (permanent – under 21 and S.C. only)**
D2393 Resin-based composite— three surfaces, posterior **(primary - under 21 only) (permanent – under 21 and S.C. only)**
D2394 Resin-based composite—four or more surfaces, posterior **(primary - under 21 only) (permanent – under 21 and S.C. only)**

603 Service Codes and Descriptions: X Rays

See 130 CMR 420.423, 420.434, and 420.444 for limitations.

Service Code	Service Description
	Radiographs
D0210	Intraoral—complete series (including bitewings) (once every three calendar years) **(ages 6 through 12**: 10 intraoral films and two posterior bitewings) **(ages 13 through 20**: minimum of 12 periapical films and two posterior bitewings) **(S.C.**: minimum of 12 periapical films and two posterior bitewings) **(21 & older — other**: minimum of 12 periapical films and two posterior bitewings as separate procedure as related to diagnosing an emergency-care condition, extracting a tooth, or to document a condition for covered treatment related to P.A. requirements)
D0220	Intraoral—periapical, first film
D0230	Intraoral—periapical, each additional film
D0270	Bitewing—single film
D0272	Bitewings—two films **(under 21 and S.C.,** twice per calendar year) **(21 & older — other,** limited as noted above)
D0274	Bitewings—four films (**under 21 and S.C. only,** twice per calendar year)
D0330	Panoramic film (nonsurgical condition — **under 21 only**) (surgical conditions — **all members)**
D0340	Cephalometric film **(under 21 only)** (P.A.)
D0350	Oral/facial images (includes intra and extraoral images) (excludes conventional radiographs) (only when requested by the Division) (P.A.) (I.C.)
	Test and Laboratory Examinations
D0470	Diagnostic casts (only when requested by the Division) (P.A.)

604 Service Codes and Descriptions: Preventive Services

See 130 CMR 420.424, 420.435, and 420.445 for limitations.

Service Code	Service Description
	Dental Prophylaxis (once per six-month period and no sooner than six months from the date of the last prophylaxis)
D1110	Prophylaxis—adult **(ages 14 through 20 and S.C. only)**
D1120	Prophylaxis—child **(to age 14)**

604 Service Codes and Descriptions: Preventive Services (cont.)

Topical Fluoride Treatment (Office Procedure)

D1203 Topical application of fluoride (prophylaxis not included)—child (once per six-month period and no sooner than six months from the date of the last topical fluoride treatment) **(under 21 only)**
(S.C. and 21 & older — other require P.A.)

Other Preventive Services

D1351 Sealant—per tooth (permanent first and second molars only) (once per three years per tooth) **(ages 5 through 20 only)**

605 Service Codes and Descriptions: Restorative Services

See 130 CMR 420.425, 420.436, and 420.446 for limitations.

Service Code — Service Description

Amalgam Restorations (Including Polishing)

D2140 Amalgam—one surface, primary or permanent **(primary - under 21 only) (permanent – under 21 and S.C. only)**
D2150 Amalgam—two surfaces, primary or permanent **(primary - under 21 only) (permanent – under 21 and S.C. only)**
D2160 Amalgam—three surfaces, primary or permanent **(primary - under 21 only) (permanent – under 21 and S.C. only)**
D2161 Amalgam—four or more surfaces, primary or permanent **(under 21 and S.C. only)**

Resin Restorations (Composite Restorations)

D2330 Resin-based composite—one surface, anterior **(under 21 and S.C. only)**
D2331 Resin-based composite —two surfaces, anterior **(under 21 and S.C. only)**
D2332 Resin-based composite —three surfaces, anterior **(under 21 only)**
D2335 Resin-based composite —four or more surfaces or involving incisal angle (anterior) (for fractured incisal angle) (includes pins) **(under 21 only)**
D2390 Resin-based composite crown, anterior **(under 21 only)**
D2391 Resin-based composite— one surface, posterior **(primary - under 21 only) (permanent – under 21 and S.C. only)**
D2392 Resin-based composite— two surfaces, posterior **(primary - under 21 only) (permanent – under 21 and S.C. only)**
D2393 Resin-based composite— three surfaces, posterior **(primary - under 21 only) (permanent – under 21 and S.C. only)**
D2394 Resin-based composite—four or more surfaces, posterior **(primary - under 21 only) (permanent – under 21 and S.C. only)**

605 Service Codes and Descriptions: Restorative Services (cont.)

Crowns—Single Restoration Only

D2710 Crown—resin (laboratory) **(under 21 only)** (P.A.)
D2751 Crown—porcelain fused to predominantly base metal **(under 21 and S.C. only)** (P.A.)

Other Restorative Services

D2910 Recement inlay **(under 21 and S.C. only)**
D2920 Recement crown **(under 21 and S.C. only)**
D2930 Prefabricated stainless steel crown—primary tooth **(under 21 only)**
D2931 Prefabricated stainless steel crown—permanent tooth **(under 21 only)**
D2932 Prefabricated resin crown (primary anterior teeth only) **(under 21 only)**
D2951 Pin retention—per tooth, in addition to restoration (two or more surfaces) (commercial amalgam bonding) **(under 21 and S.C. only)**
D2954 Prefabricated post and core in addition to crown **(under 21 and S.C. only)** (P.A.)
D2980 Crown repair, by report **(under 21 and S.C. only)** (P.A.) (I.C.)
D2999 Unspecified restorative procedure, by report **(under 21 and S.C. only)** (P.A.) (I.C.)

606 Service Codes and Descriptions: Endodontic Services

See 130 CMR 420.426, 420.437, and 420.447 for limitations.

Service Code — Service Description

Pulpotomy

D3220 Therapeutic pulpotomy (excluding final restoration)—removal of pulp coronal to the dentinocemental junction and application of medicament **(under 21 only)**

Root Canal Therapy (Including Treatment Plan, Clinical Procedures and Follow-up Care)

D3310 Anterior (excluding final restoration) (one canal) (bicuspid—one canal) **(under 21 and S.C. only)** (P.A.)
D3320 Bicuspid (excluding final restoration) (two canals) **(under 21 only)** (P.A.)
D3330 Molar (excluding final restoration) (three canals) **(under 21 only)** (P.A.)

Apicoectomy/Periradicular Services

D3410 Apicoectomy/periradicular surgery—anterior (per tooth) (includes retrograde filling) **(under 21 and S.C. only)** (P.A.)
D3421 Apicoectomy/periradicular surgery—bicuspid (first root) **(under 21 and S.C. only)** (P.A.)
D3426 Apicoectomy/periradicular surgery (each additional root) **(under 21 and S.C. only)** (P.A.)

607 Service Codes and Descriptions: Periodontic Services

See 130 CMR 420.424, 420.435, and 420.445 for limitations.

Service Code	Service Description
	Surgical Services (Including Usual Postoperative Services)
D4210	Gingivectomy or gingivoplasty—four or more contiguous teeth or bounded teeth spaces per quadrant (once per quadrant per three-year period) **(under 21 and S.C. only)** (P.A.)
D4341	Periodontal scaling and root planing—four or more contiguous teeth or bounded teeth spaces per quadrant (includes curettage) (once per quadrant per three-year period) **(under 21 and S.C. only)** (P.A.)

608 Service Codes and Descriptions: Prosthodontic (Removable) Services

See 130 CMR 420.427, 420.438, and 420.448 for limitations.

Service Code	Service Description
	Complete Dentures (Including Routine Post Delivery Care)
D5110	Complete denture—maxillary **(under 21 and S.C. only)** (P.A.)
D5120	Complete denture—mandibular **(under 21 and S.C. only)** (P.A.)
D5130	Immediate denture—maxillary **(under 21 only)** (P.A.)
D5140	Immediate denture—mandibular **(under 21 only)** (P.A.)
	Partial Dentures (Including Routine Post Delivery Care)
D5211	Maxillary partial denture—resin base (including any conventional clasps, rests, and teeth) **(under 21 and S.C. only)** (P.A.)
D5212	Mandibular partial denture—resin base (including any conventional clasps, rests, and teeth) **(under 21 and S.C. only)** (P.A.)
D5213	Maxillary partial denture—cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth) **(under 21 only)** (P.A.)
D5214	Mandibular partial denture—cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth) **(under 21 only)** (P.A.)
	Repairs to Complete Dentures
D5510	Repair broken complete denture base **(under 21 and S.C. only)**
D5520	Replace missing or broken teeth—complete denture (each tooth) **(under 21 and S.C. only)**

608 Service Codes and Descriptions: Prosthodontic (Removable) Services (cont.)

Repairs to Partial Dentures

D5610 Repair resin denture base **(under 21 and S.C. only)**
D5620 Repair cast framework **(under 21 and S.C. only)**
D5630 Repair or replace broken clasp **(under 21 and S.C. only)**
D5640 Replace broken teeth—per tooth **(under 21 and S.C. only)**
D5650 Add tooth to existing partial denture **(under 21 and S.C. only)**
D5660 Add clasp to existing partial denture **(under 21 and S.C. only)**

Denture Rebase Procedures

D5710 Rebase complete maxillary denture **(under 21 and S.C. only)** (P.A.)
D5711 Rebase complete mandibular denture **(under 21 and S.C. only)** (P.A.)
D5750 Reline complete maxillary denture (laboratory) **(under 21 and S.C. only)** (P.A.)
D5751 Reline complete mandibular denture (laboratory) **(under 21 and S.C. only)** (P.A.)

609 Service Codes and Descriptions: Prosthodontic (Fixed) Services

See 130 CMR 420.427, 420.438, and 420.448 for limitations. Each abutment and each pontic constitutes a unit in a bridge.

Service Code — Service Description

Fixed Partial Denture Pontics

D6241 Pontic—porcelain fused to predominantly base metal **(under 21 only)** (P.A.)
D6751 Crown—porcelain fused to predominantly base metal **(under 21 only)** (P.A.)

Other Fixed Partial Denture Services

D6930 Recement fixed partial denture **(ages 16 through 20 only)**
D6980 Fixed partial denture repair, by report **(ages 16 through 20 only)** (P.A.) (I.C.)
D6999 Unspecified, fixed prosthodontic procedure, by report **(under 21 and S.C. only)** (P.A.) (I.C.)

610 Service Codes and Descriptions: Exodontic Services

See 130 CMR 420.429, 420.439, and 420.449 for limitations.

Service Code	Service Description
	Extractions (Includes Local Anesthesia and Routine Postoperative Care) (Place of Service Excludes Emergency Room and Hospital Inpatient)
D7110	Extraction—single tooth
D7120	Extraction—each additional tooth
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
D7220	Removal of impacted tooth—soft tissue (P.A.)
D7230	Removal of impacted tooth—partially bony (P.A.)
D7240	Removal of impacted tooth—completely bony (P.A.)
D7281	Surgical exposure of impacted or unerupted tooth to aid eruption (for orthodontic purposes only) **(under 21 only)** (P.A.)
	Surgical Procedures (Place of Service Excludes Emergency Room and Hospital Inpatient)
D7310	Alveoplasty in conjunction with extractions—per quadrant (seven or more extractions per arch)
D7320	Alveoplasty not in conjunction with extractions—per quadrant
D7340	Vestibuloplasty—ridge extension (second epithelialization) (P.A.)
D7960	Frenulectomy (frenectomy or frenotomy)—separate procedure (S.P.)
D7970	Excision of hyperplastic tissue—per arch (P.A.)
D7999	Unspecified oral surgery procedure, by report (P.A.) (I.C.)
D9930	Treatment of complications (post-surgical)—unusual circumstances, by report (I.C.)

611 Service Codes and Descriptions: Orthodontic Services

See 130 CMR 420.428 for limitations.

Service Code	Service Description
	Orthodontic Diagnosis and Full Orthodontic Treatment
D8080	Comprehensive orthodontic treatment of the adolescent dentition **(under 21 only)** (P.A.)
D8660	Pre-orthodontic treatment visit (consultation) (accredited orthodontists only) (once per six months) **(under 21 only)** (I.C.)
D8670	Periodic orthodontic treatment visit (as part of a contract) (full orthodontic treatment, active, first year and second year, and first half of third year, if necessary, including retainer-quarterly treatment visits) **(under 21 only)** (P.A.)
D8690	Orthodontic treatment (alternative billing to a contract fee) **(under 21 only)** (P.A.) (I.C.)
	Space Maintenance (Passive Appliances)
D1510	Space maintainer—fixed-unilateral **(under 21 only)**
D1515	Space maintainer—fixed-bilateral **(under 21 only)**
D1520	Space maintainer—removable unilateral **(under 21 only)**
D1525	Space maintainer—removable-bilateral **(under 21 only)**
D1550	Recementation of space maintainer **(under 21 only)** (I.C.)
	Other Orthodontic Services
D8680	Orthodontic retention (removal of appliances, construction and replacement of retainer(s)) **(under 21 only)**
D8692	Replacement of lost or broken retainer **(under 21 only)** (P.A.) (I.C.)
D8999	Unspecified orthodontic procedure, by report **(under 21 only)** (P.A.) (I.C.)

612 Service Codes and Descriptions: General Anesthesia and IV Sedation Services — All Members

See 130 CMR 420.452 for limitations. The allowable fees include payment for cardiac monitoring and other related costs, per 15 minutes.

Service Code	Service Description
D9220	General anesthesia—first 30 minutes
D9221	General anesthesia—each additional 15 minutes (from 31 to 90 minutes)

613 Service Codes and Descriptions: Other Services — All Members

See 130 CMR 420.456 and 420.457 for limitations.

Service Code	Service Description
	Treatment of Physically or Developmentally Disabled Recipients
D9920	Behavior management, by report (P.A.) (I.C.)
	Unclassified Treatment
D9110	Palliative (emergency) treatment of dental pain—minor procedure
D9941	Fabrication of athletic mouthguard **(under 21 only)** (P.A.)
D9999	Unspecified adjunctive procedure, by report (P.A.) (I.C.)

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MASSHEALTH DENTAL SERVICES GENERAL GUIDELINES

This chart is intended for use as general guidelines for determining MassHealth covered dental services for eligible members. Please consult the regulation cited for each service for a complete description of the conditions and limitations that may apply to each service. If the guidelines conflict in any way with the dental regulations at 130 CMR 420.000, the regulations prevail.

Dental Service	Children (Up to 21)	Existing Conditions/ limits 130 CMR 420.	Adults With Special Circumstances as of 01/01/03	Conditions/ limits as of 01/01/03 130 CMR 420.	Other Adults as of 01/01/03	Conditions/ limits as of 01/01/03 130 CMR 420.
1. DIAGNOSTIC						
Oral evaluation - Comprehensive	Yes	422(A)	Yes	433	No	443
Oral evaluation- Periodic	Yes	422(B)	Yes	433	No	443
Emergency care visit	Yes	422(C)	Yes	433	Yes	443
X-rays						
• Full Mouth	Age 13-20 (>1/3CY*)	423(B)(1) (a)	Yes (>1/3CY*)	434	Yes	444(A)(1)
• Mixed Dentition	Age 6-12 (>3/CY*)	423(B)(1) (b)	No	434(A)	No	444
• Bite-wing Survey	Yes (>4/yr)	423(B)(2)	Yes (>4/yr)	434	Yes (2)	444(A)(2)
• Periapical	Yes (>4*)	423(B)(3)	Yes (>4*)	434	Yes (>4*)	444(A)(3)
• Panoramic (surgical condition – all members)	Yes	423(C)(1)	Yes	434	Yes	444(B)
• Panoramic (non-surgical under age 21 only)	Yes	423(C)(2)	No	434(B)	No	444(B)
Photographic Prints	Yes	423(D)	No, unless DMA requests	434(B)	No, unless DMA requests	444(C)
2. PREVENTIVE						
Prophylaxis/cleaning	Yes (>1/6mos*)	424(A)	Yes (>1/6mos*)	435	No	445
Topical Fluoride	Yes	424(B)(1)	Only for dry mouth*	435(A)	Only for dry mouth*	445
Fluoride supplements	Through Rx program	424(B)(2)	No	435(A)	No	445
Deep scaling/ curettage	Yes*	424(C)	Yes*	435	No	445
Gingivectomy or gingivoplasty	Yes*	424(D)	Yes*	435	No	445
Sealants	Age 5-20	424(E)	No	435(B)	No	445
Mouth Guard	Yes*	424(F)	No	435(B)	No	445
3. RESTORATIVE						
Amalgam restorations	Yes	425(A)	Yes	436	No	446
Composite resin						
• Anterior teeth	Yes	425(B)(2)	Yes	436	No	446
• Single posterior tooth	Yes	425(B)(3)	Yes	436	No	446
• Fractured permanent anterior tooth	Yes (lieu of full crown) (some*)	425(B)(4)	No	436(A)	No	446
• Composite crown-anterior	Yes	425(B)(6)	No	436(A)	No	446
• Preventive resin restorations	Yes	425(B)(7)	No	436(A)	No	446
Reinforcing pins	Yes	425(C)	Yes	436	No	446
Crowns, posts, and cores						
• Perm incisors, canines, bicuspids, first molars	Yes*	425(D)(3)	No	N/A	No	N/A
• Anterior teeth	Yes*	425(D)	Yes*	436(B)(1)	*Only as extraction alternative	446
• Posterior teeth	No	425(D)(3)	*Only as extraction alternative	436(B)(2)	*Only as extraction alternative	446
• Acrylic jacket crowns	Yes	425(D)(1)	No	436(B)(1)	No	446
• Stainless-steel or prefab resin crowns	See below	See below	No	436(B)(1)	No	446
• Above –primary incisors	Under age 6	425(D)(7)	N/A	N/A	N/A	N/A
• Above - primary canines	Under age 9	425(D)(7)	N/A	N/A	N/A	N/A
• Crown repair	Yes (some*)	425(D)(8)	Yes (some*)	436	No	446
Fixed bridgework (anterior teeth)	Age 16-20*	425(E)(1)	No	436(C)	No	446
Bridgework repair	Yes (some*)	425(E)(3)	No	436(C)	No	446

*** Medical Necessity PA Required (in addition to Special Circumstances Prior Authorization)**

Dental Service	Children (up to 21)	Existing Conditions/ limits 130 CMR 420.	Adults With Special Circumstances as of 01/01/03	Conditions/ limits as of 01/01/03 130 CMR 420.	Other Adults as of 01/01/03	Conditions/ limits as of 01/01/03 130 CMR 420.
4. ENDODONTIC						
Pulpotomy	Yes	426(A)	No	437(A)	No	447
Root canal (permanent incisors, canines, bicuspids, first molars)	Yes*	426(B)	N/A	N/A	N/A	N/A
Above – anterior teeth	Yes	426(B)	Yes*	437(B)(1)	*Only as extraction alternative	447
Above – posterior teeth	No	426(B)	*Only as denture alternative	437(B)(2)	*Only as extraction alternative	447
Apicoectomy	Yes (separate procedure*)	426(C)	Yes (separate procedure*)	437	No	447
5. PROSTHODONTIC						
Dentures						
• Full (permanent)	Yes*	427(A)(1)(a)	Yes*	438	No	448
• Immediate	Yes*	427(A)(1)(b)	No	438(A)	No	448
• Partial upper and lower (without bar) (permanent)	Yes*	427(A)(1)(c)	Yes*	438	No	448
• Partial upper and lower (with bar) (permanent)	Yes*	427(A)(1)(d)	No	438(A)	No	448
• Replacement	Yes*	427(F)	Yes*	438	No	448
• Full Relines and rebases	Yes*	427(H)	Yes*	438	No	448
Orthodontic services	Yes*	428(A)-(N)	No	428	No	428
Simple extraction	Yes	429(B)	Yes	439	Yes	449
Surgical removal of erupted tooth	Yes	429(C)	Yes	439	Yes	449
Surgical removal of impacted tooth	Yes*	429(D)	Yes*	439	Yes	449
Surgical exposure of impacted tooth	Yes*	429(D)(8)	No	439	No	449(A)
Alveoplasty (inclusive of below)	Yes (some*)	429(E)	Yes	439	Yes	449
Frenectomy	Yes	429(F)	Yes	439	Yes	449
Excision of hyperplastic tissue	Yes*	429(G)	Yes	439	Yes	449
• Post-operative visits (routine and non-routine)	Yes	429(H)	Yes	439	Yes	449
8. OTHER SERVICES						
General anesthesia and IV sedation (office, separate procedure) ^	Yes	452	Yes	452	Yes	452
Oral and maxillofacial surgery services	Yes (some*)	453(B)	Yes (some*)	453(B)	Yes (some*)	453(B)
Orthognathic surgery	Yes*	453(C)	Yes*	453(C)	Yes*	453(C)
Maxillofacial prosthetics	Yes*	455	Yes*	455	Yes*	455
Hospital admission for certain disabled members	Yes*	456(A)	Yes*	456(A)	Yes*	456(A)
Oral screenings for certain members	Yes*	456(C)	Yes*	456(C)	Yes*	456(C)

*** Medical Necessity PA Required (in addition to Special Circumstances Prior Authorization)**
^ Other analgesics and local anesthetics may be included in rate for procedure.

Dental Provider
Service Code Crosswalk

Changes Related to HIPAA

Obsolete Code	Obsolete Code Description	New Code	New Code Description	Limitation/Comment
X0331	Panoramic film (surgical conditions only)	**D0330**	Panoramic film	P.A. eliminated for both surgical and non-surgical conditions
X2004	Replace space maintainer (under age 21)	**D1510**	Space maintainer, fixed unilateral	
X2004	Replace space maintainer (under age 21)	**D1515**	Space maintainer, fixed bilateral	
X2004	Replace space maintainer (under age 21)	**D1520**	Space maintainer, removable unilateral	
X2004	Replace space maintainer (under age 21)	**D1525**	Space maintainer, removable bilateral	
X2006	Full orthodontic treatment, active, first half of third year if necessary, including a retainer (per quarter) (under age 21)	**D8670**	Periodic orthodontic treatment visit (as part of contract)	P.A. required; 1st, 2nd and 1st half of 3rd year; includes retainer; quarterly visits;
X2008	Office anesthesia- onset to 15 minutes	**D9220**	General anesthesia-first 30 minutes	first 30 minutes
X2009	Office anesthesia- 16 to 30 minutes	**D9220**	General anesthesia-first 30 minutes	first 30 minutes
X2010	Office anesthesia- 31 to 45 minutes	**D9221**	General anesthesia-each additional 15 minutes	90 minute maximum including first 30 minutes
X2011	Office anesthesia- 45 to 60 minutes	**D9221**	General anesthesia-each additional 15 minutes	90 minute maximum including first 30 minutes
X2012	Office anesthesia- 61 to 75 minutes	**D9221**	General anesthesia-each additional 15 minutes	90 minute maximum including first 30 minutes
X2013	Dental general anesthesia- 76 to 90 minutes	**D9221**	General anesthesia-each additional 15 minutes	90 minute maximum including first 30 minutes
X2098	Oral screening in an inpatient hospital setting for members scheduled for radiation treatment, chemotherapy, bone marrow transplant, or organ transplant.	**D9999**	Unspecified adjunctive procedure, by report	No HCPCS code with specific oral screening description available to replace the X code for this procedure. PA required
X2099	Oral screening in an outpatient hospital setting for members scheduled for radiation treatment, chemotherapy, bone marrow transplant, or organ transplant.	**D9999**	Unspecified adjunctive procedure, by report	No HCPCS code with specific oral screening description available to replace the X code for this procedure. PA required
X2104	Apicoectomy with root-canal filling (same visit)	**D3410**	Apicoectomy/periradicular surgery - anterior	

Dental Provider
Service Code Crosswalk

Obsolete Code	Obsolete Code Description	New Code	New Code Description	Limitation/Comment
X2105	Dental treatment of physically or developmentally disabled member in the hospital (inpatient, outpatient setting) or freestanding ambulatory surgery center. This add-on fee is in addition to the specific dental service performed, once per date of service.	**D9920**	Behavior management, by report	P.A. required
X2108	Dental treatment of physically or developmentally disabled member in the office. This add-on fee is in addition to the specific dental service performed, once per date of service.	**D9920**	Behavior management, by report	P.A. required
X2208	Orthodontic consultation (accredited orthodontists only) once per 6 months (under age 21 only)	**D8660**	Pre-orthodontic treatment visit	Once every 6 months;
X2981	Crown repair, extensive, by report	**D2980**	Crown repair, by report	P.A. required
X6981	Bridge repair, by report	**D6980**	Fixed partial denture repair, by report	P.A. required
X8000	Unspecified oral surgery procedure, emergency, by report	**D7999**	Unspecified oral surgery procedure, by report	All unspecified oral surgery procedures;
X8751	Replacement retainer (under age 21) (PA)	**D8692**	Replacement of lost or broken retainer	P.A. required
Y9700	Orthodontic diagnosis and records, models, photos, and X rays (under age 21 only)	**D8690**	Orthodontic treatment (alternative billing to a contract fee)	P.A. required
Y9701	Initial fabrication and insertion of orthodontic appliance (includes all orthodontic records, models, photos and X-rays) (under age 21 only)	**D8080**	Comprehensive orthodontic treatment of the adolescent dentition	P.A. required
Y9703	Full orthodontic treatment, active, first year (including a retainer) (per quarter) (under age 21 only)	**D8670**	Periodic orthodontic treatment visit (as part of contract)	P.A. required 1st, 2nd and 1st half of 3rd year; includes retainer; quarterly visits;
Y9704	Full orthodontic treatment, active, second year (including a retainer) (per quarter) (under age 21 only)	**D8670**	Periodic orthodontic treatment visit (as part of contract)	P.A. required 1st, 2nd and 1st half of 3rd year; includes retainer; quarterly visits;

Dental Provider
Service Code Crosswalk

Current Dental Terminology (CDT) Code Changes

Obsolete Code	Obsolete Code Description	New Code	New Code Description	Limitation/Comment
D0471	Diagnostic photographs	**D0350**	Oral/facial images	P.A. required; CDT/HCPC Code deleted in 1999
D8750	Post treatment stabilization	**D8680**	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	CDT/HCPC Code deleted prior to 1998
D2110	Amalgam-one surface, primary	**D2140**	Amalgam-one surface, primary or permanent	CDT-4 2003 Code Change Primary – under 21 only; Permanent – under 21 and S.C. only;
D2120	Amalgam-two surfaces, primary	**D2150**	Amalgam-two surfaces, primary or permanent	CDT-4 2003 Code Change Primary – under 21 only; Permanent – under 21 and S.C. only;
D2130	Amalgam-three surfaces, primary	**D2160**	Amalgam-three surfaces, primary or permanent	CDT-4 2003 Code Change Primary – under 21 only; Permanent – under 21 and S.C. only;
D2131	Amalgam-four or more surfaces, primary	**D2161**	Amalgam-four or more surfaces, permanent or primary	CDT-4 2003 Code Change Primary – under 21 only; Permanent – under 21 and S.C. only;
D2336	Resin-based composite crown-anterior-primary	**D2390**	Resin-based composite crown-anterior	CDT-4 2003 Code Change Under 21 only
D2380	Resin-based composite-one surface, posterior-primary	**D2391**	Resin-based composite-one surface, posterior	CDT-4 2003 Code Change Primary – under 21 only; Permanent – under 21 and S.C. only;
D2381	Resin-based composite-two surfaces, posterior-primary	**D2392**	Resin-based composite-two surfaces, posterior	CDT-4 2003 Code Change Primary – under 21 only; Permanent – under 21 and S.C. only;
D2382	Resin-based composite-three or more surfaces, posterior-primary	**D2393**	Resin-based composite-three or more surfaces, posterior	CDT-4 2003 Code Change Primary – under 21 only; Permanent – under 21 and S.C. only;
D2385	Resin-based composite-one surface, posterior-permanent	**D2391**	Resin-based composite-one surface, posterior	CDT-4 2003 Code Change Primary – under 21 only; Permanent – under 21 and S.C. only;
D2386	Resin-based composite-two surfaces, posterior-permanent	**D2392**	Resin-based composite-two surfaces, posterior	CDT-4 2003 Code Change Primary – under 21 only; Permanent – under 21 and S.C. only;
D2387	Resin-based composite-three surfaces-posterior-permanent	**D2393**	Resin-based composite-three surfaces, posterior	CDT-4 2003 Code Change Primary – under 21 only; Permanent – under 21 and S.C. only;
		D2394	Resin-based composite-four or more surfaces, posterior	CDT-4 2003 Code Change Primary – under 21 only; Permanent – under 21 and S.C. only;

Commonwealth of Massachusetts • Executive Office of Health and Human Services
Division of Medical Assistance • 600 Washington Street, Boston, MA 02111

Orthodontics Prior Authorization Form

For initial prior authorization, complete Parts I, II, and III. For each subsequent prior authorization, use a copy of the initially submitted form and complete Part IV.

Patient

Name: _____

Date of Birth: _____

Member Identification Number: _____

Orthodontist

Name: _____

Address: _____

_____

Telephone Number: _____

Provider Number: _____

Part I: Diagnosis Factors

Based on a preliminary evaluation, the factors checked below may have a significant bearing on the diagnosis or treatment:

- ☐ Pertinent medical history
- ☐ Oral hygiene/dental health
- ☐ Potential cooperation/motivation
- ☐ Dentofacial disfigurement, as perceived by patient and peers

Explain here: _____

Part II: Description of Malocclusion

Brief description of malocclusion, including pertinent findings (for example, facial esthetics, classification, surgical treatment, and clefts):

Part III: Treatment Objectives

Tentative treatment objectives, treatment plan, and mechanotherapy:

Part IV: Progress

Code	**Period**
D8670 (2)	From_____ (Month/Year) To_____ (Month/Year)
D8670 (3)	From_____ (Month/Year) To_____ (Month/Year)

Date treatment started: _____

Patient Cooperation: ☐ Yes ☐ No

Number appointments missed: _____

Include dated original and progress photographic prints.

Please submit the completed form, together with photographic prints, the PAR Index Recording Form, and the PA-1 form to the Orthodontic consultant, Division of Medical Assistance, 600 Washington Street, Boston, MA 02111.

Date: _____ Signature: _____