Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
600 Washington Street
Boston, MA 02111
www.mass.gov/masshealth

MASSHEALTH
TRANSMITTAL LETTER DEN-77
June 2006

TO: Dental Providers Participating in MassHealth

FROM: Beth Waldman, Medicaid Director BW

RE: *Dental Manual* (Coverage of Dental Services for Members Aged 21 Years or Older)

Due to a new state law, effective July 1, 2006, MassHealth will cover dental services to eligible members aged 21 years or older (adults).

This letter transmits amendments to the dental regulations that reflect the new dental coverage for adults. Effective July 1, 2006, dental coverage will be available for all eligible adults, not just to members with demonstrated special circumstances or to members who are pregnant or a mother of a child under the age of three years. Accordingly, providers will no longer need to seek special circumstances designation for members. MassHealth will continue to process all requests for special circumstances designation for services that will be provided before July 1, 2006. All other conditions of 130 CMR 420.000 and 450.000 continue to apply.

This letter also transmits a revised Subchapter 6 and revised pages for Appendix E of the *Dental Manual*. The revisions to these sets of codes reflect the new coverage for eligible adults.

The attached regulations were filed as emergency regulations, effective July 1, 2006.

This transmittal letter, including the attached pages, and other publications issued by MassHealth are available on the MassHealth Web site at www.mass.gov/masshealth. Click on MassHealth Regulations and Other Publications, then on Provider Library.

If you have any questions about the information in this transmittal letter please contact MassHealth Customer Service at 1-800-841-2900, e-mail your inquiry to providersupport@mahealth.net, or fax your inquiry to 617-988-8974.

NEW MATERIAL

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

Dental Manual

Pages iv, vi, 4-1 through 4-38, 6-1 through 6-8, E-3, and E-4

OBSOLETE MATERIAL

(The pages listed here are no longer in effect.)

Dental Manual

Pages iv, iv-a, vi, 4-1 through 4-8, 4-15 through 4-44, 6-1 through 6-8, E-3, and E-4 — transmitted by Transmittal Letter DEN-74

Pages 4-9 through 4-12 — transmitted by Transmittal Letter DEN-75

Pages 4-13 and 4-14 — transmitted by Transmittal Letter DEN-76

4. Program Regulations

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 MassHealth agency governing MassHealth, including but not limited to MassHealth regulations at 130 CMR 420.000 and 450.000.

(B) Coverage for members under age 21 includes services essential for the prevention and control of dental diseases and the maintenance of oral health. As further described in 130 CMR 420.000, coverage for members aged 21 years and older is more limited than coverage for members under 21 years of age.

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.

Caseload Capacity – for purposes of this regulation, caseload capacity means a MassHealth dental provider's good-faith determination of the number of MassHealth members to whom the provider is able to provide dental services.

Controlled Substance – a drug listed in Schedule 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.

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 that has been determined to be therapeutically equivalent (that is, "A"-rated) by the Food and Drug Administration for Drug Evaluation and Research (FDA CDER), or by the Massachusetts Drug Formulary Commission.

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

MassHealth Drug List – a list of commonly prescribed drugs and therapeutic class tables published by the MassHealth agency. The MassHealth Drug List specifies the drugs that are payable under MassHealth. The list also specifies which drugs require prior authorization. Except for drugs and drug therapies described in 130 CMR 420.418(B), any drug that does not appear on the MassHealth Drug List requires prior authorization, as otherwise set forth in 130 CMR 420.000.

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 Online Processing System (POPS) – the online, 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 and/or distributing drugs in unit doses, 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. Such unit doses may or may not be in unit-dose packaging.

420.403: Eligible Members

(A) (1) MassHealth Members. The MassHealth agency pays for dental services provided to MassHealth members, subject to the restrictions and limitations described in MassHealth 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 MassHealth agency 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 MassHealth 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 dental clinic may claim payment for services provided in its dental clinic.

(D) 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.

(E) A dental laboratory may claim payment for prosthetic material delivered to a dentist if 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 Executive Office of Health and Human Services (EOHHS).

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

(8) Specialist in Orthodontics. A dentist who is a specialist in orthodontics must have 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 who is a specialist in oral surgery must have completed a minimum of three years' training in an accredited oral and maxillofacial surgical program 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.

420.406: Caseload Capacity

(A) A MassHealth dental provider must promptly notify the MassHealth agency when its individual, group, or facility practice has reached the number of MassHealth members to whom the provider is able to provide dental services and is closed, as well as when its practice is accepting new MassHealth members and its caseload capacity is open.

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

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 MassHealth agency pays for a limited number of the services listed by DHCFP. Refer to Subchapter 6 of the *Dental Manual* for the MassHealth agency'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 covered dental services is more extensive for members under the age of 21 years than for members aged 21 years and older. If the service is covered only for members under the age of 21 years, or for a more restricted age group, that is noted in the service description in 130 CMR 420.000.

420.408: Noncovered Services

MassHealth does not cover the following dental services, subject to the Early and Periodic Screening, Diagnosis and Treatment provisions set forth at 130 CMR 450.144(A), which provide for prior authorization for medically necessary unlisted, limited, or noncovered 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) occlusal guards for members aged 21 years and older;

(K) orthotic splints, including mandibular orthopedic repositioning appliances (MORAs);

(L) ridge augmentations;

(M) grafts of any nature;

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

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

(P) procedures and techniques that are considered unproven or experimental, or that are not approved by the American Dental Association and its related certifying specialty boards as currently accepted dental practice;

(Q) other specialized techniques and associated procedures; and

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

420.409: Noncovered Circumstances

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

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

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

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

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

(B) Substitutions.

(1) If a member desires a noncovered substitute for, or a modification of, a covered item, the member must pay for the entire cost of the service. The MassHealth agency does not pay for any portion of the cost of a 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 services listed in 130 CMR 420.410(C) to be payable, the MassHealth agency requires that the provider obtain prior authorization. The MassHealth agency 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 MassHealth agency. Prior authorization requests are reviewed for medical necessity, including prognosis of treatment. 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 MassHealth agency. A treatment plan must be included with the prior authorization request for endodontics and crowns. A request for prior authorization should include all services proposed for treatment.

(2) The MassHealth agency may grant prior authorization after a procedure has begun if, in the judgment of the MassHealth agency, 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 MassHealth agency 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).
(5) Pursuant to 130 CMR 450.144(A), the MassHealth agency will consider prior-authorization requests for noncovered services for members under age 21.

(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 MassHealth agency 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 MassHealth agency.
(3) When the member's MassHealth eligibility is terminated before 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) periodontal scaling and root planing;
(b) gingivectomy or gingivoplasty;
(c) occlusal guard;
(d) interceptive orthodontic treatment visits;
(e) orthodontic treatment;
(f) diagnostic casts;
(g) crowns, posts, cores, and fixed bridgework;
(h) endodontics (root canals and apicoectomies);
(i) prosthodontics (full, partial, and immediate dentures);
(j) rebase of complete upper or lower denture;
(k) reline of complete upper or lower denture;
(l) removal of complete bony impacted tooth;
(m) surgical exposure of impacted tooth or unerupted tooth to aid eruption (for orthodontic purposes);
(n) vestibuloplasties (ridge extensions);
(o) excision of hyperplastic tissue, per arch;
(p) use of a hospital (inpatient or outpatient) or a freestanding ambulatory surgery center;
(q) certain surgical services performed in a hospital (for example, orthognathic surgery);
(r) additional fee for management of a physically or developmentally disabled member in the office;
(s) maxillofacial prosthetics; and
(t) 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.

420.411: Pretreatment Review

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

420.412: Individual Consideration

(A) Certain services 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 services. Service codes for unlisted or unspecified procedures are also designated as "I.C." The MassHealth agency 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, radiographs, and pathology reports. The MassHealth agency does not pay claims for "I.C." services without a complete report. If the documentation is illegible or incomplete, the MassHealth agency 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 MassHealth agency does not pay for a frenulectomy 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 MassHealth agency does pay for full-study models separately when they are requested by the MassHealth agency.) 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 radiographs, 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, radiographs, 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 radiographs, if applicable; and

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

420.415: Report Requirements

(A) General Report. A general written report that includes a diagnosis and a description of the service performed must accompany the claim for payment when the service description in Subchapter 6 or Appendix E of the *Dental Manual* stipulates "with report only," when the service is designated "I.C.," or when a service code for an unlisted procedure is used. This report must be sufficiently detailed to enable the MassHealth agency to assess the extent and nature of services performed. The report can be on the claim form or on a separate piece of paper with the provider's letterhead. Supporting documentation, including pathology, admission, and operative reports, must be attached.

(B) Operative Report. For surgical procedures designated "I.C." and for any service that is an unlisted or unspecified procedure, an operative report must accompany the provider's claim. An operative report must contain the name of the surgical procedure, the name and date of birth of the member, the date of the service, the preoperative diagnosis, the postoperative diagnosis, the names of the surgeon and of any assistant, and the technical procedures performed.

420.416: Pharmacy Services: Prescription Requirements

(A) Legal Prescription Requirements. Legend drugs, nonlegend drugs, and those medical supplies listed at 130 CMR 420.417(C) are covered only if the pharmacy has in its possession a prescription that meets all requirements for a legal prescription under all applicable federal and state laws and regulations. Each prescription, regardless of drug schedule, must contain the prescriber's unique DEA number. For Schedule VI drugs, if the practitioner has no DEA registration number, the practitioner must provide the state registration number on the prescription.

(B) Emergencies. When the pharmacist determines that an emergency exists, the MassHealth agency will pay a pharmacy for at least a 72-hour, nonrefillable supply of the drug in compliance with state and federal regulations. Emergency dispensing to a MassHealth member who is enrolled in the Controlled Substance Management Program (CSMP) must comply with 130 CMR 406.442(C)(2).

(C) Refills.

(1) The MassHealth agency does not pay for prescription refills that exceed the specific number authorized by the prescriber.

(2) The MassHealth agency pays for a maximum of 11 monthly refills, except in circumstances described in 130 CMR 420.416(C)(3).

(3) The MassHealth agency pays for more than 11 refills within a 12-month period if such refills are for less than a 30-day supply and have been prescribed and dispensed in accordance with 130 CMR 420.416(D).

(4) The MassHealth agency does not pay for any refill dispensed after one year from the date of the original prescription.

(5) The absence of an indication to refill by the prescriber renders the prescription nonrefillable.

(6) The MassHealth agency does not pay for any refill without an explicit request from a member or caregiver for each filling event. The possession by the provider of a prescription with remaining refills does not in itself constitute a request to refill the prescription.

(D) Quantities.

(1) Days' Supply Limitations. The MassHealth agency requires that all drugs be prescribed in a 30-day supply, unless the drug is available only in a larger minimum package size, except as specified in 130 CMR 420.416(D)(2).

(2) Exceptions to Days' Supply Limitations. The MassHealth agency allows exceptions to the limitations described in 130 CMR 420.416(D)(1) for the following products:

(a) drugs in therapeutic classes that are commonly prescribed for less than a 30-day supply, including but not limited to antibiotics and analgesics;

(b) drugs that, in the prescriber's professional judgment, are not clinically appropriate for the member in a 30-day supply;

(c) drugs that are new to the member, and are being prescribed for a limited trial amount, sufficient to determine if there is an allergic or adverse reaction or lack of effectiveness. The initial trial amount and the member's reaction or lack of effectiveness must be documented in the member's medical record;

(d) drugs packed in such a way that the smallest quantity that may be dispensed is larger than a 30-day supply (for example, inhalers, ampules, vials, eye drops, and other sealed containers not intended by the manufacturer to be opened by any person other than the end user of the product);

(e) drugs in topical dosage forms that do not allow the pharmacist to accurately predict the rate of the product's usage (for example, lotions or ointments);

(f) products generally dispensed in the original manufacturer's packaging (for example, fluoride preparations, prenatal vitamins, and over-the-counter drugs); and

(g) methylphenidate and amphetamine prescribed in 60-day supplies.

(E) Prescription-Splitting. Providers must not split prescriptions by filling them for a period or quantity less than that specified by the prescriber. For example, a prescription written for a single 30-day supply may not be split into three 10-day supplies. The MassHealth agency considers prescription-splitting to be fraudulent. (See 130 CMR 450.238(B)(6).)

(F) Excluded, Suspended, or Terminated Clinicians. The MassHealth agency does not pay for prescriptions written by clinicians who:

(1) have been excluded from participation based on a notice by the U.S. Department of Health and Human Services Office of Inspector General; or

(2) the MassHealth agency has suspended, terminated, or denied admission into its program for any other reason.

420.417: Pharmacy Services: Covered Drugs and Medical Supplies

(A) Drugs. The MassHealth Drug List specifies the drugs that are payable under MassHealth. In addition, the MassHealth agency pays only for legend drugs that are approved by the U.S. Food and Drug Administration and manufactured by companies that have signed rebate agreements with the U.S. Secretary of Health and Human Services pursuant to 42 U.S.C. 1396r-8.

(B) Medical Supplies. The MassHealth agency pays only for the following medical supplies:
(1) blood and urine testing reagent strips used for the management of diabetes;
(2) disposable insulin syringe and needle units;
(3) insulin cartridge delivery devices and needles or other devices for injection of medication (for example, Epipens);
(4) lancets;
(5) drug delivery systems for use with metered dose inhalers (for example, aerochambers); and
(6) alcohol swabs.

420.418: Pharmacy Services: Limitations on Coverage of Drugs

(A) Interchangeable Drug Products. The MassHealth agency pays no more for a brand-name interchangeable drug product than its generic equivalent, unless:
(1) the prescriber has requested and received prior authorization from the MassHealth agency for a nongeneric multiple-source drug (see 130 CMR 420.419); and
(2) the prescriber has written on the face of the prescription in the prescriber's own handwriting the words “brand name medically necessary” under the words “no substitution” in a manner consistent with applicable state law. These words must be written out in full and may not be abbreviated.

(B) Drug Exclusions. The MassHealth agency does not pay for the following types of drugs or drug therapy.
(1) Cosmetic. The MassHealth agency does not pay for legend or nonlegend preparations for cosmetic purposes or for hair growth.
(2) Cough and Cold. The MassHealth agency does not pay for legend or nonlegend drugs used solely for the symptomatic relief of coughs and colds, including but not limited to, those that contain an antitussive or expectorant as a major ingredient unless dispensed to an institutionalized member.
(3) Fertility. The MassHealth agency does not pay for any drug used to promote male or female fertility.
(4) Obesity Management. The MassHealth agency does not pay for any drug used for the treatment of obesity.
(5) Less-Than-Effective Drugs. The MassHealth agency does not pay for drug products (including identical, similar, or related drug products) that the U.S. Food and Drug Administration has proposed, in a Notice of Opportunity for Hearing (NOOH), to withdraw from the market because they lack substantial evidence of effectiveness for all labeled indications.
(6) Experimental and Investigational Drugs. The MassHealth agency does not pay for any drug that is experimental, medically unproven, or investigational in nature.
(7) Drugs for Sexual Dysfunction. The MassHealth agency does not pay for drugs when used for the treatment of male or female sexual dysfunction.

(C) Service Limitations.

(1) The MassHealth agency covers drugs that are not explicitly excluded under 130 CMR 420.418(B). The limitations and exclusions in 130 CMR 420.418(B)(1) through (5) do not apply to medically necessary drug therapy for MassHealth Standard enrollees under age 21. The MassHealth Drug List specifies the drugs that are payable under MassHealth. Any drug that does not appear on the MassHealth Drug List requires prior authorization, as set forth in 130 CMR 420.000. The MassHealth Drug List can be viewed online at www.mass.gov/druglist, and copies may be obtained upon request. The MassHealth agency will evaluate the prior-authorization status of drugs on an ongoing basis, and update the MassHealth Drug List accordingly. (See 130 CMR 450.303.)

(2) The MassHealth agency does not pay for the following types of drugs or drug therapy without prior authorization:

(a) immunizing biologicals and tubercular (TB) drugs that are available free of charge through local boards of public health or through the Massachusetts Department of Public Health (DPH);

(b) nongeneric multiple-source drugs; and

(c) drugs related to sex-reassignment surgery, specifically including but not limited to, presurgery and postsurgery hormone therapy. The MassHealth agency, however, will continue to pay for post sex-reassignment surgery hormone therapy for which it had been paying immediately prior to May 15, 1993.

(3) The MassHealth agency does not pay any additional fees for dispensing drugs in a unit-dose distribution system.

(4) The MassHealth agency does not pay for any drug prescribed for other than the FDA-approved indications as listed in the package insert, except as the MassHealth agency determines to be consistent with current medical evidence.

(5) The MassHealth agency does not pay for drugs that are provided as a component of a more comprehensive service for which a single rate of pay is established in accordance with 130 CMR 450.307.

(D) Insurance Coverage.

(1) Managed Care Organizations. The MassHealth agency does not pay pharmacy claims for services to MassHealth members enrolled in a MassHealth managed care organization (MCO) that provides pharmacy coverage through a pharmacy network or otherwise, except for family planning pharmacy services provided by a non-network provider to a MassHealth Standard MCO enrollee (where such provider otherwise meets all prerequisites for payment for such services). A pharmacy that does not participate in the MassHealth member's MCO must instruct the MassHealth member to take his or her prescription to a pharmacy that does participate in such MCO. To determine whether the MassHealth member belongs to an MCO, pharmacies must verify member eligibility and scope of services through POPS before providing service in accordance with 130 CMR 450.107 and 450.117.

(2) Other Health Insurance. When the member's primary carrier has a preferred drug list, the prescriber must follow the rules of the primary carrier first. The provider may bill the MassHealth agency for the primary insurer's member copayment for the primary carrier's preferred drug without regard to whether the MassHealth agency generally requires prior authorization, except in cases where the drug is subject to a pharmacy service limitation pursuant to 130 CMR 420.418(C)(2)(a) and (c). In such cases, the prescriber must obtain prior authorization from the MassHealth agency in order for the pharmacy to bill the MassHealth agency for the primary insurer's member copayment. For additional information about third party liability, see 130 CMR 450.101 et seq.

(3) Medicare Part D. Except as otherwise required in 130 CMR 406.414(C)(2) and (3), for MassHealth members who have Medicare, the MassHealth agency does not pay for any Medicare Part D drugs, or for any cost-sharing obligations (including premiums, copayments, and deductibles) for Medicare Part D drugs, whether or not the member has actually enrolled in a Medicare Part D drug plan. Medications excluded from the Medicare Part D drug program continue to be covered for MassHealth members eligible for Medicare, if they are MassHealth-covered medications.

420.419: Pharmacy Services: Prior Authorization

(A) Prescribers must obtain prior authorization from the MassHealth agency for drugs identified by the MassHealth agency in accordance with 130 CMR 450.303. If the limitations on covered drugs specified in 130 CMR 420.417(A) and 420.418(A) and (C) would result in inadequate treatment for a diagnosed medical condition, the prescriber may submit a written request, including written documentation of medical necessity, to the MassHealth agency for prior authorization for an otherwise noncovered drug.

(B) All prior-authorization requests must be submitted in accordance with the instructions for requesting prior authorization in Subchapter 5 of the *Dental Manual*. If the MassHealth agency approves the request, it will notify both the pharmacy and the member.

(C) The MassHealth agency will authorize at least a 72-hour emergency supply of a prescription drug to the extent required by federal law. (See U.S.C. 1396r-8(d)(5).) The MassHealth agency acts on requests for prior authorization for a prescribed drug within a time period consistent with federal regulations.

(D) Prior authorization does not waive any other prerequisites to payment such as, but not limited to, member eligibility or requirements of other health insurers.

(E) The MassHealth Drug List specifies the drugs that are payable under MassHealth. Any drug that does not appear on the MassHealth Drug List requires prior authorization, as set forth in 130 CMR 420.416 through 420.419. The MassHealth agency will evaluate the prior-authorization status of drugs on an ongoing basis, and update the MassHealth Drug List.

420.420: Pharmacy Services: Member Copayments

Under certain conditions, the MassHealth agency requires that members make a copayment to the dispensing pharmacy for each original prescription and for each refill for all drugs (whether legend or nonlegend) covered by MassHealth. The copayment requirements are detailed in 130 CMR 450.130.

420.421: Service Descriptions and Limitations: Introduction

All dental services provided to MassHealth members must be consistent with the descriptions and limitations specified in 130 CMR 420.422 through 420.429 and 420.452 through 420.457. In addition, services provided to members under age 21 must comply with all applicable requirements for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services set forth in 130 CMR 450.140 through 450.149.

420.422: Service Descriptions and Limitations: Diagnostic Services

(A) Comprehensive Oral Evaluation. A comprehensive oral evaluation by a dentist of a new member is reimbursable. A comprehensive oral evaluation is more thorough than a periodic oral evaluation, and is reimbursable only once per member for a dentist, dental group, or dental clinic. A comprehensive oral evaluation includes a written review of the member's medical and dental history, the examination and charting of the member's dentition and associated structures, periodontal charting if applicable, the diagnosis, and the preparation of treatment plans and reporting forms.

(B) Periodic Oral Evaluation. MassHealth covers a periodic oral evaluation twice per twelve-month period. A periodic oral evaluation includes an update of the member's medical and dental history, the examination and charting of the member's dentition and associated structures, periodontal charting if applicable, diagnosis, and the preparation of treatment plans and reporting forms. This service is not covered on the same date of service as an emergency treatment visit and is not covered if the visit results in a referral to a specialist.

(C) Emergency Dental Care. An emergency care visit is one that is intended to eliminate or alleviate acute pain or infection or both. Services that may be provided as part of an emergency care visit are those minimally required to address the immediate emergency and include, but are not limited to, diagnosis, draining of an abscess, prescribing pain medication or antibiotics, or treatment of the emergency. The provider must maintain in the member's dental records a diagnostic report of the treatment provided and must document the emergent nature of the care provided. Radiographs subject to limitations set forth in 130 CMR 420.423 and dental management of a physically or developmentally disabled member in the office (see 130 CMR 420.457) are payable with a visit for emergency dental care. Other covered nonemergency, medically necessary treatment provided during the same visit is payable.

420.423: Service Descriptions and Limitations: Radiographs

(A) Introduction. Radiographs must be taken as an integral part of diagnosis and treatment planning. The intent of limitations placed on radiographs is to confine radiation exposure of members to the minimum necessary to achieve satisfactory diagnosis. The provider must document efforts to obtain any previous radiographs before prescribing more. Radiographs must be of good diagnostic quality and, when submitted to the MassHealth agency, must be properly and securely mounted, dated, labeled for right and left views, and fully identified with the names of the dental provider and the member. When radiographs submitted to the MassHealth agency are not of good diagnostic quality, the provider may not claim payment for any retake radiographs requested by the MassHealth agency. Prior-authorization requests that are submitted with radiographs that are not of good diagnostic quality will be deferred, pending submission of radiographs that are of good diagnostic quality, or denied. Radiographs are considered to be of good diagnostic quality when they meet the following criteria:

(1) standard illumination permits differentiation between the various structures of the tooth, the periodontal ligament spacings, the supporting bone, and the normal anatomic landmarks;
(2) all crowns and roots, including apices, are fully depicted together with interproximal alveolar crests, contact areas, and surrounding bone regions; and
(3) images of all teeth and other structures are shown in proper relative size and contour with contiguous images, where anatomically possible.

(B) Intraoral Radiographs.

(1) Full-Mouth Radiographs. Full-mouth radiographs are covered only for members aged six years and older and only once every three calendar years without prior authorization. Prior authorization is required for more frequent radiographs. Full-mouth radiographs must consist of either a minimum of 10 periapical films and two posterior bitewing films, or two-to-four bitewing films and/or two periapical films taken with a panoramic film. Radiographs must be of good diagnostic quality as defined in 130 CMR 420.423(A). However, panoramic films cannot be substituted for radiographs required for prior authorization. When the provider's total fee for individual periapical films (with or without bitewings) exceeds the MassHealth agency's reimbursement for a full-mouth series, the provider may claim reimbursement only in an amount not to exceed the MassHealth agency's reimbursement for a full-mouth series.

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

(3) Periapical Films. Periapical films may be taken for specific areas where extraction is anticipated, or when infection, periapical change, or an anomaly is suspected, or when otherwise directed by the MassHealth agency. A maximum of four periapical films is allowed per visit. Prior authorization is required for more frequent radiographs.

(C) Panoramic Films. Panoramic films are not payable for crowns, endodontics, periodontics, and interproximal caries.

(1) Surgical Conditions. Panoramic films are payable 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 films 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 The MassHealth agency pays for only one panoramic film 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 MassHealth agency accepts only photographic prints, not slides, to support prior-authorization requests for orthodontic treatment. In addition, the MassHealth agency 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 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 MassHealth agency does 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 MassHealth agency as part of a prior-authorization request for orthodontic treatment. Members who satisfy conditions for comprehensive orthodontic treatment may have treatment authorized. If such treatment is approved, the MassHealth agency 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 radiographs. However, if the treatment is denied based on the diagnostic photographic prints, the MassHealth agency will grant prior authorization for the provider to obtain reimbursement for the photographic prints only.

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

420.424: Service Descriptions and Limitations: Preventive Services

(A) Prophylaxis. Prophylaxis is covered twice per 12-month period without prior authorization. The MassHealth agency may authorize this service at greater frequency if, in the MassHealth agency'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.

(B) Fluoride.

(1) Topical Fluoride Treatment.

(a) Topical fluoride treatment is covered for members under age 21. Topical fluoride treatment consists of continuous topical application of an approved fluoride agent such as gels, foams, and varnishes, for a period shown to be effective for the agent. Treatment that incorporates fluoride with the polishing compound is considered to be part of prophylaxis and is not covered as a separate procedure.

(b) The MassHealth agency only pays for topical fluoride treatment for members aged 21 years and older who also have medical or dental conditions that significantly interrupt the flow of saliva, subject to prior authorization. The prior-authorization request must include documentation of such conditions that may include, but are not limited to, radiation therapy, tumors, certain drug treatments, such as some psychotropic medications, and certain diseases and injuries.

(2) Fluoride Supplements. The MassHealth agency pays for fluoride supplements for members under age 21 only through the pharmacy program.

(C) Periodontal Scaling and Root Planing. Periodontal scaling and root planing is a periodontal procedure that is covered, when indicated, once per quadrant every three years. The provider must obtain prior authorization to perform this service. The provider must include complete periodontal charting, sufficient periapical films for diagnosis, and a statement concerning the member's periodontal condition with the prior-authorization request. The MassHealth agency does not pay for prophylaxis provided on the same day as periodontal scaling and root planing or on the same day as a gingivectomy or a gingivoplasty. The MassHealth agency pays only for periodontal scaling and root planing of two quadrants on the same date of service in an office setting.

(D) Gingivectomies and Gingivoplasties. Gingivectomies and gingivoplasties are covered once per quadrant every three years. The provider must obtain prior authorization to perform this service. The provider must include complete periodontal charting, sufficient periapical films for diagnosis, appropriate documentation of previous periodontal treatment, and a statement concerning the member's periodontal condition with the prior-authorization request. The MassHealth agency does not pay for a gingivectomy performed on the same day as a prophylaxis or periodontal scaling and root planing. The MassHealth agency pays only for the gingivectomy or gingivoplasty of two quadrants on the same date of service in an office setting.

(E) Sealants. Sealants are covered for members under age 21 only for primary or permanent first and second noncarious molars, and first and second noncarious bicuspids that have deep pits and fissures. Sealants are also covered for noncarious third molars that have deep pits and fissures. This service includes proper preparation of the enamel surface, etching, and placement and finishing of the sealant. This service is covered only once every three years per tooth. The provider must replace sealants lost or damaged during the three-year period.

(F) Occlusal Guard. Only custom-fitted laboratory-processed occlusal guards designed to minimize the effects of bruxism (grinding) and other occlusal factors are covered. All follow-up care is included in the payment. Prior authorization is required.

(G) Mouth Guard. Only custom-fitted mouth guards are covered. The MassHealth agency pays for a mouth guard only for members under age 21, only if the member is engaged in an organized contact sport, and only when the organization has no provision for the purchase of mouth guards for its participants. Mouth guards are not covered as antibruxim devices.

420.425: Service Descriptions and Limitations: Restorative Services

The MassHealth agency considers all of the following to be components of a completed restoration and includes them in the fee for this service: tooth and soft-tissue preparation, cement bases, etching and bonding agents, pulp capping, impression, local anesthesia, and polishing. The MassHealth agency does not pay for restorations replaced within one year of the date of the completion of the original restoration.

(A) Amalgam Restorations.

(1) Cavity preparation must have an outline adequate for retention and extended to conform to the principles of prevention of recurrent caries.

(2) Payment will not be made for restorations attempted on primary teeth when early exfoliation (more than two-thirds of the root structure resorbed) is expected.

(3) Only one restoration per tooth surface per year is reimbursable. Occlusal surface restorations, including all occlusal pits and fissures, are reimbursable as a one-surface restoration whether or not the transverse ridge on an upper molar is left intact.

(4) No combination of services on a single tooth during the same period of treatment is reimbursable in excess of the maximum allowable fee for a four-or-more-surface amalgam restoration.

(B) Composite Resin Restorations.

(1) Composite restorations are reimbursable for all surfaces of anterior and posterior teeth.

(2) For anterior teeth, the MassHealth agency pays no more than the maximum allowable amount for four-or-more-surface composite restoration regardless of what other services are performed on the same tooth during the composite restoration treatment period and regardless of the combination of surfaces.

(3) For a single posterior tooth, the MassHealth agency pays no more than the maximum allowable amount for a four-or-more-surface composite restoration regardless of what other services are performed on the same tooth during the composite restoration treatment period.

(4) Restoration of a fractured permanent anterior tooth with composite material and bonding or its equivalent is covered for members under age 21 only, when used instead of a full-crown restoration. The fee for this service includes payment for the use of any pins. Prior authorization is required to perform this service on other than permanent anterior teeth.

(5) The fee for all composite resins includes payment for etching and bonding.

(6) Full-coverage composite crowns are covered for members under age 21, only for anterior primary teeth.
(7) Preventive resin restorations are covered for members under age 21, 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 covered 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 covered.

(D) Crowns, Posts, and Cores.
(1) Crowns, posts, and cores require prior authorization from the MassHealth agency. For crowns, posts, and cores, the MassHealth agency grants prior-authorization requests only when both the prognosis of the tooth and remaining dentition is excellent, and then only when the MassHealth agency 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 covered for members under age 21 only.
(2) The prior-authorization request must include a treatment plan and be justified by a sufficient number of peripical films 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 film of the tooth and two posterior bitewing films. The MassHealth agency reserves the right to request current full-mouth radiographs or photographs, or both.
(3) Members under age 21 are eligible for crowns, posts, and cores on permanent incisors, cuspids, bicuspids, and first molars only.
(4) Members aged 21 years and older are eligible for crowns on anterior teeth only, subject to prior authorization. The MassHealth agency does not pay for crowns for a posterior tooth unless extraction (the alternative treatment) would cause undue medical risk for a member with or more specific medical conditions. The prior-authorization request must include documentation of these medical conditions, which include, but are not limited to:
(a) hemophilia;
(b) history of radiation therapy;
(c) acquired or congenital immune disorder;
(d) severe physical disabilities such as quadriplegia;
(e) profound mental retardation; and
(f) profound mental illness.
(5) If root-canal therapy is intended or has been performed previously, the MassHealth agency grants prior-authorization requests for crowns, posts, and cores only if the loss of coronal tissue precludes a functional occlusion of the tooth. A radiograph of the completed root-canal therapy on the tooth must accompany the request. Payment for progress radiographs on root canals is included in the fee for root-canal therapy.
(6) Payment is not authorized for crowns provided solely for cosmetic reasons.
(7) When a provider treatment plan includes both root-canal therapy and a post and core with crown, the provider may submit either a single prior-authorization request for both procedures, or a separate prior-authorization request for each procedure to the MassHealth agency. In either case, each prior-authorization request must contain sufficient information to support the medical need for the procedures requested. A radiograph of successful root-canal therapy must be maintained in the member's record.

(8) The MassHealth agency pays for stainless-steel crowns for primary and permanent posterior teeth or prefabricated resin crowns for primary and permanent anterior teeth for members under age 21 only. Stainless-steel or prefabricated resin crowns are limited to instances where the prognosis is favorable and must not be placed on primary teeth that are mobile or show advanced resorption of roots. The MassHealth agency pays for no more than four stainless-steel or prefabricated resin crowns per date of service. Prior authorization is not required.

(9) Payment for crown repair does not require prior authorization by the MassHealth agency except where the repair involves laboratory fees or extensive professional time from the dental provider. In these circumstances, providers must submit to the MassHealth agency requests for prior authorization and individual consideration. The prior-authorization request must include radiographs and documentation of estimated laboratory costs.

(E) Fixed Bridgework.

(1) Fixed bridgework requires prior authorization. The MassHealth agency grants prior-authorization requests only 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 radiographs of good diagnostic quality, dated and suitably mounted, with the request for prior authorization.

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

420.426: Service Descriptions and Limitations: Endodontic Services

The maximum allowable fee for endodontic services includes payment for all radiographs performed during the same treatment session.

(A) Pulpotomy.

(1) A pulpotomy is covered for members under age 21 only 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 years or younger, and primary incisor teeth for members aged five years or younger. Exceptions to these age limits require prior authorization.

(3) When provided in the same period of treatment, a pulpotomy is not covered 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 radiographs of remaining teeth. These radiographs must be of good diagnostic quality, dated and suitably mounted. The MassHealth agency 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 submit either 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.

(2) The MassHealth agency does not authorize payment for root-canal therapy if

(a) the prognosis of the involved tooth is poor; or

(b) the involved tooth could be extracted and incorporated into an existing or allowable denture.

(3) Payment for root-canal therapy for members under age 21 is limited to permanent incisors, cuspids, bicuspids, and first molars.

(4) Payment for root-canal therapy for members aged 21 years and older is limited to anterior teeth only, subject to prior authorization. The MassHealth agency does not pay for root-canal therapy on a posterior tooth unless removable prosthodontics (the alternative treatment) would cause undue medical risk for a member with one or more specific medical conditions. The prior-authorization request must include documentation of these medical conditions, which include but are not limited to:

(a) hemophilia;

(b) history of radiation therapy;

(c) acquired or congenital immune disorder;

(d) severe physical disabilities such as quadriplegia;

(e) profound mental retardation; and

(f) profound mental illness.

(5) All root canals must be properly prepared, shaped, and condensed to the apex.

(6) The maximum allowable fee for root-canal therapy includes payment for all preoperative and postoperative treatment; diagnostic (for example, vitality) tests; and pretreatment, treatment, and post-treatment radiographs.

(7) A radiograph of the completed root canal must be maintained in the member's record.

(C) Apicoectomy.

(1) An apicoectomy as a separate procedure requires prior authorization, and follows root-canal therapy when the canal is not to be reinstrumented. The request for prior authorization must include a treatment plan and substantiate valid evidence of the need for the service. The fee for the procedure includes payment for the retrograde filling and removal of pathological periapical tissue.

(2) The fee for an apicoectomy with root canal filling includes payment for the filling of the canal or canals and removing the pathological periapical tissue and any retrograde filling in the same period of treatment. This procedure requires prior authorization.

(3) The MassHealth agency applies the criteria at 130 CMR 420.426(B) about root-canal therapy when evaluating prior-authorization requests for apicoectomies.

420.427: Service Descriptions and Limitations: Prosthodontic Services

(A) Dentures: General Conditions.

(1) All of the following dentures are covered with prior authorization only:

(a) full dentures;

(b) immediate dentures (for members under age 21 only):

(c) partial upper and partial lower dentures with conventional clasps and rests; and

(d) partial upper and partial lower dentures with bar, conventional clasps, and rests (for members under age 21 only).

(2) The MassHealth agency pays for relining of cast partial dentures. The MassHealth agency does not pay for the relining of resin-base partial dentures.

(3) The MassHealth agency does not pay for overdentures, precision attachments, temporary dentures, cusil-type dentures, or other dentures of specialized designs or techniques.

(4) The provider must submit a complete treatment plan and prosthetic history with the request for prior authorization.

(5) As part of the denture fabrication technique, the member must approve the teeth and set-up in wax before the dentures are processed.

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

(7) All dentures must be initially inserted and subsequently examined and adjusted by the dentist at reasonable intervals consistent with practice in the community or at the member's request.

(8) The MassHealth agency pays for the replacement of dentures only under certain circumstances (see 130 CMR 420.427(F)). The member is responsible for denture care and maintenance. The member, or those responsible for the member's custodial care, must take all possible steps to prevent the loss of the member's dentures. The provider must inform the member of the MassHealth agency's policy on replacing dentures and the member's responsibility for denture care.

(B) Denture Treatment Plan and Prosthetic History.

(1) A prosthetic history must include, but is not limited to, the following information, as applicable:

(a) identification of the teeth to be extracted and, for partial dentures, the teeth to be clasped and replaced;

(b) the length of time the member has been without natural teeth;

(c) the age and current status of previous or present dentures;

(d) whether the MassHealth agency paid for previous or present dentures;

(e) the length of time the member has been without dentures; and

(f) photographs showing the condition of existing dentures and residual ridges, if requested.

(2) If the member still has natural teeth, the provider must submit with the treatment plan a current series of periapical and bitewing films of good diagnostic quality, dated and suitably mounted, of all remaining teeth. If the member has no remaining natural teeth, radiographs are not required. The fee for full dentures includes payment for all necessary adjustments, including relines, within six months after insertion of the denture. The fee for a partial denture includes payment for all necessary clasps and rests, regardless of the number.

(C) Full Dentures.

(1) Only permanent dentures are reimbursable. When the provider requests initial full dentures following multiple extractions, generally a period of two months must elapse between the time of the extractions and the time the impressions are taken.

(2) Immediate dentures are covered for members under age 21 only when the following conditions are met.

(a) These dentures will be the permanent full dentures.

(b) There are no more than six anterior teeth and no more than one posterior tooth to be extracted at the time of insertion of the denture.

(c) Impressions for the immediate dentures were taken after a suitable period of healing in the region where the posterior teeth were extracted.

(d) There is a favorable prognosis for adaptation to the immediate dentures.

(3) Preformed dentures with mounted teeth (that is, teeth that have been set in acrylic before the initial impressions) are not reimbursable.

(4) Fabrication of a denture must be specific to the individual member, consisting of the individual positioning of teeth, wax-up of the entire denture body, and conventional laboratory processing.

(D) Partial Dentures.

(1) The MassHealth agency considers prior-authorization requests for permanent partial-denture construction only if there are fewer than eight sound posterior teeth in good occlusion. The remaining dentition must be sound and have a good prognosis. Existing or planned crowns, bridges, and partial or full dentures, when present, are counted as occluding teeth.

(2) The MassHealth agency may also consider a request for a permanent partial denture when the member is missing anterior teeth.

(3) The provider must submit to the MassHealth agency an outline of the design of the permanent denture, including the identity of the teeth to be replaced and the teeth to be clasped, and current periapical and bitewing films of the remaining teeth, dated and suitably mounted.

(4) Design of the prosthesis must be as simple as possible, consistent with the basic principles of prosthodontics.

(5) The provider must certify that all carious teeth are functionally restored and that the supporting structures are in good health.

(6) Partial upper and lower dentures with bar are covered only for members under age 21.

(E) Dentures for Members in Long-Term-Care Facilities.

(1) Dental services for members in long-term-care facilities must emphasize retention of the existing dentition consistent with the health and comfort of the member. Most persons in long-term-care facilities adapt better to repairs and other adjustments to existing dentures rather than to extractions or new dentures.

(2) Dentures for members in long-term-care facilities require prior authorization. The provider must submit the following information with a prior-authorization request: a detailed statement of the member's level of medical care; a detailed medical history and diagnosis; medical evaluation of assigned diet and assessment of functional nutritional status; a description of the member's capacity to communicate and to cooperate; and a statement that the member has expressed a desire for the dentures. This documentation must be signed by the member's guardian, or the facility's director of nursing, and a copy must be included in the member's record at the long-term-care facility.

(3) The MassHealth agency does not authorize payment for dentures unless the MassHealth agency has determined that the member is capable of adjusting to a prosthesis. The provider must not prescribe dentures without the express consent of the member. Neither the absence of teeth nor cosmetic benefit, alone or in combination, is considered to be a sufficient reason for dentures. In many cases the member is better served with the fabrication of only an upper denture.

(4) The MassHealth agency reserves the right to request diagnostic photographic prints. (See 130 CMR 420.427(B)(1)(f).)

(F) Replacement of Dentures. The MassHealth agency pays for the necessary replacement of dentures, subject to prior authorization. The MassHealth agency does not authorize payment for the replacement of dentures if the member's denture history reveals any of the following conditions:

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

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

(3) a clinical evaluation suggests that the member will not adjust satisfactorily to the new denture;

(4) no medical or surgical condition in the member necessitates a change in the denture or a requirement for a new denture;

(5) the existing denture is less than seven years old and no other condition in this list applies;

(6) the denture has been relined within the previous two years;

(7) the loss of the denture was not due to extraordinary circumstances such as a fire in the home. The request for prior authorization must include documentation, such as a fire report, police report of theft, or photographic prints of broken dentures; or

(8) the member has been edentulous for more than two years, has been functioning satisfactorily without dentures and no significant improvement in the member's health can reasonably be anticipated if the member were to use dentures.

(G) Antidiscrimination Policy. No provider may discriminate against a MassHealth member. If a hospital or nursing facility has a denture-replacement policy in place for other types of insurance carriers and private paying members, the same policy must apply to MassHealth members in the hospital or nursing facility.

(H) Full-Denture Relines and Rebases. Payment for all full-denture relines and rebases requires prior authorization. The MassHealth agency pays only for full denture relines that are laboratory processed or light cured. "Cold-cure" relines are not covered.

(1) For members under age 21, the fee for dentures includes payment for any relines or rebases necessary within six months of the dispensing date of the denture. Subsequent relines or rebases are covered with prior authorization once every two years.

(2) For members aged 21 years and older, the fee for dentures includes payment for any relines necessary within 12 months of the dispensing date of the denture. Subsequent relines and rebases are covered with prior authorization once every three years.

(3) More frequent relines or rebases require prior authorization and evidence that clinical conditions exist that warrant more frequent relines or rebases (for example, a member with head and neck cancer). The request for prior authorization must include a description of the condition of the denture and must fully justify the reason that an additional reline or rebase is necessary. If a reline or rebase is performed, the MassHealth agency will not authorize an additional denture for three years for the same member. The MassHealth agency may require photographic prints of the mouth and existing dentures to support a request for prior authorization.

(I) Maxillary and Mandibular Partial Dentures – Cast Metal Framework Relines and Rebases. All cast partial denture relines and rebases are covered only for members under 21 years of age and require prior authorization. The MassHealth agency pays only for partial denture relines that are laboratory processed or light cured. "Cold-cure" relines are not covered. The fee for partial dentures includes payment for any relines or rebases necessary within six months of the dispensing date of the partial denture. Subsequent relines or rebases are reimbursable with prior authorization once every two years. More frequent relines or rebases require prior authorization and evidence that clinical conditions exist that warrant more frequent relines or rebases (for example, a member with head and neck cancer). The request for prior authorization must include a description of the condition of the partial denture and must fully justify the reason that an additional reline or rebase is necessary. If a reline or rebase is performed, the MassHealth agency will not authorize an additional partial denture for three years for the same member. The MassHealth agency may require photographic prints of the mouth and existing dentures to support a request for prior authorization. Relines and rebases are not covered for resin-based partial dentures.

(J) Resin-Based Partial Dentures. Relines and rebases are not covered for resin-based partial dentures.

420.428: Service Descriptions and Limitations: Orthodontic Services

(A) General Requirements. Orthodontic treatment is reimbursable only once per member per lifetime. The provider must begin treatment before a member is 18 years and six months of age so that it is completed before the member reaches age 21. However, the MassHealth agency will pay for the continuation of full orthodontic treatment as long as the member remains eligible for MassHealth, provided that initial treatment started before the member reached age 18 years and six months. This payment limitation also applies to any pre- or post-orthognathic surgical case.

(B) Prior Authorization.

(1) The provider must obtain prior authorization for all orthodontic treatment except for orthodontic consultation and retention following orthodontic treatment from the MassHealth agency. The reimbursement for orthodontic retention includes the fabrication and delivery of retainers and follow-up visits. The maximum number of reimbursable retention visits (post-treatment stabilization) is five.

(2) In order to initiate a prior-authorization request for orthodontic treatment, a provider must submit diagnostic photographic prints for the MassHealth agency's review (see 130 CMR 420.423(D)). If the photographic prints do not substantiate the need for treatment, as determined by application of the clinical standard described in Appendix D of the *Dental Manual*, the MassHealth agency either denies the treatment or requests that the provider submit orthodontic models, photographic prints, and radiographs. These are reimbursed only when they are requested by the MassHealth agency.

(a) If the prior-authorization request for treatment is approved based on the documentation submitted, the provider will be given prior authorization to bill the service described as "initial fabrication and insertion of orthodontic appliance," which is reimbursable once per member per lifetime and includes reimbursement for records, photographic prints, models, and radiographs. Initial fabrication and insertion of orthodontic appliances includes conventional, complete, and comprehensive state-of-the-art orthodontic treatment.

(b) If the prior-authorization request for treatment is denied based on the documentation submitted, the provider will be granted prior authorization to bill the service described as "orthodontic diagnosis and records, models, photographic prints, and radiographs."

(c) If the prior-authorization request for treatment is approved based on the documentation submitted, and the member moves or refuses further treatment, the orthodontist may bill the service described as "orthodontic diagnosis and records, models, photographic prints, and radiographs," billable once per member per lifetime. The records, or copies of them, may be requested by another orthodontist. The MassHealth agency may reimburse the second orthodontist for records at its discretion only when initial records are invalid or outdated. The orthodontist must retain pre- and post-treatment photographic prints in the member's dental record for review.

(C) Orthodontic Consultation. The MassHealth agency reimburses accredited orthodontists for an orthodontic consultation for the purpose of determining the necessity for orthodontic treatment and assessing the appropriate time to commence treatment. This service is limited to members who are younger than 18 years and six months of age. An orthodontic consultation is reimbursable as a separate procedure (see 130 CMR 420.413) and only once per six-month period. An orthodontic consultation is not reimbursable as a separate procedure when used in conjunction with ongoing or planned (within six months) orthodontic treatment. The fee for this service does not include models, or photographic prints, and prior authorization is not required. The MassHealth agency does not pay for more than one orthodontic consultation or examination on the same date of service.

(D) Orthodontic Radiographs. Radiographs as a separate procedure for orthodontic diagnostic purposes require prior authorization and are reimbursable only for members under the age of 18 years and six months. Cephalometric films are to be used in conjunction with orthodontic diagnosis. Payment for radiographs in conjunction with orthodontic diagnosis is included in the fees for orthodontic services. Payment is not made for additional radiographs from the same or another provider when required for orthodontic diagnosis. The provider must use the service code for orthodontic radiographs when billing for a full-mouth series or for panoramic films including bitewings.

(E) Interceptive Orthodontic-Treatment Visits. The goal of preventive or interceptive orthodontics is to prevent or minimize a developing malocclusion with primary or mixed dentition. Use of this treatment should preclude or minimize the need for any additional orthodontic treatment. The provider must obtain prior authorization for the number of adjustment visits in conjunction with an interceptive appliance.

(F) Space Maintainers. Space maintainers and replacement space maintainers are reimbursable. Although the initial space maintainer does not require a prior authorization, replacement space maintainers do require prior authorization. Space maintainers are indicated when there is premature loss of teeth that may lead to loss of arch integrity. For primary cuspids, space maintainers prevent midline deviation, loss of arch length and circumference. Premature loss of primary molars also indicates the use of space maintainers to prevent the migration of adjacent teeth. The loss of primary incisors usually does not require the use of a space maintainer. An initial diagnostically acceptable radiograph must be maintained in the member's record, demonstrating that the tooth has not begun to erupt or that migration of the adjacent tooth has already occurred. The provider must maintain good diagnostic-quality radiographs in the member's record. For replacement space maintainers, the provider must include an explanation of the reason for requesting the replacement space maintainer with the request for prior authorization. Treatment (adjustment) visits are not reimbursable for passive space maintainers.

(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 MassHealth agency 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 records and all appliances associated with treatment, fixed and removable (for example, rapid palatal expansion (RPE) or Head Gear). Retention (removal of appliances, construction and placement of retainers) is a separate, billable service, which also includes all retention visits. 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 radiographs 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, 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 radiographs (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 MassHealth agency 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 MassHealth agency pays for ongoing orthodontic treatment visits on a quarterly basis only for members in active orthodontic treatment. The MassHealth agency 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 MassHealth agency recognizes that illness or other extenuating circumstances may cause MassHealth members to occasionally miss appointments. Therefore, the MassHealth agency 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 MassHealth agency 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 MassHealth agency 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. The MassHealth agency pays separately for orthodontic retention (removal of appliances, construction and placement of retainer(s)). Retention includes the fabrication and delivery of the retainers(s) and follow-up visits. The maximum number of reimbursable retention visits (post-treatment stabilization) is five. 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 MassHealth agency 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 separate procedures only when requested by the MassHealth agency 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.

420.429: Service Descriptions and Limitations: Exodontic Services

(A) General Conditions. Reimbursement for exodontic services includes payment for local anesthesia, suture removal, irrigations, spicule removal, apical curettage of associated cysts and granulomas, enucleation of associated follicles, and routine preoperative and postoperative care. The MassHealth agency pays for medically necessary routine extractions provided in an office, hospital (inpatient or outpatient setting), or a freestanding ambulatory surgery center. Use of a hospital (inpatient or outpatient setting) or a freestanding ambulatory surgery center for extractions is limited to those members whose health, because of a medical condition, would be at risk if these procedures were performed in the provider's office. Member apprehension alone is not sufficient justification for use of a hospital (inpatient or outpatient setting) or a freestanding ambulatory surgery center. Lack of facilities for the administration of general anesthesia when the procedure can be routinely performed with local anesthesia does not justify the use of a hospital (inpatient or outpatient setting) or a freestanding ambulatory surgery center. Many services listed in Appendix E of the *Dental Manual* are allowed in the office.

(B) Extraction. Extraction can be either the removal of soft tissue-retained coronal remnants of a deciduous tooth or the removal of an erupted tooth or exposed root by elevation and/or forceps including routine removal of tooth structure, minor smoothing of socket bone, and closure. The removal of root tips whose main retention is soft tissue is considered a simple extraction. All simple extractions may be performed as necessary. The MassHealth agency may investigate an unusually heavy use of simple extractions in the primary dentition to determine whether such extractions were medically necessary. The MassHealth agency does not pay for the extraction of deciduous teeth that appear from radiographic evaluation to be near exfoliation. Incision and drainage performed at the time of extraction is not reimbursable as a separate procedure.

(C) Surgical Removal of Erupted Tooth. The MassHealth agency pays for the surgical removal of an erupted tooth. Surgical removal of an erupted tooth is the removal of any erupted tooth by the open method that includes the retraction of a mucoperiosteal flap and the removal of alveolar bone in order to effect the extraction or the sectioning of a tooth. This may also include root tips if the reviewer determines that retention is more than soft tissue (that is, bone). The provider must maintain a preoperative radiograph of the erupted tooth in the member's dental record to substantiate the service performed. The MassHealth agency determines the necessity of surgical extraction from radiographs and clinical documentation in the member's dental record.

(D) Surgical Removal of Impacted Tooth. The MassHealth agency pays for the surgical removal of an impacted tooth. Surgical removal of a complete bony impacted tooth requires prior authorization. When prior authorization is requested for a surgical procedure in a hospital (inpatient or outpatient setting) or a freestanding ambulatory surgery center, the provider must state the medical necessity and the particular complexity of the procedure that justifies the use of a hospital (inpatient or outpatient setting) or a freestanding ambulatory surgery center. Member apprehension alone is not sufficient justification for the use of a hospital (inpatient or outpatient setting) or a freestanding ambulatory surgery center. Lack of facilities for administering general anesthesia when the procedure can be routinely performed with local anesthesia does not justify use of a hospital (inpatient or outpatient setting) or a freestanding ambulatory surgery center.

(1) Circumstances under which the MassHealth agency pays for surgical removal of impacted teeth include but are not limited to:

(a) full bony impacted supernumerary teeth, mesiodens, or teeth unerupted because of lack of alveolar ridge length;
(b) teeth involving a cyst, tumor, or other neoplasm;
(c) unerupted teeth causing the resorption of roots of other teeth;
(d) partially erupted teeth that cause intermittent gingival inflammation; and
(e) perceptive radiologic pathology that fails to elicit symptoms.

(2) The provider must maintain a preoperative radiograph of the impacted tooth in the member's dental record to substantiate the service performed. The radiograph must clearly define the category of impaction. The MassHealth agency determines the degree of impaction from the radiographs and clinical records in the member's dental record.

(3) A root tip is not considered an impacted tooth.

(4) Surgical removal of a whole tooth with soft-tissue impaction is the removal of a tooth in which the occlusal surface of the tooth is covered by soft tissue requiring mucoperiosteal flap elevation for removal.

(5) Surgical removal of a whole tooth with partial bony impaction is the removal of a tooth in which part of the crown is covered by bone and requires mucoperiosteal flap elevation and bone excision for removal. Segmentalization of the tooth may be required.

(6) Surgical removal of a whole tooth with complete bony impaction is the removal of a tooth in which most or all of the crown is covered by bone and requires mucoperiosteal flap elevation, bone removal and possible segmentalization for removal. This service requires prior authorization.

(7) Surgical exposure of impacted or unerupted teeth to aid eruption requires prior authorization. The procedure is limited to members under age 21 for the exposure of impacted cuspids for orthodontic reasons. The MassHealth agency may request an orthodontic consultation as a result of the review of the request for prior authorization. The MassHealth agency does not pay for reexposure due to tissue overgrowth or lack of orthodontic intervention.

(E) Alveoplasty.

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

(2) The MassHealth agency pays only once for the same quadrant alveoplasty (dentulous or edentulous) when performed within six months of initial alveoplasty.

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

(F) Frenulectomy Frenulectomies may be performed to excise the frenum when the tongue has limited mobility, to aid in the closure of diastemas, and as a preparation for prosthetic surgery. Frenulectomy does not require prior authorization. If the purpose of the frenulectomy is to release a tongue, a written statement by a physician or primary care clinician and a speech pathologist clearly stating the problem must be maintained in the member's dental record. The MassHealth agency does not pay for labial frenulectomies performed before the eruption of the permanent cuspids, unless 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 MassHealth agency 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 through 420.451 Reserved)

420.452: Service Descriptions and Limitations: General Anesthesia and IV Sedation

(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

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.

(A) Introduction. Reimbursable oral and maxillofacial surgery services consist of those basic surgical services essential for the prevention and control of diseases of the oral cavity and supporting structures and for the maintenance of oral health. The MassHealth agency pays only for those services consistent with the regulations in 130 CMR 420.000. Maxillofacial surgery services are reimbursable only for the purpose of anatomic and functional reconstruction of structures that are missing, defective, or deformed because of surgical intervention, trauma, pathology, or developmental or congenital malformations. Cosmetic benefit may result from such surgical services but cannot be the primary reason for those services.

(B) General Conditions. Only oral surgery specialists may claim payment for the services listed in Appendix E of the *Dental Manual* and only if proper certification is on file at the MassHealth agency's Provider Enrollment Unit. Oral surgery specialists may also bill for services listed throughout Subchapter 6 of the *Dental Manual*. Prior authorization is required if indicated next to the service description for the oral and maxillofacial surgical service. Services not listed in the *Dental Manual* are not covered by the MassHealth agency. In no instance does the MassHealth agency pay for new procedures or materials that are not within the scope of standard clinical practice, nor does it pay for procedures considered experimental. In general, most service codes allow for the delivery in the office location where feasible and considered safe for the member. Most routine dentoalveolar surgery requires prior authorization for hospital admission or treatment except for extractions and dentulous alveoplasties.

(C) Orthognathic Surgery.

(1) Orthognathic surgery requires prior authorization. Requests for prior authorization must include at least the following:

(a) a full dental and surgical treatment plan;
(b) documentation of orthodontic consultation;
(c) full-mouth radiographs;
(d) preoperative models;
(e) preoperative cephalometric film with tracing;
(f) projected cephalometric analysis; and
(g) photographs of the face and teeth from the AP (anterior and posterior) and lateral projections.

(2) The prior-authorization request must include a complete and precise description of the requested surgical procedures and the necessity of progressive procedures (staging), if anticipated. The request must explain the medical necessity of these procedures. The MassHealth agency does not pay for orthognathic surgery performed for cosmetic or experimental reasons. Any proposed orthodontic treatment must meet all the criteria described at 130 CMR 420.428.

420. 454: Service Descriptions and Limitations: Oral and Maxillofacial Surgery Procedures

The following service descriptions and limitations apply to all members. Most oral and maxillofacial surgery codes allow for the office location where technically feasible and safe for the member. Use of a hospital (inpatient or outpatient setting) or a freestanding ambulatory surgery center is mandatory in major maxillofacial surgery such as multiple trauma and orthognathic surgery. The MassHealth agency pays for the use of such settings when it is justified by the difficulty of the surgery (for example, four deep bony impactions) in addition to the medical health of the member (for example, asthmatic on multiple medications, alcoholism, or drug history, seizure disorder, or developmentally disabled). Member fear or apprehension does not justify the use of a hospital (inpatient or outpatient setting) or a freestanding ambulatory surgery center.

(A) Utilization Management Program. The MassHealth agency pays for procedures and hospital stays that are subject to the Utilization Management Program only if the applicable requirements of the program as described in 130 CMR 450.207 through 450.209 are satisfied. Appendix G of the *Dental Manual* contains the name, address, and telephone number of the contact organization for the screening program and describes the information that must be provided as part of the review process.

(B) Surgical Assistants. Payment to surgical assistants is 15 percent of the allowable fee for the procedure performed, with a minimum payment of $20.00.

(C) Preoperative Diagnosis and Postoperative Care. For surgery procedures performed in a hospital (inpatient or outpatient setting) or a freestanding ambulatory surgery center, the fees include payment for preoperative diagnosis and postoperative care during the member's stay and are the maximum allowable amounts.

(D) Inpatient Visits. The MassHealth agency pays providers for visits to hospitalized members except for routine preoperative and postoperative care to members who have undergone or who are expected to undergo surgery. Inpatient visits are reimbursable only under exceptional circumstances such as with preoperative or postoperative complications or the need for extended care, prolonged attention, intensive-care services, or consultation services. Prior authorization is not required; however, the provider must substantiate the need for this service in the member's hospital medical record.

(E) Multiple Procedures.

(1) The MassHealth agency does not pay separately for the component parts of a major, more comprehensive service when they are performed on the same date as the comprehensive service. Payment for a comprehensive service includes any separately identified component parts of the comprehensive service, even when separate service codes exist for the component parts. For example, the provider may not claim payment for a frenulectomy performed at the time of a full vestibuloplasty with graft.

(2) Where two or more individual procedures are performed in the same operative session, the procedure with the largest fee-schedule amount is payable at the full amount, and each additional procedure is payable at 50 percent of the amount. This requires the use of modifiers and applies only to numeric service codes listed in Appendix E of the *Dental Manual*.

420.455: Service Descriptions and Limitations: Maxillofacial Prosthetics

(A) Payment for maxillofacial prosthetics is limited to dental practitioners who have completed a training program in maxillofacial prosthetics. Payment for maxillofacial prosthetics requires prior authorization and is reviewed on an individual-consideration basis. The MassHealth agency approves requests only if the maxillofacial prosthetic device will be constructed for the treatment of a member with congenital, developmental, or acquired defects of the mandible or maxilla and associated structures.

(B) A detailed description of the defect and the proposed device must be submitted with a request for prior authorization and must provide sufficient information and justification for the MassHealth agency to determine the medical necessity and appropriateness of the device. A photograph of the defect and the device may be required.

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

420.456: Service Descriptions and Limitations: Other Services

(A) Admission of Members with Certain Disabilities for Restorative, Endodontic, or Exodontic Dentistry.

(1) A severely and persistently mentally ill or physically or developmentally disabled member, under certain circumstances, may undergo restorative, endodontic, or exodontic dental procedures for which they are eligible in a hospital (inpatient or outpatient setting) or in a freestanding ambulatory surgery center. The use of these facilities for restorative, endodontic, or exodontic dentistry requires prior authorization. Use of these facilities may be indicated for a member who

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

(2) Requests for prior authorization of restorative, endodontic, or exodontic services in such settings must include the following:

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

(3) Ordinary fear, ordinary apprehension, or age alone does not justify admission to a hospital (inpatient or outpatient setting) or a freestanding ambulatory surgery center.

(B) Oral Screenings for Members Undergoing Radiation Treatment or Chemotherapy.

(1) Members undergoing radiation, chemotherapy, or both, or who are on long-term immunosuppressive therapy may require oral screenings.

(2) Oral screenings are reimbursed under a global fee. The global fee for oral screenings includes the following:

(a) comprehensive oral examination;
(b) consultation;
(c) salivary flow measurements;
(d) oral hygiene evaluations and instructions;
(e) fluoride treatments;
(f) construction of fluoride trays;
(g) follow-up examination; and
(h) follow-up salivary evaluations.

420.457: Dental Management of Members with Certain Disabilities in the Office

(A) Payment of an additional fee for management of a severely and persistently mentally ill or physically or developmentally disabled member in the office requires prior authorization. The request for prior authorization must contain the following:

(1) a clear statement of the member's illness or disability
(2) a history of treatment or previous attempts at treatment;
(3) the types of services to be furnished; and
(4) any anesthetic agents to be used.

(B) For payment of the additional fee for emergency palliative treatment of dental pain, the provider may request prior authorization after the provision of the service, if such authorization is requested before billing.

REGULATORY AUTHORITY

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

This page is reserved.

The dental service codes and descriptions that are listed in this Subchapter 6 must be used when providing dental services to MassHealth members. For each dental service code, the description indicates any limitations, such as age, pregnancy, or special circumstances designation, subject to the Early and Periodic Screening, Diagnosis and Treatment provisions set forth at 130 CMR 450.144(A), provide for prior authorization for medically necessary unlisted or noncovered services for members under age 21.

Note that prior authorization may be requested for unlisted or noncovered services and codes for members under age 21, pursuant to 130 CMR 450.144(A).

601 Explanation of Abbreviations

The following abbreviations are used in Subchapter 6.

(A) **P.A.** indicates that service-specific prior authorization is required (see 130 CMR 420.410).

(B) **I.C.** indicates that the claim will receive individual consideration to determine payment. A descriptive report must accompany the claim (see 130 CMR 420.412).

(C) **S.P**. indicates that the procedure is commonly performed as part of a total service and does not usually warrant a separate fee. The procedure must be performed separately to receive the separate fee (see 130 CMR 420.413).

602 Service Codes and Descriptions: Diagnostic Services

See 130 CMR 420.422 for limitations.

Service Code	Service Description
	Clinical Oral Evaluation
D0120	Periodic oral examination (twice per 12-month period)
D0150	Comprehensive oral evaluation—new or established patient (once per member per dentist)
D0160	Detailed and extensive oral evaluation—problem focused, by report (to be billed only for oral screening for members undergoing radiation treatment, chemotherapy, or organ transplant)

603 Service Codes and Descriptions: Radiographs

See 130 CMR 420.423 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 and older**: minimum of 10 periapical films and two posterior bitewings)
D0220	Intraoral—periapical, first film
D0230	Intraoral—periapical, each additional film
D0270	Bitewing—single film
D0272	Bitewings—two films (**,** twice per calendar year)
D0274	Bitewings—four films (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 photographic images (includes intra- and extraoral images) (excludes conventional radiographs) (only when requested by MassHealth to support a P.A. request for another service)
	Test and Laboratory Examinations
D0470	Diagnostic casts (only when requested by MassHealth) (PA)

604 Service Codes and Descriptions: Preventive Services

See 130 CMR 420.424 for limitations.

Service Code	Service Description
	Dental Prophylaxis (twice per 12-month period)
D1110	Prophylaxis—adult **(ages 14 and older)**
D1120	Prophylaxis—child **(to age 14)**
	Topical Fluoride Treatment (Office Procedure)
D1203	Topical application of fluoride (prophylaxis not included)—child **(under 21 only) (age 21 and older require P.A.)**

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

Other Preventive Services

D1351 Sealant—per tooth (primary or permanent first and second noncarious molars, first and second non-carious bicuspids (premolars) with deep pits and fissures, and noncarious third molars with deep pits and fissures) (once per three years per tooth) **(under 21 only)**

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)**

605 Service Codes and Descriptions: Restorative Services

See 130 CMR 420.425 for limitations.

Service Code	Service Description

Amalgam Restorations (Including Polishing)

D2140 Amalgam—one surface, primary or permanent
D2150 Amalgam—two surfaces, primary or permanent
D2160 Amalgam—three surfaces, primary or permanent
D2161 Amalgam—four or more surfaces, primary or permanent

Resin Restorations (Composite Restorations)

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

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

Crowns—Single Restoration Only

D2710 Crown—resin-based composite (indirect) **(under 21 only)** (P.A.)
D2751 Crown—porcelain fused to predominantly base metal (P.A.)

Other Restorative Services

D2910 Recement inlay, onlay or partial coverage restoration
D2920 Recement crown
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)
D2954 Prefabricated post and core in addition to crown (P.A.)
D2980 Crown repair, by report (P.A.)
D2999 Unspecified restorative procedure, by report (P.A.) (I.C.)

606 Service Codes and Descriptions: Endodontic Services

See 130 CMR 420.426 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) (P.A.) (no limitation on number performed per treatment period)
D3320 Bicuspid (excluding final restoration) (**under 21 only**) (P.A.) (no limitation on number performed per treatment period)
D3330 Molar (excluding final restoration) (**under 21 only**) (P.A.) (no limitation on number performed per treatment period)

Apicoectomy/Periradicular Services

D3410 Apicoectomy/periradicular surgery—anterior (per tooth) (includes retrograde filling) (P.A.)
D3421 Apicoectomy/periradicular surgery—bicuspid (first root) (P.A.)
D3426 Apicoectomy/periradicular surgery (each additional root) (P.A.)

607 Service Codes and Descriptions: Periodontic Services

See 130 CMR 420.424 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) (P.A.)
D4341	Periodontal scaling and root planing—four or more teeth per quadrant (includes curettage) (once per quadrant per three-year period) (P.A.)

608 Service Codes and Descriptions: Prosthodontic (Removable) Services

See 130 CMR 420.427 for limitations.

Service Code	Service Description
	Complete Dentures (Including Routine Post-Delivery Care)
D5110	Complete denture—maxillary (P.A.)
D5120	Complete denture—mandibular (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) (P.A.)
D5212	Mandibular partial denture—resin base (including any conventional clasps, rests, and teeth) (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
D5520	Replace missing or broken teeth—complete denture (each tooth)

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

Repairs to Partial Dentures

D5610 Repair resin denture base
D5620 Repair cast framework
D5630 Repair or replace broken clasp
D5640 Replace broken teeth—per tooth
D5650 Add tooth to existing partial denture
D5660 Add clasp to existing partial denture

Denture Rebase Procedures

D5710 Rebase complete maxillary denture (P.A.)
D5711 Rebase complete mandibular denture (P.A.)
D5720 Rebase maxillary partial denture (cast partial denture only) **(under 21 only)** (P.A.)
D5721 Rebase mandibular partial denture (cast partial denture only) **(under 21 only)** (P.A.)

Denture Reline Procedures

D5750 Reline complete maxillary denture (laboratory) (P.A.)
D5751 Reline complete mandibular denture (laboratory) (P.A.)
D5760 Reline maxillary partial denture (laboratory) (cast partial denture only) (P.A.)
D5761 Reline mandibular partial denture (laboratory) (cast partial denture only) (P.A.)

609 Service Codes and Descriptions: Prosthodontic (Fixed) Services

See 130 CMR 420.427 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.)
D6999 Unspecified, fixed prosthodontic procedure, by report (P.A.) (I.C.)

610 Service Codes and Descriptions: Exodontic Services

See 130 CMR 420.429 for limitations.

Service Code	Service Description
	Extractions (Includes Local Anesthesia and Routine Postoperative Care)
D7111	Extraction, coronal remnants—deciduous tooth
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
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
D7230	Removal of impacted tooth—partially bony
D7240	Removal of impacted tooth—completely bony (P.A.)
D7280	Surgical access of an unerupted tooth **(under 21 only)** (P.A.)
D7283	Placement of device to facilitate eruption of impacted tooth **(under 21 only)** (P.A.)
	Surgical Procedures
D7310	Alveoplasty in conjunction with extractions—per quadrant
D7311	Alveoplasty in conjunction with extractions—one to three teeth or tooth spaces, per quadrant (I.C.)
D7320	Alveoplasty not in conjunction with extractions—per quadrant
D7321	Alveoplasty not in conjunction with extractions—one to three teeth or tooth spaces, per quadrant (I.C.)
D7340	Vestibuloplasty—ridge extension (second epithelialization) (P.A.)
D7410	Excision of benign lesion up to 1.25 cm
D7411	Excision of benign lesion greater than 1.25 cm
D7960	Frenulectomy (frenectomy or frenotomy)—separate procedure (S.P.)
D7963	Frenuloplasty
D7970	Excision of hyperplastic tissue—per arch (P.A.)
D7999	Unspecified oral surgery procedure, by report (P.A.) (I.C.)
D9930	Treatment of complications (postsurgical)—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)**
D8670	Periodic orthodontic treatment visit (as part of 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.)

611 Service Codes and Descriptions: Orthodontic Services (cont.)

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.)
D8999 Unspecified orthodontic procedure, by report **(under 21 only)** (P.A.) (I.C.)

612 Service Codes and Descriptions: General Anesthesia and IV Sedation Services

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	Deep sedation/general anesthesia—first 30 minutes
D9221	Deep sedation/general anesthesia—each additional 15 minutes (from 31 to 90 minutes)

613 Service Codes and Descriptions: Other Services

See 130 CMR 420.456 and 420.457 for limitations.

Service Code	Service Description
	Treatment of Physically or Developmentally Disabled Members
D9920	Behavior management, by report (P.A.)
	Unclassified Treatment
D9110	Palliative (emergency) treatment of dental pain—minor procedure (Other nonemergency medically necessary treatment may be provided during the same visit—that is, nonemergency codes may be billed in conjunction with D9110.)
D9940	Occlusal guard, by report **(under 21 only)** (P.A.)
D9941	Fabrication of athletic mouthguard **(under 21 only)**
D9999	Unspecified adjunctive procedure, by report (P.A.) (I.C.)

620 Service Codes and Descriptions: Medical Services (cont.)

Service Code	Service Description
99252	Initial inpatient consultation for a new or established patient, which requires these three key components: - an expanded problem-focused history; - an expanded problem-focused examination; and - straightforward medical decision making
99253	Initial inpatient consultation for a new or established patient, which requires these three key components: - a detailed history; - a detailed examination; and - medical decision making of low complexity
99254	Initial inpatient consultation for a new or established patient, which requires three key components: - a comprehensive history; - a comprehensive examination; and - medical decision making of moderate complexity
99255	Initial inpatient consultation for a new or established patient, which requires these three key components: - a comprehensive history; - a comprehensive examination; and - medical decision making of high complexity

EMERGENCY DEPARTMENT SERVICES

New or Established Patient

99281	Emergency department visit for the evaluation and management of a patient, which requires these three key components: - a problem-focused history; - a problem-focused examination; and - straightforward medical decision making
99282	Emergency department visit for the evaluation and management of a patient, which requires these three key components: - an expanded problem-focused history; - an expanded problem-focused examination; and - medical decision making of low complexity

620 Service Codes and Descriptions: Medical Services (cont.)

Service Code	Service Description
99283	Emergency department visit for the evaluation and management of a patient, which requires these three key components: - an expanded problem-focused history; - an expanded problem-focused examination; and - medical decision making of moderate complexity
99284	Emergency department visit for the evaluation and management of a patient, which requires these three key components: - a detailed history; - a detailed examination; and - medical decision making of moderate complexity
99285	Emergency department visit for the evaluation and management of a patient, which requires these three key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: - a comprehensive history; - a comprehensive examination; and - medical decision making of high complexity

621 Service Codes and Descriptions: Endodontic Services

See 130 CMR 420.426 for limitations.

Service Code	Service Description
	Periapical Services
D3410	Apicoectomy/periradicular surgery—anterior (per tooth) (includes retrograde filling) (P.A.)
D3421	Apicoectomy/periradicular surgery—bicuspid (first root) (P.A.)
D3426	Apicoectomy/periradicular surgery (each additional root) (P.A.)

622 Service Codes and Descriptions: Exodontic Services

See 130 CMR 420.429 for limitations.

Service Code	Service Description
	Extractions (including local anesthesia, suture removal, and routine postoperative care)
D7111	Extraction, coronal remnants—deciduous tooth
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
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
D7230	Removal of impacted tooth—partially bony
D7240	Removal of impacted tooth—completely bony (P.A.)