




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-78
May 2007

TO: Dental Providers Participating in MassHealth
FROM: Tom Dehner, Acting Medicaid Director 
RE: *Dental Manual* (Revisions to Regulations about Medicare Part D)

This letter transmits revisions to the dental regulations about Medicare Part D, as provided in the Massachusetts state budget for fiscal year 2007. The provision extends and expands the state pharmacy assistance available to MassHealth members who have Medicare.

The fiscal year 2007 budget extended the availability of one-time 30-day supplies of prescribed medications for members with Medicare for dates of pharmacy service from July 1, 2006, until December 31, 2006. After this supply, MassHealth paid for a one-time 72-hour supply of the prescribed medication, without a copayment. Effective July 1, 2006, payment for these one-time supplies will be available when a pharmacist is unable to bill a Medicare Part D plan or the point-of-sale facilitator (currently WellPoint/Anthem). Effective January 1, 2007, the one-time 30-day supplies will no longer be available, but MassHealth will still pay for a one-time 72-hour supply of prescribed medications.

Effective July 1, 2006, for cost-sharing assistance for MassHealth members who are enrolled in a Medicare Part D prescription drug plan, if the Medicare Part D copayment or deductible is in excess of the member's applicable MassHealth copayment, the MassHealth member will pay the applicable MassHealth copayment and MassHealth will pay the difference between the applicable MassHealth copayment and the amount charged by the Medicare Part D prescription drug plan.

These regulations are being issued as emergency regulations and are effective July 1, 2006.

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 and 4-13 through 4-30

OBSOLETE MATERIAL

(The pages listed here are no longer in effect.)

Dental Manual

Pages iv and 4-13 through 4-30 — transmitted by Transmittal Letter DEN-77

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(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.

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(3) Medicare Part D.

(a) Overview. 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.

(b) Medicare Part D One-Time Supplies. The MassHealth agency pays for one-time supplies of prescribed medications, as described in 130 CMR 406.414(C)(2)(a) and (b), if the medication is a MassHealth-covered medication and the MassHealth member would otherwise be entitled to MassHealth pharmacy benefits but for being eligible for Medicare prescription drug coverage. MassHealth prior authorization does not apply to such one-time supplies. Between January 1 and June 30, 2006, the MassHealth agency pays for the one-time supplies only if the MassHealth member's Medicare Part D prescription drug plan will not cover the prescribed medication at the time the prescription is presented. Effective July 1, 2006, the MassHealth agency pays for the one-time supplies in all instances in which the pharmacist cannot bill a Medicare Part D prescription drug plan at the time the prescription is presented.

(i) Between January 1 and December 31, 2006, the MassHealth agency pays for a one-time 30-day supply of prescribed medications. Any copayment that would have been charged to the member under MassHealth will apply to a one-time 30-day supply. After this supply of the prescribed medication, the MassHealth agency pays for a one-time 72-hour supply of the same prescribed medication.

(ii) Effective January 1, 2007, the MassHealth agency pays for a one-time 72-hour supply of prescribed medications.

(c) Cost-Sharing Assistance for MassHealth Members Enrolled in a Medicare Part D Prescription Drug Plan. For the purpose of 130 CMR 420.418(D)(3)(c)(i) and (ii), the "applicable MassHealth copayment" is the copayment the MassHealth member would pay for prescription drugs if the drugs were covered by MassHealth and not covered by Medicare Part D.

(i) Between January 1 and June 30, 2006, for MassHealth members who are enrolled in a Medicare Part D prescription drug plan and are charged a copayment in excess of the member's applicable MassHealth copayment for a drug that MassHealth would otherwise cover, the member pays the applicable MassHealth copayment and the MassHealth agency pays the difference to the pharmacy, up to the amount that the Medicare Part D prescription drug plan is permitted to charge an eligible enrollee who has both MassHealth and Medicare.

(ii) Effective July 1, 2006, for MassHealth members who are enrolled in a Medicare Part D prescription drug plan and are charged a copayment or deductible in excess of the member's applicable MassHealth copayment for a drug that MassHealth would otherwise cover, the member pays the applicable MassHealth copayment and the MassHealth agency pays the difference between the applicable MassHealth copayment and the amount charged by the Medicare Part D prescription drug plan.

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

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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.

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(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

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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

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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.

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(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.

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(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 periapical 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, bicuspid, 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:

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- (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.

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420.426: Service Descriptions and Limitations: Endodontic Services

The maximum allowable fee for endodontic services includes payments for all radiographs performed during the 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, bicuspid, 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.

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(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:

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- (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.

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(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.

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(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

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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.

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(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):

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(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.

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(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.