MassHealth Dental Program

Commonwealth of Massachusetts

Published February 1, 2026

Office Reference Manual

866-616-2699

MassHealthProviderEngagement@DentaQuest.com

www.masshealth-dental.org

Quick Reference Directory

Provider Services	Phone Number	E-mail Address	Mailing Address
Member Eligibility & Benefits	866-616-2699	MassHealthProviderEngagement@dentaquest.com	MassHealth-Eligibility & Benefits P.O. Box 2906 Milwaukee, WI 53201-2906
TDD (Hearing Impaired)	800-466-7566		
MassHealth Medical Customer Service (Oral Surgeons)			
MassHealth Medical Eligibility & Benefits	800-841-2900	providersupport@masshealth.net	
MassHealth Medical Fax Inquiries	617-988-8974		
Authorizations			
Prior Authorizations (PA)	866-616-2699		MassHealth Dental – PA P.O. Box 2906 Milwaukee, WI 53201-2906
Claims			
Paper Claims Submission	866-616-2699		MassHealth Dental – Claims P.O. Box 2906 Milwaukee, WI 53201-2906
90 Day Waiver/Final Deadline Appeals Request	866-616-2699		MassHealth Dental – 90 Day MassHealth Waiver/Final Deadline Appeals P.O. Box 2906 Milwaukee, WI 53201-2906
Electronic Claims			
EDI Claims Submission (837 Transactions) and Remittance Advice	866-616-2699		MassHealth Dental – Claims P.O. Box 2906 Milwaukee, WI 53201-2906
Via Website at www.masshealth-dental.org Via Clearinghouse Payer ID CKMA1	866-616-2699	EDIteam@dentaquest.com	
Provider Complaints and Fraud			
Provider Complaints	866-616-2699		MassHealth Dental – Claims P.O. Box 2906 Milwaukee, WI 53201-2906
Fraud Hotline	800-237-9139		

MassHealth offers you the ability to submit HIPAA-compliant claims to: www.masshealth-dental.org. You may also submit claims through an approved clearinghouse trading partner. Please contact your software vendor to ensure that the MassHealth Dental Program is listed as a payer. MassHealth is CKMA1. Please contact Customer Service at 866-616-2699 or your Provider Relations Representative.

Provider Enrollment			
Provider Enrollment MassHealth Dental- PEC	866-616-2699	MassHealthEnrollment&Credentialing@dentaquest.com	P.O. Box 2906 Milwaukee, WI 53201-2906

Thank you to all providers who currently participate with MassHealth. Your commitment to serving your community and providing the best possible care to our members is greatly appreciated. Our goal is to continue to raise the bar in terms of customer service. Please contact us if you have concerns, suggestions, or praise, as we continue to work together to promote oral health within the Commonwealth of Massachusetts.

Sincerely,
The MassHealth Team at DentaQuest

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What is the MassHealth Dental Program?

The MassHealth Dental Program is based upon Commonwealth of Massachusetts regulations governing dental services found in 130 CMR 420.000 and 130 CMR 450.000. All dental providers participating in MassHealth must comply with these regulations. Please refer to the MassHealth website for complete Dental and All Provider Manuals which contain the regulations: https://www.mass.gov/lists/dental-manual-for-masshealth-providers. If there is a conflict between this Office Reference Manual and the regulations, the regulations take precedence in every case.

The goals of the MassHealth Dental Program are to:

- Improve member access to quality dental care
- Improve oral health and wellness for MassHealth members
- Increase provider participation in the MassHealth Dental Program network
- Streamline program administration, making it easier for providers to participate
- Create a partnership between MassHealth and the Dental Community

Definitions

The following definitions apply to this Office Reference Manual (ORM):

- "Agreement" means the contract between EOHHS/MassHealth and the provider.
- "Appeal" is a member's right to contest to the Office of Medicaid Board of Hearings (BOH) pursuant to 130 CMR 610.000, orally or in writing, any adverse action.
- "Board of Registration in Dentistry (BORID)" is the dental licensing and disciplinary board in Massachusetts. BORID licenses dentists and dental hygienists, receives and investigates complaints against dentists, and is responsible for implementing state laws and regulations governing licensees' practice of dentistry.
- "Claim" means an itemized statement requesting MassHealth payment for dental services rendered by a dental provider to a member.
- "Clean Claim" means a claim that can be processed without obtaining additional information from the provider of the service or from a third party. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.
- "Coverage Type" is the scope of medical services, other services, or both that are available to MassHealth members who meet specific MassHealth eligibility criteria. MassHealth coverage types currently include: Standard, CarePlus, CommonHealth, Limited and Family Assistance. The scope of services for each coverage type is found at 130 CMR 450.105.
- "Covered Services" means a dental health care service or supply that is covered in accordance with 130 CMR 420.000 and Subchapter 6 of the *MassHealth Dental Manual*, including services covered through Prior Authorization for Early and Periodic, Screening, Diagnosis, and Treatment (EPSDT) eligible members, that satisfies all of the following criteria:
    - Is medically necessary;
    - Is covered under the MassHealth Dental Program;
    - Is provided to an enrolled member by a participating provider; and
    - Is the most appropriate supply or level of care that is consistent with professionally recognized standards of dental practice within the service area and applicable policies and procedures.
- "Customer" is a member, dental provider or applicant, or other interested party.
- "Dental Covered Services" are dental services that are covered by MassHealth as provided in 130 CMR 420.000 and Subchapter 6 of the *MassHealth Dental Manual.*
- "Dental Provider" is an individual dentist, community health center, hospital-licensed health center, dental clinic, acute hospital outpatient department, chronic disease and rehabilitation hospital outpatient department, dental laboratory, public health dental hygienist providing preventive services in public settings and dental schools or dental hygiene schools enrolled in MassHealth to provide dental covered services to members pursuant to a signed provider agreement.
- "Dental Specialist" is a dental provider that has specialized training, attended, and graduated from a Commission on Dental Accreditation dental specialty program and meets the MassHealth Dental Program credentialing criteria for pediatrics, orthodontics, oral surgery, endodontics, prosthodontics, or periodontics.

- "The MassHealth Dental Program Service Area" shall be defined as the Commonwealth of Massachusetts.
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT)" means the delivery of health care services to MassHealth Standard and CommonHealth members under the age of 21, pursuant to 42 USC 1396d(a)(4),42 CFR Part 441, subpart B, and 130 CMR 450.140 through 450.149 to ascertain children's individual physical and mental illness and conditions discovered by the screening services, whether or not such services are covered.
- "Emergency Services" means covered dental services furnished by a qualified provider that are needed to evaluate or stabilize an emergency medical condition that is found to exist using the prudent layperson standard.
- "EOHHS" means the Executive Office of Health and Human Services. EOHHS is the single state agency in Massachusetts responsible for the administration of MassHealth (Medicaid), pursuant to M.G.L. c. 118E and Titles XIX and XXI of the Social Security Act and other applicable laws and waivers. The term "EOHHS" may also be used to refer to the predecessor single state agency, the Executive office of Health and Human Services Division of Medical Assistance.
- "Fair Hearing" is an administrative adjudicatory proceeding conducted according to 130 CMR 610.000 et seq. to determine the legal rights, duties, covered services, or privileges of MassHealth members.
- "General Dentist" is a practitioner licensed by the Massachusetts Board of Registration in Dentistry (BORID) to practice dentistry in Massachusetts. A general dentist is the primary dental care provider for patients in all age groups, responsible for the diagnosis, treatment, management, and overall coordination of services related to patients' oral health needs.
- "Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a comprehensive federal law (Pub. L. 104-191) established to protect the security and privacy of individual health information. The law establishes national standards for the electronic exchange of the health information by payers and providers.
- "Intervention Services" are services designed to assist members in making and keeping dental appointments, assisting in obtaining transportation in accordance with applicable regulations to and from appointments, and follow-up with members and dental providers regarding appointments.
- "Mass.gov" is a publicly available, interactive website that connects MassHealth members, providers, and other entities to certain EOHHS systems by facilitating interaction with EOHHS and its systems.
- "MassHealth" (also referred to as Medicaid) is the Medicaid program of the Commonwealth of Massachusetts, administered by EOHHS pursuant to Title XIX of the Social Security Act (42 U.S.C. 1396), Title XXI of the Social Security Act (42 U.S.C. 1397), M.G.L. c. 118E, and other applicable laws and waivers to provide and pay for medical assistance for eligible members. More information about MassHealth can be found at www.mass.gov/masshealth.
- The "MassHealth Dental Manual" guides dental providers to regulations, administrative and billing instructions, and service codes. The MassHealth Dental Manual can be found athttps://www.mass.gov/lists/dental-manual-for-masshealth-providers.
- "Medically Necessary (or Medical Necessity)" refers to the standard set forth in 130 CMR 450.204.
- "Member" means an individual determined by EOHHS to be eligible for MassHealth, and for whom dental services are covered pursuant to 130 CMR 420.000 and 130 CMR 450.105.

- “Office Reference Manual” or “ORM” refers to this MassHealth Dental Program Office Reference Manual.
- “Prior Authorization (PA)” is the process by which a determination is made, before services are delivered, in accordance with 130 CMR 420.000 and 450.000.
- “Pre-Determination” is an optional process that delineates the anticipated amount and frequency of coverage so that a provider can inform the member, in advance of the anticipated coverage. Pre-determination is not prior authorization. For further details see ORM Section 5.0.
- “Provider” is an individual or entity that has signed a provider agreement with EOHHS.
- “Provider Agreement” is the signed contract between EOHHS and a provider that describes the conditions under which the provider agrees to furnish services to MassHealth members.
- Third-Party Liability (TPL) is the legal obligation of any person, entity, institution, company, or public or private agency, including a MassHealth member’s own insurer, to pay all or part of an individual’s medical expenses. Except where a specific agreement pursuant to 42 CFR 433.139 exists, MassHealth is in all instances the payer of last resort for MassHealth members. (The only exception is the Health Safety Net program whose funds are payable only to federally qualified community health centers).

Members' Rights and Responsibilities

Mission:

The mission of the MassHealth Dental Program is to expand access to high-quality and compassionate oral health services. The MassHealth Dental Program is committed to ensuring that all members are treated in a manner that respects their rights and acknowledges its expectations of members' responsibilities.

Statement of Members' Rights & Responsibilities:

Members shall have the rights and responsibilities to:

1. Receive up-to-date information about the MassHealth Dental Program, the services the MassHealth Dental Program provides, the participating providers and dental offices, as well as members' rights and responsibilities.

2. Privacy and to be treated with respect and recognition of their dignity when receiving dental care.

3. Participate with caregivers in the decision-making process surrounding their health care.

4. Be fully informed about the appropriate and medically necessary treatment options for any condition, regardless of the coverage or cost for the care discussed. Members also have the right to request a second opinion.

5. Voice a complaint against the MassHealth Dental Program, or any of its participating dental providers, for any of the care provided by these providers when their performance has not met the member's expectations.

6. Appeal any denial decision resulting from a prior authorization request related to patient care and treatment. Members may appeal directly to the Board of Hearings.

7. Make recommendations regarding the MassHealth Dental Program members' rights and responsibilities policies.

Likewise:

8. Provide, to the best of their abilities, accurate information that the MassHealth Dental Program and its participating dentists need to receive the highest quality of healthcare services.

9. Closely follow the treatment plans and instructions for the care that they have agreed upon with their dental practitioners.

10. Make every effort to keep dental appointments and to notify the dental practitioner as far in advance as possible if an appointment cannot be kept.

11. Participate in understanding their dental problems and developing mutually agreed upon treatment goals to the degree possible.

Statement of Provider Rights and Responsibilities

Providers shall have the right to:

1. Communicate with members regarding dental treatment options.

2. Recommend a course of treatment to a member, even if the course of treatment is not a covered service or approved by the MassHealth Dental Program.

3. Supply accurate, relevant, and factual information to any member in connection with an appeal or complaint filed by the member.

4. Provide feedback on policies, procedures or decisions made by the MassHealth Dental Program.

5. Charge an eligible MassHealth member for dental services that are not covered services only if the member knowingly elects to receive the services as a private-pay patient and enters into an agreement in writing to pay for such services prior to receiving them. Non-covered services include services not covered under the MassHealth Dental Program (except prior authorizations that are requested for non- covered services for members under age 21) and services for which pre-authorization has been denied and deemed not medically necessary.

6. Be informed in a timely manner of the status of their credentialing or re-credentialing application, upon request.

7. Determine the number of MassHealth members you wish to welcome into our practice.

Providers have the responsibility to:

1. Protect the patients'/members' rights to privacy.

2. Notify the MassHealth Dental Program of any changes in their practice information, including location, telephone number, limits to participation, providers joining or leaving the practice, etc. within 14 days of change.

3. Hold the MassHealth members harmless and to not bill any member for services if the services are not covered as a result of any error or omission by the provider.

4. Adhere to the MassHealth Provider Contract and regulations.

Affirmative Statement about Incentives

Healthcare professionals involved in the prior authorization decision-making process base their decisions on the existence of coverage and whether such coverage is medically necessary in accordance with MassHealth regulations 130 CMR 450.204: Administrative and Billing Regulations and 130 CMR 420.000: Dental Services. MassHealth and DentaQuest do not reward practitioners or other individuals for issuing denials of coverage or care and do not provide financial incentives or other types of compensation to encourage decisions that result in barriers to care.

**The MassHealth Dental Program makes every effort to maintain accurate information in this manual; however, the MassHealth Dental Program and its administrator will not be held liable for any damages directly or indirectly due to typographical errors. Please contact us should you discover an error.*

1.00 Provider Services

1.1 Dedicated Call Center for Dental Providers

The MassHealth Dental Program offers Participating MassHealth Dental provider's access to Customer Service Representatives who specialize in areas such as:

- Eligibility, covered services and authorizations;
- Claims, and
- Intervention Services

You can contact customer services at 866-616-2699

1.2 Provider Training

The MassHealth Dental Program offers free provider training sessions periodically throughout the Commonwealth of Massachusetts. These sessions include important information such as: claims submission procedures, prior authorization criteria, how to access the MassHealth Dental Program's clinical personnel, etc. In addition, providers can contact a MassHealth Provider Relations Representative for assistance, or to request a personal, in-office visit at 866-616-2699

1.3 Provider News

The MassHealth Dental Program publishes periodic provider news and newsletters that include helpful information of interest to providers. News updates are available via the MassHealth provider area of the website in the document section at www.masshealth-dental.org.

1.4 Provider Web Portal

The MassHealth Dental Program offers self-service options through the Internet that allow Participating MassHealth Dental Program provider's access to several helpful options including:

- Member eligibility and verification inquiry
- Member dental treatment history inquiry
- Participating provider directory for in-network referrals
- Submitting Prior Authorization Requests, Pre-Determination Requests & Claims
- Submitting Attachments
- Viewing claim status
- Retrieve Remittance Advice(s) – 835 reports
- Submit complaints, grievances, reconsiderations, and general inquiries
- Access important Forms, trainings, and the Office Reference Manual

1.5 Specialist Referral Process

A member requiring a referral to a dental specialist can be referred directly to any specialist participating in the MassHealth Dental Program without authorization from the MassHealth Dental Program. The dental specialist is responsible for obtaining prior authorization, if necessary, for covered services according to Appendix B of this manual. Providers who are unfamiliar with the MassHealth Dental Program specialty network or need assistance locating a certain specialist can contact the MassHealth Dental Program's Provider Relations Department at866-616-2699.

1.6 Provider Directory

The MassHealth Dental Program publishes an online provider directory for MassHealth members called "Find a Dentist". This provider directory includes: provider name, practice name (if applicable), office address(es), telephone number(s), provider specialty, office hours (if available), handicap accessibility, age range of accepted patients and languages spoken (if available). You can find the Find a Provider directory on the MassHealth website at www.masshealth-dental.org.

It is very important that providers notify the MassHealth Dental Program of any changes in practice information. Please contact our Professional Relations team at MassHealthProviderEngagement@DentaQuest.com or your assigned Dental Practice Specialist with any updates to your practice, including patient panel status, office closures, changes in associated practitioners or any other information.

Separately, providers should keep their offices' "capability and preference survey" data up-to-date through the MassHealth Dental Program secure provider website at**www.masshealth-dental.org**.

Use of Your Information

As a Participating Provider or a Participating Practice, you authorize MassHealth Dental Program, its affiliates, and its Plans to include Participating Provider and Participating Practice name(s) and practice information in provider directories, in marketing, administrative and other materials, and for legal and regulatory purposes. MassHealth Dental Program and Plans may be obligated to include name and practice information in their provider directories if required by applicable law. Additionally, Participating Provider's or Participating Practices' information (which may include sensitive personal information) may be used by MassHealth Dental Program, its affiliates, and Plans (as applicable) for the purposes described in your Dental Service Agreement(s) or this ORM, including but not limited to credentialing, recredentialing, and claims adjudication. MassHealth Dental Program and its affiliates may also disclose Participating Practice's and Participating Provider's information to third parties, including brokers and service providers, that help us conduct our business, including the provision of services, or as allowed by law. If we disclose such personal information to third parties, we require them to protect the privacy and security of this information.

1.7 Translation & Interpreter Services

Does our office need to pay and/or provide translation or interpreter services?

- All MassHealth participating providers are responsible for the reasonable coordination and cost of providing translation services.
- Reasonable steps may include written translations of documents, or oral language assistance from a qualified interpreter, either in-person or using remote communication technology.
- MassHealth does not reimburse for translation or interpretation services and the member may not be charged given it is a state and federal requirement.

What resources are available to my practice?

Resources from the Massachusetts Commission for the Deaf and Hard of Hearing to request an ASL Interpreter or CART provider (for a fee to be paid by the provider's practice):

https://www.mass.gov/how-to/how-to-request-an-asl-interpreter-or-cart-provider

Non-emergencies:
Voice: 617-740-1600, 8:45 a.m. to 5:00 p.m.
TTY: 617-740-1700 TTY, 8:45 a.m. to 5:00 p.m.

Legal emergencies:
Voice AND TTY: 800-249-9949, 24 hours a day, 7 days a week

1.8 Appointment Assistance

The MassHealth Dental Program's Customer Services Department uses technology to link MassHealth members to the closest and most appropriate dental provider. On occasion, members require special assistance making appointments due to geographic or special physical needs. The Customer Services Department is responsible for locating providers for members in emergency or difficult situations and assisting members with making appointments with a participating provider. Please call Customer services for appointment assistance related questions at 866-616-2699.

1.9 Non-Compliant Members

Broken appointments are a major concern for the MassHealth Dental Program. It is recognized that broken appointments are a costly and unnecessary expense for providers, and a goal of the program is to remove any barriers that prevent dentists from participating in the MassHealth Dental Program as well as barriers that prevent MassHealth members from utilizing their benefits. The first step to accurately identify and address the barriers, is to better track, trend and understand the issue.

The "Broken Appointment" feature allows providers to electronically submit the names of MassHealth members who have missed appointments.

Broken appointments are defined as those appointments that are not rescheduled or cancelled in accordance with a provider's office policies. The MassHealth Dental Program may use information reported by providers regarding broken appointments to educate members about the importance of keeping appointments and maintaining compliance with treatment plans. Providers may log broken appointments on the provider web portal 24 hours per day, 7 days per week.

Providers and dental offices are not allowed to charge MassHealth members for missed appointments per federal rules.

1.10 Office Compliance Verification Procedures

Participating MassHealth Dentists are required to afford the same appointment availability to MassHealth members as any patient within their practice. The MassHealth Dental Program recommends that under reasonable routine circumstances, an effort be made to ensure that care will be delivered as quickly as possible.

2.00 Eligibility Verification Procedures

2.1 MassHealth Dental Program Eligibility

Dental services are covered for eligible MassHealth members as specified in 130 CMR 450.105 and420.403. Members will receive a MassHealth ID card for services, including dental.

***Please note that MassHealth Limited members are covered for *emergency services* only. See 130 CMR 450.105(G). This information is displayed as Coverage Type on the Provider Web Portal.**

2.2 MassHealth Dental Program Eligibility Systems

Participating MassHealth Dental providers may access member eligibility information 24 hours a day, 7 days a week through the MassHealth Dental Program's provider web portal located at www.masshealth-dental.org. The eligibility information received from the system is the same information available by calling MassHealth Dental Program's Customer Services Department at (866-616-2699)

Access to Eligibility Information via the Internet:

The MassHealth Dental Program's provider web portal allows providers to verify a member's eligibility online by entering the member's date of birth and the member's identification number. Eligibility information is only valid on the day for which eligibility is requested.

To ensure that the member was showing active plan coverage on the Date of Service (DOS) in question, proof of eligibility (located on the "Member Detail" page) via the Provider Web Portal should be retrieved on the actual DOS and saved for your records. A print screen verification, or an OFFICIAL Time Stamp, will automatically appear on either the top or the bottom of the member detail page. Before printing screen for your records, please make sure page is in printer friendly format. Payment is not guaranteed and is subject to the terms of conditions of applicable MassHealth regulations, including but not limited to 130 CMR 420.000.

Also, please note patient treatment history is available on the MassHealth Dental Program secure website. The history information may not be all inclusive. This information is provided as a convenience to the provider and is not to be considered as a guarantee of payment.

To report any difficulty accessing either the website, please contact the Customer Service Department at (866-616-2699) or contact your Provider Relations representative directly. They will be able to assist in using the system.

3.00 Authorization for Treatment

3.1 Prior Authorization Request for CPT Code

Oral Surgery specialists requesting prior authorization (PA) for services listed with a Current Procedural Terminology (CPT) code must submit online to medical through the MMIS Provider Online Service Center (POSC) using the MassHealth Prior Authorization (PA-1) Form.

Oral surgery specialists must register for the Provider Online Service Center (POSC) by completing the Provider Enrollment Data Collection Form and Registration Instructions (DCFR). Please copy and paste the link below into your web browser.

https://www.mass.gov/doc/provider-enrollment-data-collection-form-and-registration-instructions-posc-hcbs-0/download

Note: MassHealth Medicaid Management Information System (MMIS) Provider Online Service Center (POSC) will not process 837 transactions or ADA claim forms with CDT codes. Oral Surgery specialists will continue to submit prior authorization requests and claims with the CDT codes on the ADA-2012 form for processing.

3.2 Covered Services Requiring Authorization

Under the MassHealth Dental Program, there are several services that require authorization via prior authorization or retrospective review. Authorization is a process which requires MassHealth providers to submit documentation substantiating the medical necessity of a requested dental service for a member. Participating providers' claims will not be paid if the required authorization is not requested and approved. Authorization is not a guarantee of payment.

The criteria are included in this manual in Section 16.00. Please review these criteria as well as the covered services to understand the decision-making process used to determine payment for services provided.

- Prior Authorization shall mean authorization requested and documentation submitted before treatment begins.
- Retrospective Review shall mean documentation submitted with a claim after treatment is rendered to determine payment of the service.

The MassHealth Dental Program uses specific dental criteria as well as an authorization process to provide medically necessary services to MassHealth members. The MassHealth Dental Program's operational focus is to assure compliance with the criteria specified in 130 CMR 420.000.

Services that require prior authorization should not be started before the determination of coverage (approval or denial of the authorization). Treatment requiring prior authorization started before the determination of coverage is performed at the financial risk of the dental provider.

Services that require retrospective review, but not prior authorization, will require proper documentation before consideration for payment. Documentation will also be required when a service that normally requires prior authorization is done on an emergency basis.

The table of Covered Services (Exhibit A) contains a column marked "Required Review". This column indicates that the service listed requires either prior authorization or documentation submitted with the claim for pre-payment review to be considered for reimbursement. The "Documentation Required" column describes what information is necessary for review, and whether it must be submitted on a prior authorization basis, or with a claim following treatment for retrospective review or pre-payment claim review.

After the review of a prior authorization request, a determination to approve or deny the request is made and the provider and member are notified within 21 days of receipt of the request. A prior authorization number is provided regardless of the decision to approve or deny the request. If the prior authorization request was approved, the authorization number must be entered on the claim.

Submission of documentation should include the following:

1. Radiographs, narrative, or other information where requested (see Appendix B)
2. For orthodontic prior authorization, the Orthodontic HLD Index Form for orthodontic treatment found in Appendix A, and if applicable, supporting medical necessity documentation. (See HLD form for further information).

Electronic Submissions:

Request for prior authorization may be submitted electronically through the MassHealth provider web portal link located at www/masshealth-dental.org. Prior authorization requests are processed in the order that they are received, not to exceed 21 calendar days.

Please see the extensive user guide for the MassHealth provider web portal located at wwww.masshealth-dental.org.

Paper Submissions:

Prior authorization requests may also be submitted using an ADA claim form only if you have an electronic claim submission waiver on file with MassHealth.

3.3 Authorization for Operating Room (OR) Elective Cases

Prior authorization (PA) is not required before services can be performed in an operating room (OR) of an Acute Hospital Outpatient Department, a Hospital-Licensed Health Center, a Chronic Disease and Rehabilitation Hospital Outpatient Department, or a Freestanding Ambulatory Surgical Center to allow the member to be sedated. The facility must participate with MassHealth for the facility fees to be considered by MassHealth.

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 or a freestanding ambulatory surgery center.

Trauma, Urgent and Accident (Non-elective) Cases

Services provided in a hospital emergency room are billed by the hospital to MassHealth as a hospital claim and do not require dental prior authorization.

If the dentist/oral surgeon is salaried or contracted to the hospital, then the hospital may bill for an additional amount for the professional (dental) services.

If the dentist/oral surgeon is not salaried or contracted to the hospital, then the dentist/oral surgeon may bill for the professional (dental) services.

3.4 Payment for Non-Covered Services

A provider may charge a MassHealth member for dental services which are not covered services only if the member knowingly elects to receive the services and enters into an agreement in writing to pay for such services prior to receiving them. Non-covered services include:

- Services not covered under the MassHealth Dental Program

- Services for which prior authorization has been denied and deemed not medically necessary

Please note that prior authorization may be requested for non-covered services under EPSDT (Early and Periodic Screening, Diagnostic, and Treatment) for eligible members under age 21 in accordance with 130 CMR 420.000.

Substitutions

Providers may upgrade medically necessary services at no additional cost to the MassHealth agency or the member. MassHealth allows participating dentists to provide a service of greater value and bill for the code covered by the program accepting the allowable rate. Providers must document the service that was provided in the notes section of the claim form and cite the applicable MassHealth regulations, including 130 CMR 420.409(B): Substitutions.

3.5 Electronic Attachments

The MassHealth Dental Program accepts claim attachments (radiographs, periodontal charts, narratives, pathology reports, EOB's, clinical documentation, etc.) for prior authorization requests and retrospective review electronically via the MassHealth Provider web portal at www.masshealth-dental.org (free of charge) and through participating claim clearinghouses (fees required).

Why is it important to submit all required / necessary attachments?

To ensure proper and timely processing of any prior authorization or retrospective review request all required documentation outlined within the Office Reference Manual must be submitted.

Additionally, if reconsideration is submitted due to an issue with a prior authorization request or retrospective review, please submit all needed documentation to allow for a full review of your request.

MassHealth Provider Web Portal

If you need assistance with the MassHealth provider web portal (www.masshealth-dental.org) please contact your Provider Relations Representative to schedule training at866-616-2699.

3.6 Member Transportation

Routinely, if the member is eligible for transportation, the Prescription for Transportation (PT-1) form request is submitted by the provider and processed by the Executive Office of Health and Human Services (EOHHS) Business Support Services unit (BSS).

- Who is eligible?

Any MassHealth member within a coverage type that includes transportation, such as Standard, CommonHealth, and CarePlus. Eligibility can be verified by entering the Member ID into the portal, an indicator will appear to the right of the patient information, and show "Y" or "N" for eligibility.

- Where can I find / submit the PT1 form?

Providers can electronically submit the required form online by registering for a user account from the home page, and by adding the treating provider/practice's PIDSL as the "Provider". Once registered, a individual's log in will allow access for submitting a PT-1 on the member's behalf. https://masshealth.ehs.state.ma.us/CWP/Default

Assistance / Checking Status

If you need assistance completing a PT-1 form or would like to check the status, please contact MassHealth at 1.800.841.2900, select prompt 2 for "MassHealth Providers", then prompt 3 for "all other providers", and prompt 7

for “questions” or prompt 3 to check on a submitted “transportation request.” Members can also be advised to check the status of their PT-1 via the member view page from the home page.

https://masshealth.ehs.state.ma.us/CWP/MemberPT1View

Be advised that it can take up to three (3) business days for MassHealth to process it once received.

3.7 Transfer or Release of Authorization

To transfer an unexpired authorization for services from one provider to another at the same location, the office must submit this request on office letterhead. The request must include the member name, member identification number, the provider name to which the service had been approved, the CDT code and identifying tooth or quadrant, and the name of the new provider who will be performing the service.

To transfer an unexpired authorization to a *new provider at a new location*, the provider who received the authorization must send a request to release the authorization via the provider web portal at www.masshealth-dental.org or in writing, using office letterhead. The request must identify the member and the authorized service that is being released. The provider to whom the patient is transferring for service must submit a request for authorization on an ADA claim form. These requests can be sent separately or together; however, an authorization will not be transferred until the release from the original provider has been received.

*Please allow 4-6 weeks for a transfer from submission to completion to occur. Requests for transfer or release of authorization can be mailed or faxed to:

MassHealth Dental- Claim
P.O. Box 2906
Milwaukee, WI 53201-2906

4.00 Claim Submission Procedures (Claim Filing Options)

The MassHealth Dental Program accepts dental claims through four possible methods. These methods include:

- Electronic claims via direct data entry at www.masshealth- dental.org. This is a secure, HIPAA-compliant, direct data-entry option.
- Electronic claims in the HIPAA-compliant 837D format via upload to our secure trading partner portal. Please contact the EDI team at EDIteam@dentaquest.com.
- to ensure your practice has the necessary software to generate a HIPPA compliant 837D file, requirements for set-up are reviewed, necessary configuration takes place and testing of transaction involved is completed.
- Electronic submission via a clearinghouse partner (payer ID: CKMA1).
- Paper claims on the ADA 2012 or newer claim form only for those providers who have an approved electronic claim submission waiver on file with MassHealth.

4.1 Electronic Claim Submission through direct data entry

Participating MassHealth providers may submit claims directly by entering them through our secure provider web portal site www.masshealth-dental.org. Submitting claims online is very quick and easy.

It is essential that providers access the MassHealth provider web portal to check a member’s eligibility prior to providing the service, as it provides accurate eligibility information on that day. Providers can also verify claims submission via the MassHealth Provider Web Portal.

For questions on submitting claims or accessing the website, please contact Provider Services at 866-616-2699.

4.2 Electronic Claim Submission via Clearinghouse

Providers may submit their claims through an approved Clearinghouse trading partner using payer ID CKMA1. Please contact your practice management software vendor or clearinghouse vendor for assistance. Your software vendor can provide any information needed to ensure that submitted claims are forwarded to the MassHealth Dental Program. The MassHealth Dental Program's Payer ID is CKMA1.

4.3 Paper Claim Submission

Paper claim submission is only permitted for practices that have an approved electronic claims waiver on file with MassHealth.

- Paper claims must be submitted on ADA 2012 or newer approved forms. If the claims are not submitted on ADA 2012 or newer forms, they will be returned unprocessed.
- Affix the proper postage when mailing bulk documentation. The MassHealth Dental Program does not accept postage-due mail. This mail will be returned to the sender and will result in delay of payment.
- Rejected claims are returned to the provider with a rejection letter. If a claim is denied due to missing or incorrect information, it is returned to the provider and may be resubmitted to the MassHealth Dental Program.

Paper claims are mailed to the following address (only for providers with approved electronic waivers on file with MassHealth):

MassHealth Dental -Claim
P.O. Box 2906
Milwaukee, WI 53201-2906

Requirements for Claim Submission

- Member name, identification number, and date of birth must be listed on all claim submitted.
- If the MassHealth member identification number is missing or miscoded on the claim form, the member may not be able to be identified. This could result in the claim being denied.
- The provider and office location information must be clearly identified on the claim.
- The MassHealth provider identification number must be included.
- The date of service must be provided on the claim form for each service line submitted.
- Approved ADA dental codes as published in the current CDT book and as defined in 130 CMR 420.000: Dental Services and this manual must be used to define all services.
- List all quadrants, tooth numbers and surfaces for dental codes that necessitate identification (extractions, root canals, amalgams, and resin fillings). Missing tooth and surface identification codes will result in the denial of claim payment.

Clinical & Benefit Rule Definitions

Each covered CDT code has a benefit limitation column within Exhibit A of this ORM. All benefit limitations are set-up with rules that establish how often services are payable.

4.4 Behavior Management

Prior Authorization / Retrospective Review:

Behavior management, D9920 requires review either: **prior** to treatment (prior authorization) or **post-treatment** (**Retrospective Review**), using the same clinical criteria. If there is an emergency and your office cannot send a prior authorization the claim will be reviewed upon submission (with narrative).

Retrospective Review Note:
When submitting a claim post-treatment for retrospective review please be sure to include a narrative that meets the requirements below.

Narrative Requirements:

- In accordance with MassHealth regulations (130 CMR 420.456(B): Behavioral Management), the MassHealth agency pays an additional payment once per member per day for the management of a severely and chronically mentally, physically, or developmentally impaired member in the office.
- The provider must document a history of treatment or previous attempts at treatment in the member's medical record
- Every prior authorization must be submitted with a member specific narrative clearly describing the member's severe and chronic mental, physical, or developmental disability and previous attempts at treatment which included extra staffing and type of behavior management technique utilized
- Generic copy / pasted language that is not member specific will not be accepted.

Number of Units:
Up to 12 units of behavior management can be requested / approved at a time. All approved units must be billed prior to requesting a new unit. The prior authorization is valid for 36 months from the date of approval. All units must be billed and paid before another prior authorization can be submitted / reviewed.

4.5 Third Party Liability (TPL)

Determination of a member's other insurance must be verified before submitting a claim for that member. To verify other coverage already known to MassHealth a provider may access the MassHealth Dental Program Website or call Member Services at (866-616-2699). Evidence of other insurance that has not been recorded by MassHealth should be submitted to the MassHealth Dental Program along with the claim and the primary carriers Explanation of Benefits (EOB).

Unless otherwise permitted by regulation, a provider is not entitled to receive or retain any MassHealth payment for a service provided to a member, if on that date of service the member had any other health insurance, including Medicare, that may have covered the service. See MassHealth regulations at 130 CMR 450.316(D).

MassHealth will not pay secondary claims if the provider is out of network with the primary insurance unless there is an out of network benefit allowed by the primary payor.

MassHealth members and providers may contact the TPL vendor at the following to report TPL insurance updates, new coverage, make corrections or report terminations:

Third-Party Liability (TPL) unit
Customer Support: 888-628-7526 (TTY: 617-886-8102)
Fax: 617-357-7604
Email: MassHealthTPL@accenture.com

Mailing Address:
Third-Party Liability (TPL) Unit
519 Somerville Ave #372
Somerville, MA 02143

Additional member information on TPL topics can be found on the MassHealth website. Members may be directed to the MassHealth website for information about having private health insurance in addition to MassHealth, the MassHealth Premium Assistance Program, and Coordination of Benefits for members with private insurance.

Website links:

1. MassHealth and private health insurance also known as Third Party Liability (TPL)
   Mass.Gov- https://www.mass.gov/info-details/masshealth-and-private-health-insurance-also-known-as-third-party-liability-tpl
2. MassHealth Coordination of Benefits (COB) | Mass.gov- https://www.mass.gov/info-details/coordination-of-benefits-for-masshealth-providers

Electronic claim submission is required for all providers unless they have an approved electronic claims waiver on file. TPL claims must include the code, description and the dates of service matching the information submitted to the primary carrier along with their payment and it must be indicated in the appropriate TPL field. Instruction on including information from other payers may be obtained from the 837-Dental or 837-Professional Companion Guide. The customer service team may be contacted to inquire about our testing procedures for electronically-submitted claims. Customer Service may be reached at 866-616-2699.

When MassHealth is not the primary insurance carrier, a copy of the primary carrier's Explanation of Benefits (EOB) must be submitted with the claim. MassHealth is always the payer of last resort (the only exception is the Health Safety Net Program which applies only to Acute Outpatient Hospitals, Acute Inpatient Hospitals, Chronic Disease and Rehabilitation Outpatient Hospitals, Community Health Centers, and Hospital Licensed Health Centers), and therefore, any additional payers known to MassHealth must be billed first. Each line on the EOB should be listed as a separate claim line. The Remittance Advice will include these claims, and indicate the amount charged, the amount paid by the primary insurer(s) and the MassHealth payment. Approved claims are paid up to the MassHealth allowed fees or to the charged amount, whichever is lower.

4.6 Filing Limits

General Requirements: MassHealth Dental Program claims must be received within 90 days of the date of service or the date of the explanation of benefits from another insurer. Any claim received beyond the 90-day timely filing limit specified in the contract will be denied for "untimely filing." If a claim is denied for "untimely filing" the provider cannot bill the member.

90-Day Waiver: For claims that are not submitted within the 90-day period but that meet one of the exceptions specified below, a provider must request a waiver of the billing deadline. The exceptions are as follows:

1. The service was provided to a person who was not a member on the date of service, but was later enrolled as a member for a period that includes the date of service;
2. The service was provided to a member who failed to inform the provider in a timely fashion of the member's eligibility for MassHealth; and
3. Other exceptions that are expressly authorized by the MassHealth agency pursuant to a MassHealth transmittal letter or provider bulletin.

For further details, please refer to the MassHealth regulations at 130 CMR 450.309.

Time Limitation on Submission of Claims for Members with Other Health Insurance: In accordance with MassHealth regulations at 130 CMR 450.313, third party liability (TPL) claims must be received within 90 days of the date of the notice of final disposition from the other insurer and no later than 18 months after the date of service.

Corrections may be made to claims that were initially timely received up to 12 months from the date of service. For TPL claims, the correction deadline is extended to 18 months.

Voids, Corrected Claims: When a claim is entered incorrectly via the MassHealth provider web portal, a provider can void that claim online via the web portal and enter a new, corrected claim.

Final Deadline Appeals: Providers may submit a Final Deadline Appeal for adjudicated claims with dates of service exceeding the applicable 12- or 18-month correction deadlines if the claim was timely submitted initially and is for a date of service within 36 months. The appeal must be received within 30 days of the date the claim was denied for exceeding the final submission deadline and the provider must demonstrate that the claim was denied or underpaid as the result of a MassHealth error.

For further details on Final Deadline Appeals, please refer to MassHealth regulations at 130.CMR 450.323.

4.7 Remittance Information

Providers receive remittance information about their submitted claims in two ways:

1. Through the EDI 835 transaction
2. Through an electronic remittance advice posted to the MassHealth secure provider website.

Please contact our Customer Service Department at 866-616-2699 with any questions about claim submission or information on your remittance advice.

4.8 Claim Submission and Payment for Operating Room (OR) Cases

Facility and anesthesia services for operating room cases do not require prior authorization as outlined in ORM Section 3.3.

4.9 Rural Add-On Payment

MassHealth offers a rural add-on encounter payment for participating dental providers in the following five counties: Barnstable, Dukes, Berkshire, Franklin, and Hampshire.

MassHealth has determined that these five counties are eligible for this rural add-on payment based on the following criteria:

- Counties that are >25% rural, based on U.S. Census data (Berkshire, Dukes, Franklin, & Hampshire), OR
- Counties that the Health Resources and Services Administration (HRSA) has designated as High Needs Geographic Area. (Barnstable)

MassHealth Dental Providers that are eligible must render covered dental services to MassHealth members at their business practice address within the five counties stated above to receive the encounter fee.

Public Health Dental Hygienists (PHDHs) must render covered dental services to MassHealth members in a servicing location within the five counties stated above. PHDHs are required to maintain adequate servicing location documentation to validate that covered dental services were rendered within one of the five eligible counties.

Eligible Providers

MassHealth participating dental providers are eligible for this encounter payment when rendering covered services to a MassHealth member at their business practice address in the five counties. Participating PHDHs are eligible to bill for this encounter payment when rendering covered dental services in the five counties.

The following dental providers are eligible for this encounter payment: individual dentists, public health dental hygienists, group practices, dental clinics, and dental schools.

How to Bill

Eligible dental providers may bill for the encounter code (D9450) paid at $31 per visit. The code may only be billed at a frequency of one per member, per provider, per day. The code is only payable when submitted with another payable service. D9450 will be denied unless there is at least one payable procedure code on the same date of service.

4.10 Claim Submission for CPT Codes

Oral Surgery specialists must submit claims with CPT codes on the CMS-1500 Form, transmit electronically through the 837P format, or direct data entry (DDE) using the Web-based medical Provider Online Service Center (POSC). Instructions for submitting a claim using CPT codes are described on the MassHealth website under Provider Regulations and Other Publication/Provider Library/MassHealth Provider Forms. Refer to Subchapter 6 of the *MassHealth Dental Manual* for covered CPT codes.

Oral surgery specialists can register for the Provider Online Service Center (POSC) by completing the Data Collection Form and Registration Instructions (DCFR). Please go to www.mass.gov and type in the search box: "data collection form", then click on the form title **Provider Enrollment Data Collection Form and Registration Instructions.** Follow the form's instruction for submission.

Note: DentaQuest will not process 837P transactions or any claims billed on the CMS-1500 claim form. These claims must be submitted to MassHealth as described in the two paragraphs above.

5.00 Claim Review

DentaQuest conducts individualized (i.e., per unique claim per member) claim reviews on behalf of the MassHealth Dental Program. All claim reviews are conducted by licensed dentist consultants in accordance with MassHealth regulations.

5.1 Pre-payment Claim Review

Pre-payment claim reviews occur after the service has been rendered. DentaQuest conducts pre-payment claim reviews in order to make benefit determinations for dental covered services. The review includes a determination as to whether the service was rendered in accordance with MassHealth regulations, this includes but is not limited to:

- member eligibility determination;
- provider eligibility determination;
- determination that the services are covered under the member's plan and/or are not payable under another policy for coordination of benefit purposes;
- determination that the service is medically necessary and meets the applicable standards of care and is not duplicative of another service.

When clinical review is needed for pre-payment claim review, documentation must be submitted with the claim. Please see Section 6.0 for the general documentation requirements. Claims missing required documentation will be pended and providers will be notified of the missing documentation.

DentaQuest may conduct pre-payment claim review as a form of surveillance to detect the up-coding of certain procedures, including but not limited to prophylaxis to scaling and root planning ("SRP"), simple extractions to surgical when not supported by radiographic documentation, and the un-bundling of various procedures such as radiographs, palliative treatment, fillings, core buildup and others that have historically been prone to miscoding.

This surveillance activity assures that DentaQuest makes benefit determinations in accordance with MassHealth regulations, including but not limited to 130 CMR 420.000 and 130 CMR 450.000, and is able to detect potential fraud, waste and abuse proactively rather than relying on retrospective audits and subsequent recoupment policies. When instances of up-coding or un-bundling are detected, DentaQuest may deny the submitted procedure codes and/or further pend a given claim for additional documentation.

Because these claim review practices are conducted on a concurrent or retrospective (i.e. after services have been rendered) pre-payment basis, they do not constitute prior authorization or utilization review.

5.2 Optional Pre-Determination Review

Prior to rendering a dental covered service that is not subject to prior authorization, providers have the option to request a pre-determination review. A pre-determination review includes a determination as to whether the proposed services in the proposed treatment plan submitted by the provider are anticipated to be covered in accordance with MassHealth regulations, this includes but is not limited to consideration of the following:

- the member's current eligibility status;
- the provider's current eligibility status;
- whether the proposed services are covered under the member's plan and/or are not payable under another policy for coordination of benefit purposes;
- determination that the proposed dental services are anticipated to be medically necessary and are not anticipated to be duplicative of another service.

Pre-determination delineates the anticipated amount and frequency of coverage so that a provider can inform the member, in advance, of the anticipated coverage. Providers are not required to request pre-determination.

Pre-determination is not:

- prior authorization for a provider to perform the proposed service;
- a determination that the proposed service will be determined medically necessary and/or to meet the applicable standards of care in any review that occurs after the proposed service is rendered;
- a guarantee of payment or of the availability of coverage.

Request for pre-determination may be submitted electronically through the MassHealth provider web portal link located atwww.masshealth-dental.org. Pre-determination requests must include the required documentation as summarized in Section 6.00 and Exhibit A.

After the review of a pre-determination request, a determination to approve or deny the request is made and the provider is notified. A pre-determination number is provided regardless of the decision to approve or deny the request. If the pre-determination request was approved, the approval number must be entered on the claim. Pre-determination approvals expire after one year.

7.00 Health Insurance Portability and Accountability Act (HIPAA)

Healthcare providers are required to comply with all aspects of the HIPAA regulations that are in effect as indicated in the final publications of the various rules covered by HIPAA.

- Use of the National Provider Identifier (NPI) as a single provider identifier is required for all health care providers that conduct standard electronic transactions. Application for an NPI may be obtained through https://nppes.cms.hhs.gov or by calling: 800-465-3202.

The MassHealth Dental Program has implemented various operational policies and procedures to ensure that it is compliant with those aspects of HIPAA that apply to payers.

- Maintenance of adequate dental/medical, financial, and administrative records related to covered dental services rendered by providers in accordance with federal and state law;
- Safeguarding of all information about members according to applicable state and federal laws and regulations. All material and information, in particular information relating to members or potential members, which is provided to or obtained by or through a provider, whether verbal, written, electronic media, or otherwise, shall be reported as confidential information to the extent confidential treatment is provided under state and federal laws;
- Neither the MassHealth Dental Program nor the provider shall share confidential information with anyone other than the member or the member's eligibility representative without the member's consent for such disclosure;
- Providers must agree to comply with the requirements of HIPAA relating to the exchange of information and shall cooperate with the MassHealth Dental Program in its efforts to ensure compliance with the privacy regulations promulgated under HIPAA and other related privacy laws.

Provider and the MassHealth Dental Program agree to conduct their respective activities in accordance with the applicable provisions of HIPAA and such implementing regulations. The MassHealth Dental Program requires providers to submit all claims with the proper CDT codes in accordance with Subchapter 6 of the *MassHealth Dental Manual*, this Office Reference Manual, and MassHealth regulations at 130 CMR 420.000. In addition, all paper claims must be submitted on the current approved ADA 2012 or newer claim form.

Note: Copies of the MassHealth Dental Program's HIPAA policies are available upon request by contacting the MassHealth Dental Program's Provider Services Department at 866-616-2699 or via the provider web portal at www.masshealth- dental.org

8.00 Member Complaints and Appeals & Provider Inquiries, Complaints, Reconsideration and Peer-to-Peer Review

8.1 Member Complaints

Members may submit complaints to the MassHealth Dental Program telephonically, via the MassHealth Member Portal via the link at www.masshealth-dental.org member tab or in writing on any MassHealth Dental Program issue other than decisions that deny, delay, reduce, or terminate dental services.

Some examples of complaints include: the quality of care or services received, access to dental care services, provider care and treatment, or administrative issues. In cases where the complaint cannot be resolved telephonically, the member will be assisted in submitting a member complaint form.

Written member complaints should be directed to:

MassHealth Dental Program
Attention: MassHealth Intervention Services
P.O. Box 2906
Milwaukee, WI 53201-2906

The complaint form is available online and in hard-copy upon request.

The MassHealth Dental Program may respond to written member complaints immediately, if possible, but typically responds within 30 business days from the date a written member complaint is received.

8.2 Member Appeals

Members will be informed of their right to appeal any adverse decision the MassHealth Dental Program has made to deny, reduce, delay, or terminate dental services. Members may request assistance with filing an appeal by contacting the MassHealth Dental Program at 866-616-2699.

The Request for a Fair Hearing form is available online or in hard copy upon request.

The Request for a Fair Hearing Form must be submitted within 60 days from the date of receipt of the adverse decision notice. If the member did not receive a written notice of the action, or if MassHealth did not take an action on the member's MassHealth application, the member must file a request for a fair hearing no later than 120 calendar days from the date the action takes place or the date of the member's MassHealth application.

Hearings are held at the 100 Hancock Street in Quincy and at the MassHealth Enrollment Centers in Taunton, Springfield, Tewksbury, and Revere. Members are notified at least 10 days in advance of the date, time, and place, along with a brief description of the issue, so they can appear at the hearing in person. Members usually have a brief oral hearing, but they may request a telephonic hearing.

Members who do not attend a scheduled hearing are documented as such and the case is dismissed. If they fail to call or be granted a rescheduled hearing, a letter is sent to the appellant informing them of the dismissal. They are then given 10 days from the date of the letter to request in writing a rescheduled hearing. A dismissal is vacated only for "good cause", a standard set out in 130 CMR 610.000.

Note: Copies of the MassHealth Dental Program policies and procedures can be requested by contacting Provider Services at (866-616-2699).

8.3 Provider General Inquiries & Complaints

A General Inquiry is a type of request that is not related to a reconsideration denial. It's when you're trying to reach a specific department for help with administrative processes such as:

- Location Information Change
- Provider Authorization Department (Orthodontic Prior Authorization Release, Transfers, & Extension request.

A Complaint is an expression of concern related to MassHealth Dental Program operations that is not a General Inquiry.

Providers may submit complaints and general inquiries to the MassHealth Dental Program via the MassHealth Provider Web Portal or in writing. General inquiries and complaints must be submitted in writing in the manner and format designated by the MassHealth Dental Program. Written provider complaints should be directed to:

MassHealth Dental Program
P.O. Box 2906
Milwaukee, WI 53201-2906

8.4 Provider Reconsideration Requests and Peer-to-Peer Review

Reconsideration is a disagreement regarding a clinical or administrative claim decision or authorization decision. Providers must submit reconsideration requests within 30 days of the date of the clinical or administrative claim decision or authorization decision.

- Occasionally, a dentist or staff member may question the benefit determination of a claim or authorization request and may wish to submit a request for reconsideration.
- For a reconsideration, it is important to state the reason(s) why you disagree with the decision.
- Our team will investigate (in collaboration with the dental consultant team) using documentation submitted with the original request plus any new evidence submitted through the reconsideration to render a decision.

Providers may submit reconsideration requests to the MassHealth Dental Program via the MassHealth Provider Web Portal or in writing. Reconsideration requests must be submitted in writing in the manner and format designated by the MassHealth Dental Program. Reconsideration requests must be submitted within 30 days of the determination at issue. Some examples of reconsideration requests include:

- Denial of a prior authorization that the provider feels should be approved due to new information (information not submitted with the case originally). Submit thorough documentation including a narrative containing new information on office letterhead with the date of submission and clear photographs / radiographs (if appropriate).
- Claim denials due to tooth previously extracted, if the tooth in question was not extracted previously and a recent radiograph, clinical notes and a narrative can be submitted.
- Untimely filing denials
- Denials for service not billable due to denture placement when teeth are still present. Submit a recent radiograph of the tooth / teeth in question, clinical notes, and a narrative on office letterhead.
- Patient not eligible denials – Provide a copy of proof of eligibility from the member eligibility detail screen or member eligibility list from the date of service. Documentation provided must be time and date stamped for the patient's actual date of service.

Provider Reconsideration

For prior authorization denials, pre-payment review denials or retrospective review denials that are denied for administrative reasons (e.g., administrative denials of claims due to eligibility, frequency limitations, and/or service limitations), the reconsideration process involves the MassHealth Dental Program reviewing the submitted information and other pertinent information to reconsider whether the eligibility, frequency limitations, and/or service limitations identified in the denial apply to the claim or prior authorization request at issue.

For prior authorization denials, pre-payment review denials or retrospective review denials that are denied for clinical reasons (i.e., a lack of medical necessity), the reconsideration review process involves reconsideration of the original dentist consultant's determination by a different dental consultant. Providers should submit additional documentation and medical necessity narrative justification to support their reconsideration request.

Peer-to-Peer Review

A provider that has submitted a reconsideration request and has received a reconsideration denial may request a peer-to-peer review of the denied reconsideration request at issue. A peer-to-peer review is a discussion between the provider and the dental consultant that reviewed the denied reconsideration request or other consultant as designated by the MassHealth Dental Program. If, after a peer-to-peer review, the MassHealth Dental Program determines in its sole discretion, in accordance with the applicable MassHealth regulations and sub-regulatory documents, that the denied reconsideration request should be approved, the request will be approved. Otherwise, the request will remain denied.

Providers must request peer-to-peer review within 30 days of the date of the reconsideration denial. Peer-to-peer review requests must be submitted in the manner and format as directed by the MassHealth Dental Program. A request for peer-to-peer review does not guarantee that the requesting provider will receive such review. A peer-to-peer review request will only be granted if the MassHealth Dental Program determines that a discussion will provide additional information or assist the provider in understanding MassHealth's medical necessity guidelines.

If peer-to-peer review is granted, the provider will be instructed to contact the Grievance and Appeals department to schedule a peer-to-peer review. Peer-to-peer reviews are scheduled based upon consultant availability.

Members retain their right to fair hearing for PA denial in accordance with applicable regulations separate and apart from the peer-to-peer process. Note that a provider's request for peer-to-peer review does not toll or extend the time for a member to request a fair hearing.

9.00 Utilization Management Program

9.1 Introduction

Under the provisions of federal regulations, the MassHealth Dental Program must provide for continuing review and evaluation of the care and services paid through Medicaid, including review of utilization of the services by providers and by members. These reviews are mandated by Title 42 of the Code of Federal Regulations, Parts 455 and 456.

The MassHealth Dental Program conducts periodic utilization reviews on all providers. In addition, the MassHealth Dental Program conducts compliance reviews on providers that are found to provide services in excess of established norms, or by referrals and complaints from agencies or individuals.

Participating providers are responsible for ensuring that requirements for services rendered are met in order to receive payment from the MassHealth Dental Program. Under the MassHealth Provider Agreement, the provider also agrees to give access to records and facilities to MassHealth Dental Program representatives upon reasonable

request. This section provides information on utilization review and control requirement procedures conducted by MassHealth Dental Program personnel.

9.2 Community Practice Patterns

In following with the requirements described in Section 9.1 above, the MassHealth Dental Program has developed a philosophy of Utilization Management that recognizes the fact that there exists, as in all health care services, a relationship between the dentist's treatment planning, treatment costs, and treatment outcomes. The dynamics of this relationship, in any region, are reflected by the community practice patterns of local dentists and their peers. With this in mind, the MassHealth Dental Program's Utilization Management Programs are designed to ensure the fair and appropriate use of federal and state program dollars as defined by the regionally based community practice patterns of local dentists and their peers.

All utilization management analysis, evaluations, and outcomes are related to these patterns. The MassHealth Dental Program's Utilization Management Programs recognize that there exists a normal individual dentist variance within these patterns among a community of dentists and accounts for such variance. Also, specialty dentists are evaluated as a separate group and not with general dentists since the types and nature of treatment may differ.

The MassHealth Dental Program will monitor the quality of services delivered under the MassHealth Provider Agreement and initiate corrective action where necessary to improve quality of care, in accordance with that level of dental care that is recognized as acceptable professional practice in the respective community in which the provider practices and/or the standards established by EOHHS for the MassHealth Dental Program.

9.3 Evaluation

The MassHealth Dental Program's Utilization Management Programs evaluate claims submissions in such areas as:

- Diagnostic and preventive treatment
- Patient treatment planning and sequencing
- Types of treatment
- Treatment outcomes; and
- Treatment cost effectiveness

9.4 Results

With the objective of ensuring the fair and appropriate distribution of these "budgeted" Medicaid Assistance Dental Program dollars to dentists, the MassHealth Dental Program's Utilization Management Programs will help identify those dentists whose patterns show significant deviation from the normal practice patterns of the community of their peer dentists (typically less than 5% of all dentists). When presented with such information, dentists may be asked to implement modifications of their diagnosis and treatment processes to bring their practices back within the normal range. However, in some isolated instances, it may be necessary to recover reimbursement. Providers will be required to refund payments if they are found to have billed contrary to law, regulation, or the MassHealth Dental Program policy or failed to maintain adequate documentation to support their claims.

9.5 Fraud, Waste, and Abuse

The MassHealth Dental Program is committed to detecting, reporting, and preventing potential fraud and abuse. Fraud and abuse for the MassHealth Dental Program are defined as follows:

Fraud: Intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized service to himself or some other person. It includes any act that constitutes fraud under federal or state law.

Waste: The overutilization or inappropriate utilization of services and misuse of resources, and typically is not a criminal or intentional act.

Abuse: "Abuse" means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the MassHealth, or in reimbursement for services that are not medically necessary or that otherwise fail to comply with the applicable MassHealth regulations and sub-regulatory documents. "Abuse" also includes member practices that result in unnecessary cost to MassHealth.

Aberrant Provider Practice Patterns: Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary cost to the program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.

Member Fraud: ID fraud, drug-seeking behavior, or any other fraudulent behavior.

10.00 Quality Improvement Program

The MassHealth Dental Program administers a Quality Improvement (QI) Program. The Quality Improvement Program includes but is not limited to:

- Provider credentialing and re-credentialing;
- Member satisfaction surveys;
- Provider satisfaction surveys;
- Random chart audits;
- Member grievance monitoring and trending;
- Review process;
- Utilization management and practice patterns; and
- Quarterly quality indicator tracking (i.e., member complaint rate, appointment waiting time, access to care, etc.).

A copy of the MassHealth Dental Program's QI Program is available upon request by contacting the MassHealth Dental Program's Provider Services Department at 866-616-2699.

11.00 Credentialing

The MassHealth Dental Program has the sole right to determine which dentists (DDS or DMD) or dental providers it shall accept and continue as participating providers. The purpose of the credentialing plan is to provide a general guide for the acceptance, discipline, and termination of participating providers. The MassHealth Dental Program considers each provider's potential contribution to the objective of providing effective and efficient dental services to MassHealth members.

Upon receipt of a signed and dated agreement and application from a potential new provider, the MassHealth Dental Program will verify the following credentialing criteria:

- Current licensure status;
- Current valid anesthesia license (if applicable);
- Current valid DEA/CDS registration;
- Current professional liability insurance policy that indicates carrier name, policy number, expiration date and policy limits;
- History of State licensing sanctions or reprimands;
- Medicare/Medicaid sanctions history;
- Malpractice claims history.

Following successful verification, the provider will be enrolled in the MassHealth Dental Program. EOHHS has the final decision-making power regarding participation in the MassHealth Dental Program.

11.1 Appeal of Credentialing Committee Recommendations

If the Credentialing Committee recommends acceptance with restrictions or the denial of an application, the Committee offers the applicant an opportunity to appeal the recommendation.

The applicant must request a reconsideration/appeal in writing and the request must be received by the MassHealth Dental Program within 30 days of the date the Committee gave notice of its decision to the applicant.

11.2 Discipline of Providers

The Credentialing Committee may recommend the discipline of a Participating Provider for substandard performance, failure to comply with the administrative requirements set forth, or the professional criteria, or any other reason the Credentialing Committee deems appropriate.

11.3 Procedures for Discipline and Termination

Providers have the right to appeal decisions for discipline or termination made by MassHealth. There are two levels of appeal available to providers. A written request for appeal, along with additional documentation supporting the provider's position, must be made to the MassHealth Dental Program within 30 days of the Credentialing Committee's original decision for discipline or termination. If an unfavorable decision is made after the first Appeal, the provider may request a second Appeal, as long as it is made within 30 days of the last decision. If an Appeal is not requested within the 30-day time frame of either the first or second decision, the Credentialing Committee's decision becomes final and the provider waives all rights to further appeal.

Providers may send a written appeal to the address included on their notice.

11.4 Re-credentialing

Network providers are re-credentialed at least every 5 years.

Note: The aforementioned policies are available upon request by contacting the MassHealth Dental Program's Provider Services at 866-616-2699.

12.00 The Patient Record

See MassHealth Regulations at 130 CMR 420.414.

12.1 Organization

The record must have areas for documentation of the following information:

- registration data including a complete health history
- medical alert predominantly displayed in patient record
- initial examination data to include screening for oral cancer and results
- radiographs
- periodontal and occlusion status
- treatment plan/alternative treatment plan
- progress notes to include diagnosis, preventive services, treatment rendered, and medical/dental consultations; and
- miscellaneous items (correspondence, referrals, consent for treatment or agreement to pay for non-covered services and clinical laboratory reports)

The design of the record must provide the capability for periodic update, without the loss of documentation of the previous status, of the following information:

- health history
- medical alert
- examination/recall data
- radiographs
- periodontal status; and
- treatment plan

The design of the record must ensure that all permanent components of the record are attached or secured within the record. The design of the record must ensure that all components must be readily identified to the patient, i.e., patient name, and identification number on each page. The organization of the record system must require that individual records be assigned to each patient.

12.2 Content: The Patient Record Must Contain the Following:

A. Adequate documentation of registration information that requires entry of these items:

- patient's first and last name
- date of birth
- gender
- address
- e-mail address
- language preference/need for an interpreter
- name and telephone number of the person to contact in case of emergency

B. An adequate health history that requires documentation of these items:

- current medical treatment
- significant past illnesses
- current medications
- drug allergies
- hematologic disorders
- cardiovascular disorders
- respiratory disorders
- endocrine disorders
- communicable diseases
- neurologic disorders
- signature and date by patient
- signature and date by reviewing dentist
- history of alcohol, tobacco usage including smokeless tobacco, marijuana and opioid or other narcotics

C. An adequate update of health history at subsequent recall examinations which requires documentation of these items:

- significant changes in health status
- current medical treatment
- current medications
- dental problems/concerns
- signature and date by reviewing dentist

D. Medical Alert- It is recommended that a readily visible placed medical alert be placed in patient record, whether electronic or paper that documents medical alerts from health history. These items are:

- health problems which contraindicate certain types of dental treatment
- health problems that require precautions or pre-medication prior to dental treatment
- current medications that may contraindicate the use of certain types of drugs or dental treatment
- Medication allergies and / or sensitivities
- infectious diseases that may endanger personnel or other patients

E. Adequate documentation of the initial clinical examination which is dated and requires descriptions of findings in these items:

- blood pressure (recommended)
- head/neck examination
- soft tissue examination
- periodontal assessment
- occlusion classification
- dentition charting (noting active and treated caries)

F. Adequate documentation of the patient's status at subsequent Periodic/Recall examinations which is dated and requires descriptions of changes/new findings in these items:

- blood pressure (recommended)
- head/neck examination
- soft tissue examination
- periodontal assessment
- dentition charting (noting active and treated caries)

G. Radiographs which are:

- identified by patient name.
- dated
- designated by patient's left and right side
- mounted (if intraoral films)
- An indication of the patient's clinical problems/diagnosis

H. Adequate documentation of the treatment plan (including any alternate treatment options) that specifically describes all the services planned for the patient by entry of these items:

- procedure
- localization (area of mouth, tooth number, surface)

I. An adequate documentation of the periodontal status, which is dated and requires charting of the location and severity of these items:

- periodontal pocket depth
- furcation involvement
- mobility
- recession
- adequacy of attached gingiva
- missing teeth

J. An adequate documentation of the patient's oral hygiene status and preventive efforts which requires entry of these items:

- gingival status
- amount of plaque
- amount of calculus
- education provided to the patient
- patient receptiveness/compliance
- recall interval
- date

K. An adequate documentation of medical and dental consultations within and outside the practice which requires entry of these items:

- provider to whom consultation is directed
- information/services requested
- consultant's response

L. Adequate documentation of treatment rendered which requires entry of these items:

- Date of service/procedure
- Description of service, procedure, and observation. Documentation in treatment record must contain documentation to support the level of American Dental Association Current Dental Terminology code billed as detailed in the nomenclature and descriptors. Documentation must be written on a tooth-by-tooth basis for a per tooth code, on a quadrant basis for a quadrant
- Code and on a per arch basis for an arch code
- Type and dosage of anesthetics and medications given or prescribed
- Localization of procedure/observation, (tooth #, quadrant etc.)
- Signature of the provider who rendered the service

M. Adequate documentation of the specialty care performed by another dentist that includes:

- patient examination
- treatment plan
- treatment status

12.3 Compliance

- Patient information should be documented in a consistent format
- There is consistent use of each component of the patient record by all staff
- The components of the record that are required for complete documentation of each patient's status and care are present
- Entries in the records are legible
- Entries of symbols and abbreviations in the records are uniform, easily interpreted and are commonly understood in the practice

13.00 Patient Recall System

13.1 Recall System Recommendation

Each participating MassHealth Dental Program provider office may maintain and document a formal system for patient recall. The system can use either written or phone contact. Any system should encompass routine patient

check-ups, cleaning appointments, follow-up treatment appointments, and missed appointments for any MassHealth Dental Program member that has sought dental treatment.

If a written process is used, the following or similar language is suggested for missed appointments:

- "We missed you when you did not come for your dental appointment on month/date. Regular check-ups are needed to keep your teeth healthy."
- "Please call to reschedule another appointment. Call us ahead of time if you cannot keep the appointment. Missed appointments are very costly to us. Thank you for your help."

Dental offices indicate that patients sometimes fail to show up for appointments. The MassHealth Dental Program offers the following suggestion to decrease the frequency of these occurrences.

- Contact the member by phone or postcard prior to the appointment to remind the individual of the time and place of the appointment.

14.00 Radiology Requirements

TYPE OF ENCOUNTER	PATIENT AGE AND DENTAL DEVELOPMENTAL STAGE				
	Child with Primary Dentition (prior to eruption of first permanent tooth)	**Child with Transitional Dentition** (after eruption of first permanent tooth)	**Adolescent with Permanent Dentition** (prior to eruption of third molars)	**Adult, Dentate or Partially Edentulous**	**Adult, Edentulous**
New patient* being evaluated for dental diseases and dental development	Individualized radiographic exam consisting of selected periapical/occlusal views and/or posterior bitewings if proximal surfaces cannot be visualized or probed. Patients without evidence of disease and with open proximal contacts may not require a radiographic exam at this time.	Individualized radiographic exam consisting of posterior bitewings with panoramic exam or posterior bitewings and selected periapical images.	Individualized radiographic exam consisting of posterior bitewings with panoramic exam or posterior bitewings and selected periapical images. A full mouth intraoral radiographic exam is preferred when the patient has clinical evidence of generalized dental disease or a history of extensive dental treatment.		Individualized radiographic exam, based on clinical signs and symptoms.
Recall patient* with clinical caries or at increased risk for caries**	Posterior bitewing exam at 6-12 month intervals if proximal surfaces cannot be examined visually or with a probe			Posterior bitewing exam at 6-18 month intervals	Not applicable
Recall patient* with no clinical caries and not at increased risk for caries**	Posterior bitewing exam at 12-24 month intervals if proximal surfaces cannot be examined visually or with a probe		Posterior bitewing exam at 18-36 month intervals	Posterior bitewing exam at 24-36 month intervals	Not applicable
Recall patient* with periodontal disease	Clinical judgment as to the need for and type of radiographic images for the evaluation of periodontal disease. Imaging may consist of, but is not limited to, selected bitewing and/or periapical images of areas where periodontal disease (other than nonspecific gingivitis) can be identified clinically.				Not applicable
Patient for monitoring of growth and development	Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring of dentofacial growth and development		Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring of dentofacial growth and development. Panoramic or periapical exam to assess developing third molars	Usually not indicated	
Patient with other circumstances including, but not limited to, proposed or existing implants, pathology, restorative/endodontic needs, treated periodontal disease and caries remineralization	Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring in these circumstances.				

15.00 Preventive Health Guidelines – Ages 0-20 Years

The EPSDT Dental Protocol and Periodicity Schedule (the "Dental Schedule") is located in Appendix W of the MassHealth provider manual. The Dental Schedule consists of procedures arranged according to the intervals or age levels at which each procedure is to be provided. The Dental Schedule is based on the Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance/Counseling, and Oral Treatment for Infants, Children, and Adolescents from the American Academy of Pediatric Dentistry (AAPD) Reference Manual 2023-2024. See 130 CMR 450.140 through 450.150 for more information about Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services and Preventive Pediatric Healthcare Screening and Diagnosis (PPHSD) services. The Dental Schedule reflects recommended well and preventive child healthcare screening services. If the clinical needs of a child justify deviation from this schedule, the provider must document this fact in the member's dental record, including the provider's clinical judgment and justification for that deviation.

*Please note that prior authorization may be requested for medically necessary non-covered services under EPSDT (Early and Periodic Screening, Diagnostic, and Treatment) for eligible members under age 21 in accordance with 130 CMR 420.000.

16.00 Clinical Criteria

The clinical criteria outlined in this ORM are based upon procedure codes as defined in the American Dental Association Current Dental Terminology (CDT) Manual, 130 CMR 420.000 and Subchapter 6 of the *MassHealth Dental Manual*. In general, documentation requests for information regarding treatment using these codes are determined by generally accepted dental standards for authorization, such as radiographs, periodontal charting, treatment plans, or descriptive narratives.

These criteria were formulated from information gathered from practicing dentists, dental schools, ADA clinical articles and guidelines, insurance companies, as well as other dental related organizations. These criteria and policies must also satisfy MassHealth Dental Program and federal Medicaid requirements. They are, however, designed as guidelines for authorization and payment decisions and are not intended to be all-inclusive. As the criteria do not account for all potential scenarios, additional narrative information is recommended when there may be a special situation.

These clinical criteria will be used for making medical necessity determinations for prior authorizations, pre- or post- payment review and retrospective review. Failure to submit the required documentation may result in a disallowed request and/or a denied payment of a claim related to that request. Some services require prior authorization and some services require pre-payment review; this is detailed in Exhibit A under the "Required Review" column. Some procedures require documentation for prior authorization, retrospective review, or pre-payment claim review. *Please refer to Exhibit A for specific information needed by code.*

For all procedures, every dental provider in the MassHealth program is subject to random chart audits. Providers are required to comply with any request for records. These audits may occur in the Provider's office as well as in the office of MassHealth Dental Program. The Provider will be notified in writing of the results and findings of the audit. MassHealth providers are required to maintain comprehensive treatment records that meet professional standards for risk management and applicable MassHealth regulations, including 130 CMR 420.000 and 450.000. Please refer to the "Patient Record" section for additional detail.

Documentation in the treatment record must justify the need for the procedure performed due to medical necessity, for all procedures rendered. Appropriate diagnostic pre-operative radiographs clearly showing the adjacent and opposing teeth and substantiating any pathology or caries present are required. Post-operative radiographs are required for endodontic procedures and permanent crown placement to confirm quality of care. In the event that radiographs are not available or cannot be obtained, diagnostic quality intraoral photographs must substantiate the need for procedures rendered.

Cosmetic services are not covered by MassHealth per 130 CMR 420.421(B)(1). Restorations provided solely to replace tooth structure lost due to attrition, abrasion, erosion, or abfraction are considered cosmetic services and do not meet the criteria for coverage.

Multistage procedures are reported and may be reimbursed upon completion. The completion date for removable prosthetic appliances is the date of insertion for removable prosthetic appliances. The completion date for immediate dentures is the date that the remaining teeth are removed, and the denture is inserted. The completion date for fixed partial dentures and crowns is the cementation date regardless of the type of cement utilized. The completion date for endodontic treatment is the date the canals are permanently filled.

Failure to provide the required documentation, adverse audit findings, or the failure to maintain acceptable practice standards may result in sanctions including, but not limited to, recoupment of benefits on paid claims, follow-up audits, or removal of the Provider from the MassHealth participating provider network.

We hope that the enclosed criteria will provide a better understanding of the decision-making process for reviews. We also recognize that "local community standards of care" may vary from region to region and will continue our goal of incorporating generally accepted criteria that will be consistent with both the concept of local community standards and the current ADA concept of national community standards.

Your feedback and input regarding the constant evolution of these criteria is both essential and welcome. MassHealth shares your commitment and belief to provide quality care to MassHealth Members and we appreciate your participation in the program.

For additional information on criteria, please reference the *MassHealth Dental Manual* found on https://www.mass.gov/lists/dental-manual-for-masshealth-providers.

16.1 Restorative Codes & Determination of a Non-Restorable Tooth

Restorations without documentation of medical necessity are not covered.

Restorations replaced within one calendar year of the date of completion of the original restoration are not covered.

Restorations provided solely for cosmetic purposes, including restorations solely to replace tooth structure lost due to attrition, abrasion, erosion, or abfraction, are not covered.

Restorations for caries that is limited to the enamel and does not extend through the dentin enamel junction (DEJ) are considered to be sealants and are not covered as amalgam and resin-based composite restorations.

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 or composite restoration.

The MassHealth Dental Program 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. Billing and reimbursement for crowns, post & cores or any other fixed prosthetics shall be based on the cementation date. Restorative pins are reimbursed on a per tooth basis, regardless of the number of pins placed. Reinforcing pins are covered only when used in conjunction with a two-or-more-surface restoration on a permanent tooth.

In the application of clinical criteria for covered service determination, dental consultants must consider the overall dental health. A tooth that is determined to be non-restorable may be subject to an alternative treatment plan.

A tooth may be deemed non-restorable if one or more of the following criteria are present:

- The tooth presents with greater than a 75% loss of the clinical crown;

- The tooth has less than 50% bone support;
- The tooth has sub osseous and/or furcation caries;
- The tooth is a primary tooth with exfoliation imminent;
- The tooth apex is surrounded by severe pathologic destruction of the bone;
- The overall dental condition (i.e., periodontal) of the patient is such that an alternative treatment plan would be better suited to meet the patient's needs.

16.2 Crowns & Core Buildups

Documentation required to be included in the patient record:

- Appropriate diagnostic pre-operative radiographs showing clearly the adjacent and opposing teeth and substantiating any pathology or caries present, minimally one bitewing and one periapical for posterior teeth and minimally one periapical for anterior teeth; and FMX or panoramic radiograph.
- If radiographs are not available or cannot be obtained, diagnostic pre-operative intraoral photographs must substantiate that the service meets the clinical criteria for crowns.
- Post-operative radiographs are required for permanent crown placement to confirm quality of care.

Criteria for Crowns

Document compliance with the following guidelines in patient chart:

- In general, the criteria for crowns will be met only for permanent teeth needing multi-surface restorations where other restorative materials have a poor prognosis and at least a supportable five-year prognosis for the teeth to be crowned.
- Permanent molar teeth must have pathologic destruction to the tooth by caries or trauma and must involve four or more surfaces and two or more cusps, or be endodontically-treated.
- Permanent bicuspid teeth must have pathologic destruction to the tooth by caries or trauma and must involve three or more surfaces and at least one cusp, or be endodontically-treated.
- Permanent anterior teeth must have pathologic destruction to the tooth by caries or trauma and must involve at least one of the following:
    - Four or more surfaces and at least one incisal angle. The facial or lingual surface shall not be considered involved for a mesial or distal restoration unless the proximal restoration wraps around the tooth to at least the midline.
    - The loss of an incisal angle which involves a minimum area of both half the incisal width and half the height of the anatomical crown.

Crowns on an endodontically-treated tooth must meet the following criteria:

- A dated post-endodontic treatment radiograph showing the apex must be included in the patient record.
- The tooth must be filled within 2mm of the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the ability to fill the canal to the apex.
- The filling must be properly condensed/obturated. Filling material must not extend excessively beyond the apex.

Arch integrity and overall condition of the mouth, including the patient's ability to maintain oral health must support a favorable prognosis for the teeth to be crowned. To meet the criteria:

- A crown must be opposed by a tooth or denture in the opposite arch or be an abutment for a partial denture.
- The patient must be free from active, uncontrolled, or advanced periodontal disease. Advanced periodontal disease is classified as Stage 2 Periodontitis and above.

- There must be eight or more natural or prosthetic posterior teeth in occlusion or the tooth must be the last potential abutment for a partial denture.
- The tooth must have at least 50% remaining sound coronal tooth structure, at least 50% bone support, and a minimum 1:1 crown-root ratio.

Additional information:

- The fee for crowns includes the temporary crown that is placed on the prepared tooth and worn while the permanent crown is being fabricated for permanent teeth.
- Crowns on permanent teeth are expected to last, at a minimum, five years.
- Replacement crowns are allowed only on teeth with recurrent caries or missing crowns. Open margins, in the absence of caries, are considered cleansable and do not require replacement.
- Replacement crowns due to chipped or fractured porcelain, without caries, are considered cosmetic and are not covered.

Payment for crowns will not meet criteria if:

- a lesser means of restoration is possible;
- the tooth has sub osseous and/or furcation caries;
- the tooth has active, uncontrolled, or advanced periodontal disease;
- the tooth has mobility or less than 50% bone support;
- the tooth has furcation involvement;
- the tooth has an unfavorable crown-root ratio less than 1:1;
- the tooth is broken near the gumline with less than 4.5mm supra-alveolar tooth structure;
- the tooth has caries near the osseous crest or involved restorative procedures result in violation of biologic width with margins less than 2.5mm from the alveolar bone;
- the tooth is a primary tooth;
- crowns solely for cosmetic purposes, including crowns solely to replace tooth structure lost due to attrition, abrasion, erosion, or abfraction;
- crowns are being planned to alter vertical dimension, including but not limited to restorations, procedures, or applications done primarily to treat attrition, realign the dentition, splinting, full-mouth rehabilitation or equilibration, and the treatment of TMD syndrome; or
- The tooth is deemed unsalvageable due to caries, periodontal disease, trauma, or other pathology.

Core Buildups:

- Core buildup procedures are allowed on teeth that meet crown criteria, where clinical breakdown is at a level where the build-up material is necessary for crown retention or where there is evidence presented of caries or fracture under an existing restoration.
- Prefabricated or cast post and core procedures are allowed on endodontically-treated teeth where clinical crown breakdown is at a level where the post and core is necessary for crown retention.
- Fillers to smooth out irregularities or eliminate undercuts in the tooth preparation are considered an integral part of the crown procedure and are not allowed as a separate billable service.

For core buildups (including any pins when necessary for retention) in conjunction with a crown, a radiograph is required which indicates objectively that the service is medically necessary for crown retention or supports caries or fracture under an existing restoration. Narratives or intraoral photographs may support the radiographs but cannot serve as the sole determinant.

Core buildups can be billed without accompanying crown procedure since crowns are billed on seat date. However, the claim will be pended until appropriate documentation is received.

If a member does not return for the insertion of the completed crown procedure:

The provider is required to submit written evidence on their office letterhead of at least three attempts to contact the member over a period of one month via certified mail return receipt. Upon providing documentation, the provider may be reimbursed a percentage of the crown fee to assist in covering costs. See 130 CMR 450.231: General Conditions of Payment.

To receive payment for the lab bill and any fees associated with contacting the member, please submit an ADA claim form, using D2999 for a crown procedure, along with the following documentation:

1. Copies of the three attempts within a one-month period to notify the member. Items needed:
    a. One Copies of the certified letters and receipts from the post office showing the stamp
    b. A narrative on office letterhead explaining the situation as to why the provider was unable to insert the permanent crown
2. Copy of paid lab bill
3. Copy of member charting
4. Any other supporting documentation you feel is necessary to support the case

16.3 Prefabricated Stainless Steel and Resin Crowns

Documentation required to be included in patient record:

- Appropriate diagnostic pre-operative radiographs showing clearly the adjacent and opposing teeth and substantiating any pathology or caries present; bitewings, periapical or panoramic radiograph.
- If radiographs are not available or cannot be obtained, diagnostic pre-operative intraoral photographs must substantiate that the service meets the clinical criteria for prefabricated crowns.

Criteria for Prefabricated Stainless Steel and Resin Crowns

Document compliance with the following guidelines in patient chart:

- In general, criteria for prefabricated crowns will be met only for teeth needing multi- surface restorations where amalgams and other materials have a poor prognosis.
- Primary molars must have pathologic destruction to the tooth by caries or trauma and must involve two or more surfaces or substantial occlusal decay resulting in an enamel shell.
- In the rare circumstance that a stainless-steel crown is indicated for a permanent tooth:
    - Permanent molar teeth must have pathologic destruction to the tooth by caries or trauma and must involve four or more surfaces and two or more cusps, or be endodontically-treated.
    - Permanent bicuspid teeth must have pathologic destruction to the tooth by caries or trauma and must involve three or more surfaces and at least one cusp, or be endodontically-treated.

Treatment using prefabricated crowns will not meet criteria if:

- a lesser means of restoration is possible;
- the tooth has sub osseous and/or furcation caries;
- the tooth has advanced periodontal disease;
- the tooth is a primary tooth with exfoliation imminent;
- crowns are being planned to alter vertical dimension, including but not limited to restorations, procedures, or applications done primarily to treat attrition, realign the dentition, splinting, full-mouth rehabilitation or equilibration, and the treatment of TMD syndrome; or
- The tooth is deemed unsalvageable due to caries, periodontal disease, trauma, or other pathology.

16.4 Endodontic Treatment

Documentation required to be included in patient record:

- Sufficient and appropriate pre-operative radiographs clearly showing the adjacent and opposing teeth and a pre-operative radiograph of the tooth to be treated; bitewings, periapical or panoramic radiograph.
- Post-operative radiographs of completed final fill are required for endodontic treatment to confirm quality of care.
- Narrative of medical necessity.

Criteria for Endodontic Treatment

Root canal therapy is performed to maintain teeth that have been damaged through trauma or carious exposure.

Root canal therapy must meet the following criteria (required to be documented in patient record):

- Filler material must be within 2mm of the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the dentist's ability to fill the canal to the apex.
- Filler material must be properly condensed/obturated. Filling material must not extend excessively beyond the apex.

Payment for root-canal therapy does not meet criteria if (required to be documented in patient record):

- Gross periapical or periodontal pathosis is demonstrated radiographically (e.g. caries subcrestal or to the furcation, deeming the tooth non-restorable). The general oral condition does not justify root-canal therapy because the periodontal condition of the remaining dentition and soft tissue are stable with a favorable prognosis.
- Tooth does not demonstrate 50% bone support.
- Root-canal therapy is in anticipation of placement of an overdenture.
- A filling material not accepted by the federal Food and Drug Administration (e.g., Sargenti filling material) is used.

Other Considerations:

- Root-canal therapy for permanent teeth includes diagnosis, extirpation of the pulp, shaping and enlarging the canals, temporary fillings, filling and obliteration of root canal(s), and progress radiographs, including a root-canal fill radiograph.
- In cases where the root-canal filling does not meet the MassHealth Dental Program's treatment standards, the MassHealth Dental Program can require the procedure to be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after the MassHealth Dental Program reviews the circumstances.

16.5 Periodontal Treatment

Documentation needed for procedure:

- Appropriate diagnostic quality radiographs – a mounted FMX. Panoramic radiographs are not preferred.
- Complete periodontal charting with American Academy of Periodontolgy (AAP) case type. Dentists are required to record a six-point probing with all numbers recorded once per calendar year on all remaining teeth in the mouth for adult periodontal patients. Periodontal Screening and Recording (PSR) is not to be used instead of a full-mouth charting for periodontal patients.
- Medical necessity narrative: Include a statement concerning the member's periodontal condition, date of service of periodontal evaluation and history of previous periodontal treatment.

Periodontal scaling and root planning, per quadrant, involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. It is indicated for patients with periodontal disease and is therapeutic, not prophylactic, in nature. Root planning is the definitive procedure designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or microorganisms. Some soft tissue removal occurs. This procedure may be used as a definitive treatment in some stages of periodontal disease and as a part of presurgical procedures in others.

It is anticipated that this procedure would be requested in cases of severe periodontal conditions (i.e., late Type II, III, or IV periodontitis) where definitive comprehensive root planning requiring local/regional block anesthesia and several appointments would be indicated.

Criteria for Periodontal Treatment

- Periodontal charting indicating abnormal pocket depths in multiple sites.
- At least one of the following is present:
    - Radiographic evidence of root surface calculus; or
    - Radiographic evidence of noticeable loss of bone support

Other Considerations:

Comprehensive periodontal evaluation (code D0180) is covered for patients showing signs or symptoms of periodontal disease and for patients with risk factors such as smoking or diabetes. Documentation of a comprehensive periodontal evaluation including full six-point periodontal charting is required. Code D0180 is not covered if periodontal charting is limited to Periodontal Screening and Recording (PSR).

15.6 Removable Prosthodontics (Full and Partial Dentures)

Documentation needed for procedure:

Appropriate pre-operative diagnostic quality radiographs are required (preferably an FMX or panoramic radiograph) for members who are completely and partially edentulous. Radiographs such as bitewings, periapicals, panoramic images must clearly show adjacent and opposing teeth, and / or capture the entire mouth, upper and lower jaws surrounding structures and tissues as applicable.

Criteria for Removable Prosthodontics (Full and Partial Dentures)

Prosthetic services are intended to restore oral form and function caused by premature loss of permanent teeth that would result in significant occlusal dysfunction.

- A denture is determined to be an initial placement if the patient has never before worn a prosthesis or had a prosthesis prescribed by any provider at any time.
- Dentists are required to take diagnostic quality pre-operative radiographs for all complete denture services.
- Partial dentures are covered only for members with good oral health and hygiene, good periodontal health (AAP Type I or II), and a favorable prognosis where continuous deterioration is not expected.
- Radiographs must show no untreated cavities or active periodontal disease in the abutment teeth, and abutments must be at least 50% supported in bone.
- As part of any removable prosthetic service, dentists are expected to instruct the patient in the proper care of the prosthesis.
- In general, if there is a pre-existing removable prosthesis (includes partial and full dentures), it must be at least seven years old and unserviceable to qualify for replacement.
- The replacement teeth should be anatomically full-sized teeth.
- Immediate dentures will be considered for members under age 21 only when these dentures will be the permanent full dentures.

Removable prosthesis will not meet criteria if:

- There is a pre-existing prosthesis that is not at least seven years old and unserviceable;
- Good oral health and hygiene, good periodontal health, and a favorable prognosis are not present;
- There are untreated cavities or active periodontal disease in the abutment teeth;
- Abutment teeth are less than 50% supported in bone;
- The member cannot accommodate and properly maintain the prosthesis (i.e., gag reflex, potential for swallowing the prosthesis, severely handicapped);
- The member has a history or an inability to wear a prosthesis due to psychological or physiological reasons;
- A partial denture, less than seven years old, is converted to a temporary or permanent complete denture; or:
- Extensive repairs are performed on marginally functional partial dentures, or when a new partial denture would be better for the health of the member. However, adding teeth and/or a clasp to a partial denture is a covered service if the addition makes the denture functional.

Criteria for Replacement Prosthodontics

- If there is a pre-existing prosthesis, it must be at least seven years old and unserviceable to qualify for replacement;
- Adjustments, repairs, and relines are included with the denture fee within the first six months from the date of insertion for members;
- After the first six months from the date of insertion:
    - for members under age 21, relines and rebases will be reimbursed once every two years. More frequent relines and rebases require prior authorization and evidence that clinical conditions exist that warrant more frequent relines and rebases;
    - for members age 21 and older, relines and rebases will be reimbursed once every three years;
- A new prosthesis will not be reimbursed within two years of reline or repair of the existing prosthesis unless adequate documentation has been presented that all procedures to render the denture serviceable have been exhausted;
- Replacement of lost, stolen, or broken dentures less than seven years of age usually will not meet criteria for pre-authorization of a new denture;
- The use of preformed dentures with teeth already mounted (that is, teeth set in acrylic before the initial impression) cannot be used for the fabrication of a new denture;
- All prosthetic appliances must be inserted in the mouth and adjusted before a claim is submitted for payment; and
- When billing for partial and complete dentures, dentists must list the date that the dentures or partials were inserted as the date of service. Members must be eligible on that date in order for the denture service to be covered.

If a member does not return for the insertion of the completed processed removable or fixed prothesis:

Following 130 CMR 420.428, the provider is required to submit written evidence on their office letterhead of at least three attempts to contact the member over a period of one month via certified mail return receipt. Upon providing documentation, the provider may be reimbursed a percentage of the denture fee to assist in covering costs. See 130 CMR 450.231: General Conditions of Payment.

To receive payment for the lab bill and any fees associated with contacting the member, please submit an ADA claim form, using the covered CDT code for the denture procedure, along with the following documentation:

1. Copies of the three attempts within a one-month period to notify the member. Items needed:
    a. One Copies of the certified letters and receipts from the post office showing the stamp

b. A narrative on office letterhead explaining the situation as to why the provider was unable to insert the permanent crown/partial/denture

2. Copy of paid lab bill
3. Copy of member charting
4. Any other supporting documentation you feel is necessary to support the case

16.7 Dental Extractions

MassHealth allows providers to make the decision to submit a request for D7240 prior authorization before treatment begins or retrospective review after services have been rendered to the member.

D7999 requires prior authorization with documentation. Please refer to Exhibit A for specific documentation needed by code.

Documentation required to be included in patient record:

- Appropriate pre-operative radiographs showing clearly the adjacent and opposing teeth should be submitted: bitewings, periapicals or a panoramic radiograph.
- Narrative demonstrating medical necessity.

Criteria for Dental Extractions

The prophylactic removal of asymptomatic teeth (i.e., third molars) or teeth exhibiting no overt clinical pathology (for orthodontics) may be covered subject to consultant review.

- The removal of primary teeth whose exfoliation is imminent does not meet criteria.
- The removal of primary teeth without medical necessity does not meet criteria.
- Alveoloplasty (code D7310 or D7311) in conjunction with extractions will be covered only if the alveoplasty is distinct (separate procedure) from extractions and medical necessity is documented.
- The MassHealth agency pays for D7280 for members under the age of 21 with no prior authorization requirement. D7280 is intended to be used in conjunction with orthodontic treatment when an impacted tooth needs to be exposed to erupt appropriately. However, MassHealth interprets the service reflected by D7280 to be included when an adjacent impacted tooth is extracted; that is, D7280 may not be billed to MassHealth in conjunction with another extraction code, including codes D7220, D7230, D7240, D7241, that is billed for an adjacent impacted extraction.

16.8 Criteria for General Anesthesia and Intravenous (IV) Sedation

Prior authorization is not required 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.

- General anesthesia or IV sedation may only be performed in conjunction with covered oral surgery and maxillofacial procedures.

The administration of inhalation analgesia (nitrous oxide N2O /O2) and non-intravenous conscious sedation are reimbursed as a separate procedure. The administration of local anesthesia is considered part of an operative procedure and is not reimbursable as a separate procedure.

16.9 Operating Room (OR) Cases

For criteria for Operating Room (OR) Cases, please refer to 130 CMR 420.000

17.00 Orthodontic Treatment

Please refer to 130 CMR 420.431 for MassHealth dental program regulations regarding orthodontic treatment.

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

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

17.1 Eligibility for Orthodontic Treatment

Members under age 21 may qualify for orthodontic treatment. All orthodontic services require prior authorization with the exception of pre-orthodontic treatment visits and orthodontic retention.

Members age 21 and older may qualify for continuation of orthodontic treatment upon prior authorization if they have been fully banded prior to their 21st birthday and remain eligible for MassHealth dental benefits for the duration of the treatment. See Section 17.4 for further details.

17.2 Authorization for Comprehensive Orthodontic Treatment

MassHealth approves prior authorization requests for comprehensive orthodontic treatment of handicapping malocclusions. Specifically, treatment is authorized when: 1) the member has one of the "auto qualifying" conditions described by MassHealth in the HLD Index; 2) the member meets or exceeds the threshold score designated by MassHealth on the HLD index; or 3) comprehensive orthodontic treatment is medically necessary for the member, as demonstrated by a medical necessity narrative and supporting documentation submitted by the requesting provider. The process for submitting a prior authorization request for comprehensive orthodontic treatment is described below:

1. Provider performs pre-orthodontic treatment examination to determine if orthodontic treatment is necessary.
2. Provider submits all applicable completed forms and documentation to the MassHealth Dental Program for review. (See 2a – 2e, below)
    a. 2012 ADA Form – Appendix A
        i. Providers may request the first two years of treatment in one authorization by doing the following
            1. Request authorization for D8080/D8070 / D8090
            2. Request authorization for 8 units of D8670
            3. Enter Pre-Orthodontic records charge (D8660) with date of service. If Authorization for D8080/D8070 / D8090 is denied, code D8660 will be processed (if a claim is included with your submission) with the date of service entered on the Authorization.
    b. Cephalometric radiographs OR photographs with a measurement device are required with every case in addition to the standard set of photos. Providers are encouraged to submit a lateral cephalometric radiograph if it will clearly identify the medical necessity of treatment such as for deep impinging overbite. Models are not required.

i. Measurement Device- A calibration ruler, wire of known length, embedded measurement device, boley gauge, disposable ruler, or periodontal probe, are used to increase the accuracy and objectivity of the HLD scoring. The HLD is intended to be a quantitative, objective method for evaluating prior authorization requests for comprehensive orthodontic treatment. Providing a scale, or demonstrating measured components, reinforces the objectivity of the evaluation and benefit determination. The scale, or measurements allow accurate objective measures of overjet, open bite, and reverse overjet (mandibular protrusion). A periodontal probe or measuring device used in photos should be from the ipsilateral (same side) that the measurement is being taken. If a measured wire or object of known length is used on the lateral cephalometric, but not marked, a brief explanation should be included to aid in establishing a scale. Measurements will then be taken in accordance with the Handicapping Labio-Lingual Deviation Index Scoring Instructions, to scale.

ii. Photographic Prints and Radiographs

Photographs must include lateral and occlusal views. Photo(s) with a measurement device (Boley gauge, disposable ruler, or periodontal probe) in the patient's mouth, or on models mounted in centric occlusion should be included. When measuring overjet, reverse overjet, or mandibular protrusion, the measurement device should be placed parallel to the occlusal plane involving two directly opposing incisor teeth with the photo taken on the ipsilateral side (same side) being measured.

When measuring open bite, place the measurement device vertically to measure the opening from the incisal edge of the maxillary and mandibular incisors.

A sufficient number of photographs should be submitted with a measurement device, dependent upon the conditions present. The measurement device should be utilized in accordance with the HLD Scoring Instructions.

The following are examples of photos from Draker Handicapping Labio-Lingual Deviations: A Proposed Index for Public Health Purposes, Am J Ortho, 1960, 295-305.

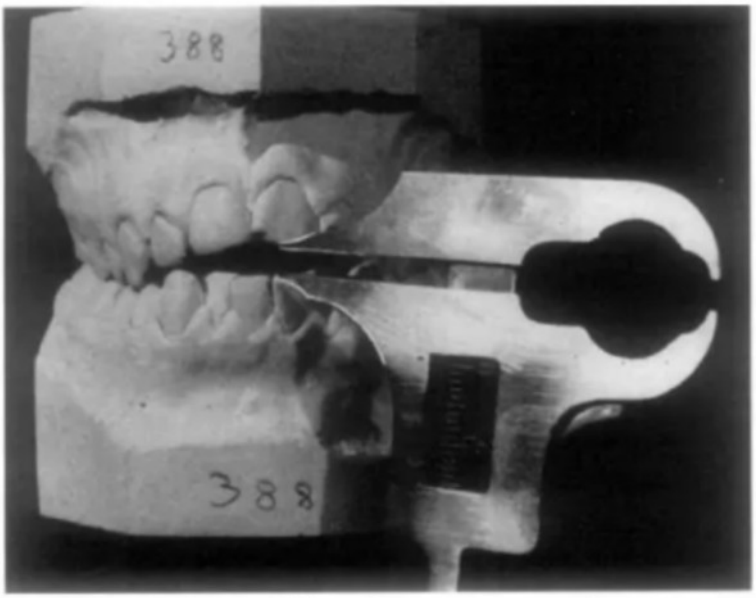


Fig. 5.

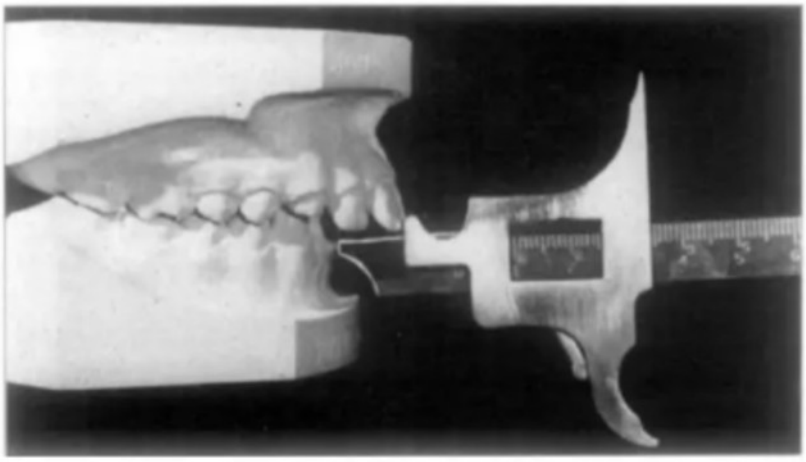


Fig. 2.

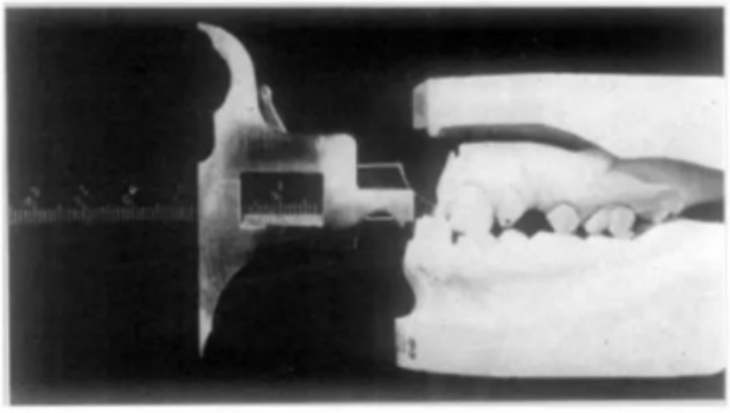


Fig. 1.

c. HLD Index Form – Appendix A

Providers may establish medical necessity for comprehensive orthodontic treatment using the HLD Index by demonstrating that the member 1) has one or more of the "auto qualifying" conditions described on the HLD Index; 2) has measurements that meet or exceed the threshold score of 22 on the HLD Index; or 3) comprehensive orthodontic treatment is medically necessary for the member, as demonstrated by a medical necessity narrative and supporting documentation submitted by the requesting provider. Subject to review and verification, MassHealth will approve comprehensive orthodontic treatment for members that satisfy any of these three criteria.

i. Medical Necessity Narrative and Supporting Documentation (if applicable). Providers may establish that comprehensive orthodontic treatment is medically necessary by submitting a medical necessity narrative and supporting documentation, where applicable. The narrative must establish that comprehensive orthodontic treatment is medically necessary to treat a handicapping malocclusion, including to correct or significantly ameliorate:

1. a severe deviation affecting the patient's mouth and/or underlying dentofacial structures.
2. a diagnosed mental, emotional, or behavioral condition caused by the patient's malocclusion.
3. a diagnosed nutritional deficiency and/or a substantiated inability to eat or chew caused by the patient's malocclusion.
4. a diagnosed speech or language pathology caused by the patient's malocclusion; or
5. a condition in which the overall severity or impact of the patient's malocclusion is not otherwise apparent.

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

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

The medical necessity narrative must be signed and dated by the requesting provider and submitted on the office letterhead of the provider, together with the required HLD Form and

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

17.3 Authorization Determination

The initial prior authorization approval for comprehensive orthodontics (D8080/D8070) and first two (2) years of treatment visits (D8670 x 8 units) will expire 36 months from the date of the authorization. Approval for the third year of orthodontics will be valid for 36 months. Providers must check the patient's eligibility on each date of service to determine whether it will be an "eligible" service date.

If the case is denied, a determination notice will be sent to the member, and a separate courtesy notice will be sent to the provider along with the reviewer's worksheet indicating that the authorization for comprehensive orthodontic treatment has been denied. However, if a claim is sent in along with the prior authorization, a payment will be issued for code D8660 to cover the pre-orthodontic work-up, including the treatment plan, radiographs, diagnostic prints and/or photos orthodontic records, and diagnostic models.

1. If the prior authorization request is DENIED:
    a. MassHealth Dental Program will mail the member a denial notice. Additionally, MassHealth Dental Program will mail to the provider and post on the Provider Web Portal a separate courtesy notice and will mail the reviewer's worksheet to the provider.
    b. MassHealth Dental Program will issue a payment for code D8660 if a claim is sent in with the prior authorization to cover pre-orthodontic work-up that includes payment for any diagnostic radiographs or photographs and adjudicate using the date of service submitted on the authorization.
    c. Providers may request a second review of a denied prior authorization by submitting to MassHealth Dental Program in writing on the provider's office letterhead within thirty days from the date of the denial notice the following information:
        i. A detailed narrative of why the provider believes the prior authorization should have been approved, and
        ii. All documents originally submitted in addition to any new supporting documentation not previously submitted, including, as appropriate, radiographs, photographs, and letters or other documentation from other licensed clinicians involved in the member's treatment or otherwise knowledgeable about the member's condition.

Comprehensive Orthodontic Treatment Requirements:

Insertion of the appliance must occur before the patient's 21st birthday. Providers must submit a claim using the actual appliance insertion date (banding date) as the date of service on the 2012 or newer ADA form.

Payment for Comprehensive Orthodontic Treatment (D8080/D8070/D8090) includes pre-orthodontic visit, records, photographic prints, models, insertion of appliance(s), and all orthodontic treatment visits occurred within the calendar month of insertion of appliance(s).

Periodic Orthodontic Treatment Visit Requirements:

Orthodontic treatment visits are paid on a quarterly (90-day) basis, with the first payment available 90 days after banding. Payment for each unit of service (D8670) includes all treatment visits provided to the patient within a

quarterly (90-day) billing period. Providers are expected to see patients every four to eight weeks, depending on the particular circumstances of the patient's treatment plan, but may bill a quarterly unit of service if at least one (1) eligible treatment date occurred during the 90-day period. Provider MUST note the actual treatment dates in the Remarks section (Box 35) on the ADA claim form (box 35 of the 2006 ADA claim form), the "Notes" section when using the billing portal or the "Remarks" field on the HIPAA-compliant 837D, specifically 2300/NTE02.

In the event the claim does not contain the actual treatment dates in the appropriate "Remarks" field, MassHealth may deny or recoup the payment and/or require a plan of correction.

If no service is provided in any given billing quarter, the next eligible treatment date should be used as the date of service on the claim. The next quarterly unit of service (D8670) must then be billed at least 90 days from this date of service. Providers may not bill members for broken, repaired, or replacement brackets or wires, and may not charge members "appointment" or "retainer" fees to set appointments regardless of if the fee is ultimately refunded to the member.

Authorization Extension:

Once the authorization period has expired and/or all eight (8) units of quarterly adjustments have been paid, the provider may request a second authorization if continued adjustments are necessary. In the second authorization request, the provider may request up to four (4) additional units of D8670 to complete the case over a subsequent 36-month period.

i. The second request must be submitted as a prior authorization and include a narrative on office letterhead, indicating the number of units being requested and a detailed justification for the additional units, including an explanation of why the initially approved units were insufficient and an updated treatment plan for completion of the case. Additionally, provider must submit a medical necessity summary narrative in box 35 of a completed 2012 ADA claim form with the request, along with any photos or radiographs needed to support the request.

ii. The MassHealth Dental Program will evaluate the authorization request based upon the submission of all documents, which includes the request and justification on office letterhead, a summary medical necessity narrative in box 35 of the completed 2012 or newer ADA claim form and any photos or radiographs needed to support the request. If the second authorization is APPROVED, then the provider may continue billing using the process described above for the number of adjustments that were approved.

iii. MassHealth will pay for a maximum of four (4) units of D8670 during the second authorization period, which may last up to eighteen months.

    If the provider did not request the maximum number of four units in the request for the second authorization period, the provider may subsequently request additional units via the prior authorization process until the maximum number of additional four units have been approved and exhausted.

    Any subsequent request for units beyond those approved in a second authorization must be submitted as a prior authorization with a narrative on office letterhead, indicating the number of units being requested and a detailed justification for the additional units, including an explanation of why the initially approved units were insufficient and an updated treatment plan for completion of the case. Additionally, provider must submit a medical necessity summary narrative in box 35 of a completed 2012 ADA claim form with the request. MassHealth/MassHealth Dental Program will evaluate the authorization request based upon the submission of all documents, which includes the request and justification on office letterhead, a summary medical necessity narrative in box 35 of the completed 2012 ADA claim form and any photos or radiographs needed to support the request.

iv. If the second authorization expires prior to the completion of treatment, a provider may request an extension of the time for treatment to allow for the patient's treatment to be completed and all four additional units to be billed. Providers must submit extension requests in writing to MassHealth Dental Program and must include the authorization number in the request.

v. For cases that require additional adjustments to complete treatment beyond the 36 months due to extenuating circumstances: If after the initial and second authorizations have expired AND the maximum units were used AND additional adjustments are still required then the provider will submit a prior authorization request for the specified number of adjustments requested (D8670), a detailed justification as a prior authorization including a narrative on office letterhead demonstrating the need for further treatment, current photographs, and a summary medical necessity narrative in box 35 of the completed 2012 or newer ADA claim form.

*Please allow 4-6 weeks from submission for extension requests to be addressed.

Retention Visit Requirements:

Retention is reimbursed separately and includes removal of appliances (de-banding), construction and delivery of retainers, and follow up visits. The maximum number of reimbursable retention visits (post- treatment stabilization) is five (5). Prior authorization is not required. If the patient loses or breaks his/her retainer(s), the provider must submit a prior authorization request and receive approval prior to billing for the repair and replacement of the retainer(s).

17.4 Authorization for Continuation of Care

If a member is already receiving comprehensive or interceptive orthodontic treatment and is transferring from another provider and/or state Medicaid program or other insurer, the MassHealth provider that seeks to continue the treatment must submit to MassHealth Dental Program a prior authorization request for continuation of care including the following documentation:

a. 2012 or newer ADA claim form listing services to be rendered.
b. Continuation of Care form
c. HLD Form
d. Panoramic radiograph

The provider is responsible for compiling and submitting the required information. Authorization for continuation of care may not be available without complete information.

17.5 Authorization for Limited* Orthodontic Treatment

*Please note that Limited Orthodontic Treatment is only covered for members upon approval under the age of 21.

The MassHealth agency approves prior authorization requests if the treatment will prevent or minimize a handicapping malocclusion based on the clinical standards described in Appendix F of the Dental Manual. The MassHealth agency limits coverage of limited orthodontic treatment to primary and transitional dentition with at least one of the following conditions: constricted palate, deep impinging overbite, Class III malocclusion including skeletal Class III cases as defined in Appendix F of the Dental Manual when a protraction facemask/reverse pull headgear or other appropriate device is necessary at a young age, craniofacial anomalies, anterior cross bite, or dentition exhibiting results of harmful habits or traumatic interferences between erupting teeth.

Providers are encouraged to treat Class III malocclusions with the appropriate limited orthodontic treatment and may submit for approval of both limited and comprehensive treatment of Class III malocclusions at the time limited

treatment is necessary. Please note the expiration date of the prior approval and submit for an extension of comprehensive treatment if comprehensive treatment is not complete prior to the expiration date.

Continuity of care is important; therefore, please notify MassHealth Dental Program if the member discontinues treatment for any reason. The process for requesting authorization and billing for limited orthodontic treatment is described below:

a. Provider performs pre-orthodontic treatment examination to determine if orthodontic treatment is necessary.
b. Provider completes and submits the following documentation:
    - 2012 or newer ADA Form requesting authorization for limited orthodontic treatment. The form must include:
        1. The code for the appliance being used (D8010, D8020, D8030, D8040)
        2. The code (D8999) for and number of treatment visits you are requesting for adjustments, up to a maximum of 5.

c. A detailed medical necessity narrative establishing that limited orthodontic treatment is medically necessary to prevent or minimize the development of a handicapping malocclusion or will preclude the need for comprehensive orthodontic treatment. This narrative must be submitted on the provider's office letterhead and any supporting documentation or imaging supporting medical necessity of the treatment should be attached.

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

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

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

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

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

If prior authorization is DENIED:

a. MassHealth Dental Program will send the provider and member a denial notice in the mail and post the denial to the Provider Web Portal.

If prior authorization is APPROVED:

a. Provider can place the appliance for the patient;
b. Provider can bill for the appliance once the appliance is placed;
c. Provider can bill for the number of adjustments (D8999) performed, up to a maximum of 5, using the actual dates of treatment as the dates of service.

18.00 MassHealth Limited

MassHealth limited covers only emergency services that are necessary to treat an acute medical condition requiring immediate care are allowed for members who have MassHealth Limited coverage as described in 130 CMR 450.105 (g)(1) below.

For MassHealth Limited members (see 130 CMR 505.008 and 519.009), MassHealth will only pay for the treatment of a medical condition (including labor and delivery) that manifests itself by acute symptoms of sufficient severity that the absence of immediate medical attention reasonably could be expected to result in:

a. placing the member's health in serious jeopardy
b. serious impairment to bodily functions; or
c. serious dysfunction of any bodily organ or part

MassHealth will cover the following dental codes for members with Limited coverage:

Limited Oral Evaluation. (D0140) The MassHealth agency pays for a limited oral evaluation twice per provider or location per calendar year. A limited oral evaluation may necessitate further diagnostic procedures (such as radiographs) to help the provider formulate a differential diagnosis about the member's specific problem. A limited oral evaluation is not covered on the same date of service as an emergency treatment visit.

Periapical Films. (D0220, D0230) 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 member per visit.

Panoramic Films. (D0330) The MassHealth agency pays for panoramic films for surgical and nonsurgical conditions as described in 130 CMR 420.423(C)(1) and (2). The MassHealth agency does not pay for panoramic films for crowns, endodontics, periodontics, and interproximal caries.

Surgical Removal of Erupted Tooth. (D7210) The MassHealth agency pays for the surgical removal of an erupted tooth. Surgical removal of an erupted tooth is the removal of any erupted tooth that includes the retraction of a mucoperiosteal flap and the removal of alveolar bone in order to aid in the extraction or the sectioning of a tooth. The provider must maintain clinical documentation demonstrating medical necessity and a preoperative radiograph of the erupted tooth in the member's dental record to substantiate the service performed.

Palliative Treatment of Dental Pain or Infection (D9110). The MassHealth agency pays for palliative treatment to alleviate dental pain or infection in an emergency. Palliative treatment includes those services minimally required to address the immediate emergency including, but not limited to, draining of an abscess, prescribing pain medication or antibiotics, or other treatment that addresses the member's chief complaint. The provider must maintain in the member's dental record a description of the treatment provided and must document the emergent nature of the condition. The MassHealth agency pays separately for medically necessary covered services provided during the same visit.

18.1 Children Medical Security Plan (CMSP)

The Children's Medical Security Plan (CMSP) is a program that provides certain uninsured children and adolescents with primary and preventive medical and dental coverage.

Populations Served

CMSP is for children under the age of 19 who are Massachusetts residents at any income level, who do not qualify for MassHealth (except MassHealth Limited), and who are uninsured.

Service Offerings

Children covered by CMSP with family incomes up to 400% of the federal poverty level are eligible for the Health Safety Net (HSN) at Massachusetts acute hospitals and community health centers for medically necessary services not covered by CMSP. A deductible, based on family size and income, may apply.

*Some examples of services not covered by CMSP include:

a. Cosmetic or surgical dentistry
b. Orthodontic Services

*See Exhibit A for covered services by code.

Please note: The service history for MassHealth and the Health Safety Net will be taken into consideration prior to payment for any covered service.

State Fiscal Year Annual Maximum

CMSP-covered services include dental services, up to the $750 maximum per state fiscal year (SFY), including preventive dental care.

CMSP benefits are calculated on a state fiscal-year basis. The state fiscal year starts on July 1st and continues through June 30th.

Members who have only CMSP coverage or choose to see a provider who is not a Health Safety Net (HSN) participating provider may have a patient responsibility after the processing of claims once the $750 state fiscal year maximum has been reached. Providers may charge the member up to the MassHealth allowable fee for any service after the annual maximum has been reached.

If a member has CMSP and HSN coverage the balance remaining, or any other covered services provided after reaching the SFY maximum will be paid under the Health Safety Net up to allowable rates with no patient responsibility.

18.2 MassHealth Health Safety Net Program

The HSN makes payments to Massachusetts hospitals and community health centers for health care services provided to low-income Massachusetts residents who are uninsured or underinsured. The HSN is administered by the Office of Medicaid within the Executive Office of Health and Human Services.

The HSN pays for the same set of dental services that are covered by MassHealth Standard, plus certain services which used to be covered by MassHealth but are not currently covered by MassHealth. Patients may be determined eligible only for the HSN or may be determined eligible for MassHealth with HSN as a secondary payer for certain services. The HSN prices dental services using MassHealth's dental fee schedule.

As of April 2025, DentaQuest administers the HSN Dental Program. HSN dental providers submit dental claims directly to DentaQuest for processing and pricing. The HSN makes a monthly payment to providers, which includes payment for both medical and dental services.
This Office Reference Manual provides important information for HSN providers about eligible dental services, claims, clinical criteria, and other processes.

* * *

The Health Safety Net Dental Program makes every effort to maintain accurate information in this manual; however, the Health Safety Net Dental Program and its administrator will not be held liable for any damages directly or indirectly due to typographical errors. Please contact us should you discover an error.

The Health Safety Net Dental Program is based upon Commonwealth of Massachusetts regulations governing dental services found in 101 CMR 613.00 and 101 CMR 614.00. All Acute Hospitals, Community Health Center (CHC), and Hospital Licensed Health Centers (HLHC) must comply with these regulations. Please refer to the Health Safety Net web page at www.mass.gov/healthsafetynet for additional information and regulations. If there is a conflict between the Office Reference Manual and the regulations, the regulations take precedence in every case.

Health Safety Net Eligibility & Reimbursable Service Provisions

Eligible Services Categories

There are three categories of services eligible for payment from the Health Safety Net, as follows:

1. Reimbursable Health Services to Low Income Patients as defined in 101 CMR 613.04.
2. Medical Hardship, pursuant to the requirements in 101 CMR 613.05; and
3. Bad Debt, pursuant to the requirements in 101 CMR 613.06.

Low Income Patients

"Low Income Patient" is the term used in Health Safety Net regulations to refer to a Health Safety Net patient. The Health Safety Net pays for Reimbursable Health Services provided to Low Income Patients for services provided during the Eligibility Period specified in 101 CMR 613.04(5). The Eligibility Period usually starts ten days before the date of application.

Reimbursable Health Services

The Health Safety Net pays only for the Reimbursable Health Services listed in this Office Reference Manual. Providers may submit claims only for Reimbursable Health Services provided by Acute Hospitals and Community Health Centers in accordance with the MassHealth Standard program using the payment codes as listed in Subchapter 6 of the *MassHealth Inpatient and Outpatient Provider Manuals* and other MassHealth Provider manuals unless otherwise specified in 101 CMR 614.00: *Health Safety Net Payments and Funding*.

Acute Hospitals

The Health Safety Net pays acute hospitals and HLHC's only for dental services identified in Subchapter 6 of the *MassHealth Dental Manual* and for Adult Dental Services not covered by MassHealth, as further clarified in Appendix B of this Office Reference Manual.

Community Health Centers

The Health Safety Net pays CHCs only for dental services identified in Subchapter 6 of the MassHealth *Dental Manual* and for Adult Dental Services not covered by MassHealth, as further clarified in Appendix B of this Office Reference Manual.

Community Health Centers may submit claims only for services provided under the Community Health Center's clinic license. A Community Health Center may submit claims only for dental services provided on site, with the exception that a Community Health Center may submit claims for dentures provided on site but manufactured or repaired at an off-site contractor.

Reimbursable Health Services Limitations

The Health Safety Net does not pay for any of the following services: nonmedical services, such as social, educational, and vocational services; cosmetic surgery; canceled or missed appointments; telephone conversations or consultations; court testimony; research or the provision of experimental, cosmetic, unproven, or otherwise medically unnecessary procedures or treatments.

Health Safety Net-Dental Plan Types

HSN Adult – HSN will pay for all HSN eligible dental services that are allowable for adults. Patients may qualify only for the HSN, or may also be enrolled in:

- Private Insurance
- ConnectorCare
- Medicare
- Student Health Insurance
- The Children's Medical Security Program (CMSP)
- Emergency Aid to the Elderly, Disabled, and Children (EAEDC)
- MassHealth Buy-In or Senior Buy-In
- MassHealth Family Assistance (Premium Assistance Only)
- Other insurance not listed above

HSN Under 21 – HSN will pay for all HSN eligible dental services that are allowable for children. Patients may qualify only for the HSN or may also be enrolled in a program or insurance plan listed above.

HSN Secondary to MassHealth Limited Adult – HSN will pay for eligible dental services that are allowable for adults and that are not covered by MassHealth Limited. Patients are eligible for MassHealth Limited as their primary payer, with the HSN as their secondary payer.

HSN Secondary to MassHealth Limited Under 21 – HSN will pay for eligible dental services that are allowable for children and that are not covered by MassHealth Limited. Patients are eligible for MassHealth Limited as their primary payer, with the HSN as their secondary payer.

HSN Secondary to MassHealth Comprehensive (Adult Only) – HSN will pay for certain dental services that MassHealth does not cover for adults at CHCs and hospital-based health centers. Patients may be enrolled in:

- MassHealth Standard
- MassHealth CarePlus
- MassHealth CommonHealth
- Most types of MassHealth Family Assistance

HSN CMSP Wrap - HSN will pay for eligible dental services allowable for eligible CMSP members that are not covered by MassHealth CMSP due to benefit coverage or exceeding the deductible. HSN CMSP wrap coverage does not have a deductible limitation for CMSP members.

Appendix A: Sample Forms

AUTHORIZATION FORM FOR COMPREHENSIVE ORTHODONTIC TREATMENT

MassHealth Handicapping Labio-Lingual Deviations Index

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

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

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

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

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

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

Procedure

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

Patient's Name (please print) **Member ID**

Address _____

Street City/County State Zip Code

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

Medical Necessity Narrative

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

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

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

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

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

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

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

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

Attestation

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

Prescribing provider's signature:_____

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

Printed name of prescribing provider

_____

Date

_____

Handicapping Labio-Lingual Deviation Index Scoring Instructions

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

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

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

AUTOQUALIFIERS

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

point of the incisal edge of the permanent mandibular incisor. To be scored as an autoqualifier, the open bite must involve 4 or more fully erupted teeth per arch. Indicate an "X" on the form. (This is considered an autoqualifying condition.)

HLD SCORING

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

Orthodontic Continuation of Care Solution Form

Date: _____

Patient Information

Name (First & Last)	Date of Birth	SS or ID#
Address	**City, State Zip**	**Area Code & Phone Number**

Provider Information

Dentist Name	Provider NPI #	Location ID#
Address	**City, State Zip**	**Area Code & Phone Number**

Name of Previous Insurer that issued original approval:

_____

Banding Date:

_____

Case Rate Approved by Previous Insurer:

_____

Amount Paid for Dates of Service that Occurred Prior Prior to the patient becoming a MassHealth member: member:

_____

Amount Owed for Dates of Service that Occurred to the patient becoming a MassHealth

_____

Balance Expected for Future Dates of Service:

_____

Numbers of Adjustments Remaining:

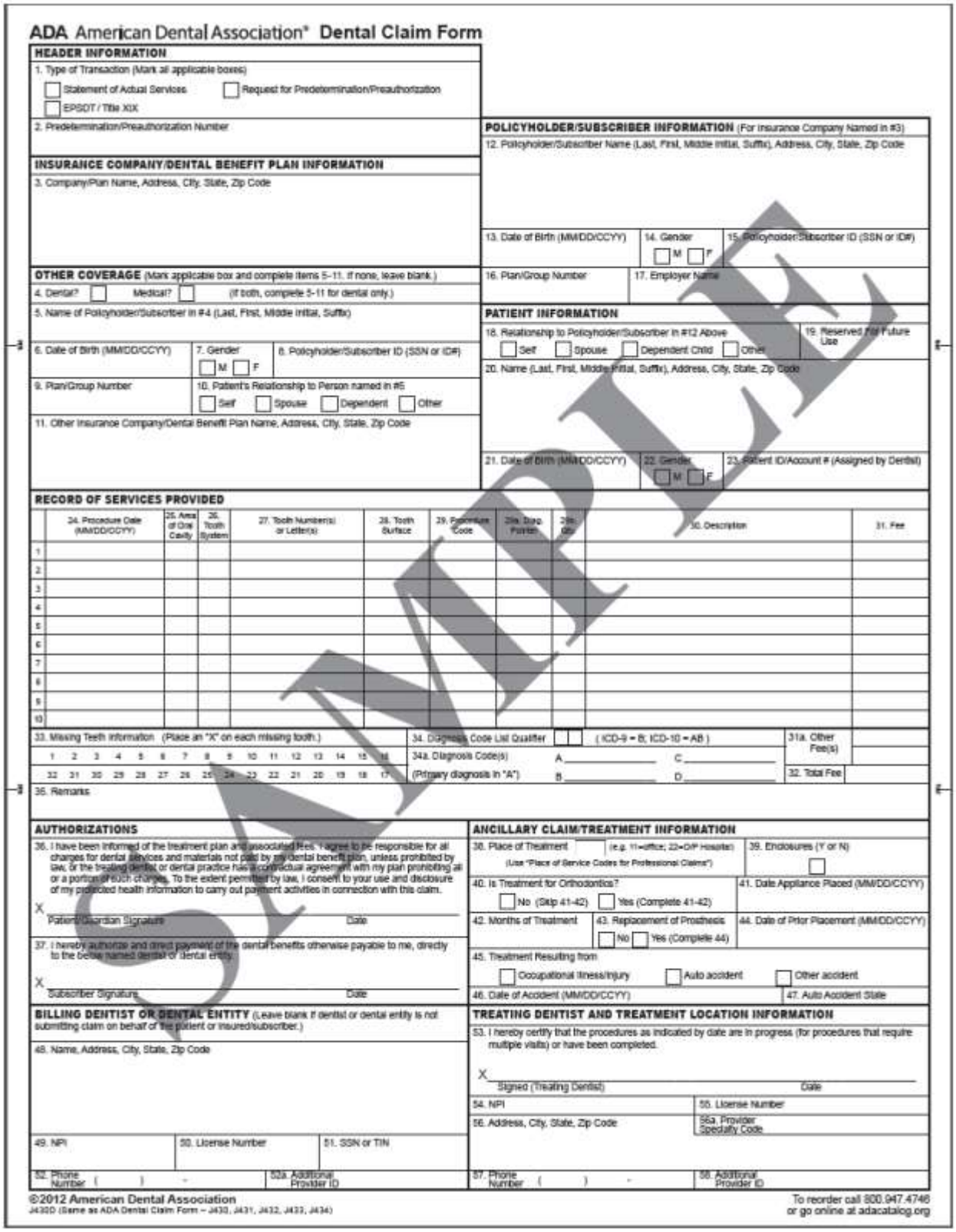
_____

Additional Information Required:

- If the member is transferring from an existing Medicaid program: Please send a copy of the original orthodontic approval to see the criteria used and/or the condition of the case where it was started if possible and the date treatment began/banding.
- If the member is private pay or transferring from a commercial insurance program: Please enclose the original diagnostic and HLD Form if possible and the date treatment began/banding. Models (or OrthoCAD equivalent) are optional.

Mail
MassHealth Dental
ATTN: MassHealth Continuation of Care
P.O. Box 2906
Milwaukee, WI 53201-2906

Dental Claim Form with Instructions



ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization
☐ EPSDT / Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐ M ☐ F | 8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number | 10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐ M ☐ F | 15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Reserved for Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐ M ☐ F | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier ☐☐ (ICD-9 = B; ICD-10 = AB)
34a. Diagnosis Code(s) A _____ C _____
(Primary diagnosis in "A") B _____ D _____

31a. Other Fee(s)
32. Total Fee

36. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber Signature Date

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code

49. NPI | 50. License Number | 51. SSN or TIN

52. Phone Number ( ) - | 52a. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims") | 39. Enclosures (Y or N) ☐

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42) | 41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment | 43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44) | 44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational Illness/Injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X _____
Signed (Treating Dentist) Date

54. NPI | 55. License Number

56. Address, City, State, Zip Code | 56a. Provider Specialty Code

57. Phone Number ( ) - | 58. Additional Provider ID

J430D (Same as ADA Dental Claim Form – J430, J431, J432, J433, J434)

To reorder call 800.947.4746 or go online at adacatalog.org

ADA American Dental Association®

America's leading advocate for oral health

The following information highlights certain form completion instructions. Comprehensive ADA Dental Claim Form completion instructions are printed in the CDT manual. Any updates to these instructions will be posted on the ADA's web site (ADA.org).

GENERAL INSTRUCTIONS

A. The form is designed so that the name and address (Item 3) of the third-party payer receiving the claim (insurance company/dental benefit plan) is visible in a standard #9 window envelope (window to the left). Please fold the form using the 'tick-marks' printed in the margin.

B. Complete all items unless noted otherwise on the form or in the CDT manual's instructions.

C. Enter the full name of an individual or a full business name, address and zip code when a name and address field is required.

D. All dates must include the four-digit year.

E. If the number of procedures reported exceeds the number of lines available on one claim form, list the remaining procedures on a separate, fully completed claim form.

COORDINATION OF BENEFITS (COB)

When a claim is being submitted to the secondary payer, complete the entire form and attach the primary payer's Explanation of Benefits (EOB) showing the amount paid by the primary payer. You may also note the primary carrier paid amount in the "Remarks" field (Item 35). There are additional detailed completion instructions in the CDT manual.

DIAGNOSIS CODING

The form supports reporting up to four diagnosis codes per dental procedure. This information is required when the diagnosis may affect claim adjudication when specific dental procedures may minimize the risks associated with the connection between the patient's oral and systemic health conditions. Diagnosis codes are linked to procedures using the following fields:

Item 29a – Diagnosis Code Pointer ("A" through "D" as applicable from Item 34a)

Item 34 – Diagnosis Code List Qualifier (B for ICD-9-CM; AB for ICD-10-CM)

Item 34a – Diagnosis Code(s) / A, B, C, D (up to four, with the primary adjacent to the letter "A")

PLACE OF TREATMENT

Enter the 2-digit Place of Service Code for Professional Claims, a HIPAA standard maintained by the Centers for Medicare and Medicaid Services. Frequently used codes are:

11 = Office; 12 = Home; 21 = Inpatient Hospital; 22 = Outpatient Hospital; 31 = Skilled Nursing Facility; 32 = Nursing Facility

The full list is available online at "www.cms.gov/PhysicianFeeSched/Downloads/Website_POS_database.pdf"

PROVIDER SPECIALTY

This code is entered in Item 56a and indicates the type of dental professional who delivered the treatment. The general code listed as "Dentist" may be used instead of any of the other codes.

Category / Description Code	Code
Dentist A dentist is a person qualified by a doctorate in dental surgery (D.D.S.) or dental medicine (D.M.D.) licensed by the state to practice dentistry, and practicing within the scope of that license.	122300000X
General Practice	1223G0001X
Dental Specialty (see following list)	Various
Dental Public Health	1223D0001X
Endodontics	1223E0200X
Orthodontics	1223X0400X
Pediatric Dentistry	1223P0221X
Periodontics	1223P0300X
Prosthodontics	1223P0700X
Oral & Maxillofacial Pathology	1223P0106X
Oral & Maxillofacial Radiology	1223D0008X
Oral & Maxillofacial Surgery	1223S0112X

Provider taxonomy codes listed above are a subset of the full code set that is posted at "www.wpc-edi.com/codes/taxonomy"

Void Request Form

Paper Voids: To submit a paper void request, please complete this form and attach a photocopy of the **Remittance Advice (RA)** containing the claim lines to be voided. Please *Circle* each claim line to be voided on the copy of the RA.

Send void requests to:

MassHealth Dental Program
Attn: MassHealth Voids
P.O. Box 2906
Milwaukee, WI 53201-2906

Please note: Previously paid claims can be voided electronically in the HIPAA-Compliant 837 format using the void and replace transaction.

Date of Request

Provider or Facility Name

MassHealth Provider Number

Provider Address

Billing Provider's NPI#

Provider City, State, Zip

Amount

Please check off one reason for requesting the void

Please note: If you need several claims voided for different reasons, please complete a request form for each reason and attach a copy of the RA indicating the claim line to be voided. A void request for serval claims that are being requested for the same reason may be batched together with one request form.

- ☐ Collection from a Primary Health Insurance
  Name of Insurance Company: _____
- ☐ Collection from Auto Insurance of Worker's Compensation Insurance
- ☐ Claim paid to the wrong provider
- ☐ Wrong MassHealth member ID (MID) on the claim
- ☐ Provider billed incorrect service date
- ☐ Duplicate payment
- ☐ Provider performed only a certain component of the entire service billed
- ☐ Other (please explain): _____

The voided claim will be processed on a future remittance advice. The total amount originally paid will appear as a negative amount and that amount will be deducted from the payments until the overpayment is recovered. If applicable, please follow the billing instructions found in your provider manual for resubmitting a replacement claim.

Provider/Facility Authorized Signature

Date

Initial Clinical Exam

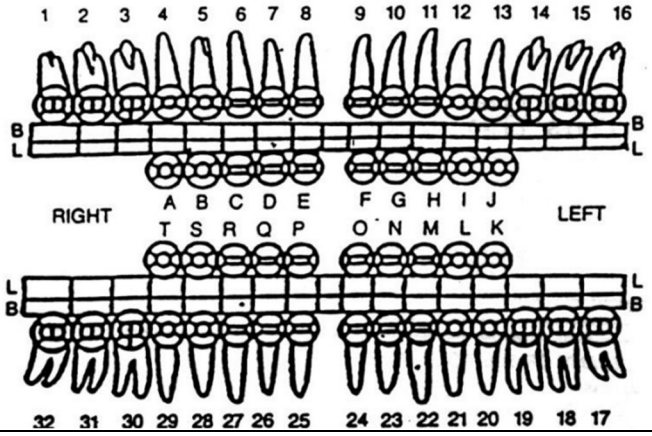
(Sample)

Allergy	Pre Med	Medical Alert

Initial Clinical Exam

Patient's Name: _____

Last First Middle



Gingiva

Mobility

Prosthesis Evaluation

Occlusion 1 11 111

Patient's Chief Complaint

	OK
Lymph Nodes	
Pharynx	
Tonsils	
Soft Palate	
Hard Palate	
Floor of Mouth	
Tongue	
Vestibules	
Buccal Mucosa	
Lips	
Skin	
TMJ	
Oral Hygiene	
Perio Exam	

Clinical Findings/Comments

Radiographs	B/P	RDH/DMD/DDS

Recommended Treatment Plan

Tooth or Area	Diagnosis	Plan A	Plan B

Signature of Dentist:_____ Date: _____

Recall Examination

(Sample)

Patient's Name: _____

Changes in Health Status/Medical History: _____

Clinical Findings/Comments

	OK		OK
Lymph Nodes		TMJ	
Pharynx		Tongue	
Tonsils		Vestibules	
Soft Palate		Buccal Mucosa	
Hard Palate		Gingiva	
Floor of Mouth		Prosthesis	
Lips		Perio Exam	
Skin		Oral Hygiene	
Radiographs		B/P	RDH/DMD/DDS

R **Work Necessary** **L**

Tooth	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Service																
Tooth	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
Service																

Comments: _____

Recall Examination

Patient's Name: _____

Changes in Health Status/Medical History: _____

Clinical Findings/Comments

	OK		OK
Lymph Nodes		TMJ	
Pharynx		Tongue	
Tonsils		Vestibules	
Soft Palate		Buccal Mucosa	
Hard Palate		Gingiva	
Floor of Mouth		Prosthesis	
Lips		Perio Exam	
Skin		Oral Hygiene	
Radiographs		B/P	RDH/DMD/DDS

R **Work Necessary** **L**

Tooth	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Service																
Tooth	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
Service																

Comments: _____

Medical and Dental History
(Sample)

Patient Name:_____Date of Birth: _____

Address: _____

Why are you here today? _____

Are you having any pain or discomfort at this time? ☐ Yes ☐ No

If yes, what type and where? _____

Have you been under the care of a medical doctor during the past two years? ☐ Yes ☐ No

Medical Doctor's Name: _____

Address: _____

Telephone: _____

Have you taken any medication or drugs during the past two years? ☐ Yes ☐ No

Are you now taking any medication, drugs, or pills? ☐ Yes ☐ No

If yes, please list medications: _____

Are you aware of being allergic to or have you ever reacted badly to any medication or substance? ☐ Yes ☐ No

If yes, please list: _____

When you walk upstairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are tired? ☐ Yes ☐ No

Do your ankles swell during the day? ☐ Yes ☐ No

Have you lost or gained more than 10 pounds in the past year? ☐ Yes ☐ No

Do you ever wake up from sleep and feel short of breath? ☐ Yes ☐ No

Are you on a special diet? ☐ Yes ☐ No

Has your medical doctor ever said you have cancer or a tumor? ☐ Yes ☐ No

If yes, where? _____

Do you use tobacco products (smoke or chew tobacco)? ☐ Yes ☐ No

If yes, how often and how much? _____

Do you drink alcoholic beverages (beer, wine, whiskey, etc.)? ☐ Yes ☐ No

Do you have or have you had any disease, or condition not listed? ☐ Yes ☐ No

If yes, please list: _____

Indicate which of the following you have had or have at present. Check "Yes" or "No" for each item.

Heart Disease or Attack	☐ Yes	☐ No	Stroke	☐ Yes	☐ No	Arteriosclerosis (hardening of arteries)	☐ Yes	☐ No
Heart Failure	☐ Yes	☐ No	Kidney Trouble	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Angina Pectoris	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No	AIDS	☐ Yes	☐ No
Congenital Heart Disease	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Blood Transfusion	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Cold Sores/Fever Blisters/Herpes	☐ Yes	☐ No
HIV Positive	☐ Yes	☐ No	Cortisone Medication	☐ Yes	☐ No	Artificial Heart Valve	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Cosmetic Surgery	☐ Yes	☐ No	Heart Pacemaker	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No	Anemia	☐ Yes	☐ No	Sickle Cell Disease	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Heart Surgery	☐ Yes	☐ No	Asthma	☐ Yes	☐ No
Chronic Cough	☐ Yes	☐ No	Bruise Easily	☐ Yes	☐ No	Yellow Jaundice	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No	Rheumatism	☐ Yes	☐ No
Liver Disease	☐ Yes	☐ No	Epilepsy or Seizures	☐ Yes	☐ No	Fainting or Dizzy Spells	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Nervousness	☐ Yes	☐ No	Chemotherapy	☐ Yes	☐ No
Allergies or Hives	☐ Yes	☐ No	Radiation Therapy	☐ Yes	☐ No	Drug Addiction	☐ Yes	☐ No
Sinus Trouble	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No	Psychiatric Treatment	☐ Yes	☐ No
Pain in Jaw Joints	☐ Yes	☐ No	Hepatitis A (Infectious)	☐ Yes	☐ No	Artificial Joints (Hip, Knee, etc.)	☐ Yes	☐ No
Hay Fever	☐ Yes	☐ No	Hepatitis B (Serum)	☐ Yes	☐ No	Hepatitis C	☐ Yes	☐ No

For Women Only:

Are you pregnant? ☐ Yes ☐ No

If yes, what month? _____

Are you nursing? ☐ Yes ☐ No

Are you taking birth control pills? ☐ Yes ☐ No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully.

Patient Signature:_____ Date: _____

Dentist's Signature:_____ Date: _____

Review Date	Changes in Health Status	Patient's Signature	Dentist's Signature

Note: The above form is only intended to be a sample. The MassHealth Dental Program is not mandating the use of this form. Please refer to the MassHealth Dental regulations at 130 CMR 420.000 for requirements and guidelines.

Appendix B - Covered Services (See Exhibit A)

This appendix identifies covered services, provides specific criteria for coverage and defines individual age and service limitations for MassHealth Dental Program members. **Providers with questions should contact the MassHealth Dental Program's Provider Services Department directly at 866-616-2699.**

The MassHealth Dental Program recognizes tooth letters "A" through "T" for primary teeth and tooth numbers "1" to "32" for permanent teeth. Supernumerary teeth should be designated by "AS through TS" for primary teeth and tooth numbers "51" to "82" for permanent teeth. These codes must be referenced in the patient's file for record retention and review.

The MassHealth Dental Program claim system will only process claims with the CDT service codes as described in 130 CMR 420.1 and Exhibit A. All other claims with service codes not contained in the following tables will be rejected when submitted for payment. A complete, copy of the CDT book can be purchased from the American Dental Association:

America
Dental
Associatio
n 211 East
Chicago
Avenue
Chicago, IL
60611
800-947-4746
http://ebusiness.ada.org/default.aspx

Furthermore, the MassHealth Dental Program subscribes to the definition of services performed as described in the CDT manual.

The covered CDT services tables (Exhibit A) are all inclusive. Each category of service is contained in a separate table and lists:

1. the ADA approved service code to submit when billing,
2. brief description of the covered service,
3. any age limits imposed on coverage,
4. a description of documentation, in addition to a completed claim must be submitted when a claim or request for prior authorization is submitted,
5. An indicator of whether or not the service is subject to prior authorization, retrospective review, or any other applicable limitations.

Refer to Subchapter 6 of the *Dental Manual* for covered CPT codes.

Benefits Covered for MassHealth – Under 21 Orthodontic

As detailed in Section 17.00 of the Office Reference Manual, Members under age 21 may qualify for orthodontic treatment (Membe
older may qualify for continuation of treatment if they have been fully banded prior to their 21st birthday). All orthodontic services r
authorization with the exception of pre- orthodontic treatment visits and orthodontic retention. For information and instructions on
prior authorization requests for orthodontic services and other relevant information, please refer to the sections of the Office Refere
listed below:

- Comprehensive Orthodontic Treatment: Sections 17.1 and 17.2 and Appendix B;
- Limited Orthodontic Treatment: Section 17.5;
- Continuation of Care: Section 17.4;

Transfers

If a member transfers to a new dental provider's office, that new dental provider's office can retake a new series or shall request a co
member's radiographs from the previous dental provider. If the films or their copies cannot be provided by the previous dental prov
dental provider shall document this fact in the member's record and proceed to take the needed films that are required to diagnose,
treatment plan and provide treatment. It is not the intention of the MassHealth agency to impede timely treatment while waiting fo
dentist to provide the requested radiographs and records.

Emergency or Postoperative

In an emergency situation, in order to establish a diagnosis which must be recorded, a radiograph may be taken at any time, as dent
Postoperative radiographs normally taken at the conclusion of dental treatment by a dental provider shall be maintained as part of t
dental records (Example: final radiographs at completion of endodontic treatment, or certain surgical procedures).

Referrals

Radiological services other than those ordinarily provided by a practitioner in his or her own office may be referred to a dental specia
provide radiological services limited to his or her own special field. Radiological services may also be requested from a physician who
in radiology or a qualified hospital facility.
Services provided by another dentist, physician, or hospital facility shall be billed directly to the MassHealth agency by that provider
referring dentist.

Exhibit A: MassHealth Dental Program Covered Benefits, Exclusions, Limitations, and Fee Schedule

MassHealth Dental Program Covered Benefits, Exclusions, Limitations & Fee Schedule												Last updated: 9/29/2025
Procedure Code	Description	Allowed Fee		MH Standard (Regular)		CMSP	MH Limited	HSN		Benefit Limitations	Required Review	Documentation Required
		<21	21+	<21	21+			<21	21+			
I. Diagnostic												
D0120	Periodic oral evaluation - established patient	$31	$24	Y	Y	Y	NC	Y	Y	Two (D0120, D0145) per 1 calendar years(s) per provider OR location. Not covered with D9110, D0140 by same provider or provider group on same date of service.	--	--
D0140	Limited oral evaluation - problem focused	$49	$43	Y	Y	Y	Y	Y	Y	Two of (D0140) per 1 Calendar year(s) Per patient. Not covered with D9110, D0120, D0180 by same provider or provider group on same date of service.	--	--
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	$27	NC	Y	NC	Y	NC	Y	NC	Age limitation: <3 years Two of (D0120, D0145) per 1 Calendar year(s) Per Provider OR Location. Not covered with D9110, D0140 by same provider or provider group on same date of service. Cannot be billed on the same date of service as D0150.	--	--
D0150	Comprehensive oral evaluation - new or established patient	$62	$41	Y	Y	Y	NC	Y	Y	One of (D0150) per 1 Lifetime Per Provider OR Location. Cannot be billed on the same date of service as D0145, D0180.	--	--
D0180	Comprehensive periodontal evaluation - new or established patient	$58	$37	Y	Y	Y	NC	Y	Y	Covered for patients showing signs or symptoms of periodontal disease and for patients with periodontal risk factors such as smoking or diabetes. One of (D0180) per 1 Calendar year(s) Per Provider OR Location. Not covered with D9110, D0140, D0145, D0150 by same provider or provider group on same date of service.	--	Comprehensive periodontal evaluation including full six-point periodontal charting is required. D0180 is not covered if periodontal charting is limited to Periodontal Screening and Recording (PSR).
D0190	Screening of a patient (PHDH only)	$29	$20	Y	Y	Y	NC	Y	Y	Two of (D0190, D0191) per 1 Calendar year(s) Per Provider OR Location. Only payable to a Public Health Dental Hygienist in a public health setting. Not covered with D9110, D0191 by same provider or provider group on same date of service. Excludes place of service (POS) codes 02, 10, 11, 21, 23, 24, 49, 50, 66	--	
D0191	Assessment of a patient (PHDH only)	$29	$20	Y	Y	Y	NC	Y	Y	Two of (D0190, D0191) per 1 Calendar year(s) Per Provider OR Location. Only payable to a Public Health Dental Hygienist in a public health setting. Not covered with D9110, D0191 by same provider or provider group on same date of service. Excludes place of service (POS) codes 02, 10, 11, 21, 23, 24, 49, 50, 66	--	
D0210	Intraoral - complete series of radiographic images	$94	$76	Y	Y	Y	NC	Y	Y	Ages limitation: 6 years and older One of (D0210) per 3 Calendar year(s) Per Provider OR Location. One complete series every three calendar years per patient per dentist or dental group. Any combination of radiographs that exceeds the maximum allowable payment for a FMX will be reimbursed at the D0210 rate.	--	Variation from ADA clinical guidelines to be kept in patient record.
D0220	Intraoral - periapical, first radiographic image	$21	$15	Y	Y	Y	Y	Y	Y	One of (D0220) per 1 Day(s) Per Provider OR Location. Twelve of (D0220, D0230) per 12 Month(s) Per patient. Maximum of one per visit. Any combination of radiographs that exceeds the maximum allowable payment for a FMX will be reimbursed at the D0210 rate.	--	Variation from ADA clinical guidelines to be kept in patient record.
D0230	Intraoral - periapical, each additional radiographic image	$17	$13	Y	Y	Y	Y	Y	Y	Three of (D0230) per 1 Day(s) Per Provider OR Location. Twelve of (D0220, D0230) per 12 Month(s) Per patient. Maximum of three per visit. Any combination of radiographs that exceeds the maximum allowable payment for a FMX will be reimbursed at the D0210 rate.	--	Variation from ADA clinical guidelines to be kept in patient record.
D0240	Intraoral - occlusal radiographic image	$26	NC	Y	NC	Y	NC	Y	NC	Age Limitation: 4 years and younger Two of (D0240) per 1 Calendar year(s) Per Provider OR Location.	--	Variation from ADA clinical guidelines to be kept in patient record.
D0270	Bitewing - single radiographic image	$17	$14	Y	Y	Y	NC	Y	Y	Two of (D0270, D0272, D0273, D0274) per 1 Calendar year(s) Per Provider OR Location. One of (D0270, D0272, D0273, D0274) per 1 Day(s) Per patient. Any combination of radiographs that exceeds the maximum allowable payment for a FMX will be reimbursed at the D0210 rate.	--	Variation from ADA clinical guidelines to be kept in patient record.

MassHealth Dental Program Covered Benefits, Exclusions, Limitations & Fee Schedule												Last updated: 9/29/2025
Procedure Code	Description	Allowed Fee		MH Standard (Regular)		CMSP	MH Limited	HSN		Benefit Limitations	Required Review	Documentation Required
		<21	21+	<21	21+			<21	21+			
D0272	Bitewings - two radiographic images	$32	$25	Y	Y	Y	NC	Y	Y	Two of (D0270, D0272, D0273, D0274) per 1 Calendar year(s) Per Provider OR Location. One of (D0270, D0272, D0273, D0274) per 1 Day(s) Per patient. Any combination of radiographs that exceeds the maximum allowable payment for a FMX will be reimbursed at the D0210 rate.	--	Variation from ADA clinical guidelines to be kept in patient record.
D0273	Bitewings - three radiographic images	$35	$27	Y	Y	Y	NC	Y	Y	Two of (D0270, D0272, D0273, D0274) per 1 Calendar year(s) Per Provider OR Location. One of (D0270, D0272, D0273, D0274) per 1 Day(s) Per patient. Any combination of radiographs that exceeds the maximum allowable payment for a FMX will be reimbursed at the D0210 rate.	--	Variation from ADA clinical guidelines to be kept in patient record.
D0274	Bitewings - four radiographic images	$46	$36	Y	Y	Y	NC	Y	Y	Two of (D0270, D0272, D0273, D0274) per 1 Calendar year(s) Per Provider OR Location. One of (D0270, D0272, D0273, D0274) per 1 Day(s) Per patient. Any combination of radiographs that exceeds the maximum allowable payment for a FMX will be reimbursed at the D0210 rate.	--	Variation from ADA clinical guidelines to be kept in patient record.
D0330	Panoramic radiographic image	$94	$69	Y	Y	Y	Y	Y	Y	One of (D0330) per 3 Year(s) Per Provider OR Location. (Not covered when billed with services related to Crowns, Endodontics, Periodontics, Restorations and Orthodontics). Not covered when the treating dentist is an orthodontist, endodontist, prosthodontist and periodontist. Non-surgical conditions. Surgical conditions are payable in excess of the 3 year limitation when used as a diagnostic tool. Any combination of radiographs that exceeds the maximum allowable payment for an FMX will be reimbursed at the same rate as D0210.	--	Variation from ADA clinical guidelines to be kept in patient record.
D0340	Cephalometric radiograph image (Oral surgeon only)	$85	$74	Y	Y	Y	NC	Y	Y	Non-orthodontic procedures. Only payable to a dental provider with specialty in oral surgery	21+ PA	21+ PA: Narrative of medical necessity supporting need in conjunction with surgical condition
II. Preventive												
D1110	Prophylaxis – adult, 14 yo or older	$75	$60	Y	Y	Y	NC	Y	Y	Age limitation: 14 years and older Two of (D1110, D1120, D4346) per 1 Calendar year(s) Per patient. Includes minor scaling procedures.	--	--
D1120	Prophylaxis – child, 0-13 yo	$55	NC	Y	NC	Y	NC	Y	NC	Age limitation: 13 years and younger Two of (D1110, D1120, D4346) per 1 Calendar year(s) Per patient. Includes minor scaling procedures.	--	--
D1206	Topical application of fluoride varnish	$28	$26	Y	Y	Y	NC	Y	NC	One of (D1206, D1208) per 90 Day(s) Per Provider OR Location. Cannot be billed with D1208 on same date of service by the same provider or location.	21+ PA	21+ PA: Narrative of Medical Necessity supporting medical or dental conditions that significantly interrupt the flow of saliva
D1208	Topical application of fluoride – excluding varnish	$31	$29	Y	Y	Y	NC	Y	NC	One of (D1206, D1208) per 90 Day(s) Per Provider OR Location. Cannot be billed with D1206 on same date of service by the same provider or location.	21+ PA	21+ PA: Narrative of Medical Necessity supporting medical or dental conditions that significantly interrupt the flow of saliva
D1351	Sealant – per tooth	$44	NC	Y	NC	Y	NC	Y	NC	Age limitation: 16 years and younger Teeth 1-3, 14-19, 30-32 One of (D1351) per 3 Year(s) Per Provider OR Location per tooth.	--	--
D1354	Application of caries arresting medicament - per tooth	$15	$15	Y	Y	Y	NC	Y	Y	Teeth 1 - 32, A - T Two of (D1354) per 1 Lifetime Per patient per tooth.	--	--
D1510	Space maintainer – fixed,unilateral – per quadrant	$229	NC	Y	NC	Y	NC	Y	NC	Age limitation: <21 years Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR) Four of (D1510, D1516, D1517, D1520, D1526, D1527, D1575) per 1 Lifetime Per patient. Excludes a Distal Shoe Maintainer.	--	Must maintain radiographs in patient record demonstrating that the tooth has not begun to erupt or that migration of the adjacent tooth has already occurred.

MassHealth Dental Program Covered Benefits, Exclusions, Limitations & Fee Schedule												Last updated: 9/29/2025
Procedure Code	Description	Allowed Fee		MH Standard (Regular)		CMSP	MH Limited	HSN		Benefit Limitations	Required Review	Documentation Required
		<21	21+	<21	21+			<21	21+			
D1516	Space maintainer- fixed- bilateral, maxillary	$345	NC	Y	NC	Y	NC	Y	NC	Age limitation: <21 years Four of (D1510, D1516, D1517, D1520, D1526, D1527, D1575) per 1 Lifetime Per patient. Excludes a Distal Shoe Maintainer.	--	Must maintain radiographs in patient record demonstrating that the tooth has not begun to erupt or that migration of the adjacent tooth has already occurred.
D1517	Space maintainer- fixed- bilateral, mandibular	$345	NC	Y	NC	Y	NC	Y	NC	Age limitation: <21 years Four of (D1510, D1516, D1517, D1520, D1526, D1527, D1575) per 1 Lifetime Per patient. Excludes a Distal Shoe Maintainer.	--	Must maintain radiographs in patient record demonstrating that the tooth has not begun to erupt or that migration of the adjacent tooth has already occurred.
D1520	Space maintainer – removable- unilateral- per quadrant	$244	NC	Y	NC	Y	NC	Y	NC	Age limitation: <21 years Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR) Four of (D1510, D1516, D1517, D1520, D1526, D1527, D1575) per 1 Lifetime Per patient. Excludes a Distal Shoe Maintainer.	--	Must maintain radiographs in patient record demonstrating that the tooth has not begun to erupt or that migration of the adjacent tooth has already occurred.
D1526	Space maintainer- removable- bilateral, maxillary	$368	NC	Y	NC	Y	NC	Y	NC	Age limitation: <21 years Four of (D1510, D1516, D1517, D1520, D1526, D1527, D1575) per 1 Lifetime Per patient. Excludes a Distal Shoe Maintainer.	--	Must maintain radiographs in patient record demonstrating that the tooth has not begun to erupt or that migration of the adjacent tooth has already occurred.
D1527	Space maintainer- removable- bilateral, mandibular	$368	NC	Y	NC	Y	NC	Y	NC	Age limitation: <21 years our of (D1510, D1516, D1517, D1520, D1526, D1527, D1575) per 1 Lifetime Per patient. Excludes a Distal Shoe Maintainer.	--	Must maintain radiographs in patient record demonstrating that the tooth has not begun to erupt or that migration of the adjacent tooth has already occurred.
D1575	Distal shoe space maintainer - fixed- unilateral- Per Quadrant	I.C.	NC	NC	NC	Y	NC	Y	NC	Age limitation: <21 years Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR) Four of (D1510, D1516, D1517, D1520, D1526, D1527, D1575) per 1 Lifetime per patient.	--	Must maintain radiogahps in patient record demonstrating that the tooth has not begun to erupt or that the migraton of the adjacent tooth has already occurred.
D1701	Pfizer-BioNTech Covid-19 vaccine administration – first dose SARSCOV2 COVID-19 VAC mRNA 30mcg/0.3mL IM DOSE 1	$45.87	$45.87	Y	Y	Y	NC	Y	Y	One of (D1701) per 1 Lifetime per patient.	--	--
D1702	Pfizer-BioNTech Covid-19 vaccine administration – second dose SARSCOV2 COVID-19 VAC mRNA 30mcg/0.3mL IM DOSE 2	$45.87	$45.87	Y	Y	Y	NC	Y	Y	One of (D1702) per 1 Lifetime per patient.	--	--
D1703	Moderna Covid-19 vaccine administration – second dose SARSCOV2 COVID-19 VAC mRNA 100mcg/0.5mL IM DOSE 2	$45.87	$45.87	Y	Y	Y	NC	Y	Y	One of (D1703) per 1 Lifetime per patient.	--	--
D1704	Moderna Covid-19 vaccine administration – second dose SARSCOV2 COVID-19 VAC mRNA 100mcg/0.5mL IM DOSE 2	$45.87	$45.87	Y	Y	Y	NC	Y	Y	One of (D1704) per 1 Lifetime per patient.	--	--
D1707	Janssen Covid-19 vaccine administration SARSCOV2 COVID-19 VAC Ad26 5x1010 VP/.5mL IM SINGLE DOSE	$45.87	$45.87	Y	Y	Y	NC	Y	Y	One of (D1707) per 1 Lifetime per patient.	--	--
D1708	Pfizer-BioNTech Covid-19 vaccine administration – third dose	$45.87	$45.87	Y	Y	Y	NC	Y	Y	One of (D1708) per 1 Lifetime per patient.	--	--
D1709	Pfizer-BioNTech Covid-19 vaccine administration – booster dose	$45.87	$45.87	Y	Y	Y	NC	Y	Y	--	--	--
D1710	Moderna Covid-19 vaccine administration – third dose	$45.87	$45.87	Y	Y	Y	NC	Y	Y	One of (D1710) per 1 Lifetime per patient.	--	--
D1711	Moderna Covid-19 vaccine administration – booster dose	$45.87	$45.87	Y	Y	Y	NC	Y	Y	--	--	--
D1712	Janssen Covid-19 vaccine administration - booster dose	$45.87	$45.87	Y	Y	Y	NC	Y	Y	--	--	--
D1713	Pfizer-BioNTech Covid-19 vaccine administration tris-sucrose pediatric – first dose	$45.87	$45.87	Y	Y	Y	NC	Y	Y	One of (D1713) per 1 Lifetime per patient.	--	--
D1714	Pfizer-BioNTech Covid-19 vaccine administration tris-sucrose pediatric – second dose	$45.87	$45.87	Y	Y	Y	NC	Y	Y	One of (D1714) per 1 Lifetime per patient.	--	--

MassHealth Dental Program Covered Benefits, Exclusions, Limitations & Fee Schedule												Last updated: 9/29/2025
Procedure Code	Description	Allowed Fee		MH Standard (Regular)		CMSP	MH Limited	HSN		Benefit Limitations	Required Review	Documentation Required
		<21	21+	<21	21+			<21	21+			
III. Restorative												
D2140	Amalgam-one surface, primary or permanent	$77	$62	Y	Y	Y	NC	Y	Y	Teeth 1 - 32, A - T One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 months Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	--	--
D2150	Amalgam-two surfaces, primary or permanent	$95	$77	Y	Y	Y	NC	Y	Y	Teeth 1 - 32, A - T One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 months Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	--	--
D2160	Amalgam-three surfaces, primary or permanent	$110	$92	Y	Y	Y	NC	Y	Y	Teeth 1 - 32, A - T One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 months Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	--	--
D2161	Amalgam-four or more surfaces, primary or permanent	$137	$116	Y	Y	Y	NC	Y	Y	Teeth 1 - 32, A - T One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 months Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	--	--
D2330	Resin-based composite – one surface, anterior	$98	$72	Y	Y	Y	NC	Y	Y	Teeth 6 - 11, 22 - 27, C - H, M - R One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 months Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	--	--
D2331	Resin-based composite – two surfaces, anterior	$118	$92	Y	Y	Y	NC	Y	Y	Teeth 6 - 11, 22 - 27, C - H, M - R One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 months Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	--	--
D2332	Resin-based composite – three surfaces, anterior	$147	$116	Y	Y	Y	NC	Y	Y	Teeth 6 - 11, 22 - 27, C - H, M - R One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 months Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	--	--
D2335	Resin-based composite – four or more surfaces or involving incisal angle (anterior)	$188	$146	Y	Y	Y	NC	Y	Y	Teeth 6 - 11, 22 - 27, C - H, M - R One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 months Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	--	--
D2390	Resin-based composite crown, anterior	$133	NC	Y	Y	Y	NC	Y	Y	Age limitation: <21 years Teeth 6 - 11, 22 - 27, C - H, M - R One of (D2390) per 12 Months Per patient per tooth.	--	--
D2391	Resin-based composite – one surface, posterior	$99	$62	Y	Y	Y	NC	Y	Y	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 months Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	--	--
D2392	Resin-based composite – two surfaces, posterior	$123	$77	Y	Y	Y	NC	Y	Y	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 months Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	--	--
D2393	Resin-based composite – three surfaces, posterior	$133	$92	Y	Y	Y	NC	Y	Y	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 months Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	--	--

MassHealth Dental Program Covered Benefits, Exclusions, Limitations & Fee Schedule												Last updated: 9/29/2025
Procedure Code	Description	Allowed Fee		MH Standard (Regular)		CMSP	MH Limited	HSN		Benefit Limitations	Required Review	Documentation Required
		<21	21+	<21	21+			<21	21+			
D2394	Resin-based composite – four or more surfaces, posterior	$182	$116	Y	Y	Y	NC	Y	Y	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 months Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	--	--
D2710	Crown – resin-based composite (indirect)	$244	NC	Y	NC	Y	NC	Y	NC	Age limitation: <21 years Teeth 3 - 14, 19 - 30 One of (D2710, D2740, D2750, D2751, D2752, D2790) per 60 Months Per patient per tooth.	--	--
D2740	Crown – porcelain/ceramic	$853	$729	Y	Y	Y	NC	Y	Y	Teeth 2 - 15, 18 - 31 One of (D2710, D2740, D2750, D2751, D2752, D2790) per 60 Months Per patient per tooth.	CR**, >1 crown for 21+, Eff: 4/1/25	**For crowns delivered to adults when more than one crown is delivered on the same date of service, the claim review documentation requirements are effective for dates of service 4/1/25 and after. CR: Pre-Tx PA radiograph; Pre-Tx BW for posterior teeth; Posterior BWs, FMX, or PAN; Post-Tx Radiograph
D2750	Crown – porcelain fused to high noble metal	$800	NC	Y	NC	Y	NC	Y	NC	Age limitation: <21 years Teeth 2 - 15, 18 - 31 One of (D2710, D2740, D2750, D2751, D2752, D2790) per 60 Months per patient per tooth.	--	--
D2751	Crown – porcelain fused to predominantly base metal	$727	$613	Y	Y	Y	NC	Y	Y	Teeth 2 - 15, 18 - 31 One of (D2710, D2740, D2750, D2751, D2752, D2790) per 60 Months per patient per tooth.	CR**, >1 crown for 21+, Eff: 4/1/25	**For crowns delivered to adults when more than one crown is delivered on the same date of service, the claim review documentation requirements are effective for dates of service 4/1/25 and after. CR: Pre-Tx PA radiograph; Pre-Tx BW for posterior teeth; Posterior BWs, FMX, or PAN; Post-Tx Radiograph
D2752	Crown – porcelain fused to noble metal	$735	NC	Y	NC	Y	NC	Y	NC	Age limitation: <21 years Teeth 2 - 15, 18 - 31 One of (D2710, D2740, D2750, D2751, D2752, D2790) per 60 Months per patient per tooth.	--	--
D2790	Crown – full cast high noble metal	$808	NC	Y	NC	Y	NC	Y	NC	Age limitation: <21 years Teeth 2 - 15, 18 - 31 One of (D2710, D2740, D2750, D2751, D2752, D2790) per 60 Months per patient per tooth.	--	--
D2910	Re-cement or re-bond inlay, onlay or partial coverage restoration	$69	$57	Y	Y	Y	NC	Y	NC	Teeth 2 - 15, 18 - 31 Not covered within 6 months of initial placement.	--	--
D2920	Re-cement or re-bond crown	$68	$57	Y	Y	Y	NC	Y	NC	Teeth 2 - 15, 18 - 31, A - T Not covered within 6 months of initial placement.	--	--
D2929	Prefabricated porcelain/ceramic crown – primary tooth	$224	NC	Y	NC	Y	NC	Y	NC	Age limitation: <21 years Teeth C - H, M - R One of (D2929, D2930, D2931, D2932, D2934) per tooth per lifetime.	--	--
D2930	Prefabricated stainless steel crown – primary tooth	$205	NC	Y	NC	Y	NC	Y	NC	Age limitation: <21 years Teeth A - T One of (D2929, D2930, D2931, D2932, D2934) per tooth per lifetime.	--	--

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		<21	21+	<21	21+			<21	21+			
D2931	Prefabricated stainless steel crown – permanent tooth	$199	$171*	Y	DDS*	Y	NC	Y	NC	Age limitation: <21 years* <21 years: Teeth 2 - 5, 12 - 15, 18 - 21, 28 - 31; DDS ONLY, Teeth 1 - 32 < 21 years: One of (D2929, D2930, D2931, D2932, D2934) per tooth per lifetime. Age limitation: DDS ONLY, 21 years and older DDS 21+: Teeth 1 - 32 DDS 21+: One of (D2931) per 36 months per patient per tooth. *Only adults with DDS have coverage for D2931	--	--
D2932	Prefabricated resin crown	$224	NC	Y	NC	Y	NC	Y	NC	Age limitation: <21 years Teeth 1 - 32, A - T One of (D2929, D2930, D2931, D2932, D2934) per tooth per lifetime.	--	--
D2934	Prefabricated esthetic coated stainless steel crown – primary tooth	$184	NC	Y	NC	Y	NC	Y	NC	Age limitation: <21 years Teeth C - H, M - R One of (D2929, D2930, D2931, D2932, D2934) per tooth per lifetime.	--	--
D2950	Core buildup, including any pins when required	$197	$164	Y	Y	Y	NC	Y	Y	Teeth 2 - 15, 18 - 31 One (D2950, D2954) per 60 month(s) per patient per tooth.	--	--
D2951	Pin retention – per tooth, in addition to restoration	$31	$27	Y	Y	Y	NC	Y	Y	Teeth 2 - 15, 18 - 31 Must be billed with a two or more surface restoration on a permanent tooth.	--	--
D2954	Prefabricated post and core in addition to crown	$229	$191	Y	Y	Y	NC	Y	Y	Teeth 2 - 15, 18 - 31 One of (D2950, D2954) per 60 month(s) per patient per tooth.	--	--
D2980	Crown repair necessitated by restorative material failure	$137	$115	Y	Y	Y	NC	Y	Y	Teeth 2 - 15, 18 - 31 For chairside repairs	--	--
D2999	Unspecified restorative procedure, by report	I.C.	I.C.	Y	Y	Y	NC	Y	Y	Teeth 1 - 32, A - T	PA	Narrative of medical necessity; For crown repairs requiring outside laboratory, include documentation to substantiate why the repair could not be done chairside
IV. Endodontics												
D3120	Pulp cap – indirect (excluding final restoration)	$40	$34	Y	Y	Y	NC	Y	Y	Teeth 1 - 32, A - T Cannot be billed in conjunction with root canal on same day of service (D3310, D3320 or D3330).	--	--
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament	$106	NC	Y	NC	Y	NC	Y	NC	Age limitation: <21 years Teeth 1 - 32, A - T Cannot be billed in conjunction with root canal on same day of service (D3310, D3320 or D3330).	--	--
D3310	Endodontic therapy, anterior (excluding final restoration)	$544	$544	Y	Y	Y	NC	Y	Y	Teeth 6 - 11, 22 - 27 One of (D3310) per 1 Lifetime Per patient per tooth. No limitation on number performed per treatment. Cannot be billed in conjunction with D3120 on the same date of service.	--	--
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	$639	$639	Y	Y	Y	NC	Y	Y	Teeth 4, 5, 12, 13, 20, 21, 28, 29 One per lifetime per patient per tooth One of (D3320) per 1 Lifetime Per patient per tooth. Cannot be billed in conjunction with D3120 on the same date of service.	--	--
D3330	Endodontic therapy, molar tooth (excluding final restoration)	$829	$829	Y	Y	Y	NC	Y	Y	Teeth 2, 3, 14, 15, 18, 19, 30, 31 One of (D3330) per 1 Lifetime Per patient per tooth. Cannot be billed in conjunction with D3120 on the same date of service.	--	--

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		<21	21+	<21	21+			<21	21+			
D3346	Retreatment of previous root canal therapy – anterior	$545	$456	Y	Y	Y	NC	Y	Y	Teeth 6 - 11, 22 - 27 Not payable to the same provider who performed the original endodontic therapy (D3310, D3320, or D3330) within 24 months.	--	--
D3347	Retreatment of previous root canal therapy – premolar	$641	$538	Y	Y	Y	NC	Y	Y	Teeth 4, 5, 12, 13, 20, 21, 28, 29 Not payable to the same provider who performed the original endodontic therapy (D3310, D3320, or D3330) within 24 months.	--	--
D3348	Retreatment of previous root canal therapy – molar	$789	$613	Y	Y	Y	NC	Y	Y	Teeth 2, 3, 14, 15, 18, 19, 30, 31 Not payable to the same provider who performed the original endodontic therapy (D3310, D3320, or D3330) within 24 months.	--	--
D3410	Apicoectomy – anterior	$471	$407	Y	Y	Y	NC	Y	Y	Teeth 6 - 11, 22 - 27 One of (D3410) per 1 Lifetime Per patient per tooth. Includes retrograde filling.	--	--
D3421	Apicoectomy – premolar (first root)	$550	$460	Y	Y	Y	NC	Y	Y	Teeth 4, 5, 12, 13, 20, 21, 28, 29 One of (D3421) per 1 Lifetime Per patient per tooth. Includes retrograde filling.	--	--
D3425	Apicoectomy – molar (first root)	$639	$598	Y	Y	Y	NC	Y	Y	Teeth 1 - 3, 14 - 19, 30 - 32 One of (D3425) per 1 Lifetime Per patient per tooth. Includes retrograde filling.	--	--
D3426	Apicoectomy (each additional root)	$264	$230	Y	Y	Y	NC	Y	Y	Teeth 1 - 5, 12 - 21, 28 - 32 One of (D3426) per 1 Lifetime Per patient per tooth for Bicuspids. Two of (D3426) per 1 Lifetime Per patient per tooth for First and Second Molars. Includes retrograde filling.	--	--
V. Periodontics												
D4210	Gingivectomy or gingivoplasty - Four or more contiguous teeth or bounded teeth spaces per quadrant	$343	$307	Y	Y	Y	NC	Y	Y	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR) One of (D4210, D4211) per 3 Calendar year(s) Per patient per quadrant. Limited to two quadrants on the same date of service in an office setting. Not payable in conjunction with D1110 and D1120 or D4341 and D4342 on same date of service.	21+ PA	21+ PA: Pre-Tx radiographs; Periodontal charting; Narrative of medical necessity
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant	$133	$111	Y	Y	Y	NC	Y	Y	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR) One of (D4210, D4211) per 3 Calendar year(s) Per patient per quadrant. Limited to two quadrants on the same date of service in an office setting. Not payable in conjunction with D1110 and D1120 or D4341 and D4342 on same date of service.	21+ PA	21+ PA: Pre-Tx radiographs; Periodontal charting; Narrative of medical necessity
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	$160	$134	Y	Y	Y	NC	Y	Y	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR) One of (D4341, D4342) per 3 Calendar year(s) Per patient per quadrant. Two of (D4341, D4342) per 1 Day(s) Per Provider OR Location in office. Four of (D4341, D4342) per 1 Day(s) Per Provider OR Location in hospital. A minimum of four (4) affected teeth in the quadrant. Not payable in conjunction with D1110 and D1120 or D4210 and D4211 on same date of service.	21+ PA	21+ PA: FMX; Periodontal charting; Narrative of medical necessity, including a statement of the periodontal condition, date of periodontal evaluation, and history of previous periodontal treatment
D4342	Periodontal scaling and root planing - one to three teeth, per quadrant	$107	$90	Y	Y	Y	NC	Y	Y	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR) One of (D4341, D4342) per 3 Calendar year(s) Per patient per quadrant. Two of (D4341, D4342) per 1 Day(s) Per Provider OR Location in office. Four of (D4341, D4342) per 1 Day(s) Per Provider OR Location in hospital. Not payable in conjunction with D1110 and D1120 or D4210 and D4211 on same date of service	21+ PA	21+ PA: FMX; Periodontal charting; Narrative of medical necessity, including a statement of the periodontal condition, date of periodontal evaluation, and history of previous periodontal treatment
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	$75	$60	Y	Y	Y	NC	Y	Y	Two of (D1110, D1120, D4346) per 1 Calendar year(s) Per patient. Includes minor scaling procedures.	--	--
VI. Prosthodontics (Removable)												

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Procedure Code	Description	Allowed Fee		MH Standard (Regular)		CMSP	MH Limited	HSN		Benefit Limitations	Required Review	Documentation Required
		<21	21+	<21	21+			<21	21+			
D5110	Complete denture – maxillary	$858	$730	Y	Y	Y	NC	Y	Y	One of (D5110) per 84 Month(s) Per patient.	--	--
D5120	Complete denture – mandibular	$852	$730	Y	Y	Y	NC	Y	Y	One of (D5120) per 84 Month(s) Per patient.	--	--
D5130	Immediate denture – maxillary	$935	NC	Y	NC	Y	NC	Y	NC	Age limitation: <21 years One of (D5130) per 1 Lifetime Per patient	--	--
D5140	Immediate denture - mandibular	$934	NC	Y	NC	Y	NC	Y	NC	Age limitation: <21 years One of (D5140) per 1 Lifetime Per patient	--	--
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth)	$650	$556	Y	Y	Y	NC	Y	Y	One of (D5211, D5213, D5225) per 84 Month(s) Per patient. Only covered if there are two or more missing posterior teeth (excluding third molars) or one or more missing anterior teeth, the remaining dentition is sound and there is a good prognosis.	--	--
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth)	$691	$595	Y	Y	Y	NC	Y	Y	One of (D5212, D5214, D5226) per 84 Month(s) Per patient. Only covered if there are two or more missing posterior teeth (excluding third molars) or one or more missing anterior teeth, the remaining dentition is sound and there is a good prognosis.	--	--
D5213	Maxillary partial denture- cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$974	NC	Y	NC	Y	NC	Y	NC	Age limitation: <21 years One of (D5211, D5213, D5225) per 84 Month(s) Per patient. Only covered if there are two or more missing posterior teeth (excluding third molars) or one or more missing anterior teeth, the remaining dentition is sound and there is a good prognosis.	--	--
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$986	NC	Y	NC	Y	NC	Y	NC	Age limitation: <21 years One of (D5212, D5214, D5226) per 84 Month(s) Per patient. Only covered if there are two or more missing posterior teeth (excluding third molars) or one or more missing anterior teeth, the remaining dentition is sound and there is a good prognosis.	--	--
D5225	Maxillary partial denture- flexible base	$974	NC	Y	NC	Y	NC	Y	NC	Age limitation: <21 years One of (D5211, D5213, D5225) per 84 Month(s) Per patient. Only covered if there are two or more missing posterior teeth (excluding third molars) or one or more missing anterior teeth, the remaining dentition is sound and there is a good prognosis.	--	--
D5226	Mandibular partial denture- flexible base	$986	NC	Y	NC	Y	NC	Y	NC	Age limitation: <21 years One of (D5212, D5214, D5226) per 84 Month(s) Per patient. Only covered if there are two or more missing posterior teeth (excluding third molars) or one or more missing anterior teeth, the remaining dentition is sound and there is a good prognosis.	--	--
D5511	Repair broken complete denture base, mandibular	$109	$85	Y	Y	Y	NC	Y	Y	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	--	--
D5512	Repair broken complete denture base, maxillary	$109	$85	Y	Y	Y	NC	Y	Y	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	--	--

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		<21	21+	<21	21+			<21	21+			
D5520	Replace missing or broken teeth - complete denture (each tooth)	$89	$77	Y	Y	Y	NC	Y	Y	Teeth 1 - 32 Three of (D5520) per 12 Month(s) Per patient. Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	--	--
D5611	Repair broken resin partial denture base, mandibular	$93	$77	Y	Y	Y	NC	Y	Y	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	--	--
D5612	Repair broken resin partial denture base, maxillary	$93	$77	Y	Y	Y	NC	Y	Y	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	--	--
D5621	Repair broken cast partial denture base, mandibular	$121	$104	Y	Y	Y	NC	Y	Y	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	--	--
D5622	Repair broken cast partial denture base, maxillary	$121	$104	Y	Y	Y	NC	Y	Y	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	--	--
D5630	Repair or replace broken retentive/clasping materials – per tooth	$107	$99	Y	Y	Y	NC	Y	Y	Teeth 1 - 32 One of (D5630) per 6 Month(s) Per patient per tooth. Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	--	--
D5640	Replace broken teeth - per tooth	$91	$77	Y	Y	Y	NC	Y	Y	Teeth 1 - 32 Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	--	--
D5650	Add tooth to existing partial denture	$110	$92	Y	Y	Y	NC	Y	Y	Teeth 1 - 32 Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	--	--
D5660	Add clasp to existing partial denture per tooth	$125	$98	Y	Y	Y	NC	Y	Y	Teeth 1 - 32 Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	--	--
D5730	Reline complete maxillary denture (direct)	$188	$158	Y	Y	Y	NC	Y	Y	One of (D5730, D5750) per 24 Month(s) Per patient. Fee for denture includes payment for any relines or rebases necessary within 6 months of denture delivery date.	--	--
D5731	Reline lower complete mandibular denture (direct)	$184	$173	Y	Y	Y	NC	Y	Y	One of (D5731, D5751) per 24 Month(s) Per patient. Fee for denture includes payment for any relines or rebases necessary within 6 months of denture delivery date.	--	--
D5740	Reline maxillary partial denture(chairside)	$169	NC	Y	NC	Y	NC	Y	NC	Age limitation: <21 years One of (D5740, D5760) per 24 Month(s) Per patient. Fee for denture includes payment for any relines or rebases necessary within 6 months of denture delivery date	--	--

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		<21	21+	<21	21+			<21	21+			
D5741	Reline mandibular partial denture(chairside)	$160	NC	Y	NC	Y	NC	Y	NC	Age limitation: <21 years One of (D5741, D5761) per 24 Month(s) Per patient. Fee for denture includes payment for any relines or rebases necessary within 6 months of denture delivery date.	--	--
D5750	Reline complete maxillary denture (indirect)	$255	$214	Y	Y	Y	NC	Y	Y	One of (D5730, D5750) per 24 Month(s) Per patient. Fee for denture includes payment for any relines or rebases necessary within 6 months of denture delivery date.	--	--
D5751	Reline complete mandibular denture (indirect)	$256	$215	Y	Y	Y	NC	Y	Y	One of (D5731, D5751) per 24 Month(s) Per patient. Fee for denture includes payment for any relines or rebases necessary within 6 months of denture delivery date	--	--
D5760	Reline maxillary partial denture (laboratory)	$252	NC	Y	NC	Y	NC	Y	NC	Age limitation: <21 years One of (D5740, D5760) per 24 Month(s) Per patient. Fee for denture includes payment for any relines or rebases necessary within 6 months of denture delivery date.	--	--
D5761	Reline mandibular partial denture (laboratory)	$252	NC	Y	NC	Y	NC	Y	NC	Age limitation: <21 years One of (D5741, D5761) per 24 Month(s) Per patient. Fee for denture includes payment for any relines or rebases necessary within 6 months of denture delivery date.	--	--
D6241	Pontic-porcelain fused metal	$691	NC	Y	NC	Y	NC	Y	NC	Age limitation: <21 years Teeth 6 - 11, 22 - 27 One of (D6241) per 60 Month(s) Per patient per tooth.	--	--
D6751	Retainer crown-porcelain fused to metal	$691	NC	Y	NC	Y	NC	Y	NC	Age limitation: <21 years Teeth 6 - 11, 22 - 27 One of (D6751) per 60 Month(s) Per patient per tooth.	--	--
D6930	Re-cement or re-bond fixed partial denture	$87	NC	Y	NC	Y	NC	Y	NC	Age limitation: <21 years Not covered within first 6 month(s) of placement.	--	--
D6980	Fixed partial denture repair	$155	NC	Y	NC	Y	NC	Y	NC	Age limitation: <21 years Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	--	--
D6999	Fixed prosthodontic procedure	I.C.	I.C.	Y	Y	Y	NC	Y	Y	Teeth 1 - 32	PA	Narrative of medical necessity
X. Oral Surgery												
D7111	Extraction, coronal remnants - primary tooth	$80	$75	Y	Y	Y	NC	Y	Y	Teeth A - T, AS - TS	--	
D7140	Extraction (Simple), erupted tooth or exposed root (elevation and/or forceps removal)	$107	$77	Y	Y	Y	Y	Y	Y		--	--
D7210	Extraction (Surgical), erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$179	$149	Y	Y	Y	Y	Y	Y	Erupted surgical extractions are defined as extractions requiring elevation of a mucoperiosteal flap and removal of bone and/or section of the tooth and closure.	--	--
D7220	Removal of impacted tooth - soft tissue	$223	$191	Y	Y	Y	NC	Y	Y	Only covered for teeth that are symptomatic, carious or pathologic.	--	--
D7230	Removal of impacted tooth - partially bony	$286	$249	Y	Y	Y	NC	Y	Y	Only covered for teeth that are symptomatic, carious or pathologic.	--	--
D7240	Removal of impacted tooth - completely bony	$378	$295	Y	Y	Y	NC	Y	Y	Removal of asymptomatic tooth not covered.	PA	PA: Pre-Tx PA radiograph or PAN; Narrative of medical necessity supporting symptomatic, carious, or pathologic condition

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Procedure Code	Description	Allowed Fee		MH Standard (Regular)		CMSP	MH Limited	HSN		Benefit Limitations	Required Review	Documentation Required
		<21	21+	<21	21+			<21	21+			
D7250	Surgical removal of residual tooth roots (cutting procedure)	$173	$144	Y	Y	Y	NC	Y	Y	Only covered for teeth that are symptomatic, carious or pathologic.	--	--
D7251	Coronectomy- intentional partial tooth removal, impacted teeth only	$173	$134	Y	Y	Y	NC	Y	Y	Teeth 1, 16, 17, 32 One of (D7251) per 1 Lifetime Per patient per tooth. Cannot be billed on same date of service with codes D7111, D7140, D7210, D7220, D7230, D7240, D7250, D7241. If D7251 is billed following any history of D7111, D7210, D7140, D7241, D7220, D7230, D7240, D7250 billed on the same tooth as code D7251, then deduct what was paid for D7251 from payment of new code.	--	--
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$145	$106	Y	Y	Y	NC	Y	Y	Teeth 1 - 32	--	--
D7280	Surgical access of an unerupted tooth	$452	NC	Y	NC	Y	NC	Y	NC	Age limitation: <21 years Teeth 1 - 32 Cannot be billed in conjunction with an adjacent impacted extraction, including D7220, D7230, D7240, D7241.	--	--
D7283	Placement of device to facilitate eruption of impacted tooth	$84	NC	Y	NC	Y	NC	Y	NC	Age limitation: <21 years Teeth 1 - 32	--	--
D7310	Alveoloplasty in conjunction with extractions-four or more teeth or tooth spaces, per quadrant	$163	$142	Y	Y	Y	NC	Y	Y	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR) One of (D7310, D7311) per lifetime per patient per quadrant. Covered only if the alveoloplasty is distinct (separate procedure) from extractions.	--	--
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$146	$128	Y	Y	Y	NC	Y	Y	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR) One of (D7310, D7311) per lifetime per patient per quadrant. Covered only if the alveoloplasty is distinct (separate procedure) from extractions.	--	--
D7320	Alveoloplasty not in conjunction with extractions-four or more teeth or tooth spaces, per quadrant	$202	$187	Y	Y	Y	NC	Y	Y	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR) One of (D7320, D7321) per lifetime per patient per quadrant. No extractions performed in edentulous area.	--	--
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$162	$149	Y	Y	Y	NC	Y	Y	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR) One of (D7320, D7321) per lifetime per patient per quadrant. No extractions performed in edentulous area.	--	--
D7340	Vestibuloplasty - ridge extension (second epithelialization)	$796	$747	Y	Y	Y	NC	Y	Y	Per Arch (01, 02, LA, UA)	PA	PA: Narrative of medical necessity supporting need to increase alveolar ridge height
D7350	Vestibuloplasty - ridge extension (Oral surgeon only)	$1,236	$943	Y	Y	Y	NC	Y	Y	Per Arch (01, 02, LA, UA) Only payable to a dental provider with specialty in oral surgery.	21+ PA	21+ PA: Narrative of medical necessity supporting need to increase alveolar ridge height
D7410	Radical excision - lesion diameter up to 1.25cm	$124	$115	Y	Y	Y	NC	Y	Y	--	--	--
D7411	Excision of benign lesion greater than 1.25 cm	$254	$208	Y	Y	Y	NC	Y	Y	--	--	--

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		<21	21+	<21	21+			<21	21+			
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	$252	$248	Y	Y	Y	NC	Y	Y	--	--	Pathology report
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$343	$288	Y	Y	Y	NC	Y	Y	--	--	Pathology report
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	$142	$121	Y	Y	Y	NC	Y	Y	--	--	Pathology report
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$194	$143	Y	Y	Y	NC	Y	Y	--	--	Pathology report
D7471	Removal of lateral exostosis (maxilla or mandible) (Oral surgeon only)	$194	$143	Y	Y	Y	NC	Y	Y	Per Arch (01, 02, LA, UA) One of (D7471) per 1 lifetime per patient per arch. Only payable to a dental provider with a specialty in oral surgery.	--	--
D7472	Removal of torus palatinus (Oral surgeon only)	$194	$143	Y	Y	Y	NC	Y	Y	One of (D7472) per 1 Lifetime Per patient per arch. Only payable to a dental provider with a specialty in oral surgery.	--	--
D7473	Removal of torus mandibularis (Oral surgeon only)	$194	$143	Y	Y	Y	NC	Y	Y	One of (D7473) per 1 Lifetime Per patient per quadrant. Only payable to a dental provider with a specialty in oral surgery.	--	--
D7961	Buccal/labial frenectomy (frenulectomy)	$353	$107	Y	Y	Y	NC	Y	Y	Per Arch (01, 02, LA, UA) One of (D7961) per 1 Lifetime Per patient per arch. The frenum may be excised for large diastemas between teeth; or when frenum interferes with a prosthetic appliance; or when it is the etiology of the periodontal tissue disease.	--	Maintain in patient record narrative describing location and medical necessity
D7962	Lingual frenectomy (frenulectomy)	$353	$107	Y	Y	Y	NC	Y	Y	One of (D7962, D7963) per 1 Lifetime Per patient. The frenum may be excised when the tongue has limited mobility; for large diastemas between teeth; or when frenum interferes with a prosthetic appliance; or when it is the etiology of the periodontal tissue disease.	--	Maintain in patient record narrative describing location and medical necessity
D7963	Frenuloplasty	$480	$416	Y	Y	Y	NC	Y	Y	One of (D7962, D7963) per 1 Lifetime Per patient. The frenum may be excised when the tongue has limited mobility; for large diastemas between teeth; or when frenum interferes with a prosthetic appliance; or when it is the etiology of the periodontal tissue disease.	--	Maintain in patient record narrative describing location and medical necessity
D7970	Excision of hyperplastic tissue - per arch	$334	$246	Y	Y	Y	NC	Y	Y	Per Arch (01, 02, LA, UA) Not payable on the same date of service as an extraction (D7111 - D7240) of the same tooth.	--	--
D7999	Unspecified oral surgery procedure, by report	I.C.	I.C.	Y	Y	Y	NC	Y	Y	--	PA	Narrative of medical necessity
XI. Orthodontic												
D8010	Limited orthodontic treamtnent of the primary transition (Orthodontist only)	$250	NC	Y	NC	NC	NC	Y	NC	Age limitation: 6-14 years Adjustments for limited orthodontic treatment are billed under the D8999 code. A maximum of five units of D8999 can be billed for approved limited orthodontic treatment. Only payable to a dental provider with a specialty in Orthodontics. Please see billing instructions in section 17.00 of the Office Reference Manual.	<21 PA	<21 PA: Narrative of Medical Necessity supporting need to prevent or minimize the development of a handicapping malocclusion or preclude the need for comprehensive orthodontic treatment; If applicable, supporting photos and/or radiographs. Please see submission instructions in section 17.00 of the Office Reference Manual.

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Procedure Code	Description	Allowed Fee		MH Standard (Regular)		CMSP	MH Limited	HSN		Benefit Limitations	Required Review	Documentation Required
		<21	21+	<21	21+			<21	21+			
D8020	Limited orthodontic treatment of the transitional dentition (Orthodontist only)	$250	NC	Y	NC	NC	NC	Y	NC	Age limitation: 6-14 years Adjustments for limited orthodontic treatment are billed under the D8999 code. A maximum of five units of D8999 can be billed for approved limited orthodontic treatment. Only payable to a dental provider with a specialty in Orthodontics. Please see billing instructions in section 17.00 of the Office Reference Manual.	<21 PA	<21 PA: Narrative of Medical Necessity supporting need to prevent or minimize the development of a handicapping malocclusion or preclude the need for comprehensive orthodontic treatment; If applicable, supporting photos and/or radiographs. Please see submission instructions in section 17.00 of the Office Reference Manual.
D8030	Limited orthodontic treatment of the adolescent dentition (Orthodontist only)	$250	NC	Y	NC	NC	NC	Y	NC	Age limitation: 6-20 years Adjustments for limited orthodontic treatment are billed under the D8999 code. A maximum of five units of D8999 can be billed for approved limited orthodontic treatment. Only payable to a dental provider with a specialty in Orthodontics. Please see billing instructions in section 17.00 of the Office Reference Manual.	<21 PA	<21 PA: Narrative of Medical Necessity supporting need to prevent or minimize the development of a handicapping malocclusion or preclude the need for comprehensive orthodontic treatment; If applicable, supporting photos and/or radiographs. Please see submission instructions in section 17.00 of the Office Reference Manual.
D8040	Limited orthodontic treatment of the adult dentition (Orthodontist only)	$250	NC	Y	NC	NC	NC	Y	NC	Age limitation: 6-20 years Adjustments for limited orthodontic treatment are billed under the D8999 code. A maximum of five units of D8999 can be billed for approved limited orthodontic treatment. Only payable to a dental provider with a specialty in Orthodontics. Please see billing instructions in section 17.00 of the Office Reference Manual.	<21 PA	<21 PA: Narrative of Medical Necessity supporting need to prevent or minimize the development of a handicapping malocclusion or preclude the need for comprehensive orthodontic treatment; If applicable, supporting photos and/or radiographs. Please see submission instructions in section 17.00 of the Office Reference Manual.
D8070	Comprehensive orthodontic treatment of the transitional dentition (Orthodontist only)	$1,302	NC	Y	NC	NC	NC	Y	NC	Age limitation: 6-20 years One of (D8070, D8080, D8090) per 1 Lifetime Per patient. Only payable to a dental provider with a specialty in Orthodontics. Please see billing instructions in section 17.00 of the Office Reference Manual.	<21 PA	<21 PA: Completed HLD form with signed attestation; FMX or PAN; Photos; If applicable, Narrative of medical necessity supporting need to treat a handicapping malocclusion. Please see submission instructions in section 17.00 of the Office Reference Manual.
D8080	Comprehensive orthodontic treatment of the adolescent dentition (Orthodontist only)	$1,302	NC	Y	NC	NC	NC	Y	NC	Age limitation: 6-20 years One of (D8070, D8080, D8090) per 1 Lifetime Per patient. Only payable to a dental provider with a specialty in Orthodontics. Please see billing instructions in section 17.00 of the Office Reference Manual.	<21 PA	<21 PA: Completed HLD form with signed attestation; FMX or PAN; Photos; If applicable, Narrative of medical necessity supporting need to treat a handicapping malocclusion. Please see submission instructions in section 17.00 of the Office Reference Manual.
D8090	Comprehensive orthodontic treatment of the adult dentition (Orthodontist only)	$1,302	NC	Y	NC	NC	NC	Y	NC	Age limitation: 6-20 years One of (D8070, D8080, D8090) per 1 Lifetime Per patient. Only payable to a dental provider with a specialty in Orthodontics. Please see billing instructions in section 17.00 of the Office Reference Manual.	<21 PA	<21 PA: Completed HLD form with signed attestation; FMX or PAN; Photos; If applicable, Narrative of medical necessity supporting need to treat a handicapping malocclusion. Please see submission instructions in section 17.00 of the Office Reference Manual.
D8660	Pre-orthodontic treatment examination to monitor growth and development (records fee) (Orthodontist only)	$136	NC	Y	NC	NC	NC	Y	NC	Age limitation: 6-20 years One of (D8660) per 6 Month(s) Per Provider OR Location. Only payable with an associated limited or comprehensive ortho PA request denial. Not billable after D8080, D8070, D8090, D8670, D8680 has been paid. Only payable to a dental provider with a speciality in Orthodontics. Please see billing instructions in section 17.00 of the Office Reference Manual.	<21 PA	<21 PA: Submit with D8080 / D8070 / D8090 or D8010 / D8020 / D8030 / D8040. Please see submission instructions in section 17.00 of the Office Reference Manual.

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		<21	21+	<21	21+			<21	21+			
D8670	Periodic orthodontic treatment visit (Orthodontist only)	$288	$215**	Y	Y**	NC	NC	Y	NC	Age limitation: 6-20 years (**Covered for 21 years and older only if comprehensive orthodontic treatment began by age 21) One of (D8670) per 90 Day(s) Per patient. Allowed as quarterly treatment visits. May not be billed less than 90 days from previous periodic orthodontic treatment visit or banding date. May not be billed prior to D8070 / D8080 / D8090. Only payable to a dental provider with a specialty in Orthodontics. Please see billing instructions in section 17.00 of the Office Reference Manual.	<21 PA	<21 PA for first 8 units: Included with D8080 / D8070 / D8090 approval <21 PA for additional unit: Narrative of medical necessity for the additional units, including an explanation of why the initially approved units were insufficient and an updated treatment plan for completion of the case. Please see submission instructions in section 17.00 of the Office Reference Manual.
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s)) (Orthodontist only)	$102	$85**	Y	Y**	NC	NC	Y	NC	Age limitation: 6-20 years (**Covered for 21 years and older only if comprehensive orthodontic treatment began by age 21) Five of (D8680) per 1 Lifetime Per patient. May not be billed prior to D8070 / D8080 / D8090. Only payable to a dental provider with a specialty in Orthodontics. Please see billing instructions in section 17.00 of the Office Reference Manual.	--	--
D8703	Replacement of lost or broken retainer- maxillary (Orthodontist only)	$95	NC	Y	NC	NC	NC	Y	NC	Age limitation: 8-20 years One of (D8703) per 2 Calendar year(s) Per patient. The MassHealth agency pays for replacement retainers only during the 2 year retention period following orthodontic treatment. Only payable to a dental provider with a specialty in Orthodontics.	PA	PA: Statement of the retention start date and reason for replacement
D8704	Replacement of lost or broken retainer- mandibular (Orthodontist only)	$95	NC	Y	NC	NC	NC	Y	NC	Age limitation: 8-20 years One of (D8704) per 2 Calendar year(s) Per patient. The MassHealth agency pays for replacement retainers only during the 2 year retention period following orthodontic treatment. Only payable to a dental provider with a specialty in Orthodontics.	PA	PA: Statement of the retention start date and reason for replacement
D8999	Unspecified orthodontic procedure, by report (Orthodontist only)	I.C	I.C**	Y	Y**	NC	NC	Y	NC	Age limitation: 6-20 years (**Covered for 21 years and older only if limited orthodontic treatment began by age 21) Five of (D8999) per 1 Lifetime Per patient. This code is used exclusively for limited orthodontic adjustments and will be approved for up to a maximum of 5 units. When requesting other unspecified orthodontic services please use the D9999 code. Only payable to a dental provider with a specialty in Orthodontics. Please see billing instructions in section 17.00 of the Office Reference Manual.	<21 PA	<21 PA for 5 units: Included with D8010 / D8020 / D8030 / D8040 approval. Please see submission instructions in section 17.00 of the Office Reference Manual.
XII. Adjunctive General Services												
D9110	Palliative treatment of dental pain – per visit	$75	$36	Y	Y	Y	Y	Y	Y	Other non-emergency medically necessary treatment may be provided during the same visit. Not covered with D0120, D0140, D0180 by same provider or provider group on same date of service.	--	Maintain in patient record description of the treatment provided and must document the emergent nature of the condition
D9222	Deep sedation/general anesthesia – first 15 minutes	$109	$90	Y	Y	Y	NC	Y	Y	--	--	--
D9223	Deep sedation/general anesthesia – each additional 15-minute increment	$109	$90	Y	Y	Y	NC	Y	Y	--	--	--
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	$22	$15	Y	Y	Y	NC	Y	Y	--	--	--
D9239	Intravenous moderate (conscious) sedation analgesia – first 15 minutes	$101	$78	Y	Y	Y	NC	Y	Y	--	--	--

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Procedure Code	Description	Allowed Fee		MH Standard (Regular)		CMSP	MH Limited	HSN		Benefit Limitations	Required Review	Documentation Required
		<21	21+	<21	21+			<21	21+			
D9243	Intravenous moderate (conscious) sedation analgesia – each additional 15 minute increment	$101	$78	Y	Y	Y	NC	Y	Y	Five of (D9243) per 1 Day(s) Per patient.	--	--
D9248	Nonintravenous conscious sedation	$45	$45	Y	Y	Y	NC	Y	Y	--	--	--
D9310	Consultation- Diagnostic service provided by dentist or physician other than requesting dentist or physician (Specialist only)	$54	$63	Y	Y	Y	NC	Y	Y	One of (D9310) per 6 Month(s) Per patient Per Provider OR Location; Only payable to a specialist.	--	The consulting specialist must provide a written narrative back to the referring dentist
D9410	House/extended care facility call, once per facility per day	$36	$39	Y	Y	Y	NC	Y	Y	One of (D9410) per 1 Day(s) Per Business Per facility. Eligible when traveling to provide care at a nursing facility, residential treatment facility, chronic disease and rehabilitation facility, hospice site, patient home or group home, school or other licensed educational facility, or other public health setting. Bill in addition to any medically necessary covered service provided during the same visit. Excludes place of service (POS) codes 02, 10, 11, 21, 23, 24, 49, 50, 66	--	Facility name and address
D9450*	Rural add-on encounter payment	$31	$31	Y	Y	Y	Y	Y	Y	Only payable to providers rendering covered services within the eligible rural counties: Barnstable, Dukes, Berkshire, Franklin, and Hampshire. One of (D9450) per 1 Day(s) Per Provider, Per Member. Only payable when submitted with another payable service.	--	--
D9920	Behavior management, by report	$86	$86	Y	Y	Y	NC	Y	Y	One of (D9920) per 1 Day(s) Per Provider OR Location per patient	PA	PA: Narrative of medical necessity clearly desrcribing the member's severe and chronic mental, physical, or developmental disability and type of behavior management technique to be utilized, including statement of previous attempts at treatment.
D9930	Treatment of complications (postsurgical) - unusual circumstances, by report	$66	$30	Y	Y	Y	NC	Y	Y	--	CR	Narrative of medical necessity
D9941	Fabrication of athletic mouthguard	$85	NC	Y	NC	Y	NC	Y	NC	Age limitation: <21 years One of (D9941) per 1 Calendar year(s) per patient.	--	Must maintain in patient record the need for the appliance, including that the member is engaged in a contact sport (including, but not limited to basketball, football, hockey, lacrosse, and soccer)
D9944	Occlusal guard - hard appliance, full arch	$308	NC	Y	NC	Y	NC	Y	NC	Age limitation: <21 years One of (D9944, D9945, D9946) per 1 Year(s) per patient.	--	Maintain in patient record evidence of the need for the appliance.
D9945	Occlusal guard - soft appliance, full arch	$308	NC	Y	NC	Y	NC	Y	NC	Age limitation: <21 years One of (D9944, D9945, D9946) per 1 Year(s) per patient.	--	Maintain in patient record evidence of the need for the appliance.
D9946	Occlusal guard - hard appliance, partial arch	$308	NC	Y	NC	Y	NC	Y	NC	Age limitation: <21 years One of (D9944, D9945, D9946) per 1 Year(s) per patient.	--	Maintain in patient record evidence of the need for the appliance.
D9999	Unspecified adjunctive procedure, by report	I.C.	I.C.	Y	Y	Y	NC	Y	Y	--	PA	Narrative of medical necessity

Note: In specific circumstances, additional documentation (e.g. charting) may be required for clinical review. Extra documentation (e.g. intraoral photographs/narrative) may be submitted to supplement required documentation and substantiate medical necessity. If required radiographs cannot be obtained, diagnostic intraoral photographs and/or narrative must substantiate medical necessity.

Procedure Code	Description	Allowed Fee		MH Standard (Regular)		CMSP	MH Limited	HSN		Benefit Limitations	Required Review	Documen
		<21	21+	<21	21+			<21	21+			

Required review types:

PA – Prior authorization required before treatment. Retrospective review after treatment may be considered for all services except orthodontics.

<21 PA – Prior authorization required for service that is only covered for members younger than 21 years of age. Service is not covered for members 21 years of age or older.

21+ PA – Prior authorization required only for members 21 years of age or older. Prior authorization not required for members younger than 21 years of age.

CR** – Claim review required before payment released. Documentation must be submitted with claim. Prior to rendering a covered dental service subject to claim review, providers have the option to request a predetermination review. Applies to all providers, including specialists. Claim review documentation requirements effective for dates of service 4/1/25 and after for crowns delivered to adults when more than one crown is delivered on the same date of service.

Abbreviations:

BW: Bitewing radiograph

CMSP: Children's Medical Security Plan. CMSP is for children under the age of 19 who are Massachusetts residents at any income level, who do not qualify for MassHealth (except MassHealth Limited), and who are uninsured. MassHealth participating providers can provide covered CMSP services. CMSP coverage has a $750 annual state fiscal year maximum (the state fiscal year is July 1-June 30).

DDS*: Department of Developmental Services; Only adults with DDS have coverage for D2931 for Teeth 1 - 32, One of (D2931) per 12 months per patient per tooth.

FMX: Full mouth intraoral series of radiographs

HLD: Handicapping Labio-Lingual Deviations Index

HSN: Health Safety Net. The HSN makes payments to Massachusetts hospitals and community health centers for health care services provided to low-income Massachusetts residents who are uninsured or underinsured. Only hospitals and community health centers are eligible to enroll as HSN providers and provide covered HSN services.

I.C.: Individual Consideration

MH: MassHealth

NC: Not Covered

PA radiograph (under "Documentation Required")**:** Periapical radiograph

PAN: Panoramic radiograph

Pre-Tx: Pre-treatment

Post-Tx: Post-treatment

Posterior BWs: Bitewing radiographs of the posterior teeth

Posterior BWs, FMX, or PAN: Selection based on individualized radiographic examination. A full mouth intraoral radiographic examination is preferred when the patient has clinical evidence of generalized oral disease or a history of extensive dental treatment.

Tx plan: Treatment plan

*: D2931 only covered for adults with DDS for Teeth 1 - 32, One of (D2931) per 12 months per patient per tooth.

**: D8670 and D8680 covered for members 21 years and older only if comprehensive orthodontic treatment began by age 21; D8999 covered for members 21 years and older only if limited orthodontic treatment began by age 21.

D9450* - Eligible CHCs and HLHCs can bill D9450 enhancement fee per 130 CMR 420.405(C), 101 CMR 304.00, 101 CMR 314.00, and 101 CMR 614.00; One of (D9450) per 1 Day(s) Per Provider, Per Member. Only payable when submitted with another payable service.