Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
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MassHealth
Transmittal Letter DEN-80
December 2007

TO: Dental Providers Participating in MassHealth

FROM: Tom Dehner, Medicaid Director TD

RE: *Dental Manual* (Revisions to Dental Regulations and Service Codes and Descriptions)

This letter transmits revisions to the MassHealth dental regulations at 130 CMR 420.000 effective January 1, 2008. The revised regulations have been streamlined and reformatted to make them more user friendly, and also to

- clarify existing MassHealth policies;
- add new definitions;
- remove unnecessary pharmacy regulatory language;
- describe what is required for community health centers and hospital-licensed health centers to qualify for an enhancement fee for dental services;
- clarify what dental services are covered for which MassHealth members;
- clarify what services require prior authorization;
- clarify when prior authorization may be requested for a service not covered for a member**;**
- eliminate the prior-authorization requirement for many services for members under age 21 and some services for members aged 21 and older; and
- eliminate Appendix E by incorporating the information from Appendix E into Subchapter 6.

Subchapter 6

Subchapter 6 of the *Dental Manual* is also attached. It has been updated and reformatted to

- consolidate all Current Dental Terminology (CDT) and Current Procedural Terminology (CPT) service codes that MassHealth pays for into one document (Previously Subchapter 6 included only CDT codes; CPT codes were in Appendix E.);
- add new CDT and CPT service codes;
- clarify the ages of members eligible for a service;
- identify each service code that requires prior authorization;
- specify what the provider must include on the prior-authorization form;
- describe whether each service code requires a report; and
- specify what the provider must include in any required report.

Elimination of Prior-Authorization Requirement

For dates of service on or after January 1, 2008, the following service codes no longer require prior authorization for **members under age 21**.

D0340 Cephalometric film
D2710 Crown – resin-based composite (indirect)
D2751 Crown - porcelain fused to predominantly base metal
D2954 Prefabricated post and core in addition to crown
D3410 Apicoectomy/periradicular surgery – anterior (per tooth) (includes retrograde filling)
D3421 Apicoectomy/periradicular surgery - bicuspid (first root)
D3426 Apicoectomy/periradicular surgery (each additional root)
D4210 Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces per quadrant (once per quadrant per three-year period
D4211 Gingivectomy or gingivoplasty – one to three contiguous teeth or bounded teeth spaces per quadrant (once per quadrant per three-year period)
D4341 Periodontal scaling and root planing (four or more contiguous teeth or bounded teeth spaces per quadrant) (once per quadrant per three-year period)
D4342 Periodontal scaling and root planing – one to three teeth per quadrant
D5110 Complete denture – maxillary
D5120 Complete denture – mandibular
D5130 Immediate denture – maxillary
D5140 Immediate denture – mandibular
D5211 Maxillary partial denture (resin base) (including any conventional clasps, rests and teeth)
D5212 Mandibular partial denture (resin base) (including any conventional clasps, rests, and teeth)
D5213 Maxillary partial denture (cast metal framework with resin denture bases) (including any conventional clasps, rests and teeth)
D5214 Mandibular partial denture- cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)
D5710 Rebase complete maxillary denture
D5711 Rebase complete mandibular denture
D5720 Rebase maxillary partial denture (cast partial denture only)
D5721 Rebase mandibular partial denture (cast partial denture only)
D5750 Reline complete maxillary denture (laboratory)
D5751 Reline complete mandibular denture (laboratory)
D5760 Reline maxillary partial denture (laboratory) (cast partial denture only)
D5761 Reline mandibular partial denture (laboratory) (cast partial denture only)
D6241 Pontic – porcelain fused to predominantly base metal
D6751 Crown – porcelain fused to predominantly base metal
D6980 Fixed partial denture repair, by report (chairside)
D7280 Surgical access of an unerupted tooth (including orthodontic attachments)
D7283 Placement of device to facilitate eruption of impacted tooth
D7970 Excision of hyperplastic tissue-per arch
D8680 Orthodontic retention (removal of appliances, construction and placement of retainer(s)

For dates of service on or after January 1, 2008, the following service codes no longer require prior authorization for members **aged 21 and older**.

D0340 Cephalometric film
D6980 Fixed partial denture repair, by report (chairside)

New Service Codes

MassHealth will use the following service codes for dates of service on or after January 1, 2008.

Current Dental Terminology (CDT) Codes

D0140 Limited oral evaluation – problem focused (twice per calendar year)
D0145 Oral evaluation for a patient under three years of age and counseling with primary care giver **(under age 21 only)**
D0273 Bitewings – three films (twice per calendar year)
D3346 Retreatment of previous root canal therapy – anterior (P.A.)
D3347 Retreatment of previous root canal therapy – bicuspid **(under age 21 only)** (P.A.)
D3348 Retreatment of previous root canal therapy – molar **(under age 21 only)** (P.A.)
D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
D8050 Interceptive orthodontic treatment of the primary dentition **(under age 21 only)**
D8060 Interceptive orthodontic treatment of the transitional dentition **(under age 21 only)** (P.A.)

Current Procedural Terminology (CPT) Codes

99211 Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.
99213 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components:
- an expanded problem focused history;
- an expanded problem focused examination; and
- medical decision making of low complexity.

Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low-to-moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.
99214 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of the following three key components:
- a detailed history;
- a detailed examination; and

- medical decision making of moderate complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate-to-high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

99215 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of the following three key components:
- a comprehensive history;
- a comprehensive examination; and
- medical decision making of high complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate-to-high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

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

NEW MATERIAL

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

Dental Manual

Pages iv, vi, 4-1 through 4-22, and 6-1 through 6-36

OBSOLETE MATERIAL

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

Dental Manual

Pages iv, 4-13 through 4-30 — transmitted by Transmittal Letter DEN-78

Pages vi, 4-1 through 4-12, 4-31 through 4-38, E-3, and E-4 — transmitted by Transmittal Letter DEN-77

Pages 6-1 through 6-8 — transmitted by Transmittal Letter DEN-79

Pages E-1, E-2, and E-5 through E-30 — transmitted by Transmittal Letter DEN-74

4. Program Regulations

6. Service Codes and Descriptions

420.401: Introduction

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

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

(C) Subchapter 6 of the *Dental Manual* lists the Current Dental Terminology (CDT) codes for dentists and Current Procedural Terminology (CPT) codes for specialists in Oral surgery that the MassHealth agency pays for, a description of those codes, and where indicated, prior-authorization requirements.

420.402: Definitions

The following terms used in 130 CMR 420.000 have the meanings given in 130 CMR 420.402, unless the context clearly requires a different meaning. The reimbursability of services defined in 130 CMR 420.000 is not determined by these definitions, but by application of regulations elsewhere in 130 CMR 420.000 and 450.000.

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

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

EPSDT – Early and Periodic Screening, Diagnosis and Treatment Services as described in federal law at 42 U.S.C. §1396d(a)(4)(b) and (r) and 42 CFR 441.50. In Massachusetts, EPSDT-eligible members are in MassHealth Standard or MassHealth CommonHealth categories of assistance, and are under age 21.

Pre-Orthodontic Work-up – includes the treatment plan, radiographs, diagnostic prints and photographs, orthodontic records, diagnosis and diagnostic models.

420.403: Eligible Members

(A) MassHealth Members. 130 CMR 405.105 specifically states for each MassHealth coverage type, which members are eligible to receive dental services. The MassHealth agency pays for dental services described in 130 CMR 420.000, provided to eligible MassHealth members.

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

(C) Member Eligibility and Coverage Type. 130 CMR 450.107 provides information on verifying member eligibility and coverage type.

420.404: Provider Eligibility: Participating Providers

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

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

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

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

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

420.405: Provider Eligibility

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

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

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

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

(4) Hospital Outpatient Department and Hospital-Licensed Health Center. Hospital outpatient departments with a dental clinic and hospital-licensed health centers with a dental clinic are eligible to participate in MassHealth as a dental provider. The MassHealth agency pays for dental services provided to members in a hospital outpatient department's dental clinic or a hospital-licensed health center's dental clinic in accordance with the hospital's signed provider agreement with the Executive Office of Health and Human Services.

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

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

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

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

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

(C) Enhancement Fee for Community Health Centers and Hospital-Licensed Health Centers. To qualify for an enhancement fee for dental services:

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

(2) The dental enhancement fee is set by the Massachusetts Division of Health Care Finance and Policy (see 114.3 CMR 4.05(1).

420.406: Caseload Capacity

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

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

420.407: Maximum Allowable Fees

The Division of Health Care Finance and Policy (DHCFP) determines the maximum allowable fees for dental services. Payment is always subject to the conditions, exclusions, and limitations set forth in 130 CMR 420.000. Payment by the MassHealth agency is the lower of the following:

(A) the provider's usual charge to the general public for the same or a similar service; or
(B) the maximum allowable fee listed in the applicable DHCFP fee schedule.

(130 CMR 420.408 Reserved)

420.409: Noncovered Circumstances

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

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

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

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

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

(B) Substitutions.

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

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

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

420.410: Prior Authorization

(A) Introduction.

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

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

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

(a) the treatment was medically necessary;

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

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

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

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

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

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

(C) Submission Requirements.

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

(2) Instructions for submitting a request for prior authorization are described in Subchapter 5 of the *Dental Manual*.

(D) Other Requirements for Payment.

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

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

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

420.411: Pretreatment Review

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

420.412: Individual Consideration

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

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

(1) the amount of time required to perform the service;

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

420.413: Separate Procedures

Certain procedures are designated "S.P." (separate procedure) in the service descriptions in Subchapter 6 of the *Dental Manual*. A separate procedure is one that is commonly performed as an integral part of a total service and therefore does not warrant a separate payment, but that commands a separate payment when performed as a separate procedure not immediately related to other services. (For example, the MassHealth agency does not pay for a frenulectomy when it is performed as part of a vestibuloplasty, and full-study models are not payable separately when performed as part of orthodontic treatment or diagnosis. Nevertheless, the MassHealth agency does pay for frenulectomy as a separate procedure when medically necessary; and full-study models separately when the MassHealth agency requests them.)

420.414: Recordkeeping Requirements

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

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

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

420.415: Report Required with Certain Claims

(A) The provider must submit with the claim for payment, a written description of the service

provided in accordance with the requirements described in Subchapter 6 of the *Dental Manual* when

(1) the service description in Subchapter 6 stipulates "by report;" or
(2) the service is designated in Subchapter 6 as "I.C."

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

420.416: Pharmacy Services: Prescription Requirements

For information on pharmacy services refer to 130 CMR 406.000.

(420.417 through 420.420 Reserved)

420.421: Covered Services: Introduction

(A) The MassHealth agency pays for the following dental services when medically necessary:
(1) the services with codes listed in Subchapter 6 of the *Dental Manual*, for all members in accordance with the service descriptions and limitations described in 130 CMR 420.422 through 420.456; and
(2) all services for EPSDT-eligible members, in accordance with 130 CMR 450.140 through 450.149, without regard for the service limitations described in 130 CMR 420.422 through 420.456, or the listing of a code in Subchapter 6. All such services are available to EPSDT-eligible members, with prior authorization, even if the limitation specifically applies to other members under age 21.

(B) The MassHealth agency does not pay for the following services for any member, except for EPSDT-eligible members with prior authorization.
(1) cosmetic services;
(2) certain dentures including unilateral partials, overdentures and their attachments temporary dentures, CuSil-type dentures, other dentures of specialized designs or techniques, and preformed dentures with mounted teeth (teeth that have been set in acrylic before the initial impressions);
(3) chair-side relines;
(4) counseling or member-education services;
(5) habit-breaking appliances;
(6) implants of any type or description;
(7) laminate veneers;
(8) oral hygiene devices and appliances, dentifrices, and mouth rinses;
(9) orthotic splints, including mandibular orthopedic repositioning appliances;
(10) panoramic films for crowns, endodontics, periodontics, and interproximal caries;
(11) root canals filled by silver point technique, or paste only;
(12) tooth splinting for periodontal purposes; and
(13) any other service not listed in Subchapter 6 of the *Dental Manual*.

(C) The MassHealth agency does not pay for the following services for members aged 21 and older:
(1) fixed partial dentures;

(2) occlusal guards;
(3) orthodontic services unrelated to orthognathic surgery and facial trauma;
(4) relining of resin-base partial dentures; and
(5) sealants.

420.422: Service Descriptions and Limitations: Diagnostic Services

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

(B) Periodic Oral Evaluation. The MassHealth agency pays for a periodic oral evaluation twice per member per calendar year. A periodic oral evaluation includes an update of the member's medical and dental history, the examination and charting of the member's dentition and associated structures, periodontal charting if applicable, diagnosis, and the preparation of treatment plans and reporting forms. This service is not covered on the same date of service as an emergency treatment visit.

(C) Limited Oral Evaluation. The MassHealth agency pays for a limited oral evaluation twice per member 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.

420.423: Service Descriptions and Limitations: Radiographs

(A) Introduction. The MassHealth agency pays for radiographs/diagnostic imaging taken as an integral part of diagnosis and treatment planning. The intent is to confine radiation exposure of members to the minimum necessary to achieve satisfactory diagnosis. The provider must document efforts to obtain any previous radiographs/diagnostic imaging before prescribing more. When radiographs and diagnostic imaging submitted to the MassHealth agency are not of good diagnostic quality, the provider may not claim payment for any retake of radiographs/diagnostic imaging requested by the MassHealth agency.

(B) Intraoral Conventional or Direct Digital Radiographs.

(1) Full-Mouth Radiographs (FMx). The MassHealth agency pays for FMx only for members aged six years and older and only once per member every three calendar years. FMx must consist either of a minimum of 10 periapical films and two posterior bitewing films, or two-to-four bitewing films and two periapical films taken with a panoramic film. However, panoramic films cannot be substituted for a FMx if an FMx is required for a prior-authorization request, unless the member has complete bony impacted teeth and other surgical conditions listed under 130 CMR 420.423(C)(1). The MassHealth agency does not pay more for individual periapical films (with or without bitewings) than it would for a full-mouth series.

(2) Bitewing Radiographs. The MassHealth agency pays for up to four bitewing films as separate procedures no more than twice per calendar year. The MassHealth agency does not pay separately for bitewing films taken as part of a full-mouth series.

(3) Periapical Films. Periapical films may be taken for specific areas where extraction is anticipated 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.

(C) Panoramic Films. 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.

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

(a) impactions;
(b) teeth requiring extractions in more than one quadrant;
(c) large cysts or tumors that are not fully visualized by intraoral films or clinical examination;
(d) salivary-gland disease;
(e) maxillary-sinus disease;
(f) facial trauma;
(g) trismus where an intraoral film placement is impossible; and
(h) orthognatic surgery.

(2) Nonsurgical Conditions.

(a) Members Under Age 21. The MassHealth agency pays for only one panoramic film per member per three-year period for nonsurgical conditions, to monitor the growth and development of permanent dentition.

(b) Members Age 21 and Older. The MassHealth agency pays for only one panoramic film per member per three year period in lieu of a full-mouth series only for those members who are unable to cooperate with the process for obtaining a full-mouth series. The provider must document in the member's dental record the reasons why the member cannot cooperate with the process for obtaining a full-mouth series.

(D) Cephalometric Film. The MassHealth agency pays for cephalometric films in conjunction with surgical conditions. Surgical conditions include, but are not limited to status post-facial trauma, mandibular fractures, dentoalveolar fractures, mandibular atrophy, and jaw dislocations. Payment for cephalometric film, or other radiographs, in conjunction with orthodontic diagnosis is included in the payment for orthodontic services. The MassHealth agency does not pay separately for additional radiographs when required for orthodontic diagnosis.

(E) Oral/Facial Photographic Images.

(1) The MassHealth agency pays for digital or photographic prints, not slides, only to support prior-authorization requests for orthodontic treatment.

(2) Payment for digital or photographic prints is included in the payment for orthodontic services. The MassHealth agency does not pay for digital or photographic prints as a separate procedure (see 130 CMR 420.413). Payment for orthodontic treatment includes payment for services provided as part of the pre-orthodontic work-up, except if the MassHealth agency denies the orthodontic treatment. In that case, the MassHealth agency pays for the pre-orthodontic work-up.

(3) The MassHealth agency may request digital or diagnostic photographic prints for other services that require prior-authorization.

(F) Diagnostic Casts. The MassHealth agency pays for diagnostic casts where medically necessary.

420.424: Service Descriptions and Limitations: Preventive Services

(A) Prophylaxis. The MassHealth agency pays for prophylaxis twice per member per calendar year. The prophylaxis must include a scaling of natural teeth, removal of acquired stains, and polishing of the teeth. As part of the prophylaxis, the practitioner must review with the member oral-hygiene methods including toothbrush instruction and flossing methods.

(B) Fluoride.

(1) Topical Fluoride Treatment.

(a) Members Under Age 21. The MassHealth agency pays for topical fluoride treatment. Topical fluoride treatment consists of continuous topical application of an approved fluoride agent such as gels, foams, and varnishes, for a period shown to be effective for the agent. The MassHealth agency pays for treatment that incorporates fluoride with the polishing compound as part of the prophylaxis. The MassHealth agency does not pay for treatment that incorporates fluoride with the polishing compound as a separate procedure.

(b) Members Aged 21 and Older. The MassHealth agency pays for topical fluoride only for members who have medical or dental conditions that significantly interrupt the flow of saliva.

(2) Fluoride Supplements. The MassHealth agency pays for fluoride supplements only for members under age 21 and through the pharmacy program (see 130 CMR 406.000).

(C) Sealants. The MassHealth agency pays for sealants for primary or permanent first and second noncarious molars, first and second non-carious bicuspids (premolars) with deep pits and fissures, and noncarious third molars with deep pits and fissures for members under age 21 only, and only once every three years per tooth. This service includes proper preparation of the enamel surface, etching, placement and finishing of the sealant, and reapplication if the process fails within three years. The MassHealth agency does not pay to replace sealants lost or damaged during the three-year period when reapplied by the same provider.

(D) Space Maintainers. The MassHealth agency pays for space maintainers and replacement space maintainers. Space maintainers are indicated when there is premature loss of teeth that may lead to loss of arch integrity. For primary cuspids, space maintainers prevent midline deviation and loss of arch length and circumference. Premature loss of primary molars also indicates the use of space maintainers to prevent the migration of adjacent teeth. The loss of primary incisors usually does not require the use of a space maintainer. An initial diagnostically acceptable radiograph must be maintained in the member's record, demonstrating that the tooth has not begun to erupt or that migration of the adjacent tooth has already occurred. The provider must maintain in the member's record, diagnostic-quality radiographs that support the need for space maintainers whether initial or replacement. Payment for subsequent visits to adjust space maintainers is included in the original payment.

420.425: Service Descriptions and Limitations: Restorative Services

The MassHealth agency pays for restorative services in accordance with 130 CMR 420.425 (A) through (D). The MassHealth agency considers all of the following to be components of a completed restoration and includes them in the payment for this service: tooth and soft-tissue preparation, cement bases, etching and bonding agents, pulp capping, impression, local anesthesia, and polishing. The MassHealth agency does not pay for restorations replaced within one year of the date of completion of the original restoration when replaced by the same provider. The initial payment includes all restorations replaced due to defects or failure less than one year from the original placement.

(A) Amalgam Restorations.

(1) The MassHealth agency does not pay for restorations attempted on primary teeth when early exfoliation (more than two-thirds of the root structure resorbed) is expected.

(2) The MassHealth agency pays for only one amalgam restoration per member per tooth surface per year. Occlusal surface restorations, including all occlusal pits and fissures, are payable as a one-surface restoration whether or not the transverse ridge on an upper molar is left intact.

(B) Resin-Based Composite Restorations.

(1) The MassHealth agency pays for the following:

(a) all resin-based composite restorations for all surfaces of anterior and posterior teeth;

(b) full-coverage composite crowns only for members under age 21, only for anterior primary teeth; and

(c) preventive resin restorations only for members under age 21, only on occlusal surfaces, and only as a single-surface posterior composite. Preventive resin restorations include instrumentation of the occlusal surfaces of grooves.

(2) For anterior teeth, the MassHealth agency pays no more than the maximum allowable payment for four-or-more-surface resin-based composite restorations on the same tooth, except for reinforcing pins and commercial amalgam bonding systems.

(3) The MassHealth agency pays for only one resin-based composite restoration per member per tooth surface per year.

(C) Crowns, Posts, Cores and Fixed Partial Dentures (Bridgework).

(1) Members Under Age 21. The MassHealth agency pays for the following:

(a) crowns made from resin-based composite (indirect);

(b) crowns–porcelain fused to predominantly base metal, posts, and cores on permanent incisors, cuspids, bicuspids, and first and second molars; and

(c) prefabricated stainless-steel crowns for primary and permanent posterior teeth or prefabricated resin crowns for primary and permanent anterior. Stainless-steel or prefabricated resin crowns are limited to instances where the prognosis is favorable and must not be placed on primary teeth that are mobile or show advanced resorption of roots. The MassHealth agency pays for no more than four stainless-steel or prefabricated resin crowns per member per date of service in an office setting.

(2) Members Aged 21 and Older. The MassHealth agency pays for crown porcelain fused to predominantly base metal, prefabricated posts, and cores on anterior teeth only. The MassHealth agency pays for porcelain fused to predominantly base metal and stainless steel crowns for posterior teeth only if extraction (the alternative treatment) would cause undue medical risk for a member with one or more medical conditions that include, but are not limited to

(a) hemophilia;
(b) history of radiation therapy;
(c) acquired or congenital immune disorder;
(d) severe physical disabilities such as quadriplegia;
(e) profound mental retardation; and
(f) profound mental illness.

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

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

420.426: Service Descriptions and Limitations: Endodontic Services

Payment by the MassHealth agency for endodontic services includes payment for all radiographs performed during the treatment session.

(A) Pulpotomy.
(1) The MassHealth agency pays for a therapeutic pulpotomy for members under age 21 only. Pulpotomy consists of the complete removal of the coronal portion of the pulp to maintain the vitality of the remaining tissue by means of an adequate dressing. It is limited to instances when the prognosis is favorable, and must not be performed on primary teeth that are ready to exfoliate or permanent teeth with advanced periodontal disease.
(2) The MassHealth agency does not pay for pulpotomy on deciduous teeth that are ready to exfoliate.
(3) The MassHealth agency does not pay for a pulpotomy performed on the same date of service as root-canal therapy. (See 130 CMR 420.456(D) regarding palliative treatment.)

(B) Root-Canal Therapy.
(1) General Conditions.
(a) Payment by the MassHealth agency for root-canal therapy includes payment for all preoperative and postoperative treatment; diagnostic (for example, pulp vitality) tests; and pretreatment, treatment, and post-treatment radiographs.
(b) The provider must maintain a radiograph of the completed root canal in the member's dental record.
(2) Members Under Age 21.
(a) The MassHealth agency pays for root-canal therapy on anterior teeth, bicuspids, and first and second molars but does not pay for root-canal therapy on third molars. Root-canal therapy is limited to the permanent dentition and then only when there is a favorable prognosis for the continued good health of both the tooth and the remaining dentition.
(b) The MassHealth agency pays for retreatment of previously root-canaled teeth for all permanent teeth with the exception of third molars.
(3) Members Aged 21 and Older.
(a) The MassHealth agency pays for root-canal therapy only on anterior teeth and then only when there is a favorable prognosis for the continued good health of both the tooth and the remaining dentition.

(b) The MassHealth agency does not pay for root-canal therapy on a posterior tooth unless extractions and/or removable prosthodontics (the alternate treatment) would cause undue medical risk for a member with one or more of the medical conditions that include but are not limited to those listed under 130 CMR 420.425(C)(2).

(C) Endodontic Retreatment.

(1) The MassHealth agency pays for endodontic retreatment of previous root-canal therapy on anterior, bicuspid, and molar teeth for members under age 21 only and endodontic retreatment of previous root-canal therapy only on anterior teeth for members aged 21 and older. This procedure may include the removal of a post, pins, old root-canal filling material, and the procedures necessary to prepare the canals and place the canal filling.

(2) The MassHealth agency does not pay for endodontic retreatment of previous root-canal therapy on a posterior tooth for members aged 21 and older unless the alternate treatment would cause undue medical risk for a member with one or more of the medical conditions that include but are not limited to those listed under 130 CMR 420.425(C)(2).

(3) Payment to the original provider includes all retreatments within 24 months of the original root canal.

(D) Apicoectomy/Periadicular Surgery.

(1) The MassHealth agency pays for an apicoectomy as a separate procedure for members following root-canal therapy when the canal cannot be retreated through reinstrumentation.

(2) Payment by the MassHealth agency for an apicoectomy with root canal filling includes payment for the filling of the canal or canals and removing the pathological periapical tissue and any retrograde filling in the same period of treatment.

420.427: Service Descriptions and Limitations: Periodontic Services

(A) Gingivectomies and Gingivoplasties. The MassHealth agency pays for gingivectomies and gingivoplasties once per member per quadrant every three years. The MassHealth agency does not pay for a gingivectomy performed on the same day as a prophylaxis or periodontal scaling and root planing, or as a separate procedure with an extraction. The MassHealth agency pays only for the gingivectomy or gingivoplasty for a maximum of two quadrants on the same date of service in an office setting.

(B) Periodontal Scaling and Root Planing. The MassHealth agency pays for periodontal scaling and root planing once per member per quadrant every three years. The MassHealth agency does not pay separately for prophylaxis provided on the same day as periodontal scaling and root planing or on the same day as a gingivectomy or a gingivoplasty. The MassHealth agency pays only for periodontal scaling and root planing for a maximum of two quadrants on the same date of service in an office setting.

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

(A) Dentures: General Conditions.

(1) Members Under Age 21. The MassHealth agency pays for the following dentures only:

(a) complete dentures;

(b) immediate dentures; and

(c) removable partial-upper and partial lower cast dentures including conventional clasps and rests.

(2) Members Aged 21 and Older.

(a) The MassHealth agency pays for the following dentures only:

(i) complete dentures (complete dentures following multiple extractions generally require a period of two months between the time the first impressions are taken); and

(ii) removable resin-based partial-upper and partial-lower dentures, including conventional clasps and rests.

(b) The MassHealth agency does not pay for full dentures when contraindications include the presence of a physical or mental illness that affects the patient's ability to cooperate during the fabrication of the denture and to accept or function with the denture, or if the patient is not interested in the replacement of their missing teeth.

(3) Denture Procedures.

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

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

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

(B) Complete Dentures. Payment by the MassHealth agency for complete dentures includes payment for all necessary adjustments, including relines, within six months after the insertion of the denture.

(C) Removable Partial Dentures. The MassHealth agency pays for removable partial dentures only if there are two or more missing posterior teeth or one or more missing anterior teeth, the remaining dentition is sound and there is a good prognosis. Payment for a partial denture includes payment for all necessary clasps and rests.

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

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

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

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

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

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

(6) the denture has been relined within the previous two years, unless the existing denture is at least seven years old, or due to a marked physiological change in the member's oral cavity, any further reline has a poor prognosis for success; or

(7) the loss of the denture was not due to extraordinary circumstances such as a fire in the home.

(E) Complete Denture Relines and Rebases. The MassHealth agency pays only for complete denture relines and rebases that are laboratory processed.

(1) Members Under Age 21. Payment includes any relines or rebases necessary within six months of the insertion date of the denture. The MassHealth agency pays for subsequent relines or rebases once every two years.

(2) Members Aged 21 and Older. Payment includes any relines necessary within 12 months of the insertion date of the denture. The MassHealth agency pays for subsequent relines and rebases once every three years.

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

(A) Fixed Partial Dentures. The MassHealth agency pays for fixed partial dentures (bridgework) for anterior teeth only for members under age 21 with fully matured teeth. The member's oral health must be excellent and the prognosis for the life of the bridge and remaining dentition must be excellent.

(B) Fixed Partial Denture Repair.

(1) The MassHealth agency pays for chairside fixed partial denture repair. A description of the repair must be documented in the member's dental record.

(2) The MassHealth agency pays for unspecified, fixed prosthodontic procedure by an outside laboratory only if the repair is extensive and cannot be done chairside.

420.430: Covered Service Descriptions and Limitations: Exodontic Services

(A) General Conditions.

(1) The MassHealth agency pays for exodontic services including payment for local anesthesia, suture removal, irrigations, spicule removal, apical curettage of associated cysts and granulomas, enucleation of associated follicles, and routine preoperative and postoperative care.

(2) The MassHealth agency pays for routine extractions provided in an office, hospital, or freestanding ambulatory surgery center. Use of a hospital or freestanding ambulatory surgery center for extractions is limited to those members whose health, because of a medical condition, would be at risk if these procedures were performed in the provider's office. Member apprehension alone is not sufficient justification for use of a hospital or freestanding ambulatory surgery center. Lack of facilities for the administration of general anesthesia when the procedure can be routinely performed with local anesthesia does not justify the use of a hospital or a freestanding ambulatory surgery center.

(B) Extraction. The MassHealth agency pays for extractions. An extraction can be either the removal of soft tissue-retained coronal remnants of a deciduous tooth or the removal of an erupted tooth or exposed root by elevation and/or forceps including routine removal of tooth structure, minor smoothing of socket bone, and closure. The removal of root tips whose main retention is soft tissue is considered a simple extraction. All simple extractions may be performed as necessary. The MassHealth agency pays for incision and drainage as a separate procedure from an extraction performed on a different tooth on the same day.

(C) Surgical Removal of Erupted Tooth. The MassHealth agency pays for the surgical removal of an erupted tooth. Surgical removal of an erupted tooth is the removal of any erupted tooth that includes the retraction of a mucoperiosteal flap and the removal of alveolar bone 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.

(D) Surgical Removal of Impacted Tooth. The MassHealth agency pays for the surgical removal of an impacted tooth in a hospital or freestanding ambulatory surgery center, when medically necessary. Member apprehension alone is not sufficient justification for the use of a hospital or freestanding ambulatory surgery center. Lack of facilities for administering general anesthesia in the office setting when the procedure can be routinely performed with local anesthesia does not justify use of a hospital or freestanding ambulatory surgery center.

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

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

(2) The provider must maintain a preoperative radiograph of the impacted tooth in the member's dental record to substantiate the service performed. The radiograph must clearly define the category of impaction.

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

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

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

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

(7) The MassHealth agency pays for surgical exposure of impacted or unerupted teeth to aid eruption only for members under age 21 for orthodontic reasons. MassHealth agency payment for surgical exposure includes reexposure due to tissue overgrowth or lack of orthodontic intervention.

(E) Alveoplasty.

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

(2) MassHealth agency payment for a quadrant alveoplasty (dentulous or edentulous) includes any additional alveoplasty of the same quadrant performed within six months of initial alveoplasty.

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

(G) Frenulectomy. The MassHealth agency pays for frenulectomy procedures. Frenulectomies may be performed to excise the frenum when the tongue has limited mobility, to aid in the closure of diastemas, and as a preparation for prosthetic surgery. If the purpose of the frenulectomy is to release a tongue, a written statement by a physician or primary care clinician and a speech

pathologist clearly stating the problem must be maintained in the member's dental record. The MassHealth agency does not pay for labial frenulectomies performed before the eruption of the permanent cuspids, unless orthodontic documentation that clearly justifies the medical necessity for the procedure is maintained in the member's dental record.

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

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

(J) Tooth Reimplanation and Stabilization of Accidentally Evulsed or Displaced Tooth. The MassHealth agency pays for tooth reimplantation and stabilization of an accidentally evulsed or displaced tooth. The procedure includes splinting and stabilization.

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

420.431: Service Descriptions and Limitations: Orthodontic Services

(A) General Requirements.

(1) The MassHealth agency pays for orthodontic treatment only for members under age 21 and only once per member per lifetime. The provider must begin initial fabrication and insertion of orthodontic appliances (initial treatment) before a member is 21 years of age. The MassHealth agency pays for the continuation of full orthodontic treatment as long as the member remains eligible for MassHealth, provided that initial treatment started before the member reached age 21. This payment limitation also applies to any pre- or post-orthognathic surgical case.

(2) The MassHealth agency pays for pre orthodontic work up (alternative billing to a contract fee) when the MassHealth agency denies a request for prior authorization for comprehensive orthodontic treatment and when the member fails to receive further treatment.

(B) Orthodontic Consultation. The MassHealth agency pays for an orthodontic consultation only for members under age 21 and only for the purpose of determining whether orthodontic treatment is necessary, and if so, when treatment should begin. The MassHealth agency pays for an orthodontic consultation as a separate procedure (see 130 CMR 420.413) only once per six-month period. The MassHealth agency does not pay for an orthodontic consultation as a separate procedure when used in conjunction with ongoing or planned (within six months) orthodontic treatment. The payment for an orthodontic consultation as a separate procedure does not include models or photographic prints. The MassHealth agency may request additional consultation for any orthodontic procedure.

(C) Orthodontic Radiographs. The MassHealth agency pays for radiographs as a separate procedure for orthodontic diagnostic purposes only for members under age 21, and only if requested by the MassHealth agency. Cephalometric films are to be used in conjunction with orthodontic diagnosis and are included in the payment for comprehensive orthodontic treatment (see 130 CMR 420.423(D)). Payment for radiographs in conjunction with orthodontic diagnosis is included in the payment for orthodontic services. If the MassHealth agency denies the request for comprehensive orthodontic treatment, the MassHealth agency pays for pre-orthodontic work-up that includes payment for radiographs.

(D) Interceptive Orthodontic-Treatment Visits. The goal of preventive or interceptive orthodontics is to prevent or minimize a developing malocclusion with primary or mixed dentition. Use of this treatment precludes or minimizes the need for additional orthodontic treatment.

(E) Comprehensive Orthodontic Treatment.

(1) The MassHealth agency pays for comprehensive orthodontic treatment only once per member under age 21 per lifetime and only when the member has a severe and handicapping malocclusion. The MassHealth agency determines whether a malocclusion is severe and handicapping based on the clinical standards described in Appendix D of the *Dental Manual*. The permanent dentition must be reasonably complete (usually by age 11). Payment covers a maximum period of two and one-half years of orthodontic treatment visits. Upon the completion of orthodontic treatment, the provider must take photographic prints and maintain them in the member's dental record.

(2) Payment for initial fabrication and insertion of the orthodontic appliance, which includes payment for records and all appliances associated with treatment: fixed and removable (for example, rapid palatal expansion (RPE) or head gear) is included in the payment for comprehensive orthodontic treatment.

(F) Orthodontic Treatment Visits. The MassHealth agency pays for ongoing orthodontic treatment visits on a quarterly basis. If a member becomes inactive for any period of time, prior authorization is not required to resume orthodontic treatment visits and subsequent billing unless the prior-authorization time limit has expired. Orthodontists should see members every four-to-six weeks and at least three times in each quarter of treatment (each quarter is one unit of service). The provider must document the number and dates of visits in the member's orthodontic record.

(G) Replacement Retainers. The MassHealth agency pays for a replacement retainer only during the two-year retention period following orthodontic treatment.

(H) Orthodontic Retention. The MassHealth agency pays separately for orthodontic retention (removal of appliances, construction and placement of retainers). Retention includes the fabrication and delivery of the initial retainers and follow-up visits. The MassHealth agency pays for a maximum of five retention visits (post-treatment stabilization).

(I) Patient Noncooperation. If the provider determines that continued orthodontic treatment is not indicated because of lack of member cooperation, the provider may request individual consideration for appliance removal and the placement of retainers, if indicated.

(130 CMR 420.432 through 420.451 Reserved)

420.452: Service Descriptions and Limitations: Anesthesia

(A) General Anesthesia and IV Sedation. The MassHealth agency pays for general anesthesia and IV sedation.

(1) General Anesthesia. General anesthesia, when administered in the office, must be administered only by a provider who possesses both an anesthesia-administration permit and an anesthesia-facility permit issued by the Massachusetts Board of Registration in Dentistry and when a member is eligible for oral-surgery services. All rules, regulations, and requirements set forth by the Massachusetts Board of Registration in Dentistry and by the Massachusetts Society of Oral and Maxillofacial Surgeons that apply to office general anesthesia, intravenous sedation, and the various forms of analgesia must be followed without exception. In most circumstances general anesthesia is used for oral surgery and maxillofacial procedures. The MassHealth agency pays for general anesthesia services for the first 30 minutes and in 15-minute increments thereafter, as set forth in the service descriptions in Subchapter 6 of the *Dental Manual*. Payment for general anesthesia in the office setting is limited to a maximum of 90 minutes.

(2) IV Sedation. The MassHealth agency pays for IV sedation when administered in the office, and when a member is eligible for oral-surgery services, only when administered by a provider who possesses both an anesthesia-administration permit and an anesthesia-facility permit issued by the Massachusetts Board of Registration in Dentistry. IV sedation may only be used for oral surgery and maxillofacial procedures. The MassHealth agency pays for IV sedation services for the first 30 minutes and in 15-minute increments thereafter, as set forth in the service descriptions in Subchapter 6 of the *Dental Manual*. Payment for IV sedation in the office setting is limited to a maximum of 90 minutes.

(B) Analgesia. The MassHealth agency pays for analgesia as follows.

(1) The MassHealth agency pays for the administration of analgesia, both orally PO, and rectally (PR), as part of an operative procedure. The MassHealth agency does not pay for the administration of non-inhalation analgesia, as a separate procedure (see 130 CMR 420.413).

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

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

(D) Documentation. The provider must maintain a completed anesthesia flowsheet in the member's dental record. In addition, the provider must document the following in the member's dental record:

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

420.453: Service Descriptions and Limitations: Oral and Maxillofacial Surgery Services

The MassHealth agency pays for oral and maxillofacial surgery services. Payment for oral and maxillofacial surgery services includes payment for routine inpatient preoperative and

postoperative care as well as for any related administrative or supervisory duties in connection with member care.

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

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

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

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

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

(F) Multiple Procedures.

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

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

(G) Orthognathic Surgery.

(1) The MassHealth agency pays for orthognathic surgery.

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

(130 CMR 420.454 Reserved)

420.455: Service Descriptions and Limitations: Maxillofacial Prosthetics

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

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

420.456: Service Descriptions and Limitations: Other Services

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

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

(a) has a condition that is reasonably likely to place the member at risk of medical complications that require medical resources that are not available in an office setting;

(b) is extraordinarily uncooperative, fearful, or anxious;

(c) has dental needs but for which local anesthesia is ineffective due to acute infection, idiosyncratic anatomy, or allergy; or

(d) has sustained orofacial or dental trauma, or both, so extensive that treatment cannot be provided safely and effectively in an office setting.

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

(a) a detailed description of the member's illness or disability;

(b) a history of previous treatment or attempts at treatment;

(c) a treatment plan listing all procedures and the teeth involved;

(d) radiographs (if radiographs are not available, an explanation is required);

(e) photographs to indicate the condition of the mouth if radiographs are not available; and

(f) documentation that there is no other suitable site of service for the member that would be less costly to the MassHealth agency.

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

(1) The MassHealth agency pays for oral screenings for members undergoing radiation, chemotherapy, or both, or who are on long-term immunosuppressive therapy.

(2) The MassHealth agency pays for a global fee for oral screenings that include payment for

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

(C) Behavioral Management. The MassHealth agency pays an additional payment once per member per day for management of a severely and chronically mentally, physically and/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.

(D) Palliative Treatment of Dental Pain or Infection. 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.

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

(F) Mouth Guard for Sports. The MassHealth agency pays for custom-fitted mouth guards where medically necessary, only for members under age 21. The member must be engaged in a contact sport, and there must be no other provision for the purchase of mouth guards for the sport's participants. Examples of contact sports include but are not limited to basketball, football, hockey, lacrosse, and soccer.

(130 CMR 420.457 Reserved)

REGULATORY AUTHORITY

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

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

601 Explanation of Abbreviations and Report Requirements

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

(A) "PA" indicates that service-specific prior authorization is required (see 130 CMR 420.410). The provider must include in any request for prior authorization sufficiently detailed clear information documenting the medical necessity of the service requested and where specified, the information described in this Subchapter 6. The MassHealth agency may require any additional information it deems necessary. Where prior authorization is not required, the provider must maintain in the member's dental record, all information necessary to disclose the medical necessity for the services provided. Pursuant to 130 CMR 420.410(B)(3) prior authorization may be requested for any exception to a limitation on a service otherwise covered for that member. (For example, MassHealth limits prophylaxis to two per member per calendar year, but will pay for additional prophylaxis for a member within a calendar year if medically necessary.)

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

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

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

(D) "By report" in the service code description column indicates that the provider must include with the claim a narrative documenting the medical necessity for the procedure.

CURRENT DENTAL TERMINOLOGY (CDT) CODES

Service Code	Service Code Description	Covered Under Age 21	Covered Aged 21 and Older	Prior Authorization Requirements, Report Requirements, and Notations
602 Service Codes and Descriptions: DIAGNOSTIC SERVICES *See 130 CMR 420.422 for service description and limitations.*				
D0120	Periodic oral examination – established patient (twice per calendar year)	Yes	Yes	
D0140	Limited oral evaluation – problem focused (twice per calendar year)	Yes	Yes	
D0145	Oral evaluation for a patient under three years of age and counseling with primary care giver	Yes (I.C.)	No	See 601(B) above.
D0150	Comprehensive oral evaluation – new or established patient (once per member per dentist)	Yes	Yes	
D0160	Detailed and extensive oral evaluation – problem focused (by report), by report (only for members undergoing radiation treatment, chemotherapy, or organ transplant)	Yes	Yes	See 601(D) above.
603 Service Codes and Descriptions: RADIOGRAPHS *See 130 CMR 420.423 for service description and limitations.*				
D0210	Intraoral – complete series (FMx) - (including bitewings) (once every three calendar years)	Yes	Yes	
D0220	Intraoral – periapical, first film	Yes	Yes	
D0230	Intraoral – periapical, each additional film	Yes	Yes	
D0270	Bitewing - single film	Yes	Yes	
D0272	Bitewings - two films (twice per calendar year)	Yes	Yes	
D0273	Bitewings – three films (twice per calendar year)	Yes (I.C.)	Yes (I.C.)	See 601(D) above.
D0274	Bitewings - four films (twice per calendar year)	Yes	Yes	
D0330	Panoramic film (nonsurgical condition) Panoramic film (surgical condition)	Yes Yes	No* Yes	* *exception for members unable to cooperate with the process for a FMx (See 130 CMR420.423 (C)(2)(b)).*
D0340	Cephalometric film	Yes	Yes	
D0350	Oral/facial photographic images (includes intra and extraoral images; excludes conventional radiographs)	Yes	Yes	
	Test and Laboratory Examinations			
D0470	Diagnostic casts	Yes (P.A.)	Yes (P.A.)	See 601(A) above.

Service Code	Service Code Description	Covered Under Age 21	Covered Aged 21 and Older	Prior Authorization Requirements, Report Requirements, and Notations
604 Service Codes and Descriptions: PREVENTIVE SERVICES *See 130 CMR 420.424 for service description and limitations.*				
D1110	Prophylaxis – adult (twice per calendar year) – permanent dentition	Yes (Use this code for ages 14-21.)	Yes	
D1120	Prophylaxis – child (twice per calendar year) – primary dentition	Yes Use this code for ages up to 14.)		
D1203	Topical application of fluoride (prophylaxis not included) – child	Yes		
D1204	Topical application of fluoride (prophylaxis not included) – adult		No*	* *exception for members who have a medical or dental condition that significantly interrupts the flow of saliva—PA required. See 601(A) above.*
	Other Preventive Services			
D1351	Sealant - per tooth (primary or permanent first and second noncarious molars, first and second non-carious bicuspids (premolars), and noncarious third molars)	Yes	No	
	Space Maintenance (Passive Appliances)			
D1510	Space maintainer - fixed-unilateral	Yes	No	
D1515	Space maintainer - fixed-bilateral	Yes	No	
D1520	Space maintainer - removable-unilateral	Yes	No	
D1525	Space maintainer - removable-bilateral	Yes	No	
D1550	Recementation of space maintainer	Yes	No	

605 Service Codes and Descriptions: RESTORATIVE SERVICES *See 130 CMR 420.425 for service description and limitations.*				
	Amalgam Restorations (Including Polishing)			
D2140	Amalgam - one surface, primary or permanent	Yes	Yes	
D2150	Amalgam - two surfaces, primary or permanent	Yes	Yes	
D2160	Amalgam - three surfaces, primary or permanent	Yes	Yes	
D2161	Amalgam - four or more surfaces, primary or permanent	Yes	Yes	
	Resin Based Composite Restorations			
D2330	Resin-based composite - one surface, anterior	Yes	Yes	

Service Code	Service Code Description	Covered Under Age 21	Covered Aged 21 and Older	Prior Authorization Requirements, Report Requirements, and Notations
D2331	Resin-based composite - two surfaces, anterior	Yes	Yes	
D2332	Resin-based composite - three surfaces, anterior	Yes	Yes	
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	Yes	Yes	
D2390	Resin-based composite crown, anterior	Yes	No	
D2391	Resin-based composite - one surface, posterior	Yes	Yes	
D2392	Resin-based composite - two surfaces, posterior	Yes	Yes	
D2393	Resin-based composite - three or more surfaces, posterior	Yes	Yes	
D2394	Resin-based composite - four or more surfaces, posterior	Yes	Yes	
	Crowns – Single Restoration Only			
D2710	Crown – resin-based composite (indirect)	Yes	No	
D2751	Crown - porcelain fused to predominantly base metal	Yes	Yes (P.A.)	Include periapical film of the tooth. See 601(A) above.
	Other Restorative Services			
D2910	Recement inlay, onlay or partial coverage restoration	Yes	Yes	
D2920	Recement crown	Yes	Yes	
D2930	Prefabricated stainless steel crown (primary tooth)	Yes	No	
D2931	Prefabricated stainless steel crown (permanent tooth)	Yes	No*	** exception for members with undue medical risk (See 130 CMR420.425 (C)(2)).*
D2932	Prefabricated resin crown (primary anterior teeth only)	Yes	No	
D2934	Prefabricated esthetic coated stainless steel crown-primary tooth	Yes	No	
D2951	Pin retention - per tooth, in addition to restoration (two or more surfaces) (commercial amalgam bonding)	Yes	Yes	
D2954	Prefabricated post and core in addition to crown	Yes	Yes (P.A.)	Include periapical film of the tooth. See 601(A) above.
D2980	Crown repair (by report) (chair-side)	Yes	Yes	See 601(D) above.
D2999	Unspecified restorative procedure, by report (outside laboratory)	Yes (P.A.) (I.C.)	Yes (P.A.) (I.C.)	(P.A.) -Include documentation to substantiate why the repair could not be done chair-side (I.C.) See 601(B) above.

Service Code	Service Code Description	Covered Under Age 21	Covered Aged 21 and Older	Prior Authorization Requirements, Report Requirements, and Notations
606 Service Codes and Descriptions: ENDODONTIC SERVICES *See 130 CMR 420.426 for service description and limitations.*				
	Pulpotomy			
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament	Yes	No	
	Root Canal Therapy (Including Pre and Post Treatment Radiographs and Follow-up Care)			
D3310	Anterior (excluding final restoration)	Yes (P.A.)	Yes (P.A.)	Include FMx. See 601(A) above.
D3320	Bicuspid (excluding final restoration)	Yes (P.A.)	No*	(P.A.) – Include FMx. See 601(A) above. ** exception for members with undue medical risk (See 130 CMR420.426 (B)(3)). – P.A. required*
D3330	Molar (excluding final restoration)	Yes (P.A.)	No*	(P.A.) – Include FMx. See 601(A) above. ** exception for members with undue medical risk (See 130 CMR420.426 (B)(3)). – P.A. required*
	Endodontic Retreatment			
D3346	Retreatment of previous root canal therapy - anterior	Yes (P.A.)	Yes (P.A.)	Include periapical film of the tooth and date of the original root canal treatment See 601(A) above.
D3347	Retreatment of previous root canal therapy – bicuspid	Yes (P.A.)	No*	(P.A) - Include periapical film of the tooth and date of the original root canal treatment. See 601(A) above. ** exception for members with undue medical risk (See 130 CMR420.426 (B)(3)).* *- P.A. required*
D3348	Retreatment of previous root canal therapy - molar	Yes (P.A.)	No*	(P.A) - Include periapical film of the tooth and date of the original root canal treatment. See 601(A) above. ** exception for members with undue medical risk (See 130 CMR420.426 (B)(3)).* *- P.A. required*
	Apicoectomy/Periradicular Services			
D3410	Apicoectomy/periradicular surgery – anterior (per tooth) (includes retrograde filling)	Yes	Yes (P.A.)	Include periapical film of the tooth and date of the original root canal treatment. See 601(A) above.
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	Yes	Yes (P.A.)	Include periapical film of the tooth and date of the original root canal treatment. See 601(A) above.
D3426	Apicoectomy/periradicular surgery (each additional root)	Yes	Yes (P.A.)	Include periapical film of the tooth and date of the original root canal treatment. See 601(A) above.

Service Code	Service Code Description	Covered Under Age 21	Covered Aged 21 and Older	Prior Authorization Requirements, Report Requirements, and Notations
607 Service Codes and Descriptions: PERIODONTIC SERVICES *See 130 CMR 420.427 for service description and limitations.*				
	Surgical Services (Including usual Postoperative Services)			
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces per quadrant (once per quadrant per three-year period)	Yes	Yes (P.A.)	Include complete periodontal charting, periapical films, documentation of previous periodontal treatment, and a statement concerning the member's periodontal condition. See 601(A) above.
D4211	Gingivectomy or gingivoplasty – one to three contiguous teeth or bounded teeth spaces per quadrant (once per quadrant per three-year period)	Yes	Yes (P.A.)	Include complete periodontal charting, periapical films, documentation of previous periodontal treatment, and a statement concerning the member's periodontal condition. See 601(A) above.
D4341	Periodontal scaling and root planing (four or more contiguous teeth or bounded teeth spaces per quadrant) (once per quadrant per three-year period)	Yes	Yes (P.A.)	Include complete periodontal charting, periapical films, documentation of previous periodontal treatment, and a statement concerning the member's periodontal condition. See 601(A) above.
D4342	Periodontal scaling and root planing – one to three teeth per quadrant	Yes	Yes (P.A.)	Include complete periodontal charting, periapical films, documentation of previous periodontal treatment, and a statement concerning the member's periodontal condition. See 601(A) above.

608 Service Codes and Descriptions: PROSTHODONTIC (REMOVABLE) SERVICES *See 130 CMR 420.428 for l service description and imitations.*				
	Complete Dentures (Including Routine Post-Delivery Care)			
D5110	Complete denture – maxillary	Yes	Yes (P.A.)	Include documentation regarding initial placement, including length of time without natural teeth or documentation of replacement and age of original prosthesis. See 601(A) above.
D5120	Complete denture – mandibular	Yes	Yes (P.A.)	Include documentation regarding initial placement, including length of time without natural teeth or documentation of replacement and age of original prosthesis. See 601(A) above.
D5130	Immediate denture – maxillary	Yes	No	
D5140	Immediate denture – mandibular	Yes	No	

Service Code	Service Code Description	Covered Under Age 21	Covered Aged 21 and Older	Prior Authorization Requirements, Report Requirements, and Notations
	Partial Dentures (Including Routine Post-Delivery Care)			
D5211	Maxillary partial denture (resin base) (including any conventional clasps, rests and teeth)	Yes	Yes (P.A.)	Include FMx and documentation of two or more missing posterior teeth and/or one or more missing anterior teeth. See 601(A) above.
D5212	Mandibular partial denture (resin base) (including any conventional clasps, rests and teeth)	Yes	Yes (P.A.)	Include FMx and documentation of two or more missing posterior teeth and/or one or more missing anterior teeth. See 601(A) above.
D5213	Maxillary partial denture (cast metal framework with resin denture bases) (including any conventional clasps, rests and teeth)	Yes	No	
D5214	Mandibular partial denture- cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	Yes	No	
	Repairs to Complete Dentures			
D5510	Repair broken complete denture base	Yes	Yes	
D5520	Replace missing or broken teeth – complete denture (each tooth)	Yes	Yes	
	Repairs to Partial Dentures			
D5610	Repair resin denture base	Yes	Yes	
D5620	Repair cast framework	Yes	Yes	
D5630	Repair or replace broken clasp	Yes	Yes	
D5640	Replace broken teeth – per tooth	Yes	Yes	
D5650	Add tooth to existing partial denture	Yes	Yes	
D5660	Add clasp to existing partial denture	Yes	Yes	
	Denture Rebase Procedures			
D5710	Rebase complete maxillary denture	Yes	Yes (P.A.)	Include date of original insertion of the denture, date(s) of prior rebase(s), if applicable, and clinical documentation of the reason for the request. See 601(A) above.
D5711	Rebase complete mandibular denture	Yes	Yes (P.A.)	Include date of original insertion of the denture, date(s) of prior rebase(s), if applicable, and clinical documentation of the reason for the request. See 601(A) above.
D5720	Rebase maxillary partial denture (cast partial denture only)	Yes	No	
D5721	Rebase mandibular partial denture (cast partial denture only)	Yes	No	

Service Code	Service Code Description	Covered Under Age 21	Covered Aged 21 and Older	Prior Authorization Requirements, Report Requirements, and Notations
D5721	Rebase mandibular partial denture (cast partial denture only)	Yes	No	
	Denture Reline Procedures			
D5750	Reline complete maxillary denture (laboratory)	Yes	Yes (P.A.)	Include date of original insertion of the denture, date(s) of prior reline(s), if applicable, and clinical documentation of the reason for the request. See 601(A) above.
D5751	Reline complete mandibular denture (laboratory)	Yes	Yes (P.A.)	Include date of original insertion of the denture, date(s) of prior reline(s), if applicable, and clinical documentation of the reason for the request. See 601(A) above.
D5760	Reline maxillary partial denture (laboratory) (cast partial denture only)	Yes	No	
D5761	Reline mandibular partial denture (laboratory) (cast partial denture only)	Yes	No	

609 Service Codes and Descriptions: PROSTHODONTIC (FIXED) SERVICES *See 130 CMR 420.429 for service description and limitations.*				
	Fixed Partial Denture Pontics			
D6241	Pontic – porcelain fused to predominantly base metal	Yes	No	
D6751	Crown – porcelain fused to predominantly base metal	Yes	No	
	Other Fixed Partial Denture Services			
D6930	Recement fixed partial denture	Yes	No	
D6980	Fixed partial denture repair (by report) (chairside)	Yes	No	See 601(A) and (D) above.
D6999	Unspecified, fixed prosthodontic procedure, by report (outside laboratory)	Yes (P.A.) (I.C.)	Yes (P.A.) (I.C.)	(P.A.) - Include documentation to substantiate why the repair could not be done chair-side. See 601(A) above. (I.C.) - See 601(B) above. (by report) - See 601 (D) above,

610 Service Codes and Descriptions: EXODONTIC SERVICES *See 130 CMR 420.430 for service description and limitations.*				
	Extractions (Includes Local Anesthesia and Routine Postoperative Care)			
D7111	Extraction, coronal remnants – deciduous tooth	Yes	Yes	
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	Yes	Yes	

Service Code	Service Code Description	Covered Under Age 21	Covered Aged 21 and Older	Prior Authorization Requirements, Report Requirements, and Notations
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	Yes	Yes	
D7220	Removal of impacted tooth – soft tissue	Yes	Yes	
D7230	Removal of impacted tooth – partially bony	Yes	Yes	
D7240	Removal of impacted tooth – completely bony	Yes (P.A.)	Yes (P.A.)	Include Panorex film. See 601(A) above.
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	Yes	Yes	
D7280	Surgical access of an unerupted tooth (including orthodontic attachments)	Yes	No	
D7283	Placement of device to facilitate eruption of impacted tooth	Yes	No	
	Surgical Procedures			
D7310	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	Yes	Yes	
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	Yes	Yes	
D7320	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	Yes	Yes	
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	Yes	Yes	
D7340	Vestibuloplasty – ridge extension (secondary epithelialization)	Yes (P.A.)	Yes (P.A.)	Include justification of the surgical procedure designed to increase alveolar ridge height. See 601(A) above.
D7350*	Vestibuloplasty – ridge extension (including soft-tissue grafts, muscle reattachments, revision of soft-tissue attachment, and management of hypertrophied and hyperplastic tissue)	Yes (P.A.)	Yes (P.A.)	* *only payable to a dental provider with a specialty in oral surgery*. See 601(A) above.
D7410	Excision of benign lesion up to 1.25 cm	Yes	Yes	
D7411	Excision of benign lesion greater than 1.25 cm	Yes	Yes	
D7450*	Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm	Yes	Yes	* *only payable to a dental provider with a specialty in oral surgery.*

Service Code	Service Code Description	Covered Under Age 21	Covered Aged 21 and Older	*Prior Authorization Requirements, Report Requirements, and Notations*
D7451*	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	Yes	Yes	** only payable to a dental provider with a specialty in oral surgery.*
D7460*	Removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25 cm	Yes	Yes	** only payable to a dental provider with a specialty in oral surgery.*
D7461*	Removal of benign nonodontogenic cyst or tumor – lesion diameter greater than 1.25 cm	Yes	Yes	** only payable to a dental provider with a specialty in oral surgery.*
D7471*	Removal of lateral exostosis (maxilla or mandible)	Yes (P.A.)	Yes (P.A.)	** only payable to a dental provider with a specialty in oral surgery.* *See 601(A) above.*
D7960	Frenulectomy (frenectomy or frenotomy) – separate procedure	Yes (S.P.)	Yes (S.P.)	*See 601(C) above.*
D7963	Frenuloplasty	Yes	Yes	
D7970	Excision of hyperplastic tissue -per arch	Yes	Yes (P.A.)	*Include a narrative documenting the medical necessity for the procedure and documentation of the planned prosthesis.* *See 601(A) above.*
D7999	Unspecified oral surgery procedure, by report	Yes (P.A.) (I.C.)	Yes (P.A.) (I.C.)	*See 601(A), (B), and (D) above.*

611 Service Codes and Descriptions: ORTHODONTIC SERVICES *See 130 CMR 420.431 for service description and limitations.*				
	Orthodontic Diagnosis and Full Orthodontic Treatment			
D8050	Interceptive orthodontic treatment of the primary dentition	Yes (P.A.) (I.C.)	No	(P.A.) - Include the number of adjustment visits required in conjunction with the type of interceptive appliance. (I.C.) – See 601(A) and (B) above.
D8060	Interceptive orthodontic treatment of the transitional dentition	Yes (P.A.) (I.C.)	No	(P.A.) - Include the number of adjustment visits required in conjunction with the type of interceptive appliance. (I.C.) - See 601(A) and (B) above.
D8080	Comprehensive orthodontic treatment of the adolescent dentition (includes pre-orthodontic visit, records, photographic prints, models, radiographs, and initial banding. Service code used upon completion of banding).	Yes (P.A.)	No	Include documentation that all restorative services were completed, Orthodontic Prior Authorization Form, photographic prints, and PAR Index Recording Form. See 601(A) above.

Service Code	Service Code Description	Covered Under Age 21	Covered Aged 21 and Older	Prior Authorization Requirements, Report Requirements, and Notations
D8660	Pre-orthodontic treatment visit (consultation) (once per six months)	Yes	No	
D8670	Periodic orthodontic treatment visit (as part of contract). Billed quarterly.	Yes (P.A.)	No*	(P.A.) - Submit separate prior authorization request for year 1, year 2, and year 3 (up to 6 months), if necessary. For years 2 and 3 only, include original photographic prints, intraoral photographic prints, documentation that all restorative services were completed, and a copy of the initially submitted orthodontics prior-authorization form with Part IV completed with progress to date. See 601(A) above. ** exception for members whose comprehensive orthodontic treatment was begun by age 21.* *- PA required.*
D8690	Orthodontic treatment (alternative billing to a contract fee)	Yes (P.A.)	No	See 601(A) above.
	Other Orthodontic Services			
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	Yes	No*	** exception for members whose comprehensive orthodontic treatment was begun by age 21. PA required.* Include the date of the initial banding and a narrative of the reason(s) for removal of the orthodontic appliance. See 601(A) above.
D8692	Replacement of lost or broken retainer	Yes (P.A.)	No*	(P.A.) - Include a statement regarding the date of the onset of retention. See 601(A) above. ** exception for members whose comprehensive orthodontic treatment was begun by age 21. - PA required.*
D8999	Unspecified orthodontic procedure, by report	Yes (P.A.) (I.C.)	No*	** exception for members whose comprehensive orthodontic treatment was begun by age 21. PA required.* See 601(A), (B), and (D) above.

612 Service Codes and Descriptions: GENERAL ANESTHESIA AND IV SEDATION SERVICES *See 130 CMR 420.452 for service description and limitations.*				
D9220	Deep Sedation/general anesthesia (first 30 minutes)	Yes	Yes	
D9221	Deep Sedation/general anesthesia each additional 15 minutes (from 31 to 90 minutes)	Yes	Yes	

Service Code	Service Code Description	Covered Under Age 21	Covered Aged 21 and Older	Prior Authorization Requirements, Report Requirements, and Notations
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	Yes	Yes	
D9241	Intravenous conscious sedation/analgesia – first 30 minutes	Yes	Yes	
D9242	Intravenous conscious sedation/analgesia – each additional 15 minutes (from 31 to 90 minutes)	Yes	Yes	

613 Service Codes and Descriptions: OTHER SERVICES *See 130 CMR 420.456 for service description and limitations.*				
	Treatment of Physically or Developmentally Disabled Members			
D9920	Behavior management, by report (once per member per day).	Yes (P.A.)	Yes (P.A.)	Include a description of the member's illness or disability, and types of services to be furnished. See 601 (D) above.
	Unclassified Treatment			
D9110	Palliative (emergency) treatment of dental pain - minor procedure (other non-emergency medically necessary treatment may be provided during the same visit – that is non-emergency codes may be billed in conjunction with D9110.	Yes	Yes	
D9930	Treatment of complications (postsurgical) – unusual circumstances, by report	Yes (I.C)	Yes (I.C.)	Include with the claim the date, the location of the original surgery, and the type of procedure. See 601(A) above.
D9940	Occlusal guard, by report	Yes (P.A.)	No	(P.A.) - Include documented evidence of the need for the appliance. (by report) - See 601(A) and (D) above.
D9941	Fabrication of athletic mouth guard	Yes	No	
D9999	Unspecified adjunctive procedure, by report	Yes (P.A.) (I.C.)	Yes (P.A.) (I.C.)	See 601(A) above, (I,C.) – See 601 (B) –above. (by report) – See 601 (D) above.

CURRENT PROCEDURAL TERMINOLOGY (CPT) CODES

The following all-numeric service codes may only be used by dental providers who have a specialty in oral surgery.

Service Code	Service Code Description	Prior Authorization Requirements, Report Requirements, and Notations
620 Service Codes and Descriptions: MEDICAL SERVICES		
	OFFICE OR OTHER OUTPATIENT SERVICES	
	New Patient	
99201	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components (does not include dentoalveolar diagnosis): - a problem focused history; - a problem focused examination; and - straightforward medical decision making	
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components (does not include dentoalveolar diagnosis): - an expanded problem-focused history; - an expanded problem-focused examination; and - straightforward medical decision making	
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components (does not include dentoalveolar diagnosis): - a detailed history; - a detailed examination; and - medical decision making of low complexity	
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components (does not include dentoalveolar diagnosis): - a comprehensive history; - a comprehensive examination; and - medical decision making of a moderate complexity	
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components (does not include dentoalveolar diagnosis): - a comprehensive history; - a comprehensive examination; and - medical decision making of high complexity	
	Established Patient	
99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.	

Service Code	Service Code Description	Prior Authorization Requirements, Report Requirements, and Notations
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components (does not include dentoalveolar diagnosis): - a problem-focused history; - a problem-focused examination; and - straightforward medical decision making	
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: - an expanded problem focused history; - an expanded problem focused examination; and - medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.	
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of the following three key components: - a detailed history; - a detailed examination; and - medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.	
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of the following three key components: - a comprehensive history; - a comprehensive examination; and - medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.	

Service Code	Service Code Description	Prior Authorization Requirements, Report Requirements, and Notations
	INITIAL HOSPITAL CARE	
	New or Established Patient	
99221	Initial hospital care, per day, for the evaluation and management of a patient, which requires these three key components: - a detailed or comprehensive history; - a detailed or comprehensive examination; and - medical decision making that is straightforward or of low complexity	
99222	Initial hospital care, per day, for the evaluation and management of a patient, which requires these three key components: - a comprehensive history; - a comprehensive examination; and - medical decision making of moderate complexity	
99223	Initial hospital care, per day, for the evaluation and management of a patient, which requires these three key components: - a comprehensive history; - a comprehensive examination; and - medical decision making of high complexity	
	SUBSEQUENT HOSPITAL CARE	
99231	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: - a problem-focused interval history; - a problem-focused examination; - medical decision making that is straightforward or of low complexity	
99232	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: - an expanded problem-focused interval history; - an expanded problem-focused examination; - medical decision making of moderate complexity	
99233	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: - a detailed interval history; - a detailed examination; - medical decision making of high complexity	
	INITIAL INPATIENT CONSULTATIONS	
	New or Established Patient	
99251	Inpatient consultation for a new or established patient, which requires these three key components: - a problem-focused history; - a problem-focused examination; and - straightforward medical decision making	

Service Code	Service Code Description	Prior Authorization Requirements, Report Requirements, and Notations
99252	Inpatient consultation for a new or established patient, which requires these three key components: - an expanded problem-focused history; - an expanded problem-focused examination; and - straightforward medical decision making	
99253	Inpatient consultation for a new or established patient, which requires these three key components: - a detailed history; - a detailed examination; and - medical decision making of low complexity	
99254	Inpatient consultation for a new or established patient, which requires three key components: - a comprehensive history; - a comprehensive examination; and - medical decision making of moderate complexity	
99255	Inpatient consultation for a new or established patient, which requires these three key components: - a comprehensive history; - a comprehensive examination; and - medical decision making of high complexity	
EMERGENCY DEPARTMENT SERVICES		
	New or Established Patient	
99281	Emergency department visit for the evaluation and management of a patient, which requires these three key components: - a problem-focused history; - a problem-focused examination; and - straightforward medical decision making	
99282	Emergency department visit for the evaluation and management of a patient, which requires these three key components: - an expanded problem-focused history; - an expanded problem-focused examination; and - medical decision making of low complexity	
99283	Emergency department visit for the evaluation and management of a patient, which requires these three key components: - an expanded problem-focused history; - an expanded problem-focused examination; and - medical decision making of moderate complexity	
99284	Emergency department visit for the evaluation and management of a patient, which requires these three key components: - a detailed history; - a detailed examination; and - medical decision making of moderate complexity	

Service Code	Service Code Description	Prior Authorization Requirements, Report Requirements, and Notations
99285	Emergency department visit for the evaluation and management of a patient, which requires these three key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: - a comprehensive history; - a comprehensive examination; and - medical decision making of high complexity	
	INTEGUMENTARY SYSTEM	
	SKIN, SUBCUTANEOUS AND ACCESSORY STRUCTURES	
	Incision and Drainage	
10060	Incision and drainage of abscess (e.g., carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single	
10061	Incision and drainage of abscess (e.g., carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); complicated or multiple	
10120	Incision and removal of foreign body, subcutaneous tissues; simple	
10121	Incision and removal of foreign body, subcutaneous tissues; complicated	
10140	Incision and drainage of hematoma, seroma, or fluid collection	
10160	Puncture aspiration of abscess, hematoma, bulla, or cyst	
10180	Incision and drainage, complex, postoperative wound infection	
	Excision-Debridement	
11010	Debridement including removal of foreign material associated with open fracture(s) and/or dislocation(s); skin and subcutaneous tissues	
11011	skin, subcutaneous tissue, muscle fascia, and muscle	
11012	skin, subcutaneous tissue, muscle fascia, muscle, and bone	
11040	Debridement; skin, partial thickness	
11041	skin, full thickness	
11042	skin and subcutaneous tissue	
11043	skin, subcutaneous tissue, and muscle	
11044	skin, subcutaneous tissue, muscle, and bone	
	Biopsy	
11100	Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion	
11101	each separate/additional lesion (List separately in addition to code for primary procedure)	
	Shaving of Epidermal or Dermal Lesions	
11310	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less	
11311	lesion diameter 0.6 to 1.0 cm	
11312	lesion diameter 1.1 to 2.0 cm	
11313	lesion diameter over 2.0 cm	

Service Code	Service Code Description	Prior Authorization Requirements, Report Requirements, and Notations
	Excision – Benign Lesions	
11440	Excision, other benign lesion including margins, except skintag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.5 cm or less	
11441	excised diameter 0.6 to 1.0 cm	
11442	excised diameter 1.1 to 2.0 cm	
11443	excised diameter 2.1 to 3.0 cm	
11444	excised diameter 3.1 to 4.0 cm	
11446	excised diameter over 4.0 cm	
	Excision – Malignant Lesions	
11640	Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 0.5 cm or less	
11641	excised diameter 0.6 to 1.0 cm	
11642	excised diameter 1.1 to 2.0 cm	
11643	excised diameter 2.1 to 3.0 cm	
11644	excised diameter 3.1 to 4.0 cm	
11646	excised diameter over 4.0 cm	
	MISCELLANEOUS	
	Introduction	
11960	Insertion of tissue expander(s) for other than breast, including subsequent expansion	
11970	Replacement of tissue expander with permanent prosthesis	
11971	Removal of tissue expander(s) without insertion of prosthesis	
	REPAIR (CLOSURE)	
	Repair - Simple	
12011	Simple repair of superficial wounds of face, ears, eyelids, nose, lips, and/or mucous membranes; 2.5 cm or less	
12013	2.6 cm to 5.0 cm	
12014	5.1 cm to 7.5 cm	
12015	7.6 cm to 12.5 cm	
12016	12.6 cm to 20.0 cm	
12017	20.1 cm to 30.0 cm	
12018	over 30.0 cm	
12020	Treatment of superficial wound dehiscence; simple closure	
12021	with packing	
	Repair - Intermediate	
12051	Layer closure of wounds of face, ears, eyelids, nose, lips, and/or mucous membranes; 2.5 cm or less	
12052	2.6 cm to 5.0 cm	
12053	5.1 cm to 7.5 cm	
12054	7.6 cm to 12.5 cm	
12055	12.6 cm to 20.0 cm	

Service Code	Service Code Description	Prior Authorization Requirements, Report Requirements, and Notations
12056	20.1 cm to 30.0 cm	
12057	over 30.0 cm	
	Repair - Complex	
13131	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; 1.1 cm to 2.5 cm	
13132	2.6 cm to 7.5 cm	
13133	each additional 5 cm or less (List separately in addition to code for primary procedure.)	
13150	Repair, complex, eyelids, nose, ears, and/or lips; 1.0 cm or less	
13151	1.1 cm to 2.5 cm	
13152	2.6 cm to 7.5 cm	
13153	each additional 5 cm or less (List separately in addition to code for primary procedure.)	
13160	Secondary closure of surgical wound or dehiscence, extensive or complicated	
	Adjacent Tissue Transfer or Rearrangement	
14040	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; defect 10 sq cm or less	
14041	defect 10.1 sq cm to 30.0 sq cm	
14060	Adjacent tissue transfer or rearrangement, eyelids, nose, ears, and/or lips; defect 10 sq cm or less	
14061	defect 10.1 sq cm to 30.0 sq cm	
	Free Skin Grafts	
15120	Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children (except 15050)	
15121	each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof (List separately in addition to code for primary procedure.)	
15240	Full thickness graft, free, including direct closure of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; 20 sq cm or less	
15241	each additional 20 sq cm (List separately in addition to code for primary procedure.)	
15260	Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and/or lips; 20 sq cm or less	
15261	each additional 20 sq cm (List separately in addition to code for primary procedure.)	
	Flaps (Skin and/or Deep Tissues)	
15570	Formation of direct or tubed pedicle, with or without transfer; trunk	
15572	scalp, arms, or legs	

Service Code	Service Code Description	Prior Authorization Requirements, Report Requirements, and Notations
	Flaps (Skin and/or Deep Tissues)	
15570	Formation of direct or tubed pedicle, with or without transfer; trunk	
15572	scalp, arms, or legs	
15574	forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, or feet	
15576	eyelids, nose, ears, lips, or intraoral	
15620	Delay of flap or sectioning of flap (division and inset); at forehead, cheeks, chin, neck, axillae, genitalia, hands, or feet	
15630	at eyelids, nose, ears, or lips	
15732	Muscle, myocutaneous, or fasciocutaneous flap; head and neck (e.g., temporalis, masseter muscle, sternocleidomastoid, levator scapulae)	
	Other Flaps and Grafts	
15770	Graft; derma-fat-fascia	
	Other Procedures	
15819	Cervicoplasty	
15820	Blepharoplasty, lower eyelid (P.A.)	See 601(A) above.
15821	with extensive herniated fat pad (P.A.)	See 601(A) above.
15822	Blepharoplasty, upper eyelid (P.A.)	See 601(A) above.
15823	with excessive skin weighting down lid (P.A.)	See 601(A) above.
15840	Graft for facial nerve paralysis; free fascia graft (including obtaining fascia)	
15841	free muscle graft (including obtaining graft)	
15842	free muscle flap by microsurgical technique	
15845	regional muscle transfer	
	Burns, Local Treatment	
16000	Initial treatment, first degree burn, when no more than local treatment is required	
	DESTRUCTION	
	Destruction, Benign or Premalignant Lesions	
17000	Destruction (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (e.g., actinic keratoses); first lesion	
17003	second through 14 lesions, each (List separately in addition to code for first lesion.)	
17004	15 or more lesions	
17106	Destruction of cutaneous vascular proliferative lesions (e.g., laser technique); less than 10 sq cm	
	Destruction Malignant Lesions, Any Method	
17280	Destruction, malignant lesion (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less	
17281	lesion diameter 0.6 to 1.0 cm	
17282	lesion diameter 1.1 to 2.0 cm	
17283	lesion diameter 2.1 to 3.0 cm	
17284	lesion diameter 3.1 to 4.0 cm	
17286	lesion diameter over 4.0 cm	

Service Code	Service Code Description	Prior Authorization Requirements, Report Requirements, and Notations
	Other Procedures	
17999	Unlisted procedure, skin, mucous membrane, and subcutaneous tissue (I.C.)	See 601(B) above.
	MUSCULOSKELETAL SYSTEM	
	GENERAL	
	Incision	
20000	Incision of soft tissue abscess (e.g., secondary to osteomyelitis); superficial	
20005	deep or complicated	
	Excision	
20200	Biopsy, muscle; superficial	
20205	deep	
20206	Biopsy, muscle, percutaneous needle	
20220	Biopsy, bone, trocar, or needle; superficial (e.g., ilium, sternum, spinous process, ribs)	
20240	Biopsy, bone, open; superficial (e.g., ilium, sternum, spinous process, ribs, trochanter of femur)	
20245	deep (e.g., humerus, ischium, femur)	
	Introduction or Removal	
20520	Removal of foreign body in muscle or tendon sheath; simple	
20525	deep or complicated	
20605	Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (e.g., temporomandibular, acromioclavicular, wrist, elbow, or ankle, olecranon bursa)	
20615	Aspiration and injection for treatment of bone cyst	
20670	Removal of implant; superficial (e.g., buried wire, pin, or rod) (S.P.)	See 601(C) above.
20680	deep (e.g., buried wire, pin, screw, metal band, nail, rod, or plate)	
20690	Application of a uniplane (pins or wires in one plane), unilateral, external fixation system	
20692	Application of a multiplane (pins or wires in more than one plane), unilateral, external fixation system (e.g., Ilizarov, Monticelli type)	
20693	Adjustment or revision of external fixation system requiring anesthesia (e.g., new pin(s) or wire(s) and/or new ring(s) or bar(s))	
20694	Removal, under anesthesia, of external fixation system	
	Grafts (or Implants)	
20900	Bone graft, any donor area; minor or small (e.g., dowel or button)	
20902	major or large	
20910	Cartilage graft; costochondral	
20912	nasal septum	
20920	Fascia lata graft; by stripper	
20922	by incision and area exposure, complex or sheet	
20924	Tendon graft, from a distance (e.g., palmaris, toe extensor, plantaris)	
20926	Tissue grafts, other (e.g., paratenon, fat, dermis)	

Service Code	Service Code Description	Prior Authorization Requirements, Report Requirements, and Notations
	Other Procedures	
20955	Bone graft with microvascular anastomosis; fibula	
20956	iliac crest	
20962	other than fibula, iliac crest, or metatarsal	
20969	Free osteocutaneous flap with microvascular anastomosis; other than iliac crest, metatarsal, or great toe	
20970	iliac crest	
20999	Unlisted procedure, musculoskeletal system, general (I.C.)	See 601(B) above.
	HEAD	
	Incision	
21010	Arthrotomy, temporomandibular joint	
	Excision	
21015	Radical resection of tumor (e.g., malignant neoplasm), soft tissue of face or scalp	
21025	Excision of bone (e.g., for osteomyelitis or bone abscess); mandible	
21026	facial bone(s)	
21029	Removal by contouring of benign tumor of facial bone (e.g., fibrous dysplasia)	
21030	Excision of benign tumor or cyst of maxilla or zygoma by enucleation and curettage	
21031	Excision of torus mandibularis	
21032	Excision of maxillary torus palatinus	
21034	Excision of malignant tumor of maxilla or zygoma	
21040	Excision of benign tumor or cyst of mandible; by enucleation and/or curettage	
21044	Excision of malignant tumor of mandible	
21045	radical resection	
21046	Excision of benign tumor or cyst of mandible; requiring intra-oral osteotomy (e.g., locally aggressive or destructive lesion(s))	
21047	requiring extra-oral osteotomy and partial mandibulectomy (e.g., locally aggressive or destructive lesion(s))	
21048	Excision of benign tumor or cyst of maxilla; requiring intra-oral osteotomy (e.g., locally aggressive or destructive lesion(s))	
21049	requiring extra-oral osteotomy and partial maxillectomy (e.g., locally aggressive or destructive lesion(s))	
21050	Condylectomy, temporomandibular joint (S.P.)	See 601(C) above.
21060	Meniscectomy, partial or complete, temporomandibular joint (S.P.)	See 601(C) above.
21070	Coronoidectomy (S.P.)	See 601(C) above.
	Introduction or Removal	
21076	Impression and custom preparation; surgical obturator prosthesis (P.A.)	See 601(A) above.
21077	orbital prosthesis (P.A.)	See 601(A) above.
21079	interim obturator prosthesis (P.A.)	See 601(A) above.
21080	definitive obturator prosthesis (P.A.)	See 601(A) above.
21081	mandibular resection prosthesis (P.A.)	See 601(A) above.

Service Code	Service Code Description	Prior Authorization Requirements, Report Requirements, and Notations
21082	palatal augmentation prosthesis (P.A.)	See 601(A) above.
21083	palatal lift prosthesis (P.A.)	See 601(A) above.
21084	speech aid prosthesis (P.A.)	See 601(A) above.
21085	oral surgical splint (P.A.)	See 601(A) above.
21086	auricular prosthesis (P.A.)	See 601(A) above.
21087	nasal prosthesis (P.A.)	See 601(A) above.
21088	facial prosthesis (P.A.) (I.C.)	See 601(A) and (B) above.
21089	Unlisted maxillofacial prosthetic procedure (P.A.) (I.C.)	See 601(A) and (B) above.
21100	Application of halo type appliance for maxillofacial fixation, includes removal (S.P.)	See 601(C) above.
21110	Application of interdental fixation device for conditions other than fracture or dislocation, includes removal	
21116	Injection procedure for temporomandibular joint arthrography	
	Repair, Revision, and/or Reconstruction	
21137	Reduction forehead; contouring only (P.A.)	See 601(A) above.
21138	contouring and application of prosthetic material or bone graft (includes obtaining autograft) (P.A.)	See 601(A) above.
21139	contouring and setback of anterior frontal sinus wall (P.A.)	See 601(A) above.
21141	Reconstruction midface, LeFort I; single piece, segment movement in any direction (e.g., for Long Face Syndrome), without bone graft (P.A.)	See 601(A) above.
21142	two pieces, segment movement in any direction, without bone graft	
21143	three or more pieces, segment movement in any direction, without bone graft	
21145	single piece, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (P.A.)	See 601(A) above.
21146	two pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (e.g., ungrafted unilateral alveolar cleft) (P.A.)	See 601(A) above.
21147	three or more pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (e.g., ungrafted bilateral alveolar cleft or multiple osteotomies) (P.A.)	See 601(A) above.
21150	Reconstruction midface, LeFort II; anterior intrusion (e.g., Treacher-Collins Syndrome) (P.A.)	See 601(A) above.
21151	any direction, requiring bone grafts (includes obtaining autografts) (P.A.)	See 601(A) above.
21154	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); without LeFort I (P.A.)	See 601(A) above.
21155	with LeFort I (P.A.)	See 601(A) above.
21159	Reconstruction midface, LeFort III (extra- and intracranial) with forehead advancement (e.g., mono bloc), requiring bone grafts (includes obtaining autografts); without LeFort I (P.A.)	See 601(A) above.
21160	with LeFort I (P.A.)	See 601(A) above.
21172	Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autografts) (P.A.)	See 601(A) above.

Service Code	Service Code Description	Prior Authorization Requirements, Report Requirements, and Notations
21175	Reconstruction, bifrontal, superior-lateral orbital rims and lower forehead, advancement or alteration (e.g., plagiocephaly, trigonocephaly, brachycephaly), with or without grafts (includes obtaining autografts) (P.A.)	See 601(A) above.
21181	Reconstruction by contouring of benign tumor of cranial bones (e.g., fibrous dysplasia), extracranial (P.A.)	See 601(A) above.
21182	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (e.g., fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting less than 40 sq cm (P.A.)	See 601(A) above.
21183	total area of bone grafting greater than 40 sq cm but less than 80 sq cm (P.A.)	See 601(A) above.
21184	total area of bone grafting greater than 80 sq cm (P.A.)	See 601(A) above.
21188	Reconstruction midface, osteotomies (other than LeFort type) and bone grafts (includes obtaining autografts) (P.A.)	See 601(A) above.
21193	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; without bone graft (P.A.)	See 601(A) above.
21194	with bone graft (includes obtaining graft) (P.A.)	See 601(A) above.
21195	Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation (P.A.)	See 601(A) above.
21196	with internal rigid fixation (P.A.)	See 601(A) above.
21198	Osteotomy, mandible, segmental (P.A.)	See 601(A) above.
21206	Osteotomy, maxilla, segmental (e.g., Wassmund or Schuchard) (P.A.)	See 601(A) above.
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant) (P.A.)	See 601(A) above.
21209	reduction (P.A.)	See 601(A) above.
21210	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft) (P.A.)	See 601(A) above.
21215	mandible (includes obtaining graft) (P.A.)	See 601(A) above.
21230	Graft; rib cartilage, autogenous, to face, chin, nose, or ear (includes obtaining graft) (P.A.)	See 601(A) above.
21235	ear cartilage, autogenous, to nose or ear (includes obtaining graft) (P.A.)	See 601(A) above.
21240	Arthroplasty, temporomandibular joint, with or without autograft (includes obtaining graft) (P.A.)	See 601(A) above.
21242	Arthroplasty, temporomandibular joint, with allograft (P.A.)	See 601(A) above.
21243	Arthroplasty, temporomandibular joint, with prosthetic joint replacement (P.A.)	See 601(A) above.
21244	Reconstruction of mandible, extraoral, with transosteal bone plate (e.g., mandibular staple bone plate) (P.A.)	See 601(A) above.
21247	Reconstruction of mandibular condyle with bone and cartilage autografts (includes obtaining grafts) (e.g., for hemifacial microsomia) (P.A.)	See 601(A) above.
21255	Reconstruction of zygomatic arch and glenoid fossa with bone and cartilage (includes obtaining autografts) (P.A.)	See 601(A) above.

Service Code	Service Code Description	Prior Authorization Requirements, Report Requirements, and Notations
21260	Periorbital osteotomies for orbital hypertelorism, with bone grafts; extracranial approach (P.A.)	See 601(A) above.
21261	combined intra- and extracranial approach (P.A.)	See 601(A) above.
21263	with forehead advancement (P.A.)	See 601(A) above.
21267	Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts; extracranial approach (P.A.)	See 601(A) above.
21268	combined intra- and extracranial approach (P.A.)	See 601(A) above.
21270	Malar augmentation, prosthetic material (P.A.)	See 601(A) above.
21275	Secondary revision of orbitocraniofacial reconstruction (P.A.)	See 601(A) above.
21280	Medial canthopexy (P.A.) (S.P.)	See 601(A) and (C) above.
21282	Lateral canthopexy (P.A.)	See 601(A) above.
21295	Reduction of masseter muscle and bone (e.g., for treatment of benign masseteric hypertrophy); extraoral approach (P.A.)	See 601(A) above.
21296	intraoral approach (P.A.)	See 601(A) above.
	Other Procedures	
21299	Unlisted craniofacial and maxillofacial procedure (P.A.) (I.C.)	See 601(A) and (B) above.
	Fracture and Dislocation	
21310	Closed treatment of nasal bone fracture without manipulation	
21315	Closed treatment of nasal bone fracture; without stabilization	
21320	with stabilization	
21325	Open treatment of nasal fracture; uncomplicated	
21330	complicated, with internal and/or external skeletal fixation	
21335	with concomitant open treatment of fractured septum	
21336	Open treatment of nasal septal fracture, with or without stabilization	
21337	Closed treatment of nasal septal fracture, with or without stabilization	
21338	Open treatment of nasoethmoid fracture; without external fixation	
21339	with external fixation	
21340	Percutaneous treatment of nasoethmoid complex fracture, with splint, wire, or headcap fixation, including repair of canthal ligaments and/or the nasolacrimal apparatus	
21343	Open treatment of depressed frontal sinus fracture	
21344	Open treatment of complicated (e.g., comminuted or involving posterior wall) frontal sinus fracture, via coronal or multiple approaches	
21345	Closed treatment of nasomaxillary complex fracture (LeFort II type), with interdental wire fixation or fixation of denture or splint	
21346	Open treatment of nasomaxillary complex fracture (LeFort II type); with wiring and/or local fixation	
21347	requiring multiple open approaches	
21348	with bone grafting (includes obtaining graft)	
21355	Percutaneous treatment of fracture of malar area, including zygomatic arch and malar tripod, with manipulation	
21356	Open treatment of depressed zygomatic arch fracture (e.g., Gilles approach)	

Service Code	Service Code Description	Prior Authorization Requirements, Report Requirements, and Notations
21360	Open treatment of depressed malar fracture, including zygomatic arch and malar tripod	
21365	Open treatment of complicated (e.g., comminuted or involving cranial nerve foramina) fracture(s) of malar area, including zygomatic arch and malar tripod; with internal fixation and multiple surgical approaches	
21366	with bone grafting (includes obtaining graft)	
21385	Open treatment of orbital floor blowout fracture; transantral approach (Caldwell-Luc type operation)	
21386	periorbital approach	
21387	combined approach	
21390	periorbital approach, with alloplastic or other implant	
21395	periorbital approach with bone graft (includes obtaining graft)	
21400	Closed treatment of fracture of orbit, except blowout; without manipulation	
21401	with manipulation	
21406	Open treatment of fracture of orbit, except blowout; without implant	
21407	with implant	
21408	with bone grafting (includes obtaining graft)	
21421	Closed treatment of palatal or maxillary fracture (LeFort I type), with interdental wire fixation or fixation of denture or splint	
21422	Open treatment of palatal or maxillary fracture (LeFort I type)	
21423	complicated (comminuted or involving cranial nerve foramina), multiple approaches	
21431	Closed treatment of craniofacial separation (LeFort III type) using interdental wire fixation of denture or splint	
21432	Open treatment of craniofacial separation (LeFort III type); with wiring and/or internal fixation	
21433	complicated (e.g., comminuted or involving cranial nerve foramina), multiple surgical approaches	
21435	complicated, utilizing internal and/or external fixation techniques (e.g., head cap, halo device, and/or intermaxillary fixation)	
21436	complicated, multiple surgical approaches, internal fixation, with bone grafting (includes obtaining graft)	
21440	Closed treatment of mandibular or maxillary alveolar ridge fracture (S.P.)	See 601 (C) above.
21445	Open treatment of mandibular or maxillary alveolar ridge fracture (S.P.)	See 601 (C) above.
21450	Closed treatment of mandibular fracture; without manipulation	
21451	with manipulation	
21452	Percutaneous treatment of mandibular fracture, with external fixation	
21453	Closed treatment of mandibular fracture with interdental fixation	
21454	Open treatment of mandibular fracture with external fixation	
21461	Open treatment of mandibular fracture; without interdental fixation	
21462	with interdental fixation	
21465	Open treatment of mandibular condylar fracture	

Service Code	Service Code Description	Prior Authorization Requirements, Report Requirements, and Notations
21470	Open treatment of complicated mandibular fracture by multiple surgical approaches including internal fixation, interdental fixation, and/or wiring of dentures or splints	
21480	Closed treatment of temporomandibular dislocation; initial or subsequent	
21485	complicated (e.g., recurrent requiring intermaxillary fixation or splinting), initial or subsequent	
21490	Open treatment of temporomandibular dislocation	
21495	Open treatment of hyoid fracture	
21497	Interdental wiring, for condition other than fracture	
	Other Procedures	
21499	Unlisted musculoskeletal procedure, head (I.C.)	See 601(B) above.
	ARTHROSCOPY	
29800	Arthroscopy, temporomandibular joint, diagnostic, with or without synovial biopsy (P.A.) (S.P.)	See 601(A) and (C) above.
29804	Arthroscopy, temporomandibular joint, surgical (P.A.)	See 601(A) above.
29999	Unlisted procedure, arthroscopy (I.C.)	See 601(B) above.
	RESPIRATORY SYSTEM	
	NOSE	
	Excision	
30130	Excision inferior turbinate, partial or complete, any method	
30140	Submucous resection turbinate, partial or complete, any method	
	Repair	
30520	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft	
30580	Repair fistula; oromaxillary (combine with 31030 if antrotomy is included)	
30600	oronasal	
	Other Procedures	
30901	Control nasal hemorrhage, anterior, simple (limited cautery and/or packing) any method	
30903	Control nasal hemorrhage, anterior, complex (extensive cautery and/or packing) any method	
30905	Control nasal hemorrhage, posterior, with posterior nasal packs and/or cautery, any method; initial	
30906	subsequent	
30999	Unlisted procedure, nose (I.C.)	See 601(B) above.
	Incision	
31000	Lavage by cannulation; maxillary sinus (antrum puncture or natural ostium)	
31020	Sinusotomy, maxillary (antrotomy); intranasal	
31030	radical (Caldwell-Luc) without removal of antrochoanal polyps	
31032	radical (Caldwell-Luc) with removal of antrochoanal polyps	
	Excision	
31225	Maxillectomy; without orbital exenteration	

Service Code	Service Code Description	Prior Authorization Requirements, Report Requirements, and Notations
	Endoscopy	
31233	Nasal/sinus endoscopy, diagnostic with maxillary sinusoscopy (via inferior meatus or canine fossa puncture)	
31256	Nasal/sinus endoscopy, surgical, with maxillary antrostomy	
31267	with removal of tissue from maxillary sinus	
31290	Nasal/sinus endoscopy, surgical, with repair of cerebrospinal fluid leak; ethmoid region	
31292	Nasal/sinus endoscopy, surgical; with medial or inferior orbital wall decompression	
31293	with medial orbital wall and inferior orbital wall decompression	
31294	with optic nerve decompression	
	Other Procedures	
31299	Unlisted procedure, accessory sinuses (I.C.)	See 601(B) above.
	LARYNX	
	Introduction	
31500	Intubation, endotracheal, emergency procedure	
31502	Tracheotomy tube change prior to establishment of fistula tract	
	TRACHEA AND BRONCHI	
	Incision	
31600	Tracheostomy, planned (S.P.)	See 601(C) above.
31603	Tracheostomy, emergency procedure; transtracheal	
31605	cricothyroid membrane	
	HEMIC AND LYMPHATIC SYSTEMS	
	LYMPH NODES AND LYMPHATIC CHANNELS	
	Excision	
38500	Biopsy or excision of lymph node(s); open, superficial	
38505	by needle, superficial (e.g., cervical, inguinal, axillary)	
38510	open, deep cervical node(s)	
	DIGENSTIVE SYSTEM	
	LIPS	
	Excision	
40490	Biopsy of lip	
40500	Vermilionectomy (lip shave), with mucosal advancement	
40510	Excision of lip; transverse wedge excision with primary closure	
40520	V-excision with primary direct linear closure	
40525	full thickness, reconstruction with local flap (e.g., Estlander or fan)	
40527	full thickness, reconstruction with cross lip flap (Abbe-Estlander)	
40530	Resection of lip, more than one-fourth, without reconstruction	
	Repair (Cheiloplasty)	
40650	Repair lip, full thickness; vermilion only	
40652	up to half vertical height	
40654	over one-half vertical height, or complex	

Service Code	Service Code Description	Prior Authorization Requirements, Report Requirements, and Notations
40700	Plastic repair of cleft lip/nasal deformity; primary, partial or complete, unilateral	
40701	primary bilateral, one stage procedure	
40702	primary bilateral, one of two stages	
40720	secondary, by recreation of defect and reclosure	
40761	with cross lip pedicle flap (Abbe-Estlander type), including sectioning and inserting of pedicle	
	Other Procedures	
40799	Unlisted procedure, lips (I.C.)	See 601(B) above.
	VESTIBULE OF MOUTH	
	Incision	
40800	Drainage of abscess, cyst, hematoma, vestibule of mouth; simple	
40801	complicated	
40804	Removal of embedded foreign body, vestibule of mouth; simple	
40805	complicated	
40806	Incision of labial frenum (frenotomy)	
40808	Biopsy, vestibule of mouth	
40810	Excision of lesion of mucosa and submucosa, vestibule of mouth; without repair	
40812	with simple repair	
40814	with complex repair	
40816	complex, with excision of underlying muscle	
40818	Excision of mucosa of vestibule of mouth as donor graft	
40819	Excision of frenum, labial or buccal (frenumectomy, frenulectomy, frenectomy)	
40820	Destruction of lesion or scar of vestibule of mouth by physical methods (e.g., laser, thermal, cryo, chemical)	
	Repair	
40830	Closure of laceration, vestibule of mouth; 2.5 cm or less	
40831	over 2.5 cm or complex	
40840	Vestibuloplasty; anterior (P.A.)	See 601(A) above.
40842	posterior, unilateral (P.A.)	See 601(A) above.
40843	posterior, bilateral (P.A.)	See 601(A) above.
40844	entire arch (P.A.)	See 601(A) above.
40845	complex (including ridge extension, muscle repositioning) (P.A.)	See 601(A) above.
	Other Procedures	
40899	Unlisted procedure, vestibule of mouth (I.C.)	See 601(B) above.
	TONGUE AND FLOOR OF MOUTH	
	Incision	
41000	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; lingual	
41005	sublingual, superficial	
41006	sublingual, deep, supramylohyoid	

Service Code	Service Code Description	Prior Authorization Requirements, Report Requirements, and Notations
41007	submental space	
41008	submandibular space	
41009	masticator space	
41010	Incision of ligual frenum (frenotomy)	
41015	Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; sublingual	
41016	submental	
41017	submandibular	
41018	masticator space	
	Excison	
41100	Biopsy of tongue; anterior two-thirds	
41105	posterior one-third	
41108	Biopsy of floor of mouth	
41110	Excision of lesion of tongue without closure	
41112	Excision of lesion of tongue with closure; anterior two-thirds	
41113	posterior one-third	
41114	with local tongue flap	
41115	Excision of lingual frenum (frenectomy)	
41116	Excision, lesion of floor of mouth	
41120	Glossectomy; less than one-half tongue	
41130	hemiglossectomy	
41135	partial, with unilateral radical neck dissection	
41140	complete or total, with or without tracheostomy, without radical neck dissection	
41145	complete or total, with or without tracheostomy, with unilateral radical neck dissection	
41150	composite procedure with resection floor of mouth and mandibular resection, without radical neck dissection	
41153	composite procedure with resection floor of mouth, with suprahyoid neck dissection	
41155	composite procedure with resection floor of mouth, mandibular resection, and radical neck dissection (Commando type)	
	Repair	
41250	Repair of laceration 2.5 cm or less; floor of mouth and/or anterior two-thirds of tongue	
41251	posterior one-third of tongue	
41252	Repair of laceration of tongue, floor of mouth, over 2.6 cm or complex	
	Other Procedures	
41500	Fixation of tongue, mechanical, other than suture (e.g., K-wire)	
41510	Suture of tongue to lip for micrognathia (Douglas type procedure)	
41520	Frenoplasty (surgical revision of frenum, e.g., with Z-plasty)	
41599	Unlisted procedure, tongue, floor of mouth (I.C.)	See 601(B) above.

Service Code	Service Code Description	Prior Authorization Requirements, Report Requirements, and Notations
	DENTOALVEOLAR STRUCTURES	
	Incision	
41800	Drainage of abscess, cyst, hematoma from dentoalveolar structures	
41805	Removal of embedded foreign body from dentoalveolar structures; soft tissues	
41806	bone	
	Excision, Destruction	
41820	Gingivectomy, excision gingiva, each quadrant (P.A.)	See 601(A) above.
41821	Operculectomy, excision pericoronal tissues	
41822	Excision of fibrous tuberosities, dentoalveolar structures	
41823	Excision of osseous tuberosities, dentoalveolar structures	
41825	Excision of lesion or tumor (except listed above), dentoalveolar structures; without repair	
41826	with simple repair	
41827	with complex repair	
41828	Excision of hyperplastic alveolar mucosa, each quadrant (specify)	
41830	Alveolectomy, including curettage of osteitis or sequestrectomy	
41850	Destruction of lesion (except excision), dentoalveolar structures (I.C.)	See 601(B) above.
	Other Procedures	
41874	Alveoloplasty, each quadrant (specify)	
41899	Unlisted procedure, dentoalveolar structures (I.C.)	See 601(B) above.
	PALATE AND UVULA	
	Incision	
42000	Drainage of abscess of palate, uvula	
	Excision, Destruction	
42100	Biopsy of palate, uvula	
42104	Excision, lesion of palate, uvula; without closure	
42106	with simple primary closure	
42107	with local flap closure	
42120	Resection of palate or extensive resection of lesion	
42140	Uvulectomy, excision of uvula (P.A.)	See 601(A) above.
42145	Palatopharyngoplasty (e.g., uvulopalatopharyngoplasty, uvulopharyngoplasty)	
42160	Destruction of lesion, palate or uvula (thermal, cryo, or chemical)	
	Repair	
42180	Repair, laceration of palate; up to 2 cm	
42182	over 2 cm or complex	
42200	Palatoplasty for cleft palate, soft and/or hard palate only	
42205	Palatoplasty for cleft palate, with closure of alveolar ridge; soft tissue only	
42210	with bone graft to alveolar ridge (includes obtaining graft)	
42215	Palatoplasty for cleft palate; major revision	
42220	secondary lengthening procedure	
42225	attachment pharyngeal flap	

Service Code	Service Code Description	Prior Authorization Requirements, Report Requirements, and Notations
42226	Lengthening of palate, and pharyngeal flap	
42227	Lengthening of palate, with island flap	
42235	Repair of anterior palate, including vomer flap	
42260	Repair of nasolabial fistula	
42280	Maxillary impression for palatal prosthesis (P.A.)	See 601(A) above.
42281	Insertion of pin-retained palatal prosthesis (P.A.)	See 601(A) above.
	Other Procedures	
42299	Unlisted procedure, palate, uvula (I.C.)	See 601(B) above.
	SALIVARY GALNDS AND DUCTS	
	Incision	
42300	Drainage of abscess; parotid, simple	
42305	parotid, complicated	
42310	Drainage of abscess; submaxillary or sublingual, intraoral	
42320	submaxillary, external	
42330	Sialolithotomy; submandibular (submaxillary), sublingual or parotid, uncomplicated, intraoral	
42335	submandibular (submaxillary), complicated, intraoral	
42340	parotid, extraoral or complicated intraoral	
	Excision	
42400	Biopsy of salivary gland; needle	
42405	incisional	
42408	Excision of sublingual salivary cyst (ranula)	
42409	Marsupialization of sublingual salivary cyst (ranula)	
42410	Excision of parotid tumor or parotid gland; lateral lobe, without nerve dissection	
42415	lateral lobe, with dissection and preservation of facial nerve	
42420	total, with dissection and preservation of facial nerve	
42425	total, en bloc removal with sacrifice of facial nerve	
42440	Excision of submandibular (submaxillary) gland	
42450	Excision of sublingual gland	
	Repair	
42500	Plastic repair of salivary duct, sialodochoplasty; primary or simple	
42505	secondary or complicated	
42507	Parotid duct diversion, bilateral (Wilke type procedure);	
42508	with excision of one submandibular gland	
42509	with excision of both submandibular glands	
42510	with ligation of both submandibular (Wharton's) ducts	
	Other Procedures	
42550	Injection procedure for sialography	
42600	Closure salivary fistula	
42650	Dilation salivary duct	
42660	Dilation and catheterization of salivary duct, with or without injection	
42665	Ligation salivary duct, intraoral	

Service Code	Service Code Description	Prior Authorization Requirements, Report Requirements, and Notations
42699	Unlisted procedure, salivary glands or ducts (I.C.)	See 601(B) above.
	PHARYNX, ADENOIDS, AND TONSILS	
	Incision	
42700	Incision and drainage abscess; peritonsillar	
42720	retropharyngeal or parapharyngeal, intraoral approach	
42725	retropharyngeal or parapharyngeal, external approach	
	Excision, Destruction	
42800	Biopsy; oropharynx	
42802	hypopharynx	
42804	nasopharynx, visible lesion, simple	
42806	nasopharynx, survey for unknown primary lesion	
42808	Excision or destruction of lesion of pharynx, any method	
42809	Removal of foreign body from pharynx	
42810	Excision branchial cleft cyst or vestige, confined to skin and subcutaneous tissues	
42815	Excision branchial cleft cyst, vestige, or fistula, extending beneath subcutaneous tissues and/or into pharynx	
42842	Radical resection of tonsil, tonsillar pillars, and/or retromolar trigone; without closure	
42844	closure with local flap (e.g., tongue, buccal)	
42845	closure with other flap	
42860	Excision of tonsil tags	
42870	Excision or destruction lingual tonsil, any method (S.P.)	See 601(C) above.
	Repair	
42900	Suture pharynx for wound or injury	
	Other Procedures	
42960	Control oropharyngeal hemorrhage, primary or secondary (e.g., post-tonsillectomy); simple	
42961	complicated, requiring hospitalization	
42962	with secondary surgical intervention	
42970	Control of nasopharyngeal hemorrhage, primary or secondary (e.g., post-adenoidectomy); simple, with posterior nasal packs, with or without anterior packs and/or cautery	
42971	complicated, requiring hospitalization	
42972	with secondary surgical intervention	
42999	Unlisted procedure, pharynx, adenoids, or tonsils (I.C.)	See 601(B) above.
	NERVOUS SYSTEM	
	EXTRACRANIAL NERVES, PERIPHERAL NERVES, AND AUTONOMIC NERVOUS SYSTEM	
	Introduction/Injection of Anesthetic Agent (Nerve Block), Diagnostic and Therapeutic Somatic Nerves	
64400	Injection, anesthetic agent; trigeminal nerve, any division or branch	
	Destruction by Neurolytic Agent (e.g., Chemical, Thermal, Electrical or Radiofrequency)	
	Somatic Nerves	

Service Code	Service Code Description	Prior Authorization Requirements, Report Requirements, and Notations
64600	Destruction by neurolytic agent, trigeminal nerve, supraorbital, infraorbital, mental, or inferior alveolar branch	
	Neuroplasty (Exploration, Neurolysis or Nerve Decompression)	
64722	Decompression; unspecified nerve(s) (specify)	
64727	Internal neurolysis, requiring use of operating microscope (list separately in addition to code for neuroplasty) (neuroplasty includes external neurolysis)	
	Transaction or Avulsion	
64732	Transection or avulsion of; supraorbital nerve	
64734	infraorbital nerve	
64736	mental nerve	
64738	inferior alveolar nerve by osteotomy	
64740	lingual nerve	
	Neurorrhaphy	
64864	Suture of facial nerve; extracranial	
	Neurorrhaphy with Nerve Graft, Vein Graft, or Conduit	
64885	Nerve graft (includes obtaining graft), head or neck; up to 4 cm in length	
	Other Procedures	
64999	Unlisted procedure, nervous system (I.C.)	See 601(B) above.
	OPERATING MICROSCOPE	
69990	Microsurgical techniques, requiring use of operating microscope (List separately in addition to code for primary procedure)	
	DIAGNOSTIC RADIOLOGY (DIAGNOSTIC IMAGING)	
	HEAD AND NECK	
70100	Radiologic examination, mandible; partial, less than four views	
70110	complete, minimum of four views	
70140	Radiologic examination, facial bones; less than three views	
70150	complete, minimum of three views	
70160	Radiologic examination, nasal bones, complete, minimum of three views	
70210	Radiologic examination, sinuses, paranasal, less than three views	
70220	Radiologic examination, sinuses, paranasal, complete, minimum of three views	
70240	Radiologic examination, sella turcica	
70328	Radiologic examination, temporomandibular joint, open and closed mouth; unilateral	
70330	bilateral	
70360	Radiologic examination; neck, soft tissue	
70380	Radiologic examination, salivary gland for calculus	