



Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
www.mass.gov/masshealth



MassHealth
Transmittal Letter DEN-102
April 2019

TO: Dental Providers Participating in MassHealth
FROM: Daniel Tsai, Assistant Secretary for MassHealth
RE: *Dental Manual* (Updates to 130 CMR 420.000 and Subchapter 6)

Updates to 130 CMR 420.000

This letter transmits revisions to the MassHealth dental services regulations at 130 CMR 420.000. These regulations have been amended to provide coverage for periodontal services including gingivectomies, gingivoplasties, periodontal scaling, and root planing for members aged 21 and older with prior authorization. These changes are effective April 22, 2019.

Updates to Subchapter 6 of the MassHealth Dental Manual

This letter also transmits changes to the service codes and descriptions in Subchapter 6 of the MassHealth *Dental Manual* to reflect new additions, removals, and changes to covered service codes in accordance with in the *Current Dental Terminology (CDT)* and the *Current Procedural Terminology (CPT)* for the calendar year 2019. These changes are effective January 1, 2019.

The following is a summary of the changes.

Dental providers who bill using CDT service codes must refer to the American Dental Association's (ADA) 2019 codebook for descriptions of service codes listed in Subchapter 6. Additionally, the periodontal service codes have been updated to reflect the periodontal services benefit for members aged 21 and older per the dental program regulation. Specific updates to Subchapter 6 are described below.

Subchapter 6 Code Changes

The MassHealth agency has added the codes below:

- D1516 Space maintainer – fixed – bilateral, maxillary
- D1517 Space maintainer – fixed – bilateral, mandibular
- D1526 Space maintainer – removable – bilateral, maxillary
- D1527 Space maintainer – removable – bilateral, mandibular
- D9945 Occlusal guard – soft appliance, full arch

MassHealth has removed the codes below.

D1515 Space maintainer – fixed - bilateral
D1525 Space maintainer – removable - bilateral
D9940 Occlusal guard – by report

Current Procedural Terminology Codes

Subchapter 6 has been updated to reflect the following service code changes, effective for dates of service on or after January 1, 2019.

MassHealth has deleted the following service codes for dentists who are specialists in oral surgery in accordance with 130 CMR 420.405(A)(7):

11100	20005
11101	41500
61610	

MassHealth has added the following service codes for dentists who are specialists in oral surgery in accordance with 130 CMR 420.405(A)(7):

99217	99225
99218	99226
99219	99234
99220	99235
99224	99236

As a reminder, dental providers 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 younger than age 21. This applies even if the service is not listed in Subchapter 6 of the *Dental Manual*.

Updates to Periodontal Services

MassHealth has updated the benefits for members aged 21 and older for the codes below, effective April 22, 2019.

D4210 Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth-bounded - spaces per quadrant
D4211 Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth-bounded-- spaces per quadrant
D4341 Periodontal scaling and root planning – four or more teeth per quadrant
D4342 Periodontal scaling and root planning – one to three teeth per quadrant

Fee Schedule

If you wish to obtain a fee schedule for dental services, you may download the Executive Office of Health and Human Services regulations at no cost at www.mass.gov/service-details/eohhs-regulations. The regulation title for dental services is 101 CMR 314.00: Dental Services.

MassHealth Website

This transmittal letter and attached pages are available on the MassHealth website at www.mass.gov/masshealth.

To sign up to receive email alerts when MassHealth issues new transmittal letters and provider bulletins, send a blank email to join-masshealth-provider-pubs@listserv.state.ma.us. No text in the body or subject line is needed.

Questions

If you have any questions about this transmittal letter, please contact the MassHealth Customer Service Center at (800) 841-2900, email your inquiry to providersupport@mahealth.net, or fax your inquiry to (617) 988-8974.

For additional information, please see the *MassHealth Dental Program Office Reference Manual* (available at www.masshealth-dental.net).

NEW MATERIAL

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

Dental Manual

Pages iv, vi, 4-9 through 4-30, and 6-1 through 6-26

OBSOLETE MATERIAL

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

Dental Manual

Pages iv, 4-9 through 4-20, and 4-23 through 4-28 — transmitted by Transmittal Letter DEN-97

Pages 4-21 and 4-22 — transmitted by Transmittal Letter DEN-100

Pages vi and 6-1 through 6-26 — transmitted by Transmittal Letter DEN-101

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420.421: Covered and Noncovered Services: Introduction

(A) Medically Necessary Services. 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*, 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) Noncovered Services. The MassHealth agency does not pay for the following services for any member, except when MassHealth determines the service to be medically necessary and the member is under age 21. Prior authorization must be submitted for any medically necessary noncovered services for members under age 21.

- (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) counseling or member-education services;
- (4) habit-breaking appliances;
- (5) implants of any type or description;
- (6) laminate veneers;
- (7) oral hygiene devices and appliances, dentifrices, and mouth rinses;
- (8) orthotic splints, including mandibular orthopedic repositioning appliances;
- (9) panoramic films for crowns, endodontics, periodontics, and interproximal caries;
- (10) root canals filled by silver point technique, or paste only;
- (11) tooth splinting for periodontal purposes; and
- (12) any other service not listed in Subchapter 6 of the *Dental Manual*.

(C) Covered Services for All Members Aged 21 and Older. The MassHealth agency pays for the services listed in 130 CMR 420.422 through 420.456 for all members aged 21 and older in accordance with the service descriptions and limitations set forth therein:

- (1) diagnostic services as described in 130 CMR 420.422;
- (2) radiographs as described in 130 CMR 420.423;
- (3) preventive services as described in 130 CMR 420.424;
- (4) restorative services as described in 130 CMR 420.425;
- (5) periodontal services as described in 130 CMR 420.427;
- (6) prosthodontic services as described in 130 CMR 420.428;

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- (7) exodontic services as described in 130 CMR 420.430, except for the following:
- (a) vestibuloplasty;
 - (b) frenulectomy;
 - (c) excision of hyperplastic tissue; and
 - (d) excision of benign lesion.
- (8) anesthesia services as described in 130 CMR 420.452;
- (9) oral and maxillofacial surgery services as described in 130 CMR 420.453;
- (10) behavior management services as described in 130 CMR 420.456(C);
- (11) palliative treatment of dental pain or infection services as described in 130 CMR 420.456(D); and
- (12) house/facility call as described in 130 CMR 420.456(G).

(D) Noncovered Services for All Members Aged 21 and Older. The MassHealth agency does not pay for the following services for all members aged 21 and older:

- (1) preventive services as described in 130 CMR 420.424(C);
- (2) prosthodontic services (fixed) as described in 130 CMR 420.429; and
- (3) other services as described in 130 CMR 420.456(A), (B), (E), and (F).

(E) Additional Covered Services for DDS Clients Aged 21 and Older. The MassHealth agency pays for the following additional services for DDS clients aged 21 and older:

- (1) endodontic services as described in 130 CMR 420.426;
- (2) the following additional exodontic services as described in 130 CMR 420.430:
 - (a) vestibuloplasty;
 - (b) frenulectomy;
 - (c) excision of hyperplastic tissue; and
 - (d) excision of benign lesion;
- (3) prosthodontic services (removable) as described in 130 CMR 420.428; and
- (4) maxillofacial prosthetics as described in 130 CMR 420.455.

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 or per location. 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, diagnosis, and the preparation of treatment plans and reporting forms. It is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues.

(B) Periodic Oral Evaluation. The MassHealth agency pays for a periodic oral evaluation twice per calendar year, per member, per provider or location. This service is not covered on the same date of service as a palliative emergency treatment visit. A periodic oral evaluation is performed on an established patient of record to determine any changes in the member's dental and medical health status since a previous comprehensive or periodic oral evaluation.

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(C) Oral Evaluation. The MassHealth agency pays for this service twice per calendar year per provider or location. An oral evaluation is counseling with a primary caregiver (parent/guardian) for members under three years of age.

(D) Limited Oral Evaluation. The MassHealth agency pays for a limited oral evaluation twice per member per calendar year. A limited oral evaluation is not covered on the same date of service as a palliative emergency treatment visit. A limited oral evaluation is an evaluation limited to a specific oral health problem or complaint. This may require interpretation of information acquired through additional diagnostic procedures. Typically, patients receiving this type of evaluation present with a specific problem and/or dental trauma, pain, or acute infection.

(E) Comprehensive Periodontal Evaluation. The MassHealth agency pays for a comprehensive periodontal evaluation once per calendar year per member; per provider or per location. A comprehensive periodontal evaluation is indicated for members showing signs or symptoms of periodontal disease and for members with risk factors such as smoking or diabetes. A comprehensive periodontal evaluation includes evaluation of periodontal conditions, probing and charting, evaluation and recording of dental caries, missing or unerupted teeth, restorations, occlusal relationships and oral cancer evaluation,

(F) Oral Screening. The MassHealth agency pays for an oral screening twice per calendar year per member per provider. An oral screening may only be billed by Public Health Dental Hygienists. An oral screening includes state or federally mandated screenings to determine a member's need to be seen by a dentist for further diagnosis.

(G) Limited Clinical Assessment. The MassHealth agency pays for a limited clinical inspection once per calendar year per member per provider. A limited clinical assessment may only be billed by Public Health Dental Hygienists. A limited clinical assessment includes identification of possible signs of oral or systemic disease, malformation, injury, and/or the potential need for a referral for diagnosis and treatment by a dentist.

420.423: Service Descriptions and Limitations: Radiographs

(A) Introduction and Definitions.

(1) The MassHealth agency pays for radiographs/diagnostic imaging taken as an integral part of diagnosis and treatment planning.

(a) Assessing extent of required radiographs – Providers should conduct a clinical examination; consider the member's oral and medical histories, as well as the member's vulnerability to environmental factors that may affect the oral health before conducting a radiographic examination to determine the type of imaging, frequency, and number of images. Radiographs should be taken only when there is an expectation that the diagnostic yield will affect patient care. The intent is to confine radiation exposure of members to the minimum necessary to achieve satisfactory diagnosis.

(b) The provider must document efforts to obtain any previous radiographs/diagnostic imaging before prescribing more.

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(c) When radiographs and diagnostic imaging submitted to the MassHealth agency as part of the prior authorization process or upon other request are not of good diagnostic quality, the provider may not claim payment for any retake of radiographs/diagnostic imaging requested by the MassHealth agency.

(2) Definitions.

(a) Bitewing Radiographs – A bitewing radiograph is a diagnostic image showing the crowns of the upper and lower teeth simultaneously.

(b) Cephalometric radiograph – a 2D image of the head made using Cephalostat to standardize anatomic, positional, with reproducible beam geometry.

(c) Intraoral complete series of radiographic images – Intraoral complete series of radiographic images surveys the whole mouth; usually consists of 14–22 periapical and posterior bitewing images, intended to display the crowns and roots of all teeth, periapical areas, and alveolar bone.

(d) Periapical Radiographs – diagnostic intraoral images showing tooth apices and surrounding structures in a particular intraoral area.

(e) Occlusal Radiographs – a supplementary radiograph designed to provide a more extensive view of the maxilla and mandible; highlighting tooth development and placement in children.

(f) Panoramic radiograph – an extraoral image showing a two-dimensional view of the patients’ entire jaw from ear to ear.

(B) Intraoral Conventional or Direct Digital Radiographs.

(1) Intraoral complete series of radiographic images. The MassHealth agency pays for intraoral complete series of radiographic images once every three calendar years per member; per provider or location. Intraoral complete series of radiographic images are recommended for members with clinical evidence of generalized oral disease or a history of extensive dental treatment. The MassHealth agency allows for substitution of the intraoral complete series of radiographic images with individualized radiographs consisting of posterior bitewings with a panoramic or occlusal radiograph and selected periapicals for members with transitional dentition. Panoramic radiographs cannot be substituted for intraoral complete series of radiographic images if intraoral complete series of radiographic images are required for a prior-authorization request, unless the member has complete bony impacted teeth, or other surgical conditions listed under 130 CM 420.423(C)(1), and is edentulous. The MassHealth agency does not pay more for individual periapical radiographs (with or without bitewings) than it would for an intraoral complete series of radiographic images. The MassHealth agency further defines the numbers of radiographs which constitute intraoral complete series of radiographic images based on age limitations described in Appendix E of the *Dental Manual*.

(2) Bitewing Radiographs. The MassHealth agency pays for up to four bitewing radiographs as separate procedures based on the clinical guidelines set forth by the American Dental Association. Providers must document variations from the ADA clinical guidelines in the member’s dental record. The MassHealth agency does not pay separately for bitewing radiographs taken as part of an intraoral complete series of radiographic images.

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(3) Periapical Radiographs. Periapical radiographs may be taken for specific areas where extraction is anticipated, or when infection, periapical change, or an anomaly is suspected, or when otherwise directed by the MassHealth agency. A maximum of four periapical radiographs is allowed per day, per member per provider or location.

(4) Occlusal Radiographs. The MassHealth agency pays for two occlusal radiographs per calendar year per member under age 5; per provider or location.

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

(6) Cephalometric Radiographs. The MassHealth agency pays for cephalometric radiographs in conjunction with surgical conditions including, but are not limited to status after facial trauma, mandibular fractures, dentoalveolar fractures, mandibular atrophy, and jaw dislocations. Payment for cephalometric radiographs, or other radiographs, in conjunction with orthodontic diagnosis is included in the payment for orthodontic services (*see* 130 CMR 420.431(C)(9)). The MassHealth agency does not pay separately for additional radiographs when required for orthodontic diagnosis.

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

- (1) impactions;
- (2) teeth requiring extractions in more than one quadrant;
- (3) large cysts or tumors that are not fully visualized by intraoral radiographs or clinical examination;
- (4) salivary-gland disease;
- (5) maxillary-sinus disease;
- (6) facial trauma;
- (7) trismus where an intraoral radiographs placement is impossible; and
- (8) orthognathic surgery.

(D) Nonsurgical Conditions.

(1) Members Under Age 21. The MassHealth agency pays for only one panoramic radiograph every three calendar years per member for nonsurgical conditions, to monitor the growth and development of permanent dentition as a part of an individualized radiograph series for the child member with transitional dentition.

(2) Members Aged 21 and Older. The MassHealth agency pays for only one panoramic radiograph every three years per member in lieu of an intraoral complete series of radiographic images only for those members who are unable to cooperate with the process for obtaining an intraoral complete series of radiographic images or is edentulous. The provider must document in the member's dental record the reasons why the member cannot cooperate with the process for obtaining an intraoral complete series of radiographic images.

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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 the removal of plaque, calculus, and stains from the tooth structures. MassHealth requires the provider to perform as part of this service, oral hygiene instruction including but not limited to proper tooth brushing and flossing instructions, and use of oral hygiene aids. The MassHealth agency does not pay a separate fee for oral hygiene instruction.

(B) Fluoride.

(1) Topical Fluoride Treatment.

(a) Members Under Age 21. The MassHealth agency pays for topical fluoride treatment every 90 days per member, per provider or location. 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 procedure. 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. Providers must submit a prior authorization request for this treatment for members aged 21 and older.

(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 members under age 17, on the occlusal surface of permanent noncarious nonrestored molars once every three calendar years per member per tooth; per provider or location. Sealants are placed on teeth by mechanically and/or chemically sealing the prepared enamel surface to prevent decay. The MassHealth agency does not pay for reapplication of sealants if the process fails within three calendar years. The MassHealth agency does not pay to replace sealants lost or damaged during the three calendar-year period when reapplied by the same provider or location. The MassHealth agency does not pay for sealants applied to any tooth that has been restored.

(D) Space Maintainers. Space maintainers are indicated when there is premature loss of teeth that may lead to loss of arch integrity. The MassHealth agency pays for two space maintainers per arch per lifetime for members under 21, to include recemented or rebonded space maintainers, and replacement space maintainers. These appliances are indicated when there is premature loss of teeth that may lead to loss of arch integrity. 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.

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420.425: Service Descriptions and Limitations: Restorative Services

The MassHealth agency pays for restorative services in accordance with the service descriptions and limitations in 130 CMR 420.425(A) through (E). The MassHealth agency considers all of the following to be components of a completed restoration (local anesthesia tooth preparation, acid etching, all adhesives applications, resin bonding agents, amalgam bonding agents, liners, bases, amalgams, resin-based composites, glass ionomers, curing and polishing) and includes them in the payment for this service. The MassHealth agency does not pay for composite or amalgam restorations replaced within one year of the date of completion of the original restoration when replaced by the same provider or dental group. The initial payment includes all restorations replaced due to defects or failure less than one year from the original placement.

(A) Amalgam Restorations. The MassHealth agency does not pay for restorations on primary teeth when early exfoliation (more than 2/3 of the root structure resorbed) is expected.

(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.

(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.

(3) The MassHealth agency pays for only one resin-based composite restoration per member per tooth surface per 12 months per provider or location.

(4) The MassHealth agency does not pay more for a composite restoration on a posterior (primary or permanent) tooth than it would for an amalgam restoration.

(C) Crowns, Posts and 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, bicuspid, 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 teeth. 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.

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(2) DDS Clients Aged 21 and Older. The MassHealth agency pays for crown porcelain fused to predominantly base metal, and 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; or
- (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 or Bridge 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

The MassHealth agency pays for endodontic services including all radiographs performed with the exception of panoramic radiographs, during the treatment visit. The MassHealth agency pays for endodontic services for members under age 21 and DDS clients only in accordance with the service descriptions and limitations described in 130 CMR 420.426.

(A) Pulpotomy.

- (1) The MassHealth agency pays for a therapeutic pulpotomy for members under age 21 only.
- (2) Therapeutic pulpotomy is the surgical removal of a portion of the pulp with the aim of maintaining the vitality of the remaining portion by means of an adequate dressing. This procedure is performed on primary or permanent teeth. 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 or to be used for apexogenesis.
- (3) The MassHealth agency does not pay for pulpotomy on deciduous teeth that are ready to exfoliate.
- (4) The MassHealth agency does not pay for pulpotomy as the first stage of root canal therapy.
- (5) 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.)

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(B) Endodontic 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 and anesthesia. MassHealth does not pay for pulpotomy as a separate procedure from root canal therapy.

(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, bicuspid, 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 only if the periodontal condition of the remaining dentition and soft tissue are stable with a favorable prognosis.

(b) The MassHealth agency pays for root canal retreatment for all permanent teeth with the exception of third molars.

(3) DDS Clients 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 of the dentition and soft tissue.

(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 anterior, bicuspid, and molar teeth for members under age 21 only and endodontic retreatment of previous root-canal therapy only on anterior teeth for DDS clients 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 pays for endodontic retreatment of posterior teeth for DDS clients aged 21 and older only if the alternate treatment would cause undue medical risk for such 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 includes all retreatments within 24 months of the original root canal.

(D) Apicoectomy/Periradicular Surgery.

(1) The MassHealth agency pays for an apicoectomy as a separate procedure for members under age 21 and DDS clients only following root-canal therapy when the canal cannot be retreated through instrumentation.

(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.

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420.427: Service Descriptions and Limitations: Periodontal Services

(A) Gingivectomies and Gingivoplasties. The MassHealth agency pays for gingivectomies and gingivoplasties once per member per quadrant every three calendar years. The MassHealth agency does not pay for a gingivectomy performed on the same day as a prophylaxis, periodontal scaling and root planing, or as a separate procedure with an extraction. The MassHealth agency pays for the gingivectomy or gingivoplasty for a maximum of two quadrants on the same date of service in an office setting. Gingivectomy or gingivoplasty procedure is performed to eliminate suprabony pockets or to restore normal architecture when gingival enlargements or asymmetrical or unaesthetic topography is evident with normal bony configuration. Prior authorization is required for members 21 years of age or older.

(B) Periodontal Scaling and Root Planing. The MassHealth agency pays for periodontal scaling and root planing once per member per quadrant every three calendar 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. Periodontal scaling and root planing involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus. It is indicated for members with active periodontal disease, not prophylactic. Root planing is the definitive procedure for the removal of rough cementum and dentin, and/or permeated by calculus or contaminated with toxins or microorganisms. Some soft tissue removal occurs. Local anesthesia is considered an integral part of periodontal procedures and may not be billed separately. Prior authorization is required for members 21 years of age or older.

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

(A) General Conditions. The MassHealth agency pays for dentures services once per seven calendar years per member, subject to the age limitations specified in 130 CMR 420.428(B). MassHealth payment includes all services associated with the fabrication and delivery process, including all adjustments necessary in the six months following insertion. The member is responsible for all denture care and maintenance following insertion. The MassHealth agency does not pay for complete dentures when the member's medical record indicates material limitations to the member's ability to cooperate during the fabrication of the denture or to accept or function with the denture, or indications that the member does not intend to utilize the denture.

(B) Prosthodontic Services. The MassHealth agency pays for complete dentures, and for members under age 21 only, immediate dentures; including relines and post insertion procedures and placement of identification.

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(C) Denture Procedures.

- (1) All denture services require appropriate diagnostic quality radiographs to be taken and stored in the member's chart.
- (2) As part of the denture fabrication process, the member must approve the teeth and setup in wax and try on the denture setup at a try-in visit before the dentures are processed.
- (3) The member's identification must be on each denture.
- (4) All dentures must be initially inserted and subsequently examined and can be adjusted up to six months after the date of insertion by the dentist at reasonable intervals consistent with the community standards.
- (5) If a member does not return for the insertion of the completed processed denture, the provider is required to submit to the MassHealth agency written evidence on their office letterhead of at least three attempts to contact the member over a period of one month via certified mail return receipt requested. Upon providing documentation, the provider may be reimbursed a percentage of the denture fee to assist in covering costs. *See* 130 CMR 450.231: *General Conditions of Payment.*

(D) Complete Dentures. Payment by the MassHealth agency for complete dentures includes payment for all necessary adjustments, including relines, as described in 130 CMR 420.428(E).

(E) Removable Partial Dentures. The MassHealth agency pays for removable partial dentures if there are two or more missing posterior teeth or one or more missing anterior teeth, the remaining dentition does not have active periodontitis and there is a favorable prognosis for treatment outcome. A tooth is considered missing if it is a natural tooth or a prosthetic tooth missing from a fixed prosthesis. Payment for a partial denture includes payment for all necessary procedures for fabrication including clasps and rest seats.

(F) 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;

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(7) there has been marked physiological change in the member's oral cavity, any further reline has a poor prognosis for success; or

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

(G) Complete Denture Relines. The MassHealth agency pays for chairside and laboratory complete denture relines. Payment for dentures includes any relines or rebases necessary within six months of the insertion date of the denture. The MassHealth agency pays for subsequent relines once every three calendar years per member.

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

(A) Fixed Partial Dentures/Bridges. The MassHealth agency pays for fixed partial dentures/ bridge for anterior teeth only for members under age 21 with two or more missing permanent teeth. The member must not have active periodontal disease, and the prognosis for the life of the bridge and remaining dentition must be excellent.

(B) Fixed Partial Denture/Bridge Repair. The MassHealth agency pays for chairside fixed partial denture/bridge repair. A description of the repair must be documented in the member's dental record.

420.430: Covered Service Descriptions and Limitations: Oral and Maxillofacial Surgery Services

(A) General Requirements.

(1) The MassHealth agency pays for oral and maxillofacial surgery services for all members, regardless of age, subject to the service descriptions and limitations as described in 130 CMR 420.430. Payment for oral and maxillofacial surgery includes payment for local anesthesia, suture removal, irrigations, bony 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.

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(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 or forceps, or both, 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 Teeth. The MassHealth agency pays for the surgical removal of an impacted tooth/teeth 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; or
- (e) perceptible 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 extraction of an erupted tooth requiring removal of bone and/or sectioning of the tooth, and including elevation of mucoperiosteal flap if indicated.

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

(6) Surgical extraction 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 removal.

(7) Surgical extraction with complete bony impaction is the removal of a tooth in which most or the entire crown is covered by bone and requires mucoperiosteal flap elevation and bone removal.

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(8) 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) Alveoloplasty. The MassHealth agency pays for alveoloplasty.

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

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

(F) Vestibuloplasty. The MassHealth agency pays for vestibuloplasty ridge extension for members under age 21 and DDS clients only.

(G) Frenulectomy. The MassHealth agency pays for frenulectomy procedures for members under age 21 and DDS clients only. 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 for members under age 21 and DDS clients only. 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 for members under age 21 and DDS clients only.

(J) Removal of Exostosis and Tori. The MassHealth agency pays for removal of exostosis and tori once per arch per member.

(K) Tooth Reimplantation and Stabilization of Accidentally Avulsed or Displaced Tooth. The MassHealth agency pays for tooth reimplantation and stabilization of an accidentally avulsed or displaced tooth. The procedure includes splinting and stabilization.

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(L) Treatment of Complications (Postsurgical). 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 Conditions. The MassHealth agency pays for orthodontic treatment, subject to prior authorization, service descriptions and limitations as described in 130 CMR 420.431. The provider must seek prior authorization for orthodontic treatment and begin initial placement and insertion of orthodontic appliances and partial banding or full banding and brackets prior to the member's 21st birthday.

(B) Definitions.

(1) Pre-Orthodontic Treatment Examination. The pre-orthodontic treatment examination include the periodic observation of the member's dentition at intervals established by the orthodontist to determine when orthodontic treatment should begin.

(2) Interceptive Orthodontic Treatment. Interceptive orthodontic treatment includes treatment of the primary and transitional dentition to prevent or minimize the development of a handicapping malocclusion and therefore, minimize or preclude the need for comprehensive orthodontic treatment.

(3) Comprehensive Orthodontic Treatment. Comprehensive orthodontic treatment includes a coordinated diagnosis and treatment leading to the improvement of a member's craniofacial dysfunction and/or dentofacial deformity which may include anatomical and/or functional relationship. Treatment may utilize fixed and/or removable orthodontic appliances and may also include functional and/or orthopedic appliances. Comprehensive orthodontics may incorporate treatment phases including adjunctive procedures to facilitate care focusing on specific objectives at various stages of dentofacial development. Comprehensive orthodontic treatment includes the transitional and adult dentition.

(4) Orthodontic Treatment Visits. Orthodontic treatment visits are periodic visits which may include but are not limited to updating wiring, tightening ligatures or otherwise evaluating and updating care while undergoing comprehensive orthodontic treatment.

(C) Service Limitations and Requirements.

(1) Pre-Orthodontic Treatment Examination. The MassHealth agency pays for a pre-orthodontic treatment examination for members under the age of 21, once per six (6) months per member, and only for the purpose of determining whether orthodontic treatment is medically necessary, and can be initiated before the member's twenty-first birthday. The MassHealth agency pays for a pre-orthodontic treatment examination as a separate procedure (see 130 CMR 420.413). The MassHealth agency does not pay for a pre-orthodontic treatment examination as a separate procedure in conjunction with pre-authorized ongoing or planned orthodontic treatment.

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(2) Interceptive Orthodontics. The MassHealth agency pays for interceptive orthodontic treatment once per member per lifetime as an extension of preventative orthodontics that may include localized tooth movement. The MassHealth agency determines if the treatment will prevent or minimize the handicapping malocclusion based on the clinical standards described in Appendix F of the *Dental Manual*. Interceptive orthodontic treatment may occur in the primary or transitional dentition, may include such procedures as the redirection of ectopically erupting teeth and correction of dental crossbite or recovery of space loss where overall space is inadequate. When initiated during the incipient stages of a developing problem, interceptive orthodontics may reduce the severity of the malformation and mitigate its causes. Complicating factors such as skeletal disharmonies, overall space deficiency, or other conditions may require subsequent comprehensive orthodontic treatment.

(3) Comprehensive Orthodontics. The MassHealth agency pays for comprehensive orthodontic treatment, subject to prior authorization, once per member per lifetime under the age of 21 and only when the member has a handicapping malocclusion. The MassHealth agency determines whether a malocclusion is handicapping based on clinical standards for medical necessity as described in Appendix D of the *Dental Manual*. Upon the completion of orthodontic treatment, the provider must take post treatment photographic prints and maintain them in the member's dental record.

The MassHealth agency pays for the office visit, radiographs and a record fee of the pre-orthodontic treatment examination (alternative billing to a contract fee) when the MassHealth agency denies a request for prior authorization for comprehensive orthodontic treatment or when the member terminates the planned treatment. The payment for a pre-orthodontic treatment consultation as a separate procedure does not include models or photographic prints. The MassHealth agency may request additional consultation for any orthodontic procedure.

Payment for comprehensive orthodontic treatment is inclusive of initial placement, and insertion of the orthodontic fixed and removable appliances (for example: rapid palatal expansion (RPE) or head gear), and records. Comprehensive orthodontic treatment may occur in phases, with the anticipation that full banding must occur during the treatment period. The payment for comprehensive orthodontic treatment covers a maximum period of three (3) calendar years. The MassHealth agency pays for orthodontic treatment as long as the member remains eligible for MassHealth, if initial placement and insertion of fixed or removable orthodontic appliances begins before the member reaches age 21.

(4) Orthodontic Treatment Visits. The MassHealth agency pays for orthodontic treatment visits on a quarterly (90-days) basis for ongoing orthodontic maintenance and treatment beginning after the initial placement, and insertion of the orthodontic fixed and removable appliances. 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. The provider must document the number and dates of orthodontic treatment visits in the member's orthodontic record.

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(5) Orthodontic Case Completion. The MassHealth agency pays for orthodontic case completion for comprehensive orthodontic treatment which includes the removal of appliances, construction and placement of retainers and follow-up visits. The MassHealth agency pays for a maximum of five (5) visits for members under the age of 21. The MassHealth agency pays for the replacement of lost or broken retainers with prior authorization.

(6) Orthodontic Transfer Cases. The MassHealth agency pays for members who transfer from one orthodontic provider to another for orthodontic services subject to prior authorization to determine the number of treatment visits remaining. Payment for transfer cases is limited to the number of treatment visits approved. Providers must submit requests using the form specified by MassHealth.

(7) Orthodontic Terminations. The MassHealth agency requires providers to make all efforts to complete the active phase of treatment before requesting payment for removal of brackets and bands of a noncompliant member. If the provider determines that continued orthodontic treatment is not indicated because of lack of member's cooperation and has obtained the member's consent, the provider must submit a written treatment narrative on office letterhead with supporting documentation, including the case prior authorization number.

(8) Radiographs. Payment for Cephalometric and radiographs used in conjunction with orthodontic diagnosis is included in the payment for comprehensive orthodontic treatment (*see* 130 CMR 420.423(D)). The MassHealth agency pays for radiographs as a separate procedure for orthodontic diagnostic purposes only for members under age 21 if requested by the MassHealth agency.

(9) Oral/Facial Photographic Images. The MassHealth agency pays for digital or photographic prints, not slides, only to support prior-authorization requests for comprehensive orthodontic treatment. Payment for digital or photographic prints is included in the payment for comprehensive orthodontic treatment or orthognathic treatment. 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 treatment examination, unless the MassHealth agency denies the prior authorization request for interceptive or comprehensive orthodontic treatment. The MassHealth agency pays for the pre-orthodontic treatment examination if prior authorization is denied for interceptive or comprehensive orthodontic treatment.

(130 CMR 420.432 through 420.451 Reserved)

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420.452: Service Descriptions and Limitations: Anesthesia

(A) General Requirements and Definitions. The MassHealth agency pays for general anesthesia and intravenous moderate (conscious) sedation/analgesia subject to the service descriptions and limitations described in 130 CMR 420.452 and in accordance with the service description of subchapter 6 in the *Dental Manual*.

(1) Deep Sedation/General Anesthesia. Deep sedation and general anesthesia, when administered in a dental 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 (BORID) and when a member is eligible for oral-surgery services. All rules, regulations, and requirements set forth by the Massachusetts BORID and by the Massachusetts Society of Oral and Maxillofacial Surgeons that must be followed without exception.

(2) Intravenous Moderate Sedation/Analgesia. The MassHealth agency pays for intravenous moderate sedation/analgesia sedation when administered in a dental office, and when a member is eligible for oral-surgery services, administered by a provider who possesses both an anesthesia-administration permit and an anesthesia-facility permit issued by the Massachusetts BORID.

(3) Inhalation of Nitrous Oxide/Oral Analgesia.

(a) The MassHealth agency pays for the oral administration of analgesia, as part of an operative procedure.

(b) The MassHealth agency pays for the administration of inhalation analgesia (nitrous oxide (N₂O/O₂)) as a separate procedure.

(4) 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).

(B) Documentation. The provider must maintain a completed anesthesia flowsheet in the member's dental record for each procedure requiring the use of anesthesia. In addition, the provider must document the following in the member's dental record:

(1) the beginning and ending times of deep sedation/general anesthesia, IV moderate sedation/analgesia, or inhalation of nitrous oxide analgesia procedure. The anesthesia time begins when the provider administers the anesthetic agent. The provider is required to follow the non-invasive monitoring protocol and remain in continuous attendance of the member. Anesthesia services are considered completed when the member may be safely left under the observation of trained personnel and the provider may safely leave the room. The level of anesthesia is determined by the provider's documentation and consideration of the member's past history with anesthesia, anesthetic effects upon the central nervous system and is not dependent upon the route of administration;

(2) preoperative, intraoperative, and postoperative vital signs;

(3) medications administered, including their dosages and routes of administration;

(4) monitoring equipment used;

(5) a statement of the member's response to the analgesic or anesthetic used including any complication or adverse reaction; and

(6) a record of the member's prior history with anesthesia or analgesics.

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

The MassHealth agency pays for oral and maxillofacial surgery services subject to the service descriptions and limitations described in 130 CMR 420.453. Payment for oral and maxillofacial surgery services includes 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. 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.

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(G) Orthognathic Surgery.

- (1) The MassHealth agency pays for orthognathic surgery including select surgical procedures related to Temporomandibular Joint Disorder or Obstructive Sleep Apnea.
- (2) Any proposed orthognathic or orthodontic treatment must meet all the criteria described at 130 CMR 420.431.

(130 CMR 420.454 Reserved)

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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 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) Behavioral Management. The MassHealth agency pays an additional payment once per member per day for management of a severely and chronically mentally, physically, or developmentally impaired member in the office. The provider must document a history of treatment or previous attempts at treatment in the member's medical record.

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(C) Palliative Treatment of Dental Pain or Infection. The MassHealth agency pays for palliative treatment to alleviate dental pain or infection as part of an emergency service visit. 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.

(D) Occlusal Guard. The MassHealth agency pays for occlusal 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.

(E) Mouth Guard for Sports. The MassHealth agency pays for custom-fitted mouth guards only for members under age 21 once per calendar year. The provider must document the following information in the member’s record: that the member is engaged in a contact sport (including, but not limited to basketball, football, hockey, lacrosse, and soccer) and there must be no other provision for the purchase of mouth guards for the sport’s participants.

(F) House/Facility Call. The MassHealth agency pays for visits to nursing facilities, chronic disease and rehabilitation hospitals, hospice facilities, schools, and other licensed educational facilities, once per facility per day, in addition to any medically necessary MassHealth-covered service provided during the same visit.

REGULATORY AUTHORITY

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

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601 Introduction

Dental providers who bill using Current Dental Terminology (CDT) codes must refer to the current version of the American Dental Association’s (ADA) code book for the service descriptions for codes listed in Subchapter 6 of the *Dental Manual*. Dentists who are specialists in oral surgery in accordance with 130 CMR 420.405(A)(7) must refer to the current version of the American Medical Association’s (AMA) Current Procedural Terminology (CPT) code book for the service descriptions for codes listed in Subchapter 6 of the *Dental Manual*.

MassHealth pays for 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 the age of 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.

Dentists Who Are Specialists in Oral Surgery

A dentist who is a specialist in oral surgery in accordance with 130 CMR 420.405(A)(7) must submit all requests for prior authorization and claims containing Current Procedural Terminology (CPT) codes directly to MassHealth rather than to any third-party administrator or other MassHealth vendor, as described in 130 CMR 420.000.

When billing for multiple surgeries performed during the same operative session or on the same day, dental providers who are specialists in oral surgery in accordance with 130 CMR 420.405(A)(7), are reminded that Modifier 51 must be added to the second, third, and subsequent lines as appropriate. The primary procedure must be on line 1.

Modifiers

The following modifiers are for Provider Preventable Conditions (PPCs) that are National Coverage Determinations.

- PA Surgical or other invasive procedure on wrong body part
- PB Surgical or other invasive procedure on wrong patient
- PC Wrong surgery or other invasive procedure on patient

For more information on the use of these modifiers, see [Appendix V](#) of your provider manual.

Public Health Dental Hygienists

Public health dental hygienists may claim payment for Service Codes D0190, D0191, D0220, D0272, D0273, D0274, D1110, D1120, D1206, D1208, D1351, D4341, D4342, D9110, and D9410.

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602 Explanation of Abbreviations and Service Code Requirements

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

(A) Prior Authorization.

(1) “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.

(2) The MassHealth agency may require any additional information it deems necessary. If 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 pays for additional prophylaxis for a member within a calendar year if medically necessary.)

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

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

603 Service Codes: Diagnostic Services

See 130 CMR 420.422 for service descriptions and limitations.

Service Code and Limitations		Covered Under Age 21?	Covered DDS Clients Aged 21 and Older?	Covered Aged 21 and Older?	Prior-Authorization Requirements, Report Requirements, and Notations
D0120	Twice per calendar year	Yes	Yes	Yes	
D0140	Twice per calendar year	Yes	Yes	Yes	
D0145	Twice per calendar year	Yes (IC)	No	No	See 602(B) above.
D0150	Once per member per dentist	Yes	Yes	Yes	
D0180	Once per calendar year	Yes	Yes	Yes	
D0190	Twice per calendar year	Yes	Yes	Yes	
D0191	Once per calendar year	Yes	Yes	Yes	

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604 Service Codes: Radiographs

See 130 CMR 420.423 and Dental Manual Appendix E for service descriptions and limitations.

Service Code and Limitations		Covered Under Age 21?	Covered DDS Clients Aged 21 and Older?	Covered Aged 21 and Older?	Prior-Authorization Requirements, Report Requirements, and Notations
D0210	Once every three calendar years	Yes	Yes	Yes	
D0220		Yes	Yes	Yes	
D0230		Yes	Yes	Yes	
D0240	Twice per calendar year	Yes	No	No	
D0270	Twice per calendar year	Yes	Yes	Yes	
D0272	Twice per calendar year	Yes	Yes	Yes	
D0273	Twice per calendar year	Yes (IC)	Yes (IC)	Yes (IC)	See 602(B) above.
D0274	Twice per calendar year	Yes	Yes	Yes	
D0330	Once every three calendar years	Yes	Yes	Yes	
D0340		Yes	Yes	Yes	

605 Service Codes: Preventive Services

See 130 CMR 420.424 for service descriptions and limitations.

Service Code and Limitations		Covered Under Age 21?	Covered DDS Clients Aged 21 and Older?	Covered Aged 21 and Older?	Prior-Authorization Requirements, Report Requirements, and Notations
D1110	Twice per calendar year	Yes (Use this code for ages 14-21.)	Yes	Yes	
D1120	Twice per calendar year	Yes (Use this code for ages up to 14.)	No	No	

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605 Service Codes: Preventive Services (cont.)

Service Code and Limitations		Covered Under Age 21?	Covered DDS Clients Aged 21 and Older?	Covered Aged 21 and Older?	Prior-Authorization Requirements, Report Requirements, and Notations
D1206		Yes	No*	No*	* Exception for members who have a medical or dental condition that significantly interrupts the flow of saliva □ (PA). See 602(A) above and 130 CMR 420.424(B)(1)(b).
D1208		Yes	No*	No*	* Exception for members who have a medical or dental condition that significantly interrupts the flow of saliva □ (PA). See 602(A) above and 130 CMR 420.424(B)(1)(b).
Other Preventive Services					
D1351	Permanent first, second, and third noncarious, nonrestored molars	Yes	No	No	
Space Maintenance (Passive Appliances)					
D1510	Twice per lifetime	Yes	No	No	
D1516		Yes	No	No	
D1517		Yes	No	No	
D1520	Twice per lifetime	Yes	No	No	
D1526		Yes	No	No	
D1527		Yes	No	No	
D1550		Yes	No	No	

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606 Service Codes: Restorative Services

See 130 CMR 420.425 for service descriptions and limitations.

Service Code and Limitations		Covered Under Age 21?	Covered DDS Clients Aged 21 and Older?	Covered Aged 21 and Older?	Prior-Authorization Requirements, Report Requirements, and Notations
Amalgam Restorations (Including Polishing)					
D2140	Once per calendar year per tooth	Yes	Yes	Yes	
D2150	Once per calendar year per tooth	Yes	Yes	Yes	
D2160	Once per calendar year per tooth	Yes	Yes	Yes	
D2161	Once per calendar year per tooth	Yes	Yes	Yes	
Resin-Based Composite Restorations					
D2330	Once per calendar year per tooth	Yes	Yes	Yes	
D2331	Once per calendar year per tooth	Yes	Yes	Yes	
D2332	Once per calendar year per tooth	Yes	Yes	Yes	
D2335	Once per calendar year per tooth	Yes	Yes	Yes	
D2390	Once per calendar year per tooth	Yes	No	No	
D2391	Once per calendar year per tooth	Yes	Yes	Yes	
D2392	Once per calendar year per tooth	Yes	Yes	Yes	
D2393	Once per calendar year per tooth	Yes	Yes	Yes	
D2394	Once per calendar year per tooth	Yes	Yes	Yes	
Crowns – Single Restoration Only					
D2710	Once per 60 months per tooth	Yes	No	No	
D2740	Once per 60 months per tooth	Yes	No	No	
D2750	Once per 60 months per tooth	Yes	No	No	

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606 Service Codes: Restorative Services (cont.)

Service Code and Limitations		Covered Under Age 21?	Covered DDS Clients Aged 21 and Older?	Covered Aged 21 and Older?	Prior-Authorization Requirements, Report Requirements, and Notations
D2751	Once per 60 months per tooth	Yes	Yes (PA)	No	Include periapical film of the tooth. See 602(A) above and 130 CMR 420.425(C)(2).
D2752	Once per 60 months per tooth	Yes	No	No	
D2790	Once per 60 months per tooth	Yes	No	No	
Other Restorative Services					
D2910		Yes	Yes	No	
D2920		Yes	Yes	No	
D2930		Yes	No	No	
D2931		Yes	No*	No	<i>* Exception for members with undue medical risk. See 130 CMR 420.425(C)(2).</i>
D2932	Primary anterior teeth only	Yes	No	No	
D2934		Yes	No	No	
D2951		Yes	Yes	No	
D2954		Yes	Yes (PA)	No	Include periapical film of the tooth. See 602(A) above and 130 CMR 420.425(C)(1)(c).
D2980	Chairside	Yes	Yes	No	
D2999	Outside laboratory	Yes (PA) (IC)	Yes (PA) (IC)	No	Include documentation to substantiate why the repair could not be done chairside. See 602(A) and (B) above and 130 CMR 420.425(E).

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607 Service Codes: Endodontic Services

See 130 CMR 420.426 for service descriptions and limitations.

Service Code and Limitations		Covered Under Age 21?	Covered DDS Clients Aged 21 and Older?	Covered Aged 21 and Older?	Prior-Authorization Requirements, Report Requirements, and Notations
Pulpotomy					
D3220		Yes	No	No	
Root Canal Therapy (Including Pre- and Post-Treatment Radiographs and Follow-up Care)					
D3310	Once per lifetime per tooth	Yes	Yes	No	
D3320	Once per lifetime per tooth	Yes	No*	No	<i>* Exception for members with undue medical risk. See 130 CMR 420.426(B)(3). PA required.</i>
D3330	Once per lifetime per tooth	Yes	No*	No	<i>* Exception for members with undue medical risk. See 130 CMR 420.426(B)(3). PA required.</i>
D3346		Yes	Yes	No	
D3347		Yes	No*	No	<i>* Exception for members with undue medical risk or with one or more medical conditions listed in 130 CMR 420.425(C)(2). See 130 CMR 420.426(C)(2). PA required.</i>

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607 Service Codes: Endodontic Services (cont.)

Service Code and Limitations		Covered Under Age 21?	Covered DDS Clients Aged 21 and Older?	Covered Aged 21 and Older?	Prior-Authorization Requirements, Report Requirements, and Notations
Endodontic Retreatment					
D3348		Yes	No*	No	* <i>Exception for members with undue medical risk or with one or more medical conditions listed in 130 CMR 420.425(C)(2). See 130 CMR 420.426(C)(2). PA required.</i>
Apicoectomy/Periradicular Services					
D3410	Per tooth; Includes retrograde filling; Once per lifetime per tooth	Yes	Yes (PA)	No	Include periapical film of the tooth and date of the original root canal treatment. See 602(A) above and 130 CMR 420.426(D).
D3421	Once per lifetime per tooth	Yes	Yes (PA)	No	Include periapical film of the tooth and date of the original root canal treatment. See 602(A) above and 130 CMR 420.426(D).
D3425	First root; Once per lifetime per tooth	Yes	Yes (PA)	No	Include periapical film of the tooth and date of the original root canal treatment. See 602(A) above and 130 CMR 420.426(D).

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607 Service Codes: Endodontic Services (cont.)

Service Code and Limitations		Covered Under Age 21?	Covered DDS Clients Aged 21 and Older?	Covered Aged 21 and Older?	Prior-Authorization Requirements, Report Requirements, and Notations
D3426	Each additional root	Yes	Yes (PA)	No	Include periapical film of the tooth and date of the original root canal treatment. See 602(A) above and 130 CMR 420.426(D).

608 Service Codes: Periodontal Services

See 130 CMR 420.427 for service descriptions and limitations.

Service Code and Limitations		Covered Under Age 21?	Covered DDS Clients Aged 21 and Older?	Covered Aged 21 and Older?	Prior-Authorization Requirements, Report Requirements, and Notations
Surgical Services (Including Usual Postoperative Services)					
D4210	Once per quadrant per three-calendar years	Yes	Yes (PA)	Yes (PA)	Include complete periodontal charting, periapical films, documentation of previous periodontal treatment, and a statement concerning the member's periodontal condition. See 602(A) above and 130 CMR 420.427(A).

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608 Service Codes: Periodontal Services (cont.)

Service Code and Limitations		Covered Under Age 21?	Covered DDS Clients Aged 21 and Older?	Covered Aged 21 and Older?	Prior-Authorization Requirements, Report Requirements, and Notations
D4211	Once per quadrant per three-calendar years	Yes	Yes (PA)	Yes (PA)	Include complete periodontal charting, periapical films, documentation of previous periodontal treatment, and a statement concerning the member's periodontal condition. See 602(A) above and 130 CMR 420.427(A).
D4341	Once per quadrant per three-calendar years	Yes	Yes (PA)	Yes (PA)	Include complete periodontal charting, periapical films, documentation of previous periodontal treatment, and a statement concerning the member's periodontal condition. See 602(A) above and 130 CMR 420.427(B).

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608 Service Codes: Periodontal Services (cont.)

Service Code and Limitations		Covered Under Age 21?	Covered DDS Clients Aged 21 and Older?	Covered Aged 21 and Older?	Prior-Authorization Requirements, Report Requirements, and Notations
D4342	Once per quadrant per three calendar years	Yes	Yes (PA)	Yes (PA)	Include complete periodontal charting, periapical films, documentation of previous periodontal treatment, and a statement concerning the member's periodontal condition. See 602(A) above and 130 CMR 420.427(B).

609 Service Codes: Prosthodontic (Removable) Services

See 130 CMR 420.428 for service descriptions and limitations.

Service Code and Limitations		Covered Under Age 21?	Covered DDS Clients Aged 21 and Older?	Covered Aged 21 and Older?	Prior-Authorization Requirements, Report Requirements, and Notations
Complete Dentures (Including Routine Post-Delivery Care)					
D5110	Once per 84 months	Yes	Yes	Yes	
D5120	Once per 84 months	Yes	Yes	Yes	
D5130		Yes	No	No	
D5140		Yes	No	No	
Partial Dentures (Including Routine Post-Delivery Care)					
D5211	Once per 84 months	Yes	Yes	Yes	
D5212	Once per 84 months	Yes	Yes	Yes	

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609 Service Codes: Prosthodontic (Removable) Services (cont.)

Service Code and Limitations		Covered Under Age 21?	Covered DDS Clients Aged 21 and Older?	Covered Aged 21 and Older?	Prior-Authorization Requirements, Report Requirements, and Notations
Partial Dentures (Including Routine Post-Delivery Care)					
D5213	Once per 84 months	Yes	No	No	
D5214	Once per 84 months	Yes	No	No	
D5225	Once per 84 months	Yes	No	No	
D5226	Once per 84 months	Yes	No	No	
Repairs to Complete Dentures					
D5511		Yes	Yes	Yes	
D5512		Yes	Yes	Yes	
D5520		Yes	Yes	Yes	
Repairs to Partial Dentures					
D5611		Yes	Yes	Yes	
D5612		Yes	Yes	Yes	
D5621		Yes	Yes	Yes	
D5622		Yes	Yes	Yes	
D5630		Yes	Yes	Yes	
D5640		Yes	Yes	Yes	
D5650		Yes	Yes	Yes	
D5660		Yes	Yes	Yes	
Denture Reline Procedures					
D5730	Once per 24 months per arch	Yes	Yes	Yes	
D5731	Once per 24 months per arch	Yes	Yes	Yes	
D5740	Once per 24 months per arch	Yes	No	No	
D5741	Once per 24 months per arch	Yes	No	No	
D5750	Once per 24 months per arch	Yes	Yes	Yes	
D5751	Once per 24 months per arch	Yes	Yes	Yes	

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609 Service Codes: Prosthodontic (Removable) Services (cont.)

Service Code and Limitations		Covered Under Age 21?	Covered DDS Clients Aged 21 and Older?	Covered Aged 21 and Older?	Prior-Authorization Requirements, Report Requirements, and Notations
D5760	Once per 24 months per arch	Yes	No	No	
D5761	Once per 24 months per arch	Yes	No	No	

610 Service Codes: Prosthodontic (Fixed) Services

See 130 CMR 420.429 for service descriptions and limitations.

Service Code and Limitations		Covered Under Age 21?	Covered DDS Clients Aged 21 and Older?	Covered Aged 21 and Older?	Prior-Authorization Requirements, Report Requirements, and Notations
Fixed Partial Denture Pontics					
D6241	Once per 60 months per tooth	Yes	No	No	
D6751	Once per 60 months per tooth	Yes	No	No	
Other Fixed Partial Denture Services					
D6930		Yes	No	No	
D6980		Yes	No	No	See 602 (B) above.

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611 Service Codes: Oral Surgery (Exodontic) Services

See 130 CMR 420.430 for service descriptions and limitations.

Service Code and Limitations		Covered Under Age 21?	Covered DDS Clients Aged 21 and Older?	Covered Aged 21 and Older?	Prior-Authorization Requirements, Report Requirements, and Notations
D6999		Yes (PA) (IC)	Yes (PA)	No	Include documentation to substantiate why the repair could not be done chairside. See 602(A), (B) above and 130 CMR 420.429(B).
Extractions (Includes Local Anesthesia and Routine Postoperative Care)					
D7111		Yes	Yes	Yes	
D7140		Yes	Yes	Yes	
D7210		Yes	Yes	Yes	
D7220		Yes	Yes	Yes	
D7230		Yes	Yes	Yes	
D7240		Yes (PA)	Yes (PA)	Yes (PA)	Include Panorex film. See 602(A) above and 130 CMR 420.430(D).
D7250		Yes	Yes	Yes	
D7270		Yes	Yes	Yes	
D7280	Including orthodontic attachments	Yes	No	No	
D7283		Yes	No	No	
Surgical Procedures					
D7310	Once per 6 months per quadrant	Yes	Yes	Yes	
D7311	Once per 6 months per quadrant	Yes	Yes	Yes	
D7320	Once per 6 months per quadrant	Yes	Yes	Yes	
D7321	Once per 6 months per quadrant	Yes	Yes	Yes	

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611 Service Codes: Exodontic Services (cont.)

Service Code and Limitations		Covered Under Age 21?	Covered DDS Clients Aged 21 and Older?	Covered Aged 21 and Older?	Prior-Authorization Requirements, Report Requirements, and Notations
D7340		Yes (PA)	Yes (PA)	No	Include justification of the surgical procedure designed to increase alveolar ridge height. See 602(A) above and 130 CMR 420.430(F).
D7350†		Yes (PA)	Yes (PA)	No	† Payable only to a dental provider with a specialty in oral surgery. In accordance with 130 CMR 420.405(A)(7). See 602(A) above and 130 CMR 420.430(F).
D7410		Yes	Yes	No	
D7411		Yes	Yes	No	
D7450		Yes	Yes	No	
D7451		Yes	Yes	No	
D7460		Yes	Yes	No	
D7461		Yes	Yes	No	
D7471†	Once per lifetime per arch	Yes (PA)	Yes (PA)	No	† Payable only to a dental provider with a specialty in oral surgery in accordance with 130 CMR 420.405(A)(7). See 602(A) above.

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611 Service Codes: Exodontic Services (cont.)

Service Code and Limitations		Covered Under Age 21?	Covered DDS Clients Aged 21 and Older?	Covered Aged 21 and Older?	Prior-Authorization Requirements, Report Requirements, and Notations
D7471†	Once per lifetime per arch	Yes (PA)	Yes (PA)	No	† Payable only to a dental provider with a specialty in oral surgery in accordance with 130 CMR 420.405(A)(7). See 602(A) above.
D7472†	Once per lifetime per arch	Yes (PA)	Yes (PA)		† Payable only to a dental provider with a specialty in oral surgery in accordance with 130 CMR 420.405(A)(7). See 602(A) above.
D7473†	Once per lifetime per arch	Yes (PA)	Yes (PA)		† Payable only to a dental provider with a specialty in oral surgery in accordance with 130 CMR 420.405(A)(7). See 602(A) above.
D7960		Yes	Yes	No	
D7963		Yes	Yes	No	
D7999		Yes (PA) (IC)	Yes (PA) (IC)	No	See 602(A) and (B) above.

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612 Service Codes: Orthodontic Services

See 130 CMR 420.431 for service descriptions and limitations.

Service Code and Limitations		Covered Under Age 21?	Covered DDS Clients Aged 21 and Older?	Covered Aged 21 and Older?	Prior-Authorization Requirements, Report Requirements, and Notations
Orthodontic Diagnosis and Full Orthodontic Treatment					
D8050†		Yes (PA) (IC)	No	No	Include the number of adjustment visits required in conjunction with the type of interceptive appliance. See 602(A) and (B) above and 130 CMR 420.431. † Payable only to a dental provider who is a specialist in orthodontics in accordance with 130 CMR 420.405(A)(6).

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612 Service Codes: Orthodontic Services (cont.)

Service Code and Limitations		Covered Under Age 21?	Covered DDS Clients Aged 21 and Older?	Covered Aged 21 and Older?	Prior-Authorization Requirements, Report Requirements, and Notations
D8060†		Yes (PA) (IC)	No	No	Include the number of adjustment visits required in conjunction with the type of interceptive appliance. See 602(A) and (B) above, 130 CMR 420.431, and Dental Manual Appendix F. † Payable only to a dental provider who is a specialist in orthodontics in accordance with 130 CMR 420.405(A)(6).

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612 Service Codes: Orthodontic Services (cont.)

Service Code and Limitations		Covered Under Age 21?	Covered DDS Clients Aged 21 and Older?	Covered Aged 21 and Older?	Prior-Authorization Requirements, Report Requirements, and Notations
D8070†	Once per lifetime for either D8070, D8080, or D8090.	Yes (PA)	No	No	Include the x-ray, photographic prints, completed copy of the Handicapping Labio-Lingual Deviations Form (HLD), and medical necessity narrative, if applicable. See 602(A) and (B) above, 130 CMR 420.431, and Dental Manual Appendix D. † Payable only to a dental provider who is a specialist in orthodontics in accordance with 130 CMR 420.405(A)(6).

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612 Service Codes: Orthodontic Services (cont.)

Service Code and Limitations		Covered Under Age 21?	Covered DDS Clients Aged 21 and Older?	Covered Aged 21 and Older?	Prior-Authorization Requirements, Report Requirements, and Notations
D8080†	Once per lifetime for either D8070, D8080, or D8090.	Yes (PA)	No	No	Include the x-ray, photographic prints, a completed copy of the Handicapping Labio-Lingual Deviations Form (HLD) and a medical necessity narrative, if applicable. See 602(A) above and 130 CMR 420.431 and Dental Manual Appendix D. † Payable only to a dental provider who is a specialist in orthodontics in accordance with 130 CMR 420.405(A)(6).

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612 Service Codes: Orthodontic Services (cont.)

Service Code and Limitations		Covered Under Age 21?	Covered DDS Clients Aged 21 and Older?	Covered Aged 21 and Older?	Prior-Authorization Requirements, Report Requirements, and Notations
D8090†	Once per lifetime for either D8070, D8080 or D8090.	Yes (PA)	No	No	Include the x-ray, photographic prints, a completed copy of the Handicapping Labio-Lingual Deviations Form (HLD) and a medical necessity narrative, if applicable. See 602(A) above and 130 CMR 420.431 and Dental Manual Appendix D. † Payable only to a dental provider who is a specialist in orthodontics in accordance with 130 CMR 420.405(A)(6).

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612 Service Codes: Orthodontic Services (cont.)

Service Code and Limitations		Covered Under Age 21?	Covered DDS Clients Aged 21 and Older?	Covered Aged 21 and Older?	Prior-Authorization Requirements, Report Requirements, and Notations
D8670†	As part of contract; billed once per quarter (90 days) on the first date of service beginning with the calendar month following the calendar month during which appliance(s) were placed	Yes (PA)	No*	No*	Submit authorization request for the first two years of treatment, include photographic prints, radiographs (lateral & occlusal views) & HLD Index Form. * <i>Exception for members whose comprehensive orthodontic treatment began by age 21.</i> See 130 CMR 420.431(A). † Payable only to a dental provider who is a specialist in orthodontics in accordance with 130 CMR 420.405(A)(6)
D8660†	Consultation - once per six months	Yes	No	No	† Payable only to a dental provider who is a specialist in orthodontics in accordance with 130 CMR 420.405(A)(6).

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612 Service Codes: Orthodontic Services (cont.)

Service Code and Limitations		Covered Under Age 21?	Covered DDS Clients Aged 21 and Older?	Covered Aged 21 and Older?	Prior-Authorization Requirements, Report Requirements, and Notations
D8680†		Yes	No*	No*	<i>* Exception for members whose comprehensive orthodontic treatment began by age 21. PA required.</i> See 130 CMR 420.431(A)(1). † Payable only to a dental provider who is a specialist in orthodontics in accordance with 130 CMR 420.405(A)(6) Include the date of the initial banding and a narrative of the reason(s) for removal of the orthodontic appliance. See 602(A) above.
D8690†		Yes (PA)	No	No	† Payable only to a dental provider who is a specialist in orthodontics in accordance with 130 CMR 420.405(A)(6) See 602(A) above.

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612 Service: Orthodontic Services (cont.)

Service Code and Limitations		Covered Under Age 21?	Covered DDS Clients Aged 21 and Older?	Covered Aged 21 and Older?	Prior-Authorization Requirements, Report Requirements, and Notations
D8692†		Yes (PA)	No	No	See 602(A) above. PA required. See 130 CMR 420.431(C)(5). † Payable only to a dental provider who is a specialist in orthodontics in accordance with 130 CMR 420.405(A)(6).
D8999†		Yes (PA) (IC)	No*	No*	* <i>Exception for members whose comprehensive orthodontic treatment began by age 21.</i> PA required. See 130 CMR 420.431(A). † Payable only to a dental provider who is a specialist in orthodontics in accordance with 130 CMR 420.405(A)(6) See 602(A), (B), and (D) above.

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613 Service Codes: General Anesthesia and IV Sedation Services

See 130 CMR 420.452 for service descriptions and limitations.

Service Code and Limitations	Covered Under Age 21?	Covered DDS Clients Aged 21 and Older?	Covered Aged 21 and Older?	Prior-Authorization Requirements, Report Requirements, and Notations
D9222	Yes	Yes	Yes	
D9223	Yes	Yes	Yes	
D9230	Yes	Yes	Yes	
D9239	Yes	Yes	Yes	
D9243	Yes	Yes	Yes	
D9248	Yes	Yes	Yes	

614 Service Codes: Adjunctive Services

See 130 CMR 420.456 for service descriptions and limitations.

Service Code and Limitations	Covered Under Age 21?	Covered DDS Clients Aged 21 and Older?	Covered Aged 21 and Older?	Prior-Authorization Requirements, Report Requirements, and Notations
Unclassified Treatment				
D9110	Yes	Yes	Yes	
Other nonemergency medically necessary treatment may be provided during the same visit – that is, nonemergency codes may be billed in conjunction with D9110.				
Professional Visits				
D9410	Yes	Yes	Yes	A visit to a nursing facility, chronic disease and rehabilitation hospital, hospice facility, school, or other licensed educational facility, once per facility per day. Bill in addition to any medically necessary MassHealth-covered service provided during the same visit. Code may be billed once per facility per day. See 130 CMR 420.456(F).

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614 Service Codes: Adjunctive Services (cont.)

Service Code and Limitations		Covered Under Age 21?	Covered DDS Clients Aged 21 and Older?	Covered Aged 21 and Older?	Prior-Authorization Requirements, Report Requirements, and Notations
Treatment of Physically or Developmentally Disabled Members					
D9920	Once per member per day	Yes (PA)	Yes (PA)	Yes (PA)	Include a description of the member's illness or disability, and types of services to be furnished. See 602(A) and (D) above and 130 CMR 420.456(B).
Miscellaneous Services					
D9930		Yes (IC)	Yes (IC)	Yes (IC)	Include with the claim the date, the location of the original surgery, and the type of procedure. See 602(A) above.
D9945		Yes (PA)	No	No	Include documented evidence of the need for the appliance. See 602(A) and (D) above.
D9941		Yes	No	No	
D9999		Yes (PA), (IC)	Yes (PA), (IC)	No	See 602(A), (B), and (D) above.

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615 Service Codes: Oral and Maxillofacial Surgery Services

See 130 CMR 420.453 and 420.455 for service descriptions and limitations.

The following all-numeric service codes may be used only by dental providers who are specialists in oral surgery, in accordance with 130 CMR 420.405(A)(7).

CPT Service Codes

10060	12002	13152	15574	17273
10061	12004	13153	15576	17274
10120	12005	13160	15610	17276
10121	12006	14000	15620	17280
10140	12007	14001	15630	17281
10160	12011	14020	15730	17282
10180	12013	14021	15731	17283
11010	12014	14040	15733	17284
11011	12015	14041	15734	17286
11012	12016	14060	15740	17999 (IC)
11042	12017	14061	15750	20100
11043	12018	14301	15756	20200
11044	12020	14302	15757	20205
11045	12021	15040	15758	20206
11046	12031	15100	15760	20220
11310	12032	15110	15770	20225
11311	12034	15111	15819	20240
11312	12035	15115	15820 (PA)	20245
11313	12036	15116	15821 (PA)	20520
11440	12037	15120	15822 (PA)	20525
11441	12041	15121	15823 (PA)	20526
11442	12042	15150	15840	20605
11443	12044	15151	15841	20615
11444	12045	15152	15842	20670
11446	12046	15155	15845	20680
11620	12047	15156	15852	20690
11621	12051	15157	15860	20692
11622	12052	15240	16000	20693
11623	12053	15241	17000	20694
11624	12054	15260	17003	20900
11626	12055	15261	17004	20902
11640	12056	15271	17106	20910
11641	12057	15272	17107	20912
11642	13120	15273	17108	20920
11643	13121	15274	17110	20922
11644	13122	15275	17111	20924
11646	13131	15276	17260	20926
11960	13132	15277	17266	20955
11970	13133	15278	17270	20956
11971	13150	15570	17271	20962
12001	13151	15572	17272	20969

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615 Service Codes: Oral and Maxillofacial Surgery Services (cont.)

20970	21151 (PA)	21325	21480	31290
20999 (IC)	21154 (PA)	21330	21485	31292
21010	21155 (PA)	21335	21490	31293
21015	21159 (PA)	21336	21495	31294
21025	21160 (PA)	21337	21497	31299 (IC)
21026	21172 (PA)	21338	21499 (IC)	31420
21029	21175 (PA)	21339	21685	31500
21030	21179	21340	29800 (PA)	31502
21031	21180	21343	29804 (PA)	31505
21032	21181	21344	29999 (IC)	31510
21034	21182	21345	30000	31511
21040	21183	21346	30020	31515
21044	21184	21347	30124	31525
21045	21188 (PA)	21348	30125	31526
21046	21193 (PA)	21355	30130	31530
21047	21194 (PA)	21356	30140	31531
21048	21195 (PA)	21360	30150	31535
21049	21196 (PA)	21365	30160	31536
21050	21198 (PA)	21366	30462	31575
21060	21206 (PA)	21385	30465	31600
21070	21208 (PA)	21386	30520	31603
21076	21209 (PA)	21387	30580	31605
21077	21210 (PA)	21390	30600	31610
21079	21215 (PA)	21395	30630	31615
21080	21230 (PA)	21400	30901	31622
21081	21235 (PA)	21401	30903	35500
21082	21240 (PA)	21406	30905	35572
21083	21242 (PA)	21407	30906	35681
21084	21243 (PA)	21408	30920	35682
21085	21244 (PA)	21421	30999 (IC)	35701
21086	21247 (PA)	21422	31000	35800
21087	21255 (PA)	21423	31020	35875
21088 (IC)	21260	21431	31030	35876
21089 (IC)	21261	21432	31032	37609
21100	21263	21433	31040	38500
21110	21267	21435	31200	38505
21116	21268	21436	31201	38510
21120	21270	21440	31205	38542
21137 (PA)	21275	21445	31225	38550
21138 (PA)	21280	21450	31230	38555
21139 (PA)	21282	21451	31231	38700
21141	21295	21452	31233	38720
21142	21296	21453	31237	38724
21143	21299 (PA),	21454	31238	38790
21145	(IC)	21461	31239	38792
21146 (PA)	21310	21462	31240	40490
21147 (PA)	21315	21465	31256	40500
21150 (PA)	21320	21470	31267	

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615 Service Codes: Oral and Maxillofacial Surgery Services (cont.)

40510	41108	42200	42804	62147
40520	41110	42205	42806	62148
40525	41112	42210	42808	64400
40527	41113	42215	42809	64600
40530	41114	42220	42810	64605
40650	41115	42225	42815	64612
40652	41116	42226	42820	64613
40654	41120	42227	42842	64615
40700	41130	42235	42844	64616
40701	41135	42260	42845	64722
40702	41140	42280 (PA)	42860	64727
40720	41145	42281 (PA)	42870	64732
40761	41150	42299 (IC)	42890	64734
40799 (IC)	41153	42300	42894	64736
40800	41155	42305	42900	64738
40801	41250	42310	42950	64740
40804	41251	42320	42953	64864
40805	41252	42330	42955	64865
40806	41510	42335	42960	64868
40808	41520	42340	42961	64872
40810	41599 (IC)	42400	42962	64874
40812	41800	42405	42970	64885
40814	41805	42408	42971	64886
40816	41806	42409	42972	64910
40818	41820 (IC),	42410	42999 (IC)	64911
40819	(PA)	42415	61580	64999 (IC)
40820	41821 (IC)	42420	61581	67715
40830	41822	42425	61582	67840
40831	41823	42426	61583	67916
40840 (PA)	41825	42440	61584	67917
40842 (PA)	41826	42450	61585	68801
40843 (PA)	41827	42500	61586	68810
40844 (PA)	41828	42505	61590	68811
40845 (PA)	41830	42507	61591	69990
40899 (IC)	41850 (IC)	42508	61592	70100
41000	41874	42509	61595	70110
41005	41899 (IC)	42510	61596	70140
41006	42000	42550	61597	70150
41007	42100	42600	61598	70160
41008	42104	42650	61600	70210
41009	42106	42660	61605	70220
41010	42107	42665	61606	70240
41015	42120	42699 (IC)	61607	70328
41016	42140	42700	61608	70330
41017	42145	42720	62142	70360
41018	42160	42725	62143	70380
41100	42180	42800	62145	99201
41105	42182	42802	62146	

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615 Service Codes: Oral and Maxillofacial Surgery Services (cont.)

99202	99214	99222	99233	99284
99203	99215	99223	99234	99285
99204	99217	99224	99235	
99205	99218	99225	99236	
99211	99219	99226	99281	
99212	99220	99231	99282	
99213	99221	99232	99283	