




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



MassHealth
Transmittal Letter DEN-97
July 2017

TO: Dental Providers Participating in MassHealth

FROM: Daniel Tsai, Assistant Secretary for MassHealth 

RE: Revisions to the *Dental Manual* (Updates to 130 CMR 420.000: Dental Services, Subchapter 6, and new Appendices E & F)

This letter transmits updates to the MassHealth dental program regulation at 130 CMR 420.000: Dental Services, new Appendixes E & F, and to Subchapter 6 of the *Dental Manual*. These updates are effective July 1, 2017.

The following is a summary of the changes. For additional information, please see the *Dental Manual* (available at <http://www.mass.gov/eohhs/gov/laws-regs/masshealth/provider-library/provider-manual/>) and the *MassHealth Dental Program Office Reference Manual* (available at www.masshealth-dental.net).

Updates to 130 CMR 420.000: Dental Services

The MassHealth dental program regulation (130 CMR 420.000) has been amended to align terminology and practice protocol with industry standards, clarify dental provider eligibility requirements, and update definitions and provisions related to certain other covered services, including diagnostic, radiographs, and orthodontic services. Key updates to the regulation are summarized in more detail below.

General Definitions (130 CMR 420.402)

The regulation includes new definitions of primary, transitional, and adult dentition.

Diagnostic Services (130 CMR 420.422)

The amended regulation includes updated definitions and limitations for certain diagnostic services. Specifically, a provision describing Detailed and Extensive Oral Evaluations has been removed from the regulation in order for more appropriate service codes to be utilized, and a provision describing Comprehensive Periodontal Evaluation has been added. The amended regulation also defines and clarifies service limitations for Oral Evaluations.

The amended regulation also includes two additional diagnostic services: Oral Screenings and Limited Clinical Assessments. Oral Screenings and Limited Clinical Assessments may only be billed by a Public Health Dental Hygienist (PHDH) who is independently enrolled as a MassHealth provider and delivers the services in a community setting (e.g., schools, nursing facilities, day-care facilities).

Radiographs (130 CMR 420.423)

The regulation contains revised definitions and provisions on radiographs that specify purpose, limitations, and guidelines for each specific radiographic image. Providers should note service updates to the description of Intraoral Complete Series, including updated uses and limitations.

A new Appendix E to the *Dental Manual* further describes the guidelines for appropriate radiographic images based on patient age range. Additionally, a provision on Occlusal Radiographs has been added to the regulation, and includes relevant descriptions and limitations.

Preventative Services (130 CMR 420.424)

The regulation provides for continued coverage of sealants for members under age 17, on the occlusal surface of permanent, noncarious, nonrestored molars once every three (3) calendar years per member per tooth (and per provider or location). Additionally, the regulation contains an updated service limitation for space maintainers.

Restorative Services (130 CMR 420.425)

The regulation includes a clarification at 130 CMR 420.413(B), regarding coverage of multisurface restorations, and a clarification that MassHealth does not cover resin restoration as a means for preventive treatment.

Prosthetic Services (130 CMR 420.428)

The regulation was updated to reflect denture coverage for all members, and the removal of rebase services.

Prosthetic Fixed Services (130 CMR 420.429)

The regulation clarifies MassHealth coverage of chairside repairs for fixed partial dentures/bridges and that MassHealth does not cover laboratory repairs of fixed partial dentures/bridges.

Oral and Maxillofacial Surgery (130 CMR 420.430)

The regulation was updated to reflect alveoloplasty coverage for all members, and the addition of coverage for removal of exostosis and tori.

Orthodontic Services (130 CMR 420.431)

The regulation clarifies definitions and provisions related to orthodontic services. Additionally, service descriptions and limitations for orthodontic services have been refined.

The regulation includes updated billing rules for orthodontic treatment visits. Effective July 1, 2017, providers must bill periodic orthodontic treatment visits on a monthly basis **beginning the calendar month after the initial placement of the appliance**. For example, if a member's orthodontic appliance was inserted on August 11th and the member had an orthodontic treatment visit on September 20th, the provider would bill for the September 20th visit.

If the member also had a orthodontic treatment visit on August 31st then the provider would not bill for the August 31st visit. All orthodontic treatment visits during a calendar month are included in the payment. For example, if a member has two orthodontic treatment visits in a calendar

month then the provider would only submit one claim for that calendar month. At least one date of service in a calendar month is required to bill for periodic orthodontic treatment visits.

Current billing rules for periodic orthodontic treatment visits allow for prospective billing for 90-day periods. As noted above, the 90-day billing rule will cease June 30, 2017, and monthly billing will begin on July 1, 2017. Providers who bill for a 90-day unit between April 1, 2017, and June 30, 2017, may begin monthly billing in the calendar month in which the final 90-day unit expires. Therefore, providers should bill for the first date of service in the 90-day billing period. For example, May 20th was the member's first visit in the 90-day period. The provider would bill on May 20th and the visit payment will cover all visits from May 20th through August 18th (90 days). Therefore, the provider could start billing using the monthly unit for orthodontic treatment visits beginning on August 19th.

The regulation also clarifies the service limitation and requirements for broken or lost retainers.

Additionally, the regulation includes clarifications to the service description and limitation for interceptive orthodontics, and a new Appendix F has been added to the *Dental Manual* to further outline the requirements for authorization for interceptive orthodontic treatment.

Adjunctive General Services (130 CMR 420.456)

The regulation contains a revised service limitation for mouth guards for sports.

Updates to Subchapter 6 of the *Dental Manual*

Subchapter 6 of the MassHealth *Dental Manual* has been updated to reflect certain additions, removal, and changes to the dental service codes. Dental providers who bill using Current Dental Terminology (CDT) service codes must refer to the American Dental Association's (ADA) 2017 code book for descriptions of service codes listed in Subchapter 6. Dental providers who are specialists in oral surgery (in accordance with 130 CMR 420.405(A)(7)), must refer to the American medical Association's (AMA) Current Procedural Terminology (CPT) 2017 code book for descriptions for service codes listed in Subchapter 6. Specific updates to Subchapter 6 are described below.

The following codes have been added:

D0180	Comprehensive periodontal evaluation
D0240	Intraoral – occlusal radiographic image
D0190	Oral screening
D0191	Limited assessment
D7472	Removal of torus palatinus
D7473	Removal of torus mandibularis
D8090	Comprehensive orthodontic treatment of the adult dentition

The following codes have been removed:

D0160	Detailed and extensive oral evaluation
D5710	Rebase complete maxillary denture
D5711	Rebase complete mandibular denture
D5720	Rebase maxillary partial denture
D5721	Rebase mandibular partial denture

Frequency limitations for the following codes have been updated:

D1510	Space maintainer-fixed unilateral
D1515	Space maintainer-fixed bilateral
D1520	Space maintainer-removable-unilateral
D1525	Space maintainer-removable-bilateral
D8692	Replacement of lost or broken retainer
D9941	Fabrication of athletic mouthguard.

Providers are reminded that they may request prior authorization for any medically necessary service payable in accordance with the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) provisions set forth in 130 CMR 450.144, 42 U.S.C.1396d(a), and 42 U.S.C. 1396d(r)(5) for a MassHealth Standard or CommonHealth member under age 21. This applies even if the service is not listed in Subchapter 6 of the Dental Manual.

MassHealth Website

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

Questions

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

NEW MATERIAL

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

Dental Manual

Pages iv, vi, 4-1 through 4-24, 6-1 through 6-24, E-1, E-2, and F-1 through F-4

OBSOLETE MATERIAL

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

[Provider type] Manual

Pages iv, 4-1 through 4-8, and 4-15 through 4-28 — transmitted by Transmittal Letter DEN-85

Page vi — transmitted by Transmittal Letter DEN-90

Pages 4-9 through 4-14 — transmitted by Transmittal Letter DEN-92

Pages 6-1 through 6-24 — transmitted by Transmittal Letter DEN-95

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420.401: Introduction

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

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

(C) Subchapter 6 of the *Dental Manual* lists the Current Dental Terminology (CDT) codes for dentists and public health dental hygienists and Current Procedural Terminology (CPT) codes for specialists in oral surgery that the MassHealth agency pays for, a description of those codes, and where indicated, prior-authorization requirements. Oral and maxillofacial surgeons must submit all claims containing CPT codes directly to MassHealth.

420.402: Definitions

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

Adult Dentition (Permanent Dentition) – Permanent teeth in the dental arch present after the cessation of growth and permanent successors to deciduous teeth have emerged.

BORID – the Board of Registration in Dentistry, or any committee or subcommittee thereof, established in the Massachusetts Department of Public Health (DPH) pursuant to the provisions of M.G.L. c. 13, §19 and c. 112 §§1, 12CC, 43-53, and 61-65E.

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

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

Department of Developmental Services (DDS) – the state agency organized under M.G.L. c. 19B.

DDS Clients – MassHealth members aged 21 and over who have been determined by DDS to be eligible for adult DDS services, pursuant to 115 CMR 6.00: *Standards to Promote Dignity*.

EPSDT – Early and Periodic Screening, Diagnosis and Treatment Services as described in federal law at 42 U.S.C. §§1396d(a)(4)(B) and 1396d(r) and 42 CFR 441 Subpart B. In Massachusetts, EPSDT-eligible members are in MassHealth Standard or MassHealth CommonHealth categories of assistance, and are under age 21.

Mobile Dental Facility (MDF) - any self-contained facility where dentistry will be practiced that may be driven, moved, towed, or transported from one location to another.

Portable Dental Operation (PDO) – any dental practice where a portable dental unit is transported to and utilized on a temporary basis at an out-of-office location.

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Primary Dentition (Deciduous Dentition) – Deciduous teeth developed and erupted first in order of time.

Public Health Setting – includes, but is not limited to, residences of the homebound; schools; Head Start programs; nursing homes and long-term care facilities licensed pursuant to M.G.L. c. 111, § 71; clinics, community health centers, and hospitals licensed pursuant to M.G.L. c. 111, § 51, medical facilities; residential treatment facilities; federal, state or local public health programs; MDFs and portable dental programs which are permitted by BORID pursuant to 234 CMR 7.00: *Mobile and Portable Dentistry* or licensed or certified by DPH pursuant to M.G.L. c. 11, § 51; and other facilities or programs deemed appropriate by BORID or DPH.

Transitional Dentition (Mixed Dentition) – the phase of the transition from Primary Dentition to Adult Dentition, in which growth has not ceased and the deciduous teeth are in the process of shedding and the permanent successors are emerging.

420.403: Eligible Members

(A) MassHealth Members. 130 CMR 450.105: *Coverage Types* specifically states for each MassHealth coverage type, which members are eligible to receive dental services. The MassHealth agency pays for dental services described in 130 CMR 420.000, provided to eligible MassHealth members.

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

(C) Member Eligibility and Coverage Type. 130 CMR 450.107: *Eligible Members and the MassHealth Card* provides information on verifying member eligibility and coverage type.

420.404: Provider Eligibility: Participating Providers

The MassHealth agency pays for services described in 130 CMR 420.000 only to providers of dental services who are participating in MassHealth on the date of service. The participating provider is responsible for the quality of all services for which payment is claimed, the accuracy of such claims, and compliance with all regulations applicable to dental services under MassHealth. In order to claim payment, the participating provider must be the individual who actually performed the service, except as described in 130 CMR 420.404 (A) through (D).

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

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

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

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

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420.405: Provider Eligibility In-state and Out-of-state

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

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

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

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

(4) Acute Hospital Outpatient Department, Hospital-Licensed Health Center, or Other Satellite Clinic. An acute hospital's outpatient department, hospital-licensed health center, or other satellite clinic that participates in MassHealth pursuant to the Executive Office of Health and Human Services (EOHHS) Acute Hospital Request for Applications (RFA) and contract is eligible to provide services designated as dental clinic services in Subchapter 6 of the MassHealth *Dental Manual* for providers under 130 CMR 420.000.

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

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

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

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

(9) Public Health Dental Hygienist. A dental hygienist engaged in private practice is eligible to participate in MassHealth as a dental provider and claim payment for certain services without the direct supervision of a dentist if he or she is licensed to practice as a registered dental hygienist by BORID and also meets the Board's requirements to practice in a public health setting pursuant to 234 CMR 2.00: *General Rules and Requirements* et seq. Private practices may include, but are not limited to, solo, partnership, or group practices.

(10) Mobile Dental Facility (MDF) or Portable Dental Operation (PDO). A dentist or public health dental hygienist is eligible to participate in MassHealth as a dental provider and claim payment for certain services provided through a MDF or PDO only if the provider satisfies the requirements of 234 CMR 7.00: *Mobile and Portable Dentistry* and has obtained a valid permit as a MDF or PDO from BORID.

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

(C) Enhancement Fee for Community Health Centers and Hospital-licensed Health Centers.

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

(2) The dental enhancement fee is set by the Executive Office of Health and Human Services (EOHHS) (see 114.3 CMR 14.00).

420.406: Caseload Capacity

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

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

420.407: Maximum Allowable Fees

The MassHealth agency pays for dental services with rates set by the Executive Office of Health and Human Services (EOHHS) at 114.3 CMR 14.00: *Dental Services* or any successor regulation, subject to the conditions, exclusions, and limitations set forth in 130 CMR 420.000 and 450.000: *Administrative and Billing Regulations*.

420.408: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services

The MassHealth agency pays for all medically necessary dental services for EPSDT-eligible members in accordance with 130 CMR 450.140 et seq., without regard to service limitations described in 130 CMR 420.000, and with prior authorization.

420.409: Noncovered Circumstances

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

- (1) services provided in a state institution by a state-employed dentist, dental consultant, or public health dental hygienist;
- (2) services provided by a provider whose salary includes compensation for professional services;
- (3) if, under comparable circumstances, the provider does not customarily bill individuals who do not have health insurance; and

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

(B) Substitutions.

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

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

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

420.410: Prior Authorization

(A) Introduction.

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

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

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

- (a) the treatment was medically necessary;
- (b) the provider discovers the need for additional services while the member is in the office and undergoing a procedure; and
- (c) it would not be clinically appropriate to delay the provision of the service.

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

- (1) those services listed in Subchapter 6 of the *Dental Manual* with the abbreviation "PA" or otherwise identified in billing instructions, program regulations, associated lists of service codes and service descriptions, provider bulletins, and other written issuances;
- (2) any service not listed in Subchapter 6 for an EPSDT-eligible member; and
- (3) any exception to a limitation on a service otherwise covered for that member as described in 130 CMR 420.421 through 420.456. (For example, MassHealth limits prophylaxis to two per member per calendar year, but pays for additional prophylaxis for a member within a calendar year if medically necessary.)

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(C) Submission Requirements.

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

(2) Instructions for submitting a request for prior authorization for Current Dental Terminology (CDT) codes are described in the MassHealth Dental Program Office Reference Manual. Dental providers requesting prior authorization for services listed with a CDT code must use the current ADA claim form.

(3) Instructions for submitting a request for prior authorization for CPT codes are described in the administrative and billing instructions (Subchapter 5) in all provider manuals. The provider must submit prior authorization requests for CPT codes to MassHealth in accordance with the instructions in Appendix A of all provider manuals.

(D) Other Requirements for Payment.

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

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

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

420.411: Pretreatment Review

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

420.412: Individual Consideration

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

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

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

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420.413: Separate Procedures

Certain procedures are designated "SP" (separate procedure) in the service descriptions in Subchapter 6 of the *Dental Manual*. A separate procedure is one that is commonly performed as an integral part of a total service and therefore does not warrant a separate payment, but that commands a separate payment when performed as a separate procedure not immediately related to other services. For example,

(A) the MassHealth agency does not pay for a frenulectomy when it is performed as part of a vestibuloplasty, and full-study models are not payable separately when performed as part of orthodontic treatment or diagnosis. Nevertheless, the MassHealth agency does pay for frenulectomy as a separate procedure when medically necessary; and

(B) the MassHealth agency does not pay for restorations placed on two (2) or more surfaces within 12 months on the same tooth as separate restorations at the one surface rate. Claims submitted as separate restorations will be paid at the appropriate multisurface restoration rates set by the Executive Office of Health and Human Services (EOHHS) at 114.3 CMR 14.00: *Dental Services* or any successor regulation, subject to the conditions, exclusions, and limitations set forth in 130 CMR 420.000 and 450.000: *Administrative and Billing Regulations*.

420.414: Recordkeeping Requirements

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

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

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

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420.415: Report Required with Certain Claims

(A) The provider must submit with the claim for payment, a written description of the service provided in accordance with the requirements described in Subchapter 6 of the *Dental Manual* when

- (1) the service description in Subchapter 6 stipulates “by report;” or
- (2) the service is designated in Subchapter 6 as “IC”. *See* 130 CMR 420.412.

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

420.416: Pharmacy Services: Prescription Requirements

For information on pharmacy services refer to 130 CMR 406.000: *Pharmacy Services*.

(420.417 through 420.420 Reserved)

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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) prosthodontic services as described in 130 CMR 420.428;
- (6) 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.
- (7) anesthesia services as described in 130 CMR 420.452;
- (8) oral and maxillofacial surgery services as described in 130 CMR 420.453;
- (9) behavior management services as described in 130 CMR 420.456(C);
- (10) palliative treatment of dental pain or infection services as described in 130 CMR 420.456(D); and
- (11) house/facility call as described in 130 CMR 420.456(G).

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(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) periodontic services as described in 130 CMR 420.427;
- (3) 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;
- (4) prosthodontic services (removable) as described in 130 CMR 420.428; and
- (5) 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.

(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,

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(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.

(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.

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

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(D) Nonsurgical Conditions.

- (a) Members Under Age 21. The MassHealth agency pays for only one panoramic radiograph every three (3) 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.
- (b) Members Aged 21 and Older. The MassHealth agency pays for only one panoramic radiograph every three (3) 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.

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 (3) 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 (3) calendar years. The MassHealth agency does not pay to replace sealants lost or damaged during the three (3) 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.

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(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.

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 (1) 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 two-thirds 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.)

(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.

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(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 reinstrumentation.

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

420.427: Service Descriptions and Limitations: Periodontic Services

(A) Gingivectomies and Gingivoplasties. The MassHealth agency pays for gingivectomies and gingivoplasties once per member per quadrant every three (3) calendar years for members under age 21 and DDS clients only. 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 (2) 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.

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(B) Periodontal Scaling and Root Planing. The MassHealth agency pays for periodontal scaling and root planing once per member per quadrant every three (3) calendar years for members under age 21 and DDS clients only. 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.

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

(A) General Conditions. The MassHealth agency pays for dentures services once per seven (7) 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.

(C) Denture Procedures.

- (a) All denture services require appropriate diagnostic quality radiographs to be taken and stored in the member's chart.
- (b) 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.
- (c) The member's identification must be on each denture.
- (d) 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.
- (e) 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.

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(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;
- (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.

(E) 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 (6) months of the insertion date of the denture. The MassHealth agency pays for subsequent relines once every three (3) 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 periodontics 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

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the procedure can be routinely performed with local anesthesia does not justify the use of a hospital or a freestanding ambulatory surgery center.

(B) Extraction. The MassHealth agency pays for extractions. An extraction can be either the removal of soft tissue-retained coronal remnants of a deciduous tooth or the removal of an erupted tooth or exposed root by elevation 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.

(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.

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(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.

(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.

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(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 monthly 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.

(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 it 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.

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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 and any adjustments (treatment visits) occurring in the calendar month of 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 monthly basis for ongoing orthodontic maintenance and treatment beginning the calendar month 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.

(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 three (3) 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.

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(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)

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.

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- (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.

(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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Intraoral complete series of radiographic images.

A. Introduction

The number of radiographs that comprise an Intraoral complete series of radiographic images relates to the MassHealth member's age. The maximum number of diagnostic radiographs which correlate to the member's age may be reimbursed as a single radiographic study every three (3) years without prior authorization (PA). See 130 CMR 420.423(B)(1). The maximum number of radiographs that comprise the triennial Intraoral complete series for various age groups are indicated below:

B. Maximum number of radiographic images per 3-year Intraoral Complete Series by age bracket:

1. Up to and including age six:
 - o No more than eight radiographs: six periapical radiographs and two bitewing radiographs.
2. Age seven up to and including age 14:
 - o No more than twelve radiographs: eight periapical radiographs and four bitewing radiographs; or
 - o one panoramic radiograph and two posterior bite wing radiographs.
3. Age 15 and up:
 - o No more than sixteen radiographs: 12 periapical radiographs and four posterior bitewing radiographs; or
 - o one panoramic radiograph and four posterior bite wing radiographs.

C. Member transfers from one age bracket to the next during the three years between intraoral complete series.

The maximum number of radiographic images per 3-year Intraoral Complete Series age bracket applies as member age transfers from one age bracket to another.

Example: A member who has eight radiographs at age six (6) is not eligible for another Intraoral Complete Series until he or she has reached age nine (9) **and** three (3) years have passed since the last Intraoral Complete series. In this case, once three years have passed since the last intraoral completes series; the member will be at least nine (9). At that point, Dental Manual Appendix E, Section B.2. above would apply until the member turns 15. From age 9 through 14, the next intraoral complete series would be:

- o No more than twelve radiographs: eight periapical radiographs and four bitewing radiographs; or
- o one panoramic radiograph and two posterior bite wing radiographs.

Sources: 1) American Dental Association Council on Scientific Affairs; Revised 2012 and 2) U.S. Department of Health and Human Services Public Health Service, FDA Administration

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Prior Authorization for Interceptive Orthodontic Treatment

MassHealth approves prior authorization (PA) requests for interceptive orthodontic treatment if such treatment will prevent or minimize the development of a handicapping malocclusion or preclude the need for comprehensive orthodontic treatment. 130 CMR 420.431(B)(2). The process for requesting PA for interceptive orthodontic treatment is described below:

(A) Provider performs pre-orthodontic treatment examination (130 CMR 420.431(C)(1)) to determine if orthodontic treatment is necessary.

(B) Provider completes and submits the following:

- (1) 2012 ADA Claim form requesting authorization for interceptive orthodontic treatment. The form must include:
 - (a) the code for the appliance requested (D8050 or D8060); and
 - (b) the code (D8999) for requested adjustments visits; and
 - (c) the number of adjustment visits requested, not to exceed five (5).

(2) **Supporting documentation.** Providers *must* submit:

- a) a medical necessity narrative explaining why, in the professional judgment of the requesting provider and any other involved clinician(s), interceptive orthodontic treatment is medically necessary to prevent or minimize the development of a handicapping malocclusion or will preclude the need for comprehensive orthodontic treatment. The medical necessity narrative must clearly demonstrate why interceptive orthodontic treatment is medically necessary for the patient.

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

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

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

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<p align="center">Dental Manual</p>	<p align="center">Transmittal Letter DEN-97</p>	<p align="center">Date 07/01/17</p>

- b) The following is a non-exclusive list of medical conditions that may, if documented, be considered in support of a request for PA for interceptive orthodontics:
- a. Two or more teeth numbers 6 through 11 in crossbite with photographic evidence documenting 100% of the incisal edge in complete overlap with opposing tooth/teeth;
 - b. Bilateral crossbite of teeth numbers 3, 14 and 19, 30 with photographic evidence documenting cusp overlap completely in fossa, or completely buccal-lingual of opposing tooth;
 - c. Bilateral crossbite of teeth number A, T and J, K with photographic evidence documenting cusp overlap completely in fossa, or completely buccal or lingual of opposing tooth;
 - d. Crowding with radiographic evidence documenting current bony impaction of teeth numbers 6 through 11 or teeth numbers 22 through 27 that requires either serial extraction(s) or surgical exposure and guidance for the impacted tooth to erupt into the arch;
 - e. Crowding with radiographic evidence documenting resorption of 25% of the root of an adjacent permanent tooth.

(3) imaging evidencing the existence of the condition(s) noted in the medical necessity narrative.

(4) a completed Appendix F attestation (found on page F-3 of Appendix F).

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Attestation

MassHealth Dental Prior Authorization Request for Interceptive Orthodontics

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

Address _____
Street City/County State Zip Code

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

Prescribing provider's signature:

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

Printed name of prescribing provider _____ Date _____

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