DentaQuest
*Serving the MassHealth Program**

MassHealth

MassHealth Dental Program

Commonwealth of Massachusetts
(March 1, 2016)

Office Reference Manual

465 Medford Street
Boston, MA 02129
800.207.5019
inquiries@masshealth-dental.net

www.masshealth-dental.net

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DentaQuest
*Serving the MassHealth Program**

MassHealth Dental Provider

Quick Reference Directory
Effective: January 1, 2013
masshealth-dental.net

MassHealth

Provider Services	Phone Number	E-mail Address	Mailing Address
Member Eligibility & Benefits	1-800-207-5019	inquiries@masshealth-dental.net	MassHealth Dental 12121 North Corporate Parkway Mequon, WI 53092
TDD (Hearing Impaired)	1-800-466-7566		
MassHealth Medical Customer Service (Oral Surgeons)			
MassHealth Medical Eligibility & Benefits	1-800-841-2900	providersupport@masshealth.net	
MassHealth Medical Fax Inquiries	1-617-988-8974		
Authorizations			
Prior Authorizations (PA)	1-800-207-5019		MassHealth Dental – PA 12121 North Corporate Parkway Mequon, WI 53092
Claims			
Paper Claims Submission	1-800-207-5019	claims@masshealth-dental.net	MassHealth Dental – Claims 12121 North Corporate Parkway Mequon, WI 53092
90 Day Waiver/Final Deadline Appeals Request	1-800-207-5019		MassHealth Dental – 90 Day Waiver/Final Deadline Appeals 465 Medford Street P.O. Box 9708 Boston, MA 02114-9708
Electronic Claims			
EDI Claims Submission (837 Transactions) and Remittance Advice	1-800-207-5019	claims@masshealth-dental.net	MassHealth Dental – Claims 12121 North Corporate Parkway Mequon, WI 53092
Via Website at www.masshealth-dental.net Via Clearinghouse Payer ID CKMA1	1-800-207-5019	EDITeam@dentaquest.com	
Provider Complaints and Fraud			
Provider Complaints Fraud Hotline	1-800-207-5019 1-800-237-9139	inquiries@masshealth-dental.net	MassHealth Dental – Claims 12121 North Corporate Parkway Mequon, WI 53092
***MassHealth offers you the ability to submit HIPAA-compliant claims to: www.masshealth-dental.net. You may also submit claims through an approved clearinghouse trading partner. Please contact your software vendor to ensure that the MassHealth Dental Program is listed as a payer. The MassHealth is CKMA1. For greater detail, please contact Customer Service at: 1-800-207-5019 or your Provider Relations Representative.			
Provider Enrollment			
Provider Enrollment	1-800-207-5019	inquiries@masshealth-dental.net	MassHealth Dental 12121 North Corporate Parkway Mequon, WI 53092
MassHealth Team at DentaQuest			
Tracy Gilman (Chase)	1-617-886-1310	tracy.chase@dentaquest.com	Contract Director
Felicia Moses	1-617-886-1725	felicia.moses@dentaquest.com	Provider Intervention Specialist
Andres Fernandez	1-617-886-1860	andres.fernandez@dentaquest.com	Member Intervention Specialist
Daniel Archambault	1-617-886-1736	daniel.archambault@dentaquest.com	Provider Relations Representative
Keisha Lopez	1-617-886-1727	keisha.lopez@dentaquest.com	Provider Relations Representative
Marianne Leahy	1-617-886-1206	marianne.leahy@greatdentalplans.com	Vice President, Network Management
Megan Mackin	1-617-886-1728	megan.mackin@dentaquest.com	Outreach Coordinator

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

Sincerely,
The MassHealth Team at DentaQuest

**DentaQuest is the subcontractor to Dental Service of Massachusetts, Inc.*

MassHealth Dental Program

Statement of Members' Rights and Responsibilities

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

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

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

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

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

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

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

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

Likewise:

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

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

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

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

MassHealth Dental Program

Statement of Provider Rights and Responsibilities

Providers shall have the right to:

1. Communicate with members regarding dental treatment options.

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

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

4. Provide feedback on policies, procedures or decisions made by the MassHealth Dental Program Charge an eligible MassHealth member for dental services that are not covered services only if the member knowingly elects to receive the services as a private-pay patient and enters into an agreement in writing to pay for such services prior to receiving them. Noncovered services include: services not covered under the MassHealth Dental Program (except prior authorizations that are requested for noncovered services for members under age 21) and services for which pre-authorization has been denied and deemed not medically necessary

5. Be informed timely of the status of their credentialing or recredentialing application, upon request.

6. Determine the number of MassHealth members you wish to welcome into your practice.

Providers have the responsibility to:

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

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

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

4. Adhere to the MassHealth Provider Contract and regulations.

* * *

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

Office Reference Manual
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What is the MassHealth Dental Program?

The MassHealth Dental Program is based upon Commonwealth of Massachusetts regulations governing dental services found in 130 CMR 420.000 and 450.000. All dental providers participating in MassHealth must comply with these regulations. Please refer to the MassHealth website at **WWW.MASS.GOV** for complete Dental and All Provider Manuals which contain the regulations. If there is a conflict between the Office Reference Manual and the regulations, the regulations take precedence in every case.

The goals of the MassHealth Dental Program are to:

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

1.00 Provider Services

1.01 Dedicated Call Center for Dental Providers

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

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

You can reach customer service at 800.207.5019.

1.02 Provider Training

The MassHealth Dental Program offers free provider training sessions periodically throughout the Commonwealth of Massachusetts. These sessions include important information such as: claims submission procedures, prior-authorization criteria, how to access the MassHealth Dental Program's clinical personnel, etc. In addition, providers can contact a MassHealth Provider Relations Representative for assistance, or to request a personal, in-office visit at 800.207.5019.

1.03 Provider Newsletters

The MassHealth Dental Program publishes biannual provider newsletters that include helpful information of interest to providers. Newsletters are available via the MassHealth provider web portal at www.masshealth-dental.net.

To request a paper copy of the MassHealth Dental Program provider newsletter, call MassHealth Provider Services Representative at 800.207.5019.

1.04 Provider Web Portal

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

- Member eligibility and verification
- Prior Authorizations

- Claims submission

- View claim status
- Create claim tracking reports
- Submission of attachments
- Message customer service
- Log a broken appointment
- Forms / Office Reference Manual

For more information, contact the MassHealth Dental Program at 800.207.5019.

1.05 Specialist Referral Process

A member requiring a referral to a dental specialist can be referred directly to any specialist participating in the MassHealth Dental Program without authorization from the MassHealth Dental Program. The dental specialist is responsible for obtaining prior authorization if necessary, for covered services according to Exhibits A-D of this Manual. Providers who are unfamiliar with the MassHealth Dental Program specialty network or need assistance locating a certain specialty can contact the MassHealth Dental Program's Provider Relations Department at 800.207.5019.

1.06 Provider Directory

The MassHealth Dental Program publishes an on-line provider directory for MassHealth members called find a provider. This provider directory includes: provider name, practice name (if applicable), office address (es), telephone number(s), provider specialty, office hours (if available), handicap accessibility, age range of accepted patients, languages spoken (if available), and any other limitations of which the MassHealth Dental Program is aware.

It is very important that providers notify the MassHealth Dental Program of any changes in practice information. The Provider Change Form found in Appendix B-25 should be completed and faxed to the MassHealth Dental Program at 262.241.4077 within 14 days of any change.

2.00 Eligibility Verification Procedures

2.01 MassHealth Dental Program Eligibility

Dental services are covered for MassHealth eligible members as specified in 130 CMR 450.105 and 420.403. Members will receive a MassHealth ID card for services, including dental.

Please note that MassHealth Limited members are covered for *emergency services only*. [130 CMR 450.105 (G)]. This information is displayed as Coverage Type on the Provider Web Portal and is provided via eligibility verification using the IVR.

2.02 MassHealth Dental Program Eligibility Systems

Participating MassHealth Dental providers may access member eligibility information 24 hours a day, 7 days a week through the MassHealth Dental Program's Interactive Voice Response (IVR) system or through the Internet at www.masshealth-dental.net. The eligibility information received from either system is the same information available by calling MassHealth Dental Program's Customer Service Department.

Access to Eligibility Information via the Internet:

The MassHealth Dental Program's provider web portal allows providers to verify a member's eligibility online by entering the member's date of birth, the expected date of service and the member's identification number or last name and first initial.

The MassHealth Dental Program website is located at www.masshealth-dental.net.

To check eligibility, information about the member, provider and service date are needed. The first step is to enter the provider and service date.

The next step is to enter member information. Enter the member's DOB and either the member's subscriber ID or name. A complete last name must be entered but a partial first name is allowed. The user has the option of checking member eligibility at this point by selecting the 'Verify Eligibility' link. The results of the eligibility check will be displayed below the member information.

Once identifying information is entered, the user selects the 'Add To List Line' button. The member information is validated before being displayed in the eligibility table at the bottom of the page. If there are any problems with the eligibility information, appropriate error messages will be displayed.

The user can generate a printable PDF report containing all the information from the eligibility table by selecting the 'Print List' button.

Access to Eligibility Information via the Interactive Voice Response (IVR) line:

To access the IVR, please call the MassHealth Dental Program's Customer Service Department at 800.207.5019. The IVR is able to address eligibility and **limited** claims history inquiries for as many members as requested.

Once these checks have been completed, you will have the option to select other choices and if needed, speak to a customer service representative to assist with additional questions, e.g., coverage information or claims inquiries.

Specific directions for the IVR to check eligibility are listed below. After the system analyzes the information, the member's eligibility for covered dental services will be verified. A fax of the member eligibility verification and history is available through the IVR system.

If the system is unable to verify the member information entered, the caller will be transferred to a Customer Service Representative during normal business hours (8:00 AM-6:00 PM, M-F).

Directions for using the MassHealth Dental Program's IVR to Verify Eligibility and Check **Limited** Claims History:
Entering system with Tax and Location ID's

- Dial – 800-207-5019
- Greeting: Welcome to the Mass Health Dental Program
- If you are a Mass Health Provider, press 1
- Welcome to DentaQuest
- If you need assistance in English, please stay on the line

****There is a self-service announcement at this point****

- Please enter your NPI Number
- Please enter the last four of your Tax Identification Number

****The system will repeat the NPI for verification****

- If you have a Member ID that is numbers only, please press 1 / If you have a Member ID that contains letters and numbers, please press 2

****The system will repeat the Member ID for verification****

- Enter the Member's Date of Birth

****The system will repeat the Member's Date of Birth****

At this point, the system will run off a list of options for the caller to hear and choose from.*

**** Please note that eligibility information is only valid on the day for which eligibility is requested. Payment is not guaranteed if the service is either not covered or if the member's coverage type does not cover dental services.**

Also, please note *limited* member history is available on both the IVR and at www.masshealth-dental.net. The history information is not all inclusive. This information is provided as a convenience to the provider and is not to be considered as a guarantee of payment.

To report any difficulty accessing either the IVR or website, please contact the Customer Service Department at 800.207.5019 or inquiries@masshealth-dental.net. They will be able to provide assistance in using either system.

3.00 Authorization for Treatment

3.01 Prior Authorization Request for CPT Codes

Oral Surgery specialists requesting prior authorization for services listed with a Current Procedural Terminology (CPT) code must submit online to medical through the MMIS Provider Online Service Center (POSC) using the **MassHealth Prior Authorization (PA-1) Form.** Refer to Appendix A of your provider manual for the mailing address for prior authorization forms. Refer to Subchapter 6 of the *Dental Manual* for prior authorization requirements.

Note: MassHealth will not process 837D transactions or ADA claim forms with CDT codes. Oral Surgery specialists will continue to submit prior authorization requests and claims with the CDT codes on the ADA-2012 form to DentaQuest for processing.

3.02 Covered Services Requiring Authorization

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

The MassHealth Dental Program uses specific dental criteria as well as an authorization process to provide medically necessary services to MassHealth members. The MassHealth Dental Program's operational focus is to assure compliance with the criteria specified in the MassHealth Dental regulation at 130 CMR 420.000. The criteria are included in this manual in Section 15.00. Please review these criteria as well as the covered services to understand the decision-making process used to determine payment for services provided.

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

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

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

Submission of documentation should include the following:

1. Radiographs, narrative, or other information where requested (See Exhibits A-D for specifics by code).
2. Orthodontic HLD Index Form for orthodontic treatment found in Appendix B-2 and if applicable, supporting medical necessity documentation. (See HLD form for further information.)

Electronic Submission:

Request for prior authorization may be submitted electronically at www.masshealth-dental.net.

The authorizations entry page allows a user to enter and submit dental authorizations online. To submit an authorization, the following type of information is needed:

- Authorization Header Information.
- Basic Information – provider, place of service.
- Member Information – member details and eligibility.
- Optional Fields – referral numbers, notes, etc.
- Service Lines Information.
- Service Line Fields – procedures codes, details and billing amounts.

Authorization Header

Authorization header information must be entered and validated before the service lines for the authorization can be entered. The first step is to enter basic information, including the provider and place of service.

The next step is to enter the member information and check eligibility. Enter the member's DOB and either the member's subscriber ID or name. A complete last name must be entered but a partial first name is allowed. Once identifying information is entered, select the 'Verify' button to check eligibility. The results of the eligibility check are displayed below the member information. Remember to verify the member's eligibility on the date of service, as a member's eligibility status may change between the time the request for authorization is made and the services are provided.

There are also optional fields in the authorization header page. These include Referral # and Notes.

Once the authorization header information is entered, service lines can be entered by selecting the 'Enter Service Lines' button. If there are any problems with the authorization header information, appropriate error messages are displayed. There is also an option to view an eligible member's claims history.

Service Lines

The authorization service lines page allows a user to enter one or more service lines for the authorization. The first step is to enter the procedure code for the service. Each procedure code has specific details that are required for the service line. Once a procedure code is entered, press the tab key to go to the required fields that correspond with the entered code. The description for the procedure code is displayed.

The user may also modify information on the service line that was defaulted or copied from the authorization header. This information includes quantity and place of service.

Once a complete service line has been entered, the user selects the 'Add Service Line' button. Each service line is validated before being displayed in the service lines tables at the bottom of the page. If there are any problems with the service line information, appropriate error messages are displayed.

Once the authorization header and service lines have all been entered, the user chooses the 'Submit Auth' button. When an authorization is submitted via the Provider Web Portal, a page is displayed with the following message, "Your authorization was submitted successfully." There is no confirmation number displayed.

The user can immediately view the submitted authorization by running the Authorization Entry Confirmation Report. The report includes all authorizations submitted up to approximately 9:00 AM EST the following day, when the authorization is picked up for processing. The submitted authorization is assigned a temporary Authorization Entry ID. After being picked up for processing, authorizations can be viewed by running the Authorization Status Report. By that time, the authorization will have been assigned an Authorization Number. Authorizations are processed within two business days, not to exceed 21 calendar days.

Paper Submission:

Prior authorization requests may also be submitted using an ADA 2012 claim form. The tables of Covered Services (Exhibits A-D) contain a column marked "Authorization Required". A "Yes" in this column indicates that the service listed requires either prior-authorization or documentation submitted with the claim for retrospective review in order to be considered for reimbursement. The "Documentation Required" column describes what information is necessary for review, and whether it must be submitted on a prior-authorization basis, or with a claim following treatment for retrospective review.

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

3.03 Authorization for Operating Room (OR) Cases

Elective Cases

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

Member apprehension alone is not sufficient justification for the use of a hospital (inpatient or outpatient setting) or a freestanding ambulatory surgery center. Lack of facilities for administering general anesthesia when the procedure can be routinely performed with local anesthesia does not justify use of a hospital or a freestanding ambulatory surgery center.

Trauma, Urgent and Accident (Non-elective) Cases

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

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

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

3.04 Payment for Non-Covered Services

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

- Services not covered under the MassHealth Dental Program,
- Services for which prior-authorization has been denied and deemed not medically necessary.

Please note that prior authorization may be requested for non-covered services for EPSDT – eligible members under age 21 in accordance with 130 CMR 420.421 and 450.140 through 450.149.

3.05 Electronic Attachments

The MassHealth Dental Program accepts dental radiographs electronically via **FastAttach™ or through the provider web portal at www.masshealth-dental.net** for prior-authorization requests and for retrospective review.

In addition, the MassHealth Dental Program via the provider web portal, free of charge and or in conjunction with National Electronic Attachment, LLC (NEA) (fee required), allows participating MassHealth Dental Program providers the opportunity to submit all prior authorizations and claims that require retrospective review for authorization such as x-rays, periodontal charts, narratives, and pathology reports via the internet. By submitting prior authorization requests through NEA or the provider web portal, providers avoid the additional time involved with mailing requests, resulting in faster determinations.

If you need assistance with the MassHealth Provider web portal please call provider relations to schedule training at 1-800-207-5019.

If providers have an account with NEA, they may submit requests for prior authorization through their practice management system. Simply enter the NEA image number(s) in the primary comments/ insurance notes field. Example: NEA# is xxxx. If submitting a prior authorization or a claim to be reviewed retrospectively via the www.masshealth-dental.net website, simply enter the NEA image number in the notes field. Example: NEA# xxxx.

For more information or to sign up for **FastAttach™** providers may go to www.nea-fast.com or contact NEA at 800.782.5150.

Orthodontic Cases: If providers have an account with OrthoCad, they may submit study models electronically for prior authorization for orthodontia claims. For additional information regarding OrthoCad, they may be contacted at 800.577.8767.

Attachments may also be uploaded to claims and authorizations submitted on the provider web portal free of charge.

3.06 Member Transportation

Routinely, if the member is eligible for transportation, the Prescription for Transportation (PT-1) form request is submitted by the provider and processed by the Executive Office of Health and Human Services (EOHHS) Customer Service Team (CST). Should the MassHealth member contact DentaQuest's Member Services Department to request assistance with transportation, the Member Service Representative will forward the request to an Intervention Specialist for follow-up.

When the member is eligible to obtain such services under applicable regulations and the situation is urgent in nature, the Intervention Specialist will assist members by initiating transportation requests when the member is unable to follow the standard process. If a PT-1 form has not yet been submitted by a provider, the Intervention Specialist will assist in completing the PT-1 form. The Intervention Specialist will complete the PT-1 form via the CSC website. Transportation request customer service will process the request and respond to the member with the decision made on the request. Transportation assistance can be arranged by calling MassHealth's transportation vendor at the following number: 800.841.2900.

Providers may also fax PT-1 forms to CST at either of the following fax numbers: 617.988.2925 or 617.988.2927.

3.07 Orthodontic

Eligible members under age 21 may qualify for orthodontic care under the MassHealth Dental Program. All orthodontic services require prior authorization from MassHealth, with the exception of pre-orthodontic treatment visits and orthodontic retention. MassHealth approves prior authorization requests for comprehensive orthodontic treatment when: 1) the member has one of the "autoqualifying" conditions described by MassHealth in the HLD Index; 2) the member meets or exceeds the threshold score designated by MassHealth on the HLD index; or 3) comprehensive orthodontic treatment is medically necessary for the member, as demonstrated by a medical necessity narrative and supporting documentation submitted by the requesting provider. Additional details regarding MassHealth's coverage of orthodontic treatment and the submission of prior authorization requests can be found in Section 16.00 and Exhibit B.

3.08 Transfer or Release of Authorization

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

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

Requests for transfer or release of authorization can be mailed or faxed to:

MassHealth Prior Authorizations
12121 N Corporate Parkway
Mequon, WI 53092

Fax: 262.241.7150

4.00 Claim Submission Procedures (Claim Filing Options) for Claims with Dates of Service on or after July 1, 2006

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

- Electronic claims via direct data entry at www.masshealth-dental.net. This is a secure, HIPAA-compliant, direct data-entry option. Easy to follow instructions are included in Section 4.01.
- Electronic claims in the HIPAA-compliant 837D or 837P format via upload to our secure trading partner portal are available at www.masshealth-dental.net
- Electronic claims in the HIPAA-compliant 837D or 837P format on CD-Rom, 3.5" floppy disk or DVD
- Electronic submission via a clearinghouse partner
- Paper claims on the ADA 2006 or newer claim form **only** for those providers who have an approved electronic claim submission waiver on file with MassHealth/DentaQuest.

4.01 Electronic Claim Submission through direct data entry

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

It is essential that providers access the MassHealth provider web portal to check a member's eligibility prior to providing the service, as it provides accurate eligibility information on that day. Providers can also create reports to verify claims submission via the MassHealth Provider Web Portal at www.masshealth-dental.net.

The claims entry page allows a user to enter and submit dental claims online. To submit a claim, the following type of information is needed:

- **Claims Header Information**
  - Basic Information – provider, service date, place of service.
  - Member Information – member details and eligibility.
  - Optional Fields – referral numbers, EOB, notes, etc.
- **Service Lines Information**
  - Service Line Fields – procedures codes, details and billing amounts.

Claims Header

Claim header information must be entered and validated before the service lines for the claim can be entered. The first step is to enter basic information, including the provider, service date and place of service.

The next step is to enter the member information and check eligibility. The member's DOB and either the member's subscriber id or name must be entered. A complete last name must be entered but a partial first name is allowed. Once identifying information is entered, the 'Verify' button to check eligibility is selected. The results of the eligibility check are displayed below the member information.

There are also optional fields in the claims header page. These include Office Ref #, Referral #, Original TCN, EOB indicator and Notes.

Once the claims header information is entered, service lines can be entered by selecting the 'Enter Service Lines' button. If there are any problems with the claims header information, appropriate error messages are displayed. There is also an option to view an eligible member's claims history.

Service Lines

The claims service lines page allows a user to enter one or more service lines for the claim. The first step is to enter the procedure code for the service. Each procedure code has specific details that are required for the service line. After entering a procedure code, press the 'Tab' key to go to the required fields that correspond with the entered code. The description for the procedure code is also displayed.

There are optional fields for the service lines. These include Authorization No, EPSDT indicator and COB information. The user may also modify information on the service line that was defaulted or copied from the claims header. This information includes service date and place of service.

Once a complete service line has been entered, the user selects the 'Add Service Line' button. Each service line is validated before being displayed in the service lines tables at the bottom of the page. If there are any problems with the service line information, appropriate error messages are displayed.

Once the claims header and service lines have all been entered, the 'Submit Claim' button is selected.

For questions on submitting claims or accessing the website, please contact Provider Services at 800.207.5019 or via e-mail at EDITeam@dentaquest.com.

4.02 Electronic Claim Submission via upload to www.masshealth-dental.net.

There are two types of electronic submissions that can take place via the electronic web based tools:

a. Trading Partner Portal: Participating MassHealth providers may submit EDI HIPAA compliant claims directly via the Trading Partner Portal at www.masshealth-dental.net, trading partner's link. Complete instructions can be found in the associated Companion Guide.
b. MassHealth Provider Web Portal: You can submit claims/attachments free of charge via the MassHealth Provider Web Portal at www.masshealth-dental.net, provider's link.

4.03 Electronic Claim Submission on hard media

Providers may submit EDI HIPAA-compliant claims via hard media. Claims submitted on hard media should be encrypted. Contact the MassHealth Dental Program Provider Services Department at 800.207.5019 or at inquiries@masshealth-dental.net regarding encryption formats. Complete instructions can be found in the associated Companion Guide. The Trading Partner Web Portal is the preferred method of EDI exchange and is an SSL encrypted session. Detail is covered in the Companion Guides that providers receive.

Claims via hard media are mailed to:

MassHealth Dental Program
12121 N. Corporate Parkway
Mequon, WI 53092

4.04 Electronic Claim Submission via Clearinghouse

Providers may submit their claims through an approved Clearinghouse trading partner. Providers may call customer service for details at 800.207.5019.

The software vendor should be contacted to make certain that they have the MassHealth Dental Program listed as a payer. The software vendor can provide any information needed to ensure that submitted claims are forwarded to the MassHealth Dental Program. The MassHealth Dental Program's Payer ID is CKMA1.

4.05 Paper Claim Submission

- Paper claim submission is only permitted for practices that have an approved electronic claims waiver on file with MassHealth/DentaQuest.
- Paper claims must be submitted on ADA 2012 or newer approved forms. If the claims are not submitted on ADA 2012 or newer forms, they will be returned unprocessed.
- Affix the proper postage when mailing bulk documentation. The MassHealth Dental Program does not accept postage-due mail. This mail will be returned to the sender and will result in delay of payment.

- Rejected claims are returned to the provider with a rejection letter. If a claim is denied due to missing or incorrect information, it is returned to the provider and may be resubmitted to the MassHealth Dental Program.

- Paper claims are mailed to the following address (Only for providers with approved electronic waivers on file with MassHealth / DentaQuest.):

  MassHealth Dental Program – Claims
  12121 N. Corporate Parkway
  Mequon, WI 53092

Requirements for Claim Submission:

- Member name, identification number, and date of birth must be listed on all claims submitted. If the MassHealth member identification number is missing or miscoded on the claim form, the member may not be able to be identified. This could result in the claim being denied.

- The provider and office location information must be clearly identified on the claim. The MassHealth provider identification number must be included.

- The date of service must be provided on the claim form for each service line submitted.

- Approved ADA dental codes as published in the current CDT book and as defined in the MassHealth dental regulations 130 CMR 420.000 and this manual must be used to define all services.

- List all quadrants, tooth numbers and surfaces for dental codes that necessitate identification (extractions, root canals, amalgams, and resin fillings). Missing tooth and surface identification codes will result in the denial of claim payment.

4.06 Third Party Liability (TPL)

Determination of a member's other insurance must be verified before submitting a claim for that member. To verify other coverage already known to MassHealth a provider may access the MassHealth Dental Program Website, access the IVR, or call Member Services at 800.207.5019. Evidence of other insurance that has not been recorded by MassHealth should be submitted to the MassHealth Dental Program along with the claim.

Electronic claim submission is required for all providers unless they have an approved electronic claims waiver on file. TPL claims must include the code, description and the dates of service matching the information submitted to the primary carrier along with their payment and it must be indicated in the appropriate TPL field. Instruction on including information from other payers may be obtained from the 837-Dental or 837-Professional Companion Guide. The customer service team may be contacted to inquire about our testing procedures for electronically-submitted claims. Customer Service may be reached at 800.207.5019.

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

A Third Party Liability Quick Reference flyer is available in Appendix C-1 of this manual.

4.07 Filing Limits

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

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

(1) The service was provided to a person who was not a member on the date of service, but was later enrolled as a member for a period that includes the date of service; and

(2) The service was provided to a member who failed to inform the provider in a timely fashion of the member's eligibility for MassHealth.

For further details, please refer to the MassHealth All Provider Manual at 130 CMR 450.309.

Time Limitation on Submission of Claims for Members with Other Health Insurance: Third party liability (TPL) claims must be received within 90 days of the date of the notice of final disposition from the other insurer and no later than 18 months after the date of service. Corrections may be made to claims that were initially timely received up to 12 months from the date of service. For TPL claims, the correction deadline is extended to 18 months.

Helpful Quick Reference: The following documents are located in Appendix C to assist in billing.

- Corrective Action for Denied Claims Appendix C-2
- Corrective Action for Incorrectly Paid Claims Appendix C-3
- Overpayments of Claims Appendix C-4

Claim Corrections: When a claim is entered incorrectly into DentaQuest's system via the Direct Data Entry method, a provider has until 1:00 PM (ET) the next business day to request that DentaQuest delete the claim from the system. Once the provider has been notified by DentaQuest that this has been done, the provider may enter a new claim with the correct information via Direct Data Entry. To make this request, providers may contact DentaQuest / MassHealth customer service via telephone at 800.207.5019.

Claims that have been paid but were submitted incorrectly (i.e., incorrect tooth number, quadrant, etc.) must be voided via the Void Request Form. This form is located in Appendix B of this manual.

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

For further details on Final Deadline Appeals, please refer to the MassHealth All Provider Manual at 130 CMR 450.323.

4.08 Remittance Information

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

- through the EDI 835 transaction.
- through an electronic remittance advice- www.masshealth-dental.net.

Please contact our Customer Services Department at 800.207.5019 with any questions about claim submission or remittance advice.

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

Facility and anesthesia services for operating room cases do not require prior authorization as outlined in Section 3.02.

4.10 Claim Submission for CPT Codes

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

Note: DentaQuest will not process 837P transactions or any claims billed on the CMS-1500 claim form.

5.00 Health Insurance Portability and Accountability Act (HIPAA)

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

- On May 23, 2007 use of the National Provider Identifier (NPI) as a single provider identifier that is required for all health care providers that conduct standard electronic transactions. Application for an NPI may be obtained through the following website: https://nppes.cms.hhs.gov.

It can also be obtained by calling: 1.800.465.3202.

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

- Maintenance of adequate dental/medical, financial, and administrative records related to covered dental services rendered by providers in accordance with federal and state law.

- Safeguarding of all information about members according to applicable state and federal laws and regulations. All material and information, in particular information relating to members or potential members, which is provided to or obtained by or through a provider, whether verbal, written, electronic media, or otherwise, shall be reported as confidential information to the extent confidential treatment is provided under state and federal laws.

- Neither the MassHealth Dental Program nor the provider shall share confidential information with anyone other than the member or the member's eligibility representative without the member's consent for such disclosure.

- Providers must agree to comply with the requirements of HIPAA relating to the exchange of information and shall cooperate with the MassHealth Dental Program in its efforts to ensure compliance with the privacy regulations promulgated under HIPAA and other related privacy laws.

Provider and the MassHealth Dental Program agree to conduct their respective activities in accordance with the applicable provisions of HIPAA and such implementing regulations.

In relation to the Administrative Simplification Standards, the covered services tables included in this ORM reflect the most current coding standards (CDT) recognized by the ADA. The MassHealth Dental Program requires providers to submit all claims with the proper CDT codes listed in the MassHealth Dental regulation at 130 CMR 420.000 and this manual. In addition, all paper claims must be submitted on the current approved ADA 2012 or newer claim form.

Note: Copies of the MassHealth Dental Program's HIPAA policies are available upon request by contacting the MassHealth Dental Program's Provider Services Department at 800.207.5019 or via e-mail at: inquiries@masshealth-dental.net.

6.00 Member Complaints and Appeals

Complaints

Members may submit complaints to the MassHealth Dental Program telephonically or in writing on any MassHealth Dental Program issue other than decisions that deny, delay, reduce, or terminate dental services. Some examples of complaints include: the quality of care or services received, access to dental care services, provider care and treatment, or administrative issues. In cases where the complaint cannot be resolved telephonically, the member will be assisted in submitting a member complaint form.

Member complaints should be directed to:

MassHealth Dental Program
Attention: Intervention Services
P.O. Box 9708
Boston, MA 02114-9708

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

The MassHealth Dental Program will respond to member complaints immediately if possible but within no more than 30 working days from the date a written complaint is received.

Member Appeals

Members will be informed of their right to appeal any adverse decision the MassHealth Dental Program has made to deny, reduce, delay or terminate dental services. Members may request assistance with filing an appeal by contacting the MassHealth Dental Program at 800.207.5019.

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

The Request for a Fair Hearing Form must be submitted within 30 days from the date of receipt of the adverse decision notice. The MassHealth Dental Program will respond in writing to all member appeals within 30 days of the date of receipt. The entire process of scheduling the hearing and completing the appeal process must be completed within 90 days.

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

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

Note: Copies of the MassHealth Dental Program policies and procedures can be requested by contacting provider Services at 800.207.5019.

7.00 Utilization Management Program

7.01 Introduction

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

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

Participating providers are responsible for ensuring that requirements for services rendered are met in order to receive payment from the MassHealth Dental Program. Under the MassHealth Provider Agreement, the provider also agrees to give access to records and facilities to MassHealth Dental Program representatives upon reasonable request. This section provides information on utilization review and control requirement procedures conducted by MassHealth Dental Program personnel.

7.02 Community Practice Patterns

In following with the requirements described in Section 7.01 above, the MassHealth Dental Program has developed a philosophy of Utilization Management that recognizes the fact that there exists, as in all health care services, a relationship between the dentist's treatment planning, treatment costs, and treatment outcomes. The dynamics of this relationship, in any region, are reflected by the community practice patterns of local dentists and their peers. With this in mind, the MassHealth Dental Program's Utilization Management Programs are designed to ensure the fair and appropriate use of federal and state program dollars as defined by the regionally based community practice patterns of local dentists and their peers.

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

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

7.03 Evaluation

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

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

7.04 Results

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

7.05 Fraud and Abuse

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

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

Member Abuse: Intentional infliction of physical harm, injury caused by negligent acts or omissions, unreasonable confinement, sexual abuse, or sexual assault.

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

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

8.00 Quality Improvement Program

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

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

A copy of the MassHealth Dental Program's QI Program, is available upon request by contacting the MassHealth Dental Program's Provider Services Department at 800.207.5019 or via e-mail at: inquiries@masshealth-dental.net.

9.00 Credentialing

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

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

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

Following successful verification, the provider will be enrolled in the MassHealth Dental Program.

EOHHS has the final decision-making power regarding participation in the MassHealth Dental Program.

9.01 Appeal of Credentialing Committee Recommendations

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

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

9.02 Discipline of Providers

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

9.03 Procedures for Discipline and Termination

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

Providers may send a written appeal to:

MassHealth Dental Program
Provider Appeals
P.O. Box 9708
Boston, MA 02114-9708

9.04 Recredentialing

Network providers are recredentialed at least every 5 years.

Note: The aforementioned policies are available upon request by contacting the MassHealth Dental Program's Provider Services at 800.207.5019 or via e-mail at: inquiries@masshealth-dental.net.

10.00 The Patient Record See MassHealth Regulations at 130 CMR 420.414

10.01 Organization

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

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

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

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

The design of the record must ensure that all permanent components of the record are attached or secured within the record.

The design of the record must ensure that all components must be readily identified to the patient, i.e., patient name, and identification number on each page.

The organization of the record system must require that individual records be assigned to each patient.

10.02 Content-The Patient Record Must Contain the Following:

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

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

An adequate health history that requires documentation of these items:

- current medical treatment;
- significant past illnesses;
- current medications;

- drug allergies;
- hematologic disorders;
- cardiovascular disorders;
- respiratory disorders;
- endocrine disorders;
- communicable diseases;
- neurologic disorders;
- signature and date by patient;
- signature and date by reviewing dentist;
- history of alcohol and/or tobacco usage including smokeless tobacco.

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

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

It is recommended that conspicuously placed medical alert be positioned inside each chart jacket that documents highly significant terms from health history. These items are:

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

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

- blood pressure (recommended);
- head/neck examination;
- soft tissue examination;
- periodontal assessment;
- occlusion classification dentition charting.

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

- blood pressure (recommended);
- head/neck examination;
- soft tissue examination;
- periodontal assessment;
- dentition charting.

Radiographs which are:

- identified by patient name;
- dated;
- designated by patient's left and right side;
- mounted (if intraoral films);

An indication of the patient's clinical problems/diagnosis.

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

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

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

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

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

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

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

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

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

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

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

- patient examination;
- treatment plan;
- treatment status.

10.03 Compliance

- The patient record has one explicitly defined format that is currently in use.
- There is consistent use of each component of the patient record by all staff.
- The components of the record that are required for complete documentation of each patient's status and care are present.
- Entries in the records are legible.
- Entries of symbols and abbreviations in the records are uniform, easily interpreted and are commonly understood in the practice.

11.00 Patient Recall System

11.01 Recall System Recommendation

Each participating MassHealth Dental Program provider office may maintain and document a formal system for patient recall. The system can use either written or phone contact. Any system should encompass routine patient check-ups, cleaning appointments, follow-up treatment appointments, and missed appointments for any MassHealth Dental Program member that has sought dental treatment.

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

- "We missed you when you did not come for your dental appointment on month/date. Regular check-ups are needed to keep your teeth healthy."

- "Please call to reschedule another appointment. Call us ahead of time if you cannot keep the appointment. Missed appointments are very costly to us. Thank you for your help."

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

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

12.00 Intervention Services Program

The Intervention Services Program will provide assistance to MassHealth providers and members. The components of the program include:

12.01 Dedicated Intervention Specialists

Dedicated Intervention Specialists will respond to complex provider and member requests that are beyond the scope of issues typically handled by the Customer Services Representatives. The Intervention Specialists will accept referrals from MassHealth providers for MassHealth members who require education on subjects such as failure to keep scheduled appointments, proper dental office procedures, the importance of follow-up treatments and good oral hygiene practice. The Intervention Specialists will also assist MassHealth providers by coordinating adjunct services prior to the services being performed.

Telephone and e-mail messages will be returned in the same business day if received by 2:00 PM or the following day if received after 2:00 PM. Faxes will be returned within one business day.

12.02 Appointment Assistance

The MassHealth Dental Program's Member Services Department uses technology to link MassHealth members to the closest and most appropriate dental provider via the find a provider tool located at www.masshealth-dental.net. On occasion, members require special assistance making appointments due to geographic or special physical needs. The Intervention Services Department is responsible for locating providers for members in emergency or difficult situations and assisting members with making appointments with a participating provider.

12.03 Non-Compliant Members

The MassHealth Dental Program will proactively educate members on the importance of keeping appointments through various outreach and educational materials, including a member handbook, and outreach. The MassHealth Dental Program will contact and educate MassHealth members who have been identified by providers as non-compliant.

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

The Broken Appointment feature allows providers to electronically submit the names of MassHealth members who have missed appointments. MassHealth/DentaQuest captures the data regarding a member's missed appointments to pull reports twice per month and mail a letter regarding the importance of oral health and keeping/rescheduling appointments.

MassHealth/DentaQuest requests that providers complete and submit the names of members who miss appointments to help us identify the members who may need additional assistance.

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

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

12.04 Office Compliance Verification Procedures

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

13.00 Radiology Requirements

Note: Please refer to Exhibits A-D for radiograph limitations and the MassHealth Dental regulations at 130 CMR 420.423.

The MassHealth Dental Program uses the guidelines published by the Department of Health and Human Services, Center for Devices and Radiological Health Panel (the Panel). These guidelines were developed in conjunction with the Food and Drug Administration.

Radiographic Examination of the New Patient

- Child – Primary Dentition

The Panel recommends Posterior Bitewing radiographs for a new patient, with a primary dentition and closed proximal contacts.

- Child – Transitional Dentition

The Panel recommends an individualized Periapical/Occlusal examination with Posterior Bitewings or a Panoramic Radiograph and Posterior Bitewings, for a new patient with a transitional dentition.

- Adolescent – Permanent Dentition Prior to the eruption of the third molars

The Panel recommends an individualized radiographic examination consisting of selected Periapicals with Posterior Bitewings for a new adolescent patient.

- Adult – Dentulous

The Panel recommends an individualized radiographic examination consisting of selected Periapicals with Posterior Bitewings for a new dentulous adult patient.

- Adult – Edentulous

The Panel recommends a Full-Mouth Intraoral Radiographic Survey OR a Panoramic Radiograph for the new edentulous adult patient.

Radiographic Examination of the Recall Patient

Patients with clinical caries or other high – risk factors for caries

- Child – Primary and Transitional Dentition

The Panel recommends that Posterior Bitewings be performed at 6-12 month intervals for those children with clinical caries or who are at increased risk for the development of caries in either the primary or transitional dentition.

- Adolescent

The Panel recommends that Posterior Bitewings be performed at 6-12 month intervals for adolescents with clinical caries or who are at increased risk for the development of caries.

- Adult – Dentulous

The Panel recommends that Posterior Bitewings be performed at 6-12 month intervals for adults with clinical caries or who are at increased risk for the development of caries.

- Adult – Edentulous

The Panel found that an examination for occult disease in this group cannot be justified on the basis of prevalence, morbidity, mortality, radiation dose and cost. Therefore, the Panel recommends that no radiographs be performed for edentulous recall patients without clinical signs or symptoms.

Patients with no clinical caries and no other high risk factors for caries

- Child – Primary Dentition

The Panel recommends that Posterior Bitewings be performed at an interval of 12-24 months for children with a primary dentition with closed posterior contacts that show no clinical caries and are not at increased risk for the development of caries.

- Adolescent

The Panel recommends that Posterior Bitewings be performed at intervals of 12-24 months for patients with a transitional dentition who show no clinical caries and are not at an increased risk for the development of caries.

- Adult – Dentulous

The Panel recommends that Posterior Bitewings be performed at intervals of 24-36 months for dentulous adult patients who show no clinical caries and are not at an increased risk for the development of caries.

Patients with periodontal disease, or a history of periodontal treatment for Child – Primary and Transitional Dentition, Adolescent and Dentulous Adult.

The Panel recommends an individualized radiographic survey consisted of selected Periapicals and/or Bitewing radiographs of areas with clinical evidence or a history of periodontal disease, (except nonspecific gingivitis).

Growth and Development Assessment

- Child – Primary Dentition

The panel recommends that prior to the eruption of the first permanent tooth, no radiographs be performed to assess growth and development at recall visits in the absence of clinical signs or symptoms.

- Child – Transitional Dentition

The Panel recommended an individualized Periapical/Occlusal series or a Panoramic Radiograph to assess growth and development at the first recall visit for a child after the eruption of the first permanent tooth.

- Adolescent

The Panel recommended that for the adolescent (age 16-19 years of age) recall patient, a single set of Periapicals of the wisdom teeth or a Panoramic Radiograph.

- Adult

The Panel recommends that no radiographs be performed on adults to assess growth and development in the absence of clinical signs or symptoms.

14.00 Preventive Health Guidelines – Ages 0-20 Years

The MassHealth dental program follows the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines of the MassHealth regulations 130 CMR 450.140 – 150, which provide for services to be available from age 0 to age 20. The Health Guidelines in this chart are based on the American Academy of Pediatric Dentistry (AAPD) Reference Manual (2007- 2008).

NOTE: Please refer to Exhibit A for limitations.

Recommendations for Preventive Pediatric Oral Health Care (AAPD Reference Manual 2007-2008)

	6-12 months	12-24 months	2-6 years	6-12 years	12 - 20 years
Clinical oral examination (1,2)	x	x	x	x	x
Assess oral growth and development (3)	x	x	x	x	x
Caries-risk assessment (4)	x	x	x	x	x
Radiograph assessment (5)	x	x	x	x	x
Prophylaxis and topical fluoride (4,5)	x	x	x	x	x
Fluoride supplementation (6,7)	x	x	x	x	x
Anticipatory guidance/counseling (8)	x	x	x	x	x
Oral hygiene counseling (9)	**Parent**	**Parent**	**Patient/Parent**	**Patient/Parent**	**Patient**
Dietary counseling (10)	x	x	x	x	x
Injury prevention counseling (11)	x	x	x	x	x
Counseling for nonnutritive habits (12)	x	x	x	x	x
Counseling for speech/language development	x	x	x		
Substance abuse screening				x	x
Screening for intraoral/perioral piercing				x	x
Assessment and treatment of developing malocclusion			x	x	x
Assessment for pit and fissure sealants (13)			x	x	x
Assessment and/or removal of third molars					x
Transition to adult dental care					x

1. First examination at the eruption of the first tooth and no later than 12 months. Repeat every 6 months or as indicated by child's risk status/susceptibility to disease.
2. Includes assessment of pathology and injuries.
3. By clinical examination.
4. Must be repeated regularly and frequently to maximize effectiveness.
5. Timing, selection, and frequency determined by child's history, clinical findings, and susceptibility to oral disease.
6. Consider when systemic fluoride exposure is suboptimal.
7. Up to at least 16 years.
8. Appropriate discussion and counseling should be an integral part of each visit for care.
9. Initially, responsibility of parent; as child develops, jointly with parent; then, when indicated, only child.
10. At every appointment; initially discuss appropriate feeding practices, then the role of refined carbohydrates and frequency of snacking in caries development and childhood obesity.
11. Initially play objects, pacifiers, car seats; then learning to walk, sports and routine playing, including the importance of mouth guards.
12. At first, discuss the need for additional sucking; digits vs. pacifiers; then the need to wean from the habit before malocclusion or skeletal dysplasia occurs. For school-aged children and adolescent patients, counsel regarding any existing habits such as fingernail biting, clenching, or bruxism.
13. For caries-susceptible primary molars, permanent molars, premolars, and anterior teeth with deep pits and fissures; placed as soon as possible for eruption.

15.00 Clinical Criteria

The clinical criteria outlined in MassHealth' s Provider Office Reference Manual are based around procedure codes as defined in the American Dental Association Current Dental Terminology (CDT) Manual and on the MassHealth Dental regulation at 130 CMR 420.000. In general, documentation requests for information regarding treatment using these codes are determined by generally accepted dental standards for authorization, such as radiographs, periodontal charting, treatment plans, or descriptive narratives.

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

These clinical criteria will be used for making medical necessity determinations for prior authorizations, post payment review and retrospective review. Failure to submit the required documentation may result in a disallowed request and/or a denied payment of a claim related to that request. Some services require prior authorization and some services require pre-payment review, this is detailed in the Benefits Covered Section(s) in the "Review Required" column.

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

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

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

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

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

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

For additional information on criteria, please reference the MassHealth Dental Manual found on www.mass.gov/masshealth.

15.01 Dental Extractions

Some procedures require prior authorization documentation. Please refer to Exhibits A-D for specific information needed by code.

Documentation needed for procedure:

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

Criteria for Dental Extractions

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

- The removal of primary teeth whose exfoliation is imminent does not meet criteria.
- Alveoloplasty (code D7310) in conjunction with three or more extractions in the same quadrant will be covered.

15.02 Cast Crowns

Some procedures require prior authorization documentation. Please refer to Exhibits A-D for specific information needed by code.

Documentation needed for procedure:

- Appropriate pre-operative radiographs showing clearly the adjacent and opposing teeth should be submitted: minimally two bitewings, and at least one periapical; or panorex.

Criteria for Cast Crowns

- In general, the criteria for crowns will be met only for permanent teeth needing multi-surface restorations where other restorative materials have a poor prognosis.
- Permanent molar teeth must have pathologic destruction to the tooth by caries or trauma, and should involve four or more surfaces and two or more cusps.
- Permanent bicuspid teeth must have pathologic destruction to the tooth by caries or trauma, and should involve three or more surfaces and at least one cusp.
- Permanent anterior teeth must have pathologic destruction to the tooth by caries or trauma, and must involve four or more surfaces and at least 50% of the incisal edge.

A request for a crown following root-canal therapy must meet the following criteria:

- The request should include a dated post-endodontic radiograph.

- The tooth should be filled sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the ability to fill the canal to the apex.

- The filling must be properly condensed/obturated. Filling material should not extend excessively beyond the apex.

To meet the criteria, a crown must be opposed by a tooth or denture in the opposite arch or be an abutment for a partial denture.

- The patient must be free from active and advanced periodontal disease.

- The fee for crowns includes the temporary crown that is placed on the prepared tooth and worn while the permanent crown is being fabricated for permanent teeth.

- Cast crowns on permanent teeth are expected to last, at a minimum, five years.

Payment for crowns will not meet criteria if:

- a lesser means of restoration is possible;

- the tooth has subosseous and/or furcation caries;

- the tooth has advanced periodontal disease;

- the tooth is a primary tooth; or

- crowns are being planned to alter vertical dimension.

15.03 Endodontic Treatment

Some procedures require prior authorization documentation. Please refer to Exhibits A-D for specific information needed by code.

Documentation needed for procedure:

- Sufficient and appropriate pre-operative radiographs showing clearly the adjacent and opposing teeth and a pre-operative radiograph of the tooth to be treated; bitewings, periapicals or panorex.

- Narrative of medical necessity and undue medical risk.

Criteria for Endodontic Treatment

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

Root-canal therapy must meet the following criteria:

- Fill should be sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the dentist's ability to fill the canal to the apex.

- Fill must be properly condensed/obturated. Filling material does not extend excessively beyond the apex.

Payment for root-canal therapy does not meet criteria if:

- Gross periapical or periodontal pathosis is demonstrated radiographically (caries subcrestal or to the furcation, deeming the tooth non-restorable).
- The general oral condition does not justify root-canal therapy due to loss of arch integrity.
- Root-canal therapy is for second (allowed for member 21 and older) or third molars, unless they are an abutment for a partial denture.
- Tooth does not demonstrate 50% bone support.
- Root-canal therapy is in anticipation of placement of an overdenture.
- A filling material not accepted by the federal Food and Drug Administration (e.g., Sargenti filling material) is used.

Other Considerations:

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

15.04 Stainless Steel Crowns

Prior authorization or retrospective review is not required.

Criteria for Stainless Steel Crowns

- In general, criteria for stainless steel crowns will be met only for teeth needing multi-surface restorations where amalgams and other materials have a poor prognosis.
- Permanent molar teeth must have pathologic destruction to the tooth by caries or trauma, and should involve four or more surfaces and two or more cusps.
- Permanent bicuspid teeth must have pathologic destruction to the tooth by caries or trauma, and should involve three or more surfaces and at least one cusp.
- Permanent anterior teeth must have pathologic destruction to the tooth by caries or trauma, and should involve four or more surfaces and at least 50% of the incisal edge.
- Primary molars must have pathologic destruction to the tooth by caries or trauma, and should involve two or more surfaces or substantial occlusal decay resulting in an enamel shell.

- The MassHealth Dental Program allows no more than four stainless steel or prefabricated resin crowns per date of service.

A crown on a permanent tooth following root-canal therapy must meet the following criteria:

- The tooth should be filled sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the dentist's ability to fill the canal to the apex.

- The filling must be properly condensed/obturated. Filling material does not extend excessively beyond the apex.

To meet the criteria, a crown must be opposed by a tooth or denture in the opposite arch or be an abutment for a partial denture.

- The patient must be free from active and advanced periodontal disease.

- The permanent tooth must be at least 50% supported in bone.

- Stainless Steel Crowns on permanent teeth are expected to last five years.

Treatment using stainless steel crowns will not meet criteria if:

- a lesser means of restoration is possible;

- the tooth has subosseous and/or furcation caries;

- the tooth has advanced periodontal disease;

- the tooth is a primary tooth with exfoliation imminent; or

- the crown is being planned to alter vertical dimension.

15.05 Operating Room (OR) Cases

Criteria for Operating Room (OR) Cases

Please refer to the MassHealth Dental Program Manual, 130 CMR 420.000 and Transmittal Letter DEN-77.

15.06 Removable Prosthodontics (Full and Partial Dentures)

Some procedures require retrospective review documentation. Please refer to Exhibits A-D covered services tables for specific information needed by code.

Documentation needed for procedure:

- If the member still has natural teeth, appropriate pre-operative radiographs showing clearly the adjacent and opposing teeth: bitewings, periapicals or panorex are required. If the member has no remaining teeth, radiographs are not required.

Criteria for Removable Prosthodontics (Full and Partial Dentures)

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

- A denture is determined to be an initial placement if the patient has never before worn a prosthesis or had a prosthesis prescribed by any provider at any time.
- Partial dentures are covered only for members with good oral health and hygiene, good periodontal health (AAP Type I or II), and a favorable prognosis where continuous deterioration is not expected.
- Radiographs must show no untreated cavities or active periodontal disease in the abutment teeth, and abutments must be at least 50% supported in bone.
- As part of any removable prosthetic service, dentists are expected to instruct the patient in the proper care of the prosthesis.
- In general, if there is a pre-existing removable prosthesis (includes partial and full dentures), it must be at least seven years old and unserviceable to qualify for replacement.
- The replacement teeth should be anatomically full sized teeth.
- Immediate dentures will be considered for members under age 21 only when these dentures will be the permanent full dentures.
- Removable prosthesis will not meet criteria if:
- there is a pre-existing prosthesis that is not at least seven years old and unserviceable;
- good oral health and hygiene, good periodontal health, and a favorable prognosis are not present;
- there are untreated cavities or active periodontal disease in the abutment teeth;
- abutment teeth are less than 50% supported in bone;
- the member cannot accommodate and properly maintain the prosthesis (i.e., gag reflex, potential for swallowing the prosthesis, severely handicapped);
- the member has a history or an inability to wear a prosthesis due to psychological or physiological reasons;
- a partial denture, less than seven years old, is converted to a temporary or permanent complete denture; or
- extensive repairs are performed on marginally functional partial dentures, or when a new partial denture would be better for the health of the member. However, adding teeth and/or a clasp to a partial denture is a covered service if the addition makes the denture functional.

Criteria for Replacement Prosthodontics

- If there is a pre-existing prosthesis, it must be at least seven years old and unserviceable to qualify for replacement.

- Adjustments, repairs, and relines are included with the denture fee within the first six months from the date of insertion for members under age 21 and within the first 12 months from the date of insertion for members age 21 and older. After that time has elapsed subsequent:

- relines and rebases will be reimbursed with prior authorization once every two years for members under age 21.

- relines and rebases will be reimbursed with prior authorization once every three years for members age 21 and older;

- more frequent relines and rebased required require prior authorization and evidence that clinical conditions exist that warrant more frequent relines and rebases;

- a new prosthesis will not be reimbursed within two years of reline or repair of the existing prosthesis unless adequate documentation has been presented that all procedures to render the denture serviceable have been exhausted; and

- replacement of lost, stolen, or broken dentures less than seven years of age usually will not meet criteria for pre-authorization of a new denture.

- The use of preformed dentures with teeth already mounted (that is, teeth set in acrylic before the initial impression) cannot be used for the fabrication of a new denture.

- All prosthetic appliances must be inserted in the mouth and adjusted before a claim is submitted for payment.

- When billing for partial and complete dentures, dentists must list the date that the dentures or partials were inserted as the date of service. Members must be eligible on that date in order for the denture service to be covered.

15.07 Determination of a Non-Restorable Tooth

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

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

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

- The tooth has less than 50% bone support.

- The tooth has subosseous and/or furcation caries.

- The tooth is a primary tooth with exfoliation imminent.

- The tooth apex is surrounded by severe pathologic destruction of the bone.

- The overall dental condition (i.e., periodontal) of the patient is such that an alternative treatment plan would be better suited to meet the patient's needs.

15.08 Criteria for General Anesthesia and Intravenous (IV) Sedation

Prior authorization is not required when administered in the office only by a provider who possesses both an anesthesia-administration permit and an anesthesia-facility permit issued by the Massachusetts Board of Registration in Dentistry and when a member is eligible for oral surgery services.

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

The administration of inhalation analgesia (nitrous oxide N2O /O2) is reimbursed as a separate procedure.

The administration of analgesia (orally (PO), rectally (PR), and local anesthesia is considered part of an operative procedure and is not reimbursable as a separate procedure.

15.09 Periodontal Treatment

Some procedures require retrospective review documentation. Please refer to Exhibits A-D for specific information needed by code.

Documentation needed for procedure:

- Radiographs – periapicals or bitewings preferred.
- Complete periodontal charting with AAP case type.

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

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

From the American Academy of Periodontology (AAP) Policy on Scaling and Root Planning:

> "Periodontal scaling is a treatment procedure involving instrumentation of the crown and root surfaces of the teeth to remove plaque, calculus, and stains from these surfaces. It is performed on patients with periodontal disease and is therapeutic, not prophylactic, in nature. Periodontal scaling may precede root planning, which is the definitive, meticulous treatment procedure to remove cementum and/or dentin that is rough and may be permeated by calculus, or contaminated with toxins or microorganisms. Periodontal scaling and root planning are arduous and time consuming. They may need to be repeated and may require local anesthetic."

Criteria for Periodontal Treatment

- Periodontal charting indicating abnormal pocket depths in multiple sites.
- At least one of the following is present:

    1. Radiographic evidence of root surface calculus; or
    2. Radiographic evidence of noticeable loss of bone support.

16.00 Orthodontic

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

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

16.01 Authorization for Comprehensive Orthodontic Treatment

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

1. Provider performs orthodontic evaluation to determine if orthodontic treatment is necessary.

2. Provider submits all applicable completed forms and documentation to DentaQuest for review. (See 2a – 2e, below)
    a. 2012 ADA Form – Appendix B-9
        i. Providers may request the first two years of treatment in one authorization by doing the following
            1. Request authorization for D8080
            2. Request authorization for 8 units of D8670
            3. Enter Pre-Orthodontic records charge (D8690) with date of service. If Authorization for D8080 is denied, code D8690 will be processed with the date of service entered on the Authorization.
    b. Photographic Prints and Radiographs.
    Providers must submit both lateral and occlusal views. Models are not required.
    c. HLD Index Form – Appendix B-5

Providers may establish medical necessity for comprehensive orthodontic treatment using the HLD Index by demonstrating that the member 1) has one or more of the "autoqualifying" conditions described on the HLD Index, or 2) has measurements that meet or exceed the threshold score of 28 on the HLD Index. Subject to review and verification, MassHealth will approve comprehensive orthodontic treatment for Members that satisfy either of these criteria.

    d. Medical Necessity Narrative and Supporting Documentation (if applicable)
    Providers may establish that comprehensive orthodontic treatment is medically necessary by submitting a medical necessity narrative and supporting documentation, where applicable. The narrative must establish that comprehensive orthodontic treatment is medically necessary to treat a handicapping malocclusion, including to correct or significantly ameliorate:
        i. a severe deviation affecting the patient's mouth and/or underlying dentofacial structures;
        ii. a diagnosed mental, emotional, or behavioral condition caused by the patient's malocclusion;
        iii. a diagnosed nutritional deficiency and/or a substantiated inability to eat or chew caused by the patient's malocclusion;
        iv. a diagnosed speech or language pathology caused by the patient's malocclusion; or

v. a condition in which the overall severity or impact of the patient's malocclusion is not otherwise apparent.

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

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

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

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

16.02 Authorization Determination

The initial prior authorization approval for comprehensive orthodontics (D8080) and first two (2) years of treatment visits (D8670 x 8 units) will expire three (3) years from the date of the authorization. Approval for the third year of orthodontics will be valid for twelve to eighteen (12-18) months, depending on the number of units requested. Providers must check the patient's eligibility on each date of service to determine whether it will be an "eligible" service date.

If the case is denied, a determination notice will be sent to the member, and a separate courtesy notice will be sent to the provider along with the reviewer's worksheet indicating that the authorization for comprehensive orthodontic treatment has been denied. However, an authorization will be issued for the payment of code D8690 to cover the pre-orthodontic work-up, including the treatment plan, radiographs, diagnostic prints and/or photos orthodontic records, and diagnostic models.

1. If the prior authorization request is DENIED:
    a. DentaQuest will mail the member a denial notice. Additionally, DentaQuest will mail to the provider and post on the Provider Web Portal a separate courtesy notice and will mail the reviewer's worksheet to the provider.
    b. DentaQuest will assign an authorization for D8690 to cover pre-orthodontic work-up that includes payment for any diagnostic radiographs or photographs and adjudicate using the date of service submitted on the authorization.
    c. Providers may request a peer-to-peer consultation with an orthodontic reviewer from DentaQuest to discuss the denial of the submitted prior authorization request. A request to schedule a peer-to-peer consultation can be placed through customer service at 1.800-207-5019 or by submitting the request by secure message directly to customer service via the MassHealth provider web portal (www.masshealth-dental.net). Providers requesting a peer-to-peer consultation must comply with the guidelines set forth in Appendix B-5. Failure to do so may result in the provider being temporarily or permanently banned from utilizing the peer-to-peer consultation process.
        i. Peer-to-peer conversations are generally limited to one, specific authorization or claim review.
        ii. If all necessary information/documentation was originally submitted with the prior authorization, the dental consultant may, in his or her discretion, approve the prior authorization based on the review and discussion of the information/documentation during the peer-to-peer discussion. In this case, an updated determination notice will be sent to the member (and an updated courtesy notice to the provider).
        iii. If the discussion during the peer-to-peer call differs or goes beyond the information/documentation that was originally submitted in the request for prior authorization, or otherwise in the discretion the dental consultant, then the provider will need to submit a new prior authorization with the additional or different information/documentation requested by the dental consultant. Alternatively, the provider may request a second review, as described below.
    d. Providers may request a second review of a denied prior authorization may be requested by submitting to DentaQuest in writing on the provider's office letterhead within thirty days from the date of the denial notice the following information:
        i. A detailed narrative of why the provider believes the prior authorization should have been approved, and
        ii. All documents originally submitted in addition to any new supporting documentation not previously submitted, including, as appropriate, radiographs, photographs, and letters or other documentation from other licensed clinicians involved in the member's treatment or otherwise knowledgeable about the ember's condition.

Please note: *A request for a peer-to-peer consultation or a request for a second review by a provider* ***does*** **not** *alter or enlarge the time in which the member can request a fair hearing related to the denial of the prior authorization request.* ***The date by which the member must request a fair hearing is always determined by the date the member received the original denial letter from MassHealth****. However, such a request by a provider may result in reconsideration of the denial and/or the possibility of submitting a revised prior authorization request with additional information and/or documentation, which may ultimately render a timely requested fair hearing unnecessary.*

2. If the prior authorization request is APPROVED:
    a. Provider may band the patient, and must ensure that patient is fully banded prior to their 21st birthday.

b. Once banding is completed, the provider must follow the required billing rules and process guidelines for the first authorization period.
    i. Electronically file or mail a copy of the completed 2012 ADA claim form with the date of service (**banding date**) filled in. Initial payment for orthodontics (code D8080) includes pre-orthodontic visit, records, photographic prints, models and initial banding. Providers may submit a claim for the initial payment for code D8080 once banding is complete.
    ii. For each quarter in which there was at least one eligible treatment date, providers may bill one unit of code D8670, provided that a subsequent claim for D8670 may not be billed within 90 days of a previous claim.
    iii. If no service is provided in any given billing quarter, the next eligible treatment date should be used as the date of service and the 90-day period will reset once a new date is established.
    iv. Provider may not bill for the first adjustment (D8670) within 90 days of the date banding is complete.
        1. Provider should note the actual treatment dates in the notes section (box 35 of the 2006 ADA Claim form)
    v. The patient must be eligible on the date of service being billed for the claim to pay without review.
        1. If the patient is ineligible on the scheduled billing date, the provider must bill the last eligible treatment date as the date of service
        2. DentaQuest will review any orthodontic quarterly adjustments that deny for "frequency limitations exhausted" due to this occurrence to determine if the patient was eligible for services rendered during that quarter.
        3. The provider would need to verify that the patient had an eligible treatment date during a paid quarter upon audit/request.
    vi. MassHealth will pay for a maximum of eight eligible quarterly adjustments (D8670 x 8) during the first authorization period, which may last up to three years.
c. Once the first authorization period has expired and/or all eight units of quarterly adjustments have been paid, the provider may request a second authorization if continued adjustments are necessary.

In the second request, the provider may request up to four additional units of D8670 over a subsequent twelve to eighteen (12-18) month period to complete the case.

    i. The second request must be submitted on office letterhead, indicating the number of units being requested and justification for the additional units. Additionally, provider must submit a medical necessity summary narrative in box 35 of a completed 2012 ADA claim form with the request. MassHealth/DentaQuest will evaluate the authorization request based upon the submission of all documents, which includes the request and justification on office letterhead, a summary medical necessity narrative in box 35 of the completed 2012 ADA claim form and any photos or X-rays needed to support the request.

d. If the second authorization is APPROVED, then the provider may continue billing using the process described above for the number of adjustments that were approved under the second authorization.
    i. MassHealth will pay for a maximum of four eligible quarterly adjustments (D8670 x 4) during the second authorization period, which may last up to eighteen months.

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

iii. The request must be submitted on office letterhead, indicating the number of units being requested and justification for the additional units. Additionally, provider must submit a medical necessity summary narrative in box 35 of a completed 2012 ADA claim form with the request. MassHealth/DentaQuest will evaluate the authorization request based upon the submission of all documents, which includes the request and justification on office letterhead, a summary medical necessity narrative in box 35 of the completed 2012 ADA claim form and any photos or X-rays needed to support the request.

iv. If the second authorization expires prior to the completion of treatment, a provider may request an extension of the time for treatment to allow for the members treatment to be completed and all four additional units to be billed.

1. Providers must submit extension requests in writing to DentaQuest, and must include the authorization number in the request.

v. For cases that require additional adjustments to complete treatment beyond the 12 due to extenuating circumstances: If after the initial and second authorizations have expired AND the maximum units were used AND additional adjustments are still required then the provider will submit a prior authorization request for the specified number of adjustments requested (D8670), a detailed justification on office letterhead demonstrating the need for further treatment, current photographs, and a summary medical necessity narrative in box 35 of the completed 2012 ADA claim form.

e. Retention

i. MassHealth reimburses providers separately for retention, which includes removal of appliances (debanding), construction and delivery of retainers, and follow-up visits.

ii. The maximum number of reimbursable retention visits (post-treatment stabilization) is five.

iii. Prior authorization is not required for retention.

iv. If the patient loses or breaks his/her retainer(s), the provider must submit a prior authorization request and receive approval prior to billing for the repair and replacement of the retainer(s).

2. Miscellaneous
Providers may not be bill members for broken, repaired, or replacement of brackets or wires.

16.03 Authorization for Continuation of Care

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

A. 2012 ADA claim form listing services to be rendered.
B. Continuation of Care form (page B-9 from the ORM).
C. Copy of the member's original approval (if covered by MassHealth at that time) and current diagnostic documentation (e.g., photographic prints and radiographs, medical necessity narrative, other supporting documentation, etc.).
D. If service was previously approved by MassHealth, a letter from the previous provider authorizing transfer the patient's authorization to the new provider (only if current authorization has not expired or been consumed).

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

16.04 Authorization for Interceptive Orthodontic Treatment

MassHealth approves prior authorization requests for interceptive orthodontic treatment if such treatment will prevent or minimize the development of a handicapping malocclusion and will therefore minimize or preclude the need for comprehensive orthodontic treatment. The process for requesting authorization and billing for interceptive orthodontic treatment is described below:

1. Provider performs orthodontic evaluation to determine if orthodontic treatment is necessary.
2. Provider completes and submits the following documentation:
    a. 2012 ADA Form requesting authorization for interceptive orthodontic treatment. The form must include:
        i. The code for the appliance being used (D8050 or D8060)
        ii. The code (D8999) for and number of treatment visits you are requesting for adjustments, up to a maximum of 5.
    b. A detailed medical necessity narrative establishing that interceptive orthodontic treatment is medically necessary to prevent or minimize the development of a handicapping malocclusion or will minimize or preclude the need for comprehensive orthodontic treatment. This narrative must be submitted on the provider's office letterhead and any supporting documentation or imaging supporting medical necessity of the treatment should be attached.
        i. Examples of criteria that are considered that may satisfy the request for prior authorization of interceptive orthodontic treatment:

1. Two or more teeth (6-11) in crossbite with photograph documenting 100% of the incisal edge in complete edge in complete overlap with opposing tooth/teeth.
2. Bilateral crossbite of teeth 3/14 and 19/30 with photographs documenting cusp overlap completely in fossa, or completely buccal/lingual of opposing tooth.
3. Bilateral crossbite of teeth A/T and J/K with photographs documenting cusp overlap completely in fossa, or completely buccal or lingual of opposing tooth.
4. Crowding with radiograph documenting current bony impaction of a tooth 6-11, 22-27 that requires either serial extractions or surgical exposure and guidance for the impacted tooth to erupt into the arch.
5. Crowding with radiograph documenting resorption of 25% of the root of an adjacent permanent tooth.
6. If prior authorization is DENIED.
    a. DentaQuest will send the provider and member a denial notice in the mail and post the denial to the Provider Web Portal.
7. If prior authorization is APPROVED.
    a. Provider can place the appliance for the patient.
    b. Provider can bill for the appliance (D8050 or D8060) once the appliance is placed.
    c. Provider can bill for the number of adjustments (D8999) performed, up to a maximum of 5, using the actual dates of treatment as the date of service. This can be billed weekly, monthly, quarterly, etc. until all 5 units are exhausted.

16.05 General Billing Information for Orthodontics

The start and billing date of comprehensive orthodontic services is defined as the date on which the patient is fully banded. The member must be eligible on this date of service and the member must be under age 21.

To ensure proper and prompt payment for orthodontic services, follow the steps below:

- Electronically file or mail a copy of the 2012 ADA claim form with the date of service (i.e., banding date) filled in. Initial payment for comprehensive orthodontics (code D8080) includes the pre-orthodontic visit, records, photographic prints, radiographs, and completion of initial banding. Providers may submit a claim for code D8080 once banding is complete.

- Providers may bill each quarter (D8670), no less than 90 days apart, as one unit of service and may bill for a quarter if they have at least one eligible treatment date in the quarter. Provider should note the actual treatment dates in the notes section of the claim form (box 35 of the 2012 ADA claim form). Provider may not bill the first quarterly adjustment less than 90 days from the date of banding.

- The member must be eligible on the date of service being billed for the claim to pay without review. If the member is ineligible as of the billing date, the provider must bill the last eligible treatment date as the date of service for payment review.

- If no service is provided in any given billing quarter, the next eligible treatment date should be used as the date of service on the claim. The next quarterly adjustment (D8670) should be billed no less than 90 days from this date of service (i.e., the 90-day period resets).

- Providers may not bill members for broken, repaired, or replacement brackets or wires.

- MassHealth reimburses providers for retention separately, which includes removal of appliances (debanding), construction and delivery of retainers, and follow-up visits. The maximum number of reimbursable retention visits (post-treatment stabilization) is five (5). Prior authorization is not required.

- Please notify DentaQuest if the member discontinues treatment for any reason.

17.00 Limited Product

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

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

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

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

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

Periapical Films. (D0220, D0230) Periapical films may be taken for specific areas where extraction is anticipated, or when infection, periapical change, or an anomaly is suspected, or when otherwise directed by the MassHealth agency. A maximum of four periapical films is allowed per member per visit.

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

Surgical Removal of Erupted Tooth. (D7140, D7210) The MassHealth agency pays for the surgical removal of an erupted tooth. Surgical removal of an erupted tooth is the removal of any erupted tooth that includes the retraction of a mucoperiosteal flap and the removal of alveolar bone in order to aid in the extraction or the sectioning of a tooth. The provider must maintain clinical documentation demonstrating medical necessity and a preoperative radiograph of the erupted tooth in the member's dental record to substantiate the service performed.

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

Additional Resources

Welcome to the MassHealth provider forms and attachment resource page. The links below provide methods to access and acquire both electronic and printable forms addressed within this document. To view copies please visit our website at http://masshealth-dental.net/MemberServices/ProviderInfo.aspx. Once you have entered the website, click on the first link called "Providers" You will then be able to log in using your password and User ID. Once logged in, select the link "Related Documents" to access the following resources:

- Orthodontic Prior Authorization Form.
- Orthodontic Handicapping Labio-Lingual Deviations Form.
- Orthodontic Continuation of Care Form.
- Dental Claim Form and Instructions,
- Void Request Form.
- Initial Clinical Exam Form.
- Recall Examination Form.
- Medical and Dental History.
- Provider Change Form.

Broken Appointments: To notify DentaQuest on MassHealth Members breaking appointments please follow below instructions

- Log into your Provider Web Portal.
- On the Navigation Pane, click Patient, click Broken Appointments.
- Fill out page completely with date of service, office information, member information, and reason why appointment broken.
- Click Submit.

If you do not have internet access, to have a copy mailed, you may also contact DentaQuest Customer Service at 800.207.5019.

APPENDIX A

General Definitions

The following definitions apply to this Office Reference Manual:

A. "Agreement" means the contract between EOHHS/MassHealth and the provider.

B. "Appeal" is a member's right to contest to the Office of Medicaid Board of Hearings (BOH) pursuant to 130 CMR 610.000, orally or in writing, any adverse action.

C. "Board of Registration in Dentistry (BORID)" is the dental licensing and disciplinary board in Massachusetts. BORID licenses dentists and dental hygienists, receives and investigates complaints against dentists, and is responsible for implementing state laws and regulations governing licensees' practice of dentistry.

D. "Claim" means an itemized statement requesting MassHealth payment for dental services rendered by a dental provider to a member.

E. "Clean Claim" means a claim that can be processed without obtaining additional information from the provider of the service or from a third party. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

F. "Coverage Type" is the scope of medical services, other services, or both that are available to MassHealth members who meet specific MassHealth eligibility criteria. MassHealth coverage types currently include: Standard, CommonHealth, Family Assistance (Direct), Family Distance (Premium Assistance), Basic, Essential and Limited. The scope of services for each coverage type is found at 130 CMR 450.105.

G. "Covered Services" means a dental health care service or supply, including those services covered through the Early and Periodic, Screening, Diagnosis, and Treatment (EPSDT) program that satisfies all of the following criteria:

- Is medically necessary;
- Is covered under the MassHealth Dental Program;
- Is provided to an enrolled member by a participating provider
- Is the most appropriate supply or level of care that is consistent with professionally recognized standards of dental practice within the service area and applicable policies and procedures.

H. "Customer" is a member, dental provider or applicant, or other interested party.

I. "Dental Covered Services" are dental services that are covered by MassHealth as provided in 130 CMR 420.000.

J. "Dental Provider" is an individual dentist, community health center, hospital-licensed health center, dental clinic, acute hospital outpatient department, chronic hospital outpatient department, dental laboratory, public health dental hygienist providing preventive services in public settings and dental schools or dental hygiene schools enrolled in MassHealth to provide dental covered services to members pursuant to a signed provider agreement.

K. "Dental Specialist" is a dental provider that has specialized training, attended and graduated from a Commission on Dental Accreditation dental specialty program and meets the MassHealth Dental Program credentialing criteria for pediatrics, orthodontics, oral surgery, endodontics, prosthodontics or periodontics.

L. "The MassHealth Dental Program Service Area" shall be defined as the Commonwealth of Massachusetts.

M. "Early and Periodic Screening, Diagnosis and Treatment (EPSDT)" means the delivery of health care services to MassHealth Standard and CommonHealth members under the age of 21, pursuant to 42 USC 1396d(a)(4),42 CFR Part 441, subpart B, and 130 CMR 450.140 through 450.149 to ascertain children's individual physical and mental illness and conditions discovered by the screening services, whether or not such services are covered.

N. "Emergency Services" means covered dental services furnished by a qualified provider that are needed to evaluate or stabilize an emergency medical condition that is found to exist using the prudent layperson standard.

O. "EOHHS" means the Executive Office of Health and Human Services.

P. "Executive Office of Health and Human Services (EOHHS)" is the single state agency in Massachusetts responsible for the administration of MassHealth (Medicaid), pursuant to M.G.L. c. 118E and Titles XIX and XXI of the Social Security Act and other applicable laws and waivers. The term "EOHHS" may also be used to refer to the predecessor single state agency, the Executive office of Health and Human Services Division of Medical Assistance.

Q. "Fair Hearing" is an administrative adjudicatory proceeding conducted according to 130 CMR 610.000 et seq. to determine the legal rights, duties, covered services, or privileges of MassHealth members.

R. "General Dentist" is a practitioner licensed by the Massachusetts Board of Registration in Dentistry (BORID) to practice dentistry in Massachusetts. A general dentist is the primary dental care provider for patients in all age groups, responsible for the diagnosis, treatment, management and overall coordination of services related to patients' oral health needs.

S. "Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a comprehensive federal law (Pub.L. 104-191) established to protect the security and privacy of individual health information. The law establishes national standards for the electronic exchange of the health information by payers and providers.

T. "Intervention Services" are services designed to assist members in making and keeping dental appointments, assisting in obtaining transportation in accordance with applicable regulations to and from appointments, and follow-up with members and dental providers regarding appointments.

U. "Mass.gov" is a publicly available, portalized interface that connects MassHealth members, providers, and other entities to certain EOHHS systems by means of customized portlets, facilitating interaction with EOHHS and its systems.

V. "MassHealth" (also referred to as Medicaid) is the Medicaid program of the Commonwealth of Massachusetts, administered by EOHHS pursuant to Title XIX of the Social Security Act (42 U.S.C. 1396), Title XXI of the Social Security Act (42 U.S.C. 1397), M.G.L. c. 118E, and other applicable laws and waivers to provide and pay for medical assistance for eligible members. More information about MassHealth can be found at www.mass.gov/masshealth.

W. "Medically Necessary (or Medical Necessity)" means the standard set forth in 130 CMR 450.204.

X. "Member" means an individual determined by EOHHS to be eligible for MassHealth, and for whom dental services are covered pursuant to 130 CMR 420.000 and 130 CMR 450.105.

Y. "Prior Authorization (PA)" is the process by which a determination is made, before services are delivered, in accordance with 130 CMR 420.000 and 450.000 including 450.204 and 450.303.

Z. "Provider" is an individual or entity that has signed a provider agreement with EOHHS.

AA. "Provider Agreement" is the signed contract between EOHHS and a provider that describes the conditions under which the provider agrees to furnish services to MassHealth members.

BB. Third-Party Liability (TPL) is the legal obligation of any person, entity, institution, company, or public or private agency, including a MassHealth member's own insurer, to pay all or part of an individual's medical expenses. Except where a specific agreement pursuant to 42 CFR 433.139 exists, MassHealth is in all instances the payer of last resort for MassHealth members. (The only exception is the Health Safety Net program whose funds are payable only to federally qualified community health centers.)

AUTHORIZATION FORM FOR COMPREHENSIVE ORTHODONTIC TREATMENT

MassHealth Handicapping Labio-Lingual Deviations Index

FOR OFFICE USE ONLY: ☐ First Reviewer: _____ ☐ Second Reviewer: _____ ☐ Third Reviewer: _____

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

The following documents **must** also be submitted with this form. ☐ X-rays ☐ photos

Procedure:

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

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

Address: _____
Street City/County State Zip Code

AUTOQUALIFIERS	**Condition Observed**	
Cleft Palate or Cranio-Facial Anomaly	Yes ☐ No ☐	
Deep impinging overbite* with severe soft tissue damage (e.g., ulcerations or tissue tears – more than indentations)*	Yes ☐ No ☐	
Anterior Impactions where extraction is not indicated	Yes ☐ No ☐	
Severe Traumatic Deviations – refers to facial accidents rather than congenital deformity. Do not include traumatic occlusions or crossbites.	Yes ☐ No ☐	
Overjet (greater than 9 mm)	Yes ☐ No ☐	
Reverse overjet (greater than 3.5 mm)	Yes ☐ No ☐	
Severe Maxillary Anterior Crowding (greater than 8 mm)	Yes ☐ No ☐	
HLD SCORING	**Measurement**	**Scores**
Overjet (in mm)	# mm X 1	
Overbite (in mm)	# mm X 1	
Mandibular Protrusion (in mm) – see scoring instructions	# mm X 5	
Anterior Open Bite – Do not count ectopic eruptions, measure the opening between maxillary and mandibular incisors in mm.	# mm X 4	
Ectopic Eruption (Number of teeth, excluding third molars) – This refers to an unusual pattern of eruption such as high labial cuspids. Do not score teeth in this category if they are scored under maxillary or mandibular crowding.	# mm X 3	
Anterior Crowding – If crowding exceeds 3.5mm in an arch, score each arch.	Maxilla: 5 pts Mandible: 5 pts Both: 10 pts	
Labio-Lingual Spread (anterior spacing in mm) – see scoring instructions.	# mm X 1	
Posterior Unilateral Crossbite – Must involve 2 or more teeth, one of which must be a molar.	4 pts	
Posterior impactions or congenitally missing posterior teeth (excluding 3rd molars).	# mm X 3	
	TOTAL	
Treatment will be authorized for cases with verified autoqualifiers or verified scores of 28 and above.		

Medical Necessity Narrative

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

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

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

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

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

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

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

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

Attestation

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

Prescribing provider's signature: _____

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

Printed name of prescribing provider: _____ Date: _____

Handicapping Labio-Lingual Deviation Index Scoring Instructions

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

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

1. **Cleft Palate Deformities:** Indicate an "X" on the form. (*This is considered an autoqualifying condition*.)
2. **Deep Impinging Overbite:** Indicate an "X" on the form when lower incisors are destroying the soft tissue of the palate (e.g., ulcerations or tissue tears – more than indentations). *(This is considered an autoqualifying condition.)*
3. **Anterior Impactions:** Indicate an "X" on the form. Anterior impactions include central incisors, lateral incisors, and canines in the maxillary and mandibular arches. *(This is considered an autoqualifying condition.)*
4. **Severe Traumatic Deviations:** Indicate an "X" on the form. Traumatic deviations refers to facial accidents rather than congenital deformity. For example, loss of a premaxilla segment by burns or by accident; the result of osteomyelitis; or other gross pathology. Do not include traumatic occlusions or crossbites. *(This is considered an autoqualifying condition.)*
5. **Overjet greater than 9mm:** Indicate an "X" on the form. This is recorded with the patient in the centric occlusion and measured from the labial of the lower incisor to the labial of the upper incisor. The measurement could apply to a protruding single tooth as well as to the whole arch. The measurement is read and rounded off to the nearest millimeter and entered on the form. *(This is considered an autoqualifying condition.)*
6. **Reverse overjet greater than 3.5mm:** Indicate an "X" on the form. This is recorded with the patient in the centric occlusion and measured from the labial of the lower incisor to the labial of the upper incisor. *(This is considered an autoqualifying condition.)*
7. **Severe Maxillary Anterior Crowding, greater than 8mm**: Indicate an "X" on the form. *(This is considered an autoqualifying condition.)*
8. **Overjet in Millimeters:** This is recorded with the patient in the centric occlusion and measured from the labial of the lower incisor to the labial of the upper incisor. The measurement could apply to a protruding single tooth as well as to the whole arch. The measurement is read and rounded off to the nearest millimeter and entered on the form.
9. **Overbite in Millimeters:** A pencil mark on the tooth indicating the extent of overlap facilitates this measurement. It is measured by rounding off to the nearest millimeter and entered on the form. "Reverse" overbite may exist in certain conditions and should be measured and recorded.
10. **Mandibular Protrusion in Millimeters:** Score exactly as measured from the buccal groove of the first mandibular molar to the MB cusp of the first maxillary molar. The measurement in millimeters is entered on the form and multiplied by 5.
11. **Open Bite in Millimeters:** This condition is defined as the absence of occlusal contact in the anterior region. It is measured from edge to edge in millimeters. This measurement is entered on the form and multiplied by 4. In cases of pronounced protrusion associated with open bite, measurement of the open bite is not always possible. In those cases, a close approximation can usually be estimated.
12. **Ectopic Eruption:** Count each tooth, excluding third molars. Enter the number of teeth on the form and multiply by 3. If Condition No. 13, Anterior Crowding, is also present, with an ectopic eruption in the anterior portion of the mouth, score only the most severe condition. Do not score both conditions.
13. **Anterior Crowding:** Arch length insufficiency must exceed 3.5 mm. Mild rotations that may react favorably to stripping or mild expansion procedures are not to be scored as crowded. Enter 5 points for maxillary and mandibular anterior crowding. If Condition No. 12, ectopic eruption, is also present in the anterior portion of the mouth, score the most severe condition. Do not score both conditions.

14. **Labio-Lingual Spread:** The measurement tool is used to determine the extent of deviation from a normal arch. Where there is only a protruded or lingually displaced anterior tooth, the measurement should be made from the incisal edge of that tooth to the normal arch line. Otherwise, the total distance between the most protruded tooth and the lingually displaced anterior tooth is measured. The labio-lingual spread probably comes close to a measurement of overall deviation from what would have been a normal arch. In the event that multiple anterior crowding of teeth is observed, all deviations from the normal arch should be measured for labio-lingual spread, but only the most severe individual measurement should be entered on the index.

    A. Additionally, anterior spacing may be measured as the total score in mm from the mesial of cuspid to the mesial of cuspid, totaling both arches.

    Only score the greater score attained by either of these two methods.

15. **Posterior Unilateral Crossbite:** This condition involves two or more adjacent teeth, one of which must be a molar. The crossbite must be one in which the maxillary posterior teeth involved may either be both palatal or both completely buccal in relation to the mandibular posterior teeth. The presence of posterior unilateral crossbite is indicated by a score of 4 on the form.

16. **Posterior impactions or congenitally missing posterior teeth**: Total the number of posterior teeth, excluding third molars that meet this criterion and multiply by 3.

Peer-to-Peer Guidelines

What is a Peer-to-Peer request?
A "Peer-to-Peer" call takes place when a Provider requests a clinical explanation in regards to why a request for benefits has been denied. A Peer-to-Peer request is a clinical discussion between two licensed dentists. An explanation of why an authorization was denied is included in the determination notice sent to the member, and the courtesy copy of the notice that is sent to the provider.

Clinical criteria and required documentation for each covered code is in the MassHealth Office Reference Manual located on the MassHealth provider web portal at www.masshealth-dental.net.

Scheduling:
A provider may initiate a request for a peer-to-peer conversation through the following channels: DentaQuest Customer Service: 1-800-207-5019.

or

MassHealth Provider Web portal: www.masshealth-dental.net.

Process:
When a peer-to-peer request is received, the details of the case are entered into the DentaQuest system and a follow-up inquiry is assigned to a DentaQuest Dental Consultant. The Dental Consultant assigned will generally call the requesting provider within 48 hours, subject to the limitations below.

Calls are returned during regular business hours, 8:00 AM-5:00 PM, Monday-Friday. DentaQuest does not make appointments and cannot generally commit to a specific time for peer-to-peer calls. However, if there is a particular day or block of time that is preferable, the provider should include this information when submitting the request via phone or the web portal.

Please note that the Dental Consultant ***will only speak with the dentist who submitted the original request***, not the office manager or other staff members. The Dental Consultant will discuss clinical criteria utilized as the basis for the decision made. The Dental Consultant will not discuss fees, eligibility, non-covered services, or other administrative reasons for denial.

Length of Call:
The length of peer-to-peer calls varies, but the average call lasts 10-20 minutes.

Number of Cases:
Peer-to-peer calls are typically limited to the discussion of one specific authorization. If the Provider has several similar authorizations that he or she would like to discuss, DentaQuest may, in his or her discretion, agree to answer general clinical questions about the review process or may request that the Provider initiate another peer-to-peer request.

Outcomes:
The peer to peer call may result in reconsideration of the denial after the peer-to-peer call in the event the Dental Consultant determines that no further documentation is needed to support the determination. However, if the Dental Consultant determines that further documentation is needed to support a determination the provider will be asked to submit a new prior authorization request including the additional information/documentation or request for a second review. Further instructions on these processes can be found in the MassHealth Office Reference Manual online at www.masshealth-dental.net.

Conduct:
Professional conduct and communication are expected by all parties on a peer-to-peer call. Unprofessional conduct during the call (e.g., yelling, disparaging remarks, rudeness, crude language) may result in immediate termination of the call, and DentaQuest, at its discretion, may suspend or terminate an individual Provider's privileges to request peer-to-peer calls as a result of such unprofessional conduct. Please note: **DentaQuest may record peer-to-peer calls**.

DentaQuest
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Orthodontic Continuation of Care Solution Form

MassHealth

Date: _____

Patient Information

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

Provider Information

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

Name of Previous Insurer that issued original approval:

_____

Banding Date: _____

Case Rate Approved by Previous Insurer: _____

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

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

Balance Expected for Future Dates of Service: _____

Numbers of Adjustments Remaining: _____

Additional Information Required:

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

Mail to:

MassHealth Dental Program
ATTN: Continuation of Care
12121 North Corporate Parkway
Mequon, WI 53092

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

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

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

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

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

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

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

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

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

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

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

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

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

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

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

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

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

RECORD OF SERVICES PROVIDED

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

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

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

31a. Other Fee(s)
32. Total Fee $0.00

35. Remarks

AUTHORIZATIONS

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

X _____
Patient/Guardian Signature Date

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

X _____
Subscriber Signature Date

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

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

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

52. Phone Number | 52a. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION

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

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

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

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

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

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

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

X _____
Signed (Treating Dentist) Date

54. NPI | 55. License Number

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

57. Phone Number | 58. Additional Provider ID

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

To reorder call 800.947.4746
or go online at adacatalog.org

ADA American Dental Association®

America's leading advocate for oral health

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

GENERAL INSTRUCTIONS

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

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

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

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

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

COORDINATION OF BENEFITS (COB)

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

DIAGNOSIS CODING

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

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

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

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

PLACE OF TREATMENT

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

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

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

PROVIDER SPECIALTY

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

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

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

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Void Request Form

MassHealth

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

Send void requests to:

MassHealth Dental Program
ATTN: Voids
12121 North Corporate Parkway
Mequon, WI 53092

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

Date of Request

Provider or Facility Name

MassHealth Provider Number

Provider Address

Billing Provider's NPI#

Provider City, State, Zip

Amount

Please check off one reason for requesting the void.

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

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

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

Provider/Facility Authorized Signature

Date

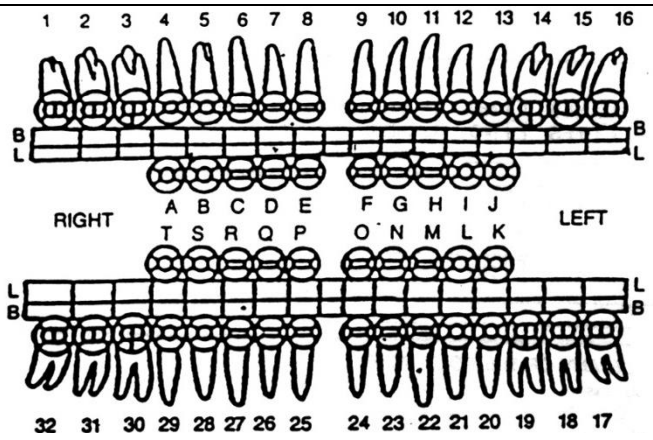
MassHealth appreciates your cooperation.

Initial Clinical Exam
(Sample)

Allergy	Pre Med	Medical Alert

Initial Clinical Exam

Patient's Name: _____
Last First Middle



Gingiva
Mobility
Prosthesis Evaluation
Occlusion 1 11 111
Patient's Chief Complaint

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

Clinical Findings/Comments

Radiographs	B/P	RDH/DDS

Recommended Treatment Plan

Tooth or Area	Diagnosis	Plan A	Plan B

Signature of Dentist: _____ Date: _____

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

Recall Examination
(Sample)

Patient's Name: _____

Changes in Health Status/Medical History: _____

Clinical Findings/Comments

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

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

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

Comments: _____

_____

Recall Examination

Patient's Name: _____

Changes in Health Status/Medical History: _____

Clinical Findings/Comments

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

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

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

Comments: _____

_____

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

Medical and Dental History
(Sample)

Patient Name: _____ Date of Birth: _____

Address: _____

Why are you here today? _____

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

If yes, what type and where? _____

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

Medical Doctor's Name: _____

Address: _____

Telephone: _____

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

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

If yes, please list medications: _____

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

If yes, please list: _____

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

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

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

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

Are you on a special diet? ☐ Yes ☐ No

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

If yes, where? _____

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

If yes, how often and how much? _____

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

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

If yes, please list: _____

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

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

For Women Only:

Are you pregnant? ☐ Yes ☐ No

If yes, what month? _____

Are you nursing? ☐ Yes ☐ No

Are you taking birth control pills? ☐ Yes ☐ No

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

Patient Signature: _____ Date: _____

Dentist's Signature: _____ Date: _____

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

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

Provider Change Form

Provider Name: _____

Provider NPI: _____

Tax ID: _____

Location Address: _____ **GID#:** _____

Location Address: _____ **GID#:** _____

Location Address: _____ **GID#:** _____

Please check the box preceding the change(s) you would like to have made to the providers record.

Provider Demographic Changes	**Current Info**	**New Info**	**Effective Date**
Name (provide proof of name change)			
Date of Birth			
Degree			
Social Security #			
Gender			
Medicaid Number Update			
Dental Home Update			
Provider NPI			
Correspondence Address			
Provider License Updates			
Dental License			
DEA			
Anesthesia License			
Location Changes			
Service Office Name			
Service Office Address			
Phone Number			
Fax Number			
Age Limitations			
Office Hours			
Not on Directory			
Existing Patients Only			
Term Provider form this Location			
Dental Home/Capitation Attributes			
Business Changes			
Business Name Change – You must submit a new contract and W9 along with this request			
Tax ID Change – You must submit a new contract and W9 along with this request			
Business NPI			
Add a New Location			
Add credentialed provider to a new location under the existing Tax ID indicated above			
Add credentialed provider to an existing location			
Payment Address Change			
Change address where EOB's are sent			
Add or Change EFT information – You must submit the EFT form and a voided check with this request			

This form may be submitted by mail to:

DentaQuest Credentialing 12121 North Corporate Parkway Mequon, WI 53092

E-mail to: standardupdates@dentaquest.com

Fax to: 262-241-4077

DentaQuest

*Serving the MassHealth Program**

Third Party Liability

MassHealth

All Providers must comply with MassHealth's Third-Party Liability (TPL) requirements under 130 CMR 450.316. TPL includes the primary insurance on file for a member. If MassHealth records indicate the member has other active insurance, generally you must bill that insurer before billing MassHealth. Certain limited exceptions exist under federal law in the case of prenatal or preventive pediatric care, or where the Department of Revenue is carrying out child-support enforcement. If you have a question about whether you must bill an insurer before billing MassHealth, you may call Customer Service at 1-800-207-5019.

How to determine if TPL Coverage exists

Providers should make diligent efforts to identify other insurers. Diligent efforts include, verifying the member's other health insurance coverage known to MassHealth, through DentaQuest's Interactive Voice Response (IVR) system or through the "Providers Only" section of DentaQuest's website at www.masshealth-dental.net. The eligibility information received from either system will be the same information you would receive by calling DentaQuest's Customer Service department; however, by utilizing either system you can get information 24 hours a day, 7 days a week without having to wait for an available Customer Service Representative.

How to update the TPL information on file*

Files can be updated when TPL coverage has ended, the information on file is incorrect, or the name of the insurance has changed. Send an explanation of benefits (EOB) showing the correct information, a completed Third Party Indicator (TPLI) form (available from the Provider Forms link on www.mass,gov/masshealth), and any other supporting documentation to the appropriate address below. **Do not send claim forms to these addresses.**

For a Commercial policy:
MassHealth
Third Party Liability Unit
P.O. Box 9209
Boston, MA 02209
Fax: 617-357-7604

For a Medicare policy:
MassHealth
CHCF-Medicare Unit
The Schrafft's Center
529 Main Street, 3rd Floor
Charlestown, MA 02129-1120
Fax: 617-886-8133

- Insurance cannot be removed from the member's file when coverage is active, but does not cover a particular service

Explanation of Benefits

Paper Submissions: Paper submissions will only be accepted from a provider with a valid, approved electronic billing waiver on filed. If you have a waiver on file, a valid EOB from another insurer is acceptable. Please refer to your MassHealth provider manual for proper billing instructions.

Electronic Submissions: Please refer to the Implementation Guide for proper billing of COB claims.

(Rev. 12/06) Visit our Website at: www.masshealth-dental.net

** DentaQuest, LLC is the subcontractor to Dental Service of Massachusetts, Inc.*

DentaQuest
*Serving the MassHealth Program**

Corrective Action for Denied Dental Claims

MassHealth

There are multiply scenarios that would cause a claim to deny.

Claims must be submitted within 90 days of the date of service.

If the claim was received by MassHealth within 90 days of the date of service or the date of explanation of benefits (EOB) from the primary insurer, participating MassHealth providers may submit corrections using the following methods:

1. Electronic claims via direct data entry at www.masshealth-dental.net.
2. Electronic claims in the HIPAA-compliant 837D or 837P format via upload to our secure website www.masshealth-dental.net.
3. Electronic claims in the HIPAA-complaint 837D or 837P format on CD –ROM, 3.5" floppy disk or DVD
4. Electronic claims submission via a clearinghouse partner.
5. Providers approved for electronic claim submission waiver may prepare a new ADA 2012 or newer claim form with the corrected information.

Submit the claim to:

MassHealth
Attn: Resubmittals
12121 North Corporate Parkway
Mequon, WI 53092

A claim may be resubmitted as many times as necessary up to 12 months from the date of service. When other insurance is involved, the time period is extended to 18 months from date of service. To resubmit a claim you need to:

- Prepare a corrected claim form or provide documentation with the corrected claim information.
- Attach any documentation that was included with your original submission.
- Enter "Resubmit" and/or "ICN" along with the 13-charcter assigned to the original claim in field 35 of the ADA 2006/2012 form.

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Corrective Action for Incorrectly Paid Dental Claims

MassHealth

There are multiply scenarios that would cause a claim to pay incorrectly such as a provider submitting incorrect provider, member or service information.

In order to correct a claim that has been "Paid", but has been paid at an incorrect amount, you must follow the Adjustment procedure:

- Prepare a new claim form or provide documentation with the corrected claim information with the correct information and attach any required documentation.
- Do not subtract the original payment from your usual charge, and do not enter it in the "Other Paid Amount" column (the processing system will perform the necessary calculation.)
- Enter "A" followed by the 10-character TCN or 13 character ICN transaction control number (TCN) from the most recent "Paid" claim in field 35 of the ADA 2006 form.

If the original submission required documentation, you must attach the documentation to the adjusted claim.

Submit the claim to:

MassHealth Dental Program
Attn: Adjustments
12121 North Corporate Parkway
Mequon, WI 53092

You cannot follow the adjustment procedure if you are making a change to the member ID number, pay-to provider number, or the invoice type. In these situations, you must request a void of the original payment, and then rebill the corrected claim, if applicable.

(Rev. 12/06) Visit our Website at: www.masshealth-dental.net

** DentaQuest, LLC is the subcontractor to Dental Service of Massachusetts, Inc.*

DentaQuest

*Serving the MassHealth Program**

Overpayments of Dental Claims

MassHealth

If you receive an overpayment on a claim, you must request that the payment be voided. If all payments on a particular remittance advice need to be refunded to MassHealth, do not return the original check received from the State Comptrollers' office. Instead, deposit the check and follow the void procedures outlined below.

Common reasons for requesting a void:

- payment to wrong provider number;
- payment for the wrong member;
- payment for overstated services;
- payment for services for which full reimbursement has been received from other payers.

To request a void:

- circle the claim line(s) to be voided on a photocopy of the remittance advice (RA);
- send the photocopy of the RA, as well as a completed Void Request form to:

MassHealth Dental Program
Attn: Voids
12121 North Corporate Parkway
Mequon, WI 53092

After the void request has been processed:

- voided claims will appear on a remittance advice;
- the total amount originally paid will appear as a negative amount;
- that amount will be deducted from payments until it is recovered.

Once the claim has been voided:

- a corrected claim can be submitted, if applicable;
- You can submit an adjusted claim.

(Rev. 12/06) Visit our Website at: www.masshealthdental.net

** DentaQuest, LLC is the subcontractor to Dental Service of Massachusetts, Inc.*

APPENDIX D

Covered Services (See Exhibits A-D)

This appendix identifies covered services, provides specific criteria for coverage and defines individual age and service limitations for MassHealth Dental Program members. **Providers with questions should contact the MassHealth Dental Program's Provider Services Department directly at 800.207.5019.**

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

The MassHealth Dental Program claim system will only process claims with the CDT service codes as described in 130 CMR 420.000 and Exhibits A-D. All other claims with service codes not contained in the following tables will be rejected when submitted for payment. A complete, copy of the CDT book can be purchased from the American Dental Association at the following address:

American Dental Association
211 East Chicago Avenue
Chicago, IL 60611
1-800.947.4746
http://ebusiness.ada.org/default.aspx

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

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

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

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

Exhibit A

Benefits Covered for MassHealth – Under 21

Orthodontic

As detailed in Section 16.00 of the *Office Reference Manual*, Members under age 21 may qualify for orthodontic treatment (Members age 21 and older may qualify for continuation of treatment if they have been fully banded prior to their 21st birthday). All orthodontic services require prior authorization with the exception of pre-orthodontic treatment visits and orthodontic retention. For information and instructions on submitting prior authorization requests for orthodontic services and other relevant information, please refer to the sections of the *Office Reference Manual* listed below.

- Comprehensive Orthodontic Treatment: Sections 16.01 and 16.02 and Appendix B
- Interceptive Orthodontic Treatment: Section 16.04
- Continuation of Care: Section 16.03
- General Billing Information for Orthodontics: Section 16.05

Exhibit A Benefits Covered for
MassHealth - Under 21

Diagnostic services include the oral examination, and selected radiographs needed to assess the oral health, diagnose oral pathology, and develop an adequate treatment plan for the member's oral health.

Reimbursement for some or multiple radiographs of the same tooth or area may be denied if DSM/DentaQuest determines the number to be redundant, excessive or not in keeping with the federal guidelines relating to radiation exposure. The maximum amount paid for individual radiographs taken on the same day will be limited to the allowance for a full mouth series.

Reimbursement for radiographs is limited to those films required for proper treatment and/or diagnosis.

The MassHealth Dental Program utilizes the guidelines published by the Department of Health and Human Services Center for Devices and Radiological Health. However, please consult the following tables for coverage limitations.

All radiographs must be of good diagnostic quality properly mounted, dated and identified with the member's name and date of birth. Substandard radiographs will not be reimbursed, or if already paid for, MassHealth Dental Program will recoup the funds previously paid.

Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0120	periodic oral evaluation - established patient	0-20		No	Two of (D0120, D0145) per 1 Calendar year(s) Per Provider OR Location. Not covered with D9110 by same provider or provider group on same date of service.	
D0140	limited oral evaluation-problem focused	0-20		No	Two of (D0140) per 1 Calendar year(s) Per patient. Not covered with D9110, D0160 by same provider or provider group on same date of service.	
D0145	oral evaluation for a patient under three years of age and counseling with primary caregiver	0-3		No	Two of (D0120, D0145) per 1 Calendar year(s) Per Provider OR Location.	
D0150	comprehensive oral evaluation - new or established patient	0-20		No	One of (D0150) per 1 Lifetime Per Provider OR Location.	
D0160	detailed and extensive oral eval-problem focused, by report	0-20		No	Two of (D0160) per 12 Month(s) Per patient. Not covered with D9110, D0140 by same provider or provider group on same date of service.	

Exhibit A Benefits Covered for MassHealth - Under 21

Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0210	intraoral - complete series of radiographic images	6 - 20		No	One of (D0210) per 3 Calendar year(s) Per Provider OR Location. One complete series every three calendar years per patient per dentist or dental group. Any combination of radiographs that exceeds the maximum allowable payment for a FMX will be recoded to D0210. Documentation of variation from ADA clinical guidelines to be kept in patient record.	
D0220	intraoral - periapical first radiographic image	0-20		No	One of (D0220) per 1 Day(s) Per Provider OR Location. Twelve of (D0220, D0230) per 12 Month(s) Per patient. Maximum of one per visit. Any combination of radiographs that exceeds the maximum allowable payment for a FMX will be recoded to D0210. Documentation of variation from ADA clinical guidelines to be kept in patient record.	
D0230	intraoral - periapical each additional radiographic image	0-20		No	Three of (D0230) per 1 Day(s) Per Provider OR Location. Twelve of (D0220, D0230) per 12 Month(s) Per patient. Maximum of three per visit. Any combination of radiographs that exceeds the maximum allowable payment for a FMX will be recoded to D0210. Documentation of variation from ADA clinical guidelines to be kept in patient record.	
D0270	bitewing - single radiographic image	0-20		No	Two of (D0270, D0272, D0273, D0274) per 1 Calendar year(s) Per Provider OR Location. Any combination of radiographs that exceeds the maximum allowable payment for a FMX will be recoded to D0210. Documentation of variation from ADA clinical guidelines to be kept in patient record.	
D0272	bitewings - two radiographic images	0-20		No	Two of (D0270, D0272, D0273, D0274) per 1 Calendar year(s) Per Provider OR Location. Any combination of radiographs that exceeds the maximum allowable payment for a FMX will be recoded to D0210. Documentation of variation from ADA clinical guidelines to be kept in patient record.	

Exhibit A Benefits Covered for MassHealth - Under 21

Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0273	bitewings - three radiographic images	0-20		No	Two of (D0270, D0272, D0273, D0274) per 1 Calendar year(s) Per Provider OR Location. Any combination of radiographs that exceeds the maximum allowable payment for a FMX will be recoded to D0210. Documentation of variation from ADA clinical guidelines to be kept in patient record.	
D0274	bitewings - four radiographic images	0-20		No	Two of (D0270, D0272, D0273, D0274) per 1 Calendar year(s) Per Provider OR Location. Any combination of radiographs that exceeds the maximum allowable payment for a FMX will be recoded to D0210. Documentation of variation from ADA clinical guidelines to be kept in patient record.	
D0330	panoramic radiographic image	0-20		No	One of (D0330) per 3 Year(s) Per patient. Non-surgical conditions. Surgical conditions are payable in excess of the 3 year limitation when used as a diagnostic tool. Any combination of radiographs that exceeds the max allowable for a FMX will be recoded to D0210. Documentation of variation from ADA clinical guidelines to be kept in patient record.	
D0340	cephalometric radiographic image	0-20		No	Non-orthodontic procedures.	

Space maintainers are a covered service when medically indicated due to the premature loss of primary tooth.

The application of topical fluoride treatment is allowed for Members up to age 21 when provided in conjunction with a prophylaxis. Treatment that incorporates fluoride with the polishing compound is considered part of the prophylaxis procedure and not a separate topical fluoride treatment.

Sealants are not allowable over restored tooth surfaces.

Preventative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D1110	prophylaxis - adult	14 - 20		No	Two of (D1110, D1120) per 1 Calendar year(s) Per patient. Includes minor scaling procedures.	
D1120	prophylaxis - child	0-13		No	Two of (D1110, D1120) per 1 Calendar year(s) Per patient. Includes minor scaling procedures.	
D1206	topical application of fluoride varnish	0-20		No	One of (D1206, D1208) per 90 Day(s) Per Provider OR Location. Cannot be billed with D1208 on same date of service by the same provider or location.	
D1208	topical application of fluoride - excluding varnish	0-20		No	One of (D1206, D1208) per 90 Day(s) Per Provider OR Location. Cannot be billed with D1206 on same date of service by the same provider or location.	
D1351	sealant - per tooth	0-16	Teeth 1 - 3, 14 - 19, 30 - 32	No	One of (D1351) per 3 Year(s) Per Provider OR Location per tooth. Permanent first and second non-carious (occlusal surface) molars and non-carious (occlusal surface)third molars.	
D1510	space maintainer-fixed-unilateral	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	Must maintain radiographs in patient record demonstrating that the tooth has not begun to erupt or that migration of the adjacent tooth has already occurred.	
D1515	space maint-fixed-bilateral	0-20	Per Arch (01, 02, LA, UA)	No	Must maintain radiographs in patient record demonstrating that the tooth has not begun to erupt or that migration of the adjacent tooth has already occurred.	
D1520	space maintainer-removable-unilateral	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	Must maintain radiographs in patient record demonstrating that the tooth has not begun to erupt or that migration of the adjacent tooth has already occurred.	

Exhibit A Benefits Covered for MassHealth - Under 21

Preventative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D1525	space maintainer-removable-bilateral	0-20	Per Arch (01, 02, LA, UA)	No	Must maintain radiographs in patient record demonstrating that the tooth has not begun to erupt or that migration of the adjacent tooth has already occurred.	
D1550	re-cement or re-bond space maintainer	0-20		No		

Restorations replaced within one year of the date of completion of the original restoration are not covered. No combination of services on a single tooth during the same period of treatment is reimbursable in excess of the maximum allowable fee for a four-or-more surface amalgam or composite restoration. When restorations involving multiple surfaces are requested or performed, that are outside the usual anatomical expectation, the allowance is limited to that of a one-surface restoration. Any fee charged in excess of the allowance for the one-surface restoration is DISALLOWED. The MassHealth Dental Program considers all of the following to be components of a completed restoration and includes them in the fee for this service: tooth and soft-tissue preparation, cement bases, etching and bonding agents, pulp capping, impression, local anesthesia and polishing. Billing and reimbursement for cast crowns, cast post & cores or any other fixed prosthetics shall be based on the cementation date. Restorative pins are reimbursed on a per tooth basis, regardless of the number of pins placed. Reinforcing pins are covered only when used in conjunction with a two-or-more-surface restoration on a permanent tooth. The MassHealth Dental Program pays for no more than four stainless steel or pre-fabricated resin crowns per date of service in an office setting. This limitation does not apply when stainless steel or pre-fabricated resin crowns are performed in the OR or outpatient facility.

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2140	Amalgam - one surface, primary or permanent	0-20	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per Business per tooth. per surface.	
D2150	Amalgam - two surfaces, primary or permanent	0-20	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per Business per tooth. per surface.	
D2160	amalgam - three surfaces, primary or permanent	0-20	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per Business per tooth. per surface.	
D2161	amalgam - four or more surfaces, primary or permanent	0-20	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per Business per tooth. per surface.	
D2330	resin-based composite - one surface, anterior	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per Business per tooth. per surface.	
D2331	resin-based composite - two surfaces, anterior	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per Business per tooth. per surface.	
D2332	resin-based composite - three surfaces, anterior	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per Business per tooth. per surface.	

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Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per Business per tooth. per surface.	
D2390	resin-based composite crown, anterior	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2390) per 12 Month(s) Per patient per tooth. per surface.	
D2391	resin-based composite - one surface, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per Business per tooth. MassHealth will no longer pay any more for a composite restoration on a primary (deciduous) posterior tooth than they would for an amalgam restoration.	
D2392	resin-based composite - two surfaces, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per Business per tooth. MassHealth will no longer pay any more for a composite restoration on a primary (deciduous) posterior tooth than they would for an amalgam restoration.	
D2393	resin-based composite - three surfaces, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per Business per tooth. MassHealth will no longer pay any more for a composite restoration on a primary (deciduous) posterior tooth than they would for an amalgam restoration.	
D2394	resin-based composite - four or more surfaces, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per Business per tooth. MassHealth will no longer pay any more for a composite restoration on a primary (deciduous) posterior tooth than they would for an amalgam restoration.	
D2710	crown - resin-based composite (indirect)	0-20	Teeth 3 - 14, 19 - 30	No	One of (D2710, D2740, D2750, D2751, D2752, D2790) per 60 Month(s) Per patient per tooth.	

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Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2740	crown - porcelain/ceramic substrate	0-20	Teeth 2 - 15, 18 - 31	No	One of (D2710, D2740, D2750, D2751, D2752, D2790) per 60 Month(s) Per patient per tooth.	
D2750	crown - porcelain fused to high noble metal	0-20	Teeth 2 - 15, 18 - 31	No	One of (D2710, D2740, D2750, D2751, D2752, D2790) per 60 Month(s) Per patient per tooth.	
D2751	crown - porcelain fused to predominantly base metal	0-20	Teeth 2 - 15, 18 - 31	No	One of (D2710, D2740, D2750, D2751, D2752, D2790) per 60 Month(s) Per patient per tooth.	
D2752	crown - porcelain fused to noble metal	0-20	Teeth 2 - 15, 18 - 31	No	One of (D2710, D2740, D2750, D2751, D2752, D2790) per 60 Month(s) Per patient per tooth.	
D2790	crown - full cast high noble metal	0-20	Teeth 2 - 15, 18 - 31	No	One of (D2710, D2740, D2750, D2751, D2752, D2790) per 60 Month(s) Per patient per tooth.	
D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	0-20	Teeth 1 - 32	No	Not covered within 6 months of initial placement.	
D2920	re-cement or re-bond crown	0-20	Teeth 1 - 32, A - T	No	Not covered within 6 months of initial placement.	
D2930	prefabricated stainless steel crown - primary tooth	0-20	Teeth A - T	No	Four of (D2930, D2931, D2932, D2934) per 1 Day(s) Per patient.	
D2931	prefabricated steel crown-permanent tooth	0-20	Teeth 2 - 5, 12 - 15, 18 - 21, 28 - 31	No	Four of (D2930, D2931, D2932, D2934) per 1 Day(s) Per patient.	
D2932	prefabricated resin crown	0-20	Teeth 1 - 32, A - T	No	Four of (D2930, D2931, D2932, D2934) per 1 Day(s) Per patient.	
D2934	prefabricated esthetic coated stainless steel crown - primary tooth	0-20	Teeth C - H, M - R	No	Four of (D2930, D2931, D2932, D2934) per 1 Day(s) Per patient.	
D2951	pin retention - per tooth, in addition to restoration	0-20	Teeth 1 - 32	No	Must be billed with a two-or-more surface restoration on a permanent tooth.	
D2954	prefabricated post and core in addition to crown	0-20	Teeth 2 - 15, 18 - 31	No		
D2980	crown repair, by report	0-20	Teeth 1 - 32	No	Chairside	
D2999	unspecified restorative procedure, by report	0-20	Teeth 1 - 32, A - T	Yes		

Payment for conventional root canal treatment is limited to treatment of permanent teeth.

The standard of acceptability employed for endodontic procedures requires that the canal(s) be completely filled apically and laterally. In cases where the root canal filling does not meet DSM/DentaQuest's treatment standards, DSM/DentaQuest can require the procedure to be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after any post payment review by the DSM/DentaQuest Consultants. A pulpotomy or palliative treatment is not to be billed in conjunction with a root canal treatment.

Filling material not accepted by the Federal Food and Drug Administration (FDA) (e.g. Sargenti filling material) is not covered.

The fee for root canal therapy for permanent teeth includes diagnosis, extirpation treatment, temporary fillings, filling and obturation of root canals, and progress radiographs. A completed fill radiograph is also included.

Endodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	0-20	Teeth 1 - 32, A - T	No	Cannot be billed in conjunction with root canals (D3310, D3320 or D3330).	
D3310	endodontic therapy, anterior tooth (excluding final restoration)	0-20	Teeth 6 - 11, 22 - 27	No	One of (D3310) per 1 Lifetime Per patient per tooth. No limitation on number performed per treatment.	
D3320	endodontic therapy, bicuspid tooth (excluding final restoration)	0-20	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	One of (D3320) per 1 Lifetime Per patient per tooth.	
D3330	endodontic therapy, molar (excluding final restoration)	0-20	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	One of (D3330) per 1 Lifetime Per patient per tooth.	
D3346	retreatment of previous root canal therapy-anterior	0-20	Teeth 6 - 11, 22 - 27	No	Not payable to the same provider who performed the original endodontic therapy (D3310, D3320, or D3330) within 24 months.	
D3347	retreatment of previous root canal therapy-bicuspid	0-20	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	Not payable to the same provider who performed the original endodontic therapy (D3310, D3320, or D3330) within 24 months.	
D3348	retreatment of previous root canal therapy-molar	0-20	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	Not payable to the same provider who performed the original endodontic therapy (D3310, D3320, or D3330) within 24 months.	
D3410	apicoectomy - anterior	0-20	Teeth 6 - 11, 22 - 27	No	One of (D3410) per 1 Lifetime Per patient per tooth. Includes retrograde filling.	pre-operative x-ray(s)

Exhibit A Benefits Covered for MassHealth - Under 21

Endodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D3421	apicoectomy - bicuspid (first root)	0-20	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	One of (D3421) per 1 Lifetime Per patient per tooth. Includes retrograde filling.	pre-operative x-ray(s)
D3425	apicoectomy - molar (first root)	0-20	Teeth 1 - 3, 14 - 19, 30 - 32	No	One of (D3425) per 1 Lifetime Per patient per tooth. Includes retrograde filling.	
D3426	apicoectomy (each additional root)	0-20	Teeth 1 - 5, 12 - 21, 28 - 32	No	One of (D3426) per 1 Lifetime Per patient per tooth for Bicuspids. Two of (D3426) per 1 Lifetime Per patient per tooth for First and Second Molars. Includes retrograde filling.	

Exhibit A Benefits Covered for MassHealth - Under 21

Periodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4210) per 36 Month(s) Per patient per quadrant. Limited to two quadrants on the same date of service in an office setting. Not payable in conjunction with D1110 and D1120 or D4341 and D4342 on same date of service.	Perio Charting, pre-op radiographs and narr of med necessity
D4211	gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	Limited to two quadrants on the same date of service in an office setting. Not payable in conjunction with D1110 and 1120 or D4341 and 4342 on same date of service.	
D4341	periodontal scaling and root planing - four or more teeth per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4341, D4342) per 36 Month(s) Per patient per quadrant. Two of (D4341, D4342) per 1 Day(s) Per Provider OR Location in office. Four of (D4341, D4342) per 1 Day(s) Per Provider OR Location in hospital. A minimum of four (4) affected teeth in the quadrant. Not payable in conjuction with D1110 and D1120 or D4210 and D4211 on same date of service.	
D4342	periodontal scaling and root planing - one to three teeth per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4341, D4342) per 36 Month(s) Per patient per quadrant. Two of (D4341, D4342) per 1 Day(s) Per Provider OR Location in office. Four of (D4341, D4342) per 1 Day(s) Per Provider OR Location in hospital. Not payable in conjuction with D1110 and D1120 or D4210 and D4211 on same date of service.	

Provision for removable prostheses when masticatory function is impaired, or when existing prostheses is unserviceable and when evidence indicates that the masticatory insufficiencies are likely to impair the general health of the member.

MassHealth pays for removable partial denture construction only if there are two or more missing posterior teeth or one or more missing anterior teeth and the remaining teeth are in good occlusion.

The remaining dentition must be sound and have a good prognosis. Existing or planned crown, bridges, partial dentures or full dentures are counted as occluding teeth.

If the ADA claim form does not accommodate the required narrative as specified, providers may include additional documentation on a separate page. Please note that fields 38, 43 & 44 of the ADA claim form are available to assist providers in supplying the appropriate information. If a replacement denture is requested, a reason, in addition to the age of the existing denture, needs to be included, i.e. ill-fitting, broken beyond repair. X-rays are not required when making the determination of medical necessity for members in nursing facilities. Diagnostic photos, however, may be requested at the discretion of the agency. If the member has no remaining natural teeth, radiographs are not required.

A preformed denture with teeth already mounted forming a denture module is not a covered service.

BILLING AND REIMBURSEMENT FOR CAST CROWNS AND POST & CORES OR REMOVABLE PROSTHETICS SHALL BE BASED ON THE CEMENTATION OR INSERTION DATE.

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5110	complete denture - maxillary	0-20	Per Arch (01, UA)	No	One of (D5110) per 84 Month(s) Per patient.	
D5120	complete denture - mandibular	0-20	Per Arch (02, LA)	No	One of (D5120) per 84 Month(s) Per patient.	
D5130	immediate denture - maxillary	0-20	Per Arch (01, UA)	No	One of (D5130) per 1 Lifetime Per patient.	
D5140	immediate denture - mandibular	0-20	Per Arch (02, LA)	No	One of (D5140) per 1 Lifetime Per patient.	
D5211	maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	0-20		No	One of (D5211) per 84 Month(s) Per patient. One of (D5211, D5213, D5225) per 84 Month(s) Per patient. Pre-op radiographs of all teeth in arch with claim for prepayment review. Documentation must indicate that there are two or more missing posterior teeth or one or more missing anterior teeth, the remaining dentition is sound and there is a good prognosis.	pre-operative x-ray(s)

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5212	mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	0-20		No	One of (D5212) per 84 Month(s) Per patient. One of (D5212, D5214, D5226) per 84 Month(s) Per patient. Pre-op radiographs of all teeth in arch with claim for prepayment review. Documentation must indicate that there are two or more missing posterior teeth or one or more missing anterior teeth, the remaining dentition is sound and there is a good prognosis.	pre-operative x-ray(s)
D5213	maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	0-20		No	One of (D5213) per 84 Month(s) Per patient. One of (D5211, D5213, D5225) per 84 Month(s) Per patient. Pre-op radiographs of all teeth in arch with claim for prepayment review. Documentation must indicate that there are two or more missing posterior teeth or one or more missing anterior teeth, the remaining dentition is sound and there is a good prognosis.	pre-operative x-ray(s)
D5214	mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	0-20		No	One of (D5214) per 84 Month(s) Per patient. One of (D5212, D5214, D5226) per 84 Month(s) Per patient. Pre-op radiographs of all teeth in arch with claim for prepayment review. Documentation must indicate that there are two or more missing posterior teeth or one or more missing anterior teeth, the remaining dentition is sound and there is a good prognosis.	pre-operative x-ray(s)
D5225	maxillary partial denture-flexible base	0-20		No	One of (D5225) per 84 Month(s) Per patient. One of (D5211, D5213, D5225) per 84 Month(s) Per patient. Pre-op radiographs of all teeth in arch with claim for prepayment review. Documentation must indicate that there are two or more missing posterior teeth or one or more missing anterior teeth, the remaining dentition is sound and there is a good prognosis.	pre-operative x-ray(s)

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5226	mandibular partial denture-flexible base	0-20		No	One of (D5226) per 84 Month(s) Per patient. One of (D5212, D5214, D5226) per 84 Month(s) Per patient. Pre-op radiographs of all teeth in arch with claim for prepayment review. Documentation must indicate that there are two or more missing posterior teeth or one or more missing anterior teeth, the remaining dentition is sound and there is a good prognosis.	pre-operative x-ray(s)
D5510	repair broken complete denture base	0-20	Per Arch (01, 02, LA, UA)	No	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	
D5520	replace missing or broken teeth - complete denture (each tooth)	0-20	Teeth 1 - 32	No	Three of (D5520) per 12 Month(s) Per patient. Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	
D5610	repair resin denture base	0-20	Per Arch (01, 02, LA, UA)	No	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	
D5620	repair cast framework	0-20	Per Arch (01, 02, LA, UA)	No	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5630	repair or replace broken clasp	0-20		No	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	
D5640	replace broken teeth-per tooth	0-20	Teeth 1 - 32	No	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	
D5650	add tooth to existing partial denture	0-20	Teeth 1 - 32	No	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	
D5660	add clasp to existing partial denture	0-20		No	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	
D5710	rebase complete maxillary denture	0-20		No	One of (D5710) per 24 Month(s) Per patient. Fee for denture includes payment for any relines or rebases necessary within 6 months of dispensing date of the denture.	
D5711	rebase complete mandibular denture	0-20		No	One of (D5711) per 24 Month(s) Per patient. Fee for denture includes payment for any relines or rebases necessary within 6 months of dispensing date of the denture.	
D5720	rebase maxillary partial denture	0-20		No	One of (D5720) per 24 Month(s) Per patient. Cast for partial denture only. Fee for partial denture includes payment for any relines or rebases necessary within 6 months of dispensing date of the denture.	

Exhibit A Benefits Covered for MassHealth - Under 21

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5721	rebase mandibular partial denture	0-20		No	One of (D5721) per 24 Month(s) Per patient. Cast for partial denture only. Fee for partial denture includes payment for any relines or rebases necessary within 6 months of dispensing date of the denture.	
D5730	reline complete maxillary denture (chairside)	0-20		No	One of (D5730, D5750) per 24 Month(s) Per patient. Fee for denture includes payment for any relines or rebases necessary within 6 months of dispensing date of the denture.	
D5731	reline complete mandibular denture (chairside)	0-20		No	One of (D5731, D5751) per 24 Month(s) Per patient. Fee for denture includes payment for any relines or rebases necessary within 6 months of dispensing date of the denture.	
D5740	reline maxillary partial denture (chairside)	0-20		No	One of (D5740, D5760) per 24 Month(s) Per patient. Fee for denture includes payment for any relines or rebases necessary within 6 months of dispensing date of the denture.	
D5741	reline mandibular partial denture (chairside)	0-20		No	One of (D5741, D5761) per 24 Month(s) Per patient. Fee for denture includes payment for any relines or rebases necessary within 6 months of dispensing date of the denture.	
D5750	reline complete maxillary denture (laboratory)	0-20		No	One of (D5750) per 24 Month(s) Per patient. One of (D5730, D5750) per 24 Month(s) Per patient. Fee for denture includes payment for any relines or rebases necessary within 6 months of dispensing date of the denture.	
D5751	reline complete mandibular denture (laboratory)	0-20		No	One of (D5751) per 24 Month(s) Per patient. One of (D5731, D5751) per 24 Month(s) Per patient. Fee for denture includes payment for any relines or rebases necessary within 6 months of dispensing date of the denture.	

Exhibit A Benefits Covered for MassHealth - Under 21

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5760	reline maxillary partial denture (laboratory)	0-20		No	One of (D5760) per 24 Month(s) Per patient. One of (D5740, D5760) per 24 Month(s) Per patient. Fee for partial denture includes payment for any relines or rebases necessary within 6 months of dispensing date of the denture.	
D5761	reline mandibular partial denture (laboratory)	0-20		No	One of (D5761) per 24 Month(s) Per patient. One of (D5741, D5761) per 24 Month(s) Per patient. Fee for partial denture includes payment for any relines or rebases necessary within 6 months of dispensing date of the denture.	

Exhibit A Benefits Covered for
MassHealth - Under 21

Fixed prosthetics will only be covered under special circumstances when no other acceptable less expensive dental service will adequately accomplish the treatment objectives. Only bridges with cast retainers or noble or base metals will be covered.

Acid etch bonded bridges should be considered as less expensive alternate treatment if circumstances permit. The MassHealth agency pays for fixed partial dentures (bridgework) for anterior teeth only for members under age 21 with fully matured teeth.

Candidates for fixed prosthetics must have demonstrated very good to excellent oral hygiene and dental health awareness.

Billing and reimbursement for cast crowns and post & cores or any other fixed prosthetic shall be based upon the cementation date.

Prosthodontics, fixed						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D6241	pontic-porcelain fused metal	0-20	Teeth 6 - 11, 22 - 27	No	One of (D6241) per 60 Month(s) Per patient per tooth.	
D6751	crown-porcelain fused to metal	0-20	Teeth 6 - 11, 22 - 27	No	One of (D6751) per 60 Month(s) Per patient per tooth.	
D6930	re-cement or re-bond fixed partial denture	0-20		No	Not covered within 6 months of placement.	
D6980	fixed partial denture repair	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No		
D6999	fixed prosthodontic procedure	0-20	Teeth 1 - 32	Yes		

Exhibit A Benefits Covered for MassHealth - Under 21

Extractions and treatment must be considered medically necessary and complicating patient's general health and be documented as such by the dentist or medical provider.

Reimbursement includes local anesthesia and routine pre-operative and post-operative care.

The extraction of asymptomatic impacted teeth is not a covered benefit. Symptomatic conditions would include pain and/or infection or demonstrated malocclusion causing a shifting of existing dentition.

Oral surgery procedures not listed in Exhibit A may be found in Subchapter 6 of the MassHealth Dental Manual and Regulation 130 CMR 420.000.

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7111	extraction, coronal remnants - deciduous tooth	0-20	Teeth A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	Erupted surgical extractions are defined as extractions requiring elevation of a mucoperiosteal flap and removal of bone and/or section of the tooth and closure.	
D7220	removal of impacted tooth-soft tissue	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	Only covered for teeth that are symptomatic, carious or pathologic.	
D7230	removal of impacted tooth-partially bony	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	Only covered for teeth that are symptomatic, carious or pathologic.	
D7240	removal of impacted tooth-completely bony	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	Removal of asymptomatic tooth not covered.	Narr of med necessity & full mouth xrays

Exhibit A Benefits Covered for MassHealth - Under 21

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7250	surgical removal of residual tooth roots (cutting procedure)	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	Only covered for teeth that are symptomatic, carious or pathologic.	
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	0-20	Teeth 1 - 32	No		
D7280	Surgical access of an unerupted tooth	0-20	Teeth 1 - 32	No		
D7283	placement of device to facilitate eruption of impacted tooth	0-20	Teeth 1 - 32	No		
D7310	alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D7310) per 6 Month(s) Per patient per quadrant. One of (D7310, D7311) per 1 Lifetime Per patient per quadrant. Limited to one per quadrant when the second procedure follows the first within 6 months.	
D7311	alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D7311) per 6 Month(s) Per patient per quadrant. One of (D7310, D7311) per 1 Lifetime Per patient per quadrant. Limited to one per quadrant when the second procedure follows the first within 6 months.	
D7320	alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D7320) per 6 Month(s) Per patient per quadrant. One of (D7320, D7321) per 1 Lifetime Per patient per quadrant. No extractions performed in edentulous area. Limited to one per quadrant when the second procedure follows the first within 6 months.	narrative of medical necessity
D7321	alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D7321) per 6 Month(s) Per patient per quadrant. One of (D7320, D7321) per 1 Lifetime Per patient per quadrant. No extractions performed on edentulous area. Limited to one per quadrant when the second procedure follows the first within 6 months.	
D7340	vestibuloplasty - ridge extension (secondary epithelialization)	0-20	Per Arch (01, 02, LA, UA)	Yes		narrative of medical necessity

Exhibit A Benefits Covered for MassHealth - Under 21

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7350	vestibuloplasty - ridge extension	0-20	Per Arch (01, 02, LA, UA)	No	Only payable to a dental provider with a specialty in oral surgery	
D7410	radical excision - lesion diameter up to 1.25cm	0-20		No		
D7411	excision of benign lesion greater than 1.25 cm	0-20		No		
D7450	removal of odontogenic cyst or tumor - lesion diameter up to 1.25cm	0-20		No	Pathology report.	
D7451	removal of odontogenic cyst or tumor - lesion greater than 1.25cm	0-20		No	Pathology report.	
D7460	removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25cm	0-20		No	Pathology report.	
D7461	removal of nonodontogenic cyst or tumor - lesion greater than 1.25cm	0-20		No	Pathology report.	
D7471	removal of exostosis - per site	0-20	Per Arch (01, 02, LA, UA)	No	Only payable to a dental provider with a specialty in oral surgery	
D7960	frenulectomy – also known as frenectomy or frenotomy – separate procedure not incidental to another procedure	0-20		No	Either a D7960 or D7963. The frenum may be excised when the tongue has limited mobility; for large diastemas between teeth; or when frenum interferes with a prosthetic appliance; or when it is the etiology of periodontal tissue disease. Narrative describing location and medical necessity must be maintained in the patient record.	narrative of medical necessity
D7963	frenuloplasty	0-20		No	Either a D7960 or D7963. The frenum may be excised when the tongue has limited mobility; for large diastemas between teeth; or when frenum interferes with a prosthetic appliance; or when it is the etiology of periodontal tissue disease. Narrative describing location and medical necessity must be maintained in the patient record.	narrative of medical necessity
D7970	excision of hyperplastic tissue - per arch	0-20	Per Arch (01, 02, LA, UA)	No	Not payable on the same date of service as an extraction (D7111 - D7240) of the same tooth.	

Exhibit A Benefits Covered for MassHealth - Under 21

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7999	unspecified oral surgery procedure, by report	0-20		Yes		narrative of medical necessity

Exhibit A Benefits Covered for
MassHealth - Under 21

Orthodontic
As detailed in Section 16.00 of the Office Reference Manual, Members under age 21 may qualify for orthodontic treatment (Members age 21 and older may qualify for continuation of treatment if they have been fully banded prior to their 21st birthday). All orthodontic services require prior authorization with the exception of pre-orthodontic treatment visits and orthodontic retention. For information and instructions on submitting prior authorization requests for orthodontic services and other relevant information, please refer to the sections of the Office Reference Manual listed below.
• Comprehensive Orthodontic Treatment: Sections 16.01 and 16.02 and Appendix B
• Interceptive Orthodontic Treatment: Section 16.04
• Continuation of Care: Section 16.03
• General Billing Information for Orthodontics: Section 16.05

Orthodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D8050	interceptive orthodontic treatment of the primary dentition	6-14		Yes	Adjustments for interceptive orthodontic treatment must be requested under the D8999 code and will be approved for a maximum of five units. Please see billing instructions in section 16 of the Office Reference Manual.	
D8060	interceptive orthodontic treatment of the transitional dentition	6-14		Yes	Adjustments for interceptive orthodontic treatment must be requested under the D8999 code and will be approved for a maximum of five units. Please see billing instructions in section 16 of the Office Reference Manual.	
D8070	comprehensive orthodontic treatment of the transitional dentition	6 - 20		Yes	One of (D8070, D8080) per 1 Lifetime Per patient. Only payable to a dental provider with a specialty of Orthodontics. Please see billing instructions in section 16 of the Office Reference Manual.	
D8080	comprehensive orthodontic treatment of the adolescent dentition	6 - 20		Yes	One of (D8070, D8080) per 1 Lifetime Per patient. Only payable to a dental provider with a specialty of Orthodontics. Please see billing instructions in section 16 of the Office Reference Manual.	
D8660	pre-orthodontic treatment examination to monitor growth and development	6 - 20		No	One of (D8660) per 6 Month(s) Per patient. Not billable after D8080,D8670, or D8680 has been paid. Only payable to a dental provider with a specialty of Orthodontics. Please see billing instructions in section 16 of the Office Reference Manual.	

Exhibit A Benefits Covered for MassHealth - Under 21

Orthodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D8670	periodic orthodontic treatment visit	6 - 20		Yes	One of (D8670) per 90 Day(s) Per patient. Allowed as quarterly treatment visits. May not be billed less than 90 days from previous adjustment of banding date. Only payable to a dental provider with a specialty of Orthodontics. Please see billing instructions in section 16 of the Office Reference Manual.	
D8680	orthodontic retention (removal of appliances)	6 - 20		No	Five of (D8680) per 1 Lifetime Per patient. Only payable to a dental provider with a specialty of Orthodontics. Please see billing instructions in Section 16 of the Office Reference Manual.	
D8690	orthodontic treatment(alternative billing to a contract fee)	6 - 20		Yes	One of (D8690) per 12 Month(s) Per Provider OR Location. Only payable to a dental provider with a specialty of Orthodontics. Please see billing instructions in Section 16 of the Office Reference Manual.	
D8692	replacement of lost or broken retainer	8 - 20	Per Arch (01, 02, LA, UA)	Yes	Three of (D8692) per 2 Calendar year(s) Per patient. The MassHealth agency pays for replacement retainers only during the 2 year retention period following orthodontic treatment. Only payable to a dental provider with a specialty of Orthodontics. Statement regarding the date of the onset of retention.	
D8999	unspecified orthodontic procedure, by report	6-14		Yes	Five of (D8999) per 1 Lifetime Per patient. This code is used exclusively for interceptive orthodontic adjustments and will be approved for up to a maximum of 5 units. When requesting other unspecified orthodontic services please use the D9999 code. Please see billing instructions in section 16 of the Office Reference Manual.	

The use of local anesthesia and analgesia, both orally and rectally is considered part of the operative procedure, and no additional payment will be made for it. The administration of inhalation analgesia (nitrous oxide) is paid as a separate procedure.

Prior authorization is not required when administered in the office only by a provider who possesses both an anesthesia-administration permit and an anesthesia-facility permit issued by the Massachusetts Board of Registration in Dentistry and when a member is eligible for oral surgery services.

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

House extended care facility-This code may be billed separately from the codes for any medically necessary services performed and maybe billed once per day, per business, per facility.

Adjunctive General Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D9110	palliative (emergency) treatment of dental pain - minor procedure	0-20		No	Other non-emergency medically necessary treatment may be provided during the same visit. Not covered with D0120,D0140,D0160 by same provider or provider group on same date of service.	
D9223	deep sedation/general anesthesia – each 15 minute increment	0-20		No		
D9230	inhalation of nitrous oxide/analgesia, anxiolysis	0-20		No	The routine administration of inhalation analgesia or oral sedation is generally considered part of the treatment procedure, unless its use is documented in the patient record as necessary to complete treatment	
D9243	intravenous moderate (conscious) sedation/analgesia – each 15 minute increment	0-20		No		
D9248	non-intravenous moderate (conscious) sedation	0-20		No		
D9410	house/extended care facility call	0-20		No	One of (D9410) per 1 Day(s)Per Business,Per facility. Claim must be submitted with one of the following place of service (POS)codes to be considered for payment (03,04,12,13,14,31,32,33,34,or 99). Facility name and address must be placed on the claim form in the narratives section.	

Exhibit A Benefits Covered for MassHealth - Under 21

Adjunctive General Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D9920	behavior management, by report	0-20		Yes	One of (D9920) per 1 Day(s) Per Provider OR Location. Include a description of the members illness or disability and types of services to be furnished.	narrative of medical necessity
D9930	treatment of complications (post-surgical) - unusual circumstances, by report	0-20		No		narrative of medical necessity
D9940	occlusal guard, by report	0-20		Yes	One of (D9940) per 1 Year(s) Per patient.	
D9941	fabrication of athletic mouthguard	0-20		No		
D9999	unspecified adjunctive procedure, by report	0-20		Yes		narrative of medical necessity

Exhibit B Benefits Covered for
MassHealth - 21 and Over (Regular)

Diagnostic services include the oral examination, and selected radiographs needed to assess the oral health, diagnose oral pathology, and develop an adequate treatment plan for the member's oral health.

Reimbursement for some or multiple radiographs of the same tooth or area may be denied if DSM/DentaQuest determines the number to be redundant, excessive or not in keeping with the federal guidelines relating to radiation exposure. The maximum amount paid for individual radiographs taken on the same day will be limited to the allowance for a full mouth series. Reimbursement for radiographs is limited to those films required for proper treatment and/or diagnosis.

The MassHealth Dental Program utilizes the guidelines published by the Department of Health and Human Services Center for Devices and Radiological Health. However, please consult the following tables for coverage limitations.

All radiographs must be of good diagnostic quality properly mounted, dated and identified with the member's name and date of birth. Substandard radiographs will not be reimbursed, or if already paid for, MassHealth Dental Program will recoup the funds previously paid.

Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0120	periodic oral evaluation - established patient	21 and older		No	Two of (D0120, D0145) per 1 Calendar year(s) Per Provider OR Location. Not covered with D9110 by same provider or provider group on same date of service.	
D0140	limited oral evaluation-problem focused	21 and older		No	Two of (D0140) per 1 Calendar year(s) Per patient. Not covered with D9110, D0160 by same provider or provider group on same date of service.	
D0150	comprehensive oral evaluation - new or established patient	21 and older		No	One of (D0150) per 1 Lifetime Per Provider OR Location.	
D0160	detailed and extensive oral eval-problem focused, by report	21 and older		No	Two of (D0160) per 12 Month(s) Per patient. Not covered with D9110, D0140 by same provider or provider group on same date of service.	
D0210	intraoral - complete series of radiographic images	21 and older		No	One of (D0210) per 3 Calendar year(s) Per Provider OR Location. One complete series every three calendar years per patient, per provider or location. Any combination of radiographs that exceeds the maximum allowable payment for a FMX will be recoded to D0210.	

Exhibit B Benefits Covered for MassHealth - 21 and Over (Regular)

Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0220	intraoral - periapical first radiographic image	21 and older		No	One of (D0220) per 1 Day(s) Per Provider OR Location. Twelve of (D0220, D0230) per 12 Month(s) Per patient. Maximum of one per 1 day per patient per (Provider or Location). Any combination of radiographs that exceeds the maximum allowable payment for a FMX will be recoded to D0210.	
D0230	intraoral - periapical each additional radiographic image	21 and older		No	Three of (D0230) per 1 Day(s) Per Provider OR Location. Twelve of (D0220, D0230) per 12 Month(s) Per patient. Maximum of 3 per day per patient per (Provider or Location). Any combination of radiographs that exceeds the maximum allowable payment for a FMX will be recoded to D0210.	
D0270	bitewing - single radiographic image	21 and older		No	Two of (D0270, D0272, D0273, D0274) per 1 Calendar year(s) Per Provider OR Location. Any combination of radiographs that exceeds the maximum allowable payment for a FMX will be recoded to D0210.	
D0272	bitewings - two radiographic images	21 and older		No	Two of (D0270, D0272, D0273, D0274) per 1 Calendar year(s) Per Provider OR Location. Any combination of radiographs that exceeds the maximum allowable payment for a FMX will be recoded to D0210.	
D0273	bitewings - three radiographic images	21 and older		No	Two of (D0270, D0272, D0273, D0274) per 1 Calendar year(s) Per Provider OR Location. Any combination of radiographs that exceeds the maximum allowable payment for a FMX will be recoded to D0210.	
D0274	bitewings - four radiographic images	21 and older		No	Two of (D0270, D0272, D0273, D0274) per 1 Calendar year(s) Per Provider OR Location. Any combination of radiographs that exceeds the maximum allowable payment for a FMX will be recoded to D0210.	

Exhibit B Benefits Covered for MassHealth - 21 and Over (Regular)

Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0330	panoramic radiographic image	21 and older		No	One of (D0330) per 3 Year(s) Per patient. Surgical conditions require pre-payment review only. Non-surgical conditions are payable once per 3 year(s) in lieu of an FMX for patients who are unable to cooperate with an FMX. Narrative of medical necessity stating the reason why member cannot cooperate with the process for obtaining a full mouth series	narrative of medical necessity
D0340	cephalometric radiographic image	21 and older		Yes	Reimbursable when used in conjunction with surgical condition, including status post-facial trauma such as LaFort, mandibular fractures and jaw dislocation	narrative of medical necessity

Treatment that incorporates fluoride with the polishing compound is considered part of the prophylaxis procedure and not a separate topical fluoride treatment.

Preventative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D1110	prophylaxis - adult	21 and older		No	Two of (D1110) per 1 Calendar year(s) Per patient.	
D1206	topical application of fluoride varnish	21 and older		Yes	One of (D1206, D1208) per 90 Day(s) Per Provider OR Location. Only allowed for members 21 & older who have medical \ dental conditions that significantly interrupt the flow of saliva.	narrative of medical necessity
D1208	topical application of fluoride - excluding varnish	21 and older		Yes	One of (D1206, D1208) per 90 Day(s) Per Provider OR Location. Only allowed for members 21 & older who have medical \ dental conditions that significantly interrupt the flow of saliva.	narrative of medical necessity

Exhibit B Benefits Covered for
MassHealth - 21 and Over (Regular)

Restorations replaced within one year of the date of completion of the original restoration are not covered. No combination of services on a single tooth during the same period of treatment is reimbursable in excess of the maximum allowable fee for a four-or-more surface amalgam or composite restoration. When restorations involving multiple surfaces are requested or performed, that are outside the usual anatomical expectation, the allowance is limited to that of a one-surface restoration. Any fee charged in excess of the allowance for the one-surface restoration is DISALLOWED. The MassHealth Dental Program considers all of the following to be components of a completed restoration and includes them in the fee for this service: tooth and soft-tissue preparation, cement bases, etching and bonding agents, pulp capping, impression, local anesthesia and polishing. Billing and reimbursement for cast crowns, cast post & cores or any other fixed prosthetics shall be based on the cementation date. Restorative pins are reimbursed on a per tooth basis, regardless of the number of pins placed. Reinforcing pins are covered only when used in conjunction with a two-or-more-surface restoration on a permanent tooth. The MassHealth Dental Program pays for no more than four stainless steel or pre-fabricated resin crowns per date of service in an office setting. This limitation does not apply when stainless steel or pre-fabricated resin crowns are performed in the OR or outpatient facility.

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2140	Amalgam - one surface, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per Business per tooth. per surface.	
D2150	Amalgam - two surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per Business per tooth. per surface.	
D2160	amalgam - three surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per Business per tooth. per surface.	
D2161	amalgam - four or more surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per Business per tooth. per surface.	
D2330	resin-based composite - one surface, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per Business per tooth. per surface.	
D2331	resin-based composite - two surfaces, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per Business per tooth. per surface.	
D2332	resin-based composite - three surfaces, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per Business per tooth. per surface.	

Exhibit B Benefits Covered for MassHealth - 21 and Over (Regular)

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per Business per tooth. per surface.	
D2391	resin-based composite - one surface, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per Business per tooth. per surface. MassHealth will no longer pay any more for a composite restoration on a primary (deciduous) posterior tooth that they would for an amalgam restoration.	
D2392	resin-based composite - two surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per Business per tooth. per surface. MassHealth will no longer pay any more for a composite restoration on a primary (deciduous) posterior tooth that they would for an amalgam restoration.	
D2393	resin-based composite - three surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per Business per tooth. per surface. MassHealth will no longer pay any more for a composite restoration on a primary (deciduous) posterior tooth that they would for an amalgam restoration.	
D2394	resin-based composite - four or more surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per Business per tooth. per surface. MassHealth will no longer pay any more for a composite restoration on a primary (deciduous) posterior tooth that they would for an amalgam restoration.	

Exhibit B Benefits Covered for
MassHealth - 21 and Over (Regular)

Provision for removable prostheses when masticatory function is impaired, or when existing prostheses is unserviceable and when evidence indicates that the masticatory insufficiencies are likely to impair the general health of the member.

MassHealth pays for removable partial denture construction only if there are two or more missing posterior teeth or one or more missing anterior teeth and the remaining teeth are in good occlusion.

The remaining dentition must be sound and have a good prognosis. Existing or planned crown, bridges, partial dentures or full dentures are counted as occluding teeth.

If the ADA claim form does not accommodate the required narrative as specified, providers may include additional documentation on a separate page. Please note that fields 38, 43 & 44 of the ADA claim form are available to assist providers in supplying the appropriate information. If a replacement denture is requested, a reason, in addition to the age of the existing denture, needs to be included, i.e. ill-fitting, broken beyond repair. X-rays are not required when making the determination of medical necessity for members in nursing facilities. Diagnostic photos, however, may be requested at the discretion of the agency. If the member has no remaining natural teeth, radiographs are not required.

A preformed denture with teeth already mounted forming a denture module is not a covered service.

BILLING AND REIMBURSEMENT FOR CAST CROWNS AND POST & CORES OR REMOVABLE PROSTHETICS SHALL BE BASED ON THE CEMENTATION OR INSERTION DATE.

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5110	complete denture - maxillary	21 and older	Per Arch (01, UA)	No	One of (D5110) per 84 Month(s) Per patient. Complete treatment plan and prosthetic history. If the member still has natural teeth, a current series of periapical and bitewing films. X-rays are not required if the patient is edentulous.	
D5120	complete denture - mandibular	21 and older	Per Arch (02, LA)	No	One of (D5120) per 84 Month(s) Per patient. Complete treatment plan and prosthetic history. If the member still has natural teeth, a current series of periapical and bitewing films. X-rays are not required if the patient is edentulous.	
D5211	maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	21 and older		No	One of (D5211) per 84 Month(s) Per patient. Pre-op radiographs of all teeth in arch with claim for prepayment review. Documentation must indicate that there are two or more missing posterior teeth or one or more missing anterior teeth, the remaining dentition is sound and there is a good prognosis.	

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5212	mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	21 and older		No	One of (D5212) per 84 Month(s) Per patient. Pre-op radiographs of all teeth in arch with claim for prepayment review. Documentation must indicate that there are two or more missing posterior teeth or one or more missing anterior teeth, the remaining dentition is sound and there is a good prognosis.	
D5510	repair broken complete denture base	21 and older	Per Arch (01, 02, LA, UA)	No	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	
D5520	replace missing or broken teeth - complete denture (each tooth)	21 and older	Teeth 1 - 32	No	Three of (D5520) per 12 Month(s) Per patient. Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	
D5610	repair resin denture base	21 and older	Per Arch (01, 02, LA, UA)	No	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	
D5620	repair cast framework	21 and older	Per Arch (01, 02, LA, UA)	No	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	
D5630	repair or replace broken clasp	21 and older		No	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	

Exhibit B Benefits Covered for MassHealth - 21 and Over (Regular)

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5640	replace broken teeth-per tooth	21 and older	Teeth 1 - 32	No	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	
D5650	add tooth to existing partial denture	21 and older	Teeth 1 - 32	No	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	
D5660	add clasp to existing partial denture	21 and older		No	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	
D5710	rebase complete maxillary denture	21 and older		No	One of (D5710) per 36 Month(s) Per patient. Fees for denture includes payment for any reline\rebase necessary w\in 12 mos. of dispensing date of denture. Include date of original insertion of the denture, date(s) of prior rebase(s), and clinical documentation of the reason for the request	
D5711	rebase complete mandibular denture	21 and older		No	One of (D5711) per 36 Month(s) Per patient. Fees for denture includes payment for any reline\rebase necessary w\in 12 mos. of dispensing date of denture. Include date of original insertion of the denture, date(s) of prior rebase(s), and clinical documentation of the reason for the request	

Exhibit B Benefits Covered for MassHealth - 21 and Over (Regular)

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5730	reline complete maxillary denture (chairside)	21 and older		No	One of (D5730, D5750) per 36 Month(s) Per patient. Cast for partial denture only. Fee for partial denture includes payment for any relines or rebases necessary within 6 months of dispensing date of the denture. Include date of original insertion of the denture, dates of prior relines, if applicable, and clinical documentation of the reason for the request.	
D5731	reline complete mandibular denture (chairside)	21 and older		No	One of (D5731, D5751) per 36 Month(s) Per patient. Cast for partial denture only. Fee for partial denture includes payment for any relines or rebases necessary within 6 months of dispensing date of the denture. Include date of original insertion of the denture, dates of prior relines, if applicable, and clinical documentation of the reason for the request.	
D5750	reline complete maxillary denture (laboratory)	21 and older		No	One of (D5730, D5750) per 36 Month(s) Per patient. Cast for partial denture only. Fee for partial denture includes payment for any relines or rebases necessary within 6 months of dispensing date of the denture. Include date of original insertion of the denture, date(s) of prior rebase(s), if applicable, and clinical documentation of the reason for the request.	
D5751	reline complete mandibular denture (laboratory)	21 and older		No	One of (D5731, D5751) per 36 Month(s) Per patient. Cast for partial denture only. Fee for partial denture includes payment for any relines or rebases necessary within 6 months of dispensing date of the denture. Include date of original insertion of the denture, date(s) of prior rebase(s), if applicable, and clinical documentation of the reason for the request.	

Exhibit B Benefits Covered for
MassHealth - 21 and Over (Regular)

Extractions and treatment must be considered medically necessary and complicating patient's general health and be documented as such by the dentist or medical provider.

Reimbursement includes local anesthesia and routine pre-operative and post-operative care.

The extraction of asymptomatic impacted teeth is not a covered benefit. Symptomatic conditions would include pain and/or infection or demonstrated malocclusion causing a shifting of existing dentition.

Oral surgery procedures not listed in Exhibit A may be found in Exhibit C or in Subchapter 6 of the MassHealth Dental Manual and Regulation 130 CMR 420.000.

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7111	extraction, coronal remnants - deciduous tooth	21 and older	Teeth A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	Erupted surgical extractions are defined as extractions requiring elevation of a mucoperiosteal flap and removal of bone and/or section of the tooth and closure.	
D7220	removal of impacted tooth-soft tissue	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	Only covered for teeth that are symptomatic, carious or pathologic.	
D7230	removal of impacted tooth-partially bony	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	Only covered for teeth that are symptomatic, carious or pathologic.	
D7240	removal of impacted tooth-completely bony	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	Removal of asymptomatic tooth not covered.	Narr of med necessity & full mouth xrays

Exhibit B Benefits Covered for MassHealth - 21 and Over (Regular)

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7250	surgical removal of residual tooth roots (cutting procedure)	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	Only covered for teeth that are symptomatic, carious or pathologic.	
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	21 and older	Teeth 1 - 32	No		
D7310	alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D7310) per 6 Month(s) Per patient per quadrant. One of (D7310, D7311) per 1 Lifetime Per patient per quadrant. Limited to one per quadrant when performed within 6 months of initial alveoloplasty.	
D7311	alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D7311) per 6 Month(s) Per patient per quadrant. One of (D7310, D7311) per 1 Lifetime Per patient per quadrant. Limited to one per quadrant when performed within 6 months of initial alveoloplasty. Up to 3 teeth\tooth spaces per quad.	narrative of medical necessity
D7320	alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D7320) per 6 Month(s) Per patient per quadrant. One of (D7320, D7321) per 1 Lifetime Per patient per quadrant. No extractions performed in edentulous area. Limited to two per quadrant when the second procedure follows the first within 6 months.	narrative of medical necessity
D7321	alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D7321) per 6 Month(s) Per patient per quadrant. One of (D7320, D7321) per 1 Lifetime Per patient per quadrant. Limited to one per quadrant when performed within 6 months of initial alveoloplasty. Up to 3 teeth\tooth spaces per quad.	

Exhibit B Benefits Covered for MassHealth - 21 and Over (Regular)

Orthodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D8670	periodic orthodontic treatment visit	21 and older		Yes	One of (D8670) per 90 Day(s) Per patient. Allowed as quarterly treatment visits. May not be billed less than 90 days from previous adjustment of banding date. Only payable to a dental provider with a specialty of Orthodontics. Please see billing instructions in section 16 of the Office Reference Manual.	
D8680	orthodontic retention (removal of appliances)	21 and older		Yes	Five of (D8680) per 1 Lifetime Per patient. Only payable to a dental provider with a specialty of Orthodontics. Please see billing instructions in Section 16 of the Office Reference Manual.	
D8692	replacement of lost or broken retainer	21 and older	Per Arch (01, 02, LA, UA)	Yes	Three of (D8692) per 2 Calendar year(s) Per patient. The MassHealth agency pays for replacement retainers only during the 2 year retention period following orthodontic treatment. Only payable to a dental provider with a specialty of Orthodontics. Statement regarding the date of the onset of retention.	

The use of local anesthesia and analgesia, both orally and rectally is considered part of the operative procedure, and no additional payment will be made for it. The administration of inhalation analgesia (nitrous oxide) is paid as a separate procedure.

Prior authorization is not required when administered in the office only by a provider who possesses both an anesthesia-administration permit and an anesthesia-facility permit issued by the Massachusetts Board of Registration in Dentistry and when a member is eligible for oral surgery services.

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

House extended care facility-This code may be billed separately from the codes for any medically necessary services performed and maybe billed once per day, per business, per facility.

Adjunctive General Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D9110	palliative (emergency) treatment of dental pain - minor procedure	21 and older		No	Other non-emergency medically necessary treatment may be provided during the same visit. Not covered with D0120,D0140,D0160 by same provider or provider group on same date of service.	
D9223	deep sedation/general anesthesia – each 15 minute increment	21 and older		No		
D9230	inhalation of nitrous oxide/analgesia, anxiolysis	21 and older		No		
D9243	intravenous moderate (conscious) sedation/analgesia – each 15 minute increment	21 and older		No		
D9248	non-intravenous moderate (conscious) sedation	21 and older		No		
D9410	house/extended care facility call	21 and older		No	One of (D9410) per 1 Day(s)Per Business,Per facility. Claim must be submitted with one of the following place of service (POS)codes to be considered for payment (03,04,12,13,14,31,32,33,34,or 99). Facility name and address must be placed on the claim form in the narratives section.	
D9920	behavior management, by report	21 and older		Yes	One of (D9920) per 1 Day(s) Per Provider OR Location. Narrative of medical necessity. Include a description of the members illness or disability and types of services to be furnished.	narrative of medical necessity

Exhibit B Benefits Covered for MassHealth - 21 and Over (Regular)

Adjunctive General Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D9930	treatment of complications (post-surgical) - unusual circumstances, by report	21 and older		No	Include with claim the date, the location of the original surgery and the type of procedure.	

Exhibit C Benefits Covered for
MassHealth - 21 and Over (DDS)

Diagnostic services include the oral examination, and selected radiographs needed to assess the oral health, diagnose oral pathology, and develop an adequate treatment plan for the member's oral health.

Reimbursement for some or multiple radiographs of the same tooth or area may be denied if DSM/DentaQuest determines the number to be redundant, excessive or not in keeping with the federal guidelines relating to radiation exposure. The maximum amount paid for individual radiographs taken on the same day will be limited to the allowance for a full mouth series.

Reimbursement for radiographs is limited to those films required for proper treatment and/or diagnosis.

The MassHealth Dental Program utilizes the guidelines published by the Department of Health and Human Services Center for Devices and Radiological Health. However, please consult the following tables for coverage limitations.

All radiographs must be of good diagnostic quality properly mounted, dated and identified with the member's name and date of birth. Substandard radiographs will not be reimbursed, or if already paid for, MassHealth Dental Program will recoup the funds previously paid.

Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0120	periodic oral evaluation - established patient	21 and older		No	Two of (D0120, D0145) per 1 Calendar year(s) Per Provider OR Location. Not covered with D9110 by same provider or provider group on same date of service.	
D0140	limited oral evaluation-problem focused	21 and older		No	Two of (D0140) per 1 Calendar year(s) Per patient. Not covered with D9110, D0160 by same provider or provider group on same date of service.	
D0150	comprehensive oral evaluation - new or established patient	21 and older		No	One of (D0150) per 1 Lifetime Per Provider OR Location.	
D0160	detailed and extensive oral eval-problem focused, by report	21 and older		No	Two of (D0160) per 12 Month(s) Per patient. Not covered with D9110, D0140 by same provider or provider group on same date of service.	
D0210	intraoral - complete series of radiographic images	21 and older		No	One of (D0210) per 3 Calendar year(s) Per Provider OR Location. One complete series every three calendar years per patient per dentist or dental group. Any combination of radiographs that exceeds the maximum allowable payment for a FMX will be recoded to D0210.	

Exhibit C Benefits Covered for MassHealth - 21 and Over (DDS)

Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0220	intraoral - periapical first radiographic image	21 and older		No	One of (D0220) per 1 Day(s) Per Provider OR Location. Twelve of (D0220, D0230) per 12 Month(s) Per patient. Any combination of radiographs that exceeds the maximum allowable payment for a FMX will be recoded to D0210.	
D0230	intraoral - periapical each additional radiographic image	21 and older		No	Three of (D0230) per 1 Day(s) Per Provider OR Location. Twelve of (D0220, D0230) per 12 Month(s) Per patient. Any combination of radiographs that exceeds the maximum allowable payment for a FMX will be recoded to D0210.	
D0270	bitewing - single radiographic image	21 and older		No	Two of (D0270, D0272, D0273, D0274) per 1 Calendar year(s) Per Provider OR Location. Any combination of radiographs that exceeds the maximum allowable payment for a FMX will be recoded to D0210.	
D0272	bitewings - two radiographic images	21 and older		No	Two of (D0270, D0272, D0273, D0274) per 1 Calendar year(s) Per Provider OR Location. Any combination of radiographs that exceeds the maximum allowable payment for a FMX will be recoded to D0210.	
D0273	bitewings - three radiographic images	21 and older		No	Two of (D0270, D0272, D0273, D0274) per 1 Calendar year(s) Per Provider OR Location. Any combination of radiographs that exceeds the maximum allowable payment for a FMX will be recoded to D0210.	
D0274	bitewings - four radiographic images	21 and older		No	Two of (D0270, D0272, D0273, D0274) per 1 Calendar year(s) Per Provider OR Location. Any combination of radiographs that exceeds the maximum allowable payment for a FMX will be recoded to D0210.	

Exhibit C Benefits Covered for MassHealth - 21 and Over (DDS)

Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0330	panoramic radiographic image	21 and older		No	One of (D0330) per 3 Year(s) Per patient. Surgical conditions require pre-payment review only. Non-surgical conditions are payable once per 3 year(s) in lieu of an FMX for patients who are unable to cooperate with an FMX. Narrative of medical necessity stating the reason why member cannot cooperate with the process for obtaining a full mouth series	narrative of medical necessity
D0340	cephalometric radiographic image	21 and older		Yes	Reimbursable when used in conjunction with surgical condition, including status post-facial trauma such as LaFort, mandibular fractures and jaw dislocation.	narrative of medical necessity

Space maintainers are a covered service when medically indicated due to the premature loss of primary tooth.

The application of topical fluoride treatment is allowed for Members up to age 21 when provided in conjunction with a prophylaxis. Treatment that incorporates fluoride with the polishing compound is considered part of the prophylaxis procedure and not a separate topical fluoride treatment.

Sealants are not allowable over restored tooth surfaces.

Preventative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D1110	prophylaxis - adult	21 and older		No	Two of (D1110) per 1 Calendar year(s) Per patient.	
D1206	topical application of fluoride varnish	21 and older		Yes	One of (D1206, D1208) per 90 Day(s) Per Provider OR Location. Only allowed for members 21 & older who have medical \ dental conditions that significantly interrupt the flow of saliva.	narrative of medical necessity
D1208	topical application of fluoride - excluding varnish	21 and older		Yes	One of (D1206, D1208) per 90 Day(s) Per Provider OR Location. Only allowed for members 21 & older who have medical \ dental conditions that significantly interrupt the flow of saliva.	narrative of medical necessity

Exhibit C Benefits Covered for
MassHealth - 21 and Over (DDS)

Restorations replaced within one year of the date of completion of the original restoration are not covered. No combination of services on a single tooth during the same period of treatment is reimbursable in excess of the maximum allowable fee for a four-or-more surface amalgam or composite restoration. When restorations involving multiple surfaces are requested or performed, that are outside the usual anatomical expectation, the allowance is limited to that of a one-surface restoration. Any fee charged in excess of the allowance for the one-surface restoration is DISALLOWED. The MassHealth Dental Program considers all of the following to be components of a completed restoration and includes them in the fee for this service: tooth and soft-tissue preparation, cement bases, etching and bonding agents, pulp capping, impression, local anesthesia and polishing. Billing and reimbursement for cast crowns, cast post & cores or any other fixed prosthetics shall be based on the cementation date. Restorative pins are reimbursed on a per tooth basis, regardless of the number of pins placed. Reinforcing pins are covered only when used in conjunction with a two-or-more-surface restoration on a permanent tooth. The MassHealth Dental Program pays for no more than four stainless steel or pre-fabricated resin crowns per date of service in an office setting. This limitation does not apply when stainless steel or pre-fabricated resin crowns are performed in the OR or outpatient facility.

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2140	Amalgam - one surface, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per Business per tooth. per surface.	
D2150	Amalgam - two surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per Business per tooth. per surface.	
D2160	amalgam - three surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per Business per tooth. per surface.	
D2161	amalgam - four or more surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per Business per tooth. per surface.	
D2330	resin-based composite - one surface, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per Business per tooth. per surface.	
D2331	resin-based composite - two surfaces, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per Business per tooth. per surface.	
D2332	resin-based composite - three surfaces, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per Business per tooth. per surface.	

Exhibit C Benefits Covered for MassHealth - 21 and Over (DDS)

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Day(s) Per Business per tooth. per surface.	
D2391	resin-based composite - one surface, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per Business per tooth. per surface. MassHealth will no longer pay any more for a composite restoration on a primary (deciduous) posterior tooth than they would for an amalgam restoration.	
D2392	resin-based composite - two surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per Business per tooth. per surface. MassHealth will no longer pay any more for a composite restoration on a primary (deciduous) posterior tooth than they would for an amalgam restoration.	
D2393	resin-based composite - three surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per Business per tooth. per surface. MassHealth will no longer pay any more for a composite restoration on a primary (deciduous) posterior tooth than they would for an amalgam restoration.	
D2394	resin-based composite - four or more surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per Business per tooth. per surface. MassHealth will no longer pay any more for a composite restoration on a primary (deciduous) posterior tooth than they would for an amalgam restoration.	
D2751	crown - porcelain fused to predominantly base metal	21 and older	Teeth 6 - 11, 22 - 27	Yes	One of (D2710, D2740, D2750, D2751, D2752, D2790) per 60 Month(s) Per patient per tooth. Posterior teeth covered only when extraction would cause undue medical risk for a member w\ 1 or more specific medical conditions.	pre-operative x-ray(s)

Exhibit C Benefits Covered for MassHealth - 21 and Over (DDS)

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	21 and older	Teeth 1 - 32	No	Not covered within 6 months of initial placement.	
D2920	re-cement or re-bond crown	21 and older	Teeth 1 - 32, A - T	No	Not covered within 6 months of initial placement.	
D2931	prefabricated steel crown-permanent tooth	21 and older	Teeth 1 - 32	Yes	Four of (D2930, D2931, D2932, D2934) per 1 Day(s) Per patient. Covered only if extraction would cause undue medical risk for a member with specific documented medical conditions. Maximum of 4 per day if performed in an office setting. No limitation if performed in the OR or outpatient facility.	narrative of medical necessity
D2951	pin retention - per tooth, in addition to restoration	21 and older	Teeth 1 - 32	No	Must be billed with a two-or-more surface restoration on a permanent tooth.	
D2954	prefabricated post and core in addition to crown	21 and older	Teeth 6 - 11, 22 - 27	Yes	Posterior teeth are covered only if extraction would cause undue medical risk for a member with specific documented medical conditions.	Periapical x-ray(s)
D2980	crown repair, by report	21 and older	Teeth 1 - 32	No		
D2999	unspecified restorative procedure, by report	21 and older	Teeth 1 - 32, A - T	Yes		narrative of medical necessity

Payment for conventional root canal treatment is limited to treatment of permanent teeth.

The standard of acceptability employed for endodontic procedures requires that the canal(s) be completely filled apically and laterally. In cases where the root canal filling does not meet DSM/DentaQuest's treatment standards, DSM/DentaQuest can require the procedure to be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after any post payment review by the DSM/DentaQuest Consultants.

A pulpotomy or palliative treatment is not to be billed in conjunction with a root canal treatment.

Filling material not accepted by the Federal Food and Drug Administration (FDA) (e.g. Sargenti filling material) is not covered.

The fee for root canal therapy for permanent teeth includes diagnosis, extirpation treatment, temporary fillings, filling and obturation of root canals, and progress radiographs. A completed fill radiograph is also included.

Endodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D3310	endodontic therapy, anterior tooth (excluding final restoration)	21 and older	Teeth 6 - 11, 22 - 27	No	One of (D3310) per 1 Lifetime Per patient per tooth. No limitation on number performed per treatment period. Total diagnosis and treatment plan supported by radiograph of remaining teeth.	
D3320	endodontic therapy, bicuspid tooth (excluding final restoration)	21 and older	Teeth 4, 5, 12, 13, 20, 21, 28, 29	Yes	One of (D3320) per 1 Lifetime Per patient per tooth. Covered only if extraction would cause undue medical risk for a member with specific documented medical conditions.	narrative of medical necessity
D3330	endodontic therapy, molar (excluding final restoration)	21 and older	Teeth 2, 3, 14, 15, 18, 19, 30, 31	Yes	One of (D3330) per 1 Lifetime Per patient per tooth. Covered only if extraction would cause undue medical risk for a member with specific documented medical conditions.	narrative of medical necessity
D3346	retreatment of previous root canal therapy-anterior	21 and older	Teeth 6 - 11, 22 - 27	No	Not payable to the same provider who performed the original endodontic therapy (D3310,D3320 or D3330) within 24 months. Include periapical film of the tooth and date of original root canal treatment.	
D3347	retreatment of previous root canal therapy-bicuspid	21 and older	Teeth 4, 5, 12, 13, 20, 21, 28, 29	Yes	Covered only if extraction would cause undue medical risk for a member with specific documented medical conditions. Not payable to the same provider who performed the original endodontic therapy (D3310, D3320 or D3330) within 24 months.	narrative of medical necessity

Exhibit C Benefits Covered for MassHealth - 21 and Over (DDS)

Endodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D3348	retreatment of previous root canal therapy-molar	21 and older	Teeth 2, 3, 14, 15, 18, 19, 30, 31	Yes	Covered only if extraction would cause undue medical risk for a member with specific documented medical conditions. Not payable to the same provider who performed the original endodontic therapy (D3310, D3320 or D3330) within 24 months.	narrative of medical necessity
D3410	apicoectomy - anterior	21 and older	Teeth 6 - 11, 22 - 27	Yes	One of (D3410) per 1 Lifetime Per patient per tooth. Includes retrograde filling.	
D3421	apicoectomy - bicuspid (first root)	21 and older	Teeth 4, 5, 12, 13, 20, 21, 28, 29	Yes	One of (D3421) per 1 Lifetime Per patient per tooth. Includes retrograde filling.	
D3425	apicoectomy - molar (first root)	21 and older	Teeth 1 - 3, 14 - 19, 30 - 32	Yes	One of (D3425) per 1 Lifetime Per patient per tooth. Includes retrograde filling.	pre-operative x-ray(s)
D3426	apicoectomy (each additional root)	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32	Yes	One of (D3426) per 1 Lifetime Per patient per tooth for Bicuspids. Two of (D3426) per 1 Lifetime Per patient per tooth for First and Second Molars. Includes retrograde filling.	

Exhibit C Benefits Covered for MassHealth - 21 and Over (DDS)

Periodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210) per 36 Month(s) Per patient per quadrant. Limited to two quadrants on the same date of service in an office setting. Not payable in conjunction with D1110 and D1120 or D4341 and D4342 on same date of service. Narrative of medical necessity. Include complete periodontal charting,periapical films,documentation of previous periodontal treatment and a statement concerning the member's periodontal condition.	narrative of medical necessity
D4211	gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	Limited to two quadrants on the same date of service in an office setting. Not payable in conjunction with D1110 and 1120 or D4341 and 4342 on same date of service. Narrative of medical necessity. Include complete periodontal charting,periapical films,documentation of previous periodontal treatment and a statement concerning the member's periodontal condition.	narrative of medical necessity
D4341	periodontal scaling and root planing - four or more teeth per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4341, D4342) per 36 Month(s) Per patient per quadrant. Two of (D4341, D4342) per 1 Day(s) Per Provider OR Location in office. Four of (D4341, D4342) per 1 Day(s) Per Provider OR Location in hospital. A minimum of four (4) affected teeth in the quadrant. Not payable in conjuction with D1110 and D1120 or D4210 and D4211 on same date of service. Narrative of medical necessity.Include complete periodontal charting,periapical films,documentation of previous periodontal treatment and a statement concerning the member's periodontal condition.	narrative of medical necessity

Exhibit C Benefits Covered for MassHealth - 21 and Over (DDS)

Periodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D4342	periodontal scaling and root planing - one to three teeth per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4341, D4342) per 36 Month(s) Per patient per quadrant. Two of (D4341, D4342) per 1 Day(s) Per Provider OR Location in office. Four of (D4341, D4342) per 1 Day(s) Per Provider OR Location in hospital. Not payable in conjunction with D1110 and D1120 or D4210 and D4211 on same date of service. Narrative of medical necessity. Include complete periodontal charting, periapical films, documentation of previous periodontal treatment and a statement concerning the member's periodontal condition.	narrative of medical necessity

Provision for removable prostheses when masticatory function is impaired, or when existing prostheses is unserviceable and when evidence indicates that the masticatory insufficiencies are likely to impair the general health of the member.

MassHealth pays for removable partial denture construction only if there are two or more missing posterior teeth or one or more missing anterior teeth and the remaining teeth are in good occlusion.

The remaining dentition must be sound and have a good prognosis. Existing or planned crown, bridges, partial dentures or full dentures are counted as occluding teeth.

If the ADA claim form does not accommodate the required narrative as specified, providers may include additional documentation on a separate page. Please note that fields 38, 43 & 44 of the ADA claim form are available to assist providers in supplying the appropriate information. If a replacement denture is requested, a reason, in addition to the age of the existing denture, needs to be included, i.e. ill-fitting, broken beyond repair. X-rays are not required when making the determination of medical necessity for members in nursing facilities. Diagnostic photos, however, may be requested at the discretion of the agency. If the member has no remaining natural teeth, radiographs are not required.

A preformed denture with teeth already mounted forming a denture module is not a covered service.

BILLING AND REIMBURSEMENT FOR CAST CROWNS AND POST & CORES OR REMOVABLE PROSTHETICS SHALL BE BASED ON THE CEMENTATION OR INSERTION DATE.

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5110	complete denture - maxillary	21 and older	Per Arch (01, UA)	No	One of (D5110) per 84 Month(s) Per patient. Complete treatment plan and prosthetic history. If the member still has natural teeth, a current series of periapical and bitewing films. X-rays are not required if the patient is edentulous.	
D5120	complete denture - mandibular	21 and older	Per Arch (02, LA)	No	One of (D5120) per 84 Month(s) Per patient. Complete treatment plan and prosthetic history. If the member still has natural teeth, a current series of periapical and bitewing films. X-rays are not required if the patient is edentulous.	
D5211	maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	21 and older		No	One of (D5211) per 84 Month(s) Per patient. Pre-op radiographs of all teeth in arch with claim for prepayment review. Documentation must indicate that there are two or more missing posterior teeth or one or more missing anterior teeth, the remaining dentition is sound and there is a good prognosis.	

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5212	mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	21 and older		No	One of (D5212) per 84 Month(s) Per patient. Pre-op radiographs of all teeth in arch with claim for prepayment review. Documentation must indicate that there are two or more missing posterior teeth or one or more missing anterior teeth, the remaining dentition is sound and there is a good prognosis.	
D5510	repair broken complete denture base	21 and older	Per Arch (01, 02, LA, UA)	No	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	
D5520	replace missing or broken teeth - complete denture (each tooth)	21 and older	Teeth 1 - 32	No	Three of (D5520) per 12 Month(s) Per patient. Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	
D5610	repair resin denture base	21 and older	Per Arch (01, 02, LA, UA)	No	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	
D5620	repair cast framework	21 and older	Per Arch (01, 02, LA, UA)	No	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	
D5630	repair or replace broken clasp	21 and older		No	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	

Exhibit C Benefits Covered for MassHealth - 21 and Over (DDS)

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5640	replace broken teeth-per tooth	21 and older	Teeth 1 - 32	No	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	
D5650	add tooth to existing partial denture	21 and older	Teeth 1 - 32	No	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	
D5660	add clasp to existing partial denture	21 and older		No	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	
D5710	rebase complete maxillary denture	21 and older		No	One of (D5710) per 36 Month(s) Per patient. Fees for denture includes payment for any reline\rebase necessary w\in 12 mos. of dispensing date of denture. Include date of original insertion of the denture, date(s) of prior rebase(s), and clinical documentation of the reason for the request	
D5711	rebase complete mandibular denture	21 and older		No	One of (D5711) per 36 Month(s) Per patient. Fees for denture includes payment for any reline\rebase necessary w\in 12 mos. of dispensing date of denture. Include date of original insertion of the denture, date(s) of prior rebase(s), and clinical documentation of the reason for the request.	

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5730	reline complete maxillary denture (chairside)	21 and older		No	One of (D5730, D5750) per 36 Month(s) Per patient. Cast for partial denture only. Fee for partial denture includes payment for any relines or rebases necessary within 6 months of dispensing date of the denture. Include date of original insertion of the denture, dates of prior relines, if applicable, and clinical documentation of the reason for the request.	
D5731	reline complete mandibular denture (chairside)	21 and older		No	One of (D5731, D5751) per 36 Month(s) Per patient. Cast for partial denture only. Fee for partial denture includes payment for any relines or rebases necessary within 6 months of dispensing date of the denture. Include date of original insertion of the denture, dates of prior relines, if applicable, and clinical documentation of the reason for the request.	
D5750	reline complete maxillary denture (laboratory)	21 and older		No	One of (D5730, D5750) per 36 Month(s) Per patient. Cast for partial denture only. Fee for partial denture includes payment for any relines or rebases necessary within 6 months of dispensing date of the denture. Include date of original insertion of the denture, date(s) of prior rebase(s), if applicable, and clinical documentation of the reason for the request.	
D5751	reline complete mandibular denture (laboratory)	21 and older		No	One of (D5731, D5751) per 36 Month(s) Per patient. Cast for partial denture only. Fee for partial denture includes payment for any relines or rebases necessary within 6 months of dispensing date of the denture. Include date of original insertion of the denture, date(s) of prior rebase(s), if applicable, and clinical documentation of the reason for the request.	

Fixed prosthetics will only be covered under special circumstances when no other acceptable less expensive dental service will adequately accomplish the treatment objectives. Only bridges with cast retainers or noble or base metals will be covered.

Acid etch bonded bridges should be considered as less expensive alternate treatment if circumstances permit. The MassHealth agency pays for fixed partial dentures(bridgework) for anterior teeth only for members under age 21 with fully matured teeth.

Candidates for fixed prosthetics must have demonstrated very good to excellent oral hygiene and dental health awareness.

Billing and reimbursement for cast crowns and post & cores or any other fixed prosthetic shall be based upon the cementation date.

Prosthodontics, fixed						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D6999	fixed prosthodontic procedure	21 and older	Teeth 1 - 32	Yes		narrative of medical necessity

Exhibit C Benefits Covered for
MassHealth - 21 and Over (DDS)

Extractions and treatment must be considered medically necessary and complicating patient's general health and be documented as such by the dentist or medical provider.

Reimbursement includes local anesthesia and routine pre-operative and post-operative care.

The extraction of asymptomatic impacted teeth is not a covered benefit. Symptomatic conditions would include pain and/or infection or demonstrated malocclusion causing a shifting of existing dentition.

Oral surgery procedures not listed in Exhibit A may be found in Exhibit C or in Subchapter 6 of the MassHealth Dental Manual and Regulation 130 CMR 420.000.

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7111	extraction, coronal remnants - deciduous tooth	21 and older	Teeth A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	Erupted surgical extractions are defined as extractions requiring elevation of a mucoperiosteal flap and removal of bone and/or section of the tooth and closure.	
D7220	removal of impacted tooth-soft tissue	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	Only covered for teeth that are symptomatic, carious or pathologic.	
D7230	removal of impacted tooth-partially bony	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	Only covered for teeth that are symptomatic, carious or pathologic.	
D7240	removal of impacted tooth-completely bony	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	Removal of asymptomatic tooth not covered.	Narr of med necessity & full mouth xrays

Exhibit C Benefits Covered for MassHealth - 21 and Over (DDS)

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7250	surgical removal of residual tooth roots (cutting procedure)	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	Only covered for teeth that are symptomatic, carious or pathologic.	
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	21 and older	Teeth 1 - 32	No		
D7310	alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D7310) per 6 Month(s) Per patient per quadrant. One of (D7310, D7311) per 1 Lifetime Per patient per quadrant. Limited to one per quadrant when performed within 6 months of initial alveoloplasty.	
D7311	alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D7311) per 6 Month(s) Per patient per quadrant. One of (D7310, D7311) per 1 Lifetime Per patient per quadrant. Limited to one per quadrant when performed within 6 months of initial alveoloplasty. Up to 3 teeth\tooth spaces per quad.	narrative of medical necessity
D7320	alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D7320) per 6 Month(s) Per patient per quadrant. One of (D7320, D7321) per 1 Lifetime Per patient per quadrant. No extractions performed in edentulous area. Limited to two per quadrant when the second procedure follows the first within 6 months.	narrative of medical necessity
D7321	alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D7321) per 6 Month(s) Per patient per quadrant. One of (D7320, D7321) per 1 Lifetime Per patient per quadrant. Limited to 1 per quad when performed w\in 6 months of initial alveoloplasty. Up to 3 teeth or tooth spaces per quadrant.	
D7340	vestibuloplasty - ridge extension (secondary epithelialization)	21 and older	Per Arch (01, 02, LA, UA)	Yes	Include justification of the surgical procedure designed to increase alveolar ridge height.	narrative of medical necessity
D7350	vestibuloplasty - ridge extension	21 and older	Per Arch (01, 02, LA, UA)	Yes	Only payable to a dental provider with a specialty in oral surgery	
D7410	radical excision - lesion diameter up to 1.25cm	21 and older		No		

Exhibit C Benefits Covered for MassHealth - 21 and Over (DDS)

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7411	excision of benign lesion greater than 1.25 cm	21 and older		No		
D7450	removal of odontogenic cyst or tumor - lesion diameter up to 1.25cm	21 and older		No	Pathology report.	
D7451	removal of odontogenic cyst or tumor - lesion greater than 1.25cm	21 and older		No	Pathology report.	
D7460	removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25cm	21 and older		No	Pathology report.	
D7461	removal of nonodontogenic cyst or tumor - lesion greater than 1.25cm	21 and older		No	Pathology report.	
D7471	removal of exostosis - per site	21 and older	Per Arch (01, 02, LA, UA)	Yes	Only payable to a dental provider with a specialty in oral surgery	narrative of medical necessity
D7960	frenulectomy – also known as frenectomy or frenotomy – separate procedure not incidental to another procedure	21 and older		No	Either a D7960 or D7963. The frenum may be excised when the tongue has limited mobility; for large diastemas between teeth; or when frenum interferes with a prosthetic appliance; or when it is the etiology of periodontal tissue disease.	
D7963	frenuloplasty	21 and older		No	Either a D7960 or D7963. The frenum may be excised when the tongue has limited mobility; for large diastemas between teeth; or when frenum interferes with a prosthetic appliance; or when it is the etiology of periodontal tissue disease.	
D7970	excision of hyperplastic tissue - per arch	21 and older	Per Arch (01, 02, LA, UA)	Yes	Not payable on the same date of service as an extraction (D7111-D7240) of the same tooth.	narrative of medical necessity
D7999	unspecified oral surgery procedure, by report	21 and older		Yes		narrative of medical necessity

Exhibit C Benefits Covered for MassHealth - 21 and Over (DDS)

Orthodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D8670	periodic orthodontic treatment visit	21 and older		Yes	One of (D8670) per 90 Day(s) Per patient. Allowed as quarterly treatment visits. May not be billed less than 90 days from previous adjustment of banding date. Only payable to a dental provider with a specialty of Orthodontics. Please see billing instructions in section 16 of the Office Reference Manual.	
D8680	orthodontic retention (removal of appliances)	21 and older		Yes	Five of (D8680) per 1 Lifetime Per patient. Only covered for member whose comprehensive treatment had begun prior to age 21. Maximum of 5. Only payable to dental provider whith a specialty of Orthodontics. Please see billing instructions in Section 16 of the Office Reference Manual.	
D8692	replacement of lost or broken retainer	21 and older	Per Arch (01, 02, LA, UA)	Yes	Three of (D8692) per 2 Calendar year(s) Per patient. The MassHealth agency pays for replacement retainers only during the 2 year retention period following orthodontic treatment. Only payable to a dental provider with a specialty of Orthodontics. Statement regarding the date of the onset of retention.	

The use of local anesthesia and analgesia, both orally and rectally is considered part of the operative procedure, and no additional payment will be made for it. The administration of inhalation analgesia (nitrous oxide) is paid as a separate procedure.

Prior authorization is not required when administered in the office only by a provider who possesses both an anesthesia-administration permit and an anesthesia-facility permit issued by the Massachusetts Board of Registration in Dentistry and when a member is eligible for oral surgery services.

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

House extended care facility-This code may be billed separately from the codes for any medically necessary services performed and maybe billed once per day, per business, per facility.

Adjunctive General Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D9110	palliative (emergency) treatment of dental pain - minor procedure	21 and older		No	Other non-emergency medically necessary treatment may be provided during the same visit. Not covered with D0120,D0140,D0160 by same provider or provider group on same date of service.	
D9223	deep sedation/general anesthesia – each 15 minute increment	21 and older		No		
D9230	inhalation of nitrous oxide/analgesia, anxiolysis	21 and older		No		
D9243	intravenous moderate (conscious) sedation/analgesia – each 15 minute increment	21 and older		No		
D9248	non-intravenous moderate (conscious) sedation	21 and older		No		
D9410	house/extended care facility call	21 and older		No	One of (D9410) per 1 Day(s)Per Business,Per facility. Claim must be submitted with one of the following place of service (POS)codes to be considered for payment (03,04,12,13,14,31,32,33,34,or 99). Facility name and address must be placed on the claim form in the narratives section.	
D9920	behavior management, by report	21 and older		Yes	One of (D9920) per 1 Day(s) Per Provider OR Location. Include a description of the members illness or disability and types of services to be furnished.	narrative of medical necessity

Exhibit C Benefits Covered for MassHealth - 21 and Over (DDS)

Adjunctive General Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D9930	treatment of complications (post-surgical) - unusual circumstances, by report	21 and older		No	Include with claim the date, the location of the original surgery and the type of procedure.	
D9999	unspecified adjunctive procedure, by report	21 and older		Yes		narrative of medical necessity

Exhibit D Benefits Covered for MassHealth - Limited (Emergency Coverage Only)

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

Periapical Films. (D0220, D0230) Periapical films may be taken for specific areas where extraction is anticipated, or when infection, periapical change, or an anomaly is suspected, or when otherwise directed by the MassHealth agency. A maximum of four periapical films is allowed per member per visit.

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

Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0140	limited oral evaluation-problem focused	All Ages		No	Two of (D0140) per 1 Calendar year(s) Per patient. Twice per calendar year. Not covered with D9110, D0160 by same provider or provider group on same date of service.	
D0220	intraoral - periapical first radiographic image	All Ages		No	One of (D0220) per 1 Day(s) Per Provider OR Location. Twelve of (D0220, D0230) per 12 Month(s) Per patient. Maximum of one per visit.	
D0230	intraoral - periapical each additional radiographic image	All Ages		No	Three of (D0230) per 1 Day(s) Per Provider OR Location. Twelve of (D0220, D0230) per 12 Month(s) Per patient. Maximum of 3 per visit.	
D0330	panoramic radiographic image	All Ages		No	One of (D0330) per 3 Year(s) Per patient. Surgical conditions require pre-payment review only. Non-surgical conditions are payable once per 3 year(s) in lieu of an FMX for patients who are unable to cooperate with an FMX. Narrative of medical necessity stating the reason why member cannot cooperate with the process for obtaining a full mouth series	narrative of medical necessity

Surgical Removal of Erupted Tooth. (D7140, D7210) The MassHealth agency pays for the surgical removal of an erupted tooth. Surgical removal of an erupted tooth is the removal of any erupted tooth that includes the retraction of a mucoperiosteal flap and the removal of alveolar bone in order to aid in the extraction or the sectioning of a tooth. The provider must maintain clinical documentation demonstrating medical necessity and a preoperative radiograph of the erupted tooth in the member's dental record to substantiate the service performed.

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	All Ages	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	All Ages	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	Erupted surgical extractions are defined as extractions requiring elevation of a mucoperiosteal flap and removal of boneand/or section of the tooth and closure.	

Exhibit D Benefits Covered for
MassHealth - Limited (Emergency Coverage Only)

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

D9450, Case Presentation Code- Not included in ORM due to limited billing allowed.

Adjunctive General Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D9110	palliative (emergency) treatment of dental pain - minor procedure	All Ages		No	Other non-emergency medically necessary treatment may be provided during the same visit. Not covered with D0140 by same provider or provider group on same date of service.	