# Dental Services – MassHealth ACO Payment Policy

## Applicability

This Policy applies to the following Fallon Health products:

☐ Fallon Medicare Plus, Fallon Medicare Plus Central (Medicare Advantage)
☒ MassHealth ACO
☐ NaviCare HMO SNP
☐ NaviCare SCO (Medicaid-only)
☐ Summit Eldercare PACE
☐ Fallon Health Weinberg PACE
☐ Community Care (Commercial/Exchange)

## Policy

**Emergency-Related Dental Services**
The Plan covers emergency-related dental services furnished by a provider that is qualified to furnish such services, and needed to evaluate or stabilize an Emergency Medical Condition, including, but not limited to, draining of an abscess, prescribing pain medication or antibiotics, or other treatment that addresses the member's chief complaint (130 CMR 420.456 (C)).

Note: The Plan does not reimburse Current Dental Terminology (CDT) codes for MassHealth ACO members. All claims for dental services billed with CDT codes must be submitted to MassHealth.

**Oral and Maxillofacial Surgery Services Performed by Specialists in Oral Surgery**
The Plan covers oral and maxillofacial surgery services performed by Specialists in Oral Surgery that are Medically Necessary to treat a medical condition.

Oral and maxillofacial surgery must be provided by a Specialist in Oral Surgery defined in 130 CMR 420.405(A)(7), and billed with a Current Procedural Terminology (CPT) code listed in Subchapter 6 Section 615 of the MassHealth Dental Manual. Refer to 130 CMR 420.453 for service descriptions and limitations.

Oral and maxillofacial surgery should be performed in the office location where technically feasible and safe for the member. The Plan will cover oral and maxillofascial surgery in an acute hospital or ambulatory surgical center when it is justified by the difficulty of the surgery and/or the condition of the member (for example, asthmatic on multiple medications, history of substance use disorder, seizure disorder, or developmentally disabled). Member fear or apprehension does not justify the use of an acute hospital or freestanding ambulatory surgery center.

**Maxillofacial Prosthetics**
The Plan covers maxillofacial prosthetics provided by providers who have completed a CODA certificate program in maxillofacial prosthetics (as described in 130 CMR 420.405(A)(8)) and only where the maxillofacial prosthetic device will be constructed for the treatment of a member with congenital, developmental, or acquired defects of the mandible or maxilla and associated structures. Refer to 130 CMR 420.455 for service descriptions and limitations and Subchapter 6 Section 615 of the MassHealth Dental Manual for covered CPT codes.

Opposing appliances are only reimbursed when Medically Necessary for the balance or retention of the primary maxillofacial prosthetic device.

**Dental Services Reimbursed by MassHealth**
MassHealth reimburses preventive and basic services for the prevention and control of dental diseases and the maintenance of oral health for children and adults. Refer to 130 CMR 420.422 through 130 CMR 420.452 for service descriptions and limitations, and Subchapter 6, Sections

603 through 614 of the Dental Manual for the Current Dental Terminology (CDT) codes that are reimbursed by MassHealth.

**Facility and Other Related Charges (Including Anesthesia) when an Acute Outpatient Hospital or Ambulatory Surgical Center Setting is Medically Necessary for the Safe Delivery of Restorative, Endodontic, or Exodontic Dental Procedures**
The Plan covers Medically Necessary facility and other related charges (including anesthesia) when an acute outpatient hospital or ambulatory surgical center setting is medically necessary for the safe delivery of restorative, endodontic, or exodontic dental procedures. Plan prior authorization is required.

Claims for dental services billed with CDT codes must be submitted to MassHealth, even when the dental services are provided in an acute outpatient hospital or ambulatory surgical center setting.

An acute outpatient hospital or ambulatory surgical center setting may be indicated for a member who (a) has a condition that is reasonably likely to place the member at risk of medical complications that require medical resources that are not available in an office setting; (b) is extraordinarily uncooperative, fearful, or anxious; (c) has dental needs, but local anesthesia is ineffective due to acute infection, idiosyncratic anatomy, or allergy; or (d) has sustained orofacial or dental trauma, or both, so extensive that treatment cannot be provided safely and effectively in an office setting (130 CMR 420.456(A)(1)).

The member's medical record must include: (a) a detailed description of the member's illness or disability; (b) a history of previous treatment or attempts at treatment; (c) a treatment plan listing all procedures and the teeth involved; (d) radiographs (if radiographs are not available, an explanation is required); (e) photographs to indicate the condition of the mouth if radiographs are not available; and (f) documentation that there is no other suitable site of service for the member that would be less costly to the Plan (130 CMR 420.456(A)(2)).

## Definitions

**Emergency Medical Condition** – a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that, in the absence of prompt medical attention, could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in placing the health of an Enrollee or another person or, in the case of a pregnant individual, the health of the individual or their unborn child, in serious jeopardy, serious impairment to bodily function, or serious dysfunction of any body organ or part; or, with respect to a pregnant individual, as further defined in Section 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. § 1395dd(e)(1)(B).

**Medically Necessary or Medical Necessity** – in accordance with 130 CMR 450.204, Medically Necessary services are those services (1) which are reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the Enrollee that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a disability, or result in illness or infirmity; and (2) for which there is no other medical service or site of service, comparable in effect, available, and suitable for the Enrollee requesting the service, that is more conservative or less costly. Medically Necessary services must be of a quality that meets professionally recognized standards of health care, and must be substantiated by records including evidence of such medical necessity and quality.

**Other Dental Specialists –** A dentist who is a specialist in any other area of dentistry (for example, pedodontics, anesthesiology, endodontics, periodontics, or prosthodontics) must have completed the appropriate CODA-accredited certificate program that satisfies eligibility requirements for the specific specialty board (130 CMR 420.405(A)(8)).

**Specialist in Oral Surgery** – A dentist who is a specialist in oral surgery must have completed a minimum of four years' training in an oral and maxillofacial surgery advanced education program, fulfilling the requirements for advanced training in oral and maxillofacial surgery as outlined by

CODA and leading to a Certificate of Advanced Graduate Studies (CAGS) (130 CMR 420.405(A)(7).

## Reimbursement

The Plan does not reimburse Current Dental Terminology (CDT) codes for MassHealth ACO members. All claims for dental services billed with CDT codes must be submitted to MassHealth.

The Plan reimburses oral and maxillofascial surgery provided by a Specialist in Oral Surgery, as defined in 130 CMR 420.405(A)(7), and billed with a Current Procedural Terminology (CPT) code listed in Subchapter 6 Section 615 of the MassHealth Dental Manual.

The Plan reimburses maxillofascial prosthetics provided by a provider who has completed a CODA certificate program in maxillofacial prosthetics, as defined in 130 CMR 420.405(A)(8), and billed with a Current Procedural Terminology (CPT) code listed in Subchapter 6 Section 615 of the MassHealth Dental Manual.

## Referral/notification/prior authorization requirements

Oral and maxillofascial surgery services and maxillofascial prosthetics may require prior authorization. Providers may use the Procedure code look-up tool on the Fallon Health website (https://fallonhealth.org/en/providers) to find prior authorization requirements.

Although the Plan cannot authorize services that are not reimbursed, or may be reimbursed by MassHealth, i.e. Current Dental Terminology (CDT) codes, facility charges (i.e. acute outpatient hospital and ambulatory surgery center facility fees, anesthesia fees, etc.) which are reimbursed by Fallon Health require prior authorization and are subject to medical neccessity review.

## Billing/coding guidelines

The Plan requires all professional charges to be submitted on a CMS-1500 claims form and hospital charges to be submitted on a UB-04 claims form, or in HIPAA-standard electronic formats, per industry standard guidelines.

The Plan applies industry standard claims edits.

Refer to Subchapter 6 Section 615 of the MassHealth Dental Manual for the CPT codes that are payable by Fallon Health when provided by a Specialist in Oral Surgery as defined in 130 CMR 420.405(A)(7) or by a provider who has completed a CODA certificate program in maxillofacial prosthetics as defined in 130 CMR 420.405(A)(8). Refer to 130 CMR 420.453 and 420.455 for service descriptions and limitations.

## Place of service

This policy applies dental services provided in all settings.

## Policy history

| | |
|---|---|
| Origination date: | 03/01/2025 |
| Connection date & details: | January 2025 – Policy origination. |

*The criteria listed above apply to Fallon Health plan and its subsidiaries. This payment policy has been developed to provide information regarding general billing, coding, and documentation guidelines for the Plan. Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member individual benefit plans may apply and this policy is not a guarantee of payment. The Plan reserves the right to apply this payment policy to all of the Plan companies and subsidiaries. The Plan routinely verifies that charges billed are in accordance with the guidelines stated in this payment policy and are appropriately documented in the medical records. Payments are subject to post-payment audits and retraction of overpayments.*