MassHealth Dental Program Covered Benefits, Exclusions, Limitations & Fee Schedule												Last updated: 8/8/2025
Procedure Code	Description	Allowed Fee		MH Standard (Regular)		CMSP	MH Limited	HSN		Benefit Limitations	Required Review	Documentation Required
		<21	21+	<21	21+			<21	21+			
D2160	Amalgam-three surfaces, primary or permanent	$110	$92	Y	Y	Y	NC	Y	Y	Teeth 1 - 32, A - T One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 months Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	--	--
D2161	Amalgam-four or more surfaces, primary or permanent	$137	$116	Y	Y	Y	NC	Y	Y	Teeth 1 - 32, A - T One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 months Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	--	--
D2330	Resin-based composite – one surface, anterior	$98	$72	Y	Y	Y	NC	Y	Y	Teeth 6 - 11, 22 - 27, C - H, M - R One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 months Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	--	--
D2331	Resin-based composite – two surfaces, anterior	$118	$92	Y	Y	Y	NC	Y	Y	Teeth 6 - 11, 22 - 27, C - H, M - R One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 months Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	--	--
D2332	Resin-based composite – three surfaces, anterior	$147	$116	Y	Y	Y	NC	Y	Y	Teeth 6 - 11, 22 - 27, C - H, M - R One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 months Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	--	--
D2335	Resin-based composite – four or more surfaces or involving incisal angle (anterior)	$188	$146	Y	Y	Y	NC	Y	Y	Teeth 6 - 11, 22 - 27, C - H, M - R One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 months Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	--	--
D2390	Resin-based composite crown, anterior	$133	NC	Y	Y	Y	NC	Y	Y	Age limitation: <21 years Teeth 6 - 11, 22 - 27, C - H, M - R One of (D2390) per 12 Months Per patient per tooth.	--	--
D2391	Resin-based composite – one surface, posterior	$99	$62	Y	Y	Y	NC	Y	Y	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 months Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	--	--
D2392	Resin-based composite – two surfaces, posterior	$123	$77	Y	Y	Y	NC	Y	Y	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 months Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	--	--
D2393	Resin-based composite – three surfaces, posterior	$133	$92	Y	Y	Y	NC	Y	Y	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 months Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	--	--
D2394	Resin-based composite – four or more surfaces, posterior	$182	$116	Y	Y	Y	NC	Y	Y	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 months Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	--	--
D2710	Crown – resin-based composite (indirect)	$244	NC	Y	NC	Y	NC	Y	NC	Age limitation: <21 years Teeth 3 - 14, 19 - 30 One of (D2710, D2740, D2750, D2751, D2752, D2790) per 60 Months Per patient per tooth.	CR Eff: 10/1/25	CR: Pre-Tx PA; Pre-Tx BW for posterior teeth; Posterior BWs, FMX, or PAN; Post-Tx Radiograph

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D2740	Crown – porcelain/ceramic	$853	$729	Y	Y	Y	NC	Y	Y	Teeth 2 - 15, 18 - 31 One of (D2710, D2740, D2750, D2751, D2752, D2790) per 60 Months Per patient per tooth.	CR** >1 crown for 21+, Eff: 4/1/25 1 crown for 21+ OR crown(s) for <21, Eff: 10/1/25	**For crowns delivered to adults when more than one crown is delivered on the same date of service, the claim review documentation requirements are effective for dates of service 4/1/25 and after. For children younger than 21 years old and for crowns delivered to adults when only one crown is delivered on a date of service, claim review documentation requirements are effective for dates of service 10/1/25 and after. CR: **Pre-Tx PA; Pre-Tx BW for posterior teeth; Posterior BWs, FMX, or PAN; Post-Tx Radiograph**
D2750	Crown – porcelain fused to high noble metal	$800	NC	Y	NC	Y	NC	Y	NC	Age limitation: <21 years Teeth 2 - 15, 18 - 31 One of (D2710, D2740, D2750, D2751, D2752, D2790) per 60 Months per patient per tooth.	CR Eff: 10/1/25	CR: **Pre-Tx PA; Pre-Tx BW for posterior teeth; Posterior BWs, FMX, or PAN; Post-Tx Radiograph**
D2751	Crown – porcelain fused to predominantly base metal	$727	$613	Y	Y	Y	NC	Y	Y	Teeth 2 - 15, 18 - 31 One of (D2710, D2740, D2750, D2751, D2752, D2790) per 60 Months per patient per tooth.	CR** >1 crown for 21+, Eff: 4/1/25 1 crown for 21+ OR crown(s) for <21, Eff: 10/1/25	**For crowns delivered to adults when more than one crown is delivered on the same date of service, the claim review documentation requirements are effective for dates of service 4/1/25 and after. For children younger than 21 years old and for crowns delivered to adults when only one crown is delivered on a date of service, claim review documentation requirements are effective for dates of service 10/1/25 and after. CR: **Pre-Tx PA; Pre-Tx BW for posterior teeth; Posterior BWs, FMX, or PAN; Post-Tx Radiograph**
D2752	Crown – porcelain fused to noble metal	$735	NC	Y	NC	Y	NC	Y	NC	Age limitation: <21 years Teeth 2 - 15, 18 - 31 One of (D2710, D2740, D2750, D2751, D2752, D2790) per 60 Months per patient per tooth.	CR Eff: 10/1/25	CR: **Pre-Tx PA; Pre-Tx BW for posterior teeth; Posterior BWs, FMX, or PAN; Post-Tx Radiograph**
D2790	Crown – full cast high noble metal	$808	NC	Y	NC	Y	NC	Y	NC	Age limitation: <21 years Teeth 2 - 15, 18 - 31 One of (D2710, D2740, D2750, D2751, D2752, D2790) per 60 Months per patient per tooth.	CR Eff: 10/1/25	CR: **Pre-Tx PA; Pre-Tx BW for posterior teeth; Posterior BWs, FMX, or PAN; Post-Tx Radiograph**
D2910	Re-cement or re-bond inlay, onlay or partial coverage restoration	$69	$57	Y	Y	Y	NC	Y	NC	Teeth 2 - 15, 18 - 31 Not covered within 6 months of initial placement.	--	--
D2920	Re-cement or re-bond crown	$68	$57	Y	Y	Y	NC	Y	NC	Teeth 2 - 15, 18 - 31, A - T Not covered within 6 months of initial placement.	--	--
D2929	Prefabricated porcelain/ceramic crown – primary tooth	$224	NC	Y	NC	Y	NC	Y	NC	Age limitation: <21 years Teeth C - H, M - R One of (D2929, D2930, D2931, D2932, D2934) per tooth per lifetime.	CR General Dentists Eff: 10/1/25	CR: **Pre-Tx PA; Posterior BWs, FMX, or PAN**
D2930	Prefabricated stainless steel crown – primary tooth	$205	NC	Y	NC	Y	NC	Y	NC	Age limitation: <21 years Teeth A - T One of (D2929, D2930, D2931, D2932, D2934) per tooth per lifetime.	CR General Dentists Eff: 10/1/25	CR: **Pre-Tx PA; Posterior BWs, FMX, or PAN**
D2931	Prefabricated stainless steel crown – permanent tooth	$199	$171*	Y	DDS*	Y	NC	Y	NC	Age limitation: <21 years* <21 years: **Teeth 2 - 5, 12 - 15, 18 - 21, 28 - 31; DDS ONLY, Teeth 1 - 32** < 21 years: **One of (D2929, D2930, D2931, D2932, D2934) per tooth per lifetime.** **Age limitation: DDS ONLY, 21 years and older** DDS 21+: **Teeth 1 - 32** DDS 21+: **One of (D2931) per 36 months per patient per tooth.** ***Only adults with DDS have coverage for D2931**	CR General Dentists Eff: 10/1/25	CR: **Pre-Tx PA; Posterior BWs, FMX, or PAN**

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D2932	Prefabricated resin crown	$224	NC	Y	NC	Y	NC	Y	NC	Age limitation: <21 years Teeth 1 - 32, A - T One of (D2929, D2930, D2931, D2932, D2934) per tooth per lifetime.	CR General Dentists Eff: 10/1/25	CR: Pre-Tx PA; Posterior BWs, FMX, or PAN
D2934	Prefabricated esthetic coated stainless steel crown – primary tooth	$184	NC	Y	NC	Y	NC	Y	NC	Age limitation: <21 years Teeth C - H, M - R One of (D2929, D2930, D2931, D2932, D2934) per tooth per lifetime.	CR General Dentists Eff: 10/1/25	CR: Pre-Tx PA; Posterior BWs, FMX, or PAN
D2950	Core buildup, including any pins when required	$197	$164	Y	Y	Y	NC	Y	Y	Teeth 2 - 15, 18 - 31 One (D2950, D2954) per 60 month(s) per patient per tooth.	CR Eff: 10/1/25	CR: Pre-Tx PA; Pre-Tx BW for posterior teeth; Posterior BWs, FMX, or PAN
D2951	Pin retention – per tooth, in addition to restoration	$31	$27	Y	Y	Y	NC	Y	Y	Teeth 2 - 15, 18 - 31 Must be billed with a two or more surface restoration on a permanent tooth.	--	--
D2954	Prefabricated post and core in addition to crown	$229	$191	Y	Y	Y	NC	Y	Y	Teeth 2 - 15, 18 - 31 One of (D2950, D2954) per 60 month(s) per patient per tooth.	CR Eff: 10/1/25	CR: Pre-Tx PA; Pre-Tx BW for posterior teeth; Posterior BWs, FMX, or PAN
D2980	Crown repair necessitated by restorative material failure	$137	$115	Y	Y	Y	NC	Y	Y	Teeth 2 - 15, 18 - 31 For chairside repairs	--	--
D2999	Unspecified restorative procedure, by report	I.C.	I.C.	Y	Y	Y	NC	Y	Y	Teeth 1 - 32, A - T	PA	Narrative of medical necessity; For crown repairs requiring outside laboratory, include documentation to substantiate why the repair could not be done chairside
IV. Endodontics												
D3120	Pulp cap – indirect (excluding final restoration)	$40	$34	Y	Y	Y	NC	Y	Y	Teeth 1 - 32, A - T Cannot be billed in conjunction with root canal on same day of service (D3310, D3320 or D3330).	--	--
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament	$106	NC	Y	NC	Y	NC	Y	NC	Age limitation: <21 years Teeth 1 - 32, A - T Cannot be billed in conjunction with root canal on same day of service (D3310, D3320 or D3330).	CR General Dentists Eff: 10/1/25	CR: Pre-Tx radiograph
D3310	Endodontic therapy, anterior (excluding final restoration)	$544	$544	Y	Y	Y	NC	Y	Y	Teeth 6 - 11, 22 - 27 One of (D3310) per 1 Lifetime Per patient per tooth. No limitation on number performed per treatment. Cannot be billed in conjunction with D3120 on the same date of service.	CR General Dentists Eff: 10/1/25	CR: Pre-Tx PA; Post-Tx PA of completed final fill
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	$639	$639	Y	Y	Y	NC	Y	Y	Teeth 4, 5, 12, 13, 20, 21, 28, 29 One per lifetime per patient per tooth One of (D3320) per 1 Lifetime Per patient per tooth. Cannot be billed in conjunction with D3120 on the same date of service.	CR General Dentists Eff: 10/1/25	CR: Pre-Tx PA; Post-Tx PA of completed final fill
D3330	Endodontic therapy, molar tooth (excluding final restoration)	$829	$829	Y	Y	Y	NC	Y	Y	Teeth 2, 3, 14, 15, 18, 19, 30, 31 One of (D3330) per 1 Lifetime Per patient per tooth. Cannot be billed in conjunction with D3120 on the same date of service.	CR General Dentists Eff: 10/1/25	CR: Pre-Tx PA; Post-Tx PA of completed final fill
D3346	Retreatment of previous root canal therapy – anterior	$545	$456	Y	Y	Y	NC	Y	Y	Teeth 6 - 11, 22 - 27 Not payable to the same provider who performed the original endodontic therapy (D3310, D3320, or D3330) within 24 months.	CR General Dentists Eff: 10/1/25	CR: Pre-Tx PA; Post-Tx PA of completed final fill

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		<21	21+	<21	21+			<21	21+			
D3347	Retreatment of previous root canal therapy – premolar	$641	$538	Y	Y	Y	NC	Y	Y	Teeth 4, 5, 12, 13, 20, 21, 28, 29 Not payable to the same provider who performed the original endodontic therapy (D3310, D3320, or D3330) within 24 months.	CR General Dentists Eff: 10/1/25	CR: Pre-Tx PA; Post-Tx PA of completed final fill
D3348	Retreatment of previous root canal therapy – molar	$789	$613	Y	Y	Y	NC	Y	Y	Teeth 2, 3, 14, 15, 18, 19, 30, 31 Not payable to the same provider who performed the original endodontic therapy (D3310, D3320, or D3330) within 24 months.	CR General Dentists Eff: 10/1/25	CR: Pre-Tx PA; Post-Tx PA of completed final fill
D3410	Apicoectomy – anterior	$471	$407	Y	Y	Y	NC	Y	Y	Teeth 6 - 11, 22 - 27 One of (D3410) per 1 Lifetime Per patient per tooth. Includes retrograde filling.	CR General Dentists Eff: 10/1/25	CR: Pre-Tx PA; Post-Tx PA
D3421	Apicoectomy – premolar (first root)	$550	$460	Y	Y	Y	NC	Y	Y	Teeth 4, 5, 12, 13, 20, 21, 28, 29 One of (D3421) per 1 Lifetime Per patient per tooth. Includes retrograde filling.	CR General Dentists Eff: 10/1/25	CR: Pre-Tx PA; Post-Tx PA
D3425	Apicoectomy – molar (first root)	$639	$598	Y	Y	Y	NC	Y	Y	Teeth 1 - 3, 14 - 19, 30 - 32 One of (D3425) per 1 Lifetime Per patient per tooth. Includes retrograde filling.	CR General Dentists Eff: 10/1/25	CR: Pre-Tx PA; Post-Tx PA
D3426	Apicoectomy (each additional root)	$264	$230	Y	Y	Y	NC	Y	Y	Teeth 1 - 5, 12 - 21, 28 - 32 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.	CR General Dentists Eff: 10/1/25	CR: Pre-Tx PA; Post-Tx PA
V. Periodontics												
D4210	Gingivectomy or gingivoplasty - Four or more contiguous teeth or bounded teeth spaces per quadrant	$343	$307	Y	Y	Y	NC	Y	Y	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR) One of (D4210, D4211) per 3 Calendar year(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.	21+ PA	21+ PA: Pre-Tx radiographs; Periodontal charting; Narrative of medical necessity
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant	$133	$111	Y	Y	Y	NC	Y	Y	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR) One of (D4210, D4211) per 3 Calendar year(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.	21+ PA	21+ PA: Pre-Tx radiographs; Periodontal charting; Narrative of medical necessity
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	$160	$134	Y	Y	Y	NC	Y	Y	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR) One of (D4341, D4342) per 3 Calendar year(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 conjunction with D1110 and D1120 or D4210 and D4211 on same date of service.	21+ PA	21+ PA: FMX; Periodontal charting; Narrative of medical necessity, including a statement of the periodontal condition, date of periodontal evaluation, and history of previous periodontal treatment
D4342	Periodontal scaling and root planing - one to three teeth, per quadrant	$107	$90	Y	Y	Y	NC	Y	Y	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR) One of (D4341, D4342) per 3 Calendar year(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	21+ PA	21+ PA: FMX; Periodontal charting; Narrative of medical necessity, including a statement of the periodontal condition, date of periodontal evaluation, and history of previous periodontal treatment

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D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	$75	$60	Y	Y	Y	NC	Y	Y	Two of (D1110, D1120, D4346) per 1 Calendar year(s) Per patient. Includes minor scaling procedures.	--	--
VI. Prosthodontics (Removable)												
D5110	Complete denture – maxillary	$858	$730	Y	Y	Y	NC	Y	Y	One of (D5110) per 84 Month(s) Per patient.	CR General Dentists Eff: 10/1/25	CR: FMX or PAN; If teeth present, charting and proposed Tx
D5120	Complete denture – mandibular	$852	$730	Y	Y	Y	NC	Y	Y	One of (D5120) per 84 Month(s) Per patient.	CR General Dentists Eff: 10/1/25	CR: FMX or PAN; If teeth present, charting and proposed Tx
D5130	Immediate denture – maxillary	$935	NC	Y	NC	Y	NC	Y	NC	Age limitation: <21 years One of (D5130) per 1 Lifetime Per patient	CR General Dentists Eff: 10/1/25	CR: FMX or PAN, if teeth present, charting and proposed Tx
D5140	Immediate denture - mandibular	$934	NC	Y	NC	Y	NC	Y	NC	Age limitation: <21 years One of (D5140) per 1 Lifetime Per patient	CR General Dentists Eff: 10/1/25	CR: FMX or PAN; If teeth present, charting and proposed Tx
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth)	$650	$556	Y	Y	Y	NC	Y	Y	One of (D5211, D5213, D5225) per 84 Month(s) Per patient. Only covered if there are two or more missing posterior teeth (excluding third molars) or one or more missing anterior teeth, the remaining dentition is sound and there is a good prognosis.	CR General Dentists Eff: 10/1/25	CR: FMX or PAN; Charting of missing teeth or teeth planned to be extracted
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth)	$691	$595	Y	Y	Y	NC	Y	Y	One of (D5212, D5214, D5226) per 84 Month(s) Per patient. Only covered if there are two or more missing posterior teeth (excluding third molars) or one or more missing anterior teeth, the remaining dentition is sound and there is a good prognosis.	CR General Dentists Eff: 10/1/25	CR: FMX or PAN; Charting of missing teeth or teeth planned to be extracted
D5213	Maxillary partial denture- cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$974	NC	Y	NC	Y	NC	Y	NC	Age limitation: <21 years One of (D5211, D5213, D5225) per 84 Month(s) Per patient. Only covered if there are two or more missing posterior teeth (excluding third molars) or one or more missing anterior teeth, the remaining dentition is sound and there is a good prognosis.	CR General Dentists Eff: 10/1/25	CR: FMX or PAN; Charting of missing teeth or teeth planned to be extracted
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$986	NC	Y	NC	Y	NC	Y	NC	Age limitation: <21 years One of (D5212, D5214, D5226) per 84 Month(s) Per patient. Only covered if there are two or more missing posterior teeth (excluding third molars) or one or more missing anterior teeth, the remaining dentition is sound and there is a good prognosis.	CR General Dentists Eff: 10/1/25	CR: FMX or PAN; Charting of missing teeth or teeth planned to be extracted
D5225	Maxillary partial denture- flexible base	$974	NC	Y	NC	Y	NC	Y	NC	Age limitation: <21 years One of (D5211, D5213, D5225) per 84 Month(s) Per patient. Only covered if there are two or more missing posterior teeth (excluding third molars) or one or more missing anterior teeth, the remaining dentition is sound and there is a good prognosis.	CR General Dentists Eff: 10/1/25	CR: FMX or PAN; Charting of missing teeth or teeth planned to be extracted

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D5226	Mandibular partial denture-flexible base	$986	NC	Y	NC	Y	NC	Y	NC	Age limitation: <21 years One of (D5212, D5214, D5226) per 84 Month(s) Per patient. Only covered if there are two or more missing posterior teeth (excluding third molars) or one or more missing anterior teeth, the remaining dentition is sound and there is a good prognosis.	CR General Dentists Eff: 10/1/25	CR: FMX or PAN; Charting of missing teeth or teeth planned to be extracted
D5511	Repair broken complete denture base, mandibular	$109	$85	Y	Y	Y	NC	Y	Y	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.	--	--
D5512	Repair broken complete denture base, maxillary	$109	$85	Y	Y	Y	NC	Y	Y	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)	$89	$77	Y	Y	Y	NC	Y	Y	Teeth 1 - 32 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.	--	--
D5611	Repair broken resin partial denture base, mandibular	$93	$77	Y	Y	Y	NC	Y	Y	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.	--	--
D5612	Repair broken resin partial denture base, maxillary	$93	$77	Y	Y	Y	NC	Y	Y	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.	--	--
D5621	Repair broken cast partial denture base, mandibular	$121	$104	Y	Y	Y	NC	Y	Y	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.	--	--
D5622	Repair broken cast partial denture base, maxillary	$121	$104	Y	Y	Y	NC	Y	Y	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 retentive/clasping materials – per tooth	$107	$99	Y	Y	Y	NC	Y	Y	Teeth 1 - 32 One of (D5630) per 6 Month(s) Per patient per tooth. 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	$91	$77	Y	Y	Y	NC	Y	Y	Teeth 1 - 32 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	$110	$92	Y	Y	Y	NC	Y	Y	Teeth 1 - 32 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.	--	--

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		<21	21+	<21	21+			<21	21+			
D5660	Add clasp to existing partial denture per tooth	$125	$98	Y	Y	Y	NC	Y	Y	Teeth 1 - 32 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.	--	--
D5730	Reline complete maxillary denture (direct)	$188	$158	Y	Y	Y	NC	Y	Y	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 denture delivery date.	--	--
D5731	Reline lower complete mandibular denture (direct)	$184	$173	Y	Y	Y	NC	Y	Y	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 denture delivery date.	--	--
D5740	Reline maxillary partial denture(chairside)	$169	NC	Y	NC	Y	NC	Y	NC	Age limitation: <21 years 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 denture delivery date	--	--
D5741	Reline mandibular partial denture(chairside)	$160	NC	Y	NC	Y	NC	Y	NC	Age limitation: <21 years 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 denture delivery date.	--	--
D5750	Reline complete maxillary denture (indirect)	$255	$214	Y	Y	Y	NC	Y	Y	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 denture delivery date.	--	--
D5751	Reline complete mandibular denture (indirect)	$256	$215	Y	Y	Y	NC	Y	Y	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 denture delivery date	--	--
D5760	Reline maxillary partial denture (laboratory)	$252	NC	Y	NC	Y	NC	Y	NC	Age limitation: <21 years 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 denture delivery date.	--	--
D5761	Reline mandibular partial denture (laboratory)	$252	NC	Y	NC	Y	NC	Y	NC	Age limitation: <21 years 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 denture delivery date.	--	--
D6241	Pontic-porcelain fused metal	$691	NC	Y	NC	Y	NC	Y	NC	Age limitation: <21 years Teeth 6 - 11, 22 - 27 One of (D6241) per 60 Month(s) Per patient per tooth.	CR Eff: 10/1/25	CR: Pre-Tx PA; Pre-Tx BW for posterior teeth; Posterior BWs, FMX, or PAN; Post-Tx Radiograph
D6751	Retainer crown-porcelain fused to metal	$691	NC	Y	NC	Y	NC	Y	NC	Age limitation: <21 years Teeth 6 - 11, 22 - 27 One of (D6751) per 60 Month(s) Per patient per tooth.	CR Eff: 10/1/25	CR: Pre-Tx PA; Pre-Tx BW for posterior teeth; Posterior BWs, FMX, or PAN; Post-Tx Radiograph
D6930	Re-cement or re-bond fixed partial denture	$87	NC	Y	NC	Y	NC	Y	NC	Age limitation: <21 years Not covered within first 6 month(s) of placement.	--	--
D6980	Fixed partial denture repair	$155	NC	Y	NC	Y	NC	Y	NC	Age limitation: <21 years Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	--	--
D6999	Fixed prosthodontic procedure	I.C.	I.C.	Y	Y	Y	NC	Y	Y	Teeth 1 - 32	PA	Narrative of medical necessity
X. Oral Surgery												
D7111	Extraction, coronal remnants - primary tooth	$80	$75	Y	Y	Y	NC	Y	Y	Teeth A - T, AS - TS	--	
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$107	$77	Y	Y	Y	Y	Y	Y		--	--

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		<21	21+	<21	21+			<21	21+			
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$179	$149	Y	Y	Y	Y	Y	Y	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.	CR General Dentists Eff: 10/1/25	CR: Pre-Tx PA or PAN
D7220	Removal of impacted tooth - soft tissue	$223	$191	Y	Y	Y	NC	Y	Y	Only covered for teeth that are symptomatic, carious or pathologic.	CR General Dentists Eff: 10/1/25	CR: Pre-Tx PA or PAN; Narrative of medical necessity supporting symptomatic, carious, or pathologic condition
D7230	Removal of impacted tooth - partially bony	$286	$249	Y	Y	Y	NC	Y	Y	Only covered for teeth that are symptomatic, carious or pathologic.	CR General Dentists Eff: 10/1/25	CR: Pre-Tx PA or PAN; Narrative of medical necessity supporting symptomatic, carious, or pathologic condition
D7240	Removal of impacted tooth - completely bony	$378	$295	Y	Y	Y	NC	Y	Y	Removal of asymptomatic tooth not covered.	PA	PA: Pre-Tx PA or PAN; Narrative of medical necessity supporting symptomatic, carious, or pathologic condition
D7250	Surgical removal of residual tooth roots (cutting procedure)	$173	$144	Y	Y	Y	NC	Y	Y	Only covered for teeth that are symptomatic, carious or pathologic.	CR General Dentists Eff: 10/1/25	CR: Pre-Tx PA or PAN; Narrative of medical necessity supporting symptomatic, carious, or pathologic condition
D7251	Coronectomy- intentional partial tooth removal, impacted teeth only	$173	$134	Y	Y	Y	NC	Y	Y	Teeth 1, 16, 17, 32 One of (D7251) per 1 Lifetime Per patient per tooth. Cannot be billed on same date of service with codes D7111, D7140, D7210, D7220, D7230, D7240, D7250, D7241. If D7251 is billed following any history of D7111, D7210, D7140, D7241, D7220, D7230, D7240, D7250 billed on the same tooth as code D7251, then deduct what was paid for D7251 from payment of new code.	CR General Dentists Eff: 10/1/25	CR: Pre-Tx PA or PAN; Narrative of medical necessity supporting symptomatic, carious, or pathologic condition
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$145	$106	Y	Y	Y	NC	Y	Y	Teeth 1 - 32	--	--
D7280	Surgical access of an unerupted tooth	$452	NC	Y	NC	Y	NC	Y	NC	Age limitation: <21 years Teeth 1 - 32 Cannot be billed in conjunction with an adjacent impacted extraction, including D7220, D7230, D7240, D7241.	CR General Dentists Eff: 10/1/25	CR: Pre-Tx PA or PAN
D7283	Placement of device to facilitate eruption of impacted tooth	$84	NC	Y	NC	Y	NC	Y	NC	Age limitation: <21 years Teeth 1 - 32	CR General Dentists Eff: 10/1/25	CR: Pre-Tx PA or PAN
D7310	Alveoloplasty in conjunction with extractions-four or more teeth or tooth spaces, per quadrant	$163	$142	Y	Y	Y	NC	Y	Y	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR) One of (D7310, D7311) per lifetime per patient per quadrant. Covered only if the alveoloplasty is distinct (separate procedure) from extractions.	CR General Dentists Eff: 10/1/25	CR: Narrative of medical necessity to recontour and smooth bone as a separate procedure from extractions
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$146	$128	Y	Y	Y	NC	Y	Y	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR) One of (D7310, D7311) per lifetime per patient per quadrant. Covered only if the alveoloplasty is distinct (separate procedure) from extractions.	CR General Dentists Eff: 10/1/25	CR: Narrative of medical necessity to recontour and smooth bone as a separate procedure from extractions

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		<21	21+	<21	21+			<21	21+			
D7320	Alveoloplasty not in conjunction with extractions-four or more teeth or tooth spaces, per quadrant	$202	$187	Y	Y	Y	NC	Y	Y	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR) One of (D7320, D7321) per lifetime per patient per quadrant. No extractions performed in edentulous area.	CR General Dentists Eff: 10/1/25	CR: Narrative of medical necessity to recontour and smooth bone
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$162	$149	Y	Y	Y	NC	Y	Y	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR) One of (D7320, D7321) per lifetime per patient per quadrant. No extractions performed in edentulous area.	CR General Dentists Eff: 10/1/25	CR: Narrative of medical necessity to recontour and smooth bone
D7340	Vestibuloplasty - ridge extension (second epithelialization)	$796	$747	Y	Y	Y	NC	Y	Y	Per Arch (01, 02, LA, UA)	PA	PA: Narrative of medical necessity supporting need to increase alveolar ridge height
D7350	Vestibuloplasty - ridge extension (Oral surgeon only)	$1,236	$943	Y	Y	Y	NC	Y	Y	Per Arch (01, 02, LA, UA) Only payable to a dental provider with specialty in oral surgery.	21+ PA	21+ PA: Narrative of medical necessity supporting need to increase alveolar ridge height
D7410	Radical excision - lesion diameter up to 1.25cm	$124	$115	Y	Y	Y	NC	Y	Y	--	--	--
D7411	Excision of benign lesion greater than 1.25 cm	$254	$208	Y	Y	Y	NC	Y	Y	--	--	--
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	$252	$248	Y	Y	Y	NC	Y	Y	--	--	Pathology report
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$343	$288	Y	Y	Y	NC	Y	Y	--	--	Pathology report
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	$142	$121	Y	Y	Y	NC	Y	Y	--	--	Pathology report
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$194	$143	Y	Y	Y	NC	Y	Y	--	--	Pathology report
D7471	Removal of lateral exostosis (maxilla or mandible) (Oral surgeon only)	$194	$143	Y	Y	Y	NC	Y	Y	Per Arch (01, 02, LA, UA) One of (D7471) per 1 lifetime per patient per arch. Only payable to a dental provider with a specialty in oral surgery.	--	--
D7472	Removal of torus palatinus (Oral surgeon only)	$194	$143	Y	Y	Y	NC	Y	Y	One of (D7472) per 1 Lifetime Per patient per arch. Only payable to a dental provider with a specialty in oral surgery.	--	--
D7473	Removal of torus mandibularis (Oral surgeon only)	$194	$143	Y	Y	Y	NC	Y	Y	One of (D7473) per 1 Lifetime Per patient per arch. Only payable to a dental provider with a specialty in oral surgery.	--	--
D7961	Buccal/labial frenectomy (frenulectomy)	$353	$107	Y	Y	Y	NC	Y	Y	Per Arch (01, 02, LA, UA) One of (D7961) per 1 Lifetime Per patient per arch. 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 the periodontal tissue disease.	--	Maintain in patient record narrative describing location and medical necessity

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		<21	21+	<21	21+			<21	21+			
D7962	Lingual frenectomy (frenulectomy)	$353	$107	Y	Y	Y	NC	Y	Y	One of (D7962, D7963) per 1 Lifetime Per patient. 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 the periodontal tissue disease.	--	Maintain in patient record narrative describing location and medical necessity
D7963	Frenuloplasty	$480	$416	Y	Y	Y	NC	Y	Y	One of (D7962, D7963) per 1 Lifetime Per patient. 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 the periodontal tissue disease.	--	Maintain in patient record narrative describing location and medical necessity
D7970	Excision of hyperplastic tissue - per arch	$334	$246	Y	Y	Y	NC	Y	Y	Per Arch (01, 02, LA, UA) Not payable on the same date of service as an extraction (D7111 - D7240) of the same tooth.	--	--
D7999	Unspecified oral surgery procedure, by report	I.C.	I.C.	Y	Y	Y	NC	Y	Y	--	PA	Narrative of medical necessity
XI. Orthodontic												
D8010	Limited orthodontic treamtnent of the primary transition (Orthodontist only)	$250	NC	Y	NC	NC	NC	Y	NC	Age limitation: 6-14 years Adjustments for limited orthodontic treatment are billed under the D8999 code. A maximum of five units of D8999 can be billed for approved limited orthodontic treatment. Only payable to a dental provider with a specialty in Orthodontics. Please see billing instructions in section 17.00 of the Office Reference Manual.	<21 PA	<21 PA: Narrative of Medical Necessity supporting need to prevent or minimize the development of a handicapping malocclusion or preclude the need for comprehensive orthodontic treatment; If applicable, supporting photos and/or radiographs. Please see submission instructions in section 17.00 of the Office Reference Manual.
D8020	Limited orthodontic treatment of the transitional dentition (Orthodontist only)	$250	NC	Y	NC	NC	NC	Y	NC	Age limitation: 6-14 years Adjustments for limited orthodontic treatment are billed under the D8999 code. A maximum of five units of D8999 can be billed for approved limited orthodontic treatment. Only payable to a dental provider with a specialty in Orthodontics. Please see billing instructions in section 17.00 of the Office Reference Manual.	<21 PA	<21 PA: Narrative of Medical Necessity supporting need to prevent or minimize the development of a handicapping malocclusion or preclude the need for comprehensive orthodontic treatment; If applicable, supporting photos and/or radiographs. Please see submission instructions in section 17.00 of the Office Reference Manual.
D8030	Limited orthodontic treatment of the adolescent dentition (Orthodontist only)	$250	NC	Y	NC	NC	NC	Y	NC	Age limitation: 6-20 years Adjustments for limited orthodontic treatment are billed under the D8999 code. A maximum of five units of D8999 can be billed for approved limited orthodontic treatment. Only payable to a dental provider with a specialty in Orthodontics. Please see billing instructions in section 17.00 of the Office Reference Manual.	<21 PA	<21 PA: Narrative of Medical Necessity supporting need to prevent or minimize the development of a handicapping malocclusion or preclude the need for comprehensive orthodontic treatment; If applicable, supporting photos and/or radiographs. Please see submission instructions in section 17.00 of the Office Reference Manual.
D8040	Limited orthodontic treatment of the adult dentition (Orthodontist only)	$250	NC	Y	NC	NC	NC	Y	NC	Age limitation: 6-20 years Adjustments for limited orthodontic treatment are billed under the D8999 code. A maximum of five units of D8999 can be billed for approved limited orthodontic treatment. Only payable to a dental provider with a specialty in Orthodontics. Please see billing instructions in section 17.00 of the Office Reference Manual.	<21 PA	<21 PA: Narrative of Medical Necessity supporting need to prevent or minimize the development of a handicapping malocclusion or preclude the need for comprehensive orthodontic treatment; If applicable, supporting photos and/or radiographs. Please see submission instructions in section 17.00 of the Office Reference Manual.
D8070	Comprehensive orthodontic treatment of the transitional dentition (Orthodontist only)	$1,302	NC	Y	NC	NC	NC	Y	NC	Age limitation: 6-20 years One of (D8070, D8080, D8090) per 1 Lifetime Per patient. Only payable to a dental provider with a specialty in Orthodontics. Please see billing instructions in section 17.00 of the Office Reference Manual.	<21 PA	<21 PA: Completed HLD form with signed attestation; FMX or PAN; Photos; If applicable, Narrative of medical necessity supporting need to treat a handicapping malocclusion. Please see submission instructions in section 17.00 of the Office Reference Manual.
D8080	Comprehensive orthodontic treatment of the adolescent dentition (Orthodontist only)	$1,302	NC	Y	NC	NC	NC	Y	NC	Age limitation: 6-20 years One of (D8070, D8080, D8090) per 1 Lifetime Per patient. Only payable to a dental provider with a specialty in Orthodontics. Please see billing instructions in section 17.00 of the Office Reference Manual.	<21 PA	<21 PA: Completed HLD form with signed attestation; FMX or PAN; Photos; If applicable, Narrative of medical necessity supporting need to treat a handicapping malocclusion. Please see submission instructions in section 17.00 of the Office Reference Manual.

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		<21	21+	<21	21+			<21	21+			
D8090	Comprehensive orthodontic treatment of the adult dentition (Orthodontist only)	$1,302	NC	Y	NC	NC	NC	Y	NC	Age limitation: 6-20 years One of (D8070, D8080, D8090) per 1 Lifetime Per patient. Only payable to a dental provider with a specialty in Orthodontics. Please see billing instructions in section 17.00 of the Office Reference Manual.	<21 PA	<21 PA: Completed HLD form with signed attestation; FMX or PAN; Photos; If applicable, Narrative of medical necessity supporting need to treat a handicapping malocclusion. Please see submission instructions in section 17.00 of the Office Reference Manual.
D8660	Pre-orthodontic treatment examination to monitor growth and development (records fee) (Orthodontist only)	$136	NC	Y	NC	NC	NC	Y	NC	Age limitation: 6-20 years One of (D8660) per 6 Month(s) Per Provider OR Location. Only payable with an associated limited or comprehensive ortho PA request denial. Not billable after D8080, D8070, D8090, D8670, D8680 has been paid. Only payable to a dental provider with a speciality in Orthodontics. Please see billing instructions in section 17.00 of the Office Reference Manual.	<21 PA	<21 PA: Submit with D8080 / D8070 / D8090 or D8010 / D8020 / D8030 / D8040. Please see submission instructions in section 17.00 of the Office Reference Manual.
D8670	Periodic orthodontic treatment visit (Orthodontist only)	$288	$215**	Y	Y**	NC	NC	Y	NC	Age limitation: 6-20 years (**Covered for 21 years and older only if comprehensive orthodontic treatment began by age 21) One of (D8670) per 90 Day(s) Per patient. Allowed as quarterly treatment visits. May not be billed less than 90 days from previous periodic orthodontic treatment visit or banding date. May not be billed prior to D8070 / D8080 / D8090. Only payable to a dental provider with a specialty in Orthodontics. Please see billing instructions in section 17.00 of the Office Reference Manual.	<21 PA	<21 PA for first 8 units: Included with D8080 / D8070 / D8090 approval <21 PA for additional unit: Narrative of medical necessity for the additional units, including an explanation of why the initially approved units were insufficient and an updated treatment plan for completion of the case. Please see submission instructions in section 17.00 of the Office Reference Manual.
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s)) (Orthodontist only)	$102	$85**	Y	Y**	NC	NC	Y	NC	Age limitation: 6-20 years (**Covered for 21 years and older only if comprehensive orthodontic treatment began by age 21) Five of (D8680) per 1 Lifetime Per patient. May not be billed prior to D8070 / D8080 / D8090. Only payable to a dental provider with a specialty in Orthodontics. Please see billing instructions in section 17.00 of the Office Reference Manual.	--	--
D8703	Replacement of lost or broken retainer- maxillary (Orthodontist only)	$95	NC	Y	NC	NC	NC	Y	NC	Age limitation: 8-20 years One of (D8703) 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 in Orthodontics.	PA	PA: Statement of the retention start date and reason for replacement
D8704	Replacement of lost or broken retainer- mandibular (Orthodontist only)	$95	NC	Y	NC	NC	NC	Y	NC	Age limitation: 8-20 years One of (D8704) 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 in Orthodontics.	PA	PA: Statement of the retention start date and reason for replacement
D8999	Unspecified orthodontic procedure, by report (Orthodontist only)	I.C	I.C**	Y	Y**	NC	NC	Y	NC	Age limitation: 6-20 years (**Covered for 21 years and older only if limited orthodontic treatment began by age 21) Five of (D8999) per 1 Lifetime Per patient. This code is used exclusively for limited 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. Only payable to a dental provider with a specialty in Orthodontics. Please see billing instructions in section 17.00 of the Office Reference Manual.	<21 PA	<21 PA for 5 units: Included with D8010 / D8020 / D8030 / D8040 approval. Please see submission instructions in section 17.00 of the Office Reference Manual.
XII. Adjunctive General Services												
D9110	Palliative treatment of dental pain – per visit	$75	$36	Y	Y	Y	Y	Y	Y	Other non-emergency medically necessary treatment may be provided during the same visit. Not covered with D0120, D0140, D0180 by same provider or provider group on same date of service.	--	Maintain in patient record description of the treatment provided and must document the emergent nature of the condition
D9222	Deep sedation/general anesthesia – first 15 minutes	$109	$90	Y	Y	Y	NC	Y	Y	--	--	--
D9223	Deep sedation/general anesthesia – each additional 15-minute increment	$109	$90	Y	Y	Y	NC	Y	Y	--	--	--

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		<21	21+	<21	21+			<21	21+			
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	$22	$15	Y	Y	Y	NC	Y	Y	--	--	--
D9239	Intravenous moderate (conscious) sedation analgesia – first 15 minutes	$101	$78	Y	Y	Y	NC	Y	Y	--	--	--
D9243	Intravenous moderate (conscious) sedation analgesia – each additional 15 minute increment	$101	$78	Y	Y	Y	NC	Y	Y	Five of (D9243) per 1 Day(s) Per patient.	--	--
D9248	Nonintravenous conscious sedation	$45	$45	Y	Y	Y	NC	Y	Y	--	--	--
D9310	Consultation- Diagnostic service provided by dentist or physician other than requesting dentist or physician (Specialist only)	$54	$63	Y	Y	Y	NC	Y	Y	One of (D9310) per 6 Month(s) Per patient Per Provider OR Location; Only payable to a specialist.	--	The consulting specialist must provide a written narrative back to the referring dentist
D9410	House/extended care facility call, once per facility per day	$36	$39	Y	Y	Y	NC	Y	Y	One of (D9410) per 1 Day(s) Per Business Per facility. Eligible when traveling to provide care at a nursing facility, residential treatment facility, chronic disease and rehabilitation facility, hospice site, patient home or group home, school or other licensed educational facility, or other public health setting. Bill in addition to any medically necessary covered service provided during the same visit. Excludes place of service (POS) codes 02, 10, 11, 21, 23, 24, 49, 50, 66	--	Facility name and address
D9450*	Rural add-on encounter payment	$31	$31	Y	Y	Y	Y	Y	Y	Only payable to providers rendering covered services within the eligible rural counties: Barnstable, Dukes, Berkshire, Franklin, and Hampshire. One of (D9450) per 1 Day(s) Per Provider, Per Member. Only payable when submitted with another payable service.	--	--
D9920	Behavior management, by report	$86	$86	Y	Y	Y	NC	Y	Y	One of (D9920) per 1 Day(s) Per Provider OR Location per patient	PA	PA: Narrative of medical necessity clearly desrcribing the member's severe and chronic mental, physical, or developmental disability and type of behavior management technique to be utilized, including statement of previous attempts at treatment.
D9930	Treatment of complications (postsurgical) - unusual circumstances, by report	$66	$30	Y	Y	Y	NC	Y	Y	--	CR	Narrative of medical necessity
D9941	Fabrication of athletic mouthguard	$85	NC	Y	NC	Y	NC	Y	NC	Age limitation: <21 years One of (D9941) per 1 Calendar year(s) per patient.	--	Must maintain in patient record the need for the appliance, including that the member is engaged in a contact sport (including, but not limited to basketball, football, hockey, lacrosse, and soccer)
D9944	Occlusal guard - hard appliance, full arch	$308	NC	Y	NC	Y	NC	Y	NC	Age limitation: <21 years One of (D9944, D9945, D9946) per 1 Year(s) per patient.	--	Maintain in patient record evidence of the need for the appliance.
D9945	Occlusal guard - soft appliance, full arch	$308	NC	Y	NC	Y	NC	Y	NC	Age limitation: <21 years One of (D9944, D9945, D9946) per 1 Year(s) per patient.	--	Maintain in patient record evidence of the need for the appliance.
D9946	Occlusal guard - hard appliance, partial arch	$308	NC	Y	NC	Y	NC	Y	NC	Age limitation: <21 years One of (D9944, D9945, D9946) per 1 Year(s) per patient.	--	Maintain in patient record evidence of the need for the appliance.
D9999	Unspecified adjunctive procedure, by report	I.C.	I.C.	Y	Y	Y	NC	Y	Y	--	PA	Narrative of medical necessity

MassHealth Dental Program Covered Benefits, Exclusions, Limitations & Fee Schedule												Last updated: 8/8/2025
Procedure Code	Description	Allowed Fee		MH Standard (Regular)		CMSP	MH Limited	HSN		Benefit Limitations	Required Review	Documentation Required
		<21	21+	<21	21+			<21	21+			

Note: In specific circumstances, additional documentation (e.g. charting) may be required for clinical review. Extra documentation (e.g. intraoral photographs/narrative) may be submitted to supplement required documentation and substantiate medical necessity. If required radiographs cannot be obtained, diagnostic intraoral photographs and/or narrative must substantiate medical necessity.

Required review types:
PA – Prior authorization required before treatment. Retrospective review after treatment may be considered for all services except orthodontics.
<21 PA – Prior authorization required for service that is only covered for members younger than 21 years of age. Service is not covered for members 21 years of age or older.
21+ PA – Prior authorization required only for members 21 years of age or older. Prior authorization not required for members younger than 21 years of age.
CR – Claim review required before payment released. Documentation must be submitted with claim. Prior to rendering a covered dental service subject to claim review, providers have the option to request a pre-determination review. Applies to all providers, including specialists.

CR, >1 crown for 21+, Eff: 4/1/25; 1 crown for 21+ OR crown(s) for <21, Eff: 10/1/25** – Claim review documentation requirements effective for dates of service 4/1/25 and after for crowns delivered to adults when more than one crown is delivered on the same date of service. For children younger than 21 years old and for crowns delivered to adults when only one crown is delivered on a date of service, claim review documentation requirements are effective for dates of service 10/1/25 and after. Applies to all providers, including specialists.
CR, Eff: 10/1/25 – Claim review documentation requirements effective for dates of service 10/1/25 and after. Applies to all providers, including specialists.
CR, General Dentists, Eff: 10/1/25 – Claim review documentation requirements for general dentists effective for dates of service 10/1/25 and after. With the exception of permanent lab-processed crowns and core buildups, specialists are not required to submit routine claim review documentation.

Abbreviations:
BW: Bitewing radiograph
CMSP: Children's Medical Security Plan. CMSP is for children under the age of 19 who are Massachusetts residents at any income level, who do not qualify for MassHealth (except MassHealth Limited), and who are uninsured. MassHealth participating providers can provide covered CMSP services. CMSP coverage has a $750 annual state fiscal year maximum (the state fiscal year is July 1-June 30).
DDS*: Department of Developmental Services; Only adults with DDS have coverage for D2931 for Teeth 1 - 32, One of (D2931) per 12 months per patient per tooth.
FMX: Full mouth intraoral series of radiographs
HLD: Handicapping Labio-Lingual Deviations Index
HSN: Health Safety Net. The HSN makes payments to Massachusetts hospitals and community health centers for health care services provided to low-income Massachusetts residents who are uninsured or underinsured. Only hospitals and community health centers are eligible to enroll as HSN providers and provide covered HSN services.
I.C.: Individual Consideration
MH: MassHealth
NC: Not Covered
PA (under "Documentation Required")**:** Periapical radiograph
PAN: Panoramic radiograph
Pre-Tx: Pre-treatment
Post-Tx: Post-treatment
Posterior BWs: Bitewing radiographs of the posterior teeth
Posterior BWs, FMX, or PAN: Selection based on individualized radiographic examination. A full mouth intraoral radiographic examination is preferred when the patient has clinical evidence of generalized oral disease or a history of extensive dental treatment.
Tx plan: Treatment plan
*: D2931 only covered for adults with DDS for Teeth 1 - 32, One of (D2931) per 12 months per patient per tooth.
**: D8670 and D8680 covered for members 21 years and older only if comprehensive orthodontic treatment began by age 21; D8999 covered for members 21 years and older only if limited orthodontic treatment began by age 21.

D9450* - Eligible CHCs and HLHCs can bill D9450 enhancement fee per 130 CMR 420.405(C), 101 CMR 304.00, 101 CMR 314.00, and 101 CMR 614.00; One of (D9450) per 1 Day(s) Per Provider, Per Member. Only payable when submitted with another payable service.