Reimbursement Policy

Dental Services

Policy Number: 4.15
Version Number: 3
Version Effective Date: 07/01/2015

<table>
<thead>
<tr>
<th>Product Applicability</th>
<th>□ All Plan* Products</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well Sense Health Plan</td>
<td></td>
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<tr>
<td>□ New Hampshire Medicaid</td>
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<tr>
<td>□ NH Health Protection Program</td>
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<tr>
<td>Boston Medical Center HealthNet Plan</td>
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<tr>
<td>❌ MassHealth</td>
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<tr>
<td>❌ Qualified Health Plans/ConnectorCare/Employer Choice Direct</td>
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Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

The Plan reimburses covered dental services based on the provider’s contractual rates with the Plan and the terms of reimbursement identified within this policy.

Prior-authorization

Please refer to the Plan’s Prior Authorization Requirements Matrix at www.bmchp.org.
Definitions

Dental services - any service provided by a licensed dentist involving the diagnosis or treatment of any disease, pain, injury, deformity or other condition of the human teeth, alveolar process, gums, jaw or associated structures of the mouth

Non-Emergency Dental Reimbursement

MassHealth:
All dental services, except emergency and oral surgery as described in this policy, are covered by MassHealth. Please contact MassHealth or refer to the MassHealth Provider Manual for more information about the benefit and billing.

Qualified Health Plans/ConnectorCare/Employer Choice Direct:
The Plan does not pay for any dental services, except the emergency dental services and preventive dental services specifically covered in a member’s plan.

Emergency Dental Reimbursement

The Plan reimburses the following emergency dental services only when there is a traumatic injury to sound, natural and permanent teeth caused by a source external to the mouth; and the emergency dental services are provided by a physician in a hospital emergency room or operating room within 48 hours following the injury:
• X-rays; and
• Emergency oral surgery related to the repair of damaged tissues and/or the repositioning of displaced or fractured teeth.

MassHealth:
The Plan reimburses emergency related dental services and oral surgery performed in an outpatient setting which is medically necessary to treat a medical condition.

Qualified Health Plans/ConnectorCare/Employer Choice Direct:
The Plan reimburses facility and other related charges (i.e., radiology, lab and anesthesia) for non-dental covered services when admission to a network hospital, a surgical day care unit or to an ambulatory surgical facility is medically necessary in order to receive non-covered dental services due to a serious non-dental medical condition. The Plan does not reimburse for the dental procedure. For a non-inclusive list of serious non-dental medical conditions, reference the Plan’s medical policy, Medically Necessary Hospital Services for Non-Covered Dental Services, OCA 3.723.

Service Limitations

• The Plan does not pay for splints or oral appliances.
• Preventative dental services
Plan refers to Boston Medical Center Health Plan, Inc. and its affiliates and subsidiaries offering health coverage plans to enrolled members. The Plan operates in Massachusetts under the trade name Boston Medical Center HealthNet Plan and in other states under the trade name Well Sense Health Plan.

<table>
<thead>
<tr>
<th>Original Approval Date</th>
<th>Original Effective Date</th>
<th>Policy Owner</th>
<th>Approved by</th>
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</thead>
<tbody>
<tr>
<td>10/26/2011</td>
<td>01/01/2012</td>
<td>Payment Policy</td>
<td>Payment Policy Committee</td>
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### Policy History

<table>
<thead>
<tr>
<th>Review Date</th>
<th>Summary of Revisions</th>
<th>Revision Effective Date</th>
<th>Approved by</th>
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<tbody>
<tr>
<td>12/04/2013</td>
<td>Updated template, product applicability section, and references for BMC HealthNet Plan Qualified Health Plans, including ConnectorCare; Added BMC HealthNet Plan Qualified Health Plans, including ConnectorCare dental, cleft palate and cleft lip coverage.</td>
<td>12/04/2013</td>
<td>Payment Policy Committee</td>
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<tr>
<td>05/28/2015</td>
<td>Annual review, new template, removed Commonwealth Choice, Commonwealth Care. Removed Cleft lip/palate section</td>
<td>07/01/2015</td>
<td>Payment Policy Committee</td>
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### Next Review Date

2016

### Other Applicable Policies

**Reimbursement Policies:**
- General Billing and Coding Guidelines, 4.31
- General Clinical Editing and Payment Accuracy Review Guidelines, 4.108
- Outpatient Hospital, 4.17
- Physician and Non Physician Practitioner Services, 4.608

**Medical Policies:**
- Medically Necessary Hospital Services for Non-Covered Dental Services, OCA 3.723

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References

- DHCFP Regulation 114.3 CMR 17.00 – Medicine
- Contract between The Office of Health and Human Services (EOHHS), and Boston Medical Center HealthNet Plan MassHealth
- BMC HealthNet Plan Qualified Health Plans, including ConnectorCare Evidence of Coverage
- BMC HealthNet Plan Employer Choice Direct Evidence of Coverage

Disclaimer Information

This Policy provides information about the Plan’s reimbursement/claims adjudication processing guidelines. The use of this Policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement. Member cost-sharing (deductibles, coinsurance and copayments) may apply – depending on the member’s benefit plan. Unless otherwise specified in writing, reimbursement will be made at the lesser of billed charges or the contractual rate of payment. Plan policies may be amended from time to time, at Plan’s discretion. Plan policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization guidelines (including NCQA). The Plan reserves the right to conduct Provider audits to ensure compliance with this Policy. If an audit determines that the Provider did not comply with this Policy, the Plan will expect the Provider to refund all payments related to non-compliance. For more information about the Plan’s audit policies, refer to the Provider Manual.

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