MassHealth Adult Dental Annual Maximum

Frequently Asked Questions (FAQs)

Effective August 1, 2026, MassHealth anticipates implementing an adult dental annual maximum. This document explains how the annual maximum works and provides answers to frequently asked questions.

General Information

1. **What is changing?**
   Effective August 1, 2026, MassHealth anticipates implementing an annual maximum of $1,750 for adult dental benefits for eligible members 21 and older who are not clients of the Department of Developmental Services (DDS).

   This anticipated change does not apply to members younger than 21 or adults who are DDS clients.

2. **What is the annual maximum?**
   The annual maximum is the total amount MassHealth is anticipated to pay for a member's covered dental services during a benefit year.

3. **When does the annual maximum take effect?**
   The annual maximum is anticipated to apply to covered services provided on or after August 1, 2026, for applicable members.

4. **How much is the annual maximum?**
   The annual maximum is anticipated to be $1,750 per member per benefit year.

5. **What is the benefit year?**
   The initial benefit year (Benefit Year 2027) is anticipated to run from August 1, 2026, through June 30, 2027.

   After Benefit Year 2027, benefit years are anticipated to run from July 1 through June 30. E.g., Benefit Year 2028 is anticipated to be July 1, 2027 through June 30, 2028.

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6. **Why is the benefit year different from the calendar year?**
   The benefit year is anticipated to align with the Massachusetts state fiscal year, which runs from July 1 through June 30, rather than the calendar year (January 1 through December 31).

7. **Does any unused annual maximum roll over to the next benefit year?**
   No. Unused amounts do not roll over. The annual maximum is anticipated to reset to $1,750 at the beginning of each benefit year.

Member Eligibility

8. **Which members are subject to the annual maximum?**
   The annual maximum is anticipated to apply to members age 21 and older who are enrolled in MassHealth Standard, MassHealth CommonHealth, MassHealth Family Assistance, or MassHealth CarePlus. It also applies to individuals whose services are paid for by the Health Safety Net at a hospital or community health center.

   The annual maximum does not apply to members age 21 or older who are clients of the Department of Developmental Services (DDS).

9. **Which members are not subject to the annual maximum?**
   The annual maximum is not anticipated to apply to:

   - Members younger than age 21
   - Members age 21 and older who are DDS clients

Annual Maximum Administration

10. **How is a member's annual maximum balance calculated?**
    During the benefit year, the member's annual maximum balance is anticipated to reflect finalized claim payments only. Claims that are pending or still processing are not expected to be included until they are finalized.

    The amount applied toward the annual maximum is the allowed amount paid by MassHealth for covered services, not the provider's billed charge or the MassHealth rate.

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Because the annual maximum is based on finalized claim payments, providers are encouraged to verify the member's current accumulator balance *before* providing services that may be subject to the annual maximum.

11. How are claims applied toward the annual maximum?

Claims are anticipated to be applied toward the member's annual maximum on a first-in basis as claims are finalized and paid. The order in which claims are applied is not based on the date of service.

Because claims may be processed and paid in an order that differs from the date services were provided, providers are encouraged to check the member's remaining annual maximum balance *before* providing services that may be subject to the annual maximum.

Providers should consider the potential impact of the annual maximum when planning treatment and discuss potential financial responsibility with members in advance when the annual maximum may be reached.

12. Why should providers verify the remaining annual maximum before treatment?

Because the annual maximum is based on finalized claim payments, the member's available balance may change as claims are processed.

Providers are encouraged to verify a member's remaining annual maximum *before* providing services that are subject to the annual maximum, particularly when planned treatment may approach or exceed the member's remaining available benefit.

Verifying the member's remaining annual maximum before treatment can help providers determine whether services are expected to be covered, whether an exception to the annual maximum may apply, or whether the member may need to elect to receive non-covered services as a private-pay patient in accordance with applicable billing requirements, including but not limited to Section 3.4 of the MassHealth Dental Program Office Reference Manual (ORM).

13. How can providers determine a member's remaining annual maximum?

Providers are anticipated to be able to view a member's remaining annual maximum in the provider portal. The balance is anticipated to be available within the Member Eligibility Detail page under the Accumulator Details. Providers should verify the

accumulator details to verify the annual maximum balance *before* providing services that may be subject to the annual maximum.

How to Check the Accumulator Details on the Member Detail page:

1) From the **Member Eligibility** *Search Results* page, click on the **Member Number** to open the **Member Eligibility Detail** page.
2) From the **Member Detail** page, click **VIEW ACCUMULATOR** to check a member's benefit year balance.
3) The **Accumulator Details** page shows the "Applied" and "Remaining" balance amounts for the member's annual maximum.

14. **UPDATED What happens if a member reaches the annual maximum?**

Once the annual maximum has been reached, MassHealth is not anticipated to make additional payments for covered services that are subject to the annual maximum during that benefit year. Provider will see on their remittance advice denial code reason 2054: *The annual maximum benefit has been reached*.

Certain services may continue to be eligible for reimbursement after the annual maximum has been reached, provided all applicable coverage requirements are met.

If the annual maximum has been reached and no applicable coverage exception applies, services that are subject to the annual maximum are non-covered. Providers must comply with all applicable requirements for billing members for non-covered services, including but not limited to entering into a written agreement before services are provided in accordance with Section 3.4 of the ORM.

15. When does the annual maximum reset?

The annual maximum is anticipated to reset to $1,750 at the beginning of each benefit year.

16. What happens if a member turns 21 during the benefit year?

Dental coverage for members under age 21 is not subject to an annual maximum. For members who are not DDS clients, coverage for services rendered on and after the date of their 21st birthday is subject to the adult annual dental maximum of $1,750.

In the benefit year of the member's 21st birthday, the $1,750 annual maximum applies from the member's 21st birthday through the end of the current benefit year on June 30.

On July 1, the beginning of the new benefit year, the member's annual maximum is anticipated to reset to $1,750, subject to applicable coverage requirements.

17. ****NEW** What happens if a member's coverage changes or they lose and regain coverage during the benefit year?**

    If a member's coverage changes or they lose and regain coverage during the benefit year, the amount applied toward the annual maximum does not reset. The member's annual maximum balance continues from the amount remaining at the time of the coverage change or loss of coverage. The annual maximum resets to $1,750 on July 1, the beginning of the new benefit year.

18. **What if a claim is voided or reprocessed?**

    If a claim is voided or reprocessed, the amount applied toward the member's annual maximum is anticipated to be adjusted to reflect the final paid amount. As a result, the member's remaining annual maximum balance may increase or decrease.

19. **Does the annual maximum apply to billed charges or allowed amounts?**

    The amount applied toward the annual maximum is the allowed amount paid by MassHealth for covered services, not the provider's billed charge or the MassHealth rate.

Covered Services

20. ****NEW** Are there any changes to covered services or benefit limitations?**

    No. There are no changes in the services that are covered by MassHealth for adult members age 21 and older. The covered services and benefit limitations remain the same.

    A non-covered service, such as a night guard for an adult, remains non-covered regardless of whether there is any remaining annual maximum benefit amount.

    Providers can review the MassHealth Dental Program Office Reference Manual (ORM) to confirm which service codes are covered for adults. The code-by-code list of covered services and applicable benefit limitations can be found in the Exhibits at the end of the ORM.

21. Do all covered dental services count toward the annual maximum?

Most covered dental services are anticipated to apply toward the annual maximum.

Certain services may continue to be eligible for reimbursement after the annual maximum has been reached, provided applicable coverage requirements are met.

22. **UPDATED Which services are excluded from the annual maximum?**

Payments for the following procedure codes do not count toward the annual maximum and remain eligible for reimbursement after the annual maximum has been reached, subject to applicable coverage requirements:

- D9410 – *House / Extended care facility call*
- D9450 – *Rural add-on encounter payment* or *CHC enhancement fee*
- D9920 – *Behavior management*

Additionally, for members who turn age 21 while actively undergoing MassHealth approved orthodontic treatment, the following services do not apply to the annual maximum and are eligible for coverage beyond the annual maximum, subject to applicable coverage requirements:

- D8670, D8671, D8680, D8999

23. **NEW What does "subject to applicable coverage requirements" mean?**

"Subject to applicable coverage requirements" means that all existing coverage rules and benefit limitations continue to apply. A service may be excluded from the annual maximum or remain eligible for reimbursement after the annual maximum has been reached, but the service must still meet all other applicable coverage requirements. The requirements include, but are not limited to, billing requirements, documentation requirements, member eligibility, frequency limitations, and medical necessity.

24. **NEW If other services are not covered because the annual maximum has been reached, are D9410, D9450, or D9920 still payable?**

No. Although D9410, D9450, and D9920 are excluded from the annual maximum and may remain eligible for reimbursement after the annual maximum has been reached, these codes are only payable when submitted with another payable covered service on the same date of service. If no other payable covered service is provided on that date

because the annual maximum has been reached, D9410, D9450, and D9920 are not payable.

25. **NEW If a covered service is only partially payable because the annual maximum is reached, are D9410, D9450, and D9920 payable?**

Yes. D9410, D9450, and D9920 may remain eligible for reimbursement if another covered service on the same date of service has a payable amount after application of the annual maximum. These codes are not payable when no other covered service has a payable amount on that date of service.

26. Which services may be covered after the annual maximum has been reached?

The following services count toward the member's annual maximum but remain eligible for reimbursement after the annual maximum has been reached, subject to applicable coverage requirements:

Limited Diagnostic Services

- D0140

Diagnostic Radiographs

- D0220, D0230, D0270, D0330, D0340

Denture Repair Services

- D5511, D5512, D5520, D5611, D5612, D5621, D5622, D5630, D5640, D5650, D5660, D5730, D5731, D5750, D5751

Extractions

- D7111, D7140, D7210, D7220, D7230, D7240, D7250, D7251, D7270

Palliative Treatment

- D9110

Anesthesia

- D9222, D9223, D9230, D9239, D9243, D9224, D9225, D9244, D9245, D9246

Treatment of Surgical Complications

- D9930

27. **NEW Are there any special billing instructions for services that remain eligible for reimbursement after the annual maximum has been reached?**

No. There are no special billing guidelines for these services. Provides should continue to submit claims as usual. If applicable, the claim system will automatically apply the exception and process eligible services for coverage beyond the annual maximum, subject to applicable coverage requirements.

Exception for Initial Complete Denture

28. Are initial complete dentures covered after the annual maximum has been reached?

Initial complete dentures (D5110 and D5120) are eligible for reimbursement beyond the annual maximum only when they are provided as the member's first-ever complete denture following full arch extractions, subject to applicable coverage requirements.

29. Are replacement complete dentures eligible for this exception?

No. Replacement complete dentures remain subject to the annual maximum.

30. **UPDATED Are there special billing instructions for initial complete dentures?**

No. There are no special billing guidelines for initial complete dentures. Providers should continue to submit D5110 and D5120 claims as usual. If applicable, the claim system will automatically apply the exception and process eligible initial complete denture services for coverage beyond the annual maximum, subject to applicable coverage requirements.

Exception for Continued Orthodontic Services

31. What happens if a member turns age 21 during active orthodontic treatment?

Members who turn age 21 while actively undergoing MassHealth-approved orthodontic treatment may continue to receive coverage beyond the annual maximum for the following procedure codes, subject to applicable coverage requirements:

- D8670
- D8671
- D8680
- D8999

Transition of Care

32. Will there be a transition period when the annual maximum is implemented?

Yes. MassHealth anticipates implementing a temporary transition of care period to support members and providers during implementation.

During this transition period, certain in-process multi-visit procedures may be eligible for reimbursement beyond the annual maximum when specific criteria are met. To qualify, the procedure must have reached the applicable decisive step before August 1, 2026, and the treatment must be completed by October 31, 2026.

The transition of care exceptions apply only to eligible multi-visit procedures and are subject to applicable coverage requirements.

33. Which procedures qualify for transition of care?

The following in-process multi-visit procedures may be eligible for reimbursement beyond the annual maximum during the transition of care period, provided that:

- The decisive step occurred before August 1, 2026; and
- Treatment is completed by October 31, 2026.

The table below identifies the eligible procedure codes and the corresponding decisive step for each procedure. Amounts paid for these services apply toward the member's annual maximum but remain eligible for reimbursement after the annual maximum has been reached, subject to applicable coverage requirements.

Eligible Multi-Visit Procedures During Transition of Care

Type of Service	Eligible Multi-Visit Procedure Codes	Decisive Step
Crowns	D2740, D2751	Tooth preparation or final impression
Root Canal Therapy	D3310-D3348	Pulp extirpation or debridement to at least the apical 1/3 of all canals
Complete Dentures	D5110, D5120	Final impression
Partial Dentures	D5211, D5212	Final impression

34. **UPDATED Are there special billing instructions for transition of care procedures?**

No. There are no special billing guidelines for services to be eligible for transition of care. Providers should continue to submit claims for eligible multi-visit procedures as usual, including using the actual delivery date or completion date as the date of service. If the claim gets denied with PP2054: *The annual maximum benefit has been reached*, your office should submit a reconsideration through the provider portal with the chart notes showing that the decisive step occurred before August 1, 2026.

Billing Members After the Annual Maximum

35. Can I bill a member after they have reached the annual maximum?

Once a member has reached the annual maximum, services that are not eligible for one of the exceptions described in this document are considered non-covered services by MassHealth.

In accordance with ORM Section 3.4, a provider may charge a member for these non-covered services only if the member:

- Knowingly elects to receive the services as a private-pay patient; and
- Signs a written agreement to pay for the services before the services are provided.

36. Can I bill the member if the service is no longer covered because the annual maximum has been reached?

Yes, but only if the member knowingly elects to receive the service as a private-pay patient and signs a written agreement to pay for the service before it is provided.

Without a prior written agreement, as described in ORM Section 3.4, the provider may not bill the member for the non-covered service.

37. What if the annual maximum is reached during a service?

If the annual maximum is reached during a service and only part of the service is covered, the remaining non-covered portion may be billed to the member only if the member knowingly elected to receive the services as a private-pay patient and signed a written agreement before the services were provided.

38. Does the written agreement have to be signed before treatment is provided?

Yes. See ORM Section 3.4. Before providing a non-covered service that the member will pay for, the provider must obtain a written agreement in which the member knowingly elects to receive the services as a private-pay patient and agrees to pay for them.

39. Are providers required to verify a member's remaining annual maximum before treatment?

Providers are encouraged to verify a member's eligibility and remaining annual maximum before providing services, particularly when planned treatment may approach or exceed the available maximum benefit.

40. Can a provider require a member to pay privately instead of billing MassHealth?

No. Covered services must continue to be billed to MassHealth. A member may be treated as a private-pay patient only for services that are non-covered because the annual maximum has been reached and only after the member knowingly elects private-pay status and signs a written agreement before receiving the services.

41. Can providers bill members using their usual and customary rates (UCR) or contracted rates for non-covered services?

Providers may determine the amount to charge members for services that are non-covered because the annual maximum has been reached. Providers are not required to use MassHealth rates or usual and customary rates (UCR) when establishing charges for these services.

However, MassHealth encourages providers to consider using MassHealth rates when determining member charges for non-covered services to promote consistency and affordability for members.

Providers must follow all applicable requirements for billing members for non-covered services, including obtaining the member's written agreement to receive the services as a private-pay patient before the services are provided.