BOSTON PUBLIC HEALTH COMMISSION

Ryan White Dental Program

UPDATED 10.16.25

Provider Manual

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Dear Valued Providers,

This Provider Manual has been revised and updated to better describe the role and requirements of our program and how to participate in it.

RWDP was established in July of 1991 through the extraordinary work of Helene Bednarsh BS, RDH, MPH. This program is now in its 34th year of service and we currently have over 90 dental practices participating. RWDP is a comprehensive dental access program for persons with HIV in Massachusetts and Southern New Hampshire (three counties). This program is funded by the Ryan White HIV/AIDS Treatment Extension Act, Part A (referred to as Ryan White Part A) and the Massachusetts Department of Public Health (referred to as MDPH). Funding under the Ryan White Part A program runs from March 1st through the end of February for clients residing in the Boston Eligible Metropolitan Area (EMA). The EMA covers seven counties in Massachusetts (Bristol, Essex, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester) and three counties in Southern New Hampshire (Hillsborough, Rockingham, and Strafford). Funding under MDPH runs from July 1st through the end of June for clients residing in Cape Cod and Western Massachusetts.

RWDP pays for dental care for eligible clients with HIV who are uninsured or underinsured. RWDP may also reimburse for services not covered or denied by Medicaid or another insurance carrier if these fall within the program's scope of services. Payment by RWDP is considered payment in full. Balance billing or patient co-payment is not permitted. Although RWDP does not permit co-pays and remaining balances for patients, late fees, no-show cancellation fees, and other penalties associated with scheduling issues are permitted and will be the patient's responsibility. RWDP does not reimburses either patients or providers for these aforementioned fees. RWDP recommends participating dentists to institute the best practices that promote patient adherence.

Each participating dentist determines their own level of participation, ranging from eligible clients of record only to any desired number of referrals the dentist requests. RWDP is not a part of the Medicaid program, and participating dentists do not have to be Medicaid providers. All information regarding clients and participating dentists is kept strictly confidential and lists of providers and clients are never distributed.

I thank you for your dedication and service to this very important program.

Sincerely,

Anthony Silva
Ryan White Dental Program - Infectious Disease Bureau
Boston Public Health Commission

PROGRAM OVERVIEW

RYAN WHITE DENTAL PROGRAM

The Ryan White Dental Program (RWDP) was established in 1991 and is funded by a grant from the Ryan White HIV/AIDS Treatment Extension Act, Part A and from funding through the Massachusetts Department of Public Health (MDPH). The primary goal of this program is to increase access to oral health care for persons with HIV from eligible communities. This manual describes the procedures participating dentists must follow for payment or prior approval for services within our attached scope of services rendered to eligible clients.

PATIENT ELIGIBILITY

Persons with HIV from eligible communities (see Appendix A: List of Eligible Communities) who are enrolled with RWDP and have no dental third-party payment source, have limited coverage through a third party, or have services denied by the third party, are eligible for treatment reimbursed by RWDP. Coverage for patients is **only good for twelve months and they must re-enroll with RWDP to maintain coverage**. Patient eligibility status must be checked 3 weeks prior to their appointment. This will allow time for RWDP to contact the client before their appointment if an update is needed. Payment for services can only be paid on active clients.

Dental providers are reimbursed directly by the fund. Any questions about patient eligibility should be referred to RWDP at (617) 534-2344 or to the following address:

Ryan White Dental Program - 2nd Floor
Boston Public Health Commission
1010 Massachusetts Avenue,
Boston, MA 02118

SCOPE OF SERVICES AND PAYMENT

The scope of services and the rate of payment are based on the Massachusetts Rate Setting Commission (RSC) fee schedule, which is similar to the 2021 Medicaid fee schedule. A revised listing of allowable services and fees can be found in Appendix C: Dental Fee Schedule. This listing should also serve as a guideline to the scope of treatment services. However, the nature of a patient's illness may indicate treatment beyond those services listed in the fee schedule. Any additional services will be reviewed on an individual basis and must have approval prior to treatment.

Prior approval is not necessary for routine diagnostic, restorative, or preventative services. Prior approval is necessary for endodontic and prosthodontic services and for select periodontal and oral surgical procedures. Only services within the scope of the program can be reimbursed. Please feel free to contact the program with any questions

regarding services not listed in this manual.

Endodontic/crown procedures are limited to two full procedures per patient per fiscal year. Services covered under this fund are fairly comprehensive from first molar to first molar. RWDP cannot cover fixed bridgework, orthodontics, implants, cosmetic dentistry and select other procedures. Program staff can discuss alternate treatment options with you.

RWDP understands the importance of periodontal services. If necessary please consider that quadrant scaling be done once or twice a year and, in the interim, consider full mouth debridement and/or periodontal maintenance if a prophylaxis is not sufficient. The program also encourages fluoride treatment.

Cosmetic or elective procedures including orthodontics and implants are not covered. Since the purpose of RWDP services is to maintain and restore function, fixed prosthodontics is not covered but removable prosthodontics such as acrylic partials are within the scope.

This fund does not replace the patient's dental insurance or Medicaid, or the Health Safety Net as the primary payor for services. However, some services not covered by these payors may be covered by the RWDP. This is done on a prior approval basis. In such an instance, a copy of the denial notice from Medicaid or the dental insurance carrier should be attached to the dental claim submitted to our office. All MassHealth eligible clients must be treated by a provider accepting MassHealth payments. Billing must be made to MassHealth and is then considered payment in full. Please note that RWDP does not reimburse insurance co-pays, the co-pay is the patient's responsibility. Please see attachment provided by MassHealth (Appendix D) with instructions on how to bill them when the client is eligible for both programs.

HOW TO ENROLL AS A PROVIDER

Interested dentists should submit a completed Appendix F: RWDP Participation Letter which indicates their willingness to accept the RWDP fee schedule, accept the terms outlined in this manual and participate in the program. At the dentist's request, participation may be limited to eligible patients of record or other limitations agreed upon between the dental provider and RWDP. Please call the program regarding participation concerns. All provider and patient information are kept confidential. Provider and client lists are never distributed. Completed Appendix F forms should be sent to RWDP. License number and TIN/SSN are needed to establish a vendor code for payment purposes only. Once you have submitted Appendix F, RWDP will send you an official BPHC Dentist Agreement required by the BPHC legal department for all providers.

IMPORTANT INFORMATION ON PATIENT CONFIDENTIALITY

RWDP is for patients who are HIV positive. Under Massachusetts General Laws Chapter 111, Section 70F, confidentiality of HIV status must be assured in a dental setting.

If you do not have a specific policy or procedure in your office to guarantee confidentiality of HIV and/or other medical information, you are strongly encouraged to develop one. RWDP will gladly assist you in this process. You may also wish to seek legal counsel. Written informed consent by the patient is necessary before releasing any medical information, including HIV information. This includes submitting dental claim forms for payment through the RWDP. Appendix E: Consent for Release of Information must be completed every year by the patient. You should keep a copy in their dental record. This is written informed consent for billing. Dental claims forms must be completed and submitted in confidential manner, and the forms must not include confidential medical information, including HIV status. Please do not refer to RWDP clients as "HIV," "HIV dental" or in some way which identifies their status. Please use RWDP on claims. These forms should be handled with discretion to protect the patient's privacy. All documents will be treated in a strictly confidential manner in our program.

CLAIM OVERVIEW

HOW TO SUBMIT A CLAIM FORM

Proposed Treatment Plan: A proposed treatment plan should be submitted for each patient for prior approval **before providing treatment** for those services requiring prior approval. Appendix C: Fee Schedule denotes those service with an asterisk (*). Appendix B: Dental Treatment Claim Form provides an example of the type of form that may be used.

Please complete the entire form including charting. Because funding is limited, services may have to be prioritized or modified with the consent of the dental provider. Any supporting material you feel relevant to a particular case may be included with the claim to help in the review process of more complicated cases. You may wish to call and discuss this before submitting the supporting materials. Please call if you have any questions on codes, fees, or other aspects of the dental claim form. *Routine services do not require a prior approval, but you must ensure that the patient is currently eligible for RWDP funded services.*

Prior Approval: **Requests for prior approvals will be reviewed within 2 business days. Prior approval may also be obtained by phone *on a limited or emergency basis.*** Please call (617) 534-2344 or fax forms to (617) 534-2819. Services that require prior approval that have not received prior approval will not be paid.

Please inform the RWDP of any changes to or cancellation of a prior approval as soon as possible. It is important to inform RWDP if a prior approval may be canceled for managing RWDP funding. Prior approvals are valid for 90 days or the length of the remaining fiscal year if less than 90 days. If treatment has not been started or completed, it may be either extended or canceled. All prior approvals must be completed within the fiscal year.

Completed Treatment: In completing the dental claim form, enter appropriate codes, your usual and customary fees, and all other information of importance on the dental claim form. Fees will be adjusted according to the fund's fee schedule to reflect actual payment.

Steps to Complete a Claim Form (Appendix C):

1. Patient Section- Complete by entering the appropriate patient information.
2. Dentist Section- Complete by entering the appropriate provider information. Be sure your direct deposit information is on file. If there is a practice name, please enter the practice name, for payment, even if the dentist's signature is different on the bottom of the claim.
3. Examination and Treatment Plan- Complete by entering the appropriate treatment information, including tooth number or letter, description of service, date, code, and your usual and customary fee. The administrative use column will be completed in this office to indicate the corresponding fee for the service/code entered. The RWDP staff may call you to discuss individual consideration to determine an appropriate fee for those procedures without an assigned fee.
4. Signature- Please sign and date the claim form.
5. Please include charting in section 33.

Claim Submission: Send all completed claims via:

Fax – This is our preferred method. Send fax to:
Ryan White Dental Program
Fax: (617) 534-2819

Or

Email – Email your completed claims to: RWDPClaims@bphc.org

Mail – This should be a last resort submission of your completed claims. Mail completed claims to:

Ryan White Dental Program - 2nd Floor
Boston Public Health Commission 1010
Massachusetts Avenue
Boston, MA 02118

CLAIM PAYMENTS

RWDP operates under two fiscal years depending on the funding source. One fiscal year is March 1 – February 28(9) for clients residing in the Boston EMA, and the other is July 1 – June 30 for clients residing in Cape Cod and in Western MA (Non-EMA Counties of MA). The provider will be directly reimbursed for services rendered and in accordance with BPHC's Fiscal Rules. (Refer to your Dental Agreement for a copy of the Fiscal Rules.)

Payment Rules:

- Payment cannot be made to patients.
- Fees paid under the Ryan White Part A and MDPH funds are considered payment in full.
- Balance billing and/or patient co-payments are not allowed.
- Services that require multiple steps can only be billed to RWDP after the final date of completion for that specific service/code.
- Payment request for claims that have been denied in full or partially by a third-party payer must be submitted with the EOB attached for program records. Note patient co-pays are not covered.
- RWDP processes claims on a monthly basis and payments will be made within 30 days of the submission deadline (if no issue with submission).
- Payment delays may occur at the start of the fiscal year while reimbursement procedures are established.
- Payments will be made via Direct Deposit only.
- A copy of the dental claim(s) will be sent as back up to your direct deposit.

All claims must be submitted to RWDP **no later than the 15th of the month** following the month in which the service was provided. For example, claims completed in March should be submitted no later than April 15th in accordance with BPHC's Fiscal Rules. If you are waiting for a determination from a third-party payer and holding claims prior to billing RWDP, please inform the program. Claims that have missed the regular submission deadline will be classified as supplemental claims and will only be processed twice during the fiscal year.

All **final claims** for a given fiscal years must be submitted by **March 15th** or **July 15th** depending on the fiscal year/funding source. Claims received after the final deadlines will not be paid since the grant funding will be closed and unpaid balances cannot be carried over to the next fiscal year.

SUBMISSION DATES REMINDER

Claims	Service Date(s)	Due Date
Regular Claims	Monthly	15th of Each Following Month
Boston EMA **Final Claims**	February 1 - 28/29	March 15
Non-EMA Counties (MA only) **Final Claims**	June 1 - 30	July 15
Supplemental Claims		
Boston EMA Supplemental Claims	March - July	September 15
Boston EMA Supplemental Claims	August – January	March 15
Non-EMA Counties (MA only) Supplemental Claims	July – November	January 15
Non-EMA Counties (MA only) Supplemental Claims	December – May	July 15

**Refer to the Fiscal Rules of the Dental Agreement for more details*

If billing companies are utilized to submit claims on your behalf, please bring the above deadlines to their attention.

EMERGENCY SERVICES

Emergency services, provided for the relief of pain or infection, will be covered for eligible clients, provided funds are available and the services are within the scope of RWDP. Prior approval is still required for those services indicated as such.

ATTACHMENTS

APPENDIX A- "List of Eligible Communities"- list of communities in which clients are eligible to participate in the dental treatment fund. Eligibility is based on where the client resides.

APPENDIX B- "Dental Treatment Claim Form," a sample claim form, however you may use any ADA approved claim form. Please refer to the section above on "How to Submit a Claim."

APPENDIX C- "Dental Fee Schedule," the fee schedule used to reimburse dental provider.

APPENDIX D- "BPHC Third Party Liability Claim Submission Instruction (DentaQuest)" Billing instructions for patients eligible for MassHealth and RWDP.

APPENDIX E – "Consent for Release of Information," the RWDP consent form should be signed by the patient. Please note in their record that this form should be submitted every year. Please keep a copy in your patient's dental record.

APPENDIX F- Provider Forms – "Participation Letter" This form indicates willingness to participate in the RWDP and any limitations or special considerations. (This form is only for new providers.)

All of the above forms may be copied and used for RWDP. If you need additional sample forms or provider manuals, please call our office at (617) 534-2344.

APPENDIX A: LIST OF ELIGIBLE COMMUNITIES

Residents in all cities and towns in the following areas are eligible for RWDP:

1. All of Massachusetts counties:
    - Barnstable
    - Berkshire
    - Bristol
    - Dukes
    - Essex
    - Franklin
    - Hampden
    - Hampshire
    - Middlesex
    - Nantucket
    - Norfolk
    - Plymouth
    - Suffolk
    - Worcester

2. In New Hampshire, the following three counties:
    - Hillsboro
    - Rockingham
    - Stafford

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

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

2. Predetermination/Preauthorization Number

DENTAL BENEFIT PLAN INFORMATION

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

3a. Payer ID

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 ☐U | 8. Policyholder/Subscriber ID (Assigned by Plan)

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

11a. Other Payer ID

POLICYHOLDER/SUBSCRIBER INFORMATION (Assigned by Plan 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 ☐U | 15. Policyholder/Subscriber ID (Assigned by Plan)

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 ☐U | 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-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in "**A**") A _____ B _____ C _____ D _____

31a. Other Fee(s)

32. Total Fee

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 (alll dates in MM/DD/CCYY format)

38. Place of Treatment ☐ (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")

39. Enclosures (Y or N)

39a. Date Last SRP

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

53a. Locum Tenens Treating Dentist? ☐

54. NPI | 55. License Number

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

57. Phone Number ( ) - | 58. Additional Provider ID

J43024 (Same as ADA Dental Claim Form – J43124, J43224, J43424, J43024T)

APPENDIX C: DENTAL FEE SCHEDULE

Attached is the current Fee Schedule for Dental Services. RWDP will cover all listed services as long as those requiring a prior approval have been approved by RWDP. Please note that routine services such as diagnostic, preventive, restorative and minor oral surgery do not require a prior approval.

If you have any questions, please call (617) 534-2344.

Code	Fee	Description of Services
		I. Diagnostic
D0120	$ 24.00	Periodic oral evaluation - established patient
D0140	$ 43.00	Limited oral evaluation - problem focused
D0150	$ 41.00	Comprehensive oral evaluation - new or established patient
D0160	$ 64.00	Detailed and extensive oral evaluation - problem focused, by report
D0170	$ 39.00	Re-evaluation - limited, problem focused (established patient; not postoperative visit)
D0180	$ 37.00	Comprehensive periodontal evaluation - new or established patient
D0210	$ 76.00	Intraoral - complete series of radiographic images
D0220	$ 15.00	Intraoral - periapical, first radiographic image
D0230	$ 13.00	Intraoral - periapical, each additional radiographic image
D0240	$ 21.00	Intraoral - occlusal radiographic image
D0270	$ 14.00	Bitewing - single radiographic image
D0272	$ 25.00	Bitewings - two radiographic images (twice per calendar year)
D0273	$ 29.00	Bitewings – three radiographic images (twice per calendar year)
D0274	$ 36.00	Bitewings - four three radiographic images (twice per calendar year)
D0330	$ 69.00	Panoramic radiographic image
D0460	$ 31.00	Pulp vitality tests
D0470*	$ 62.00	Diagnostic casts
		II. Preventive
D1110	$ 60.00	Prophylaxis – adult

*** Denotes Prior Authorization required**

D1120	$ 55.00	Prophylaxis – child
D1206	$ 26.00	Topical application of fluoride varnish
D1208	$ 29.00	Topical application of fluoride
D1351	$ 30.00	Sealant – per tooth
D1354	$ 15.00	Application of caries arresting medicament - per tooth
		III. Restorative
D2140	$ 62.00	Amalgam – one surface, primary or permanent
D2150	$ 77.00	Amalgam – two surfaces, primary or permanent
D2160	$ 92.00	Amalgam – three surfaces, primary or permanent
D2161	$ 116.00	Amalgam – four or more surfaces, primary or permanent
D2330	$ 72.00	Resin-based composite – one surface, anterior
D2331	$ 92.00	Resin-based composite – two surfaces, anterior
D2332	$ 116.00	Resin-based composite – three surfaces, anterior
D2335	$ 146.00	Resin-based composite – four or more surfaces or involving incisal angle (anterior)
D2390	$ 106.00	Resin-based composite crown, anterior (under 21 only)
D2391	$ 62.00	Resin-based composite – one surface, posterior
D2392	$ 77.00	Resin-based composite – two surfaces, posterior
D2393	$ 92.00	Resin-based composite – three surfaces, posterior
D2394	$ 116.00	Resin-based composite – 4 or more surfaces, posterior
D2710*	$ 230.00	Crown – resin- based composite (indirect); under 21 and only for primary or permanent anterior teeth
D2740*	$ 729.00	Crown – porcelain/ceramic

*** Denotes Prior Authorization required**

D2751*	$ 613.00	Crown – porcelain fused to predominantly base metal
D2752*	$ 633.00	Crown – porcelain fused to noble metal
D2790*	$ 690.00	Crown – porcelain fused to high noble metal
D2910	$ 57.00	Re-cement or re-bond inlay, onlay or partial coverage restoration
D2920	$ 57.00	Recement crown or re-bond crown
D2930*	$ 153.00	Prefabricated stainless steel crown - primary tooth (under 21 only)
D2931*	$ 171.00	Prefabricated stainless steel crown - permanent tooth (under 21 only)
D2932*	$ 211.00	Prefabricated resin crown (under 21 only)
D2940	$ 61.00	Protective restoration
D2950*	$ 164.00	Core buildup, including any pins when required
D2951	$ 27.00	Pin retention – per tooth, in addition to restoration
D2952*	$ 233.00	Post and core in addition to crown, indirectly fabricated
D2954*	$ 191.00	Prefabricated post and core in addition to crown
D2980	$ 115.00	Crown repair necessitated by restorative material failure
D2999*	I.C.	Unspecified restorative procedure, by report
		IV. Endodontics
D3110	$ 34.00	Pulp Cap – Direct (excluding final restoration)
D3120	$ 34.00	Pulp Cap – Indirect (excluding final restoration)
D3220	$ 88.00	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament (under 21 only)
D3310*	$ 544.00	Endodontic therapy, anterior (excluding final restoration)

*** Denotes Prior Authorization required**

D3320*	$ 639.00	Endodontic therapy, premolar tooth (excluding final restoration)
D3321	$ 100.00	Pulpal debridement
D3330*	$ 829.00	Endodontic therapy, molar tooth (excluding final restoration)
D3346*	$ 456.00	Retreatment of previous root canal – anterior
D3347*	$ 538.00	Retreatment of previous root canal – bicuspid
D3348*	$ 613.00	Retreatment of previous root canal – molar
D3351*	$ 125.00	Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.)
D3410	$ 407.00	Apicoectomy – anterior
D3421*	$ 460.00	Apicoectomy – premolar (first root)
D3425*	$ 598.00	Apicoectomy – molar (first root)
D3426*	$ 230.00	Apicoectomy (each additional root)
D3430	$ 77.00	Retrograde Filling – per root
D3450	$ 288.00	Root amputation – per root
D3999*	I.C.	Unspecified endodontic procedure by report
		V. Periodontics
D4210*	$ 307.00	Gingivectomy or gingivoplasty - Four or more contiguous teeth or bounded teeth spaces per quadrant
D4211*	$ 111.00	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant
D4240*	$ 449.00	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant
D4241*	$ 375.00	Gingival Flap Procedure, including root planning – one to three contiguous teeth or tooth bound spaces per quadrant
D4249*	$ 460.00	Clinical crown lengthening, hard tissue
D4265*	$ 95.00	Biologic materials to aid in soft and osseous tissue regeneration, per site

*** Denotes Prior Authorization required**

D4272*	$ 250.00	Apically repositioning flap procedure
D4320	$ 95.00	Provisional splinting – intracoronal
D4321	$ 106.00	Provisional splinting – extracoronal
D4340	$ 65.00	Periodontal scaling and root planning – entire mouth – once per year
D4341*	$ 134.00	Periodontal scaling and root planing - four or more teeth per quadrant
D4342*	$ 100.00	Periodontal scaling and root planing - one to three teeth, per quadrant
D4355	$ 77.00	Full Mouth Debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit
D4910	$ 80.00	Periodontal maintenance (once per year)
D4999*	I.C.	Unspecified periodontal procedure, by report
		VI. Prosthodontics
D5110*	$ 730.00	Complete denture – maxillary
D5120*	$ 730.00	Complete denture – mandibular
D5211*	$ 556.00	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)
D5212*	$ 595.00	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)
D5410	$ 42.00	Adjust complete denture – maxillary
D5411	$ 42.00	Adjust complete denture – mandibular
D5421	$ 53.00	Adjust partial denture – maxillary
D5422	$ 39.00	Adjust partial denture – mandibular
D5510	$ 85.00	Repair broken complete denture base
D5511	$ 85.00	Repair broken complete denture base – mandibular

*** Denotes Prior Authorization required**

D5512	$ 85.00	Repair broken complete denture base – maxillary
D5520	$ 77.00	Replace missing or broken teeth – complete denture (each
D5610	$ 77.00	Repair resin denture base
D5611	$ 77.00	Repair resin denture base – mandibular
D5612	$ 77.00	Repair resin denture base – maxillary
D5620	$ 104.00	Repair cast framework
D5621	$ 104.00	Repair cast framework – mandibular
D5622	$ 104.00	Repair cast framework – maxillary
D5630	$ 99.00	Repair or replace broken clasp
D5640	$ 77.00	Replace broken teeth - per tooth
D5650	$ 92.00	Add tooth to existing partial denture
D5660	$ 98.00	Add clasp to existing partial denture
D5710*	$ 253.00	Rebase complete maxillary denture
D5711*	$ 201.00	Rebase complete mandibular denture
D5720*	$ 230.00	Rebase maxillary partial denture
D5721*	$ 284.00	Rebase mandibular partial denture
D5731*	$ 173.00	Reline lower complete mandibular denture (direct)
D5740*	$ 142.00	Reline maxillary partial denture (direct)
D5741*	$ 134.00	Reline mandibular partial denture (direct)
D5750*	$ 214.00	Reline complete maxillary denture (indirect)
D5751*	$ 215.00	Reline complete mandibular denture (indirect)

*** Denotes Prior Authorization required**

D5760*	$ 211.00	Reline maxillary partial denture (indirect)
D5761*	$ 211.00	Reline mandibular partial denture (indirect)
D5820*	I.C	Interim partial denture (including retentive/clasping materials, rests and teeth), maxillary
D5821*	I.C.	Interim partial denture (including retentive/clasping materials, rests and teeth), mandibular
D5867	$ 200.00	Replacement of replaceable part of semi-precision or precision attachment, per attachment
D5988	$ 250.00	Surgical splint
D5999*	I.C.	Unspecified prosthodontic procedure by report
		VII. Prosthodontics (Fixed)
D6930	$ 72.00	Recement bridge
D6999*	I.C.	Unspecified, fixed prosthodontic procedure, by report
		VIII. Exodontic
D7111	$ 75.00	Extraction, coronal remnants –primary tooth
D7140	$ 77.00	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
D7210	$ 149.00	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated
D7220	$ 191.00	Removal of impacted tooth – soft tissue
D7230	$ 249.00	Removal of impacted tooth – partially bony
D7240	$ 295.00	Removal of impacted tooth – completely bony
D7241	$ 326.00	Removal of impacted tooth – completely bony, with unusual surgical complications
D7250	$ 144.00	Surgical removal of residual tooth roots (cutting procedure)
D7251	$ 134.00	Coronectomy – intentional partial tooth removal, impacted teeth only
D7260	$ 339.00	Orolantral fistula closure

*** Denotes Prior Authorization required**

D7270	$ 106.00	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
D7272	$ 161.00	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization
D7280*	$ 380.00	Exposure of an unerupted tooth (under 21 only)
D7285	$ 122.00	Incisional biopsy of oral tissue – hard (bone, tooth)
D7286	$ 164.00	Incisional biopsy of oral tissue - soft
D7288	$ 125.00	Brush biopsy - transepithelial sample collection
D7290	$ 79.00	Surgical repositioning of teeth
D7291	$ 137.00	Transseptal fiberotomy/supra crestal fiberotomy, by report
D7310	$ 142.00	Alveoloplasty in conjunction with extractions-four or more teeth or tooth spaces, per quadrant
D7311	$ 128.00	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant
D7320	$ 187.00	Alveoloplasty not in conjunction with extractions-four or more teeth or tooth spaces, per quadrant
D7321	$ 149.00	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant
D7350	$ 943.00	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachments, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)
D7410	$ 115.00	Excision of benign lesion up to 1.25 cm
D7411	$ 208.00	Excision of benign lesion, greater than 1.25cm
D7413	$ 175.00	Excision of malignant lesion up to 1.25 cm
D7414	$ 234.00	Excision of malignant lesion greater than 1.25 cm
D7450	$ 248.00	Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm
D7451	$ 288.00	Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm
D7460	$ 121.00	Removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25 cm

D7461	$ 143.00	Removal of benign nonodontogenic cyst or tumor – lesion diameter greater than 1.25 cm
D7471	$ 143.00	Removal of lateral exostosis (maxilla or mandible)
D7472*	$ 250.00	Removal of torus palatinus
D7473*	$ 280.00	Removal of torus, mandibularis
D7510	$ 96.00	Incision and drainage of abscess - intraoral soft tissue
D7511	$ 66.00	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)
D7520	$ 80.00	Incision and drainage of abscess – extraoral soft tissue
D7910	$ 31.00	Suture of recent small wounds up to 5 cm
D7911	$ 106.00	Complicated suture – up to 5 cm
D7912	$ 106.00	Complicated suture – greater than 5 cm
D7961*	$ 107.00	Buccal/ labial frenectomy (frenulectomy)
D7962*	$ 107.00	Lingual frenectomy (frenulectomy)
D7963*	$ 416.00	Frenuloplasty
D7970*	$ 246.00	Excision of hyperplastic tissue – per arch
D7980	$ 106.00	Surgical sialolithotomy
D7999*	I.C.	Unspecified oral surgery procedure, by report
		IX. Adjunctive General Services
D9110	$ 36.00	Palliative treatment of dental pain – per visit
D9210	$ 33.00	Local anesthesia not in conjunction with operative or surgical procedures
D9220	$ 114.00	General anesthesia – first 30 minutes
D9221	$ 89.00	General anesthesia – each additional 15 minutes (from 31-90 minutes)

*** Denotes Prior Authorization required**

D9222	$ 90.00	Deep sedation/general anesthesia first 15 minutes
D9223	$ 90.00	Deep sedation/general anesthesia each additional 15 minute increment
D9230	$ 15.00	Analgesia, anxiolysis, inhalation of nitrous oxide
D9239	$ 90.00	Intravenous moderate (conscious) sedation/analgesia – first 15 minutes
D9242	$ 90.00	Intravenous conscious sedation/analgesia each additional 15 minutes (from 31-90 minutes)
D9243	$ 90.00	Intravenous moderate (conscious) sedation analgesia – each additional 15 minute increment
D9310	$ 54.00	Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician
D9430	$ 18.00	Office visit for observation (during regularly scheduled hours) – no other services performed
D9610	$ 29.00	Therapeutic parenteral drug, single administration
D9630	$ 8.00	Drugs or medicaments dispensed in the office for home use
D9910	$ 21.00	Application of desensitizing medicament
D9930*	$ 30.00	Treatment of complications (post-surgical) - unusual circumstances, by report
D9940*	$ 253.00	Occlusal guard; only custom-fitted laboratory-processed occlusal guards designed to minimize the effects of bruxism and other occlusal
D9941*	$ 61.00	Fabrication of athletic mouthguard
D9944*	$ 253.00	occlusal guard – hard appliance, full arch
D9945*	$ 253.00	occlusal guard – soft appliance, full arch
D9951	$ 32.00	Occlusal adjustment – limited
D9952	$ 149.00	Occlusal adjustment – complete
D9995	$ 50.00	Teledentistry– synchronous; real-time encounter
D9996	$ 50.00	Teledentistry– asynchronous; information stored and forwarded to dentist for subsequent review
D9999*	I.C.	Unspecified adjunctive procedure, by report

*** Denotes Prior Authorization required**

		X. Medical Procedures
D90600	$ 40.00	Initial consultation limited
D90605	$ 60.00	Initial consultation intermediate
D90630	$ 90.00	Initial consultation complex
D90640	$ 30.00	Follow-up consultation brief
D99199 *	I.C.	Unlisted special services or report

*** Denotes Prior Authorization required**

APPENDIX D: BPHC Third Party Liability Claim Submission Instruction (DentaQuest)

The RWDP is not a part of MassHealth, however our fees are based on their schedule but our services are more extensive. The RWDP is funded by federal and state grant funds and not a third party payer. RWDP is the payer of last resort according to federal requirements and can only reimburse services for MassHealth eligible clients if they have been denied or are not covered but are within the RWDP scope of services. These instructions were created to assist you in billing MassHealth. Please follow these when indicated.

Boston Public Health Commission Third Party Liability Claim Submission Instruction

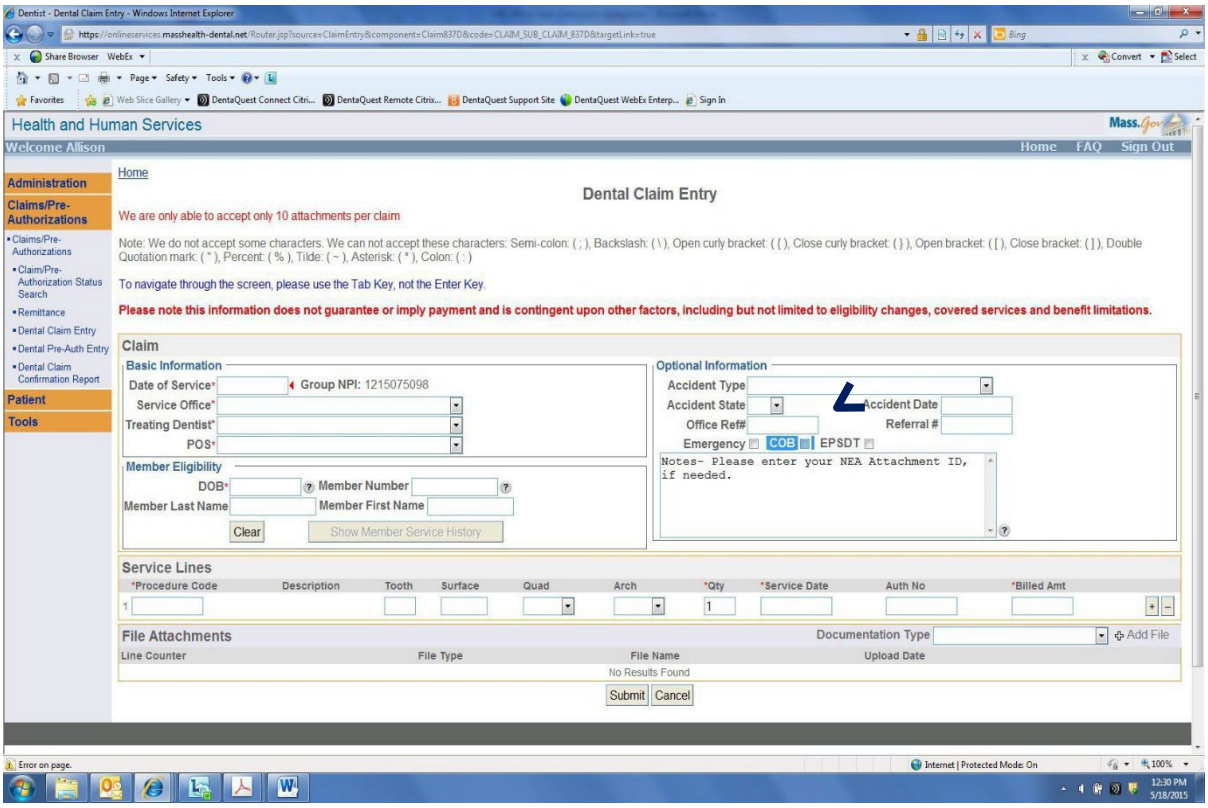
Due to the fact that the system requires MassHealth to be the payer of last resort, the office must submit the claim in the following manner:

1. If using the MassHealth web portal, **DO NOT mark COB** in Optional Information Box * See 1 MassHealth Web Portal

2. If submitting by paper, if you have a Paper Claim Waiver, in Box 4 of the ADA Claim form DO NOT mark yes for Other Insurance **See 2 Paper Claim Submittal

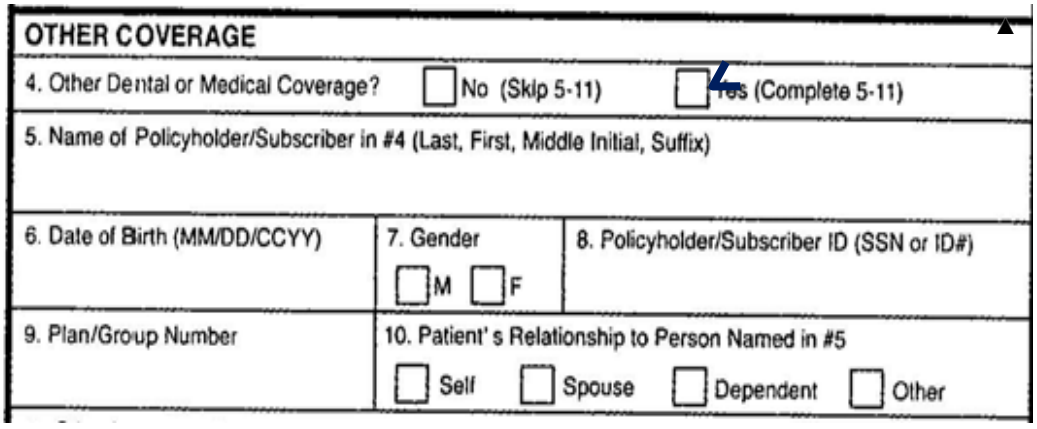
3. If submitting through a Clearinghouse, indicate MassHealth as Primary

*1. MassHealth Web Portal



**2. Paper Claim Submittal

- **Do NOT mark "YES"** for other insurance when submitting a claim to MassHealth or the claim will deny systematically looking for the Primary EOB
- MassHealth is always the Primary



APPENDIX E: CONSENT FOR RELEASE OF INFORMATION

CONSENT FOR RELEASE OF INFORMATION

FOR PATIENTS ONLY

I, _____:

I. Authorize the Ryan White Dental Program (RWDP) at the Boston Public Health Commission to disclose to dental provider: _____ my name and eligibility in the RWDP, which includes my HIV status.

II. Authorize the release of my dental treatment plan(s) and other confidential health information from: _____ to RWDP for the purpose of determining my eligibility into RWDP. This may include, but not be limited to, information such as my name, diagnoses related to HIV status, substance abuse treatment information, financial circumstances, and living arrangements. I understand that review of my file by RWDP staff will only be used to determine my eligibility in the RWDP and that the information will never be copied or shared outside of RWDP unless expressly authorized by myself.

III. Authorize the release of my dental treatment plan(s) and confidential information to discuss with my case manager: _____.

IV. Authorize RWDP to discuss confidential information with my primary care physician: _____.

V. Authorize RWDP to discuss my dental information, which may include disclosure of my HIV status, with my significant other, sibling, parent, guardian ad litem, peer advocate, or other: _____.

* _____ (Initial) I consent to the use of phone and email communication between myself and RWDP.
* _____ (Initial) I consent to the use of phone and email communication between RWDP and my case manager to confirm my name and eligibility, treatment plans, and other confidential information as necessary for my compliance in RWDP.
* _____(Initial) I consent to the use of phone and email communication between RWDP and my dental provider to confirm my name and eligibility, treatment plans, and other confidential information as necessary for my compliance in RWDP.

I accept the risks to the forms of release outlined above, despite the precautions undertaken by RWDP for confidentiality. I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality. This consent is subject to revocation at any time except to the extent that the program/provider which is to make the disclosure has already taken action in reliance on it. If not previously revoked, this consent will terminate one (1) year after it is signed.

Signature of patient: _____ Date: _____

Signature of parent/guardian:_____ Date: _____
(where required)

APPENDIX F: Provider Participation Letter

This form is only for new providers

RYAN WHITE DENTAL PROGRAM PARTICIPATION LETTER

I, _____ (Dentist Full Name) have read the Ryan White Dental Program Provider's Manual and am willing to participate in this program. I understand that payment for dental services provided to patients with HIV is in accordance with instructions in the manual at approximately the Massachusetts Rate Setting Commission (Medicaid) fees.

Signed: _____ Date: _____

Dentist License #:_____

MassHealth Provider: ☐ yes ☐ no

Specialty (if applicable): _____

Practice Name: _____

Address: _____

Tax Identification #:_____

Telephone #:_____

Fax #:_____

E-Mail: _____

Please indicate any special instructions/and or limitations:

_____

_____

_____

Please return to:
BPHC Ryan White Dental Program
1010 Massachusetts Avenue, 2nd floor
Boston, MA 02118
Fax: (617) 534-2819
Email: RWDP@bphc.org

Please affix business card below: