Missouri Medicaid Coverage

The following information is drawn from the 2017 STATE OF MISSOURI DENTAL MANUAL. For additional information, please see the complete manual at http://manuals.momed.com/collections/collection_den/print.pdf

9.6.E DENTAL SCREEN PROCEDURE CODE DESCRIPTION MO HEALTHNET MAXIMUM ALLOWABLE AMOUNT

99429 HCY Dental Screen $20.00
99429UC HCY Dental Screen with Referral $20.00

A dental screen is available to the HCY/EPSDT population on a periodicity schedule that is different from that of the full HCY/EPSDT screen. Children may receive age-appropriate dental screens and treatment services until they become 21 years old. A child's first visit to the dentist should occur no later than 12 months of age so that the dentist can evaluate the infant's oral health, intercept potential problems such as nursing caries, and educate parents in the prevention of dental disease in their child.

It is recommended that preventive dental services and oral treatment for children begin at age 6 to 12 months and be repeated every six months or as indicated. When a child receives a full medical screen by a physician, nurse practitioner or nurse midwife*, it includes an oral examination, which is not a full dental screen. A referral to a dental provider must be made where medically indicated when the child is under the age of 1 year. When the child is 1 year or older, a referral must be made, at a minimum, according to the dental periodicity schedule. The physician, nurse practitioner or nurse midwife may not bill the dental screening procedure 99429 or 99429UC separately.
*only infants age 0-2 months; and females age 15-20 years

9.11 PERIODICITY SCHEDULE FOR HCY (EPSDT) SCREENING SERVICES

DENTAL SCREENING SCHEDULE • Twice a year from age 6 months to 21 years.

12.2 DENTAL SERVICES

Reimbursement for dental services is made on a fee-for-service basis. The maximum allowable fee for a unit of service has been determined by the State Agency to be a reasonable fee, consistent with efficiency, economy, and quality of care. Payment for covered services is the lower of the provider's actual billed charge (should be the provider's usual and customary charge to the general public for the service), or the maximum allowable per unit of service.

12.3 ON-LINE FEE SCHEDULE MO

HealthNet fee schedules through the MO HealthNet Division are available at http://www.dss.mo.gov/mhd/providers/index.htm. The on-line fee schedule identifies covered and noncovered procedure codes, restrictions, allowed units and the MO HealthNet allowable fee per unit. The on-line fee schedule is updated quarterly and is intended as a reference not a guarantee for payment.

13.1 DENTAL SERVICES

Dental services covered by the MO HealthNet program shall only include those which are clearly shown to be medically necessary. Children under 21 years of age and participants in a category of assistance for pregnant women, the blind or vendor nursing facility residents are eligible for the complete dental benefit.

13.31 EXTRACTIONS

The following policies apply to extraction services.
• Enter an alpha letter A through T (primary teeth) in Field #27 of the Dental Claim Form to identify teeth extracted. Alpha letter AS through TS are used in the case of a supernumerary primary tooth.
• Enter a tooth number 1 through 32 in Field #27 of the Dental Claim Form to identify permanent teeth. Tooth numbers 51 through 82 are used in case of a supernumerary permanent tooth.
• The location of a supernumerary tooth must be provided on the claim.
• Pre-operative x-rays involving extractions are not to be submitted unless requested by the State Dental Consultant.
• Post-operative x-rays of extractions are not covered.
• Extraction fees for routine extractions and impacted teeth (including supernumerary teeth) include the fee for local anesthesia and routine post-operative treatment.
• Surgical extraction of impacted teeth is a covered service. Claims submitted for removal of impacted teeth other than third molars must include x-rays.
The following criteria applies to third molar extractions.
• Surgical extraction of impacted and erupted third molar teeth is a covered service.

Indications of removal and criteria or conditions allowable for reimbursement are to include erupted, partially erupted, and unerupted/impacted third molars. One or more of the following conditions must be present and documented in the participant dental record:
1. Pain;
2. Pericoronitis;
3. Carious lesion;
4. Facilitation of the management of or limitation of progression of periodontal disease;
5. Nontreatable pulpal or periapical lesion;
6. Acute and/or chronic infection;
7. Ectopic position;
8. Elective therapeutic removal;
9. Abnormalities of tooth size or shape precluding normal function;
10. Facilitation of orthodontic tooth movement and promotion of dental stability;
11. Tooth impeding the normal eruption of an adjacent tooth;
12. Tooth in line of fracture;
13. Impacted tooth;
14. Pathology associated with tooth;
15. Pathology associated with impacted tooth (odontogenic cysts, neoplasms);
16. Tooth involved in tumor resection;
17. Preventive or prophylactic removal, when indicated, for patients with medical or surgical conditions or treatments;
18. Clinical findings of fractured tooth or teeth;
19. Internal or external resorption of tooth or adjacent teeth;

13.32 FLUORIDE TREATMENT (PREVENTIVE)
13.32.A TOPICAL FLUORIDE TREATMENT

Topical fluoride treatment is a covered service for participants age 20 and under. Fluoride treatment for participants age 21 and over is limited to the following participants and conditions or criteria:

- Participants with rampant or severe caries (decay);
- Participants who are undergoing radiation therapy to the head and neck;
- Participants with diminished salivary flow;
- Intellectually disabled participants who cannot perform their own hygiene maintenance; or
- Participants with cemental or root surface caries secondary to gingival recession.

Fluoride treatment is limited to one (1) application of stannous fluoride, acid-phosphate fluoride or fluoride varnish for each participant, two (2) times per rolling year, per provider. Sodium fluoride series treatments are not covered.

Each allowable fluoride treatment must include both the upper and lower arch. Fluoride treatment must be a separate service from prophylaxis (reference Section 13.34 of the Dental Provider Manual).

13.32.B FLUORIDE VARNISH

Fluoride varnish is covered for participants age 20 and under when applied in a dental office. Fluoride varnish is covered for participants' age five (5) and under, when the need is identified through an Early Periodic Screening, Diagnostic, and Treatment (EPSDT) visit. Fluoride varnish may be applied by physicians and nurse practitioners along with other medical professionals (RN, LPN, Physician Assistant) working in a physician's office or clinic. Fluoride treatment is limited to one (1) application of stannous fluoride, acid-phosphate fluoride or fluoride varnish for each participant, two (2) times per rolling year, per provider.

13.33 INJECTIONS

The procedure codes in Section 19 include injections covered in the Dental Program. Use the appropriate code and the amount injected (based on the unit value shown in Section 19 of the Dental Provider Manual) when billing.

13.34 PROPHYLAXIS (PREVENTIVE)

Prophylaxis of either the upper or lower arch or both arches is covered once in a six (6)-month period by the same provider. Prophylaxis must include scaling and polishing of teeth. Prophylaxis must be a separate service from fluoride treatment (reference Section 13.32 of the Dental Provider Manual).

Other preventive services, such as dietary planning, oral hygiene instruction and training in preventive dental care are not allowable, as they are included in the reimbursement for other services provided, i.e., preventive, restorative, etc.

13.35 PULP TREATMENT (ENDODONTIC)

A pulpotomy may only be performed on primary teeth.
A pulpotomy must include the complete amputation of the vital coronal pulp and the placement of a drug (approved by the ADA Council of Scientific Affairs) over the remaining exposed tissue.
The fee for a pulpotomy excludes the fee for final restoration.
Pulp vitality tests are covered.
Pulp caps are covered.

Root canal therapy is a covered service for permanent teeth only (reference Section 13.37 of the Dental Provider Manual).
• Apicoectomy, periradicular surgery of bicuspid—first root (D3421) is a covered service.
• Apicoectomy, periradicular surgery of molar—first root (D3425) is a covered service.
An apicoectomy may only be performed on permanent teeth and is a covered service only when conventional root canal therapy has not been successful.
An apicoectomy and root canal may not be allowed on the same tooth for the same participant on the same date of service.
Other endodontic procedures are not covered.

13.36 RESTORATIONS

When billing for any of the amalgam, composite or resin restorations, the tooth number and tooth surface code(s) must be entered in the appropriate fields under #27 and #28 on the Dental Claim Form.
Amalgam and resin restorations on posterior teeth are covered.
Fees for amalgam fillings include polishing.
Resin restorations on anterior teeth are covered.
A restoration of any material other than those named above is not covered.
Pin retention, exclusive of amalgam or composite resin, is a covered item.
Same restoration on same tooth in less than a six (6)-month interval is not allowed.
Restorations for either permanent or primary teeth include the fees for local anesthesia and treatment base, where required.
X-rays involving restorations are not to be submitted unless specifically requested.

13.36.A MULTI-SURFACE RESTORATIONS

Reimbursement for restorative dental services will be based on the number of unique surfaces per tooth, per date of service. A surface may only be counted once per tooth, per date of service for purposes of billing the appropriate Code on Dental Procedures and Nomenclature (CDT) code. A restoration is considered a “two or more surface restoration” only when two or more actual tooth surfaces are involved. Restoration services for multiple surfaces on the same tooth with different materials (i.e., amalgam and composite) will be reimbursed at the least costly multiple surface codes. Tooth preparation, all adhesives (including amalgam and resin bonding agents), acid etching, copalite liners, bases and curing are included as part of the restorationand cannot be billed separately.

CDT CODES TO USE

The appropriate CDT codes and descriptions for billing restorative dental services with description are as follows:
D2140Amalgam – one surface, primary and permanent
D2150 Amalgam – two surfaces, primary or permanent
D2160 Amalgam – three surfaces, primary or permanent
D2161 Amalgam – four or more surfaces, primary or permanent
D2330 Resin-based composite – one surface, anterior
D2331 Resin-based composite – two surfaces, anterior
D2332 Resin-based composite – three surfaces, anterior
D2335 Resin-based composite – four or more surfaces or involving incisal angle, anterior
D2391 Resin-based composite – one surface, posterior
D2392 Resin-based composite – two surfaces, posterior
D2393 Resin-based composite – three surfaces, posterior
D2394 Resin-based composite – four or more surfaces, posterior
Claims for restorative services for an individual tooth will reimburse no more than once in a thirty (30) day period. Dental claims submitted by the same provider for the same participant with a restoration procedure code that has the same tooth number as a claim for a restoration procedure code that has been paid within the last 30 days will be denied.

13.37 ROOT CANAL THERAPY (ENDODONTIC)

Root canal therapy is restricted to permanent teeth.
Root canal therapy fees include all in-treatment x-rays.
Root canal therapy fees exclude final restoration fees.
An apicoectomy may only be performed on permanent teeth and is a covered service only when conventional root canal therapy has not been successful. Other endodontic procedures are not covered.
X-rays involving root canal therapy are not to be submitted unless specifically requested.

13.38 SEALANTS

MO HealthNet covers pit and fissure sealants for all Healthy Children and Youth (HCY) MO HealthNet eligible participants ages five (5) through 20.
Sealants may be applied only on healthy (without occlusal restorations) first and second permanent molars (tooth numbers 2, 3, 14, 15, 18, 19, 30 and 31). No payment is made for sealants applied to third molars. Sealants will not be a covered service if applied to primary teeth.
Sealants may only be applied every three (3) years per provider, per participant, per tooth.
Permanent first and second molars may be sealed as they erupt or, for older or newly-approved MO HealthNet participants (ages five (5) through 20) whose teeth have never been sealed, all eight (8) molars may be sealed in one (1) setting.

13.39 X-RAYS

No x-rays are to be submitted for interpretation by the State Dental Consultant. All other x-rays are immediately returned.
X-rays that are of no diagnostic value for interpretation are not covered.
All x-rays must be of the intraoral type, excluding a panoramic type of film.

Panoramic types of film and sialograph survey films are the only extraoral x-rays that are covered for a dentist. Procedure code D0330 (panoramic film) will only be reimbursed for participants age six (6) and older. If medically necessary for children under age six (6), a panoramic film may be reimbursed if billed using procedure code D0999 and a narrative report describing the situation is attached to the claim.
A maximum of four (4) additional periapical x-rays (D0230) is covered after the first (D0220) on any given date of service.
A pre-operative full-mouth x-ray survey of permanent or primary teeth or of mixed dentition is covered once in a 24-month interval.
A pre-operative full-mouth x-ray survey of permanent teeth is defined as 14 periapical films plus two (2) bitewing films (one [1] each right and left) or a total of 16 single films — OR — one (1) panoramic film and two (2) bitewings (one [1] each right and left).
A pre-operative full-mouth x-ray survey of primary teeth is defined as four (4) periapical films plus two (2) bitewing films (one [1] each right and left) or a total of six (6) films — OR — one (1) panoramic film and two (2) bitewings (one [1] each right and left).
A pre-operative full-mouth x-ray survey of mixed dentition is defined as six (6) periapical films (one (1) each upper and lower anterior teeth, one (1) each upper and lower right teeth, one (1) each upper and lower left teeth) plus two (2) bitewing films (one [1] each right and left) or a total of eight (8) films—OR—one (1) panoramic film and two (2) bitewings (one [1] each right and left).
A maximum of two (2) pre-operative bitewing x-rays are covered within a six (6)-month period.
Refer to Section 13.42.H of the Dental Provider Manual for x-rays that are required as part of the orthodontic records submitted for approval of orthodontic treatment.
Post-operative x-rays of extractions are not covered.

13.40 ORTHODONTIC TREATMENT/SPACE MANAGEMENT THERAPY

Orthodontic braces and treatment are not covered unless they are found to be medically necessary as a result of a full or partial HCY (EPSDT) screening and approved by the State Orthodontic Consultant (reference Section 13.42 of the Dental Provider Manual).
Pre-orthodontic care, such as extractions and restorations, is covered.
Minor orthodontic appliances for interceptive and oral development, as listed in Section 19 of the Dental Provider Manual, are covered.
Fixed space-maintainers, unilateral and bilateral, are provided for the premature loss of primary teeth only.
Removable space maintainers are not covered.
Recementation of a space maintainer is covered.
Treatment of malocclusion is not covered unless prior authorized as an expanded HCY service.
Placement of device to facilitate eruption of impacted tooth (i.e., an orthodontic bracket, band or other device) is a covered service only when the participant has been authorized to receive orthodontia services.
Comprehensive orthodontic treatment is available only for participants who meet the criteria in Section 13.42, transitional mixed (dentition) or full adult dentition. Exceptions to this policy are granted only in cases of cleft palate or severe facial anomalies where early intervention is in the best interest of the participant.