SECTION 7
BENEFITS & LIMITATIONS

MO HealthNet will only consider dental services for adults, age 21 and over, if the dental care is related to trauma of the mouth, jaw, teeth or other contiguous sites as a result of injury or if the absence of dental treatment would adversely affect a preexisting medical condition. Services for participants under age 21 remain unchanged as well as services for adult participants under a category of assistance for pregnant women, the blind, or residents of a vendor nursing facility.

Oral Evaluation Codes
A comprehensive oral evaluation, D0150, is limited to once per provider for a new patient or when an established patient has not been seen within two (2) years for a periodic oral exam, or when an established patient presents with a significant health change that can be documented in the patient's record.

The periodic oral evaluation code, D0120, must be used for all other general office visits for an established patient.

The limited oral evaluation code, D0140, must be used when the patient presents with a specific problem or dental emergency, to include a visual exam of the mouth by the dental provider.

The oral evaluation of a patient under the age of three (3), D0145 can be used each time the patient presents for a dental visit.

Office Visit Limitations
An office visit includes, but is not limited to, the following:

- Oral examination of the participant for symptoms or indications of a dental condition requiring treatment;
- Establishment of the written participant record;
- Surgical gloves, drapes, tongue depressors, swabs, gauze, medications, administration of injection(s) and any other items or supplies considered to be routine to the dentist’s private practice; and
- Local anesthesia.

Office visits are limited to one visit per participant per provider on any given day and may not be billed on the same date of service as another office or outpatient visit, dental screen, subsequent hospital visit, consultation or nursing home visit. An office visit may be billed on the same date of service as a hospital admission.

Billing for an office visit is *expected only* for the first session in a series of treatments.

Providers cannot bill a participant for missed/broken appointments, nor will the MO HealthNet Division reimburse providers for missed/broken appointments.

Preventative

Prophylaxis of either the upper or lower arch or both arches is covered once in a six-month period by the same provider. Prophylaxis must include scaling and polishing of teeth. Prophylaxis must be a separate service from fluoride treatment.

D1110 – Ages 13-125
D1120 – Ages 0-12

Topical fluoride treatment is a covered service for participants under the age of 21.

Fluoride treatment for participants age 21 and over is limited to the following criteria:

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

Fluoride varnish is covered for participants under the age of 21 when applied in a dental office.

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.

Dental sealants may be applied only on healthy, without occlusal restorations, first and second permanent molars. Valid tooth numbers are 2, 3, 14, 15, 18, 19, 30 and 31. No payment is made for sealants applied to third molars. Sealants are not a covered service if applied to primary teeth. Sealants may only be applied every three years per provider, per participant, per tooth.

Antimicrobial Agents

The localized delivery of antimicrobial agents may only be billed in conjunction with prior authorized scaling and root planning. The following CDT codes for scaling and root planning must be billed on the same date of service as D4381.

- D4341 periodontal scaling and root planning-four (4) or more teeth per quadrant
- D4342 periodontal scaling and root planning-one (1) to three (3) teeth per quadrant

The participant's record must document the specific agent administered. A Chorhexidine rinse is not covered under D4381. The antimicrobial agent must be reported in field #30 in the ADA claim form.

Restorations

- The same restoration on the same tooth in less than a six-month interval is not allowed.
- Restorations for either permanent or primary teeth include the fees for local anesthesia and treatment base, where required.
- When billing for any of the amalgam, composite or resin restorations, the tooth number and tooth surface code(s) must be entered on the claim.
- Amalgam and resin restorations on posterior teeth are covered; resin restorations are covered on *anterior* teeth.
- Fees for amalgam fillings include polishing.

Crowns

- A fixed crown of chrome, porcelain/ceramic or stainless steel is covered.
- A fixed polycarbonate crown is covered for an anterior tooth; a fixed polycarbonate crown for a posterior tooth is not covered.
- The fee for a fixed crown includes all prior preparations.
- Porcelain crowns are covered for participants under the age of 21 on a prior authorized basis.
- Provisional crowns are a covered service if procedure code D2799 is used. A crown utilized as an interim restoration of a least six (6) months duration during restorative treatment to allow adequate time for healing or completion of other procedures. This includes, but is not limited to, changing vertical dimension, completing periodontal therapy or cracked tooth syndrome. This is not to be used as a temporary crown for a routine restoration.
- Bridges, bridge pontics and bridge retainers are covered for participants age 20 and under but must be prior authorized.
- Recementation of a bridge, crown or inlay is a covered service.
- Replacement of a broken acrylic or porcelain facing where the post backing is intact is covered.
- Replacement of a broken acrylic or porcelain facing where the post backing is broken is covered.
- Replacement crowns are not allowed within six (6) months of the previous placement by the same provider.

Extractions

- Alpha characters A – T are used to identify primary teeth; AS – TS are for supernumerary primary teeth.
- Tooth numbers 1 – 32 identify permanent teeth; 51 – 82 are used to identify supernumerary permanent teeth.
- The location of a supernumerary tooth must be provided on the claim form.

- Surgical extraction of impacted teeth is a covered service. Claims submitted for removal of impacted teeth other than third molars must include x-rays.
- 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 and impacted teeth (including supernumerary teeth) include the fee for local anesthesia and post-operative treatment.

Please refer to sections 13 and 19 of the MO HealthNet Dental Provider Manual for comprehensive coverage of dental benefits and limitations as well as covered procedure codes. The manual is available on the Internet at http://dss.mo.gov/mhd/providers/.