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Preventive Services

	Is the service Covered?	Frequency	List any service - specific limitations
Cleanings	Yes	1 x 6 months	D1120 through 12 years of age, D1110 ages 13 through 20
Fluoride treatments (including fluoride varnishes)	Yes	1 x 6 months	Covered for participants that are age 0-20. Varnish may be applied by physicians and hygienists.
Sealants (list any tooth-specific limits)	Yes	1 x every 3 years	Ages 5-20. 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 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 5through 20) whose teeth have never been sealed, all 8 molars may be sealed in one setting.
Space maintainers	Yes - only with prior authorization		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.

Diagnostic Services

	Is the service Covered?	Frequency	List any service - specific limitations	Recommended age of first visit ?
Oral health screening or assessment	Yes	1 x 6 months	Children may receive age-appropriate dental screens and treatment services until they become 21years old.	
Dental examinations	Yes	1 x 6 months	It is recommended that preventative dental services and oral treatment for children begin at age 6-12 months and be repeated every 6months or as medically indicated.	1 year
Assessment of risk for tooth decay	Yes	1 x 6 months		
X-Rays				

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Diagnostic Services

	Is the service Covered?	Frequency	List any service - specific limitations	Recommended age of first visit ?
Bitewing	Yes	1 x 6 months	A pre-operative full mouth x-ray survey of permanent teeth is defined as 14 periapical films plus 2 bitewing films (1 each right and left) or a total of 16 single films — OR — 1 panoramic film and 2 bitewings (1 each right and left). A preoperative full-mouth x-ray survey of primary teeth is defined as 4 periapical films plus 2 bitewing films (1 each right and left) or a total of 6 films — OR — 1 panoramic film and 2 bitewings (1 each right and left). A pre-operative full mouth x-ray survey of mixed dentition is defined as 6 periapical films (1 each upper and lower anterior teeth, 1 each upper and lower right teeth, 1 each upper and lower left teeth) plus 2 bitewing films (1 each right and left) or a total of 8 films—OR—1 panoramic film and 2 bitewings (1 each right and left). A maximum of 2 preoperative bitewing x-rays are covered 2 times per calendar year for all eligible participants. Providers may bill this code 2 times for dates of service that occur between the months of January and June and 2 times for dates of service that occur between the months of July and December.	

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Diagnostic Services

	Is the service Covered?	Frequency	List any service - specific limitations	Recommended age of first visit ?
Full Mouth	Yes	1 x every 2 years	A pre-operative full mouth x-ray survey of permanent teeth is defined as 14 periapical films plus 2 bitewing films (1 each right and left) or a total of 16 single films — OR — 1 panoramic film and 2 bitewings (1 each right and left). A pre-operative full mouth x-ray survey of primary teeth is defined as 4 periapical films plus 2 bitewing films (1 each right and left) or a total of 6 films — OR — 1 panoramic film and 2 bitewings (1 each right and left). A pre-operative full mouth x-ray survey of mixed dentition is defined as 6 periapical films (1 each upper and lower anterior teeth, 1 each upper and lower right teeth, 1 each upper and lower left teeth) plus 2 bitewing films (1 each right and left) or a total of 8 films—OR—1 panoramic film and 2 bitewings (1 each right and left).	
Panoramic	Yes	1 x year	Procedure code D0330 (panoramic film) will only be reimbursed for participants age 6 and older. If medically necessary for children under age 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.	

Treatment Services

	Is the service Covered?	Frequency	List any service - specific limitations	Criteria for coverage
Anti-microbial treatments that stop decay from spreading	Yes		The localized delivery of antimicrobial agents may only be	

Treatment Services

	Is the service Covered?	Frequency	List any service - specific limitations	Criteria for coverage
			billed in conjunction with scaling and root planing. CDT codes D4341 and D4342 for scaling and root planing must be billed on the same date of service as D4381.	
Fillings				
Silver amalgam	Yes		An amalgam (D2140, D2150, D2160 and D2161) which is placed after a sealant (D1351) on the same tooth, same surface, by the same provider, within 1 year of the sealant will not be reimbursed by MO HealthNet. Amalgam restorations on posterior teeth are covered. Fees for amalgam fillings include polishing. A restoration of any other material (amalgam or resin) is not covered. Same restoration on same tooth in less than a 6-month interval is not allowed.	
Tooth colored composite	Yes		Resin restorations on posterior and anterior teeth are covered. A restoration of any other material is not covered. A second, same restoration on the same tooth in less than a 6-month interval is not allowed.	
Crowns/tooth caps				
Stainless steel crowns	Yes		Replacement crowns are not allowed within 6 months of the previous placement by the same provider. 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.	

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Treatment Services

	Is the service Covered?	Frequency	List any service - specific limitations	Criteria for coverage
Metal (only) crowns	Yes		Replacement crowns are not allowed within 6 months of the previous placement by the same provider. 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.	
Metal/porcelain crowns	Yes - only with prior authorization		Replacement crowns are not allowed within 6 months of the previous placement by the same provider. 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.	
Porcelain (only) crowns	Yes - only with prior authorization		Replacement crowns are not allowed within 6 months of the previous placement by the same provider. 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.	
Root Canals (endodontics)				

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Treatment Services

	Is the service Covered?	Frequency	List any service - specific limitations	Criteria for coverage
Root canals on baby teeth (pulpotomies)	Yes		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.	
Root canals on permanent teeth	Yes		Root canal therapy is a covered service for permanent teeth only.	
Gum (periodontal) therapy	Yes - only with prior authorization		A gingivectomy or gingivoplasty is allowed for participants age 5 and over. Limited occlusal adjustment is covered under emergency treatment only. No other periodontal procedures are covered.	
Dentures				

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Treatment Services

	Is the service Covered?	Frequency	List any service - specific limitations	Criteria for coverage
Partial dentures	Yes		A partial denture must replace permanent teeth. Partial dentures are not covered after full dentures. A partial denture without clasps replacing 1 permanent anterior tooth is covered. A partial denture without clasps must replace more than 1 permanent posterior tooth. A partial denture without clasps is limited to a maximum of 4 teeth. A partial denture with clasps must replace a minimum of 3 permanent teeth, excluding third molars. (Procedure codes D5211 and D5212.) A partial denture involving third molars (wisdom teeth) is not covered. Bent-wire, cast gold or cast chrome clasps are covered. Adding a tooth or teeth to an existing partial denture, where possible, is a covered service. Partial dentures with lingual or palatal bars are not covered. Partial overdentures are not covered.	

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Treatment Services

	Is the service Covered?	Frequency	List any service - specific limitations	Criteria for coverage
Complete dentures	Yes		A full denture must be constructed of an acrylic type of material in order to be covered under the MO HealthNet Program and all dentures must meet the following criteria: • Full arch impression; • Bite Registration; • Each tooth set individually in wax; • Try-in of teeth set individually in wax before denture processing; • Insertion of the processed denture; and • 6-month follow-up adjustments. Full overdentures are not covered.	
Bridges	Yes - only with prior authorization		Bridges, bridge pontics and bridge retainers are covered for participants age 20 and under, but must be prior authorized.	
Orthodontics*				
Retainers (orthodontic)	Yes - only with prior authorization		Included as part of comprehensive orthodontic treatment.	

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Treatment Services

	Is the service Covered?	Frequency	List any service - specific limitations	Criteria for coverage
Braces	Yes - only with prior authorization		See criteria for coverage.	To be eligible for orthodontia services, the participant must meet all of the following general requirements: 1) be under 21 years of age; and 2) have good oral hygiene documented in the child's treatment plan; and 3) have all dental work complete; and 4) have permanent dentition. The determination whether or not a participant will be approved for orthodontic services shall be initially screened using the Handicapping Labio-Lingual Deviation (HLD) Index. The HLD Index must be fully completed in accordance with the instructions and must be submitted with the Prior Authorization (PA)form. MO HealthNet will approve orthodontic services when the participant meets all the criteria above and one of the criteria listed below: 1) has a cleft palate; 2) has a deep impinging overbite when the lower incisors are damaging the soft tissue of the palate (lower incisor contact only on the palate is not sufficient); 3) has a cross-bite of individual anterior teeth when damage of soft tissue is present; 4) has severe traumatic deviations; 5) has an over-jet greater than 9mm or

Treatment Services

	Is the service Covered?	Frequency	List any service - specific limitations	Criteria for coverage
				reverse overjet of greater than 3.5mm; 6) has an impacted maxillary central incisor; or 7) scores 28 points or greater on the HLD Index. If the participant does not meet any of the above criteria, MO HealthNet will consider whether orthodontic services should be provided based upon other evidence that orthodontic services are medically necessary.
Oral surgery				
Simple extractions	Yes		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.	
Surgical extractions	Yes		Pre-treatment x-rays and office notes must be submitted with claim.	
Care of abscesses	Yes			
Cleft palate treatment	Yes - only with prior authorization			
Cancer treatment	Yes			
Treatment of fractures	Yes			
Biopsies	Yes - only with prior authorization		Some biopsies may require prior authorization or an operative report.	
Treatment of jaw joint problems (TMJ)	Yes			

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Treatment Services

	Is the service Covered?	Frequency	List any service - specific limitations	Criteria for coverage
Emergency room services provided by a dentist	Yes		Covered procedure codes are 99281, 99282, 99283 and 99284.	Emergency services are services required when there is a sudden or unforeseen situation or occurrence or a sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in: 1) placing the participant's health in serious jeopardy; or 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part. Dentures and expanded Health Children and Youth (HCY) services shall not be allowed under these emergency treatment provisions.
Inpatient Hospital Services	Yes		Inpatient hospital admissions for MO HealthNet participants must be certified as medically necessary and appropriate for inpatient services before payment is made. All hospitals in Missouri and bordering states are subject to the admission certification requirement.	
Anesthesia				

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Treatment Services

	Is the service Covered?	Frequency	List any service - specific limitations	Criteria for coverage
General anesthesia	Yes		General anesthesia administered in the office is a covered service. General anesthesia administered in the hospital or an ambulatory surgical center by a participating certified anesthesiologist or CRNA is a covered service under the Physician Program and must be billed by the physician or CRNA on the CMS-1500 claim form.	
Intravenous conscious sedation	Yes		Intravenous sedation administered in the office is a covered service.	
Non-intravenous conscious sedation	Yes			
Analgesia (nitrous oxide)	Yes			

* When this information is posted on the Insure Kids Now website, we will include a special note for orthodontic services explaining that parents and caretakers should work with their child's orthodontist to ensure that the treatment and payment terms and conditions are clear at the outset of treatment (for example, what happens in the case of a child who becomes ineligible for Medicaid or CHIP while he or she is undergoing orthodontic treatment?).