Beneficiaries under twenty-one (21) years of age may receive benefits for restorative services when medically necessary and when carious activity has extended through the dentoenamel junction (DEJ).

Amalgam and Composite Restorations

- All restored surfaces on a single tooth are considered connected if performed on the same date. Payment will be made for a particular surface on a single tooth only once in each episode of treatment, irrespective of the number or combinations of restorations placed.
- When submitting a claim for amalgam or composite restorations, all **surfaces** restored **must** be indicated on the same line with appropriate code and fee.
- The program reimburses for amalgam, composite restorations, or stainless steel crowns for treatment of caries. If a tooth can be restored with such material, any laboratory-processed crown or jacket is not covered.
- Amalgam restorations are covered on teeth distal to the cuspids for beneficiaries under age twenty-one (21). However, composite restorations are covered on anterior **and** posterior teeth.
- Tooth and soft tissue preparation, temporary restorations, cement bases, amalgam or acrylic build-ups, and local anesthesia are considered components of and included in the fee for a completed restorative service.
- A provider is responsible for any replacements necessary in the primary teeth within the first twelve (12) months of restoration and the first twenty four (24) months for any restoration in permanent teeth, except when failure or breakage results from circumstances beyond the control of the provider. Detailed documentation in the beneficiary's record **must** clearly state what the circumstances were that led to the early replacements.

Crowns

The overall condition of the mouth, beneficiary's ability to comply, oral health status, arch integrity, and prognosis of remaining teeth must be considered when evaluating the beneficiary for crowns. Crowns should be considered when longevity is essential and a lesser service will not suffice ~~because~~ due to extensive coronal destruction as defined under the criteria below. ~~is supported by a narrative documentation, or is radiographically demonstrated and treatment is beyond intercoronal restoration. Radiographs along with documentation to substantiate the need for a crown are required prior to performing placement of any type of crown and must be kept on file in the provider's office.~~

Providers must complete radiographs **and** narrative documentation **prior to** placement of any type of crown. If the radiographs do not support extensive coronal destruction the narrative documentation must support it.

Porcelain fused to metal crowns will only be allowed on secondary anterior teeth for the older child. Stainless steel crowns are indicated for restoration of primary or young permanent teeth.
Criteria for crowns include, but ~~may~~ are not ~~be~~ limited to, the following:

- Molars show traumatic or pathological destruction to the crown of the tooth, which involves four (4) or more tooth surfaces including two (2) or more cusps. Stainless steel crowns are currently the only accepted method of providing full tooth coverage. Medicaid will cover only stainless steel type crowns for molars.

- Anterior teeth show traumatic or pathological destruction to the crown of the tooth which involves four (4) or more tooth surfaces including loss of one incisal angle. Porcelain or cast crowns may be covered with prior authorization and a radiograph to support the assessment.

- Bicuspids (premolars) show traumatic or pathological destruction to the crown of the tooth and involve three or more tooth surfaces including one (1) cusp. Stainless steel crowns are currently the only accepted method of providing full tooth coverage. Medicaid will cover only stainless steel type crowns for molars.

- Extensive caries

- Significant hypoplastic enamel

- Hereditary anomaly i.e. dentinogenesis imperfecta or amelogenesis imperfecta

- Significant fracture

- Pulpotomy or pulpectomy has been performed

- Crown serves as an attachment for a space maintainer

The provider is responsible for any replacements necessary in primary teeth within the first twelve (12) months of the procedure and the first twenty-four (24) months of the procedure for any stainless steel crown in permanent teeth, except when failure or breakage results from circumstances beyond the control of the provider. The provider **must** retain documentation in the beneficiary's record that clearly substantiates circumstances that led to the early replacements.

Sedative Fillings

~~Prior authorization **with radiographs** is required on all sedative fillings.~~
Prior authorization is required for all sedative fillings. Radiographs must be submitted with the prior authorization request.

Endodontic Therapy

Endodontics therapy (root canals) for permanent teeth of beneficiaries under age twenty-one (21) ~~years~~ does not require prior authorization. A post-operative x-ray is required by DOM to verify that the service was provided.

Post-operative x-rays are included in the fee for endodontic therapy. The fee for endodontic therapy does not include restoration to close a root canal access.

Post and Core

Cast or prefabricated post and cores are cemented into a portion of the root canal after endodontic therapy. They are designed to provide an abutment for a crown restoration in cases where there is not enough natural tooth structure remaining to support a crown. Without this procedure, teeth would have to be unnecessarily extracted.

Post and core coverage is limited to beneficiaries under age twenty-one (21). Coverage is further limited to anterior endodontically treated teeth. Prior authorization is required. Radiographs must be submitted with the prior authorization form. Authorization will be approved on a case by case basis only when it is determined to be medically necessary.

Providers must retain proper and complete documentation (including radiographs) to verify medical necessity.

Dental Benefit Limit - Annual

Dental expenditures, excluding orthodontia-related services, are limited to $2,500 per beneficiary per fiscal year. All American Dental Association (ADA) dental procedure codes, except orthodontia-related services, are applied to the $2,500 annual limit. This limit applies to all beneficiaries, including children and adults. Dental expenditures may exceed the annual limit only if the services are prior authorized by the Division of Medicaid. Prior authorizations must be submitted as required in Section 11.20 of this manual.

Orthodontia Benefit Limit - Lifetime

Orthodontia-related services are limited to $4,200 per beneficiary per lifetime. Orthodontia-related services are only covered for beneficiaries under age twenty-one (21) as described in Section 11.18. The American Dental Association (ADA) dental procedure codes D8000 through D8999 are applied to the $4,200 lifetime orthodontia benefit limit. Additional dental services in excess of the $4,200 lifetime limit may be ~~provided~~ covered with prior approval from the Division of Medicaid.

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An occlusal guard (night guard) is defined as a custom made appliance designed to prevent damage to the dentition from Bruxism (grinding) and potential damage to the temporomandibular joint. Bruxism, if left untreated, can result in teeth becoming severely worn; requiring restoration with crowns. In addition, long standing Bruxism can result in temporomandibular dysfunction (TMD). Symptoms of TMD include, but are not limited to, pain, headache, muscle spasm, and limitation of movement.

Occlusal guard coverage is limited to beneficiaries under age twenty-one (21). Prior authorization is required. Radiographs must be submitted with the prior authorization form. Authorization will be approved on a case by case basis only when it is determined to be medically necessary.

Providers must retain proper and complete documentation (including radiographs) to verify medical necessity.