

Dental Benefit Package for NJFC Medicaid/CHIP Program January 2013

We cover the diagnostic, preventive, restorative, endodontic, periodontal, prosthodontic, oral and maxillofacial surgical, orthodontic and certain adjunctive services in the dental benefit package as described in this provision for covered persons prior to the 18th birthday.

- An age one dental visit is covered.
- A second opinion is allowed.
- Emergency treatment is available without prior authorization. Emergency treatment includes, but may not be limited to treatment for: pain, acute or chronic infection, facial, oral or head and neck injury, laceration or trauma, facial, oral or head and neck swelling, extensive, abnormal bleeding, fractures of facial bones or dislocation of the mandible.
- Diagnostic and preventive services are linked to the provider, thus allowing a member to transfer to a different provider/practice and receive these services. The new provider is encouraged to request copies of diagnostic radiographs if recently provided. If they are not available radiographs needed to diagnose and treat can be provided.
- Denials of services to the dentist shall include an explanation and identify the reviewer including their contact information.
- Services with a dental laboratory component that cannot be completed can be considered for prorated payment based on stage of completion.
- Unspecified services for which a specific procedure code does not exist can be considered with detailed documentation and diagnostic materials as needed by report.
- Services that are considered experimental in nature will not be considered.
- No payment can be made for broken appointments.

Diagnostic Services

* Indicated diagnostic services that can be considered every 3 months for individuals with special healthcare needs are denoted with an asterisk.

- a) *Clinical oral evaluations once every 6 months **
 - Comprehensive – complete evaluation which includes a comprehensive and thorough inspection of the oral cavity to include diagnosis, an oral cancer screening, charting of all abnormalities, and development of a complete treatment plan
 - Periodic – subsequent thorough evaluation of an established patient*
 - Oral evaluation for patient under the age of 3 and counseling with primary caregiver*
 - Limited oral evaluations that are problem focused
 - Detailed oral evaluations that are problem focused
- b) Diagnostic Imaging with interpretation
 - A full mouth series can be provided every 3 years. The number of films/views expected is based on age with the maximum being 16 intraoral films/views.
 - An extraoral panoramic film/view and bitewings may be substituted for the full mouth series with the same frequency limit.
 - Additional films/views needed for diagnosing can be provided as needed.

- Bitewings, periapicals, panoramic and cephalometric radiographic images
- Intraoral and extraoral radiographic images
- Oral/facial photographic images
- Maxillofacial MRI, ultrasound
- Cone beam image capture
- c) Tests and Examinations
- d) Viral culture
- e) Collection and preparation of saliva sample for laboratory diagnostic testing
- f) Diagnostic casts – for diagnostic purposes only and not in conjunction with other services
- g) Oral pathology laboratory
 - Accession/collection of tissue, examination – gross and microscopic, preparation and transmission of written report
 - Accession/collection of exfoliative cytologic smears, microscopic examination, preparation and transmission of a written report
 - Other oral pathology procedures, by report

Preventive Services

* Indicates preventive services that can be considered every 3 months for individuals with special healthcare needs are denoted with an asterisk.

- a) Dental prophylaxis once every 6 months*
- b) Topical fluoride treatment once every 6 months – in conjunction with prophylaxis as a separate service*
- c) Fluoride varnish once every 4 months for children under the age of 6
- d) Sealants, limited to one time application to all occlusal surfaces that are unfilled and caries free, in premolars and permanent molars. Replacement of sealants can be considered with prior authorization.
- e) Space maintainers – to maintain space for eruption of permanent tooth/teeth, includes placement and removal
 - fixed – unilateral and bilateral
 - removable – bilateral only
 - recementation of fixed space maintainer
 - removal of fixed space maintainer – considered for provider that did not place appliance

Restorative Services

- There are no frequency limits on replacing restorations (fillings) or crowns.
- Request for replacement due to failure soon after insertion, may require documentation to demonstrate material failure as the cause.
- Reimbursement will include the restorative material and all associated materials necessary to provide the standard of care, polishing of restoration, and local anesthesia.
- The reimbursement for any restoration on a tooth shall be for the total number of surfaces to be restored on that date of service.
- Only one procedure code is reimbursable per tooth except when amalgam and composite

restorations are placed on the same tooth.

- Reimbursement for an occlusal restoration includes any extensions onto the occlusal one-third of the buccal, facial or lingual surface(s) of the tooth.
- Extension of interproximal restorations into self-cleansing areas will not be considered as additional surfaces. Extension of any restoration into less than 1/3 of an adjacent surface is not considered an additional surface and will not be reimbursable (or if paid will be recovered).

Restorative service to include:

- a) Restorations (fillings) – amalgam or resin based composite for anterior and posterior teeth. Service includes local anesthesia, pulp cap (direct or indirect) polishing and adjusting occlusion.
- b) Gold foil - . Service includes local anesthesia, polishing and adjusting occlusion.
- c) Inlay/onlay restorations – metallic, service includes local anesthesia, cementation, polishing and adjusting occlusion.
- d) Porcelain fused to metal, cast and ceramic crowns (single restoration) – to restore form and function.
 - Service requires prior authorization and will not be considered for cosmetic reasons or for teeth that are not in occlusion or function and have a poor long term prognosis
 - Service includes local anesthesia, temporary crown placement, insertion with cementation, polishing and adjusting occlusion.
 - Provisional crowns are not covered.
- e) Recement of inlay, onlay, custom fabricated/cast or prefabricated post and core and crown,
- f) Prefabricated stainless steel, stainless steel crown with resin window and resin crowns. Service includes local anesthesia, insertion with cementation and adjusting occlusion.
- g) Core buildup including pins
- h) Pin retention
- i) Indirectly fabricated (custom fabricated/cast) and prefabricated post and core
- j) Additional fabricated (custom fabricated/cast) and prefabricated post
- k) Post removal
- l) Temporary crown (fractured tooth)
- m) Additional procedures to construct new crown under existing partial denture
- n) Coping
- o) Crown repair
- p) Protective restoration/sedative filling

Endodontic Services

- Service includes all necessary radiographs.
- Teeth must be in occlusion, periodontally sound, needed for function and have good long term prognosis.
- Emergency services for pain do not require prior authorization.
- Service requires prior authorization and will not be considered for teeth that are not in occlusion or function and have poor long term prognosis.

Endodontic service to include:

- a) Therapeutic pulpotomy for primary and permanent teeth
- b) Pulpal debridement for primary and permanent teeth
- c) Partial pulpotomy for apexogenesis
- d) Pulpal therapy for anterior and posterior primary teeth
- e) Endodontic therapy and retreatment
- f) Treatment for root canal obstruction, incomplete therapy and internal root repair of perforation
- g) Apexification: initial, interim and final visits
- h) Pulpal regeneration
- i) Apicoectomy/Periradicular Surgery
- j) Retrograde filling
- k) Root amputation
- l) Surgical procedure for isolation of tooth with rubber dam
- m) Hemisection
- n) Canal preparation and fitting of preformed dowel or post
- o) Post removal

Periodontal Services

Services require prior authorization with submission of diagnostic materials and documentation of need.

- a) Surgical services
 - Gingivectomy and gingivoplasty
 - Gingival flap including root planning
 - Apically positioned flap
 - Clinical crown lengthening
 - Osseous surgery
 - Bone replacement graft – first site and additional sites
 - Biologic materials to aid soft and osseous tissue regeneration
 - Guided tissue regeneration
 - Surgical revision
 - Pedicle and free soft tissue graft
 - Subepithelial connective tissue graft
 - Distal or proximal wedge
 - Soft tissue allograft
 - Combined connective tissue and double pedicle graft
- b) Non-Surgical Periodontal Service
 - Provisional splinting – intracoronal and extracoronal – can be considered for treatment of dental trauma
 - Periodontal root planing and scaling – can be considered every 6 months for individuals with special healthcare needs
 - Full mouth debridement to enable comprehensive evaluation
 - Localized delivery of antimicrobial agents

c) Periodontal maintenance

Prosthodontic Services

- All dentures, fixed prosthodontics (fixed bridges) and maxillofacial prosthetics require prior authorization.
- New dentures or replacement dentures may be considered every 7 ½ years unless dentures become obsolete due to additional extractions or are damaged beyond repair.
- All needed dental treatment must be completed prior to denture fabrication.
- Patient identification must be placed in dentures in accordance with State Board regulation.
- Insertion of dentures includes adjustments for 6 months post insertion.
- Prefabricated dentures or transitional dentures that are temporary in nature are not covered.

Prosthodontic services to include:

- a) Complete dentures and immediate complete dentures – maxillary and mandibular to address masticatory deficiencies. Excludes prefabricated dentures or dentures that are temporary in nature
- b) Partial denture – maxillary and mandibular to replace missing anterior tooth/teeth (central incisor(s), lateral incisor(s) and cuspid(s)) and posterior teeth where masticatory deficiencies exist due to fewer than eight posterior teeth (natural or prosthetic) resulting in balanced occlusion.
 - Resin base and cast frame dentures including any conventional clasps, rests and teeth
 - Flexible base denture including any clasps, rests and teeth
 - Removable unilateral partial dentures or dentures without clasps are not considered
- c) Overdenture – complete and partial
- d) Denture adjustments – 6 months after insertion or repair
- e) Denture repairs – includes adjustments for first 6 months following service
- f) Denture rebase – requires prior authorization and includes adjustments for first 6 months following service
- g) Denture relines – once a year without prior authorization and includes adjustments for first 6 months following service
- h) Precision attachment, by report
- i) Maxillofacial prosthetics - includes adjustments for first 6 months following service
 - Facial mouldage, nasal, auricular, orbital, ocular, facial, nasal septal, cranial, speech aid, palatal augmentation, palatal lift prosthesis – initial, interim and replacement
 - Obturator prosthesis: surgical, definitive and modifications
 - Mandibular resection prosthesis with and without guide flange
 - Feeding aid
 - Surgical stents
 - Radiation carrier
 - Fluoride gel carrier

- Commissure splint
 - Surgical splint
 - Topical medicament carrier
 - Adjustments, modification and repair to a maxillofacial prosthesis
 - Maintenance and cleaning of maxillofacial prosthesis
- j) Implant Services – are limited to cases where facial defects and or deformities (including agenesis) resulting from trauma or disease result in loss of dentition capable of supporting a prosthesis or cases where documentation demonstrates lack of retention and the inability to function with a complete denture for a period of two years.
Covered services include: implant body, abutment and crown.
- k) Fixed prosthodontics (fixed bridges) – are selective and limited to cases with an otherwise healthy dentition with unilateral missing tooth or teeth generally for anterior replacements where adequate space exists.
- The replacement of an existing defective fixed bridge is also allowed when noted criteria are met.
 - A child with special health needs that result in the inability to tolerate a removable denture can be considered for a fixed bridge or replacement of a removable denture with a fixed bridge.
 - Considerations and requirements noted for single crowns apply
 - Posterior fixed bridge is only considered for a unilateral case when there is masticatory deficiency due to fewer than eight posterior teeth in balanced occlusion with natural or prosthetic teeth.
 - Abutment teeth must be periodontally sound and have a good long term prognosis
 - Repair and recementation
- l) Pediatric partial denture – for select cases to maintain function and space for permanent anterior teeth with premature loss of primary anterior teeth.

Oral and Maxillofacial Surgical Services

Local anesthesia, suturing and routine post op visit for suture removal are included with service.

- a) Extraction of teeth:
- Extraction of coronal remnants – deciduous tooth,
 - Extraction, erupted tooth or exposed root
 - Surgical removal of erupted tooth or residual root
 - Impactions: removal of soft tissue, partially boney, completely boney and completely boney with unusual surgical complications
- b) Extractions associated with orthodontic services must not be provided without proof that the orthodontic service has been approved.
- c) Other surgical Procedures
- Oroantral fistula
 - Primary closure of sinus perforation and sinus repairs
 - Tooth reimplantation of an accidentally avulsed or displaced by trauma or accident
 - Surgical access of an unerupted tooth
 - Mobilization of erupted or malpositioned tooth to aid eruption
 - Placement of device to aid eruption

- Biopsies of hard and soft tissue, exfoliative cytological sample collection and brush biopsy
- Surgical repositioning of tooth/teeth
- Transseptal fiberotomy/supra crestal fiberotomy
- Surgical placement of anchorage device with or without flap
- Harvesting bone for use in graft(s)
- d) Alveoloplasty in conjunction or not in conjunction with extractions
- e) Vestibuloplasty
- f) Excision of benign and malignant tumors/lesions
- g) Removal of cysts (odontogenic and nonodontogenic) and foreign bodies
- h) Destruction of lesions by electrosurgery
- i) Removal of lateral exostosis, torus palatinus or torus mandibularis
- j) Surgical reduction of osseous tuberosity
- k) Resections of maxilla and mandible - Includes placement or removal of appliance and/or hardware to same provider.
- l) Surgical Incision
 - Incision and drainage of abscess - intraoral and extraoral
 - Removal of foreign body
 - Partial ostectomy/sequestrectomy
 - Maxillary sinusotomy
- m) Fracture repairs of maxilla, mandible and facial bones – simple and compound, open and closed reduction. Includes placement or removal of appliance and/or hardware to same provider.
- n) Reduction of dislocation and management of other temporomandibular joint dysfunctions (TMJD), with or without appliance. Includes placement or removal of appliance and/or hardware to same provider.
 - Reduction - open and closed of dislocation. Includes placement or removal of appliance and/or hardware to same provider.
 - Manipulation under anesthesia
 - Condylectomy, discectomy, synovectomy
 - Joint reconstruction
 - Services associated with TMJD treatment require prior authorization
- o) Arthrotomy, arthroplasty, arthrocentesis and non-arthroscopic lysis and lavage
- p) Arthroscopy
- q) Occlusal orthotic device – includes placement and removal to same provider
- r) Surgical and other repairs
 - Repair of traumatic wounds – small and complicated
 - Skin and bone graft and synthetic graft
 - Collection and application of autologous blood concentrate
 - Osteoplasty and osteotomy
 - LeFort I, II, III with or without bone graft
 - Graft of the mandible or maxilla – autogenous or nonautogenous
 - Sinus augmentations
 - Repair of maxillofacial soft and hard tissue defects
 - Frenectomy and frenoplasty

- Excision of hyperplastic tissue and pericoronal gingiva
- Sialolithotomy, sialodochoplasty, excision of the salivary gland and closure of salivary fistula
- Emergency tracheotomy
- Coronoidectomy
- Implant – mandibular augmentation purposes
- Appliance removal – “by report” for provider that did not place appliance, splint or hardware

Orthodontic Services

Medical necessity must be met by demonstrating severe functional difficulties, developmental anomalies of facial bones and/or oral structures, facial trauma resulting in functional difficulties or documentation of a psychological/psychiatric diagnosis from a mental health provider that orthodontic treatment will improve the mental/psychological condition of the child.

- Orthodontic treatment requires prior authorization and is not considered for cosmetic purposes.
- Orthodontic consultation can be provided once annually as needed to the same provider.
- Pre-orthodontic treatment visit for completion of the HLD (NJ-Mod2) assessment form and diagnostic photographs and panoramic radiograph/views is required for consideration of services.
- Orthodontic cases that require extraction of permanent teeth must be approved for orthodontic treatment prior to extractions being provided. The orthodontic approval should be submitted with referral to oral surgeon or dentist providing the extractions and extractions should not be provided without proof of approval for orthodontic service.
- Initiation of treatment should take into consideration time needed to treat the case to ensure treatment is completed prior to 18th birthday.
- Periodic oral evaluation, preventive services and needed dental treatment must be provided prior to initiation of orthodontic treatment.
- The placement of the appliance represents the treatment start date.
- Reimbursement includes placement and removal of appliance. Removal can be requested by report as separate service for provider that did not start case and requires prior authorization.
- Completion of treatment must be documented to include diagnostic photographs and panoramic radiograph/view of completed case and submitted when active treatment has ended and bands are removed. Date of service used is date of band removal.

Orthodontic service to include:

- a) Limited treatment for the primary, transitional and adult dentition
- b) Interceptive treatment for the primary and transitional dentition
- c) Minor treatment to control harmful habits
- d) Continuation of transfer cases or cases started outside of the program
- e) Comprehensive treatment for handicapping malocclusions of adult dentition. Case must demonstrate medical necessity based on score total equal to or greater than 26 on the

HLD (NJ-Mod2) assessment form with diagnostic tools substantiation or total scores less than 26 with documented medical necessity.

- f) Orthognathic Surgical Cases with comprehensive orthodontic treatment
- g) Repairs to orthodontic appliances
- h) Replacement of lost or broken retainer
- i) Rebonding or recementing of brackets and/or bands

Request for treatment must include diagnostic materials to demonstrate need, the completed HDL (NJ-Mod2) form and documentation that all needed dental preventive and treatment services have been completed.

Approval for comprehensive treatment is for up to 12 visits at a time with request for continuation to include the previously mentioned documentation and most recent diagnostic tools to demonstrate progression of treatment.

Adjunctive General Services

- a) Palliative treatment for emergency treatment – per visit
- b) Anesthesia
 - Local anesthesia NOT in conjunction with operative or surgical procedures.
 - Regional block
 - Trigeminal division block.
 - Deep sedation/general anesthesia provided by a dentist regardless of where the dental services are provided for a medical condition covered by this Policy which requires hospitalization or general anesthesia. 2 hour maximum time
 - Intravenous conscious sedation/analgesia – 2 hour maximum time
 - Nitrous oxide/analgesia
 - Non-intravenous conscious sedation – to include oral medications
- c) Behavior management – for additional time required to provide services to a child with special needs that requires more time than generally required to provide a dental service. Request must indicate specific medical diagnosis and clinical appearance.
 - One unit equals 15 minutes of additional time
 - Utilization thresholds are based on place of service as follows. Prior authorization is required when thresholds are exceeded.
 - o Office or Clinic maximum – 2 units
 - o Inpatient/Outpatient hospital – 4 units
 - o Skilled Nursing/Long Term Care – 2 units
- d) Consultation by specialist or non-primary care provider
- e) Professional visits
 - House or facility visit – for a single visit to a facility regardless of the number of members seen on that day.
 - Hospital or ambulatory surgical center call
 - o For cases that are treated in a facility.
 - o For cases taken to the operating room –dental services are provided for patient with a medical condition covered by this Policy which requires this admission as in-patient or out-patient. Prior authorization is required.

- o General anesthesia and hospitalization for dental services are covered
 - o Dental services rendered in these settings by a dentist not on staff are considered separately
- Office visit for observation – (during regular hours) no other service performed
- f) Drugs
 - Therapeutic parenteral drug
 - o Single administration
 - o Two or more administrations - not to be combined with single administration
 - Other drugs and/or medicaments – by report
- g) Application of desensitizing medicament – per visit
- h) Occlusal guard – for treatment of bruxism, clenching or grinding
- i) Athletic mouthguard
- j) Occlusal adjustment
 - Limited - (per visit)
 - Complete (regardless of the number of visits), once in a lifetime
- k) Odontoplasty
- l) Internal bleaching