ITEM 10. DENTAL SERVICES

For beneficiaries under age 21, all medically necessary dental services are covered in accordance with EPSDT requirements (Item 4.b.). Coverage and service limits do not apply, and some may be subject to prior authorization.

For beneficiaries aged 21 and older, dental services including preventive, diagnostic, restorative, and endodontic procedures are covered when medically necessary. Medical necessity is determined by the Medicaid program.

~~Coverage of non-surgical treatment of temporomandibular joint disorders is limited to the fabrication of an occlusal orthotic appliance (TMJ splint). Prior authorization is required for most special dental procedures.~~

For beneficiaries aged 21 and older, ~~excluding pregnant and postpartum women, the~~ dental ~~benefit is~~ services are limited to $1,500~~$1,000~~ per beneficiary per calendar year. Preventive services will not be counted towards the ~~$1000~~ annual dollar limit. Emergency dental services to ameliorate pain, infection, or bleeding are covered when medically necessary after the annual limit has been met.

Individuals who are pregnant or in the postpartum eligibility period are not subject to the annual cap.

The Medicaid program maintains a Medicaid Dental Supplement and fee schedule on its website that details covered and non-covered services and service limitations. Some items require prior authorization.

~~Non-covered services for beneficiaries age 21 and older, excluding pregnant and postpartum women, include; cosmetic procedures; and certain elective procedures, including but not limited to: bonding, sealants, periodontal surgery, comprehensive periodontal care, orthodontic treatment, processed or cast crowns and bridges.~~