Description of Dental Benefits Provided Under Medicaid and the Children's Health Insurance Program (CHIP)
State: California

Updated: 7/16/09

The following information will identify the general categories of services available in your State. Please note that while a service may be available, you must consult with your dental provider to ensure that the service is medically necessary for your specific condition. For more specific information, please contact your State program.

State Contact: California contracts with managed care plans to provide services to CHIP beneficiaries. The members/beneficiaries can contact the plans if they have questions about benefits. It would not be helpful for the members/beneficiaries to contact the state.

Medicaid Program

☐ Under the Medicaid State Plan dental benefits are provided to eligible individuals under the age of 21 in compliance with the requirements of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services.
State Program Name:

CHIP Program

☐ CHIP Medicaid Expansion Program ONLY, i.e., offering complete oral health services under Early and Periodic Screening, Diagnostic and Treatment (EPSDT)
State Program Name:

☒ CHIP Stand-Alone/Separate Program ONLY
State Program Name: Healthy Families Program (HFP)
- ☐ Dental Services Provided through State-defined benefit package
- ☒ Benchmark Equivalent Program:
  Name of : California State Employees Benefits Program
- ☐ Optional Supplemental Dental Coverage for CHIP eligible children with private or group insurance

☐ CHIP Medicaid Expansion and Stand-Alone Program (dental services are as described above)
State Program Name:

If providing dental benefits other than as defined by EPSDT, States must complete the following:

CHIP Stand-Alone Program Dental Benefits

NOTE: Please identify any limits or other criteria using terms commonly recognized by individuals without extensive oral health terminology knowledge rather than using technical dental terminology. For example, use molar rather than posterior, or front versus anterior.

Schedule of Services

☐ State EPSDT definition

OR

☐ Nationally Recognized Standard
Name and Description:

Recommended Age for First Oral Health Examination: HFP Preventive Chart recommends first visit at 6 months of age

Preventive Services:

☒ Cleanings (Prophylaxis Services)
a. Recommended frequency: Two in a 12 month period
b. Exceptions: n/a

☒ Fluoride treatments
   a. Ages: n/a
   b. Recommended frequency: n/a
   c. Also provided by physicians: ☐ n/a
   d. Also provided by hygienists: ☐ n/a
   e. Exceptions: n/a

☒ Sealants
   a. Ages: n/a
   b. Recommended frequency: n/a
   c. Exceptions: n/a Limited as follows: Permanent first and second molars ONLY

☒ Oral hygiene instruction
   a. Ages: n/a
   b. Recommended frequency: n/a

☒ Space Maintainers
   a. Limits: n/a
   b. Prior approval required: Y/N n/a – Determined by the dental plan.

Diagnostic Services:

☒ Dental Examinations by Dentists
   a. Recommended age of first visit: n/a – HFP Preventive Chart recommends first visit at 6 months of age
   b. Recommended frequency: n/a
   c. Limits: n/a

☒ Dental Screens and Other Services by Hygienists
   a. Recommended frequency: n/a
   b. Limits: n/a

☒ X-Rays
   a. Limits:
      1. Bitewing x-rays in conjunction with periodic examinations are limited to one series of four films in any 6 consecutive month period. Isolated bitewing or periapical films are allowed on an emergency or episodic basis.

      2. Full mouth x-rays in conjunction with periodic examinations are limited to once every 24 consecutive months.

      3. Panoramic film x-rays are limited to once every 24 consecutive months.

Treatment Services:

☒ Fillings
   1. Silver amalgam: ☒
      a. Limits: n/a
   2. Tooth colored composite: ☒
      a. Limits: n/a (optional in posterior teeth)

☒ Crowns/Tooth Caps
   1. Stainless steel crowns: ☒
      a. Limits: Replacement is once every 36 consecutive months or if medically necessary as determined by the plan.
      b. Prior approval required: ☒ Determined by the plan.
   2. Metal (only) crowns ☒
      a. Limits: Replacement is once every 36 consecutive months or if medically necessary as determined by the plan.
      b. Prior approval required: ☒ Determined by the plan.
   3. Metal/Porcelain crowns: ☒

a. Limits: Replacement is once every 36 consecutive months or if medically necessary as determined by the plan.
b. Prior approval required: ☒ Determined by the plan.

4. Porcelain (only): ☒
a. Limits: Replacement is once every 36 consecutive months or if medically necessary as determined by the plan.
b. Prior approval required: ☒ Determined by the plan.

☒ Root Canals (endodontics)

1. Root canals on baby teeth (Pulpotomies): ☒
a. Limits: Retreatment of root canals is a covered benefit only if clinical or radiographic signs of abscess formation are present, and/or the patient is experiencing symptoms. Removal or retreatment of silver points, overfills, underfills, incomplete fills, or broken instruments lodged in a canal, in the absence of pathology is not a covered benefit..
b. Prior approval required: ☒ n/a – determined by the dental plan.

2. Root canals on permanent teeth: ☒
a. Limits: Retreatment of root canals is a covered benefit only if clinical or radiographic signs of abscess formation are present, and/or the patient is experiencing symptoms. Removal or retreatment of silver points, overfills, underfills, incomplete fills, or broken instruments lodged in a canal, in the absence of pathology is not a covered benefit
b. Prior approval required: ☐ n/a – determined by the dental plan.

☒ Gum (periodontal) Therapy
a. Limits: 5 quadrant treatment in any 12 consecutive months
b. Prior approval required: ☒ n/a

☒ Dentures

1. Partial dentures: ☒
a. Prior approval required: n/a

2. Complete dentures: ☒
a. Prior approval required: The covered dental benefit for complete dentures will be limited to the benefit level for a standard procedure. If a more personalized or specialized treatment is chosen by the patient and the dentist, the applicant will be responsible for all additional charges.

☒ Retainers (orthodontic)
a. Limits: Limited. Available only if the subscriber child meets the eligibility requirements for medically necessary orthodontia coverage under the California Children's Services Program (CCS). Benefits are be provided and determined by CCS.

☒ Bridges
a. Limits: : ☒
1. Fixed bridges will be used only when a partial cannot satisfactorily restore the case. If fixed bridges are used when a partial could satisfactorily restore the case, it is considered optional treatment.
2. A fixed bridge is covered when it is necessary to replace a missing permanent anterior tooth in a person 16 years of age or older and the patient's oral health and general dental condition permits. Under the age of 16, it is considered optional dental treatment. If performed on a subscriber under the age of 16, the applicant must pay the difference in cost between the fixed bridge and a space maintainer.
3. Fixed bridges used to replace missing posterior teeth are considered optional when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic.
4. Fixed bridges are optional when provided in connection with a partial denture on the same arch.
5. Replacement of an existing fixed bridge is covered only when it cannot be made satisfactory by repair.
b. Prior approval required: n/a

☒ Implants:
a. Criteria: Implants are considered an optional benefit. Some plans may offer coverage for implants, but coverage of implants is not required.

☒ Oral Surgery
1. Simple extractions: ☒
   a. Limits: Removal of impacted teeth, limited as follows: Surgical removal of impacted teeth is a covered benefit only when evidence of pathology exists.
   Prior approval required: n/a
2. Surgical extractions: ☒
   a. Limits: Removal of impacted teeth, limited as follows: Surgical removal of impacted teeth is a covered benefit only when evidence of pathology exists.
   b. Prior approval required: n/a
3. Care of abscesses: ☒
   a. Limits: Incision and drainage of abscesses
   b. Prior approval required: n/a
4. Cleft palate treatment: ☐
   a. Limits: EXCLUDED
   b. Prior approval required: ☐
5. Cancer treatment: ☐
   b. Limits: EXCLUDED
   c. Prior approval required: ☐
6. Treatment of Fractures: ☐
   a. Limits: EXCLUDED
   b. Prior approval required: ☐
7. Biopsies: ☒
   a. Limits: oral tissues
   b. Prior approval required: n/a

☒ Treatment of Jaw Joint (TMJ)
   a. Criteria: Varies by plan.
   b. Prior approval required: ☒

☒ Braces (Orthodontia)
   a. Criteria: Limited. Available only if the subscriber child meets the eligibility requirements for medically necessary orthodontia coverage under the California Children's Services program (CCS). Benefits are be provided and determined by the CCS program.
   a. Prior approval required: ☒ CCS determines benefits.
   b. Payment if eligibility lost: ☐

☒ Emergency Room Services
   a. Identify services: Palliative
   b. Criteria: Emergency treatment

☐ In-patient Hospital Services
   a. Criteria: EXCLUDED (Hospital charges of any kind)
   b. Prior approval required: ☐

☒ Special Anesthesia
   a. Criteria: Oral sedatives when dispensed in a dental office by a practitioner acting within the scope of their licensure.
   b. Prior approval required: n/a

The scope of dental benefits shall also include all dental benefits which are covered under the CCS program provided the subscriber meets the medical eligibility requirements of that program, as determined by that program.

Excluded Services

1. Identify services:

   - Any benefits in excess of limits.
   - Services, supplies, items, procedures or equipment, which are not medically necessary as determined by the plan.
   - Any benefits received or costs that were incurred in connection with any dental procedures started prior to the subscriber's effective date of coverage. This exclusion

does not apply to covered services to treat complications arising from services received prior to the subscriber's effective date of coverage.

- Any benefits that are received subsequent to the time the subscriber's coverage ends.
- Experimental or investigational services, including any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supply which is not recognized as being in accordance with generally accepted professional medical standards, or for which the safety and efficiency have not been determined for use in the treatment of a particular illness, injury or medical condition for which the item or service in question is recommended or prescribed.
- Dental services that are received in an emergency care setting for conditions that are not emergencies if the subscriber reasonably should have known that an emergency care situation did not exist.
- Procedures, appliances, or restorations to correct congenital or developmental malformations are not covered benefits unless specifically listed in program regulations.
- Cosmetic dental care.
- General anesthesia or intravenous/conscious sedation unless specifically listed as a benefit or is given by a dentist for covered oral surgery.
- Hospital charges of any kind.
- Major surgery for fractures and dislocations.
- Loss or theft of dentures or bridgework.
- Malignancies.
- Dispensing of drugs not normally supplied in a dental office.
- Additional treatment costs incurred because a dental procedure is unable to be performed in the dentist's office due to the general health and physical limitations of the subscriber.
- The cost of precious metals used in any form of dental benefits.
- The surgical removal of implants.
- Services of a pedodontist/pediatric dentist for subscriber children except when a subscriber child is unable to be treated by his or her provider, or treatment by a pedodontist/pediatric dentist is medically necessary, or his or her provider is a pedodontist/pediatric dentist.