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

## State: Iowa

Updated: 7/30/2009

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.

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**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 and Well Kids in Iowa (***hawk-i***) only
- ☒ Dental Services Provided through State-defined benefit package
- ☐ Benchmark Equivalent Program:
  Name of :
- ☐ 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: Delta Dental

Recommended Age for First Oral Health Examination: 3 years

**Preventive Services:**

☒ Cleanings
a. Recommended frequency: Twice per year
b. Exception s:

☒ Fluoride treatments
- a. Ages: children under age 19
- b. Recommended frequency: once every year
- c. Also provided by physicians: ☐
- d. Also provided by hygienists: ☒
- e. Exception s:

☐ Sealants
- a. Ages: children under age 19
- b. Recommended frequency: First and second molars once per lifetime
- c. E xceptions:

☐ Oral hygiene instruction
- a. Ages:
- b. Re commended frequency:

☒ Space Maintainers
- a. Limits: children under age 19
- b. Prior approval required: Yes

**Diagnostic Services:**

☒ Dental Examinations by Dentists
- a. Recommended age of first visit: 3 years
- b. Recommended frequency: twice per year
- c. Limits :

☐ Dental Screens and Other Services by Hygienists
- a. Re commended frequency:
- b. Limits:

☒ X-Rays
- a. Limits:
  1. Bitewing x-rays – once every 12 months
  2. Full-mouth x-rays – once every 5 years
  3. Occlusal & extraoral x-rays - once every 12 months

**Treatment Services:**

☒ Fillings
1. Silver amalgam: ☒
   - a. Limits:
2. Tooth colored composite: ☒
   - a. Limits: Benefits are limited to the amount that would be paid for a silver amalgam. The member would be responsible for the difference.

☒ Crowns/Tooth Caps
1. Stainless steel crowns: ☒
   - a. Limits:
   - b. Prior approval required: ☒ recommended
2. Metal (only) crowns ☒
   - a. Limits: once every 5 years
   - b. Prior approval required: ☒ recommended
3. Metal/Porcela in crowns: ☒
   - a. Limits: once every 5 years
   - b. Prior approval required: ☒ recommended
4. Porcelain (only): ☒
   - a. Limits: once every 5 years
   - b. Prior approval required: ☒ recommended

☒ Root Canals (endodontics)
1. Root canals on baby teeth (Pulpotomies): ☒
   - a. Limits:
   - b. Prior approval required: ☒ recommended

2. Root canals on permanent teeth: ☒
    a. Limits:
    b. Prior approval required: ☒ recommended

☒ Gum (periodontal) Therapy
    a. Limits:
        1. Full Mouth Debridement – once in a lifetime
        2. Root Planing and Scaling – once every 24 consecutive months per quadrant
        3. Surgical Periodontal – once per benefit period per quadrant
        4. Periodontal Maintenance Therapy – benefits are available up to 4 times in the first benefit period and then twice per benefit period.
    b. Prior approval required: ☒ recommended

☒ Dentures
1. Partial dentures: ☒
    a. Prior approval required: ☒ recommended
2. Complete dentures: ☒
    a. Prior approval required: ☒ recommended

☐ Retainers (orthodontic)
    a. Limits:

☒ Bridges
    a. Limits: once every 5 years
    b. Prior approval required: ☒ recommended

☐ Implants:
    a. Criteria:

☒ Oral Surgery
1. Simple extractions: ☒
    a. Limits:
    b. Prior approval required: ☐
2. Surgi cal extractions: ☒
    a. Limits:
    b. Prior approval required: ☐
3. Care of abscesses: ☒
    a. Limits:
    b. Prior approval required: ☐
4. Cleft palate treatment: ☐
    a. Limits:
    b. Prior approval required: ☐
5. Cancer treatment: ☐
    b. Limits:
    c. Prior approval required: ☐
6. Treatment of Fractures: ☐
    a. Limits:
    b. Prior approval required: ☐
7. Biopsie s: ☒
    a. Limits:
    b. Prior approval required: ☐

☐ Treatment of Jaw Joint (TMJ)
    a. Criteria:
    b. Prior approval required: ☐

☐ Braces (Orthodontia)
    a. Criteria:
    b. Prior approval required: ☐
    c. Payment if eligibility lost: ☐

☐ Emergency Room Services
    a. Identify services:
    b. Criteria:

☐ In-patient Hospital Services
    a. Criteria:
    b. Prior approval required: ☐

☒ Special Anesthesia

a. Criteria: General anesthesia and IV sedation are benefits only when provided with covered oral surgery and when billed by the dentist
b. Prior approval required: ☐

**Excluded Services**

1. Identify services:
   a. Broken or missed appointments
   b. Co smetic services
   c. Dentists who do not participate with the dental plan
   d. De sensitization material
   e. Dru gs
   f. Sealants for primary teeth, wisdom teeth or restored teeth
   g. Experimental or investigative services