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

Updated: 7/20/09

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: **Florida KidCare Customer Service**
Telephone Number: **800-821-5437**
E-mail Address: **FHKSupport@acs-inc.com**

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: **Medicaid**

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:
- ☐ 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:
Medicaid Expansion program – infants under 1 with incomes between 186% - 200% FPL
Separate program – MediKids (children 1 through 4)
Separate program - Children's Medical Services Network (children with special health care needs)
Medicaid and these programs all offer the same services, based on EPSDT, services listed below.
Florida's other separate CHIP program, Healthy Kids, uses benchmark equivalent services.

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:

Preventive Services:

☒ Cleanings

a. Recommended frequency: Every 6 months
b. Exceptions: None

☒ Fluoride treatments
a. Ages: 0-20
b. Recommended frequency: Every 6 months
c. Also provided by physicians: ☒
d. Also provided by hygienists: ☐
e. Exceptions: Fluoride varnish application may be provided by non-dentists every 90 days to a child 6-42 months of age.

☒ Sealants
a. Ages: 0-20
b. Recommended frequency: Every 3 years.
c. Exceptions: Sealants may be applied to permanent first and second molars

☒ Oral hygiene instruction
a. Ages: 0-20
b. Recommended frequency: As often as needed

☒ Space Maintainers
a. Limits: Space maintainers will not be reimbursed if the space is to be maintained for less than 6 months.
b. Prior approval required: No

Diagnostic Services:

☒ Dental Examinations by Dentists
a. Recommended age of first visit: 3 years or earlier if medically necessary
b. Recommended frequency: Every 6 months
c. Limits: Cannot be combined with any other type evaluation.

☐ Dental Screens and Other Services by Hygienists
a. Recommended frequency:
b. Limits:

☒ X-Rays
a. Limits: Complete series and panorex limited to once every 3 years. Bitewings every 6 months.

Treatment Services:

☒ Fillings
1. Silver amalgam: ☒
   a. Limits: One restoration per tooth surface except for the occlusal surface of permanent max. 1st and 2nd molars. One restoration for a mesial or distal lesion.
2. Tooth colored composite: ☒
   a. Limits: One posterior one-surface resin restoration (D2391) every 3 years per tooth number or letter per tooth surface. Both permanent and primary teeth are included.

☒ Crowns/Tooth Caps
1. Stainless steel crowns: ☒
   a. Limits: None
   b. Prior approval required: ☐No
2. Metal (only) crowns ☐
   a. Limits:
   b. Prior approval required: ☐
3. Metal/Porcelain crowns: ☒
   a. Limits: Permanent posterior teeth when the tooth has been treated endodontically and cannot be adequately restored with a stainless steel crown, amalgam, or resin. Permanent anterior teeth when the tooth cannot be adequately restored with a resin restoration.
   b. Prior approval required: ☐No
4. Porcelain (only): ☐
   a. Limits:
   b. Prior approval required: ☐

☐ Root Canals (endodontics)
1. Root canals on baby teeth (Pulpotomies): ☒
   a. Limits: Cannot be billed in conjunction with D3310, D3320, or D3330 by the same provider, same tooth, same recipient.
   b. Prior approval required: ☐No

2. Root canals on permanent teeth: ☒
   a. Limits: 1) Questionable prognosis for perio reasons. 2) The tooth must have a restorable crown. 3) Exfoliation of a primary tooth is not anticipated within 18 months.
   b. Prior approval required: ☐No

☒ Gum (periodontal) Therapy
   a. Limits: Child must have pockets in excess of the 4 to 5 mm. range.
   b. Prior approval required: ☐No

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

☒ Retainers (orthodontic)
   a. Limits: Replacements are limited to 2 per lifetime and are prior authorized.

☐ Bridges
   a. Limits:
   b. Prior approval required: ☐

☐ Implants:

☒ Oral Surgery
1. Simple extractions: ☒
   a. Limits:
   b. Prior approval required: ☐
2. Surgical 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: No☐
6. Treatment of Fractures: ☒
   a. Limits:
   b. Prior approval required: ☐No
7. Biopsies: ☒
   a. Limits:
   b. Prior approval required: ☐

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

☒ Braces (Orthodontia)
   a. Criteria: Most severely handicapping malocclusion
   b. Prior approval required: ☒
   c. Payment if eligibility lost: ☐No

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

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

☒ Special Anesthesia
   a. Criteria:
   b. Prior approval required: ☐

Excluded Services

1. Identify services: