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

State: Wyoming

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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: Grant Christensen, DDS or Trish O'Grady, RDH
Telephone Number: 307-777-2976 307-777-7947
E-mail Address: grant.christensen@health.wyo.gov trish.ogrady@health.wyo.gov

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:
- ☒ 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:

Recommended Age for First Oral Health Examination:

Preventive Services:

☒ Cleanings
a. Recommended frequency: Once ina 6 month period, not to exceed 2 in a year
b. Exceptions: Allows for a one month window

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☒ Fluoride treatments
- a. Ages: no limitation
- b. Recommended frequency: Once in a 6 month period
- c. Also provided by physicians: ☐
- d. Also provided by hygienists: ☐
- e. Exceptions:

☒ Sealants
- a. Ages:through the age of 18
- b. Recommended frequency: Once in a 3 year period
- c. Exception s: none

☐ Oral hygiene instruction - Part of exam, cleaning, x-ray – not a separate benefit
- a. Ages:
- b. Re commended frequency:

☒ Space Maintainers
- a. Limits: once in a 3 year period
- b. Prior approval required: Y/N -- None

Diagnostic Services:

☒ Dental Examinations by Dentists
- a. Recommended age of first visit: n/a
- b. Recommended frequency: Once in a 6 month period
- c. Limits: same as cleanings

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

☒ X-Rays
- a. Limits: Once in a 6 month period not to exceed 2 in one year. Full month once in a 36 month period

Treatment Services:

☒ Fillings
1. Silver amalgam: ☒
   - a. Limits: One time per year per tooth surface
2. Tooth colored composite: ☒
   - a. Limits: Only on front teeth

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

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

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

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☐ Gum (periodontal) Therapy
   a. Limits:
   b. Prior approval required: ☐

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

☐ Retainers (orthodontic)
   a. Limits:

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

☐ 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: Only non-IV conscious sedation
   b. Prior approval required: ☒ - up to age 8

Excluded Services

1. Identify services: General anesthesia, orthodontic, surgical procedures, prescription drugs, impalnts, cosmetic dentistry and TMJ.