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

Updated: 7/14/2009

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

X 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: Idaho Health Plan for Enhanced Plan Participants (specials needs).

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

X 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

X State EPSDT definition
OR
☐ Nationally Recognized Standard
Name and Description:

Recommended Age for First Oral Health Examination: Age 1 or at eruption of first tooth if earlier

Preventive Services:

X Cleanings
a. Recommended frequency: Every 6 months
b. Exceptions:

X Fluoride treatments
   a. Ages: All ages
   b. Recommended frequency: Every 6 months
   c. Also provided by physicians: X
   d. Also provided by hygienists: X
   e. Exceptions: Only covered to age 21 when done by physicians or midlevel pracitioners

X Sealants
   a. Ages: Ages 0 to 21
   b. Recommended frequency: Every 3 years per tooth
   c. Exceptions:

☐ Oral hygiene instruction
   a. Ages:
   b. Recommended frequency:

X Space Maintainers
   a. Limits: Ages 0 - 21
   b. Prior approval required: NO

Diagnostic Services:

X Dental Examinations by Dentists
   a. Recommended age of first visit: 1 year or eruption of first tooth if sooner
   b. Recommended frequency: Every 6 months and as needed for problems
   c. Limits:

X Dental Screens and Other Services by Hygienists
   a. Recommended frequency: Every 6 months and as needed for problems
   b. Limits: Must be billed by Public Health Dental Program

X X-Rays
   a. Limits: Complete series and panoramic films only once every 3 years. Bitewings total of 4 every 6 months. Vertical bitewings (7 – 8 films) every 6 months.

Treatment Services:

X Fillings
1. Silver amalgam: **X**
   a. Limits:
2. Tooth colored composite: **X**
   a. Limits:

X Crowns/Tooth Caps
1. Stainless steel crowns: **X**
   a. Limits:
   b. Prior approval required: ☐
2. Metal (only) crowns **X**
   a. Limits:
   b. Prior approval required: **X**
3. Metal/Porcelain crowns: **X**
   a. Limits:
   b. Prior approval required: **X**
4. Porcelain (only): **X**
   a. Limits: Ages 0-21
   b. Prior approval required: **X**

X Root Canals (endodontics)
1. Root canals on baby teeth (Pulpotomies): **X**
   a. Limits: Ages 0-21 only. Not covered

same day as root canal.
b. Prior approval required: ☐

2. Root canals on permanent teeth: X
   a. Limits: Ages 0-21 only.
   b. Prior approval required: ☐

X Gum (periodontal) Therapy
   a. Limits: Ages 0-21 only.
   b. Prior approval required: ☐

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

X Retainers (orthodontic)
   a. Limits: Up to age 21

X Bridges
   a. Limits: Up to age 21
   b. Prior approval required: X

☐ Implants:
   a. Criteria:

X Oral Surgery
1. Simple extractions: X
   a. Limits:
   b. Prior approval required: ☐
2. Surgical extractions: X
   a. Limits:
   b. Prior approval required: ☐
3. Care of abscesses: X
   a. Limits:
   b. Prior approval required: ☐
4. Cleft palate treatment: X
   a. Limits: Orthodontics covered. Surgeries covered under medical benefits
   b. Prior approval required: ☐
5. Cancer treatment: X
   b. Limits: Biopsies covered. Other treatment covered under medical benefits.
   c. Prior approval required: ☐
6. Treatment of Fractures: X
   a. Limits: Covered under medical benefits
   b. Prior approval required: ☐
7. Biopsies: X
   a. Limits: Mild scraping and soft oral tissue biopsies only. Other biopsies covered under medical benefits.
   b. Prior approval required: ☐

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

X Braces (Orthodontia)
   a. Criteria: Up to age 21. Must meet Idaho's Malocclusion Index score of 8 or more.
   b. Prior approval required: X
   c. Payment if eligibility lost: ☐

☐ Emergency Room Services
   a. Identify services:

b. Criteria:

X In-patient Hospital Services
   a. Criteria: When medically necessary.
   b. Prior approval required: ☐

X Special Anesthesia
   a. Criteria: Provider must be certified by Board of Dentistry.
   b. Prior approval required: ☐

Excluded Services

Identify services: Procedures not recognized by the American Dental Association are not covered. Cosmetic, convenience, or comfort services are not covered.