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

State Contact: Lee P. Perry
Telephone Number: Technical Assistance Hotline (518) 474-3575 or (800) 342-3005
E-mail Address: dental@health.state.ny.us

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 Program (Medicaid Managed Care, Medicaid Fee-For-Service)**

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: **Child Health Plus**
- ☒ 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.

Medicaid Program

Schedule of Services

☐ State EPSDT definition
OR
☒ Nationally Recognized Standard
Name and Description: **American Academy of Pediatric Dentistry**

Recommended Age for First Oral Health Examination: **Within 6 months of the eruption of the first primary tooth, no later than age 12 months.**

Preventive Services:

☒ Cleanings
a. Recommended frequency: **two times per year**

b. Exceptions:

☒ Fluoride treatments
   a. Ages:
   b. Recommended frequency: **twice per year**
   c. Also provided by physicians: ☐
   d. Also provided by hygienists: ☒
   e. Exceptions:

☒ Sealants
   a. Ages: **5 to 15**
   b. Recommended frequency: **3 years as needed**
   c. Exceptions: **first and second permanent first molars**

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

☒ Space Maintainers
   a. Limits:
   b. Prior approval required: **No**

Diagnostic Services:

☒ Dental Examinations by Dentists
   a. Recommended age of first visit: **by 12 months of age**
   b. Recommended frequency: **2 times per year**
   c. Limits:

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

☒ X-Rays
   a. Limits:

Treatment Services:

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

☒ 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/Porcelain crowns: ☒
      a. Limits: **Anterior teeth and upper 1st bicuspids**
      b. Prior approval required: ☒
   4. Porcelain (only): ☒
      a. Limits: **Anterior teeth and upper 1st bicuspids**
      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: ☒

☒ Gum (periodontal) Therapy

a. Limits: **Limited to scaling and root planning once every 2 years and gingivectomy for drug or hormonal induced hyperplasia**
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: **Only provided for cleft palate stabilization or medical necessity due to seizures, etc.**
   b. Prior approval required: ☒

☐ Implants:
   a. Criteria:

☒ 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: ☐
6. Treatment of Fractures: ☒
   a. Limits:
   b. Prior approval required: ☐
7. Biopsies: ☒
   a. Limits:
   b. Prior approval required: ☐

☒ Treatment of Jaw Joint (TMJ)
   a. Criteria: **Limited to occlusal guards**
   b. Prior approval required: ☐

☒ Braces (Orthodontia)
   a. Criteria: Meet **the criteria of a "physically handicapping malocclusion"**
   b. Prior approval required: ☒
   c. Payment if eligibility lost: ☒ **Limited to six months following loss of eligibility**

☒ 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: **Implants**

Child Health Plus Program

Schedule of Services

☐ State EPSDT definition

OR

☒ Nationally Recognized Standard

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Preventive Services:

☒ Cleanings

a. Recommended frequency: **two times per year**
b. Exceptions:

☒ Fluoride treatments

a. Ages:
b. Recommended frequency: **twice per year**
c. Also provided by physicians: ☐
d. Also provided by hygienists: ☒
e. Exceptions:

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a. Ages: **5 to 15**
b. Recommended frequency: **3 years as needed**
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☐ Oral hygiene instruction

a. Ages:
b. Recommended frequency:

☒ Space Maintainers

a. Limits
b. Prior approval required: **No**

Diagnostic Services:

☒ Dental Examinations by Dentists

a. Recommended age of first visit: **by 12 months of age**
b. Recommended frequency: **2 times per year**
c. Limits:

☐ Dental Screens and Other Services by Hygienists

a. Recommended frequency:
b. Limits:

☒ X-Rays

a. Limits:

Treatment Services:

☒ Fillings

1. Silver amalgam: ☒
   a. Limits:
2. Tooth colored composite: ☒
   a. Limits:

☒ 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/Porcelain crowns: ☒
   a. Limits: **Anterior teeth and upper 1st bicuspids**
   b. Prior approval required: ☒
4. Porcelain (only): ☒
   a. Limits: **Anterior teeth and upper 1st bicuspids**
   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: ☒

☒ Gum (periodontal) Therapy
   a. Limits: **Limited to scaling and root planning once every 2 years and gingivectomy for drug or hormonal induced hyperplasia**
   b. Prior approval required: ☐

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

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   a. Limits

☒ Bridges
   a. Limits: **Only provided for cleft palate stabilization or medical necessity due to seizures, etc.**
   b. Prior approval required: ☒

☐ Implants:
   a. Criteria

☒ Oral Surgery
1. Simple extractions: ☒
   a. Limits
   b. Prior approval required: ☐
2. Surgical extractions: ☒
   a. Limits:
   b. Prior approval required: ☒
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   a. Limits:
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4. Cleft palate treatment: ☒
   a. Limits:
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5. Cancer treatment: ☒
   a. Limits:
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   a. Limits:
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   a. Criteria: **Limited to occlusal guards**
   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:
b. Prior approval required: ☐

Excluded Services

1. Identify services: **Implants, Orthodontia**