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

Updated:8/04/2009

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: Medicaid Client Services
Telephone Number: 1-800-852-3342 x 4344 or 603-271-4344
E-mail Address:

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: **Healthy Kids Gold**

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:
All answers provided below are in reference to services provided to children under age 21 years.

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: **By Age One**

Preventive Services:

☒ Cleanings
a. Recommended frequency: **Covered service no more frequently than once every 150 days unless deemed medically necessary.**
b. Exceptions:

☒ Fluoride treatments
a. Ages: **up to age 13**

b. Recommended frequency: **Up to 2 times per year**
c. Also provided by physicians: ☐
d. Also provided by hygienists: ☐
e. Exceptions:

☒ Sealants
a. Ages: **Up to age 16**
b. Recommended frequency: **every 5 years (for permanent and deciduous molars)**
c. Exceptions:

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

☒ Space Maintainers
a. Limits: **2 bilaterals per arch**
b. Prior approval required: **No**

Diagnostic Services:

☒ Dental Examinations by Dentists
a. Recommended age of first visit:
b. Recommended frequency: **No more frequently than every 150 days unless medically necessary.**
c. Limits:

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

☒ X-Rays
a. Limits: **complete series or panographic survey, once every 3 years; bitewings every 12 months; all types of dental x-rays regardless of limits noted herein as required to rule out a differential diagnosis.**

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: **All types of crowns are covered with the exception of titanium crowns**
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: ☐

☒ Gum (periodontal) Therapy

a. Limits:
b. Prior approval required: ☒ **(for surgical periodontal therapy)**

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

☒ Retainers (orthodontic)
   a. Limits: **Included with comprehensive treatment. Coverage allowed for one replacement.**

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

☐ Implants:
   a. Criteria:

☒ Oral Surgery
1. Simple extractions: ☒
   a. Limits:
   b. Prior approval required: ☒ **(for asymptomatic teeth)**
2. Surgical extractions: ☒
   a. Limits:
   c. Prior approval required: ☒ **(for asymptomatic teeth)**
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:
   b. Prior approval required: ☐

☒ Braces (Orthodontia)
   a. Criteria: **See Dental Services Rules (He-W 566)**
   b. Prior approval required: ☒
   c. Payment if eligibility lost: ☒

☒ Emergency Room Services
   a. Identify services: **If submitted by a dental provider for a covered dental service**
   b. Criteria:

☒ In-patient Hospital Services
   a. Criteria: **If submitted by a dental provider for a covered dental service**
   b. Prior approval required: ☐

☒ Special Anesthesia
   a. Criteria: **Only general anesthesia covered**
   b. Prior approval required: ☐

Excluded Services

1. Identify services: **See Dental Services Rules He-W 566.06**
   Non-covered services include:
   a. Any services for which there is no medical necessity or for which the medical necessity has not been established;

b. Services which are not medical in nature, except that transportation shall be covered in accordance with HE-W 546.05(d)
c. Experimental or investigational procedures in accordance with He-W 530;
d. Services that have not been proven to be safe or effective, as documented in medical peer review literature; and
e. Services which are more costly than other services, which could be expected to provide the recipient with the same outcome.