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

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.

MONTANA CHIP
State Contact: Barbara Arnold
Telephone Number: (406) 444-7046
E mail Address: barnold2@mt.gov
Website: http://chip.mt.gov

MONTANA MEDICAID
State Contact: Jan Paulsen
Telephone Number: (406) 444-3182
E-mail Address: jpaulsen@mt.gov
Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml

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:

X CHIP Stand-Alone/Separate Program ONLY
State Program Name: Montana CHIP

X Dental Services Provided through State-defined benefit package
The Montana CHIP dental benefit is a maximum of $412 in services for each benefit year. The benefit year is October 1 through September 30.

☐ 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

X State EPSDT definition

Dental benefits for Montana CHIP children are LIMITED. The Montana CHIP dental benefit is a maximum of $412 in services for each benefit year. The benefit year is October 1 through September 30. Most dental services are included in the limited benefit. The dental services not included in the benefit are braces, implant services, and maxillofacial prosthetics,

OR

☐ Nationally Recognized Standard
Name and Description:

Recommended Age for First Oral Health Examination: After first tooth erupts but no later than a child's first birthday.

Preventive Services: All dental work limited to the maximum benefit of $412. in services per year .

X Cleanings Limited
- a. Recommended frequency: n/a
- b. Exceptions:

X Fluoride treatments Limited
- a. Ages:
- b. Recommended frequency:
- c. Also provided by physicians: x
- d. Also provided by hygienists: x
- e. Exceptions:

X Sealants Limited
- a. Ages: n/a
- b. Recommended frequency:
- c. Exceptions:

X Oral hygiene instruction Limited
- a. Ages:
- b. Recommended frequency:

X Space Maintainers Limited
- a. Limits: yes
- b. Prior approval required: N

Diagnostic Services: All dental work limited to the maximum benefit of $412. in services per year .

X Dental Examinations by Dentists Limited
- a. Recommended age of first visit: After first tooth erupts but no later than a child's first birthday.
- b. Recommended frequency:
- c. Limits:

X Dental Screens and Other Services by Hygienists
- a. Recommended frequency: n/a
- b. Limits: yes

X X-Rays Limited
- a. Limits: yes

Treatment Services: All dental work limited to the maximum benefit of $412. in services per year .

X Fillings Limited
1. Silver amalgam: x
   - a. Limits: yes
2. Tooth colored composite: x
   - a. Limits: yes

X Crowns/Tooth Caps :
1. Stainless steel crowns: x
   Limits: yes
   a. Prior approval required: x
2. Metal (only) crowns x
   a. Limits: yes
   b. Prior approval required: ☐
3. Metal/Porcelain crowns: x
   a. Limits: yes
   b. Prior approval required: ☐
4. Porcelain (only): x
   a. Limits: yes
   b. Prior approval required: ☐

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

2. Root canals on permanent teeth: x
   a. Limits: yes
   b. Prior approval required: ☐

X Gum (periodontal) Therapy
   a. Limits: yes
   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:

X Oral Surgery
1. Simple extractions: x
   a. Limits: yes
   b. Prior approval required: ☐
2. Surgical extractions: x
   a. Limits: yes
   b. Prior approval required: ☐
3. Care of abscesses: x
   a. Limits: yes
   b. Prior approval required: ☐
4. Cleft palate treatment: x
   a. Limits: Provided separately under the MT CHIP medical benefit and in coordination with MT's Children's Special Health Services Program.
   b. Prior approval required: Yes
5. Cancer treatment: x
   b. Limits: Provided separately and varies with illness and treatment under the MT CHIP medical benefit.
   c. Prior approval required: Yes
6. Treatment of Fractures: x
   d. Limits: Provided separately under the MT CHIP medical benefit.
   a. Prior approval required: Yes

7. Biopsies: ☐
    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: ☐

X Emergency Room Services
    a. Identify services:
    b. Criteria: Surgical repair of the mouth and gums due to an accident or congenital defect may be covered under the MT CHIP medical benefit.

☐ In-patient Hospital Services
    a. Criteria: If appropriate under the MT CHIP medical benefit
    b. Prior approval required: Yes

X Special Anesthesia
    a. Criteria: Must be a child age 5 and under and no prior approval is required.
    b. Prior approval required: Yes, if the child has special needs and is older than age 5.

Excluded Services

1. Identify services:
    a. Orthodontic Services (Braces)
    b. Implant Services
    c. Maxillofacial Prosthetics