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

Updated: 7/31/2009

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:
Telephone Number:
E-mail Address:

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: Kentucky Medicaid Dental Services

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:

X☐ 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

X☐ Nationally Recognized Standard
Name and Description: Current Dental Terminology 2009-2010

Recommended Age for First Oral Health Examination: With eruption of first tooth.

Preventive Services:

X☐ Cleanings
a. Recommended frequency: 2 per 12 month period
b. Exceptions:

X ☐ Fluoride treatments
   a. Ages**: 0 to 20**
   b. Recommended frequency: **2 in a 12 month period**
   c. Also provided by physicians: ☐
   d. Also provided by hygienists: ☐**X**
   e. Exceptions:

X☐ Sealants
   a. Ages: **5 through 20 yrs. of age**
   b. Recommended frequency: **Once every 4 years**
   c. Exceptions:

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

X☐ Space Maintainers
   a. Limits:**2 in a 12 month period**
   b. Prior approval required: Y/N **N**

Diagnostic Services:

X☐ Dental Examinations by Dentists
   a. Recommended age of first visit: **With eruption of first tooth**
   b. Recommended frequency: **2 in a 12 month period**
   c. Limits:

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

X☐ X-Rays
   a. Limits: **14 PAs and up to 4 bitewings in a 12 month period, Panoramic x-ray-1 in a 24 month period**

Treatment Services:

X☐ Fillings
1. Silver amalgam: ☐**X**
   a. Limits: **None**
2. Tooth colored composite ☐**X**
   a. Limits: **None**

X☐ Crowns/Tooth Caps
1. Stainless steel crowns: **X**☐
   a. Limits: **Members under 21 years of age & 2 per tooth**
   b. Prior approval required: ☐
2. Metal (only) crowns ☐X
   a. Limits:**Only covered through the EPSDT Program**
   b. Prior approval required: ☐**X**
3. Metal/Porcelain crowns: ☐**X**
   a. Limits:**Only covered through the EPSDT Program**
   b. Prior approval required: ☐**X**
4. Porcelain (only): ☐**X**
   a. Limits: **Only covered through the EPSDT Program**
   b. Prior approval required: ☐**X**

X☐ Root Canals (endodontics)
1. Root canals on baby teeth (Pulpotomies): ☐**X**
   a. Limits:**None**
   b. Prior approval required: ☐

2. Root canals on permanent teeth: ☐**X**
   - **a.** Limits:**None**
   - **b. Prior approval required:** ☐

X☐ Gum (periodontal) Therapy
   - a. Limits: **D4355 – Limited to Pregnant Women Only**
   - b. Prior approval required: ☐

X☐ Dentures
1. Partial dentures: ☐**X Covered through the EPSDT Program**
2. Prior approval required: ☐**X**
3. Complete dentures: ☐**X Covered through the EPSDT Program**
   a. Prior approval required: ☐**X**

X☐ Retainers (orthodontic)
   a. Limits:**Covered through the EPSDT Program Only & Requires Prior Authorization**

X☐ Bridges
   a. Limits: **Covered through the EPSDT Program only**
   b. Prior approval required: ☐**X**

☐ Implants:
   a. Criteria:

X☐ Oral Surgery
1. Simple extractions: ☐**X**
   a. Limits: **None**
   b. Prior approval required: ☐
2. Surgical extractions: ☐**X**
   a. Limits: **None**
   b. Prior approval required: ☐
3. Care of abscesses: ☐**X**
   a. Limits: **None**
   b. Prior approval required: ☐
4. Cleft palate treatment: ☐**X**
   a. Limits: **This is covered through the Commission for Children With Special Health Care Needs**
   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: ☐**X**
   a. Limits:**None**
   b. Prior approval required: ☐

X☐ Treatment of Jaw Joint (TMJ)
   a. Criteria:**Listed in the Dental Services regulation 907 KAR 1:026**
   b. Prior approval required: ☐**X Limited to one per lifetime**

X☐ Braces (Orthodontia)
   a. Criteria: **Listed in the Dental Services Regulation 907 KAR 1:026**
   b. Prior approval required: ☐**X**
   c. Payment if eligibility lost: ☐**X**

X☐ Emergency Room Services
   - **a.** Identify services: **Hospital Call**
   - 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: