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

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: Sheena Olson, Medical Assistance Administrator
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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: ARKids First A Dental Program

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: ARKids First B Dental Program

- 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 <u>and</u> 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:

Preventive Services:

X Cleanings
a. Recommended frequency: every 6 months

b. Exceptions: More frequent cleanings may be approved if medically necessary with prior authorization

X Fluoride treatments

a. Ages:
b. Re commended frequency:
c. Also provided by physicians: ☐
d. Also provided by hygienists: ☐
e. Exception s:

X Sealants

a. Ages:
b. Recommended frequency: once per lifetime
c. Exceptions: on 1st and 2nd permanent molar only

☐ Oral hygiene instruction

a. Ages:
b. Re commended frequency:

X Space Maintainers

a. Limits:
b. Prior approval required: Yes

Diagnostic Services:

X Dental Examinations by Dentists

a. Recommended age of first visit:
b. Recommended frequency: every 6 months
c. Limits :

☐ Dental Screens and Other Services by Hygienists

a. Re commended frequency:
b. Limits:

X X-Rays

a. Limits: bitewings every six months, pano every 5 years for ages 6 and over

Treatment Services:

X Fillings

1. Silver amalgam: X
   a. Limits: once per tooth, service every two years
2. Tooth colored composite: X
   a. Limits: reimbursed the same as amalgam

X Crowns/Tooth Caps

1. Stainless steel crowns: X
   a. Limits:
   b. Prior approval required: X on permanent teeth
2. Metal (only) crowns ☐
   a. Limits:
   b. Prior approval required: ☐
3. Metal/Porcelain crowns: X
   a. Limits:
   b. Prior approval required: X
4. Porcelain (only): ☐
   a. Limits:
   b. Prior approval required: ☐

X Root Canals (endodontics)

1. Root canals on baby teeth (Pulpotomies): X
   a. Limits: one per tooth

b. Prior approval required: ☐

2. Root canals on permanent teeth: X
   a. Limits: one per tooth
   b. Prior approval required: X

X Gum (periodontal) Therapy
   a. Limits:
   b. Prior approval required: X

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

X Retainers (orthodontic)
   a. Limits: prior approved – for ARKids First A only, not CHIP

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

☐ 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: X
   3. Care of abscesses: X
      a. Limits:
      b. Prior approval required: ☐
   4. Cleft palate treatment: ☐ part of physician program
      a. Limits:
      b. Prior approval required: ☐
   5. Cancer treatment: ☐ part of physician program
      b. Limits:
      c. Prior approval required: ☐
   6. Treatment of Fractures: ☐ part of physician program
      a. Limits:
      b. Prior approval required: ☐
   7. Biopsies: X
      a. Limits:
      b. Prior approval required: X

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

X Braces (Orthodontia)
   a. Criteria: score of 26 on HLD scoring sheet
   b. Prior approval required: X
   c. Payment if eligibility lost: X payment in full upon proof of placement

☐ Emergency Room Services
   a. Identify services:
   b. Criteria:

☐ In-patient Hospital Services
   a. Criteria:
   b. Prior approval required: ☐

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☐ Special Anesthesia

a. Criteria:

b. Prior approval required: ☐

Excluded Services

1. Identify services: