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

Updated:7/15/2009

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: **Cathy Halverson**
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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:

☐ 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:

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:

Preventive Services:

Cleanings

☒
a. Recommended frequency: **Every 6 months per calendar year**
b. Exceptions: **Beneficiaries who have special health care needs may receive cleanings at a higher frequency, however medical necessity must be determined by dentists and approved by the DC Department of Health Care Finance.**

☒ Fluoride treatments
   a. Ages: **All (Adults & Children)**
   b. Recommended frequency: **Once per calendar year**
   c. Also provided by physicians: ☐
   d. Also provided by hygienists: ☐
   e. Exceptions:

☒ Sealants
   a. Ages: **3 years and up**
   b. Recommended frequency: **Once**
   c. Exceptions:

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

☒ Space Maintainers
   a. Limits: **30 maximum (fixed unilateral and bilateral only)**
   b. Prior approval required: **N**

Diagnostic Services:

☒ Dental Examinations by Dentists
   a. Recommended age of first visit: **6 months (or when first tooth erupts)**
   b. Recommended frequency: **Once per calendar year**
   c. Limits: **An evaluation performed on a patient of record to determine any changes in the patients dental and medical health status since a previous comprehensive or periodic evaluation. This includes an oral cancer evaluation and periodontal screening where indicated, and may require interpretation of information acquired through additional diagnostic procedures. Report additional diagnostic procedures separately.**

☒ Dental Screens and Other Services by Hygienists
   a. Recommended frequency: **Once per calendar year**
   b. Limits:

☒ X-Rays
   a. Limits: **All Per Calendar Year. For benefit determination purposes, DHCF considers a complete series of x-rays (D0210) as: nine or more periapical x-rays (D220-D2030) or with bitewings x-rays (D0220-D0230); or with three or more additional bitewings x-rays; or, a combination of panoramiz film (D0330) and bitewing x-rays, or periapical x-rays.**

D0210	INTRAOR COMPLETE FILM SER	1
D0230	PERIAPICAL X RAY; EACH AD	4
D0270	BITEWING,SINGLE,FIRST FIL	1
D0220	PERIAPICAL X RAY; FIRST F	1
D0240	OCCLUSAL X RAY	28
D0272	DENTAL BITEWINGS TWO FILM	1
D0274	DENTAL BITEWINGS FOUR FIL	1
D0340	CEPHALOMETRIC FILM	9
D0330	PANOREX	1
D0350	ORAL/FACIAL IMAGES	1

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:
   b. Prior approval required: ☐
4. Porcelain (only): ☒
   a. Limits**: 20 years and under**
   b. Prior approval required: ☐

☒ Root Canals (endodontics)
1. Root canals on baby teeth (Pulpotomies): ☒
   a. Limits: **To be performed on primary or permanent teeth; not to be construed as the first stage of root canal therapy**
   b. Prior approval required: ☐

2. Root canals on permanent teeth: ☒
   a. Limits: **10**
   b. Prior approval required: ☐

☒ Gum (periodontal) Therapy
   a. Limits: See Blow

Code	Procedure	PA Req?	Limit/Per Calendar Yr
D4211	GINGIVECTOMY/PLASTY PER T	Y	1
D4241	GNGVL FLAP W ROOTPLAN 1-3	N	4
D4263	BONE REPLCE GRAFT FIRST S	Y	1
D4341	PERIODONTAL SCALING AND R	Y	4
D4210	GINGIVECTOMY/PLASTY PER Q	Y	4
D4240	GINGIVAL FLAP PROC W/ PLA	N	4
D4249	CROWN LENGTHEN HARD TISSU	N	1
D4264	BONE REPLCE GRAFT EACH AD	Y	1
D4355	FULL MOUTH DEBRIDEMENT	N	1

   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:

☒ 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:
   b. Prior approval required: ☐

☒ Braces (Orthodontia)
   a. Criteria: HLC score 15
   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: