

**Description of Dental Benefits Provided Under  
Medicaid and the Children's Health Insurance Program (CHIP)  
State: Michigan  
Updated: 07/16/09**

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: MI Enrolls  
Telephone Number: 1-888-367-6557  
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: Michigan Medicaid and/or *Healthy Kids Dental*

**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: **MiChild**
- 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:

**Annual Maximum:** \$600 per child

## Michigan

### Preventive Services:

- Cleanings
  - a. Recommended frequency: Twice per year
  - b. Exceptions:
- Fluoride treatments
  - a. Ages: up to age 15
  - b. Recommended frequency: Twice per year
  - c. Also provided by physicians:
  - d. Also provided by hygienists:
  - e. Exceptions:
- Sealants
  - a. Ages:
  - b. Recommended frequency: Payable once per tooth
  - c. Exceptions: Only first and second permanent molars
- Oral hygiene instruction
  - a. Ages:
  - b. Recommended frequency:
- Space Maintainers
  - a. Limits: One per space allowed.
  - b. Prior approval required:

### Diagnostic Services:

- Dental Examinations by Dentists
  - a. Recommended age of first visit:
  - b. Recommended frequency:
  - c. Limits: Twice per year
- Dental Screens and Other Services by Hygienists
  - a. Recommended frequency:
  - b. Limits:
- X-Rays
  - a. Limits: Only bitewing x-rays once per year

### Treatment Services:

- Fillings
  - 1. Silver amalgam: 
    - a. Limits:
  - 2. Tooth colored composite: 
    - a. Limits: Not on molar teeth
- 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:
    - 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:

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

Michigan

**Excluded Services**

1. Identify services: Full mouth X-rays, Orthodontics, Root canals, Wisdom teeth extractions, Implants, Gum Therapy, Gold crowns and bridges, Complete and Partial Dentures