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

State: **VERMONT**

Updated: **July 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.

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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: **Dr Dynasaur is the program name for health care services to children.**

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: **For marketing purposes, Vermont SCHIP is considered part of Dr Dynasaur**

- ☐ Dental Services Provided through State-defined benefit package
- ☐ Benchmark Equivalent Program:
- ☒ Name of : **Dr Dynasaur**
- ☐ 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:
b. Exceptions:

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- ☐ Fluoride treatments
  - a. Ages:
  - b. Recommended frequency:
  - c. Also provided by physicians: ☐
  - d. Also provided by hygienists: ☐
  - e. Exceptions:
- ☐ Sealants
  - a. Ages:
  - b. Recommended frequency:
  - c. Exceptions:
- ☐ Oral hygiene instruction
  - a. Ages:
  - b. Recommended frequency:
- ☐ Space Maintainers
  - a. Limits:
  - b. Prior approval required: Y/N

Diagnostic Services:

- ☐ Dental Examinations by Dentists
  - a. Recommended age of first visit:
  - b. Recommended frequency:
  - c. Limits:

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

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:
     - 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: ☐
   - 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: ☐

Excluded Services

1. Identify services: