

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

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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:

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: [American Dental Association Guidelines](#)

Recommended Age for First Oral Health Examination: One (1) to no later than three (3) years of age

Preventive Services:

- Cleanings
- a. Recommended frequency: [1 every 6 months](#)
 - b. Exceptions: None

- Fluoride treatments
 - a. Ages: 1 – 5 years old
 - b. Re commended frequency: 1 every 6 months
 - c. Also provided by physicians:
 - d. Also provided by hygienists:
 - e. Exception s:
- Sealants
 - a. Ages: 2 to 6 (primary molars); 6 – 12 (first permanent molars); 12 – 18 (2nd permanent molars)
 - b. Recommended frequency:
 - c. E xceptions:
- Oral hygiene instruction
 - a. Ages: First Visit to dentist
 - b. Recommended frequency: 1 every 6 months
- Space Maintainers
 - a. Limits:
 - b. Prior approval required: Y/N

Diagnostic Services:

- Dental Examinations by Dentists
 - a. Recommended age of first visit: 1 – 3 years
 - b. Recommended frequency: 1 periodic (0120) exam per 6 months
 - c. Limits :
- Dental Screens and Other Services by Hygienists
 - a. Recommended frequency: 1 per 6 months
 - b. Limits:
- X-Rays
 - a. Limits: complete series: Full series – one (1) every 36 months
Bitewings – one (1) every 6 months

Treatment Services:

- Fillings
 - 1. Silver amalgam:
 - a. Limits: 1 every 3 years
 - 2. Tooth colored composite:
 - a. Limits: 1 every 3 years
- Crowns/Tooth Caps
 - 1. Stainless steel crowns:
 - a. Limits:
 - b. Prior approval required:
 - 2. Metal (only) crowns
 - a. Limits: One (1) every five (5) years
 - b. Prior approval required:
 - 3. Metal/Porcelain crowns:
 - a. Limits: One (1) every five (5) years
 - b. Prior approval required:
 - 4. Porcelain (only):
 - a. Limits:
 - b. Prior approval required:
- Root Canals (endodontics)
 - 1. Root canals on baby teeth (Pulpotomies): (D3351)
 - a. Limits: One (1) every three (3) years
 - b. Prior approval required:
 - 2. Root canals on permanent teeth:
 - a. Limits: None
 - 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
 - a. Limits:
- Bridges
 - a. Limits:
 - b. Prior approval required:
- Implants:
 - a. Criteria:
- Oral Surgery
 - 1. Simple extractions:
 - a. Limits: None
 - b. Prior approval required:
 - 2. Surgical extractions:
 - a. Limits: [Medical Necessity, i.e. impacted teeth](#)
 - b. Prior approval required:
 - 3. Care of abscesses:
 - a. Limits: [Initial office visit and follow up](#)
 - b. Prior approval required:
 - 4. Cleft palate treatment:
 - a. Limits: [Initial visit \(treatment covered under medical plan\)](#)
 - b. Prior approval required:
 - 5. Cancer treatment:
 - b. Limits: [Initial visit \(treatment covered under medical plan\)](#)
 - c. Prior approval required:
 - 6. Treatment of Fractures:
 - a. Limits: [Initial visit \(treatment covered under medical plan\)](#)
 - b. Prior approval required:
 - 7. Biopsies:
 - a. Limits: None
 - 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: [Covered under medical plan](#)
 - b. Criteria:
- In-patient Hospital Services
 - a. [Criteria: Medically necessary adjunctive services that directly support the delivery of dental procedures, which, in the judgment of the dentist, are necessary for the provision of optimal quality therapeutic and preventive oral care to patients with medical, physical or behavioral conditions. These services include but are not limited to sedation, general anesthesia, and utilization of outpatient or inpatient surgical facilities.](#)
 - b. Prior approval required:
- Special Anesthesia
 - a. [Criteria: Deep sedation/general anesthesia in conjunction with dental surgery or procedures normally excluded under the medical plan as medically necessary in EITHER of the following situations:](#)
 - [a properly-equipped and staffed office, with appropriately trained personnel, when dental services are provided by an oral surgeon or oral maxillofacial surgeon](#)

- a hospital or outpatient surgery center when dental services are provided by a dentist, oral surgeon or oral maxillofacial surgeon

For any of the following:

- **individual age seven years or younger**
- **individual who is severely psychologically impaired or developmentally disabled**
- **individual who has one or more significant medical comorbidities which:**
 - preclude the use of either local anesthesia or conscious sedation **OR**
 - for which careful monitoring is required during and immediately following the planned procedure

b. Prior approval required:

Excluded Services

1. **Identify services:** TMJ, Orthodontia, Dentures, Intraoral prosthetic devices or any other method of treatment to alter vertical dimension or for TMJ not caused by disease or physical trauma. Any other procedure not listed as covered in the Summary Plan Description (SPD).