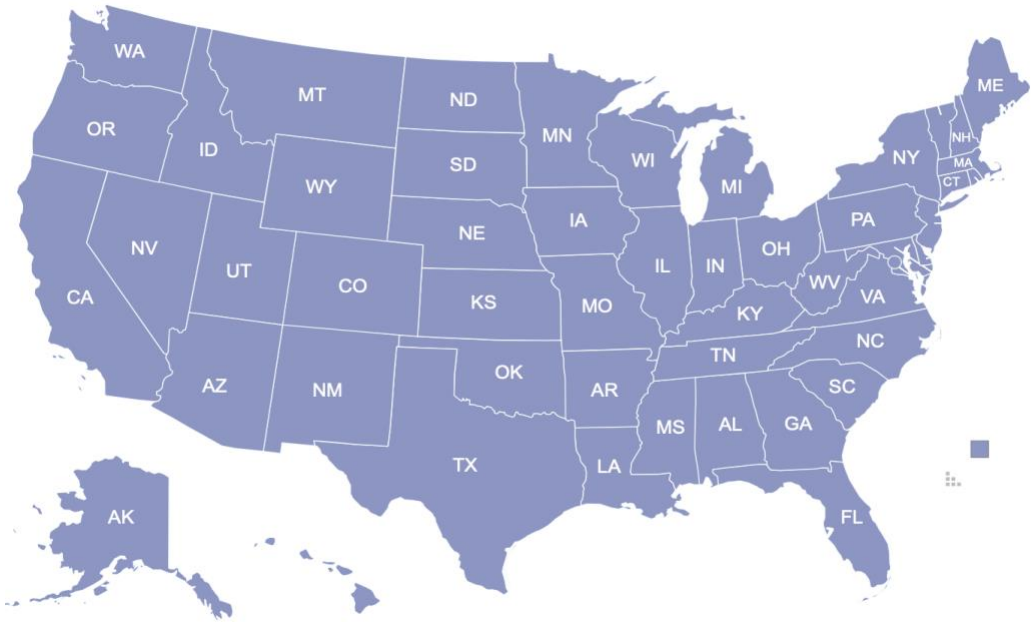
National Profile of State Medicaid & CHIP Dental Programs

MSDA
MEDICAID | MEDICARE | CHIP
SERVICES DENTAL ASSOCIATION



Policy Report 2024

MSDA National Profile of State Medicaid and CHIP Dental Programs

The Medicaid Medicare CHIP Services Dental Association (MSDA) is the national membership organization representing all State Medicaid and CHIP dental programs, their directors and staff, managed care organizations, health plans, providers, and other corporate vendors from across the country that aim to advance oral health equity for all Medicaid, Medicare, and CHIP beneficiaries.

In 2013, MSDA established the *National Profile of State Medicaid and CHIP Oral Health Programs* (National Profile). Since that time, much information and data about state Medicaid dental programs, policies and services has been collected for use by federal and state administrators, policy makers, professional organizations, dental schools, health plans, providers, and others for research, program evaluation, planning, policy development and administration.

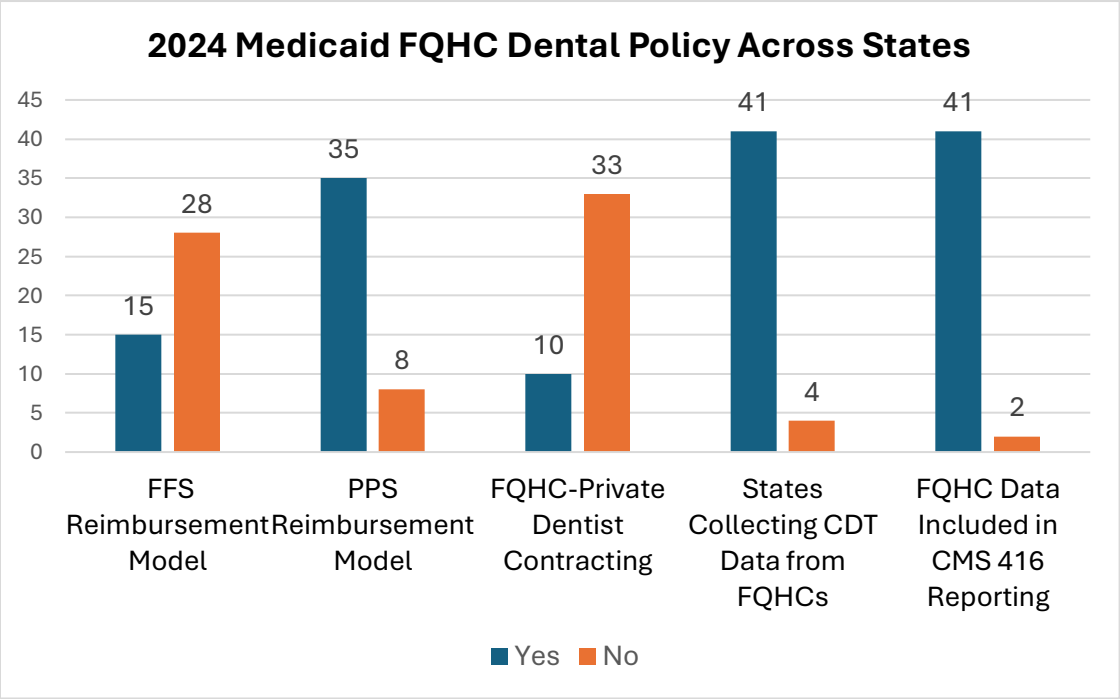
The MSDA National Profile is made up of five sections: *General State Information; Policy; Benefits; Administration; and Management.* Each year MSDA updates and publishes one or more section(s) of the National Profile to maintain a valid, relevant, and reliable resource for Medicaid and CHIP stakeholders. MSDA undertakes a multi-step process to ensure that information and data collected are accurate. This process includes an annual assessment of survey questions for relevance, updates where needed, re-design, implementation, and state member training. Questions are updated based on environmental changes in federal and state Medicaid and CHIP legislation, regulation and policy. Once the survey tool is finalized, the *MSDA National Medicaid and CHIP Oral Health Program Survey Questionnaire* is disseminated to state members.

A cross-sectional study design is used to document a snapshot of each state Medicaid and CHIP oral health program at a given point in time. MSDA employs this methodology because it is economical and like a census, information may be systematically obtained and recorded. It further allows for regular updates, comparisons within and across state programs, and helps to identify and assess program gaps, trends and best practices. The collection contains descriptive, quantitative, and qualitative information and data.

The *2024 National Profile of State Medicaid & CHIP Programs* focuses on relevant *POLICY* across the Medicaid and CHIP dental programs. ©

2024 Policy Report: FQHC Dental Reimbursement and CMS 416 Reporting				
Does your state use the Fee for Service (FFS) method to reimburse FQHCs for dental services?	**Does your state use the Prospective Payment System (PPS) or Encounter Rate method to reimburse FQHCs for dental services.**	**Do any FQHCs in your state contract with private dental provider offices?**	**Does your state receive CDT-level information for dental services delivered at FQHC's?**	**Does your state include dental services provided to children at FQHCs as part of your CMS-416 Reporting?**

Federally Qualified Health Centers (FQHC) serve as a safety-net delivering essential primary care services to vulnerable individuals across the US. All FQHCs are Medicaid providers and are reimbursed via a fee-for service (FFS) or perspective payment service (PPS) (also known as an *encounter rate),* methodology. Some FQHCs contract with private dental providers to deliver dental care to their health center patients. Each year, state Medicaid programs report use of services for enrollees in their Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program to CMS using the Form CMS-416. The purpose of these questions is to understand the degree to which states have the infrastructure and capacity to collect and subsequently report oral health services rendered at FQHCs and/or their contracted providers to CMS.



The graph to the left shows that 28 state Medicaid programs employ a FFS methodology to reimburse FQHCs, while 35 programs use the PPS.

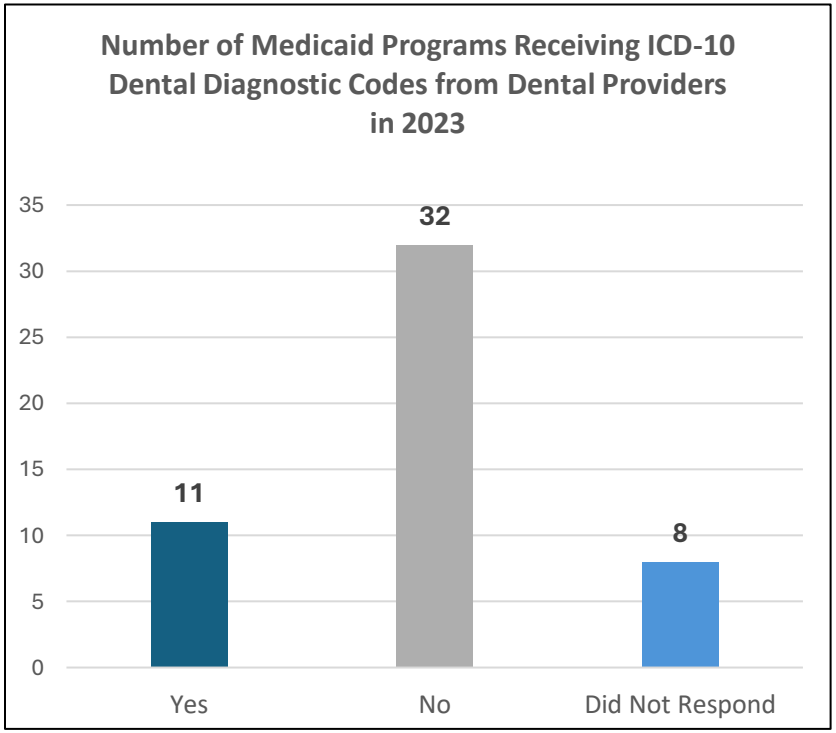
When asked about FQHCs contracting with private dental providers, only 10 state Medicaid programs responded that their FQHCs participate in FQHC-dental provider contracting.

Regarding annual the states capacity to collect and report CDT level data, 39 state Medicaid programs stated that they collect CDT-level data on claim forms submitted by FQHCs with the vast majority, (41) reporting that they have the infrastructure sand capacity to include such data on the I annual CMS-416 Report.

2024 Policy Report: ICD-10 Dental Diagnostic Codes

Does your state receive ICD-10 DENTAL DIAGNOSTIC CODES from dental providers on the dental provider claim form?

Despite new federal regulations requiring the use of ICD-10 dental diagnostic codes in dental claims processing by Medicare providers, use of such codes is not yet standard practice in dentistry as it is in Medicine. As a result, system gaps exist, with no formal mechanism for 1) measuring oral health status and outcomes; 2) documenting medical necessity; 3) integrating dental and medical services; 4) measuring oral *healthcare* equity; and 5) measuring oral *health* equity. The purpose of this question is to better understand and monitor the degree to which state Medicaid programs have the infrastructure and capacity to implement the use of (medical and/or dental) ICD-10 diagnosis codes by dental providers; and promote their use in Medicaid dental program administration across the country.



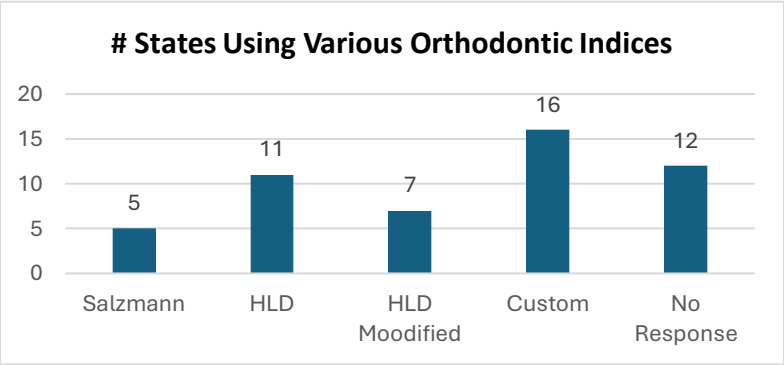
Results reveal that eleven (11) state Medicaid dental programs are implementing the use of ICD-10 dental diagnostic codes from dental providers on dental claim forms. Thirty-two (32) states reported that they are not, and an additional eight (8) states did not respond to this question.

Follow-up with the states that are implementing the use of ICD-10 dental diagnostic codes revealed that provider acceptance was very positive, and that most dental providers found the new ICD-10 policies to be easily implemented.

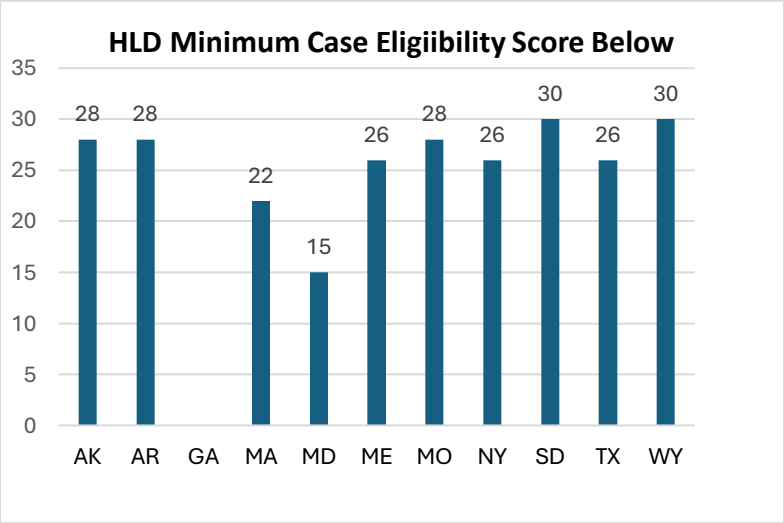
This information and data demonstrate that a viable solution exists to close these system gaps to advance oral health equity for all Medicaid and CHIP members.

2024 Policy Report: Orthodontics		
What tools does your state use to determine orthodontic eligibility?	**Please provide your state's minimum case eligibility Score.**	**Does your dental program reimburse the full case rate if the patient ages out before treatment is completed?**

Many state Medicaid dental programs and commercial dental plans use an orthodontic index to establish criteria for medical necessity and payment of dental claims. Several orthodontic indices currently exist. The following report reveals the indices currently being used by state Medicaid dental programs and their corresponding benchmarks for determining eligibility and coverage.



When asked what tools state Medicaid programs use to establish medical necessity for orthodontic services, thirty-nine (39) states responded to this question. Among the respondents, six (6) reported to use the Salzmann Index, eleven (11) the HLD Index; seven, (7) HLD Modified Index; and 16 reported the use of a custom designed tool. The graph to the left demonstrates the number of states using each of the identified indices.



First used in 1960, the HLD Index was developed to assist the state of New York in identifying qualifying patients to admit to its state dental rehabilitative program. The HLD is a quantitative, objective method for measuring malocclusion; however, it does not diagnose malocclusion. The HLD provides a single score, based on a series of measurements that represent the degree to which a case deviates from normal alignment and occlusion.

Among the eleven (11) states that reported to use the HLD Index, most states reported a case eligibility score between 26 and 30. One state, Maryland reported an eligibility score of 15; while another state, Georgia reported to use the tool but indicated that the final decision was based on the reviewer's assessment.

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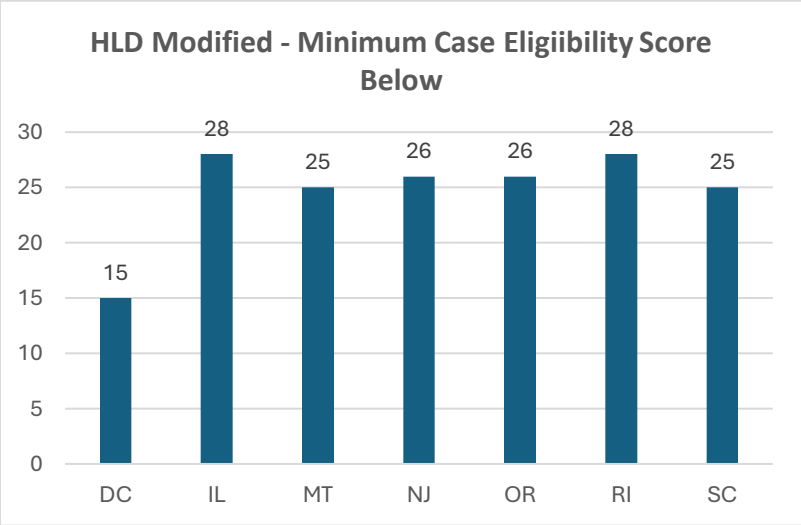
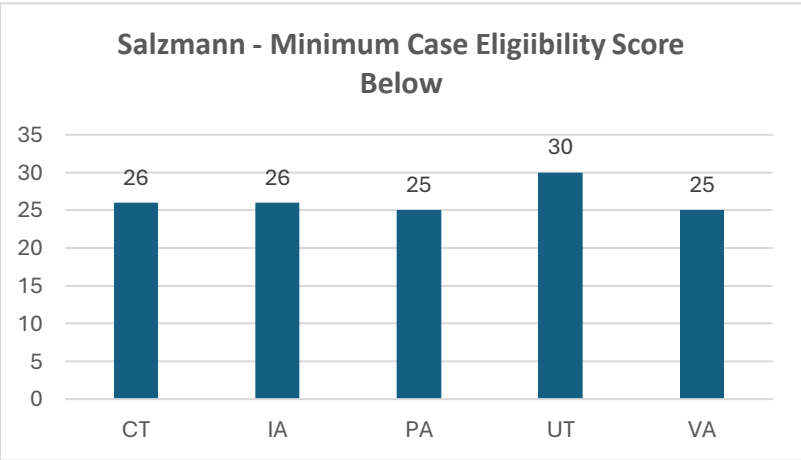


California Medicaid was the first state program to modify the HLD index to meet the unique needs of the agency. Changes were made to a number of the scoring components, while leaving the legacy framework in place. The HLD Modified is now implemented by state programs that use the basic components and scoring of the original HLD but make modifications based on their prevailing conditions. Some states have added other customizations outside of the Index that may include questions about treatment plan compliance and home care habits.

Seven (7) states reported to use the HLD Modified Index. Scores ranges between a low of 15 for the District of Columbia and 28 for Illinois and Rhode Island. The score used most often was 26.



Developed in 1967, the Salzmann Orthodontic Index, also known as the "Handicapping Malocclusion Assessment Record (HMAR)," is a scoring system used by orthodontists to evaluate the severity of a patient's malocclusion. Point values are assigned to intra- and inter-arch deviations and other aspects of bite misalignment to determine if orthodontic treatment is medically necessary. A higher score indicates a more severe malocclusion requiring treatment.

Of the states that reported to use the Salzmann Index, a score of 25 or 26 was most commonly used. One state, Utah, reported to use a score of 30.

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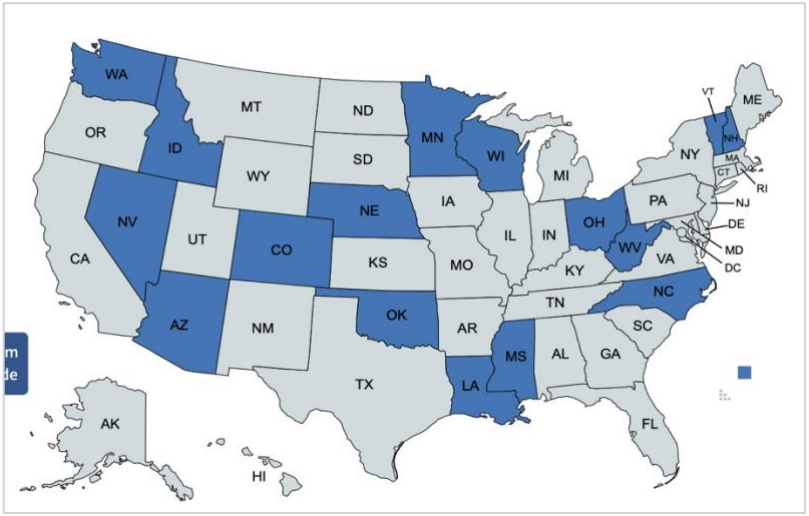
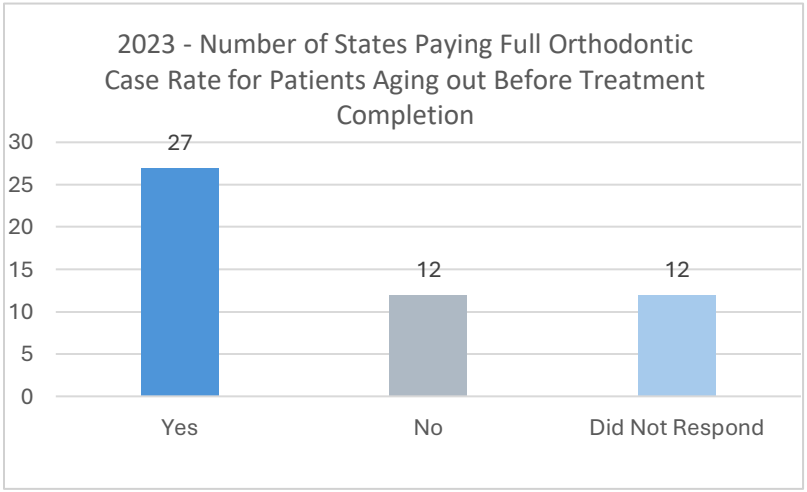


In 2024, sixteen (16) states reported to use their own custom-designed methodology to determine medical necessity for orthodontia. It appears that this strategy is a growing trend as some states have reported the indices listed above include *cosmetic criteria* which favors approval that may not be consistent with medical necessity criteria.

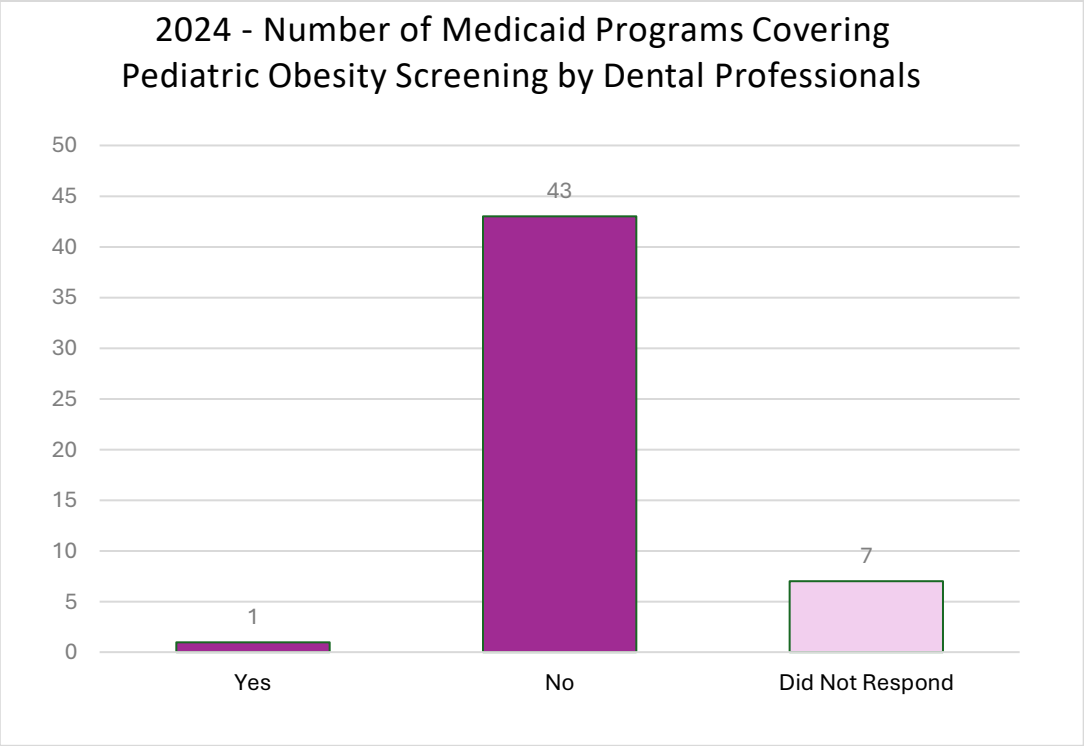


Orthodontic treatment is generally covered by Medicaid programs for children under age 21 and is typically paid using an incremental methodology that is contingent on the Member's continued Medicaid eligibility.

Since treatment and case completion can often overlap Medicaid eligibility status, states were asked if the full orthodontic case rate was covered if the member aged out of the program before completion. The graph shows that 27 state Medicaid programs cover the full case rate regardless of eligibility; 12 states do not; and 12 did not respond to the question.

2024 Policy Report: Pediatric Obesity

Does your state pay for Pediatric Obesity Screening performed by a dental professional?



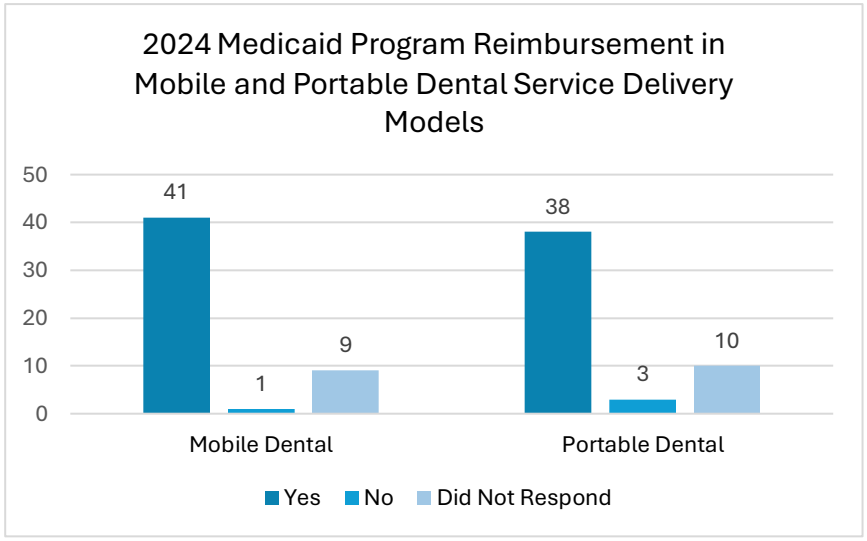
Obesity continues to prevail as an epidemic among children in the US. According to the Centers for Disease Control and Prevention (CDC), 19.3% of children ages 2-19 experience obesity.[1] To address this crisis, medical and dental healthcare providers have teamed up to screen children and intervene at earlier ages. This question was asked to identify state Medicaid Programs that cover these services by dental providers.

Among the 44 states reporting, one state indicated that they do cover obesity screening by dental providers using a CDT code, while 43 reported they did not. Here lies an opportunity for improved healthcare integration among primary medical and dental providers.

[1] https://www.cdc.gov/nchs/data/hestat/obesity-child-17-18/obesity-child.htm#table1

2024 Policy Report: Portable and Mobile Dental Policy	
Does your program reimburse for dental services when Mobile Dental Vans/Clinics are used?	**Does your program reimburse for dental services when Portable Dental Units are used?**

Over the last two decades great strides have been made toward advancing technology supporting the delivery of dental care services. These improvements are now evident in both portable and mobile dental infrastructure. Both mobile vans *and* portable units now provide greater capacity to serve as *dental homes*, allowing for the safe delivery of effective and efficient oral health care services to vulnerable Medicaid beneficiaries across the country.



According to the American Academy of Pediatric Dentistry (AAPD), *a Dental Home is the ongoing relationship between the dentist and the patient, inclusive of all aspects of oral health care delivered in a safe, culturally-sensitive, individualized, comprehensive, continuous, accessible, coordinated, compassionate, and patient- and family-centered way regardless of race, ethnicity, religion, sexual or gender identity, medical status, family structure, or financial circumstances.*

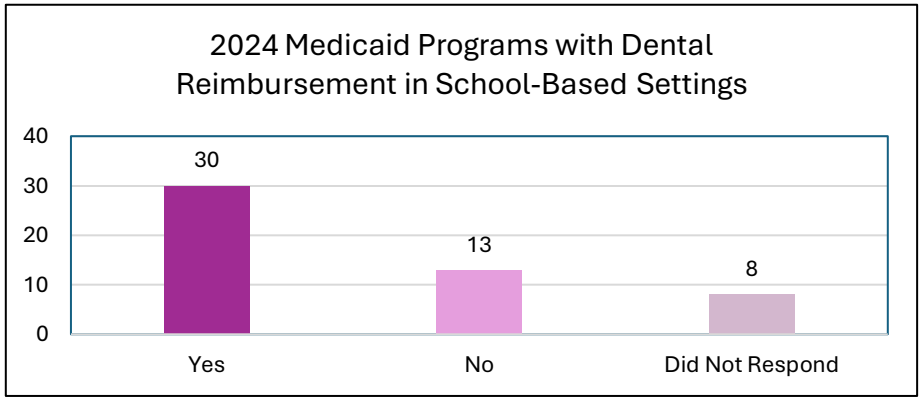
The dental home should be established no later than 12 months of age to help children and their families institute a lifetime of optimal oral health. A dental home addresses anticipatory guidance and preventive, acute, and comprehensive oral health care and includes referral to dental specialists when appropriate.[2]

To support the sustainability of such services in low-access areas, the use portable *and* mobile dental care delivery has become essential. In 2024, 41 state programs reported that they cover mobile dental services yet only 38 programs reportedly cover portable dental services. This data demonstrates that opportunity exists to expand Medicaid policy to include both the use of mobile and portable dental units to better affect dental care access.

[2] https://www.aapd.org/research/oral-health-policies--recommendations/Dental-Home/

2024 Policy Report: School-Based Dental Programs

Does your state reimburse for dental services provided in School-Based (SB) Programs?	Please list any coverage limitations.

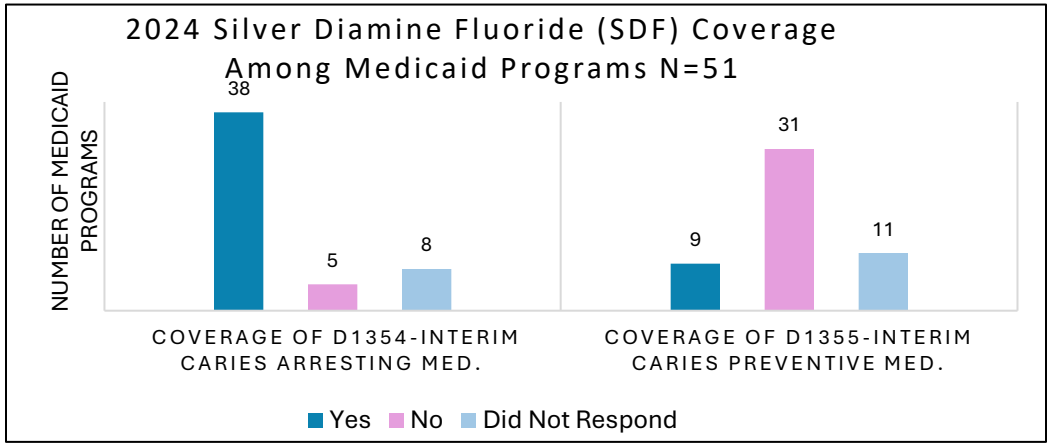


School-based dental programs operate as a dental home for many under-served Medicaid enrolled children. Thirty (30) state Medicaid dental programs reported that they reimburse for dental care delivered in school-based settings. An additional 13 reported that they do not.

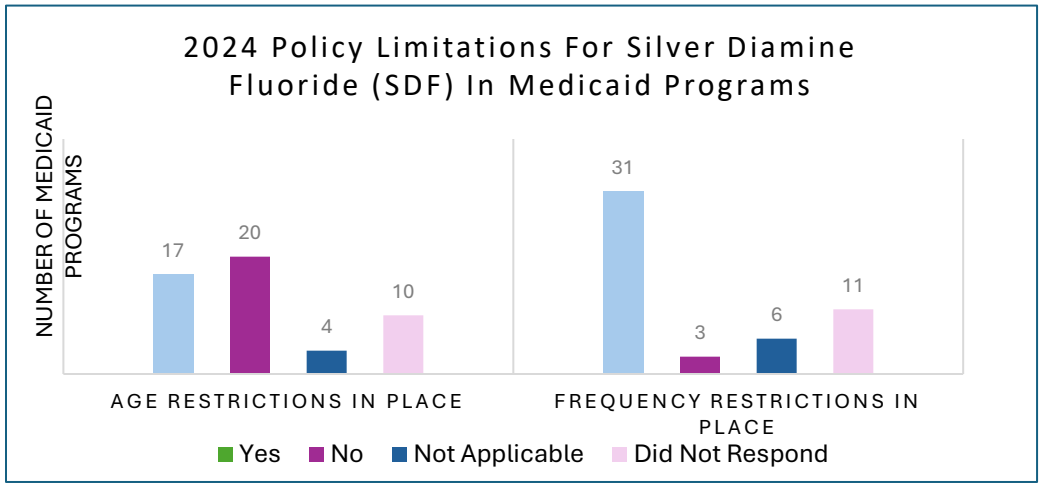
Among the states that reported to cover dental care in school-based settings, several described policy limitations. See Table below.

State	Coverage Limitations Reported
GA	In GA, the Department of Public Health (DPH) Districts and Boards of Health Dental Hygienists limit services in school-based settings to: D0270 Bitewing, single radiographic image; D0272 Bitewing, two radiographic images; D0274 Bitewings, four radiographic images; D0330 Panoramic radiographic image, 1 per 3 years; D1110 Prophylaxis-adult-pregnant women. 2 per year; D1120 Prophylaxis-child. 2 per year; D1206 Fluoride Varnish. 2 per year; D1208 Topical Fluoride; D1351 Sealant-per tooth, one per tooth in a 4-year period); D9995 Teledentistry – Real time encounter with initiating site and Dentist; D9996 Teledentistry - Information stored and forwarded to dentist for review; D0140 Teledentistry Exam
IA	Services provided by Title V Contractors are limited but billable based on a prescribed fee schedule: https://secureapp.dhs.state.ia.us/MedicaidFeeSched/X30.xml
ID	School services are provided through a separate contract for in-school services
IL	Only five preventive codes are allowed in the school-based dental program. D0120, D1120, D1208, D1206, D1351 and all claims must include one of the three risk assessment codes: D0601, D0602 or D0603 to be paid.
NH	Limited to prophylaxis, fluoride varnish, and sealants
NV	Limited to persons less than 21 years of age. Fillings are limited to the use of amalgam or tooth-colored restorations. Crowns are limited to stainless steel and composite resin repairs.
NY	All SBHC services are carved out of Managed Care reimbursement.

2024 Policy Report: Silver Diamine Fluoride-D1354 and D1355			
Does your state provide coverage for D1354 – Interim Caries Arresting Medicament application?	**Does your state provide coverage for D1355 – Interim Caries Preventive Medicament application?**	**Are there any age restrictions?**	**Are there any frequency restrictions?**



Scientific evidence demonstrates that fluoride is highly effective in preventing and reducing dental caries.[3] In 2016 Silver Diamine Fluoride (SDF) was introduced as a caries arresting medicament, with its preventive properties subsequently emerging. State Medicaid programs followed suit by establishing coverage for both services. In 2024, thirty-eight (38) states reported coverage for SDF D1354 with five (5) reporting that they did not cover it. In addition, only nine (9) states indicated that they covered SDF D1355 with thirty-one (31) reporting that the did not.



State program administrators were asked if certain limitations exist for SDF D1354 and/or D1355. Seventeen (17) states reported that age-related restrictions exist, while thirty-one (31) states reported frequency restrictions. If a state administrator answered "No" to the previous coverage questions, they answered "NA" to having policy limitations in place. The Table below provides specific policy limitations regarding age and frequency for SDF as reported by the states as well as Value-added coverage provided by third-party vendors.

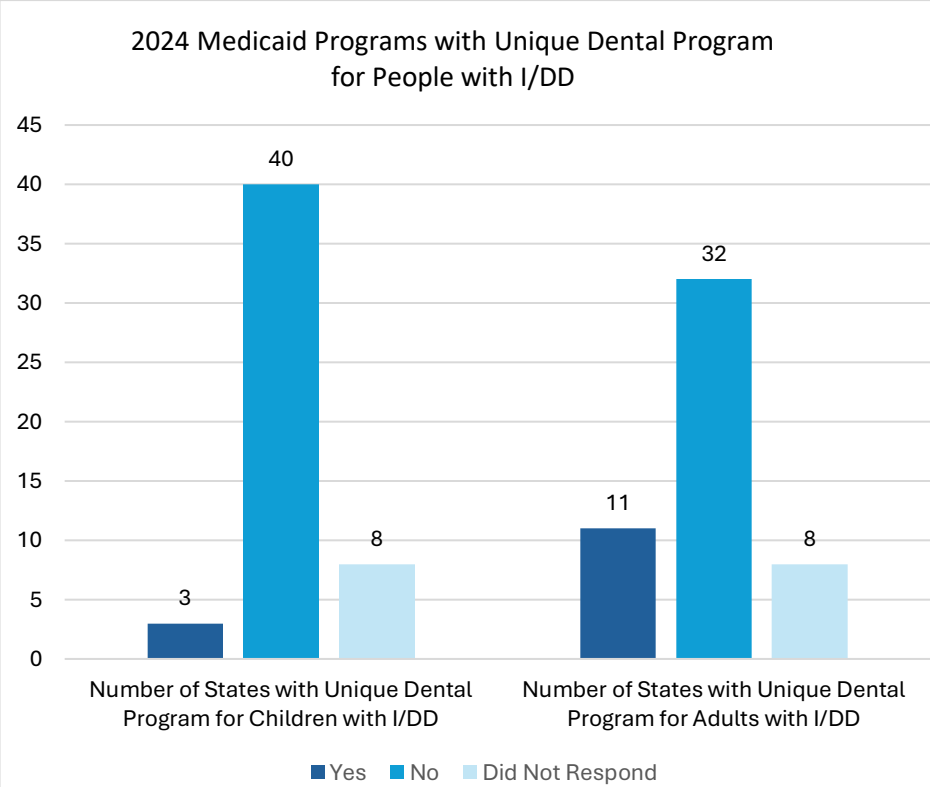
[3] https://pmc.ncbi.nlm.nih.gov/articles/PMC6500430/#:~:text=Thus%2C%20SDF%20becomes%20one%20of,treatment%20for%20lower%20income%20groups.

2024 Policy Report: Silver Diamine Fluoride-D1354 and D1355		
	Please describe restrictions for either D1354 or D1355.	**Do any third-party vendors cover D1354 and D1355 as a value-added service?**
AL	Limited to 5 per six calendar months. Limited to 4 applications per tooth per lifetime. Informed consent including pictures of SDF staining. No other treatment allowed on the same tooth on the same day of service. Tooth number must be noted on the dental claim form.	No
AR	Not a covered benefit.	Yes, Covered by Delta Dental of Arkansas as a value-added benefit.
AZ	Frequency for D1355 is 5 per day. Frequency for D1354 is 4 times per year per tooth.	No
CO	Children and Adults: Two of D1354 per 12 months per patient per tooth. Cannot be billed on the same day as D3110, D3120, or any D2000 series code. For IDD members: Four of D1354 per 12 months per patient per tooth.	No
CT	All teeth requiring SDF application in the oral cavity shall be treated in one visit and not over multiple appointments regardless of the type of provider, facility, clinic or Federally Qualified Health Center (FQHC) delivering the service. At the time of this policy bulletin, code D1354 with SDF is not a generally accepted standard to be used in conjunction with restorative treatment of the same tooth on the same date of service. If teeth treated with SDF are restored by the same billing provider within three months, DSS will recoup the D1354 fee, If in the rare instance, using the 'sandwich' technique with SDF and a permanent direct placement restoration, a PA should be submitted using the D1999 code for the use of the SDF.	No
DC	Not a covered benefit.	Yes, two (2) of three (3) managed care vendors cover the D1354 and D1355 as a value-added service.
GA	Both procedures are for under age 21 only. D1354 two applications per tooth and prior authorization, (Fee for Service requirement)	No
IA	See link: file:///C:/Users/hmiller2/Downloads/1962-FFS-D_CurrentDentalTerminology_CDT_D1354%20(2).pdf	No
ID	Two treatments per tooth per year.	No
IL	Can be applied to up to four teeth per day, provided teeth have no previous or same day history of restorative or endodontic treatment. Two applications per tooth per year for a maximum of six applications per lifetime.	No

KS	Twice per calendar year with 6 applications per tooth/lifetime.	
LA	Not a covered service.	Yes. On a limited basis for patients with special needs
MA	D1354 limited to members ages 0-20 years.	No
MD	D1354 is covered for children ages birth through six w/o a PA. A PA is required for children ages 7-20.	No
ME	Covered twice per tooth per year for members with a documented history of high caries. Medicament applications are not covered on teeth that have received a restorative service in the last twelve (12) months.	No
MI	Not a covered service.	No
MN	D1354 covered once per six months/tooth. Tooth number is required. Cannot be performed on same date as D1206 or D9910.	
MO	D1354 covered for children ages 1 through 5. One application per 6 months with a lifetime maximum of 4 applications per tooth. D1355 covered for children ages 0-14 years.	No
MS	Not a covered service.	No
NC	D1354 covered for members of all ages. Allowed once every six calendar months/tooth. Valid for tooth numbers A-T and 1-32. Limited to a total of four applications per tooth. D1355 covered for members ages five through fourteen years of age. Allowed for permanent first and second molars. Valid tooth numbers (02, 03, 14, 15, 18, 19, 30, and 31). Allowed once per lifetime.	No
ND	D1354 - Maximum of two per tooth per calendar year; Lifetime maximum of 4 applications per tooth; service authorization required for teeth requiring restoration (D2000-D2999) within 6 months of application by same treating dental office	No
NE	Topical fluoride and fluoride varnish are covered for adults and children at the frequency determined appropriate by the treating dental provider.	No
NH	D1354 treatment twice per tooth per lifetime	No
NJ	D1354 is allowed twice per rolling year without prior approval.	No
NV	Service limits: 1 service unit per 6 months/tooth. Non-covered for persons ages 21 years or older.	Yes. Liberty Dental provides SDF for adults with special needs ages 21 or older, and all enrolled adults
NY	Limitation listed on Page 36 for D1354 https://www.emedny.org/ProviderManuals/Dental/PDFS/Dental_Policy_and_Procedure_Manual.pdf	No. MMC plans are required to cover D1354. D1355 unknown.
OH	Not a covered service.	Yes. DentaQuest covers both Envolve covers D1354 SKYGEN covers D1354

OK	Available for primary and permanent teeth once every six (6) months for two (2) occurrences per tooth in a lifetime. The following criteria must be met for reimbursement: (i) A member is documented to be unable to receive restorative services in the typical office environment within a reasonable amount of time; (ii) A tooth that has been treated should not have any non-carious structure removed; (iii) A tooth that has been treated should not receive any other definitive restorative care for three (3) months following an application; (iv) Reimbursement for extraction of a tooth that has been treated will not be allowed for three (3) months following an application; and (v) The specific teeth treated and number and location of lesions must be documented.	
OR	D1354 Limited to a maximum of two applications per year.	Yes
PA	D1354 Limited to 1 per tooth per day, maximum of 10 teeth per day, 4 times per tooth per year (Under 21 years of age only; 6 per tooth per lifetime).	No
RI	Currently under age 21 only.	No
SC	Four applications per tooth/lifetime. Must be applied in conjunction w/ D0120, D0145, D0150, D9310.	No
SD	D1354 covered at a maximum of two applications per tooth, per year. A lifetime maximum of four treatments per tooth, per patient is allowed. Reimbursement for teeth requiring restoration prior to one year after application of Silver Diamine Fluoride will be reduced by the amount the provider was reimbursed for the application of Silver Diamine Fluoride when done by the same office.	Unknown
TX	D1354 is limited to once per lifetime per TID (A-T and 3, 14, 19, and 30). Denied if billed on the same date of service for the same TID as procedure code D1351 or D1352 by any provider. D1355 is not a benefit.	Yes. DentaQuest added SDF as value added service in 2020.
UT	D1355 is not a covered code D1354 is covered for all ages and is billed per tooth.	No
VA	D1354 - Up to 2x per lifetime	Unknown
VT	D1354 covered four per tooth per lifetime, no age restrictions.	No
WA	Two times per client, per tooth, in a 12-month period	No
WI	D1354 covered once per tooth, per six-month period for a maximum of five teeth per DOS for a maximum of four applications per tooth, per lifetime, per member. Not allowable on the same DOS as a restoration on same tooth. Reimbursable when services rendered by dentists, dental hygienists, and HealthCheck providers only. Frequency limitation may be exceeded up to four times per tooth per 12-month period for members with high caries risk. Providers are required to retain documentation demonstrating medical necessity.	Unknown
WV	Two applications per tooth per year.	No
WY	D1354-Covered for 0-20 years of age.	No

2024 Policy Report: State Programs for Members with Intellectual and Developmental Disabilities	
Does your state have a unique dental health plan or program for *children* with I/DD?	**Does your state have a unique dental health plan or program for *adults* with I/DD?**

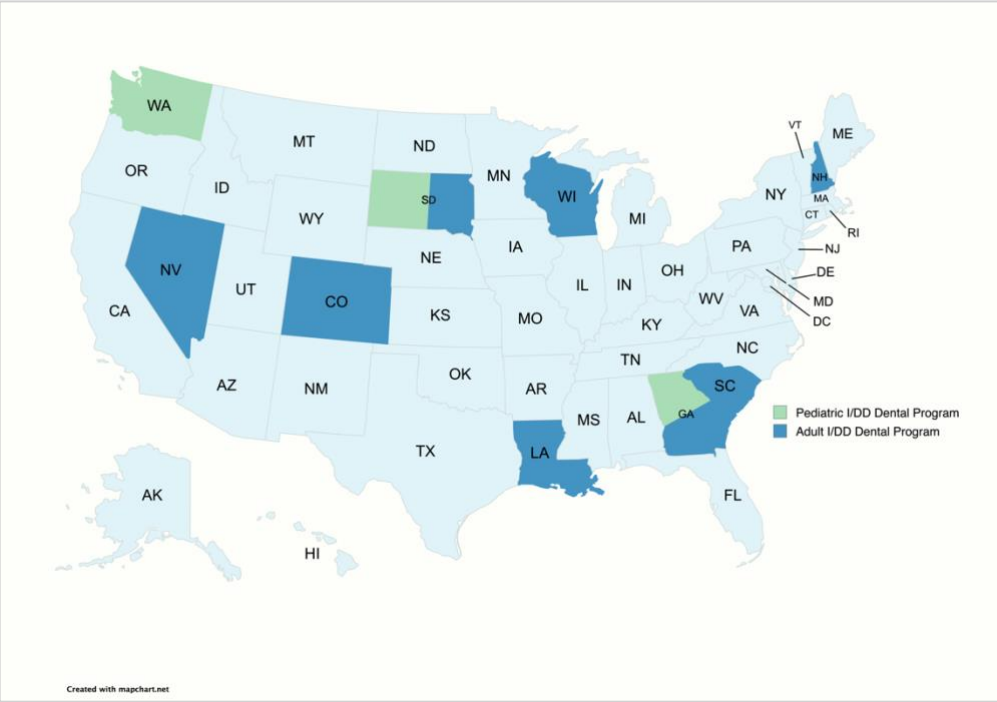


Individuals living with intellectual and developmental disabilities often experience complex medical and dental conditions with unique needs, often requiring additional support services, as well as supplementary healthcare. State Medicaid dental programs were asked whether they have a unique stand-alone dental plan/program for their members living with I/DD. Specifically states were asked to respond to this question for both children and adults.

The graph at the left demonstrates the number of that reported to have separate stand-alone programs. Three (3) state Medicaid programs indicated that they offer unique dental services for children; and eleven (11) indicated that they offer them for adults. The majority of states responded that they do not offer unique dental services to children and adults respectively, leaving tremendous opportunity to support a more person-centered approach to the delivery of dental care to this particularly vulnerable population. Eight (8) state Medicaid programs did not answer either question.

2024 Policy Report: State Programs for Members with Intellectual and Developmental Disabilities			
Does your state have a unique dental health plan or program for children with I/DD?	**If yes, under what authority does the program exist**	**Does your state have a unique dental health plan or program for adults with I/DD?**	**If yes, under what authority does the program exist?**

2024 State Programs for Medicaid Members with I/DD



In 2024, three (3) states reported that they have a stand-alone dental program for children with I/DD—Washington State; South Dakota; and Georgia. All indicated that these programs are implemented under the authority of their State Plan.

Eight states reported that they have a special program for their adult members with I/DD. These include Nevada, Colorado, Wisconsin, South Dakota, Georgia, Louisianna, South Carolina, and New Hampshire. Among these states, one operates under the State Plan; another operates under an 1115 Demonstration Waiver; and the remainder operate under a 1915c Home and Community Based Waiver Program.

State	2024 Policy Report: Medical Necessity Criteria
AK	Medical Necessity Criteria
AR	• A service is "medically necessary" if it is reasonably calculated to prevent, diagnose, correct, cure, alleviate, or prevent the worsening of conditions that endanger life, cause suffering or pain, result in illness or injury, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction and if there is no other equally effective (although more conservative or less costly) course of treatment available or suitable for the beneficiary requesting the service. For this purpose, a "course of treatment" may include mere observation or (where appropriate) no treatment at all. • The determination of medical necessity may be made by the Medical Director for the Medicaid Program or by the Medicaid Program Quality Improvement Organization (QIO). • Coverage may be denied if a service is not medically necessary in accordance with the preceding criteria or is generally regarded by the medical profession as experimental, inappropriate, or ineffective using unless objective clinical evidence demonstrates circumstances making the service necessary.
AZ	Medical necessity is determined at the MCO level.
CO	Medical Necessity Criteria
CT	Medical Necessity Criteria
GA	Medical Necessity Criteria
IA	• "The Contractor shall use appropriate licensed professionals to supervise all medical necessity decisions and specify the type of personnel responsible for each level of UM, including Prior Authorization and decision making. • The Contractor shall develop, implement, and adhere to written procedures documenting access to dentists and dental hygienists to assist in making medical necessity determinations. • Any decision to deny a Service Authorization request or to authorize a service in an amount, duration or scope that is less than requested shall be made by an oral health care professional who has appropriate clinical expertise in treating the Enrolled Member's condition or disease. Medical necessity determinations shall not be more restrictive than the Medicaid State Plan, State, and Federal law.
ID	Medical Necessity Criteria
IL	Medical Necessity Criteria and Dental Criteria
LA	Medical Necessity Criteria
MA	Medical Necessity Criteria
MD	Medical Necessity Criteria
ME	Medical Necessity or Medically Necessary services are those reasonably necessary medical and remedial services that are: • Provided in an appropriate setting.

	• Recognized as standard medical care, based on national standards for best practices and safe, effective, quality care. • Required for the diagnosis, prevention and/or treatment of illness, disability, infirmity or impairment and which are necessary to improve, restore or maintain health and well-being. • MaineCare covered services (subject to age, eligibility, and coverage restrictions as specified in other Sections of this Manual as well as Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT) requirements as detailed in Chapter II, Section 94 of this Manual). • Performed by enrolled providers within their scope of licensure and/or certification. • Provided within the regulations of this Manual.
MI	Medical Necessity Criteria
MN	Medical Necessity Criteria
MO	Medical Necessity Criteria
MS	Medical Necessity Criteria
MT	Medical Necessity Criteria
NC	North Carolina EPSDT policies [https://files.nc.gov/ncdhhs/epsdtpolicyinstructions.pdf] define medical necessity as: services which include any medical or remedial care that is medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problem]. This means that EPSDT covers most of the treatments a recipient under 21 years of age needs to stay as healthy as possible, and North Carolina Medicaid must provide for arranging for (directly or through referral to appropriate agencies, organizations, or individuals) corrective treatment the need for which is disclosed by such child health screening services. **"Ameliorate"** means to improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Even if the service will not cure the recipient's condition, it must be covered if the service is medically necessary to improve or maintain the recipient's overall health.
ND	Within any limitations which may be established by rule, regulation, or statute and within the limits of legislative appropriations, eligible recipients may obtain the medically necessary medical and remedial care and services which are described in the approved Medicaid and children's health insurance program state plan in effect at the time the service is rendered by providers. Services may include: Dental services. "Dental services" means any diagnostic, preventive, or corrective procedures administered by or under the supervision of a dentist in the practice of the dentist's profession and not excluded from coverage. Dental services include treatment of the teeth and associated structures of the oral cavity, and of disease, injury, or impairment which may affect the oral or general health of the individual. Dental services reimbursed under 42 C.F.R. 440.90 may only be reimbursed if provided through a public or private nonprofit entity that provides dental services.
NE	Medical Necessity Criteria
NH	Re-adopt with amendment He-W 502 (state.nh.us)

NJ	Medically Necessary Services: Services or supplies necessary to prevent, evaluate, diagnose, correct, prevent the worsening of, alleviate, ameliorate, or cure a physical or mental illness or condition; to maintain health; to prevent the onset of an illness, condition, or disability; to prevent or treat a condition that endangers life or causes suffering or pain or results in illness or infirmity; to prevent the deterioration of a condition; to promote the development or maintenance of maximal functioning capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capacities that are appropriate for individuals of the same age; to prevent or treat a condition that threatens to cause or aggravate a handicap or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the enrollee. The services provided, as well as the type of provider and setting, must be reflective of the level of services that can be safely provided, must be consistent with the diagnosis of the condition and appropriate to the specific medical needs of the enrollee and not solely for the convenience of the enrollee or provider of service and in accordance with standards of good medical practice and generally recognized by the medical scientific community as effective. Course of treatment may include mere observation or, where appropriate, no treatment at all. Experimental services or services generally regarded by the medical profession as unacceptable treatment are not medically necessary for purposes of this contract.
NV	Medical Necessity Criteria
NY	"Medically necessary" is set forth as "medical, dental and remedial care, services and supplies…" which are necessary to prevent, diagnose, correct or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap…" New York State Social Services Law § 365-a(2).
OH	Medical Necessity Criteria
OK	Medical Necessity Criteria
OR	The Oregon Health Evidence Review Commission (HERC) ranks health care conditions and treatment pairs in order of clinical effectiveness and cost effectiveness. The Prioritized List emphasizes prevention and patient education. • Treatments that help prevent illness are ranked higher than services that treat illness after it occurs. • Medicaid covers treatments that are ranked on a covered Prioritized List line for the client's reported medical condition. Medical Necessity Criteria
PA	Medical Necessity Criteria
RI	Medical Necessity Criteria
SC	Dental Services Provider Manual 5.11.2023 (scdhhs.gov)
SD	Medical Necessity Criteria
TX	
UT	Medical Necessity Criteria
VA	Office Reference Manual pg.39-52:

VT	Vermont Medicaid Provider Manual
WA	Medical Necessity Criteria
WI	Medical Necessity Criteria
WV	Medical Necessity Criteria
WY	Medical Necessity Criteria

2024 Policy Report: Medicaid Waivers		
	If your state is operating the dental program under any Waivers, please select all that apply.	***Enter Name and Description of "Other" Waivers***
State	**Waiver Authority**	**Description**
AR	1915b	
AZ	1115 Demonstration	• Covers an additional preventative dental benefit for the state's long-term care population. • Covers dental services in excess of the $1,000 limit to beneficiaries who are American Indian/Alaska Native (AI/AN) served in an IHS/638 facility. • Waiver: 11-W-00275/9
IA	1115 Demonstration	Iowa Health and Wellness Plan
ID	1915(b)	
KS	1115 Demonstration	
LA	1915(b)	
MA	1115 Demonstration	
ME	1115 Demonstration	
MO	Other	*Partnership for Hope (PFH) Waiver* • Dental services covered in this waiver include -topical fluoride applications and therapeutic dental treatment such as pulp therapy for permanent teeth; and limited provision of removable prostheses when masticatory function is impaired, when an existing prosthesis is unserviceable.
NE	1915 (b)	*Heritage Health (NE-03)*

NJ	1115 Demonstration	*NJ FamilyCare Comprehensive Demonstration*
NV	1915 (b)	*Dental Prepaid Ambulatory Health Plan Program (PAHP)* • To allow a PAHP, Dental Benefits Administrator to administer/deliver dental services to Medicaid recipients residing in urban Clark and Washoe Counties in Nevada.
OK	1115 Demonstration	*1915 (c) Waiver*
OR	1115 Demonstration	
PA	1915 (b)	*"Other" Concurrent 1915(b) and 1915(c) waivers* • The HealthChoices waiver has 3 components: 1) Fully capitated, risk-comprehensive physical health managed care; and 2) Behavioral health prepaid inpatient health plan; and 3) Fee-for-Service Selective Contracting (Specialty Pharmacy Drug Program). • The HealthChoices MCO or PIHP are responsible for providing, prior authorizing or making referrals for all medically necessary and appropriate primary care, behavioral, dental, pharmacy, specialty, and rehabilitation services. • Provides managed physical health care (to include dental services), and Long-Term Services and Supports (LTSS), including nursing facility, hospice, home and community-based services, through managed care organizations for individuals ages 21 or older who are dually eligible for Medicare and Medicaid and individuals who qualify for Medicaid LTSS, both in the community and in nursing facilities.
RI	1115 Demonstration	*RIteCare/RIte Smiles* • Established in 2006 and continues to serve children enrolled in EPSDT Program born on or after 2000.
TX	1915 (b) 1115 Demonstration	
UT	1915 (b)	• Waiver provides the authority for EPSDT and pregnant members to receive dental benefits under a managed care model. Choice of dental care delivery is also permitted.
VT	1115 Demonstration	• Waiver authority allows coverage of an enhanced dental benefit in excess of the limitations set forth in the State Plan for two waiver groups—Community Mental Health Rehabilitation and Treatment and Adults in the Developmental Disability Services groups, as these individuals may have more significant dental needs than other Medicaid enrollees. Complete coverage, limitations, and exclusions may be found in Vermont administrative rule.
WA	1915 (b) 1115 Demonstration	

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Medicaid | Medicare | CHIP Services Dental Association

2024 National Profile of State Medicaid & CHIP Dental Programs

Policy Report