



Government of the Virgin Islands of the United States

DEPARTMENT OF HUMAN SERVICES

Medicaid Division

Medicaid Program Public Notice **Dental Provider Policy Manual Public Comment**

September 14, 2026

The U.S. Virgin Islands (USVI) Medicaid Program is issuing this 30-day public notice requesting public review and comment on the proposed Medicaid Program Dental Provider Manual. This manual establishes guidelines and requirements for the provision, coverage, and billing of dental and oral health services under the Medicaid program.

Interested parties can share their feedback on the proposed manual with the USVI Department of Human Services (DHS) by submitting comments via email to: map.publiccomment@dhs.vi.gov. Please include “**Dental Manual Comment**” in the subject line of the email. The final day to submit comments will be October 14, 2026.



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DEPARTMENT OF HUMAN SERVICES

Medicaid Division

United States Virgin Islands Department of Human Services

Dental Manual

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1.0 General Information

The Virgin Islands (VI) Medicaid Program Dental Services Manual contains detailed information about the program's coverage of dental and oral health benefits, non-covered services, and coverage limitations. The VI Medicaid Program makes every attempt to help ensure that the information in the provider manual is reliable as of the date of issuance. Providers must comply with all applicable territory laws, regulations, and administrative guidelines, as well as applicable federal laws and regulations.

Information in this policy manual is included to assist the provider in determining how the VI Medicaid Program covers specific dental services. This information should be used in conjunction with all other applicable policies and provisions of the VI Medicaid Program's provider manuals, including the General Information Manual.

1.1 Provider Enrollment

The VI Medicaid Program recognizes Doctor of Dental Surgery (DDS), Doctor of Dental Medicine (DMD), and Doctor of Oral Maxillofacial Surgery (OMS) as eligible practitioners to provide general dental, orthodontic, and oral and maxillofacial surgery services to enrolled Medicaid members.

Dental providers must be enrolled with the VI Medicaid Program and must comply with licensure requirements and scope of practice standards established by territory law and licensing boards. Providers may only bill for services within their lawful scope of practice. General dentists, specialty dentists, and dual-degree practitioners who possess both dental Doctor of Osteopathic Medicine (DO) and medical Doctor of Medicine (MD) licenses may provide a variety of covered dental services in accordance with their license.

1.1.1 Dental Hygienist/Dental Assistants

Dental hygienists and dental assistants are not eligible to enroll individually as Medicaid providers or receive direct reimbursement. Enrolled and licensed dental providers can assign intra-oral tasks to employed dental hygienists or dental assistants within the scope of their practice under territory law and licensing standards. Services are to be billed under the dentist's National Provider Identifier (NPI).

1.2 Member Eligibility and General Coverage Rules

Providers must verify member eligibility on the date of service. Eligibility does not guarantee payment; payment depends on benefit coverage, medical necessity, prior authorization, the adult annual maximum expenditure, and compliance with billing rules.

When a member has other insurance coverage, Medicaid is generally the payer of last resort. Providers must follow program requirements for billing other coverage and submitting necessary documentation with Medicaid claims.

2.0 Benefit Overview

The VI Medicaid Dental Program covers medically necessary dental services, with comprehensive dental benefits for members under age 21 and a more limited benefit for adults, subject to program rules and medical necessity.

Medically necessary dental services are covered when:

- consistent with generally accepted standards of dental practice;
- clinically appropriate in type, frequency, extent, site, and duration;
- not primarily for convenience or cosmetic purposes; and
- the least costly, effective alternative when multiple appropriate options exist.

Coverage of dental services is generally limited to services furnished by Department of Health clinics and Federally Qualified Health Centers (FQHCs). Some services may require prior authorization.

Dental services provided by other qualified dental providers are covered only with prior authorization from the Department of Human Services Medical Assistance Program, except that preventive dental services and emergency dental services may be provided without prior authorization. For purposes of this section:

- **Preventive Dental Services** means services intended to promote oral health, prevent dental disease, and identify oral conditions at an early stage. Preventive dental services include, but are not limited to, oral examinations, prophylaxis (cleanings), fluoride treatments, sealants, oral health education, and other clinically appropriate services designed to prevent the development or progression of dental disease.
- **Emergency Dental Services** means services necessary to evaluate, stabilize, or treat acute dental conditions involving severe pain, infection, swelling, bleeding, trauma, or other circumstances requiring immediate dental intervention.

2.1. Members Under Age 21 (EPSDT)

Dental benefits for members under age 21 are provided under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, which requires comprehensive preventive services and medically necessary treatment to correct or ameliorate conditions.

Medicaid members under age 21 are eligible for covered diagnostic, preventive, restorative, periodontic, prosthodontics, maxillofacial prosthetics, oral and maxillofacial surgery, and orthodontics. Dental periodic screenings are based on recommended guidelines set forth by the American Academy of Pediatric Dentistry (AAPD) and Bright Futures. Prior authorization may be required for specific services and when service limits are exceeded. See Section 3 for additional information on EPSDT coverage.

See Appendix A: Covered Oral Health Services – Children Under Age 21 for a list of covered services and associated limits.

2.2 Members Age 21 and Older

Adults receive a comprehensive dental benefit subject to coverage criteria, program limits, and a calendar year annual maximum expenditure of \$3,500 for covered services.

Covered dental services for enrolled adults 21 years and older are limited to the following categories of service and may require prior authorization:

- 1) Emergency procedures to treat fractures, reduce pain, or eliminate infection
- 2) Diagnostic services
- 3) Preventive services
- 4) Restorative care
- 5) Endodontic services
- 6) Periodontal services
- 7) Prosthodontic services
- 8) Oral surgery

Prior authorization may be required for specific emergency services and when service limits are exceeded.

See Appendix B: Covered Emergency Oral Health Services for Adults Age 21 and Older for a list of covered services and associated limits.

See Appendix C: Covered Preventive and Restorative Services for Adults Age 21 And Older for covered services and associated limits.

Beginning January 1, 2027, adult dental services will have a coverage limit of \$3,500 per member per calendar year. See Section 8 of this manual for additional information on the annual limit.

3.0 Early and Periodic Screenings, Diagnosis and Treatment (EPSDT)

3.1 EPSDT Overview

EPSDT is a federal Medicaid requirement ensuring children and adolescents under age 21 receive comprehensive and preventive services, including dental health services. EPSDT includes screening, diagnostic, and treatment services needed to correct and ameliorate physical and oral health conditions.

3.2 Dental Periodicity Schedule

The VI Medicaid Program adopts the AAPD recommended dental periodicity schedule as the program's dental standard for service frequency for members under age 21. The periodicity schedule serves as a baseline ("floor") for preventive and diagnostic timing and supports establishing a dental home early in life.

Providers are to consult the current AAPD schedule and provide care at recommended intervals and as medically necessary under EPSDT. Refer to www.aapd.org for the AAPD periodicity schedule.

3.3 EPSDT Medical Necessity and Limit Overrides

For members under age 21, services that exceed typical frequency limits or other standard limitations can be covered when medically necessary under EPSDT. Requests must be supported by documentation demonstrating that the service is needed to correct or ameliorate a dental condition.

When requesting services beyond typical limits, documentation should include clinical findings, chart notes, diagnostic-quality radiographs (as indicated), photographs, periodontal charting when applicable, and a narrative explaining medical necessity under EPSDT.

4.0 Emergency Dental Services (All Ages)

The VI Medicaid Program covers medically necessary emergency dental services.

4.3.1 Definition of Emergency Dental Condition

An emergency dental condition is an acute oral health condition requiring immediate intervention to evaluate, stabilize or treat an acute dental condition. Emergency dental services include services to relieve severe pain, treat infection, swelling, manage uncontrolled bleeding, or address other trauma to teeth and supporting structures.

4.3.2 Covered Emergency Dental Services

When medically necessary, emergency dental services may include evaluation and stabilization; diagnostic radiographs needed to assess the condition; palliative treatment to relieve pain; treatment of acute dental conditions such as infection (including drainage when indicated); emergency extractions, and other services necessary to stabilize the emergency condition thus requiring immediate dental intervention.

The provider can evaluate the member and bill Medicaid for the emergency visit without prior authorization approval. If a follow-up visit is needed, the treatment plan must be submitted to the Medicaid program for review and prior authorization approval. Dental notes and any images must be attached.

See Appendix B: Covered Emergency Oral Health Services for Adults Age 21 and Older for more information.

4.3.3 Documentation for Emergency Services

Coverage of emergency dental services must be supported by documentation describing presenting symptoms, onset, clinical findings and diagnosis, services performed to stabilize the condition, and radiographs or images as clinically indicated.

4.3.4 Emergency Services and the Adult Annual Maximum

For adults age 21 and older, covered emergency dental services are **not** included in the \$3,500 annual maximum limit.

5.0 Covered Dental Benefits

Covered services are subject to medical necessity, documentation, age limits, utilization limits, any required prior authorization, and the adult annual maximum (with preventive services exemption as defined). The categories below broadly describe covered benefits. Specific coverage service limitations and special instructions are maintained in the VI Medicaid Dental Services, Appendices A, B, and C.

5.1 Diagnostic Services

Diagnostic dental services are covered when they are required to evaluate dental pain, infection, trauma, or suspected pathology; necessary to establish or update a diagnosis and develop or modify a treatment plan; and performed in accordance with generally accepted dental standards of care.

Diagnostic services include, but are not limited to, the following:

- Comprehensive, periodic, and problem-focused evaluations
- Emergency evaluations for pain, infection, or trauma
- Radiographs and other diagnostic imaging when clinically indicated
- Dental caries risk assessment and other diagnostic testing as necessary

5.2 Preventive Services

The VI Medicaid Program covers preventive dental services intended to prevent oral disease, detect conditions early, and maintain oral health.

Preventive services include, but are not limited to, the following:

- Oral examinations
- Prophylaxis (cleaning)
- Topical fluoride application
- Sealants for children and adolescents when indicated
- Oral health/hygiene instruction and anticipatory guidance (including pediatric counseling)
- Other clinically appropriate services designed to prevent the development or progression of dental disease

For adults age 21 and older, preventive dental services are **not** included in the \$3,500 annual maximum limit.

5.3 Restorative Services

Restorative dental services are covered when necessary to repair damaged teeth, restore oral function, and maintain dental health.

Restorative services include, but are not limited to, the following:

- Direct restorations (amalgam/composite)
- Interim restorations when medically necessary
- Stainless steel crowns and prefabricated crowns when indicated
- Conventional crowns when criteria are met and the tooth is restorable

5.4 Endodontic Services

Endodontic services are covered when medically necessary to treat pulp disease, infection, inflammation, or dental trauma. Services are covered when intended to preserve a restorable, functional tooth, rather than extraction, consistent with accepted dental practice standards. Services must be supported by clinical evaluation and diagnostic findings, including radiographs demonstrating pulpal or periapical pathology.

Endodontic services include, but are not limited to, the following:

- Pulp therapy for primary teeth when appropriate
- Root canal therapy when the tooth is restorable and meets criteria

Coverage is limited to restorable permanent teeth with adequate periodontal support. Teeth with advanced periodontal disease, insufficient structure for restoration, or a poor long-term prognosis may be excluded. One root canal treatment is covered per tooth per lifetime; retreatment is not covered.

5.5 Periodontal Services

The VI Medicaid Program covers periodontal services necessary to diagnose, treat, and manage diseases of the gums and supporting structures of the teeth, with the goal of preserving natural teeth and preventing tooth loss.

Periodontal services include, but are not limited to, the following:

- Periodontal evaluation and charting
- Scaling and root planing
- Periodontal maintenance following active therapy
- Periodontal surgery when medically necessary

Periodontal scaling and root planing are covered only when the services are **not** performed on the same date of service as prophylaxis, periodontal maintenance, scaling in the presence of generalized moderate or severe gingival inflammation, gingivectomy, or gingivoplasty.

5.6 Removable Prosthodontics

Removable prosthodontic services are covered when necessary to replace missing teeth, restore oral function, and maintain nutritional health and speech when fixed restorative options are not appropriate or feasible.

Removable prosthodontics services include, but are not limited to, the following:

- Complete dentures and removable partial dentures when medically necessary
- Repairs, relines, and rebases as clinically indicated
- Adjustments and follow-up care within defined time frames

When billing for a complete or partial denture, the date of service is the date the denture was delivered to the member. Reimbursement for a complete or partial denture includes all necessary adjustments, relines, repairs, duplication, etc. within **six** months of insertion.

For adults age 21 and older, dentures are **not** included in the \$3,500 annual maximum limit.

5.7 Fixed Prosthodontics (Fixed Bridges)

For members under age 21, fixed bridges may be covered pursuant to EPSDT when necessary to correct or ameliorate a dental or craniofacial condition and when no effective alternative treatment exists. Prior authorization is required. Supporting documentation requirements include an assessment of functional impairment, adequate periodontal support, prognosis of abutment teeth, and documentation of alternatives considered.

5.8 Implant Services

For members under age 21, dental implant and implant-supported prosthetics services may be covered pursuant to EPSDT when necessary to correct or ameliorate a dental or craniofacial condition and when no effective alternative treatment exists. Prior authorization is required. Supporting documentation must include a site evaluation, periodontal stability assessment, documentation of functional need and prognosis, and a restorative plan.

5.9 Oral and Maxillofacial Surgery

The VI Medicaid Program covers oral and maxillofacial surgical procedures that are medically necessary to diagnose, treat, or manage diseases, injuries, or defects affecting the oral cavity and related structures.

Surgical services include, but are not limited to, the following:

- Simple and surgical extractions
- Management of oral infection and abscess
- Alveoloplasty when medically necessary
- Biopsies when clinically indicated

5.10 Anesthesia, Sedation, and Adjunctive Services

Anesthesia in the form of general anesthesia, conscious sedation, or anxiolysis is covered when basic behavior guidance techniques have not been successful or when members cannot cooperate due to lack of psychological or emotional maturity and/or mental, physical, or medical disability. In addition, it may be required for members where the use of sedation may protect the developing psyche and/or reduce medical risk. Anesthesia is only covered when performed in collaboration with other covered services.

No dentist may induce central nervous system anesthesia without first having obtained an anesthesia permit and/or certificate from the Virgin Islands Board of Dental Examiners or from the applicable State Board of Dental Examiners or the level of anesthesia being used.

Local anesthesia and oral sedation are considered part of treatment procedures and may not be billed separately.

For more information on certain anesthesia services coverage criteria, see the Physician Services Provider Manual.

5.11 Orthodontics

For members under age 21, orthodontic services must be medically necessary and require prior authorization before services are provided. Orthodontics for cosmetic alignment without documented functional impairment or medical necessity are not covered. Clinical documentation, including a treatment plan of care, radiograph results, and photographs, must be available for prior authorization review and final determination of approval. If more than one comprehensive orthodontic procedure code is billed, the claim will be denied. One treatment of comprehensive orthodontia procedure codes per lifetime per member is covered.

For members age 21 and older, orthognathic surgical procedures with orthodontic treatment are covered if the needed surgery is documented in the original orthodontic plan of care and the request and the service began prior to the member's 21st birthday.

Orthodontic services require prior authorization regardless of primary insurance.

5.12 Fluoride Varnish Services by Primary Care Practitioners

The VI Medicaid Program reimburses enrolled primary care providers for fluoride varnish application to members under 21 years of age. The application of the fluoride varnish should include communication with and counseling of the child's caregiver, including a referral to a dentist.

USVI recognizes the following types of primary care providers to be eligible for payment of this service:

- Pediatrician
- General and Family Practice Doctor

- Advanced Practice Registered Nurse (APRN)
- Physician Assistant (PA)

The USVI allows coverage of four fluoride varnish applications per calendar year. Two may be performed by a dental provider, and two may be performed by a non-dental provider as specified above. The applications performed by non-dental providers must be provided and billed in conjunction with a comprehensive well-child exam using the appropriate Current Procedural Terminology (CPT) code. The applications performed by a dental provider can be reimbursed during a dental visit using the appropriate Current Dental Terminology (CDT) code. Billing both CPT and CDT procedure codes for the same procedure on the same date of service is prohibited, and any duplicate reimbursement is subject to recoupment by the Medicaid program.

Note: CPT codes must be billed on the Centers for Medicare & Medicaid Services (CMS) CMS-1500 claim form or an 837 electronic claim format with the rendering provider's NPI. CDT codes must be billed on the current American Dental Association (ADA) claim form or an 837 electronic format with the rendering dental provider's NPI.

6.0 Non-Covered Dental Services

Non-covered services include, but are not limited to:

- Experimental/investigational or services for research purposes
- Removal of primary teeth whose exfoliation is imminent
- Dental services when required prior authorization has been denied or not obtained
- Dental services for the convenience of the member, the member's caretaker, or the service provider
- Procedures for cosmetic purposes
- Anesthesia services when solely for the convenience of the member, the member's caretaker, or the service provider (See Section 5.10: Anesthesia)
- Dental services provided by providers not enrolled with USVI Medicaid
- Missed appointment charges, form completion charges, separate infection-control surcharges or office fees not recognized as covered benefits
- Duplicate/spare prostheses without medical necessity
- Material upgrades or premium options when standard materials are clinically appropriate and covered
- Local anesthesia and oral sedation are considered part of the treatment procedures and may not be billed separately

For additional information on non-covered services, please refer to the VI Medicaid Program's General Information Manual.

Non-covered services are not eligible for a USVI Department of Health and Human Services Fair Hearing or a Desk/Document review. See the Providers' General Information Manual for more information.

7.0 Prior Authorization

Medical necessity review criteria may be based on adaptations of dental standards developed by the VI Medicaid Program. These include, but are not limited to, the Periodicity and Anticipatory Guidance Recommendations by the AAPD, the American Academy of Pediatrics (AAP), the ADA, research-based/nationally accredited medical appropriateness criteria, or other appropriate criteria approved by the VI Medicaid Program.

If it is noted in an Appendix that a CDT code requires prior authorization, the service requires prior authorization regardless of the place of service. CDT codes that are not shown as requiring prior authorization still require PA if performed in a setting other than a Department of Health clinic, an FQHC, or on-island hospital, except emergency or preventive services. Inpatient hospitalization shall not be reimbursed when the service could be provided in an outpatient setting. Requests for prior authorization do not guarantee approval or payment.

The VI Medicaid program reserves the right, at its sole discretion, to authorize payment for covered dental services that exceed the adult annual maximum in limited, extenuating circumstances. Approval of services beyond the annual maximum requires prior authorization and is subject to Medicaid coverage rules, reimbursement limits, and applicable provider requirements. Approval of one exception does not guarantee approval of future requests.

Refer to the Dental Services Appendices A, B, and C for the list of covered services, specific procedure codes requiring prior authorization, and service limits.

Retrospective authorization is available in the following circumstances:

- A procedure/service denied by the member's primary payer, providing all requirements for the primary payer have been followed, including appeal processes; or
- Retroactive Medicaid eligibility.

8.0 Adult Annual Maximum Benefit

8.1 Annual Maximum Amount

Beginning January 1, 2027, adult Members have an annual maximum dental benefit of \$3,500 per member per calendar year for covered dental services.

The following services are not counted toward a member's annual dental services limit:

- Preventive dental services
- Emergency dental services
- Dentures

Accumulated annual maximum amounts are specific to the member's current Medicaid enrollment year and do not transfer from prior coverage periods. Remaining balances at the end of the year CANNOT be carried over to the following year.

8.2 Annual Maximum Limit Calculation

The annual maximum dental benefit is calculated on a calendar year basis, beginning January 1 and ending December 31. The annual maximum resets automatically at the start of each new calendar year and is not prorated based on the member's enrollment date or changes in eligibility during the year.

Claims are applied toward the annual maximum based on the order in which they are processed and paid by Medicaid, not the order in which they are rendered. Providers are encouraged to submit claims in a timely manner to avoid unexpected denials.

The annual maximum is based on the Medicaid allowed amount paid for covered non-preventive and non-emergency services during the calendar year. Enrolled dental providers can view whether a procedure code has been previously used for eligible Medicaid members when logged into their Trading Partner Account (TPA).

Verification of remaining annual maximum benefits is not a guarantee of payment. All claims remain subject to eligibility, coverage, medical necessity, prior authorization, and program limitations in effect on the date the services are rendered.

Denials resulting solely from exhaustion of the annual maximum are not subject to appeal unless the member or provider believes the annual maximum was applied incorrectly.

8.3 Member Financial Liability After the Maximum Is Met

After the \$3,500 annual maximum is reached for covered, non-preventive services, non-emergency services, and additional non-exempt services are not payable by Medicaid for that benefit year. These services may become the member's responsibility if the provider has complied with program rules regarding member notice and consent for non-covered or non-payable services.

8.4 Impact on Staged Procedures (Crowns, Implants, Etc.)

Staged services frequently occur across multiple visits. The annual maximum is applied as the covered services are rendered and paid within the calendar year. If the remaining annual maximum is insufficient to cover a later stage, Medicaid may deny payment for that later stage even if earlier stages were paid.

Provider best practices include checking remaining annual maximum before initiating high-cost staged treatment; sequencing care in clinically appropriate phases; and documenting member communication regarding potential financial responsibility.

9.0 Documentation Requirements

Documentation requirements for dental services include, but are not limited to:

- A referral for treatment
- The primary diagnosis and appropriate CDT code for service to be provided
- A treatment plan
- Radiographs
- Photos, when appropriate
- Dental molds, when appropriate
- Documentation to justify medical necessity
- Prior authorization, when applicable

10.0 Billing and Reimbursement

Providers must bill dental services in accordance with nationally recognized dental coding standards and VI Medicaid policy requirements.

Dual-degree practitioners, such as an MD or DO with a DDS/OMS license, may bill CPT or CDT procedure codes for dental/oral maxillofacial facial services within their scope of practice. The practitioner may bill a combination of the appropriate CPT and CDT codes for the services provided. However, duplicate billing of a service or part of a service by billing CPT and CDT codes for the same service is not allowed. These practitioners are assigned both a medical and dental provider number.

Additional dental services billing and reimbursement guidance includes, but is not limited to:

- CDT: all oral surgery services must be billed using the most current ADA CDT codes that accurately describe the procedure performed.
- Code specificity: providers must bill the most specific code available and cannot unbundle or fragment procedures to obtain additional reimbursement.
- Single procedure reporting: when multiple procedures are components of a more comprehensive surgical service, only the primary procedure is reimbursable, unless separate reimbursement is explicitly permitted by policy.
- Tooth-specific reporting: claims must include the correct tooth number, quadrant, or arch, as applicable.

The VI Medicaid program will NOT reimburse for services that involve any of the following:

- Use of an unlisted code when a national CDT code is available
- Unbundled CDT codes

Revision History

The revision history identifies the document version number, date, changes made to the document, and a brief description of revisions applied.

Table 1: Version History

Document Version #	Date	Revisions Applied
1.0	September 2026	Initial Publication

DRAFT