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**State/Territory Name: IA**

**State Plan Amendment (SPA) #: 17-0011**

This file contains the following documents in the order listed:


1) Approval Letter
2) Summary Form (with 179-like data)
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 East 12th Street, Suite 355
Kansas City, Missouri 64106

**Division of Medicaid and Children's Health Operations**

October 30, 2017

Jerry R. Foxhoven, Director
Department of Human Services
Hoover State Office Building
1305 East Walnut, 5th Floor
Des Moines, IA 50319-0114

Dear Mr. Foxhoven:

On September 15, 2017, the Centers for Medicare & Medicaid Services (CMS) received Iowa's State Plan Amendment (SPA) transmittal #17-0011. This SPA better defines the dental benefit available to adults under the full benefit package and the basic benefit package.

SPA #17-0011 was approved October 27, 2017, with an effective date of July 1, 2017, as requested by the state. Enclosed is a copy of the CMS-179 Summary Form, as well as the approved pages for incorporation into the Iowa State Plan.

If you have any questions regarding this amendment, please contact Karen Hatcher or Sandra Levels, at (816) 426-5925.

Sincerely,

10/30/2017

James G. Scott
Associate Regional Administrator
for Medicaid and Children's Health Operations

Sign

Enclosure

cc:
Mikki Stier
Alisa Horn
Jennifer Steenblock

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

# TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

**FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER: 17 — 011
2. STATE: IOWA
3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: July 1, 2017

5. TYPE OF PLAN MATERIAL (Check One)

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☑ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION

7. FEDERAL BUDGET IMPACT
a. FFY 2017 $ ~~(3,844,258.00)~~ 0 *
b. FFY 2018 $ ~~(15,273,706.00)~~ 0 *

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Supplement 2 to Attachment 3.1-A, Pages 21, 22, 23, 24

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Supplement 2 to Attachment 3.1-A, Pages 21, 22, 23,2 4

10. SUBJECT OF AMENDMENT
SPA is to better define the Medicaid dental benefits available for Medicaid enrollees.

11. GOVERNOR'S REVIEW *(Check One)*
☑ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED

12. SIGNATURE OF STATE AGENCY OFFICIAL

13. TYPED NAME: Jerry R. Foxhoven

14. TITLE: DIRECTOR

15. DATE SUBMITTED: 9-15-17

16. RETURN TO
Jerry R. Foxhoven
DIRECTOR
DEPARTMENT OF HUMAN SERVICES
1305 EAST WALNUT 5TH FLOOR
DES MOINES IA 50319-0114

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED: September 15, 2017

18. DATE APPROVED: October 27, 2017

**PLAN APPROVED - ONE COPY ATTACHED**

19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2017

20. SIGNATURE OF REGIONAL OFFICIAL

21. TYPED NAME: James G Scott

22. TITLE: Associate Regional Administrator for Medicaid and Children's Health Operations

23. REMARKS
* Pen and ink change per email dated 10.17.17

FORM CMS-179 (07/92) *Instructions on Back*

State/Territory: Iowa

## 10. DENTAL SERVICES

Dental services, as defined in 42 CFR 440.100, are covered for children and adults and must be medically necessary for the prevention, diagnosis and treatment of dental disease or injuries. The following limitations apply to dental services, except for children under 21 years of age for which medically necessary services are covered in accordance with the EPSDT provision. Limits can be exceeded based on medical necessity.

### Full Dental Benefits

A. *Preventive services.*

a. Oral prophylaxis, including necessary scaling and polishing. *Limitation:* Once in a six-month period except for persons who, because of physical or mental disability, need more frequent care.

b. Topical application of fluoride. *Limitation:* Once in a 90-day period. (This does not include the use of fluoride prophylaxis paste as fluoride treatment.)

c. Pit and fissure sealants. *Limitation:* Covered on first and second deciduous and permanent molars only for children through 21 years of age and for others who have a physical or mental disability that impairs their ability to maintain adequate oral hygiene.

B. *Diagnostic services.*

a. Comprehensive oral evaluation. *Limitation:* maximum of 1 every 3 years per dentist.

b. Periodic oral examination. *Limitation:* maximum of 2 per 12 months, 6 months apart.

c. Full mouth radiograph survey consisting of a minimum of 14 periapical films and bitewing films. *Limitations:* Once in a 5year period, except when medically necessary to evaluate development, and to detect anomalies, inuries and diseases. Full mouth radiograph surveys are not payable under the age of six.

d. Supplemental bitewing films. *Limitations:* Once in a 12-month period.

e. Single periapical films, intraoral radiograph, occlusal, extraoral radiograph, posterior-anterior and lateral skull and facial bone radiograph, survey film, temporomandibular joint radiograph, and cephalometric film when medically necessary.

C. *Restorative services.*

a. Treatment of dental caries in those areas which require immediate attention. *Limitation:* Restoration of incipient or nonactive carious lesions are not covered.

b. Amalgam alloy and composite resin-type filling materials. *Limitation:* Once for the same restoration in a two-year period. An amalgam restoration is covered following a sedative filling in the same tooth only if the sedative filling was placed more than 30 days previously.

c. Stainless steel crowns are covered when a more conservative procedure would not be serviceable. *Limitation:* Stainless steel crowns with a resin window are limited to anterior teeth.

d. Laboratory fabricated crowns. Prior authorization is required. *Limitation:* Noble metals are limited to individuals who are allergic to all other restorative materials.

e. Cast post and core, post and composite or amalgam in addition to a crown. *Limitation:* Covered if a tooth is functional and the integrity of the tooth would be jeopardized by no post support.

D. *Periodontal services.* Full mouth debridement is covered once every 24 months and is not allowed on the same date of service when prophylaxis or other periodontal services are provided. Periodontal treatment procedures require prior authorization.

E. *Endodontic services.* Covered when there is a fair to good prognosis for maintaining the tooth. Endodontic retreatment requires prior authorization.

F. *Orthodontic services.* Covered for a severe, handicapping malocclusion. Prior authorization is required. *Limitation:* Not covered for enrollees 21 years of age and over.

G. Reserved

H. *Prosthetic services.*

a. An immediate denture or a first-time complete denture including six months' post-delivery care when provided to establish masticatory function. *Limitations:* Immediate and first-time complete dentures are covered only once following the removal of teeth it replaces.

b. Removable and fixed partial dentures require prior authorization. *Limitations:* A missing anterior tooth must have adequate space for replacement with a partial denture. Partial dentures replacing missing

posterior teeth are not covered when there are at least eight posterior teeth in occlusion. Fixed partial dentures are covered only for members who have a physical or mental condition that precludes the use of a removable partial denture, or who have a full denture in one arch and a fixed partial denture replacing posterior teeth is required to balance occlusion in the opposing arch.

c. Replacement dentures. *Limitations:* Replacement of immediate, complete, removable and fixed partial dentures requires prior authorization and is limited to once in a five-year period. When the denture is lost, stolen, or broken beyond repair one replacement is allowed during the five-year period. Prior authorization is also allowed for more than one denture replacement per arch within five years when the member has a medical condition that necessitates thorough mastication. Replacement due to resorption is not covered.

d. Relines. *Limitation:* Chairside relines and laboratory processed relines are covered only once per prosthesis every 12 months.

e. Tissue conditioning. *Limitation:* Covered twice per prosthesis in a 12-month period.

f. Repairs. *Limitation:* Only two repairs per prosthesis are allowed in a 12- month period.

f. Obturator. *Limitation:* For surgically excised palatal tissue or deficient velopharyngeal function of cleft palate patients.

k. Adjustments to a complete or removable partial denture. *Limitation:* If medically necessary after six months' post-delivery care.

I. *Implants.* Covered when a conventional denture cannot be used due to missing
significant oral structures as a result of cancer, traumatic injuries, or developmental defects such as cleft palate. Prior authorization is required.

G. *Treatment in a hospital.* Covered only when the mental, physical, or emotional condition of the patient prevents the dentist from providing necessary care in the office.

Basic Dental Benefits

As provided under the authority of section 1115 Iowa Dental Wellness Plan waiver approved

on July 27, 2017 and represent a subset of the full dental benefits listed above.

1. Periodic evaluation - *Limitation*: Maximum of 2 per 12 months, 6 months apart.
2. Comprehensive evaluation - *Limitation*: maximum of 1 every 3 years per dentist.
3. Problem focused evaluation
4. Periodontal comprehensive evaluation - *Limitation*: maximum of 1 per 12 months.
5. Oral prophylaxis, including necessary scaling and polishing - *Limitation*: Once in 6-month period except for persons who, because of physical or mental disability, need more frequent care.
6. Periodontal maintenance - *Limitation*: maximum of once every 3 months.
7. Pulp vitality test
8. Sedation
9. Tooth re-implantation/splinting
10. Incision and drainage of abscess
11. Periapical/panoramic radiographs - *Limitation*: maximum of 1 every 5 years, except when medically necessary to evaluate development, and to detect anomalies, injuries and diseases.
12. Pulpal debridement and pulpotomy
13. Office visit after regularly scheduled hours
14. Biopsy
15. Palliative treatment of dental pain
16. Extraction and surgical removal of residual tooth roots
17. Surgical extraction, impactions