

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
JFK Federal Building, Government Center
Room 2275
Boston, Massachusetts 02203



CENTERS for MEDICARE & MEDICAID SERVICES

Division of Medicaid and Children's Health Operations / Boston Regional Office

September 20, 2011

Nicholas A. Toumpas, Commissioner
Department of Health and Human Services
129 Pleasant Street
Concord, New Hampshire 03301-3857

Dear Mr. Toumpas:

We are pleased to enclose a copy of approved State plan amendment (SPA) 11-002 with an effective date of June 1, 2011, as requested by your agency.

This SPA transmitted a proposed amendment to New Hampshire's approved Title XIX State plan reflecting updates and revisions in the NH Medicaid dental program including the restructuring of the billing process for orthodontia, updating treatment frequencies and ages to industry standards, and applying prior authorization requirements necessary to ensure quality and appropriate care. During the approval process, the State assured that children entitled to early and periodic screening, diagnostic, and treatment (EPSDT) services would continue to receive the full extent of these benefits.

If there are any questions, please contact Angel Miller. She can be reached at Angel.Miller@cms.hhs.gov or 617-565-1324.

Sincerely,

/s/

Richard R. McGreal
Associate Regional Administrator

Enclosure

cc: Kathleen Dunn, Medicaid Director
Dawn Landry, State Plan Coordinator
Diane Peterson, Medicaid Policy Administrator

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL	1. TRANSMITTAL NUMBER: 11-002	2. STATE NH
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
FOR: HEALTH CARE FINANCING ADMINISTRATION		4. PROPOSED EFFECTIVE DATE June 1, 2011
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		

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: 42 CFR 440.100; 42 CFR 441, Subpart B; 42 CFR 440.230(d)	7. FEDERAL BUDGET IMPACT: no fiscal impact
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8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 3.1A, page 4a Attachment 3.1B, page 4a Attachment 4.19B, page 2 Attachment 4.19B, page 2a	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 3.1A, page 4a, TN 01-11 Attachment 3.1B, page 4a, TN 99-08 Attachment 4.19B, page 2, TN 07-010 Attachment 4.19B, none; 2a is new page for overflow
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10. SUBJECT OF AMENDMENT:
Dental Updates and Improvements

11. GOVERNOR'S REVIEW (Check One):

GOVERNOR'S OFFICE REPORTED NO COMMENT OTHER, AS SPECIFIED: comments, if any, will follow

COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL	16. RETURN TO: Dawn Landry Division of Family Assistance/Brown Building Department of Health and Human Services 129 Pleasant Street Concord, NH 03301
13. TYPED NAME: _____	
14. TITLE: Commissioner	
15. DATE SUBMITTED: June 22, 2011	

FOR REGIONAL OFFICE USE ONLY	
17. DATE RECEIVED: June 22, 2011	18. DATE APPROVED: September 20, 2011
PLAN APPROVED - ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: June 1, 2011	20. SIGNATURE OF REGIONAL OFFICIAL:
21. TYPED NAME: Richard R. McGreal	22. TITLE: Associate Regional Administrator

23. REMARKS:

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED

Title XIX – NH
Attachment 3.1-A
Page 4a

9. Clinic Services

Out-of-state clinic services require prior authorization from the Department. Such payment authorization may be given only if substantiated by the attending physician's statement of medical necessity.

10. Dental Services

Treatment covered for recipients under 21 includes: (a) prophylaxis every 150 days, (b) restorative treatment, (c) periodic examinations, no more frequently than every one hundred fifty days, unless they are medically necessary to diagnose an illness or condition, (d) vital pulpotomy, (e) extractions of symptomatic teeth, (f) extractions of asymptomatic teeth subject to prior authorization, (g) third molar extraction subject to prior authorization, (h) general anesthesia and nitrous oxide analgesia (i) orthodontic therapy subject to prior authorization, (j) x-rays including complete or panoramic every 5 years, bitewings every 12 months if medically necessary, and all types regardless of limits if required to complete a differential diagnosis, (k) palliative treatment, (l) removable prosthetic replacement of permanent teeth, subject to prior authorization, (m) topical fluoride treatment two times/year until age 15, (n) endodontia, including root canal therapy, (o) crowns, (p) periodontic treatment limited to prophylaxis, scaling, and root planing, (q) sealants for permanent and deciduous molars every 5 years until age 17, (r) surgical periodontal treatment subject to prior authorization, and (s) any other services that meet EPSDT medical necessity criteria as determined by the Department. Any limits to services do not apply to EPSDT recipients as long as medical necessity criteria as determined by the Department have been met.

Dental services covered for recipients 21 and over for the treatment for relief of acute pain or elimination of acute infection are: (a) palliative treatment, (b) extraction of the causative tooth or teeth, (c) treatment of severe trauma, (d) surgical procedures performed in a hospital, and (e) x-rays for areas described above.

Prior authorization from the Department is also required for (a) orthodontic therapy considered under the EPSDT medical necessity provisions, and (b) services not listed but identified in an EPSDT screening. Prior authorization for all orthodontic therapy is granted based upon substantiation of the meeting of conditions specified by the Department. Orthodontic therapy is covered only until the recipient reaches the age of 21.

11. Physical Therapy and Related Services

When provided by a home health agency, visiting nurse association, or independent therapist, these services are limited to eighty (80) 15-minute units per recipient per state fiscal year. The eighty (80) units may be used for one type of therapy or in any combination of therapies in an outpatient setting. Prior authorization from the Department is required when therapy services are prescribed over the service limit.

Services provided by a rehabilitation center are limited to twelve (12) visits per recipient per fiscal year for all types of services except therapies which are subject to the above limits.

TN No: 11-002
Supersedes
TN No: 01-11

Approval Date 9/20/11

Effective Date: 06/01/11

**PAYMENT RATES FOR ALL TYPES OF CARE OTHER THAN INPATIENT
HOSPITAL, SKILLED NURSING, OR INTERMEDIATE NURSING CARE SERVICES**

7. **Home Health Care Services** – Payment rates for nursing and home health aide services are established in accordance with state statute at RSA 161:4, VI(a), RSA 161:4, VI(b), and RSA 126-A:18-a. The reimbursement methodology is detailed in the department's rules at He-W 553. A unit means a 15 minute unit. Skilled nursing services are reimbursed a flat rate per visit. Home health aide visits composed of fewer than 8 units of direct care time are reimbursed a flat rate per visit. Home health aide visits composed of eight or more units of direct care time are reimbursed a flat rate per unit of direct care time. The agency's rates were set on April 1, 2010 in accordance with DHHS rules at He-W 553, and are effective for services provided on or after that date. Physical, occupational, and speech therapy/audiology services are reimbursed a per unit rate set by the department pursuant to NH RSA 161:4, VI and in accordance with # 11 below. Medical supplies, equipment and appliances are reimbursed at rates set by the department pursuant to NH RSA 161:4, VI. Additionally, in accordance with NH RSA 126-A:3, III, no provider shall bill or charge the department more than the provider's usual and customary charge. The fee schedule, which is applicable to all public and private providers of home health care services, can be accessed at www.nhmedicaid.com. For equipment which is prior authorized, the approved reimbursement amount, which is based upon the provider's acquisition and retail costs and other individualized circumstances of the request such as rental/trial periods, accessories, etc., is provided on the prior authorization approval notice which is sent to the provider. For those supplies, equipment and appliances which are not individually priced based on the above circumstances, rates were set on April 1, 2010 and are effective for services provided on or after that date.
8. **Private Duty Nursing Services** – Payment is made at a fee per hour in accordance with a fee schedule established by the department pursuant to NH RSA 161:4, VI. The department's rates are reviewed biennially in accordance with RSA 126-A:18-b. Rates were set as of October 1, 2008 and are effective for services provided on or after that date. In accordance with NH RSA 126-A:3, III, no provider shall bill or charge the department more than the provider's usual and customary charge. All fee schedules are accessible at www.nhmedicaid.com and are applicable to all public and private providers.
9. **Clinic Services** – The individual practitioners who practice in the clinics are reimbursed according to the methodologies described in various entries in the state plan for the various types of practitioners providing the service. All fee schedules are accessible at www.nhmedicaid.com and are applicable to all public and private providers.

**PAYMENT RATES FOR ALL TYPES OF CARE OTHER THAN INPATIENT
HOSPITAL, SKILLED NURSING, OR INTERMEDIATE NURSING CARE SERVICES**

10. **Dental Services** -- Payment is made in accordance with a fee schedule established by the department pursuant to NH RSA 161:4, VI. The department's rates are reviewed biennially in accordance with RSA 126-A:18-b. Rates were set as of June 1, 2011, and are effective for services provided on or after that date. In accordance with NH RSA 126-A:3, III, no provider shall bill or charge the department more than the provider's usual and customary charge. All fee schedules are accessible at www.nhmedicaid.com/Downloads/procedurecodes.html and are applicable to all public and private providers.

Effective June 1, 2011, interceptive orthodontia will be paid in one payment, inclusive of records. Also effective June 1, 2011, comprehensive orthodontia will be paid in three payments, inclusive of records: at banding, no sooner than 12 months after banding, and when evidence confirms that the case is completed. "Inclusive of records" means inclusive of the casts/models and various types of xrays such as panorex and cephalometric xrays that are required as part of the orthodontic consultation.

11. **Physical Therapy and Related Services (Occupational and Speech Therapy)** -- Payment for physical, occupational and speech therapy services is based upon a 15 minute unit of service, unless the CPT code is defined otherwise, and made in accordance with a fee schedule established by the department pursuant to NH RSA 161:4, VI. The department's rates are reviewed biennially in accordance with RSA 126-A:18-b. Rates were set as of October 1, 2008, and are effective for services provided on or after that date. In accordance with NH RSA 126-A:3, III, no provider shall bill or charge the department more than the provider's usual and customary charge. All fee schedules are accessible at www.nhmedicaid.com/Downloads/procedurecodes.html and are applicable to all public and private providers.

TN No: 11-002
Supersedes
TN No: 07-010

Approval Date 9/20/11

Effective Date: 06/01/2011