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State/Territory Name: New Hampshire

State Plan Amendment (SPA) #: 14-0014

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form
3) Approved SPA Pages

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

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

March 13, 2015

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

Re: New Hampshire SPA TN 14-0014

Dear Commissioner Toumpas,

We are pleased to enclose a copy of approved New Hampshire State Plan Amendment (SPA) No. 14-0014 with an effective date of December 1, 2014. This SPA transmitted a proposed amendment to your approved Title XIX State plan to suspend prior authorization for dental extractions of third molars

If there are questions, please contact Joyce Butterworth at (617) 565-1220 or by e-mail at Joyce.Butterworth@cms.hhs.gov.

Sincerely,

/s/

Richard R. McGreal
Associate Regional Administrator

Enclosure/s

cc: Kathleen Dunn, State Medicaid Director
Diane Peterson, Medicaid Business and Policy

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 14-014

2. STATE: NH

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: December 1, 2014

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 440.50, 42 CFR 440.60, and 42 CFR 440.230(d)

7. FEDERAL BUDGET IMPACT:
FFY 2015: 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attch 3.1-A, page 4-a
Attch 3.1-B, page 4-a
~~Attch 4.19-B, page 2-a (no reimbursement changes; updating only)~~

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attch 3.1-A, page 4-a, TN 11-002
Attch. 3.1-B, page 4-a, TN 11-002
~~Attch 4.19-B, page 2-a, TN 11-009~~

10. SUBJECT OF AMENDMENT:
Suspend prior authorization requirement – dental extractions of third molars

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: comments, if any, will follow

12. SIGNATURE OF STATE AGENCY OFFICIAL:
/s/

13. TYPED NAME:

14. TITLE: Commissioner

15. DATE SUBMITTED: December 26, 2014

16. RETURN TO:
Dawn Landry
Office of Medicaid Business and Policy/Brown Building
Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: December 26, 2014

18. DATE APPROVED: March 13,2015

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: December 1, 2014

20. SIGNATURE OF REGIONAL OFFICIAL:
/s/

21. TYPED NAME: Richard R. McGreal

22. TITLE: Associate Regional Administrator
Division of Medicaid & Children's Health Operations, Boston, MA

23. REMARKS:
1/15/15 - NH requests pen & ink change withdrawing Attachment 4.19 B page 2a

OFFICIAL

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 associated with diagnosed pathology as documented in the provider's treatment record, (f) extractions of asymptomatic teeth subject to prior authorization, with the exception of third molars for which the prior authorization requirement is suspended through May 31, 2015, (g) extractions of third molars associated with diagnosed pathology as documented in the provider's treatment record, and subject to prior authorization, except that the prior authorization requirement is suspended through May 31, 2015, (h) general anesthesia and nitrous oxide analgesia (i) orthodontic therapy subject to prior authorization, (j) x-rays including complete or panographic 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, (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, (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 causitive 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 (Occupational and Speech Therapy)

When provided by a home health agency, visiting nurse association, outpatient hospital (to include rehabilitation center), 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. The limits may be exceeded if prior authorization is granted from the Department based on medical necessity.

8. Private Duty Nursing Services

Private duty nursing services which are covered are those provided by a registered or licensed practical nurse under the order and general direction of the patient's physician to a patient only in his place of residence, not a long term care facility. Prior authorization is required every sixty (60) days from the Department.

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 associated with diagnosed pathology as documented in the provider's treatment record, (f) extractions of asymptomatic teeth subject to prior authorization, with the exception of third molars for which the prior authorization requirement is suspended through May 31, 2015, (g) extractions of third molars associated with diagnosed pathology as documented in the provider's treatment record, and subject to prior authorization, except that the prior authorization requirement is suspended through May 31, 2015, (h) general anesthesia and nitrous oxide analgesia, (i) orthodontic therapy subject to prior authorization, (j) x-rays including complete or panographic 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, (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, (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.

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Prior authorization from the Department is 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 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.