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State/Territory Name: WA

State Plan Amendment (SPA) #: 13-26

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Seattle Regional Office
2201 Sixth Avenue, Mail Stop 43
Seattle, Washington 98121

CENTERS FOR MEDICARE & MEDICAID SERVICES

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

Dorothy Frost Teeter, Director
MaryAnne Lindeblad, Medicaid Director
Health Care Authority
Post Office Box 45502
Olympia, Washington 98504-5010

JAN 17 2014

Dear Ms. Teeter and Ms. Lindeblad:

The Centers for Medicare & Medicaid Services (CMS) Seattle Regional Office has completed its review of State Plan Amendment (SPA) Transmittal Number 13-26. This amendment restores comprehensive dental services, including dentures, restorative and preventative services, for all adult clients under the State Plan.

This SPA is approved effective January 1, 2014.

If you have any questions, please contact me, or have your staff contact Kendra Sippel-Theodore at (206) 615-2065 or via email at kendra.sippel-theodore@cms.hhs.gov.

Sincerely,

[redacted]
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

cc: Ann Myers, State Plan Coordinator.

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: 13-26

2. STATE: Washington

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
January 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:
1905(a)(5)(A) & (10), 1861(r)(2), 42 CFR 440.50 & 100 (P&I)

7. FEDERAL BUDGET IMPACT:
a. FFY 2014 $12,545,000
b. FFY 2015 $36,676,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Att. 3.1-B pages 19, 27, 28, 28a (new), 28b (new)
Att. 3.1-B pages 19, 28, 28a, 28b (new), 28c (new)
Att. 4.19-B page 14

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Att. 3.1-B pages 19, 27, 28
Att. 3.1-B pages 19, 28, 28a
Att. 4.19-B page 14

10. SUBJECT OF AMENDMENT

Adult Dental Services

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: Exempt

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME:
MARYANNE LINDEBLAD

14. TITLE:
MEDICAID DIRECTOR

15. DATE SUBMITTED:
11-4-13

16. RETURN TO:
Ann Myers
Office of Rules and Publications
Legal and Administrative Services
Health Care Authority
626 8th Ave SE MS: 42716
Olympia, WA 98504-2716

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
11/04/2013

18. DATE APPROVED:
1.17.14

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
1.01.14

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME:
Carol J.C. Peverly

22. TITLE: Associate Regional Administrator
Division of Medicaid & Children's Health

23. REMARKS:

12-23-13 State authorizes P&I change to box 6

FORM HCFA-179 (07-92)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL
CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

5. b. Medical and surgical services furnished by a dentist

Services may be provided by a physician, doctor of dentistry, or doctor of dental surgery.

Short stay procedures also take place in ambulatory surgery settings.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

10. Dental services and dentures

The Medicaid Agency covers the services listed below for eligible clients as indicated. Some of these services may require prior authorization. Limitations described do not apply for children age 20 and under for EPSDT purposes and may be exceeded based on documented medical necessity with prior authorization.

I. For clients age 21 and over

A. Preventive care
1. Behavior management (limited to clients with autism and clients of the Developmental Disabilities Administration)
2. Examinations
   a. Periodic oral evaluations once every 6 months
   b. Comprehensive evaluations once every 5 years
3. Fluoride, once in a 12-month period, per client, per provider/clinic
4. Prophylaxis
   a. Once every 12 months
   b. Not covered in conjunction with periodontal maintenance or root planing/scaling
   c. Must be at least 12 months after periodontal maintenance or root planing/scaling
5. X-rays (radiographs)
   a. Intraoral complete series once every 3 years
   b. Maximum of 4-bitewing x-rays every 12 months
   c. Panoramic x-rays in conjunction with 4-bitewings once every 3 years, only if the agency has not paid for an intraoral complete series in the same 3-year period

B. Treatment
1. Biopsy
   a. Soft oral tissue
   b. Brush
2. Endodontic treatment for permanent anterior teeth
3. Extractions
   a. Prior authorization required for extractions of 4 or more teeth in a 6 month period resulting in edentulism
   b. Prior authorization required for unusual and complicated surgical extractions
4. Periodontic services
   a. Scaling and root planning performed at least 12 months after periodontal maintenance
   b. Maintenance performed at least 12 months after scaling and root planing
5. Resin-based composite restorations 1 time in a 2-year period unless the restoration has an additional adjoining carious surface

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL
CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

10. Dental services and dentures (cont)

6. Non-emergency oral surgeries performed in an inpatient hospital setting are not covered. The exception is for clients of the Developmental Disabilities Administration whose surgery cannot be performed in an office setting. Documentation must be maintained in the client's record.

C. Dentures
1. Complete and overdentures
   a. 1 maxillary and 1 mandibular in a 5-year period
   b. Prior authorization required
2. Complete or partial rebase or relines once every 3 years when performed at least 6 months after the seating date
3. Resin partial dentures
   a. Once every 3 years
   b. Prior authorization required

II. For clients age 20 and under

A. Preventive care
1. Examinations
   a. Periodic oral evaluations once every 6 months
   b. Comprehensive evaluations once every 5 years
2. Fluoride
   a. For clients age 6 and younger, 3 times in a 12-month period
   b. For clients age 7 through 18, 2 times in a 12-month period
   c. For clients age 19 through 20, 1 time in a 12-month period
3. Oral hygiene instruction
   a. For clients age 8 and younger only
   b. Up to 2 times in a 12-month period in a setting other than a dental office
4. Prophylaxis
   a. Not covered in conjunction with periodontal maintenance or root scaling/planing
   b. For clients age 18 and younger
      i. Once every 6 months
      ii. Must be at least 6 months after periodontal maintenance or root scaling/planing
   c. For clients age 19 through 20
      i. Once every 12 months
      ii. Must be at least 12 months after periodontal maintenance or root scaling/planing

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

10. Dental services and dentures (cont)

5. Pulp vitality test, one per visit
6. Sealants
   a. Once per tooth in a 3-year period
   b. Only for permanent teeth 2, 3, 14, 15, 18, 19, 30, 31
   c. Only for primary teeth A, B, I, J, K, L, S, T
   d. Only when placed on a tooth with no preexisting occlusal restoration or any occlusal restoration placed on the same day
7. Space maintenance
   a. Only one space maintainer per quadrant
   b. Fixed unilateral or fixed bilateral space maintainers, including recementation for missing primary molars A, B, I, J, K, L, S, T
8. X-rays (radiographs)
   a. Occlusal intraoral x-rays once in a 2-year period
   b. Intraoral complete series for clients age 4 and older
   c. Maximum of 4-bitewing x-rays every 4 months
   d. Panoramic x-rays in conjunction with 4-bitewings once every 3 years, only if the agency has not paid for an intraoral complete series in the same 3-year period

B. Treatment
1. Apexification/apicoestomy
   a. Apexification for apical closures for anterior permanent teeth
      i. Limited to the initial visit and 3 interim treatment visits
      ii. Prior authorization required
   b. Apicoestomy for anterior teeth only
2. Biopsy
   a. Soft oral tissue
   b. Brush
3. Crowns
   a. Prefabricated stainless steel crowns
      i. For primary anterior and posterior teeth once every 3 years for clients age 20 and younger
      ii. For permanent posterior teeth, excluding 1, 16, 17, 32
      iii. Prior authorization required for anterior teeth for clients age 13 through 20
   b. Indirect crowns
      i. Once every 5 years for permanent anterior teeth for clients age 15 through 20
      ii. Prior authorization required
4. Endodontic treatment
   a. For primary incisor teeth D, E, F, and G if entire root is present
   b. For permanent anterior, bicuspid, and molar teeth, excluding 1, 16, 17, 32
5. Extractions
   a. Prior authorization required for unusual and complicated surgical extractions
   b. Prior authorization required for extractions of 4 or more teeth in a 6-month period resulting in edentulislm
6. Occlusal orthotic devices for clients age 12 through 20 with prior authorization

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: WASHINGTON

10. Dental services and dentures (cont)

7. Office-based anesthesia – prior authorization required for clients age 9 through 20
8. Oral surgery
   a. In an ambulatory surgery center, outpatient, or inpatient hospital setting when the service cannot be performed in an office setting
   b. Prior authorization required for clients age 9 through 20
   c. Prior authorization not required for clients of the Disability Determination Administration
9. Periodontic services
   a. Prior authorization required for gingivectomy/gingivoplasty
   b. Periodontal scaling/root planing for clients age 13 through 20
      i. Once per quadrant, per client, in a 2-year period
      ii. Must be performed at least 12 months after periodontal maintenance
      iii. Prior authorization required for clients age 13 through 18
   c. Periodontal maintenance for clients age 13 through 20
      i. Once per client in a 12-month period
      ii. Must be performed at least 12 months after periodontal root scaling/planing
      iii. Prior authorization required for clients age 13 through 18
10. Pulpotomy
   a. Therapeutic pulpotomy on primary teeth
   b. Pulpal debridement on permanent teeth, excluding 1, 16, 17, 32
11. Surgical incisions
   a. For frenuloplasty/frenulectomy
   b. Prior authorization required for clients age 7 through 20

C. Orthodontic treatment
1. Limited to medically necessary treatment

D Dentures
1. Complete and overdentures
   a. 1 maxillary and 1 mandibular denture in a 5-year period
   b. Prior authorization required
2. Partial dentures
   a. Cast metal, once every 5 years
   b. Resin, once every 3 years and requires prior authorization
3. Complete or partial rebase or reline once every 3 years when performed at least 6 months after the seating date.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL
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   a. Intraoral complete series once every 3 years
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State WASHINGTON

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: WASHINGTON

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: WASHINGTON

POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN (cont.))

VI. Dental Services and Dentures

A. The Medicaid agency pays directly to the specific provider the lesser of the usual and customary charge or a fee based on an agency fee schedule, for dental services provided within their specific scope of practice by dentists, dental hygienists, and denturists throughout the state. There are no geographical or other variations in the fee schedule.

B. The usual and customary charge is defined as that fee usually charged for a given service by an individual dentist, dental hygienist, or denturist to private patients (e.g., that provider's usual fee) and which fee is within the range of usual fees charged by dentists, dental hygienists, or denturists of similar training and experience.

C. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of dental services and dental hygiene. The fee schedule is published on the agency's website at http://www.hca.wa.gov/medicaid/rbrvs/Pages/index.aspx. The agency's fee schedule rate was set as of January 1, 2014, and is effective for services provided on or after that date.

VI.(a) Dentures

A. The Medicaid agency pays directly to the specific provider the lesser of the usual and customary charge or a fee based on an agency fee schedule for dentures. There are no geographical or other variations in the fee schedule.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of dentures. The fee schedule is published on the agency's website at http://www.hca.wa.gov/medicaid/rbrvs/Pages/index.aspx. The agency's fee schedule rate was set as of January 1, 2014, and is effective for services provided on or after that date.