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State/Territory Name: Washington

State Plan Amendment (SPA) #: 15-0005

This file contains the following documents in the order listed:

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

RE: Washington State Plan Amendment (SPA) Transmittal Number 15-0005

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 15-0005. This SPA adds information for preventative dental services for children age 20 and under that was inadvertently removed from the Medicaid state plan.

This SPA is approved effective January 8, 2015.

If you have any questions, please contact me, or have your staff contact Janice Adams at (206) 615-2541 or via email at janice.adams@cms.hhs.gov.

Sincerely,

Frank Schneider
Acting Associate Regional Administrator
Division of Medicaid and Children’s Health Operations

cc: Ann Myers, State Plan Coordinator
**TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL**

FOR: HEALTH CARE FINANCING ADMINISTRATION

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
   - [x] AMENDMENT

6. FEDERAL STATUTE/REGULATION CITATION:
   - 1905(a) of the Social Security Act; 42 USC 1396d

7. FEDERAL BUDGET IMPACT:
   - a. FFY 2015 $0
   - b. FFY 2016 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
   - 3.1-A pg 28
   - 3.1-B pg 28a

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):
   - 3.1-A pg 28
   - 3.1-B pg 28a

10. SUBJECT OF AMENDMENT
    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
    - [x] OTHER, AS SPECIFIED: Exempt

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: MARYANNE LINDEBLAD

14. TITLE: MEDICAID DIRECTOR

15. DATE SUBMITTED: 2-10-15

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

17. DATE RECEIVED: 2/10/15

18. DATE APPROVED: 3/09/15

19. EFFECTIVE DATE OF APPROVED MATERIAL: 1/08/2015

20. SIGNATURE OF REGIONAL OFFICIAL:
    Acting Associate Regional Administrator Division of Medicaid and Children's Health

21. TYPED NAME: Frank Schneider

22. TITLE: 

23. REMARKS:

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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

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 (per client per provider/clinic)
   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/planning
   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/planning
   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/planning

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State _____________________________ WASHINGTON _____________________________

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY NEEDED GROUP(S): ALL

10. Dental services and dentures (cont)

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Approval Date 3/09/15
Effective Date 1/8/15

Supersedes TN# 13-26