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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

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Seattle Regional Office
701 Fifth Avenue, Suite 1600, MS/RX-200
Seattle, WA 98104



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

MAR 09 2015

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,

A large black rectangular redaction box covers the signature area of the letter.

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	1. TRANSMITTAL NUMBER: 15-0005	2. STATE Washington
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
FOR: HEALTH CARE FINANCING ADMINISTRATION	4. PROPOSED EFFECTIVE DATE January 8, 2015	
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: 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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable) 3.1-A pg 28 3.1-B pg 28a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

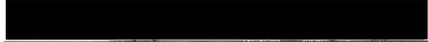
Dental Services

11. GOVERNOR'S REVIEW (Check One):

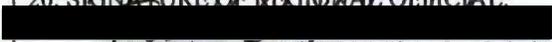
GOVERNOR'S OFFICE REPORTED NO COMMENT OTHER, AS SPECIFIED: Exempt

COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL: 	16. RETURN TO: Ann Myers Office of Rules and Publications Legal and Administrative Services Health Care Authority 626 8 th Ave SE MS: 42716 Olympia, WA 98504-2716
13. TYPED NAME: MARYANNE LINDEBLAD	
14. TITLE: MEDICAID DIRECTOR	
15. DATE SUBMITTED: 2-10-15	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 2/10/15	18. DATE APPROVED: 3/09/15
PLAN APPROVED - ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: 1/08/2015	20. SIGNATURE OF REGIONAL OFFICIAL: 
21. TYPED NAME: Frank schneider	22. TITLE: Acting Associate Regional Administrator Division of Medicaid and Children's Health

23. REMARKS:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTONAMOUNT, 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 WASHINGTONAMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE
MEDICALLY NEEDY GROUP(S): ALL

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