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10. DENTAL SERVICES

Dental services, as defined in 42 CFR 440.100, are covered for children and adults and must be medically necessary and cost effective for the prevention, diagnosis and treatment of dental disease or injuries. The following limitations apply to dental services, except for children under 21 years of age for which medically necessary services are covered in accordance with the EPSDT provision. Limits can be exceeded based on medical necessity.

A. *Preventive services.*

- a. Oral prophylaxis, including necessary scaling and polishing. *Limitation:* Once in a six month period except for persons who, because of physical or mental disability, need more frequent care.
- b. Topical application of fluoride. *Limitation:* Once in a 90 day period. (This does not include the use of fluoride prophylaxis paste as fluoride treatment.)
- c. Pit and fissure sealants. *Limitation:* Covered on first and second deciduous and permanent molars only for children through 21 years of age and for others who have a physical or mental disability that impairs their ability to maintain adequate oral hygiene.

State/Territory: \_\_\_\_\_

IOWA

B. *Diagnostic services.*

- a. A comprehensive oral evaluation. *Limitation:* Once per patient per dentist, or when the patient has not seen that dentist in a three-year period.
- b. A periodic oral examination. *Limitation:* Once in a six-month period.
- c. A full mouth radiograph survey consisting of a minimum of 14 periapical films and bitewing films. *Limitations:* Once in a five-year period, except when medically necessary to evaluate development, and to detect anomalies, injuries and diseases. Full mouth radiograph surveys are not payable under the age of six.
- d. Supplemental bitewing films. *Limitations:* Once in a 12-month period.
- e. Single periapical films, intraoral radiograph, occlusal, extraoral radiograph, posterior-anterior and lateral skull and facial bone radiograph, survey film, temporomandibular joint radiograph, and cephalometric film when medically necessary.

C. *Restorative services.*

- a. Treatment of dental caries in those areas which require immediate attention. *Limitation:* Restoration of incipient or nonactive carious lesions are not covered.
- b. Amalgam alloy and composite resin-type filling materials. *Limitation:* Once for the same restoration in a two-year period. An amalgam restoration is covered following a sedative filling in the same tooth only if the sedative filling was placed more than 30 days previously.
- c. Stainless steel crowns are covered when a more conservative procedure would not be serviceable. *Limitation:* Stainless steel crowns with a resin window are limited to anterior teeth.
- d. Laboratory Fabricated Crowns. Prior authorization is required. *Limitation:* Noble metals are limited to individuals who are allergic to all other restorative materials.
- e. Cast post and core, post and composite or amalgam in addition to a crown. *Limitation:* Covered if a tooth is functional and the integrity of the tooth would be jeopardized by no post support.

- D. *Periodontal services.* Full mouth debridement is covered once every 24 months and is not allowed on the same date of service when prophylaxis or other periodontal services are provided. Periodontal treatment procedures require prior authorization.

State Plan TN #    IA-13-010  
Superseded TN #   MS-06-003

Effective  
Approved

MAY 1 2013

SEP 26 2013

# Revised Submission 8.12.13

Supplement 2 to  
Attachment 3.1-A  
PAGE - 23 -

State/Territory:

IOWA

- E. *Endodontal services.* Covered when there is a fair to good prognosis for maintaining the tooth. Endodontic retreatment requires prior authorization.
- F. *Orthodontic services.* Covered for a severe, handicapping malocclusion. Prior authorization is required. *Limitation:* Not covered for adults 21 years of age and over.
- G. Reserved
- H. *Prosthetic services.*
  - a. An immediate denture or a first-time complete denture including six months' post delivery care when provided to establish masticatory function. *Limitations:* Immediate and first-time complete dentures are covered only once following the removal of teeth it replaces.
  - b. Removable and fixed partial dentures require prior authorization. *Limitations:* A missing anterior tooth must have adequate space for replacement with a partial denture. Partial dentures replacing missing posterior teeth are not covered when there are at least eight posterior teeth in occlusion. Fixed partial dentures are covered only for members who have a physical or mental condition that precludes the use of a removable partial denture, or who have a full denture in one arch and a fixed partial denture replacing posterior teeth is required to balance occlusion in the opposing arch.
  - c. Replacement dentures. *Limitations:* Replacement of immediate, complete, removable and fixed partial dentures requires prior authorization and is limited to once in a five year period. When the denture is lost, stolen, or broken beyond repair one replacement is allowed during the five year period. Prior authorization is also allowed for more than one denture replacement per arch within five years when the member has a medical condition that necessitates thorough mastication. Replacement due to resorption is not covered.

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State Plan TN #    IA-13-010  
Superseded TN #    MS-006-003

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Effective            MAY 1 2013  
Approved           SEP 20 2013

State/Territory: \_\_\_\_\_

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- d. Relines. *Limitation:* Chairside relines and laboratory processed relines are covered only once per prosthesis every 12 months.
  - e. Tissue conditioning. *Limitation:* Covered twice per prosthesis in a 12-month period.
  - f. Repairs. *Limitation:* Only two repairs per prosthesis are allowed in a 12-month period.
  - f. Obturator for surgically excised palatal tissue or deficient velopharyngeal function of cleft palate patients.
  - k. Adjustments to a complete or removable partial denture are covered if medically necessary after six months' post-delivery care.
- I. *Implants.* Covered when a conventional denture cannot be used due to missing significant oral structures as a result of cancer, traumatic injuries, or developmental defects such as cleft palate. Prior authorization is required.
- G. *Treatment in a hospital.* Covered only when the mental, physical, or emotional condition of the patient prevents the dentist from providing necessary care in the office.

State Plan TN # IA-13-010  
Superseded TN # MS-06-003

Effective MAY 1 2013  
Approved SEP 20 2013

State/Territory:

IOWA

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11. THERAPIES11.a PHYSICAL THERAPY

Physical therapy services and provider qualifications meet the requirements set forth in 42 CFR 440.110. Physical therapy services are covered under this item only if provided by (1) a Medicare certified rehabilitation agency, in accordance with its conditions of certification or (2) a physical therapist in private practice. Physical therapy services provided by a rehabilitation agency are subject to the limitations described in Item 7e, except for children under 21 years of age for which medically necessary services are covered in accordance with the EPSDT provisions. Physical therapy services provided by a therapist in private practice are limited in amount, scope and duration under Medicare Part B as set forth in 42 CFR 410.60.

Services are covered in accordance with an active treatment plan established by the physician and provided by a licensed physical therapist within the scope of his or her practice as defined by state law and regulation referenced below. Services provided by a physical therapist include: screening, evaluation, diagnostic or trial therapy, rehabilitation, remediation and reevaluation. Services provided by a licensed physical therapist assistant must be in accordance with the established treatment plan and under the supervision of the physical therapist.

*Reference: Iowa Administrative Code Part 645 (Professional Licensing) – Chapter 200 (Licensure of Physical Therapists and Physical Therapy Assistants) and Chapter 201 (Practice of Physical Therapists and Physical Therapy Assistants). Physical therapist regulations stipulate graduation from a physical therapy program accredited by an approved national accreditation agency and a passing score on the National Physical Therapy Examination or other nationally recognized equivalent examination as defined by the Board of Physical and Occupational Therapy Examiners. Physical therapy assistant regulations stipulate graduation from a physical therapy assistant program accredited by an approved national accreditation agency and a passing score on the National Physical Therapy Examination or other approved nationally recognized equivalent as set forth in 42 CFR 484.4.*

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State Plan TN # IA-13-010  
Superseded TN # IA-12-023

Effective  
Approved

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MAY 1 2013  
SEP 20 2013

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