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State/Territory Name: North Dakota

State Plan Amendment (SPA) #: 17-0024

This file contains the following documents in the order listed:

1) Approval Letter
2) 179
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Denver Regional Office
1961 Stout Street, Room 08-148
Denver, CO 80294

REGION VIII - DENVER

December 21, 2017

Maggie Anderson, Medicaid Director
Division of Medical Services
North Dakota Department of Human Services
600 East Boulevard Avenue, Dept. 325
Bismarck, ND 58505-0250

RE: North Dakota #17-0024

Dear Ms. Anderson:

We have reviewed the proposed State Plan Amendment (SPA) submitted under transmittal number (TN) 17-0024. This amendment makes technical corrections to the state plan pages.

Please be informed that this State Plan Amendment was approved December 20, 2017 with an effective date of October 1, 2017. We are enclosing the CMS-179 and the amended plan page(s).

If you have any questions concerning this amendment, please contact Kirstin Michel at (303) 844-7036.

Sincerely,

[redacted]

Richard C. Allen
Associate Regional Administrator
Division for Medicaid & Children's Health Operations

cc: Melissa Rosales

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES	1. TRANSMITTAL NUMBER: **17-0024**	2. STATE **North Dakota**
	3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)**	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE AND MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE **October 1, 2017**	

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: **N/A – Technical Correction Only**	7. FEDERAL BUDGET IMPACT: a. FFY **2018** **$N/A** b. FFY **2019** **N/A**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment to Page 4 of Attachment 3.1-A** **Attachment to Page 4 of Attachment 3.1-B** **Attachment 3.1-B, Page 7**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment to Page 4 of Attachment 3.1-A** **Attachment to Page 4 of Attachment 3.1-B** **Attachment 3.1-B, Page 7**

10. SUBJECT OF AMENDMENT:
Amends the State Plan to make technical corrections to state plan pages and refereneed pages.

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:
Maggie D. Anderson, Director
Medical Services Division

12. SIGNATURE OF STATE AGENCY OFFICIAL: [redacted]	16. RETURN TO:
13. TYPED NAME: **Maggie D. Anderson**	**Maggie D. Anderson, Director** **Medical Services Division** **ND Department of Human Services** **600 East Boulevard Avenue Dept 325** **Bismarck ND 58505-0250**
14. TITLE: **Director, Medical Services Division**	
15. DATE SUBMITTED: **December 15, 2017**	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: December 15, 2017	18. DATE APPROVED: December 20, 2017
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: October 1, 2017	20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]
21. TYPED NAME: Richard C. Allen	22. TITLE: ARA, DMCHO

23. REMARKS:

LIMITATIONS ON AMOUNT, DURATION AND SCOPE

10. Dental Services. The Department maintains a Medicaid Dental Manual that details all covered and non-covered codes. Emergency services that ameliorate pain or infections are covered without limitations.

OTHER LIMITATIONS

1. Effective September 1, 2003, payment for single crowns on posterior teeth for individuals 21 years of age and older is limited to stainless steel crowns. Other crowns may be allowed in the anterior portion of the mouth for adults if the crown is necessary because of previously approved root canal therapy or for other compelling reasons approved by the Department dental consultant. Payment for single crowns on posterior teeth for individuals under 21 years of age is limited to stainless steel crowns unless a dental condition exists that makes stainless steel crowns impracticable. Any exceptions must be approved through a prior authorization process approved by the department dental consultant.

2. Payment for missing single teeth in the posterior portion of the mouth is not a covered service.

3. Payment for removal of third molars for non-symptomatic reasons is not a covered service.

4. Payment of sterile trays is not a covered service.

5. Orthodontic services except for those children covered through the Early Periodic, Screening, Diagnosis and Treatment Program that meet medical necessity requirements are not a covered service unless the services are provided in conjunction with, or in lieu of, oral maxillofacial surgical services and the orthodontic service is likely to correct or mitigate a congenital or acquired deformity associated with a significant functional impairment on drinking, eating, swallowing or speaking.

6. Replacement of lost or broken orthodontic appliances and splints is limited to one replacement. This limit can be exceeded based on medical necessity.

7. Individuals 21 years of age and older are limited to no more than one non-emergency dental examination per year. Prior authorization form the dental consultant is necessary to exceed this limit.

8. Individuals 21 years of age and older are limited to one prophylaxis per year. Prior authorization from the dental consultant is necessary to exceed this limit.

9. Individuals under 21 years of age are limited to two prophylaxes per year. Prior authorization from the dental consultant is necessary to exceed this limit.

10. Dental Services (Continued)

OTHER LIMITATIONS (Continued)

10. Individuals 21 years of age and older are limited to one panoramic film at the time of their initial dental visit to a dentist. Prior authorization from the dental consultant is necessary to exceed this limit

11. Individuals under 21 years of age are limited to one panoramic film every five years. Prior authorization from the dental consultant is necessary to exceed this limit.

12.

a. Full dentures are covered except for codes D5810-D5811, Temporary Complete Dentures.

b. Effective September 1, 2003, coverage for partial dentures except for individuals eligible for the Early, Periodic, Screening, Diagnosis and Treatment Program is limited to codes D5820 and D5821 (Interim Prosthesis) except that other types of partial dentures can be allowed to replace teeth in the anterior portion of the mouth if prior approval is obtained from the Department dental consultant.

c. Replacement of dentures is limited to every five years unless the change is prior approved by the dental consultant due to a change in the physical condition of a recipient that renders the present dentures unusable.

13. Reline of dentures in an immediate/emergency situation is limited to once every 12 months. Other than immediate/emergency situations, reline of dentures is limited to once every 24 months. For children up to age 21, these limits may be exceeded based on medical necessity.

14. Other services that require prior authorization are identified in the North Dakota Provider Manual for Dentists. Dental services identified as requiring prior authorization and listed in the manual will not be allowed for payment unless providers obtain prior authorization to perform the service.

15. All limitations can be exceeded based on medical necessity for EPSDT eligible individuals.

LIMITATIONS ON AMOUNT, DURATION AND SCOPE

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OTHER LIMITATIONS

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2. Payment for missing single teeth in the posterior portion of the mouth is not a covered service.

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4. Payment of sterile trays is not a covered service.

5. Orthodontic services except for those children covered through the Early Periodic, Screening, Diagnosis and Treatment Program that meet medical necessity requirements are not a covered service unless the services are provided in conjunction with, or in lieu of, oral maxillofacial surgical services and the orthodontic service is likely to correct or mitigate a congenital or acquired deformity associated with a significant functional impairment on drinking, eating, swallowing or speaking.

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10. Dental Services (Continued)

OTHER LIMITATIONS (Continued)

10. Individuals 21 years of age and older are limited to one panoramic film at the time of their initial dental visit to a dentist. Prior authorization from the dental consultant is necessary to exceed this limit

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c. Replacement of dentures is limited to every five years unless the change is prior approved by the dental consultant due to a change in the physical condition of a recipient that renders the present dentures unusable.

13. Reline of dentures in an immediate/emergency situation is limited to once every 12 months. Other than immediate/emergency situations, reline of dentures for other situations is limited to once every 24 months. For children up to age 21, these limits may be exceeded based on medical necessity.

14. Other services that require prior authorization are identified in the North Dakota Provider Manual for Dentists. Dental services identified as requiring prior authorization and listed in the manual will not be allowed for payment unless providers obtain prior authorization to perform the service.

15. All limitations can be exceeded based on medical necessity for EPSDT eligible individuals.

State/Territory: NORTH DAKOTA

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S):_____

19. Case management services and Tuberculosis related services

a. Case management services as defined in, and to the groups specified in, Supplement 1, Supplement 2, Supplement 4, and Supplement 7 to ATTACHMENT 3.1-B (in accordance with section 1905 (a) (19) or section 1915 (g) of the Act).

X Provided: X With limitations*

____ Not provided.

b. Special tuberculosis (TB) related services under section 1902 (z) (2) (F) of the Act.

____ Provided: ____ With limitations*

X Not provided.

20. Extended services for pregnant women.

a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and for any remaining days in the month in which the 60th day falls.

\+ ++

X Provided: ____ Additional coverage

b. Services for any other medical conditions that may complicate pregnancy.

\+ ++

X Provided: ____ Additional coverage ____ Not provided.

21. Certified pediatric or family nurse practitioners' services.

X Provided: X No limitations ____ With limitations*

____ Not provided.

\+ Attached is a list of major categories of services (e.g., inpatient hospital, physician, etc.) and limitations on them, if any, that are available as pregnancy-related services or services for any other medical condition that may complicate pregnancy.

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

*Description provided on attachment.