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State/Territory Name: Ohio

State Plan Amendment (SPA) #: 21-0016

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form
- 3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services 601 E. 12th St., Room 355 Kansas City, Missouri 64106 Medicaid



Medicaid and CHIP Operations Group

June 24, 2021

Maureen M. Corcoran, Director Ohio Department of Medicaid P.O. Box 182709 50 West Town Street, Suite 400 Columbus, Ohio 43218

RE: State Plan Amendment Transmittal Number 21-0016

Dear Ms. Corcoran:

Enclosed for your records is an approved copy of the following State Plan Amendment:

Transmittal #21-0016 - Coverage, Limitations, and Payment for Services: Dental Services

Effective Date: April 1, 2021Approval Date: June 24, 2021

If you have any questions regarding this State Plan Amendment, please have a member of your staff contact Christine Davidson at (312) 886-3642 or by email at christine.davidson@cms.hhs.gov.

Sincerely,

Ruth A. Hughes Acting Director

Division of Program Operations

Enclosures

cc: Carolyn Humphrey, ODM

Becky Jackson, ODM Greg Niehoff, ODM Myla Adams, CMCS Debi Benson, CMCS

2TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL	1. TRANSMITTAL NUMBER: 21-016	2. STATE OHIO
FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES	3. PROGRAM IDENTIFICATION: TIT SOCIAL SECURITY ACT (MEDICA	LE XIX OF THE
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE April 1, 2021	
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 AMEN		amendment)
6. FEDERAL STATUTE/REGULATION CITATION:	7. FEDERAL BUDGET IMPACT: a. FFY 21 \$177.0 thousands	
42 CFR 440.100 42 U.S.C. 1396d	a. FFY 21 \$177.0 thousands b. FFY 22 \$352.6 thousands	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 3.1-A, Item 10, page 1 of 1 Attachment 4.19-B, Item 10, page 1 of 2	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable) Attachment 3.1-A, Item 10, page 1 of 1 (TN 20-005) Attachment 4.19-B, Item 10, page 1 of 2 (TN 21-011)	
10. SUBJECT OF AMENDMENT: Coverage and Limitations and Payment for Services: Dental Services Updates		
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 SPEC The State Medicaid Direct	IFIED: or is the Governor's designee
12. SIGNATURE OF STATE AGENCY OFFICIAL.	16. RETURN TO:	
13. TYPED NAME: MAUREEN M. CORCORAN	Carolyn Humphrey Ohio Department of Medicaid	
	P.O. BOX 182709	
14. TITLE: STATE MEDICAID DIRECTOR	Columbus, Ohio 43218	
15. DATE SUBMITTED: May 13, 2021		
FOR REGIONAL OFFICE USE ONLY		
17. DATE RECEIVED: May 13, 2021	18. DATE APPROVED: 06/24/202	21
PLAN APPROVED – ONE COPY ATTACHED		
19. EFFECTIVE DATE OF APPROVED MATERIAL: April 1, 2021	20. SIGNATURE OF REGIONA	
21. TYPED NAME: Ruth A. Hughes	22. TITLE: Acting Director, Division of Program Ope	ouations.
23. REMARKS:	Division of Program Ope	zi auluiis

10. Dental services.

The dental benefit for beneficiaries 21 years of age and older includes services in the following categories: clinical oral examination; diagnostic imaging and interpretation; tests and laboratory examinations; preventive services; restorative services; endodontic services; periodontic services; prosthodontic services; oral surgery; orthodontic services; other services, and anesthesia.

Limitations:

- Comprehensive oral evaluation 1 per 5 years per provider per patient;
- Periodic oral evaluation Patient younger than 21, pregnant, or in other optional eligibility groups as established by Ohio law: 1 per 180 days. Patient 21 or older: 1 per 365 days;
- Comprehensive periodontal evaluation, new or established patient 1 per 365 days;
- Intraoral images, complete series (including bitewings) 1 per 5 years per provider;
- Bitewing image, one 1 per 6 months;
- Bitewing images, two 1 per 6 months (recommended interval from 6 to 24 months for a complete series);
- Bitewing images, three 1 per 6 months (recommended interval from 6 to 24 months for a complete series);
- Bitewing images, complete series (at least four images) 1 per 6 months (recommended interval from 6 to 24 months for a complete series);
- Panoramic image Patient 6 or older: 1 per 5 years;
- Cone beam CT view both jaws with or without cranium: 1 per 5 years per provider;
- Dental prophylaxis, adult Patient younger than 21: 1 per 180 days. Patient 21 or older: 1 per 365 days;
- Dental prophylaxis, child 1 per 180 days;
- Topical fluoride treatment 1 per 180 days;
- Tobacco counseling for control and prevention of oral disease 2 per 365 days;
- Sealant 1 per 5 years per first or second molar per provider per patient;
- Interim caries arresting medicament application 4 teeth per date of service;
- Periodontal maintenance 1 per 365 days;
- Relining, all dentures 1 per 3 years;
- Alveoplasty, in conjunction with extraction, 1 per quadrant;
- Alveoplasty, not in conjunction with extraction, 1 per quadrant.
- Protective restoration, primary or permanent dentition 1 per 180 days per tooth;
- Interim therapeutic restoration, primary dentition 1 per 180 days per tooth;
- Counseling for the control and prevention of adverse oral, and systemic health effects associated with high-risk substance use 2 per 365 days;
- Re-cementing/re-bonding crown 1 per 5 years per tooth;

Prior authorization is required for the following dental services: porcelain crowns, post and core, gingivectomy, gingivoplasty, scaling and root planing, dentures, surgical extractions, comprehensive orthodonture, temporomandibular joint therapy, maxillofacial prosthetics and unspecified procedures not adequately described by a procedure code.

Dental services may be provided in an amount beyond established limits with prior authorization, upon a demonstration of medical necessity.

Individuals up to age 21 can access dental benefits without limitation when medically necessary.

TN: <u>21-016</u> Approval Date: <u>06/24/2021</u>

Supersedes:

TN: <u>20-005</u> Effective Date: <u>04/01/2021</u>

State of Ohio Attachment 4.19-B

Item 10

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10. Dental services.

Dental services under this section are covered by Ohio Medicaid in accordance with 42 CFR 440.100.

Payment for Dental services is the lesser of the billed charges or an amount based on the Medicaid maximum for the service, except for 'Rural Dental Providers.' The Medicaid maximum is the amount listed on the Department's Dental services fee schedule.

Effective for dates of service on and after January 1, 2016, the maximum reimbursement for dental services rendered by a provider whose office address is in a rural Ohio county is the lesser of the billed charges or 105 percent of the Medicaid maximum for the particular service.

All rates are published on the agency's website at: https://medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx.

The agency's dental services fee schedule was set as of April 1, 2021 and is effective for services provided on or after that date.

By-report services require manual review by the appropriate single state agency staff. The reimbursement rate for these services is determined using one of a variety of different payment methodologies. Examples of the possible methodologies are pricing using a similar service, product, or procedure that has an established reimbursement rate or a percentage of charges. The specific methodology utilized depends on the service, product, or procedure performed.

Except as otherwise noted in the plan, state-developed fee schedules and rates are the same for both governmental and private providers.

Selected dental services are subject to a co-payment as specified in Attachment 4.18-A of the State plan.

TN: <u>21-016</u> Approval Date: <u>06/24/2021</u>

Supersedes: TN: <u>21-011</u> Effective Date: <u>04/01/2021</u>