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MEMORANDUM

TO: **EMILY MCCLELLAN**
Regulatory Supervisor
Virginia Department of Medical Assistance Services

FROM: **KIM F. PINER**
Senior Assistant Attorney General

DATE: **July 31, 2018**

SUBJECT: **Exempt final regulation to limit dental services for nursing facility residents 12VAC 30-50-190**

I have reviewed the attached exempt final regulation to limit the amount of routine dental services that residents of nursing facilities are permitted to use to modify their patient pay amounts. You have asked the Office of the Attorney General to review and determine if the Department of Medical Assistance Services ("DMAS") has the legal authority to amend the regulation and if the regulation comports with state and federal law.

Based on my review and pursuant to the 2018 Acts of the Assembly, Chapter 2, Item 303.NN, the Director of DMAS, acting on behalf of the Board of Medical Assistance Services, in accordance with Virginia Code §§ 32.1-324 and 325, has the authority to amend these regulations, subject to compliance with the provisions of Article 2 of the Administrative Process Act ("APA") and has not exceeded that authority. It is my view that the amendment of this regulation is exempt from the procedures of Article 2 of the APA pursuant to Va. Code § 2.2-4006(A). This will amend the State Plan; therefore, approval by the Centers for Medicare and Medicaid Services will be required.

If you have any questions about this matter, please contact me at 786-3524.

Attachment

12VAC30-50-190. Dental services.

A. Dental services shall be covered for individuals younger than 21 years of age in fulfillment of the treatment requirements under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program and defined as routine diagnostic, preventive, or restorative procedures necessary for oral health provided by or under the direct supervision of a dentist in accordance with the State Dental Practice Act.

1. The state agency will provide any medically necessary dental service to individuals younger than 21 years of age.

2. Certain dental services, as described in the agency's Office Reference Manual (Smiles for Children, March 13, 2014), prepared by DMAS' dental benefits administrator, require preauthorization or prepayment review by the state agency or its designee.

3. Dental services for individuals younger than the age of 21 years that do not require preauthorization or prepayment review are initial, periodic, and emergency examinations; required radiography necessary to develop a treatment plan; patient education; dental prophylaxis; fluoride treatments; routine amalgam and composite restorations; stainless steel crowns, prefabricated steel post and temporary (polycarbonate crowns) and stainless steel bands; crown recementation; pulpotomies; emergency endodontics for temporary relief of pain; pulp capping; sedative fillings; therapeutic apical closure; topical palliative treatment for dental pain; removal of foreign body; simple extractions; root recovery; incision and drainage of abscess; surgical exposure of the tooth to aid eruption; sequestrectomy for osteomyelitis; and oral antral fistula closure.

B. Dental services determined by the dental provider to be medically appropriate for an adult woman during the term of her pregnancy and through the end of the month following the 60th day postpartum shall be provided to a Medicaid-enrolled pregnant woman. The dental services that shall be covered are (i) diagnostic x-rays and exams; (ii) preventive cleanings; (iii) restorative fillings; (iv) endodontics (root canals); (v) periodontics (gum-related treatments); (vi) prosthodontics, both removable and fixed (crowns, bridges, partial plates, and dentures); (vii) oral surgery (tooth extractions and other oral surgeries); and (viii) adjunctive general services (all covered services that do not fall into specific professional categories). These services require prepayment review by the state agency or its designee.

C. For the dental services covered for Medicaid-enrolled adult pregnant women, the state agency may place appropriate limits on a service based on medical necessity, for utilization control, or both. Examples of service limitations are: examinations, prophylaxis, fluoride treatment (once/six months); space maintenance appliances; bitewing x-ray two films (once/12 months); routine amalgam and composite restorations (once/three years); dentures (once/five years); extractions, tooth guidance appliances, permanent crowns and bridges, endodontics, patient education and sealants (once).

D. Limited oral surgery procedures, as defined and covered under Title XVIII (Medicare), are covered for all recipients, and require preauthorization or prepayment review by the state agency or its designee as described in Agency guidance documents.

E. Residents of nursing facilities shall be permitted to deduct the costs of limited specific dental procedures from their payments towards the costs of their nursing facility care. Nursing facility residents shall be limited to deducting the following dental procedures: (i) routine exams and x-rays, and dental cleaning twice yearly; (ii) full mouth x-rays once every three years; and (iii) deductions for extractions and fillings shall be permitted only if medically necessary as determined by the department.