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| <b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>  |  | 1. TRANSMITTAL NUMBER:<br>09-006   | 2. STATE<br>Montana |
| <b>FOR: HEALTH CARE FINANCING ADMINISTRATION</b>  |  | 3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)   |                     |
| TO: REGIONAL ADMINISTRATOR<br>HEALTH CARE FINANCING ADMINISTRATION<br>DEPARTMENT OF HEALTH AND HUMAN SERVICES   |  | 4. PROPOSED EFFECTIVE DATE<br>01/01/2009   |                     |
| 5. TYPE OF PLAN MATERIAL (Check One):<br><input checked="" type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input type="checkbox"/> AMENDMENT<br>COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)                 |  |  |                     |
| 6. FEDERAL STATUTE/REGULATION CITATION:<br>N/A  |  | 7. FEDERAL BUDGET IMPACT:<br>a. FFY 2009      \$1,790<br>b. FFY 2010      \$2,387  |                     |
| 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:<br><br><b>4.19B Methods &amp; Standards for Establishing Payment Rates:</b><br>Service 6(d), Other Practitioners' Services, Hygienist Services.<br><br><b>Supplement to Attachment 3.1A and 3.1B:</b><br>Service 6d, Other Practitioners', Hygiene Services |  | 9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):<br><br>None, this State Plan is NEW.  |                     |
| 10. SUBJECT OF AMENDMENT:<br>The purpose of this amendment is to include Hygienist Services with Other Practitioners 'as they are allowed to bill separately when working under public health supervision with a limited access permit  |  |  |                     |
| 11. GOVERNOR'S REVIEW (Check One):<br><input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> OTHER, AS SPECIFIED:<br><input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED<br><input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL               |  |  |                     |
| 12. SIGNATURE OF STATE AGENCY OFFICIAL:<br><i>Mary E. Dalton</i>  |  | 16. RETURN TO:<br>Montana Dept of Public Health and Human Services<br>Mary E. Dalton, State Medicaid Director<br>Attn: Jo Thompson<br>PO Box 4210<br>Helena MT 59604 |                     |
| 13. TYPED NAME: Mary E. Dalton  |  |  |                     |
| 14. TITLE: State Medicaid Director  |  |  |                     |
| 15. DATE SUBMITTED: 3/31/09   |  |  |                     |
| <b>FOR REGIONAL OFFICE USE ONLY</b>   |  |  |                     |
| 17. DATE RECEIVED: 3/31/09  |  | 18. DATE APPROVED: 11/17/09  |                     |
| <b>PLAN APPROVED - ONE COPY ATTACHED</b>  |  |  |                     |
| 19. EFFECTIVE DATE OF APPROVED MATERIAL:<br>January 1, 2009   |  | 20. SIGNATURE OF REGIONAL OFFICIAL:<br><i>[Signature]</i>  |                     |
| 21. TYPED NAME:<br>Richard C. Allen   |  | 22. TITLE:<br>Associate Regional Administrator   |                     |
| 23. REMARKS:  |  |  |                     |

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
1600 Broadway, Suite 700  
Denver, CO 80202-4967



**Region VIII**

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November 17, 2009

Mary Dalton, Medicaid & Health Services Manager  
Montana Department of Health & Human Services  
1400 Broadway  
PO Box 202951  
Helena, MT 59620

Re: SPA 09-006

Dear Ms Dalton:

Please be advised CMS has approved Montana State Amendment 09-006, "Dental Hygienists included with Other Practitioners". This state plan amendment is approved with an effective date of January 1, 2009.

We appreciate the cooperation extended by your staff in the review and approval of this state plan amendment.

If you have any questions regarding this State Plan Amendment please contact Dee Raisl at 303-844-2682.

Sincerely,

/s/

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

Cc: Duane Preshinger  
Jo Thompson

MONTANA

1. Reimbursement for Dental Hygienist Services, as defined in 3.1A and 3.1B, shall be the lowest of the following:
  - a. The provider's usual and customary charge for the service;
  - b. The Department's fee schedule for dental services.
2. The Department's fee schedule is calculated as follows:
  - a. Dental Hygienist procedures are identified through the following process:
    - (1) Procedures identified through ADA/CDT coding manual.
  - b. Definitions:  
Relative Value Unit (RVU) The unit value assigned to a specific procedure code published in c.(1).  
Relative Value for Dentists (RVD): a value given to each procedure code outlined in 2.c.(1)(b)(i).
  - c. Reimbursement rates are set by one of the following methods:
    - (1) For procedures listed in the "Relative Values for Dentists" published biennially by Relative Value Studies, Incorporated, reimbursement rates shall be determined using the following methodology:
      - (a) The fee for a covered service shall be the amount determined by multiplying the (RVU) by the conversion factor specified in 2.c.(1)(b)(iii).
      - (b) The conversion factor and provider fees for dentists, dental hygienists, and denturists procedures are calculated as follows:
        - (i) The total units of each procedure code paid in a prior period is multiplied by the RVU to equal the RVD for each procedure code. Typically, the prior period used is the prior state fiscal year.
        - (ii) The sum of all RVDs calculated in 2.c.(1)(b)(i) equals the total units of dental service.

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(iii) The Montana Legislature's appropriation for dental service during the appropriation period is divided by the total units of dental service calculated in 2.c.(1)(b)(ii). The resulting dollar value is equal to one unit of dental value and is the dental conversion factor.

(iv) The RVU for each dental procedure is multiplied by the dental conversion factor calculated in 2.c.(1)(b)(iii) to calculate the Medicaid reimbursement for the procedure. When this calculation is made for all covered procedures the Montana Medicaid Dental, Dental Hygienist, and Denturist Fee Schedules are generated.

(v) A policy adjuster may be applied to some fees calculated in 2.c.(1)(b)(iv) for certain categories of services or to the conversion factor to increase or decrease the fees paid by Medicaid.

(2) Where a fee cannot be set using this methodology, the reimbursement is determined using the "by report" methodology. "By report" reimbursement is paid at 85% of the provider's usual and customary charge.

3. The agency's rates were set as of January 1, 2009 and are effective for services on or after that date. All rates are published on the agency's website [www.mtmedicaid.org](http://www.mtmedicaid.org). Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private providers.

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The following limitations apply to licensed Dental Hygienist services:

1. A licensed Dental Hygienist is an independent licensed preventative oral health practitioner who does not require the supervision of a dentist under the following circumstances:
  - a. The licensed dental hygienist has obtained a limited access permit (LAP) to provide dental hygiene preventative services from the Montana Board of Dentistry.
  - b. Services are performed in a public health facility or program or in any other setting specified by the Montana Board of Dentistry.
2. Covered dental hygiene preventive services are found on the Department's Fee Schedule for Dental Hygienists on-line at [www.mtmedicaid.org](http://www.mtmedicaid.org).

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