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State/Territory Name: Montana

State Plan Amendment (SPA) #: MT-09-017

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

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

Region VIII

February 22, 2010

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

Re: SPA 09-017

Dear Ms Dalton:

Please be advised CMS has approved Montana State Plan Amendment (SPA) 09/017, "Reimbursement Methodology for Dental Services" with an effective date of July 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 SPA 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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 09-017

2. STATE: Montana

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
07/01/2009

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN X☐ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
N/A

7. FEDERAL BUDGET IMPACT:
a. FFY 09 $27,838
b. FFY 10 $111,353

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

3.1A, 3.1B and 4.19B Methods & Standards for Establishing Payment Rates for Service 10 Dental Services.

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

3.1A, 3.1B and 4.19B Methods & Standards for Establishing Payment Rates for Service 10 Dental Services.

10. SUBJECT OF AMENDMENT:
The purpose of this amendment is to document the date of an increase to the provider reimbursement rate. Reimbursement methodology for Dental services has been updated as well.

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:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME: Mary E. Dalton

14. TITLE: State Medicaid Director

15. DATE SUBMITTED: 11/25/09

16. RETURN TO:
Montana Dept of Public Health and Human Services
Mary E. Dalton, State Medicaid Director
Attn: Jo Thompson
PO Box 4210
Helena MT 59604

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 11/25/09

18. DATE APPROVED: 2/22/10

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 7/1/09

20. [redacted] OFFICIAL:

21. TYPED NAME: Richard C. Allen

22. TITLE: Associate Regional Administrator

23. REMARKS:

MONTANA

Limits to the Dental Services program are noted below. All limits to dental services may be found on the fee schedule dated 7/1/2009 at www.mtmedicaid.org.

1. Diagnostic and preventative dental services:
   a. Fluoride treatments are limited to six (6) month intervals.
   b. Full mouth x-rays or panorex x-rays are limited to three (3) year intervals.
   c. Bite-wing x-rays are limited to one (1) year intervals.
   d. Examinations are limited to six (6) month intervals.
   e. Prophylaxis are limited to six (6) month intervals.

2. Restoration:
   a. Gold in-lays are not a benefit

3. Endodontic Services:
   a. Root canal services for third molars are not a benefit.

4. Periodontal Services:
   a. Gingival resections are limited to treatment of gingival hyperplasia due to medication reaction.

5. Crowns:
   a. For adults, Crowns are limited to pre-fabricated stainless steel, or pre-fabricated resin crowns.
   b. For children under age 21, non pre-fabricated crowns are a benefit for anterior teeth.

6. Orthodontic Services are limited to:
   a. Cases involving a possible Cleft/Craniofacial condition syndrome, congenital anomalies, cases related to malocclusion caused by traumatic injury and cases related to interceptive orthodontia must receive prior authorization to determine individual eligibility for such orthodontia services.
   b. Orthodontia for recipients age 20 and younger who have malocclusion caused by traumatic injury or needed as part of treatment with orthodontic implications.
   c. Recipients are limited to a lifetime cap of $7000.00 for interceptive and full band orthodontia phases. Surgeries are not included in this lifetime cap.
   d. Interceptive orthodontia is limited to children 12 years of age or younger with one or more of the following conditions:
      i. Posterior crossbite with shift;
      ii. Anterior crossbite and/or anterior deep bite at 80% or greater vertical incisor overbite.

MONTANA

7. Dental implants are not a covered benefit of the Medicaid program.

8. Bridges are not a covered benefit of the Medicaid program for individuals age 21 and older.

9. Cosmetic Dental Services:
Dental services for conditions or ailments considered cosmetic in nature are not a benefit of the Montana Medicaid Program except in such cases where it can be demonstrated the physical well-being and the psycho-social well-being of the recipient are severely affected in a detrimental manner. The Department or its designated review organization will determine whether a service is cosmetic or a recipient's physical well-being and psycho-social wellbeing are severely affected in a detrimental manner.

10. Experimental Services:
Services considered experimental are not a benefit of the Montana Medicaid Program. Experimental services include:

   a. All procedures and items, including prescribed drugs, considered experimental by the U.S. Department of Health and Human Services or any other appropriate federal agency.
   b. All procedures and items, including prescribed drugs, provided as part of a control study, approved by the Department of Health and Human Services or any other appropriate federal agency to demonstrate whether the item, prescribed drug or procedure is safe and effective in curing/preventing, correcting or alleviating the effects of certain medical conditions.
   c. All procedures and items, including prescribed drugs, which may be subject to question but are not covered in (a) and (b) above, will be evaluated by the Department's designated medical review organization.

11. Prior Authorization:
The following Dental Services require prior authorization by the designated review organization:

   a. Orthodontia.
   b. For children under age 21, Non Pre-Fabricated Crowns for posterior teeth. For adults, Non Pre-Fabricated Crowns for anterior and posterior teeth.

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MONTANA

1. Reimbursement for Dental Services 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 procedures are identified through the following process:
      (1) Procedures identified through ADA/CDT coding manual; or
      (2) Dental procedures identified by the Department not identified in the current ADA/CDT.

   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.

            (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.

MONTANA

(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. The "by report' reimbursement is paid at 85% of the provider's usual and customary charge.

(3) For orthodontia services the fee is established at 85% of the provider's usual and customary charges per treatment phase. The Department will initially pay 40% of the treatment phase with the remainder to be paid in equal payments over the treatment period.

(4) Unless otherwise specified in the plan, the same published methodology is used to reimburse governmental providers and non-governmental providers.

(5) The agency's rates were set as of July 1, 2009 and are published at www.mtmedicaid.org