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State/Territory Name: Montana

State Plan Amendment (SPA) #: MT-14-0030

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

December 4, 2014

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

Re: SPA MT-14-030

Dear Ms. Dalton:

We have reviewed the proposed State Plan Amendment (SPA) submitted under transmittal number MT-14-030. This SPA amends Dental Services, Denturists and Denture Services, and Dental Hygienists Services, removing the "by report" payment methodology and describe the new method for setting fees, distribute a 2% provider rate increase and update ceramic crown coverage to posterior teeth for EPSDT services as per current dental practice standards.

Please be informed that this State Plan Amendment was approved today with an effective date of July 1, 2014. We are enclosing the summary page and the amended plan page(s).

In order to track expenditures associated with this amendment, Montana should follow the CMS-64 reporting instructions outlined in Section 2500 of the State Medicaid Manual (SMM).

For those individuals whose expenditures qualify for the newly eligible federal medical assistance percentage report on the Form CMS-64.9 VIII and those not enrolled in the new adult group, claims should be reported on the Form CMS-64.9 Base.

This amendment would affect expenditures reported on Line 8.

If you have any questions regarding this SPA please contact Cindy Smith at 303-844-7041.

Sincerely,

/s/

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

Cc: Richard Opper, Department Director
Duane Preshinger
Jo Thompson
Mary Eve Kulawik

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: 14-030

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
07/01/2014

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:
SECTION 1902(a)(30)(A)

7. FEDERAL BUDGET IMPACT:
a. FFY 14 $76,975
b. FFY 15 $306,368
c. FFY 16 $303,486

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

4.19B Methods & Standards for Establishing Payment Rates for:
Dental Services 10 pages 1-2 of 2
Denturist Services 6(d) pages 1-2 of 2
Denture Services 12(b) pages 1-2 of 2
Dental Hygienist Services 6(d) pages 1-2 of 2
Supplement to Attachment 3.1A Dental Services 10 pages 1-2 of 2
Supplement to Attachment 3.1B Dental Services 10 pages 1-2 of 2

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

4.19B Methods & Standards for Establishing Payment Rates for:
Dental Services 10 pages 1-2 of 2
Denturist Services 6(d) pages 1-2 of 2
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Dental Hygienist Services 6(d) pages 1-2 of 2
Supplement to Attachment 3.1A Dental Services 10 pages 1-2 of 2
Supplement to Attachment 3.1B Dental Services 10 pages 1-2 of 2

10. SUBJECT OF AMENDMENT:
The purpose of this amendment is to comply with CMS's request to eliminate the "by report" payment methodology and describe the Department's new method for setting fees, distribute a 2% provider rate increase and update ceramic crown coverage to posterior teeth for EPSDT services as per current dental practice standards.

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:
Single Agency Director review

12. SIGNA[redacted]

13. TYPED NAME: Mary E. Dalton

14. TITLE: State Medicaid Director

15. DATE SUBMITTED: 7-3-14

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: **7/3/14**

18. DATE APPROVED: **12/4/14**

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: **7/1/14**

20. SIGNATURE OF REGIONAL OFFICIAL: **/s/**

21. TYPED NAME: **Richard C. Allen**

22. TITLE: **ARA, DMCHO**

23. REMARKS:

MONTANA

Limits to the Dental Services program are noted below.

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 porcelain fused to base metal crowns for anterior and posterior teeth and base metal crowns for second molars; a total of two per person per calendar year.
   b. For children under age 21, the benefit for anterior and posterior teeth crowns are limited to non-pre-fabricated crowns; porcelain/ ceramic substrate; porcelain fused to high noble; or base metal.

6. Orthodontic Services for children:
   a. Must be prior authorized;
   b. Are limited to Cleft/Craniofacial condition syndrome; congenital anomalies; and malocclusion caused by traumatic injury for children under age 21;
   c. Based on recognized national practice standards, 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.
   d. Benefits are limited to a lifetime cap of $7000 for both interceptive and full band orthodontia phases. Surgeries are not included in this lifetime cap.

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 individual are severely affected in a detrimental manner. The Department or its designated review organization will determine whether a service is cosmetic or individual'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 incurring/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.

MONTANA

Limits to the Dental Services program are noted below.

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   b. Full mouth x-rays or panorex x-rays are limited to three (3) year intervals.
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MONTANA

1. Reimbursement for Dental Services shall be the lower of the following for dentists, dental hygienists, and denturists:

   a. The provider's usual and customary charge for the service; or

   b. Reimbursement provided in accordance with the methodology described in number 2.

2. The Department's fee schedule is determined:

   a. For procedures listed in the "Relative Values for Dentists" published biennially by Relative Value Studies, Incorporated, the fee is determined using the following methodology:

      (1) The fee for a covered service is the amount determined by multiplying the (RVU) by the Montana Medicaid specific conversion factor.

         (a) The Relative Value Unit (RVU) is a numerical value assigned by Relative Value Studies Incorporated to a specific procedure code. The RVU assigned to a particular code expresses the relative effort and expense expended by a provider in providing one service as compared with another service.

         (b) The Montana Medicaid specific conversion factor is a dollar amount.

MONTANA

(c) A policy adjuster may be applied to some fees' calculation for certain categories of services or to the conversion factor to increase or decrease the fees paid by Medicaid.

b. For items or services when there is no relative value unit available, the department will set the fee at the same rate as a service similar in scope.

3. Unless otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of physician services. The agency's rates were set as of the date on the Attachment 4.19B Introduction Page and are published at www.mtmedicaid.org.

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