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**State/Territory Name: Montana**

**State Plan Amendment (SPA) #: 18-0049**

This file contains the following documents in the order listed:

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

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
Denver Regional Office  
1961 Stout Street, Room 08-148  
Denver, CO 80294



**REGION VIII - DENVER**

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October 22, 2018

Marie Matthews, Medicaid & CHIP Director  
Montana Department of Public Health & Human Services  
P.O. Box 4210  
Helena, MT 59604

Dear Ms. Matthews:

We have reviewed the proposed State Plan Amendment (SPA) submitted under transmittal number MT-18-0049. This amendment restores adult dental coverage.

Please be informed that this State Plan Amendment was approved today, with an effective date of October 1, 2018. 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.

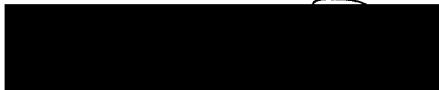

If you have any questions regarding this SPA please contact Barbara Prehmus at (303) 844-7472.

Sincerely,

A solid black rectangular box used to redact the signature of the sender.

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

cc: Sheila Hogan, Department Director  
Duane Preshinger  
Mary Eve Kulawik

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>  <b>FOR: HEALTH CARE FINANCING ADMINISTRATION</b>		1. TRANSMITTAL NUMBER: 18-0049	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 10/01/2018	
5. TYPE OF PLAN MATERIAL (Check One):  <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> 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), 42CFR440.100		7. FEDERAL BUDGET IMPACT:  a. FFY 18 \$0 b. FFY 19 \$0 c. FFY 20 \$0  Amounts are reflected on the MT 18-0040 Reimbursement Introduction Page.	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  Supplement to Attachment 3.1A and 3.1B, Dental Services, 10, pages 1-2 of 2		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):  Supplement to Attachment 3.1A and 3.1B, Dental Services, 10, pages 1-2 of 2	
10. SUBJECT OF AMENDMENT:  This amendment restores the adult dental benefits that were reduced effective March 1, 2018.			
11. GOVERNOR'S REVIEW (Check One):  <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL		<input checked="" type="checkbox"/> OTHER, AS SPECIFIED: Single Agency Director review	
12. SIGNATURE OF STATE AGENCY OFFICIAL:  		16. RETURN TO:  Montana Department of Public Health and Human Services Marie Matthews Attn: Mary Eve Kulawik PO Box 4210 Helena MT 59620	
13. TYPED NAME: Marie Matthews			
14. TITLE: State Medicaid Director			
15. DATE SUBMITTED: 9-7-18			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED: September 7, 2018		18. DATE APPROVED: October 22, 2018	
PLAN APPROVED – ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: October 1, 2018		20. SIGNATURE OF REGIONAL OFFICIAL: 	
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, pre-fabricated stainless steel, or pre-fabricated resin crowns are available without limits. Porcelain fused to base metal crowns for anterior and posterior teeth and base metal crowns for second molars are limited to no more than two per person per calendar year. Crown replacement is available per tooth once per five years.
  - 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.

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 and psychosocial wellbeing of the individual is severely affected in a detrimental manner. The Department or its designated review organization will determine whether a service is cosmetic or an individual's physical wellbeing and psychosocial 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.
11. Adult Treatment Services Financial Cap:  
  
Medically necessary dental treatment services for adults are limited to \$1,125 per benefit year (July 1-June 30). Diagnostic, preventive, denture and anesthesia services are excluded from the financial cap.

MONTANA

Limits to the Dental Services program are noted below.

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