

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION		1. TRANSMITTAL NUMBER: 11-023	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 08/01/2011	
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: N/A		7. FEDERAL BUDGET IMPACT: a. FFY 11 (\$137.23) b. FFY 12 (\$814.77)	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: 3.1A, 3.1B and 4.19B Methods & Standards for Establishing Payment Rates for Hygienist Service 6(d).		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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): 3.1A, 3.1B and 4.19B Methods & Standards for Establishing Payment Rates for Hygienist Service 6(d).	
10. SUBJECT OF AMENDMENT: The purpose of this amendment is to change the date the agency's rates were set.			
11. GOVERNOR'S REVIEW (Check One): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL:		16. RETURN TO:	
13. TYPED NAME: Mary E. Dalton		Montana Dept of Public Health and Human Services Mary E. Dalton, State Medicaid Director Attn: Jo Thompson PO Box 4210 Helena MT 59604	
14. TITLE: State Medicaid Director			
15. DATE SUBMITTED: 6-30-11			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: 6/30/11		18. DATE APPROVED: 8/19/11	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 8/1/11		20. SIGNATURE OF REGIONAL OFFICIAL:	
21. TYPED NAME: RICHARD C. ALLEN		22. TITLE: APA, DMCHO	
23. REMARKS:			

MONTANA

1. Reimbursement for Dental Hygienist Services provided when a Dental Hygienist has a limited access permit to practice under "public health supervision" 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 preventative 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)(1).
 - 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:

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(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.

(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. The agency's rates were set as of August 1, 2011 and are effective for services on or after that date. All rates are published on the agency's website www.mt-medicaid.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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