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: 11-021

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)*:

☐ 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:
N/A

7. FEDERAL BUDGET IMPACT:
a. FFY 11 ($1,149.68)
b. FFY 12 ($6,825.85)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

3.1A, 3.1B and 4.19B Methods & Standards for Establishing Payment Rates for Denturist 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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: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 Denturist 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)*:
☐ 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:

13. TYPED NAME: Mary E. Dalton

14. TITLE: State Medicaid Director

15. DATE SUBMITTED:
6-30-11

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: 6/30/11

18. DATE APPROVED: 8/15/11

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: ARA, DMCHO

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 8/1/2011 at ww.mtmedicaid.or .

1. Replacement of dentures is allowed when one of the following circumstances occur:

    a. partial dentures that are at least five years old and full dentures that are at least 10 years old. One lifetime exception to the 10 year or 5 year replacement limit is allowed per recipient if one of the following exceptions exists and is authorized by the department:
        i. it is determined that the existing dentures are no longer serviceable and cannot be relined, or rebased.
        ii. the dentures are lost, stolen, or damaged beyond repair.
        iii. The existing dentures are causing serious physical health problems.

2. Rebasing is allowed for dentures older than five (5) years.
3. Coverage of denture services by a denturist is subject to the following requirements and limitations:
    a. A denturist may provide initial immediate full prosthesis and initial immediate partial prosthesis only when prescribed by a dentist.
    b. Requests for full prosthesis must show the approximate date of the most recent extractions, and/or the age and type of the present prosthesis.

Services considered experimental are not a benefit of the Montana Medicaid Program. Experimental services include all procedures, items and prescribed drugs:

1. Considered experimental by the U.S. Department of Health and Human Services (HHS) or any other appropriate federal agency.

MONTANA

2. Provided as part of a control study, approved by HHS 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; and,

3. Which may be subject to question but not covered in #1 and #2 above. These services will be evaluated by the Department's designated medical review organization.

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Montana

I. Reimbursement for Denturist 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 denture services.

II. The Department's fee schedule is calculated as follows:

A. Denture procedures are identified through the following process:

1. Procedures identified through ADA/CDT coding manual; or
2. Denture 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.

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

(4) The agency's rates were set as of August 1, 2011 and are published at www.mtmedicaid.org.