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State/Territory Name: Montana

State Plan Amendment (SPA) #: MT-10-005

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 16, 2010

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

Re: SPA 10-005

Dear Ms Dalton:

Please be advised CMS has approved Montana State Plan Amendment (SPA) 10-005, "Hearing Aid Payment Methodology Change and Limitations" with an effective date of January 1, 2010.

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 Diana Maiden at 303-844-7114.

Sincerely,

/s/

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

Cc: Duane Preshinger
Jo Thompson

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 10-005	2. STATE Montana
FOR: HEALTH CARE FINANCING ADMINISTRATION		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 01/01/2010	
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 2009 None b. FFY 2010 None	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Page(s) 1 of 1 Attachment 4.19B, 3.1A and 3.1B Methods & Standards For Establishing Payment Rates and Service 12.c Hearing Aid Services and Section 12.c Prosthetic Devices		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Page(s) 1 of 1 Attachment 4.19B, 3.1A and 3.1B Methods & Standards For Establishing Payment Rates Service 12.c Hearing Aid Services and Section 12.c Prosthetic Devices	
10. SUBJECT OF AMENDMENT: Hearing Aid Payment Methodology Change and Limitations.			
11. GOVERNOR'S REVIEW (Check One): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" 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: Montana Dept. of Public Health and Human Services Mary E. Dalton State Medicaid Director Attn: Jo Thompson PO Box 4210 Helena, MT 59604	
13. TYPED NAME: Mary E. Dalton			
14. TITLE: State Medicaid Director			
15. DATE SUBMITTED: 12/21/09			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: 12/21/09		18. DATE APPROVED: 2/16/10	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 1/1/10		REGIONAL OFFICIAL: 	
21. TYPED NAME: Richard C. Allen		22. TITLE: Associate Regional Administrator	
23. REMARKS:			

MONTANA

The following limitations apply to Prosthetic Devices:

1. Orthopedic shoes are excluded unless they are attached to a brace. This does not include diabetic shoes as defined by Medicare or outlined by Medicare.
2. Shoe repair and corrections are excluded.
3. Prior to the fitting and purchase of a hearing aid, a physician or mid-level practitioner must complete a hearing aid evaluation or refer the Medicaid recipient to a licensed audiologist for the hearing aid evaluation.
4. For individuals 21 years of age and older, a hearing aid purchased by Medicaid will be replaced no more than once in a 5-year period unless:
 - a. The original hearing aid has been irreparably broken after the 1-year warranty period or has been lost;
 - b. The provider's records document the loss or broken condition of the original hearing aid; or
 - c. The original hearing aid no longer meets the needs of the recipient and a new hearing aid is determined to be medically necessary by a licensed audiologist.

The following prior authorizations apply to Prosthetic Devices:

1. All requests for the purchase of hearing aid(s) are prior authorized by the Department or its designee.
2. Items (other than hearing aids) costing \$1000 or more require prior authorization before the service is provided.
3. Items (other than hearing aids) costing less than \$1000 do not require prior authorization unless the item is required as indicated in the program fee schedule.

TN 10-005

Approved Date: 2/16/10

Effective Date: 01/01/2010

Supersedes TN 03-038

MONTANA

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TN 10-005 Approved Date: 2/16/10 Effective Date: 01/01/2010

Supersedes TN 03-028

MONTANA

- I. Reimbursement for Hearing Aid Services (excluding hearing aids) shall be the lower of the following:
 - a. The provider's* usual and customary charge for the service, or
 - b. The Department's fee schedule
 - II. Reimbursement for Hearing Aids shall be:
 - a. The invoice cost for hearing aids from the manufacturer not to exceed the established rate on the fee schedule.
 - b. The invoice cost from the manufacturer for hearing aid repairs or
 - c. 100% of the Medicare region D fee for other hearing devices and accessories.
 - III. The Department's fee schedule is determined by:
 - a. Establishing a fee for each new service which has been billed at least 50 times by all providers in the aggregate during the previous 12 month period. The Department shall set each fee at 90% of the average charge billed by all providers in the aggregate.
 - IV. All private and governmental providers are reimbursed according to the same published fee schedule. The agency's rates were set as of July 1, 2009 and are effective for services on or after that date. All rates are available on the Department's website at www.mt.gov/medicaid.org.
- *A provider is a licensed hearing aid dispenser who is individually enrolled in the Montana Medicaid program.

TN 10-005 Approved: 2/16/10 Effective 01/01/2010

Supersedes TN 09-014