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: 10-008

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
07/01/2010

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 2010 $0
FFY 2011 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Page(s) 1 of 1
Attachment 4.19B
Methods & Standards For Establishing Payment Rates
12.c Hearing Aids

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Page(s) 1 of 1
Attachment 4.19B
Methods & Standards For Establishing Payment Rates
12.c Hearing Aids

10. SUBJECT OF AMENDMENT:
Hearing Aid Fee Schedule Change (Date)

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: 6/28/2010

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: 6/28/10

18. DATE APPROVED: 8/12/10

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 7/1/10

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Mary Marchioni

22. TITLE: Acting ARA

23. REMARKS:

FORM HCFA-179 (07-92)

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 Aid(s) 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, 2010 and are effective for services on or after that date. All rates are available on the Department's website at www.mtmedicaid.org.

*A provider is a licensed hearing aid dispenser who is individually enrolled in the Montana Medicaid program.