

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 11-045	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 10/01/2011	
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 2011 (0) Hearing Aids FFY 2012 (0) Hearing Aids	
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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Page(s) 1 of 1 Attachment 4.19B Methods & Standards For Establishing Payment Rates 12.c Hearing Aids	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: A change in licensing requirements for Audiologists no longer require Audiologists to have a dispensing fee licence to dispense hearing aids.			
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: 9/14/11			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: 9/14/11		18. DATE APPROVED: 10/14/11	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 10/1/11		20. SIGNATURE OF REGIONAL OFFICIAL:	
21. TYPED NAME: RICHARD C. ALLEN		22. TITLE: ARA, DMCHO	
23. REMARKS:			

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 August 1, 2011 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 or audiologist who is individually enrolled in the Montana Medicaid program.