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: 11-036

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
September 1, 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:

7. FEDERAL BUDGET IMPACT:
a. FFY 2011 $0
b. FFY 2012 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Service 5a Physician Services
Attachment 4.19B

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Service 5a Physician Services
Attachment 4.19B

10. SUBJECT OF AMENDMENT:
Amend Service 5a Physician Services to update fee schedule. Notice of Public Hearing on Proposed Amendment, MAR Notice No. 37-541

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: SINGLE AGENCY DIRECTOR REVIEW

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: **Mary E. Dalton**

14. TITLE: **State Medicaid Director**

15. DATE SUBMITTED: 8/22/2011

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: 8/22/11

18. DATE APPROVED: 10/14/11

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 9/1/11

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: RICHARD C. ALLEN

22. TITLE: ARA, DMCHO

23. REMARKS:

FORM HCFA-179 (07-92)

MONTANA

I. Reimbursement for Physician Services shall be:

A. The lower of:

1. The provider's usual and customary charge for the service; or

2. Reimbursement provided in accordance with the methodology described In Number II.

II. The Department's fee schedule for Physician Services is determined:

A. In accordance with the Resource Based Relative Value Scale (RBRVS) methodology, by multiplying Medicare's Relative Value Units (RVU), or Medicare's base and time units for anesthesia services, which is numeric, by the Montana Medicaid specific conversion factor, which is a dollar amount, to equal a fee. Specific to Montana Medicaid, there is an ability to multiply the fee times a policy adjuster (either plus or minus) to affect the fee.

B. "Resource based relative value scale (RBRVS)" means the version of the Medicare resource based relative value scale contained in the Medicare Physician Fee Schedule adopted by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services published January 11 2011.

C. "Relative value unit (RVU)" means a numerical value assigned in the resource based relative value scale to each procedure code used to bill for services provided by a health care provider. The relative value unit assigned to a particular code expresses the relative effort and expense expended by a provider in providing one service as compared with another service.

MONTANA

D. The RVUs are adopted from the RBRVS.

1. If Medicare sets RVUs, the Medicare RVUs are applicable;
2. If Medicare does not set RVUs but Medicaid sets RVUs, the Medicaid RVUs are set in the following manner:

a) convert the existing dollar value of a fee to an RVU value;
b) evaluate the RVU of similar services and assign an RVU value; or
c) convert the average by report dollar value of a fee to an RVU value.

E. If neither Medicare nor Medicaid sets RVUs, then reimbursement is 'by report'. 'By report' means paying a percentage of billed charges. The percentage is derived by dividing the previous state fiscal year's total Medicaid reimbursement for services included in the RBRVS by the previous state fiscal year's total Medicaid billings.

F. Reimbursement for physician-administered drugs effective July 1, 2010 is based upon:

1. The Medicare Average Sales Price (ASP) methodology if there is an ASP fee;
2. The RBRVS fee if there is an RBRVS fee;
3. The estimated acquisition cost (EAC) as defined in the outpatient drug services state plan (service 12a); or
4. The 'by report' amount.

G. Consistent with the policies described in this section, the agency's fee schedule for SFY 2012 is updated September 1, 2011 and is effective for services provided on or after that date. All rates are published on the agency's website at http://medicaidprovider.hhs.mt.gov/.