MONTANA ADMINISTRATIVE REGISTER

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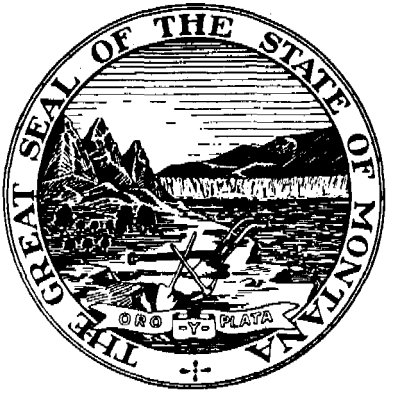

NOTICE OF FUNCTIONS OF ADMINISTRATIVE CODE COMMITTEE

The Administrative Code Committee reviews all proposals for adoption of new rules or amendment or repeal of existing rules filed with the Secretary of State. Proposals of the Department of Revenue are reviewed only in regard to the procedural requirements of the Montana Administrative Procedure Act. The Committee has the authority to make recommendations to an agency regarding the adoption, amendment, or repeal of a rule or to request that the agency prepare a statement of the estimated economic impact of a proposal. In addition, the Committee may poll the members of the Legislature to determine if a proposed rule is consistent with the intent of the Legislature or, during a legislative session, introduce a Joint Resolution directing an agency to adopt, amend or repeal a rule.

The Committee welcomes comments from the public and invites members of the public to appear before it or to send it written statements in order to bring to the Committee's attention any difficulties with existing or proposed rules. The address is Room 138, State Capitol, Helena, Montana, 59620.

HOW TO USE THE ADMINISTRATIVE RULES OF MONTANA AND THE MONTANA ADMINISTRATIVE REGISTER

Definitions: Administrative Rules of Montana (ARM) is a loose-leaf compilation by department of all rules of state departments and attached boards presently in effect, except rules adopted up to three months previously.

Montana Administrative Register (MAR) is a soft back, bound publication, issued twice-monthly, containing notices of rules proposed by agencies, notices of rules adopted by agencies, and interpretations of statute and rules by the attorney general (Attorney General's Opinions) and agencies (Declaratory Rulings) issued since publication of the preceding register.

Use of the Administrative Rules of Montana (ARM):

Known Subject Matter	1.	Consult General Index, Montana Code Annotated to determine department or board associated with subject matter or statute number.
Department	2.	Refer to Chapter Table of Contents, Title 1 through 46, page i, Volume 1, ARM, to determine title number of department's or board's rules.
	3.	Locate volume and title.
Subject Matter and Title	4.	Refer to topical index, end of title, to locate rule number and catchphrase.
Title Number and Department	5.	Refer to table of contents, page 1 of title. Locate page number of chapter.
Title Number and Chapter	6.	Go to table of contents of chapter, locate rule number by reading catchphrase (short phrase describing rule.)
Statute Number and Department	7.	Go to cross reference table at end of each title which lists each MCA section number and corresponding rules.
Rule in ARM	8.	Go to rule. Update by checking the accumulative table and the table of contents for the last register issued.

ACCUMULATIVE TABLE

The Administrative Rules of Montana (ARM) is a compilation of existing permanent rules of those executive agencies which have been designated by the Montana Administrative Procedure Act for inclusion in the ARM. The ARM is updated through March 31, 1981. With the exception of this issue of the Montana Administrative Register (MAR), this accumulative table includes all rulemaking action published in each register since March 31, 1981.

To be current on rulemaking, it is necessary to check the ARM updated through March 31, 1981, this table and the table of contents of this issue of the MAR.

This table indicates the department name, title number, rule number in ascending order, catchphrase or the subject matter of the rule and the page number at which the action is published.

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RULE SECTION

NOTICE: The July 1977 through June 1980 Montana Administrative Registers have been placed on microfiche. For information, please contact Jim Waltermire, Secretary of State, Room 202, Capitol Building, Helena, Montana, 59620.

STATE OF MONTANA
DEPARTMENT OF PROFESSIONAL AND OCCUPATIONAL LICENSING
BOARD OF LANDSCAPE ARCHITECTS

IN THE MATTER of the proposed amendment of ARM 40.22.409 concerning fees) NOTICE OF PROPOSED AMENDMENT OF ARM 40.22.409 FEE SCHEDULE

NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons:

1. On July 11, 1981, the Board of Landscape Architects proposes to amend ARM 40.22.409 concerning fees.

2. The amendment as proposed will read as follows: (new matter underlined, deleted matter interlined)

"40.22.409 FEE SCHEDULE (1) Fees shall be transmitted by money order or check payable to Montana State Board of Landscape Architects. The board assumes no responsibility for loss in transit of such remittances. Applications not accompanied by the proper fee will be returned to the applicant. All fees are non-refundable.

(2) In every case should the board deny the issuance of a certificate to any applicant, the fee deposited shall be retained by the board.

(3) Landscape Architects Fee Schedule:

Application (not included in examination fees)		$75.00
Certificate (license)		35.00
Examination (full)	~~120.00~~	190.00
Examination - Section A		30.00
Section B		30.00
Section C	~~30.00~~	65.00
Section D	~~30.00~~	65.00
UNE Re-evaluation per sheet for performance problems		25.00
License renewal		90.00
Duplicate certificate		35.00"

3. The board is proposing the amendment because of increased examination costs.

4. Interested parties may submit their data, views or arguments concerning the proposed amendment in writing to the Board of Landscape Architects, Lalonde Building, Helena, Montana 59620, no later than July 9, 1981.

5. If a person who is directly affected by the proposed amendment wishes to express his data, views or arguments orally or in writing at a public hearing, he must make written request for a hearing and submit this request along with any written comments he has to the Board of Landscape Architects, Lalonde Building, Helena, Montana 59620, no later than July 9, 1981.

6. If the board receives requests for a public hearing on the proposed amendments from either 10% or 25, whichever is less, of the persons who are directly affected by the proposed amendment; from the Administrative Code Committee of the legislature; from a governmental agency or subdivision; or from an association having not less than 25 members who will be

directly affected, a hearing will be held at a later date. Notice of the hearing will be published in the Montana Administrative Register.

7. The authority of the board to make the proposed amendment is based on section 37-66-202, MCA and implements the same.

BOARD OF LANDSCAPE ARCHITECTS
ESTHER HAMEL, CHAIRMAN

BY: _____
ED CARNEY, DIRECTOR
DEPARTMENT OF PROFESSIONAL
AND OCCUPATIONAL LICENSING

Certified to the Secretary of State, June 1, 1981.

BEFORE THE DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES OF THE
STATE OF MONTANA

In the matter of the amendment of Rule 46.10.403 pertaining to AFDC table of assistance standards	)))))	NOTICE OF PUBLIC HEARING ON THE PROPOSED AMENDMENT OF RULE 46.10.403 PERTAINING TO AFDC TABLE OF ASSISTANCE STANDARDS

To: All Interested Persons:

1. On July 2, 1981, at 11:00 a.m., a public hearing will be held in the auditorium of the Social and Rehabilitation Services Building, 111 Sanders, Helena, Montana, to consider the amendment of Rule 46.10.403 pertaining to the AFDC table of assistance standards.

2. The rule as proposed to be amended provides as follows:

46.10.403 TABLE OF ASSISTANCE STANDARDS (1) The table of assistance standards contains the requirements of individuals or families according to the number of persons, the type of living arrangement, and whether shelter is or is not included.

(a) Basic Requirements - Adults included in the assistance unit.

~~BUDGET TO BE USED WHEN ADULTS ARE INCLUDED IN THE ASSISTANCE UNIT~~

~~No. Of Persons in Household~~	~~With Shelter Obligation Per Month~~	~~With Shelter Obligation Per Day~~	~~Without Shelter Obligation Per Month~~	~~Without Shelter Obligation Per Day~~
~~1~~	~~$154~~	~~$5.13~~	~~$117~~	~~$3.90~~
~~2*~~	~~193~~	~~6.43~~	~~146~~	~~4.86~~
~~3~~	~~259~~	~~8.63~~	~~196~~	~~6.53~~
~~4~~	~~331~~	~~11.03~~	~~248~~	~~8.26~~
~~5~~	~~381~~	~~12.70~~	~~286~~	~~9.53~~
~~6~~	~~433~~	~~14.43~~	~~329~~	~~10.97~~
~~7~~	~~474~~	~~15.80~~	~~360~~	~~12.00~~
~~8~~	~~537~~	~~17.90~~	~~408~~	~~13.60~~
~~9~~	~~600~~	~~20.00~~	~~455~~	~~15.17~~
~~10~~	~~663~~	~~22.10~~	~~503~~	~~16.77~~
~~11~~	~~726~~	~~24.20~~	~~551~~	~~18.37~~
~~12~~	~~789~~	~~26.30~~	~~599~~	~~19.97~~
~~13~~	~~852~~	~~28.40~~	~~647~~	~~21.57~~
~~14~~	~~915~~	~~30.50~~	~~694~~	~~23.13~~
~~15~~	~~978~~	~~32.60~~	~~742~~	~~24.73~~
~~16~~	~~1041~~	~~34.70~~	~~790~~	~~26.33~~

~~* For two adult no child cases use $230 (with shelter obligation) and $175 (without shelter obligation).~~

BUDGET TO BE USED WHEN ADULTS ARE INCLUDED IN THE ASSISTANCE UNIT

No. Of Persons in Household	With Shelter Obligation Per Month	With Shelter Obligation Per Day	Without Shelter Obligation Per Month	Without Shelter Obligation Per Day
1	$ 177	$ 5.90	$ 64	$ 2.13
2	234	7.80	103	3.43
3	278	9.27	140	4.67
4	356	11.87	182	6.07
5	420	14.00	216	7.20
6	473	15.77	243	8.10
7	523	17.43	268	8.93
8	574	19.13	294	9.80
9	624	20.80	320	10.67
10	674	22.47	346	11.53
11	724	24.13	372	12.40
12	774	25.80	398	13.27
13	824	27.47	424	14.13
14	874	29.13	450	15.00
15	924	30.80	476	15.87
16	974	32.47	502	16.73

(b) Basic Requirements - No adults included in the assistance unit.

~~BUDGET TO BE USED WHEN NO ADULTS ARE INCLUDED IN THE ASSISTANCE UNIT~~

~~No. of Children in Household~~	~~Grant Amount Per Month~~	~~Grant Amount Per Day~~
~~1~~	~~$ 67~~	~~$ 2.23~~
~~2~~	~~132~~	~~4.40~~
~~3~~	~~192~~	~~6.40~~
~~4~~	~~241~~	~~8.03~~
~~5~~	~~307~~	~~10.23~~
~~6~~	~~348~~	~~1.60~~
~~7~~	~~411~~	~~13.70~~
~~8~~	~~474~~	~~15.80~~
~~9~~	~~537~~	~~17.90~~
~~10~~	~~600~~	~~20.00~~
~~11~~	~~663~~	~~22.10~~
~~12~~	~~726~~	~~24.20~~
~~13~~	~~789~~	~~26.30~~
~~14~~	~~852~~	~~28.40~~
~~15~~	~~915~~	~~30.50~~
~~16~~	~~978~~	~~32.60~~

BUDGET TO BE USED WHEN NO ADULTS ARE INCLUDED IN THE ASSISTANCE UNIT

No. of Children in Household	Grant Amount Per Month	Grant Amount Per Day
1	$ 53	$ 1.77
2	86	2.87
3	127	4.23
4	168	5.60
5	209	6.97
6	252	8.40
7	295	9.83
8	338	11.27
9	381	12.70
10	424	14.13
11	467	15.57
12	510	17.00
13	553	18.43
14	596	19.87
15	639	21.30
16	682	22.73

The per-day column in both tables is to be used to compute basic requirements for part of a month. Example - A household of four with shelter obligation eligible for 10 days in a month = ~~$11.03~~ $11.87 x 10 = ~~$110.30~~ $118.70 or ~~$111.00~~ $119.00. The total is rounded up to the nearest dollar beginning with 25¢ and over.

~~SPECIAL ALLOWANCE~~

~~Personal needs in a Nursing Home----------$25.00~~
~~Children in Boarding School----------$16.00~~
~~Adult Foster Care---$257.20~~
~~Children in Boarding School Home on Weekends----$-31.00~~

~~The boarding school situations where children are in the boarding school on a full- or part-time basis, the children are to be budgeted according to the special allowance table. In situations where all the children are in boarding school, the needy caretaker relative is to be budgeted on the basis of a single- person- household.~~

3. This rule is being amended to reflect the increase in funding as provided by the 1981 Legislature and to ensure that the Department will have, through the entire fiscal year, enough funds to maintain AFDC recipients most in need at a standard of living conducive to decency and health.

4. Interested persons may present their data, views or arguments, either orally or in writing, at the hearing. Written data, views or arguments may also be submitted to the Office of Legal Affairs, Department of Social and Rehabilitation Services, P.O. Box 4210, Helena, MT 59604, no later than July 10, 1981.

5. The Office of Legal Affairs, Department of Social and Rehabilitation Services has been designated to preside over and conduct the hearing.

6. The authority of the agency to amend the rule is based on Section 53-4-212, MCA, and the rule implements Section 53-4-241, MCA.

Director, Social and Rehabilitation Services

Certified to the Secretary of State June 1, 1981.

BEFORE THE DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES OF THE
STATE OF MONTANA

In the matter of the amendment of Rule 46.12.303 pertaining to medical services; billing, reimbursement, claims processing, and payment.	))))	NOTICE OF PUBLIC HEARING ON PROPOSED RULE 46.12.303 PERTAINING TO MEDICAL SERVICES

TO: All Interested Persons

1. On July 2, 1981, at 10:00 a.m., a public hearing will be held in the auditorium of the Social and Rehabilitation Services Building, 111 Sanders, Helena, Montana, to consider the amendment of Rule 46.12.303 pertaining to medical services; billing, reimbursement, claims processing, and payment.

2. The rule proposed to be amended provides as follows:

46.12.303 BILLING, REIMBURSEMENT, CLAIMS PROCESSING, AND PAYMENT (1) Providers shall submit claims within 180 days of the date the service was performed, within 180 days after the applicants eligibility is determined, or within 180 days after a written notice from a third party resource, whichever occurs last. For providers of hospital services, the service shall be deemed to have been performed upon the recipient's discharge from one continuous confinement. A written inquiry to the department or to the local county welfare department regarding eligibility within the 180 day limit shall constitute evidence of an effort to bill medicaid for these services.

(a) All claims to the Montana medicaid program by individual practitioners and sole proprietorships, whether or not incorporated as a public service corporation, are to be submitted on personally signed state approved billing forms, or they shall not be considered valid and proper claims.

(b) All claims submitted to the Montana medicaid program by other legal business entities are to be submitted on state approved billing forms with the personal signature of a person who has actual written authority to bind and represent the provider for this purpose. The provider must furnish a verified original signature of this person on a form that has been furnished by the department for this purpose. Claims not submitted in this manner shall not be considered valid and proper.

(2) The program shall pay 90 percent of all valid and proper claims within 30 days after receipt of said claim. Should the bureau contend that a claim is not valid or proper, the bureau shall inform the provider of the details of the contention within 30 days after receipt of the claim.

(a) The program shall pay 99 percent of all valid and proper claims within 90 days of receipt of the claims.

(b) The program shall make payment on all claims within 180 days of the receipt of the claim unless it determines payment to be improper under this chapter or applicable federal regulations.

(c) The department shall be entitled to promptly (within 60 days) recover all payments erroneously or improperly made to a provider. At the option of the provider, refunds shall be accomplished either by mailing a check made out to "State Department of Social and Rehabilitation Services" directly to that department at Box 4210, Helena, MT 59601, or by notifying the department in writing of the receipt and the amount of payment over and above the amount reimbursable by the Montana medicaid program, which amount shall then be automatically deducted from future payments to the provider. Regardless of the method of repayment chosen, the provider shall identify on the check or notifying document the patient, by name and claim number, who received services for which the over payment was made and specify the dates of services for which over payments were received. If the provider contests the department's decision that the provider has been overpaid, recovery shall depend on the final administrative decision.

(3) Unless stated elsewhere, payments made by the Montana medicaid program shall not exceed the lower of the amount payable for like services in the same locality by the medicare program (Title XVIII of the Social Security Act), or the provider's usual and customary charges that are reasonable.

(4) Providers are required to accept, as payment in full, the amount paid by the Montana medicaid program for a service provided to an eligible medicaid recipient in accordance with the rules of the department. Providers shall not seek any payment in addition to or in lieu of the amount paid by the Montana medicaid program from a recipient or his representative.

(5) In the event that a provider of services is entitled to a retroactive increase of payment for services rendered, the provider shall submit a claim within 180 days of the written notification of the retroactive increase or the provider forfeits any rights to the retroactive increase.

(6) The Montana medicaid program shall make payments directly to the individual provider of service unless the individual provider is required, as a condition of his employment, to turn his fees over to his employer.

(a) Exceptions to the above requirement may, at the discretion of the department, be made for transportation and/or per diem costs incurred to enable a recipient to obtain medically appropriate services.

(7) The method of determining payment rates for out-of-state providers will be the same as for in-state providers except as otherwise provided in the rules of the department.

(8) A government agency may bill the medicaid program for covered medical services under the following circumstances:

(a) The government agency has complied with all federal and state law governing the medicaid program, and assures that the provider has complied with all state and federal law governing the medicaid program, including reimbursement levels.

(b) The government agency accepts assignment from an eligible medicaid provider for services provided prior to eligibility determination.

3. The proposed amendment allows Medicaid to reimburse local government or other governmental agencies when they have previously paid for services to a recipient later found to have been Medicaid eligible. This ability does not exist at the present time.

4. Interested parties may submit their data, views, or arguments, either orally or in writing at the hearing. Written data, views or arguments may also be submitted to the Office of Legal Affairs, Department of Social and Rehabilitation Services, P.O. Box 4210, Helena, Montana, 59604, no later than July 10, 1981.

5. The Office of Legal Affairs, Department of Social and Rehabilitation Services has been designated to preside over and conduct the hearing.

6. The authority of the agency to amend the rule is based on Section 53-6-113, MCA, and the rule implements Sections 53-6-111, 53-6-113, and 53-6-141, MCA.

John LaFaver

Director, Social and Rehabilitation Services

Certified to the Secretary of State June 1, 1981.

BEFORE THE DEPARTMENT OF
SOCIAL AND REHABILITATION SERVICES
OF THE STATE OF MONTANA

In the matter of the adoption of a rule and the amendment of Rules 46.12.102 and 46.12.201 pertaining to medical assistance, medically needy income standards and definition of family size	))))))	NOTICE OF PUBLIC HEARING ON PROPOSED ADOPTION OF A RULE AND THE AMENDMENT OF RULES 46.12.102 AND 46.12.201 PERTAINING TO MEDICAL SERVICES

TO: All Interested Persons

1. On July 2, 1981, at 9:00 a.m., a public hearing will be held in the auditorium of the Social and Rehabilitation Services Building, 111 Sanders, Helena, Montana, to consider the adoption of a rule and the amendment of Rules 46.12.102 and 46.12.201 pertaining to medical assistance, medically needy income standards and family size definition.

2. The rule proposed to be adopted provides as follows:

RULE I MEDICALLY NEEDY INCOME STANDARDS (1) The following table contains the amount of net income protected for maintenance by family size in compliance with the following federal regulations which are hereby incorporated by reference. The federal regulations incorporated by reference are 42 CFR 435.811, "general requirements"; 42 CFR 435.812 (a) (1) and (2), and (b) (1) and (2), "medically needy income standard for one-person, non-institutionalized"; 42 CFR 435.814 (a) (1) and (2), and (b) (1) and (2), "medically needy income standard for two-persons, non-institutionalized"; 42 CFR 435.816, "medically needy income standards for three or more persons"; and 42 CFR 435.1007, "medically needy." A copy of the above-cited regulations may be obtained from the Department of Social and Rehabilitation Services, P.O. Box 4210, Helena, Montana 59601.

MEDICALLY NEEDY INCOME LEVELS

FAMILY SIZE	INCOME LIMIT
1	$242.00
2	317.00
3	375.00
4	475.00
5	567.00
6	633.00
7	700.00
8	767.00
9	833.00
Each Additional Person	75.00

(2) All families are assumed to have a shelter obligation, and no urban or rural differentials are recognized in establishing those amounts of net income protected for maintenance.

AUTH: Sec. 53-6-113,MCA; IMP:Sec.53-6-101,53-6-131,53-6-141,MCA

3. The rules proposed to be amended provide as follows:

46.12.102 MEDICAL ASSISTANCE, DEFINITIONS (1) Department means the Montana department of social and rehabilitation services.

(2) Medically necessary service means a service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate, or prevent the worsening of conditions in a patient which:

(a) endanger life, or

(b) cause suffering or pain, or

(c) result in illness or infirmity, or

(d) threaten to cause or aggravate a handicap, or

(e) cause physical deformity or malfunction and, there is no other equally effective, more conservative, or substantially less costly course of treatment more suitable for the recipient requesting the service or, when appropriate, no treatment at all.

(i) Services which are considered by the medical profession as experimental or which are generally regarded by the medical profession as unacceptable treatment will not be considered medically necessary for the purpose of the medical assistance program.

(3) Montana medicaid program means the Montana medical assistance program authorized by sections 53-6-101 through 53-6-144, 53-6-201 and 53-6-202 et seq. MCA and 42 USC 1396 et seq.

(4) Provider means a natural person, firm, corporation, association or institution which is providing and has been approved to provide medical assistance to a recipient pursuant to the state medical assistance program.

(5) Third party means an individual, institution, corporation, or a public or private agency which may be or is liable to pay all or part of the medical cost of injury, disease, or disability of an applicant for or a recipient of services provided by the Montana medicaid program.

(6) Usual and customary charges which are reasonable means those charges which fall within the 75th percentile of all charges for similar service in the statewide area during the last calendar year elapsing prior to the start of the fiscal year in which the bill is submitted.

(7) Valid and proper claim means a claim which has been signed and submitted on a department approved billing form with all the requested information supplied, and for which no further written information or substantiation is required for payment.

(8) Designated review organization means an organized group or an individual who has contracted with the department or is designated by law to determine whether services are medically necessary.

(9) Affiliates means persons having an overt or covert relationship such that any one of them directly or indirectly controls or has the power to control another.

(10) Provider agreement means an agreement that continues for a specific period of time not to exceed twelve months and which must be renewed in order for the provider to continue to participate in the medicaid program.

(11) Fiscal agent means an organization which processes and pays provider claims on behalf of the department.

(12) Suspension of payments means the withholding of all payments due a provider pending the resolution of the matter in dispute between the provider and the department.

(13) Suspension of participation means an exclusion from participation in the medicaid program for a specified period of time.

(14) Termination from participation means an exclusion from participation in the medicaid program.

(15) Withholding of payments means a reduction or adjustment of the amounts paid to a provider on pending and subsequently submitted bills for purposes of offsetting overpayments previously made to the provider.

(16) Grounds for sanctions are fraudulent, abusive, or improper activities engaged in by providers of medical assistance services.

(17) Intern means a medical practitioner involved in a period of on-the-job training as part of a larger educational program.

(18) Resident means a medical practitioner involved in a prolonged period of on-the-job training which may either be part of a formal educational program or be undertaken separately after completion of a formal program, sometimes in fulfillment of a requirement for credentialing.

(19) License means permission granted to an individual or organization by competent authority to engage in a practice, occupation or activity which would otherwise be unlawful. It is granted in the state where the practice, occupation or activity is carried out.

(20) Certification means the process by which a governmental or non-governmental agency or association evaluates and recognizes an individual, institution or educational program as meeting predetermined standards.

(21) Outpatient drugs means drugs which are obtained outside of a hospital.

(22) Maximum allowable cost (MAC) is the upper limit the department will pay for drugs in accordance with 42 CFR 447. 331 which is a federal regulation dealing with limits of payment. The department hereby adopts and incorporates 42 CFR

447.331 by reference. A copy of the above-cited regulation may be obtained from the department of Social and Rehabilitation Services, Economic Assistance Division, 111 Sanders, Helena, Montana, 59601.

(23) Estimated acquisition cost is the cost for drugs for which no MAC price has been determined. The estimated acquisition cost is established and adjusted monthly by the department upon notification of drug prices by pharmacies or legitimate pharmacy supplies.

(24) In the medically needy program, family size means the number of eligible individuals and responsible relatives living in the same household unit. Ineligible persons living in the same household who are not responsible relatives are not counted when determining family size.

AUTH: Sec.53-6-113,MCA; IMP Sec.53-6-101,53-6-131,53-6-141,MCA

46.12.201 MEDICAL ASSISTANCE, ELIGIBILITY REQUIREMENTS

(1) Medical assistance shall be granted on behalf of all persons in the state of Montana, including persons temporarily absent from the state who meet the following requirements:

(a) For the categorically needy:

(i) Those who receive all or part of their income from the federally aided assistance programs which include people who, in December 1973, were eligible for medical assistance as an essential spouse or who has, as spouse, continued to live with and be essential to the well-being of a recipient of cash assistance, so long as the recipient with whom the essential spouse is living continues to meet the December 1973 criteria of the state of Montana's aid to the aged, blind, aid to the permanently and totally disabled assistance; those people who were eligible for aid to dependent children including the unborn child and needy caretaker relative of such children, and recipients of supplemental security income under the categories of aged, blind or disabled, or who would be eligible for such a program if application were made; those persons who, for any month from September 1972, who for the current month would have been eligible for AFDC or SSI, if the increase in monthly insurance benefits under Title II of the Social Security Act resulting from the enactment of P.L. 92-336 had not been applicable to him, provided such individual was, for the month of August 1972, eligible for or receiving OAA, AB, APTD or AFDC and also entitled to monthly payments under Title II of the Act; all blind and disabled persons who meet the current financial eligibility standard of this plan, and in December 1973 met the conditions of eligibility including financial eligibility for aid under the State's approved ANB or APTD plan and who were eligible under this plan, and who continue to meet the criteria for blindness and disability and meet the financial criteria under the State's approved ANB or APTD plan as in effect in December 1973.

(ii) Persons in medical institutions who, if they were no longer in such institution, would be eligible for financial assistance under any one of the above programs, including all individuals in medical institutions in December 1973 who, if not institutionalized, would have been eligible for OAA, ANB and APTD and continue to meet December 1973 eligibility criteria.

(iii) All children under 21 years who meet the conditions of eligibility for AFDC, other than with respect to school attendance or age.

(iv) All children under 21 years who are in foster care under the supervision of the state, private non-profit child care agency, or private child care institution.

(v) All children under 21 years who were in foster care under the supervision of the state, and who have been adopted as "hard-to-place" children as defined in section MCA.

(vi) Persons under 21 years who are eligible for any of the above-enumerated federally aided categories shall receive such early and periodic screening and diagnosis to ascertain physical and mental defects, and treatment of the conditions discovered to the extent of the services offered under the medical assistance program including the amount, duration and scope of such services.

(b) For the medically needy:

(i) Whose income is less than 133 1/3% of the income level for AFDC ~~or the income level for supplemental security income under the categories of aged, blind, or disabled,~~ and;

(ii) In arriving at a determination of whether an individual is eligible for the medically needy program, the division shall evaluate resources and income in the following manner.

(A) Clients most closely related to eligibility criteria of supplemental security income and AFDC for the medically needy program shall have their resources and income evaluated in the following manner.

(I) All real property including a home and lot not to exceed a market value of $26,000 shall be imposed. Income-producing property necessary for self-support, producing a reasonable rate of return, is to be excluded as a resource for medically needy eligibility.

(II) A personal property limitation of $1,500 shall be imposed for a single person or $2,250 for two people with an additional $100 for each additional eligible person in the household and an automobile not to exceed $1,500 retail value. Where the auto is encumbered, the amount of owner equity only will be considered. Exempted for the personal property limitations stated above are household goods, life insurance policies not exceeding a cash value of $1,500 and an auto used for employment or needed for medical purposes. Any individual

in a nursing home will be allowed a $25.00 exemption from his income.

(III) The first $20 of unearned or earned income is to be disregarded and the next $65 plus half the remainder or earned income will be disregarded.

(IV) Educational grants, scholarships, fellowships, foster care payments and 1/3 of the child support payments shall be disregarded.

(V) A transfer of real property made to bring the persons within the real property limitation of $26,000 is subject to the personal property limitation outlined in (II) above.

(VI) All other supplemental security income criteria concerning treatment of income and resources shall be observed where it is appropriate.

(B) AFDC cases shall have their resources and income evaluated in the manner for medically needy as outlined above.

(I) The income and resource requirements found in the above paragraph (b) (ii) of this rule shall govern in medically needy cases related to AFDC.

(II) The $30 plus 1/3 disregard of earned income is not available as a disregard under the medically needy program.

(iii) Who meet eligibility requirements under any federally aided assistance program above enumerated with the exception that where the other requirements of AFDC are met, assistance will be granted where it is an unemployed parent in the family who qualifies for assistance as an unemployed parent under ARM 46.10.304.

(iv) Medically needy individuals who have incomes in excess of 133 1/3% of AFDC eligibility standards become eligible for medical assistance when their incurred medical expenses, both paid and unpaid, are greater than or equal to their excess incomes for four consecutive months, including the month in which eligibility is sought. These medical expenses may be for medical insurance premiums and/or medical services licenses under state law not subject to third party liability.

(v) Individuals under the age of 21 who are placed in foster homes or private institutions by a public or private non-profit agency or who reside in intermediate care facilities or psychiatric hospitals are eligible for Title XIX, medically needy, if they meet the following requirements:

(A) Are not within the definition of dependent children, and;

(B) After all of the disregards and set-asides allowed under the AFDC plan and after applying any payment the individual is making toward his care and after any spend down is deducted, has no more than $56.00 per month personal need money, and;

(C) Payments on behalf of persons in state-operated institutions shall be made only from funds appropriated specifically for this purpose, as such funds are available. However, if available funds are not sufficient to provide an adequate medical care program for all eligible persons, first as the categorically needy.

AUTH:Sec.53-6-113,MCA; IMP:Sec.53-6-101,53-6-131,53-6-141,MCA

4. The Table of Standards amounts were developed by using 133-1/3% of AFDC Standards for FY 82 for families of the same size, that amount being the maximum allowable for maximum federal financial participation.

The distinctions between child only and adult family units have been deleted and replaced by a MNIL Table of Standards indicating the one person, two-person and three or more person household. This change is consistent with the structure of the AFDC Table of Standards and brings the structure of the MNIL Table of Standards into conformance with the CFR that does not distinguish household units by adult/child standards.

A definition of family size is being added to the definition section (ARM 46.12.102) to assist in utilizing the MNIL Table of Standards. This definition is specialized for the Medically Needy Program.

42 CFR 435.1007 provides that maximum federal financial participation is available for medically needy individuals if their income does not exceed 133-1/3% of an amount reasonably related to the AFDC payment for a family of two. The MNIL for an individual has been based upon the AFDC standard for the family of one; that figure is reasonably related to the AFDC standard for a family of two.

Deletion of the reference to SSI Income Levels in ARM 46.12.201(b)(i) is proposed to bring the ARM into conformity with the federal regulations.

5. Interested persons may submit their data, views, or arguments, either orally or in writing at the hearing. Written data, views or arguments may also be submitted to the Office of Legal Affairs, Department of Social and Rehabilitation Services, P.O. Box 4210, Helena, Montana, 59604, no later than July 10, 1981.

6. The Office of Legal Affairs, Department of Social and Rehabilitation Services has been designated to preside over and conduct the hearing.

7. The authority of the agency to amend the rule is based on Section 53-6-113, MCA, and the rule implements Sections 53-6-101, 53-6-131, and 53-6-141, MCA.

Director, Social and Rehabilitation Services

Certified to the Secretary of State June 1, 1981.

BEFORE THE DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES OF THE
STATE OF MONTANA

In the matter of the repeal of Rules 46.4.201, 46.4.202, 46.4.203 and 46.4.204 pertaining to project funds; child and youth development bureau	))))))	NOTICE OF PROPOSED REPEAL OF RULES 46.4.201, 46.4.202, 46.4.203 AND 46.4.204 PERTAINING TO PROJECT FUNDS. NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons

1. On July 20, 1981, the Department of Social and Rehabilitation Services proposes to repeal Rules 46.4.201, 46.4.202, 46.4.203 and 46.4.204 pertaining to project funds, child and youth development bureau.

2. The rules proposed to be repealed are on pages 46-125 and 46-133 of the Administrative Rules of Montana.

3. The Department is proposing to repeal these rules because the process of funding agencies and projects to provide child, youth and family services will no longer be unique to these services and the process of funding these services will in the future be consistent with general department contracting procedures.

4. Interested parties may submit their data, views or arguments concerning the proposed repeals in writing to the Office of Legal Affairs of the Department of Social and Rehabilitation Services, P.O. Box 4210, Helena, MT 59604 no later than July 13, 1981.

5. The authority of the agency to make the proposed repeals is based on Section 53-4-111, MCA, and the rules implement Section 53-4-112, MCA.

Director, Social and Rehabilitation Services

Certified to the Secretary of State June 1, 1981.

BEFORE THE DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES OF THE
STATE OF MONTANA

In the matter of the amendment of Rule 46.5.1001, pertaining to services provided by contract, community services division	)))))	NOTICE OF PROPOSED AMENDMENT OF RULE 46.5.1001 PERTAINING TO SERVICES PROVIDED BY CONTRACT. NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons

1. On July 20, 1981, the Department of Social and Rehabilitation Services proposes to amend Rule 46.5.1001 which pertains to services provided by contract, community services division.

2. The rule proposed to be amended provides as follows:

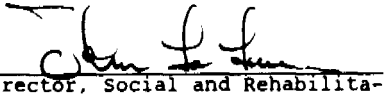
46.5.1001 SERVICES PROVIDED BY CONTRACT (1) Purchased services must be services which are included in the Title XX services plan. ~~or in the state plan for adult services.~~

(2) Purchased services must be services which the agency cannot provide or obtain without charge from another agency.

3. The Department proposes to amend this rule as there is no federal or state requirement for a state plan for adult services and there is no current state plan for adult services.

4. Interested parties may submit their data, views or arguments concerning the proposed amendment in writing to the Office of Legal Affairs of the Department of Social and Rehabilitation Services, P.O. Box 4210, Helena, MT 59604 no later than July 13, 1981.

5. The authority of the agency to make the proposed amendment is based on Section 53-2-201, MCA, and the rule implements Section 53-20-407, MCA.



Director, Social and Rehabilitation Services

Certified to the Secretary of State June 1, 1981.

BEFORE THE DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES OF THE
STATE OF MONTANA

In the matter of the repeal of Rules 46.9.101 and 46.9.102 pertaining to the description and purpose of the organization of the economic assistance division	)))))))	NOTICE OF PROPOSED REPEAL OF RULES 46.9.101 and 46.9.102 PERTAINING TO ORGANIZATION OF ECONOMIC ASSISTANCE DIVISION. NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons

1. On July 20, 1981, the Department of Social and Rehabilitation Services proposes to repeal Rules 46.9.101 and 46.9.102 pertaining to the description and purpose of the organization of the Economic Assistance Division.

2. The rules proposed to be repealed are on page 46-625 of the Administrative Rules of Montana.

3. The reason the agency is proposing to repeal these rules is that the substance of them is already covered at ARM 46.1.101.

4. Interested parties may submit their data, views or arguments concerning the proposed repeal in writing to the Office of Legal Affairs of the Department of Social and Rehabilitation Services, P.O. Box 4210, Helena, MT 59604 no later than July 13, 1981.

5. The authority of the agency to make the proposed repeal is based on Section 53-2-201, MCA, and the rules implement Section 53-2-201, MCA.

Director, Social and Rehabilitation Services

Certified to the Secretary of State June 1, 1981.

BEFORE THE SUPERINTENDENT OF PUBLIC INSTRUCTION
OF THE STATE OF MONTANA

In the matter of the amendment of Sub-Chapter 1 of Chapter 44 concerning secondary vocational education forms and fund allocation procedures	NOTICE OF THE AMENDMENT OF SUB-CHAPTER 1 OF CHAPTER 44 10.44.101, 10.44.102, 10.44.103, 10.44.104, 10.44.105, 10.44.106, 10.44.107

TO: All Interested Persons:

1. On April 30, 1981, the superintendent of public instruction published notice of a proposed amendment of subchapter 1 of chapter 44 concerning secondary vocational education forms and fund allocation procedures at page 376 of the 1981 Montana Administrative Register, issue number eight.
2. The agency has amended the rule as proposed.
3. No comments or testimony were received.

Ed Argenbright
Superintendent of Public Instruction

Certified to the Secretary of State May 29, 1981.

BEFORE THE BOARD OF HEALTH AND ENVIRONMENTAL SCIENCES
OF THE STATE OF MONTANA

In the matter of the repeal of rule 16.8.501 setting procedures for hearings on proposed ambient air quality standards	))))	NOTICE OF THE REPEAL OF RULE 16.8.501 (Procedures for Adopting Ambient Air Quality Standards)

TO: All Interested Persons

1. On March 26, 1981, the board published notice of a proposed repeal of rule 16.8.501 concerning the setting of procedures for hearings on proposed ambient air quality standards at page 239 of the 1981 Montana Administrative Register, issue number 6.

2. The board has repealed rule 16.8.501 found on page 16-144 of the Administrative Rules of Montana.

3. No comments or testimony were received.

JOHN F. McGREGOR, M.D., Chairman

By JOHN J. DRYNAN, M.D., Director
Department of Health and
Environmental Sciences

Certified to the Secretary of State June 1, 1981

BEFORE THE DEPARTMENT
OF PUBLIC SERVICE REGULATION
OF THE STATE OF MONTANA

IN THE MATTER of Proposed Amendment of rules governing Interim Utility Rate Increases.	)))	NOTICE OF AMENDMENT OF RULES 38.5.503 AND 38.5.505

TO: All Interested Persons

1. On April 30, 1981, the Department of Public Service Regulation published notice of proposed amendment of rules 38.5.503 and 38.5.505 regarding notice and supporting material for interim utility rate increases at pages 384-385 of the 1981 Montana Administrative Register, issue number 8.

2. The agency has amended the rules as proposed.

38.5.503 NOTICE
38.5.505 SUPPORTING MATERIAL

3. No comments were received.

GORDON E. BOLLINGER, Chairman

CERTIFIED TO THE SECRETARY OF STATE JUNE 1, 1981.

BEFORE THE DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES OF THE
STATE OF MONTANA

In the matter of the amendment of Rules 46.5.903, 46.5.904, and 46.5.905 pertaining to Day Care home centers and facilities.	))))))	NOTICE OF THE AMENDMENT OF RULES 46.5.903, 46.5.904 AND 46.5.905 PERTAINING TO DAY CARE HOME CENTERS AND FACILITIES.

TO: All Interested Persons

1. On April 30, 1981, the Department of Social and Rehabilitation Services published notice of the proposed amendment of Rules 46.5.903, 46.5.904, and 46.5.905 pertaining to day care home centers and facilities at page 386 of the Montana Administrative Register, issue number 8.

2. The agency has amended the rules as proposed

3. No comments or testimony were received.

In the matter of the amendment of Rule ARM 46.10.404 pertaining to Special Needs, Title IV-A Day Care for Recipients working, in training or in need of protective services	)))))	NOTICE OF THE AMENDMENT OF RULE 46.10.404 PERTAINING TO SPECIAL NEEDS, TITLE IV-A DAY CARE

TO: All Interested Persons

1. On April 30, 1981, the Department of Social and Rehabilitation Services published notice of the proposed amendment of Rule 46.10.404 pertaining to special needs, Title IV-A Day Care for recipients working, in training or in need of protective services at page 393 of the Montana Administrative Register, issue number 8.

2. The agency has amended the rule as proposed.

3. No comments or testimony were received.

Director, Social and Rehabilitation Services

Certified to the Secretary of State June 1, 1981.

BEFORE THE DEPARTMENT OF
SOCIAL AND REHABILITATION SERVICES
OF THE STATE OF MONTANA

In the matter of the amendments of Rules 46.12.102, 46.12.303, 46.12.522, 46.12.527, 46.12.532, 46.12.537, 46.12.542, 46.12.547, 46.12.557, 46.12.567, 46.12.582, 46.12.605, 46.12.801, 46.12.905, 46.12.915, 46.12.1005, 46.12.1015, 46.12.1025, and 46.12.2003 pertaining to medical services, reimbursement	NOTICE OF THE AMENDMENTS OF RULES 46.12.102, 46.12.303, 46.12.522, 46.12.527, 46.12.532, 46.12.537, 46.12.542, 46.12.547, 46.12.557, 46.12.567, 46.12.582, 46.12.605, 46.12.801, 46.12.905, 46.12.915, 46.12.1005, 46.12.1015, 46.12.1025, and 46.12.2003 PERTAINING TO MEDICAL SERVICES

TO: All Interested Persons

1. On April 30, 1981, the Department of Social and Rehabilitation Services published notice of proposed amendments to Rules 46.12.102, 46.12.303, 46.12.522, 46.12.527, 46.12.532, 46.12.537, 46.12.542, 46.12.547, 46.12.557, 46.12.567, 46.12.582, 46.12.605, 46.12.801, 46.12.905, 46.12.915, 46.12.1005, 46.12.1015, 46.12.1025, and 46.12.2003 pertaining to medical services, reimbursement at page 395 of the Montana Administrative Register, issue number 8.

2. The agency has amended the rules as proposed except for some rewording of the amendments for the purpose of clarification only:

46.12.102 MEDICAL ASSISTANCE, DEFINITIONS (1) Department means the Montana department of social and rehabilitation services.

(2) Medically necessary service means a service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate, or prevent the worsening of conditions in a patient which:

(a) endanger life, or
(b) cause suffering or pain, or
(c) result in illness or infirmity, or
(d) threaten to cause or aggravate a handicap, or
(e) cause physical deformity or malfunction and, there is no other equally effective, more conservative, or substantially less costly course of treatment more suitable for the recipient requesting the service or, when appropriate, no treatment at all.

(i) Services which are considered by the medical profession as experimental or which are generally regarded by the medical profession as unacceptable treatment will not be considered medically necessary for the purpose of the medical

assistance program.

(3) Montana medicaid program means the Montana medical assistance program authorized by sections 53-6-101 through 53-6-144, 53-6-201 and 53-6-202 et seq. MCA and 42 USC 1396 et seq.

(4) Provider means a natural person, firm, corporation, association or institution which is providing and has been approved to provide medical assistance to a recipient pursuant to the state medical assistance program.

(5) Third party means an individual, institution, corporation, or a public or private agency which may be or is liable to pay all or part of the medical cost of injury, disease, or disability of an applicant for or a recipient of services provided by the Montana medicaid program.

(6) ~~Usual and customary charges which are reasonable means those charges which fall within the 75th percentile of all charges for similar service in the statewide area during the last calendar year elapsing prior to the start of the fiscal year in which the bill is submitted.~~ Upper limits of reimbursement for noninstitutional services are:

(a) the provider's actual charge (the amount submitted on the claim to medicaid);

(b) the medicaid median charge as determined from medicaid claims submitted during all of the calendar year preceding the state fiscal year in which the determination is made; however, if the individual can supply the department with convincing evidence that the department's determination of median charge does not reasonably represent the individual provider's median charge, the department may conduct an analysis that documents a more appropriate figure;

(c) the amount allowable for the same service under medicare and the prevailing charge under part B, medicare;

(d) the 75th percentile of the range of weighted medicaid median charges ~~in the state that are~~ FOR THAT PARTICULAR COVERED SERVICE. THIS PERCENTILE IS set by the department during the calendar year preceding the state fiscal year in which the determination is made.

(7) Valid and proper claim means a claim which has been signed and submitted on a department approved billing form with all the requested information supplied, and for which no further written information or substantiation is required for payment.

(8) Designated review organization means an organized group or an individual who has contracted with the department or is designated by law to determine whether services are medically necessary.

(9) Affiliates means persons having an overt or covert relationship such that any one of them directly or indirectly controls or has the power to control another.

(10) Provider agreement means an agreement that con-

tinues for a specific period of time not to exceed twelve months and which must be renewed in order for the provider to continue to participate in the medicaid program.

(11) Fiscal agent means an organization which processes and pays provider claims on behalf of the department.

(12) Suspension of payments means the withholding of all payments due a provider pending the resolution of the matter in dispute between the provider and the department.

(13) Suspension of participation means an exclusion from participation in the medicaid program for a specified period of time.

(14) Termination from participation means an exclusion from participation in the medicaid program.

(15) Withholding of payments means a reduction or adjustment of the amounts paid to a provider on pending and subsequently submitted bills for purposes of offsetting overpayments previously made to the provider.

(16) Grounds for sanctions are fraudulent, abusive, or improper activities engaged in by providers of medical assistance services.

(17) Intern means a medical practitioner involved in a period of on-the-job training as part of a larger educational program.

(18) Resident means a medical practitioner involved in a prolonged period of on-the-job training which may either be part of a formal educational program or be undertaken separately after completion of a formal program, sometimes in fulfillment of a requirement for credentialing.

(19) License means permission granted to an individual or organization by competent authority to engage in a practice, occupation or activity which would otherwise be unlawful. It is granted in the state where the practice, occupation or activity is carried out.

(20) Certification means the process by which a governmental or non-governmental agency or association evaluates and recognizes an individual, institution or educational program as meeting predetermined standards.

(21) Outpatient drugs means drugs which are obtained outside of a hospital.

(22) Maximum allowable cost (MAC) is the upper limit the department will pay for drugs in accordance with 42 CFR 447.331 which is a federal regulation dealing with limits of payment. The department hereby adopts and incorporates 42 CFR 447.331 by reference. A copy of the above-cited regulation may be obtained from the department of Social and Rehabilitation Services, Economic Assistance Division, 111 Sanders, Helena, Montana, 59601.

(23) Estimated acquisition cost is the cost for drugs for which no MAC price has been determined. The estimated acquisition cost is established and adjusted monthly by the

department upon notification of drug prices by pharmacies or legitimate pharmacy supplies.

46.12.303 BILLING, REIMBURSEMENT, CLAIMS PROCESSING, AND PAYMENT (1) Providers shall submit claims within 180 days of the date the service was performed, within 180 days after the applicants eligibility is determined, or within 180 days after a written notice from a third party resource, whichever occurs last. For providers of hospital services, the service shall be deemed to have been performed upon the recipient's discharge from one continuous confinement. A written inquiry to the department or to the local county welfare department regarding eligibility within the 180 day limit shall constitute evidence of an effort to bill medicaid for these services.

(a) All claims to the Montana medicaid program are to be submitted on personally signed state approved billing forms, or they shall not be considered valid and proper claims.

(2) The program shall pay 90 percent of all valid and proper claims within 30 days after receipt of said claim. Should the bureau contend that a claim is not valid or proper, the bureau shall inform the provider of the details of the contention within 30 days after receipt of the claim.

(a) The program shall pay 99 percent of all valid and proper claims within 90 days of receipt of the claims.

(b) The program shall make payment on all claims within 180 days of the receipt of the claim unless it determines payment to be improper under this chapter or applicable federal regulations.

(c) The department shall be entitled to promptly (within 60 days) recover all payments erroneously or improperly made to a provider. At the option of the provider, refunds shall be accomplished either by mailing a check made out to "State Department of Social and Rehabilitation Services" directly to that department at Box 4210, Helena, MT 59601, or by notifying the department in writing of the receipt and the amount of payment over and above the amount reimbursable by the Montana medicaid program, which amount shall then be automatically deducted from future payments to the provider. Regardless of the method of repayment chosen, the provider shall identify on the check or notifying document the patient, by name and claim number, who received services for which the over payment was made and specify the dates of services for which over payments were received. If the provider contests the department's decision that the provider has been overpaid, recovery shall depend on the final administrative decision.

~~(3) Unless stated elsewhere, payments made by the Montana medicaid program shall not exceed the lower of the amount payable for like services in the same locality by the medicare program (Title XVIII of the Social Security Act), or~~

~~the provider's usual and customary charges that are reasonable.~~

~~(4)~~ (3) Providers are required to accept, as payment in full, the amount paid by the Montana medicaid program for a service provided to an eligible medicaid recipient in accordance with the rules of the department. Providers shall not seek any payment in addition to or in lieu of the amount paid by the Montana medicaid program from a recipient or his representative.

~~(5)~~ (4) In the event that a provider of services is entitled to a retroactive increase of payment for services rendered, the provider shall submit a claim within 180 days of the written notification of the retroactive increase or the provider forfeits any rights to the retroactive increase.

~~(6)~~ (5) The Montana medicaid program shall make payments directly to the individual provider of service unless the individual provider is required, as a condition of his employment, to turn his fees over to his employer.

(a) Exceptions to the above requirement may, at the discretion of the department, be made for transportation and/or per diem costs incurred to enable a recipient to obtain medically appropriate services.

~~(7)~~ (6) The method of determining payment rates for out-of-state providers will be the same as for in-state providers except as otherwise provided in the rules of the department.

46.12.522 PODIATRY SERVICES, REIMBURSEMENT/GENERAL REQUIREMENTS AND MODIFIERS (1) ~~Payments for podiatry services will be the lesser of usual and customary charges which are reasonable, the amount payable by medicare, or the following fee schedule.~~ THE DEPARTMENT WILL PAY THE LOWEST OF THE FOLLOWING FOR PODIATRY SERVICES NOT ALSO COVERED BY MEDICARE: THE PROVIDER'S ACTUAL (SUBMITTED) CHARGE FOR THE SERVICE; THE 75TH PERCENTILE OF THE RANGE OF WEIGHTED MEDICAID MEDIAN CHARGES FOR EACH SERVICE COVERED BY THIS RULE; OR THE DEPARTMENT'S FEE SCHEDULE FOUND IN RULE 46.12.523.

The Department will pay the lowest of the following for podiatry services~~.~~ WHICH ARE ALSO COVERED BY MEDICARE: the provider's actual (submitted) charge for the services; the provider's Medicaid median charge for the service; the amount allowable for the same service under Medicare; OR THE DEPARTMENT'S FEE SCHEDULE FOUND IN RULE 46.12.523. ~~and for those services which are not covered by Medicare the provider's 75th percentile of the range of weighted Medicaid median charges, or the podiatry fee schedule in Section (2) and ARM 46.12.523.~~ Services paid by report (BR) will be paid at 70% of all Montana podiatrist's 1980 usual and customary charges for the specified service.

(2) MODIFIERS

Listed services and procedures may be modified under certain circumstances. When applicable, the modifying circumstance should be identified by the addition of the appropriate modifier code, which is a two digit number placed after the usual procedure number from which it is separated by a hyphen. If more than one modifier is used, the "Multiple Modifiers" code placed first after the procedure code indicates that one or more additional modifier codes will follow. All procedures where a modifier is used may be paid By Report (BR). Modifiers commonly used are as follows:

-22 Unusual Services: When the service(S) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier '-2' to the usual procedure number. A report may also be appropriate. (Pertains to Medicine, Anesthesia, Surgery, Radiology, and Pathology and Laboratory.)

-23 Unusual Anesthesia: Periodically, a procedure, which usually requires either no anesthesia or local anesthesia, because of unusual circumstances must be done under general anesthesia. This circumstance may be reported by adding the modifier '-23' to the procedure code of the basic service. (Pertains to Anesthesia, Surgery.)

-26 Professional Component: Certain procedures (eg, laboratory, radiology, specific diagnostic services) are a combination of a podiatric component and a technical component. When the podiatric component is reported separately, the service may be identified by adding the modifier '-26' to the usual procedure number. (Pertains to Medicine, Surgery, Radiology, and Pathology and Laboratory.)

-30 Anesthesia Service: The anesthesia service may be identified by adding the modifier '-30' to the usual procedural code number of the basic service. (Pertains to Anesthesia.)

46.12.527 OUTPATIENT PHYSICAL THERAPY SERVICES, REIMBURSEMENT ~~Medicaid payment for outpatient physical therapy services will be the lesser of usual and customary charges which are reasonable, the maximum allowed by medicare, or the following physical therapy fee schedule.~~ THE DEPARTMENT WILL PAY THE LOWEST OF THE FOLLOWING FOR OUTPATIENT PHYSICAL THERAPY SERVICES NOT ALSO COVERED BY MEDICARE: THE PROVIDER'S ACTUAL (SUBMITTED) CHARGE FOR THE SERVICE; THE PROVIDER'S MEDICAID MEDIAN CHARGE FOR THE SERVICE; THE 75TH

PERCENTILE OF THE RANGE OF WEIGHTED MEDICAID MEDIAN CHARGES FOR EACH SERVICE COVERED BY THIS RULE; OR THE DEPARTMENT'S FEE SCHEDULE CONTAINED IN THIS RULE.

The department will pay the lowest of the following for outpatient physical therapy services: WHICH ARE ALSO COVERED BY MEDICARE: the provider's actual (submitted) charge for the service; the amount allowable for the same service under medicare; OR THE DEPARTMENT'S FEE SCHEDULE CONTAINED IN THIS RULE ~~and for those services not covered by medicare, the provider's medicaid median charge or the 75th percentile of the range of weighted medicaid median charges, or the following fee schedule:~~

A. D. L.	16.50
Consultation	27.50
Electrophysiological evaluation	27.50
Electromyography	55.00
Physical Therapy Evaluation	27.50
Home Instruction	27.50
Muscle Testing	27.50
Hubbard Tub	22.00
Hubbard Tub + 1 modality	22.00
Hubbard Tub + 2 modalities	25.30
Hubbard Tub + 3 modalities	27.50
Isolation Hubbard Tub	22.00
Whirlpool	13.20
Whirlpool + 1 modality	14.30
Whirlpool + 2 modalities	22.00
Whirlpool + 3 modalities	33.00
Gait Training	22.00
Postural Drainage	14.30
Therapeutic Exercise	16.50
One Modality	11.00
Two Modalities	12.10
Three Modalities	16.50
Four Modalities	16.50
Five Modalities	19.80

46.12.532 SPEECH PATHOLOGY SERVICES, REIMBURSEMENT

(1) ~~Payment for outpatient speech pathology services shall not exceed the lowest of usual and customary charges which are reasonable, actual charges,~~ THE DEPARTMENT WILL PAY THE LOWEST OF THE FOLLOWING FOR SPEECH PATHOLOGY SERVICES NOT COVERED BY MEDICARE: THE PROVIDER'S ACTUAL (SUBMITTED) CHARGE FOR THE SERVICE; THE PROVIDER'S MEDICAID MEDIAN CHARGE FOR THE SERVICE; THE 75TH PERCENTILE OF THE RANGE OF WEIGHTED MEDICAID MEDIAN CHARGES FOR EACH SERVICE COVERED BY THIS RULE; OR $21.50 PER HOUR.

The department will pay the lowest of the following for speech pathology services: WHICH ARE ALSO COVERED BY MEDICARE: the provider's actual (submitted) charge for the

service; the amount allowable for the same service under medicare~~, and for those services not covered by medicare, the provider's medicaid median charge or the 75th percentile of the range of weighted medicaid median charges~~; or $21.50 per hour.

46.12.537 AUDIOLOGY SERVICES, REIMBURSEMENT ~~Payment for audiology services shall not exceed the lowest of usual and customary charges which are reasonable, actual charges, or the rates allowed by the audiology fee schedule.~~ THE DEPARTMENT WILL PAY THE LOWEST OF THE FOLLOWING FOR AUDIOLOGY SERVICES NOT ALSO COVERED BY MEDICARE: THE PROVIDER'S ACTUAL (SUBMITTED) CHARGE FOR THE SERVICE; THE PROVIDER'S MEDICAID MEDIAN CHARGE FOR THE SERVICE; THE 75TH PERCENTILE OF THE RANGE OF WEIGHTED MEDICAID MEDIAN CHARGES FOR EACH SERVICE COVERED BY THIS RULE; OR THE DEPARTMENT'S FEE SCHEDULE CONTAINED IN THIS RULE.

The department will pay the lowest of the following for audiology services: WHICH ARE ALSO COVERED BY MEDICARE: the provider's actual (submitted) charge for the service; the amount allowable for the same service under medicare~~,~~; OR THE DEPARTMENT'S FEE SCHEDULE CONTAINED IN THIS RULE. ~~and for those services not covered by medicare, the provider's medicaid median charge or the 75th percentile of the range ofweighted medicaid median charges, or the following fee schedule:~~

AUDIOLOGY FEE SCHEDULE

Basic Audio Assessment (BAA)	$40.00
Hearing Aid Evaluation (HAE)	20.00
Speech Discrimination Test	8.00
Speech Reception Threshold	8.00
Pure Tone Air Threshold	8.00
Pure Tone Bone Threshold	8.00
Tympanogram (unilateral)	3.00
Tympanogram (bilateral)	6.00
Acoustic Reflex (bilateral)	8.00
Static Compliance	6.00
Bekesy	10.00
SISI (two or more frequency)	10.00
Loudness Balance or ABLB	10.00
Stenger	10.00
Doefler - Stewart	10.00
Lombard	10.00

46.12.542 HEARING AID SERVICES, REIMBURSEMENT (1) ~~Reimbursement for hearing aid services shall not exceed the usual and customary charges which are reasonable or the amounts allowed by the hearing aid fee schedule, whichever is lowest.~~ THE DEPARTMENT WILL PAY THE LOWEST OF THE FOLLOWING FOR HEAR-

ING AID SERVICES NOT ALSO COVERED BY MEDICARE: THE PROVIDER'S ACTUAL (SUBMITTED) CHARGE FOR THE SERVICE; THE PROVIDER'S MEDICAID MEDIAN CHARGE FOR THE SERVICE; THE 75TH PERCENTILE OF THE RANGE OF WEIGHTED MEDICAID MEDIAN CHARGES FOR EACH SERVICE COVERED BY THIS RULE; OR THE DEPARTMENT'S FEE SCHEDULE CONTAINED IN THIS RULE.

The department will pay the lowest of the following for hearing aid services: WHICH ARE ALSO COVERED BY MEDICARE: the provider's actual (submitted) charge for the service; the amount allowable for the same service under medicare; OR THE DEPARTMENT'S FEE SCHEDULE CONTAINED IN THIS RULE. ~~and for those services not covered by medicare, the provider's medicaid median charge or the 75th percentile of the range of weighted medicaid median charges, or the following fee schedule:~~

(2) Hearing aid fee schedule:

List of Services	Fee
Purchase of instrument	Wholesale cost & $250.00 dispensing fee
Hearing aid rental	$1.00 per day
Hearing aid service & repair (which includes a 6 month warranty)	$60.00 maximum per year per aid
Hearing aid recasing	$30.00 maximum per year per aid
Accessories (Cords, receivers, etc.)	$35.00 maximum per year per aid
Bone ossilator	$65.00 maximum per year per aid
Ear mold replacement	$15.00
Hearing aid batteries	$7.50/silver oxide standard package $5.00/all other standard package

46.12.547 OUTPATIENT OCCUPATIONAL THERAPY SERVICES, REIMBURSEMENT ~~Medicaid payment for outpatient occupational therapy services will be the lesser of usual and customary charges which are reasonable, the maximum allowed by medicare, or the following occupational therapy fee schedule:~~ THE DEPARTMENT WILL PAY THE LOWEST OF THE FOLLOWING FOR OUTPATIENT OCCU-

PATIONAL THERAPY SERVICES NOT ALSO COVERED BY MEDICARE: THE PROVIDER'S ACTUAL (SUBMITTED) CHARGE FOR THE SERVICE; THE PROVIDER'S MEDICAID MEDIAN CHARGE FOR THE SERVICE; THE 75TH PERCENTILE OF THE RANGE OF WEIGHTED MEDICAID MEDIAN CHARGES FOR EACH SERVICE COVERED BY THIS RULE; OR THE DEPARTMENT'S FEE SCHEDULE CONTAINED IN THIS RULE.

The department will pay the lowest of the following for outpatient occupational therapy services, WHICH ARE ALSO COVERED BY MEDICARE: the provider's actual (submitted) charge for the service; the amount allowable for the same service under medicare; OR THE DEPARTMENT'S FEE SCHEDULE CONTAINED IN THIS RULE. ~~and for those services not covered by medicare, the provider's medicaid median charge or the 75th percentile of the range of weighted medicaid median charges, or the following fee schedule:~~

A. D. L.	16.50
Occupational Therapy Evaluation	27.50
Home Instruction	27.50
One Modality	11.00
Two Modalities	12.10

46.12.557 PERSONAL CARE SERVICE, REIMBURSEMENT THE DEPARTMENT WILL PAY THE LOWEST OF THE FOLLOWING FOR PERSONAL CARE SERVICES NOT ALSO COVERED BY MEDICARE: THE PROVIDER'S ACTUAL (SUBMITTED) CHARGE FOR THE SERVICE; THE PROVIDER'S MEDICAID MEDIAN CHARGE FOR THE SERVICE; THE 75TH PERCENTILE OF THE RANGE OF WEIGHTED MEDICAID MEDIAN CHARGES FOR EACH SERVICE COVERED BY THIS RULE; OR THE DEPARTMENT'S FEE SCHEDULE CONTAINED IN THIS RULE.

The department will pay the lowest of the following for personal care services, WHICH ARE ALSO COVERED BY MEDICARE: the provider's actual (submitted) charge for the service; ~~or~~ the amount allowable for the same service under medicare; OR THE DEPARTMENT'S FEE SCHEDULE CONTAINED IN THIS RULE. ~~and for those services not covered by medicare, the provider's medicaid median charge or the 75th percentile of the range of weighted medicaid median charges, or the following fee schedule:~~ (1) Payment for personal care service shall be minimum wage plus 15 percent in lieu of fringe benefits except where exigent circumstances exist, a reasonable payment rate may be negotiated between the department and the provider.

(2) On a weekly basis, payment shall not exceed 80 percent of the cost of nursing home per diem except when prior authorized.

(3) Payment for registered nurse supervision shall be:

(a) ~~skilled nursing service rate established by a fee schedule when provided by a licensed home health agency under contract with the department,~~ established by a contract with the department when provided by a licensed home health agency;

(b) $7.50 per hour when provided by an independent registered nurse; or

(c) where exigent circumstances exist, a reasonable payment rate may be negotiated between the department and the provider.

46.12.567 PRIVATE DUTY NURSING SERVICE, REIMBURSEMENT ~~Payment for private duty nursing services shall not exceed the lowest of usual and customary charges which are reasonable, the maximum amount payable by medicare,~~ THE DEPARTMENT WILL PAY THE LOWEST OF THE FOLLOWING FOR PRIVATE DUTY NURSING SERVICES NOT ALSO COVERED BY MEDICARE: THE PROVIDER'S ACTUAL (SUBMITTED) CHARGE FOR THE SERVICE; THE PROVIDER'S MEDICAID MEDIAN CHARGE FOR THE SERVICE; THE 75TH PERCENTILE OF THE RANGE OF WEIGHTED MEDICAID MEDIAN CHARGES FOR EACH SERVICE COVERED BY THIS RULE; OR $40.00 PER EIGHT (8) HOUR SHIFT.

The department will pay the ~~lower~~ LOWEST of the following for private duty nursing services, WHICH ARE ALSO COVERED BY MEDICARE: the provider's actual (submitted) charge for the service; ~~or~~ the amount allowable for the same service under medicare; ~~and for those services not covered by medicare, the provider's medicaid median charges,~~ or $40.00 per eight (8) hour shift.

46.12.582 PSYCHOLOGICAL SERVICES, REIMBURSEMENT ~~Reimbursement for services shall be the lowest of,~~

~~(1) customary charges which are reasonable, or~~

~~(2) the amount payable by medicare for the same service, or~~ THE DEPARTMENT WILL PAY THE LOWEST OF THE FOLLOWING FOR PSYCHOLOGICAL SERVICES NOT ALSO COVERED BY MEDICARE: THE PROVIDER'S ACTUAL (SUBMITTED) CHARGE FOR THE SERVICE; THE PROVIDER'S MEDICAID MEDIAN CHARGE FOR THE SERVICE; THE 75TH PERCENTILE OF THE RANGE OF WEIGHTED MEDICAID MEDIAN CHARGES FOR EACH SERVICE COVERED BY THIS RULE; OR THE DEPARTMENT'S FEE SCHEDULE FOUND IN THIS RULE.

The department will pay the lowest of the following for psychological services, WHICH ARE ALSO COVERED BY MEDICARE: ~~(1)~~ the provider's actual (submitted) charge for the service; ~~(2)~~ the amount allowable for the same service under medicare; OR THE DEPARTMENT'S FEE SCHEDULE CONTAINED IN THIS RULE. ~~and for those services not covered by medicare, the provider's 75th percentile of the range of weighted medicaid median charges, or~~

~~(3) the following fee schedule:~~

~~(3)~~ ~~(a)~~ (1) $34.27 for individual psychological services; or

~~(4)~~ ~~(b)~~ (2) $10.28 for group psychological services.

46.12.605 DENTAL SERVICES, REIMBURSEMENT ~~Payment for dental services shall be limited to the lowest of usual and~~

~~customary charges which are reasonable, the maximum amount payable by medicare,~~ THE DEPARTMENT WILL PAY THE LOWEST OF THE FOLLOWING FOR DENTAL SERVICES NOT ALSO COVERED BY MEDICARE: THE PROVIDER'S ACTUAL (SUBMITTED) CHARGE FOR THE SERVICE; THE PROVIDER'S MEDICAID MEDIAN CHARGE FOR THE SERVICE; THE 75TH PERCENTILE OF THE RANGE OF WEIGHTED MEDICAID MEDIAN CHARGES FOR EACH SERVICE COVERED BY THIS RULE; OR THE DEPARTMENT'S FEE SCHEDULE FOUND IN THIS RULE.

The department will pay the lowest of the following for dental services, WHICH ARE ALSO COVERED BY MEDICARE: the provider's actual (submitted) charge for the service; the provider's medicaid median charge for the service; the amount allowable for the same service under medicare; OR THE DEPARTMENT'S FEE SCHEDULE CONTAINED IN THIS RULE. ~~and for those services which are not covered by Medicare the provider's 75th percentile of the range of weighted medicaid median charges, or the following fee schedule:~~

(1) Preventive and diagnostic services:

(a) examination and execution of forms - 7.80;

(b) complete intra-oral radiograms, minimum 14 films - 26.00;

(c) single periapical radiograms, first film - 5.20;

(d) each additional film, periapical - 2.60;

(e) bite-wing radiograms, 2 films - 7.80;

(f) intra-oral occlusal maxillary or mandibular - 6.50;

(g) cephalometric radiograms or panorex, diagnostic only - 26.00;

(h) extra-oral radiograms, maxillary or mandibular lateral film -19.50;

(i) allowable charges for x-rays in a single visit shall not exceed the allowable charges for a full mouth x-ray;

(j) consultation fee (necessity to be shown) per session -13.00;

(k) hospital calls - 19.50;

(l) simple operations under general anesthesia in hospital - 39.00;

(m) house calls and nursing home calls - 9.10;

(n) vitality tests one tooth or per quadrant - 7.80;

(o) palliative (emergency treatment of dental pain (includes only minor procedures, i.e., temporary fillings, incision and drainage, topical medicaments, irrigation, pericoronitis, etc.) - 7.80;

(p) stannus flouride 8%, one treatment, including prophylaxis - 22.10;

(q) flouride - 7.70;

(r) prophyliaxis, includes routine scaling and polishing/adults and children - 16.90;

(2) Amalgam restorations:

(a) deciduous, one surface - 12.32;

(b) deciduous, two surface - 20.16;

(c) deciduous, three surface - 28.16;
(d) each additional surface, deciduous - 3.30;
(e) one surface, permanent - 12.32;
(f) two surface, permanent - 20.16;
(g) three surface, permanent - 28.16;
(h) each additional surface (includes cusp restoration, veneer, groove extension, etc.) permanent - 4.80;
(i) pins for retention (maximum 2) each pin - 3.90.
(3) Silicates and fiberglass restorations (per surface):
(a) silicate - 13.00;
(b) compost resin (addent, dakor, adaptic, concise, prestige, etc.) - 19.20.
(c) composite fillings for posterior teeth will be paid at the rate of a similar amalgam restoration except for buccal surfaces.
(4) Additional operative procedures:
(a) acrylic jacket, immediate treatment for fractured anterior - 26.00;
(b) treatment filling (emergency) - 6.50;
(c) recement inlay - 6.50;
(d) pulpotomy - need authorization - 19.20;
(e) No extra fee for pulp capping or bases.
(5) Crown and bridge:
(a) three-quarter cast crown - 125.45;
(b) full cast crown - 125.45;
(c) cured acrylic jacket crown, laboratory processed - 104.00;
(d) porcelain jacket - 143.00;
(e) porcelain veneer (microbond, ceramco, etc.) - 184.00;
(f) full cast crown with acrylic facing - 184.00;
(g) gold and semi-precious crowns will be reimbursed at the same rate.
(6) Pedodontics, spacers, crowns, etc. amalgam restorations same as permanent teeth:
(a) chrome crown - 40.00;
(b) immediate treatment of fractured anterior permanent tooth, includes pulp testing, pulp capping and use of metal band or crown form with sedative filling - 20.80;
(c) chrome crown and loop spacer or other types (space maintainer) - 52.00;
(d) bilateral space maintainer or lingual arch - 82.50;
(e) acrylic denture, without clasps, supplying 1 to 4 (flipper) - 65.00;
(f) each additional tooth, permanent on acrylic denture (flipper) - 6.50;
(g) chrome wire clasps, adams, t or ball, each - 6.50;
(h) stainless steel band - 12.00.
(7) Prosthodontics:
(a) complete maxillary denture, acrylic, plus necessary adjustment - 336.00;

(b) complete mandibular denture, acrylic, plus necessary adjustment - 336.00;

(c) acrylic upper or lower partial denture with cast chrome clasps and rests replacing at least 4 posterior teeth plus adjustments - 260.00;

(d) maxillary cast chrome partial denture, acrylic saddles, 2 clasps and rests, replacing missing posterior teeth and one or more anterior teeth, plus adjustments - 325.00.

(8) Relines and repairs, etc.:

(a) Cured resin reline, lower - 86.45;

(b) cured resin reline, upper - 86.45;

(c) broken denture repair, no teeth, metal involved -32.00;

(d) denture adjustment - only where dentist did not make dentures - 7.80;

(e) replacing broken tooth on denture, first tooth - 24.00;

(f) each additional tooth after procedure (e) and (g) -6.50;

(g) adding teeth to partial to replace extracted natural teeth, first tooth - 32.50;

(h) replacing clasp, new clasp - 45.50;

(i) repairing (welding or soldering) palatal bars, lingual bars, metal connectors, etc. on chrome partials - 84.50;

(j) duplicate (jump) upper complete denture - 110.50;

(k) lower jump or duplicate - 110.50;

(l) placing name on new, full or partial dentures - 10.00.

(9) Pontics:

(a) steele's facing type, each - 97.50;

(b) pontic - ceramic only - 147.50;

(c) cured acrylic, laboratory processed, veneer - 97.50;

(10) Repairs:

(a) recement bridge - 13.00;

(b) recement crown - 6.50;

(c) porcelain facing - 26.00;

(d) replace broken steele's facing, post intact - 22.00;

(e) gold post - 55.00;

(f) steel post or dowel with amalgum buildup - 26.00;

(g) replace broken steele's facing, post broken - 32.50.

(11) Oral surgery:

(a) I and D of abcess intra-oral - 50.00;

(b) removal of tooth (includes shaping of ridge bone) - 14.88;

(c) surgical removal of tooth, soft tissue impaction - 32.50;

(d) surgical removal of tooth, partial bone impaction - 58.50;

(e) surgical removal of tooth, complete bone impaction - 97.50;

(f) alveolectomy, not in conjection with extractions, per quadrant - 32.50;
(g) excision of hyperplastic tissue/each quad - 32.50;
(h) removal of retained, residual roots, foreign bodies in bony tissue - 32.50;
(i) removal of cyst - 50.00;
(j) removal of retained, residual roots, foreign bodies in maxillary sinus - 97.50;
(k) frenectomy - 45.50;
(l) removal of exostosis torus, maxillary or mandibular - 65.00;
(m) biopsy, including pathology lab charges - 26.00;
(n) maxilla, open reduction - 326.30;
(o) fracture, simple, maxilla, treatment and care - 253.50;
(p) mandible, open reduction - 436.80;
(q) fracture, simple, mandible, treatment and care - 253.50;
(r) facial surgery - usual and customary charges which are reasonable.
(12) Endodontics:
(a) root canal chemotherapy and mechanical preparation, scaling and filing) - 112.00;
(b) root canal, each additional root up to two - 30.00;
(c) root canal and apicoectomy combined operation - 97.50;
(d) apicoectomy not in conjunction with root canal - 58.50.
(13) Anesthesia:
(a) general anesthesia administered in office - 39.00;
(b) nitrous oxide - 4.00;
(c) oral premedication - $10.00;
(d) parenteral premedication - $39.00
(14) Periodontal services: .
(a) periodontal prophylaxis per quadrant - 16.90;
(b) gingival resection - 32.50;
(15) Dentist examining more than one medicaid recipient in a long-term care facility on the same day shall be allowed payment for one nursing home call over the examination fees. Examination is considered a recorded evaluation.
(16) Reimbursement - orthodontia:
(a) examination - 7.80;
(b) full treatment - records and diagnosis - 45.50;
(c) full treatment, initial fee - includes appliances - 315.00;
(d) full treatment, monthly fee (prior authorization will state maximum number at months) - 31.50;
(e) full treatment, retention service - 3.50;
(f) serial extractions, supervision - 3.50;
(g) partial treatment, expansion appliance - 175.00;
(h) partial treatment - head gear appliance - 175.00;

(i) special appliance, bilateral space maintainer, upper and lower - 82.50;
(j) special appliance, unilateral space maintainer - 52.00;
(k) special appliance, expansion appliance - 175.00;
(l) special appliance, retainer - 87.50;
(m) special appliance, habit appliance - 87.50.

46.12.801 PROSTHETIC DEVICES, DURABLE MEDICAL EQUIPMENT, AND MEDICAL SUPPLIES (1) Prosthesis, appliances and medical supplies may be provided upon the recommendation of the attending physician. This includes artificial limbs, artificial eyes, hearing aids, braces, splints, durable medical equipment such as wheelchairs, walkers, canes, crutches, hospital beds, and sickroom equipment. The rental or purchase of oxygen and oxygen equipment will also be charged to the prosthesis and appliance benefit.

(2) All prosthesis, braces, splints, durable medical equipment and other appliances which cost less than $75.00 may be purchased without prior authorization from the medical assistance bureau. It is necessary, however, to have a physician prescription attached to each claim. The equipment must be primarily medical in nature and appropriate for home use. It is necessary to secure prior authorization from the medical assistance bureau for items which cost more than $75.00. If equipment is to be rented, the total rental cost should not exceed the purchase price.

(3) In addition to the $75.00 value restriction without prior authorization, the following are limitations of the medical assistance program as it relates to prosthesis, appliances, and medical supplies;

(a) Orthopedic shoes are not a benefit unless they are attached to a brace or other device.

(b) Shoe repair and shoe corrections are not benefits of the program.

(c) Wheelchairs, walkers, etc. utilized by nursing home patients may not be provided unless the item is of special design for the particular patient and is used exclusively by him or unless it is a necessary part of a discharged home plan.

(d) Convenience and comfort items such as air cleaners, grab bars, bed tables and tub seats are not a benefit of the program.

(4) THE DEPARTMENT WILL PAY THE LOWEST OF THE FOLLOWING FOR PROSTHETIC DEVICES, DURABLE MEDICAL EQUIPMENT, AND MEDICAL SUPPLIES NOT ALSO COVERED BY MEDICARE: THE PROVIDER'S ACTUAL (SUBMITTED) CHARGE FOR THE ITEM; THE PROVIDER'S MEDICAID MEDIAN CHARGE FOR THE ITEM; THE 75TH PERCENTILE OF THE RANGE OF WEIGHTED MEDICAID MEDIAN CHARGES FOR EACH ITEM COVERED BY THIS RULE.

The department will pay the lower of the following for prosthetic devices, durable medical equipment and medical supplies: WHICH ARE ALSO COVERED BY MEDICARE: the provider's actual (submitted) charge for the item; or the amount allowable for the same item under medicare; . and for those items not covered by medicare, the provider's medicaid median charge or the 75th percentile of the range of weighted medicaid median charges.

46.12.905 OPTOMETRIC SERVICES, REIMBURSEMENT (1) Payments for optometric services shall be the lowest of usual and customary charges which are reasonable or the amount payable by medicare or the following fee schedule for covered optometric services: THE DEPARTMENT WILL PAY THE LOWEST OF THE FOLLOWING FOR OPTOMETRIC SERVICES NOT ALSO COVERED BY MEDICARE: THE PROVIDER'S ACTUAL (SUBMITTED) CHARGE FOR THE SERVICE; THE PROVIDER'S MEDICAID MEDIAN CHARGE FOR THE SERVICE; THE 75TH PERCENTILE OF THE RANGE OF WEIGHTED MEDICAID MEDIAN CHARGES FOR EACH SERVICE COVERED BY THIS RULE; OR THE DEPARTMENT'S FEE SCHEDULE CONTAINED IN THIS RULE.

The department will pay the lowest of the following for optometric services: WHICH ARE ALSO COVERED BY MEDICARE: the provider's actual (submitted) charge for the service; or the amount allowable for the same service under medicare; OR THE DEPARTMENT'S FEE SCHEDULE CONTAINED IN THIS RULE. and for those services not covered by medicare, the provider's medicaid median charge or the 75th percentile of the range of weighted medicaid median charges, or the following fee schedule:

(1) through (16) remains the same.

46.12.915 EYEGLASSES, REIMBURSEMENT Reimbursement for eyeglasses shall be the lowest of usual and customary charges which are reasonable, the amount payable by medicare, or the amount reflected in the following fee schedule: THE DEPARTMENT WILL PAY THE LOWEST OF THE FOLLOWING FOR EYEGLASSES NOT ALSO COVERED BY MEDICARE: THE PROVIDER'S ACTUAL (SUBMITTED) CHARGE FOR THE SERVICE; THE PROVIDER'S MEDICAID MEDIAN CHARGE FOR THE SERVICE; THE 75TH PERCENTILE OF THE RANGE OF WEIGHTED MEDICAID MEDIAN CHARGES FOR EACH SERVICE COVERED BY THIS RULE; OR THE DEPARTMENT'S FEE SCHEDULE CONTAINED IN THIS RULE.

The department will pay the lowest of the following for eyeglasses: WHICH ARE ALSO COVERED BY MEDICARE: the provider's actual (submitted) charge for the service; or the amount allowable for the same service under medicare; OR THE DEPARTMENT'S FEE SCHEDULE CONTAINED IN THIS RULE. and for those services not covered by medicare, the provider's medicaid median charge or the 75th percentile of the range of weighted medicaid median charges, or the following fee schedule:

(1) Lab costs for eyeglasses - optometrist

	Per Pair	
Hardened lenses-single vision	$19.80	
Hardened Lenses-bifocals	30.80	
Hardened lenses-trifocals	36.30	
Plastic lenses		
Add to single lenses	2.20	
Add to bifocal/trifocal	6.60	
Tinting, add to lense	3.30	
Frames	21.00	
Contact lenses	35.00	
Cataract lense	61.60	per lense
Balance lense	22.00	per lense

(2) Costs for eyeglasses - opticians and opthamologist

	Per Pair	
Single Vision	$30.00	
Bifocal	43.00	
Trifocal	55.00	
Plastic lenses		
Add to single lenses	4.00	
Add to bifocal/trifocal	11.00	
Tint (soft light 1, 2, and 3)	3.30	
Frame	26.00	
Metal Frame	30.00	
Cataract lense	61.60	per lense
Balance lense	22.00	per lense
4 drop cataract		
Single vision	165.00	
Bifocal	190.00	
Balance lense	67.50	
Frame (for 4 drop cataract)	30.00	

46.12.1005 TRANSPORTATION AND PER DIEM, REIMBURSEMENT THE DEPARTMENT WILL PAY THE LOWEST OF THE FOLLOWING FOR TRANSPORTATION AND PER DIEM NOT ALSO COVERED BY MEDICARE: THE PROVIDER'S ACTUAL (SUBMITTED) CHARGE FOR THE SERVICE; THE PROVIDER'S MEDICAID MEDIAN CHARGE FOR THE SERVICE; THE 75TH PERCENTILE OF THE RANGE OF WEIGHTED MEDICAL MEDIAN CHARGES FOR EACH SERVICE COVERED BY THIS RULE; OR THE DEPARTMENT'S FEE SCHEDULE CONTAINED IN THIS RULE.

The department will pay the lowest of the following for transportation and per diem, WHICH ARE ALSO COVERED BY MEDICARE: the provider's actual (submitted) charge for the service; ~~or~~ the amount allowable for the same service under medicare; OR THE DEPARTMENT'S FEE SCHEDULE CONTAINED IN THIS RULE. ~~and for those services not covered by medicare, the provider's medicaid median charge or the 75th percentile of~~

~~the range of weighted medicaid median charges, or the following fee schedule:~~

(1) Reimbursement for common carrier will be paid on the basis of usual and customary charges.

(2) Reimbursement for transportation by private vehicle will be at the current state rate for state employees.

(3) Reimbursement for per diem shall be actual expenses incurred up to a maximum of $17.00 per day for each person.

(4) Reimbursement for private air charter shall be 93 cents per mile.

46.12.1015 SPECIALIZED NONEMERGENCY MEDICAL TRANSPORTATION, REIMBURSEMENT ~~(1) Reimbursement for specialized nonemergency medical transportation shall be the lowest of~~ THE DEPARTMENT WILL PAY THE LOWEST OF THE FOLLOWING FOR SPECIALIZED NONEMERGENCY MEDICAL TRANSPORTATION NOT ALSO COVERED BY MEDICARE: THE PROVIDER'S ACTUAL (SUBMITTED) CHARGE FOR THE SERVICE; THE PROVIDER'S MEDICAID MEDIAN CHARGE FOR THE SERVICE; THE 75TH PERCENTILE OF THE RANGE OF WEIGHTED MEDICAID MEDIAN CHARGES FOR EACH SERVICE COVERED BY THIS RULE; OR THE DEPARTMENT'S FEE SCHEDULE CONTAINED IN THIS RULE.

The department will pay the lowest of the following for specialized nonemergency transportation: WHICH ARE ALSO COVERED BY MEDICARE: the provider's actual (submitted) charge for the service; ~~or~~ the amount allowable for the same service under medicare; OR THE DEPARTMENT'S FEE SCHEDULE CONTAINED IN THIS RULE. ~~and for those services not covered by medicare, the provider's medicaid median charge or the 75th percentile of the range of weighted medicaid median charges:~~

(1) the provider's rates as approved by the public service commission; or the rates allowed by the following specialized nonemergency medical transportation fee schedule.

(2) Specialized nonemergency medical transportation fee schedule.

(a) Transportation under 16 miles.....$ 8.00 one way
$14.00 round trip

Transportation over 16 mile.....$ .50 per mile

Waiting time for transportation over 16 miles.....$ 4.00 per hour Computed in 15 minute increments or fraction thereof

Waiting time for under 16 miles....No payment

When one way transportation is over 16 miles and the unloaded miles exceeds ten percent of the loaded miles, the miles from the departure point to the

pick-up point plus the miles from the delivery point to the departure point shall be paid for at the rate of.....$ .25 per mile

(b) There shall be no charge for usual passenger baggage which is not cargo.

(c) Children under six years of age accompanied by an adult paying passenger shall be carried free.

46.12.1025 AMBULANCE SERVICES, REIMBURSEMENT (1) Ambulance attendant services are included in the providers base rate.

(2) Reusable devices and equipment such as backboards, neckboards and inflatable leg and arm splints are considered part of the ambulance service and are included in the providers base rate.

(3) Nonreusable items and disposable supplies such as oxygen, gauze and dressings, are reimbursable as a separate charge.

(4) Medicaid reimbursement for mileage is allowed for patient loaded miles only outside the city limits.

(5) ~~Medicaid reimbursement will be the lesser of usual and customary charges which are reasonable, the individual providers medicare rate or the individual providers January 1980 medicaid rate plus 10 percent.~~ THE DEPARTMENT WILL PAY THE LOWEST OF THE FOLLOWING FOR AMBULANCE SERVICES NOT ALSO COVERED BY MEDICARE: THE PROVIDER'S ACTUAL (SUBMITTED) CHARGE FOR THE SERVICE; THE PROVIDER'S MEDICAID MEDIAN CHARGE FOR THE SERVICE; THE 75TH PERCENTILE OF THE RANGE OF WEIGHTED MEDICAID MEDIAN CHARGES FOR EACH SERVICE COVERED BY THIS RULE; OR THE INDIVIDUAL PROVIDER'S JANUARY 1980 MEDICAID RATE PLUS 10 PERCENT. The department will pay the lowest of the following for ambulance services, WHICH ARE ALSO COVERED BY MEDICARE: the provider's actual (submitted) charge for the service; ~~or~~ the amount allowable for the same service under medicare; ~~and for those services not covered by medicare, the provider's medicaid median charge or the 75th percentile of the range of weighted medicaid median charges,~~ or the individual provider's January 1980 medicaid rate plus 10 percent.

46.12.2003 PHYSICIAN SERVICES, REIMBURSEMENT/GENERAL REQUIREMENTS AND MODIFIERS ~~(1) Payments for physician services will be the lesser of usual and customary charges which are reasonable, the amount payable by medicare, or the following fee schedule:~~ THE DEPARTMENT WILL PAY THE LOWEST OF THE FOLLOWING FOR PHYSICIAN SERVICES NOT ALSO COVERED BY MEDICARE: THE PROVIDER'S ACTUAL (SUBMITTED) CHARGE FOR THE SERVICE; THE PROVIDER'S MEDICAID MEDIAN CHARGE FOR THE SERVICE; THE 75TH PERCENTILE OF THE RANGE OF WEIGHTED MEDICAID MEDIAN CHARGES FOR EACH SERVICE COVERED BY THIS RULE; OR THE DEPARTMENT'S FEE SCHEDULE FOUND IN RULES 46.12.2004, 46.12.2005, 46.12.2006, 46.12.2007, AND 46.12.2008.

The department will pay the lowest of the following for physician services: WHICH ARE ALSO COVERED BY MEDICARE: the provider's actual (submitted) charge for the service; the provider's medicaid median charge for the service; ~~or~~ the amount allowable for the same service under medicare; OR THE DEPARTMENT'S FEE SCHEDULES FOUND IN RULES 46.12.2004, 46.12.2005, 46.12.2006, 46.12.2007, AND 46.12.2008. ~~and for those services not covered by medicare, the provider's 75th percentile of the range of weighted medicaid median charges, or the following fee schedule. Services paid by report (BR) will be paid at 94.6000% of the fees which are comparable to usual and customary charges established by the provider in 1976.~~ The following reimbursement fee schedule applies to all rules in this sub-chapter.

(1) Services paid by report (BR) will be paid at 94.6000% of the fees which are comparable to usual and customary charges established by the provider in 1976.

(2) MODIFIERS

Listed services and procedures may be modified under certain circumstances. When applicable, the modifying circumstance should be identified by the addition of the appropriate modifier code, which is a two digit number placed after the usual procedure number from which it is separated by a hyphen. If more than one modifier is used, the "Multiple Modifiers" code placed first after the procedure code indicates that one or more additional modifier codes will follow. All procedures where a modifier is used may be paid By Report (BR). Modifiers commonly used are as follows:

-22 Unusual Services: When the service(S) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier '-2' to the usual procedure number. A report may also be appropriate. (Pertains to Medicine, Anesthesia, Surgery, Radiology, and Pathology and Laboratory.)

-23 Unusual Anesthesia: Periodically, a procedure, which usually requires either no anesthesia or local anesthesia, because of unusual circumstances must be done under general anesthesia. This circumstance may be reported by adding the modifier '-23' to the procedure code of the basic service. (Pertains to Anesthesia, Surgery.)

-26 Professional Component: Certain procedures (eg, laboratory, radiology, electrocardiogram, specific diagnostic services) are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding the modifier '-26' to the usual procedure number. (Pertains to Medicine, Surgery, Radiology, and Pathology and Laboratory.)

-30 Anesthesia Service: The anesthesia service may be identified by adding the modifier '-30' to the usual procedural code number of the basic service. (Pertains to Anesthesia.)

-47 Anesthesia by Surgeon: When regional or general anesthesia is provided by the surgeon, it may be reported by adding the modifier '-47' to the basic service. (This does not include local anesthesia.) (Pertains to Anesthesia, and Surgery.)

-50 Multiple or Bilateral Procedures: When multiple or bilateral procedures are provided at the same operative session, the first major procedure may be reported as listed. The secondary or lesser procedure(s) may be identified by adding the modifier '-50' to the usual procedure number(s). (Pertains to Surgery, and Radiology.)

-52 Reduced Services: Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's election. Under these circumstances the service provided can be identified by its usual procedure number and the addition of the modifier '-52', signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. (Pertains to Medicine, Anesthesia, Surgery, Radiology, and Pathology and Laboratory.)

-54 Surgical Care Only: When one physician performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding the modifier '-54' to the usual procedure number. (Pertains to Surgery.)

-55 Postoperative Management Only: When one physician performs the postoperative management and another physician has performed the surgical procedure, the postoperative component may be identified by adding the modifier '-55' to the usual procedure number. (Pertains to Medicine, and Surgery.)

-56 Preoperative Management Only: When one physician performs the preoperative care and evaluation and another physician performs the surgical procedure, the preoperative component may be identified by adding the modifier '-56' to the usual procedure number. (Pertains to Medicine, and Surgery.)

-66 Surgical Team: Under some circumstances, highly complex procedures (requiring the concomitant services of several

physicians, often of different specialties, plus other highly skilled, specially trained personnel and various types of complex equipment) are carried out under the 'surgical team' concept. Such circumstances may be identified by each participating physician with the addition of the modifier '-66' to the basic procedure number used for reporting services. (Pertains to Surgery.)

-75 Concurrent Care. Services Rendered by More than One Physician: When the patient's condition requires the additional services of more than one physician, each physician may identify his or her services by adding the modifier '-75' to the basic service performed. (Pertains to Medicine, Anesthesia, Surgery, and Radiology.)

-76 Repeat Procedure by Same Physician: The physician may need to indicate that a procedure or service was repeated subsequent to the original service. This may be reported by adding the modifier '-76' to the procedure code of the repeated service (Pertains to Medicine, Surgery, and Radiology.)

-77 Repeat Procedure by Another Physician: The physician may need to indicate that a basic procedure performed by another physician had to be repeated. This may be reported by adding modifier '-77' to the repeated service. (Pertains to Medicine, Surgery, and Radiology.)

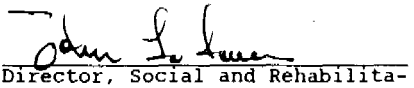
-80 Assistant Surgeon: Surgical assistant services may be identified by addint the modifier '-80' to the usual procedure number(s). (Pertains to Surgery.)

-81 Minimum Assistant Surgeon: Minimum surgical assistant services are identified by adding the modifier '-81' to the usual procedure number. (Pertains to Surgery.)

-90 Reference (Outside) Laboratory: When laboratory procedures are performed by a party other than the treating or reporting physician, the procedure may be identified by adding the modifier '-90' to the usual procedure number. (Pertains to Medicine, Surgery, Radiology, and Pathology and Laboratory.)

-99 Multiple Modifiers: Under certain circumstances two or more modifiers may be necessary to completely delineate a service. In such situations modifier '-99' should be added to the basic procedure, and other applicable modifiers may be listed as a part of the description of the service. (Pertains to Medicine, Anesthesia, Surgery, and Radiology.)

3. No comments or testimony were received.



Director, Social and Rehabilitation Services

Certified to the Secretary of State June 1, 1981.