



ADMINISTRATIVE RULES OF MONTANA

37.82.102 MEDICAL ASSISTANCE, DEFINITIONS

- (1) "AABD" means aid to the aged, blind, and disabled under Title XVI of the Social Security Act.
- (2) "AB" means Aid to the Blind under Title X of the Social Security Act.
- (3) "AFDC" means Aid to Families with Dependent Children under Title IV-A of the Social Security Act.
- (4) "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.
- (5) "APTD" means aid to the permanently and totally disabled under Title XIV of the Social Security Act.
- (6) "Categorically needy" means aged, blind or disabled individuals or families and children:
 - (a) who are otherwise eligible for Medicaid and who meet the financial eligibility requirements of section 1951 of the Social Security Act, SSI, or an optional state supplement; or
 - (b) whose categorical eligibility is otherwise provided for in ARM Title 37, chapter 82, subchapters 7, 9, 11, and 13.
- (7) "Certification" means the process by which a governmental or nongovernmental agency or association evaluates and recognizes an individual, institution or educational program as meeting predetermined standards.
- (8) "Department" means the Montana Department of Public Health and Human Services.
- (9) "Designated review organization" means either the department or other entity, contracting with the department or designated by law to determine the medical necessity of medical services rendered to recipients of public assistance.
- (10) "Electronic media claims" means claims submitted to the Montana Medicaid Program via magnetic tape or another acceptable electronic media approved by the department in accordance with ARM 37.85.406.
- (11) "Emergency service" means inpatient and outpatient hospital services that are necessary to treat an emergency medical condition as defined in 42 CFR 489.24(b).
- (12) "Families and children" refers to eligible members of families with dependent children who are financially eligible under family-related rules in subchapters 7, 11, and 13. In addition, this group includes individuals under 19 who are not dependent children but who are financially eligible under the above-cited subchapters. It does not include individuals under age 21 whose eligibility for Medicaid is based on the blindness or disability; for these individuals, the SSI-related rules in ARM Title 37, chapter 82, subchapters 9, 11, and 13 apply.

- (13) "Family size", for SSI-related medically needy, 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. For family-related medically needy, "family size" means the number of eligible individuals in the same household unit. Ineligible persons living in the same household, including ineligible responsible relatives, are not counted in determining family size.
- (14) "Fiscal agent" means an organization which processes and pays provider claims on behalf of the department.
- (15) "Grounds for sanctions" are fraudulent, abusive, or improper activities engaged in by providers of medical assistance services.
- (16) "Intern" means a medical practitioner involved in a period of on-the-job training as part of a larger educational program.
- (17) "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.
- (18) "Medically necessary service" means a service or item reimbursable under the Montana Medicaid program, as provided in these rules:
 - (a) Which is reasonably calculated to prevent, diagnose, correct, cure, alleviate, or prevent the worsening of conditions in a patient which:
 - (i) endanger life;
 - (ii) cause suffering or pain;
 - (iii) result in illness or infirmity;
 - (iv) threaten to cause or aggravate a handicap; or
 - (v) cause physical deformity or malfunction.
 - (b) A service or item is not medically necessary if there is another service or item for the recipient that is equally safe and effective and substantially less costly including, when appropriate, no treatment at all.
 - (c) Experimental services or services which are generally regarded by the medical profession as unacceptable treatment are not medically necessary for purposes of the Montana Medicaid program.
 - (i) Experimental services are procedures and items, including prescribed drugs, considered experimental or investigational by the U.S. Department of Health and Human Services, including the Medicare program, or the department's designated review organization or procedures and items approved by the U.S. Department of Health and Human Services for use only in controlled studies to determine the effectiveness of such services.
 - (d) With respect to abortion services reimbursable under the Montana Medicaid program, subsection (a) is limited by ARM 37.86.104(11).

- (19) "Medically needy" means aged, blind or disabled individuals or families and children who are otherwise eligible for Medicaid and whose income is above the prescribed limits for the categorically needy but within the limits prescribed in ARM Title 37, chapter 82, subchapter 11.
- (20) "Montana Medicaid Program" means the Montana Medical Assistance Program authorized by Title 53, chapter 6, MCA and Title XIX of the Federal Social Security Act.
- (21) "OAA" means Old Age Assistance under Title I of the Social Security Act.
- (22) "OASDI" means Old Age, Survivors, and Disability Insurance under Title II of the Social Security Act.
- (23) "Optional state supplement" means a cash payment made by the department to an aged, blind or disabled individual.
- (24) "Postpartum continuous eligibility coverage" means members who are currently enrolled in Healthy Montana Kids (HMK) or Medicaid may receive 12 months of continuous postpartum coverage, regardless of any changes in circumstances. The 12-month postpartum period begins on the last day of a member's pregnancy and extends through the end of the month in which the 12-month period ends.
- (25) "Professional component" means the cost of professional services of the physician including examination of the patient, when indicated, performance and/or supervision of the procedure, interpretation and reporting of the examination and consultation of the referring physician. It does not include the cost of personnel, materials, equipment or other facilities.
- (26) "Provider" means an individual, company, partnership, corporation, institution, facility, or other entity or business association that has enrolled or applied to enroll as a provider of services or items under the Montana Medicaid program.
- (27) "Recipient overpayment" means an amount of public assistance paid to or on behalf of a recipient in excess of the amount that is proper.
- (28) "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.
- (29) "Services" means services, items and any other amounts reimbursable under the Montana Medicaid program.
- (30) "SSI" means Supplemental Security Income under Title XVI of the Social Security Act.
- (31) "Suspension of participation" means an exclusion from participation in the Medicaid Program for a specified period of time.
- (32) "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.
- (33) "Technical component" means the cost of personnel, materials including visual contrast media and drugs, space, equipment and other facilities, but does not include the cost of radioisotopes.
- (34) "Termination from participation" means an exclusion from participation in the Medicaid program.
- (35) "Total value" means the combined value of the professional component and the technical component of physician services.

- (36) "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.

Authorizing statute(s): 53-2-201, 53-6-113, MCA

Implementing statute(s): 53-2-201, 53-6-101, 53-6-106, 53-6-107, 53-6-111, 53-6-113, 53-6-131, 53-6-141, MCA

History: NEW, 1980 MAR p. 1190, Eff. 4/11/80; AMD, 1980 MAR p. 2978, Eff. 11/29/80; AMD, 1981 MAR p. 559, Eff. 6/12/81; AMD, 1981 MAR p. 769, Eff. 7/31/81; AMD, 1982 MAR p. 105, Eff. 1/29/82; AMD, 1982 MAR p. 729, Eff. 4/16/82; AMD, 1983 MAR p. 757, Eff. 7/1/83; AMD, 1983 MAR p. 1197, Eff. 8/26/83; AMD, 1985 MAR p. 248, Eff. 3/15/85; AMD, 1985 MAR p. 1409, Eff. 9/27/85; AMD, 1986 MAR p. 359, Eff. 3/14/86; AMD, 1986 MAR p. 1967, Eff. 12/1/86; AMD, 1987 MAR p. 894, Eff. 6/26/87; AMD, 1987 MAR p. 907, Eff. 7/1/87; AMD, 1988 MAR p. 753, Eff. 5/1/88; AMD, 1991 MAR p. 2049, Eff. 11/1/91; AMD, 1997 MAR p. 474, Eff. 3/11/97; AMD, 1998 MAR p. 495, Eff. 2/13/98; TRANS, from SRS, 2000 MAR p. 476; AMD, 2003 MAR p. 15, Eff. 1/17/03; AMD, 2023 MAR p. 414, Eff. 5/1/23; AMD, 2024 MAR p. 2021, Eff. 8/10/24.