



Ambulatory Surgical Center Services

*Medicaid and Other Medical
Assistance Programs*

June 2011

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My NPI:

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Key Contacts

Hours for Key Contacts are 8 a.m. to 5 p.m. Monday through Friday (Mountain Time), unless otherwise stated. The phone numbers designated “In state” will not work outside Montana.

Ambulatory Surgical Centers

(406) 444-4349 Phone
(406) 444-1861 Fax

Send written inquiries to:
ASC Program Officer
Hospital and Clinical Services Section
DPHHS
P.O. Box 202951
Helena, MT 59620-2951

Chemical Dependency Bureau

For coverage information and other details regarding chemical dependency treatment, write or call:

(406) 444-3964 Phone
(406) 444-4435 Fax

Send written inquiries to:
Chemical Dependency Bureau
Addictive and Mental Disorders Division
DPHHS
P.O. Box 202905
Helena, MT 59620-2905

Claims

Send paper claims to:
Claims Processing Unit
P.O. Box 8000
Helena, MT 59604

CLIA Certification

For questions regarding CLIA certification, call or write:
(406) 444-1451 Phone
(406) 444-3456 Fax

Send written inquiries to:
Quality Assurance Division
Certification Bureau
DPHHS
2401 Colonial Drive
P.O. Box 202953
Helena, MT 59620-2953

Client Eligibility

FaxBack
(800) 714-0075 (24 hours)

Automated Voice Response System (AVRS)
(800) 714-0060 (24 hours)

Montana Access to Health Web Portal
<http://mtaccessstohealth.acs-shc.com/mt/general/home.do>

Medifax EDI
(800) 444-4336, Extension 2072 (24 hours)

Direct Deposit Arrangements

Providers who would like to receive their remittance advices electronically and electronic funds transfer should call the number below.
(406) 444-5283

EDI Technical Help Desk

For questions regarding electronic claims submission:
(800) 987-6719 In- and out-of-state
(406) 442-1837 Helena
(406) 442-4402 Fax

Mail to:

ATTN: MT EDI
ACS
P.O. Box 4936
Helena, MT 59604

Send e-mail inquiries to:

MTEDIHelpdesk@ACS-inc.com

Fraud and Abuse

If you suspect fraud or abuse by an enrolled Medicaid client or provider, you may call one of the Program Compliance Bureau's fraud hotlines:

(800) 201-6308 Client Eligibility Fraud
(800) 362-8312 Medicaid Help Line
(Call this number to report suspected client abuse of Medicaid.)
(800) 376-1115 Provider Fraud

Lab**Public Health Lab assistance:**

(800) 821-7284 In-state
(406) 444-3444 Out-of-state and Helena

Send written inquiries to:

DPHHS Public Health Lab
1400 Broadway
P.O. Box 6489
Helena, MT 59620

Medicaid Client Help Line

Clients who have Medicaid or Passport questions may call the Montana Medicaid Client Help Line:

(800) 362-8312

Send written inquiries to:

Passport to Health
P.O. Box 254
Helena, MT 59624-0254

Nurse First

For questions regarding the Nurse Advice Line, contact:

(406) 444-4540 Phone
(406) 444-1861 Fax

Nurse First Program Officer
Managed Care Bureau
DPHHS
P.O. Box 202951
Helena, MT 59620-2951

Prior Authorization

The following are some of the Department's prior authorization contractors. Providers are expected to refer to their specific provider manual for prior authorization instructions.

Mountain-Pacific Quality Health

For questions regarding prior authorization for transplant services, private duty nursing services, out-of-state inpatient services, medical necessity therapy reviews, interim inpatient hospital stays, other services requiring prior authorization, and case management assistance:

Phone:

(800) 262-1545 X5850 In- and out-of-state
(406) 443-4020 X5850 Helena

Fax:

(800) 497-8235 In- and out-of-state
(406) 443-4585 Out-of-state and Helena

Send written inquiries to:

Mountain-Pacific Quality Health
3404 Cooney Drive
Helena, MT 59602

For questions regarding prior authorization for alcohol and drug detoxification:

(406) 444-0061 Phone
(406) 444-4441 Fax

Magellan Medicaid Administration (previously dba First Health)

For questions regarding prior authorization and continued stay review for selected mental health services.

(800) 770-3084 Phone

(800) 639-8982 Fax

(800) 247-3844 Fax

Magellan Medicaid Administration
4300 Cox Road
Glen Allen, VA 23060

Provider Policy Questions

For policy questions, contact the appropriate division of the DPHHS; see the *Introduction* chapter in the *General Information for Providers* manual.

Provider Relations

For questions about enrollment, eligibility, payments, denials, general claims questions, or Passport questions, or to request provider manuals or fee schedules:

(800) 624-3958 In- and out-of-state

(406) 442-1837 Helena

(406) 442-4402 Fax

Send written inquiries to:

Provider Relations Unit
P.O. Box 4936
Helena, MT 59604

Send e-mail inquiries to:

MTPRHelpdesk@ACS-inc.com

For Passport enrollment or caseload questions:

(800) 362-8312

Send Passport correspondence to:

Passport to Health
P.O. Box 254
Helena, MT 59624-0254

Secretary of State

The Secretary of State's office publishes the most current version of the Administrative Rules of Montana (ARM):

(406) 444-2055 Phone

Secretary of State
P.O. Box 202801
Helena, MT 59620-2801

Team Care

For questions regarding the Team Care Program:

(406) 444-4540 Phone

(406) 444-1861 Fax

Team Care Program Officer
Managed Care Bureau
DPHHS
P.O. Box 202951
Helena, MT 59620-2951

Third Party Liability

For questions about private insurance, Medicare or other third-party liability:

(800) 624-3958 In- and out-of-state

(406) 442-1837 Helena

(406) 442-0357 Fax

Send written inquiries to:

ACS Third Party Liability Unit
P.O. Box 5838
Helena, MT 59604

Key Websites

Web Address	Information Available
ACS EDI Gateway www.acs-gcro.com/	Select MT DPHIS. ACS EDI Gateway is Montana's HIPAA clearinghouse. Visit this website for more information on: <ul style="list-style-type: none"> • Provider services • EDI support • Enrollment • Manuals • Software • Companion guides • FAQs • Related links
Centers for Disease Control and Prevention (CDC) Website http://www.cdc.gov/vaccines/	Immunization and other health and safety information
Healthy Montana Kids (HMK) Website www.hmk.mt.gov	Information on Healthy Montana Kids (HMK)
Provider Information Website http://medicaidprovider.hhs.mt.gov/ Montana Access to Health Web Portal http://mtaccesstohealth.acs-shc.com/mt/general/home.do	<ul style="list-style-type: none"> • Medicaid information • Medicaid news • Provider manuals • Notices and manual replacement pages • Fee schedules • Remittance advice notices • Forms • Provider enrollment • Frequently asked questions (FAQs) • Upcoming events • Electronic billing information • Newsletters • Key contacts • Links to other websites and more • Montana Access to Health: Eligibility, provider summary information, claim status and payment amounts, X12 transactions, remittance advices, enrollment, and medical claims history for hospitals, physicians, and mid-level practitioners
State of Montana DPHHS Website http://www.dphhs.mt.gov	<ul style="list-style-type: none"> • General information about DPHHS: Advisory councils, director's office, divisions and websites, goals and objectives, organizational charts, phone numbers, and policies and procedures • Legal Information: ADA commendation notice, ARM, Emergency notices, MAR, Other state and federal legal resources, proposed manual changes, requests for bids or proposals, requests for information • News: Bulletins, events calendar consumer product safety commission, meeting minutes, Montana Medicaid DUR board, press releases • Services: Applications and forms, guidelines, office locations, plans, programs available, publications, related website, reports, statistical information.

Introduction

Thank you for your willingness to serve clients of the Montana Medicaid program and other medical assistance programs administered by the Department of Public Health and Human Services.

Manual Organization

This manual provides information specifically for ambulatory surgical center services.

Most chapters have a section titled *Other Programs* that includes information about other Department programs such as the Mental Health Services Plan (MHSP) and Healthy Montana Kids (HMK). Other essential information for providers is contained in the separate *General Information for Providers* manual. Each provider is asked to review both the general manual and the specific manual for his or her provider type.

A table of contents and an index allow you to quickly find answers to most questions. The margins contain important notes with extra space for writing notes. There is a list of *Key Contacts* at the beginning of each manual. We have also included a space on the back side of the front cover to record your NPI/API for quick reference when calling Provider Relations.

Manual Maintenance

Manuals must be kept current. Changes to manuals are provided through notices and replacement pages. When replacing a page in a manual, file the old pages and notices in the back of the manual for use with claims that originated under the old policy.

Rule References

Providers must be familiar with all current rules and regulations governing the Montana Medicaid program. Provider manuals are to assist providers in billing Medicaid; they do not contain all Medicaid rules and regulations. Rule citations in the text are a reference tool; they are not a summary of the entire rule. **In the event that a manual conflicts with a rule, the rule prevails.** Links to rules are available on the Provider Information website (see *Key Websites*). Paper copies of rules are available through the Secretary of State's office (see *Key Contacts*). In addition to the general Medicaid rules outlined in the *General Information for Providers* manual, the following rules and regulations are also applicable to the ambulatory surgical center program:

- Code of Federal Regulations (CFR)
 - 42 CFR 416



Providers are responsible for knowing and following current laws and regulations.

- Montana Code Annotated (MCA)
 - MCA 50-5-101
- Administrative Rules of Montana (ARM)
 - ARM 37.86.1401–37.86.1406 Ambulatory Surgical Centers

Claims Review (MCA 53-6-111, ARM 37.85.406)

The Department is committed to paying Medicaid providers' claims as quickly as possible. Medicaid claims are electronically processed and usually are not reviewed by medical experts prior to payment to determine if the services provided were appropriately billed. Although the computerized system can detect and deny some erroneous claims, there are many erroneous claims which it cannot detect. For this reason, payment of a claim does not mean that the service was correctly billed or the payment made to the provider was correct. Periodic retrospective reviews are performed which may lead to the discovery of incorrect billing or incorrect payment. If a claim is paid and the Department later discovers that the service was incorrectly billed or paid or the claim was erroneous in some other way, the Department is required by federal regulation to recover any overpayment, regardless of whether the incorrect payment was the result of Department or provider error or other cause.

Covered Services

General Coverage Principles

Medicaid covers almost all ambulatory surgical center services when they are medically necessary. This chapter provides covered services information that applies specifically to ambulatory surgical center services. Like all health care services received by Medicaid clients, these services must also meet the general requirements listed in the *Provider Requirements* chapter of the *General Information for Providers* manual.

Ambulatory surgical center services (ARM 37.86.1402)

Covered surgical procedures can only be rendered by a licensed ambulatory surgical center. Clinic services must be provided by a clinic which is licensed as an outpatient facility by the appropriate licensing entity of the state where the facility is located and meet the requirements for participation in Medicaid. Clinic services must be provide by or under the direction of a licensed physician or, where appropriate, a licensed dentist. Patients receiving ambulatory surgical center services must be either Class I anesthesia risk or Class II anesthesia risk.

All of the following are conditions for coverage of listed ambulatory surgical center procedures:

- Covered surgical procedures are limited to those procedures that do not generally exceed a total of 90 minutes operating time and a total of 4 hours recovery or convalescent time.
- If the covered surgical procedure requires anesthesia, the anesthesia must be local or regional anesthesia, or general anesthesia of 90 minutes or less duration.
- Covered surgical procedures may not be of a type that generally result in extensive blood loss; require a major or prolonged invasion of body cavities; directly involve major blood vessels; are generally emergent or life threatening in nature; or can safely be performed in a physician's or dentist's office.

Services for children (ARM 37.86.2201–2221)

The Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) is a comprehensive approach to health care for Medicaid clients ages 20 and under. It is designed to prevent, identify, and then treat health problems before they become disabling. Under EPSDT, Medicaid-eligible children may receive any medically-necessary covered service, including all ambulatory surgical center services described in this manual. All applicable Passport to Health and prior authorization requirements apply.

Noncovered services (ARM 37.85.207 and 37.86.3002)

The following is a list of services not covered by Medicaid. Some of these services may be covered under the EPSDT program for children age 20 and younger based on medical necessity or for individuals covered under the Qualified Medicare Beneficiary (QMB) program (see the *Eligibility* chapter in the *General Information for Providers* manual).

- Acupuncture
- Chiropractic services
- Dietician/nutritional services
- Massage services
- Dietary supplements
- Homemaker services
- Infertility treatment
- Delivery services not provided in a licensed health care facility unless as an emergency service
- Outpatient physical therapy, occupational therapy, and speech therapy services that are primarily maintenance therapy. Providers should refer to the *Therapy Services* manual available on the Provider Information website (see *Key Websites*).
- Outpatient hospital services provided outside the United States
- Naturopath services
- Services provided by surgical technicians who are not physicians or mid-level practitioners
- Services considered experimental, cosmetic, or investigational
- Claims from outpatient hospitals for pharmaceuticals and supplies only
- Reference lab services. Providers may bill Medicaid only for those lab services they have performed themselves.
- Exercise programs and programs that are primarily educational, such as:
 - Cardiac rehabilitation exercise programs
 - Pulmonary rehabilitation programs
 - Nutritional programs
 - Independent exercise programs (e.g., pool therapy, swim programs, or health club memberships)
- Services provided to Medicaid clients who are absent from the state, with the following exceptions:
 - Medical emergency
 - Required medical services are not available in Montana. Passport approval is required and prior authorization may also be required for certain services. See the *Passport* and *Prior Authorization* chapters in this manual.

- If the Department has determined that the general practice for clients in a particular area of Montana is to use providers in another state
- When out-of-state medical services and all related expenses are less costly than in-state services
- When Montana makes adoption assistance or foster care maintenance payments for a client who is a child residing in another state
- Services that are not medically necessary. The Department may review for medical necessity at any time before or after payment. The Medicaid client is financially responsible for these services and the Department recommends the client agree in writing before the services are provided. See *When to Bill Medicaid Clients* in the *Billing Procedures* chapter of this manual.
- Donor search expenses
- Autopsies
- Telephone contacts are not a clinic service.
- Medicaid does not cover services that are not direct patient care such as the following:
 - Missed or canceled appointments
 - Mileage and travel expenses for providers
 - Preparation of medical or insurance reports
 - Service charges or delinquent payment fees
 - Telephone services in home
 - Remodeling of home
 - Plumbing service
 - Car repair and/or modification of automobile

Importance of fee schedules

The easiest way to verify coverage for a specific service is to check the Department's fee schedule for your provider type. In addition to being listed on the fee schedule, all services provided must also meet the coverage criteria listed in the *Provider Requirements* chapter of the *General Information for Providers* manual and in this chapter. Use the current fee schedule in conjunction with the more detailed coding descriptions listed in the current CPT-4 and HCPCS Level II coding books. Take care to use the fee schedule and coding books that pertain to the date of service. Current fee schedules are available on the Provider Information website (see *Key Websites*).



Use the current fee schedule for your provider type to verify coverage for specific services.

Coverage of Specific Services (ARM 37.86.1405)

The following are coverage rules for specific ambulatory surgical center services.

Clinic Services, Covered Procedures (ARM 37.86.1405)

Ambulatory surgical center (ASC) services:

- Are services that will be covered by Medicaid if provided in an outpatient ASC setting incident to provisions of physician or dental services to the patient where the services and supplies are furnished in the ASC on a physician's or dentist's order by ASC personnel under the supervision of ASC medical staff.
- Are limited as provided by ARM 37.861402(1)–(5) with the term “clinic” taken to mean ASC.
- Clinic services covered by the Medicaid program include physician services covered in ARM 37.86.101, 37.86.104, and 37.86.105.
- Clinic services covered by the Medicaid program include mid-level practitioner services covered in ARM 37.86.201, 37.86.202, and 37.86.205.

Passport

What is Passport to Health? (ARM 37.86.5101–5120, ARM 37.86.5303, and ARM 37.86.5201–5206)

Passport to Health is the managed care organization for Montana Medicaid and Healthy Montana Kids (HMK) *Plus* clients. Our four Passport programs encourage and support Medicaid and HMK *Plus* clients and providers in establishing a medical home and in ensuring the appropriate use of Medicaid and HMK *Plus* services:

- Passport to Health Primary Care Case Management
- Team Care
- Nurse First Advice Line
- Health Improvement Program

Medicaid and HMK *Plus* clients who are eligible for Passport must enroll in the program (about 70% of Montana Medicaid and HMK *Plus* clients are eligible). Each enrollee has a designated Passport provider who is typically a physician, midlevel practitioner, or primary care clinic.

Passport to Health Primary Care Case Management (ARM 37.86.5101–5120)

The Passport provider provides primary care case management (PCCM) services to their clients. This means they provide or coordinate the client's care and make referrals to other Montana Medicaid and HMK *Plus* providers when necessary. Under Passport, Medicaid and HMK *Plus* clients choose one primary care provider (PCP) and develop an ongoing relationship that provides a medical home. The medical home is a concept which encourages a strong doctor/patient relationship. An effective medical home is accessible, continuous, comprehensive, and coordinated, and operates within the context of family and community.

With some exceptions (see *Services That Do Not Require Passport Provider Approval* in this chapter), all services to Passport clients must be provided or approved by the client's Passport provider or Medicaid/HMK *Plus* will not reimburse for those services. The client's Passport provider is also referred to as the PCP.

Team Care (ARM 37.86.5303)

Team Care is designed to educate clients on how to effectively access medical care. Clients with a history of using services at an amount or frequency that is not medically necessary are enrolled in Team Care. Clients enrolled in Team Care are also enrolled in Passport. Team Care follows the same Passport rules and guidelines for referrals, enrollment/disenrollment, prior authorization, and billing processes. However, while Passport clients can change providers with-

out cause, as often as once a month, Team Care clients are locked in to one provider and one pharmacy. Providers are encouraged to make a referral to the Team Care Program Officer if they feel one of their clients is appropriate for the program. A Passport provider receives an enhanced case management fee of \$6 per member per month for Team Care clients. When checking Medicaid or HMK *Plus* eligibility on the web portal on the Provider Information website (see *Key Websites*), a Team Care client's provider and pharmacy will be listed. Write all Medicaid and HMK *Plus* prescriptions to the designated pharmacy.

Nurse First Advice Line

The Nurse First Advice Line at 1-800-330-7847 is a 24/7, toll-free and confidential nurse triage line staffed by licensed registered nurses is available to all Montana Medicaid and HMK clients. There is no charge to clients or providers. Clients are encouraged to use the Nurse First Advice Line as their first resource when they are sick or hurt. Registered nurses are available 24/7 to triage clients over the phone and recommend appropriate care. Health coaches are also available to answer general health or medication questions. Nurses do not diagnose or provide treatment. The Nurse First Advice Line will fax a triage report to the Passport PCP when one of their clients calls to be triaged.

Passport providers are encouraged to provide education to their clients regarding the appropriate use of the emergency department (ED), including using the Nurse First Advice Line, before going to the ED.

Health Improvement Program (ARM 37.86.5201–5206)

Montana has a new Health Improvement Program (HIP) for Medicaid and HMK *Plus* patients with chronic illnesses or risks of developing serious health conditions. HIP is operated statewide through a regional network of 14 community and tribal health centers. Medicaid and HMK *Plus* patients eligible for the Passport program are enrolled and assigned to a health center for case management. Current Passport patients stay with their providers for primary care, but are eligible for case management through HIP. Nurses and health coaches certified in professional chronic care will conduct health assessments; work with the PCP to develop care plans; educate patients in self-management and prevention; provide pre- and post-hospital discharge planning; help with local resources; and remind patients about scheduling needed screening and medical visits.

Montana uses predictive modeling software to identify chronically ill patients. This software uses medical claims, pharmacy and demographic information to generate a risk score for each patient. Although the software will provide a great deal of information for interventions, it will not identify patients who have not received a diagnosis or generated claims. PCPs may also identify and recommend Passport patients at high risk for chronic health conditions that would benefit from case management from HIP.

In practice, providers will most often encounter Medicaid and HMK *Plus* clients who are enrolled in Passport. Specific services may also require prior authorization (PA) regardless of whether the client is a Passport enrollee. Passport referral and approval requirements and PA requirements are described below. Specific PA requirements can be found in the provider fee schedules.

Role of the Passport Provider

- Must be enrolled as a Montana Medicaid provider. Providers may download the provider enrollment information from the Provider Information website or contact Provider Relations (see *Key Websites* and *Key Contacts*).
- Sign and agree to the terms of the Passport Provider agreement.
- Must meet the requirements listed in the *Provider Requirements* and *Passport to Health* chapters of the *General Information for Providers* manual.
- Accept enrollees in the order in which clients are enrolled. Providers are automatically assigned Passport enrollees as long as they have openings and the enrollees meet the PCP-defined restrictions.
- Provide primary care, preventive care, health maintenance, treatment of illness and injury, and coordination of client's access to medically necessary specialty care by providing referrals, authorizations, and follow-up.
- Authorize inpatient admissions.
- Provide or arrange for suitable coverage for needed services, consultations, and approval of referrals during the provider's normal hours of operation.
- Provide an appropriate and confidential exchange of information among providers.
- Educate and assist clients in finding self-referral services (e.g., family planning, mental health services, immunizations and other services).
- Educate clients about appropriate use of the emergency department (ED).
- Provide or arrange for well child checkups, EPSDT services, blood lead screenings and testings, and immunizations.
- Maintain a unified patient medical record for each Passport enrollee. This must include a record of all approved referrals to other providers. Providers must transfer a copy of the client's medical record to a new PCP if requested in writing and authorized by the client.
- Provide all documentation requested by the Department (or its designee). The Department may review provider records to assure appropriate, timely, reasonably priced, quality services are being provided to Montana Medicaid clients.
- May not discriminate against protected classes or in the selection of Passport clients.
- Federal regulation requires you to provide interpreter services to all patients with limited English proficiency.

Providing Passport referral and authorization

- Before referring a Passport client to another provider, verify that the provider accepts Medicaid.
- When referring a client to another provider, you must give that provider your Passport number.
- All referrals must be documented in the client's medical record or a telephone log. Documentation should not be submitted with the claim.
- Passport approval may be for a one-time visit, a time-specific period, or the duration of an illness or pregnancy, as determined by the Passport provider.

See the *Passport Referral and Approval* section on the next page for details.

Client disenrollment

A provider can ask to disenroll a Passport client for any reason including:

- The provider-client relationship is mutually unacceptable.
- The client fails to follow prescribed treatment (unless this lack of compliance is a symptom of the medical condition).
- The client is abusive.
- The client could be better treated by a different type of provider, and a referral process is not feasible.

Providers cannot terminate a provider-client relationship in mid-treatment. To disenroll a client, write to Passport to Health (see *Key Contacts*). Providers must continue to provide Passport management services to the client while the disenrollment process is being completed.

Termination of Passport agreement

To terminate your Passport agreement, notify Passport to Health (see *Key Contacts*) in writing at least 30 days before the date of termination. Termination is effective on the first day of the month following notice of termination, or the first day of the second month following notice of termination, whichever allows a 30-day time period to elapse.

Utilization review

Passport providers' utilization patterns are analyzed on a regular basis. When a provider's average rates for service utilization are consistently high or low, the provider may be asked to furnish information regarding unusual practice patterns.

Caseload limits

Passport providers may serve as few as one or as many as 1,000 Medicaid clients. Group practices and clinics may serve up to 1,000 clients for each full-time equivalent provider.

Client Eligibility Verification

Client eligibility verification will indicate whether the client is enrolled in Passport. The client's Passport provider and phone number are also available, and whether the client has Full or Basic coverage. To check on a client's eligibility, go to the Montana Access to Health (MATH) web portal on the Provider Information website (see *Key Websites*). Other methods of checking client eligibility can be found in the *Client Eligibility and Responsibilities* chapter of the *General Information for Providers* manual.

Medicaid Services – Provider Requirements

To be covered by Medicaid, all services must be provided in accordance with the requirements listed in the *Provider Requirements* chapter of the *General Information for Providers* manual and in the *Covered Services* chapter of this manual. Prior authorization and Team Care requirements must also be followed.

Passport Referral and Approval (ARM 37.86.5110)

If a client is enrolled in Passport, most services must be provided or approved by the client's Passport provider. While Passport referral and approval is needed for most medically-necessary services that the client's Passport provider does not provide there are some exceptions (see *Services That Do Not Require Passport Provider Approval* in the following section).

Making a referral

Referrals can be made to any other provider who accepts Montana Medicaid. Referrals can be verbal or in writing, and must be accompanied by the Passport provider's Passport approval number. Passport providers are required to document Passport referrals in the client's records or in a telephone log book. Documentation should not be submitted with the claim. The Passport provider establishes the parameters of referrals, which may be for a one-time visit, a time-specific period, or the duration of an illness or pregnancy. An optional referral form is available at the Passport link on the Provider Information website (see *Key Websites*).

Receiving a referral as the non-PCP

The client's Passport provider must be contacted for approval for each visit unless another time parameter was established. It is best to get Passport approval in advance, in writing, and specific to services and dates. Using another provider's Passport number without approval is considered fraud. If a provider accepts a client as a Medicaid client and provides a service that

requires Passport provider approval without the client's Passport provider's approval, Medicaid will deny the claim. If a provider tries unsuccessfully to get approval from the PCP, the provider cannot bill the client. The provider can bill the client if the client agreed to pay privately before services were rendered (ARM 37.85.406). For details on when providers can bill Medicaid clients, see the *Billing Procedures* chapter in this manual.

If a Passport provider refers a client to you, do not refer that client to someone else without the Passport provider's approval, or Medicaid will not cover the service.

Passport approval and prior authorization

Passport approval and prior authorization (PA) are different, and both may be required for a service. PA refers to a list of services that require authorization through a Department contractor, Mountain Pacific Quality Health. See *Additional Medicaid Requirements for Passport Clients* in your *Passport to Health Provider Handbook*, and the Medicaid billing manual for your specific provider type for more information on PA and Passport. The Medicaid Covered Services table in *Appendix A* of the *General Information for Providers* manual is an overview of services with PA and Passport indicators.

Services That Do Not Require Passport Provider Approval (37.86.5110)

- Ambulance
- Anesthesiology
- Audiology
- Blood lead testing
- Dental
- Dialysis
- Durable medical equipment
- Emergency department
- Eye exams and eyeglasses
- Family planning
- Hearing exams and aids
- Home- and community-based services
- Home infusion therapy
- Hospice
- Hospital swing bed
- Immunizations
- Intermediate care facilities for the mentally retarded

- Laboratory tests
- Licensed clinical counseling
- Mental health case management
- Mental health services
- Nursing facilities
- Obstetrics
- Optometrists and ophthalmologists
- Personal assistance services in a client's home
- Pharmacy
- Podiatry
- Psychologists
- Residential treatment centers
- Social workers (licensed)
- Substance dependency treatment
- Targeted case management
- Therapeutic family care
- Transportation (commercial and specialized non-emergency)
- X-rays

Passport and Emergency Services (ARM 37.86.5110)

Passport providers must provide direction to clients in need of 24/7 emergency care. For more information on direction, education, and suitable coverage for emergency care, see the *Passport to Health Provider Handbook*.

- **Emergency services provided in the emergency department (ED).** **Passport provider approval is not required for emergency services.** Emergency medical services are those services required to treat and stabilize an emergency medical condition. Nonemergencies in the ED will not be reimbursed, except for the screening and evaluation fee and any appropriate imaging and diagnostic services that are part of the screening. For more information, see *Emergency Services* on the Provider Information website (see *Key Websites*) or in the Medicaid billing manual for your provider type.
- **Post stabilization and Passport.** If inpatient hospitalization is recommended as post-stabilization treatment, the hospital must get a referral from the client's Passport provider. If the hospital attempts to contact the Passport provider and does not receive a response within 60 minutes, authorization is assumed. To be paid for these services, documentation must be sent to the Passport Program Officer (see *Key Contacts*) for review. The documentation must include the time an attempt was made to

reach the provider and the time the inpatient hospitalization began. There must be a 60-minute time lapse between these two events.

Passport and Indian Health Services

Clients who are eligible for both Indian Health Service (IHS) and Medicaid may choose IHS or another provider as their Passport provider. Clients who are eligible for IHS do not need a referral from their Passport provider to obtain services from IHS. However, if IHS refers the client to a non-IHS provider, the Passport provider must approve the referral.

Complaints and Grievances

Providers may call Provider Relations (see *Key Contacts*) to report a complaint that something inappropriate has taken place. A grievance is a written complaint and must be addressed to the Passport Program Officer (see *Key Contacts*). See the *Passport to Health Provider Handbook* for a full review of complaints, administrative reviews and fair hearings.

Getting Questions Answered

The *Key Contacts* list provides important phone numbers and addresses. Provider and client help lines are available to answer almost any Passport or general Medicaid question. You may call Provider Relations to discuss any problems or questions regarding your Passport clients, or to enroll as a Passport provider. You can keep up with changes and updates to the Passport program by reading the Passport provider newsletters. Newsletters and other information are available on the Provider Information website (see *Key Websites*). For claims questions, call Provider Relations.

Becoming a Passport Provider (ARM 37.86.5111–5112)

A PCP can be a physician, primary care clinic, or mid-level practitioner, other than a certified registered nurse anesthetist, who provides primary care case management by agreement with the Department. The Department allows any provider who has primary care within his or her professional scope of practice to be a PCP. The Department does, however, recognize that certain specialties are more likely to practice primary care. The Department actively recruits these providers. Passport providers receive a primary case management fee of \$3.00 a month for each enrollee.

To enroll in Passport, Medicaid providers must complete and sign a Passport provider agreement. The Passport provider agreement and the *Passport to Health Provider Handbook* are available on the Provider Information website (see *Key Websites*). Providers may also call Provider Relations (see *Key Contacts*) for information on becoming a Passport provider and to get the Passport provider agreement.

Solo Passport provider

A solo Passport provider is enrolled in the program as an individual provider with one Passport number. The solo provider is listed as the client's Passport provider. The solo provider is responsible for managing his or her individual Passport caseload. For details on referral documentation, see *Passport Referral and Approval* in this section of the manual. Case management fees are paid to the individual provider under the solo provider's Passport number in addition to the fee-for-service reimbursement.

Group Passport provider

A group Passport provider is enrolled in the program as having one or more Medicaid providers practicing with one Passport number. The group name will be listed as the client's Passport provider and could be a private group clinic, rural health clinic, federally qualified health center, or Indian Health Service (IHS). All participating providers sign the Passport agreement group signature page and are responsible for managing the caseload. As a group provider, clients may visit any provider within the group practice without a Passport referral. Case management fees are paid as a group under the group Passport number in addition to the fee-for-service reimbursement.

Passport Tips

- View the client's Medicaid eligibility verification at each visit by going to the MATH web portal on the Provider Information website (see *Key Websites*) or by using one of the other methods described in the *Client Eligibility and Responsibilities* chapter of the *General Information for Providers* manual.
- Do not bill for case management fees; they are paid automatically to the provider each month.
- If you are not your client's Passport PCP, include the Passport PCP's Passport approval number on the claim, or it will be denied.
- The same cost sharing, service limits, and provider payment rules apply to Passport and non-Passport Medicaid clients and services.
- For claims questions, refer to the *Billing Procedures* chapter in this manual, or call Provider Relations (see *Key Contacts*).

Other Programs

Clients who are enrolled in the Mental Health Services Plan (MHSP) or Healthy Montana Kids (HMK) are not enrolled in Passport, so the Passport requirements in this chapter do not apply. However, prior authorization may be required for certain services. Refer to the mental health services manual.

For more HMK information, contact Blue Cross and Blue Shield of Montana at 1-877-543-7669. Additional HMK information is available on the HMK website (see *Key Websites*).

Prior Authorization

What Is Prior Authorization? (ARM 37.86.5101–5120)

Prior authorization (PA) is another example of the Department's efforts to ensure the appropriate use of Medicaid services. In most cases, providers need approval before services are provided to a particular client. Passport approval and PA are different, and some services may require both. A different code is issued for each type of approval and must be included on the claim form. See the *Submitting a Claim* chapter in this manual.

PA refers to a list of services. If a service requires PA, the requirement exists for all Medicaid clients. When PA is granted, the provider is issued a PA number which must be on the claim.

In practice, providers will most often encounter clients who are enrolled in Passport. Specific services may also require PA regardless of whether the client is a Passport enrollee. For example, if a Passport client comes to a plastic surgeon requesting a cosmetic procedure, then Passport approval is required from the Passport provider and PA is required from the Department's Surveillance and Utilization Review Section (SURS) Unit. Refer to the fee schedules for PA requirements. Refer to the *Passport* chapter for more information on Passport approval.

Generally, ASC services do not require PA. However, certain procedures do require PA. A partial list of those procedures which must have PA includes reduction mammoplasty, rhinoplasty, septoplasty, penis operation to correct angulation, and corneal transplant. To determine if a procedure requires PA, contact Provider Relations (see *Key Contacts*). If a procedure is determined to require PA, Mountain-Pacific Quality Health must be contacted (see *Key Contacts*) to obtain authorization or the procedure will be denied.

Some services require PA before they are provided. When seeking PA, keep in mind the following:

- The referring provider should initiate all authorization requests.
- Always refer to the current Medicaid fee schedule to verify if PA is required for specific services.
- Have all required documentation included in the packet before submitting a request for PA.
- When PA is granted, providers will receive notification containing a PA number. This PA number must be included on the claim.

Medical Necessity

The designated review organization and the Department's SURS Unit conduct utilization and peer review of ambulatory surgical center services. Medicaid payments are not available for ASC services unless the services are considered medically necessary.



Different codes are issued for Passport approval and prior authorization, and both must be recorded on the CMS-1500 claim form,



Medicaid does not pay for services when prior authorization or Passport requirements are not met.

Coordination of Benefits

When Clients Have Other Coverage

Medicaid clients often have coverage through Medicare, workers' compensation, employment-based coverage, individually purchased coverage, etc. Coordination of benefits is the process of determining which source of coverage is the primary payer in a particular situation. In general, providers must bill other carriers before billing Medicaid, but there are some exceptions. See *Exceptions to billing third party first* later in this chapter. Medicare coverage is processed differently than other sources of coverage.

Identifying Other Sources of Coverage

The client's Medicaid eligibility verification may identify other payers such as Medicare or other third party payers (see *Client Eligibility and Responsibilities* in the *General Information for Providers* manual). If a client has Medicare, the Medicare ID number is provided. If a client has other coverage (excluding Medicare), it will be shown under the "TPL" section. Some examples of third party payers include:

- Private health insurance
- Employment-related health insurance
- Workers' compensation insurance*
- Health insurance from an absent parent
- Automobile insurance*
- Court judgments and settlements*
- Long-term care insurance

*These third party payers (and others) may **not** be listed on the client's eligibility verification.

Providers must use the same procedures for locating third party sources for Medicaid clients as for their non-Medicaid clients. Providers cannot refuse service because of a third party payer or potential third party payer.

When a Client Has Medicare

Medicare claims are processed and paid differently than claims involving other payers. The other sources of coverage are referred to as "third party liability" (TPL), but Medicare is not.

For details on how Medicaid calculates payment for Medicare claims, see the *How Payment Is Calculated* chapter in this manual.

Medicare Part A and Part B crossover claims automatically cross over from Medicare.

When billing Medicaid for a client with coverage from multiple sources, see the *Billing Procedures* chapter in this manual.

Medicare Part B crossover claims

Medicare Part B covers ASC services. These claims automatically cross over from Medicare for dually eligible clients, so providers do not need to send in their Part B crossovers on paper. The Department's fiscal agent must have the provider's NPI/API on file to process claims and providers should include their NPI/API on their Medicare claims.

Medicare will process the claim, submit it to Medicaid, and send the provider an explanation of Medicare benefits (EOMB). Providers must check the EOMB for the statement indicating that the claim has been referred to Medicaid for further processing. It is the provider's responsibility to follow up on crossover claims and make sure they are correctly billed to Medicaid within the timely filing limit.

When you receive an EOMB from Medicare stating that your claim has been processed, please wait 45 days for that claim to cross over from Medicare to Medicaid before submitting that claim to Medicaid. This allows time for the claim to cross over and be processed through our system. If your claim is submitted to Medicaid prior to the 45-day limit, it will be returned to you as soon as it is received.

When Medicare pays or denies a service

- When Medicare automatic crossover claims are paid or denied, they should automatically cross over to Medicaid for processing, so the provider does not need to submit the claim to Medicaid. If Medicare denies a claim because the service was not medically necessary, Medicaid will also deny the claim.
- When Medicare crossover claims are billed on paper and are paid or denied, the provider must submit the claim to Medicaid with the Medicare EOMB and the explanation of denial codes.

When Medicaid does not respond to crossover claims

When Medicaid does not respond within 45 days of the provider receiving the Medicare EOMB, submit a claim and a copy of the Medicare EOMB to Medicaid for processing. When Medicaid is a secondary payer to Medicare and Medicare has paid the claim but not crossed it over to Medicaid, you must submit Medicare's payment in Box 29 of the CMS-1500 form. When Medicare has denied the service, you must attach the denial and any explanation of denial codes to the claim.

Submitting Medicare claims to Medicaid

When submitting a paper claim to Medicaid, use Medicaid billing instructions and codes. Medicare's instructions, codes, and modifiers may not be the same as Medicaid's. The claim must include the Medicaid provider number and Medicaid client ID number. The Medicare EOMB and explanation of denial codes are required only if the claim was denied.

When a Client Has TPL (ARM 37.85.407)

When a Medicaid client has additional medical coverage (other than Medicare), it is often referred to as third party liability (or TPL). In most cases, providers must bill other insurance carriers before billing Medicaid.

When another payer is involved, Medicaid cannot process ASC claims without being accompanied by either a denial or statement indicating the payment from the relevant third party payer.

Providers are required to notify their clients that any funds the client receives from third party payers equal to what Medicaid paid (when the services were billed to Medicaid) must be turned over to the Department. Amounts in excess of what Medicaid paid must be returned to the provider. The following words printed on the client's statement will fulfill this requirement: "When services are covered by Medicaid and another source, any payment the client receives from the other source must be turned over to Medicaid."

Exceptions to billing third party first

In a few cases, providers may bill Medicaid first.

- When a Medicaid client is also covered by Indian Health Service (IHS) or the Montana Crime Victims Compensation Fund, providers must bill Medicaid before IHS or Crime Victims. These are not considered third party liability.
- When a client has Medicaid eligibility and Mental Health Services Plan (MHSP) eligibility for the same month, Medicaid must be billed before MHSP.
- If the third party has only potential liability, such as automobile insurance, the provider may bill Medicaid first. Do not indicate the potential third party on the claim form. Instead, notify the Department of the potential third party by sending the claim and notification to Third Party Liability (see *Key Contacts*).

Requesting an exemption

Providers may request to bill Medicaid first under certain circumstances. In each of these cases, the claim and required information must be sent directly to Third Party Liability (see *Key Contacts*).



For details on how Medicaid calculates payment for TPL claims, see the *How Payment Is Calculated* chapter in this manual.

If the provider receives a payment from a third party after the Department has paid the provider, the provider must return the lower of the two payments to the Department within 60 days.



- If another insurance has been billed, and 90 days have passed with no response, attach a note to the claim explaining that the insurance company has been billed, or attach a copy of the letter sent to the insurance company). Include the date the claim was submitted to the insurance company and certification that there has been no response.
- When the provider has billed the third party insurance and has received a non-specific denial (e.g., no client name, date of service, amount billed), submit the claim with a copy of the denial and a letter of explanation directly to Medicaid in order to avoid missing the timely filing deadline.
- When the child support enforcement division has required an absent parent to have insurance on a child, the claim can be submitted to Medicaid when the following requirements are met:
 - The third party carrier has been billed, and 30 days or more have passed since the date of service.
 - The claim is accompanied by a certification that the claim was billed to the third party carrier, and payment or denial has not been received.

When the third party pays or denies a service

When a third party payer is involved (excluding Medicare) and the other payer:

- Pays the claim, indicate the amount paid in the “amount paid” field of the claim when submitting to Medicaid for processing. These claims may be submitted either electronically or on paper.
- Allows the claim, and the allowed amount went toward the client’s deductible, include the insurance Reason and Remarks (formerly EOB) when billing Medicaid. With HIPAA implementation, these claims may be submitted on paper or electronically with the paper attachment mailed in separately. A paper attachment cover sheet is available on the Provider Information website (see *Key Websites*). Until HIPAA implementation, continue to bill on paper with attachments.
- Denies the claim, include a copy of the denial (including the denial reason codes) with the claim form, and submit to Medicaid on paper.

When the third party does not respond

If another insurance has been billed, including Medicare, and 90 days have passed with no response, bill Medicaid as follows:

- Attach a note to the paper claim explaining that the insurance company has been billed, or attach a copy of the letter sent to the insurance company.
- Include the date the claim was submitted to the insurance company.
- Send this information to Third Party Liability (see *Key Contacts*).

Billing Procedures

Claim Forms

Services provided by the health care professionals covered in this manual must be billed either electronically or on a CMS-1500 claim form. CMS-1500 forms are available from various publishing companies; they are not available from the Department or Provider Relations.

Timely Filing Limits (ARM 37.85.406)

Providers must submit clean claims to Medicaid within the latest of:

- Twelve months from whichever is later:
 - the date of service
 - the date retroactive eligibility or disability is determined
- For claims involving Medicare or TPL, if the twelve-month time limit has passed, providers must submit clean claims to Medicaid within:
 - **Medicare crossover claims:** Six months from the date on the Medicare explanation of benefits approving the service (if the Medicare claim was timely filed and the client was eligible for Medicare at the time the Medicare claim was filed).
 - **Claims involving other third party payers (excluding Medicare):** Six months from the date on an adjustment notice from a third party payer who has previously processed the claim for the same service, and the adjustment notice is dated after the periods described above.

Clean claims are claims that can be processed without additional information or action from the provider. The submission date is defined as the date that the claim was received by the Department or the claims processing contractor. A claim lost in the mail is not considered received. All problems with claims must be resolved within this 12-month period.

Tips to avoid timely filing denials

The best method to guard against claim denial for timely filing is to establish and employ strict office procedures for claim follow-up. Follow-up procedures should include these steps:

- Always work the denied claims on the Medicaid remittance advice.
- Correct and resubmit denied claims promptly. See the *Remittance Advices and Adjustments* chapter in this manual.
- Call and ask if you do not understand a denial; **do not continue** to resubmit the same claim with no corrections.

- If a claim submitted to Medicaid does not appear on the remittance advice within 45 days, contact Provider Relations for claim status (see *Key Contacts*).
- A common reason for exceeding the time filing limit is waiting for another insurance to pay. If another insurer has been billed and 90 days have passed with no response, you can bill Medicaid. See the *Coordination of Benefits* chapter in this manual for more information.
- To meet timely filing requirements for Medicare/Medicaid crossover claims, see the *Coordination of Benefits* chapter in this manual.
- Report eligibility problems to the county office as soon as they appear on the remittance advice.
- Submit and/or resubmit only legible claims.

When to Bill Medicaid Clients (ARM 37.85.406)

In most circumstances, providers may not bill Medicaid clients for services covered under Medicaid. The main exception is that providers may collect cost sharing from clients.

More specifically, providers cannot bill clients directly:

- For the difference between charges and the amount Medicaid paid.
- For a covered service provided to a Medicaid-enrolled client who was accepted as a Medicaid client by the provider, even if the claim was denied.
- When the provider bills Medicaid for a covered service, and Medicaid denies the claim because of billing errors.
- When a third-party payer does not respond.
- When a client fails to arrive for a scheduled appointment. Medicaid may not be billed for no-show appointments.
- When services are free to the client, such as in a public health clinic. Medicaid may not be billed for those services.

Under certain circumstances, providers may need a signed agreement in order to bill a Medicaid client (see the table on the next page).



If a provider bills Medicaid and the claim is denied because the client is not eligible, the provider may bill the client directly.

When to Bill a Medicaid Client (ARM 37.85.406)			
	<ul style="list-style-type: none"> • Client is Medicaid enrolled • Provider accepts client as a Medicaid client 	<ul style="list-style-type: none"> • Client is Medicaid enrolled • Provider does not accept client as a Medicaid client 	<ul style="list-style-type: none"> • Client is not Medicaid enrolled
Service is covered by Medicaid	Provider can bill client only for cost sharing	Provider can bill Medicaid client if the client has signed a routine agreement	Provider can bill client
Service is not covered by Medicaid	Provider can bill client only if custom agreement has been made between client and provider before providing the service	Provider can bill Medicaid client if the client has signed a routine agreement	Provider can bill client

Routine Agreement: This may be a routine agreement between the provider and client which states that the client is not accepted as a Medicaid client, and that he or she must pay for the services received.

Custom Agreement: This agreement lists the service and date the client is receiving the service and states that the service is not covered by Medicaid and that the client will pay for it.

Client Cost Sharing (ARM 37.85.204 and 37.85.402)

Cost sharing fees are a set dollar amount per visit, and they are based on the average Medicaid allowed amount for the provider type and rounded to the nearest dollar. There is no cost sharing cap. Do not show cost sharing as a credit on the claim; it is automatically deducted during claims processing and is shown on the remittance advice. Cost sharing for ASC services is \$5.00 per visit.

The following clients are exempt from cost sharing:

- Clients under 21 years of age (i.e., EPSDT services)
- Pregnant women (until end of postpartum, which begins on the last day of pregnancy and ends at the end of the month in which 60 days have passed)
- Inpatients in a hospital, skilled nursing facility, intermediate care facility, or other medical institution if the individual is required to spend all but their personal needs allowance on the cost of care.
- Medicaid clients who also have Medicare or another insurance are exempt from cost sharing if the service is allowed by Medicare or paid by the other insurance, and Medicaid is the secondary payer.



Do not show cost sharing as a credit on the claim; it is automatically deducted.



Client cost sharing for ambulatory surgical center services is \$5.00 per visit.

Cost sharing may not be charged for the following services:

- Emergencies (see *Definitions*)
- Family planning
- Hospice
- Independent lab and x-ray services
- Personal assistance services
- Home dialysis attendant services
- Home- and community-based waiver services
- Non-emergency medical transportation services
- Eyeglasses purchased by the Medicaid program under a volume purchasing arrangement
- EPSDT services

A provider cannot deny services to a Medicaid client because the client cannot pay cost sharing fees at the time services are rendered. However, the client's inability to pay cost sharing fees when services are rendered does not lessen the client's obligation. If a provider has a policy on collecting delinquent payment from non-Medicaid clients, that same policy may be used for Medicaid clients.

Billing for Clients with Other Insurance

If a Medicaid client is also covered by Medicare, has other insurance, or some other third party is responsible for the cost of the client's health care, see the *Coordination of Benefits* chapter in this manual.

Billing for Retroactively Eligible Clients

When a client becomes retroactively eligible for Medicaid, the ASC provider may:

- Accept the client as a Medicaid client from the current date.
- Accept the client as a Medicaid client from the date retroactive eligibility was effective.
- Require the client to continue as a private-pay client.

When the provider accepts the client's retroactive eligibility, the provider has 12 months from the date retroactive eligibility was determined to bill for those services. When submitting claims for retroactively eligible clients, attach a copy of the FA-455 (eligibility determination letter) to the claim if the date of service is more than 12 months earlier than the date the claim is submitted. Providers may need to contact the client's local office of public assistance (see the *General Information for Providers* manual, *Appendix B: Local Offices of Public Assistance*).

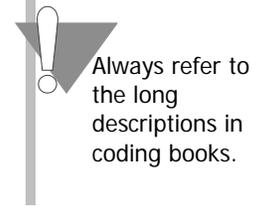
When a provider chooses to accept the client from the date retroactive eligibility was effective, and the client has made a full or partial payment for services, the provider must refund the client’s payment for the services before billing Medicaid for the services.

Place of Service

Place of Service 24 (ASC) must be entered correctly on each line. Medicaid typically reduces payment for services provided in hospitals and ASCs since these facilities typically bill Medicaid separately.

Coding

Providers are responsible for billing their services correctly. Standard use of medical coding conventions and the rules established by the American Medical Association (AMA) are required when billing Medicaid. Providers should become familiar with these volumes as Medicaid relies on them when setting its coding policies. If providers have questions regarding definition of codes, they may be directed to the AMA Health Information Services at (800) 634-6922. There is a charge for this service. Provider Relations or the Department cannot suggest specific codes to be used in billing for services. For coding assistance and resources, see the *Coding Resources* table below. The following suggestions may help reduce coding errors and unnecessary claim denials:



Coding Resources		
Please note that the Department does not endorse the products of any particular publisher.		
Resources	Description	Contact
ICD-9-CM	<ul style="list-style-type: none"> • ICD-9-CM diagnosis and procedure codes definitions • Updated each October 	Available through various publishers and bookstores
CPT-4	<ul style="list-style-type: none"> • CPT-4 codes and definitions • Updated each January 	American Medical Association (800) 621-8335 www.amapress.com or Medicode (Ingenix) (800) 765-6588 www.ingenixonline.com
HCPCS Level II	<ul style="list-style-type: none"> • HCPCS Level II codes and definitions • Updated each January and throughout the year 	Available through various publishers and bookstores or from CMS at www.cms.gov
CPT Assistant	A newsletter on CPT-4 coding issues	American Medical Association (800) 621-8335 www.amapress.com
Miscellaneous resources	Various newsletters and other coding resources.	Medicode (Ingenix) (800) 765-6588 www.ingenixonline.com

Coding Resources

Please note that the Department does not endorse the products of any particular publisher.

Resources	Description	Contact
CCI Policy and Edits Manual	This manual contains Correct Coding Initiative (CCI) policy and edits, which are pairs of CPT-4 or HCPCS Level II codes that are not separately payable except under certain circumstances. The edits are applied to services billed by the same provider for the same client on the same date of service.	National Technical Information Service (800) 363-2068 (703) 605-6060 www.ntis.gov/products/cci.aspx

Using Modifiers

- Review the guidelines for using modifiers in the most current CPT-4, HCPCS Level II, or other helpful resources.
- Always read the complete description for each modifier; some modifiers are described in the CPT-4 manual while others are in the HCPCS Level II book.
- The Medicaid claims processing system recognizes only two pricing modifiers and one informational modifier per claim line. Providers are asked to place any modifiers that affect pricing in the first two modifier fields.
- When billing with Modifier 50 for bilateral services, put all information on one line with one unit of service. Care should be taken not to designate a procedure as bilateral when the procedure is already identified as a bilateral service in the CPT definition. Modifiers RT and LT should *not* be billed by ASCs.
- When bilateral procedures are performed at the same session on the same patient, the procedure will be paid at 150% of the fee schedule amount if the service is not subject to the multiple procedure discount.
- For codes defined as bilateral when a unilateral procedure is done, the procedure should be reported with Modifier 52.
- When multiple procedures are performed at the same session on the same patient, the primary procedure will be paid at 100% of the customary rate. Subsequent procedures will be paid at 50% of the customary rate. Modifiers are to be placed in the first or second slot of Field 24d so the claim will price correctly.
- The following CPT modifiers can be reported by an ASC provider:

CPT Modifier	Description
50	Bilateral procedure
52	Reduced services
58	Staged or related procedure or service by the same physician during the postoperative period
59	Distinct procedural service

ASCs should put the most important modifiers in the first position.



CPT Modifier	Description (continued)
73	Discontinued outpatient hospital/ASC procedure prior to the administration of anesthesia
74	Discontinued outpatient hospital/ASC procedure after the administration of anesthesia
76	Repeat procedure by the same physician
77	Repeat procedure by another physician
78	Return to the operating room for a related procedure during the postoperative period
79	Unrelated procedure or service by the same physician during the postoperative period
91	Repeat clinical diagnostic laboratory test

- It should be noted that, in some instances, more than one modifier may be necessary per line. All applicable modifiers must be reported.
- Always bill your main surgical procedure on line 1 of the claim with one unit only. All other subsequent procedures should be billed with the number of units done for each code per line. Do not separate out subsequent procedure codes (e.g., Code 11601-51 twice) on separate lines. This will cause exact duplicate line denials. Subsequent procedure modifiers should be used when appropriate, except when billing add-on codes or Modifier 51 exempt codes.

Submitting a Claim

Paper claims

Unless otherwise stated, all paper claims must be mailed to:

Claims Processing
P.O. Box 8000
Helena, MT 59604

Electronic claims

Providers who submit claims electronically experience fewer errors and quicker payment. Claims may be submitted electronically by the following methods:

- **ACS field software WINASAP 2003.** ACS makes available this free software, which providers can use to create and submit claims to Montana Medicaid, MHSP, and HMK (dental and eyeglasses only). It does not support submissions to Medicare or other payers. This software creates an 837 transaction, but does not accept an 835 transaction back from the Department.
- **ACS clearinghouse.** Providers can send claims to the ACS clearinghouse (ACS EDI Gateway) in X12 837 format using a dial-up connection. Electronic submitters are required to certify their 837 transactions as HIPAA-compliant before sending their transactions through the ACS clear-

inghouse. EDIFECS certifies the 837 HIPAA transactions at no cost to the provider. EDIFECS certification is completed through ACS EDI Gateway.

- **Clearinghouse.** Providers can contract with a clearinghouse so that the provider can send the claim to the clearinghouse in whatever format the clearinghouse accepts. The provider's clearinghouse then sends the claim to the ACS clearinghouse in the X12 837 format. The provider's clearinghouse also needs to have their 837 transactions certified through EDIFECS before submitting claims to the ACS clearinghouse. EDIFECS certification is completed through ACS EDI Gateway.

For more information on electronic claims submission, contact Provider Relations or the EDI Technical Help Desk (see *Key Contacts*).

Claim Inquiries

Contact Provider Relations for questions regarding payments, denials, general claim questions, client eligibility (see *Key Contacts*).

If you prefer to communicate with Provider Relations in writing, download the *Claim Inquiry* form from the Provider Information website. Complete the top portion of the form with the provider's name and address.

Provider Relations will respond to the inquiry within 7 to 10 days. The response will include the status of the claim: paid (date paid), denied (date denied), or in process. Denied claims will include an explanation of the denial and steps to follow for payment (if the claim is payable).

The Most Common Billing Errors and How to Avoid Them

Paper claims are often returned to the provider before they can be processed, and many other claims (both paper and electronic) are denied. To avoid unnecessary returns and denials, double-check each claim to confirm the following items are included and accurate.

Common Billing Errors	
Reasons for Return or Denial	How to Prevent Returned or Denied Claims
National provider identifier number missing or invalid	The NPI is a 10-digit number assigned to the provider during Medicaid enrollment. Verify the correct NPI is on the claim.
Authorized signature missing	Each claim must have an authorized signature belonging to the provider, billing clerk, or office personnel. The signature may be typed, stamped, handwritten, or computer-generated.
Signature date missing	Each claim must have a signature date.
Incorrect claim form used	The claim must be the correct form for the provider type. Services covered in this manual require a CMS-1500 claim form.
Information on claim form not legible	Information on the claim form must be legible. Use dark ink and center the information in the field. Information must not be obscured by lines.
Recipient number not on file, or recipient was not eligible on date of service	Before providing services to the client, verify client eligibility by using one of the methods described in the <i>Client Eligibility and Responsibilities</i> chapter of the <i>General Information for Providers</i> manual. Medicaid eligibility may change monthly.
Procedure requires Passport provider approval – No Passport approval number on claim	A Passport provider approval number must be on the claim form when such approval is required. Passport approval is different from prior authorization (PA). See the <i>Passport</i> chapter in this manual.
PA number is missing	PA is required for certain services, and the PA number must be on the claim form. PA is different from Passport authorization. See the <i>Prior Authorization</i> chapter in this manual.
PA does not match current information	Claims must be billed and services performed during the prior authorization span. The claim will be denied if it is not billed according to the spans on the authorization.
Duplicate claim	Check all remittance advices (RAs) for previously submitted claims before resubmitting. When making changes to previously paid claims, submit an adjustment form rather than a new claim form. See <i>Remittance Advice and Adjustments</i> in this manual.

Common Billing Errors	
Reasons for Return or Denial	How to Prevent Returned or Denied Claims
TPL on file and no credit amount on claim	<p>If the client has any other insurance (or Medicare), bill the other carrier before Medicaid. See <i>Coordination of Benefits</i> in this manual.</p> <p>If the client's TPL coverage has changed, providers must notify the TPL Unit (see <i>Key Contacts</i>) before submitting a claim.</p>
Claim past 365-day filing limit	<p>The Claims Processing Unit must receive all clean claims and adjustments within the timely filing limits described in this chapter.</p> <p>To ensure timely processing, claims and adjustments must be mailed to Claims at the address shown in Key Contacts.</p>
Missing Medicare EOMB	All denied Medicare crossover claims billed to Medicaid on paper must have an Explanation of Medicare Benefits (EOMB) with denial reason codes attached.
Provider is not eligible during dates of services, enrollment has lapsed due to licensure requirements, or provider number terminated	<p>Out-of-state providers must update licensure for Medicaid enrollment early to avoid denials. If enrollment has lapsed due to expedite licensure, claims submitted with a date of service after the expiration date will be denied until the provider updates his or her enrollment.</p> <p>New providers cannot bill for services provided before Medicaid enrollment begins.</p> <p>If a provider is terminated from the Medicaid program, claims submitted with date of service after the termination date will be denied.</p>
Procedure is not allowed for provider type	<p>Provider is not allowed to perform the service. Verify the procedure code is correct using current HCPCS and CPT-4 billing manual.</p> <p>Check the appropriate Medicaid fee schedule to verify the procedure code is valid for your provider type.</p>

Submitting a Claim

The services described in this manual are billed either electronically on a professional claim or on a CMS-1500 paper claim form. Claims submitted with all of the necessary information are referred to as “clean” and are usually paid in a timely manner (see the *Billing Procedures* chapter in this manual).

Claims are completed differently for the different types of coverage a client has. This chapter includes instructions and a sample claim for each of the following scenarios:

- Client has Medicaid coverage only
- Client has Medicaid and Medicare coverage
- Client has Medicaid and third party liability coverage
- Client has Medicaid, Medicare, and third party liability coverage
- Client has Medicaid, Medicare, and Medicare supplement coverage

When completing a claim, remember the following:

- Required fields are indicated by “*”.
- Fields that are required if the information is applicable to the situation or client are indicated by “**”.
- Field 24h, *EPSDT/Family Plan*, is used as an indicator to specify additional details for certain clients or services. The following are accepted codes:

EPSDT/Family Planning Indicators		
Code	Client/Service	Purpose
1	EPSDT	This indicator is used when the client is under age 21
2	Family planning	This indicator is used when providing family planning services.
3	EPSDT and family planning	This indicator is used when the client is under age 21 and is receiving family planning services
4	Pregnancy (any service provided to a pregnant woman)	This indicator is used when providing services to pregnant women
6	Nursing facility client	This indicator is used when providing services to nursing facility residents

- Unless otherwise stated, all paper claims must be mailed to the following address:
 Claims Processing
 P.O. Box 8000
 Helena, MT 59604

Client Has Medicaid Coverage Only

Field#	Field Title	Instructions
1	Program	Check Medicaid.
1a	Insured's ID number	Leave this field blank for Medicaid only claims.
2*	Patient's name	Enter the client's name as it appears on the Medicaid client's eligibility information.
3	Patient's birth date and sex	Client's birth date in month/day/year format. Check male or female box.
5	Patient's address	Client's address.
10	Is patient's condition related to:	Check "Yes" or "No" to indicate whether employment, auto accident, or other accident involvement applies to one or more of the services described in Field 24. If you answered "Yes" to any of these, enter the two-letter state abbreviation where the accident occurred on the "Place" line.
10d*	Reserved for local use	Enter the client's Medicaid ID number as it appears on the client's Medicaid eligibility information.
11d*	Is there another health benefit plan?	Enter "No." If "Yes," follow claim instructions for appropriate coverage later in this chapter.
14	Date of current illness, injury, or pregnancy	Enter date in month/day/year (mm/dd/yy) format. This field is optional for Medicaid-only claims.
16	Dates patient unable to work in current occupation	If applicable, enter date in month/day/year (mm/dd/yy) format. This field is optional for Medicaid-only claims.
17	Name of referring provider or other source	Enter the name of the referring physician. For Passport clients, the name of the client's Passport provider goes here.
17b**	Referring provider NPI	Enter the referring provider's NPI. For Passport clients, enter the client's Passport provider's Passport ID number.
18	Hospitalization dates related to current services	Enter dates if the medical service is furnished as a result of, or subsequent to, a related hospitalization. This field is optional for Medicaid-only claims.
19	Reserved for local use	This field is used for any special messages regarding the claim or client.
20	Outside lab?	Check "No." Medicaid requires all lab tests to be billed directly by the provider who performed them.
21*	Diagnosis or nature of illness or injury	Enter the appropriate ICD-9-CM diagnosis codes. Enter up to 4 codes in priority order (primary, secondary, etc.).
23**	Prior authorization number	If the service requires prior authorization (PA), enter the PA number you received for this service.
24a*	Date(s) of service	Enter dates of service for each procedure, service, or supply.
24b*	Place of service	Enter Place of Service 24.
24c*	EMG (Emergency)	Not used.
24d*	Procedures, services, or supplies	Enter the appropriate CPT-4 or HCPCS code for the procedure, service, or supply. When applicable, enter the appropriate CPT-4/HCPCS modifier. Medicaid allows up to 3 modifiers per procedure code. ASC service groups are determined by the CPT-4 code entered here.
24e*	Diagnosis pointer	Enter the corresponding diagnosis code reference number (1, 2, 3 or 4) from Field 21. Do not enter the diagnosis code. Any combination of applicable diagnosis reference numbers may be listed on one line.
24f*	Charges (dollar amt)	Enter your reasonable and customary charges or the Department-designated charges for the procedures on this line.
24g*	Days or units	Enter the number of units or days for the procedure and dates of service billed on this line. See <i>Billing Procedures, Coding</i> for additional tips on days/units. Anesthesia providers must bill using minutes.
24h**	EPSDT/family plan	If applicable, enter the appropriate code for the client/service: 1, 2, 3, 4, or 6. See complete description in the <i>EPSDT/Family Planning Indicators</i> table earlier in this chapter.
24i	ID Qual	
28*	Total charge	Enter the sum of all charges billed in Field 24f.
29	Amount paid	Leave blank or enter \$0.00. Do not report any client copay or Medicaid payment amounts on this form.
30	Balance due	Enter the balance due as recorded in Field 28.
31*	Signature and date	This field must contain an authorized signature and date, which can be handwritten, stamped, or computer-generated.
32	Service facility location information (name and address)	Enter the name and address of the person, organization, or facility providing the services if other than the client's home or physician's office.
33*	Billing provider's info (name and address) and phone number	Enter the name, billing address, phone number and Montana Medicaid provider number (not UPIN) of the physician or supplier who provided the service.

* = Required field ** = Required if applicable

Client Has Medicaid Coverage Only

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>									
1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input checked="" type="checkbox"/> (Medicaid #) TRICARE CHAMPUS <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA BLK LUNG <input type="checkbox"/> (SSN) OTHER <input type="checkbox"/> (ID)										1a. INSURED'S I.D. NUMBER (For Program in Item 1)									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Smith, Chuckie L.										3. PATIENT'S BIRTH DATE MM DD YY 04 26 06 SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>									
5. PATIENT'S ADDRESS (No., Street) 123 Anystreet #1										6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>									
CITY Anytown					STATE MT					7. INSURED'S ADDRESS (No., Street)					8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>				
ZIP CODE 59999					TELEPHONE (Include Area Code) (406) 555-5555					9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>									
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>										b. EMPLOYER'S NAME OR SCHOOL NAME									
c. EMPLOYER'S NAME OR SCHOOL NAME										c. INSURANCE PLAN NAME OR PROGRAM NAME									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. RESERVED FOR LOCAL USE									
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>										11. INSURED'S POLICY GROUP OR FECA NUMBER									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____									
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY 02 10 07										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Doug Ross, MD										17a. _____ 17b. NPI 98999999									
19. RESERVED FOR LOCAL USE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 752.61 3. 752.69 2. 752.63 4. _____										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER									
1 02 10 07 54328 1, 2, 3 2922 00 1 NPI										F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #									
2 5 6																			
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO.									
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$ 2922 00 29. AMOUNT PAID \$ 0 00 30. BALANCE DUE \$ 2922 00									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Doug Ross, MD 03/20/07										32. SERVICE FACILITY LOCATION INFORMATION Anytown Surgicenter 123 Medical Drive Anytown, MT 59999									
33. BILLING PROVIDER INFO & PH # (406) 555-5555																			
SIGNED _____ DATE _____										a. 0000099999 b. _____									

CARRIER ↑ PATIENT AND INSURED INFORMATION ↓ PHYSICIAN OR SUPPLIER INFORMATION ↓

Client Has Medicaid and Medicare Coverage

Field#	Field Title	Instructions
1	Program	Check Medicaid.
1a*	Insured's ID number	Enter the client's Medicare ID number.
2*	Patient's name	Enter the client's name as it appears on the Medicaid client's eligibility information.
3	Patient's birth date and sex	Client's birth date in month/day/year format. Check Male or Female box.
4	Insured's name	Enter the name of the insured or "Same."
5	Patient's address	Client's address.
7	Insured's address	Enter the insured's address and telephone number or "Same."
10	Is patient's condition related to:	Check "Yes" or "No" to indicate whether employment, auto accident, or other accident involvement applies to one or more of the services described in Field 24. If you answered "Yes" to any of these, enter the two-letter state abbreviation where the accident occurred on the "Place" line.
10d*	Reserved for local use	Enter the client's Medicaid ID number as it appears on the client's Medicaid eligibility information.
11	Insured's policy group or FECA number	This field should be blank.
11c	Insurance plan or program name	This field should be blank.
11d*	Is there another health benefit plan?	Check "No."
14	Date of current illness, injury, or pregnancy	Enter date in month/day/year (mm/dd/yy) format.
16	Dates patient unable to work in current occupation	If applicable, enter date in month/day/year (mm/dd/yy) format.
17	Name of referring provider or other source	Enter the name of the referring physician. For Passport clients, the name of the client's Passport provider goes here.
17b**	Referring physician NPI (or other source)	Enter the referring or ordering physician's Medicaid ID number. For Passport clients, enter the client's Passport provider's Passport ID number.
18	Hospitalization dates related to current services	Enter dates if the medical service is furnished as a result of, or subsequent to, a related hospitalization.
19	Reserved for local use	This field is used for any special messages regarding the claim or client.
20	Outside lab?	Check "No." Medicaid requires all lab tests to be billed directly by the provider who performed them.
21*	Diagnosis or nature of illness or injury	Enter the appropriate ICD-9-CM diagnosis codes. Enter up to four codes in priority order (primary, secondary, etc.).
23**	Prior authorization number	If the service requires prior authorization (PA), enter the PA number you received for this service.
24a*	Date(s) of service	Enter dates of service for each procedure, service, or supply.
24b*	Place of service	Enter Place of Service 24.
24c*	EMG (Emergency)	Not used.
24d*	Procedures, services, or supplies	Enter the appropriate CPT-4 or HCPCS code for the procedure, service, or supply. When applicable, enter appropriate modifiers. Medicaid recognizes two pricing and one informational modifier per code. ASC service groups are determined by the CPT-4 code entered here.
24e*	Diagnosis pointer	Enter the corresponding diagnosis code reference number (1, 2, 3 or 4) from Field 21. Do not enter the diagnosis code. Any combination of applicable diagnosis reference numbers may be listed on one line.
24f*	Charges (dollar amt)	Enter your reasonable and customary charges or the Department-designated charges for the procedures on this line.
24g*	Days or units	Enter the number of units or days for the procedure and dates of service billed on this line. See <i>Billing Procedures, Coding</i> for additional tips on days/units. Anesthesia providers must bill using minutes.
24h**	EPSDT/Family Plan	If applicable, enter the appropriate code for the client/service: 1, 2, 3, 4 or 6. See complete description in the <i>EPSDT/Family Planning Indicators</i> table earlier in this chapter.
24i	ID Qual	
28*	Total charge	Enter the sum of all charges billed in Field 24f.
29	Amount paid	Leave this field blank. Do not include any adjustment amounts or coinsurance. The Medicare payment amount will be determined from the EOMB attached to the claim.
30	Balance due	Enter the balance due as listed in Field 28.
31*	Signature and date	This field must contain an authorized signature and date, which can be hand-signed, stamped, or computer-generated.
32	Service facility location information	Enter the name and address of the person, organization, or facility providing the services if other than the client's home or physician's office.
33*	Billing provider info and phone number	Enter the name, address, phone number and NPI of the physician or supplier who provided the service.

* = Required field ** = Required if applicable

Client Has Medicaid and Medicare Coverage

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>									
1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input checked="" type="checkbox"/> (Medicaid #) TRICARE CHAMPUS <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA BLK LUNG <input type="checkbox"/> (SSN) OTHER <input type="checkbox"/> (ID)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 999999999A									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Jones, Jerri										3. PATIENT'S BIRTH DATE MM DD YY 11 15 29 SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>									
5. PATIENT'S ADDRESS (No., Street) 4321 Anystreet										6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>									
CITY Anytown					STATE MT					7. INSURED'S ADDRESS (No., Street)					8. PATIENT STATUS Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>				
ZIP CODE 59999					TELEPHONE (Include Area Code) (406) 555-9999					9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) _____ c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) _____ c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										11. INSURED'S POLICY GROUP OR FECA NUMBER									
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/> SEX										a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/> SEX									
c. EMPLOYER'S NAME OR SCHOOL NAME										b. EMPLOYER'S NAME OR SCHOOL NAME									
d. INSURANCE PLAN NAME OR PROGRAM NAME										c. INSURANCE PLAN NAME OR PROGRAM NAME									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____									
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Carter, Edward MD										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 721.3 3. 722.52 2. 724.02 4. _____										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.									
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER										F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #									
1 07 20 06 07 20 06 24 64622 50 SG										1312 50 1 NPI									
2 07 20 06 07 20 06 24 64623 50 51 SG 1										656 25 NPI									
3 07 20 06 07 20 06 24 64623 50 51 SG 1										656 25 NPI									
4 _____										NPI									
5 _____										NPI									
6 _____										NPI									
25. FEDERAL TAX I.D. NUMBER 99-9999999 SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO. 9999999999ABC									
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$ 2625.00 29. AMOUNT PAID \$ 0.00 30. BALANCE DUE \$ 2625.00									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Edward Carter, MD 06/15/07										32. SERVICE FACILITY LOCATION INFORMATION Anytown Surgicenter 123 Medical Drive Anytown, MT 59999									
SIGNED _____ DATE _____										33. BILLING PROVIDER INFO & PH # (406) 555-5555 Family Healthcare 321 Medical Drive Anytown, MT 59999									
a. NPI										a. 0000099999 b.									

CARRIER ↑ PATIENT AND INSURED INFORMATION ↓ PHYSICIAN OR SUPPLIER INFORMATION ↓

Client Has Medicaid and Third Party Liability Coverage

Field#	Field Title	Instructions
1	Program	Check Medicaid.
1a*	Insured's ID number	Enter the client's ID number for the primary carrier.
2*	Patient's name	Enter the client's name as it appears on the Medicaid client's eligibility information.
3	Patient's birth date and sex	Client's birth date in month/day/year format. Check male or female box.
4	Insured's name	Enter the name of the insured or "SAME".
5	Patient's address	Client's address.
7	Insured's address	Enter the insured's address and telephone number or "SAME".
9-9d	Other insured's information	Use these fields only if there are two or more third party insurance carriers (not including Medicaid and Medicare).
10	Is patient's condition related to:	Check "Yes" or "No" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in field 24. If you answered "yes" to any of these, enter the two-letter state abbreviation where the accident occurred on the "Place" line.
10d*	Reserved for local use	Enter the client's Medicaid ID number as it appears on the client's Medicaid eligibility information.
11	Insured's policy group	Leave this field blank, or enter the client's ID number for the primary payer.
11c*	Insurance plan or program	Enter the name of the other insurance plan or program (i.e. BlueCross BlueShield, New West, etc.).
11d*	Is there another health benefit plan?	Check "YES".
14	Date of current illness, injury, pregnancy	Enter date in month/day/year (mm/dd/yy) format.
16	Dates patient unable to work in current occupation	If applicable, enter date in month/day/year (mm/dd/yy) format.
17	Name of referring physician	Enter the name of the referring physician. For Passport clients, the name of the client's Passport provider goes here.
17a**	ID number of referring physician	Enter the referring or ordering physician's Medicaid ID number. For Passport clients, enter the client's Passport provider's Passport ID number.
18	Hospitalization dates related to current service	Enter dates if the medical service is furnished as a result of, or subsequent to, a related hospitalization.
19	Reserved for local use	This field is used for any special messages regarding the claim or client.
20	Outside lab?	Check "No". Medicaid requires all lab tests to be billed directly by the provider who performed them.
21*	Diagnosis or nature of illness or injury	Enter the appropriate ICD-9-CM diagnosis codes. Enter up to four codes in priority order (primary, secondary, etc.).
23**	Prior authorization number	If the service requires prior authorization (PA), enter the PA number you received for this service.
24a*	Date(s) of service	Enter date(s) of service for each procedure, service, or supply.
24b*	Place of service	Enter place of service 24.
24c*	Type of service	Enter Montana's type of service code: Nursing facilities are "9", and all others are "0" (zero).
24d*	Procedure, service, or supplies	Enter the appropriate CPT-4 or HCPCS code for the procedure, service, or supply. When applicable, enter appropriate modifiers. Medicaid recognizes two pricing and one informational modifier per code. ASC service groups are determined by the CPT-4 code entered here.
24e*	Diagnosis code	Enter the corresponding diagnosis code reference number (1, 2, 3 or 4) from field 21 (do not enter the diagnosis code). Any combination of applicable diagnosis reference numbers may be listed on one line.
24f*	Charges	Enter your reasonable and customary charges (or the Department-designated charges) for the procedure(s) on this line.
24g*	Days or units	Enter the number of units or days for the procedure and date(s) of service billed on this line (see <i>Billing Procedures, Coding</i> for additional tips on days/units). Anesthesia providers must bill using minutes.
24h**	EPSDT/family planning	If applicable, enter the appropriate code for the client/service: 1, 2, 3, 4 or 6 (see complete description in the <i>EPSDT/Family Planning Indicators</i> table earlier in this chapter).
24i	EMG (Emergency)	Not used.
28*	Total charge	Enter the sum of all charges billed in field 24f.
29*	Amount paid	Enter the amount paid by the other insurance. Do not include any adjustment amounts or coinsurance.
30*	Balance due	Enter the balance due (the amount in field 28 less the amount in field 29).
31*	Signature and date	This field must contain an authorized signature and date, which can be hand signed, stamped, or computer generated.
32	Name and address of facility	Enter the name and address of the person, organization, or facility performing the services if other than the client's home or physician's office.
33*	Physician's, supplier's billing name, address, phone number	Enter the name, address, phone number and NPI of the physician or supplier who provided service.

* = Required field ** = Required if applicable

Client has Medicaid and Third Party Liability Coverage

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA										PICA																																																						
1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) TRICARE CHAMPUS <input checked="" type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA BLK LUNG <input type="checkbox"/> (SSN) OTHER <input type="checkbox"/> (ID)										1a. INSURED'S I.D. NUMBER (For Program in Item 1)																																																						
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Jackson, John P.										3. PATIENT'S BIRTH DATE MM DD YY 01 10 05					SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial) Same																																												
5. PATIENT'S ADDRESS (No., Street) 4321 Anystreet										6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street) Same																																												
CITY Anytown					STATE MT					8. PATIENT STATUS Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>										CITY					STATE																																							
ZIP CODE 59999					TELEPHONE (Include Area Code) (406) 999-9999					Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>										ZIP CODE					TELEPHONE (Include Area Code) ()																																							
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:										11. INSURED'S POLICY GROUP OR FECA NUMBER																																												
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO										a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>																																												
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____										b. EMPLOYER'S NAME OR SCHOOL NAME																																												
c. EMPLOYER'S NAME OR SCHOOL NAME										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO										c. INSURANCE PLAN NAME OR PROGRAM NAME																																												
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. RESERVED FOR LOCAL USE										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>																																												
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.																																																																
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.																																																						
SIGNED _____ DATE _____										SIGNED _____																																																						
14. DATE OF CURRENT: MM DD YY					ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																																																	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a. _____					17b. NPI 9999999999					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																												
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES _____										22. MEDICAID RESUBMISSION CODE _____ ORIGINAL REF. NO. _____																																												
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)										23. PRIOR AUTHORIZATION NUMBER																																																						
1. _____										3. _____										24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY																																												
2. _____										4. _____										B. PLACE OF SERVICE					C. EMG					D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER					E. DIAGNOSIS POINTER					F. \$ CHARGES					G. DAYS OR UNITS					H. EPST Family Plan					I. ID. QUAL.					J. RENDERING PROVIDER ID. #				
1										2										08 20 06 08 20 06 24					69436					SG 50					1					510 00					1					NPI														
3										4										08 20 06 08 20 06 24					42830					SG					2					1222 50					NPI																			
5										6																																																						
6										7																																																						
25. FEDERAL TAX I.D. NUMBER 99-9999999 SSN EIN <input type="checkbox"/> <input type="checkbox"/>										26. PATIENT'S ACCOUNT NO. 9999999999 ABC					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE \$ 1732 50					29. AMOUNT PAID \$ 104 47					30. BALANCE DUE \$ 1628 03																																		
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on this apply to this bill and are made a p John Pied, MD 01/16/07										32. SERVICE FACILITY LOCATION INFORMATION Anytown Surgicenter 123 Medical Drive Anytown, MT 59999										33. BILLING PROVIDER INFO & PH # (406) 555-5555 Anytown Surgicenter 321 Medical Drive Anytown, MT 59999																																												
SIGNED _____ DATE _____										a. NPI					b. _____					a. 0000099999					b. _____																																							

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Client Has Medicaid, Medicare, and Third Party Liability Coverage

Field#	Field Title	Instructions
1	Program	Check Medicaid.
1a*	Insured's ID number	Enter the client's Medicare ID number.
2*	Patient's name	Enter the client's name as it appears on the Medicaid client's eligibility information.
3	Patient's birth date and sex	Client's birth date in month/day/year format. Check Male or Female box.
4	Insured's name	Enter the name of the insured or "Same."
5	Patient's address	Client's address.
7	Insured's address	Enter the insured's address and telephone number or "Same."
9-9d	Other insured's information	Use these fields only if there are two or more third party insurance carriers (not including Medicaid and Medicare).
10	Is patient's condition related to:	Check "Yes" or "No" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in Field 24. If you answered yes to any of these, enter the two-letter state abbreviation where the accident occurred on the "Place" line.
10d*	Reserved for local use	Enter the client's Medicaid ID number as it appears on the client's Medicaid eligibility information.
11*	Insured's policy group or FECA number	Enter the client's primary payer (TPL) ID number.
11c*	Insurance plan name or program name	Enter the name of the primary payer.
11d*	Is there another health benefit plan?	Check "Yes."
14	Date of current illness, injury, pregnancy	Enter date in month/day/year (mm/dd/yy) format.
16	Dates patient unable to work in current occupation	If applicable, enter date in month/day/year (mm/dd/yy) format.
17	Name of referring provider or other source	Enter the name of the referring physician. For Passport clients, the name of the client's Passport provider goes here.
17b**	ID number of referring physician	Enter the referring or ordering physician's NPI. For Passport clients, enter the client's Passport provider's Passport ID number.
18	Hospitalization dates related to current service	Enter dates if the medical service is furnished as a result of, or subsequent to, a related hospitalization.
19	Reserved for local use	This field is used for any special messages regarding the claim or client.
20	Outside lab?	Check "No." Medicaid requires all lab tests to be billed directly by the provider who performed them.
21*	Diagnosis or nature of illness or injury	Enter the appropriate ICD-9-CM diagnosis codes. Enter up to four codes in priority order (primary, secondary, etc.).
23**	Prior authorization number	If the service requires prior authorization (PA), enter the PA number you received for this service.
24a*	Dates of service	Enter date of service for each procedure, service, or supply.
24b*	Place of service	Enter Place of Service 24.
24c*	EMG (Emergency)	Not used.
24d*	Procedures, services, or supplies	Enter the appropriate CPT-4 or HCPCS code for the procedure, service, or supply. When applicable, enter appropriate modifiers. Medicaid recognizes two pricing and one informational modifier per code. ASC service groups are determined by the CPT-4 code entered here.
24e*	Diagnosis pointer	Enter the corresponding diagnosis code reference number (1, 2, 3 or 4) from Field 21 (do not enter the diagnosis code). Any combination of applicable diagnosis reference numbers may be listed on one line.
24f*	Charges	Enter your reasonable and customary charges (or the Department-designated charges) for the procedures on this line.
24g*	Days or units	Enter the number of units or days for the procedure and dates of service billed on this line (see <i>Billing Procedures, Coding</i> for additional tips on days/units). Anesthesia providers must bill using minutes.
24h**	EPSDT/Family Plan	If applicable, enter the appropriate code for the client/service: 1, 2, 3, 4 or 6. See complete description in the <i>EPSDT/Family Planning Indicators</i> table earlier in this chapter.
24i	ID Qual	Not used.
28*	Total charge	Enter the sum of all charges billed in field 24f.
29*	Amount paid	Enter the amount paid by the primary payer (not Medicare). Do not include any adjustment amounts or coinsurance. The Medicare payment amount will be determined from the EOMB attached to the claim.
30*	Balance due	Enter the balance due (the amount in field 28 less the amount in field 29).
31*	Signature of physician or supplier including degrees or credentials and date	This field must contain an authorized signature and date, which can be hand signed, stamped, or computer generated.
32	Service facility location information (name and address)	Enter the name and address of the person, organization, or facility providing the services if other than the client's home or physician's office.
33*	Billing provider information and phone number	Enter the name, address, phone number and NPI of the of the physician or supplier who furnished service.

* = Required field ** = Required if applicable

Client Has Medicaid, Medicare, and Third Party Liability Coverage

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>																													
1. MEDICARE <input type="checkbox"/> (Medicare #)					MEDICAID <input type="checkbox"/> (Medicaid #)					TRICARE CHAMPUS <input checked="" type="checkbox"/> (Sponsor's SSN)					CHAMPVA <input type="checkbox"/> (Member ID#)					GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID)					FECA BLK LUNG <input type="checkbox"/> (SSN)					OTHER <input type="checkbox"/> (ID)									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Olsen, Karen Z.										3. PATIENT'S BIRTH DATE MM DD YY 11 17 25										SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1)									
5. PATIENT'S ADDRESS (No., Street) 98765 Anystreet										6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street) Same																			
CITY Anytown					STATE MT					8. PATIENT STATUS Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>										CITY					STATE														
ZIP CODE 59999					TELEPHONE (Include Area Code) (406) 999-9999					Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>										ZIP CODE					TELEPHONE (Include Area Code) ()														
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:										11. INSURED'S POLICY GROUP OR FECA NUMBER 999999999A																			
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>																			
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)										b. EMPLOYER'S NAME OR SCHOOL NAME																			
c. EMPLOYER'S NAME OR SCHOOL NAME										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										c. INSURANCE PLAN NAME OR PROGRAM NAME 999999999A																			
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. RESERVED FOR LOCAL USE										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>																			
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.										12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.																			
SIGNED _____										DATE _____										SIGNED _____																			
14. DATE OF CURRENT: MM DD YY 12 01 06					ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																								
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a. _____					17b. NPI 9999999999					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																			
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)										23. PRIOR AUTHORIZATION NUMBER										24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER																			
1. _____										3. _____										F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #																			
2. _____										4. _____										1 12 01 06 12 01 06 24 66984 LT SG 1 2000 00 1 NPI																			
3										5										2 NPI																			
4										6										3 NPI																			
5										7										4 NPI																			
6										8										5 NPI																			
6										9										6 NPI																			
25. FEDERAL TAX I.D. NUMBER 99-9999999										SSN EIN <input type="checkbox"/>					26. PATIENT'S ASSIGNMENT NO. 9999999999ABC					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE \$ 2000 00					29. AMOUNT PAID \$ 187 80					30. BALANCE DUE \$ 1812 20				
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on this apply to this bill and are made a p Steven Sloan, MD 01/31/07 SIGNED DATE										32. SERVICE FACILITY LOCATION INFORMATION Anytown Surgicenter 123 Medical Drive Anytown, MT 59999										33. BILLING PROVIDER INFO & PH # (406) 999-9999 Anytown Surgicenter 123 Medical Drive Anytown, MT 59999																			
										a. NPI					b.					a. 0000099999					b.														

CARRIER ↑

PATIENT AND INSURED INFORMATION ↓

PHYSICIAN OR SUPPLIER INFORMATION ↓

Client Has Medicaid, Medicare, and Medicare Supplement Coverage

Field#	Field Title	Instructions
1	Program	Check Medicaid.
1a*	Insured's ID number	Enter the client's Medicare ID number.
2*	Patient's name	Enter the client's name as it appears on the Medicaid client's eligibility information.
3	Patient's birth date and sex	Client's birth date in month/day/year format. Check male or female box.
4	Insured's name	Enter the name of the insured or "SAME".
5	Patient's address	Client's address.
7	Insured's address	Enter the insured's address and telephone number or "SAME".
9-9d	Other insured's information	Use these fields only if there are two or more third party insurance carriers (not including Medicaid and Medicare).
10	Is patient's condition related to:	Check "Yes" or "No" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in field 24. If you answered "yes" to any of these, enter the two-letter state abbreviation where the accident occurred on the "Place" line.
10d*	Reserved for local use	Enter the client's Medicaid ID number as it appears on the client's Medicaid eligibility information.
11*	Insured's policy group	Enter the client's ID number for the primary payer.
11c*	Insurance plan or program	Enter the name of the other insurance plan or program (i.e. BlueCross BlueShield, New West, etc.).
11d*	Is there another health benefit plan?	Check "YES".
14	Date of current illness, injury, pregnancy	Enter date in month/day/year (mm/dd/yy) format.
16	Dates patient unable to work in current occupation	If applicable, enter date in month/day/year (mm/dd/yy) format.
17	Name of referring physician	Enter the name of the referring physician. For Passport clients, the name of the client's Passport provider goes here.
17b**	ID number of referring physician	Enter the referring or ordering physician's Medicaid ID number. For Passport clients, enter the client's Passport provider's Passport ID number.
18	Hospitalization dates related to current service	Enter dates if the medical service is furnished as a result of, or subsequent to, a related hospitalization.
19	Reserved for local use	This field is used for any special messages regarding the claim or client.
20	Outside lab?	Check "No". Medicaid requires all lab tests to be billed directly by the provider who performed them.
21*	Diagnosis or nature of illness or injury	Enter the appropriate ICD-9-CM diagnosis codes. Enter up to four codes in priority order (primary, secondary, etc.).
23**	Prior authorization number	If the service requires prior authorization (PA), enter the PA number you received for this service.
24a*	Date(s) of service	Enter date(s) of service for each procedure, service, or supply.
24b*	Place of service	Enter place of service 24.
24c*	EMG (Emergency)	Not used.
24d*	Procedure, service, or supplies	If applicable, enter the appropriate CPT-4 or HCPCS code for the procedure, service, or supply. When applicable, enter appropriate modifiers. Medicaid recognizes two pricing and one informational modifier per code. ASC service groups are determined by the CPT-4 code entered here.
24e*	Diagnosis code	Enter the corresponding diagnosis code reference number (1, 2, 3 or 4) from field 21 (do not enter the diagnosis code). Any combination of applicable diagnosis reference numbers may be listed on one line.
24f*	Charges	Enter your reasonable and customary charges (or the Department-designated charges) for the procedure(s) on this line.
24g*	Days or units	Enter the number of units or days for the procedure and dates of service billed on this line (see <i>Billing Procedures, Coding</i> for additional tips on days/units). Anesthesia providers must bill using minutes.
24h**	EPSDT/family planning	Enter the appropriate code for the client/service: 1, 2, 3, 4 or 6. See complete description in the <i>EPSDT/Family Planning Indicators</i> table earlier in this chapter.
24i	ID Qual	
28*	Total charge	Enter the sum of all charges billed in Field 24f.
29*	Amount paid	Enter the amount paid by the Medicare supplement insurance only. Do not include any adjustment amounts or coinsurance. Medicare payment is determined from the EOMB attached to the claim.
30*	Balance due	Enter balance due (amount in Field 28 less the amount in Field 29).
31*	Signature and date	This field must contain an authorized signature and date, which can be hand-signed, stamped, or computer generated.
32	Name and address of facility	Enter the name and address of the person, organization, or facility performing the services if other than the client's home or physician's office.
33*	Physician's, supplier's billing name, address, phone number	Enter the name, address, phone number and NPI of the physician or supplier who furnished service.

* = Required field ** == Required if applicable

Client Has Medicaid, Medicare, and Medicare Supplement Coverage

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA <input type="checkbox"/>		PICA <input type="checkbox"/>	
1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input checked="" type="checkbox"/> (Medicaid #) TRICARE CHAMPUS <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA BLK LUNG <input type="checkbox"/> (SSN) OTHER <input type="checkbox"/> (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 999999999A	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Smith, Georgina P.		3. PATIENT'S BIRTH DATE MM DD YY SEX 05 07 38 M <input type="checkbox"/> F <input checked="" type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) 123 Sun City Road		6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY Anytown STATE MT		7. INSURED'S ADDRESS (No., Street) Same	
ZIP CODE 59999 TELEPHONE (Include Area Code) (406) 555-5555		8. PATIENT STATUS Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) _____ c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		11. INSURED'S POLICY GROUP OR FECA NUMBER 999999999B	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
c. EMPLOYER'S NAME OR SCHOOL NAME		b. EMPLOYER'S NAME OR SCHOOL NAME Paywell Supplemental Insurance	
d. INSURANCE PLAN NAME OR PROGRAM NAME		c. INSURANCE PLAN NAME OR PROGRAM NAME Paywell Supplemental Insurance	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		10d. RESERVED FOR LOCAL USE 999999999	
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)		11. INSURED'S POLICY GROUP OR FECA NUMBER 999999999B	
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY		a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY		b. EMPLOYER'S NAME OR SCHOOL NAME	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		c. INSURANCE PLAN NAME OR PROGRAM NAME Paywell Supplemental Insurance	
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>	
19. RESERVED FOR LOCAL USE		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____	
20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES		14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	
1. 715.16		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
2. _____		17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	
3. _____		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
4. _____		19. RESERVED FOR LOCAL USE	
22. MEDICAID RESUBMISSION CODE		20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES	
23. PRIOR AUTHORIZATION NUMBER		21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #		22. MEDICAID RESUBMISSION CODE	
1 11 13 06 11 13 06 24 29877 SG LT 1 2769 00 1 NPI		23. PRIOR AUTHORIZATION NUMBER	
2 _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ NPI		24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #	
3 _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ NPI		25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>	
4 _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ NPI		26. PATIENT'S ACCOUNT NO.	
5 _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ NPI		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
6 _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ NPI		28. TOTAL CHARGE \$ 2769.00 29. AMOUNT PAID \$ 96.63 30. BALANCE DUE \$ 2672.37	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Steven Sloan MD 01/31/07 SIGNED _____ DATE _____		32. SERVICE FACILITY LOCATION INFORMATION Steven Sloan MD P.O. Box 999 Anytown, MT 59999	
33. BILLING PROVIDER INFO & PH # (406) 999-9999 Steven Sloan, MD P.O. Box 999 Anytown, MT 59999		33. BILLING PROVIDER INFO & PH # (406) 999-9999 Steven Sloan, MD P.O. Box 999 Anytown, MT 59999	

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CMS-1500 Agreement

Your signature on the CMS-1500 constitutes your agreement to the terms presented on the back of the form. This form is subject to change by the Centers for Medicare and Medicaid Services (CMS).

Avoiding Claim Errors

Claims are often denied or even returned to the provider before they can be processed. To avoid denials and returns, double-check each claim to confirm the following items are accurate. For more information on returned and denied claims, see the *Billing Procedures* chapter in this manual.

Common Claim Errors	
Claim Error	Prevention
Required field is blank	Check the claim instructions earlier in this chapter for required fields (indicated by * or **). If a required field is blank, the claim may either be returned or denied.
Client ID number missing or invalid	This is a required field (Field 10d); verify that the client's Medicaid ID number is listed as it appears on the client's eligibility information.
Client name missing	This is a required field (Field 2); check that it is correct.
National Provider Identifier (NPI) missing or invalid	The NPI is a 10-digit number assigned to the provider during Medicaid enrollment. Verify the correct NPI is on the claim.
Referring or Passport provider name and ID number missing	When a provider refers a client to another provider, include the referring provider's name and ID number or Passport number. See <i>Passport</i> and <i>Prior Authorization</i> chapters in this manual.
Prior authorization number missing	When prior authorization (PA) is required for a service, the PA number must be listed on the claim in Field 23 (see <i>Prior Authorization</i> in this manual).
Not enough information regarding other coverage	Fields 1a and 11d are required fields when a client has other coverage. Refer to the examples earlier in this chapter.
Authorized signature missing	Each claim must have an authorized signature belonging to the provider, billing clerk, or office personnel. The signature may be hand-written, stamped, or computer-generated.
Signature date missing	Each claim must have a signature date.
Incorrect claim form used	Services covered in this manual require a CMS-1500 claim form or an electronic professional claim.
Information on claim form not legible	Information on the claim form must be legible. Use dark ink and center the information in the field. Information must not be obscured by lines.
Medicare EOMB not attached	When Medicare is involved in payment on a claim, the Medicare EOMB must be attached to the claim or it will be denied.

Remittance Advices and Adjustments

Remittance Advice Description

The remittance advice (RA) is the best tool providers have to determine the status of a claim. RAs accompany payment for services rendered. The RA provides details of all transactions that have occurred during the previous remittance advice cycle. Providers may select a one- or two-week payment cycle (see *Payment and the RA* later in this chapter). Each line of the remittance advice represents all or part of a claim, and explains whether the claim has been paid, denied, or suspended (also referred to as pending). If the claim was suspended or denied, the RA also shows the reason. See the sample RA on the following page.

RA notice

The RA notice is on the first page of the remittance advice. This section contains important messages about rate changes, revised billing procedures, and many other items that affect providers and claims.

Paid claims

This section shows claims paid during the previous cycle. It is the provider's responsibility to verify that claims were paid correctly. If Medicaid overpays a claim and the problem is not corrected, it may result in an audit and the provider having to return the overpayment plus interest. If a claim was paid at the wrong amount or with incorrect information, the claim must be adjusted (see *Adjustments* later in this chapter).

Denied claims

This section shows claims denied during the previous cycle. If a claim has been denied, refer to the Reason/Remark Codes column (Field 16). The reason and remark code description explains why the claim was denied and is located at the end of the RA. See *The Most Common Billing Errors and How to Avoid Them* in the *Billing Procedures* chapter. Please make necessary changes to the claim before rebilling Medicaid.

Pending claims

All claims that have not reached final disposition will appear in this area of the RA. The RA uses "suspended" and "pending" interchangeably. They both mean that the claim has not reached final disposition. If a claim is pending, refer to the Reason/Remark Code column (Field 16). The reason and remark code description located at the end of the RA will explain why the claim is suspended. This section is informational only. Please do not take any action on claims displayed here. Processing will continue until each claim is paid or denied.



If a claim was denied, read the description of the reason and remark code before taking any action on the claim.



The pending claims section of the RA is informational only. Do not take any action on the claims shown here.

Sample Remittance Advice

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES
 HELENA, MT 59604
 REMITTANCE ADVICE FOR MEDICAID/CHIP/MHSP

1

COMMUNITY SURGICAL CENTER
 2100 NORTH MAIN STREET
 CENTRAL CITY MT 59988

2 PROVIDER# 0001234567 3 REMIT ADVICE #123456 4 WARRANT # 654321 5 DATE:02/15/2007 6 PAGE 2

RECIP ID	NAME	SERVICE DATES FROM TO	UNIT OF SVC	PROCEDURE REVENUE NDC	TOTAL CHARGES	ALLOWED	CO-PAY	REASON/REMARK CODES
7	8	10	11	12	13	14	15	16
PAID CLAIMS - MISCELLANEOUS CLAIMS								
123456789 9 ICN	DOE, JOHN EDWARD 0020401135000700	010307 010307	1	69436 42830	1222.50 510.00	764.97 315.05	N	
				LESS MEDICARE PAID**		104.47		
				LESS COPAY DEDUCTION*		0		17
				CLAIM TOTAL**	975.55			
DENIED CLAIMS - MISCELLANEOUS CLAIMS								
123456789 ICN	DOE, JOHN EDWARD 0020401135000800	020107 020107	1	54328	2922.00	0.00	17	Y
			16	***CLAIM TOTAL*****	2922.00	0.00		31 MA61
PENDING CLAIMS - MISCELLANEOUS CLAIMS								
123456789 ICN	DOE, JOHN EDWARD 0020401135000900	020407 020407	1	66984	2000.00	0.00	17	N 31
				CLAIM TOTAL**	2000.00			

*****THE FOLLOWING IS A DESCRIPTION OF THE REASON/REMARK CODES THAT APPEAR ABOVE*****

- 31 CLAIM DENIED AS PATIENT CANNOT BE IDENTIFIED AS OUR INSURED.
- MA61 DID NOT COMPLETE OR ENTER CORRECTLY THE PATIENT'S SOCIAL SECURITY NUMBER OR HEALTH INSURANCE CLAIM NUMBER.

Key Fields on the Remittance Advice	
Field	Description
1. Provider name and address	Provider's business name and address as recorded with the Department
2. National provider identifier (NPI)	The 10-digit number assigned to the provider by Medicaid
3. Remittance advice number	The remittance advice number
4. Warrant number	Not used
5. Date	The date the RA was issued
6. Page Number	The page number of the RA
7. Recipient ID	The client's Medicaid ID number
8. Name	The client's name
9. Internal control number (ICN)	<p>Each claim is assigned a unique 17-digit number (ICN). Use this number when you have any questions concerning your claim. The claim number represents the following information:</p> <p><u>0</u> <u>00111</u> <u>11</u> <u>123</u> <u>000123</u> A B C D E</p> <p>A = Claim medium 0 = Paper claim 2 = Electronic claim 3 = Encounter claim 4 = System generated claim (mass adjustment, nursing home turn-around document, or point-of-sale (POS) pharmacy claim) B = Julian date (e.g., April 20, 2000, was the 111th day of 2000) C = Microfilm number 00 = Electronic claim 11 = Paper claim D = Batch number E = Claim number If the first number is: 0 = Regular claim 1 = Negative side adjustment claim (Medicaid recovers payment) 2 = Positive side adjustment claim (Medicaid reprocesses)</p>
10. Service dates	Dates services were provided. If services were performed in a single day, the same date will appear in both columns.
11. Unit of service	The units of service rendered under this procedure, NDC code, or revenue code.
12. Procedure/revenue/NDC	The procedure code (CPT, HCPCS, or local), NDC, or revenue code will appear in this column. If a modifier was used, it will also appear in this column.
13. Total charges	The amount a provider billed for this service.
14. Allowed	The Medicaid allowed amount.
15. Copay	A "Y" indicates cost sharing was deducted from the allowed amount, and an "N" indicates cost sharing was not deducted.
16. Reason/Remark code	A code which explains why the service was denied or pended. Descriptions of these codes are listed at the end of the RA.
17. Deductions, billed amount, and paid amount	Any deductions, such as cost sharing or third party liability are listed first. The amount the provider billed is next, followed by the amount of Medicaid reimbursement.

Claims shown as pending with Reason Code 133 require additional review before a decision to pay or deny is made. If a claim is being held while waiting for client eligibility information, it may be suspended for a maximum of 30 days. If Medicaid receives eligibility information within the 30-day period, the claim will continue processing. If no eligibility information is received within 30 days, the claim will be denied. When a claim is denied for lack of eligibility, the provider should verify that the correct Medicaid ID number was billed. If the ID number was incorrect, resubmit the claim with the correct ID number.

Credit balances

Credit balances occur when claim adjustments reduce original payments causing the provider to owe money to the Department. These claims are considered in process and continue to appear on the RA until the credit has been satisfied.

Credit balances can be resolved in two ways:

1. By “working off” the credit balance. Remaining credit balances can be deducted from future claims. These claims will continue to appear on consecutive RAs until the credit has been paid.
2. By sending a check payable to DPHHS for the amount owed. This method is required for providers who no longer submit claims to Montana Medicaid. Please attach a note stating that the check is to pay off a credit balance and include your NPI. Send the check to the attention of Third Party Liability (see *Key Contacts*).

Rebilling and Adjustments

Rebillings and adjustments are important steps in correcting any billing problems you may experience. Knowing when to use the rebilling process versus the adjustment process is important.

How long do I have to rebill or adjust a claim?

- Providers may resubmit or adjust any initial claim within the timely filing limits described in the *Billing Procedures* chapter of this manual.
- These time periods do not apply to overpayments that the provider must refund to the Department. After the 12-month time period, a provider may not refund overpayments to the Department by completing a claim adjustment. The provider may refund overpayments by issuing a check or asking that Provider Relations complete a gross adjustment.



The credit balance section is informational only. Do not post from credit balance statements.



Medicaid does not accept any claim for resubmission or adjustment after 12 months from the date of service (see *Timely Filing Limits in Billing Procedures* chapter).

Rebilling Medicaid

Rebilling is when a provider submits a claim to Medicaid that was previously submitted for payment but was either returned or denied. Claims are often returned to the provider before processing because key information such as Medicaid provider number or authorized signature and date are missing or unreadable. For tips on preventing returned or denied claims, see the *Billing Procedures* and *Submitting a Claim* chapters.

When to rebill Medicaid

- ***Claim denied.*** Providers can rebill Medicaid when a claim is denied in full, as long as the claim was denied for reasons that can be corrected. When the entire claim is denied, check the reason and remark code, make the appropriate corrections, and resubmit the claim on a CMS-1500 form (not the adjustment form).
- ***Claim returned.*** Rebill Medicaid when the claim is returned under separate cover. Occasionally, Medicaid is unable to process the claim and will return it to the provider with a letter stating that additional information is needed to process the claim. Correct the information as directed and resubmit your claim.

How to rebill

- Check any reason and remark code listed and make your corrections on a copy of the claim, or produce a new claim with the correct information.
- Enter any insurance (TPL) information on the corrected claim, or attach insurance denial information to the corrected claim, and send it to Claims Processing (see *Key Contacts*).

Adjustments

If a provider believes that a claim has been paid incorrectly, the provider may call Provider Relations (see *Key Contacts*) or submit a claim inquiry for review (see the *Billing Procedures* chapter, *Claim Inquiries*). Once an incorrect payment has been verified, the provider may submit an *Individual Adjustment Request* form (in *Appendix A*) to Provider Relations. If incorrect payment was the result of an ACS keying error, contact Provider Relations.

When adjustments are made to previously paid claims, the Department recovers the original payment and issues appropriate repayment. The result of the adjustment appears on the provider's RA as two transactions. The original payment will appear as a credit transaction. The replacement claim reflecting the corrections will be listed as a separate transaction and may or may not appear on the same RA as the credit transaction. The replacement transaction will have nearly the same ICN number as the credit transaction, except the 12th



Rebill denied claims only after appropriate corrections have been made.



Adjustments can only be made to paid claims.

digit will be a 2, indicating an adjustment. See *Key Fields on the Remittance Advice* earlier in this chapter. Adjustments are processed in the same time frame as claims.

When to request an adjustment

- Request an adjustment when a claim was overpaid or underpaid.
- Request an adjustment when a claim was paid but the information on the claim was incorrect (such as client ID, provider number, date of service, procedure code, diagnoses, units, etc.).
- Request an adjustment when a single line on a multi-line claim was denied.

How to request an adjustment

To request an adjustment, use the *Individual Adjustment Request* form in *Appendix A*. The requirements for adjusting a claim are as follows:

- Claims Processing must receive individual claim adjustment requests within 12 months from the date of service (see *Timely Filing Limits* in the *Billing Procedures* chapter). After this time, *gross adjustments* are required (see *Definitions*).
- Use a separate adjustment request form for each ICN.
- If you are correcting more than one error per ICN, use only one adjustment request form, and include each error on the form.
- If more than one line of the claim needs to be adjusted, indicate which lines and items need to be adjusted in the *Remarks* section of the adjustment form.

Completing an Adjustment Request Form

1. Download the *Individual Adjustment Request* form from the Provider Information website (see *Key Websites*). Complete Section A first with provider and client information and the claim's ICN number (see following table and sample RA).
2. Complete Section B with information about the claim. Remember to fill in only the items that need to be corrected (see following table):
 - Enter the date of service or the line number in the Date of Service or Line Number column.
 - Enter the information from the claim form that was incorrect in the Information on Statement column.
 - Enter the correct information in the column labeled Corrected Information.

Completing an Individual Adjustment Request Form	
Field	Description
Section A	
1. Provider name and address	Provider's name and address (and mailing address if different).
2. Recipient name	The client's name is here.
3.* Internal control number (ICN)	There can be only one ICN per adjustment request form. When adjusting a claim that has been previously adjusted, use the ICN of the most recent claim.
4.* Provider number	The provider's NPI/API.
5.* Recipient Medicaid number	Client's Medicaid ID number.
6. Date of payment	Date claim was paid is found on remittance advice Field 5 (see the sample RA earlier in this chapter).
7. Amount of payment	The amount of payment from the remittance advice Field 17 (see the sample RA earlier in this chapter.).
Section B	
1. Units of service	If a payment error was caused by an incorrect number of units, complete this line.
2. Procedure code/NDC/ Revenue code	If the procedure code, NDC, or revenue code is incorrect, complete this line.
3. Dates of service (DOS)	If the dates of service is incorrect, complete this line.
4. Billed amount	If the billed amount is incorrect, complete this line.
5. Personal resource (Nursing facility)	If the client's personal resource amount is incorrect, complete this line.
6. Insurance credit amount	If the client's insurance credit amount is incorrect, complete this line.
7. Net (Billed – TPL or Medicare paid)	If the payment error was caused by a missing or incorrect insurance credit, complete this line. Net is billed amount minus the amount third party liability or Medicare paid.
8. Other/Remarks	If none of the above items apply, or if you are unsure what caused the payment error, complete this line.

* Required field

1. Attach copies of the RA and a corrected claim if necessary.

- If the original claim was billed electronically, a copy of the RA will suffice.
- If the RA is electronic, attach a screen print of the RA.

2. Verify the adjustment request has been signed and dated.

3. Send the adjustment request to Claims Processing (see *Key Contacts*).

- If an original payment was an underpayment by Medicaid, the adjustment will result in the provider receiving the additional payment amount allowed.

- If an original payment was an overpayment by Medicaid, the adjustment will result in recovery of the overpaid amount through a credit. If the result is a credit balance, it can be worked off or the provider can pay off the balance by check (see *Credit balances* earlier in this chapter).

- Any questions regarding claims or adjustments must be directed to Provider Relations (see *Key Contacts*).

Mass adjustments

Mass adjustments are done when it is necessary to reprocess multiple claims. They generally occur when:

- Medicaid has a change of policy or fees that is retroactive. In this case federal laws require claims affected by the changes to be mass adjusted.
- A system error that affected claims processing is identified.

Providers are informed of mass adjustments on the first page of the remittance advice (RA Notice section). Mass adjustment claims shown on the RA have an ICN that begins with a 4. See *Key Fields on the Remittance Advice* earlier in this chapter.

**Montana Health Care Programs
Medicaid • Mental Health Services Plan • Healthy Montana Kids
Individual Adjustment Request**

Instructions:
This form is for providers to correct a claim which has been paid at an incorrect amount or was paid with incorrect information. Complete all the fields in Section A with information about the paid claim from your statement. Complete only the items in Section B which represent the incorrect information that needs changing. For help with this form, refer to the *Remittance Advices and Adjustments* chapter in your program manual or the *General Information for Providers* manual, or call (800) 624-3958 (Montana and out-of-state providers) or (406) 442-1837 (Helena).

A. Complete all fields using the remittance advice (RA) for information.

1. Provider Name & Address Name: Community Surgical Center Street or P.O. Box: 123 Medical Drive City: Anytown, MT State: 59999 ZIP: 59999	3. Internal Control Number (ICN) 00204011250000600
2. Client Name Jane Doe	4. NPI/API 1234567
	5. Client ID Number 123456789
	6. Date of Payment 02/15/07
	7. Amount of Payment \$ 11.49

B. Complete items which need to be corrected.

	Date of Service or Line Number	Information on Statement	Corrected Information
1. Units of Service			
2. Procedure Code/NDC/Revenue Code	Line 2	2	1
3. Dates of Service (DOS)	Line 3	02/01/07	01/23/07
4. Billed Amount			
5. Personal Resource (Nursing Facility)			
6. Insurance Credit Amount			
7. Net (Billed - TPL or Medicare paid)			
8. Other/Remarks (Be specific.)			

Signature: *John R. Smith, M.D.* Date: **04/15/07**

When the form is complete, attach a copy of the RA and a copy of the corrected claim.



Mail to: ACS
P.O. Box 8000
Helena, MT 59604



Sample Adjustment Request

Payment and the RA

Providers may receive their Medicaid payment and remittance advice either weekly or biweekly. Payment can be via check or electronic funds transfer (EFT). Direct deposit is another name for EFT. Providers who wish to receive weekly payment must request both EFT and electronic RAs and specifically request weekly payment. For biweekly payment, providers can choose any combination of paper/electronic payment method and RA.

Electronic funds transfer

With EFT, the Department deposits the funds directly to the provider's bank account. If the scheduled deposit day is a holiday, funds will be available on the next business day. This process does not affect the delivery of the remittance advice that providers currently receive with payments. RAs will continue to be mailed to providers unless they specifically request an electronic RA.

To participate in EFT, providers must complete a *Direct Deposit Sign-Up Form* (Standard Form 1199A) (see the following table). One form must be completed for each provider number.

Once electronic transfer testing shows payment to the provider's account, all Medicaid payments will be made through EFT. To arrange for EFT, call the number listed under *Direct Deposit Arrangements* in *Key Contacts*.

Electronic remittance advice

To receive an electronic RA, the provider must complete the *Electronic Remittance Advice and Payment Cycle Enrollment Form* (see the following table), have Internet access, and be registered for the Montana Access to Health (MATH) web portal. You can access your electronic RA through the web portal on the Internet by going to the Provider Information website (see *Key Website*) and selecting *Log in to Montana Access to Health*. In order to access the MATH web portal, you must first complete an *EDI Provider Enrollment Form* and an *EDI Trading Partner Agreement* (see the following table).

After these forms have been processed, you will receive a user ID and password that you can use to log on to the web portal. The verification process also requires a provider ID, a submitter ID, and a tax ID number. Each provider must complete an *EDI Trading Partner Agreement*, but if there are several providers in one location who are under one tax ID number, they can use one submitter number. These providers should enter the submitter ID in both the provider number and submitter ID fields. Otherwise, enter the provider number in the provider number field.

RAs are available in PDF format. You can read, print, or download PDF files using Adobe Acrobat Reader, which is available on the web portal home page. Due to space limitations, each RA is only available for 90 days.



Weekly payments are available only to providers who receive both EFT **and** electronic RAs.



Electronic RAs are available for only 90 days on the web portal.

Required Forms for EFT and/or Electronic RA			
All four forms are required for a provider to receive weekly payment			
Form	Purpose	Where to Get	Where to Send
Electronic Remittance Advice and Payment Cycle Enrollment Form	Allows providers to receive electronic remittance advices on the Montana Access to Health (MATH) web portal (must also include an EDI Provider Enrollment Form and EDI Trading Partner Agreement)	<ul style="list-style-type: none"> • MATH web portal • Provider Relations (see <i>Key Contacts</i>) 	Provider Relations (see <i>Key Contacts</i>)
Direct Deposit Sign-up Form Standard Form 1199A	Allows the Department to automatically deposit Medicaid payment into provider's bank account	<ul style="list-style-type: none"> • MATH web portal (see <i>Key Contacts</i>) • Provider's bank 	Provider Relations (see <i>Key Contacts</i>)
EDI Provider Enrollment Form and EDI Trading Partner Agreement	Allow provider to access their RA on the Montana Access to Health Web Portal (must also include an Electronic Remittance Advice and Payment Cycle Enrollment Form)	<ul style="list-style-type: none"> • MATH web portal • ACS EDI Gateway website (see <i>Key Contacts</i>) 	ACS address on the form

Other Programs

The information in this chapter applies to ambulatory surgical center services for clients who are enrolled in the Mental Health Services Plan (MHSP).

The information in this chapter does not apply to clients enrolled in Healthy Montana Kids (HMK). The HMK medical manual is available through Blue Cross and Blue Shield of Montana at 877-543-7669.

How Payment Is Calculated

Overview

Though providers do not need the information in this chapter to submit claims to the Department, the information allows providers to understand how payment is calculated and to predict approximate payment for particular claims.

Ambulatory Surgical Centers

Effective for dates of service on or after April 1, 2008, Montana Medicaid implemented a prospective ambulatory surgical center (ASC) payment system in line with the Centers for Medicare and Medicaid Services (CMS) ASC methodology. This payment system prospectively determines amounts to be paid for covered surgical and ancillary services identified by codes and modifiers established under the CMS Healthcare Common Procedure Coding System (HCPCS). This payment system also indicates which costs are packaged and which surgical procedures are excluded.

Montana Medicaid rates will follow the CMS quarterly ASC payment updates. Listings of payable HCPCS codes and their corresponding payment rates are available on the Montana Medicaid ASC fee schedules. CMS also publishes quarterly addendums indicating covered surgical and ancillary services as well as noncovered surgical services.

Whenever CMS proposes to revise the payment rate for ASCs, CMS publishes a notice in the Federal Register describing the revision. The notice also explains the basis on which the rates were established. After reviewing public comments, CMS publishes a notice establishing the rates authorized by this section. In setting these rates, CMS may adopt reasonable classifications of facilities and may establish different rates for different types of surgical procedures.

Providers should review the Montana Medicaid ASC fee schedules or CMS website for a list of services and rates. Call Provider Relations (see *Key Contacts*) for claim inquiries or for payment methodology inquiries, call the Department at (406) 444-4540.

Other Issues

Outpatient services

When Medicaid pays an ASC for outpatient services, the separate claim for the physician's services must show the ASC as the place of service (i.e., place of service is 24 for ASCs). This place of service code will result in the physician receiving the "facility fee" listed in the physician fee schedule.

Modifiers

Certain modifiers can affect the way a service is paid.

- Modifiers may not be applicable for all services.
- Modifiers may affect surgical services differently than nonsurgical services.
- The list shows summary modifier descriptions. See the CPT-4 and HCPCS Level II coding books for the full text.
- Only the first modifier listed on the line item will affect payment. Discontinued or reduced service modifiers (Modifiers 52 and 73) should be listed before other pricing modifiers.

CPT Modifier	Description and How Payment is Affected
50	Bilateral procedure. Prices at 150% of the listed fee schedule amount unless the service is subject to the multiple procedure discount pricing.
52	Reduced services. The service is paid at 50% of the listed fee schedule amount.
73	For single surgical services, the service is paid at 50% of the listed fee schedule amount unless subject to the multiple procedure discount.
74	Discontinued outpatient hospital/ASC procedure after the administration of anesthesia. The service is paid at 100% of the listed fee schedule amount.

How payment is calculated on TPL claims

When a client has coverage from both Medicaid and another insurance company, the other insurance company is often referred to as third party liability or TPL. In these cases, the other insurance is the primary payer (as described in the *Coordination of Benefits* chapter of this manual), and Medicaid makes a payment as the secondary payer. Medicaid will make a payment only when the TPL payment is less than the Medicaid allowed amount.

How payment is calculated on Medicare crossover claims

When a client has coverage from both Medicare and Medicaid, Medicare is the primary payer. Medicaid will pay the coinsurance and deductible, less any TPL or incurment, on ambulatory surgical center (ASC) claims for these dually-eligible individuals.

Payment examples for dually-eligible clients

Client has Medicare and Medicaid coverage. A provider submits an ASC claim for a client with Medicare and Medicaid. The Medicare coinsurance and deductible are \$65.00 and \$185.00. This total (\$250.00) becomes the Medicaid allowed amount. Medicaid will pay this amount (\$250.00) as long as no TPL or incurment amounts are applicable.

Client has Medicare, Medicaid, and TPL. A provider submits an ASC claim for a client with Medicare, Medicaid, and TPL. The Medicare coinsurance and deductible are \$65.00 and \$185.00. This total (\$250.00) becomes the Medicaid allowed amount. The other insurance company paid \$225.00. This amount is subtracted from the Medicaid allowed amount leaving \$25.00. Medicaid pays \$25.00 for this claim. If the TPL payment had been \$250.00 or more, this claim would have paid at \$0.00.

Client has Medicare, Medicaid, and Medicaid Incurment. A provider submits an ASC claim for a client with Medicare, Medicaid, and a Medicaid incurment. The Medicare coinsurance and deductible are \$65.00 and \$185.00. This total (\$250.00) becomes the Medicaid allowed amount. The client owes \$150 for his Medicaid incurment, so this amount is subtracted from the \$250.00. Medicaid will pay the provider \$100.00 for this claim.

Appendix A: Forms

- *Individual Adjustment Request*
- *Medicaid Abortion Certification (MA-37)*
- *Informed Consent to Sterilization (MA-38)*
- *Medicaid Hysterectomy Acknowledgment (MA-39)*
- *Claim Inquiry Form*
- *Paperwork Attachment Cover Sheet*

Montana Health Care Programs

Medicaid • Mental Health Services Plan • Healthy Montana Kids

Individual Adjustment Request Individual Adjustment Request

Instructions:

This form is for providers to correct a claim which has been **paid** at an incorrect amount or was **paid** with incorrect information. Complete all the fields in Section A with information about the paid claim from your statement. Complete **only** the items in Section B which represent the incorrect information that needs changing. For help with this form, refer to the *Remittance Advices and Adjustments* chapter in your program manual or the *General Information for Providers* manual, or call (800) 624-3958 (Montana and out-of-state providers) or (406) 442-1837 (Helena).

A. Complete all fields using the remittance advice (RA) for information.

<p>1. Provider Name & Address</p> <p>_____</p> <p>Name</p> <p>_____</p> <p>Street or P.O. Box</p> <p>_____</p> <p>City State ZIP</p>	<p>3. Internal Control Number (ICN)</p> <p>_____</p> <p>4. NPI/API</p> <p>_____</p> <p>5. Client ID Number</p> <p>_____</p> <p>6. Date of Payment _____</p> <p>7. Amount of Payment \$ _____</p>
<p>2. Client Name</p> <p>_____</p>	

B. Complete only the items which need to be corrected.

	Date of Service or Line Number	Information on Statement	Corrected Information
1. Units of Service			
2. Procedure Code/NDC/Revenue Code			
3. Dates of Service (DOS)			
4. Billed Amount			
5. Personal Resource (Nursing Facility)			
6. Insurance Credit Amount			
7. Net (Billed – TPL or Medicare paid)			
8. Other/Remarks (Be specific.)			

Signature: _____ Date: _____

When the form is complete, attach a copy of the RA and a copy of the corrected claim.



Mail to: ACS
 P.O. Box 8000
 Helena, MT 59604



MEDICAID RECIPIENT/PHYSICIAN ABORTION CERTIFICATION

MEDICAID CLAIMS FOR ABORTION SERVICES WILL NOT BE PAID UNLESS THIS FORM IS COMPLETED IN FULL AND A COPY IS ATTACHED TO THE MEDICAID CLAIM FORM.

Recipient Name: _____ Provider Name: _____

Part I, II or III must be completed and the physician completing the procedure must sign below.

I. IF THE ABORTION IS NECESSARY TO SAVE THE RECIPIENT'S LIFE, THE FOLLOWING MUST BE COMPLETED BY THE PHYSICIAN:

In my professional opinion, recipient suffers from a physical disorder, physical injury or physical illness (or life-endangering physical condition caused by or arising from the pregnancy itself) that would place the recipient in danger of death unless an abortion is performed.

(attach additional sheets as necessary)

II. IF THE PREGNANCY RESULTED FROM RAPE OR INCEST, THE FOLLOWING MUST BE COMPLETED BY THE RECIPIENT AND PHYSICIAN:

RECIPIENT CERTIFICATION: I Hereby certify that my current pregnancy resulted from an act of rape or incest.

PHYSICIAN CERTIFICATION: If the pregnancy resulted from rape or incest, the physician must mark one of the following and sign below:

- ___ a. The recipient has stated to me that she has reported the rape or incest to a law enforcement or protective services agency having jurisdiction in the matter or, if the patient is a child enrolled in a school, to a school counselor; or
- ___ b. Based upon my professional judgement, the recipient was and is unable for physical or psychological reasons to report the act of rape or incest.

III. IF THE ABORTION IS MEDICALLY NECESSARY BUT THE RECIPIENT'S LIFE IS NOT IN DANGER, THE FOLLOWING MUST BE COMPLETED BY THE PHYSICIAN:

In my professional opinion, an abortion is medically necessary for the following reasons:

(attach additional sheets as necessary)

PHYSICIAN SIGNATURE: _____ **DATE:** _____

Abortions (ARM 37.86.104)

A completed *Medicaid Recipient/Physician Abortion Certification* (MA-37) form must be attached to every abortion claim or payment will be denied. Complete only one part (I, II, or III) of this form; the part used must be clearly indicated on the form. This is the only form Medicaid accepts for abortions.

Abortions are covered when one of the following conditions is met:

- The client's life would be endangered if the fetus is carried to term.
- The pregnancy is the result of rape or incest.
- The abortion is determined by the attending physician to be medically necessary, even if the client's life is not endangered if the fetus is carried to term.

When using mifepristone (Mifeprex or RU 486) to terminate a pregnancy, it must be administered within 49 days from the beginning of the last menstrual period by or under the supervision of a physician who:

- Can assess the duration of a pregnancy.
- Can diagnose ectopic pregnancies.
- Can provide surgical intervention in cases of incomplete abortion or severe bleeding, or can provide such care through other qualified physicians.
- Can assure access to medical facilities equipped to provide blood transfusion and resuscitation.
- Has read, understood and explained to the client the prescribing information for mifepristone.

STATE OF MONTANA
DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES
INFORMED CONSENT TO STERILIZATION

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from _____ (Doctor or Clinic). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care to treatment. I will not lose any help or benefits from programs receiving Federal funds, such as AFDC or Medicaid that I am now getting or for which I may become eligible. I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN. I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected those alternatives and chosen to be sterilized. I understand that I will be sterilized by an operation known as a _____. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction. I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by Federally funded programs.

I am at least 21 years of age and was born on _____ (month) (day) (year). I, _____, hereby consent of my own free will to be sterilized by _____ (Doctor) by a method called _____. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to: Representatives of the Department of Health & Human Services or Employees of programs or projects funded by that department but only for determining if Federal laws were observed. I have received a copy of this form.

(Signature) (Date)
You are requested to supply the following information, but it is not required. Race and ethnicity designation (please check):
 American Indian or Alaskan Native
 Black (not of Hispanic origin)
 Asian or Pacific Islander
 Hispanic
 White (not of Hispanic origin)

■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized: I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

(Interpreter) (Date)

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before _____ signed (name of individual) the consent form, I explained to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief, the individual to be sterilized is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

(Signature of person obtaining consent) (date)

(Facility)

(Address)

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon _____ (Name of person being sterilized) on _____ (date of sterilization operation) I explained to him/her the nature of the sterilization operation _____, the fact that it is _____ (specify type of operation) intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief, the individual to be sterilized is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

- (1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.
- (2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):
 Premature delivery
 Individual's expected date of delivery: _____
 Emergency abdominal surgery:
(describe circumstances): _____

(Physician) (Date)

Sterilization (ARM 37.86.104)

Elective sterilizations are sterilizations done for the purpose of becoming sterile. For **elective sterilizations**, a completed *Informed Consent to Sterilization* (MA-38) form must be attached to the claim for each provider involved or payment will be denied. This form must be legible, complete, and accurate, and revisions are not accepted. It is the provider's responsibility to obtain a copy of the form from the primary or attending physician.

Medicaid covers elective sterilization for men and women when all of the following requirements are met:

- Client must complete and sign the *Informed Consent to Sterilization* (MA-38) form at least 30 days, but not more than 180 days, prior to the sterilization procedure. This form is the **only** form Medicaid accepts for elective sterilizations (see *Appendix A: Forms* for the form and instructions). If this form is not properly completed, payment will be denied.

The 30-day waiting period may be waived for either of the following reasons:

- **Premature Delivery.** The *Informed Consent to Sterilization* must be completed and signed by the client at least 30 days prior to the estimated delivery date and at least 72 hours prior to the sterilization.
- **Emergency Abdominal Surgery.** The *Informed Consent to Sterilization* form must be completed and signed by the client at least 72 hours prior to the sterilization procedure.
 1. Client must be at least 21 years of age when signing the form.
 2. Client must not have been declared *mentally incompetent* (see *Definitions*) by a federal, state or local court, unless the client has been declared competent to specifically consent to sterilization.
 3. Client must not be confined under civil or criminal status in a correctional or rehabilitative facility, including a psychiatric hospital or other correctional facility for the treatment of the mentally ill.

Before performing a sterilization, the following requirements must be met:

- The client must have the opportunity to have questions regarding the sterilization procedure answered to his/her satisfaction.
- The client must be informed of his/her right to withdraw or withhold consent anytime before the sterilization without being subject to retribution or loss of benefits.
- The client must be made aware of available alternatives of birth control and family planning.
- The client must understand the sterilization procedure being considered is irreversible.
- The client must be made aware of the discomforts and risks which may accompany the sterilization procedure being considered.
- The client must be informed of the benefits and advantages of the sterilization procedure.
- The client must know that he/she must have at least 30 days to reconsider his/her decision to be sterilized.
- An interpreter must be present and sign for those clients who are blind, deaf, or do not understand the language to assure the person has been informed.

Informed consent for sterilization may not be obtained under the following circumstances:

- If the client is in labor or childbirth.
- If the client is seeking or obtaining an abortion.
- If the client is under the influence of alcohol or other substance which affects his/her awareness.
- Medicaid does not reimburse for hysterectomies done primarily for sterilization purposes.

When sterilization results from a procedure performed to address another medical problem, it is considered a **medically necessary sterilization**. These procedures include hysterectomies, oophorectomies, salpingectomies and orchiectomies.

For medically necessary sterilizations, one of the following must be attached to the claim, or payment will be denied:

- A completed *Medicaid Hysterectomy Acknowledgement* form (MA-39) for each provider submitting a claim. It is the provider's responsibility to obtain a copy of the form from the primary or attending physician. Complete only one section (A, B, or C) of this form. When no prior sterility (Section B) or life-threatening emergency (Section C) exists, the client (or representative, if any) and physician must sign and date Section A of this form prior to the procedure. (See 42 CFR 441.250 for the federal policy on hysterectomies and sterilizations.). Also, for Section A, signatures dated after the surgery date require manual review of medical records by the Department. The Department must verify that the client (and representative, if any) was informed orally and in writing, prior to the surgery, that the procedure would render the client permanently incapable of reproducing. The client does not need to sign this form when Sections B or C are used.
- For clients who have become retroactively eligible for Medicaid, the physician must certify in writing that the surgery was performed for medical reasons and must document one of the following:
 - The individual was informed prior to the hysterectomy that the operation would render the client permanently incapable of reproducing.
 - The reason for the hysterectomy was a life-threatening emergency.
 - The client was already sterile at the time of the hysterectomy and the reason for prior sterility.

When submitting claims for retroactively eligible clients, attach a copy of the FA-455 (eligibility determination letter) to the claim if the date of service is more than 12 months earlier than the date the claim is submitted. For more information on sterilizations, see the *Covered Services* chapter in this manual.

- For clients who have become retroactively eligible for Medicaid, the physician must certify in writing that the surgery was performed for medical reasons and must document one of the following:
 - The individual was informed prior to the hysterectomy that the operation would render the client permanently incapable of reproducing.
 - The reason for the hysterectomy was a life-threatening emergency.

- The client was already sterile at the time of the hysterectomy and the reason for prior sterility.

For further information on the Medicaid requirements for payment of sterilizations, hysterectomies and abortions, consult the Physician-Related Services manual.

Public Health Department Services

Public Health Department services consist of the following types of services:

- Mid-level practitioner services which:
 - Are provided through a Public Health Department; and
 - Meet all the mid-level practitioner services requirements specified in ARM 37.86.201, ARM 37.86.202, and ARM 37.86.205.
- Physician services which:
 - Are provided either directly by the physician or by a public health nurse under a physician's immediate supervision. This means the physician has seen the patient and ordered the services except that a minimal service does not require the physician to see the patient. Minimal services are covered when provided by a licensed registered nurse under protocols provided by a physician affiliated with the Public Health Department. Protocols shall be updated at least annually.
 - Meet the physician services requirements specified in ARM 37.86.101, ARM 37.86.104 and ARM 37.86.105.
 - Telephone contacts are not a clinic service.

MEDICAID HYSTERECTOMY ACKNOWLEDGMENT

A. RECIPIENT ACKNOWLEDGMENT STATEMENT

I certify that prior to the surgery (hysterectomy), I received both orally and in writing information which explained that I would become permanently sterile and that I would be incapable of reproducing children after the surgery is completed.

Signature of Recipient: _____ Date: _____

Signature of Representative (If Required): _____ Date: _____

PHYSICIAN ACKNOWLEDGMENT STATEMENT

I certify that prior to performing the surgery, I advised _____
(Name of Recipient)
both orally and in writing that the surgical procedure known as a hysterectomy would render her permanently sterile and that she would be incapable of reproducing children after the surgical procedure is completed. I also certify that this procedure is being done primarily for medical reasons other than sterilization.

Signature of Physician: _____ Date: _____

SIGNATURE OF INTERPRETER (If Required)

Signature of Interpreter: _____ Date: _____

B. STATEMENT OF PRIOR STERILITY

I certify that _____
(Name of Recipient)
was already sterile and unable to bear children at the time the hysterectomy or other procedure capable of causing sterility was performed. The cause of this recipient's sterility was: _____

Signature of Physician: _____ Date: _____

C. STATEMENT OF LIFE THREATENING EMERGENCY

I certify that the hysterectomy or other sterility causing procedure performed on _____
(Name of Recipient)
was completed under a life threatening emergency situation in which prior acknowledgment was not possible. The nature of the emergency was _____

Signature of Physician: _____ Date: _____

This form may also be used as a substitute for the sterilization consent form for sterilization procedures where the patient is already sterile and for sterilization procedures (i.e., salpingo-oophorectomy, orchiectomy) done only for medical reasons. With these cases, replace "hysterectomy" with the appropriate procedure name.

Instructions for Completing the Medicaid Hysterectomy Acknowledgment Form (MA-39)

Complete only one section (A, B, or C) of this form. The client does not need to sign this form when Sections B or C are used. This form may be used as a substitute for the *Informed Consent to Sterilization* form for sterilization procedures where the client is already sterile, and for sterilization procedures (e.g., salpingo-oophorectomy, orchiectomy) done only for medical reasons. In these cases, replace the word “hysterectomy” with the appropriate procedure name.

Recipient Acknowledgment Statement

This section is used to document that the client received information about the hysterectomy (or other sterilization-causing procedure such as salpingo-oophorectomy or orchiectomy) before it was performed. The client and the physician must complete this portion of the form together (with an interpreter if applicable) prior to the procedure. Do not use this section for cases of prior sterility or life-threatening emergency. 1. The client or representative must sign and date the form prior to the procedure. 2. Enter the client’s name. 3. The physician must sign and date the form prior to the procedure. 4. If interpreter services are used, the interpreter must sign and date the form prior to the procedure.

Statement of Prior Sterility

Complete this section if the client was already sterile at the time of the hysterectomy or other sterilization causing procedure (e.g., salpingo-oophorectomy or orchiectomy). 1. Enter the client’s name. 2. Explain the cause of the client’s sterility (e.g., post menopausal, post hysterectomy). 3. The physician must sign and date this portion of the form.

Statement of Life Threatening Emergency

Complete this section in cases where the *Medicaid Hysterectomy Acknowledgment* could not be completed prior to the surgery because of a life threatening emergency. 1. Enter the client’s name. 2. Explain the nature of the life-threatening emergency. 3. The physician must sign and date this portion of the form.

Montana Health Care Programs Claim Inquiry Form



A **xerox** Company

Provider Name _____
 Contact Person _____
 Address _____
 Date _____
 Phone Number _____
 Fax Number _____



For status on a claim, please complete the information on this form and mail to the address below or fax to the number shown. You may attach a copy of the claim, but it is not required.

<p>NPI/API _____</p> <p>Client Number _____</p> <p>Date of Service _____</p> <p>Total Billed Amount _____</p> <p>Date Submitted for Processing _____</p>	<p>ACS Response _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p>NPI/API _____</p> <p>Client Number _____</p> <p>Date of Service _____</p> <p>Total Billed Amount _____</p> <p>Date Submitted for Processing _____</p>	<p>ACS Response _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p>NPI/API _____</p> <p>Client Number _____</p> <p>Date of Service _____</p> <p>Total Billed Amount _____</p> <p>Date Submitted for Processing _____</p>	<p>ACS Response _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>

Mail to: Provider Relations
 P.O. Box 8000
 Helena, MT 59604

Fax to: (406) 442-4402

Paperwork Attachment Cover Sheet

Paperwork Attachment Control Number: _____

Date of Service: _____

Billing NPI/API: _____

Client ID Number: _____

Type of Attachment: _____

Instructions:

This form is used as a cover sheet for attachments to electronic and paper Montana Health Care Programs (Medicaid; Mental Health Services Plan; Healthy Montana Kids; Indian Health Services Program) claims sent to ACS.

The *Paperwork Attachment Control Number* must be the same number as the *attachment control number* on the corresponding electronic claim. This number should consist of the provider's NPI/API, the client's ID number and the date of service (mmddyyyy), each separated by a dash (NPI: 9999999999-999999999-999999999/Atypical Provider ID: 9999999-9999999999-99999999).

This form may be copied or downloaded from the Provider website (<http://medicaidprovider.hhs.mt.gov/>). If you have questions about which paper attachments are necessary for a claim to process, please call ACS Provider Relations at (406) 442-1837 or (800) 624-3958.

Completed forms can be mailed or faxed to: ACS
P.O. Box 8000
Helena, MT 59604
Fax: 1-406-442-4402

Definitions and Acronyms

This section contains definitions, abbreviations, and acronyms used in this manual.

Administrative Rules of Montana (ARM)

The rules published by the executive departments and agencies of the state government.

Allowed Amount

The maximum amount reimbursed to a provider for a health care service as determined by Medicaid or another payer. Other cost factors, (such as cost sharing, TPL, or incurment) are often deducted from the allowed amount before final payment. Medicaid's allowed amount for each covered service is listed on the Department fee schedule.

Ambulatory Surgical Center Services

Services that are provided in a licensed, free-standing ambulatory surgical center. Surgical center services do not include physician services, anesthesiologist services, ambulance services, or major prosthetic appliances such as intraocular lenses.

Ancillary Provider

Any provider that is subordinate to the client's primary provider, or providing services in the facility or institution that has accepted the client as a Medicaid client.

Assignment of Benefits

A voluntary decision by the client to have insurance benefits paid directly to the provider rather than to the client. The act requires the signing of a form for the purpose. The provider is not obligated to accept an assignment of benefits. However, the provider may require assignment in order to protect the provider's revenue.

Authorization

An official approval for action taken for, or on behalf of, a Medicaid client. This approval is only valid if the client is eligible on the date of service.

Basic Medicaid

Patients with Basic Medicaid have limited Medicaid services. See the *General Information for Providers* manual, *Appendix A: Medicaid Covered Services*.

Cash Option

Cash option allows the client to pay a monthly premium to Medicaid and have Medicaid coverage for the entire month rather than a partial month.

Centers for Medicare and Medicaid Services (CMS)

Administers the Medicare program and oversees the state Medicaid programs. Formerly the Health Care Financing Administration (HCFA).

Class I Anesthesia Risk

An individual with no detectable systemic diseases and no physical abnormalities that would in any way impair the functioning of his/her jaw, neck, airway, chest, or abdominal function.

Class II Anesthesia Risk

An individual who has only one systemic disease that threatens the safe outcome of anesthesia.

Clean Claim

A claim that can be processed without additional information from or action by the provider of the service.

Client

An individual enrolled in a Department medical assistance program.

Clinic Services

Preventive, diagnostic, therapeutic, rehabilitative or palliative items or services provided under the direction of a physician by an outpatient facility that is not part of a hospital, but is organized and operated to provide medical care to outpatients independent of a hospital. Clinic services may be provided in surgical centers and public health departments. Clinic services do not include mental health center services as defined in ARM 37.88.901.

Code of Federal Regulations (CFR)

Rules published by executive departments and agencies of the federal government.

Coinsurance

The client's financial responsibility for a medical bill as assigned Medicare (usually a percentage). Medicare coinsurance is usually 20 percent of the Medicare allowed amount.

Copayment

The client's financial responsibility for a medical bill as assigned by Medicaid (usually a flat fee).

Cosmetic

Serving to modify or improve the appearance of a physical feature, defect, or irregularity.

Cost Sharing

The client's financial responsibility for a medical bill assessed by flat fee or percentage of charges.

Crossovers

Claims for clients who have both Medicare and Medicaid. These claims may come electronically from Medicare or directly from the provider.

DPHHS, State Agency

The Montana Department of Public Health and Human Services (DPHHS or the Department) is the designated State Agency that administers the Medicaid program. The Department's legal authority is contained in Title 53, Chapter 6 of the Montana Code Annotated (MCA). At the Federal level, the legal basis for the program is contained in Title XIX of the Social Security Act and Title 42 of the Code of Federal Regulations (CFR). The program is administered in accordance with the Administrative Rules of Montana (ARM), Title 37, Chapter 86.

Dual Eligibles

Clients who are covered by Medicare and Medicaid are often referred to as "dual eligibles."

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

This program provides Medicaid-covered children with comprehensive health screenings, diagnostic services, and treatment of health problems.

Emergency Medical Condition

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part; or

With respect to a pregnant woman who is having contractions:

- That there is inadequate time to effect a safe transfer to another hospital before delivery; or
- That transfer may pose a threat to the health or safety of the woman or the unborn child.

Experimental

A non-covered item or service that researchers are studying to investigate how it affects health.

Fiscal Agent

ACS State Healthcare LLC is the fiscal agent for the State of Montana and processes claims at the Department's direction and in accordance with ARM 37.86 *et seq.*

Full Medicaid

Patients with Full Medicaid have a full scope of Medicaid benefits. See the *General Information for Providers* manual, *Appendix A: Medicaid Covered Services*.

Gross Adjustment

A lump sum debit or credit that is not claim specific made to a provider.

Health Improvement Program

An enhanced primary care case management program that is part of Passport to Health. Services for high risk and/or high cost Medicaid and HMK *Plus* Passport patients provided by nurses and health coaches to prevent or slow the progression of disease, disability and other health conditions, prolong life, and promote physical and mental health. Services are provided through community and tribal health centers on a regional basis and include: health assessment, care planning, hospital discharge planning, help with social services and education, and support for clients in self-management of health conditions.

Predictive modeling software and provider referral are used to identify patients with the most need.

Healthy Montana Kids (HMK)

This plan covers some children whose family incomes make them ineligible for Medicaid. DPHHS sponsors the program, which is administered by Blue Cross and Blue Shield of Montana.

Indian Health Service (IHS)

IHS provides health services to American Indians and Alaska Natives.

Individual Adjustment

A request for a correction to a specific paid claim.

Investigational

A non-covered item or service that researchers are studying to investigate how it affects health.

Mass Adjustment

Request for a correction to a group of claims meeting specific defined criteria.

Medicaid

A program that provides health care coverage to specific populations, especially low-income families with children, pregnant women, disabled people and the elderly. Medicaid is administered by state governments under broad federal guidelines.

Montana Access to Health Web Portal

A secure website on which providers may view clients' medical history, verify client eligibility, submit claims to Medicaid, check the status of a claim, verify the status of a warrant, and download remittance advice reports.

Medically Necessary

A term describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client. These conditions must be classified as one of the following: endanger life, cause suffering or pain, result in an illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or mal-function. There must be no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this definition, “course of treatment” may include mere observation or, when appropriate, no treatment at all.

Medicare

The federal health insurance program for certain aged or disabled clients.

Mental Health Services Plan (MHSP)

This plan is for individuals who have a serious emotional disturbance (SED) or a severe and disabling mental illness (SDMI), are ineligible for Medicaid, and have a family income that does not exceed an amount established by the Department.

Mentally Incompetent

According to CFR 441.251, a mentally incompetent individual means an individual who has been declared mentally incompetent by a federal, state, or local court of competent jurisdiction for any purpose, unless the individual has been declared competent for purposes which include the ability to consent to sterilization.

Minimal Services

According to CPT 2001, when client’s visit does not require the presence of the physician, but services are provided under the physician’s supervision, they are considered minimal services. An example would be a patient returning for a monthly allergy shot.

Montana Breast and Cervical Cancer Treatment Program

This program provides Basic Medicaid coverage for women who have been screened through the Montana Breast and Cervical Health Program (MBCHP) and diagnosed with breast and/or cervical cancer or a pre-cancerous condition.

Mutually Exclusive Code Pairs

These codes represent services or procedures that, based on either the CPT-4 definition or standard medical practice, would not or could not reasonably be performed at the same session by the same provider on the same patient. Codes representing these services or procedures cannot be billed together.

Nurse First Advice Line

A 24-hour/7-day-a-week nurse triage line. Clients can call in with general health questions, medication questions, or questions about illness or injury. If the caller or person they are calling about is symptomatic, a registered nurse follows clinically-based algorithms to an “end point” care recommendation. The care recommendation explains what level of health care is needed, including self-care. If self-care is recommended, clients are given detailed self-care instructions.

Passport Referral Authorization Number

A 7-digit number assigned to Passport providers. When a Passport provider refers a client to another provider for services, this number is given to the other provider and is required when processing the claim.

Passport to Health

The Medicaid primary care case management (PCCM) managed care program where the client selects a primary care provider who manages the client's health care needs.

Prior Authorization (PA)

The approval process required before certain services or supplies are paid by Medicaid. Prior authorization must be obtained before providing the service or supply.

Private-Pay

When a client chooses to pay for medical services out of his or her own pocket.

Protocols

Written plans developed by a public health clinic in collaboration with physician and nursing staff. Protocols specify nursing procedures to be followed in giving a specific exam, or providing care for particular conditions. Protocols must be updated and approved by a physician at least annually.

Provider or Provider of Service

An institution, agency, or person:

- Having a signed agreement with the Department to furnish medical care and goods and/or services to clients; and
- Eligible to receive payment from the Department.

Public Health Department Services

Physician services and mid-level practitioner services as provided for in 50-2-116, 50-2-118 and 50-2-119, MCA.

Qualified Medicare Beneficiary (QMB)

QMB clients are clients for whom Medicaid pays their Medicare premiums and some or all of their Medicare coinsurance and deductibles.

Reference Lab Billing

Reference lab billing occurs when a Medicaid provider draws a specimen and sends it to a “reference lab” for processing. The reference lab then sends the results back to the Medicaid provider and bills the provider for the lab service. The Medicaid provider is then expected

to bill Medicaid for the lab service. Medicaid does not cover lab services when they are billed by the referring provider.

Remittance Advice (RA)

The results of claims processing (including paid, denied, and pending claims) are listed on the RA.

Retroactive Eligibility

When a client is determined to be eligible for Medicaid effective prior to the current date.

Routine Podiatric Care

Routine podiatric care includes the cutting or removing of corns and calluses, the trimming and debridement of nails, the application of skin creams, and other hygienic, preventive maintenance care.

Sanction

The penalty for noncompliance with laws, rules, and policies regarding Medicaid. A sanction may include withholding payment from a provider or terminating Medicaid enrollment.

Special Health Services (SHS)

SHS or Children’s Special Health Services (CSHS) assists children with special health care needs who are not eligible for Medicaid by paying medical costs, finding resources, and conducting clinics.

Specified Low-Income Medicare Beneficiaries (SLMB)

For these clients, Medicaid pays the Medicare premium only. They are not eligible for other Medicaid benefits, and must pay their own Medicare coinsurance and deductibles.

Spending Down

Clients with high medical expenses relative to their income can become eligible for Medicaid by “spending down” their income to specified

levels. The client is responsible to pay for services received before eligibility begins, and Medicaid pays for remaining covered services.

Team Care

A utilization control program designed to educate clients on how to effectively use the Medicaid system. Team Care clients are managed by a “team” consisting of a PASSPORT PCP, one pharmacy, the Nurse First Advice Line, and Montana Medicaid.

Third Party Liability (TPL)

Any entity that is, or may be, liable to pay all or part of the medical cost of care for a Medicaid, MHSP or HMK client.

Timely Filing

Providers must submit clean claims (claims that can be processed without additional information or documentation from or action by the provider) to Medicaid within the latest of

- 12 months from whichever is later:
 - the date of service
 - the date retroactive eligibility or disability is determined
- 6 months from the date on the Medicare explanation of benefits approving the service
- 6 months from the date on an adjustment notice from a third party payor who has previously processed the claim for the same service, and the adjustment notice is dated after the periods described above.

Usual and Customary

The fee that the provider most frequently charges the general public for a service or item.

WINASAP 2003

WINASAP 2003 is a Windows-based electronic claims entry application for Montana Medicaid. This software was developed as an

alternative to submitting claims on paper. For more information contact the EDI Technical Help Desk (see *Key Contacts*).

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