



Audiology Services and Hearing Aid Services

*Medicaid and Other Medical
Assistance Programs*

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My NPI/API:

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Key Contacts

Hours for Key Contacts are 8:00 a.m. to 5:00 p.m. Monday through Friday (Mountain Time), unless otherwise stated. The phone numbers designated “In state” will not work outside Montana.

Claims

Send paper claims to:

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

Direct Deposit Arrangements

Providers who need to enroll in electronic funds transfer (EFT) and electronic remittance advices (RAs) should contact Provider Relations and fax their completed documentation to Provider Relations.

1.800.624.3958 or **406.442.1837**
406.442.4402 Fax

EDI Solutions Help Desk

For questions regarding electronic claims submission:

800.987.6719	In/Out of state
406.442.1837	Helena
406.442.4402	Fax

Send e-mail inquiries to:

MTEDIHelpdesk@xerox.com

Xerox EDI Solutions – Montana
P.O. Box 4936
Helena, MT 59604

Send written inquiries to:

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

Member Eligibility

There are several methods for verifying member eligibility (see below). For additional methods and details on each, see the Member Eligibility and Responsibilities chapter in the *General Information for Providers* manual.

FaxBack

800.714.0075

Integrated Voice Response

800.714.0060

Montana Access to Health

<https://mtaccesstohealth.acs-shc.com/>

Nurse First

For questions regarding the Nurse First Advice Line, 1.800.362.8312, 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

For prior authorization for hearing aids:

DMEPOS Program Officer
Health Resources Division
Medicaid Acute Services Bureau
DPHHS
P.O. Box 202951
Helena, MT 59620-2951

Provider Enrollment

For enrollment changes or questions:

800.624.3958 In/Out of state
406.442.1837 Helena

Send written inquiries to:

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

Provider's Policy Questions

For policy questions or issues:

406.444.5296 DME Program Officer
406.444.2764 Claim Specialist
406.444.1861 Fax

Provider Relations

For questions about eligibility, payments, denials, or Passport.

800.624.3958 In/Out of state
406.442.1837 Helena

Send e-mail inquiries to:

MTPRHelpdesk@xerox.com

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 Program

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/Out of state
406.442.1837 Helena
406.442.0357 Fax

Send written inquiries to:

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

Key Websites	
Web Address	Information Available
EDI Solutions www.acs-gcro.com/	Xerox EDI Solutions (formerly ACS EDI Gateway) is the Xerox clearinghouse. Visit this website for more information on: <ul style="list-style-type: none"> • EDI support • EDI enrollment • Electronic Transaction Instructions for HIPAA 5010 • Manuals • Provider services • Software
Healthy Montana Kids (HMK) www.hmk.mk.mt.gov	<ul style="list-style-type: none"> • Information on HMK.
Montana Medicaid Member Information http://www.dphhs.mt.gov/medicaid/member/	<ul style="list-style-type: none"> • Big Sky Rx • Dental Services • EPSDT • Find a Health Care Provider • Member Guide • Health Improvement Program • Health Insurance Premium Payment • Healthy Montana Kids (HMK) • Home- and Community-Based Waiver Services • My Health Record • Nurse First • Passport to Health • Plan First • Prescription Drug Coverage • Team Care • Transportation Services
Montana Medicaid Provider Information http://medicaidprovider.hhs.mt.gov/ Montana Access to Health Web Portal https://mtaccesstohealth.acs-shc.com/	<ul style="list-style-type: none"> • <i>Claim Jumper</i> newsletters • Electronic billing information • Fee schedules • Forms • Frequently asked questions (FAQs) • Key contacts • Links to other websites • Medicaid news and information • Provider enrollment (web portal) • Provider manuals • Provider notices and manual replacement pages • Remittance advice notices (web portal) • Upcoming events
Secretary of State www.sos.mt.gov Administrative Rules of Montana http://www.mtrules.org/	Secretary of State and Administrative Rules of Montana
Washington Publishing Company www.wpc-edi.com There is a fee for documents; however, code lists are viewable online at no cost.	<ul style="list-style-type: none"> • HIPAA 5010 guides • Code lists

Introduction

Thank you for your willingness to serve members 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 providers of audiology services and hearing aid services. 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/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 inside 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 provider notices and replacement pages. When replacing a page in a paper manual, file the old pages and provider 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 rule references 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.)

The following rules and regulations are specific to the Audiology Services and Hearing Aid Services programs. Additional Medicaid rule references are available in the *General Information for Providers* Manual.

- Administrative Rules of Montana (ARM)
 - ARM 37.86.701–37.86.705 Audiology Services
 - ARM 37.86.801–37.86.805 Hearing Aid Services



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

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.

Getting Questions Answered

The provider manuals are designed to answer most questions; however, questions may arise that require a call to a specific group (such as a program officer, Provider Relations, or a prior authorization unit). The list of Key Contacts at the front of this manual has important phone numbers and addresses pertaining to this manual. The Introduction chapter in the *General Information for Providers* manual also has a list of contacts for specific program policy information. Medicaid provider manuals, provider notices, replacement pages, fee schedules, forms, and more are available on the Provider Information website. (See Key Websites.)

Covered Services

General Coverage Principles

This chapter provides covered services information that applies specifically to services and supplies provided by audiology service and hearing aid providers. Like all health care services received by Medicaid members, services rendered by these providers must also meet the general requirements listed in the Provider Requirements chapter of the *General Information for Providers* manual.

Services Provided by Audiologists

Audiologists must hold a current audiology license issued by the Montana Board of Speech Language Pathologists and Audiologists under Title 37, Montana Codes Annotated, be enrolled as a Montana Medicaid provider and be the provider of the service. If the provider is serving recipients outside Montana, he/she must maintain a current license in the equivalent category under the laws of the state in which the services are provided. Audiology services are hearing aid evaluations and basic audio assessments provided to members with hearing disorders within the scope of service permitted by state law.

Services for Children (ARM 37.86.2201–2221)

Members under age 21 will be evaluated under the well-child Early and Periodic Screening, Diagnosis and Testing (EPSDT) service, which covers all medically necessary services for children under age 21.

Supplier Documentation (ARM 37.86.702)

Audiology services must be referred by a physician or mid-level practitioner. The referral must indicate that an audiological evaluation would be medically appropriate to evaluate the patient's hearing loss. Verbal referrals must be followed up by a written order received by the provider within 30 days. Referrals and orders are valid for Medicaid purposes for no more than 90 days.

Written orders, diagnostic and evaluation reports, and appropriate records that demonstrate compliance with Medicaid requirements, must be current and available upon the request of the Department or its designated representatives at no charge.

The audiologist's written report must document the medical necessity for the service and shall contain the following information:

- The member's name, date of birth, and Medicaid identification number.
- Results of audiometric tests at 500, 1,000, 2,000 and 3,000 Hertz for the right and left ears, and word recognition or speech discrimination scores at levels which ensure pb max.

- A written summary regarding the results of the evaluation indicating, in his or her professional opinion, whether a hearing aid is required, the type of hearing aid (e.g., in-the-ear, behind-the-ear, body amplifier) and whether monaural or binaural aids are requested.
- The audiologist's name, address and license number in typed or preprinted form.
- The audiologist shall sign and date the form.

The audiologist should give a copy of the report to the member to take to the hearing aid dispenser (if the audiologist is not providing the hearing aid). The audiologist retains the original report in the individual's medical file. The hearing aid dispenser will submit the audiologist's report to the Medicaid Program for approval of the hearing aid before dispensing of the aid.

For additional documentation requirements, see the *General Information for Providers* manual, Provider Requirements chapter.

Request for Prior Authorization

Hearing aids require prior authorization, and a Prior Authorization Request form is required to provide supporting documentation for the member's medical indications. The PA column of the Montana Medicaid fee schedule indicates if prior authorization is required. The Prior Authorization Request form is available on the Forms page of the Provider Information [website](#).

Rental/Purchase

Rental of hearing aids is limited to 30 days. Montana Medicaid does not reimburse for a separate dispensing fee on rentals.

Noncovered Services (ARM 37.85.207 and ARM 37.86.205)

Some services not covered by Medicaid include the following:

- Services considered experimental or investigational.
- Services provided to Medicaid members who are absent from the state, with the following exceptions:
 - Medical emergency.
 - Required medical services are not available in Montana. Prior authorization may be required; see the Passport and Prior Authorization chapters in this manual.
 - If the Department has determined that the general practice for members 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 member who is a child residing in another state.

- 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.
- Some able-bodied, employable adults age 21 and older are on Montana's welfare reform project known as FAIM (Families Achieving Independence in Montana). The provider must verify eligibility to determine if these members have **Full** or **Basic** Medicaid. Individuals with Basic are not eligible for audiology or hearing aid services unless the exam is needed for hearing aid services relative to employment reasons. Staff at the local Office of Public Assistance will assist these members in completing the Essential for Employment paperwork to determine if Medicaid may reimburse for the hearing exam and/or hearing aid. All criteria stated in this manual also must be met.
- Warranty fee/replacement fee and/or deductible for replacing a lost hearing aid within the two-year warranty period.

Verifying Coverage

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 and HCPCS Level II coding books. Take care to use the fee schedule and coding books that pertain to the date of service.

Fee schedules are available on the Provider Information [website](#).

Coverage of Specific Services

The following are specific criteria for certain items/services Medicaid covers that are either in addition to Medicare requirements or are services Medicare does not cover.

Basic Audio Assessments and Hearing Aid Evaluations

Basic audio assessments (BAA) must include at a minimum, for each ear, under ear phones in a sound-attenuated room:

- Speech discrimination (word recognition) test under pb max conditions.
- Speech reception thresholds.
- Pure tone air conduction thresholds (at the frequencies of .5, 1, 2, 3, and 4 KHZ).
- Either pure tone bone thresholds at the above frequencies or tympanometry including tympanogram with acoustic reflexes and static compliance.

Hearing aid evaluation (HAE) includes those procedures necessary to determine the acoustic specifications most appropriate for the individual's hearing loss.

Reimbursement for BAA or HAE includes all related supplies and items used in the performance of the assessment or evaluation.

Hearing Aids

For a hearing aid to be covered, the member must be referred by a physician or mid-level practitioner for an audiological exam, and the physician or mid-level practitioner must have determined that a hearing evaluation would be medically appropriate to evaluate the patient's hearing loss.

A hearing aid will be covered if the examination by a licensed audiologist results in a determination that a hearing aid or aids are needed, and either of the following criteria is met:

- For persons age 21 and older, the audiological examination results show that there is an average pure tone hearing loss of at least 40 decibels for each of the frequencies of 500, 1,000, 2,000 and 3,000 Hertz in the better ear and word recognition or speech discrimination scores are obtained at a level to ensure pb max.
- Persons age 20 and under are evaluated under the Well Child Early and Periodic Screening, Diagnosis, and Testing (EPSDT) service. The Department or its designee determines after review of the audiology report that the hearing aid would be appropriate for the person. For more information on the EPSDT program, see the *Physician-Related Services* manual.

Medicaid payment covers the manufacturer's invoice price (excluding warranty charges) of the hearing aid. The invoice must contain the hearing aid model and serial number. Medicaid also will pay a dispensing fee (see the Hearing Aid Fitting section below).

Monaural Hearing Aids

Monaural hearing aids are covered for invoice cost up to \$400.

Binaural Hearing Aids

For coverage of binaural hearing aids for adults ages 21 and older, **all** of the following criteria must be met:

- The two-frequency average at 1 KHZ and 2 KHZ must be greater than 40 decibels in both ears;
- The two-frequency average at 1 KHZ and 2 KHZ must be less than 90 decibels in both ears;
- The two-frequency average at 1 KHZ and 2 KHZ must have an interaural difference of less than 15 decibels;
- The interaural word recognition or speech discrimination score must have a difference of not more than 20%;
- Demonstrated successful use of a monaural hearing aid for at least six (6) months; and
- Documented need to understand speech with a high level of comprehension based on an educational or vocational need.

Binaural hearing aids are covered for invoice cost up to \$800.

Hearing Aid Fitting

The provider may bill Medicaid for a dispensing fee as specified in the fee schedule, in addition to the invoice price for the purchase of the hearing aid or aids. Hearing aid fitting must include either sound field testing in an appropriate acoustic environment or real ear measurements to determine that the hearing aid adequately fits the member's needs. It also must include at least one follow-up visit and warranty coverage for the hearing aid for a period of at least two years.

Hearing Aid Replacement

For members age 21 or over, a hearing aid purchased by Medicaid will be replaced no more than once every five years and only if:

- The original hearing aid has been lost or irreparably broken after the warranty period;
- The provider's records document the loss or broken condition of the original hearing aid; and



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

- The hearing loss criteria specified in this manual continue to be met; or
- The original hearing aid no longer meets the needs of the individual and a new hearing aid is determined to be medical necessary by a licensed audiologist.

Hearing Aid Miscellaneous Codes

When a provider bills with a miscellaneous code, a description of the item is required or payment will be denied.

Other Programs

This is how the information in this manual applies to Department programs other than Medicaid.

Mental Health Services Plan (MHSP)

The information in this manual does not apply to the Mental Health Services Plan (MHSP). For more information on the MHSP program, see the mental health manual available on the Provider Information [website](#). (See Key Websites.)

Healthy Montana Kids (HMK)

The information in this manual does not apply to HMK members. For an HMK medical manual, contact Blue Cross and Blue Shield of Montana at 1.800.447.7828, Extension 8647. Additional information regarding HMK is available on the HMK website. (See Key Websites.)

Passport to Health

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

Passport to Health is the managed care program for Montana Medicaid and Healthy Montana Kids (HMK) *Plus* members. The four Passport programs encourage and support Medicaid and HMK *Plus* members 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* members who are eligible for Passport must enroll in the program (about 70% of Montana Medicaid and HMK *Plus* members are eligible). Each enrollee has a designated Passport provider who is typically a physician, mid-level 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 members. This means he/she provides or coordinates the member's care and makes referrals to other Montana Medicaid and HMK *Plus* providers when necessary. Under Passport, Medicaid and HMK *Plus* members 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, all services to Passport members must be provided or approved by the member's Passport provider or Medicaid/HMK *Plus* will not reimburse for those services. The member's Passport provider is also referred to as the PCP.

Team Care (ARM 37.86.5303)

Team Care is designed to educate members to effectively access medical care. Members with a history of using services at an amount or frequency that is not medically necessary are enrolled in Team Care. Members 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 members can change providers without cause, as often as once a month, Team Care members 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 members is appropriate for the program. A Passport provider receives an enhanced case management fee of \$6 per member per month for Team Care members. When checking Medicaid or HMK *Plus* eligibility on the web portal, a Team Care member's provider and pharmacy will be listed. (See Key Websites.) 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 24/7/365, toll-free, and confidential nurse triage line staffed by licensed registered nurses is available to all Montana Medicaid/HMK *Plus*, and HMK members. There is no charge to members or providers. Members are encouraged to use the Nurse First Advice Line as their first resource when they are sick or hurt. Registered nurses are available 24/7/365 to triage members 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 members calls to be triaged.

Passport providers are encouraged to provide education to their members 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)

The Health Improvement Program (HIP) is for Medicaid and HMK *Plus* members 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 members stay with their PCPs for primary care, but are eligible for case management services through HIP. Nurses and health coaches certified in professional chronic care will conduct health assessments; work with PCPs to develop care plans; educate members in self management and prevention; provide pre- and post-hospital discharge planning; help with local resources; and remind members about scheduling needed screening and medical visits.

Medicaid uses predictive modeling software to identify chronically ill members. This software uses medical claims, pharmacy and demographic information to generate a risk score for each member. Although the software will provide a great deal of information for interventions, it will not identify members who have not received a diagnosis or generated claims. PCPs may also identify and recommend Passport members at high risk for chronic health

conditions that would benefit from case management from HIP using the HIP referral form included under the Health Improvement Program link on the Provider Information [website](#).

In practice, providers will most often encounter Medicaid and HMK *Plus* members who are enrolled in Passport. Specific services may also require prior authorization (PA) even if the member 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 members 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 member'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 members in finding self-referral services (e.g., family planning, mental health services, immunizations and other services).
- Educate members about appropriate use of the 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 member's medical record to a new PCP if requested in writing and authorized by the member.
- 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 members.

- May not discriminate against protected classes or in the selection of Passport members.
- Federal regulation requires you to provide interpreter services to all patients with limited English proficiency.

Providing Passport Referral and Authorization

- Before referring a Passport member to another provider, verify that the provider accepts Medicaid.
- When referring a member to another provider, you must give that provider your Passport number.
- All referrals must be documented in the member'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.

Member Disenrollment

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

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

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

Termination of Passport Agreement

To terminate your Passport agreement, notify Passport to Health in writing at least 30 days before the date of termination. (See Key Contacts.) 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 members. Group practices and clinics may serve up to 1,000 members for each full-time equivalent provider.

Member Eligibility Verification

Member eligibility verification will indicate whether the member is enrolled in Passport. The member's Passport provider and phone number are also available, and whether the member has Full or Basic coverage. To check on a member's eligibility, go to the Montana Access to Health (MATH) web portal on the Provider Information website. (See Key Websites.) Other methods of checking member eligibility can be found in the Member 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 member is enrolled in Passport, most services must be provided or approved by the member's Passport provider. While Passport referral and approval is needed for most medically-necessary services that the member'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 member'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 member'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 member as a Medicaid member and provides a service that requires Passport provider approval without the member'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 member. The provider can bill the member if the member agreed to pay privately before services were rendered (ARM 37.85.406). For details on when providers can bill Medicaid members, see the Billing Procedures chapter.

If a Passport provider refers a member to you, do not refer that member 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 are different, and both may be required for a service. Prior authorization refers to a list of services that require authorization through a Department contractor, Mountain-Pacific Quality Health. See Additional Medicaid Requirements for Passport Members in your *Passport to Health Provider Handbook*, and the Medicaid billing manual for your specific provider type for more information on prior authorization and Passport. The Medicaid Covered Services table in the *General Information for Providers* manual is an overview of services with prior authorization 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 member's home
- Pharmacy
- Psychologists
- Residential treatment centers
- Social workers (licensed)
- Substance dependency treatment
- Targeted case management
- Therapeutic family care
- Transportation (commercial and specialized non-emergency)

Passport and Emergency Services (ARM 37.86.5110)

Passport providers must provide direction to members 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, click the Emergency Services link on the Provider Information [website](#).
- **Post stabilization and Passport.** If inpatient hospitalization is recommended as post-stabilization treatment, the hospital must get a referral from the member'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 for review. (See Key Contacts.) 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

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

Complaints and Grievances

Providers may call Provider Relations 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 member 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 members, 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](#). 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](#). Providers may also call Provider Relations for information on becoming a Passport provider and to get the Passport provider agreement. (See Key Contacts.)

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 member's Passport provider. The solo provider is responsible for managing his/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 member's Passport provider and could be a private group clinic, rural health clinic, federally qualified health center, or Indian Health Services (IHS). All participating providers sign the Passport agreement group signature page and are responsible for managing the caseload. As a group provider, members 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 member's Medicaid eligibility verification at each visit by going to the MATH web portal on the Provider Information [website](#), or by using one of the other methods described in the Member 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 member'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 members and services.
- For claims questions, refer to the Billing Procedures chapter in this manual, or call Provider Relations. (See Key Contacts.)

Other Programs

Members 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 manual.

For more HMK information, contact Blue Cross and Blue Shield of Montana at 1.800.447.7828, Extension 8647. Additional HMK information is available on the HMK website. (See Key Websites.)

Prior Authorization

What Is Prior Authorization? (ARM 37.85.205 and 37.86.5101–5120)

Prior authorization (PA) is another 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 member.

If a service requires PA, the requirement exists for all Medicaid members. When PA is granted, the provider is issued a PA number which must be on the claim.

Prior Authorization (ARM 37.85.410, 37.86.1806)

To ensure federal funding requirements are met, certain items/services are reviewed before delivery to a Medicaid member. These items/services are reviewed for appropriateness based on the member's medical need. In determining medical appropriateness of an item/service, the Department or designated review organization may consider the type or nature of the service, the provider of the service, the setting in which the service is provided and any additional requirements applicable to the specific service or category of service.

If an item/service is considered medically necessary, payment authorization is based on when the request was received for review from the provider, not the delivery of the item/service to the member.

When requesting prior authorization, remember:

- Only Medicaid enrolled providers may request PA for items/services.
- Documentation must support medical necessity.
- Documentation must coincide with other documentation provided by those involved with the member.
- Documentation must be complete, including appropriate signatures and dates.
- member must be eligible for Medicaid.
- Use current correct coding.

To request prior authorization for an item/service:

- Submit a completed Request for Prior Authorization Form.
- Submit a completed Certificate of Medical Necessity.
- Include appropriate supporting documentation with the request. See the PA Criteria table on the next page.
- Fax or mail the request and supporting documentation to the Department. See the PA Criteria table on the next page.

- Upon completion of the review, the member and the requesting provider are notified. The provider receives an authorization number that must be included on the claim. If the requesting provider does not receive the authorization number within 10 business days of being notified of the review approval, the requesting provider may call Provider Relations. (See Key Contacts.)

No prior authorization is required for hearing aid services and supplies or the handling fee for hearing aid repairs or batteries.

PA Criteria		
Covered Service	PA Contact	Requirements
<ul style="list-style-type: none"> • Hearing aid and dispensing fee • Hearing aid for members under 21 years of age 	Health Policy and Services Division Medicaid Services Bureau DPHHS P.O. Box 202951 Helena, MT 59620-2951	Medical necessity documentation must include all of the following: <ul style="list-style-type: none"> • Completed Request for Prior Authorization form. • Completed CMN form. • Supporting documentation, which must include at a minimum: <ul style="list-style-type: none"> • A copy of the physician or mid-level practitioner’s referral • An audiogram • A report from the licensed audiologist

Coordination of Benefits

When Members Have Other Coverage

Medicaid members 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 should bill other carriers before billing Medicaid, but there are some exceptions. (See Exceptions to Billing Third Party First in this chapter.) Medicare is processed differently than other sources of coverage.

Identifying Additional Coverage

The member's Medicaid eligibility verification may identify other payers such as Medicare or other third party payers (TPL). See the *General Information for Providers* manual, Member Eligibility and Responsibilities. If Medicare or other carrier information is known, the Medicare ID number is provided or the carrier is shown on the eligibility information. 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 member's eligibility verification.

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

When a Member Has Medicare

Medicare claims are processed and paid differently than other non-Medicaid claims. The other sources of coverage are called third party liability or TPL, but Medicare is not considered a TPL.

Medicare Part B Crossover Claims

Medicare does not cover hearing aids and exams for fitting hearing aids. Hearing and balance exams to see if medical treatment is needed are covered under Medicare Part B only when ordered by the member's physician. The Department has an agreement with Medicare Part B carrier for Montana and the Durable Medical Equipment Regional Carrier DMERC under which the carriers provide the Department with claims for members who have both Medicare and Medicaid coverage. Providers must tell Medicare that they want their claims sent to Medicaid automatically, and must have their Medicare provider number on file with Medicaid.

When members have both Medicare and Medicaid covered claims, and the provider has made arrangements with both Medicare and Medicaid, Part B services need not be submitted to Medicaid. When a crossover claim is submitted only to Medicare, 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. (See the Billing Procedures chapter in this manual.)

Providers should submit Medicare crossover claims to Medicaid only when:

- The referral to Medicaid statement is missing. In this case, submit a claim and a copy of the Medicare EOMB to Medicaid for processing.
- The referral to Medicaid statement is present, but you do not hear from Medicaid within 45 days of receiving the Medicare EOMB. Submit a claim and a copy of the Medicare EOMB to Medicaid for processing.
- Medicare denies the claim, you may submit the claim to Medicaid with the EOMB and denial explanation (as long as the claim has not automatically crossed over from Medicare).

When submitting electronic claims with paper attachments, see the Billing Electronically with Paper Attachments section in the Submitting a Claim chapter in this manual.

When submitting a claim with the Medicare EOMB, use Medicaid billing instructions and codes. Medicare's instructions, codes, and modifiers may not be the same as Medicaid's. The claim must also include the Medicaid provider number and Medicaid member ID number. 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. (See the Billing Procedures chapter in this manual.)

In order to avoid confusion and paperwork, submit Medicare Part B crossover claims to Medicaid only when necessary.

All Part B Crossover claims submitted to Medicaid before the 45-day response time from Medicare will be returned to the provider.

When a Member Has TPL (ARM 37.85.407)

When a Medicaid member 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.

Providers are required to notify their members that any funds the member receives from third party payers (when the services were billed to Medicaid) must be turned over to the Department. The following words printed on the member's statement will fulfill this obligation: *When services are covered by Medicaid and another source, any payment the member receives from the other source must be turned over to Medicaid.*

Payments can be sent to the Third Party Liability Unit. (See Key Contacts.)

Exceptions to Billing Third Party First

In a few cases, providers may bill Medicaid first:

- When a Medicaid member is also covered by Indian Health Services (IHS) or Crime Victims Compensation, providers must bill Medicaid first. These are not considered a third party liability.
- When a member has Medicaid eligibility and MHSP eligibility for the same month, Medicaid must be billed first.
- 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. Instead, notify the Department of the potential third party by sending the claim and notification to the Third Party Liability Unit. (See Key Contacts.)
- Audiology services, hearing aids and batteries may be billed to Medicaid first.

Requesting an Exemption

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

- When a provider is unable to obtain a valid assignment of benefits, the provider should submit the claim with documentation that the provider attempted to obtain assignment and certification that the attempt was unsuccessful.
- When the provider has billed the third party insurance and has received a non-specific denial (e.g., no member name, date of service, amount billed), submit the claim with a copy of the denial and a letter of explanation.

- 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.
- If another insurance has been billed, and 90 days have passed with no response, submit the claim with a note explaining that the insurance company has been billed (or 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 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 when submitting the claim to Medicaid for processing.
- Allows the claim, and the allowed amount went toward member's deductible, include the insurance Explanation of Benefits (EOB) when billing Medicaid.
- Denies the claim, submit the claim and a copy of the denial (including the reason explanation) to Medicaid.
- Denies a line on the claim, bill the denied line on a separate claim and submit to Medicaid. Include the explanation of benefits (EOB) from the other payer as well as an explanation of the reason for denial (e.g., definition of denial codes).

When the Third Party Does Not Respond

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

- Submit the claim and a note explaining that the insurance company has been billed (or 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 the Third Party Liability Unit. (See Key Contacts.)

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.

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 12 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 12-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 member 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. All problems with claims must be resolved within this 12-month period.

Tips to Avoid Timely Filing Denials

- Correct and resubmit denied claims promptly. (See the Remittance Advices and Adjustments chapter in this manual.)
- If a claim submitted to Medicaid does not appear on the remittance advice within 30 days, contact Provider Relations for claim status. (See Key Contacts.)
- 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.

Usual and Customary Charge (ARM 37.85.406)

Providers should bill Medicaid their usual and customary charge for each service; that is, the same charge that is made to other payers for that service. The amount of the provider’s usual and customary charge may not exceed the reasonable charge usually and customarily charged by the provider to all payers. For more information on reasonable charges, see the How Payment Is Calculated chapter in this manual.

When to Bill Medicaid Members (ARM 37.85.406)

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

More specifically, providers cannot bill members directly:

- For the difference between charges and the amount Medicaid paid.
- For a covered service provided to a Medicaid-enrolled member who was accepted as a Medicaid member 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 member fails to arrive for a scheduled appointment. Medicaid may not be billed for no-show appointments either.
- When services are free to the member, such as in a public health clinic. Medicaid may not be billed for those services either.

Under certain circumstances, providers may need a signed agreement in order to bill a Medicaid member (see the following table).

When to Bill a Medicaid Patient (ARM		
	Patient Is Medicaid-Enrolled and Provider Accepts Patient as a Medicaid Member	Patient Is Medicaid-Enrolled and Provider Does Not Accept Patient as a Medicaid Member
Service is covered by Medicaid	Provider can bill member only for cost sharing	Provider can bill Medicaid member if the member has signed a routine agreement
Service is not covered by Medicaid	Provider can bill member only if custom agreement has been made between member and provider before providing the service	Provider can bill Medicaid member if the member has signed a routine agreement



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

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

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

Member 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 audiology and hearing aid services is \$2.00 per visit. The following members are exempt from cost sharing:

- Members under 21 years of age.
- 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 members who also have Medicare or another insurance are exempt from cost sharing only when the service is allowed by Medicare or paid by the other insurance, and Medicaid is the secondary payer.

A provider cannot deny services to a Medicaid member because the member cannot pay cost sharing fees at the time services are rendered. However, the member's inability to pay cost sharing fees when services are rendered does not lessen the member's obligation. If a provider has a policy on collecting delinquent payment from non-Medicaid members, that same policy may be used for Medicaid members. A provider may sever the relationship with a member who has unpaid cost sharing obligation, as long as a consistent policy is followed with Medicaid and non-Medicaid members. Once the relationship is severed, with prior notice to the member either verbally or in writing, the provider may refuse to serve the member.

When Members Have Other Insurance

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

Billing for Retroactively Eligible Members

When a member becomes retroactively eligible for Medicaid, the provider has 12 months from the date retroactive eligibility was determined to bill for those services. When submitting claims for retroactively eligible members, 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.

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

For more information on retroactive eligibility, see the Member Eligibility and Responsibilities chapter in the *General Information for Providers* manual.

Coding

Standard use of medical coding conventions is required when billing Medicaid. 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 on the following page.

Coding Tips

The following suggestions may help reduce coding errors and unnecessary claim denials:

- Use current CPT, HCPCS Level II, and ICD coding books.
- Always read the complete description and guidelines in the coding books. Relying on short descriptions can result in inappropriate billing.
- Attend classes on coding offered by certified coding specialists.
- Use the correct “units” measurement on CMS-1500 claims. In general, Medicaid follows the definitions in the CPT and HCPCS Level II billing manuals. Always check the long text of the code description.

Miscellaneous/Not Otherwise Specified HCPCS Codes

Most HCPCS Level II coding categories have miscellaneous/not otherwise specified codes. Providers must determine if an alternative HCPCS Level II code better describes the item/service being reported. These codes should only be used if a more specific code is unavailable. Claims containing a miscellaneous/not otherwise specified HCPCS must have one of the following:

- A description of the item/service attached to the claim. (See the Billing Electronically with Paper Attachments section in the Submitting a Claim chapter of this manual.)
- A description of the item included on the claim form directly to the right or below the code used.



Always refer to the long descriptions in coding books.

Failure to include such descriptions will result in the claim being denied.

Claims containing miscellaneous/not otherwise specified HCPCS codes are subject to prepayment review. Review of these claims may result in processing and payment delays. Claim processing staff are dedicated to processing claims as quickly as possible to avoid lengthy delays in payment. Providers must provide clear and complete descriptions of the item/service on the claim line or on an attachment to assist in minimizing delays. For more information on claim status, see the Remittance Advices and Adjustments chapter in this manual.

Prepayment review is not a prior authorization process before delivery of the item and the payment of a claim does not mean that the item/service was reviewed for its necessity and/or appropriateness. Paid claims are subject to retrospective review auditing.

Coding Resources		
The Department does not endorse the products of any particular publisher.		
Resource	Description	Contact
CPT	<ul style="list-style-type: none"> • CPT codes and definitions • Updated each January 	American Medical Association 1.800.621.8335 www.amapress.com/
CPT Assistant	A newsletter on CPT coding issues	American Medical Association 1.800.621.8335 www.amapress.com/
HCPCS Level II	<ul style="list-style-type: none"> • HCPCS Level II codes and definitions • Updated each January and throughout the year 	Available from CMS at www.cms.gov or through various publishers and bookstores.
ICD	<ul style="list-style-type: none"> • ICD diagnosis and procedure codes definitions • Updated each October. 	Available through various publishers and bookstores
Miscellaneous Resources	Various newsletters and other coding resources.	Optum https://www.optumcoding.com
National CCI Policy and Edits Manual	This manual contains National Correct Coding Initiative (NCCI) policy and edits, which are pairs of CPT or HCPCS codes that are not separately payable except under certain circumstances. The edits are applied to services billed by the same provider for the same member on the same date of service.	National Technical Information Services 1.800.363.2068 1.703.605.6060 www.ntis.gov/products/cci.aspx

Using the Medicaid Fee Schedule

When billing Medicaid, it is important to use the Department's fee schedule for your provider type in conjunction with the detailed coding descriptions listed in the current CPT and HCPCS coding books. In addition to covered services and

payment rates, fee schedules often contain helpful information such as appropriate modifiers. Department fee schedules are updated each January and July. Fee schedules are available on the Provider Information [website](#).

Place of Service

Place of service must be entered correctly on each line. (See Appendix B: Place of Services Codes.) Medicaid typically reduces payment for services provided in hospitals and ambulatory surgical centers since these facilities typically bill Medicaid separately for facility charges.

Date of Service

The date of service for hearing aids or repairs is the day the hearing aid or repair is ordered from the manufacturer.

Using Modifiers

- Review the guidelines for using modifiers in the current CPT manual and/or HCPCS book.
- Always read the complete description for each modifier; some modifiers are described in the CPT manual while others are in the HCPCS book.
- The Medicaid claims processing system recognizes only three 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.
- The HCPCS codes for monaural hearing aids require the use of modifiers to identify whether the aid is for the left (LT) or right (RT) ear. Use of the modifiers is mandatory for payment of monaural hearing aids. **Monaural hearing aids billed without the LT or RT modifier will be denied.**

Billings Tips for Specific Services

Hearing Aids

The provider bills for hearing aids using two separate procedure codes: one for the hearing aid and one for the dispensing fee. Valid diagnosis codes are mandatory on hearing aid claims. Providers may contact the physician or mid-level practitioner for the appropriate diagnosis code in a particular case. Also, a copy of the invoice must be attached to the claim. No other attachments are required.

Handling Fee for Repairs

Submit claims for hearing aid repairs with one charge for each service or supply item provided, and one charge for a handling fee.

Batteries

The maximum number of hearing aid batteries is four cells per month per hearing aid. The eight cells per month limit cannot be exceeded unless prior authorization has been received from the Medicaid Services Bureau.

Hearing Aid Rentals

Maximum rental is 30 days. Montana Medicaid does not reimburse for a separate dispensing fee on rentals.

Submitting a Claim

See the Submitting a Claim chapter in this manual for instructions on completing claims forms, submitting paper and electronic claims, and inquiring about a claim.

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
NPI/API missing or invalid	The NPI is a 10-digit number assigned to the provider. (The API is 7 digits.). Verify the correct NPI/API provider number is on the claim.
Authorized signature missing	Each paper claim must have an authorized signature belonging to the provider, billing clerk, or office personnel. The signature may be computer generated, typed, stamped, or hand-written.
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 an electronic professional claim or 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 member: <ul style="list-style-type: none"> • View the member's eligibility information at each visit. Medicaid eligibility may change monthly. • Verify member eligibility by using one of the methods described in the Member Eligibility and Responsibilities chapter of the <i>General Information Providers</i> manual.

Common Billing Errors (Continued)	
Reasons for Return or Denial	How to Prevent Returned or Denied Claims
Duplicate claim	<ul style="list-style-type: none"> • Please 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 the Remittance Advices and Adjustments chapter in this manual.) • Please allow 45 days for the Medicare/Medicaid Part B crossover claim to appear on the RA before submitting the claim directly to Medicaid.
Prior authorization number is missing	<ul style="list-style-type: none"> • Prior authorization (PA) is required for certain services, and the PA number must be on the claim form. (See the Passport and Prior Authorization chapters in this manual.).
TPL on file and no credit amount on claim	<ul style="list-style-type: none"> • If the member has any other insurance (or Medicare), bill the other carrier before Medicaid. See the Coordination of Benefits chapter in this manual. • If the member's TPL coverage has changed, providers must notify the TPL unit before submitting a claim. (See Key Contacts.)
Claim past 365-day filing limit	<ul style="list-style-type: none"> • The Claims Processing Unit must receive all clean claims and adjustments within the timely filing limits described in this chapter. • To ensure timely processing, claims and adjustments must be mailed to Claims Processing at the address shown in the Key Contacts chapter.
Missing Medicare EOMB	All Medicare crossover claims must have an Explanation of Medicare Benefits (EOMB) included. (See Billing Electronically with Paper Attachments in the Submitting a Claim chapter in this manual.)
Provider is not eligible during dates of services, or provider number terminated	<ul style="list-style-type: none"> • Out-of-state providers must update enrollment early to avoid denials. If enrollment has lapsed, claims submitted with a date of service after the expiration date will be denied until the provider updates his or her enrollment. • New providers cannot bill for services provided before Medicaid enrollment begins. • If a provider is terminated from the Medicaid program, claims submitted with a date of service after the termination date will be denied.
Type of service/procedure is not allowed for provider type	<ul style="list-style-type: none"> • Provider is not allowed to perform the service, or type of service is invalid. • Verify the procedure code is correct using current HCPCS and CPT billing manual. • Check the Medicaid fee schedule to verify the procedure code is valid for your provider type.

Submitting a Claim

Electronic Claims

Professional and institutional claims submitted electronically are referred to as ANSI ASC X12N 837 transactions. Providers who submit claims electronically experience fewer errors and quicker payment. Claims may be submitted electronically by the following methods:

- **WINASAP 5010.** This free software is available for providers to create and submit claims to Montana Medicaid, MHSP, and HMK (dental and eyeglasses only) and FQHC/RHC. It does not support submissions to Medicare or other payers, and creates an 837 transaction, but does not accept an 835 transaction back from the Department.
- **Xerox EDI Solutions Clearinghouse.** Providers can send claims to Xerox EDI Solutions (previously ACS EDI Gateway) clearinghouse 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 EDI Solutions. EDIFECS certifies the 837 HIPAA transactions at no cost to the provider. EDIFECS certification is completed through EDI Solutions.
- **Clearinghouse.** Providers can contract with a clearinghouse and send claims to the clearinghouse in whatever format they accept. The provider's clearinghouse then sends the in the X12 837 format. The provider's clearinghouse also needs to have their 837 transactions certified through EDIFECS before submitting claims. EDIFECS certification is completed through EDI Solutions. For information on electronic claims submission, contact Provider Relations. (See Key Contacts.)
- **Montana Access to Health (MATH) web portal.** Providers can upload and download electronic transactions 7 days a week through the web portal. This availability is subject to scheduled and unscheduled host downtime.
- **ACS B2B Gateway SFTP/FTPS site.** Providers can use this method to send electronic transactions through this secure FTP process. This is typically encountered with high volume/high-frequency submitters.
- **ACS MOVEit DMZ.** Providers can use this secure transmission protocol and secure storage landing zone (intermediate storage) for the exchange of files between trading partners and Xerox. Its use is intended for those trading partners/submitters who will be submitting a larger volume of physical files (in excess of 20 per day) or whose physical file sizes regularly exceed 2 MB.

Providers should be familiar with the federal rules and regulations on preparing electronic transactions.

Billing Electronically with Paper Attachments

A copy of the hearing aid invoice must be attached to the claim. No other attachments are required.

When submitting claims that require additional supporting documentation, the Attachment Control Number field must be populated with an identifier. Identifier formats can be designed by software vendors or clearinghouses, but the preferred method is the provider's NPI/API followed by the member's ID number and the date of service, each separated by a dash:

9999999999	-	8888888888	-	11182012
Provider NPI		Member ID		Date of Service (mmdyyy)

The supporting documentation must be submitted with a paperwork attachment cover sheet (located on the Provider Information website). The number in the paper Attachment Control Number field must match the number on the cover sheet.

Paper Claims

The services described in this manual are billed on CMS-1500 claim forms. 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 member has. This chapter includes instructions and a sample claim for each of the following scenarios:

- Member has Medicaid coverage only.
- Member has Medicaid and Medicare coverage.
- Member has Medicaid and third party liability coverage.
- Member has Medicaid, Medicare, and third party liability coverage.
- Member 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 member are indicated by “**”.
- Field 24h, *EPSDT/family planning*, is used as an indicator to specify additional details for certain members or services. The following are accepted codes:

EPSDT/Family Planning Indicators		
Code	Member/Service	Purpose
1	EPSDT	This indicator is used when the member 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 member 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 member	This indicator is used when providing services to nursing facility residents

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

Claim Inquiries

Contact Provider Relations for questions regarding claims, payments, denials, and member eligibility. (See Key Contacts.)

Avoiding Claim Errors

Claims are sometimes denied or returned to the provider before they can be processed. To avoid denials and returns, double-check each claim to confirm it is 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 in this chapter for required fields (indicated by * or **). If a required field is blank, the claim may either be returned or denied.
Member ID number missing or invalid	This is a required field; verify that the member's Medicaid ID number is listed as it appears on the member's eligibility information.
Member name missing	This is a required field (field 2); check that it is correct.
Provider's Medicaid number missing or invalid	The provider number is a 10-digit number. (API is 7 digits.) Verify the correct NPI/API is on the claim.
Prior authorization number missing	When prior authorization (PA) is required for a service, the PA number must be listed on the claim in field 63.
Not enough information regarding other coverage	Fields 1a and 11d are required fields when a member has other coverage. (Refer to the examples 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 typed, computer generated, stamped, or hand-written.
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.
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 included with the claim or it will be denied.

Member Has Medicaid Coverage Only

Field	Field Title	Instructions
Member Information		
2*	Patient's Name	Enter patient's name as seen on the Montana Health Care Programs information
10d*	Reserved for Local Use	If member's ID is not located in 10d, these three fields are searched for the number.
1a, 9a, 11**	Insured's ID number	Enter the insured's ID number as it appears on the member's Montana Health Care Programs information.
Provider Information		
17a**	Untitled	Enter referring provider's Passport number if a Passport member (a qualifier is not necessary).
17b**	NPI	Enter referring provider's NPI.
24a shaded area	NDC	Enter Qualifier N4 followed by the NDC, units qualifier, and units as described by the qualifier.
24i shaded**	ID Qualifier	ZZ for the taxonomy qualifier.
24j shaded**	Untitled	Enter the taxonomy code for the rendering provider.
24j **	Untitled	Enter NPI for the rendering provider.
31*	Signature of Physician or Supplier, and Date	Enter signature of physician or supplier including credentials and date.
33*	Billing Provider Info and Phone	Enter physical address with a 4+ZIP code and phone number.
33a*	NPI	Enter NPI for billing/pay-to provider.
33b*	Untitled	Enter Qualifier ZZ and the billing provider's taxonomy code.
Billing Information		
21.1–21.4*	Diagnosis or Nature of Illness or Injury	Enter at least one diagnosis code.
24A*	Date(s) of Service	Enter the dates of service; include beginning and ending date even if same.
24B*	Place of Service	Enter the code for place of service.
24C**	EMG	Emergency indicator if applicable.
24D*	Procedures, Services, or Supplies	Enter the procedure code used; enter modifiers if applicable.
24E*	Diagnosis Pointer	Enter the corresponding diagnosis pointer (1, 2, 3, or 4) that refers to the codes in Field 21
24F*	Charges	Enter the line item charge.
24G*	Days or Units	Enter the days or units used for the procedure.
28*	Total Charge	Enter total charges from all line items.

* = Required Field ** = Required, if applicable

Member Has Medicaid Coverage Only

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input checked="" type="checkbox"/> (Medicaid #) TRICARE <input type="checkbox"/> 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) 999999999					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Rhoades, Rocky					3. PATIENT'S BIRTH DATE MM DD YY SEX 08 19 95 M			4. INSURED'S NAME (Last Name, First Name, Middle Initial)							
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"/>			7. INSURED'S ADDRESS (No., Street)							
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) 555-5555			9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					ZIP CODE		TELEPHONE (Include Area Code) ()			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			11. INSURED'S POLICY GROUP OR FECA NUMBER							
a. OTHER INSURED'S POLICY OR GROUP NUMBER					b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> PLACE (State)			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"/>					c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			b. EMPLOYER'S NAME OR SCHOOL NAME							
c. EMPLOYER'S NAME OR SCHOOL NAME					10d. RESERVED FOR LOCAL USE			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? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> If yes, return to and complete item 9 a-d.							
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.					
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 _____					
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 Great Gazoo, M.D.					17a. NPI			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY							
19. RESERVED FOR LOCAL USE					17b. NPI			20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> \$ CHARGES							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.					
1. _____ 3. _____										23. PRIOR AUTHORIZATION NUMBER					
2. _____ 4. _____										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/HCCPS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSTD Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #					
1 10 14 12 10 14 12 11 92585 26 1 148 00 1 NPI ZZ 36LP000X 1234567890															
2 _____ NPI															
3 _____ NPI															
4 _____ NPI															
5 _____ NPI															
6 _____ NPI															
25. FEDERAL TAX I.D. NUMBER SSN EIN <input checked="" type="checkbox"/>					26. PATIENT'S ACCOUNT NO. 99999			27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		28. TOTAL CHARGE \$		29. AMOUNT PAID \$		30. BALANCE DUE \$	
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.) Mary Bender 08/02/13					32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.			33. BILLING PROVIDER INFO & PH # (406)555-5555 Hometown Audiology P.O. Box 999 Anytown, MT 59999-9999							
SIGNED _____ DATE _____					a. _____ b.			a. 0000099999 b. ZZ 400RT001X							

Member Has Medicaid and Medicare Coverage

Field	Field Title	Instructions
Member Information		
1a*	Insured's ID Number	Enter the member's Medicare ID number.
2*	Patient's Name	Enter patient's name as seen on member's Montana Health Care Programs information.
10d*	Reserved for Local Use	If member's ID is not located in 10d, these fields are searched for the number.
11d*	Is There Another Health Benefit Plan?	Check No.
9a, 11**	Insured's ID Number	Enter the insured's ID number as it appears on the member's Montana Health Care Programs information.
Provider Information		
17a**	Untitled	Enter referring provider's Passport number if a Passport member (a qualifier is not necessary).
17b**	NPI	Enter referring provider's NPI.
24A shaded area	NDC	Enter Qualifier N4 followed by the NDC, units qualifier, and units as described by the qualifier.
24I shaded**	Untitled	Enter Qualifier ZZ for the taxonomy qualifier.
24J shaded**	Untitled	Enter the taxonomy code for the rendering provider.
24J **	Rendering Provider NPI	Enter NPI for the rendering provider.
31*	Signature of Physician or Supplier, and Date	Enter signature of physician or supplier including credentials and date
33*	Billing Provider Info and Phone	Enter physical address with a 9-digit ZIP code and phone number.
33a*	NPI	Enter NPI for billing/pay-to provider.
33b*	Untitled	Enter Qualifier ZZ and the billing provider's taxonomy code.
Billing Information		
21.1–21.4*	Diagnosis or Nature of Illness or Injury	Enter at least one diagnosis.
24A*	Date(s) of Service	Enter the dates of service; include beginning and ending date even if same.
24B*	Place of Service	Enter the code for place of service.
24C**	EMG	Emergency indicator if applicable.
24D*	Procedures, Services or Supplies	Enter the procedure code used; enter modifiers if applicable.
24E*	Diagnosis Pointer	Enter the corresponding diagnosis pointer (1, 2, 3, or 4) that refers to the codes in Field 21.
24F*	Charges	Enter the line item charge.
24G*	Days or Units	Enter the days or units used for the procedure.
28*	Total Charge	Enter total charges from all line items.
24J shaded**	Untitled	Enter the taxonomy code for the rendering provider.

* = Required Field ** = Required, if applicable

Member Has Medicaid and Medicare Coverage

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA PICA											
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) Frost, Joe					3. PATIENT'S BIRTH DATE MM DD YY M <input checked="" type="checkbox"/> F <input type="checkbox"/> 04 27 96		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 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"/>						
ZIP CODE 59999		TELEPHONE (Include Area Code) (406 555-9999)			9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						
9a. OTHER INSURED'S POLICY OR GROUP NUMBER					10. IS PATIENT'S CONDITION RELATED TO:						
9b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>					10a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						
9c. EMPLOYER'S NAME OR SCHOOL NAME					10b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						
9d. INSURANCE PLAN NAME OR PROGRAM NAME					10c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						
10d. RESERVED FOR LOCAL USE 999999999					11. INSURED'S POLICY GROUP OR FECA NUMBER						
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. 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: MM DD YY			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 _____		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						
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 389.9					22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.						
2. _____ 3. _____ 4. _____					23. PRIOR AUTHORIZATION NUMBER						
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. ICD-9-CM Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 10 15 12 10 15 12 11		92556	1		50.00	1	50.00	1	1		
2 _____											
3 _____											
4 _____											
5 _____											
6 _____											
25. FEDERAL TAX I.D. NUMBER 99-9999999			SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. 99999999ABC		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 50.00	29. AMOUNT PAID \$ _____	30. BALANCE DUE \$ 50.00
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.) _____ Mary Bender 08/02/13					32. SERVICE FACILITY LOCATION INFORMATION a. NPI		33. BILLING PROVIDER INFO & PH # Hometown Audiology P.O. Box 999 Anytown, MT 59999				
SIGNED _____ DATE _____					b. _____		a. NPI	b. _____			

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Member Has Medicaid and Third Party Liability Coverage

Field	Field Title	Instructions
Member Information		
1a**	Insured's ID Number	Enter the member's Medicare ID number
2*	Patient's Name	Enter patient's name as seen on member's Montana Health Care Programs information
10d*	Reserved for Local Use	If member's ID is not located in 10d, these fields are searched for the number.
11*	Insured's Policy Group	Enter the member's primary payer (TPL) ID number
11c*	Insurance Plan/Program	Enter the name of the primary payer
11d*	Is There Another Health Benefit Plan?	Check Yes.
Provider Information		
17a**	Untitled	Enter referring provider's Passport number if a Passport member (a qualifier is not necessary).
17b**	NPI	Enter referring provider's NPI.
24A shaded area	NDC	Enter Qualifier N4 followed by the NDC, units qualifier, and units as described by the qualifier.
24I shaded**	ID Qualifier	Enter Qualifier ZZ for the taxonomy qualifier.
24J shaded**	Untitled	Enter the taxonomy code for the rendering provider
24J**	Rendering Provider NPI	Enter NPI for the rendering provider.
31*	Signature and Date	Enter Signature and Date.
33*	Billing Provider Info	Enter Physical Address with a 9 digit ZIP code and phone number.
33a*	NPI	Enter NPI number for billing/pay-to provider.
33b*	Taxonomy Code	Enter Qualifier ZZ and the billing provider's taxonomy code.
Billing Information		
21.1–21.4*	Diagnosis or Nature of Illness or Injury	Enter at least one diagnosis.
24A*	Date(s) of Service	Enter the dates of service; include beginning and ending date even if same.
24B*	Place of Service	Enter the code for place of service.
24C**	EMG	Enter emergency indicator if applicable.
24D*	Procedures, Services or Supplies	Enter the procedure code used; enter modifiers if applicable.
24E*	Diagnosis Pointer	Enter the corresponding diagnosis pointer (1, 2, 3, or 4) that refers to the codes in Field 21.
24F*	Charges	Enter the line item charge.
24G*	Days or Units	Enter the days or units used for the procedure.
28*	Total Charge	Enter total charges from all line items.
24J shaded**	Untitled	Enter the taxonomy code for the rendering provider.
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).

* = Required Field ** = Required, if applicable

Member Has Medicaid and TPL

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA <input type="checkbox"/>														
1. MEDICARE <input type="checkbox"/> (Medicare #) <input checked="" type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> (Medicaid #) <input type="checkbox"/> TRICARE CHAMPUS <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> CHAMPVA <input type="checkbox"/> (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/> (ID) <input type="checkbox"/>					1a. INSURED'S I.D. NUMBER (For Program in Item 1) 999999999B									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Frost, Joe					3. PATIENT'S BIRTH DATE MM DD YY 04 27 96 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		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			9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO: Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>			11. INSURED'S POLICY GROUP OR FECA NUMBER 999999999B			
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 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 checked="" type="checkbox"/> NO					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				
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE 999999999					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>				
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.				
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 _____				
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				
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE					17a. _____ 17b. NPI _____					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION 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					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)										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.				
1. 389 11										23. PRIOR AUTHORIZATION NUMBER				
2. _____										24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY				
3. _____										B. PLACE OF SERVICE				
4. _____										C. EMG				
5. _____										D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER				
6. _____										E. DIAGNOSIS POINTER				
7. _____										F. \$ CHARGES				
8. _____										G. DAYS OR UNITS				
9. _____										H. EFSPT Family Plan				
10. _____										I. ID. QUAL.				
11. _____										J. RENDERING PROVIDER ID. #				
12. _____										13. _____				
14. _____										15. _____				
16. _____										17. _____				
18. _____										19. _____				
19. _____										20. _____				
20. _____										21. _____				
21. _____										22. _____				
22. _____										23. _____				
23. _____										24. _____				
24. _____										25. _____				
25. FEDERAL TAX I.D. NUMBER 99-9999999 SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>										26. PATIENT'S ACCOUNT NO. 999999999ABC				
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$ 10.00				
29. AMOUNT PAID \$ 5.00										30. BALANCE DUE \$ 5.00				
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.) <i>Mary Bender</i> 08/02/13										32. SERVICE FACILITY LOCATION INFORMATION a. NPI b. _____				
SIGNED _____ DATE _____										33. BILLING PROVIDER INFO & PH # (406) 999-9999 Hometown Hearing Aids P.O. Box 999 Anytown, MT 59999				

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Member Has Medicaid, Medicare, and Third Party Liability

Field	Field Title	Instructions
Member Information		
1a**	Insured's ID Number	Enter the member's Medicare ID number
2*	Patient's Name	Enter patient's name as seen on member's Montana Health Care Programs information
10d*	Reserved for Local Use	If member's ID is not located in 10d, these fields are searched for the number.
11*	Insured's Policy Group	Enter the member's primary payer (TPL) ID number
11c*	Insurance Plan/Program	Enter the name of the primary payer
11d*	Is There Another Health Benefit Plan?	Check Yes.
Provider Information		
17a**	Untitled	Enter referring provider's Passport number if a Passport member (a qualifier is not necessary).
17b**	NPI	Enter referring provider's NPI.
24A shaded area	NDC	Enter Qualifier N4 followed by the NDC, units qualifier, and units as described by the qualifier.
24I shaded**	ID Qualifier	Enter Qualifier ZZ for the taxonomy qualifier.
24J shaded**	Untitled	Enter the taxonomy code for the rendering provider
24J**	Rendering Provider NPI	Enter NPI for the rendering provider.
31*	Signature and Date	Enter Signature and Date.
33*	Billing Provider Info	Enter Physical Address with a 9 digit ZIP code and phone number.
33a*	NPI	Enter NPI number for billing/pay-to provider.
33b*	Taxonomy Code	Enter Qualifier ZZ and the billing provider's taxonomy code.
Billing Information		
21.1–21.4*	Diagnosis or Nature of Illness or Injury	Enter at least one diagnosis.
24A*	Date(s) of Service	Enter the dates of service; include beginning and ending date even if same.
24B*	Place of Service	Enter the code for place of service.
24C**	EMG	Enter emergency indicator if applicable.
24D*	Procedures, Services or Supplies	Enter the procedure code used; enter modifiers if applicable.
24E*	Diagnosis Pointer	Enter the corresponding diagnosis pointer (1, 2, 3, or 4) that refers to the codes in Field 21.
24F*	Charges	Enter the line item charge.
24G*	Days or Units	Enter the days or units used for the procedure.
28*	Total Charge	Enter total charges from all line items.
24J shaded**	Untitled	Enter the taxonomy code for the rendering provider.
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).

* = Required Field ** = Required, if applicable

Member Has Medicaid, Medicare, and TPL

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

<input type="checkbox"/> PICA		PICA <input type="checkbox"/>					
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> (Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)				1a. INSURED'S I.D. NUMBER (For Program in Item 1) 999999999			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, John				3. PATIENT'S BIRTH DATE MM DD YY SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/> 09 20 97			
5. PATIENT'S ADDRESS (No., Street) 98765 Anystreet #2				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		CITY		STATE	
ZIP CODE 59999		TELEPHONE (Include Area Code) (406) 999-9999		ZIP CODE		TELEPHONE (Include Area Code) ()	
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 999999999A			
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			
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. RESERVED FOR LOCAL USE 999999999			
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				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 _____			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. V72.1				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				23. PRIOR AUTHORIZATION NUMBER			
10 12 12 10 12 12 11 92587 26 1				F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. # 45 00 1 NPI			
25. FEDERAL TAX I.D. NUMBER SSN EIN 99-9999999 <input type="checkbox"/> <input checked="" type="checkbox"/>				26. PATIENT'S ACCOUNT NO. 999999999ABC		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
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.) <i>Mary Bender</i> 08/02/13				32. SERVICE FACILITY LOCATION INFORMATION a. NPI b. _____		28. TOTAL CHARGE \$ 45.00 29. AMOUNT PAID \$ 30.00 30. BALANCE DUE \$ 15.00	
33. BILLING PROVIDER INFO & PH # (406) 999-9999 Hometown Audiology P.O. Box 999 Anytown, MT 59999				a. NPI b. _____			

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Member has Medicaid, Medicare, and Medicare Supplement

Field	Field Title	Instructions
Member Information		
1a**	Insured's ID Number	Enter the member's Medicare ID number
2*	Patient's Name	Enter patient's name as seen on member's Montana Health Care Programs information
10d*	Reserved for Local Use	If the member's ID is not located in 10d, these fields are searched for the number.
11*	Insured's Policy Group	Enter the member's ID number for the primary payer.
11c*	Insurance Plan or Program	Enter the name of the other insurance plan or program (e.g., Blue Cross and Blue Shield, New West)
11d*	Is There Another Health Benefit Plan?	Check Yes.
Provider Information		
17a**	Untitled	Enter referring provider's Passport number if a Passport member (a qualifier is not necessary).
17b **	NPI	Enter referring provider's NPI.
24A shaded area	NDC	Enter Qualifier N4 followed by the NDC, units qualifier, and units as described by the qualifier
24I shaded**	ID Qualifier	ZZ for the taxonomy qualifier
24J shaded**	Untitled	Enter the taxonomy code for the rendering provider.
24J**	Rendering Provider NPI	Enter NPI for the rendering provider.
31*	Signature of Physician or Supplier, and Date	Enter signature and date.
33*	Billing Provider Info and Phone	Enter physical address with a 9-digit ZIP code and phone number.
33a*	NPI	Enter NPI for billing/pay-to provider.
33b*	Untitled	Enter Qualifier ZZ and the billing provider's taxonomy code.
Billing Information		
21.1–21.4*	Diagnosis or Nature of Illness or Injury	Enter at least one diagnosis.
24A*	Date(s) of Service	Enter the dates of service; include begin and ending date even if same.
24B*	Place of Service	Enter the code for place of service.
24C**	EMG	Emergency indicator if applicable
24D*	Procedure Code	Enter the procedure code used/Enter modifiers if applicable.
24E*	Diagnosis Pointer	Enter the corresponding diagnosis pointer (1, 2, 3, or 4) that refers to the codes in Field 21.
24F*	Charges	Enter the line item charge.
24G*	Days or Units	Enter the days or units used for the procedure.
28*	Total Charges	Enter total charges from all line items.
24J shaded**	Untitled	Enter the taxonomy code for the rendering provider.
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 Medicare EOMB attached to the claim.
30*	Balance Due	Enter the balance due (amount in Field 28 less the amount in Field 29).

* = Required Field ** = Required, if applicable

Member Has Medicaid, Medicare, and Medicare Supplement

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 #) <input checked="" type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> (Medicaid #) <input type="checkbox"/> TRICARE CHAMPUS <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> CHAMPVA <input type="checkbox"/> (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/> (ID) <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 999999999																			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, John										3. PATIENT'S BIRTH DATE MM DD YY SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/> 09 20 97										4. INSURED'S NAME (Last Name, First Name, Middle Initial) Same									
5. PATIENT'S ADDRESS (No., Street) 98765 Anystreet #2										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					CITY					STATE														
ZIP CODE 59999					TELEPHONE (Include Area Code) (406) 999-9999					ZIP CODE					TELEPHONE (Include Area Code) () ()														
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 10d. RESERVED FOR LOCAL USE 999999999										11. INSURED'S POLICY GROUP OR FECA NUMBER 999999999A a. 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. INSURANCE PLAN NAME OR PROGRAM NAME 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>									
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: 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 _____										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. 23. PRIOR AUTHORIZATION NUMBER									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. V72.1										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. #																			
10 12 12 10 12 12 11 92587 26 1 45 00 1 NPI										25. FEDERAL TAX I.D. NUMBER SSN EIN 99-9999999 <input type="checkbox"/> <input checked="" type="checkbox"/> 26. PATIENT'S ACCOUNT NO. 999999999ABC 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO 28. TOTAL CHARGE \$ 45.00 29. AMOUNT PAID \$ 30.00 30. BALANCE DUE \$ 15.00																			
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.) <i>Mary Bender</i> 08/02/13										32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.										33. BILLING PROVIDER INFO & PH # (406) 999-9999 Hometown Audiology P.O. Box 999 Anytown, MT 59999									
SIGNED _____ DATE _____										a. NPI b.										a. NPI b.									

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CMS-1500 Agreement

This form is subject to change by the Centers for Medicare and Medicaid Services (CMS).

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101; 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, "Carrier Medicare Claims Record," published in the [Federal Register](#), Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," [Federal Register](#) Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and routine documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0999. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

Remittance Advices and Adjustments

The Remittance Advice

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 RA cycle. Providers are paid weekly. Each line of the RA represents all or part of a claim, and explains whether the claim or service has been paid, denied, or suspended (also referred to as pending). If the claim was suspended or denied, the RA also shows the reason.

Providers who enrolled in Montana Health Care Programs after July 2013, were required to enroll in electronic funds transfer (EFT) and register to receive electronic RAs. Existing providers who receive paper checks or paper RAs will be being transitioned to the electronic-only system effective January 1, 2014.

To enrollment in electronic funds transfer (also known as direct deposit), providers must complete the Direct Deposit form available on the Forms page of the Provider Information [website](#).

To receive electronic RAs, providers must have Internet access, complete the EDI Trading Partner Agreement, and register for the Montana Access to Health web portal. Providers access RAs through the MATH web portal.

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

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; however, 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.

After enrollment, providers receive a user ID and password to log on to the MATH web portal.



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



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

Sections of the RA

RA Notice

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

Paid Claims

This section shows claims paid and any claims paid with denied lines 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 requiring the provider to return the overpayment plus interest. If a claim was paid at the wrong amount or with incorrect information, the claim must be adjusted.

Denied Claims

This section shows claims denied during the previous cycle. If a claim has been denied, refer to the Reason/Remark column. The reason and remark code description explains why the claim was denied and is located at the end of the RA.

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. The Reason/Remark Code description located at the end of the RA explains why the claim is suspended. **This section is informational only. Do not take any action on claims displayed here.** Processing will continue until each claim is paid or denied.

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 member 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 NPI/API was billed. If the ID number was incorrect, resubmit the claim with the correct ID number.

Credit Balance Claims

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:

- 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.
- 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. Attach a note stating that the check is to pay off a credit balance and include your provider number. Send the check to the attention of Third Party Liability Unit in the Key Contacts chapter.

Gross Adjustments

Any gross adjustments performed during the previous cycle are shown here.

Reason and Remark Code Description

This section lists the reason and remark codes that appear throughout the RA with a brief description of each.

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.

Rebilling Medicaid

Rebilling occurs 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 the NPI/API, authorized signature, or date are missing or unreadable. For tips on preventing returned or denied claims, see the Billing Procedures chapter in this manual.

Timeframe for Rebilling or Adjusting a Claim

- Providers may resubmit, modify, or adjust any initial claim within the timely filing limits described in the Billing Procedures chapter.
- The 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 Provider Relations to complete a gross adjustment.

When to Rebill Medicaid

- ***Claim Denied.*** Providers may rebill Medicaid when a claim is denied. Check the reason and remark codes, make the appropriate corrections and resubmit the claim (do not use the adjustment form).



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 the Billing Procedures chapter.)



Rebill denied claims only after appropriate corrections have been made.

- **Line Denied.** When an individual line is denied on a multiple-line claim, correct any errors and rebill Medicaid. An adjustment form should be used for claims with denied lines that have codes that must be billed together. (See Adjustments.)
- **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 the claim.

How to Rebill

- Check any reason and remark code listed and make corrections on a copy of the claim, or produce a new claim with the correct information.
- When making corrections on a copy of the claim, remember to line out or omit all lines that have already been paid.
- Submit insurance information with the corrected claim.

Adjustments

If a provider believes that a claim has been paid incorrectly, the provider may call Provider Relations or submit a claim inquiry for review. (See Key Contacts.) Once an incorrect payment has been verified, the provider should submit an [Individual Adjustment Request form](#) to Provider Relations. If incorrect payment was the result of a Xerox 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 digit will be a 2, indicating an adjustment. Adjustments are processed in the same time frame as claims.

When to Request an Adjustment

- Request an adjustment when the claim was overpaid or underpaid.
- Request an adjustment when the claim was paid but the information on the claim was incorrect (e.g., member ID, provider number, date of service, procedure code, diagnoses, units, etc.).

How to Request an Adjustment

To request an adjustment, use the Individual Adjustment Request form on the website. The requirements for adjusting a claim are:

- Adjustments can be submitted only on paid claims; denied claims cannot be adjusted.
- Claims Processing must receive individual claim adjustments within 12 months from the date of service. (See Timely Filing in the Billing Procedures chapter of this manual.) After this time, *gross adjustments* are required. (See the Definitions chapter.)
- 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.

Completing an Adjustment Request Form

1. Download the Individual Adjustment Request form from the Provider Information website. Complete Section A first with provider and member information and the claim’s ICN number. (See the table entitled Completing an Individual Adjustment Request Form.)
2. Complete Section B with information about the claim. Fill in only the items that need to be corrected.

- 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.



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 Provider Relations at 1.800.624.3958 (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 and Address	3. Internal Control Number (ICN)		
Hometown Audiology	00404011250000600		
Name	4. NPI/API		
P.O. Box 999	1234567		
Street or P.O. Box	5. Member ID Number		
Anytown, MT 59999	123456789		
City State ZIP	6. Date of Payment		
2. Member Name	10/01/12		
Jane Doe	7. Amount of Payment		
	\$ 180.00		

B. Complete only the items which need to be corrected.			
Item	Date of Service or Line Number	Information on Statement	Corrected Information
1. Units of Service	Line 2	2	1
2. Procedure Code/NDC/Revenue Code			
3. Dates of Service (DOS)	Line 3	09/01/05	09/15/05
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 Mary Bender Date 10/15/12

When the form is complete, attach a copy of the RA and a copy of the corrected claim, and mail to:
 Claims
 P.O. Box 8000
 Helena, MT 59604

Updated 03/2013

3. Attach copies of the RA and a corrected claim if necessary.
 - If the original claim was billed electronically, a copy of the RA will do.
 - If the RA is electronic, attach a screen print of the RA.
4. Verify the adjustment request has been signed and dated.
5. Send the adjustment request to Provider Relations. (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 from the provider. This can be done in two ways: by the provider issuing a check to the Department, or by maintaining a credit balance until it has been satisfied with future claims. (See Credit Balance in this chapter.)
- Questions regarding claims or adjustments should be directed to Provider Relations. (See [Key Contacts](#).)

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 member's name.
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.
5.* Recipient Medicaid number	Member's Medicaid ID number.
6. Date of Payment	Date claim was paid found on Remittance Advice.
7. Amount of Payment	The amount of payment from the Remittance Advice.
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 are incorrect, complete this line.
3. Dates of Service (DOS)	If the date of service is incorrect, complete this line.
4. Billed Amount	If the billed amount is incorrect, complete this line.
5. Personal Resource (Nursing Home)	If the member's personal resource amount is incorrect, complete this line.
6. Insurance Credit Amount	If the member'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 TPL 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

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), the monthly *Claim Jumper*, or provider notices. Mass adjustment claims shown on the RA have an ICN that begins with a 4.

Payment and the RA

As of July 2013, new providers were required to register for payment via electronic funds transfer (EFT) and electronic remittance advice (RAs). Existing providers who receive paper checks or paper RAs are being transitioned over time.

Direct deposit is another name for EFT.

With EFT, the Department deposits the funds directly to the provider's bank account. If the scheduled deposit day is a holiday, funds and the RA will be available on the next business day.

To participate in EFT, providers must complete a Direct Deposit Sign-Up Form (Standard Form 1199A). 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. Contact Provider Relations for instructions enrolling for EFT and electronic RAs.

Required Forms for EFT and/or Electronic RA			
Form	Purpose	Where to Get	Where to Send
Direct Deposit Sign-up Form Standard Form 1199A	Allows the Department to automatically deposit Medicaid payment into provider's bank account	• Provider Information website. See Key Contacts.	Provider Relations
EDI Trading Partner Agreement	Allows 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)	• Provider Information website.	Fax to 406.442.4402.

How Payment Is Calculated

Overview

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

The RBRVS Fee Schedule

Most services by provider types covered in this manual are reimbursed for using the Department’s Resource-Based Relative Value Scale (RBRVS). The fee schedule includes several thousand CPT codes and HCPCS Level II codes. Within the CPT coding structure, only anesthesia services (00100–01999) and clinical lab services (almost the entire 80000–89999 range) are not reimbursed for using the RBRVS fee schedule.

RBRVS was developed for the Medicare program, which first implemented it in 1992. Medicare does a major update annually, with smaller updates performed quarterly. Montana Medicaid implemented its RBRVS-based fee schedule in 1997. It is based largely on the Medicare model, with a few differences that will be described below. By adapting the Medicare model to the needs of the Montana Medicaid program, the Department was able to take advantage of the research performed by the federal government and national associations of physicians and other health care professionals. RBRVS-based payment methods are widely used across the U.S. by Medicaid programs, Blue Cross and Blue Shield Plans, workers’ compensation plans and commercial insurers.



Many Medicaid payment methods are based on Medicare, but there are differences. In these cases, the Medicaid method prevails.

Fee Calculation

Each fee is the product of a relative value times a conversion factor.

Basis of Relative Values

For almost all services, Medicaid uses the same relative values as Medicare in Montana. Nationally, Medicare adjusts the relative values for differences in practice costs between localities, but Montana is considered a single locality. For fewer than 1% of codes, relative values are not available from Medicare. For these codes, the Department has set the relative values .

When Medicaid payment differs from the fee schedule, consider the following:

- The Department pays the lower of the established Medicaid fee or the provider’s charge.
- Modifiers (see *Other Modifiers* in this chapter).
- Provider type (see *Professional Differentials* in this chapter).
- Place of service (see *Site of Service Differential* in this chapter).
- Date of service (fees for services may change over time).
- Also check for cost sharing and Medicare or TPL payments which will be shown on the RA.

Composition of Relative Values

For each code, the relative value is the sum of a relative value for the work effort (including time, stress, and difficulty), the associated transitional practice expense, and the associated malpractice expense.

Site of Service Differential

The Medicare program has calculated two sets of relative values for each code: one reflects the practitioner's practice cost of performing the service in an office and one reflects the practitioner's practice cost of performing the service in a facility.

Medicaid typically pays a lower fee if the service is provided in a facility because Medicaid typically also pays the facility.

Conversion Factor

The Department sets the conversion factor for the state fiscal year (July through June) and it is listed on the fee schedule.

Policy Adjuster

To encourage access to maternity services and family planning services, the Department increases fees for these codes using a policy adjuster that increases the fee. The fee listed on the fee schedule includes the policy adjuster.

Global Periods

For many surgical services and maternity services, the fee covers both the service and all related care within a specified "global" period. For almost all such codes, the global periods used by Medicaid are identical to those used by Medicare, but in cases of differences the Medicaid policy applies. See the Billing Procedures chapter in this manual for more information on global periods.

Professional and Technical Components

Many imaging services as well as some other diagnostic services are divided into the technical component (performing the test) and the professional component (interpreting the test). A practitioner who only performs the test would bill the service with modifier TC; a practitioner who only interprets the test would bill modifier 26; and a practitioner who performs both components would bill the code without a modifier. Performance of both components is called the global service. The fee schedule has separate fees for each component and for the global service.

Other Modifiers

Under the RBRVS fee schedule, certain other modifiers also affect payment. Modifiers affecting reimbursement are listed in the table on the next page.



Providers must take extra care in billing codes that have global periods or are divided into technical and professional components.

Payment for Audiology Services

Medicaid payment for audiology services will be the lower of the provider's usual and customary charge for the service or 100% of the published RBRVS fee schedule.

Payment for Hearing Aid Services

Medicaid payment for covered hearing aid services and items will be the lower of the provider's usual and customary charge for the service or item, the submitted price on the invoice, or the Department's fee schedule.

How Cost Sharing Is Calculated on Medicaid Claims

Member cost sharing for services provided by audiology services and hearing aid services providers is \$2.00/day per visit. The member's cost sharing amount is shown on the remittance advice and deducted from the Medicaid allowed amount. (See the Remittance Advices and Adjustments chapter in this manual). For example, an audiology services provider supplies a Medicaid member with air and bone audiometry (92553). The Medicaid allowed amount in July 2013 for this item is \$26.57. The member owes the provider \$2.00 for cost sharing, and Medicaid would pay the provider the remaining \$24.57.

How Payment Is Calculated on TPL Claims

When a member 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. For example, a Medicaid member who also has insurance through her job receives a monaural hearing aid to wear behind her right ear (V5060RT). The invoice amount is \$375.00. The member's other insurance is billed first and pays \$200.00. The Medicaid allowed amount for this item is the invoice amount up to \$400.00. The amount the other insurance paid (\$200.00) is subtracted from the Medicaid allowed amount (\$375), leaving a balance of \$175.00.

How Payment Is Calculated on Medicare Crossover Claims

When a member has coverage from both Medicare and Medicaid, Medicare is the primary payer. Medicaid will pay the Medicare co-insurance and deductible amounts not to exceed the Medicaid fee for the service for these dually eligible individuals. See the How Payment Is Calculated chapter in the *Physician-Related Services* manual for examples on how payment is calculated on Medicare crossover claims.

How Modifiers Change Pricing

- Modifiers may not be applicable for all services. For services paid via the RBRVS fee schedule, the fee schedule shows the list of services for which modifiers 26, TC, 50, 51, 62, 66 and 80 apply.
- If a modifier does not appear in this list, then it does not affect pricing.
- The list shows summary modifier descriptions. See the CPT and HCPCS coding books for the full text.

Modifier	Definition	How the Modifier Affects Payment
21	Prolonged evaluation and management	The service is paid at 110% of fee.
22	Unusual procedural service	Pay by report.
26	Professional component	For services paid via the RBRVS fee schedule, see the specific service. For other services, payment equals 40% of the fee.
47	Anesthesia by surgeon	Pay by report
50	Bilateral procedure	The procedure is paid at 150% of the fee.
51	Multiple procedures	Each procedure is paid at 50% of the fee.
52	Reduced service	The service is paid at 50% of the fee.
53	Discontinued procedure	The service is paid at 50% of the fee.
54	Surgical care only	The service is paid at 75% of the fee.
55	Postoperative management only	The service is paid at 25% of the fee.
56	Preoperative management only	The service is paid at 25% of the fee.
62	Two surgeons	Each surgeon is paid at 62.5% of the fee.
66	Surgical team	Each surgeon is paid by report.
80	Assistant surgeon	The service is paid at 16% of the fee.
81	Minimum assistant surgeon	The service is paid at 16% of the fee.
82	Assistant surgeon; qualified resident surgeon not available	The service is paid at 16% of the fee.
90	Reference laboratory	Modifier not allowed.
AD	Medical supervision of more than four concurrent anesthesia procedures	Each service is paid at 52.5% of the fee.
AS	Physician assistant, nurse practitioner or clinical nurse specialist as assistant at surgery	The service is paid at 16% of the fee.
QK	Medical supervision of 2-4 concurrent anesthesia procedures	Each service is paid at 52.5% of the fee.
QZ	Certified registered nurse anesthesiologist service without medical direction	The modifier does not reduce the fee, but a professional differential of 90% is applied due to provider type. See Professional Differentials in this chapter.
SA	Nurse practitioner	Payment equals 90% of the fee for some services but 100% for others. See Professional Differentials in this chapter.
SB	Nurse midwife	Payment equals 90% of the fee for some services but 100% for others. See Professional Differentials in this chapter.
TC	Technical component	For services paid via the RBRVS fee schedule, see the specific service. For other services, payment equals 60% of the fee.

Professional Differentials

For some services within the scope of RBRVS payment methods, mid-level practitioners are paid differently. Audiologists are paid at 100% of the fee schedule.

Charge Cap

For the services covered in this manual, Medicaid pays the lower of the established Medicaid fee or the provider's charge.

Payment by Report

About 4% of services covered by the RBRVS fee schedule do not have fees set for them; these services are typically rare or vaguely specified in the coding guidelines. For these services, payment is set at a percentage of the provider's charge. As of July 2013 the percentage was 44% for audiology services. For hearing aid services, the percentage depends on provider type and service/supply. The Department typically reviews this percentage each July.

Bundled Codes

A few services are covered by the Department but have a fee of zero, meaning that payment for the service is considered bundled into the payment for services that are usually provided with it. Because these services are covered by Medicaid, providers may not bill members for them on a private pay basis. Audiology codes are not bundled.

Status Codes

The RBRVS fee schedule includes status codes that show how each service is paid. The list of status codes is based on that used by Medicare, as shown in the following table.

Table A			
Medicare and Medicaid RBRVS Status Values			
Medicare Status		Medicaid Status	
A	Active code paid using RVUs	A	Active code paid using RVUs set by Medicare
B	Bundled code	B	Bundled code
C	Carrier determines coverage and payment	C	Pay by report
D	Deleted code	D	Discontinued code
E	Excluded from fee schedule by regulation		[Medicaid reviews each code and usually assigns A, K or X status]
F	Deleted/discontinued code; no grace period	D	Discontinued code
G	Use another code; grace period allowed	G	Use another code; grace period set code-by-code
H	Modifier deleted		[Assigned to D status]
I	Use another code; no grace period		[Assigned to G status]
		J	Anesthesia code
		K	Active code paid using RVUs set by Medicaid
		L	Not paid via RBRVS. See lab fee schedule.
		M	Not paid via RBRVS. See non-RBRVS fee schedule.
N	Excluded from fee schedule by policy		[Medicaid reviews each code and usually assigns A, K or X status]
P	Bundled or excluded		[Medicaid reviews each code and usually assigns B or X status]
R	Restricted coverage		[Medicaid reviews each code and usually assigns A or K status]
T	Injections		[Medicaid reviews each code and usually assigns A status]
X	Excluded from fee schedule by statute	X	Not covered
Notes:			
<ul style="list-style-type: none"> • Medicare publishes RVUs for codes that have Medicare status values of R and sometimes publishes RVUs for codes with status values of E, N or X. • Medicare uses the label “injections” for status T but now uses the code for other situations (e.g., pulse oximetry) where Medicare pays for the service only if no other service is performed on the same day. 			

Other Programs

The information in this chapter does not apply to the Mental Health Services Plan (MHSP) or Healthy Montana Kids (HMK). The mental health manual is available on the Provider Information website. The HMK medical manual is available through Blue Cross and Blue Shield of Montana at 1.800.447.7828, Extension 8647.

Appendix A: Forms

- *Individual Adjustment Request*
- *Paperwork Attachment Cover Sheet*
- *Hearing Aid Request for Prior Authorization*
- *Hearing Aid Certificate of Medical Necessity*



Paperwork Attachment Cover Sheet

Paperwork Attachment Control Number _____

Date of Service _____

Billing NPI/API _____

Member 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 the address below.

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

This form may be copied or downloaded from the Provider Information website (<http://medicaidprovider.hhs.mt.gov/>).

If you have questions about paper attachments that are necessary for a claim to process, call Provider Relations at 1.800.624.3958 or 406.442.1837.

Completed forms can be mailed or faxed to: P.O. Box 8000
Helena, MT 59604
Fax: 1.406.442.4402

MEDICAID

MONTANA MEDICAID PRIOR AUTHORIZATION REQUEST FORM

Hearing Aid Services (Rev., July 2003)

HEARING AID				
Patient Name , Address, Telephone Number, Date of Birth		Hearing Aid Dispenser Name , Address, Telephone Number		
Medicaid Number		Medicaid Provider Number		
Referring Physician Name , Address, Telephone Number		Audiologist Name , Address, Telephone Number		
<p>1. Does the patient presently have hearing aid(s)? Y / N If yes, please complete the following:</p> <p>Make _____, Model _____, Date Acquired _____</p> <p><u>Replacement Remarks:</u></p>				
2. Does the patients conditions meet the criteria specified in the Montana Medicaid Hearing Aid Services Provider Manual? Y / N				
3. Has the patient received a trial use of this item? Y / N If yes , for how long: _____				
4. Does the patient have the ability to operate/use this requested item as intended by the items manufacture? Y / N				
SPECIFICATION LIST				
<i>NOTE: ALL BILLABLE ITEMS/SERVICES THAT MAKE UP THIS REQUEST MUST BE LISTED INDIVIDUALLY BELOW. If additional space is needed, a continued sheet can be attached to this document as long as the pertinent patient and supplier information is included at the top of the attachment.</i>				
HCPCS	Description	Manufacture	Model/Product #	Departmental Use Only

I certify that the information contained in this document and its attachments/supporting documents are true, accurate and complete, to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact in this document may subject me to civil or criminal liability. I further understand my responsibilities, as a condition of participation in the Montana Medicaid Program, to comply with all applicable state and federal statutes, rules, regulations and policies.

Dispenser Signature: _____ **DATE** ____/____/____ (Stamps Are Not Acceptable)

Attachments: This form must be accompanied by copies of supporting documentation to justify the medical need of the requested items. Supporting documentation includes, but is not limited the physicians referral for audiological evaluations, audiology report, audiogram and CMN.

MEDICAID

MONTANA MEDICAID CERTIFICATE OF MEDICAL NECESSITY

Hearing Aid Services (Rev., July 2003)

HEARING AID EVALUATION	
Patient Name , Address, Telephone Number, Date of Birth Medicaid Number	Audiologist Name , Address, Telephone Number
Referring Physician Name , Address, Telephone Number	Date of Evaluation/Referral _____
Diagnosis	
Date of Audiological Examination	
Audiometric Test Results:	Y / N The two-frequency average at 1 KHZ and 2 KHZ is greater than 40 decibels in both ears.
<u>Right Ear</u> <u>Left Ear</u>	Y / N The two-frequency average at 1 KHZ and 2 KHZ is less than 90 decibels in both ears.
500Hz _____ / _____	Y / N The two-frequency average at 1 KHZ and 2 KHZ has an interaural difference of less than 15 decibels.
1000Hz _____ / _____	
2000Hz _____ / _____	Y / N Word recognition or speech discrimination score is not greater than 20%.
3000Hz _____ / _____	
Total Average _____ / _____	
PB Max Level _____ / _____	
<u>Comments/Recommendations</u>	

I certify that I am the audiologist completing the audiological evaluation for the patient identified in this form. I certify that the information contained in this document and its attachments are true, accurate, complete and supported by clinical information in the patients record. I understand that any falsification, omission, or concealment of material fact in this document may subject me to civil or criminal liability.

Audiologist Signature _____ **Date** ____/____/____ (Stamps Are Not Acceptable)

Attachments: This form must be accompanied by copies of supporting documentation to include, but not limited to the physician=s referral for hearing aid services, diagnostic and evaluation reports. Attachments are necessary for dispenser to request approval of the hearing aid(s) prior to the actual dispensing of the aid(s).

Place-of-Service Codes

Below is a list of place-of-service (POS) codes, corresponding names, and a brief description of each.

Place of Service Codes		
Code	Name	Description
01	Pharmacy***	A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients.
02	Unassigned	N/A
03	School	A facility whose primary purpose is education.
04	Homeless shelter	A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters).
05	Indian Health Service freestanding facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and nonsurgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization.
06	Indian Health Service provider-based facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.
07	Tribal 638 freestanding facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and nonsurgical), and rehabilitation services to tribal members who do not require hospitalization.
08	Tribal 638 provider-based facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and nonsurgical), and rehabilitation services to tribal members admitted as inpatients or outpatients.
09–10	Unassigned	N/A
11	Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, state or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
13	Assisted living facility*	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services.

Place of Service Codes (Continued)		
Code	Name	Description
14	Group home**	A residence, with shared living areas, where members receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services (e.g., medication administration).
15	Mobile unit	A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.
16	Temporary lodging	A short-term accommodation such as a hotel, campground, hostel, cruise ship, or resort where the patient receives care, and which is not identified by any other POS code.
16	Family planning****	A facility or location providing services such as contraceptive services and supplies, certain laboratory tests, and family planning counseling.
17	Walk-in retail health clinic*****	A walk-in health clinic, other than an office, urgent care facility, pharmacy, or independent clinic, and not described by any other POS code, that is located within a retail operation and provides, on an ambulatory basis, preventive and primary care services.
18–19	Unassigned	N/A
20	Urgent care facility	Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.
21	Inpatient hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	Outpatient hospital	A portion of a hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
23	Emergency room – hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
24	Ambulatory surgical center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
25	Birth center	A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate post-partum care as well as immediate care of newborn infants.
26	Military treatment facility	A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).
27–30	Unassigned	N/A

Place of Service Codes (Continued)		
Code	Name	Description
31	Skilled nursing facility	A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
32	Nursing facility	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick person, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.
33	Custodial care facility	A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.
34	Hospice	A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
35–40	Unassigned	N/A
41	Ambulance – land	A land vehicle specifically designed, equipped, and staffed for lifesaving and transporting the sick or injured.
42	Ambulance – air or water	An air or water vehicle specifically designed, equipped, and staffed for lifesaving and transporting the sick or injured.
43–48	Unassigned	N/A
49	Independent clinic	A location, not part of a hospital and not described by any other POS code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only.
50	Federally qualified health center	A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
51	Inpatient psychiatric facility	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.
52	Psychiatric facility – partial hospitalization	A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full-time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.
53	Community mental health center (CMHC)	A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour-a-day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services: screening for patients being considered for admission to state mental health facilities to determine the appropriateness of such admission; and consultation and education services.

Place of Service Codes (Continued)		
Code	Name	Description
54	Intermediate care facility/mentally retarded	A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF.
55	Residential substance abuse treatment facility	A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.
56	Psychiatric residential treatment center	A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically-planned and professionally-staffed group living and learning environment.
57	Nonresidential substance abuse treatment facility	A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.
58–59	Unassigned	N/A
60	Mass immunization center	A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as a public health center, pharmacy, or mall, but may include a physician office setting.
61	Comprehensive inpatient rehabilitation facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.
62	Comprehensive outpatient rehabilitation facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
63–64	Unassigned	N/A
65	End-stage renal disease treatment facility	A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.
66–70	Unassigned	N/A
71	State or local public health clinic	A facility maintained by either state or local health departments that provides ambulatory primary medical care under the general direction of a physician.
72	Rural health clinic	A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.
73–80	Unassigned	N/A

Place of Service Codes (Continued)		
Code	Name	Description
81	Independent laboratory	A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.
82-98	Unassigned	N/A
99	Other place of service	Other place of service not identified above.

Codes are effective on or before January 1, 2003, unless otherwise noted.

* Revised, effective October 1, 2003.

**Revised, effective October 1, 2005.

***Effective October 1, 2003; description revised effective April 1, 2004.

****Effective April 1, 2008.

*****No later than May 1, 2010.

Definitions and Acronyms

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

270/271 Transactions

The ASC X12N eligibility inquiry (270) and response (271) transactions.

276/277 Transactions

The ASC X12N claim status request (276) and response (277) transactions.

278 Transactions

The ASC X12N request for services review and response used for prior authorization.

835 Transactions

The ASC X12N payment and remittance advice (explanation of benefits) transaction.

837 Transactions

The ASC X12N professional, institutional, and dental claim transactions (each with its own separate Implementation Guide).

Accredited Standards Committee X12, Insurance Subcommittee (ASC X12N)

The ANSI-accredited standards development organization, and one of the 6 designated standards maintenance organizations (DSMO) that created and is tasked with maintaining the administrative and financial transactions standards adopted under HIPAA for all health plans, clearinghouses, and providers who use electronic transactions.

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/HMK *Plus*, MHSP, HMK/CHIP, or another payer. Other cost factors (e.g., cost sharing, TPL, 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.

Ancillary Provider

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

Assignment of Benefits

A voluntary decision by the member to have insurance benefits paid directly to the provider rather than to the member. 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 member. This approval is only valid if the member is eligible on the date of service.

Basic Medicaid

Patients with Basic Medicaid have limited Medicaid services. See the Medicaid Covered Services chapter in the *General Information for Providers* manual.

Bundled

Items or services that are deemed integral to performing a procedure or visit are not paid separately in the APC system. They are packaged (also called bundled) into the payment for the procedure or visit. Medicare developed the relative weights for surgical, medical and other types of visits so that the weights reflect the packaging rules used in the APC method. Items or services that are packaged receive a status code of “N”.

Cash Option

Cash option allows the member 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.

Children’s Health Insurance Program (CHIP)

The Montana plan is now known as Healthy Montana Kids (HMK).

Children’s Special Health Services (CSHS)

CSHS assists children with special health care needs who are not eligible for Medicaid by paying medical costs, finding resources, and conducting clinics.

Clean Claim

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

Code of Federal Regulations (CFR)

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

Coinsurance

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

Conversion Factor

A state specific dollar amount that converts relative values into an actual fee. This calculation allows each payer to adopt the RBRVS to its own economy.

Copayment

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

CPT

Physicians’ *Current Procedural Terminology* contains procedure codes which are used by medical practitioners in billing for services rendered. The book is published by the American Medical Association.

Credit Balance Claims

Adjusted claims that reduce original payments, causing the provider to owe money to the Department. These claims are considered in process and continue to appear on the remittance advice until the credit has been satisfied.

Crossovers

Claims for members 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 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

Members who are covered by Medicare and Medicaid.

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.

Electronic Funds Transfer (EFT)

Payment of medical claims that are deposited directly to the provider's bank account.

Emergency Services

A service is reimbursed as an emergency if one of the following criteria is met:

- The service is billed with CPT Code 99284 or 99285
- The member has a qualifying emergency diagnosis code. A list of emergency diagnosis codes is available on the Provider Information website.
- The services did not meet one of the previous two requirements, but the hospital

believes an emergency existed. In this case, the claim and documentation supporting the emergent nature of the service must be mailed to the emergency department review contractor.

Experimental

A noncovered item or service that researchers are studying to investigate how it affects health.

Explanation of Medicare Benefits (EOMB)

A notice sent to providers informing them of the services which have been paid by Medicare.

Fiscal Agent

Xerox 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.

Free Care Rule

If a service is free to non-Medicaid members, then it must also be free to Medicaid members. Medicaid cannot be billed for services that are provided free to non-Medicaid members.

Full Medicaid

Patients with Full Medicaid have a full scope of Medicaid benefits. See the Medicaid Covered Services chapter in the *General Information for Providers* manual.

Gross Adjustment

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

HCPCS

Acronym for the Healthcare Common Procedure Coding System, and is pronounced "hick-picks." There are two types of HCPCS codes:

- Level 1 includes the CPT codes.
- Level 2 includes the alphanumeric codes A–V which CMS maintains for a

wide range of services from ambulance trips to hearing aids which are not addressed by CPT coding.

Health Improvement Program (HIP)

A service provided under the Passport to Health program for members who have one or more chronic health conditions. Care management focuses on helping members improve their health outcomes through education, help with social services, and coordination with the member's medical providers.

Health Insurance Portability and Accountability Act (HIPAA)

A federal plan designed to improve efficiency of the health care system by establishing standards for transmission, storage, and handling of data.

Healthy Montana Kids (HMK)

HMK offers low-cost or free health care coverage for low-income children younger than 19. Children must be uninsured U.S. citizens or qualified aliens, Montana residents who are not eligible for Medicaid. DPHHS administers the program with Blue Cross and Blue Shield of Montana (BCBSMT). For eligibility and enrollment information, contact HMK at 1.877.543.7669 (toll-free, follow menu) or 1.855.258.3489 (toll-free, direct). For information about medical benefits, contact BCBSMT at 1.406.447.8647 (Helena) or 1.800.447.7828 (toll-free). HMK dental and eyeglasses benefits are provided by DPHHS through the same contractor (Xerox State Healthcare, LLC) that handles Medicaid provider relations and claims processing.

International Classification of Disease (ICD)

The International Classification of Diseases contains the diagnosis codes used in coding claims and the procedure codes used in billing for services performed in a hospital setting.

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.

Internal Control Number (ICN)

The unique number assigned to each claim transaction that is used for tracking.

Investigational

A noncovered item or service that researchers are studying to investigate how it affects health.

Mass Adjustment

Adjustments made to multiple claims at the same time. They generally occur when the Department has a change of policy or fees that is retroactive, or when a system error that affected claims processing is identified.

Medicaid/HMK Plus

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.

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 member. 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 malfunction. There must be no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the member 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 members.

Member

An individual enrolled in a Department medical assistance program.

Mental Health Services Plan (MHSP)

This plan is for individuals who have 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.

Montana Access to Health (MATH) Web Portal

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

Montana Breast and Cervical Cancer Treatment Program

This program provides Full 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.

Nurse First Advice Line

The Nurse First Advice Line is a toll-free, confidential number members may call any time any day for advice from a registered nurse about injuries, diseases, health care, or medications.

Passport Referral Number

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

Passport to Health

A Medicaid medical home program where the member selects a primary care provider who manages the member's health care needs.

Pay-and-Chase

Medicaid pays a claim and then recovers payment from the third party carrier that is financially responsible for all or part of the claim.

Pending Claim

These claims have been entered into the system, but have not reached final disposition. They require either additional review or are waiting for member eligibility information.

Potential Third Party Liability

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

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 member 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 members; and
- Eligible to receive payment from the Department.

Qualified Medicare Beneficiary (QMB)

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

Reason and Remark Code

A code which prints on the Medicaid remittance advice (RA) that explains why a claim was denied or suspended. The explanation of the Reason/Remark codes is found at the end of the RA (formerly called EOB code).

Referral

When providers refer members to other Medicaid providers for medically necessary services that they cannot provide.

Remittance Advice (RA)

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

Relative Value Scale (RVS)

A numerical scale designed to permit comparisons of appropriate prices for various services. The RVS is made up of the relative value units (RVUs) for all the objects in the class for which it is developed.

Relative Value Unit (RVU)

The numerical value given to each service in a relative value scale.

Resource-Based Relative Value Scale (RBRVS)

A method of determining physicians' fees based on the time, training, skill, and other factors required to deliver various services.

Retroactive Eligibility

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

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.

School-Based Services

Medically necessary health-related services provided to Medicaid eligible children up to and including age 20. These services are provided in a school setting by licensed medical professionals.

Specified Low-Income Medicare Beneficiaries (SLMB)

For these members, 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

Members with high medical expenses relative to their income can become eligible for Medicaid by “spending down” their income to specified levels. The member is responsible to pay for services received before eligibility begins, and Medicaid pays for remaining covered services.

Team Care

A restricted services program that is part of Passport to Health. Restricted services programs are designed to assist members in making better health care decisions so that they can avoid overutilizing health services. Team Care members are joined by a team assembled to assist them in accessing health care. The team consists of the member, the PCP, a pharmacy, the Department, the Department’s quality improvement organization, and the Nurse First Advice Line. The team may also include a community-based care manager from the Department's Health Improvement Program.

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 member.

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:

- Twelve months from whichever is later:
 - the date of service;
 - the date retroactive eligibility or disability is determined;
- Six months from the date on the Medicare explanation of benefits approving the service; or
- 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.

Usual and Customary

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

WINASAP 5010

WINASAP 5010 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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