



Medicaid Indian Health Services

*Medicaid and Other Medical
Assistance Programs*



June 2014

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My NPI/API:

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Key Contacts

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

Claims

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

Electronic Funds Transfer/ Electronic Remittance Advices

Providers who need to enroll in electronic funds transfer (EFT) and register for electronic remittance advices (ERAs) can contact Provider Relations for assistance. Providers should mail or fax their completed documentation to Provider Relations:

Provider Relations
P.O. Box 4936
Helena, MT
406.442.4402 Fax

Health Improvement Program

For questions regarding the Health Improvement Program (HIP):

406.444.4455 Phone
406.444.1861 Fax

Health Improvement Program
Member Health Management Bureau
DPHHS
P.O. Box 202951
Helena, MT 59620-2951

IHS Program

406.444.4540 Phone
406.444.1861 Fax

IHS Program Officer
Hospital and Physician Services Bureau
DPHHS
P.O. Box 202951
Helena, MT 59620-2951

Indian Health Services Centers

Browning Indian PHS Indian Hospital

760 Hospital Circle
Browning, MT 59417
406.338.6154

Confederated Salish and Kootenai Tribal Health/Human Services

P.O. Box 880, Mission Drive
St. Ignatius, MT 59865
406.745.3525

Crow Agency PHS Indian Hospital

Hospital Road
Crow Agency, MT 59022
406.638.3461

Fort Belknap PHS Indian Health Center

456 Gros Ventre Avenue
Harlem, MT 59526
406.353.3100

Hays PHS Indian Health Center

123 White Crow Canyon Road
Hays, MT 59527
406.673.3777

Heart Butte PHS Indian Health

20 Disney
Heart Butte, MT 59448
406.338.2151

Lame Deer PHS Indian Health Services

100 Cheyenne Avenue
Lame Deer, MT 59043
406.477.6700

Lodge Grass PHS Indian Health Center

Main Street
Lodge Grass, MT 59050
406.639.2317

Pryor PHS Indian Health Station

Main Street
Pryor, MT 59066
406.259.9813

Poplar PHS Indian Health Center

107 H Street
Poplar, MT 59255
406.768.3491

Rocky Boy Health Center

RR 1, Box 664
Box Elder, MT 59521
406.395.4486 (638 Compacted Tribe)

Medicaid Help Line

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

800.362.8312

Passport to Health
P.O. Box 254
Helena, MT 59604-0254

Member Eligibility

There are several methods for verifying member eligibility. The most common are below. For details, see the Member Eligibility and Responsibilities chapter of the *General Information for Providers* manual.

Provider Relations

1.800.624.3958
406.442.1837

FaxBack

800.714.0075 (24 hours)

Voice Response System

800.714.0060 (24 hours)

Montana Access to Health Web Portal

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

Emdeon

1.877.363.3666 (Sales; requires contract)

Montana Tribal Nations**Assiniboine and Sioux Tribes**

Fort Peck Council
P.O. Box 1027
Fort Peck Agency
Poplar, MT 59255
406.768.5155 Phone
406.768.5478 Fax

Blackfeet Tribe

Blackfeet Tribal Business Council
Box 850
Blackfeet Agency
Browning, MT 59417
406.338.7179 Phone
406.338.7530 Fax

Chippewa Cree Tribe

Chippewa Cree Business Committee
Rocky Boy Route 544
Rocky Boy Agency
Box Elder, MT 59521
406.395.4282 Phone
406.395.4497 Fax

Crow Tribal Council

Box 159
Crow Agency, MT 59022
406.638.2601 Phone
406.638.3881 Fax

Fort Belknap Tribal Council

RR 1, Box 66
Harlem, MT 59526-9998
406.353.2205 Phone
406.353.2797 Fax

Little Shell Tribe

Little Shell Tribe
Box 1384
105 Smelter Avenue Mini Mall
Great Falls, MT 59403
406.452.2892 Phone
406.452.2982 Fax

Northern Cheyenne Tribe

Northern Cheyenne Tribal Council
P.O. Box 128
Northern Cheyenne Agency
Lame Deer, MT 59043
406.477.6284 Phone
406.477.6120 Fax

Salish and Kootenai Tribe

Confederated Salish and Kootenai
P.O. Box 278
Flathead Agency
Pablo, MT 59855
406.675.2700 Phone
406.675.2806 Fax

Nurse First

For questions regarding the Nurse First Advice Line, **800.330.7847**, contact:

406.444.4455 Phone
406.444.1861 Fax

Nurse First Program Officer
Member Health Management Bureau
DPHHS
P.O. Box 202951
Helena, MT 59620-2951

Passport to Health Information

Members who have Passport or Medicaid questions may call the Montana Medicaid Help Line or write to:

800.362.8312 In/Out of state
Passport to Health
P.O. Box 254
Helena, MT 59624-0254

Passport to Health Program

For questions regarding the Passport to Health program:

406.444.4455 Phone
406.444.1861 Fax

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

Presumptive Eligibility

For more information about presumptive eligibility training or certification, call:

406.444.3098 Helena
877.543.7669, X 3098 Toll-free

Prior Authorization

Below are the Department's prior authorization contractors.

Magellan Medicaid Administration (dba First Health Services)

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

800.770.3084 Phone
800.639.8982 Fax
800.247.3844 Fax

Health Care Management Division
Magellan Medicaid Administration
4300 Cox Road
Glen Allen, VA 23060

Mountain-Pacific Quality Health

For prior authorization for certain services, contact MPQH. See the Prior Authorization chapter in this manual.

Phone
800.262.1545 Long-distance
406.443.4020 Local
Fax
800.497.8235
406.513.1922 Toll-free

Send written inquiries to:

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

Provider Policy Questions

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

Provider Relations

For general claims questions or questions about enrollment, eligibility, payments, denials, or Passport.

800.624.3958 In/Out of state
406.442.1837 Helena
406.442.4402 Fax

Send written inquiries to:

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

Send e-mail inquiries to:

mtprhelpdesk@xerox.com

Secretary of State

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

406.444.2055 Phone

Secretary of State
P.O. Box 202801
Helena, MT 59620-2801
www.sos.mt.gov/

Team Care Program

For questions regarding Team Care:

406.444.4455 Phone
406.444.1861 Fax

Team Care Program Officer
Member Health Management 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

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

Xerox EDI Support Unit

For questions regarding electronic claims submission:

800.987.6719 In/Out of state
406.442.1837 Helena
406.442.4402 Fax

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

Send e-mail inquiries to:
MTEDIHelpdesk@xerox.com

Key Websites	
Web Address	Information Available
Centers for Disease Control and Prevention (CDC) www.cdc.gov/	Immunization and other health information
Centers for Medicare and Medicaid Services (CMS) www.cms.gov/	A federal government website managed by CMS, an agency within the U.S. Department of Health and Human Services responsible for administration of several key federal health care programs.
Department of Public Health and Human Services (DPHHS) www.dphhs.mt.gov/	Montana DPHHS website.
Healthy Montana Kids (HMK) www.hmk.mt.gov/	Information on Healthy Montana Kids (HMK).
Medicaid Mental Health / Mental Health Services Plan http://www.dphhs.mt.gov/mentalhealth/index.shtml	Mental health services information for Medicaid/MHSP.
Montana Access to Health (MATH) https://mtaccesstohealth.acs-shc.com/ Montana Medicaid Provider Information http://medicaidprovider.hhs.mt.gov (or www.mtmedicaid.org)	<ul style="list-style-type: none"> • Electronic billing information • Fee schedules • Frequently asked questions (FAQs) • Forms • Key contacts • Links to other websites • Medicaid information • Medicaid news • Newsletters • Provider enrollment • Provider manuals • Provider manuals replacement pages • Provider notices • Remittance advice notices • Training resources • Upcoming events
Public Assistance Toolkit https://dphhs.mt.gov/	Select Human Services for information on: <ul style="list-style-type: none"> • Medicaid: member information, eligibility information, and provider information • Montana access card • Provider resource directory • TPL carrier directory
Secretary of State http://sos.mt.gov/ http://sos.mt.gov/ARM/index.asp Administrative Rules of Montana (ARM) http://www.mtrules.org/	Secretary of State website and Administrative Rules of Montana (ARM) website.

Key Websites	
Web Address	Information Available
<p>Washington Publishing www.wpc-edi.com/</p> <p>A fee is charged for documents; however, code lists are viewable online at no cost.</p>	<ul style="list-style-type: none"> • HIPAA guides • HIPAA tools
<p>Xerox EDI Solutions www.acs-gcro.com/</p>	<p>EDI Gateway is the Xerox HIPAA clearinghouse. Visit this website for information on:</p> <ul style="list-style-type: none"> • EDI support • EDI enrollment • Frequently asked questions (FAQs) • Manuals • Provider services • Related links • Software

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 Indian Health Services (IHS) providers who provide services to members who are eligible for both Medicaid and Indian Health Services.

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 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. File all notices behind the Notices tab.

Rule References

Providers, office managers, billers, and other medical staff should familiarize themselves with all current rules and regulations governing the Montana Medicaid program. Provider manuals are to assist providers in billing Medicaid; they do not contain all Medicaid rules and regulations. Rule citations in the text are a reference tool; they are not a summary of the entire rule. **In the event that a manual conflicts with a rule, the rule prevails.** Links to rules are available on the Provider Information website. (See Key Websites.) Paper copies of rules are available through the Secretary of State's office. (See Key Contacts.) In addition to the general Medicaid rules outlined in the *General Information for Providers* manual, the following rules and regulations are also applicable to the Indian Health Services program:

- Code of Federal Regulations (CFR)
 - 42 CFR Part 136 and 136A
- Montana Codes Annotated (MCA)
 - MCA 53-6-101
- Administrative Rules of Montana (ARM)
 - ARM 37.82.101



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 it cannot detect. For this reason, payment of a claim does not mean the service was correctly billed or the payment made to the provider was correct. Periodic retrospective reviews are performed that may lead to the discovery of incorrect billing or incorrect payment. If a claim is paid and the Department later discovers 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 manuals, provider notices, replacement pages, fee schedules, forms, and much 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 Indian Health Service (IHS) providers who provide services to members who are eligible for both Medicaid and IHS. Like all health care services received by Medicaid members, these services must also meet the general requirements listed in the Provider Requirements chapter of the *General Information for Providers* manual.

Members of federally recognized Indian tribes and their descendants are eligible for services provided by IHS, an agency of the U.S. Public Health Service, Department of Health and Human Services.

The Montana Medicaid Program covers most medical services for Medicaid-eligible Native Americans who receive those services through an IHS facility or other approved tribal provider. By law, the Medicaid program acts as the pass-through agency for these services, funded with 100% of federal funds.

Provider Requirements

IHS physicians must meet Montana Medicaid's State Plan requirements. Physician requirements are available in the *Physician-Related Services* manual available on the Provider Information [website](#). Montana Medicaid does not require IHS physicians to hold a Montana physician license; however, they must meet the substantive licensure requirements. The Department must be satisfied that the physicians can demonstrate they are authorized to practice medicine. A copy of the physician's current license from another state would satisfy this requirement.

Services for Children (ARM 37.86.2201–2221)

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program is a comprehensive approach to health care for Medicaid members ages 20 and under. It is designed to prevent, identify, and then treat health problems before they become disabling. Under EPSDT, Medicaid eligible children may receive any medically necessary covered service, including all outpatient hospital services described in this manual. All applicable Passport to Health and prior authorization requirements must be followed. See the Passport and Prior Authorization chapters in this manual.

Coverage of Specific Services

Medicaid covers the same services for members who are enrolled in Medicaid and IHS as those members who are enrolled in Medicaid only. All requirements for Medicaid services (such as prior authorization, Passport and others) also apply to Medicaid enrolled members who qualify for IHS services. Requirements for spe-

cific services are covered in the Medicaid provider manual for the service provided (e.g., *Physician-Related Services*; *Durable Medical Equipment, Prosthetics, Orthotics and Supplies*). Manuals are found on the Provider Information [website](#).

The following services have special conditions.

Abortions and Sterilizations

Medicaid covers abortions and sterilizations **only** when all requirements are met. Refer to the *Physician-Related Services* manual or *Hospital Outpatient* manual for requirements and essential forms.

Prescription Drugs

For detailed information about prescription drugs, refer to the *Prescription Drug Program* manual. The DUR Board has set monthly limits on certain drugs. Use over these amounts requires prior authorization. Refer to the Prior Authorization chapter of the *Prescription Drug Program* manual for limits.

Noncovered Services (ARM 37.85.207 and 37.86.3002)

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

- Acupuncture.
- Chiropractic services.
- Dietician/nutritional services.
- Massage services.
- Dietary supplements.
- Homemaker services.
- Infertility treatment.
- Delivery services not provided in a licensed health care facility unless as an emergency service.
- Outpatient physical therapy, occupational therapy, and speech therapy services that are primarily maintenance therapy. Providers should refer to the *Therapy Services* manual available on the Provider Information [website](#).
- Outpatient hospital services provided outside the United States.
- Naturopath services.
- Services provided by surgical technicians who are not physicians or mid-level practitioners.
- Services considered experimental or investigational.
- Claims from outpatient hospitals for pharmaceuticals and supplies only.

- Reference lab services. Providers may bill Medicaid only for those lab services they have performed themselves.
- Exercise programs and programs that are primarily educational, such as:
 - Cardiac rehabilitation exercise programs
 - Pulmonary rehabilitation programs
 - Nutritional programs
 - Independent exercise programs (e.g., pool therapy, swim programs, or health club memberships)
- Services provided to Medicaid members who are absent from the state, with the following exceptions:
 - Medical emergency
 - Required medical services are not available in Montana. Passport approval is required and prior authorization may also be required for certain services. See the Passport and Prior Authorization chapters in this manual.
 - If the Department has determined that the general practice for 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.
- Services that are not medically necessary. The Department may review for medical necessity at any time before or after payment. The Medicaid member is financially responsible for these services and the Department recommends the member agree in writing before the services are provided. See the section titled When to Bill a Medicaid Member in the Billing Procedures chapter of this manual.
- Donor search expenses.
- Autopsies.
- Medicaid does not cover services that are not direct patient care such as:
 - Missed or canceled appointments.
 - Mileage and travel expenses for providers.
 - Preparation of medical or insurance reports.
 - Service charges or delinquent payment fees.
 - Telephone services in home.
 - Remodeling of home.
 - Plumbing service.
 - Car repair and/or modification of automobile.

Importance of Fee Schedules

The easiest way to verify coverage for a specific service is to check the Department's fee schedule for your provider type. In addition to being listed on the fee schedule, all services provided must also meet the coverage criteria listed in the Provider Requirements chapter of the *General Information for Providers* manual and in this chapter. Use the 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](#).

Passport to Health Program

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

Passport to Health is the managed care 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, midlevel practitioner, or primary care clinic.

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

The Passport provider provides primary care case management (PCCM) services to their 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 that 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. (See the section titled Services That Do Not Require Passport Provider Approval later in this chapter.) 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



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



Different codes are issued for Passport approval and prior authorization, and both must be recorded on the claim form, if appropriate.

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 MATH web portal, a Team Care member's provider and pharmacy will be listed. Write all Medicaid and HMK *Plus* prescriptions to the designated pharmacy.

Nurse First Advice Line

The Nurse First Advice Line, 1-800-330-7847, is a toll-free, confidential number members may call 24/7/365 for advice from a registered nurse about injuries, diseases, health care or medications. The Advice Line is available to all Montana Medicaid, HMK, and HMK *Plus* 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* members 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 at the [Health Improvement Program link](#) on the Provider Information [website](#). (See Key Websites.)

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

- Maintain a written record of all referrals given and received for every Passport member treated.
- Provide primary and preventive care, health maintenance, treatment of illness and injury, and coordination of member's access to medically necessary specialty care by providing referrals and follow-up.
- Provide well-child checkups, EPSDT services, blood lead screenings, and immunizations.
- Develop an ongoing relationship with Passport members for the purpose of providing continuity of care.
- Educate members about appropriate use of office visits, the emergency department (ED), and urgent care clinics.
- Identify and refer members to the Team Care program whose use of services is excessive and inappropriate with respect to medical need.
- Coordinate and collaborate with care managers in Medicaid HIP, including providing information regarding the needs of the member, reviewing and commenting on care plans prepared by care managers, and providing copies of medical records when requested.
- Provide coverage for needed services, consultation, and approval or denial of referrals during regular office hours.
- Provide 24-hour availability of information for seeking emergency services.
- Accept auto assignment of members when PCP has openings and the members meet the PCP-defined restrictions.
- Provide appropriate and HIPAA-compliant 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).
- Maintain a member medical record for each Passport member. Providers must transfer the member's medical record to a new primary care provider if requested in writing and authorized by the member.

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, 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 for details.

Member Disenrollment

A provider may disenroll a Passport or Team Care member for the following reasons:

- The provider-member relationship is mutually unacceptable.
- Member fails to follow prescribed treatment (unless this lack of compliance is a symptom of the medical condition).
- Member is abusive.
- Member could be better treated by a different type of provider, and a referral process is not feasible.
- Member has not established care.
- Member is seeking primary care elsewhere.
- Member consistently fails to show up for appointments

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

Termination of Passport Agreement

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

Utilization Review

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

Caseload Limits

Passport providers may serve as few as one or as many as 1,000 Medicaid 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 Medicaid coverage. To check a member's eligibility, go to the [MATH web portal](#). (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. PA 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 the section titled Services That Do Not Require Passport Provider Approval later in this chapter.

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 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 patient 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 in the Medicaid billing manual for your provider type.

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

Services That Do Not Require Passport Provider Approval (ARM 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
- Home Support Services and Therapeutic Foster Care
- Hospice
- Hospital inpatient radiology (x-rays)

- 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
- Transportation (commercial and specialized non-emergency)

Passport and Emergency Services (ARM 37.86.5110)

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

- **Emergency services provided in the 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. For more information, see Emergency Services on the Provider Information [website](#) or in the Medicaid billing manual for your provider type.
- **Post stabilization and Passport.** Services for members admitted through an emergency room (identified by the presence of Revenue Code 45X or 65X on the claim) will be exempt from Passport requirements and from cost share requirements.

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 provide 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. Help Lines are available to answer almost any Passport or general Medicaid question. Providers may call Provider Relations to discuss any problems or questions regarding your Passport members, or to enroll as a Passport provider. Providers can keep up with changes and updates to the Passport program by reading newsletters and other information 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 services by agreement with the Department. The Department allows any provider who has primary care within his/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.

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 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 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.

For more HMK information, contact Blue Cross and Blue Shield of Montana (BCBSMT) at 800-447-7828 (toll-free) or 447-7828 (Helena). Additional HMK information is available on the HMK website. (See Key Websites.)

Prior Authorization

Prior authorization (PA) refers to a list of services that require approval from the Medicaid program prior to the service being rendered. If a service requires PA, the requirement exists for all Medicaid members. When PA is granted, the provider is issued a PA number that must be on the claim.

Medicaid does not pay for services when PA requirements are not met.

Prior Authorization for Retroactively Eligible Members

When a member becomes retroactively eligible for Medicaid, he/she should present the provider with a 100-M form. Providers may choose whether to accept retroactive eligibility. If a provider accepts the retroactive eligibility, he/she must contact the member's local OPA and request a **160-M**. (See the *General Information for Providers* manual, Member Eligibility chapter.) All PA requirements must be met to receive Medicaid payment. When requesting PA, attach a copy of the 160-M to the PA request. See the Billing Procedures chapter in the *General Information for Providers* manual for retroactive eligibility billing requirements.

When seeking PA, keep in mind the following:

- The referring provider should initiate all authorization requests.
- Always refer to the current Medicaid fee schedule to verify if PA is required for specific services.
- The Prior Authorization Criteria for Specific Services table (see next page) lists services that require PA, who to contact, and specific documentation requirements. For details on each services, call the PA contact listed.
- PA criteria forms for most services are available on the Provider Information [website](#).
- When PA is granted from Mountain-Pacific Quality Health (MPQH), providers will receive notification from both MPQH and the Claims Processing Unit. The Prior Authorization Notice from the Claims Processing Unit will have a PA number. This PA number must be included on the claim.

For prior authorization criteria for prescription drugs, see the Prescription Drug Program manual on the Provider Information website.

PA Criteria for Specific Services		
Services	PA Contact	Documentation Requirements
<p>All transplant services</p> <p>Out-of-state hospital inpatient services</p> <p>All rehab services</p>	<p>Mountain-Pacific Quality Health 3404 Cooney Drive Helena, MT 59602</p> <p>Phone 406.443.4020 X5850 Helena 800.262.1545 X5850 In/Out of state</p> <p>Fax 406.443.4585 Helena 800.497.8235 In/Out of state</p> <p>Medical Surgical Procedures</p> <p>Phone 406.457.5887 Local 877.443.4021 X5887 In/Out of state</p> <p>Fax 877.443.2580</p>	<p>Required information includes:</p> <ul style="list-style-type: none"> • Member's name • Member's Medicaid ID number • State and hospital where member is going <p>Documentation that supports medical necessity. This varies based on circumstances. MPQH will instruct providers on required documentation on a case-by-case basis.</p>
<p>Transportation</p> <p>(scheduled ambulance transport, commercial and specialized non-emergency transportation)</p> <p>For emergency ambulance transport services, providers have 60 days following the service to obtain authorization.</p>	<p>Mountain-Pacific Quality Health 3404 Cooney Drive Helena, MT 59602</p> <p>Phone 800.292.7114</p> <p>Fax 800.291.7791</p> <p>E-Mail: ambulance@mpqhf.org</p>	<p>Ambulance providers may call, leave a message, fax, or e-mail requests.</p> <p>Required information includes:</p> <ul style="list-style-type: none"> • Name of transportation provider • Provider's NPI • Member's name • Member's Medicaid ID number • Point of origin to the point of destination • Date and time of transport • Reason for transport • Level of services to be provided during transport (e.g., BLS, ALS, mileage, oxygen) <p>Providers must submit the trip report and copy of the charges for review after transport.</p> <p>For commercial or private vehicle transportation, members call and leave a message, or fax travel requests prior to traveling.</p>
<p>Eye prosthesis</p> <p>New technology codes (Category III CPT codes)</p> <p>Other reviews referred by Medicaid program staff</p>	<p>Mountain-Pacific Quality Health 3404 Cooney Drive Helena, MT 59602</p> <p>Phone 406.457.5887 Helena 877.443.4021 X5887 In/Out of state</p> <p>Fax 406.443.2580 Helena 877.443.2580 In/Out of state</p>	<ul style="list-style-type: none"> • Documentation that supports medical necessity • Documentation regarding the member's ability to comply with any required after care • Letters of justification from referring physician • Documentation should be provided at least two weeks prior to the procedure date.

PA Criteria for Specific Services (Continued)		
Services	PA Contact	Documentation Requirements
<p>Circumcision</p>	<p>Mountain-Pacific Quality Health 3404 Cooney Drive Helena, MT 59602</p> <p>Phone 406.457.5887 Helena 877.443.4021 X5887 In/Out of state</p> <p>Fax 406.443.2580 Helena 877.443.2580 In/Out of state</p>	<p>Description Circumcision is the surgical removal of the sleeve of the skin and mucosal tissue that normally covers the glans (head) of the penis. The request for a circumcision will be reviewed on a case-by-case basis, based on medical necessity. Routine circumcisions are not covered.</p> <p>Indications for Circumcision The one absolute indication for circumcision is scarring of the opening of the foreskin making it non-retractable (pathological phimosis). The occurrence of phimosis must be treated with non-surgical methods (i.e., topical steroids, before circumcision is indicated).</p> <ul style="list-style-type: none"> • Urinary obstruction • Urinary tract infection • Balanitis
<p>Dispensing and fitting of contact lenses</p>	<p>Provider Relations P.O. Box 4936 Helena, MT 59604</p> <p>Phone 406.442.1837 Helena 800.624.3958 In/Out of state</p>	<ul style="list-style-type: none"> • PA required for contact lenses and dispensing fees. • Diagnosis must be one of the following: <ul style="list-style-type: none"> • Keratoconus • Aphakia • Sight cannot be corrected to 20/40 with eyeglasses
<p>Prescription drugs</p> <p>For a list of drugs that require PA, see the Prescription Drug Services manual.</p>	<p>Drug Prior Authorization Unit Mountain-Pacific Quality Health 3404 Cooney Drive Helena, MT 59602</p> <p>Phone 406.443.6002 Helena 800.395.7961 In/Out of state</p> <p>Fax 406.513.1928 Helena 800.294.1350 In/Out of state</p>	<p>Refer to the <i>Prescription Drug Services manual</i> for a list of drugs that require PA.</p> <p>Providers must submit the information requested on the Request for Drug Prior Authorization Form to the Drug Prior Authorization Unit. This form is on the Provider Information website on the <i>Forms page</i>.</p> <p>The prescriber (physician, pharmacy) may submit requests by mail, telephone, or fax.</p>

PA Criteria for Specific Services (Continued)		
Services	PA Contact	Documentation Requirements
<p>Maxillofacial/Cranial surgery</p>	<p>Mountain-Pacific Quality Health 3404 Cooney Drive Helena, MT 59602</p> <p>Phone 406.443.5887 Helena 877.443.4021 X5887 In/Out of state</p> <p>Fax 406.443.2580 Helena 877.443.2580 In/Out of state</p>	<p>Surgical services are only covered when done to restore physical function or to correct physical problems resulting from:</p> <ul style="list-style-type: none"> • Motor vehicle accidents • Accidental falls • Sports injuries • Congenital birth defects <p>Documentation requirements include a letter from the attending physician documenting:</p> <ul style="list-style-type: none"> • Member’s condition • Proposed treatment • Reason treatment is medically necessary <p>Medicaid does not cover these services for:</p> <ul style="list-style-type: none"> • Improvement of appearance or self-esteem (cosmetic) • Dental implants • Orthodontics
<p>Blepharoplasty</p>	<p>Mountain-Pacific Quality Health 3404 Cooney Drive Helena, MT 59602</p> <p>Phone 406.443.5887 Helena 877.443.4021 X5887 In/Out of state</p> <p>Fax 406.443.2580 Helena 877.443.2580 In/Out of state</p>	<p>Reconstructive blepharoplasty may be covered for:</p> <ul style="list-style-type: none"> • Correct visual impairment caused by drooping of the eyelids (ptosis) • Repair defects caused by trauma-ablative surgery (ectropion/entropion corneal exposure) • Treat periorbital sequelae of thyroid disease and nerve palsy • Relieve painful symptoms of blepharospasm (uncontrollable blinking). <p>Documentation must include:</p> <ul style="list-style-type: none"> • Surgeon must document indications for surgery • When visual impairment is involved, a reliable source for visual-field charting is recommended • Complete eye evaluation • Pre-operative photographs <p>Medicaid does not cover cosmetic blepharoplasty</p>

PA Criteria for Specific Services (Continued)		
Services	PA Contact	Documentation Requirements
Botox myobloc	<p>Mountain-Pacific Quality Health 3404 Cooney Drive Helena, MT 59602</p> <p>Phone 406.443.5887 Helena 877.443.4021 X5887 In/Out of state</p> <p>Fax 406.443.2580 Helena 877.443.2580 In/Out of state</p>	<p>For more details on botox criteria, coverage, and limitations, visit the Provider Information website (see “Key Websites”).</p> <p>Botox is covered for treating the following:</p> <ul style="list-style-type: none"> • Blepharospasm • Hemifacial spasm of the nerve • Torticollis, unspecified • Torsion dystonia • Fragments of dystonia • Hereditary spastic paraplegia • Strabismus and other disorders of binocular eye movements • Multiple sclerosis • Spastic hemiplegia • Infantile cerebral palsy • Other specified infantile cerebral palsy • Achalasia and cardiospasm • Spasm of muscle • Other demyelinating diseases of the central nervous system • Hyperhidrosis <p>Documentation requirements include a letter from the attending physician supporting medical necessity including:</p> <ul style="list-style-type: none"> • Member’s condition (diagnosis) • A statement that traditional methods of treatments have been tried and proven unsuccessful. Provide examples of tried and failed treatments. • Proposed treatment (dosage/frequency of injections) • Support the clinical evidence of the injections • Specify the sites injected • Myobloc is reviewed on a case-by-case basis

PA Criteria for Specific Services (Continued)		
Services	PA Contact	Documentation Requirements
<p>Excising excessive skin/subcutaneous tissue</p>	<p>Mountain-Pacific Quality Health 3404 Cooney Drive Helena, MT 59602</p> <p>Phone 406.443.5887 Helena 877.443.4021 X5887 In/Out of state</p> <p>Fax 406.443.2580 Helena 877.443.2580 In/Out of state</p>	<p>Required documentation includes:</p> <ul style="list-style-type: none"> • The referring physician and surgeon must document, in the history and physical, the justification for the resection of skin and fat redundancy following massive weight loss. • The duration of symptoms of at least six months and the lack of success of other therapeutic measures. Provide examples of failed treatments. • Pre-operative photographs <p>This procedure is contraindicated for, but not limited to, individuals with the following conditions:</p> <ul style="list-style-type: none"> • Severe cardiovascular disease • Severe coagulation disorders • Pregnancy <p>Medicaid does not cover cosmetic surgery to reshape the normal structure of the body or to enhance a member's appearance.</p>
<p>Rhinoplasty septorhinoplasty</p>	<p>Mountain-Pacific Quality Health 3404 Cooney Drive Helena, MT 59602</p> <p>Phone 406.443.5887 Helena 877.443.4021 X5887 In/Out of state</p> <p>Fax 406.443.2580 Helena 877.443.2580 In/Out of state</p>	<p>The following do not require PA:</p> <ul style="list-style-type: none"> • Septoplasty to repair deviated septum and reduce nasal obstruction • Surgical repair of vestibular stenosis to repair collapsed internal valves to treat nasal airway obstruction • Medicaid covers rhinoplasty in the following circumstances: • To repair nasal deformity caused by a cleft lip/cleft palate deformity for members 18 years of age and younger • Following a trauma (e.g., a crushing injury) which displaced nasal structures so that it causes nasal airway obstruction. <p>Documentation requirements include a letter from the attending physician documenting:</p> <ul style="list-style-type: none"> • Member's condition • Proposed treatment • Reason treatment is medically necessary <p>Not covered</p> <ul style="list-style-type: none"> • Cosmetic rhinoplasty done alone or in combination with a septoplasty • Septoplasty to treat snoring

PA Criteria for Specific Services (Continued)		
Services	PA Contact	Documentation Requirements
<p>Temporomandibular joint (TMJ) arthroscopy/surgery</p>	<p>Mountain-Pacific Quality Health 3404 Cooney Drive Helena, MT 59602</p> <p>Phone 406.443.5887 Helena 877.443.4021 X5887 In/Out of state</p> <p>Fax 406.443.2580 Helena 877.443.2580 In/Out of state</p>	<p>Nonsurgical treatment for TMJ disorders must be utilized first to restore comfort, and improve jaw function to an acceptable level.</p> <p>Nonsurgical treatment may include the following in any combination depending on the case:</p> <ul style="list-style-type: none"> • Fabrication and insertion of an intra-oral orthotic • Physical therapy treatments • Adjunctive medication • Stress management <p>Surgical treatment may be considered when both of the following apply:</p> <ul style="list-style-type: none"> • Other conservative treatments have failed (must be documented), and chronic jaw pain and dysfunction have become disabling. Conservative treatments must be utilized for six months before consideration of surgery. • There are specific, severe structural problems in the jaw joint. These include problems that are caused by birth defects, certain forms of internal derangement caused by misshapen discs, or degenerative joint disease. For surgical consideration, arthrogram results must be submitted for review. <p>Not covered:</p> <ul style="list-style-type: none"> • Botox injections for the treatment of TMJ is considered experimental. • Orthodontics to alter the bite • Crown and bridge work to balance the bite • Bite (occlusal) adjustments
<p>Dermabrasion/Abrasion chemical peel</p>	<p>Mountain-Pacific Quality Health 3404 Cooney Drive Helena, MT 59602</p> <p>Phone 406.443.5887 Helena 877.443.4021 X5887 In/Out of state</p> <p>Fax 406.443.2580 Helena 877.443.2580 In/Out of state</p>	<p>Services covered for the following:</p> <ul style="list-style-type: none"> • Treating severe, deep acne scarring not responsive to conservative treatment. All conservative treatments must have been attempted and documented for at least six months before medical necessity is determined. • The removal of precancerous skin growths (keratoses) <p>Documentation requirements include a letter from the attending physician documenting:</p> <ul style="list-style-type: none"> • Member’s condition • Proposed treatment • Reason treatment is medically

PA Criteria for Specific Services (Continued)		
Services	PA Contact	Documentation Requirements
<p>Positron emission tomography (PET) scans</p>	<p>Mountain-Pacific Quality Health 3404 Cooney Drive Helena, MT 59602</p> <p>Phone 406.443.5887 Helena 877.443.4021 X5887 In/Out of state</p> <p>Fax 406.443.2580 Helena 877.443.2580 In/Out of state</p>	<p>PET scans are covered for the following clinical conditions. For more details on each condition and required documentation, contact MPQH.</p> <ul style="list-style-type: none"> • Solitary pulmonary nodules (SPNs) – Characterization • Lung cancer (non small cell) – Diagnosis, staging, restaging • Esophageal cancer – Diagnosis, staging, restaging • Colorectal cancer – Diagnosis, staging, restaging • Lymphoma – Diagnosis, staging, restaging. • Melanoma – Diagnosis, staging, restaging. Not covered for evaluating regional nodes. • Breast cancer – As an adjunct to standard imaging modalities for staging members with distant metastasis or restaging members with locoregional recurrence or metastasis; as an adjunct to standard imaging modalities for monitoring tumor response to treatment for women with locally and metastatic breast cancer when a change in therapy is anticipated. • Head and neck cancers (excluding central nervous system and thyroid) – Diagnosis, staging, restaging • Myocardial viability – Primary or initial diagnosis, or following an inconclusive SPECT prior to revascularization. SPECT may not be used following an inconclusive PET scan. • Refractory seizures – Covered for presurgical evaluation only. • Perfusion of the heart using Rubidium 82 tracer (not DFG-PET) – Covered for noninvasive imaging of the perfusion of the heart.

PA Criteria for Specific Services (Continued)		
Services	PA Contact	Documentation Requirements
Reduction mammoplasty	<p>Mountain-Pacific Quality Health 3404 Cooney Drive Helena, MT 59602</p> <p>Phone 406.443.5887 Helena 877.443.4021 X5887 In/Out of state</p> <p>Fax 406.443.2580 Helena 877.443.2580 In/Out of state</p>	<p>Referring physician and surgeon must submit documentation.</p> <p>Back pain must have been documented and present for at least 6 months, and causes other than weight of breasts must have been excluded.</p> <p>Indications for female member</p> <ul style="list-style-type: none"> • Contraindicated for pregnant women and lactating mothers. A member must wait 6 months after the cessation of breast feeding before requesting this procedure. • Female member 16 years or older with a body weight less than 1.2 times the ideal weight. • There must be severe, documented secondary effects of large breasts, unresponsive to standard medical therapy administered over at least a 6-month period. This must include at least two of the following conditions: <ul style="list-style-type: none"> • Upper back, neck, shoulder pain that has been unresponsive to at least 6 months of documented and supervised physical therapy and strengthening exercises • Paresthesia radiating into the arms. If paresthesia is present, a nerve conduction study must be submitted. • Chronic intertrigo (a superficial dermatitis) unresponsive to conservative measures such as absorbent material or topical antibiotic therapy. Document extent and duration of dermatological conditions requiring antimicrobial therapy. • Significant shoulder grooving unresponsive to conservative management with proper use of appropriate foundation garments which spread the tension of the support and lift function evenly over the shoulder, neck and upper back.

PA Criteria for Specific Services (Continued)												
Services	PA Contact	Documentation Requirements										
Reduction Mammoplasty, cont'd	<p>Mountain-Pacific Quality Health 3404 Cooney Drive Helena, MT 59602</p> <p>Phone 406.443.4020 X5850 Helena 800.262.1545 X5850 In/Out of state</p> <p>Fax 406.443.4585 Helena 800.497.8235 In/Out of state</p>	<p>Documentation in the member's record must indicate/support:</p> <ul style="list-style-type: none"> History of the member's symptoms related to large, pendulous breasts. The duration of the symptoms of at least 6 months and the lack of success of other therapeutic measures (e.g., documented weight loss programs with 6 months of food and calorie intake diary, medications for back/neck pain). Guidelines for the anticipated weight of breast tissue removed from each breast related to the member's height (must be documented): <table border="0"> <tr> <td colspan="2">HeightWeight of tissue per breast</td> </tr> <tr> <td>less than 5'</td> <td>250 grams</td> </tr> <tr> <td>5' 0" to 5' 2"</td> <td>350 grams</td> </tr> <tr> <td>5' 2" to 5' 4"</td> <td>450 grams</td> </tr> <tr> <td>> 5' 4"</td> <td>500 grams</td> </tr> </table> <ul style="list-style-type: none"> Preoperative photographs of the pectoral girdle showing changes related to macromastia. Medication use history. Breast enlargements may be caused by various medications (e.g., sironolactone, cimetidine) or illicit drug abuse (e.g., marijuana, heroin, steroids). Although rare in women, drug effects should be considered as causes of breast enlargement prior to surgical treatment since the problem may recur after the surgery if the drugs are continued. Increased prolactin levels can cause breast enlargement (rare). Liver disease, adrenal or pituitary tumors may also cause breast enlargement and should also be considered prior to surgery. <p>Indications for male member:</p> <ul style="list-style-type: none"> If the condition persists, a member may be considered a good candidate for surgery. Members who are alcoholic, illicit drug abusers (e.g., steroids, heroin, marijuana) or overweight are not good candidates for the reduction procedure until they attempt to correct their medical problem first. Documentation required: length of time gynecomastia has been present, height, weight, and age of the member, preoperative photographs. 	HeightWeight of tissue per breast		less than 5'	250 grams	5' 0" to 5' 2"	350 grams	5' 2" to 5' 4"	450 grams	> 5' 4"	500 grams
HeightWeight of tissue per breast												
less than 5'	250 grams											
5' 0" to 5' 2"	350 grams											
5' 2" to 5' 4"	450 grams											
> 5' 4"	500 grams											

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

Identifying Other Sources of Coverage

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

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

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

Providers must 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 claims involving other payers. The other sources of coverage are referred to as third party liability (TPL), but Medicare is not.

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

Medicare Part A crossover claims do not automatically cross over from Medicare.

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

Medicare Part A Claims

Medicare Part A covers inpatient hospital care, skilled nursing care and other services. To date, Medicare has not made arrangements with Medicare Part A carriers for electronic exchange of claims covering Part A services. Providers must submit the claim first to Medicare. After Medicare processes the claim, an Explanation of Medicare Benefits (EOMB) is sent to the provider. The provider then reviews the EOMB, and submits the claim to Medicaid.

Medicare Part B Crossover Claims

Medicare Part B covers outpatient hospital care, physician care and other services. Although outpatient hospital care is covered under Part B, it is processed by Medicare Part A. This means that outpatient hospital claims are completed on a facility claim form and must be submitted directly to Medicaid. These claims do not automatically cross over from Medicare.

When Medicare Pays or Denies a Service

When outpatient hospital claims for members with Medicare and Medicaid:

- Are paid, submit the claim to Medicaid on a facility claim form with the Medicare coinsurance and deductible information in value code form locators and Medicare paid amounts in prior payment form locators. See the *Billing Procedures and Submitting a Claim* chapters in this manual.
- Are allowed, and the allowed amount went toward the member's deductible, include the deductible information and submit the claim to Medicaid on paper.
- Are denied, the provider submits a paper claim to Medicaid with the Medicare EOMB and the explanation of denial codes attached. If Medicare denies a claim because the service was not medically necessary, Medicaid will also deny the claim.

Submitting Medicare Claims to Medicaid

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

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 equal to what Medicaid paid (when the services were billed to Medicaid) must be turned over to the Department. Amounts in excess of what

Medicaid paid must be returned to the provider. The following words printed on the member's statement will fulfill this requirement: *When services are covered by Medicaid and another source, any payment the member receives from the other source must be turned over to Medicaid.*

Exceptions to Billing Third Party First

In a few cases, providers may bill Medicaid first:

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

Requesting an Exemption

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

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

When the Third Party Pays or Denies a Service

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

- Pays the claim, indicate the amount paid in the prior payment form locator of the claim when submitting to Medicaid for processing.
- Allows the claim, and the allowed amount went toward member's deductible, include the insurance Reason and Remarks (formerly EOB) when billing Medicaid. With HIPAA implementation, these claims may be submitted on paper or electronically with the paper attachment mailed in separately. The Paper Attachment Cover Sheet is available on the Forms page of the Provider Information [website](#).
- Denies the claim, include a copy of the denial (including the denial reason codes) with the claim form, and submit to Medicaid.

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:

- Attach a note to the paper claim explaining that the insurance company has been billed, or attach a copy of the letter sent to the insurance company.
- Include the date the claim was submitted to the insurance company.
- Send this information to 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.



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

Billing Procedures

Claim Forms

Services provided by the health care professionals covered in this manual must be billed either electronically or on a UB-04 claim form. UB-04 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:

Twelve months from whichever is later:

- the date of service
- the date retroactive eligibility or disability is determined

For claims involving Medicare or TPL, if the 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 45 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.

When to Bill Medicaid Members (ARM 37.85.406)

In most circumstances, providers may not bill Medicaid members for services covered under Medicaid.

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.
- When services are free to the member, and free to non-Medicaid covered individuals such as in a public health clinic.

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

When to Bill a Patient (ARM 37.85.406)			
	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	Patient is not Medicaid-enrolled
Service is covered by Medicaid	Provider can bill member only for cost sharing if the member is not exempt.	Provider can bill Medicaid member if the member has signed a routine agreement.	Provider can bill patient.
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.	Provider can bill patient.

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 that he/she must pay for the services received.

Custom Agreement: This agreement lists the service and date the member is receiving the service 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)

Native Americans who have ever been treated at an IHS, Tribal or Urban facility are exempt from cost sharing fees.

Billing for Retroactively Eligible Members

When a member becomes retroactively eligible for Medicaid, the IHS provider may:

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

When the provider accepts the member's retroactive eligibility, the provider has 12 months from the date retroactive eligibility was determined to bill for those services. When submitting claims for retroactively eligible 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. Providers may need to contact the member's local Office of Public Assistance. (See the *General Information for Providers* manual.) 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.

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

- Use current CPT, HCPCS Level II, and ICD diagnosis 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.
- Bill for the appropriate level of service provided. Evaluation and management services have three to five levels. See your CPT manual for instructions on determining appropriate levels of service.
- Revenue codes 25X do not require CPT or HCPCS codes; however, providers are advised to place appropriate CPT or HCPCS Level II codes on each line.
- Take care to use the correct units measurement. In general, Medicaid follows the definitions in the CPT and HCPCS Level II billing manuals. Unless otherwise specified, one unit equals one visit or one procedure.

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 800.621.8335 Optum 800.464.3649 www.optumcoding.com
CPT Assistant	A newsletter on CPT coding issues	American Medical Association 800.621.8335 800.262.3211 (AMA members) https://catalog.ama-assn.org/Catalog/home.jsp
HCPCS	<ul style="list-style-type: none"> • HCPCS codes and definitions • Updated each January and throughout the year 	Available through various publishers and bookstores or from CMS at www.cms.gov/ .
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 800.464.3649 www.optumcoding.com
NCCI Policy and Edits Manual	This manual contains National Correct Coding Initiative (NCCI) policy and edits, which are pairs of CPT or HCPCS Level II codes that are not separately payable except under certain circumstances. The edits are applied to services billed by the same provider for the same member on the same date of service.	National Technical Information Service http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html
UB-04 National Uniform Billing Expert	National UB-04 billing instructions	Available through various publishers and editors.

Number of Lines on Claim

Providers are asked to put no more than 40 lines on a UB-04 claim. Although additional lines may be billed on the same claim, the Department claims processing system is most efficient for outpatient claims with 40 lines or fewer.

Multiple Services on Same Date

IHS providers can submit single or multiple claims for all services provided to the same member on the same day. Like revenue codes billed on the same date of service will deny.

Span Bills

Providers may include services for more than one day on a single claim, so long as the service is billed with the IHS revenue code and the date is shown on the line. See the Reimbursement Methods for Specific Services table in the How Payment Is Calculated chapter of this manual.

Reporting Service Dates

- All line items must have a valid date of service in form locator (FL) 45.
- The following revenue codes require a separate line for each date of service and a valid CPT or HCPCS Level II code:
 - 51X Clinic
 - 77X Preventive Care Services

IHS Revenue Codes

IHS providers may bill Medicaid with the revenue codes shown in the following table using their IHS provider number.

IHS Revenue Codes for Billing Medicaid		
Service	Revenue Code	Description
Inpatient	100	All inclusive room, board plus ancillary
General Class Medical/ Surgical Supplies	270	
General Class – Durable Medical Equipment	290	
Rental – Durable Medical Equipment	291	
Purchase – Durable Medical Equipment	292	
Lab	300	Lab services
Radiology	320	Diagnostic
Outpatient Surgery	490	Outpatient surgery

IHS Revenue Codes for Billing Medicaid (Continued)

Service	Revenue Code	Description
Outpatient Clinic Visit	500	General class outpatient clinic services (e.g., physician, mid-level, therapy)
Eyeglasses	509	Eye exam and dispensing
Dental	512	Dental clinic visit
Psychiatric	513	Psychiatric clinic visit
Additional Visit	519	Other outpatient visit
VFC	771	VFC administration
Inpatient Physician Visit	987	Professional fees – hospital visit

Billing for Specific Services

Prior authorization is required for some services. Passport and prior authorization are different, and some services may require both. (See the Passport and Prior Authorization chapters in this manual.) Different codes are issued for each type of approval and must be included on the claim form. (See the Submitting a Claim chapter in this manual.)

Some services provided by an IHS are billed with the IHS provider number and codes specific to IHS. (See the IHS Revenue Codes for Billing Medicaid table previously in this manual.) Other services require the IHS to enroll as a Medicaid provider for the type of services provided (e.g., dialysis clinic services, nursing facility services, home health) and are billed using the Medicaid provider number assigned to that provider type. All providers must be enrolled with Medicaid before billing for services. The table below describes billing procedures for different services.

Every claim for Medicaid services must indicate the provider of service. Claims for services rendered in IHS facilities are submitted using the IHS facility's provider number. However, when services are rendered in a non-IHS facility, the claim should be submitted using the individual's provider number.

IHS physicians do not receive reimbursement directly from Medicaid but from the IHS. IHS providers must show the Billings Area Indian Health Services as the "pay to" address on the enrollment form so that all payments will go directly to the IHS office.

<p align="center">Billing Procedures for Specific Services Manuals are available on the Provider Information website.</p>		
Service	Billing Method	NPI for Billing
Ambulance	Bill Medicaid according to the instructions in the <i>Ambulance Services</i> manual.	Ambulance provider
Audiology	Bill Medicaid using the IHS clinic visit revenue code.	IHS provider
Chiropractor (QMB and children under 20 only)	Bill Medicaid according to the instructions in the <i>Chiropractic Services</i> manual.	Chiropractic provider
Dental	Bill Medicaid using the IHS dental revenue code.	IHS provider
Denturist	Bill Medicaid according to the instructions in the <i>Dental and Denturist Services</i> manual.	Denturist provider
Dialysis Clinic	Bill Medicaid according to the instructions in the <i>Dialysis Clinic Services</i> manual.	Dialysis clinic provider
Durable Medical Equipment, Prosthetics, Orthotics and Medical Supplies (DMEPOS)	Bill Medicaid according to the instructions in the <i>Durable Medical Equipment, Prosthetics, Orthotics and Medical Supplies</i> manual.	DME provider
EPSDT (children age 21 and under)	Bill Medicaid using the IHS clinic visit revenue code.	IHS provider
Eyeglasses	Eyeglass purchases must be made through the Department's eyeglass contractor. See the <i>Optometric and Eyeglass Services</i> manual. The eyeglass contractor bills Medicaid for lab and materials and the optometric provider bills Medicaid for the clinic visit.	Billed by the Department's eyeglass contractor.
Family Planning	Bill Medicaid using the IHS clinic visit revenue code.	IHS provider
Freestanding Dialysis Clinic	Bill Medicaid according to the instructions in the <i>Dialysis Clinic Services</i> manual.	Dialysis clinic provider
Hearing Aids	Bill Medicaid according to the instructions in the <i>Durable Medical Equipment, Prosthetics, Orthotics and Medical Supplies</i> manual.	Hearing aid provider
Home and Community Services (HCBS)	Bill Medicaid according to the instructions in the <i>Home- and Community-Based Services</i> manual.	HCBS provider
Home Dialysis	Bill Medicaid according to the instructions in the <i>Dialysis Clinic Services</i> manual.	Home dialysis provider
Home Health	Bill Medicaid according to the instructions in the <i>Home Health Services</i> manual.	Home health provider

Billing Procedures for Specific Services (Continued)		
Manuals are available on the Provider Information website.		
Service	Billing Method	NPI for Billing
Home Infusion Therapy	Bill Medicaid according to the instructions in the <i>Home Infusion Therapy Services</i> manual.	Home infusion therapy provider
Inpatient/Outpatient Hospital	Bill Medicaid using the IHS inpatient or outpatient hospital visit revenue code.	IHS provider
Lab and X-ray	These services are included in the IHS clinic visit revenue code; do not bill separately for lab and x-ray services.	N/A
Licensed Professional Counselor	Bill Medicaid using the IHS psychiatric revenue code.	IHS provider
Nursing Facility	Bill Medicaid according to the instructions in the <i>Nursing Facility and Swing Bed Services</i> manual.	Nursing facility or swing bed provider
Occupational Therapy	Bill Medicaid using the IHS outpatient clinic visit revenue code.	IHS provider
Optician/Optomety	Bill Medicaid using the IHS vision clinic visit revenue code.	IHS provider
Outpatient Clinic	Bill Medicaid using the IHS outpatient clinic visit revenue code.	IHS provider
Oxygen	Bill Medicaid according to the instructions in the <i>Durable Medical Equipment, Prosthetics, Orthotics and Medical Supplies</i> manual or the <i>Nursing Facility and Swing Bed Services</i> manual.	DME provider
Personal Assistance	Bill Medicaid according to the instructions in the <i>Personal Assistance Services</i> manual.	Personal assistance provider
Pharmacy	Bill Medicaid using the IHS pharmacy prescription refill code.	IHS provider
Physical Therapy	Bill Medicaid using the IHS outpatient clinic visit revenue code.	IHS provider
Physician and Mid-Level Practitioner IHS Clinic Visit	Bill Medicaid using the IHS outpatient clinic visit revenue code.	IHS provider
Physician and Mid-Level Practitioner IHS Inpatient Hospital Visit/Service	Bill Medicaid using the IHS inpatient physician visit revenue code.	IHS provider

Billing Procedures for Specific Services (Continued)		
Manuals are available on the Provider Information website.		
Service	Billing Method	NPI for Billing
Physician and Mid-Level Practitioner Non-IHS Inpatient Visit	For an inpatient visit from an IHS physician (at a non-IHS facility), bill Medicaid using the IHS inpatient physician visit revenue code. For an inpatient visit from a non-IHS physician (at a non-IHS facility), the physician bills Medicaid using the <i>Physician-Related Services</i> manual.	IHS provider for IHS physician Physician provider for non-IHS physician
Podiatry	Bill Medicaid according to the instructions in the <i>Physician-Related Services</i> manual.	Physician provider
Prosthetics	Bill Medicaid according to the instructions in the <i>Durable Medical Equipment, Prosthetics, Orthotics and Medical Supplies</i> manual.	DME provider
Psychologist	Bill Medicaid using the IHS psychiatric revenue code.	IHS provider
Residential Treatment Center	Bill Medicaid according to the instructions in the mental health manuals for adult and youth.	Mental health provider
RHC and FQHC	Bill Medicaid according to the instructions in the <i>Rural Health Clinics and Federally Qualified Health Centers</i> manual.	RHC or FQHC provider
School-Based Services	Bill Medicaid according to the instructions in the <i>School-Based Services</i> manual.	School-based services provider
Social Worker	Bill Medicaid using the IHS outpatient clinic visit revenue code.	IHS provider
Speech Therapy	Bill Medicaid using the IHS outpatient clinic visit revenue code.	IHS provider
Swing Bed	Bill Medicaid according to the instructions in the <i>Nursing Facility and Swing Bed Services</i> manual.	Nursing facility or swing bed provider
Targeted Case Management (TCM)	Bill Medicaid according to the instructions in the <i>Targeted Case Management Services</i> manual.	TCM provider
Transportation	Bill Medicaid according to the instructions in the <i>Commercial and Specialized Non-Emergency Transportation Services</i> manual.	Transportation provider

Submitting a Claim

See the Submitting a Claim chapter in this manual for instructions on completing claim 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 both paper and electronic claims 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 missing or invalid	The NPI is a 10-digit number assigned to the provider. Verify the correct NPI is on the claim.
Incorrect claim form used	The claim must be the correct form for the provider type. Services covered in this manual require a UB-04 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 form locator. Information must not be obscured by lines.
Member number not on file, or member was not eligible on date of service	Before providing services to the member, verify member eligibility by using one of the methods described in the Member Eligibility and Responsibilities chapter of the <i>General Information for Providers</i> manual. Medicaid eligibility may change monthly.
Procedure requires Passport provider approval – No Passport approval number on claim	A Passport provider approval number must be on the claim form when such approval is required. Passport approval is different from prior authorization (PA). See the Passport and Prior Authorization chapters in this manual.
Prior authorization (PA) number is missing	PA is required for certain services, and the PA number must be on the claim form. PA is different from Passport authorization. See the Passport and Prior Authorization chapters in this manual.
Prior authorization (PA) does not match current information	Claims must be billed and services performed during the PA span. The claim will be denied if it is not billed according to the spans on the authorization.

Common Billing Errors (Continued)	
Reasons for Return or Denial	How to Prevent Returned or Denied Claims
Duplicate claim	<p>Check all remittance advices (RAs) for previously submitted claims before resubmitting.</p> <p>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.</p>
Missing Medicare EOMB	<p>All denied Medicare crossover claims must have an Explanation of Medicare Benefits (EOMB) with denial reason codes attached, and be billed to Medicaid on paper.</p>
Provider is not eligible during dates of services, enrollment has lapsed due to licensing requirements, or provider number terminated	<p>Out-of-state providers must update licensure for Medicaid enrollment early to avoid denials. If enrollment has lapsed due to expired licensure, claims submitted with a date of service after the expiration date will be denied until the provider updates his/her enrollment. New providers cannot bill for services provided before Medicaid enrollment begins.</p> <p>If a provider is terminated from the Medicaid program, claims submitted with a date of service after the termination date will be denied.</p>
Procedure is not allowed for provider type	<p>Provider is not allowed to perform the service. Verify the procedure code is correct using the appropriate HCPCS and CPT billing manual.</p> <p>Check the appropriate Medicaid fee schedule to verify the procedure code is valid for your provider type.</p>

Submitting a Claim

Electronic Claims

Providers who submit claims electronically experience fewer errors and quicker payment. Providers should be familiar with federal rules and regulations on preparing electronic transactions. Claims may be submitted electronically by the following methods:

- **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.
- **WINASAP 5010.** Xerox makes this free software available. Providers may use it to submit claims to Montana Medicaid, MHSP, HMK (dental and eyeglasses only) and FQHC/RHC. It does not support submissions to Medicare or other payers. This software creates an 837 transaction, but does not accept an 835 transaction back from the Department.
- **Xerox EDI Solutions.** Providers can send claims to the Xerox clearinghouse, Xerox EDI Solutions (formerly ACS EDI Gateway), in X12 837 format using a dial-up connection. Electronic submitters are required to certify their 837 transactions as HIPAA-compliant before sending their transactions through the Xerox clearinghouse. EDIFECs certifies the 837 HIPAA transactions at no cost to the provider. EDIFECs certification is completed through Xerox EDI Solutions.
- **Clearinghouse.** Providers can contract with a clearinghouse so that the provider can send the claim in whatever format the clearinghouse accepts. The provider's clearinghouse then sends the claim to Xerox EDI Solutions in the X12 837 format. The provider's clearinghouse also needs to have their 837 transactions certified through EDIFECs before submitting claims to Xerox. EDIFECs certification is completed through EDI Solutions. For more information on electronic claims submission, contact Provider Relations or the EDI Support Unit. (See Key Contacts.)
- **Xerox 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.
- **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 2MB.

Billing Electronically with Paper Attachments

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 Medicaid ID number followed by the member’s ID number and the date of service, each separated by a dash:

999999999 - 888888888 - 11182003
 Provider NPI Member ID Number Date of Service (mmdyyy)

The supporting documentation must be submitted with a Paperwork Attachment Cover Sheet. (See the Forms page 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 electronically or on facility 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.)

Sample forms are on the IHS provider type page on the website.

Claim Inquiries

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

Passport and Cost Sharing Indicators	
Passport to Health Indicators	
Code	Description
FPS	This indicator is used when providing family planning services.
OBS	This indicator is used when providing obstetrical services.
TCM	This indicator is used when providing targeted case management services.
Cost Sharing Indicators	
E	This indicator is used when providing emergency services.
F	This indicator is used when providing family planning services.
P	This indicator is used when providing services to pregnant women.

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

Avoiding Claim Errors

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

Common Claim Errors	
Claim Error	Prevention
Required form locator is blank	Check the claim instructions earlier in this chapter for required form locators. If a required form locator is blank, the claim may either be returned or denied.
Member ID number missing or invalid	This is a required form locator; verify that the member's Medicaid ID number is listed as it appears on the member's eligibility verification. See the <i>General Information for Providers</i> , Member Eligibility chapter.
Member name missing	This is a required form locator; check that it is correct.
NPI missing or invalid	The NPI is a 10-digit number assigned to the provider during Medicaid enrollment. Verify the correct NPI is on the claim.
Passport provider name and ID number missing	When services are not provided by the member's Passport provider, include the provider's Passport number. See the Passport chapters in this manual.
Prior authorization number missing	When prior authorization (PA) is required for a service, the PA number must be listed on the claim. See the Prior Authorization chapter in this manual.
Not enough information regarding other coverage	Certain fields are required when a member has other coverage.
Incorrect claim form used	Services covered in this manual require a facility 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 form locator. Information must not be obscured by lines.

Remittance Advices and Adjustments

Remittance Advice Description

The remittance advice is the best tool providers have to determine the status of a claim. Remittance advices accompany payment for services rendered and provide details of all transactions that have occurred during the previous remittance advice cycle. Providers are paid weekly, and each line of the remittance advice represents all or part of a claim, and explains whether the claim has been paid, denied, or suspended/pending. If the claim was suspended or denied, the remittance advice also shows the reason. Remittance advices are available electronically through the Montana Access to Health (MATH) web portal. Providers must complete a Trading Partner Agreement to register for the MATH web portal. In addition, payments are made via electronic funds transfer/direct deposit. Providers must complete the Electronic Funds Transfer (EFT)/Electronic Remittance Advice (ERA) Authorization Agreement to receive payment. Contact Provider Relations or visit the Montana Medicaid Provider Information website.

RA Notice

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

Paid Claims

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

Denied Claims

This section shows claims denied during the previous cycle. If a claim has been denied, refer to the Reason/Remark Codes column (Field 18). The reason and remark code description explains why the claim was denied and is located at the end of the RA. See the table titled The Most Common Billing Errors and How to Avoid Them in the Billing Procedures chapter. Make necessary changes to the claim before rebilling Medicaid.

Pending Claims

All claims that have not reached final disposition will appear in this area of the RA. The RA uses *suspended* and *pending* interchangeably. Both mean that the claim has not reached final disposition. If a claim is pending, refer to the Rea-



Due to HIPAA regulations, the APC and the lab panel it bundled to will not show on the RA.



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



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

son/Remark (R&R) Code column. The R&R code description 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 7 days. If Medicaid receives eligibility information within the 7-day period, the claim will continue processing. If no eligibility information is received within 7 days, the claim will be denied. When a claim is denied for lack of eligibility, the provider should verify that the correct Medicaid ID number was billed. If the ID number was incorrect, resubmit the claim with the correct ID number.

Credit Balances

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

Credit balances can be resolved in two ways:

1. By working off the credit balance. Remaining credit balances can be deducted from future claims. These claims will continue to appear on consecutive RAs until the credit has been paid.
2. By sending a check payable to DPHHS for the amount owed. This method is required for providers who no longer submit claims to Montana Medicaid. Attach a note stating that the check is to pay off a credit balance and include your NPI/API. Send the check to the Third Party Liability address. in the Key Contacts chapter of this manual.

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

For details regarding billing, see below.

How Long Do I have to Rebill or Adjust a Claim?

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

Rebilling Medicaid

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

When to Rebill Medicaid

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

How to Rebill

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

Adjustments

If a provider believes that a claim has been paid incorrectly, he/she may call Provider Relations or submit a claim inquiry for review. (See the Claim Inquiries section in the Submitting a Claim chapter.) Once an incorrect payment has been verified, the provider may submit an Individual Adjustment Request form (Forms page, Provider Information [website](#)) 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 a claim was overpaid or underpaid.
- Request an adjustment when a claim was paid but the information on the claim was incorrect (e.g., member ID, provider NPI, date of service, procedure code, diagnoses, units).
- Request an adjustment when a single line on a multi-line claim was denied.

How to Request an Adjustment

To request an adjustment, use the Individual Adjustment Request form on the Provider Information [website](#). The requirements for adjusting a claim are as follows:

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

Completing an Adjustment Request Form

1. Download the Individual Adjustment Request form from the Provider Information website to ensure you are using the current form. Complete Section A with provider and member information and the ICN number.
2. Complete Section B of the form with information about the claim. Remember to fill in only the items that need to be corrected. (See table.)



Sample Adjustment Request

**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.

<p>1. Provider Name and Address Open Range PHS Name 33 Best Road Street or P.O. Box Open Range MT 59003 City State ZIP</p>	<p>3. Internal Control Number (ICN) 0020401125000600</p> <p>4. NPI/API 1000010000</p> <p>5. Member ID Number 111001111</p>
<p>2. Member Name Jane Doe</p>	<p>6. Date of Payment 02/15/2010</p> <p>7. Amount of Payment \$ 150.00</p>

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	02/01/2010	01/23/2010
4. Billed Amount			
5. Personal Resource (Nursing Facility)			
6. Insurance Credit Amount			
7. Net (Billed - TPL or Medicare Paid)			
8. Other/Remarks (Be specific.)			

Signature John R. Smith, M.D. Date 04/15/2010

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

- Enter the date of service or the line number in the Date of Service or Line Number column.
- Enter the information from the claim form that was incorrect in the Information on Statement column.
- Enter the correct information in the column labeled Corrected Information.

Completing an Individual Adjustment Request Form	
Field	Description
Section A	
1. Provider name and address	Provider's name and physical address (and mailing address if different).
2. Member 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.* NPI	The provider's National Provider Identifier (NPI).
5.* Recip ID	Member's Medicaid ID number.
6. Date of payment	Date claim was paid is found on the RA (Field 5); see the sample RA earlier in this chapter.
7. Amount of payment	The amount of payment from the remittance advice (Field 16); see the sample RA earlier in this chapter.
Section B	
1. Units of service	If a payment error was caused by an incorrect number of units, complete this line.
2. Procedure code/NDC/Revenue code	If the procedure code, NDC, or revenue code is incorrect, complete this line.
3. Dates of service (DOS)	If the date of service is incorrect, complete this line.
4. Billed amount	If the billed amount is incorrect, complete this line.
5. Personal resource (nursing facility)	If the 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 third party liability or Medicare paid.
8. Other/Remarks	If none of the above items apply, or if you are unsure what caused the payment error, complete this line.

*Indicates a required field.

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 suffice.
 - 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 Claims. (See Key Contacts.)
 - If an original payment was an underpayment by Medicaid, the adjustment will result in the provider receiving the additional payment amount allowed.
 - If an original payment was an overpayment by Medicaid, the adjustment will result in recovery of the overpaid amount through a credit. If the result is a credit balance, it can be worked off or the provider can pay off the balance by check. (See the Credit Balances section earlier in this chapter.)
 - Any questions regarding claims or adjustments must be directed to Provider Relations. (See Key Contacts).

Mass Adjustments

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

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

Providers are informed of mass adjustments on the first page of the remittance advice (RA Notice section). Mass adjustment claims shown on the remittance advice have an ICN that begins with a 4.

Payment and the Remittance Advice

Providers receive their Medicaid payment and remittance advices electronically and are required to enroll in electronic funds transfer (EFT) and register for the Montana Access to Health (MATH) web portal to receive their electronic remittance advices (ERAs). Direct deposit is another term for EFT.

To participate in EFT, providers must complete the Electronic Funds Transfer (EFT)/Electronic Remittance Advice (ERA) Authorization Agreement. One form must be completed for each provider number.

With EFT, the Department deposits the funds directly into the provider's bank account. If the scheduled deposit day is a holiday, funds will be available on the next business day. The electronic remittance advices will also be available the next business day.

Once electronic transfer testing shows payment to the provider's account, all Medicaid payments will be made through EFT. Contact Provider Relations for assistance.

The MATH web portal provides the tools and resources to help health care providers conduct business electronically.

Providers must complete the Trading Partner Agreement, register for the Montana Access to Health (MATH) web portal, and have Internet access to access their electronic RAs. Due to space limitations, each RA is only available for 90 days.

For instructions on enrolling in EFT, registering for and using the MATH web portal, contact Provider Relations at 1.800.624.3958.

Required Forms for EFT and/or Electronic RA			
Form	Purpose	Where to Get	Where to Send
EFT/ERA Authorization Agreement	Allows the Department to automatically deposit Medicaid payment into provider's bank account	<ul style="list-style-type: none"> Provider Information website 	Provider Relations Fax to (406) 442-4402.
Trading Partner Agreement	Allow provider to register for the MATH web portal and access their ERA on the web portal.	<ul style="list-style-type: none"> Provider Relations MATH web portal 	Provider Relations Fax to (406) 442-4402.

How Payment Is Calculated

Overview

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

Montana Medicaid payments to IHS Medicaid facilities are contracted. Medicaid pays outpatient IHS services on an all-inclusive encounter basis and pays for inpatient services using a per diem payment.

Montana operates the IHS according to the State Plan, which states that services provided by IHS and/or tribal 638 facilities are paid with federal funds according to rates prescribed by the Centers for Medicare and Medicaid Services (CMS) and established by the U.S. Public Health Services for IHS as set forth in the Federal Register. Subsequent payment adjustments will be made pursuant to changes published in the Federal Register.”

Section 1905(b) of the Social Security Act (the Act) provides that 100% Federal Medical Assistance Percentages (FMAP) is available to states for amounts spent on medical assistance received through an IHS facility whether operated by the IHS or by an Indian tribe or tribal organization, as defined in Sec. 4 of the Indian Health Care Improvement Act.

Physician services provided by IHS physicians in non-IHS facilities are **not** eligible for 100% federal funds, but rather at the regular federal/state match rate of approximately 70% federal funds and 30% state funds. Montana Medicaid pays for these physician services by utilizing the Medicare Resource-Based Relative Value Scale (RBRVS) with a Montana-specific conversion factor.

IHS Rates Established by CFR

IHS/tribal facilities are paid in accordance with the most current Federal Register Notice, published by IHS and approved by CMS.

Services provided by facilities of the IHS, which include at the option of a tribe or tribal organization, services by tribal 638 facilities funded by Title I or Title III of the Indian Self-Determination and Education Assistance Act (P.L. 93-638), are paid at the rates negotiated between CMS and the IHS and published in the Federal Register.

Payment for IHS/tribal 638 inpatient hospital services is made in accordance with the most current inpatient hospital per diem rate published in the Federal Register by the IHS. Payment for IHS/tribal 638 outpatient services is made in accordance with the most current outpatient per-visit rate published by the IHS in the Federal Register.

Other Payment Rates

Payments for vaccinations are \$9.50 per visit.

All IHS services performed in an IHS facility, whether paid as fee for service or at CFR rates, are 100% Federal Pass Through (see table).

Reimbursement Method for Specific Services

Manuals referenced here are available on the Provider Information website.

Service	Reimbursement Method
Ambulance	Medicaid fee for service. See the Medicaid Ambulance fee schedule and the chapter titled How Payment Is Calculated chapter of the <i>Ambulance Services</i> manual.
Audiology	IHS contract rate.
Chiropractor (QMB and children under 20 only)	Medicaid fee for service. See the Medicaid Chiropractic fee schedule and the chapter titled How Payment Is Calculated in the <i>Chiropractic Services</i> manual.
Dental	IHS contract rate.
Denturist	Medicaid fee for service. See the Medicaid Dental and Denturist fee schedule and the chapter titled How Payment Is Calculated chapter in the <i>Dental and Denturist Services</i> manual.
Dialysis Clinic	Medicaid negotiated rate. See the chapter titled How Payment Is Calculated in the <i>Dialysis Clinic Services</i> manual.
Durable Medical Equipment, Prosthetics, Orthotics and Medical Supplies (DMEPOS)	IHS contract rate.
EPSDT (children age 21 and under)	IHS contract rate.
Eyeglasses	IHS contract rate.
Family Planning	Per IHS contract.
Freestanding Dialysis Clinic	Medicaid per diem rate. See the chapter titled How Payment Is Calculated in the <i>Dialysis Clinic Services</i> manual.
Hearing Aids	Medicaid fee for service. See the Medicaid Hearing Aid fee schedule and the chapter titled How Payment Is Calculated in the <i>Audiology and Hearing Aid Services</i> manual.
Home and Community Services	Medicaid fee for service. See the Medicaid Home and Community-Based Services fee schedule and the chapter titled How Payment Is Calculated in the <i>Home and Community-Based Services</i> manual.
Home Dialysis	Medicaid fee for service.
Home Health	Fee for service.
Home Infusion Therapy	Fee for service. See the Medicaid Home Infusion fee schedule and the chapter titled How Payment Is Calculated in the <i>Home Infusion Therapy Services</i> manual.

Reimbursement Method for Specific Services	
Manuals referenced here are available on the Provider Information website.	
Service	Reimbursement Method
Inpatient/Outpatient Hospital/Outpatient Clinic	Rate established by the U.S. Public Health Service for IHS; inpatient physician services are paid by negotiated rate between Department and IHS.
Lab and X-ray	IHS contract rate.
Licensed Professional Counselor	IHS contract rate.
Nursing Facility	Medicaid per diem rate and fee for service for some ancillary services. See the Medicaid Nursing Facility fee schedule and the chapter titled How Payment Is Calculated in the <i>Nursing Facility and Swing Bed Services</i> manual.
Occupational Therapy	IHS contract rate.
Optician/Optomety	IHS contract rate.
Oxygen	Medicaid fee for services. See the Medicaid fee schedule for the service setting (e.g., physician, DMEPOS, nursing facility). See also the chapter titled How Payment Is Calculated in the corresponding manuals.
Personal Assistance	Fee for service. See the Medicaid Personal Assistance fee schedule.
Pharmacy	Refills paid per IHS contract; initial prescription included in physician payment.
Physical Therapy	IHS contract rate.
Physician and Mid-Level Practitioner IHS Clinic Visit	IHS contract rate.
Physician and Mid-Level Practitioner IHS Inpatient Hospital Visit/Service	IHS negotiated rate.
Physician and Mid-Level Practitioner Non-IHS Inpatient Visit	IHS contract rate.
Podiatry	Fee for service. See the Medicaid Podiatry fee schedule and the chapter titled How Payment Is Calculated in the <i>Physician-Related Services</i> manual.
Prosthetics	Medicaid fee for services. See the Medicaid DMEPOS fee schedule and the chapter titled How Payment Is Calculated in the <i>DMEPOS</i> manual.
Psychologist	IHS contract rate.
Residential Treatment Center	Per diem rate. See the chapter titled How Payment Is Calculated in the mental health manual.
RHC and FQHC	Per diem rate. See the chapter titled How Payment Is Calculated in the <i>FQHC and RHC Services</i> manual.
School-Based Services	Fee for service. See the Medicaid School-Based Services fee schedule and the chapter titled How Payment Is Calculated in the <i>School-Based Services</i> manual.
Social Worker	IHS contract rate.
Speech Therapy	IHS contract rate.

Reimbursement Method for Specific Services
 Manuals referenced here are available on the Provider Information website.

Service	Reimbursement Method
Swing Bed	Medicaid per diem rate and fee for service for some ancillary services. See the Medicaid Nursing Facility fee schedule and the chapter titled How Payment Is Calculated in the <i>Nursing Facility and Swing Bed Services</i> manual.
Targeted Case Management	Fee for service. See the Medicaid targeted case management fee schedule.
Transportation	Fee for service. See the Medicaid Commercial and Specialized Non-Emergency Transportation fee schedule and the chapter titled How Payment Is Calculated in the <i>Commercial and Specialized Non-Emergency Transportation Services</i> manual.

Appendix A: Forms

The forms below and others are found on the [Forms page](#) of the Montana Medicaid Provider Information website.

- Individual Adjustment Request
- Paperwork Attachment Cover Sheet

Definitions and Acronyms

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

Administrative Rules of Montana (ARM)

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

Allowed Amount

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

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 of the *General Information for Providers* manual.

Billable Visit

A documented one-on-one visit between a Medicaid eligible beneficiary and a qualified health care professional where a Medicaid covered service is provided.

Bundled

Items or services that are deemed integral to performing a procedure or visit that 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 by Medicare (usually a percentage). Medicare coinsurance is usually 20% of the Medicare allowed amount.

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 flat fee or percentage of charges.

Crossovers

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

Date of Submission

The date the claim is stamped received by Xerox or the Department. A claim lost in the mail is not considered received.

Designated Professional Review Organization

The organization or its agents or representatives with whom the State has contracted to provide professional review of medical claims.

DPHHS, State Agency

The Montana Department of Public Health and Human Services (DPHHS or the Department) is the designated State Agency that administers the Montana Health Care Programs. 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 are often referred to as dual eligibles.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

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

Emergency Medical Condition

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

- Placing the health of the individual in serious jeopardy;
- Serious impairment to body functions; or
- Serious dysfunction of any bodily organ or party; or with respect to a pregnant woman, who is having contractions:

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

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. (See Key Contacts on your provider type page or in your provider manual.)

Experimental

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

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.

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.

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.

Healthy Montana Kids (HMK)

HMK offers low-cost or free health insurance for low-income children younger than 19. Children must be uninsured U.S. citizens, qualified aliens, or Montana residents who are not eligible for Medicaid. DPHHS administers the program and purchases health insurance from Blue Cross and Blue Shield of Montana (BCBSMT). Benefits for dental services and eyeglasses are provided by DPHHS through the same contractor (Xerox State Healthcare, LLC) that handles Medicaid provider relations and claims processing.

Healthy Montana Kids *Plus* (HMK *Plus*)

Medicaid eligibility group for children under age 19.

Inpatient Hospital Services

Services that are ordinarily furnished in a hospital, under the direction of a physician or dentist, for the care and treatment of inpatients. The services are furnished in an institution that

- Is maintained primarily for the care and treatment of patients with disorders other than mental diseases.
- Is licensed or formally approved as a hospital by an officially designated authority for state standard-setting.
- Meets the requirements for participation in Medicare as a hospital.
- Has in effect a utilization review plan, applicable to all Medicaid patients, that meets the requirements of Section 482.3 of Title 42 of the CFR, unless a waiver has been granted by the Secretary.

Inpatient hospital services do not include SNF and ICF services furnished by a hospital with a swing bed approval.

Indian Health Service (IHS)

IHS provides health services to American Indians and Alaska Natives.

Indian Health Service (IHS) Facility

An IHS facility is an entity that is either owned or leased by the IHS of the Public Health Service. The IHS equates facilities that are leased by IHS to those that are owned by IHS for purposes of defining an IHS facility. IHS keeps a specific listing of its owned and leased facilities. Some IHS facilities, although owned by IHS, may be operated by a tribe or tribal organization.

Indian Health Service (IHS) Freestanding Facility

A facility or location owned and operated by the IHS which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians who do not require hospitalization.

Indian Health Service (IHS) Provider-Based Facility

A facility or location owned and operated by the IHS, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services by, or under the supervision of, physicians to American Indians who are admitted as inpatients or outpatients.

Individual Adjustment

A request for a correction to a specific paid claim.

Inpatient

A patient who has been admitted to a medical institution as an inpatient on recommendation of a physician or dentist and who receives room, board, and professional services in the

institution for a 24-hour period or longer, or is expected by the institution to receive room, board, and professional services in the institution for a 24-hour period or longer. The member is considered an inpatient even though he or she dies, is discharged, or is transferred to another facility and does not actually stay in the institution for 24 hours.

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 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 payment, 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 precancerous condition.

Nurse First Advice Line

The Nurse First Advice Line is a toll-free, confidential number members may call 24/7/365 for advice from a registered nurse about injuries, diseases, health care or medications.

Outpatient

A person who has not been admitted by a hospital as an inpatient, who is expected by the hospital to receive services in the hospital for less than 24 hours, who is registered on the hospital records as an outpatient, and who receives outpatient hospital services, other than supplies or prescription drugs alone, from the hospital.

Outpatient Services

Preventive, diagnostic, therapeutic, rehabilitative or palliative services that are furnished to outpatients by or under the direction of a physician, dentist, or mid-level practitioner (physician assistant, nurse practitioner, nurse mid-wife, or other specialized nurse practitioner as defined in Section 406.2401 and 491.2 of Title 42 of the Code of Federal Regulations).

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 Program

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

Patient Day

An individual present and receiving medical services in a facility for a whole 24-hour period. Although an individual may not be present for a whole 24-hour period on the day of admission, such a day will be considered a patient day. The day of discharge will not be counted as a patient day except when the patient is admitted and discharged on the same day.

Prior Authorization (PA)

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

Private-Pay

When a member chooses to pay for medical services out of his/her own pocket.

Provider or Provider of Service

An institution, agency, or person having a signed agreement with the Department to furnish medical care, goods, and/or services to members, and eligible to receive payment from the Department.

Public Assistance Toolkit

This website (<https://dphhs.mt.gov/>) contains information about human services, justice, commerce, labor and industry, education, voter registration, the Governor's Office, and Montana.

Qualified Individual

For these members, Medicaid pays the Medicare premium only. They are not eligible for other Medicaid benefits, and they must pay their own Medicare insurance and deductible.

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.

Reference Lab Billing

Reference lab billing occurs when a Medicaid provider draws a specimen and sends it to a reference lab for processing. The reference lab then sends the results back to the Medicaid provider. Medicaid does not cover lab services when they are billed by the referring provider.

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

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

Remittance Advice (RA)

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

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.

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 deductible.

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 over-utilizing 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, 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/CHIP 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:

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

Tribal 638 Freestanding Facility

A facility or location owned and operated by a federally recognized American Indian Tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members admitted as inpatients or outpatients.

Usual and Customary

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

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