



Private Duty Nursing Services



*Medicaid and Other Medical
Assistance Programs*



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My NPI/API:

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Key Contacts and Websites

Hours for Key Contacts are 8:00 a.m. to 5:00 p.m. Monday through Friday (Mountain Time), unless otherwise stated. The phone numbers designated **only** “In state” will not work outside Montana. For additional contacts and websites, choose the Contact Us link in the left menu on the Provider Information [website](#).

Prior Authorization

For prior authorization requests or for authorization for private duty nursing services requests not included in the Medicaid fee schedule:

800-262-1545, X5850
406-443-4020 Helena

Mail backup documentation to:
Medicaid Utilization Review Department
Mountain-Pacific Quality Health
P.O. Box 6488
Helena, MT 59604-64882

Fax backup documentation to:
877-428-0684
406-513-1922 Helena

Private Duty Nursing Services

406-444-4189 Phone
406-444-1861 Fax

Send written inquiries to:
Program Officer
Private Duty Nursing Services
Medicaid Services Bureau
DPHHS
P.O. Box 202951
Helena, MT 59620-2951

Introduction

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

Manual Organization

This manual provides information specifically for providers of private duty nursing services. Additional essential information for providers is contained in the separate *General Information for Providers* manual. Each provider is asked to review both manuals.

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. Each manual contains a list of *Key Contacts*. We have also included a space on the back of the front cover to record your NPI/API for quick reference when calling Provider Relations.

Manual Maintenance

In order to remain accurate, manuals must be kept current. Changes to manuals are provided through notices and replacement pages, which are posted on the Provider Information website (see *Key Websites*). When replacing a page in a paper manual, file the old pages and notices in the back of the manual for use with claims that originated under the old policy.

Rule References

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

In addition to the general Medicaid rules outlined in the *General Information for Providers* manual, the following rules and regulations are also applicable to the private duty nursing services program:

- Code of Federal Regulations (CFR)
 - 42 CFR 440.80 Private Duty Nursing Services
- Montana Code Annotated (MCA)
 - MCA 53-6-101
- Administrative Rules of Montana (ARM)
 - ARM 37.85.2701–37.86.2217 EPSDT Private Duty Nursing Services



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

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

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

Getting Questions Answered

The provider manuals are designed to answer most questions; however, questions may arise that require a call to a specific group (such as a prior authorization contractor or Provider Relations). 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, notices, replacement pages, fee schedules, forms, and much more are available on the Provider Information website (see *Key Websites*).

Other Department Programs

The Medicaid private duty nursing services in this manual are not benefits of the Mental Health Services Plan (MHSP), so the information in this manual does not apply to MHSP. For more information on MHSP, see the mental health manual available on the Provider Information website (see *Key Websites*).

The Medicaid private duty nursing services in this manual are not covered benefits of Healthy Montana Kids (HMK). Additional information regarding HMK benefits is available by contacting Blue Cross and Blue Shield of Montana at 1-877-543-7669 (toll-free, follow menu) or 1-855-258-3489 (toll-free, direct), or by visiting the HMK website (see *Key Websites*).

Covered Services

General Coverage Principles

This chapter provides covered services information that applies specifically to services provided by private duty nursing services providers. Like all health care services received by Medicaid clients, services rendered by these providers must also meet the general requirements listed in the *General Information for Providers* manual, *Provider Requirements* chapter.

Services within scope of practice (ARM 37.85.401)

Services are covered only when they are within the scope of the provider's license. As a condition of participation in the Montana Medicaid program all providers must comply with all applicable state and Federal statutes, rules and regulations, including but not limited to Federal regulations and statutes found in Title 42 of the Code of Federal Regulations and the United States Code governing the Medicaid program and all applicable Montana statutes and rules governing licensure and certification.

Licensing

Private duty nursing services providers must be registered nurses or licensed practical nurses.

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 clients ages 20 and under. It is designed to prevent, identify, and then treat health problems before they become disabling. Under EPSDT, Medicaid-eligible children may receive any medically necessary covered service, including all private duty nursing services described in this manual. All applicable Passport to Health and prior authorization requirements apply. See the *Physician-Related Services* manual for more information on the EPSDT program.

Noncovered Services (ARM 37.85.207)

Medicaid does not cover the following services:

- Services provided to Medicaid clients who are absent from the state, with the following exceptions:
 - Medical emergency.
 - Required medical services are not available in Montana. Prior authorization may be required; see the *Prior Authorization* chapter in this manual.
 - If the Department has determined that the general practice for clients in a particular area of Montana is to use providers in another state.

- When out-of-state medical services and all related expenses are less costly than in-state services.
- When Montana makes adoption assistance or foster care maintenance payments for a client who is a child residing in another state.
- Private duty nursing services do not include psychological or mental health counseling; nurse supervision services including chart review, case discussion, or scheduling by a registered nurse; travel time to and/or from the client's place of service; or services provided to allow the client, family, or caregiver to work or go to school.
- Respite care is not a benefit of the private duty nursing program. If eligible, respite services may be covered through the Home- and Community-Based Services waiver program.

Coverage of Specific Services

Home Infusion Therapy Services

Home infusion therapy services are nursing services provided by a registered nurse employed by a home infusion therapy agency. These nursing services are provided to all patients who require home infusion therapy. See the *Home Infusion Therapy Services* manual for more information.

Home Health Nursing Services

Home health nursing services are provided by an enrolled Medicaid home health agency. These nursing services are provided to patients of all ages who require home health care. They must be billed by that agency in accordance with current home health program procedures and not under home infusion therapy or private duty nursing services. See the *Home Health Services* manual for more information.

Private Duty Nursing

Private duty nursing services are limited to skilled nursing services provided directly to a child under age 21 and patient-specific training provided to a registered nurse or licensed practical nurse when a child is new to the nursing agency, when a change in the condition of a child requires additional training for the current nurse, or when a change in nursing personnel requires a new nurse to be trained to care for a child.

Private duty nursing services may be provided to a child without parents or guardians being present. However, providers may require a parent or guardian to be present while services are being provided. The issue of whether to require a parent or guardian to be present during private duty nursing services is between the provider and the client. Medicaid will not dictate this policy.

Private duty nursing services must be authorized prior to the initial provision of services, and any time the condition of the client changes resulting in a change to the amount of skilled nursing services being provided. Authorization must be renewed with the Department or the Department's designated review agent every 90 days during the first 6 months of services, and every 6 months thereafter.

Authorization for private duty nursing services provided through school districts may be authorized for the duration of the regular school year. Services provided during the summer months are additional services that require separate prior authorization.

Authorization is based on approval of a plan of care by the Department or the Department's designated review agent.

A provider of private duty nursing services must be an incorporated entity meeting the legal criteria for independent contractor status that either employs or contracts with nurses for the provision of nursing services. The Department does not contract with or reimburse individual nurses as providers of private duty nursing services.

Private duty nursing services provided to an eligible client by a person who is the client's legally responsible person, as that term is used in this rule, must be prior authorized by the Department or its designee.

For purposes of this rule, "legally responsible person" means a person who has a legal obligation under the provisions of Montana law to care for another person. Legally responsible person includes the parents (natural, adoptive, or foster) of minor children, legally assigned caretaker relatives of minor children, and spouses.

For private duty nursing services provided to a Medicaid client by a person who is legally responsible for the Medicaid client, the Department will approve no more than 40 hours of services under the EPSDT program in a 7-day period. The legally responsible person must meet the Department's criteria for providing private duty nursing services. The individual must be a licensed RN or LPN and be employed by an agency enrolled to provide private duty nursing services.

Verifying Coverage

The easiest way to verify coverage for a specific service is to check the Department's fee schedule for your provider type. In addition to being listed on the fee schedule, all services provided must also meet the coverage criteria listed in this chapter and in the *General Information for Providers* manual, *Provider Requirements* chapter. Use the fee schedule in conjunction with the more detailed coding descriptions listed in the CPT and HCPCS Level II coding books. **Use the fee schedule and coding books that pertain to the date of service.**

Current fee schedules are available on the Provider Information [website](#) (see *Key Websites*).

Passport to Health Program

For Passport to Health information, see the *Passport to Health* manual. The manual is available on the Passport to Health page and applicable provider type pages on the Provider Information [website](#).

Prior Authorization

Prior Authorization

All private duty nursing services must be prior authorized by the Department's designee (see *Key Contacts*). Prior authorization requests must be accompanied by a practitioner's prescription for the services.

The number of private duty nursing services units approved is based on the time required to perform a skilled nursing task. Medicaid authorizes a set number of private duty nursing hours based upon the needs of the individual child for a specific time period. How these hours are used is between the provider and the client and his/her parents. Clients may use their allotted number of hours for direct skilled care within the specific time period. The scheduling of the hours and how they are going to be used is between the provider, the client and his/her family; however, direct skilled care must be provided by the private duty nursing staff. **Additional hours will not be allowed if the family has used all allotted hours before the specified time period ends and wishes to have more to cover the rest of the time period unless there has been a medical change in the child. Unused hours for the specified time period do not carry forward.**

Private duty nursing services must be authorized prior to provision of the services and any time the plan of care is amended. Authorization must be renewed with the Department or Department's designated review agent (see *Key Contacts*) every 90 days during the first 6 months of service, and every 6 months thereafter.

Authorization is based on approval of a plan of care by the Department or Department's designated review agent.

Montana Medicaid will not perform retrospective reviews of private duty nursing authorization requests for services that have already been provided to clients and not authorized by the Department or its designee.

Private duty nursing hours for new clients will be handled as requests are received from providers as clients are discharged from the hospital or other medical setting. The prior authorization must be requested at the time of the initial submission of the plan of care.

For clients currently receiving private duty nursing services, providers are required to renew prior authorization requests in 2 weeks before the end date on the current prior authorization request. Renewals of prior authorization requests must be made every 90 days during the first 6 months, and every 6 months after that. Prior authorization also must be requested any time the plan of care is amended.

To request a prior authorization, submit a completed Request for Authorization, Private Duty Nursing Services which can be found on the Provider Information website. Send it to the address listed in *Key Contacts*.

The Medicaid program uses an automated prior authorization system. A record of each authorization will be entered into the claims processing system. A prior authorization number will be assigned and notification of all prior authorization approvals and denials will appear on your remittance advice. This 10-digit number is specific to each prior authorization request and must be entered in Field 23 of the CMS-1500 claim form as proof of authorization.

If a provider receives prior authorization for a service, the Medicaid client must still be eligible for Medicaid at the time the service is provided. If the recipient is not eligible for Medicaid, payment will be denied based on client eligibility even if services were prior authorized.

You are requested to estimate the number of private duty nursing hours per day for each child. The number of hours authorized by the Department may be different than the number of hours the nursing firm requested. Federal regulations require Medicaid to authorize reimbursement only for the time required to perform a skilled nursing task. Therefore, units authorized may be different than units requested. Other services such as personal care attendants, home health care, etc. may be obtained under other programs if all program requirements are met.

Coordination of Benefits

When Clients Have Other Coverage

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

Identifying Additional Coverage

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

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

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

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

When a Client Has Medicare

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

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



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



When submitting a Medicare crossover claim to Medicaid, use Medicaid billing instructions and codes; they may not be the same as Medicare's.



Medicare Part B crossover claims

Private duty nursing services may be covered under Medicare Part B. The Department has an agreement with the Medicare Part B carrier for Montana (Noridian) and the Durable Medical Equipment Regional Carrier (DMERC) under which the carriers provide the Department with claims for clients who have both Medicare and Medicaid coverage. Providers must tell Medicare that they want their claims sent to Medicaid automatically, and must have their Medicare provider number on file with Medicaid.

When clients have both Medicare and Medicaid covered claims, and have made arrangements with both Medicare and Medicaid, Part B services need not be submitted to Medicaid. When a crossover claim is submitted only to Medicare, Medicare will process the claim, submit it to Medicaid, and send the provider an Explanation of Medicare Benefits (EOMB). Providers must check the EOMB for the statement indicating that the claim has been referred to Medicaid for further processing. It is the provider's responsibility to follow up on crossover claims and make sure they are correctly billed to Medicaid within the timely filing limit (see the *Billing Procedures* chapter in this manual).

Providers should submit Medicare crossover claims to Medicaid only when:

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

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

When submitting a claim with the Medicare EOMB, use Medicaid billing instructions and codes. Medicare's instructions, codes, and modifiers may not be the same as Medicaid's. The claim must also include the Medicaid provider number and Medicaid client ID number. It is the provider's responsibility to follow up on crossover claims and make sure they are correctly billed to Medicaid within the timely filing limit (see the *Billing Procedures* chapter in this manual).

When a Client Has TPL (ARM 37.85.407)

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

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

Exceptions to billing third party first

In a few cases, providers may bill Medicaid first:

- When a Medicaid client is also covered by Indian Health Services (IHS) or Crime Victim Compensation, providers must bill Medicaid first. These are not considered a third party liability.
- If the third party has only potential liability, such as automobile insurance, the provider may bill Medicaid first. Do not indicate the potential third party on the claim. Instead, notify the Department of the potential third party by sending the claim and notification directly to the Third Party Liability Unit (see *Key Contacts*).

Requesting an exemption

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

- When a provider is unable to obtain a valid assignment of benefits, the provider should submit the claim with documentation that the provider attempted to obtain assignment and certification that the attempt was unsuccessful.
- When the provider has billed the third party insurance and has received a non-specific denial (e.g., no client name, date of service, amount billed), submit the claim with a copy of the denial and a letter of explanation.
- When the Child Support Enforcement Division has required an absent parent to have insurance on a child, the claim can be submitted to Medicaid when the following requirements are met:
 - The third party carrier has been billed, and 30 days or more have passed since the date of service.
 - The claim is accompanied by a certification that the claim was billed to the third party carrier, and payment or denial has not been received.
 - If another insurance has been billed, and 90 days have passed with no response, submit the claim with a note explaining that the insurance company has been billed, or 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.



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.

When the third party pays or denies a service

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

- Pays the claim, indicate the amount paid when submitting the claim to Medicaid for processing.
- Allows the claim, and the allowed amount went toward the client's deductible, include the insurance explanation of benefits (EOB) when billing Medicaid.
- Denies the claim, submit the claim and a copy of the denial (including the reason explanation) to Medicaid.
- Denies a line on the claim, bill the denied line on a separate claim and submit to Medicaid. Include the EOB from the other payer as well as an explanation of the reason for denial (e.g., definition of denial codes).

When the third party does not respond

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

- Submit the claim and a note explaining that the insurance company has been billed, or 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*).

Billing Procedures

Claim Forms

Services provided by private duty nursing service providers must be billed either electronically or on a CMS-1500 claim form. CMS-1500 forms are available from various publishing companies; they are not available from the Department or Provider Relations.

Timely Filing Limits (ARM 37.85.406)

Providers must submit clean claims to Medicaid within:

- 12 months from the latest of:
 - the date of service
 - the date retroactive eligibility or disability is determined
- 6 months from the date on the Medicare EOMB approving the service (if the Medicare claim was timely filed and the client was eligible for Medicare at the time the Medicare claim was filed).
- 6 months from the date on an adjustment notice from a third party payer who has previously processed the claim for the same service, and the adjustment notice is dated after the periods described above.

Clean claims are claims that can be processed without additional information or action from the provider. The submission date is defined as the date that the claim was received by the Department or the claims processing contractor. All problems with claims must be resolved within this 12-month period.

Tips to avoid timely filing denials

- Correct and resubmit denied claims promptly (see the *Remittance Advices and Adjustments* chapter in this manual).
- If a claim submitted to Medicaid does not appear on the remittance advice within 30 days, contact Provider Relations for claim status (see *Key Contacts*).
- If another insurer has been billed and 90 days have passed with no response, you can bill Medicaid (see the *Coordination of Benefits* chapter in this manual for more information).
- To meet timely filing requirements for Medicare/Medicaid crossover claims, see the *Coordination of Benefits* chapter in this manual.

When to Bill Medicaid Clients (ARM 37.85.406)

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

More specifically, providers cannot bill clients directly:

- For the difference between charges and the amount Medicaid paid.
- When the provider bills Medicaid for a covered service, and Medicaid denies the claim because of billing errors.
- When a third party payer does not respond.
- When a client fails to arrive for a scheduled appointment. Medicaid may not be billed for no-show appointments.
- When services are free to the client. Medicaid may not be billed for those services either.

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

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

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

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

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

Client Cost Sharing (ARM 37.85.204)

Cost sharing fees are a set dollar amount per visit, and they are based on the average Medicaid allowed amount for the provider type and rounded to the nearest dollar. EPSDT and private duty nursing services are exempt from cost sharing.

When Clients Have Other Insurance

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

Billing for Retroactively Eligible Clients

When a client becomes retroactively eligible for Medicaid, the provider has 12 months from the date retroactive eligibility was determined to bill for those services. When submitting claims for retroactively eligible clients, attach a copy of the FA-455 (eligibility determination letter) to the claim if the date of service is more than 12 months earlier than the date the claim is submitted.

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

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

Usual and Customary Charge (ARM 37.85.406)

Providers should bill Medicaid their usual and customary charge for each service; that is, the same charge that is made to other payers for that service.

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 table of *Coding Resources* on the following page. The following suggestions may help reduce coding errors and unnecessary claim denials:

- Use current CPT, HCPCS Level II, and ICD coding books.
- Always read the complete description and guidelines in the coding books. Relying on short descriptions can result in inappropriate billing.
- Attend classes on coding offered by certified coding specialists.
- Use the correct units measurement on the claim.

Coding Resources		
Please note that the Department does not endorse the products of any particular publisher.		
Resource	Description	Contact
CCI Policy and Edits Manual	<ul style="list-style-type: none"> This manual contains Correct Coding Initiative (CCI) 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 client on the same date of service. 	National Technical Information Service (800) 363-2068 (703) 605-6060 www.ntis.gov/products/cci.aspx
CPT Assistant	<ul style="list-style-type: none"> A newsletter on CPT coding issues 	American Medical Association (800) 621-8335 www.amapress.com
CPT	<ul style="list-style-type: none"> CPT codes and definitions Updated each January 	American Medical Association (800) 621-8335 www.amapress.com
HCPCS Level II	<ul style="list-style-type: none"> HCPCS Level II codes and definitions Updated each January and throughout the year 	Available 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	<ul style="list-style-type: none"> Various newsletters and other coding resources. 	Medicode (Ingenix) www.shopingenix.com

Using the Medicaid Fee Schedule

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

In addition to covered services and payment rates, fee schedules often contain helpful information such as appropriate modifiers and prior authorization indicators. Department fee schedules are updated each January and July. Current fee schedules are available on the Provider Information website (see *Key Websites*).

Using Modifiers

- Review the guidelines for using modifiers in the most current CPT, HCPCS Level II, or other helpful resources.
- Always read the complete description for each modifier; some modifiers are described in the CPT manual while others are in the HCPCS Level II book.

- The Medicaid claims processing system recognizes only two pricing modifiers and one informational modifier per claim line. Providers are asked to place any modifiers that affect pricing in the first two modifier fields.
- Modifier 52 must be used when billing for a partial EPSDT well-child screen.

Billing Tips for Specific Providers

Private Duty Nursing Services

A provider of private duty nursing services must be an incorporated entity meeting the legal criteria for independent contractor status that either employs or contracts with nurses for the provision of nursing services. The Department does not contract with or reimburse individual nurses as providers or private duty nursing services.

The Most Common Billing Errors and How to Avoid Them

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

Common Billing Errors	
Reasons for Returns or Denials	How to Prevent Returned or Denied Claims
NPI missing or invalid	The provider number is a 10-digit number assigned to the provider during Medicaid enrollment. Verify the correct NPI provider number is on the claim.
Authorized signature missing	Each claim must have an authorized signature belonging to the provider, billing clerk, or office personnel. The signature may be typed, stamped, or handwritten.
Signature date missing	Each claim must have a signature date.
Incorrect claim form used	The claim must be the correct form for the provider type. Services covered in this manual require a CMS-1500 claim form.
Information on claim form not legible	Information on the claim form must be legible. Use dark ink and center the information in the field. Information must not be obscured by lines.
Client number not on file, or client was not eligible on date of service	Before providing services to the client: <ul style="list-style-type: none"> • View the client's eligibility information at each visit; Medicaid eligibility may change monthly. • Verify client eligibility by using one of the methods described in the <i>Client Eligibility and Responsibilities</i> chapter of the <i>General Information for Providers</i> manual.
Procedure requires Passport provider approval – No Passport approval number on claim	<ul style="list-style-type: none"> • A Passport provider approval number must be on the claim form when such approval is required. See the <i>Passport</i> chapter in this manual.

Common Billing Errors	
Reasons for Returns or Denials	How to Prevent Returned or Denied Claims
Duplicate claim	<ul style="list-style-type: none"> • Check all remittance advices (RAs) for previously submitted claims before resubmitting. • When making changes to previously paid claims, submit an adjustment form rather than a new claim form (see <i>Remittance Advices and Adjustments</i> in this manual). • Allow 45 days for the Medicare/Medicaid Part B crossover claim to appear on the RA before submitting the claim directly to Medicaid.
Prior authorization number is missing	<ul style="list-style-type: none"> • Prior authorization (PA) is required for certain services, and the PA number must be on the claim form (see the <i>Prior Authorization</i> chapter in this manual).
TPL on file and no credit amount on claim	<ul style="list-style-type: none"> • If the client has any other insurance (or Medicare), bill the other carrier before Medicaid. See <i>Coordination of Benefits</i> in this manual. • If the client's TPL coverage has changed, providers must notify the TPL Unit (see <i>Key Contacts</i>) before submitting a claim.
Claim past 365-day filing limit	<ul style="list-style-type: none"> • The Claims Processing Unit must receive all clean claims and adjustments within the timely filing limits described in this chapter. • To ensure timely processing, claims and adjustments must be mailed to Claims Processing at the address shown in <i>Key Contacts</i>.
Missing Medicare EOMB	<ul style="list-style-type: none"> • All Medicare crossover claims on CMS-1500 forms must have an EOMB attached.
Provider is not eligible during dates of services, or provider number terminated	<ul style="list-style-type: none"> • Out-of-state providers must update enrollment early to avoid denials. If enrollment has lapsed, claims submitted with a date of service after the expiration date will be denied until the provider updates his or her enrollment. • New providers cannot bill for services provided before Medicaid enrollment begins. • If a provider is terminated from the Medicaid program, claims submitted with a date of service after the termination date will be denied.
Type of service/procedure is not allowed for provider type	<ul style="list-style-type: none"> • Provider is not allowed to perform the service. • Verify the procedure code is correct using current HCPCS and CPT billing manual. • Check the Medicaid fee schedule to verify the procedure code is valid for your provider type.

Submitting a Claim

Electronic Claims

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

- **ACS field software WINASAP 5010.** ACS makes available this free software, which providers can use to create and submit claims to Montana Medicaid, MHSP, and HMK (dental and eyeglasses only), and FQHC and 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.
- **ACS clearinghouse.** Providers can send claims to the ACS clearinghouse (ACS EDI Gateway) in X12 837 format using a dial-up connection. Electronic submitters are required to certify their 837 transactions as HIPAA-compliant before sending their transactions through the ACS clearinghouse. EDIFECS certifies the 837 HIPAA transactions at no cost to the provider. EDIFECS certification is completed through ACS EDI Gateway.
- **Clearinghouse.** Providers can contract with a clearinghouse so that the provider can send the claim to them in whatever format they accept. The provider's clearinghouse then sends the claim to ACS in the X12 837 format. The provider's clearinghouse also needs to have their 837 transactions certified through EDIFECS before submitting claims to ACS. EDIFECS certification is completed through ACS EDI Gateway. For more information on electronic claims submission, contact Provider Relations or the EDI Technical Help Desk (see *Key Contacts*).
- **Montana Access to Health (MATH) web portal.** Providers can upload and download electronic transactions 7 days a week through the MATH web portal. This availability is subject to scheduled and unscheduled host downtime.
- **ACS B2B Gateway SFTP/FTPS Site.** Providers can use this method to send electronic transactions through this secure FTP process. This is typically encountered with high-volume/high-frequency submitters.
- **ACS MOVEit DMZ.** Providers can use this secure transmission protocol and secure storage landing zone (intermediate storage) for the exchange of files between Trading Partners and ACS. 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

Providers should be familiar with Federal rules and regulations and instructions on preparing electronic transactions.

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 client's ID number and the date of service, each separated by a dash:

999999999	-	888888888	-	11182003
NPI/API		Client ID Number		Date of Service (mmddyyyy)

The supporting documentation must be submitted with a Paperwork Attachment Cover Sheet (on the Provider Information website and in *Appendix A: Forms*). The number in the paper Attachment Control Number field must match the number on the cover sheet. For information on attachment control numbers and submitting electronic claims, contact Provider Relations.

Paper Claims

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

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

- Client has Medicaid coverage only
- Client has Medicaid and third party liability coverage

When completing a claim, remember the following:

- Required fields are indicated by “*”.
- Fields that are required if the information is applicable to the situation or client are indicated by “**”.
- Field 24H, *EPSDT/Family Planning*, is used to override copayment and Passport authorization requirements for certain clients or services.

The following are accepted codes:

EPSDT/Family Planning Overrides		
Code	Client/Service	Purpose
1	EPSDT	Overrides some benefit limits for client under age 21
2	Family planning	Overrides the Medicaid cost sharing and Passport authorization on the line
3	EPSDT and family planning	Overrides Medicaid cost sharing and Passport authorization for persons under the age of 21
4	Pregnancy (any service provided to a pregnant woman)	Overrides Medicaid cost sharing on the claim
6	Nursing facility client	Overrides the Medicare edit for oxygen services on the line

Unless otherwise stated, all paper claims are mailed to:

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

All Medicaid claims must be submitted on Department approved claim forms. CMS-1500 forms are available from various publishing companies; they are not available from the Department or Provider Relations.

Client Has Medicaid Coverage Only

Field	Field Title	Instructions
1	Program	Check Medicaid.
1a	Insured's ID number	Leave this field blank for Medicaid only claims.
2*	Patient's name	Enter the client's name as it appears on the Medicaid client's eligibility information.
3	Patient's birth date and sex	Client's birth date in mm/dd/yyyy format. Check M (male) or F (female) box.
5	Insured's address	Client's address.
10	Is patient's condition related to employment, auto accident, other accident?	Check Yes or No to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in Field 24. If you answered Yes to any of these, enter the two-letter state abbreviation on the Place line to indicate where the accident occurred.
10d*	Reserved for local use	Enter the client's Medicaid ID number as it appears on the client's Medicaid eligibility information.
11d*	Is there another health benefit plan?	Enter No, or if Yes, follow claim instructions for appropriate coverage later in this chapter.
14	Date of current illness, injury, or pregnancy	Enter date in mm/dd/yyyy format. This field is optional for Medicaid-only claims.
16	Dates patient unable to work in current occupation	If applicable, enter date in mm/dd/yyyy format. This field is optional for Medicaid-only claims.
17	Name of referring provider or other source	Enter the name of the referring provider. For Passport clients, the name of the client's Passport provider goes here.
17a**	NPI of referring provider	Enter the referring or ordering physician's NPI. For Passport clients, enter the client's Passport provider's Passport ID number.
18	Hospitalization dates related to current service	Enter dates if the medical service is furnished as a result of, or subsequent to, a related hospitalization. This field is optional for Medicaid only claims.
19	Reserved for local use	This field is used for any special messages regarding the claim or client.
20	Outside lab?	Check No. Medicaid requires all lab tests to be billed directly by the provider who performed them.
21*	Diagnosis or nature of illness or injury	Enter the appropriate ICD diagnosis codes (up to 4 codes in priority order (primary, secondary)).
23**	Prior authorization number	If the service requires prior authorization (PA), enter the PA number you received for this service.
24A*	Dates of service	Enter date of service for each procedure, service, or supply.
24B*	Place of service	Enter the appropriate two-digit place of service.
24C*	EMG (Emergency)	Enter an X if this service was rendered in a hospital emergency room to override Medicaid cost share.
24D*	Procedures, services, or supplies	Enter the appropriate CPT or HCPCS code for the procedure, service, or supply. When applicable, enter the appropriate CPT/HCPCS modifier. Medicaid allows up to three modifiers per procedure code.
24E*	Diagnosis code	Enter the corresponding diagnosis code reference number (1, 2, 3 or 4) from Field 21 (do not enter the diagnosis code). Any combination of applicable diagnosis reference numbers may be listed on one line.
24F*	Charges	Enter provider's usual and customary charge for the procedure on this line.
24G*	Days or units	Enter the number of units or days for the procedure and date of service billed on this line (see <i>Billing Procedures, Coding</i> for additional tips on days/units).
24H**	EPSDT/Family Plan(ning)	If applicable, enter the appropriate code for the client/service: 1, 2, 3, 4 or 6 (see complete description in the <i>EPSDT/Family Planning Overrides</i> table in this chapter).
24I**	ID qualifier	
28*	Total charge	Enter the sum of all charges billed in Field 24F.
29	Amount paid	Leave blank or enter \$0.00. Do not report client cost share or Medicaid payment amounts on this form.
30*	Balance due	Enter the balance due as recorded in Field 28.
31*	Signature and date	This field must contain an authorized signature of physician or supplier (include degree or credentials) which is either handwritten, stamped, or computer-generated, and a date.
32	Service facility location	Enter the name, address, city, state, and ZIP code of the person, organization, or facility performing the services if other than the client's home or physician's office.
33*	Billing provider info and phone	Enter the name, address, city, state, ZIP code, and phone number and NPI of the provider or supplier who furnished the service.

* = Required field ** = Required, if applicable

Client Has Medicaid Coverage Only

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>																								
1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input checked="" type="checkbox"/> (Medicaid #) TRICARE CHAMPUS <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA BLK LUNG <input type="checkbox"/> (SSN) OTHER <input type="checkbox"/> (ID)										1a. INSURED'S I.D. NUMBER (For Program in Item 1)																								
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Rhoads, Rock Y.										3. PATIENT'S BIRTH DATE MM DD YY 02 28 11					SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial)														
5. PATIENT'S ADDRESS (No., Street) 123 Anystreet #1										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					7. INSURED'S ADDRESS (No., Street)																			
CITY Anytown					STATE					8. PATIENT STATUS MT Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>					CITY					STATE														
ZIP CODE 59999					TELEPHONE (Include Area Code) (406) 555-5555										ZIP CODE					TELEPHONE (Include Area Code) ()														
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:										11. INSURED'S POLICY GROUP OR FECA NUMBER														
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>														
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)										b. EMPLOYER'S NAME OR SCHOOL NAME														
c. EMPLOYER'S NAME OR SCHOOL NAME										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										c. INSURANCE PLAN NAME OR PROGRAM NAME														
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. RESERVED FOR LOCAL USE 999999999					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>																			
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____																								
14. DATE OF CURRENT: MM DD YY					ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Harold Hunter, MD										17a. _____					17b. NPI 9989999					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY														
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO																								
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 783 3										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.										23. PRIOR AUTHORIZATION NUMBER 999999														
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER				E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPST Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #														
1 05 24 11 05 24 11		22		97802						179 00		4		NPI		9999999999																		
2 07 16 11 07 16 11		22		97803						79 00		2		NPI		9999999999																		
3														NPI																				
4														NPI																				
5														NPI																				
6														NPI																				
25. FEDERAL TAX I.D. NUMBER 99-9999999					SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/> X					26. PATIENT'S ACCOUNT NO. 99999					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE \$ 258 00					29. AMOUNT PAID					30. BALANCE DUE \$ 258 00				
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) <i>Betty Biller</i> 04/01/04										32. SERVICE FACILITY LOCATION INFORMATION a. NPI b. _____										33. BILLING PROVIDER INFO & PH # (406) 555-5555 City Medical P.O. Box 999 Anytown, MT 59999														
SIGNED _____ DATE _____										a. 0000099999 b. _____																								

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Client Has Medicaid and Third Party Liability Coverage

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

* = Required Field

** = Required if applicable

Client Has Medicaid and Third Party Liability Coverage

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>																																																	
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 999999999B																																																	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) White, Snow										3. PATIENT'S BIRTH DATE MM DD YY 02 26 11					SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>																																												
5. PATIENT'S ADDRESS (No., Street) 4321 Anystreet										6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>																																																	
CITY Anytown					STATE					7. INSURED'S ADDRESS (No., Street) Same					CITY					STATE																																							
ZIP CODE 59999					TELEPHONE (Include Area Code) (406) 999-9999					8. PATIENT STATUS Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>					ZIP CODE					TELEPHONE (Include Area Code) ()																																							
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:										11. INSURED'S POLICY GROUP OR FECA NUMBER																																							
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO										a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>																																							
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO										b. EMPLOYER'S NAME OR SCHOOL NAME																																							
c. EMPLOYER'S NAME OR SCHOOL NAME										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO										c. INSURANCE PLAN NAME OR PROGRAM NAME Paywell Insurance																																							
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. RESERVED FOR LOCAL USE 9999999										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>																																							
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____																																																	
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																																							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Smith, Steven R. MD										17a. _____					17b. NPI 99999999					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																							
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 783 xx										23. PRIOR AUTHORIZATION NUMBER																																																	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY										B. PLACE OF SERVICE					C. EMG					D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER					E. DIAGNOSIS POINTER					F. \$ CHARGES					G. DAYS OR UNITS					H. EPSDT Family Plan					I. ID. QUAL.					J. RENDERING PROVIDER ID. #									
1 05 24 11 05 24 11 22										97802										179 00										NPI					9999999999																								
2																														NPI																													
3																																			NPI																								
4																																								NPI																			
5																																													NPI														
6																																																		NPI									
25. FEDERAL TAX I.D. NUMBER										SSN EIN					26. PATIENT'S ACCOUNT NO.					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE \$ 179 00					29. AMOUNT PAID \$ 80 00					30. BALANCE DUE \$ 99 00																								
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) <i>Betty Biller</i> 05/01/11 SIGNED _____ DATE _____										32. SERVICE FACILITY LOCATION INFORMATION a. NPI b. _____										33. BILLING PROVIDER INFO & PH # (406) 999-9999 City Medical P.O. Box 999 Anytown, MT 59999 a. 9999999999 b. _____																																							

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CMS-1500 Agreement

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

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

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

REFERS TO GOVERNMENT PROGRAMS ONLY

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

BLACK LUNG AND FECA CLAIMS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

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

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

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

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

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

Claim Inquiries

Claim inquiries can be obtained electronically through ANSI ASC X12N 276/277 transactions or by contacting Provider Relations. Providers may also contact Provider Relations for questions regarding payments, denials, and other claim questions (see *Key Contacts*).

If you prefer to communicate with Provider Relations in writing, use the Montana Health Care Programs *Claim Inquiry Form* on the Provider Information website (see *Key Websites*). A copy of the form is also in *Appendix A: Forms*. Complete the top portion of the form with the provider's name and address.

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

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 field is blank	Check the claim instructions earlier in this chapter for required fields (indicated by * or **). If a required field is blank, the claim may either be returned or denied.
Client ID number missing or invalid	This is a required field (Field 10d); verify that the client's Medicaid ID number is listed as it appears on the client's eligibility information.
Client name missing	This is a required field (Field 2); check that it is correct.
NPI/API missing or invalid	The NPI is a 10-digit number (API is a 7-digit) assigned to the provider. Verify the correct NPI/API is on the claim.
Referring or Passport provider name and ID number missing	When a provider refers a client to another provider, include the referring provider's name and ID number or Passport number (see the <i>Passport</i> chapter in this manual).
Prior authorization number missing	When prior authorization (PA) is required for a service, the PA number must be on the claim (see the <i>Prior Authorization</i> chapter in this manual).
Not enough information regarding other coverage	Fields 1a and 11d are required fields when a client has other coverage (see examples earlier in this chapter).
Authorized signature missing	Each claim must have an authorized signature belonging to the provider, billing clerk, or office personnel. The signature may be typed, stamped, or handwritten.
Signature date missing	Each claim must have a signature date.

Common Claim Errors (Continued)	
Claim Error	Prevention
Incorrect claim form used	Services covered in this manual require a CMS-1500 claim form.
Information on claim form not legible	Information on the claim form must be legible. Use dark ink and center the information in the field. Information must not be obscured by lines.
Medicare EOMB not attached	When Medicare is involved in payment on a claim, the Medicare EOMB must be submitted with the claim or it will be denied.

Remittance Advices and Adjustments

The Remittance Advice

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

Electronic Remittance Advice

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

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

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

Paper Remittance Advice

The paper RA is divided into the following sections: RA Notice, Paid Claims, Denied Claims, Pending Claims, Credit Balance Claims, Gross Adjustments, and Reason and Remark Codes and Descriptions. See the following sample paper RA and the *Keys to the Paper RA* table.



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



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



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

Sections of the Paper RA	
Section	Description
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 may 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 requiring the provider to return the overpayment plus interest. If a claim was paid at the wrong amount or with incorrect information, the claim must be adjusted (see <i>Adjustments</i> 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 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 <i>The Most Common Billing Errors and How to Avoid Them</i> in the <i>Billing Procedures</i> chapter.
Pending Claims	<p>All claims that have not reached final disposition will appear in this area of the paper RA (pending claims are not available on X12N 835 transactions). The RA uses "suspended" and "pending" interchangeably. They both mean that the claim has not reached final disposition. If a claim is pending, refer to the Reason/Remark Code column (Field 18). The reason and remark code description located at the end of the RA will explain why the claim is suspended. This section is informational only. Do not take any action on claims displayed here. Processing will continue until each claim is paid or denied.</p> <p>Claims shown as pending with Reason Code 133 require additional review before a decision to pay or deny is made. If a claim is being held while waiting for client eligibility information, it may be suspended for a maximum of 30 days. If Medicaid receives eligibility information within the 30-day period, the claim will continue processing. If no eligibility information is received within 30 days, the claim will be denied. When a claim is denied for lack of eligibility, the provider should verify that the correct Medicaid ID number was billed. If the ID number was incorrect, resubmit the claim with the correct ID number.</p>
Credit Balance Claims	Credit balance claims are shown in this section until the credit has been satisfied.
Gross Adjustments	Any gross adjustments performed during the previous cycle are shown in this section.
Reason and Remark Code Description	This section lists the reason and remark codes that appear throughout the RA with a brief description of each.

Sample Paper Remittance Advice

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES
HELENA, MT 59604

MEDICAID REMITTANCE ADVICE

1

HOME IV SERVICES
P.O. BOX 999
ANYTOWN MT 59999

PROVIDER # 0001234567 (2) REMIT ADVICE # 123456 (3) EFT/CHK # 123456 (4) DATE:04/01/2010 (5) PAGE 2 (6)
NPI # 0001234567 (7) TAXONOMY # 123456 (8)

RECIP ID (9)	NAME (10)	SERVICE DATES FROM TO (12)	UNIT OF SVC (13)	PROCEDURE REVENUE NDC (14)	TOTAL CHARGES (15)	ALLOWED (16)	CO-PAY (17)	REASON/REMARK CODES (18)
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PAID CLAIMS - MISCELLANEOUS CLAIMS

123456789	DOE, JOHN EDWARD	030104 030504	1	S9327	115.00	105.00		
(11) ICN	00009111123000700			***LESS COPAY DEDUCTION*****		5.00	(19)	
				CLAIM TOTAL **	115.00	100.00		

DENIED CLAIMS - MISCELLANEOUS CLAIMS

123456790	DOE, JOE EDWARD	030104 030504	1	S9330	150.00	0.00		M68
ICN	00009111123000800			(18)				

PENDING CLAIMS - MISCELLANEOUS CLAIMS

123456791	DOE, JANE EDWINA	030104 030504	5	S9351	625.00	625.00		MA61
ICN	00009111123000900							

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

- MA61 DID NOT COMPLETE OR ENTER CORRECTLY THE PATIENT'S SOCIAL SECURITY NUMBER OR HEALTH INSURANCE CLAIM NUMBER.
- M68 MISSING/INCOMPLETE/INVALID ATTENDING OR REFERRING PHYSICIAN IDENTIFICATION.

Montana Department of Public Health and Human Services

Key to the Paper RA

Field	Description
1. Provider name and address	Provider's business name and address as recorded with the Department
2. Provider number	The 7-digit number assigned to the provider when applying for Medicaid
3. Remittance advice number	The remittance advice number
4. Warrant number	Not used
5. Date	The date the RA was issued
6. Page number	The page number of the RA
7. NPI #	NPI is a unique 10-digit identification number required by HIPAA for all health care providers in the United States. Providers must use their NPI to identify themselves in all HIPAA transactions.
8. Taxonomy #	These are used to identify and code an external provider table that would be able to standardize provider types and provider areas of specialization for all medical-related providers.
9. Recipient ID	The client's Medicaid ID number
10. Name	The client's name
11. Internal control number (ICN)	<p>Each claim is assigned a unique 17-digit number (ICN). Use this number when you have any questions concerning your claim. The claim number represents the following information:</p> <p><u>0</u> <u>00111</u> <u>11</u> <u>123</u> <u>000123</u> A B C D E</p> <p>A = Claim medium 0 = Paper claim 2 = Electronic claim 3 = Encounter claim 4 = System generated claim (mass adjustment, nursing home turn-around document, or POS pharmacy claim) 6 = Pharmacy</p> <p>B = Julian date (e.g., April 1, 2010 was the 91st day of 2010) C = Microfilm number 00 = Electronic claim 11 = Paper claim D = Batch number E = Claim number</p> <p>If the first number is: 0 = Regular claim 1 = Negative side adjustment claim (Medicaid recovers payment) 2 = Positive side adjustment claim (Medicaid reprocesses)</p>
12. Service dates	Dates services were provided. If services were performed in a single day; the same date will appear in both columns
13. Unit of service	The number of services rendered under this procedure or NDC code.
14. Procedure/revenue/NDC	The procedure, revenue, HCPCS, or NDC billed will appear in this column. If a modifier was used, it will also appear in this column.
15. Total charges	The amount a provider billed for this service.
16. Allowed	The Medicaid allowed amount.
17. Copay	Y indicates cost sharing was deducted, and N indicates cost sharing was not deducted from the payment.
18. Reason/Remark Code	A code which explains why the specific service was denied or pended. Descriptions of these codes are listed at the end of the RA.
19. Deductions, Billed Amount, and Paid Amount	Any deductions, such as cost sharing or third party liability are listed first. The amount the provider billed is next, followed by the amount of Medicaid reimbursement.

Credit balance claims

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

Credit balances can be resolved in two ways:

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

Rebilling and Adjustments

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

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

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



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



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



Rebill denied claims only after appropriate corrections have been made.

When to rebill Medicaid

- ***Claim Denied.*** Providers may rebill Medicaid when a claim is denied. Check the Reason and Remark Codes, make the appropriate corrections, and resubmit the claim (do not use the adjustment form).
- ***Line Denied.*** When an individual line is denied on a multiple-line claim, correct any errors and submit only the denied line to Medicaid. For CMS-1500 claims, do not use an 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 the claim.

How to rebill

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

Adjustments

If a provider believes that a claim has been paid incorrectly, the provider may call Provider Relations (see *Key Contacts*) or submit a claim inquiry for review (see *Claim Inquiries* in the *Submitting a Claim* chapter of this manual). Once an incorrect payment has been verified, the provider should submit an *Individual Adjustment Request* form (see *Appendix A: Forms*) to Provider Relations. If incorrect payment was the result of a 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 over will be a 2, indicating an adjustment. See the *Key to the Paper RA* section earlier in this chapter. Adjustments are processed in the same time frame as claims.

When to request an adjustment

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

How to request an adjustment

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

- Adjustments can only be submitted on paid claims; denied claims cannot be adjusted.
- Claims Processing must receive individual claim adjustments within 12 months from the date of service (see *Timely Filing* in the *Billing Procedures* chapter of this manual). After this time, gross adjustments are required (see the *Definitions and Acronyms* chapter).
- Use a separate adjustment request form for each ICN.
- If you are correcting more than one error per ICN, use only one adjustment request form, and include each error on the form.
- If more than one line of the claim needs to be adjusted, indicate which lines and items need to be adjusted in the Reason and Remarks section.

Completing an Adjustment Request Form

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

Completing an Individual Adjustment Request Form

Field	Description
Section A	
1. Provider Name and Address	Provider's name and address (and mailing address if different).
2. Recipient Name	The client's name.
3.* Internal Control Number (ICN)	There can be only one ICN per Adjustment Request form. When adjusting a claim that has been previously adjusted, use the ICN of the most recent claim.
4*. Provider number	The provider's Medicaid ID number.
5*. Recipient Medicaid Number	Client's Medicaid ID number.
6. Date of Payment	Date claim was paid found on Remittance Advice Field 5 (see the sample RA earlier in this chapter).
7. Amount of Payment	The amount of payment from the Remittance Advice Field 19 (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 are incorrect, complete this line.
3. Dates of Service (DOS)	If the date of service is incorrect, complete this line.
4. Billed Amount	If the billed amount is incorrect, complete this line.
5. Personal Resource (Nursing Facility)	If the client's personal resource amount is incorrect, complete this line.
6. Insurance Credit Amount	If the client's insurance credit amount is incorrect, complete this line.
7. Net (Billed - TPL or Medicare Paid)	If the payment error was caused by a missing or incorrect insurance credit, complete this line. Net is billed amount minus the amount TPL or Medicare paid.
8. Other/Remarks	If none of the above items apply, or if you are unsure what caused the payment error, complete this line.

*Indicates a required field

- If an original payment was an underpayment by Medicaid, the adjustment results in the provider receiving the additional payment amount allowed.
- If an original payment was an overpayment by Medicaid, the adjustment results in recovery of the overpaid amount from the provider. This can be done in 2 ways: by the provider issuing a check to the Department or by maintaining a credit balance until it has been satisfied with future claims (see *Credit Balance* in this chapter).
- Any questions regarding claims or adjustments should 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), the monthly *Claim Jumper* newsletter, or provider notice. Mass adjustment claims shown on the RA have an ICN that begins with 4 (see *Key Fields on the Remittance Advice* earlier in this chapter).

Payment and the RA

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

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

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

Once electronic transfer testing shows payment to the provider’s account, all Medicaid payments will be made through EFT. See *Direct Deposit Arrangements* under *Key Contacts* for questions or changes regarding EFT.



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

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

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. These examples are for August 2005 and these rates may not apply at other times.

How Payment Is Calculated on TPL Claims

When a client has coverage from both Medicaid and another insurance company, the other insurance company is often referred to as third party liability or TPL. In these cases, the other insurance is the primary payer (as described in the *Coordination of Benefits* chapter in this manual), and Medicaid makes a payment as the secondary payer. For example, a client receives four 15-minute visits from an RN (T1002). The third party insurance is billed first and pays \$15.00. The Medicaid allowed amount for this service totals \$22.64. The amount the insurance paid (\$15.00) is subtracted from the Medicaid allowed amount (\$22.64), leaving a balance of \$7.64, which Medicaid will pay on this claim.

How Payment is Calculated on Medicare Crossover Claims

When a client has coverage from both Medicaid and Medicare, Medicare is the primary payer as described in the *Coordination of Benefits* chapter of this manual. Medicaid then makes a payment as the secondary payer. For the provider types covered in this manual, Medicaid's payment is calculated so that the total payment to the provider is either the Medicaid allowed amount less the Medicare paid amount or the sum of the Medicare coinsurance and deductible, whichever is lower. This method is sometimes called 'lower of' pricing.

Other Factors That May Affect Payment

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

- The Department pays the lower of the established Medicaid fee or the provider's charge.
- The client may have an incurment amount that must be met before Medicaid will pay for services (see the *General Information for Providers* manual, *Client Eligibility and Responsibilities* chapter, *Coverage for the Medically Needy* section).
- Date of service; fees for services may change over time.
- Cost sharing, Medicare, and/or TPL payments, which are shown on the remittance advice.



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

Appendix A: Forms

For the forms listed below and others, see the [Forms](#) page on the Provider Information website.

- Montana Healthcare Programs Medicaid/MHSP/HMK Individual Adjustment Request
- Paperwork Attachment Cover Sheet

Definitions and Acronyms

For definitions and acronyms, see the Definitions and Acronyms page of the Provider Information [website](#).

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