



Physician Related Services

Provided by:

*Physicians, Mid-Level Practitioners,
Podiatrists, Laboratories, Imaging
Facilities, Independent Diagnostic
Testing Facilities, and Public Health
Clinics*

*Medicaid and Other Medical
Assistance Programs*



September 2005

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My Medicaid Provider ID Number:

My CHIP Provider ID Number:

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Key Contacts

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

Provider Enrollment

For enrollment changes or questions:

(800) 624-3958 In and out-of-state
(406) 442-1837 Helena

Send e-mail inquiries to:

MTPRHelpdesk@ACS-inc.com

Send written inquiries to:

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

Provider Relations

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

(800) 624-3958 In and out-of-state
(406) 442-1837 Helena

Send e-mail inquiries to:

MTPRHelpdesk@ACS-inc.com

Send written inquiries to:

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

Claims

Send paper claims to:

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

Third Party Liability

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

(800) 624-3958 In and out-of-state
(406) 442-1837 Helena

Send written inquiries to:

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

PASSPORT Client Help Line

Clients who have general Medicaid questions may call the Client Help Line:

(800) 362-8312

Send written inquiries to:

PASSPORT To Health
P.O. Box 254
Helena, MT 59624-0254

PASSPORT Program Officer

Send inpatient stay documentation to:

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

Provider's Policy Questions

For policy questions, contact the appropriate division of the Department of Public Health and Human Services; see the *Introduction* chapter in the *General Information For Providers* manual.

Direct Deposit Arrangements

Providers who would like to receive their remittance advices electronically and electronic funds transfer should call the number below.

(406) 444-5283

CLIA Certification

For questions regarding CLIA certification call or write:

(406) 444-1451 Phone

(406) 444-3456 Fax

Send written inquiries to:

DPHHS

Quality Assurance Division

Certification Bureau

2401 Colonial Drive

P.O. Box 202953

Helena, MT 59620-2953

Lab and X-ray

Public Health Lab assistance:

(800) 821-7284 In state

(406) 444-3444 Out of state and Helena

Send written inquiries to:

DPHHS Public Health Lab

1400 Broadway

P.O. Box 6489

Helena, MT 59620

Claims for multiple x-rays of same type on same day, send to:

DPHHS

Lab & X-ray Services

Health Policy & Services Division

P.O. Box 202951

Helena, MT 59620

EDI Technical Help Desk

For questions regarding electronic claims submission:

(800) 987-6719 In and out-of-state

(406) 442-1837 Helena

(406) 442-4402 Fax

Send e-mail inquiries to:

MTEDIHelpdesk@ACS-inc.com

Mail to:

ACS

ATTN: MT EDI

P.O. Box 4936

Helena, MT 59604

Team Care Program Officer

For questions regarding the Team Care Program:

(406) 444-4540 Phone

(406) 444-1861 Fax

Team Care Program Officer

DPHHS

Managed Care Bureau

P.O. Box 202951

Helena, MT 59620-2951

Nurse First

For questions regarding Nurse First Disease Management or the Nurse Advice Line, contact:

(406) 444-4540 Phone

(406) 444-1861 Fax

Nurse First Program Officer

DPHHS

Managed Care Bureau

P.O. Box 202951

Helena, MT 59620-2951

Secretary of State

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

(406) 444-2055 Phone

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

Client Eligibility

For client eligibility, see the *Client Eligibility and Responsibilities* chapter in the *General Information For Providers* manual.

Prior Authorization

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

Surveillance/Utilization Review

For prior authorization for certain services (see the *PASSPORT and Prior Authorization* chapter in this manual), contact SURS:

For clients with last names beginning with A - L, call:

(406) 444-3993 Phone

For clients with last names beginning with M - Z, call:

(406) 444-0190

Information may be faxed to:

(406) 444-0778 Fax

Send written inquiries to:
Surveillance/Utilization Review
2401 Colonial Drive
P.O. Box 202953
Helena, MT 59620-2953

First Health

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

(800) 770-3084 Phone

(800) 639-8982 Fax

(800) 247-3844 Fax

First Health Services
4300 Cox Road
Glen Allen, VA 23060

Mountain-Pacific Quality Health Foundation

For questions regarding prior authorization for out-of-state hospital services, transplant services, and private duty nursing services, or emergency department reviews, contact:

Phone:

(800) 262-1545 X5850 In state

(406) 443-4020 X5850 Out of state and
Helena

Fax:

(800) 497-8235 In state

(406) 443-4585 Out of state and Helena

Send written inquiries to:

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

Key Web Sites	
Web Address	Information Available
Virtual Human Services Pavilion (VHSP) vhsp.dphhs.mt.gov	Select <i>Human Services</i> for the following information: <ul style="list-style-type: none"> • Medicaid: Medicaid Eligibility & Payment System (MEPS). Eligibility and claims history information. • Senior and Long Term Care: Provider search, home/housing options, healthy living, government programs, publications, protective/legal services, financial planning. • DPHHS: Latest news and events, Mental Health Services Plan information, program information, office locations, divisions, resources, legal information, and links to other state and federal web sites. • Health Policy and Services Division: Children's Health Insurance Plan (CHIP), Medicaid provider information such as manuals, newsletters, fee schedules, and enrollment information.
Provider Information Website www.mtmedicaid.org	<ul style="list-style-type: none"> • Medicaid news • Provider manuals • Notices and manual replacement pages • Fee schedules • Remittance advice notices • Forms • Provider enrollment • Frequently asked questions (FAQs) • Upcoming events • HIPAA Update • Newsletters • Key contacts • Links to other websites and more
Client Information Website www.dphhs.mt.gov/hpsd/medicaid/medrecip/medrecip.htm	<ul style="list-style-type: none"> • Medicaid program information • Client newsletters • Who to call if you have questions • Client Notices & Information
Center for Disease Control and Prevention (CDC) web site www.cdc.gov/nip	Immunization and other health information
Parents Lets Unite for Kids (PLUK) www.pluk.org	This web site gives information on PLUK – an organization designed to provide support, training, and assistance to children with disabilities and their parents.
Medicaid Mental Health and Mental Health Services Plan www.dphhs.state.mt.us/about_us/divisions/addictive_mental_disorders/services/public_mental_health_services.htm	Mental Health Services information for Medicaid and MHSP

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

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

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

Cosmetic services (ARM 37.86.104)

Medicaid covers cosmetic services only when it can be demonstrated that the condition has a severe detrimental effect on the client's physical and psychosocial wellbeing. Mastectomy and reduction mammoplasty services are covered only when medically necessary. Medical necessity for reduction mammoplasty is related to signs and symptoms resulting from macromastia. Medicaid covers surgical reconstruction following breast cancer treatment. Before cosmetic services are performed, they must be prior authorized (see the *PASSPORT and Prior Authorization* chapter in this manual). Services are authorized on a case-by-case basis.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) (ARM 37.86.2201 – 2221)

The Well Child EPSDT program covers all medically necessary services for children age 20 and under. Providers are encouraged to use a series of screening and diagnostic procedures designed to detect diseases, disabilities, and abnormalities in the early stages (see the *Well Child EPSDT* chapter in this manual). Some services are covered for children that are not covered for adults, such as the following:

- Nutritionist services
- Private duty nursing
- Respiratory therapy
- Therapeutic family and group home care
- Substance dependency inpatient and day treatment services
- School based services

All prior authorization and PASSPORT approval requirements must be followed. See the *PASSPORT and Prior Authorization* chapter in this manual.



All forms required for abortions can be copied from *Appendix A Forms*, can be ordered using the *Medicaid Form Order* sheet in the *General Information For Providers* manual, or downloaded from the *Provider Information Web Site* (see *Key Contacts*).

Family planning services (ARM 37.86.1701)

Family planning services include the following:

- Initial visit
- Initial physical examination
- Comprehensive history
- Laboratory services
- Medical counseling
- Annual visits
- Routine visits

Medicaid covers prescription contraceptive supplies, implantation or removal of subcutaneous contraceptives, and fitting or removal of an IUD and fitting of a diaphragm. Approval by the PASSPORT provider is not required for family planning services. See the *Completing a Claim* chapter in this manual for PASSPORT indicators. Specific billing procedures must be followed for family planning services (see *Billing Procedures*).

Home obstetrics (ARM 37.85.207)

Home deliveries are only covered on an emergency basis (see *Definitions*) by a physician or licensed midwife.

Immunizations

The Vaccines For Children (VFC) Program makes available at no cost to providers selected vaccines for eligible children 18 years old and under. Medicaid will therefore pay only for the administration of these vaccines (oral or injection). VFC covered vaccines may change from year to year. For more information on the VFC program and current VFC covered vaccines, call the Department's Immunization Program at (406) 444-5580.

Medicaid does not cover pneumonia and flu vaccines for clients with Medicare Part B insurance because Medicare covers these immunizations.

Infertility (ARM 37.85.207)

Medicaid does not cover treatment of infertility.

Prescriptions (ARM 37.86.1102)

- Drugs are limited to a 34-day supply.
- No more than two prescriptions of the same drug may be dispensed in a calendar month except for the following:
 - Antibiotics
 - Schedule II and III drugs
 - Antineoplastic agents

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

When submitting claims for retroactively eligible clients, attach a copy of the FA-455 (Eligibility determination letter) to the claim if the date of service is more than 12 months earlier than the date the claim is submitted.

Surgical services

- The fee schedule shows Medicaid policies code by code on global periods, bilateral procedures, assistants at surgery, co-surgeons, and team surgery. These policies are almost always identical to Medicare policies but in cases of discrepancy the Medicaid policy applies.
- Medicaid only covers “assistant at surgery” services when provided by physicians or mid-level practitioners who are Medicaid providers.
- Medicaid does not cover surgical technician services.
- See the *Billing Procedures* chapter regarding the appropriate use of modifiers for surgical services.

Telemedicine services

- Medicaid covers telemedicine services when the consulting provider is enrolled in Medicaid.
- The requesting provider need not be enrolled in Medicaid nor be present during the telemedicine consult.
- Medicaid does not cover network use charges.

Transplants

All Medicaid transplant services must be prior authorized (see the *PASSPORT and Prior Authorization* chapter in this manual). Medicaid covers the following transplant services:

- For clients 21 years or older: only bone marrow, kidney, or cornea transplants.
- For clients less than 21 years old: all transplants that are covered by Medicare that are not considered experimental or investigational.

Weight reduction

- Physicians and mid-level practitioners who counsel and monitor clients on weight reduction programs can be paid for those services. If medical necessity is documented, Medicaid will also cover lab work. Similar services provided by nutritionists are not covered for adults.
- Medicaid does **not** cover the following weight reduction services:
 - Weight reduction plans or programs (e.g., Jenny Craig, Weight Watchers, etc.)
 - Nutritional supplements
 - Dietary supplements
 - Health club memberships
 - Educational services of a nutritionist
 - Gastric bypass

Emergency department visits

The Department covers emergency services provided in the emergency department. Emergency medical services are those services required to treat and stabilize an emergency medical condition. Beginning August 1, 2003, a service is reimbursed as an emergency if one of the following criteria is met:

- The service is billed with a CPT code of 99284 or 99285
- The client has a qualifying emergency diagnosis code. A list of the Department's pre-approved emergency diagnosis codes is available on the Provider Information website under *Emergency Diagnosis Codes* (see *Key Contacts*).

- The service did not meet one of the previous two requirements, but the medical professional rendering the medical screening and evaluation believes an emergency existed. In this case, the claim and documentation supporting the emergent nature of the services must be mailed to the emergency department review contractor (see *Key Contacts*).
- If the client is under two years old and is seen in the emergency room on a weekend or on January 1, July 4, or December 25, then the claim will be considered and processed as emergent.
- If the client is under two and is seen in the emergency room on a week-day outside of regular office hours, or on a holiday other than January 1, July 4, or December 25, and the claim contains procedure code 99050 (services requested after posted office hours in addition to basic service), then the claim will be considered and processed as an emergency.

If the visit does not meet one of the emergency criteria, then services beyond the screening and related diagnostic tests are not reimbursed and cost sharing should be collected. If the visit meets the emergency criteria, cost sharing is not collectible.

If an inpatient hospitalization is recommended as post stabilization treatment, the hospital must get a referral from the client's PASSPORT provider. If the hospital attempts to contact the PASSPORT provider and does not receive a response within 60 minutes, authorization is assumed. To be paid for these services, documentation that clearly shows the time of the attempt to reach the PASSPORT provider and the time of the initiation of post stabilization treatment must be sent to the PASSPORT program officer (see *Key Contacts*) for review. The documentation must include the time an attempt was made to reach the provider and the time the inpatient hospitalization began. There must be a 60 minute time lapse between these two events.

Other Programs

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

Mental Health Services Plan (MHSP)

Clients who are enrolled in MHSP have limited coverage for physician-related services. See the *Mental Health Services Plan* manual.

For Medicaid clients seeking mental health services, the information in this chapter applies to mental health services just as it does for physical health services.

Well Child EPSDT

Early and Periodic Screening, Diagnosis and Treatment is the federally sponsored, comprehensive health care benefits package for Medicaid-enrolled children through age 20. It helps families get early identification and treatment of medical, dental, vision, mental health and developmental problems for their children. All Medicaid families are encouraged to use these services.

EPSDT includes a medical screen (sometimes called a well child check-up), vision screen, dental screen and hearing screen for all Medicaid-enrolled children. There are four periodicity schedules, one each for well child screens, dental screens, vision screens, and hearing screens. These periodicity schedules are shown in Appendix B. These screens help spot and take care of health problems early in a child's growth. Each screen includes a detailed health and developmental history; a comprehensive, unclothed physical exam; age-appropriate immunizations and laboratory tests; and health education. The screens are provided at specific periods throughout a child's growth. See *Appendix B: Well Child Screen Chart* for specific recommendations for each age.

When a Medicaid-eligible child requires medically necessary services, those services may be covered under Medicaid even if they are not covered for adults. Health care, diagnostic services, treatments and other measures that would correct or improve defects or physical or mental illnesses or conditions are available based on medical necessity. If these services are not a "covered service" of Montana Medicaid, prior authorization is required. For more information on prior authorization, see the *Key Contacts* chapter of this manual.

The Well Child Screen

The foundation of Well Child EPSDT is the Well Child Screen. These screens should begin as early as possible in a child's life or as soon as the child is enrolled in Medicaid. The Well Child EPSDT program's Well Child Screens are based on a periodicity schedule established by medical, dental and other health care experts, including the American Academy of Pediatrics. The *Well Child Screen Recommendations* chart in *Appendix B* is designed for providers to copy and maintain for their records.

Montana Medicaid has initiated a project to improve provider awareness of the EPSDT program and the comprehensiveness of the well child screen. Beginning January 2006 an enhanced fee will be added to the reimbursement for well child screens. The Department will be conducting audits of medical records to ensure that the screens provided meet the expectations defined in this chapter.

Every infant should have a newborn evaluation after birth. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time. If a Well Child Screen shows that a child is “at risk” based on the child’s environment, history, or test results, the provider should perform required or recommended tests even though they may not be indicated for the child’s age. Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits.

A. Initial/interval history

A comprehensive history, obtained from the parent or other responsible adult who is familiar with the child’s history, should be done during the initial visit. Once it is done, it only needs to be updated at subsequent visits. The history should include the following:

- Developmental history to determine whether the child’s individual developmental processes fall within a normal range of achievement compared to other children of his or her age and cultural background.
 - Discuss the child’s development, as well as techniques to enhance the child’s development, with the parents.
- Nutritional history and status. Questions about dietary practices identify unusual eating habits, such as pica or extended use of bottle feedings, or diets which are deficient or excessive in one or more nutrients.
- Complete dental history.

B. Assessments

- **Appropriate developmental screening.** Providers should administer an age-appropriate developmental screen during each Well Child Screen. Results should be considered in combination with other information gained through the history, physical examination, observation, and reports of behavior. If developmental problems are identified, appropriate follow-up and/or referral to proper resources should be made.

Speech and language screens identify delays in development. The most important readiness period for speech is 9 to 24 months. Parents should be urged to talk to their children early and frequently. Refer the child for speech and language evaluation as indicated.

Parents of children with developmental disabilities should be encouraged to contact Parents Let’s Unite for Kids (PLUK). PLUK is an organization designed to provide support, training, and assistance to children with disabilities and their parents. Visit the web site (see *Key Contacts*), or call or write:

PLUK
 516 N. 32nd St.
 Billings, MT 59101
 (406) 255-0540 Phone
 (800) 222-7585
 (406) 255-0523 Fax

- **Nutritional Screen.** Providers should assess the nutritional status at each Well Child Screen. Children with nutritional problems may be referred to a licensed nutritionist or dietician for further assessment or counseling.
- **Risk Assessment Screen.**
 - **Emotional.** Signs and symptoms of emotional disturbances represent deviations from or limitation in healthy development. These problems usually will not warrant a psychiatric referral but can be handled by the provider. He or she should discuss problems with parents and give advice. If a psychiatric referral is warranted, the provider should refer to an appropriate provider.
 - **Risky behaviors.** The provider should screen for risky behaviors (substance abuse, unprotected sexual activity, tobacco use, firearm possession, etc.). In most instances, indications of such behavior will not warrant a referral but can be handled by the provider. He or she should discuss the problems with the client and the parents and give advice. If a referral is warranted, the provider should refer to an appropriate provider.
 - **Blood lead.** Medicaid children should be **tested** for lead poisoning at 12 and 24 months of age. Children up to age 6 who have not been checked for lead poisoning before should also be tested. **All** children in Medicaid are at risk of lead poisoning. To ensure good health for the child, the federal government **requires** that all Medicaid children be tested. All Medicaid children at other ages should be screened.

Complete a verbal risk assessment for all Medicaid children to age 6 at each EPSDT screening:

- Does your child live in Butte, Walkerville or East Helena, which are designated high-risk areas?
- Does your child live near a lead smelter, battery recycling plant, or other industry (operating or closed) likely to release lead?
- Does your child live in or regularly visit a house built before 1960, which may contain lead paint?
- Does your child live near a heavily traveled major highway where soil and dust may be contaminated with lead?
- Does your child live in a home where the plumbing consists of lead pipes or copper with lead solder joints?



Providers must use their medical judgment in determining applicability of performing specific test.



A blood lead level test should be performed on all children at 12 and 24 months of age.

- Does your child frequently come in contact with an adult who works with lead, such as construction, welding, pottery, reloading ammunition (making own bullets), etc.?
- Is the child given any home or folk remedies? If yes, discuss.

If the answers to all questions are negative, a child is considered at low risk for high doses of lead exposure. Children at **low risk** for lead exposure must receive a **blood test at 12 and 24 months**. If the answer to any question is positive, a child is considered at **high risk** for high doses of lead exposure and a **blood lead level test must be obtained immediately** regardless of the child's age.

- **Tuberculin.** Tuberculin testing should be done on individuals in high-risk populations or if historical findings, physical examination or other risk factors so indicate. High-risk populations include Asian refugees, Native American children, and migrant children.

C. Unclothed physical inspection

At each visit, a complete physical examination is essential. Infants should be totally unclothed and older children undressed and suitably draped.

D. Vision screen

A vision screen appropriate to the age of the child should be conducted at each Well Child Screen. If the child is uncooperative, rescreen within six months.

E. Hearing screens

A hearing screen appropriate to the age of the child should be conducted at each Well Child Screen. All newborns should be screened.

F. Laboratory tests

Providers who conduct Well Child Screens must use their medical judgment in determining applicability of performing specific laboratory tests. Appropriate tests should be performed on children determined "at risk" through screening and assessment.

- **Hematocrit and hemoglobin.** Hematocrit or hemoglobin tests should be done for "at risk" (premature and low birth weight) infants at ages newborn and 2 months. For children who are not at risk, follow the recommended schedule.
- **Blood lead level.** All children enrolled in Medicaid are at risk of lead poisoning. To ensure good health for the child, the federal government requires that all Medicaid children ages 12 and 24 months of age, or up to 72 months if not previously tested, should have a blood lead level test unless medically contraindicated. If an elevated blood level is discovered, a child should be retested every three to four months until lead levels are within normal limits, and then annually through 6 years of age. See page 3.3 for more details.

- ***Tuberculin screening.*** Tuberculin testing should be done on individuals in high-risk populations or if historical findings, physical examination or other risk factors so indicate. See page 3.4 for more details.
- ***Urinalysis.***
 - Because of heightened incidence of bacteriuria in girls, testing may be appropriate.
 - Children who have had previous urinary tract infections should be rescreened more frequently.
 - If test results are positive but the history and physical examination are negative, the child should be tested again in two weeks.
- ***STD screening.*** All sexually active clients should be screened for sexually transmitted diseases (STDs).
- ***Pelvic exam.*** All sexually active females, and all females 18 and over regardless of sexual activity, should have a pelvic exam. A pelvic exam and routine pap smear should be offered as part of preventive health maintenance.

G. Immunizations

- The immunization status of each child should be reviewed at each Well Child Screen. This includes interviewing parents or caretakers, reviewing immunization records, and reviewing risk factors.
- A checklist for a child's immunization regimen is provided in the *Well Child Screen Recommendations* chart (*Appendix B*) for your convenience. The *Recommended Childhood Immunization* schedule is available on the *Provider Information web site* (see *Key Contacts*) and the *Centers for Disease Control and Prevention (CDC) web site* (see *Key Contacts*). This schedule is approved by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP). The schedule on the website is updated as recommendations from the ACIP are received.
- If a child was not immunized at the recommended time, use the *Recommended Childhood Immunization* schedule to bring the child's immunizations current.

H. Dental screen

The child's dentist should perform annual dental screens, and results should be included in the child's initial/interval history. Other providers should perform an oral inspection, fluoride varnish (as available) and make a referral to a dentist for any of the following reasons:

- When the first tooth erupts and at least yearly thereafter.
- If a child with a first tooth has not obtained a complete dental examination by a dentist in the past 12 months.
- If an oral inspection reveals cavities, infection, or the child is developing a handicapping malocclusion or significant abnormality.

1. Discussion and counseling/Anticipatory guidance

Providers should discuss examination results, address assessed risks, and answer any questions in accordance with the parents' level of understanding. Age-appropriate discussion and counseling should be an integral part of each visit. Please allow sufficient time for unhurried discussions.

At each screening visit, provide age-appropriate anticipatory guidance concerning such topics as the following:

- Auto safety: Car seats, seat belts, air bags, positioning young or light-weight children in the backseat.
- Recreational safety: Helmets and protective padding, playground equipment.
- Home hazards: Poisons, accidental drownings, weapons, matches and lighters, staying at home alone, and use of detectors for smoke, radon gas, and carbon monoxide.
- Exposure to sun and secondhand smoke.
- Adequate sleep, exercise and nutrition, including eating habits and disorders.
- Peer pressure.
- General health: Immunizations, patterns of respiratory infections, skin eruptions, care of teeth.
- Problems such as stealing, setting fires, whining, etc. (as indicated by parental concern).
- Behavior and development: Sleep patterns, temper, attempts at independence (normal and unpleasant behavior), curiosity, speech and language, sex education and development, sexual activities, attention span, toilet training, alcohol and tobacco use, substance abuse.
- Interpersonal relations: Attitude of father; attitude of mother; place of child in family; jealousy; selfishness, sharing, taking turns; fear of strangers; discipline—obedience; manners—courtesy; peer companionship/relations; attention getting; preschool, kindergarten and school readiness and performance; use of money; assumption of responsibility; need for affection and praise; competitive athletics.

Completing an EPSDT Card

EPSDT Well Child Cards track a child's Well Child Checkup, dental, and immunization schedule. When a client presents an EPSDT Well Child Card, it should be completed as follows (see sample following page):

1. In the first column, find the age the child is closest to.
2. Find the column indicating the service rendered.
3. Record the date and signature in the corresponding space.

- 4. Shaded areas on the card indicate that a particular activity is not required at that age.
- 5. If a child did not receive one of the activities by the required age, make note of the reason in the comment section.

If a child is behind (or ahead) on immunizations, please fill in the date immunization was given regardless of the age column.

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(New 8/96)

State of Montana
Department of Public Health and Human Services

**EPSDT HEALTH SCREENING AND
IMMUNIZATION CHECKLIST**

Early medical check-ups for children find problems before they are too serious.

All children under the age of 21 receiving Medicaid are eligible for Well Child Screening services as well as other services available to children under the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT).

When you call for an appointment, be sure to say that you want a Well Child Screen for your child.

If you have questions, contact:
Health Policy Services Division
Department of Public Health and Human Services
PO Box 202951
Helena Montana 59620-2951



A Well Child Health Program

Child's Name: _____

Child's SSN: _____

Child's Date of Birth: _____

Parent's Name: _____

Parent's SSN: _____

COUNTY USE SPACE:

Case Number: _____

EPSDT Card Front

BY AGE	WELL CHILD		DENTAL		IMMUNIZATION	
	DATE	INITIAL	DATE	INITIAL	DATE	INITIAL
BIRTH	_____	_____				
1 MO	_____	_____				
2 MO	_____	_____			DTP _____	_____
					Hib _____	_____
					Polio _____	_____
					HBV _____	OPTIONAL
4 MO	_____	_____			DTP _____	_____
					Hib _____	_____
					Polio _____	_____
					HBV _____	OPTIONAL
6 MO	_____	_____			DTP _____	_____
					Hib _____	_____
9 MO	_____	_____				
12 MO	_____	_____				
15 MO	_____	_____			Hib _____	_____
					MMR _____	_____
18 MO	_____	_____			DTP _____	_____
					Hib _____	_____
					Var _____	OPTIONAL
					HBV _____	OPTIONAL
24 MO	_____	_____				
3 YRS	_____	_____	_____	_____		
4 YRS	_____	_____	_____	_____		
5 YRS	_____	_____	_____	_____		
6 YRS	_____	_____	_____	_____	DTP _____	_____
					Polio _____	_____
					MMR _____	_____
7 YRS	_____	_____	_____	_____		
8 YRS	_____	_____	_____	_____		
9 YRS	_____	_____	_____	_____		
10 YRS	_____	_____	_____	_____		
11 YRS	_____	_____	_____	_____		
12 YRS	_____	_____	_____	_____	MMR _____	OPTIONAL
					HBV _____	OPTIONAL
					Var _____	OPTIONAL

EPSDT Card Center

BY AGE	WELL CHILD	DENTAL	IMMUNIZATION
	DATE INITIAL	DATE INITIAL	DATE INITIAL
13 YRS		_____ _____	
14 YRS	_____ _____	_____ _____	
15 YRS		_____ _____	
16 YRS	_____ _____	_____ _____	TD _____ _____
17 YRS		_____ _____	
18 YRS	_____ _____	_____ _____	
19 YRS		_____ _____	
20 YRS	_____ _____	_____ _____	

DTP - Combined vaccine to protect against Diphtheria, Tetanus and Pertussis. Polio - Vaccine to prevent Polio. MMR - Combined vaccine to protect against Measles, Mumps and Rubella. First dose is routinely given between 12-15 months of age. Second dose MMR can be given any time before child enters middle school. The second dose must be separated from the first by at least 30 days. Hib - Vaccine to prevent Hemophilus b disease (meningitis), a very serious disease for infants. There are two vaccines available for children under 15 months of age. Check with your doctor, health department or nurse about which vaccine your child will receive. HBV - Vaccine to prevent Hepatitis B, a highly infectious virus which attacks the liver, causing severe illness and liver damage. This vaccine is now recommended. Ask your physician, health department, or nurse about this protection for your child. VAR - Chicken Pox. TD - Tetanus & diphtheria
IF YOUR CHILD IS NOT ON THE RECOMMENDED SCHEDULE, see your physician, health department or clinic. A schedule will be set up for the best protection for your child.
 COMMENTS:

5

EPSDT Card Back

Some physician-related services also do not require PASSPORT provider approval:

- Anesthesiology
- Family planning
- Obstetrics
- Outpatient hospital emergency department services

Well Child EPSDT clients (all Medicaid clients under age 21) do not need PASSPORT provider approval for the following specific services:

- Immunizations
- Blood lead testing

PASSPORT and emergency services

PASSPORT provider approval is not required for emergency services. However, if an inpatient hospitalization is recommended as post stabilization treatment, see *Emergency department visits* in the *Covered Services* chapter of this manual for requirements.

Complaints and grievances

Providers may call Provider Relations (see *Key Contacts*) to report a complaint that something inappropriate has taken place. A grievance is a written complaint and must be addressed to the PASSPORT Program Officer (see *Key Contacts*).

PASSPORT and Indian Health Services

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

Getting questions answered

The *Key Contacts* list (at the front of this manual) provides important phone numbers and addresses. Provider and Client HelpLines are available to answer almost any PASSPORT or general Medicaid question. You may call the PASSPORT Provider HelpLine to obtain materials for display in your office, discuss any problems or questions regarding your PASSPORT clients, or enroll in PASSPORT. You can keep up with changes and updates to the PASSPORT program by reading the PASSPORT provider newsletters. Newsletters and other information is available on the *Provider Information* web site (see *Key Contacts*). For claims questions, call Provider Relations.

When Your Client Is Enrolled in PASSPORT (And You Are Not the PASSPORT Provider)

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

- If a client is enrolled in PASSPORT, the services must be provided or approved by the client's PASSPORT provider. Some exceptions to this requirement are described in the *PASSPORT referral and approval* section earlier in this chapter.
- The PASSPORT provider's approval may be verbal or written but must be documented and maintained in the client's file, and the claim must contain the PASSPORT provider's PASSPORT number. Documentation should not be submitted with the claim.
- The client's PASSPORT provider must be contacted for approval for each visit. Using another provider's PASSPORT number without approval is considered fraud.
- If a PASSPORT provider refers a client to you, do not refer that client to someone else without the PASSPORT provider's approval, or Medicaid will not cover the service.
- To verify client eligibility, see the *Client Eligibility* chapter in the *General Information For Providers* manual.

Role of the PASSPORT Provider

PASSPORT providers manage a client's health care in several ways:

- Provide primary care, including preventive care, health maintenance, and treatment of illness and injury.
- Coordinate the client's access to medically necessary specialty care and other health services. Coordination includes referral, authorization, and follow-up.
- Authorize inpatient admissions.
- Provide or arrange for qualified medical personnel to be accessible 24 hours a day, 7 days a week to provide direction to clients in need of emergency care.
- Provide or arrange for suitable coverage for needed services, consultations, and approval of referrals during the provider's normal hours of operation.
- Provide or arrange for Well Child Check Ups and immunizations according to the periodicity schedule in the *Well Child EPSDT* chapter and *Appendix B* of this manual.
- Maintain a unified medical record for each PASSPORT client. This must include a record of all approvals for other providers. Providers must trans-

Using Modifiers

- Review the guidelines for using modifiers in the most current CPT-4, HCPCS Level II, or other helpful resources.
- Always read the complete description for each modifier; some modifiers are described in the CPT-4 manual while others are in the HCPCS Level II book.
- The Medicaid claims processing system recognizes only two pricing modifiers and one informational modifier per claim line. Providers are asked to place any modifiers that affect pricing in the first two modifier fields.
- When billing with modifier 50 for bilateral services, put all information on one line with one unit. For example, a bilateral carpal tunnel surgery would be billed like this:

24.	A DATE(S) OF SERVICE						B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F \$ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
	From MM DD YY	To MM DD YY	MM	DD	YY	MM										
1	08	23	02	08	23	02	22	0	64721 50	1	800.00	1				

- Check the fee schedule to see if Medicaid allows the use of the following modifiers for a particular code: bilateral (50), multiple procedures (51), co-surgery (62), assistant at surgery (80, 81, 82, AS), and team surgery (66).
- Always bill your main surgical procedure code on line 1 of the claim with one unit only. All other subsequent procedures should be billed with the number of units done for each code per line. For instance, if the main procedure code is 11600, one unit, and the subsequent procedure code is 11601, two units, bill as follows:

24.	A DATE(S) OF SERVICE						B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F \$ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
	From MM DD YY	To MM DD YY	MM	DD	YY	MM										
1	03	05	02	03	05	02	11	0	11600	1	115.00	1				
2	03	05	02	03	05	02	11	0	11601 51	1	140.00	2				

Do not separate out subsequent procedure codes (e.g., code 11601 51 twice) on separate lines. This will cause exact duplicate line denials. Subsequent procedure modifiers should be used when appropriate (for example: modifiers 51 or 59), except when billing add-on codes and modifier 51 exempt codes.

Billing Tips for Specific Provider Types

Mid-level practitioner billing

Mid-level practitioners must bill under their own Medicaid ID number rather than under a physician number.

Physician billing

- Medicaid-enrolled providers may bill for locum tenens services using modifier Q6.
- Durable medical equipment (DME) providers must bill prosthetic and orthotic devices under their DME provider number. Physicians may bill

only specific DME supplies and must check the fee schedule for appropriate codes.

Podiatrist billing

Podiatrists must use appropriate codes and modifiers from their specific fee schedule.

Independent diagnostic testing facilities

IDTF providers must use appropriate fee schedules, codes, and modifiers for their provider type.

Independent labs

- The provider’s current CLIA certification number must be on file with Provider Relations or all lab claims will be denied. See *Key Contacts* for CLIA certification information.
- This requirement also applies to public health labs. Questions regarding public health labs may be directed to the Public Health Lab Assistance hot-line (see *Key Contacts*).

Imaging

- Repeat modifiers should be used to indicate multiple radiology services of the same radiology code performed on the same day for the same client by the same or different providers. Repeat modifiers are specific modifiers used to indicate that a service is a repeat rather than a duplicate. Examples are modifiers -76 and -77.
- For multiple radiology services of the same code provided by the **same** provider on the same date of service, bill the first unit as one unit on one line, followed by additional units of the same code on an additional line with a -76 modifier. See the example below.

24.	A DATE(S) OF SERVICE						B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES		E DIAGNOSIS CODE	F \$ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
	From MM DD YY	To MM DD YY	CPT/HCPCS	MODIFIER													
1	03	05	02	03	05	02	11	0	71010		1	34.00	1				
2	03	05	02	03	05	02	11	0	71010	76	1	34.00	2				

- For radiology services of the same code provided by a **different** provider on the same date of service as another provider, bill all units on one line with a -77 modifier. See the example below.

24.	A DATE(S) OF SERVICE						B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES		E DIAGNOSIS CODE	F \$ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
	From MM DD YY	To MM DD YY	CPT/HCPCS	MODIFIER													
1	03	05	02	03	05	02	11	0	71010	77	1	34.00	2				

- If a claim is denied as a duplicate, send copies of the radiology report, the denial statement, and the claim to the appropriate Department program officer (see *Key Contacts, Lab and X-ray*) for review.

- For bilateral x-rays, bill on separate lines, one line with modifier RT and one line with modifier LT. The exception would be codes that are described as bilateral in their code description. These are to be billed on one line with one unit.
- Imaging providers must take particular care in the use of modifiers. The TC modifier is used when only the technical portion of the service is provided. The provider who interprets the results uses modifier 26. When both technical and professional services are performed by the same provider, no modifier is required.

Billing Tips for Specific Services

Abortions

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

Anesthesia

- Use appropriate CPT-4 anesthesia codes.
- Do not use surgery codes with an anesthesia modifier.
- For services where codes or definitions differ between the CPT-4 and the *American Society of Anesthesiologists' Relative Value Guide*, Medicaid adopts the CPT-4 version.
- Include the total number of minutes on the claim. Medicaid will convert the number of minutes to the number of time units. Do not include the base units on the claim as the claims processing system determines the number of base units (see the *Completing a Claim* chapter in this manual).

Bundled services

Certain services with CPT-4 codes (eg., telephone advice, some pulse oximetry services) are covered by Medicaid but have a fee of zero. This means that the service is typically “bundled” with an office visit or other service. Since the bundled service is covered by Medicaid, providers may not bill the client separately for it.

Cosmetic services

Include the prior authorization number in on the claim (see the *Completing a Claim* chapter in this manual).

EPSDT Well Child Screens

- Bill for a complete screen using the appropriate evaluation and management (E&M) code for preventive medicine services.
- When billing for partial screens, use the appropriate preventive medicine code with modifier 52 (reduced services).
- See also the Well Child EPSDT chapter in this manual.
- For Well Child EPSDT indicators, see the *Completing a Claim* chapter in this manual.

Family planning services

Contraceptive supplies and reproductive health items provided free to family planning clinics cannot be billed to Medicaid. When these supplies are not free to the clinic, providers associated with a family planning clinic can bill Medicaid for the following items:

Item	Code
Diaphragm	A4266
Male condoms	A4267
Female condoms	A4268
Spermicide	A4269
Oral contraceptives	S4993

For family planning indicators, see the *Completing a Claim* chapter in this manual.

Immunizations

- Use code 90471 or 90465 with modifier SL to bill for the first administration of vaccines under the Vaccines for Children (VFC) program. Use 90472-SL or 90446-SL for subsequent VFC administrations. (For proper code assignment, refer to your CPT code manual for the code description differences for codes 90465 and 90466 versus codes 90471 and 90472.)
- There must be a VFC covered vaccine code for each unit of service billed with code 90471-SL and 90472-SL or 90465-SL and 90466-SL. For a list of VFC covered vaccines, contact the Department's immunization program at (406) 444-5580.
- No more than four diagnosis codes are necessary.
- Bill each VFC vaccine code with \$0.00 charges.

For example, a provider administers three vaccines: MMR, pneumococcal conjugate, and DTaP.

24.	A DATE(S) OF SERVICE						B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F \$ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
	From	To	MM	DD	YY	MM										
1	12	12	03	12	12	03	11	0	90471 SL	1	10.00	1				
2	12	12	03	12	12	03	11	0	90472 SL	1	20.00	2				
3	12	12	03	12	12	03	11	0	90707	1	0.00	1				
4	12	12	03	12	12	03	11	0	90669	1	0.00	1				
5	12	12	03	12	12	03	11	0	90700	1	0.00	1				

Obstetrical services

If the provider’s care includes prenatal (antepartum) and/or postnatal (postpartum) care in addition to the delivery, the appropriate global OB code must be billed. Antepartum care includes all visits until delivery, and there are different codes for specified numbers of visits. There are also different codes for antepartum and postpartum care when only one or the other is provided. Please review your CPT coding book carefully.

Reference lab billing

Under federal regulations, all lab services must be billed to Medicaid by the lab that performed the service. Modifier 90, used to indicate reference lab services, is not covered by Medicaid.

Sterilization

- For elective sterilizations, a completed *Informed Consent to Sterilization* (MA-38) form must be attached to the claim for each provider involved or payment will be denied. This form must be legible, complete, and accurate, and revisions are not accepted. It is the provider’s responsibility to obtain a copy of the form from the primary or attending physician.
- For medically necessary sterilizations (including hysterectomies, oophorectomies, salpingectomies, and orchiectomies), one of the following must be attached to the claim, or payment will be denied:
 - A completed *Medicaid Hysterectomy Acknowledgement* form (MA- 39) for each provider submitting a claim. See *Appendix A Forms*. It is the provider’s responsibility to obtain a copy of the form from the primary or attending physician. Complete only one section (A, B, or C) of this form. When no prior sterility (section B) or life-threatening emergency (section C) exists, the client (or representative, if any) and physician must sign and date Section A of this form prior to the procedure (see 42 CFR 441.250 for the federal policy on hysterectomies and sterilizations). Also, for section A, signatures dated after the surgery date

require manual review of medical records by the Department. The Department must verify that the client (and representative, if any) was informed orally and in writing, prior to the surgery, that the procedure would render the client permanently incapable of reproducing. The client does not need to sign this form when sections B or C are used. Please refer to *Appendix A* for more detailed instructions on completing the form.

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

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

Surgical services

- Medicaid does not provide additional payment for the “operating room” in a physician's office. Medicaid pays facility expenses only to licensed hospitals and ambulatory surgical centers.
- ***Reporting surgical services:*** Certain surgical procedures must not be reported together, such as:
 - Procedures that are mutually exclusive based on the CPT-4 code description or standard medical practice.
 - When both comprehensive and component procedures are performed, only the comprehensive procedure must be billed.
 - When the CPT-4 manual describes several procedures of increasing complexity, only the code describing the most extensive procedure performed must be reported.

Medicaid edits for some surgical services using Medicare's Correct Coding Initiative (CCI) edits and performs post-payment review on others. See *Coding Resources* earlier in this chapter for more information on CCI.

- **Assistant at surgery**
 - When billing for an assistant at surgery, refer to the current Medicaid Department fee schedule to see if an assist is allowed for that procedure.
 - If an assistant at surgery does not use the appropriate modifier, then either the assistant's claim or the surgeon's claim (whichever is received later) will be denied as a duplicate service.
 - Physicians must bill assistant at surgery services using the appropriate surgical procedure code and modifier 80, 81, or 82.
 - Mid-level practitioners must bill assistant at surgery services under their own provider number using the appropriate surgical procedure code and modifier AS, 80, 81, or 82.
- **Global surgery periods:** Global surgery periods are time spans assigned to surgery codes. During these time spans, services related to the surgery may **not** be billed. Group practice members that are of the same specialty must bill Medicaid as if a single practitioner provided all related follow-up services for a client. For example, Dr. Armstrong performs orthopedic surgery on a client. The client comes in for a follow-up exam, and Dr. Armstrong is on vacation. Dr. Armstrong's partner, Dr. Black, performs the follow-up. Dr. Black cannot bill this service to Medicaid, because the service was covered in the global period when Dr. Armstrong billed for the surgery.
 - For major surgeries, this span is 90 days and includes the day prior to the surgery and the following services: post-operative surgery related care and pain management and surgically-related supplies and miscellaneous services.
 - For minor surgeries and endoscopies, the spans are either one day or ten days. They include any surgically-related follow-up care and supplies on the day of surgery, and for a 10-day period after the surgery.
 - For a list of global surgery periods by procedure code, please see the current Department fee schedule for your provider type.
 - If the CPT-4 manual lists a procedure as including the surgical procedure only (i.e., a "starred" procedure) but Medicaid lists the code with a global period, the Medicaid global period applies. Almost all Medicaid fees are based on Medicare relative value units (RVUs), and the Medicare relative value units were set using global periods even for starred procedures. Montana Medicaid has accepted these RVUs as the basis for its fee schedule.
 - In some cases, a physician (or the physician's partner of the same specialty in the same group practice) provides care within a global period that is unrelated to the surgical procedure. In these circumstances, the

unrelated service must be billed with the appropriate modifier to indicate it was not related to the surgery.

Telemedicine services

- When performing a telemedicine consult, use the appropriate CPT-4 evaluation and management (E&M) consult code.
- The place of service is the location of the provider providing the telemedicine service.
- Medicaid does not pay for network use or other infrastructure charges.

Transplants

Include the prior authorization number on the claim (field 23 on the CMS-1500 claim form). See the *Completing a Claim* chapter in this manual. All providers must have their own prior authorization number for the services. For details on obtaining prior authorization, see the *PASSPORT and Prior Authorization* chapter in this manual.

Weight reduction

Providers who counsel and monitor clients on weight reduction programs must bill Medicaid using appropriate evaluation and management (E&M) codes.

Submitting 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 2003.*** ACS makes available this free software, which providers can use to create and submit claims to Montana Medicaid, MHSP, and CHIP (dental and eyeglasses only). It does not support submissions to Medicare or other payers. This software creates an 837 transaction, but does not accept an 835 (electronic RA) transaction back from the Department. The software can be downloaded directly from the ACS EDI Gateway website. For more information on WINASAP 2003, visit the ACS EDI Gateway website, or call the number listed in the *Key Contacts* section of this manual.
- ***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. EDIFICS certifies the 837 HIPAA transactions at no cost to the provider. EDIFICS certification is completed through ACS

EDI Gateway. For more information on using the ACS clearinghouse, contact ACS EDI Gateway (see *Key Contacts*).

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

Providers should be familiar with the *Implementation Guides* that describe federal rules and regulations and provide instructions on preparing electronic transactions. These guides are available from the Washington Publishing Company (see *Key Contacts*). *Companion Guides* are used in conjunction with *Implementation Guides* and provide Montana-specific information for sending and receiving electronic transactions. They are available on the ACS EDI Gateway website (see *Key Contacts*).

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:

9999999	-	888888888	-	11182003
Medicaid Provider ID		Client ID Number		Date of Service (mmdyyy)

The supporting documentation must be submitted with a paperwork attachment coversheet (located 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 more information on attachment control numbers and submitting electronic claims, see the *Companion Guides* located on the ACS EDI website (see *Key Contacts*).

Submitting Paper Claims

For instructions on completing a paper claim, see the *Completing a Claim* chapter in this manual. Unless otherwise stated, all paper claims must be mailed to:

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

Claim Inquiries

Contact Provider Relations for questions regarding client eligibility, payments, denials, general claim questions, or to request billing instructions, manuals, or fee schedules (see *Key Contacts*).

If you prefer to communicate with Provider Relations in writing, use the *Montana Medicaid Claim Inquiry* form in *Appendix A*. Complete the top portion of the form with the provider's name and address. If you are including a copy of the claim, complete side A; if a copy of the claim is not included, complete side B.

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

The Most Common Billing Errors and How to Avoid Them

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

Common Billing Errors	
Reasons for Return or Denial	How to Prevent Returned or Denied Claims
Medicaid provider number missing or invalid	The provider number is a 7-digit number assigned to the provider during Medicaid enrollment. Verify the correct Medicaid 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 hand-written.
Signature date missing	Each claim must have a signature date.
Incorrect claim form used	The claim must be the correct form for the provider type. Services covered in this manual require a CMS-1500 claim form (or electronic Professional claim).
Information on claim form not legible	Information on the claim form must be legible. Use dark ink and center the information in the field. Information must not be obscured by lines.
Recipient number not on file, or recipient 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.

Common Billing Errors (continued)	
Reasons for Return or Denial	How to Prevent Returned or Denied Claims
Duplicate claim	<ul style="list-style-type: none"> • Please check all remittance advices (RAs) for previously submitted claims before resubmitting. • When making changes to previously paid claims, submit an adjustment form rather than a new claim (see <i>Remittance Advices and Adjustments</i> in this manual). • Please allow 45 days for the Medicare/Medicaid Part B crossover claim to appear on the RA before submitting the claim directly to Medicaid.
Procedure requires PASSPORT provider approval – No PASSPORT approval number on claim	A PASSPORT provider approval number must be on the claim when such approval is required. See the <i>PASSPORT and Prior Authorization</i> chapter in this manual.
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 (see the <i>PASSPORT and Prior Authorization</i> chapter in this manual). • Mental Health Services Plan (MHSP) claims must be billed and services performed during the prior authorization span. The claim will be denied if it is not billed according to the spans on the authorization. See the <i>Mental Health Services Plan</i> 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	All Medicare crossover claims must have an Explanation of Medicare Benefits (EOMB) included.
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.

Common Billing Errors (continued)

Reasons for Return or Denial	How to Prevent Returned or Denied Claims
Type of service/procedure is not allowed for provider type	<ul style="list-style-type: none"> • Provider is not allowed to perform the service, or type of service is invalid. • Verify the procedure code is correct using current HCPCS and CPT-4 billing manual. • Check the Medicaid fee schedule to verify the procedure code is valid for your provider type.

Other Programs

These billing procedures also apply to the Mental Health Services Plan (MHSP). These billing procedures do not apply to the Children’s Health Insurance Plan (CHIP). The CHIP Medical Manual is available through BlueCross BlueShield at (800) 447-7828 X8647.

Completing a Claim Form

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

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

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

When completing a claim, remember the following:

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

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

- Unless otherwise stated, all paper claims must be mailed to the following address:

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

Client Has Medicaid Coverage Only

Field#	Field Title	Instructions
1	Program	Check Medicaid.
1a	Insured's ID number	Leave this field blank for Medicaid only claims.
2*	Patient's name	Enter the client's name as it appears on the Medicaid client's eligibility information.
3	Patient's birth date and sex	Client's birth date in month/day/year format. Check male or female box.
5	Patient's address	Client's address.
10	Is patient's condition related to:	Check "Yes" or "No" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in field 24. If you answered "yes" to any of these, enter the two-letter state abbreviation where the accident occurred on the "Place" line.
10d*	Reserved for local use	Enter the client's Medicaid ID number as it appears on the client's Medicaid eligibility information.
11d*	Is there another health benefit plan?	Enter "No". If "Yes", follow claim instructions for appropriate coverage later in this chapter.
14	Date of current illness, injury, pregnancy	Enter date in month/day/year format. This field is optional for Medicaid only claims.
16	Dates patient unable to work in current occupation	If applicable, enter date in month/day/year format. This field is optional for Medicaid only claims.
17	Name of referring physician	Enter the name of the referring physician. For PASSPORT clients, the name of the client's PASSPORT provider goes here.
17a**	ID number of referring physician	Enter the referring or ordering physician's Medicaid ID number. For PASSPORT clients, enter the client's PASSPORT provider's PASSPORT ID number.
18	Hospitalization dates related to current service	Enter dates if the medical service is furnished as a result of, or subsequent to, a related hospitalization. This field is optional for Medicaid only claims.
19	Reserved for local use	This field is used for any special messages regarding the claim or client.
20	Outside lab?	Check "No". Medicaid requires all lab tests to be billed directly by the provider who performed them.
21*	Diagnosis or nature of illness or injury	Enter the appropriate ICD-9-CM diagnosis codes. Enter up to four codes in priority order (primary, secondary, etc.).
23**	Prior authorization number	If the service requires prior authorization (PA), enter the PA number you received for this service.
24a*	Date(s) of service	Enter date(s) of service for each procedure, service, or supply.
24b*	Place of service	Enter the appropriate two-digit place of service (see <i>Appendix C</i>).
24c*	Type of service	Enter Montana's type of service code: Nursing facilities are "9", and all others are "0" (zero).
24d*	Procedure, service, or supplies	Enter the appropriate CPT-4 or HCPCS code for the procedure, service, or supply. When applicable, enter the appropriate CPT-4/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 your reasonable and customary charges (or the Department-designated charges) for the procedure(s) on this line.
24g*	Days or units	Enter the number of units or days for the procedure and date(s) of service billed on this line (see <i>Billing Procedures, Coding</i> for additional tips on days/units). Anesthesia providers must bill using minutes.
24h**	EPSDT/family planning	If applicable, enter the appropriate code for the client/service: 1, 2, 3, 4, or 6 (see complete description in the <i>EPSDT/Family Planning Indicators</i> table earlier in this chapter).
24i**	EMG (Emergency)	Enter an "X" if this service was rendered in a hospital emergency room to override Medicaid copay.
28*	Total charge	Enter the sum of all charges billed in field 24f.
29	Amount paid	Leave blank or enter \$0.00. Do not report any client copay or Medicaid payment amounts on this form.
30	Balance due	Enter the balance due as recorded in field 28.
31*	Signature and date	This field must contain an authorized signature and date, which is either hand signed, stamped, or computer generated.
32	Name and address of facility	Enter the name and address of the person, organization, or facility performing the services if other than the client's home or physician's office.
33*	Physician's, supplier's billing name, address, phone number	Enter the name, address, phone number and Montana Medicaid provider number (not UPIN) of the physician or supplier who furnished service.

* = Required Field

** = Required if applicable

Client Has Medicaid Coverage Only

APPROVED OMB-0938-0008

For Medicaid use. Do not write in this area.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Montana Department of Public Health and Human Services

HEALTH INSURANCE CLAIM FORM

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER 1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Smith, Chuckie L. 3. PATIENT'S BIRTH DATE MM DD YY 04 28 96 M SEX F

5. PATIENT'S ADDRESS (No., Street) 123 Anystreet #1 6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

8. PATIENT STATUS Single Married Other

CITY Anytown STATE MT ZIP CODE 59999 TELEPHONE (Include Area Code) (406) 555-5555

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10. IS PATIENT'S CONDITION RELATED TO: 11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F b. AUTO ACCIDENT? YES NO PLACE (State)

c. EMPLOYER'S NAME OR SCHOOL NAME c. OTHER ACCIDENT? YES NO

d. INSURANCE PLAN NAME OR PROGRAM NAME 10d. RESERVED FOR LOCAL USE 999999999

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) 09 10 00 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE Doug Ross, MD 17a. I.D. NUMBER OF REFERRING PHYSICIAN 9989999

19. RESERVED FOR LOCAL USE 20. OUTSIDE LAB? YES NO \$ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

1. 381.20 3. 474.01 23. PRIOR AUTHORIZATION NUMBER

2. 474.12 4. 24. A B C D E F G H I J K

Table with columns: DATE(S) OF SERVICE, Place of Service, Type of Service, PROCEDURES, SERVICES, OR SUPPLIES, DIAGNOSIS CODE, \$ CHARGES, DAYS OR UNITS, EPSDT Family Plan, EMG, COB, RESERVED FOR LOCAL USE. Rows 1-6.

25. FEDERAL TAX I.D. NUMBER 99-9999999 26. PATIENT'S ACCOUNT NO. 99999 27. ACCEPT ASSIGNMENT? YES NO 28. TOTAL CHARGE \$ 950.00 29. AMOUNT PAID \$ 0.00 30. BALANCE DUE \$ 950.00

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.) 32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

SIGNED DATE Doug Ross, MD 03/20/02 Anytown Surgicenter 123 Medical Drive Anytown, MT 59999

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # The Pediatric Center P.O. Box 999 Anytown, MT 59999 PIN# 0000099999 GRP# (406) 555-5555

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

Client Has Medicaid and Medicare Coverage

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

* = Required Field

** = Required if applicable

Client Has Medicaid and Medicare Coverage

APPROVED OMB-0938-0008

For Medicaid use. Do not write in this area.

HEALTH INSURANCE CLAIM FORM

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Jones, Jerry
3. PATIENT'S BIRTH DATE 02 04 33
4. INSURED'S I.D. NUMBER 999999999A
5. PATIENT'S ADDRESS (No., Street) 4321 Anystreet
6. PATIENT RELATIONSHIP TO INSURED Self
7. INSURED'S ADDRESS (No., Street) Same
8. PATIENT STATUS Single
9. OTHER INSURED'S NAME
10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE Carter, Edward MD
17a. I.D. NUMBER OF REFERRING PHYSICIAN 9999999
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
19. RESERVED FOR LOCAL USE
20. OUTSIDE LAB? \$ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 486
22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

Table with 11 columns: A (DATE(S) OF SERVICE From To), B (Place of Service), C (Type of Service), D (PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER), E (DIAGNOSIS CODE), F (\$ CHARGES), G (DAYS OR UNITS), H (EPSDT Family Plan), I (EMG), J (COB), K (RESERVED FOR LOCAL USE). Rows 1-6 show procedure 99223 with diagnosis 1 and charges of 200.00, 75.00, 75.00, 75.00, 75.00, 75.00.

25. FEDERAL TAX I.D. NUMBER 99-9999999
26. PATIENT'S ACCOUNT NO. 99999999ABC
27. ACCEPT ASSIGNMENT? YES
28. TOTAL CHARGE \$ 575.00
29. AMOUNT PAID \$
30. BALANCE DUE \$ 575.00
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS Edward Carter, MD 06/15/02
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED Anytown Hospital 12345 Medical Drive Anytown, MT 59999
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # Family Healthcare 321 Medical Drive Anytown, MT 59999

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Montana Department of Public Health and Human Services

Client Has Medicaid and Third Party Liability Coverage

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

* = Required Field

** = Required if applicable

Client Has Medicaid and Third Party Liability Coverage

APPROVED OMB-0938-0008

PLEASE DO NOT STAPLE IN THIS AREA

For Medicaid use. Do not write in this area.

CARRIER

HEALTH INSURANCE CLAIM FORM

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER
2. PATIENT'S NAME Jackson, Renee P.
3. PATIENT'S BIRTH DATE 08/31/80
4. INSURED'S NAME Same
5. PATIENT'S ADDRESS 4321 Anystreet
6. PATIENT RELATIONSHIP TO INSURED Self
7. INSURED'S ADDRESS Same
8. PATIENT STATUS Single
9. OTHER INSURED'S NAME
10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER 999999999B
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS OR INJURY 01/16/02
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS.
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE Smith, Steven R. MD
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
19. RESERVED FOR LOCAL USE
20. OUTSIDE LAB?
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. 845.02
22. MEDICAID RESUBMISSION CODE
23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

Table with 11 columns: A (DATE(S) OF SERVICE), B (Place of Service), C (Type of Service), D (PROCEDURES, SERVICES, OR SUPPLIES), E (DIAGNOSIS CODE), F (\$ CHARGES), G (DAYS OR UNITS), H (EPSDT Family Plan), I (EMG), J (COB), K (RESERVED FOR LOCAL USE). Rows 1-6 contain procedure data.

25. FEDERAL TAX I.D. NUMBER
26. PATIENT'S ACCOUNT NO.
27. ACCEPT ASSIGNMENT?
28. TOTAL CHARGE \$ 245.00
29. AMOUNT PAID \$ 129.00
30. BALANCE DUE \$ 116.00
31. SIGNATURE OF PHYSICIAN OR SUPPLIER John Pied, DPM 01/16/02
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED The Foot Group, 25 Medical Drive, Anytown, MT 59999
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # The Foot Group, P.O. Box 999, Anytown, MT 59999

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

Client Has Medicaid, Medicare, and Third Party Liability Coverage

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

* = Required Field

** = Required if applicable

APPROVED OMB-0938-0008

PLEASE
DO NOT
STAPLE
IN THIS
AREA

For Medicaid use. Do not write in this area.

CARRIER

HEALTH INSURANCE CLAIM FORM

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER
 (Medicare #) (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
Olsen, Karen Z.

3. PATIENT'S BIRTH DATE
 MM DD YY
11 07 62 M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Same

5. PATIENT'S ADDRESS (No., Street)
98765 Anystreet #2

6. PATIENT RELATIONSHIP TO INSURED
 Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)
Same

CITY STATE
Anytown MT

8. PATIENT STATUS
 Single Married Other

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:
 a. EMPLOYMENT? (CURRENT OR PREVIOUS)
 YES NO
 b. AUTO ACCIDENT? PLACE (State)
 YES NO
 c. OTHER ACCIDENT?
 YES NO

11. INSURED'S POLICY GROUP OR FECA NUMBER
999999999A

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 _____ DATE _____

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)
 MM DD YY
06 23 02

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 PHYSICIAN OR OTHER SOURCE

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
 FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? \$ CHARGES
 YES NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
 1. **690.10**
 2. **078.10**

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
 23. PRIOR AUTHORIZATION NUMBER

PATIENT AND INSURED INFORMATION

A			B			C			D			E			F			G			H			I			J			K		
DATE(S) OF SERVICE			Place of Service			Type of Service			PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)			DIAGNOSIS CODE			\$ CHARGES			DAYS OR UNITS			EPSDT Family Plan			EMG			COB			RESERVED FOR LOCAL USE		
From	To								CPT/HCPCS	MODIFIER																						
12	20	01	12	20	01	11	0	17110			1,2	79	20	1																		
2																																
3																																
4																																
5																																
6																																

25. FEDERAL TAX I.D. NUMBER SSN EIN
99-9999999

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back)
 YES NO

28. TOTAL CHARGE \$ **79.20**

29. AMOUNT PAID \$ **32.00**

30. BALANCE DUE \$ **47.20**

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Steven Sloan, MD 01/31/02
 SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
**Steven Sloan, MD
 P.O. Box 999
 Anytown, MT 59999**

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
**Steven Sloan, MD
 P.O. Box 999
 Anytown, MT 59999**
 PIN# **999999** GRP# **(406) 999-9999**

PHYSICIAN OR SUPPLIER INFORMATION

Montana Department of Public Health and Human Services

Client Has Medicaid, Medicare, and Medicare Supplement Coverage

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

* = Required Field

** = Required if applicable

- If an original payment was an underpayment by Medicaid, the adjustment will result in the provider receiving the additional payment amount allowed.
- If an original payment was an overpayment by Medicaid, the adjustment will result in recovery of the overpaid amount through a credit balance or a check from the provider (see *Credit balances* earlier in this chapter).
- Any questions regarding claims or adjustments must be directed to Provider Relations (see *Key Contacts*).

Mass adjustments

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

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

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

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). One form must be completed for each provider number. See the following table, *Required Forms for EFT and/or Electronic RA*.

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.

Required Forms For EFT and/or Electronic RA All three forms are required for a provider to receive weekly payment			
Form	Purpose	Where to Get	Where to Send
Electronic Remittance Advice and Payment Cycle Enrollment Form	Allows provider to receive electronic remittance advices on MEPS (must also include MEPS Access Request form)	<ul style="list-style-type: none"> • Provider Information website • 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"> • Provider Information website (see <i>Key Contacts</i>) • Provider's bank 	Provider Relations (see <i>Key Contacts</i>)
MEPS Access Request Form	Allows provider to receive a password to access their RA on MEPS	<ul style="list-style-type: none"> • Provider Information website • Virtual Human Services Pavilion • Direct Deposit Arrangements (see <i>Key Contacts</i>) 	DPHHS address on the form

Other Programs

The information in this chapter also applies to the Mental Health Services Plan (MHSP) and the Children's Health Insurance Plan (CHIP) vision and dental services only.

Instructions for Completing the *Informed Consent to Sterilization (MA-38)*

- No fields on this form may be left blank, except the interpreter's statement.
- This form must be legible, accurate, and revisions are not accepted.
- Do not use this form for hysterectomies (see following *Hysterectomy Acknowledgment* form.)

Consent to Sterilization (complete at least 30 days prior to procedure)

1. Enter the doctor's name or clinic name.
2. Enter the name of the sterilization procedure (e.g., tubal ligation, vasectomy, etc.).
3. Enter the client's date of birth in month/day/year format. The client must be at least 21 years old at the time of consent.
4. Enter the client's full name. Do not use nicknames. The name should match the client's name on the Medicaid eligibility information.
5. Enter the name of the physician who will perform the procedure.
6. Enter the name of the specific procedure (method) to be used.
7. Have the client sign and date the form. **This date must be at least 30 days before the sterilization procedure is to be performed** (see *Covered Services* for exceptions).

Interpreter's Statement

Complete this section only if the client requires an interpreter because of blindness, deafness, or inability to speak the language. In these cases interpreter services must be used to assure that the client clearly understands the concepts of the informed consent.

1. Identify the manner the interpreter used to provide the explanation. (e.g., Spanish, sign language, etc.)
2. Have the interpreter sign and date the form. This date should be the same as the date the client signs the form.

Statement of Person Obtaining Consent

1. Enter the client's name.
2. Enter the name of the sterilization procedure.
3. Enter the signature and date of the person who explained the sterilization procedure to the client and obtained the consent.
4. Enter the name of the facility where consent was obtained, such as clinic name.
5. Enter the address of the facility where the consent was obtained.

Physician's Statement

This section must be completed by the attending physician on or after the date the procedure was performed.

1. Enter the name of the client.
2. Enter the date the procedure was performed. This date and the date of service on the claim must match.
3. Enter the name of the procedure.
4. Use the space under *Instructions for use of alternative final paragraphs* to explain unusual situations, or attach a letter to explain the circumstances. In cases of premature delivery, this must include the client's expected date of delivery. In cases of emergency abdominal surgery, include an explanation of the nature of the emergency.
5. The Physician signs and dates on or after the date of the procedure.

If the physician signs and dates this section prior to the sterilization procedure, the claims will be denied. If the form was filled out after the sterilization but was dated incorrectly, the physician must attach a written explanation of the error. This written explanation must be signed by the physician. Copies of the letter will need to be supplied to all other providers involved with this care before their claims will be paid.

The attending physician must complete the second *alternative final paragraphs* of the Physician's Statement portion of the consent form in cases of premature deliver or emergency abdominal surgery. In cases of premature delivery, the expected delivery date must be completed in this field as well.

MEDICAID HYSTERECTOMY ACKNOWLEDGMENT

A. RECIPIENT ACKNOWLEDGMENT STATEMENT

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

Signature of Recipient: _____ Date: _____

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

PHYSICIAN ACKNOWLEDGMENT STATEMENT

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

Signature of Physician: _____ Date: _____

SIGNATURE OF INTERPRETER (If Required)

Signature of Interpreter: _____ Date: _____

B. STATEMENT OF PRIOR STERILITY

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

Signature of Physician: _____ Date: _____

C. STATEMENT OF LIFE THREATENING EMERGENCY

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

Signature of Physician: _____ Date: _____

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

Appendix B: Well Child Screen Chart

Well Child Screen Recommendations

Child's Name _____ Child's SSN _____ Child's Date of Birth _____

Parent's Name _____ Parent's SSN _____

Well Child Screen component	Age requirements	Date completed
A. Initial/Interval History		
Developmental history	all ages	
Nutritional history	all ages	
Complete dental history	all ages	
B. Assessments		
Appropriate developmental screen		
motor	all ages	
social	all ages	
cognitive	all ages	
speech	all ages	
Nutritional Screen	all ages	
Age Appropriate Risk Assessment Screen		
Emotional	all ages	
Risky behaviors	all ages	
Blood Lead	all ages	
TB	all ages	
C. Unclothed Physical Inspection		
Height/weight	all ages	
Head circumference	newborn through 2 years old	
Standard body systems	all ages	
Check for signs of abuse	all ages	
Blood pressure	3 years on	
D. Vision Screen		
External inspection for gross abnormalities or obvious strabismus	all ages	
Gross visual acuity with fixation test	birth to 2 years	
Light sensation with papillary light reflex test	birth to 2 years	
Observation and report of parent	birth to 2 years	
Examination of red reflex	all ages	
Alternate cover test	2 years to 5 years	
Corneal light reflex	2 years to 5 years	
Visual acuity using the Illiterate Snellen E chart (or similar)	4 years and over	
Color discrimination on all boys (once)	5 years and over	
E. Hearing Screen		
History, physical and developmental assessment	all ages	
Middle ear exam by otoscopy	all ages	
Administration of high risk criteria	6 months OR 2 years	
Assess hearing capability	6 months OR 2 years	
Administration of puretone audiometry	5 years and over	
F. Laboratory Tests (use medical judgment and risk assessment to determine need EXCEPT for blood lead)		
Hematocrit or hemoglobin	9-15 months if indicated by risk assessment	
Urinalysis	if indicated by risk assessment	
Tuberculin	if indicated by risk assessment	

		if indicated by risk assessment and age appropriate (8 - 14)	
	Cholesterol		
	Hereditary/metabolic screening (e.g., thyroid, hemoglobinopathies, PKU, galactosemia)	newborn	
	Blood lead	12 and 24 months and other ages if at risk	
	STD screening	sexually active adolescents	
	Pap smear	sexually active adolescents	
	Other tests as needed		
G.	Immunizations (the immunization schedule approved by the Advisory Committee on Immunization Practices (ACIP); if the committee has released an updated schedule, that schedule supercedes this one)		
	Hepatitis B (Hep B)	1 at birth, 2nd by 4 months, 3rd between 6-18 months, and "catch up" at any time	
	Diphtheria, tetanus, pertussis (DTaP)	2 mos, 4 mos, 6 mos, 15-18 mos, 4-6 years	
	H. influenza type b (Hib)	2 mos, 4 mos, 6 mos, 12-15 mos	
	Inactivated polio (IPV)	2 mos, 4 mos, 6-18 mos, 4-6 years	
	Pneumococcal conjugate (PCV)	2 mos, 4 mos, 6 mos, 12-15 mos	
	Measles, mumps, rubella (MMR)	12-15 mos, 4-6 years, "catch up" any time	
	Varicella (Var) (if given after 12 years, 2 doses separated by 1 month should be given)	12-18 mos, "catch up" any time	
	Tetanus (Td)	11-12 years, then every 10 years	
H.	Dental Screen (to be done by medical health provider)		
	Counseling on oral hygiene	all ages	
	Counseling for non-nutritive habits (thumb-sucking, etc.)	through age 6 years	
	Initial/interval dental history	all ages	
	Oral inspection of mouth, teeth, gums	all ages	
I.	Discussion and Counseling/Anticipatory Guidance		
	Address needs and topics appropriate for age level per risk assessment	all ages	

Appendix C

Place of Service Codes

Place of Service Codes		
Codes	Names	Descriptions
01	Pharmacy**	A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients.
02	Unassigned	N/A
03	School	A facility whose primary purpose is education.
04	Homeless shelter	A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters).
05	Indian Health Service free-standing facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization.
06	Indian Health Service provider-based facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.
07	Tribal 638 free-standing facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members who do not require hospitalization.
08	Tribal 638 provider-based facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members admitted as inpatients or outpatients.
09 - 10	Unassigned	N/A
11	Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, state or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
13	Assisted living facility	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services.
14	Group home	A residence, with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services (e.g., medication administration).
15	Mobile unit	A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.
16 - 19	Unassigned	N/A

Place of Service Codes (continued)		
Codes	Names	Descriptions
20	Urgent care facility	Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.
21	Inpatient hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	Outpatient hospital	A portion of a hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
23	Emergency room - hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
24	Ambulatory surgical center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
25	Birthing center	A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate post-partum care as well as immediate care of newborn infants.
26	Military treatment facility	A medical facility operated by one or more of the uniformed services. Military treatment facility (MTF) also refers to certain former U.S. public health service (USPHS) facilities now designated as uniformed service treatment facilities (USTF).
27 - 30	Unassigned	N/A
31	Skilled nursing facility	A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
32	Nursing facility	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick person, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.
33	Custodial care facility	A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.
34	Hospice	A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
35 - 40	Unassigned	N/A
41	Ambulance - land	A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
42	Ambulance - air or water	An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
43 - 48	Unassigned	N/A
49	Independent clinic	A location, not part of a hospital and not described by any other place of service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only.
50	Federally qualified health center	A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
51	Inpatient psychiatric facility	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.

Place of Service Codes (continued)		
Codes	Names	Descriptions
52	Psychiatric facility -partial hospitalization	A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.
53	Community mental health center	A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services: screening for patients being considered for admission to state mental health facilities to determine the appropriateness of such admission; and consultation and education services.
54	Intermediate care facility/mentally retarded	A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF.
55	Residential substance abuse treatment facility	A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.
56	Psychiatric residential treatment center	A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.
57	Non-residential substance abuse treatment facility	A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.
58 - 59	Unassigned	N/A
60	Mass immunization center	A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.
61	Comprehensive inpatient rehabilitation facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.
62	Comprehensive outpatient rehabilitation facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
63 - 64	Unassigned	N/A
65	End-stage renal disease treatment facility	A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.
66 - 70	Unassigned	N/A
71	Public health clinic	A facility maintained by either state or local health departments that provides ambulatory primary medical care under the general direction of a physician.

Place of Service Codes (continued)		
Codes	Names	Descriptions
72	Rural health clinic	A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.
73 - 80	Unassigned	N/A
81	Independent laboratory	A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.
82 - 98	Unassigned	N/A
99	Other place of service	Other place of service not identified above.

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