



***Durable Medical
Equipment,
Prosthetics,
Orthotics and
Medical Supplies
(DMEPOS)***

***Medicaid and Other Medical
Assistance Programs***



June 2008

This publication supersedes all previous Durable Medical Equipment, Orthotics, Prosthetics and Supplies (DMEOPS) handbooks. Published by the Montana Department of Public Health & Human Services, January 2005.

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My NPI:

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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 state
(406) 442-1837 Out of state and Helena

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 state
(406) 442-1837 Out of state and 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

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

Third Party Liability

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

(800) 624-3958 In state
(406) 442-1837 Out of state and Helena
(406) 442-0357 Fax

Send written inquiries to:

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

Provider's Policy Questions

For policy questions or issues:

(406) 444-5296 Program Officer
(406) 444-3846 Fax

Client Eligibility

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

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:

MTPRHelpdesk@ACS-inc.com

Mail to:

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

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

Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC)

For coding advice and other SADMERC information:

(877) 735-1326

Mon-Fri 9:00 a.m.- 4:00 p.m. Eastern Time

SADMERC
P.O. Box 100143
Columbia, SC 29202-3143

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

Prior Authorization

Mountain Pacific Quality Health Foundation

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

Phone:

(406) 457-5887 Local

(877) 443-4021, ext 5887 Long-distance

Fax:

(877) 443-2580 Toll-free local and long-distance

Send written inquiries to:

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

Fraud and Abuse

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

(800) 201-6308 Client Eligibility Fraud

(800) 362-8312 Medicaid Help Line

(please call this number to report suspected client abuse of Medicaid)

(800) 376-1115 Provider Fraud

Key Websites	
Web Address	Information Available
Provider Information Website www.mtmedicaid.org or http://medicaidprovider.hhs.mt.gov/	<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 http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml	<ul style="list-style-type: none"> • Medicaid program information • Client newsletters • Who to call if you have questions • Client Notices & Information
ACS EDI Gateway www.acs-gcro.com/Medicaid_Account/Montana/montana.htm	ACS EDI Gateway is Montana's HIPAA clearinghouse. Visit this website for more information on: <ul style="list-style-type: none"> • Provider Services • EDI Support • Enrollment • Manuals • Software • Companion Guides
Medicare Pricing, Data Analysis and Coding (PDAC) www.dmepdac.com Phone: (877) 735-1326	PDAC (formerly SADMERC) information is available under <i>Other Partners</i> . This website assists manufacturers and suppliers with DMEPOS billing and coding information.
Noridian Administrative Services https://www.noridianmedicare.com/	Equipment Regional Carriers (DMERCs) website. DMERC processes Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) for Medicare.
ARM Rules http://www.dphhs.mt.gov/legal_section/administrative_rules_montana/arm_title_37/arm_title_37.htm	Administrative Rules of Montana
Washington Publishing Company www.wpc-edi.com	<ul style="list-style-type: none"> • EDI implementation guides • HIPAA implementation guides and other tools • EDI education

Key Websites (continued)

Web Address	Information Available
<p>CHIP Website www.chip.mt.gov</p>	<ul style="list-style-type: none"> • Information on the Children’s Health Insurance Plan (CHIP)

Introduction

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

Manual Organization

This manual provides information specifically for providers of Durable Medical Equipment, Prosthetics, Orthotics and Medical Supplies (DMEPOS). Other essential information for providers is contained in the separate *General Information For Providers* manual. Each provider is asked to review both the general manual and the specific manual for his or her provider type.

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

Manual Maintenance

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

Rule References

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

- Administrative Rules of Montana (ARM)
 - ARM 37.86.1801 - 37.86.1807 Prosthetic Devices, Durable Medical Equipment and Medical Supplies



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

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

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

Getting Questions Answered

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

Covered Services

General Coverage Principles

This chapter provides covered services information that applies specifically to services and supplies provided by Durable Medical Equipment, Prosthetic, Orthotic and Medical Supply (DMEPOS) providers. Like all health care services received by Medicaid clients, services rendered by these providers must also meet the general requirements listed in the *Provider Requirements* chapter of the *General Information For Providers* manual.

Montana Medicaid follows Medicare's coverage requirements for most items. A Medicare manual is available from the DMERC website. The Provider Information website contains a link to the DMERC site (see *Key Contacts*). Montana Medicaid considers Medicare, Region D, DMERC medical review policies as the minimum DMEPOS industry standard. This manual covers criteria for certain items/services which are either in addition to Medicare requirements or are services Medicare does not cover.

Montana Medicaid coverage determinations are a combination of Medicare, Region D DMERC policies, Centers for Medicare and Medicaid Services (CMS) National Coverage Decisions, Local Coverage Determinations, and Department designated medical review decisions. DMEPOS providers are required to follow specific Montana Medicaid policy or applicable Medicare policy when Montana Medicaid policy does not exist. When Medicare makes a determination of medical necessity, that determination is applicable to the Medicaid program.

Essential for Employment Program

In limited circumstances, Medicaid will cover a durable medical equipment service normally excluded under "Basic" Medicaid if it is essential to obtaining or maintaining employment. When this is the case, the client will present a signed *Medicaid Services Essential for Employment Form* (DPHHS-HCS-782). Prior to receiving DME services as an *Essential for Employment* benefit, the client must obtain this form through their eligibility specialist at their local County Office of Public Assistance.

- Service/limitations, coverage, and reimbursement may be the same for approved services as they would be for a "Full" Medicaid client.
- Claims must be accompanied by a completed *Medicaid Services Essential for Employment Form* (DPHHS-HCS-782), located in *Appendix A: Forms* and on the Provider Information web site.
- If the item/equipment requires prior authorization, the Essentials and all documentation will be sent for PA after the Essential is approved.

Prescriptions for DMEPOS items must include the diagnosis, medical necessity, and projected length of need for the item.



Services for children (ARM 37.86.2201 – 2221)

The Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) is a comprehensive approach to health care for Medicaid clients under age 21. It is designed to prevent, identify, and then treat health problems before they become disabling. Under EPSDT, Medicaid eligible children may receive any medically necessary covered service, including DMEPOS items/services described in this manual. All applicable prior authorization requirements apply.

Basic Medicaid

Medicaid generally does not cover Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) for clients on Basic Medicaid. Providers should verify client’s eligibility before providing services. The *only* HCPCS codes covered under Basic Medicaid are:

A4206 through A4259	A4310 through A4554	A4611 through A4629
A4772	A5051 through A5513	A6530 through A6544
A7027 through A7046	E0424 through E0450	E0457 through E0460
E0463 through E0480	E0550 through E0570	E0575 through E0601
E0605 through E0607	E0781	E0784
E1372	E1390	E1405 and E1406
K0455	K0552	L5000 through L8510

DMEPOS suppliers must obtain a written prescription in accordance with Administrative Rule of Montana (ARM) 37.86.1802. Suppliers should also maintain documentation showing the client meets the Medicare coverage criteria.

Other DME items for Basic Medicaid clients may be covered under the Essentials for Employment program if they are necessary to obtaining or maintaining employment. When this is the case, the client will present a signed Medicaid Services Essential for Employment Form (DPHHS-HCS-782). Prior to receiving DME items as an Essential for Employment benefit, the client must obtain this form through their eligibility specialist at their local County Public Assistance Office.

Provision of services (ARM 37.86.1802)

Federal regulations require that items/services covered by the Department are reasonable and necessary in amount, duration and scope to achieve their purpose. DMEPOS items/supplies must be medically necessary, prescribed in writing and delivered in the most appropriate and cost effective manner, and may not be excluded by any other state or federal rules or regulations.

The effective date of an order/script is the date in which it was signed.



Supplier documentation (ARM 37.86.1802)

All covered DMEPOS items for clients with Medicaid as the primary payer, must be prescribed by a physician or other licensed practitioner of the healing arts within the scope of the provider's practice as defined by state law. The prescription must indicate the diagnosis, the medical necessity, projected length of need for the covered item, and utilization instructions. Prescriptions for oxygen must also include the liter flow per minute, hours of use per day and the client's P02 or oxygen saturation blood test results.

DMEPOS suppliers must obtain a written prescription in accordance with Administrative Rule of Montana (ARM) 37.86.1802. Suppliers should also maintain documentation showing the client meets the Medicare coverage criteria.

Effective January 1, 2008, ARM 37.86.1802 describes how prescriptions/orders can be transmitted. The prescription/order must indicate the diagnosis, the medical necessity, quantity and the length of need. The rule refers providers to the Medicare guidelines. Prescriptions can now be oral, faxed or hard copy. For items that are dispensed based on a verbal order, the supplier must obtain a written order that meets the requirements in Chapter 3 of the Medicare Supplier Manual. The rule refers to current Medicare rules and regulations in the Region D Supplier manual (including the most current local coverage determinations (LCDs)). Chapters 3 and 4 of the Medicare Manual outline the documentation requirements for suppliers.

Even though a prescription is required, coverage decisions are not based solely on the prescription. Coverage decisions are based on objective, supporting information about the client's condition in relation to the item/service prescribed. Supporting documentation may include, but is not limited to (if applicable) a Certificate of Medical Necessity (CMN), DME Information Form (DIF), and/or a physician's, therapist's or specialist's written opinion/attestation for an item/service based on unique individual need.

The client's medical record must contain sufficient documentation of the client's medical condition to substantiate the necessity for the prescribed item/service. The client's medical record is not limited to the physician's office records. It may include hospital, nursing home, or home health agency records and records from other professionals including, but not limited to, nurses, physical and occupational therapists, prosthetists, and orthotists. It is recommended that suppliers obtain (for their files) sufficient medical records to determine whether the client meets Medicaid coverage and payment rules for the particular item.

Proof of delivery is required in order to verify that the client received the DMEPOS item. Proof of delivery documentation must be made available to the Department upon request. Medicaid does not pay for delivery, mailing or shipping fees or other costs of transporting the item to the client's residence.

Providers must retain the original prescription, supporting medical need documentation and proof of delivery. For additional documentation requirements, see the *General Information for Providers* manual, *Provider Requirements* chapter, and Chapters 3 and 4 of the Medicare manual.

Certificate of medical necessity

For a number of DMEPOS items, a certificate of medical necessity (CMN) is required to provide supporting documentation for the client's medical indication(s). The "CMN" column of the Montana Medicaid fee schedule indicates if a CMN is required. Montana Medicaid adopts the CMNs used by Medicare Durable Medical Equipment Regional Carriers (DMERCs), approved by the Office of Management and Budget (OMB), and required by the Centers for Medicare & Medicaid Services (CMS). These forms are available in *Appendix A: Forms*, on the Provider Information website (see *Key Contacts*) and on the following websites:

<http://www.cms.hhs.gov/providers/mr/cmn.asp>

<https://www.noridianmedicare.com/>

The following is a list of items that require a CMN and the corresponding form. This reference list will be updated as changes are made. If any discrepancies exist between these referenced forms and what is published by CMS and Medicare, then the CMS and Medicare policy shall take precedence. See Chapter 4 of the Medicare policy manual.

CMN Forms		
Item	Form	Date
Lymphedema Pumps (Pneumatic Compression Devices)	CMS-846	09/05
Osteogenesis Stimulators	CMS-847	09/05
Oxygen	CMS-484	09/05
Seat Lift Mechanisms	CMS-849	09/05
Section C Continuation Form	CMS-854	09/05
Transcutaneous Electrical Nerve Stimulators (TENS)	CMS-848	09/05

DME Information Forms		
Item	Form	Date
External Infusion Pumps	CMS-10125	09/05
Enteral and Parental Nutrition	CMS-10126	09/05

Rental/purchase (ARM 37.86.1801 - 1806)

The rental period for items identified by Medicare as capped, routine or inexpensive are limited to 13 months of rental reimbursement. After 13 months of continuous rental, the item is considered owned by the client and the provider must transfer ownership to the client. Total Medicaid rental reimbursement for items listed in Medicare's capped rental program or classified by Medicare as routine and inexpensive rental are limited to the purchase price for that item listed on the Medicaid fee schedule. If purchasing the rental item is cost effective, the Department may cover the purchase of the item. See Chapter 5 of the Medicare supplier manual.

A statement of medical necessity for rental of DME equipment must indicate the length of time the equipment is needed, and all prescriptions must be signed and dated.

Servicing. During the 13-month rental period, Medicaid rental payment includes all supplies, maintenance, repair, components, adjustments and services related to the item during the rental month. Separately billable supply items identified and allowed by Medicare are also separately billable to Medicaid under the same limitations. No additional amounts related to the item may be billed or reimbursed for the item during the 13-month period. During the rental period, the supplier providing the rental equipment is responsible for all maintenance and service. After the 13-month rental period when ownership of the item is transferred to the client, the provider may bill Medicaid for the supplies, maintenance, repair components, adjustment and services related to the items. Medicaid does not cover repair charges during the manufacturer's warranty period.

Items classified by Medicare as needing frequent and substantial servicing are covered on a monthly rental basis only. The 13-month rental limit does not apply and rental payment may continue as long as the item is medically necessary.

Interruptions in rental period. Interruptions in the rental period of less than 60 days will not result in the start of a new 13-month period or new purchase price limit. Periods in which service is interrupted do not count toward the 13-month rental limit.



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

Change in supplier. A change in supplier during the 13-month rental period will not result in the start of a new 13-month period or new purchase price limit. Providers are responsible to investigate whether another supplier has been providing the item to the client; Medicaid does not notify suppliers of this information. The provider may rely upon a separate written client statement that another supplier has not been providing the item, unless the provider has knowledge of other facts or information indicating that another supplier has been providing the item. The supplier providing the item in the thirteenth month of the rental period is responsible for transferring ownership to the client.

Change in equipment. If rental equipment is changed to different but similar equipment, the change will result in the start of a new 13-month period or new purchase price limit only when all of the following are met:

- The change in equipment is medically necessary as a result of a substantial change in the client's medical condition.
- A new certification of medical necessity for the new equipment is completed and signed by a physician.

Non-covered services (ARM 37.86.1802)

The following are items and/or categories of items that are not covered through the DMEPOS program. All coverage decisions are based on federal and state mandates for program funding by the Centers for Medicare & Medicaid Services, including the Medicare Program or the Department's designated review organization.

- Adaptive items for daily living
- Environmental control items
- Building modifications
- Automobile modifications
- Convenience/comfort items
- Disposable incontinence wipes
- Sexual aids or devices
- Personal care items
- Personal computers
- Alarms/alert items
- Institutional items
- Exercise/therapeutic items
- Educational items

No more than one month's medical supplies may be provided to a client at one time.



- Items/services provided to a client in a nursing facility setting (see the *Nursing Facility Services* manual for details)
- Furniture associated with the use of a seat lift mechanism.
- Scales (covered if monitoring weight is part of any congestive heart failure (CHF) treatment regimen.
- Backup equipment
- Items included in the nursing home per diem

Verifying coverage

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

Current fee schedules are available on the *Provider Information* website, disk, or hardcopy. For disk or hard copy, contact Provider Relations (see *Key Contacts*).

Coverage of Specific Services

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

Apnea Monitors

The rental of an apnea monitor will be covered initially for a six-month period from the date of the physician's order. Apnea monitors are covered under at least one of the following conditions:

- A sibling has died from SIDS
- Infant has symptomatic apnea
- Observation of apparent life-threatening events (ALTE)
- Infant is on oxygen
- Symptomatic apnea due to neurological impairment

For coverage after the initial six-month period, additional months coverage must be prior authorized by the Department and the following conditions must exist and be documented by the physician:

- Infant continues to have significant alarms (log must be kept on file)
- Unresolved symptomatic apnea

Automatic blood pressure monitor—A4670

Effective immediately blood pressure equipment used for non-dialysis clients must be coded E1399 (durable medical equipment, miscellaneous) per Medicare Article A2988.

Custom-made equipment, prosthetics or orthotics

Durable medical equipment must be billed using the date of service the client receives the equipment or item.

The only exception is in the case of custom-made equipment, prosthetics or orthotics. In these instances the date when the item is casted, molded and/or fitted may be used. **Note: Before a provider can bill for any custom-made equipment, prosthetic or orthotic, the work on the item must be complete and the client must have signed the delivery ticket.**

Because Medicaid eligibility is determined on a month to month basis, providers must check eligibility **before** an item is ordered or work has begun and **document** the client's eligibility in their file.

Diapers, under pads, liners/shields

The T codes listed below are more specific to the type of incontinence products being distributed by Montana Medicaid durable medical equipment providers. These codes will be paid the "by report" percentage of 75% of billed charges. Also, maximum allowable amounts will be attached to each code. The allowables are 180 disposable diapers per month, 36 reusable diapers, underpads, liners/shields per year (3 per month), and 240 disposable under pads per month.

HCPSC Code	Description
T4521	Adult sized disposable incontinence product, brief/diaper, small, each
T4522	Adult sized disposable incontinence product, brief/diaper, medium, each
T4523	Adult sized disposable incontinence product, brief/diaper, large, each
T4524	Adult sized disposable incontinence product, brief/diaper, extra large, each
T4525	Adult sized disposable incontinence product, protective underwear/pull-on, small, each
T4526	Adult sized disposable incontinence product, protective underwear/pull-on, medium, each
T4527	Adult sized disposable incontinence product, protective underwear/pull-on, large, each
T4528	Adult sized disposable incontinence product, protective underwear/pull-on, extra large, each
T4529	Pediatric sized disposable incontinence product, brief/diaper, small/medium size, each
T4530	Pediatric sized disposable incontinence product, brief/diaper, large size, each

T4531	Pediatric sized disposable incontinence product, protective underwear/pull-on, small/medium size, each
T4532	Pediatric sized disposable incontinence product, protective underwear/pull-on, large size, each
T4533	Youth sized disposable incontinence product, brief/diaper, each
HCPCS Code	Description
T4534	Youth sized disposable incontinence product, protective underwear/pull-on, each
T4535	Disposable liner/shield/guard/pad/ undergarment, for incontinence, each
T4536	Incontinence product, protective underwear/pull-on, reusable, any size, each
T4537	Incontinence product, protective underpad, reusable, bed size, each
T4539	Incontinence product, diaper/brief, reusable, any size, each
T4540	Incontinence product, protective underpad, reusable, chair size, each
T4541	Incontinence product, disposable underpad, large, each
T4542	Incontinence product, disposable underpad, small size, each
T4543	Disposable incontinence product, brief/diaper, bariatric, each

Diapers, under pads, liners and shields are covered for individuals who have a medical need for the items based on their diagnosis. These items are not covered for clients under three years of age or clients in long term care (nursing facility) settings.

Disposable diapers are limited to 180 diapers per month. Disposable under pads, liners/shields are limited to 240 per month. Reusable diapers, under pads, liners/shields are limited to 36 units each per year (three per month).

Electric breast pump

The use of an electric breast pump is considered medically appropriate if at least one of the following criteria is met:

- Client has a pre-term infant of 37 weeks or less gestation
- Client's infant has feeding difficulties due to neurological or physical conditions which impairs adequate suckling
- Illness of mother and/or infant that results in their separation
- Mother is on medication that compromises milk supply

Electric breast pump rental is limited for two months unless additional months are prior authorized by the Department. Medicaid covers all supplies, maintenance, repair, components, adjustments and services related to the pump. Payment may not be provided through the infant's eligibility for Medicaid.

Gait trainers

A gait trainer is a device used to support a patient during ambulation. Criteria for coverage of a gait trainer include:

- The client is unable to ambulate independently with a standard front or reverse walker because of the need for postural support, due to a chronic neurological condition including abnormal movement patterns, poor balance, poor endurance, or other clearly documented reasons.
- The anticipated functional benefits of walking are not attainable with the use of a walker.
- Must demonstrate tolerance for standing and weight bearing through the lower extremities.
- Potential benefits to the individual of assisted walking must be clearly documented as follows:
 - The client must be involved in a therapy program established by a physical therapist. The program must include measurable documented objectives and functional goals related to the client and equipment that includes a written carry over plan to be utilized by the client and/or caregiver. The equipment must match the user's needs and ability level.
 - The client has had a trial of the requested gait trainer (GT) and the client shows compliance, willingness, and ability to use the GT in the home.
 - Video of client using the requested GT home demonstrating ability to use GT by showing potential for progress to meet goals and objectives.

Group 2 support surfaces

Rentals will be reviewed on a monthly basis for clients.

In the event that Prior Authorization staff receives additional medical information directly from the care provider, that information will be included in the cover letter to the DME vendor along with a copy of the authorization.

The criteria for "reasonable and necessary" for group 2 support surfaces are defined by the following indications and limitations of coverage and/or medical necessity.

A group 2 support surface is covered if the patient meets:

- Criterion 1 and 2 and 3, or
 - Criterion 4, or
 - Criterion 5 and 6.
1. Multiple stage II pressure ulcers located on the trunk or pelvis (ICD-9 707.02 - 707.05).
 2. Patient has been on a comprehensive pressure ulcer treatment program for at least the past month which has included the use of an appropriate group 1 support surface.
 3. The pressure ulcers have worsened or remained the same over the past month.

4. Large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis (ICD-9 707.02 -707.05).
5. Recent myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis (surgery within the past 60 days) (ICD-9 707.02 - 707.05).
6. The patient has been on a group 2 or 3 support surface immediately prior to a recent discharge from a hospital or nursing facility (discharge within the past 30 days).

The comprehensive pressure ulcer treatment described in #2 above should generally include:

- Education of the patient and caregiver on the prevention and/or management of pressure ulcers.
- Regular assessment by a nurse, physician, or other licensed healthcare practitioner (usually at least weekly for a patient with a stage III or IV ulcer).
- Appropriate turning and positioning.
- Appropriate wound care (for a stage II, III, or IV ulcer).
- Appropriate management of moisture/incontinence.
- Nutritional assessment and intervention consistent with the overall plan of care.

If the patient is on a group 2 surface, there should be a care plan established by the physician or home care nurse which includes the above elements. The support surface provided for the patient should be one in which the patient does not “bottom out.”

When a group 2 surface is covered following a myocutaneous flap or skin graft, coverage generally is limited to 60 days from the date of surgery.

When the stated coverage criteria for a group 2 mattress or bed are not met, ***an authorization will not be issued*** unless there is clear documentation which justifies the medical necessity for the item in the individual case.

Continued use of a group 2 support surface ***is determined on a case by case basis***. It is covered until the ulcer is healed or, if healing does not continue, there is documentation in the medical record to show that: (1) other aspects of the care plan are being modified to promote healing, or (2) the use of the group 2 support surface is medically necessary for wound management.

A group 2 support surface will be considered for purchase if the following criteria are met:

- Has met the above Indications and Limitations of Coverage and/or Medical Necessity for rental and is necessary for wound management for more than 6 months or

- Has met the above indications of Coverage and/or Medical Necessity for rental and the ulcer (s) have healed. However, the client has a history of previous decubitus ulcers and is at significant risk for recurrent breakdown if the surface is removed.

The purchase of a group 2 support surface will be reviewed on a case by case basis.

It must be determined that:

- The client is compliant with the use of the surface and
- Other factors have been addressed that are/may be contributing to the recurrent breakdown such as infection, nutrition, incontinence management, repositioning etc.

Oral nutrition

Medicaid may cover oral nutritional products for clients under the age of 21 who have had an EPSDT screen resulting in a diagnosed medical condition that impairs absorption of a specific nutrient(s). The client must also have a measurable nutrition plan developed by a nutritionist and the client's primary care provider (PCP). Use modifier -BO when nutrition is orally administered, not by a feeding tube (only for clients under age 21).

Phototherapy (bilirubin) light with photometer

The E0202 RR will be reimbursed at 75% of billed charges for infants ages 0-1. One unit of service is to be billed for each day. The capped rental period will be two months. In order to assure correct coding, providers are encouraged to refer to the current HCPCS coding manual. DMEPOS suppliers must obtain a written prescription in accordance with Administrative Rule of Montana (ARM) 37.86.1802. Suppliers should also maintain supporting documentation showing the client meets the Medicaid coverage criteria.

Services for children and adults over the age of 1 will be reviewed for medical necessity by the DME Program Officer at Health Resources Division.

Pulse oximetry meter

A pulse oximetry meter measures oxygen saturation levels using a noninvasive probe. Pulse oximetry meters provide an estimate of arterial oxyhemoglobin saturation (SaO₂), using selected wavelengths of light, to determine the saturation of oxyhemoglobin (SpO₂).

A pulse oximetry meter is covered for ventilator dependent patients. Continuous read oximetry meters and any meter used for diagnostic purposes are not covered.

A pulse oximetry meter is covered for pediatric patients when all of the following criteria are met:

- The client has a chronic, progressive respiratory or cardiovascular condition that requires continuous or frequent oxygen therapy.
- Oxygen need varies from day to day or per activity (e.g., feeding, sleeping, movement), and a medical need exists to maintain oxygen saturation within a very narrow range in which unpredictable, sub-therapeutic fluctuations of oxygen saturation levels occur that cannot be clinically determined and have an adverse effect if not treated.
- A trained caregiver is available to respond to changes in oxygen saturation.

Standing frame

A standing frame is used to develop weight bearing through the legs for those who cannot stand independently. Standers may be fixed or adjustable in their design. Accessories must contribute significantly to the therapeutic function of the device. Designs and accessories primarily for a caregiver's convenience are not considered medically necessary. For the coverage of a standing frame, the following conditions must be met:

- Client can demonstrate tolerance for standing and partial weight bearing
- Client and/or caregivers demonstrate the capability and motivation to be compliant in the use of the standing frame
- Client is unable to stand without the aid of adaptive equipment
- Clients must be involved in a therapy program established by a physical or occupational therapist. The program must include measurable documented objectives related to the client and equipment that includes a written carry over plan to be utilized by the client and/or caregiver. The equipment must match the user's needs and ability level.

Wheelchair seating in the nursing home

Indications and limitations for a wheelchair seating system for an existing wheelchair such as a facility wheelchair, patient owned wheelchair or a donated wheelchair. The seating system would be the least costly alternative that is able to be adapted to meet the positioning needs of a resident in a Nursing Home and will be covered under the following conditions:

There must be a comprehensive written evaluation by a licensed clinician who is not an employee of or otherwise paid by a supplier.

Included in the evaluation referenced above would be the following:

- Seating Systems for increased independence
 - Documentation must support all of the following:

- The client must be able to self propel to specific destinations, such as to and from the dining room, to and from the activity room, etc.
- Be able to do a functionally independent task as a result of the seating system such as feed self.
- The client must be evaluated to determine that he/she is able to safely self propel and does not have the potential cause harm.
- Be alert and oriented and capable of being completely independent in use of the wheelchair after adapted seating system is placed.

OR

- Seating Systems for positioning purposes
 - Seating for positioning purposes will be reviewed on a case by case basis.
 - Documentation must support that all other less costly alternatives have been ruled out, to include but not be limited to the following:
 - Use of geri chairs provided by nursing home and use of standard off-the-shelf seating products have been tried and ruled out; and
 - Use of rolled towels, blankets, pillows, wedges or similar devices by facility caregivers to reasonably position and reposition client and
 - Documentation that has determined that nursing staff is unable to accomplish repositioning by any other means while resident is up and out of bed and;
 - Resident is not incapacitated to the point that he/she is bedridden.

Wheelchairs

In addition to the Medicare, Region D, DMERC Medical Review Policies for wheelchairs, the following also applies. In order to meet the needs of a particular individual, various wheelchair options or accessories are typically selected. The addition of options or accessories does not deem the wheelchair one that is custom.

Wheelchairs in nursing facilities

Nursing facilities are expected to make available wheelchairs with typical options or accessories in a range of sizes to meet the needs of its residents. If a typical option or accessory is not available for a currently owned nursing facility wheelchair, an accommodating wheelchair is expected to be made available by the nursing facility. Only wheelchairs (including power chairs) that cannot be reasonably used by another nursing home resident will be considered for purchase. Wheelchairs must be used primarily for mobility. Roll-about chairs

which cannot be self propelled are specifically designed to meet the needs of ill, injured, or otherwise impaired individuals and are considered similar to wheelchairs. Roll-about chairs may be called by other names such as *transport* or *mobile geriatric* chairs (Geri-Chairs). Roll-about chairs are not wheelchairs; however, many of the same options and accessories can be found for use on them. Like standard wheelchairs, roll-about chairs are expected to be available to residents by the nursing facility.

Other Programs

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

Mental Health Services Plan (MHSP)

The information in this manual does not apply to the Mental Health Services Plan (MHSP). For more information on the MHSP program, see the *Mental Health Manual* available on the Provider Information website (see *Key Contacts*).

Children's Health Insurance Plan (CHIP)

The information in this manual does not apply to CHIP clients. For a CHIP medical manual, contact BlueCross BlueShield of Montana at (800) 447-7828 x8647. Additional information regarding CHIP is available on the CHIP website (see *Key Contacts*).

Coordination of Benefits

When Clients Have Other Coverage

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

Identifying Additional Coverage

The client's Medicaid eligibility verification may identify other payers such as Medicare or other third party payers (TPL). See the *General Information For Providers* manual, *Client Eligibility and Responsibilities*. If Medicare or other carrier information is known, the Medicare ID number is provided or the carrier is shown on the eligibility information. Some examples of third party payers include:

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

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

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

When a Client Has Medicare

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

Medicare Part B crossover claims

DMEPOS items and services are covered under Medicare Part B. The Department has an agreement with Medicare Part B carriers for Montana (BlueCross BlueShield of Montana and the Durable Medical Equipment Regional Carrier [DMERC]) under which the carriers provide the Department with a magnetic tape of professional claims for clients who have both Medicare and Medicaid coverage. Providers must tell Medicare that they want their claims sent to Medicaid automatically, and must have their Medicare provider number on file with Medicaid.

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

Providers should submit Medicare crossover claims to Medicaid only when:

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

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

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

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

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

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

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

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

Client Cost Sharing (ARM 37.85.204 and 37.85.402)

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

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

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

When Clients Have Other Insurance

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

Billing for Retroactively Eligible Clients

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

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

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

If the item/equipment requires prior authorization, see Chapter 3.

Coding

Standard use of medical coding conventions is required when billing Medicaid. Provider Relations or the Department cannot suggest specific codes to be used in billing for services. For coding assistance and resources, see the table of *Coding Resources* on the following page.

Coding tips

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

- Use current CPT-4, HCPCS Level II, and ICD-9-CM coding books.
- If a provider is unable to determine the appropriate code for a covered item/service from such publications, contact the manufacturer or dis-

Always refer to the long descriptions in coding books.



tributor of the item/service for coding guidance. Providers may also contact the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) for coding advice (see *Key Contacts*).

- Always read the complete description and guidelines in the coding books. Relying on short descriptions can result in inappropriate billing.
- Attend classes on coding offered by certified coding specialists.
- Use the correct “units” measurement on CMS-1500 claims. In general, Medicaid follows the definitions in the CPT-4 and HCPCS Level II billing manuals. Always check the long text of the code description. When billing for rentals, for example, 1 unit equals one month of rental.

Miscellaneous/not otherwise specified HCPCS codes

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

- A description of the item/service attached to the claim (see *Billing electronically with paper attachments* in the *Submitting a Claim* chapter of this manual)
- A description of the item included on the claim form directly to the right or below the code used (paper claim).

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

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

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

Coding Resources		
Please note that the Department does not endorse the products of any particular publisher.		
Resource	Description	Contact
ICD-9-CM	<ul style="list-style-type: none"> • ICD-9-CM diagnosis and procedure codes definitions • Updated each October. 	Available through various publishers and bookstores
CPT-4	<ul style="list-style-type: none"> • CPT-4 codes and definitions • Updated each January 	American Medical Association (800) 621-8335 www.amapress.com or Medicode (Ingenix) (800) 765-6588 www.medicode.com or www.ingenixonline.com
HCPCS Level II	<ul style="list-style-type: none"> • HCPCS Level II codes and definitions • Updated each January and throughout the year 	Available through various publishers and bookstores or from CMS at www.cms.gov
CPT Assistant	A newsletter on CPT-4 coding issues	American Medical Association (800) 621-8335 www.amapress.com
Miscellaneous resources	Various newsletters and other coding resources.	Medicode (Ingenix) (800) 765-6588 www.medicode.com or www.ingenixonline.com
CCI Policy and Edits Manual	This manual contains Correct Coding Initiative (CCI) policy and edits, which are pairs of CPT-4 or HCPCS Level II codes that are not separately payable except under certain circumstances. The edits are applied to services billed by the same provider for the same client on the same date of service.	National Technical Information Service (800) 363-2068 (703) 605-6060 www.ntis.gov/product/correct-coding.htm
Medicare Pricing, Data Analysis and Coding (PDAC)	PDAC (formerly SADMERC) information is available under <i>Other Partners</i> . This website assists manufacturers and suppliers with DMEPOS billing and coding information.	www.dmepdac.com (877) 735-1326

Using the Medicaid Fee Schedule

When billing Medicaid, it is important to use the Department's fee schedule for your provider type in conjunction with the detailed coding descriptions listed in the current CPT-4 and HCPCS Level II coding books. In addition to covered services and payment rates, fee schedules often contain helpful information such as appropriate modifiers. Department fee schedules are updated each January. Current fee schedules are available on the *Provider Information* website (see *Key Contacts*). For disk or hardcopy, contact Provider Relations (see *Key Contacts*).

Place of Service

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

Date of Service

The date of service for custom molded or fitted items is the date upon which the provider completes the mold or fitting and either orders the equipment from another party or makes an irrevocable commitment to the production of the item.

Rental

Payment includes the entire initial month of rental even if actual days of use are less than the full month. Payment for second or subsequent months is allowed only if the item is used at least 15 days in such months.

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.
- Use modifier -BO when nutrition is orally administered, not by a feeding tube (only for clients under age 21).
- Claims where Medicaid is the primary payer are paid on a monthly basis. These claims are submitted using the -RR modifier with one unit of service. For example, a client rents a nebulizer. The first rental month is billed as one unit as shown:

24.	A DATE(S) OF SERVICE						B	C	D PROCEDURES, SERVICES, OR SUPPLIES			E	F	G	H	I	J	K
	From	To	Place	Type	(Explain Unusual Circumstances)			DIAGNOSIS	\$ CHARGES		DAYS	EPSDT	OR	Family	EMG	COB	RESERVED FOR	
	MM	DD	YY	MM	DD	YY	of Service	of Service	CPT/HCPCS	MODIFIER	CODE		UNITS	Plan			LOCAL USE	
	08	21	04	08	31	04	12	0	E0570	RR	1	25	00	1				

Another example is a client who uses oxygen. Regardless of how much oxygen is used during a month, it is billed as 1 unit as follows:

24.	A DATE(S) OF SERVICE						B	C	D PROCEDURES, SERVICES, OR SUPPLIES			E	F	G	H	I	J	K
	From	To	Place	Type	(Explain Unusual Circumstances)			DIAGNOSIS	\$ CHARGES		DAYS	EPSDT	OR	Family	EMG	COB	RESERVED FOR	
	MM	DD	YY	MM	DD	YY	of Service	of Service	CPT/HCPCS	MODIFIER	CODE		UNITS	Plan			LOCAL USE	
	08	01	04	08	31	04	12	0	E1390	RR	1	250	00	1				

Submitting a Claim

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

The Most Common Billing Errors and How to Avoid Them

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

Common Billing Errors	
Reasons for Return or Denial	How to Prevent Returned or Denied Claims
Provider NPI missing or invalid	The provider NPI is a 10-digit number assigned to the provider by the National Plan and Provider Enumeration System. Verify the correct provider NPI is on the claim.
Authorized signature missing	Each paper claim must have an authorized signature belonging to the provider, billing clerk, or office personnel. The signature may be computer generated, typed, stamped, or hand-written.
Signature date missing	Each claim must have a signature date.
Incorrect claim form used	The claim must be the correct form for the provider type. Services covered in this manual require an electronic professional claim or a CMS-1500 claim form.
Information on claim form not legible	Information on the claim form must be legible. Use dark ink and center the information in the field. Information must not be obscured by lines.
Recipient number not on file, or recipient was not eligible on date of service	Before providing services to the 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.
Duplicate claim	<ul style="list-style-type: none"> • Please check all remittance advices (RAs) for previously submitted claims before resubmitting. • When making changes to previously paid claims, submit an adjustment form rather than a new claim form (see <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.

Common Billing Errors (continued)	
Reasons for Return or Denial	How to Prevent Returned or Denied Claims
Prior authorization number is missing	<ul style="list-style-type: none"> • Prior authorization (PA) is required for certain services, and the PA number must be on the claim form (see the <i>PASSPORT and Prior Authorization</i> chapter in this manual).
TPL on file and no credit amount on claim	<ul style="list-style-type: none"> • If the client has any other insurance (or Medicare), bill the other carrier before Medicaid. See <i>Coordination of Benefits</i> in this manual. • If the client’s TPL coverage has changed, providers must notify the TPL unit (see <i>Key Contacts</i>) before submitting a claim.
Claim past 365-day filing limit	<ul style="list-style-type: none"> • The Claims Processing Unit must receive all clean claims and adjustments within the timely filing limits described in this chapter. • To ensure timely processing, claims and adjustments must be mailed to Claims Processing at the address shown in <i>Key Contacts</i>.
Missing Medicare EOMB	All Medicare crossover claims must have an Explanation of Medicare Benefits (EOMB) included (see <i>Billing Electronically with Paper Attachments</i> in the <i>Submitting a Claim</i> chapter in this manual).
Provider is not eligible during dates of services, or provider NPI terminated	<ul style="list-style-type: none"> • Out-of-state providers must receive authorization for a Montana resident to assure provider NPI is current and other provider information is updated for each approved stay. • New providers cannot bill for services provided before Medicaid enrollment begins. • If a provider is terminated from the Medicaid program, claims submitted with a date of service after the termination date will be denied.
Type of service/procedure is not allowed for provider type	<ul style="list-style-type: none"> • Provider is not allowed to perform the service, or type of service is invalid. • Verify the procedure code is correct using current HCPCS and CPT-4 billing manual. • Check the Medicaid fee schedule to verify the procedure code is valid for your provider type.

Submitting a Claim

Electronic Claims

Professional 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. EDIFECS certifies the 837 HIPAA transactions at no cost to the provider. EDIFECS 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 NPI followed by the client's ID number and the date of service, each separated by a dash:

<u>999999999</u>	-	<u>888888888</u>	-	<u>11182003</u>
Provider NPI		Client ID Number		Date of Service (mmddyyyy)

The supporting documentation must be submitted with a paperwork attachment cover sheet (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*).

Paper Claims

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

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

Claim Inquiries

Contact Provider Relations for questions regarding payments, denials, general claim questions, client eligibility, 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.

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).

Client Has Medicaid Coverage Only

Field#	Field Title	Instructions
Client Information		
2*	Client's Name	Enter patient's name as seen on client's Medicaid information
10d*	Client's Medicaid ID	Enter the client's Medicaid ID number as it appears on the client's Medicaid information.
1a, 9a, 11**	Client's Medicaid ID	If client's ID is not located in 10d these three fields are searched for the number
Provider Information		
17a**	Referring Provider's Medicaid/ Passport #	Enter referring provider's two-digit ID qualifier (1D) followed by Medicaid #. Enter referring provider's Passport number if a Passport client (a qualifier is not necessary).
17b**	Referring Provider's NPI #	Enter referring provider's NPI #
24i shaded*	ID Qualifier	ZZ for the taxonomy qualifier
31*	Signature and Date	Enter signature and date
33*	Billing Provider Info	Enter physical address with a nine-digit ZIP code and phone number
33a**	NPI #	Enter NPI number for billing provider.
33b*	Taxonomy #	Enter the ID qualifier (ZZ) and the billing provider's taxonomy code
Billing Information		
21.1 - 21.4*	Diagnosis Codes	Enter at least one diagnosis
24a*	Date(s) of Service	Enter the dates of service include beginning and ending date even if same
24b*	Place of Service	Enter the code for place of service
24c**	EMG	Emergency indicator if applicable
24d*	Procedure Code	Enter the procedure code used / Enter modifiers if applicable
24e*	Diagnosis Pointer	Enter the corresponding diagnosis pointer (1, 2, 3, or 4) that refers to the codes in field 21
24f*	Charges	Enter the line item charge
24g*	Days/Units	Enter the days or units used for the procedure
28*	Total Charges	Enter total charges from all line items.

* = Required Field

** = Conditional (required if applicable)

Client Has Medicaid Coverage Only

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA										PICA																													
1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input checked="" type="checkbox"/> (Medicaid #) TRICARE CHAMPUS <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA BLK LUNG <input type="checkbox"/> (SSN) OTHER <input type="checkbox"/> (ID)										1a. INSURED'S I.D. NUMBER (For Program in Item 1)																													
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Rhoads, Rocky										3. PATIENT'S BIRTH DATE 04 28 92					SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial)																			
5. PATIENT'S ADDRESS (No., Street) 123 Anystreet #1										6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street)																			
CITY Anytown					STATE MT					8. PATIENT STATUS Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>					CITY					STATE																			
ZIP CODE 59999					TELEPHONE (Include Area Code) (406) 555-5555					Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>					ZIP CODE					TELEPHONE (Include Area Code) ()																			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:										11. INSURED'S POLICY GROUP OR FECA NUMBER																			
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>																			
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										b. EMPLOYER'S NAME OR SCHOOL NAME																			
c. EMPLOYER'S NAME OR SCHOOL NAME										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										c. INSURANCE PLAN NAME OR PROGRAM NAME Medicaid																			
d. INSURANCE PLAN NAME OR PROGRAM NAME 999999999										10d. RESERVED FOR LOCAL USE										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>																			
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____																				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____																			
14. DATE OF CURRENT: MM DD YY 07 19 08 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Great Gazoo, M.D.										17a. ID 9954321										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																			
17b. NPI 1234567890										19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 357 0 2. 349 9 3. _____ 4. _____										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.										23. PRIOR AUTHORIZATION NUMBER 999999999																			
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE EMG		C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER				E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #																					
1 07 19 08 07 19 08		12 0		K0005				1,2		2,050 00		1		NPI																									
2 07 19 08 07 19 08		12 0		K0040				1,2		105 00		2		NPI																									
3 07 19 08 07 19 08		12 0		K0075				1,2		65 00		2		NPI																									
4														NPI																									
5														NPI																									
6														NPI																									
25. FEDERAL TAX I.D. NUMBER 99-9999999					SSN EIN <input checked="" type="checkbox"/>					26. PATIENT'S ACCOUNT NO. 99999					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE \$ 2,220 00					29. AMOUNT PAID \$ 0 00					30. BALANCE DUE \$ 2,220 00									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) <i>Mary Bender</i> 08/02/08										32. SERVICE FACILITY LOCATION INFORMATION a. NPI b. _____										33. BILLING PROVIDER INFO & PH # (406) 555-1234 Hometown Medical Equipment P.O. Box 999 Anytown, MT 59999-9999 a. 9876543210 b. ZZ 400RT001X																			

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

Montana Department of Public Health and Human Services

Client Has Medicaid and Medicare Coverage

Field#	Field Title	Instructions
Client Information		
1a*	Insured's ID Number	Enter the client's Medicare ID number
2*	Client's Name	Enter patient's name as seen on client's Medicaid information
10d*	Client's Medicaid ID	Enter the client's Medicaid ID number as it appears on the client's Medicaid information.
11d*	Is there another health benefit plan?	Check "NO."
9a, 11**	Client's Medicaid ID	If client's ID is not located in 10d these fields are searched for the number
Provider Information		
17a**	Referring Provider's Medicaid/ Passport #	Enter referring provider's two-digit ID qualifier (1D) followed by Medicaid #. Enter referring provider's Passport number if a Passport client (a qualifier is not necessary).
17b**	Referring Provider's NPI #	Enter referring provider's NPI #
24i shaded*	ID Qualifier	ZZ for the taxonomy qualifier
31*	Signature and Date	Enter signature and date
33*	Billing Provider Info	Enter physical address with a nine-digit ZIP code and phone number
33a**	NPI #	Enter NPI number for billing provider.
33b*	Taxonomy #	Enter the 1D qualifier (ZZ) and the billing provider's taxonomy code
Billing Information		
21.1 - 21.4*	Diagnosis Codes	Enter at least one diagnosis
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 the dates of service include beginning and ending date even if same
24b*	Place of Service	Enter the code for place of service
24c**	EMG	Emergency indicator if applicable
24d*	Procedure Code	Enter the procedure code used / Enter modifiers if applicable
24e*	Diagnosis Pointer	Enter the corresponding diagnosis pointer (1, 2, 3, or 4) that refers to the codes in field 21
24f*	Charges	Enter the line item charge
24g*	Days/Units	Enter the days or units used for the procedure
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 in this chapter)
28*	Total Charges	Enter total charges from all line items.

* = Required Field

** = Conditional (required if applicable)

Client Has Medicaid and Medicare Coverage

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA		PICA	
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE CHAMPUS (Sponsor's SSN) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 999999999A	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Rhoads, Rocky		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
3. PATIENT'S BIRTH DATE MM DD YY 04 28 92 SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)	
5. PATIENT'S ADDRESS (No., Street) 123 Anystreet #1		8. PATIENT STATUS Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>	
CITY Anytown STATE MT		CITY STATE	
ZIP CODE 59999 TELEPHONE (Include Area Code) (406) 555-5555		ZIP CODE TELEPHONE (Include Area Code)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)	
c. EMPLOYER'S NAME OR SCHOOL NAME		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> 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. SIGNED _____	
14. DATE OF CURRENT: MM DD YY 07 19 08 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Great Gazoo, M.D.		17a. ID 9954321 17b. NPI 1234567890	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 357 0 2. 349 9		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #			
1 07 19 08 07 19 08 12 0 K0005 1,2 2,050 00 1 NPI			
2 07 19 08 07 19 08 12 0 K0040 1,2 105 00 2 NPI			
3 07 19 08 07 19 08 12 0 K0075 1,2 65 00 2 NPI			
4		NPI	
5		NPI	
6		NPI	
25. FEDERAL TAX I.D. NUMBER 99-9999999 SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. 99999	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Mary Bender 08/02/08		27. ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.		28. TOTAL CHARGE \$ 2,220 00 29. AMOUNT PAID \$ 30. BALANCE DUE \$ 2,220 00	
SIGNED _____ DATE _____		33. BILLING PROVIDER INFO & PH # (406) 555-1234 Hometown Medical Equipment P.O. Box 999 Anytown, MT 59999-9999 a. 9876543210 b. ZZ 400RT001X	

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Client Has Medicaid and Third Party Liability Coverage

Field#	Field Title	Instructions
Client Information		
1a**	Insured's ID Number	Enter the client's ID number for the primary carrier.
2*	Client's Name	Enter patient's name as seen on client's Medicaid information
9a**	Other Insured's Information	Enter the client's ID number if there are two or more third-party insurance carriers.
10d*	Client's Medicaid ID	Enter the client's Medicaid ID number as it appears on the client's Medicaid information.
11*	Insured's Policy Number	Enter the client's ID number for the primary payer
11c*	Insured's Plan	Enter primary payer's name
11d*	Another health plan benefit besides Medicaid	Check "YES."
Provider Information		
17a**	Referring Provider's Medicaid/ Passport #	Enter referring provider's two-digit ID qualifier (1D) followed by Medicaid #. Enter referring provider's Passport number if a Passport client (a qualifier is not necessary).
17b**	Referring Provider's NPI #	Enter referring provider's NPI #
24i shaded*	ID Qualifier	Enter 1D as the atypical qualifier or ZZ for the taxonomy qualifier
31*	Signature and Date	Enter signature and date
33*	Billing Provider Info	Enter physical address with a nine-digit ZIP code and phone number
33a**	NPI #	Enter NPI number if applicable
33b*	Atypical/Taxonomy #	Enter the 1D qualifier and atypical provider number or the ZZ qualifier and the provider's taxonomy code
Billing Information		
21.1 - 21.4*	Diagnosis Codes	Enter at least one diagnosis
24a*	Date(s) of Service	Enter the dates of service include beginning and ending date even if same
24b*	Place of Service	Enter the code for place of service
24c**	EMG	Enter emergency code if applicable
24d*	Procedure Code	Enter the procedure code used / Enter modifiers if applicable
24e*	Diagnosis Pointer	Enter the corresponding diagnosis pointer (1, 2, 3, or 4) that refers to the codes in field 21
24f*	Charges	Enter the line item charge
24g*	Days/Units	Enter the days or units used for the procedure
28*	Total Charges	Enter total charges from all line items.

* = Required Field

** = Conditional (required if applicable)

Client Has Medicaid and Third Party Liability Coverage

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA	PICA																		
1. MEDICARE <input type="checkbox"/> (Medicare #) <input checked="" type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> (Medicaid #) <input type="checkbox"/> TRICARE CHAMPUS (Sponsor's SSN) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/>	1a. INSURED'S I.D. NUMBER (For Program in Item 1) 999999999A																		
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Rhoads, Rocky				3. PATIENT'S BIRTH DATE MM DD YY 04 28 92			SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>			4. INSURED'S NAME (Last Name, First Name, Middle Initial)									
5. PATIENT'S ADDRESS (No., Street) 123 Anystreet #1				6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			7. INSURED'S ADDRESS (No., Street)			8. PATIENT STATUS Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>									
CITY Anytown		STATE MT		9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			11. INSURED'S POLICY GROUP OR FECA NUMBER 999999999B									
ZIP CODE 59999		TELEPHONE (Include Area Code) (406) 555-5555		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State)			a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>			b. EMPLOYER'S NAME OR SCHOOL NAME									
c. EMPLOYER'S NAME OR SCHOOL NAME				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			c. INSURANCE PLAN NAME OR PROGRAM NAME Paywell Insurance			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>									
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. RESERVED FOR LOCAL USE 999999999			12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____			13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____									
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY 07 19 08				15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY			17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Great Gazoo, M.D.									
17a. ID 9954321				17b. NPI 1234567890			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY			19. RESERVED FOR LOCAL USE									
20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES				21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 490			22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.			23. PRIOR AUTHORIZATION NUMBER									
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
1 07 19 08 07 19 08		12 0		E0570		RR		1		25 00		1		NPI					
2														NPI					
3														NPI					
4														NPI					
5														NPI					
6														NPI					
25. FEDERAL TAX I.D. NUMBER 99-9999999				SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. 123456789				27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 25 00		29. AMOUNT PAID \$ 20 00		30. BALANCE DUE \$ 5 00			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) <i>Mary Bender</i> 08/02/08						32. SERVICE FACILITY LOCATION INFORMATION a. NPI b. ZZ 400RT001X						33. BILLING PROVIDER INFO & PH # (406) 555-1234 Hometown Medical Equipment P.O. Box 999 Anytown, MT 59999-9999							

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

Montana Department of Public Health and Human Services

Client Has Medicaid, Medicare, and Third Party Liability Coverage

Field#	Field Title	Instructions
Client Information		
1a*	Insured's ID Number	Enter the client's Medicare ID number..
2*	Client's Name	Enter patient's name as seen on client's Medicaid information
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 of the name of the primary payer.
11d*	Is there another health benefit plan?	Check "YES."
Provider Information		
17a**	Referring Provider's Medicaid/ Passport #	Enter referring provider's two-digit ID qualifier (1D) followed by Medicaid #. Enter referring provider's Passport number if a Passport client (a qualifier is not necessary).
17b**	Referring Provider's NPI #	Enter referring provider's NPI #
24i shaded*	ID Qualifier	ZZ for the taxonomy qualifier
31*	Signature and Date	Enter signature and date
33*	Billing Provider Info	Enter physical address with a nine-digit ZIP code and phone number
33a**	NPI #	Enter NPI number for billing provider.
33b*	Taxonomy #	Enter the 1D qualifier (ZZ) and the billing provider's taxonomy code
Billing Information		
21.1 - 21.4*	Diagnosis Codes	Enter at least one diagnosis
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 the dates of service include beginning and ending date even if same
24b*	Place of Service	Enter the code for place of service
24c**	EMG	Emergency indicator if applicable
24d*	Procedure Code	Enter the procedure code used / Enter modifiers if applicable
24e*	Diagnosis Pointer	Enter the corresponding diagnosis pointer (1, 2, 3, or 4) that refers to the codes in field 21
24f*	Charges	Enter the line item charge
24g*	Days/Units	Enter the days or units used for the procedure
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 in this chapter)
28*	Total Charges	Enter total charges from all line items.
29*	Amount Paid	Enter the amount paid by the primary payer (not Medicare). Do not include any adjustment amounts or coinsurance. The Medicare payment amount will be determined from the EOMB attached to the claim.
30*	Balance Due	Enter the balance due (the amount in field 28 less the amount in field 29).

* = Required Field

** = Conditional (required if applicable)

Client Has Medicaid, Medicare, and Third Party Liability Coverage

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA										PICA																			
1. MEDICARE <input type="checkbox"/> (Medicare #) <input checked="" type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> (Medicaid #) <input type="checkbox"/> TRICARE CHAMPUS <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> CHAMPVA <input type="checkbox"/> (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/> (ID) <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 999999999A																			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Rhoads, Rocky					3. PATIENT'S BIRTH DATE MM DD YY 04 28 92 SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial)																			
5. PATIENT'S ADDRESS (No., Street) 123 Anystreet #1					6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					7. INSURED'S ADDRESS (No., Street)																			
CITY Anytown			STATE MT		8. PATIENT STATUS Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>					CITY			STATE																
ZIP CODE 59999			TELEPHONE (Include Area Code) (406) 555-5555		Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>					ZIP CODE			TELEPHONE (Include Area Code) ()																
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					11. INSURED'S POLICY GROUP OR FECA NUMBER 999999999A																			
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>					a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>																			
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>					b. EMPLOYER'S NAME OR SCHOOL NAME					b. EMPLOYER'S NAME OR SCHOOL NAME																			
c. EMPLOYER'S NAME OR SCHOOL NAME					c. INSURANCE PLAN NAME OR PROGRAM NAME Paywell Insurance					c. INSURANCE PLAN NAME OR PROGRAM NAME																			
d. INSURANCE PLAN NAME OR PROGRAM NAME 999999999					10d. RESERVED FOR LOCAL USE					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>																			
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____																			
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY 07 19 08					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Great Gazoo, M.D.					17a. ID 9954321					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																			
					17b. NPI 1234567890																								
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. L496										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.					23. PRIOR AUTHORIZATION NUMBER														
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER			E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #										
1 07 19 08 07 19 08		12 0		A7015			1,2		5 00 1		1		NPI																
2 07 19 08 07 19 08		12 0		E1390 RR			1,2		325 00 1		1		NPI																
3 07 19 08 07 19 08		12 0		E0431 RR			1,2		50 00 1		1		NPI																
4													NPI																
5													NPI																
6													NPI																
25. FEDERAL TAX I.D. NUMBER 99-9999999					26. PATIENT'S ACCOUNT NO. 123456789					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE \$ 380 00					29. AMOUNT PAID \$ 304 00					30. BALANCE DUE \$ 76 00				
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) <i>Mary Bender</i> 08/02/08 SIGNED _____ DATE _____										32. SERVICE FACILITY LOCATION INFORMATION a. NPI b. _____										33. BILLING PROVIDER INFO & PH# (406) 555-1234 Hometown Medical Equipment P.O. Box 999 Anytown, MT 59999-9999 a. 9876543210 b. ZZ 400RT001X									

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Montana Department of Public Health and Human Services

Client Has Medicaid, Medicare, and Medicare Supplement Coverage

Field#	Field Title	Instructions
Client Information		
1a*	Insured's ID Number	Enter the client's Medicare ID number
2*	Client's Name	Enter patient's name as seen on client's Medicaid information
10d*	Client's Medicaid ID	Enter the client's Medicaid ID number as it appears on the client's Medicaid 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."
Provider Information		
17a**	Referring Provider's Medicaid/ Passport #	Enter referring provider's two-digit ID qualifier (1D) followed by Medicaid #. Enter referring provider's Passport number if a Passport client (a qualifier is not necessary).
17b**	Referring Provider's NPI #	Enter referring provider's NPI #
24i shaded*	ID Qualifier	ZZ for the taxonomy qualifier
31*	Signature and Date	Enter signature and date
33*	Billing Provider Info	Enter physical address with a nine-digit ZIP code and phone number
33a**	NPI #	Enter NPI number for billing provider.
33b*	Taxonomy #	Enter the 1D qualifier (ZZ) and the billing provider's taxonomy code
Billing Information		
21.1 - 21.4*	Diagnosis Codes	Enter at least one diagnosis
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 the dates of service include beginning and ending date even if same
24b*	Place of Service	Enter the code for place of service
24c**	EMG	Emergency indicator if applicable
24d*	Procedure Code	Enter the procedure code used / Enter modifiers if applicable
24e*	Diagnosis Pointer	Enter the corresponding diagnosis pointer (1, 2, 3, or 4) that refers to the codes in field 21
24f*	Charges	Enter the line item charge
24g*	Days/Units	Enter the days or units used for the procedure
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 in this chapter)
28*	Total Charges	Enter total charges from all line items.
29*	Amount Paid	Enter the amount paid by the Medicare supplement insurance only. Do not include any adjustment amounts or coinsurance. Medicare payment is determined from the Medicare EOMB attached to the claim.
30*	Balance Due	Enter balance due (amount in field 28 less the amount in field 29).

* = Required Field

** = Conditional (required if applicable)

Client Has Medicaid, Medicare, and Medicare Supplement Coverage

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>														
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 999999999A														
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Rhoads, Rocky										3. PATIENT'S BIRTH DATE MM DD YY 04 28 92					SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>									
5. PATIENT'S ADDRESS (No., Street) 123 Anystreet #1										6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>														
CITY Anytown					STATE MT					7. INSURED'S ADDRESS (No., Street)					7. INSURED'S ADDRESS (No., Street)									
ZIP CODE 59999					TELEPHONE (Include Area Code) (406) 555-5555					CITY					STATE									
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 999999999B														
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (Current or Previous)					a. INSURED'S DATE OF BIRTH					SEX									
b. OTHER INSURED'S DATE OF BIRTH					b. AUTO ACCIDENT?					b. EMPLOYER'S NAME OR SCHOOL NAME					b. EMPLOYER'S NAME OR SCHOOL NAME									
c. EMPLOYER'S NAME OR SCHOOL NAME					c. OTHER ACCIDENT?					c. INSURANCE PLAN NAME OR PROGRAM NAME Paywell Supplemental Insurance														
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE 999999999					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>														
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.														
SIGNED _____ DATE _____										SIGNED _____														
14. DATE OF CURRENT: <input type="checkbox"/> ILLNESS (First symptom) OR <input type="checkbox"/> INJURY (Accident) OR <input type="checkbox"/> PREGNANCY(LMP)					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION														
MM DD YY 07 19 08					MM DD YY _____					FROM MM DD YY TO MM DD YY														
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Great Gazoo, M.D.										17a. ID 1D9954321					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES									
										17b. NPI 1234567890					FROM MM DD YY TO MM DD YY									
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO														
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.														
1. 496										23. PRIOR AUTHORIZATION NUMBER														
2. _____										24. A. DATE(S) OF SERVICE														
From		To		B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #		
MM	DD	YY	MM	DD	YY			CPT/HCPCS	MODIFIER					\$										
1	07	19	08	07	19	08	12	0	E1390	RR			1	325.00	1									
2	07	19	08	07	19	08	12	0	E0431	RR			1	50.00	1									
3	07	19	08	07	19	08	12	0	A7003				1	8.00	1									
4																								
5																								
6																								
25. FEDERAL TAX I.D. NUMBER 99-9999999										SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. 123456789					27. ACCEPT ASSIGNMENT? (If for govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 393.00		29. AMOUNT PAID \$ 314.40		30. BALANCE DUE \$ 78.60	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) <i>Mary Bender</i> 08/02/08										32. SERVICE FACILITY LOCATION INFORMATION														
SIGNED _____ DATE _____										33. BILLING PROVIDER INFO & PH # (406) 555-1234 Hometown Medical Equipment P.O. Box 999 Anytown, MT 59999-9999														
										a. NPI					b. ZZ 400RT001X									
										a. 9876543210					b. ZZ 400RT001X									

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Montana Department of Public Health and Human Services

CMS-1500 Agreement

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

Montana Department of Public Health and Human Services

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

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

REFERS TO GOVERNMENT PROGRAMS ONLY

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

BLACK LUNG AND FECA CLAIMS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

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

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

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

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

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

Avoiding Claim Errors

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

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

Remittance Advices and Adjustments

The Remittance Advice

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

Electronic RA

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

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

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

Paper RA

The paper RA is divided into the following sections: RA notice, paid claims, denied claims, pending claims, credit balance claims, gross adjustments, and reason and remark codes and descriptions. See the following sample paper RA and the *Keys to the Paper RA* table.



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



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

Sections of the Paper RA	
Section	Description
RA notice	The RA Notice is on the first page of the remittance advice. This section contains important messages about rate changes, revised billing procedures, and many other items that may affect providers and claims.
Paid claims	This section shows claims paid and any claims paid with denied lines during the previous cycle. It is the provider's responsibility to verify that claims were paid correctly. If Medicaid overpays a claim and the problem is not corrected, it may result in an audit requiring the provider to return the overpayment plus interest. If a claim was paid at the wrong amount or with incorrect information, the claim must be adjusted (see <i>Adjustments</i> later in this chapter).
Denied claims	This section shows claims denied during the previous cycle. If a claim has been denied, refer to the Reason/Remark column (Field 16). The reason and remark code description explains why the claim was denied and is located at the end of the RA. See <i>The Most Common Billing Errors and How to Avoid Them</i> in the <i>Billing Procedures</i> chapter.
Pending claims	<p>All claims that have not reached final disposition will appear in this area of the RA. The RA uses "suspended" and "pending" interchangeably. They both mean that the claim has not reached final disposition. If a claim is pending, refer to the Reason/Remark Code column (Field 16). The reason and remark code description located at the end of the RA will explain why the claim is suspended. This section is informational only. Please do not take any action on claims displayed here. Processing will continue until each claim is paid or denied.</p> <p>Claims shown as pending with reason code 133 require additional review before a decision to pay or deny is made. If a claim is being held while waiting for client eligibility information, it may be suspended for a maximum of 30 days. If Medicaid receives eligibility information within the 30-day period, the claim will continue processing. If no eligibility information is received within 30 days, the claim will be denied. When a claim is denied for lack of eligibility, the provider should verify that the correct Medicaid ID number was billed. If the ID number was incorrect, resubmit the claim with the correct ID number.</p>
Credit balance claims	Credit balance claims are shown here until the credit has been satisfied.
Gross adjustments	Any gross adjustments performed during the previous cycle are shown here.
Reason and remark code description	This section lists the reason and remark codes that appear throughout the RA with a brief description of each.

Sample Remittance Advice

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES
HELENA, MT 59604

MEDICAID REMITTANCE ADVICE

HOMETOWN MEDICAL EQUIPMENT
P.O. BOX 999
ANYTOWN, MT 59999

(2) PROVIDER# 0001234567
(3) REMIT ADVICE #123456
(4) WARRANT # 654321
(5) DATE:08/15/04
PAGE 2
(6)

(1)

RECIP ID	NAME	SERVICE DATES FROM	TO	UNIT OF SVC	PROCEDURE REVENUE NDC	TOTAL CHARGES	ALLOWED	CO-PAY	REASON/REMARK CODES
(7)	(8)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	
PAID CLAIMS - MISCELLANEOUS CLAIMS									
123456789	DOE, JOHN EDWARD	070104	070104	1	K0005	2,050.00	1,640.00	Y	
(9)	ICN 0041830050000700	***LESS MEDICARE PAID*****							
		LESS COPAY DEDUCTION**					5.00	(17)	
		CLAIM TOTAL **				2,050.00	1,635.00		
DENIED CLAIMS - MISCELLANEOUS CLAIMS									
123456789	DOE, JANE	070104	070104	1	E0570	25.00	0.00	N	
	ICN 0041830050000800							(17)	N
		CLAIM TOTAL **				25.00			31MA61
PENDING CLAIMS - MISCELLANEOUS CLAIMS									
123456789	DOE, SUSAN	070104	073104	1	E1390	325.00	0.00	(17)	N 133
	ICN 0041830050000900	070104	073104	1	E0431	50.00	0.00	N	133
		CLAIM TOTAL **				380.00			

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

- 31 CLAIM DENIED AS PATIENT CANNOT BE IDENTIFIED AS OUR INSURED.
- 133 THE DISPOSITION OF THIS CLAIM/SERVICE IS PENDING FURTHER REVIEW.
- MA61 DID NOT COMPLETE OR ENTER CORRECTLY THE PATIENT'S SOCIAL SECURITY NUMBER OR HEALTH INSURANCE CLAIM NUMBER.

Key to the Paper RA

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

Credit balance claims

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

Credit balances can be resolved in two ways:

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

Rebilling and Adjustments

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

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

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

Rebilling Medicaid

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

When to rebill Medicaid

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



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



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



Rebill denied claims only after appropriate corrections have been made.

- **Line Denied.** When an individual line is denied on a multiple-line claim, correct any errors and rebill Medicaid. An adjustment form should be used for claims with denied lines that have codes that must be billed together (see *Adjustments*).
- **Claim Returned.** Rebill Medicaid when the claim is returned under separate cover. Occasionally, Medicaid is unable to process the claim and will return it to the provider with a letter stating that additional information is needed to process the claim. Correct the information as directed and resubmit the claim.

How to rebill

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

Adjustments

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

When adjustments are made to previously paid claims, the Department recovers the original payment and issues appropriate repayment. The result of the adjustment appears on the provider's RA as two transactions. The original payment will appear as a credit transaction. The replacement claim reflecting the corrections will be listed as a separate transaction and may or may not appear on the same RA as the credit transaction. The replacement transaction will have nearly the same ICN number as the credit transaction, except the 12th digit over will be a 2, indicating an adjustment. See the *Key to the Paper RA* in this chapter. Adjustments are processed in the same time frame as claims.

When to request an adjustment

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

How to request an adjustment

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

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

Completing an Adjustment Request Form

1. Copy the *Montana Medicaid Individual Adjustment Request* form from *Appendix A*, or download it from the Provider Information website. Complete *Section A* first with provider and client information and the claim's ICN number (see following table, *Completing an Individual Adjustment Request Form*).
2. Complete *Section B* with information about the claim. Remember to fill in only the items that need to be corrected (see following table):
 - Enter the date of service or the line number in the *Date of Service or Line Number* column.
 - Enter the information from the claim form that was incorrect in the *Information on Statement* column.
 - Enter the correct information in the column labeled *Corrected Information*.
3. Attach copies of the RA and a corrected claim if necessary.
 - If the original claim was billed electronically, a copy of the RA will suffice.
 - If the RA is electronic, attach a screen print of the RA.
4. Verify the adjustment request has been signed and dated.

MONTANA MEDICAID/MHSP/CHIP INDIVIDUAL ADJUSTMENT REQUEST			
INSTRUCTIONS: <small>This form is for providers to correct a claim which has been paid at an incorrect amount or was paid with incorrect information. Complete all the fields in Section A with information about the paid claim from your statement. Complete ONLY the items in Section B which represent the incorrect information that needs changing. For help with this form, refer to the <i>Remittance Advices and Adjustments</i> chapter in your program manual or the <i>General Information For Providers II</i> manual, or call (800) 624-3958 (Montana Providers) or (406) 442-1837 (Helena and out-of-state providers).</small>			
A. COMPLETE ALL FIELDS USING THE PAYMENT STATEMENT (R.A.) FOR INFORMATION			
1. PROVIDER NAME & ADDRESS		3. INTERNAL CONTROL NUMBER (ICN)	
Hometown Medical Equip.		0040401125000600	
Name		4. PROVIDER NUMBER	
P.O. Box 999		1234567	
Street or P.O. Box		5. CLIENT ID NUMBER	
Anytown, MT 59999		123456789	
City State Zip		6. DATE OF PAYMENT	
		10/01/04	
2. CLIENT NAME		7. AMOUNT OF PAYMENT \$	
Jane Doe		180.00	
B. COMPLETE ONLY THE ITEM(S) WHICH NEED TO BE CORRECTED			
	DATE OF SERVICE OR LINE NUMBER	INFORMATION STATEMENT	CORRECTED INFORMATION
1. Units of Service	Line 2	2	1
2. Procedure Code/N.D.C./Revenue Code			
3. Dates of Service (D.O.S.)	Line 3	09/01/04	09/15/04
4. Billed Amount			
5. Personal Resource (Nursing Home)			
6. Insurance Credit Amount			
7. Net (Billed - TPL or Medicare Paid)			
8. Other/REMARKS (BE SPECIFIC)			
SIGNATURE: <u>Mary Bender</u> DATE: <u>10/15/04</u>			
<small>When the form is complete, attach a copy of the payment statement (RA) and a copy of the corrected claim (unless you bill EMC).</small>			
<small>MAIL TO: Provider Relations ACS P.O. Box 8000 Helena, MT 59604</small>			

Sample Adjustment Request

5. Send the adjustment request to Provider Relations (see *Key Contacts*).
 - If an original payment was an underpayment by Medicaid, the adjustment will result in the provider receiving the additional payment amount allowed.
 - If an original payment was an overpayment by Medicaid, the adjustment will result in recovery of the overpaid amount from the provider. This can be done in two ways, by the provider issuing a check to the Department, or by maintaining a credit balance until it has been satisfied with future claims (see *Credit Balance* in this chapter).
 - Any questions regarding claims or adjustments should be directed to Provider Relations (see *Key Contacts*).

Completing an Individual Adjustment Request Form

Field	Description
Section A	
1. Provider Name and Address	Provider's name and address (and mailing address if different).
2. Recipient Name	The client's name is here.
3.* Internal Control Number (ICN)	There can be only one ICN per Adjustment Request form. When adjusting a claim that has been previously adjusted, use the ICN of the most recent claim.
4.* Provider NPI	The provider's NPI.
5.* Recipient Medicaid Number	Client's Medicaid ID number.
6. Date of Payment	Date claim was paid found on Remittance Advice Field #5 (see the sample RA in this chapter).
7. Amount of Payment	The amount of payment from the Remittance Advice Field #17 (see the sample RA in this chapter.).
Section B	
1. Units of Service	If a payment error was caused by an incorrect number of units, complete this line.
2. Procedure Code/ N.D.C/ Revenue Code	If the procedure code, NDC, or revenue code are incorrect, complete this line.
3. Dates of Service (D.O.S)	If the date(s) of service is incorrect, complete this line.
4. Billed Amount	If the billed amount is incorrect, complete this line.
5. Personal Resource (Nursing Home)	If the client's personal resource amount is incorrect, complete this line.
6. Insurance Credit Amount	If the client's insurance credit amount is incorrect, complete this line.
7. Net (Billed – TPL or Medicare Paid)	If the payment error was caused by a missing or incorrect insurance credit, complete this line. Net is billed amount minus the amount TPL or Medicare paid.
8. Other/Remarks	If none of the above items apply, or if you are unsure what caused the payment error, complete this line.

* Indicates a required field

Mass adjustments

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

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

Providers are informed of mass adjustments on the first page of the remittance advice (RA Notice section), the monthly Claim Jumper, or provider notice. Mass adjustment claims shown on the RA have an ICN that begins with a “4” (see *Key to the Paper RA* in this chapter).

Payment and the RA

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

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

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

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



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

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

How Payment Is Calculated

Overview

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

Usual and Customary Charge (ARM 37.85.406, 37.86.1806)

Providers should bill Medicaid their usual and customary charge for each service; that is, the same charge that is made to other payers for that service. The amount of the provider's usual and customary charge may not exceed the reasonable charge usually and customarily charged by the provider to all payers. For DMEPOS providers, a charge is considered reasonable if it is less than or equal to the manufacturer's suggested list price.

For items without a manufacturer's suggested list price, the charge is considered reasonable if the provider's acquisition cost from the manufacturer is at least 50% of the charge amount. For items that are custom fabricated at the place of service, the amount charged will be considered reasonable if it does not exceed the average charge of all Medicaid providers by more than 20%.

Payment for DMEPOS Items/Services (ARM 37.86.1807)

Payment for DMEPOS is equal to the lowest of either the provider's usual and customary charge for the item or the Medicaid fee schedule amount in effect for the date of service.

Medicaid payment is equal to 100% of Medicare Region D fee schedule for current procedure codes where a Medicare fee is available, less applicable cost sharing, inurement and/or other applicable fees. Generic or miscellaneous procedure codes are excluded from the Medicare fee schedule. Payment for such excluded procedure codes is 75% of the provider's submitted charge. For all other procedure codes where no Medicare fee is available, payment is 75% of the submitted charge.

Rental items

If the purchase of a rental item is cost effective in relation to the patient's need of the item, the purchase may be negotiated. The purchase price would be the amount indicated on the applicable fee schedule, less previous payments made to the provider of the item.

Total Medicaid rental reimbursement for items listed in Medicare's capped rental program or classified by Medicare as routine and inexpensive rental is limited to the purchase price for that item. Monthly rental fees are limited to 10% of the purchase for the item, limited to 13 monthly payments. Interruptions in the rental period of less than 60 days do not result in the start of a new 13-month period or new purchase price limit, but periods during which service is interrupted will not count toward the 13-month limit.

How Cost Sharing is Calculated on Medicaid Claims

Client cost sharing for services provided by DMEPOS providers is \$5.00 per visit. The client's cost sharing amount is shown on the remittance advice and deducted from the Medicaid allowed amount (see the *Remittance Advices and Adjustments* chapter in this manual). For example, a DMEPOS provider supplies a Medicaid client with a set of crutches (E0114). The Medicaid allowed amount in July 2004 for this item is \$8.57. The client owes the provider \$5.00 for cost sharing, and Medicaid would pay the provider the remaining \$3.57.

How Payment is Calculated on TPL Claims

When a client has coverage from both Medicaid and another insurance company, the other insurance company is often referred to as third party liability or TPL. In these cases, the other insurance is the primary payer (as described in the *Coordination of Benefits* chapter of this manual), and Medicaid makes a payment as the secondary payer. For example, a Medicaid client who also has insurance through her job receives a nebulizer (E0570) for her bronchitis. The client's other insurance is billed first and pays \$10.00. The Medicaid allowed amount for this service is \$19.73. The amount the other insurance paid (\$10.00) is subtracted from the Medicaid allowed amount (\$19.73), leaving a balance of \$9.73. The Medicaid cost sharing (\$5.00) is deducted from the balance, leaving a net payment of \$4.73 on this claim.

Appendix A: Forms

- ***Montana Medicaid /MHSP/CHIP Individual Adjustment Request***
- ***Montana Medicaid Claim Inquiry Form***
- ***Paperwork Attachment Cover Sheet***
- ***Certificates of Medical Necessity***
 - *Lymphedema Pumps (Pneumatic Compression Devices) (CMS-846)*
 - *Osteogenesis Stimulators (CMS-847)*
 - *Oxygen (CMS-484)*
 - *Seat Lift Mechanisms (CMS-849)*
 - *Section C Continuation Form (CMS-854)*
 - *Transcutaneous Electrical Nerve Stimulators (TENS) (CMS-848)*
- ***DME Information Forms***
 - *External Infusion Pumps DME 09.03 (CMS 10125)*
 - *Enteral and Parenteral Nutrition DME 10.03 (CMS 10126)*
- ***DMEPOS Medical Review Request Form***
- ***Request for Blanket Denial Letter***

**MONTANA MEDICAID/MHSP/CHIP
INDIVIDUAL ADJUSTMENT REQUEST**

INSTRUCTIONS:

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

A. COMPLETE ALL FIELDS USING THE PAYMENT STATEMENT (R.A.) FOR INFORMATION

<p>1. PROVIDER NAME & ADDRESS</p> <p>_____</p> <p>Name</p> <p>_____</p> <p>Street or P.O. Box</p> <p>_____</p> <p>City State Zip</p>	<p>3. INTERNAL CONTROL NUMBER (ICN)</p> <p>_____</p> <p>4. BILLING PROVIDER NUMBER</p> <p>_____</p> <p>5. CLIENT ID NUMBER</p> <p>_____</p> <p>6. DATE OF PAYMENT _____</p> <p>7. AMOUNT OF PAYMENT \$ _____</p>
<p>2. CLIENT NAME</p> <p>_____</p>	

B. COMPLETE ONLY THE ITEM(S) WHICH NEED TO BE CORRECTED

	DATE OF SERVICE OR LINE NUMBER	INFORMATION STATEMENT	CORRECTED INFORMATION
1. Units of Service			
2 Procedure Code/N.D.C./Revenue Code			
3. Dates of Service (D.O.S.)			
4. Billed Amount			
5. Personal Resource (Nursing Home)			
6. Insurance Credit Amount			
7. Net (Billed - TPL or Medicare Paid)			
8. Other/REMARKS (BE SPECIFIC)			

SIGNATURE: _____ **DATE:** _____

When the form is complete, attach a copy of the payment statement (RA) and a copy of the corrected claim (unless you bill EMC).

**MAIL TO: ACS
P.O. Box 8000
Helena, MT 59604**

Montana Healthcare Claim Inquiry Form

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



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

Billing number _____ Client number _____ Date of service _____ Total billed amount _____ Date submitted for processing _____	ACS Response: _____ _____ _____ _____ _____
--	---

Billing number _____ Client number _____ Date of service _____ Total billed amount _____ Date submitted for processing _____	ACS Response: _____ _____ _____ _____ _____
--	---

Billing number _____ Client number _____ Date of service _____ Total billed amount _____ Date submitted for processing _____	ACS Response: _____ _____ _____ _____ _____
--	---

Mail to:

Provider Relations
 P.O. Box 8000
 Helena, MT 59604

Fax to: (406) 442-4402

Paperwork Attachment Cover Sheet

Paperwork Attachment Control Number: _____

Date of service: _____

Billing Provider number: _____

Client ID number: _____

Type of attachment: _____

Instructions:

This form is used as a cover sheet for attachments to electronic and paper Montana Healthcare Programs (Medicaid/MSHP/CHIP/IHS) claims sent to ACS. The *Paperwork Attachment Control Number* must be the same number as the *Attachment Control Number* on the corresponding electronic claim. This number should consist of the provider's billing number, the client's ID number and the date of service (mmddyyyy), each separated by a dash (9999999-999999999-99999999). This form may be copied or downloaded from the Montana's Healthcare provider website at www.mtmedicaid.org. If you have questions about which paper attachments are necessary for a claim to process, please call ACS Provider Relations at (406) 442-1837 or (800) 624-3958.

Completed forms can be sent to: ACS
P.O. Box 8000
Helena, MT 59604 OR
FAX to: 1-406-442-4402

REQUEST FOR BLANKET DENIAL LETTER

DATE REQUESTED _____ **BILLING #** _____

CLIENT NAME _____

CLIENT ID # _____

INSURANCE COMPANY NAME ON FILE _____

PROCEDURE CODES NEEDED:

1. _____

2. _____

3. _____

4. _____

5. _____

CONTACT _____

PHONE NUMBER _____

FAX NUMBER _____

PLEASE FAX ALL REQUESTS TO 406-442-0357

Cost Sharing

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

Crossovers

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

DPHHS, State Agency

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

Dual Eligibles

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

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

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

Emergency Services

Those services which are required to evaluate and stabilize a medical condition manifesting itself by acute symptoms of sufficient severity (including pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or

unborn child) in serious jeopardy, serious impairment to bodily function or serious dysfunction of any bodily organ or part.

Experimental

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

Fiscal Agent

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

Frequently Maintained Rental

Rentals that need frequent and substantial servicing are not subject to a cap and the provider may continue to rent the item as long as it is medically necessary. All supplies needed to operate the equipment are included in the rental fee.

Full Medicaid

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

Gross Adjustment

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

Incurment

See "Spending Down."

Indian Health Service (IHS)

IHS provides health services to American Indians and Alaska Natives.

Individual Adjustment

A request for a correction to a specific paid claim.

Investigational

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

Mass Adjustment

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

Maximum Allowable

The maximum dollar amount for which a provider may be reimbursed as established by Montana Medicaid for specific services, supplies and/or equipment.

Medicaid

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

Medically Necessary

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

Medicare

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

Mental Health Services Plan (MHSP)

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

Montana Access to Health (MATH) Web Portal

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

Montana Breast and Cervical Cancer Treatment Program

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

PASSPORT To Health

A Medicaid managed care program where the client selects a primary care provider who manages the client's health care needs.

Prior Authorization (PA)

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

Private-pay

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

Provider or Provider of Service

An institution, agency, or person:

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

Qualified Medicare Beneficiary (QMB)

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

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