



Nursing Facility and Swing Bed Services

*Medicaid and Other Medical
Assistance Programs*

This publication supersedes all previous Nursing Facility and Swing Bed Services handbooks. Published by the Montana Department of Public Health & Human Services, January 2005.

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My NPI/API:

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Key Contacts

ACS EDI Gateway, Inc.

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

Certification for Medical Need

Swing Bed Hospitals must obtain a certificate of need from the Quality Assurance Division in order to provide swing bed services.

(406) 444-2099 Phone

Send written inquiries to:
Quality Assurance Division
P.O. Box 202953
Helena, MT 59620-2953

Claims

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

Client Eligibility

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

Direct Deposit Arrangements

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

(406) 444-5283

Drug Prior Authorization

For all questions regarding drug prior authorization:

(800) 395-7961
(406) 443-6002 6003? (Helena)
8:00 a.m. to 5:00 p.m., Monday–Friday
(Mountain Time)

Mail backup documentation to:
Mountain-Pacific Quality Health
3404 Cooney Drive
Helena, MT 59602

Fax backup documentation to:
(800) 294-1350
(406) 513-1928 (Helena)

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:

Client Eligibility Fraud
(800) 201-6308

Medicaid Client Help Line
(800) 362-8312

Lien and Estate Recovery

Providers must give any personal funds they are holding for a Medicaid-eligible resident to the Department within 30 days following the resident's death.

Phone:

(800) 694-3084 In-state
(406) 444-7313 Out-of-state and Helena

Fax:

(800) 457-1978 In-state
(406) 444-1829 Out-of-state and Helena

Send written inquiries to:

Third Party Liability Unit
Lien and Estate Recovery
DPHHS
P.O. Box 202953
Helena, MT 59620-2953

Nurse Aide Registry

To verify the nurse aide's certification status:
(406) 444-4980

Send written inquiries to:

Montana Nurse Aide Registry
2401 Colonial Drive, 2nd Floor
P.O. Box 202953
Helena, MT 59620

Point-of-Sale (POS) Help Desk

For assistance with online POS claims adjudication:

ACS, Atlanta
Technical POS Help Desk

(800) 365-4944
6:00 a.m to midnight, Monday–Saturday
10:00 a.m. to 9:00 p.m., Sunday,
(Eastern Time)

Preadmission Screening

For preadmission screening and level-of-care screening for clients entering a nursing facility or swing bed hospital, contact:

Phone:

(800) 219-7035 In- and out-of-state
(406) 443-0320

Fax:

(800) 413-3890 In- and out-of-state
(406) 443-4585

Send written inquiries to:

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

Provider's Policy Questions

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

Provider Relations

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

(800) 624-3958 In- and out-of-state
(406) 442-1837 Helena
(406) 442-4402 Fax

Send written inquiries to:

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

Send e-mail inquiries to:

MTPRHelpdesk@ACS-inc.com

- Privately hired nurses or aides
- Specially prepared or alternative food requested by the resident instead of food generally prepared by the facility
- The difference between the cost of items usually reimbursed under the per diem rate and the cost of specific items or brands requested by the resident which are different from that which the facility routinely stocks or provides (e.g., special lotion, powder, diapers)
- Personal comfort items (e.g., tobacco products and accessories, notions, novelties, and confections)
- Personal dry cleaning
- Private rooms that are not medically necessary. Medicaid pays the same rate for private rooms as double occupancy rooms. If a private room is medically necessary, the facility may not bill the resident for the difference between the amount Medicaid pays and the amount of the room. If the resident requests a private room but it is not medically necessary, the facility may bill the resident for the difference. Before providing the service, the facility must clearly inform the resident that he or she must pay extra for the private room and the resident will no longer have a private room when payment stops.

Other Programs

Mental Health Services Plan (MHSP)

The information in this manual does not apply to the Mental Health Services Plan (MHSP). Clients who qualify for MHSP may receive mental health services during nursing facility care. For more information on the MHSP program, see the mental health manual available on the Provider Information website (see *Key Websites*) or call (406) 444-3964.

Healthy Montana Kids (HMK) Plan

The information in this manual does not apply to HMK clients. For an HMK medical manual, contact Blue Cross and Blue Shield of Montana on the direct toll-free line at 855-258-3489. Additional information regarding HMK is available on the HMK website (see *Key Websites*).

When a Client Has TPL (ARM 37.85.407)

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

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



Exceptions to billing third party first

When a Medicaid client is also covered by Indian Health Services (IHS), providers must bill Medicaid first. IHS is not considered a third party liability.

If the third party has only potential liability, the provider may bill Medicaid first. **Do not indicate the potential third party on the claim.** Instead, send the claim and notification to the Third Party Liability Unit (see *Key Contacts*):

Requesting an exemption

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

- When a provider is unable to obtain a valid assignment of benefits, the provider should submit the claim with documentation that the provider attempted to obtain assignment and certification that the attempt was unsuccessful.
- When the provider has billed the third party insurance and has received a nonspecific denial (e.g., no client name, date of service, amount billed), submit the claim with a copy of the denial and a letter of explanation.
- If another insurance has been billed, and 90 days have passed with no response, submit the claim with a note explaining that the insurance company has been billed or with a copy of the letter sent to the insurance company. Include the date the claim was submitted to the insurance company and certification that there has been no response.

When the third party pays or denies a service

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

- ***Pays the claim***, indicate the amount paid when submitting the claim to Medicaid for processing.
- ***Allows the claim***, and the allowed amount went toward client's deductible, include the insurance explanation of benefits (EOB) when billing Medicaid.



If the provider receives a payment from a third party after the Department has paid the provider, the provider must return the lower of the two payments to the Department within 60 days.

- ***Denies the claim***, submit the claim and a copy of the denial (including the reason explanation) to Medicaid.
- ***Denies a line on the claim***, bill the denied lines together on a separate claim and submit to Medicaid. Include the EOB from the other payer as well as an explanation of the reason for denial (e.g., definition of denial codes).

When the third party does not respond

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

- Submit the claim with a note explaining that the insurance company has been billed or with a copy of the letter sent to the insurance company.
- Include the date the claim was submitted to the insurance company.
- Send this information to the ACS Third Party Liability Unit (see *Key Contacts*).

Blanket denials

Providers who routinely bill for Medicaid covered ancillary services that other insurance companies do not cover, may request a blanket denial letter. Providers may complete a *Request for Blanket Denial Letter* (located in *Appendix A: Forms* and on the Provider Information website) and submit the form to the Third Party Liability Unit (see *Key Contacts*). The TPL Unit usually requests the provider send an explanation of benefits showing the services have been denied by the client's other insurance company. The provider is then notified that the services have been approved for a blanket denial.

Providers who bill electronically (ANSI ASC X12N 837 transactions) will receive a memo from the TPL Unit with a tracking number for use when billing Medicaid. This number must be included in the *paperwork attachment indicator* field when billing electronically for the specific services.

Providers who bill on paper will receive a memo from the TPL Unit. This memo must be copied and submitted with each claim for the approved procedure codes.

The number can be used for two years, and then the provider must submit a new *Request for Blanket Denial Letter*. Any claims submitted with procedure codes not listed (or not approved) on the memo must be submitted with a specific denial from the other insurance company or Medicaid will deny those services.

Billing Procedures

Timely Filing Limits (ARM 37.85.406)

Providers must submit clean claims to Medicaid within the latest of:

- 12 months from the latest of:
 - The date of service
 - The date retroactive eligibility is determined; or
 - The date disability was determined
- Six months from the date on the Medicare EOB approving the service, if the Medicare claim was timely filed and the recipient was Medicare-eligible at the time the Medicare claim was filed; or
- Six months from the date on an adjustment notice from a third party payer, where the third party payer has previously processed the claim for the same service and the adjustment notice is dated after the periods described above.

Clean claims are claims that can be processed without additional information or documentation from or action by the provider of the service. The submission date is defined as the date the claim was received by the Department or the claims processing contractor. All errors and problems with claims must be resolved within the timeframes shown above.



Tips to Avoid Timely Filing Denials

- Submit claims in a timely manner.
- Correct and resubmit denied claims promptly (see the *Remittance Advices and Adjustments* chapter in this manual). When reviewing denied claims, pay particular attention to the reason for denial, and correct the claim as appropriate. Some areas to watch for include the following:
 - Ensure coding is correct and valid for your provider type
 - Make sure the the dates of service are the days being claimed. For example, the day of discharge cannot be claimed so should not be included in the dates of service.
 - Confirm that the resident's Medicaid ID number is correct
- If a claim continues to deny, contact Provider Relations for assistance in resolving the claim (see *Key Contacts*).
- If a provider has made several attempts to resolve a claim and the provider believes that the claim is a clean claim, and it still denies, contact Senior and Long-Term Care for review of the claim (see *Key Contacts*).
- Under very limited circumstances, providers may need to submit an adjustment for a claim over 365 days from the date of service (for reasons such as an audit

that has revealed that Medicaid was overbilled, or a resident's personal resource obligation changed). In these cases, submit the claim to Senior and Long-Term Care for review and special handling.

- If a claim submitted to Medicaid does not appear on the remittance advice within 45 days, contact Provider Relations for claim status (see *Key Contacts*).
- If another insurer has been billed and 90 days have passed with no response, you can bill Medicaid (see the *Coordination of Benefits* chapter in this manual for more information).

Billing for Retroactively Eligible Clients (ARM 37.40.202)

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, submit a copy of the FA-455 (eligibility determination letter) when the date of service is outside the 12-month limit. In order to bill for retroactive services, a level of care screening must have been completed at the time services were provided (see *Preadmission screening and level of care determinations* in the *Covered Services* chapter of this manual).

Institutional providers (including nursing facilities and swing bed providers) must accept the client as a Medicaid client from the date retroactive eligibility was effective. If the client has made a full or partial payment for services, the provider must refund the client's payment for the services before billing Medicaid for the services.

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 *Coordination of Benefits*.

When Can I Bill a Medicaid Client Directly? (ARM 37.85.406)

In most circumstances, providers may not bill clients for services covered under Medicaid. Medicaid does not cover some items and services, which may be billed directly to the resident, as long as the resident is informed of and agrees to the charges. For a list of these items and services, see *Noncovered Services* in the *Covered Services* chapter of this manual.

More specifically, providers cannot bill clients directly:

- For the difference between charges and the amount Medicaid paid. There are exceptions covered under ARM 37.40.331:
 - Medicaid does not reimburse the facility for private rooms, and a facility must provide a medically necessary private room at no additional

In order to bill for retroactive services, a level-of-care screening must have been completed at the time services were provided.

charge. If a resident requests a private room that is not medically necessary, the facility may charge the resident for the difference between the amount that Medicaid pays and the cost of the private room. The resident must be clearly informed that there will be an additional charge, the amount of that charge, and that the choice of a private room with the additional charge is voluntary.

- If a resident requests a specific brand of an item that is different than the brand the facility routinely supplies (e.g., incontinence products, lotions, soaps), the facility may charge the resident the difference in cost between the item routinely supplied and the specific brand item requested.
- When a third party payer does not respond.
- When the provider bills Medicaid for a covered service, and Medicaid denies the claim because of billing errors.
- When services are being provided free to the client. Medicaid may not be billed for those services either.

Providers may bill Medicaid clients directly under the following circumstances:

- For the items and services listed in the *Noncovered Services* section of the *Covered Services* chapter in this manual.
- For services not covered by Medicaid, as long as the provider and client have agreed in writing prior to providing services. For example, if a resident wants a private room that is not medically necessary, the resident must be informed and agree in writing that he or she is responsible for the additional charges. Likewise, if a resident requests a specific brand of item, such as lotion or soap, that is more expensive than the brand the facility normally provides, the resident can be charged the difference as long as he or she has agreed in writing to pay for the difference.

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 edition and HCPCS Level II coding books. Department fee schedules are updated each January and July. Current fee schedules are available on the Provider Information website (see *Key Websites*).

Coding

Standard use of medical coding conventions is required when billing Medicaid. The most current edition of the following manuals should be used:

- ICD
- CPT
- HCPCS Level II



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

There are many variables to selecting the correct codes for billing for services. It is Department policy that Provider Relations or the Department do not suggest specific codes to be used in billing for services. If the facility does receive coding suggestions, the facility may not rely on the suggestion unless it is in writing (such as a prior authorization). The facility is responsible for using the correct codes for the services provided. The following suggestions may help reduce coding errors:

- Refer to the Montana Medicaid fee schedule for covered codes that are valid for your provider type (available on the Provider Information website; see *Key Websites*).
- Use current CPT, HCPCS Level II, and ICD coding books, and refer to the long descriptions. Relying on short descriptions can result in inappropriate billing.
- Providers who are submitting ANSI ASC X12N 837 transactions must use the current revenue codes.
- Attend classes on coding offered by certified coding specialists.
- Use specific codes rather than miscellaneous codes. For example, rather than using Diagnosis Code 250.0, use 250.09.
- Pay close attention to modifiers used with CPT and HCPCS codes on claims. Modifiers are becoming more prevalent in health care billing, and they often affect payment calculations.
- Use the correct “units” measurement on claims. In general, Medicaid follows the definitions in the CPT and HCPCS billing manuals. Unless otherwise specified, one unit equals one visit or one procedure. For specific codes, however, one unit may be 15 minutes, a percentage of body surface area, or another quantity. Always check the long text of the code description.



Always refer to the long descriptions in coding books.

Coding Resources		
Please note that the Department does not endorse the products of any particular publisher.		
Resource	Description	Contact
CCI Policy and Edits Manual	This manual contains Correct Coding Initiative (CCI) policy and edits, which are pairs of CPT or HCPCS Level II codes that are not separately payable except under certain circumstances. The edits are applied to services billed by the same provider for the same client on the same date of service.	National Technical Information Service (800) 363-2068 (703) 605-6060 http://www.ntis.gov/products/cci.aspx
CPT	<ul style="list-style-type: none"> • CPT codes and definitions • Updated each January 	American Medical Association (800) 621-8335 https://catalog.ama-assn.org/Catalog/home.jsp or Medicode (Ingenix) (800) 765-6588 http://www.shopingenix.com
CPT Assistant	A newsletter on CPT coding issues	American Medical Association (800) 621-8335 https://catalog.ama-assn.org/Catalog/home.jsp
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 www.cms.gov/
ICD	<ul style="list-style-type: none"> • ICD diagnosis and procedure codes definitions • Updated each October. 	Available through various publishers and bookstores
Miscellaneous Resources	Various newsletters and other coding resources.	Medicode (Ingenix) (800) 765-6588 http://www.shopingenix.com
UB-04 National Uniform Billing Data Element Specifications	Montana UB-04 billing instructions	National Uniform Billing Committee www.nubc.org

Client Cost Sharing (ARM 37.85.204 and 37.85.402)

Nursing facility and swing bed residents are exempt from cost sharing beyond their personal resource obligation, so cost sharing fees cannot be collected for these clients.

Billing for Services Included in the Daily Rate

Most services provided by nursing facilities and swing bed providers are included in a daily rate and billed to Medicaid on an MA-3 claim form or an MA-3 turn around document (TAD).

Bed hold days

Therapeutic home visits (THV) and hospital hold (HH) days are billed on three separate claim lines as follows.

Claim line one. On the first claim line, claim the dates and the number of days the resident was at the facility before THV or HH. Do not claim the date the resident leaves the facility. If the resident’s personal resources are greater than or equal to the Total Charges amount, enter the same amount as the Total Charges in the Personal Resources field. This results in a Net Charges amount of zero (0). Then subtract the amount used from the personal resources for a remaining personal resources balance (see following example).

Claim line two. On the second claim line, bill for the remaining days in the month following the THV or HH days. Claim the date the resident returned to the facility. If there is any remaining personal resource amount, deduct it on this claim line.

Claim line three. The third claim line is for THV or HH days, but these days cannot be billed until the facility receives an approved THV form (DPHHS-SLTC-042), or an approved HH form (DPHHS-SLTC-052). This claim includes the date the client left the facility, but not the date the client returns to the facility. Enter THV or HH on the claim.

For example, Jane Smith was a resident the entire month of May and she went on a home visit from May 4–9 (5 days). She has a personal resource amount of \$525.00 and the facility’s per diem rate is \$105.00.

Claim #1 for days 05/1/04–05/03/04

3 days x \$105.00 (facility rate per day) = \$315.00 (total charges)

\$315.00 (total charges) - 315.00 (personal resources) = \$0.00

Net Charges = \$0.00

Claim #1

PATIENT: LAST NAME 1 Smith		FIRST Jane	MIDDLE INITIAL Z.	M S F X	COUNTY 20	INDIVIDUAL NUMBER 999999999	AUTH.
DIAGNOSIS Osteoarthritis		DIAG. CODE 715.9	DATE OF BIRTH MO. DAY YEAR 10 29 15	DATE ADMITTED MO. DAY YEAR 02 15 04	STATEMENT PERIOD MO. FROM DAY YEAR TO MO. DAY YEAR 05 01 04 05 03 04		
NEW DIAGNOSIS/RECENT COMPLICATIONS		DIAG. CODE	NO. OF DAYS 3	LEVEL OF CARE 2	TOTAL CHARGES 315.00	(LESS) PERSONAL RESOURCES 315.00	NET CHARGES 0.00

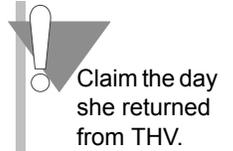
Personal resources of \$525.00 - \$315.00 = \$210.00 remaining personal resources

Do not claim the day the resident leaves for THV.



Claim #2 for days 05/09/04–05/31/04

23 days x \$105.00 (facility rate) = \$2,415.00 (total charges)
 \$2,415 (total charges) - \$210.00 (remaining personal resources) = \$2,205.00
 Net Charges = \$2,205.00

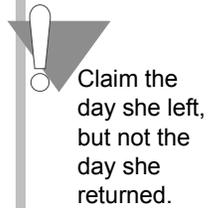


Claim #2

PATIENT: LAST NAME 1 Smith		FIRST Jane	MIDDLE INITIAL Z.	M	S	F	COUNTY 20	INDIVIDUAL NUMBER 999999999	AUTH.
		DIAG. CODE 715.9		DATE OF BIRTH MO. DAY YEAR 10 29 15		DATE ADMITTED MO. DAY YEAR 02 15 04		STATEMENT PERIOD FROM MO. DAY YEAR TO MO. DAY YEAR 05 09 04 05 31 04	
NEW DIAGNOSIS/RECENT COMPLICATIONS		DIAG. CODE		NO. OF DAYS 23	LEVEL OF CARE 2	TOTAL CHARGES 2,415.00	(LESS) PERSONAL RESOURCES 210.00	NET CHARGES 2,205.00	

Claim #3 for THV or HH days 05/04/04–05/08/04

5 days x \$105.00 (facility rate) = \$525.00 (total charges)
 \$525.00 (total charges) - \$0.00 (personal resources remaining) = \$525.00
 Net Charges = \$525.00



Claim #3

PATIENT: LAST NAME 1 Smith		FIRST Jane	MIDDLE INITIAL Z.	M	S	F	COUNTY 20	INDIVIDUAL NUMBER 999999999	AUTH.
		DIAG. CODE 715.9		DATE OF BIRTH MO. DAY YEAR 10 29 15		DATE ADMITTED MO. DAY YEAR 02 15 04		STATEMENT PERIOD FROM MO. DAY YEAR TO MO. DAY YEAR 05 04 04 05 08 04	
NEW DIAGNOSIS/RECENT COMPLICATIONS		DIAG. CODE		NO. OF DAYS 5	LEVEL OF CARE 2	TOTAL CHARGES 525.00	(LESS) PERSONAL RESOURCES 0.00	NET CHARGES 525.00	

When completing claims for THV or HH, remember the following:

- Enter THV or HH in the memo field (New Diagnosis/Recent Complications) on the paper claim.
- Enter only the dates being claimed in the From and To fields. This will reduce delays or denials because of overlapping service dates.
- Any unused personal resources from previous claims should be applied to hold days.
- Do not include copies of the THV or HH bed hold forms with your claims.

Medicare coinsurance days

When a Medicaid resident is covered by Medicare and Medicaid and returns to a nursing facility or swing bed hospital following a qualifying inpatient hospital stay, Medicaid assists with Medicare coinsurance for Days 21–100 as long as the resident continues to meet skilled level of care. To bill Medicaid for coinsurance days, first determine whether the facility’s per diem rate or the coinsurance rate is lower. Medicaid must be billed the lower of the two rates.

For example, the provider’s per diem rate is \$115.97 and the Medicare coinsurance rate for the calendar year is \$109.50. Bill Medicaid \$109.50 for each coinsurance day. As long as a resident meets the criteria for Medicare payment (e.g., qualifying stay, level of care, available benefit), Medicare pays completely for Days 1–20. These days may not be billed to Medicaid.

Ancillary services included in Medicare's bundled rate may not be billed during Medicare qualifying days. To determine how many days Medicare allowed as coinsurance days, divide the coinsurance amount by \$109.50 (or the coinsurance rate at the time of service). The Medicare EOMB shows a coinsurance of \$1,095.00; divide that by \$109.50 for 10 coinsurance days.

If the provider's per diem rate is \$105.00 and the Medicare coinsurance rate is \$109.50. The facility bills the days at their per diem rate.

NO. OF DAYS	LEVEL OF CARE	TOTAL CHARGES	(LESS) PERSONAL RESOURCES	NET CHARGES
10	2	1,095.00	350.00 →	\$ 745.00

Separately Billable Services

Ancillary items

Some ancillary items may be billed separately to Medicaid. These items must be billed at the facility acquisition cost with no markup. The Nursing Facility/Swing Bed fee schedule includes these items, with prior authorization (PA) indicators, and is located on the Provider Information website (see *Key Websites*). These items are billed either electronically or on a CMS-1500 claim form. If the service requires PA, the PA number must be included on the claim (see the *Prior Authorization* and *Submitting a Claim* chapters in this manual).

Parenteral/enteral nutritional solutions

Medicaid pays the facility's acquisition cost only, with no additional markup for parenteral/enteral (PEN) solutions. The PA number must be included on the claim (see the *Prior Authorization* chapter in this manual). When a resident has both Medicaid and Medicare, submit the claim first to Medicare. If Medicare pays in excess of the acquisition cost, do not bill Medicaid.

Routine supplies used in extraordinary amounts

Routine supplies used in extraordinary amounts are billed either electronically or on a CMS-1500 claim, and the PA number must be included.

Other services

Some Medicaid covered services are provided in a nursing facility setting but may not be billed by the nursing facility under a nursing facility NPI. Some examples include hospice services, waiver respite care and some durable medical equipment (DME) and therapy services. These services must be billed to Medicaid by the provider of the service. If the nursing facility is providing the service, the facility must be enrolled as a Medicaid provider for each type of service provided. See the Medicaid billing manual for type of services being billed (e.g., *Hospice Care Services* manual, *Durable Medical Equipment, Orthotics, Prosthetics and Supplies* manual). Waiver respite care is billed with the Home- and Community-Based Services provider number. Contact the referring case management team for instruction on billing respite.

Recording Changes on TADs

Turn around documents (TADs) are MA-3 reports pre-completed with billing information for residents who were in the facility the previous month. These are generated and sent to facilities during the third week of the month.

Providers must make all necessary changes to the TADs before returning them for processing. If the resident is discharged, hospitalized with no authorized bed hold days, expires, has unauthorized or over the limit (24 days per fiscal year) therapeutic home visits, or has a change in personal resources, mark out No. of Days, Total Charges, Personal Resources, and/or Net Charges, and enter the corrected information. Any new or additional information such as new diagnosis/recent complications may also be entered.

The authorized agent must sign and date the reports after all changes are made and after the last billing date, and the TAD should be returned to Claims Processing unit at the following address:

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

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 others are denied. To avoid returns and denials, double-check each claim form to confirm the following items are included and accurate.

Common Billing Errors	
Reasons for Return	How to Prevent Returned 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 claim form must have an authorized signature belonging to the provider, billing clerks, or office personnel. The signature may be typed, stamped, computer-generated, or handwritten.
Signature date missing	Each form must have a signature date.
Incorrect claim form used	The claim form must be the correct form for the services being billed.
Information on claim form not legible	Information on the claim form should be legible. Use dark ink and center the information in the field – information should 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, verify client eligibility by using one of the methods described in the <i>General Information for Providers</i> manual, <i>Client Eligibility and Responsibilities</i> chapter. See <i>Resolving Client Eligibility Problems</i> in this chapter.
Duplicate claim	<ul style="list-style-type: none"> • Please check all RAs for previously-submitted claims before resubmitting. • When making changes to previously-paid claims, submit an adjustment form rather than a new claim form, even if the claim is paid and the payment amount is “0” (see <i>Remittance Advices and Adjustments</i>). • Please allow 45 days for the Medicare/Medicaid Part B crossover claim to appear on the RA before submitting the claim directly to Medicaid.
Procedure requires Passport provider approval – No Passport approval number on claim	<ul style="list-style-type: none"> • Occasionally a nursing facility claim will deny for lack of Passport approval. This happens when a Passport client enters a facility during a month when his or her Passport enrollment is still active. When this happens, call Provider Relations and ask them to force the claim (see <i>Key Contacts</i>).
Prior authorization number is missing	<ul style="list-style-type: none"> • PA is required for certain services, and the PA number must be on the claim form. Refer to your specific provider 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>. • If the client’s TPL coverage has changed, providers must notify the TPL Unit (see <i>Key Contacts</i>) before submitting a claim.

Common Billing Errors (Continued)	
Reasons for Return	How to Prevent Returned Claims
Claim past 365-day filing limit	<ul style="list-style-type: none"> • To ensure timely processing, paper claims and adjustments should be mailed to Claims Processing at the address shown in <i>Key Contacts</i>. • See <i>Tips to Avoid Timely Filing Denials</i> in this chapter.
Missing Medicare EOMB	Paper Medicare crossover claims on CMS-1500 forms must have an EOMB attached.
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 billing manual. • Check the Medicaid fee schedule to verify the procedure code is valid for your provider type.
Date of service not in nursing facility span	<ul style="list-style-type: none"> • Verify the correct billing dates were used • Verify the nursing facility span dates authorized for the resident with the county office. If county office confirms span is correct and the claim still denies for date of service not in span, contact Senior and Long-Term Care (see <i>Key Contacts</i>).
Accommodation rate x days not equal to charge	<ul style="list-style-type: none"> • Verify that the correct number of days were billed • Verify that charges were calculated correctly
Date of service later than date of death	<ul style="list-style-type: none"> • Check that both the correct dates of service and number of days were billed

Resolving Client Eligibility Problems

When a claim is denied because the client is not eligible for Medicaid, providers should contact Provider Relations (see *Key Contacts*). If Provider Relations shows the client is not Medicaid-eligible, providers should contact the Local Office of Public Assistance (see *Appendix B: Local Offices of Public Assistance* in the *General Information for Providers* manual). If the problem cannot be resolved through the Local Office of Public Assistance or Provider Relations, providers may contact Senior and Long-Term Care (see *Key Contacts*). Providers should make every effort to resolve claim issues within the timely filing limits (see *Timely Filing Limits* in this chapter). For information on correcting and resubmitting claims, see the *Remittance Advices and Adjustments* chapter in this manual.

Other Programs

The Mental Health Services Plan (MHSP) and the Healthy Montana Kids (HMK) Plan do not cover nursing facility services. If a resident is enrolled in the MHSP plan, see the mental health manual for information on those services. For program manuals and more information, visit the Provider Information website (see *Key Websites*).

Submitting a Claim

Electronic Claims

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

- **ACS field software WINASAP 5010.** ACS makes available this free software, which providers can use to create and submit claims to Montana Medicaid, MHSP, and HMK (dental and eyeglasses only) and FQHC/RHC. It does not support submissions to Medicare or other payers. This software creates an 837 transaction, but does not accept an 835 transaction back from the Department.
- **ACS clearinghouse.** Providers can send claims to the ACS clearinghouse (ACS EDI Gateway) in X12 837 format using a dial-up connection. Electronic submitters are required to certify their 837 transactions as HIPAA-compliant before sending their transactions through the ACS clearinghouse. EDIFECS certifies the 837 HIPAA transactions at no cost to the provider. EDIFECS certification is completed through ACS EDI Gateway.
- **Clearinghouse.** Providers can contract with a clearinghouse so that the provider can send the claim to 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. For more information on electronic claims submission, contact Provider Relations or the EDI Technical Help Desk (see Key Contacts).
- **Montana Access to Health (MATH) web portal.** Providers can upload and download electronic transactions 7 days a week through the web portal. This availability is subject to scheduled and unscheduled host downtime.

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 Websites*). *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 Websites*).

Paper Claims

Clean claims (see *Definitions*) submitted with all of the necessary information are usually paid in a timely manner. Nursing facilities may submit claims on MA-3s, TADs, or CMS-1500s.

MA-3s

Nursing facilities and swing bed providers bill routine services to Medicaid on the MA-3 form. MA-3 forms are used when billing for new residents and coinsurance days. Below are instructions for completing an MA-3. Required fields are indicated by an asterisk (*).

Completing an MA-3 Form		
Entry	Field Name	Instructions
1	Nursing facility – name and address	List facility name and address
2*	Prov. Information	The provider's NPI/API/taxonomy.
3*	Patient	Resident's last name, first name, and middle initial. Do not use nicknames.
4	Sex	F for female or M for male.
5	County	Enter the two-digit county number where the facility is located.
6*	Individual Number	Resident's nine-digit Medicaid ID number
7	Diagnosis	Description of diagnosis
8*	Diagnosis Code	ICD diagnosis code
9*	Date of Birth	Resident's birthdate in MMDDYY format
10*	Date Admitted	Day of admission to the nursing facility
11*	Statement Period	Enter the "from" and "to" dates being billed in MMDDYY format. Do not enter the day of discharge as "to" date.
12*	No. of Days	Number of billable days during the statement period. Billable days do not include unauthorized hospital hold days or unauthorized THV days, or the day of discharge.
13*	Level of Care	Enter 1 for skilled and 2 for intermediate. Medicaid pays the same daily rate regardless of the level of care; however, this field must be completed. Continued-stay reviews indicate whether the facility is a Level 1 or 2. If continued-stay reviews are not available, nursing staff are usually familiar with the level of care.
14*	Total Charges	Number of days multiplied by the Medicaid per diem rate. See the <i>How Payment Is Calculated</i> chapter in this manual for more information on the per diem rate.
15*	Personal Resources	This is the resident's monthly obligation toward nursing facility care.
16*	Net Charges	Subtract the <i>Personal Resources</i> amount from <i>Total Charges</i> and enter the result here.
17*	Provider Signature	Authorized signature. This can be handwritten, stamped, or computer-generated.
18*	Date	Billing date in MMDDYYY format. This date must be later than the "to" date of the statement period (Field 11).

Mailing Paper Claims and TADs

Unless otherwise stated, all paper claims and TADs are mailed to:

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

All Medicaid claims must be submitted on Department approved claim forms. Nursing Facility MA-3 claim forms are available through Provider Relations (see *Key Contacts*). CMS-1500 forms are available from various publishing companies; they are not available from the Department or Provider Relations. A *Medicaid Form Order* sheet is available under the *Forms* section of the Provider Information website.

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

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

The supporting documentation must be submitted with a Paperwork Attachment Cover Sheet. (See *Appendix A: Forms* or the Provider Information website.) 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 Websites*).

Claim Inquiries

Claim inquiries can be obtained electronically through ANSI ASC X12N 276/277 transactions or by contacting Provider Relations. See the *Companion Guides* located on the ACS EDI Gateway website for more information on electronic transactions (see *Key Websites*). Providers may contact Provider Relations for questions regarding payments and denials, and other claim questions (see *Key Contacts*).

If you prefer to communicate with Provider Relations in writing, use the Montana Health Care Programs *Claim Inquiry Form* 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 includes the status of the claim: paid (date paid), denied (date denied), or in process. Denied claims will include an explanation of the denial and steps to follow for payment (if the claim is payable).

Avoiding Claim Errors

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

Common Claim Errors	
Claim Error	Prevention
Required field is blank	Check the claim instructions earlier in this chapter for required fields (indicated by * or **). If a required field is blank, the claim may either be returned or denied.
Client ID number missing or invalid	This is a required field (Field 10d); verify that the client's Medicaid ID number is listed as it appears on the client's ID card.
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 the <i>Prior Authorization</i> chapter in this manual.
Not enough information regarding other coverage	Fields 1a and 11d on a CMS-1500 claim form are required fields when a client has other coverage. Refer to the examples earlier in this chapter.
Authorized signature missing	Each claim must have an authorized signature belonging to the provider, billing clerk, or office personnel. The signature may be typed, stamped, computer-generated, or handwritten.
Signature date missing	Each claim must have a signature date.
Incorrect claim form used	When billing on paper, services covered in this manual require an MA-3 per diem claim form for routine services or a CMS-1500 claim form for ancillary services.
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.
Missing Medicare EOMB	When Medicare is involved in payment on a claim, the Medicare EOMB must be submitted with the claim or it will be denied. When billing electronically, see <i>Billing Electronically with Paper Attachments</i> in this chapter.

Other Programs

The Mental Health Services Plan (MHSP) and the Healthy Montana Kids (HMK) Plan do not cover nursing facility services. If a resident is enrolled in the MHSP plan, see the mental health manual for information on those services. For program manuals and more information, visit the Provider Information website (see *Key Websites*).

Remittance Advice and Adjustment

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 line has been paid, denied, or suspended (also referred to as pending). If the claim was suspended or denied, the RA also shows the reason.

Electronic remittance advice

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

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

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

Paper RA

Paper RAs accompany payment for services rendered. The paper RA is divided into the following sections: RA Notice, Paid Claims, Denied Claims, Pending Claims, and Reason and Remark Codes and Descriptions. See the following sample paper RA and the *Key to the Paper RA* table.

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

! If a claim was denied, read the Reason and Remark Code Description before taking any action on the claim.

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

Sections of the Paper RA	
Section	Description
RA Notice	The RA Notice is on the first page of the remittance advice. This section contains important messages about rate changes, revised billing procedures, and many other items that may affect providers and claims.
Paid Claims	This section shows claims paid 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 (are still in process) 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>
Reason and Remark Code Description	This section lists the reason and remark codes that appear throughout the RA with a brief description of each.

Sample Paper Remittance Advice

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES
HELENA, MT 59604

MEDICAID REMITTANCE ADVICE

ASSISTED LIVING SERVICES
112 EASTVIEW ROAD
ANYTOWN MT 59999

①

② NPI 0001234567 ③ REMIT ADVICE # 123456 ④ WARRANT # 123456 ⑤ DATE:02/04/04 PAGE 2 ⑥

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 - NURSING FACILITY CLAIMS								
123456789	DOE, JOHN EDWARD	010104 013104	31	160	3595.79			
⑨	ICN 00433111123000700	***LESS RECIPIENT PAYMENT*****				430.00	⑰	
		CLAIM TOTAL **			3595.79	3165.79		
DENIED CLAIMS - NURSING FACILITY CLAIMS								
123456790	DOE, JOE EDWARD	010104 013104	31	160	3595.79			31MA61
	ICN 00433111123000800		⑱					
PENDING CLAIMS - NURSING FACILITY CLAIMS								
123456791	DOE, JANE EDWINA	013104 013104	31	160	3595.79			31
	ICN 00433111123000900							

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

- 31 CLAIM DENIED AS PATIENT CANNOT BE IDENTIFIED AS OUR INSURED.
- MA61 DID NOT COMPLETE OR ENTER CORRECTLY THE PATIENT'S SOCIAL SECURITY NUMBER OR HEALTH INSURANCE CLAIM NUMBER.

Montana Department of Public Health and Human Services

Key to the Paper RA

Field	Description
1. Provider name and address	Provider's business name and address as recorded with the Department
2. NPI	The 10-digit number assigned to the provider by the National Plan and Provider Enumeration System (NPPES)
3. Remittance advice (RA) number	The RA 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 00111 11 123 000123</u> A B C D E A = Claim medium 0 = Paper claim 2 = Electronic claim 3 = Encounter claim 4 = System generated claim (mass adjustment, nursing facility turn around document, or POS pharmacy claim) B = Julian date (e.g., April 20, 2000, was the 111th day of 2000) C = Microfilm number 00 = Electronic claim 11 = Paper claim D = Batch number 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	Dates services were provided. If services 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. Copay	Not applicable for nursing facility residents.
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 personal resources 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 NPI. Send the check to the attention of the Third Party Liability Unit (see *Key Contacts*).

Rebilling and Adjustments

Rebillings and adjustments are important steps in correcting any billing problems providers 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. A clean claim must be submitted within timely filing limits in order for the provider to be paid. If a claim denies, and you have reviewed the claim and believe that it is a clean claim, and Provider Relations and the county office of public assistance cannot resolve it, contact Senior and Long-Term Care for review of the claim (see *Key Contacts*). If there are circumstances beyond the facility’s control (e.g., eligibility issues or resource adjustments) that causes a claim to continue to deny past the timely filing limit, and a clean claim was originally submitted within the timely filing limit, you may contact Senior and Long-Term Care and request a review of the claim.

Rebilling Medicaid

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



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



Rebill denied claims only after appropriate corrections have been made.

When to rebill Medicaid

- ***Claim Denied.*** Providers may rebill Medicaid when a claim is denied. Check the reason and remark codes, make the appropriate corrections and resubmit the claim (do not use the adjustment form).
- ***Line Denied.*** When an individual line is denied on a multiple-line CMS-1500 claim, correct any errors and rebill Medicaid for the denied line only. 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 *Billing Procedures, 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* earlier in this chapter. Adjustments are processed in the same time frame as claims.

If an adjustment needs to be made after the timely filing limits, send documentation explaining the reason the adjustment needs to be made and what adjustment is being requested to Senior and Long-Term Care. They will determine whether an adjustment is appropriate and either force special handling or initiate a gross adjustment.

When to request an adjustment

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

How to request an adjustment

To request an adjustment, use the *Montana Health Care Programs Individual Adjustment Request* form in *Appendix A*. 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).
- 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.

Sample Adjustment Request

Completing an Adjustment Request Form

1. Download the *Individual Adjustment Request* form from the Provider Information website. Complete Section A with provider and client information and the claim’s ICN number (see table on following page).

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.



Updated 6/4/2011

Montana Health Care Programs
Medicaid • Mental Health Services Plan • Healthy Montana Kids
Individual Adjustment Request

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

A. Complete all fields using the remittance advice (RA) for information.

1. Provider Name & Address Assisted Living Services 112 Eastview Road Anytown MT 59999	3. Internal Control Number(ICN) 00404011250000600
2. Client Name Jane Doe	4. NPI/APL 1234567
	5. Client ID Number 123456789
	6. Date of Payment 10/01/01
	7. Amount of Payment \$ 180.00

B. Complete only the items which need to be corrected.

	Date of Service or Line Number	Information on Statement	Corrected Information
1. Units of Service	Line 2	2	1
2. Procedure Code/NDC/Revenue Code			
3. Dates of Service (DOS)	Line 3	09/01/04	09/15/04
4. Billed Amount			
5. Personal Resource (Nursing Facility)			
6. Insurance Credit Amount			
7. Net (Billed—TPL or Medicare Paid)			
8. Other/Remarks (Be specific.)			

Signature: *Mary Bender* Date: 10/15/04
 When the form is complete, attach a copy of the RA and a copy of the corrected claim.

Mail to: ACS
 P.O. Box 8000
 Helena, MT 59604

3. Attach copies of the RA and a corrected claim if necessary.
 - If the original claim was billed electronically, a copy of the RA will suffice.
 - If the RA is electronic, attach a screen print of the RA.
4. Verify the adjustment request has been signed and dated.
5. Send the adjustment request to Claims Processing (see *Key Contacts*).

Completing an Individual Adjustment Request Form

Field	Description
Section A	
1. Provider Name and Address	Provider's name and address (and mailing address if different).
2. Client 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.* NPI/API	The provider's NPI/API.
5.* Client ID Number	Client's Medicaid ID number.
6. Date of Payment	Date claim was paid found on Remittance Advice Field 5 (see the sample RA earlier in this chapter).
7. Amount of Payment	The amount of payment from the Remittance Advice Field 17 (see the sample RA earlier in this chapter.).
Section B	
1. Units of Service (number of patient days)	If a payment error was caused by an incorrect number of units, complete this line.
2. Procedure Code/NDC/Revenue Code	If the procedure code, NDC, or revenue code are incorrect, complete this line.
3. Dates of Service (DOS)	If the dates of service are incorrect, complete this line.
4. Billed Amount	If the billed amount is incorrect, complete this line.
5. Personal Resource (Nursing Facility)	If the client's personal resource amount is incorrect, complete this line.
6. Insurance Credit Amount	If the client's insurance credit amount is incorrect, complete this line.
7. Net (Billed – TPL or Medicare Paid)	If the payment error was caused by a missing or incorrect insurance credit, complete this line. Net is billed amount minus the amount TPL or Medicare paid.
8. Other/Remarks	If none of the above items apply, or if you are unsure what caused the payment error, or if clarification is necessary, complete this line.

* Indicates a required field

- 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* earlier in this chapter).
- Any questions regarding claims or adjustments should be directed to Provider Relations (see *Key Contacts*).

Mass adjustments

Mass adjustments are done when it is necessary to reprocess multiple claims. They are usually initiated by the Department and 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 (Title XIX, SEC. 1923. [42 U.S.C. 1396r-4]).
- A system error that affected claims processing is identified.

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

Payment and the RA

Providers may receive their Medicaid payment and RAs 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 RA 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 table on the following page. One form must be completed for each 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.

Required Forms for EFT and/or Electronic RA

All four forms are required for a provider to receive weekly payment

Form	Purpose	Where to Get	Where to Send
Electronic Remittance Advice and Payment Cycle Enrollment Form	Allows 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 website • Provider Relations (see <i>Key Contacts</i>) 	Provider Relations (see <i>Key Contacts</i>)
Direct Deposit Sign-up Form Standard Form 1199A	Allows the Department to automatically deposit Medicaid payment into provider's bank account	<ul style="list-style-type: none"> • Provider Information website (see <i>Key Websites</i>) • Provider's bank 	Provider Relations (see <i>Key Contacts</i>)
EDI Provider Enrollment Form and EDI Trading Partner Agreement	Allow provider to access their RA on the 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 website • ACS EDI Gateway website (see <i>Key Websites</i>) 	ACS address on the form

Other Programs

The Mental Health Services Plan (MHSP) and Healthy Montana Kids (HMK) do not cover nursing facility services. If a resident is enrolled in the MHSP plan, see the mental health manual for information on those services. For program manuals and more information, visit the Provider Information website (see *Key Websites*).

Appendix A: Forms

- **Montana Health Care Programs *Individual Adjustment Request***
- **Montana Health Care Programs *Claim Inquiry Form***
- ***Level I Screen (DPHHS-SLTC-145)***
- ***Level of Care Determination (DPHHS-SLTC-86)***
- ***Notice of Transfer or Discharge***
- ***Monthly Nursing Facility Staffing Report (DPHHS-SLTC-015)***
- ***Request for Therapeutic Home Visit Bed Reservation (DPHHS-SLTC-041)***
- ***Request for Bed Reservation for Therapeutic Home Visit in Excess of 72 Hours (DPHHS-SLTC-042)***
- ***Request for Nursing Facility Bed Reservation During Resident's Temporary Hospitalization (DPHHS-SLTC-052)***
- ***Nurse Aide Certification/Training and Competency Evaluation (Testing) Survey Form***
- ***Request for Blanket Denial Letter***
- ***Paperwork Attachment Cover Sheet***

Montana Health Care Programs

Medicaid • Mental Health Services Plan • Healthy Montana Kids

Individual Adjustment Request

Instructions:

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

A. Complete all fields using the remittance advice (RA) for information.

<p>1. Provider Name & 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. NPI/API</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 items which need to be corrected.

	Date of Service or Line Number	Information on Statement	Corrected Information
1. Units of Service			
2. Procedure Code/NDC/Revenue Code			
3. Dates of Service (DOS)			
4. Billed Amount			
5. Personal Resource (Nursing Facility)			
6. Insurance Credit Amount			
7. Net (Billed – TPL or Medicare Paid)			
8. Other/Remarks (Be specific.)			

Signature: _____ Date: _____

When the form is complete, attach a copy of the RA and a copy of the corrected claim.



Mail to: ACS
 P.O. Box 8000
 Helena, MT 59604



Definitions and Acronyms

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

270/271 Transactions

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

276/277 Transactions

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

278 Transactions

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

835 Transactions

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

837 Transactions

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

Accredited Standards Committee X12, Insurance Subcommittee (ASC X12N)

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

Adjustment

When a claim has been incorrectly paid, the payment amount can be changed by submitting an adjustment request.

Administrative Review

Administrative reviews are the Department's effort to resolve a grievance about a Department decision in order to avoid a hearing.

The review includes an informal conference with the Department to review facts, legal authority, and circumstances involved in the adverse action by the Department.

Administrative Rules of Montana (ARM)

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

Administrator

The person licensed by the State as a nursing facility or hospital administrator with daily responsibility for operation of the facility. This person may be someone other than the titled administrator of the facility.

Assignment of Benefits

When a provider accepts the maximum allowable charge offered for a given procedure by the insurance company, it is said that the provider accepts assignment.

Audit

A formal or periodic verification of accounts.

Authorization

An official approval for action taken for, or on behalf of, a Medicaid client. This approval is only valid if the client is eligible on the date of service. Authorization may be required before billing for a service or before providing a service. *Prior authorization* is authorization required before providing and/or billing Medicaid for a service.

Basic Medicaid

Clients with Basic Medicaid have limited Medicaid services. See *Appendix A: Medicaid Covered Services* in the *General Information for Providers* manual.

Carrier

A private insurance company.

Centers for Medicare and Medicaid Services (CMS)

Administers the Medicare program and oversees the State Medicaid program. Formerly the Health Care Financing Administration (HCFA).

Children's Special Health Services (CSHS)

CSHS provides assistance for children with special health care needs. CSHS assists in paying for medical expenses related to specific conditions, specialty clinics, and finding resources. Medicaid-eligible children do not receive assistance with medical expenses from CSHS, but specialty clinics are open to all children with special health care needs. CSHS is funded by Title V, the Maternal and Child Health Block Grant.

Claims Attachment

Supplemental information about the services provided to a client that supports medical or other evaluation for payment, post-payment review, or quality control requirements that are directly related to one or more specific services billed on the claim.

Claims Clearinghouse

When a provider contracts with a clearinghouse, the clearinghouse supplies the provider with software that electronically transmits claims to the clearinghouse. The clearinghouse then transmits the claims to the appropriate payers.

Clean Claim

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

Client

An individual enrolled in a Department medical assistance program.

Coinsurance

The client's financial responsibility for a medical bill as assigned by Medicare. Medicare coinsurance is usually 20% of the Medicare allowed amount.

Companion Guide

A document provided by some health plans to supplement or clarify information about HIPAA standard transactions (available on the ACS EDI Gateway website).

Copayment

The client's financial responsibility for a medical bill as assigned by Medicaid (usually a flat fee).

Cosmetic

Serving to modify or improve the appearance of a physical feature, defect, or irregularity.

Cost Sharing

The client's financial responsibility for a medical bill, usually in the form of a flat fee.

CPT – Current Edition

Physicians' Current Procedural Terminology reference manuals contain procedure codes that are used by medical practitioners in billing for services rendered. These books are published by the American Medical Association.

Credit Balance Claims

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

Crossovers

Claims for 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 & Periodic Screening, Diagnosis & Treatment (EPSDT) Program

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

Electronic Data Interchange (EDI)

The communication of information in a stream of data from one party's computer system to another party's computer system.

Electronic Funds Transfer (EFT)

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

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.

Definitions and Acronyms

Experimental

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

Explanation of Benefits (EOB) Codes

A three-digit code which prints on a Medicaid remittance advice (RA) that explains why a claim was denied or suspended. The EOB codes are found at the end of the RA.

Explanation of Medicare Benefits (EOMB)

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

Fair Hearing

Providers may request a fair hearing when they believe the Department's administrative review determination fails to comply with applicable laws, regulations, rules or policies. Fair hearings include a hearing officer, attorneys, and witnesses for both parties.

Fiscal Agent

ACS is the fiscal agent for the State of Montana and processes claims at the Department's direction and in accordance with ARM 37.85 *et seq.*

Full Medicaid

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

Gross Adjustment

These adjustments are done in a lump-sum payment or reduction without regard to individual claims.

Healthy Montana Kids (HMK)

HMK offers low-cost or free health insurance for low-income children younger than 19. Children must be uninsured U.S. citizen-qualified aliens, Montana residents who are not eligible for Medicaid. DPHHS

administers the program and purchases health insurance from Blue Cross and Blue Shield of Montana (BCBSMT). Benefits for dental services and eyeglasses are provided by DPHHS through the same contractor (ACS) that handles Medicaid provider relations and claims processing.

HCPCS

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

- Level 1 includes the CPT codes.
- Level 2 includes the alphanumeric codes A–V which CMS maintains for a wide range of services from ambulance trips to hearing aids which are not addressed by CPT coding.
- Level 3 includes the alphanumeric codes W–Z which are assigned for use by State agencies (also known as local codes).

Health Improvement Program

An enhanced primary care case management program that is part of Passport to Health. Services for high-risk and/or high-cost Medicaid and HMK*Plus* Passport patients provided by nurses and health coaches to prevent or slow the progression of disease, disability, and other health conditions, prolong life, and promote physical and mental health. Services are provided through community and tribal health centers on a regional basis and include health assessment, care planning, hospital discharge planning, help with social services and education, and support for clients in self-management of health conditions. Predictive modeling software and provider referral are used to identify patients with the most need.

Health Insurance Portability and Accountability Act (HIPAA)

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

B.4

ICD – Current Edition

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

Implementation Guide (IG)

The official source of specifications with respect to how the HIPAA administrative and financial transactions are to be implemented (available on the Washington Publishing Company website).

Indian Health Services (IHS)

IHS provides Federal health services to American Indians and Alaska Natives.

Internal Control Number (ICN)

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

Investigational

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

Mass Adjustment

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

Medicaid

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 malfunction. 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 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.

Newsletter

An informational letter sent to providers (such as the Montana Health Care Programs *Claim Jumper* or the *Passport to Health* provider newsletter).

Nursing Facility Services

Services provided by a nursing facility in accordance with 42 CFR, Part 483, Subpart B.

Nurse First Advice Line

A 24/7 nurse line. Clients can call in with general health questions, medication questions, or questions about illness or injury. If the caller or person they are calling about is symptomatic, a registered nurse follows clinically based algorithms to an end point care recommendation. The care recommendation explains what level of health care is needed, including self-care. If self-care is recommended, clients are given detailed self-care instructions.

Passport Referral Number

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

Passport to Health

The Medicaid primary care case management (PCCM) managed care program where the client selects a primary care provider who manages the client’s health care needs.

Patient Contribution

Also called *personal resource*, this is the total of all of the resident’s income from any source available to pay for the cost of care, less the resident’s personal needs allowance.

Patient Day

A 24-hour period that a person is present and receiving nursing facility services regardless of payment source. Even though a person may not be present for a whole 24-hour period on the day of admission or day of death, these days will be considered patient days. For nursing facilities only (not swing bed providers), when authorized by the Department, a resident may take a temporary leave from the facility to be hospitalized or to make a home visit. A 24-hour period of absence is considered a patient day. The day of discharge is not a billable day.

Pay-and-Chase

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

Pending Claim

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

Personal Resource

Also called *patient contribution*, this is the total of all of the resident's income from any source available to pay for the cost of care, less the resident's personal needs allowance.

Potential Third Party Liability

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

Prior Authorization (PA)

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

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.

Public Assistance Toolkit

This Internet site (<https://dphhs.mt.gov/>) contains information about employment and health services, energy assistance, justice, commerce, labor & industry, education, voter registration, the Governor's Office, and Montana.

Rebilling

When a provider submits a claim that was previously submitted for payment but was either returned or denied.

Referral

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

Related Party

A related party may be any of the following:

- A person or corporation who is an owner, partner, or stockholder of the current provider and who has a direct or indirect interest of 5% or more, or a power, whether or not legally enforceable, to directly or indirectly influence or direct the actions or policies of the entity.
- A spouse, ancestor, descendant, sibling, uncle, aunt, niece, or nephew of the person mentioned above.
- A spouse of an ancestor, descendant, sibling, uncle, aunt, niece, or nephew of the person mentioned above.
- A sole proprietorship, partnership corporation or other entity in which a person described above has a direct or indirect interest of 5% or more, or a power, whether or not legally enforceable, to directly or indirectly influence or direct the actions or policies of the entity.

Remittance Advice (RA)

Provides details of all transactions that have occurred during the previous two weeks, includes paid, denied, and pending claims.

Remittance Advice Notice

The first page of the RA that contains important messages for providers.

Resident

A person admitted to a nursing facility who has been present in the facility for at least one 24-hour period.

Retroactive Eligibility

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

Sanction

The penalty for noncompliance with laws, rules, and policies regarding Medicaid. A sanction may include withholding payment from a provider or terminating Medicaid enrollment.

Swing Bed Services

Services provided by a licensed hospital or licensed medical assistance facility which is Medicare certified to provide post-hospital SNF care as defined in 42 CFR 409.20.

Team Care

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

Third Party Liability (TPL)

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

Timely Filing

Providers must submit clean claims (claims that can be processed without additional information or documentation from or action by the provider) to Medicaid within the latest of:

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

Trust Funds

Resident accounts maintained by the nursing facility at the resident's request.

Unrelated Party

A person or entity that is not a related party.

Usual and Customary

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

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