

Dental and Denturist Program

This publication supersedes all previous dental and denturist provider handbooks. Published by the Montana Department of Public Health & Human Services, July 2001.

Updated July 2002, July 2003, July 2004, August 2004, July 2005, July 2009, April 2011, and July 2013.

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Key Contacts

Hours for Key Contacts are 8:00 a.m. to 5:00 p.m. Monday through Friday (Mountain Time), unless otherwise stated.

American Dental Association

To order the current CDT Dental Terminology manual, contact the ADA at:

800.947.4746

7:00 a.m. to 5:00 p.m. Monday–Friday
(Central Time)

Send written inquiries to:

American Dental Association
Council on Dental Care Programs
211 East Chicago Avenue
Chicago, IL 60611-2678

Direct Deposit Arrangements

Providers who would like to receive electronic funds transfer (EFT) and electronic RAs should fax their information to Provider Relations:

406.442.4402

EDI Technical Help Desk

For questions regarding electronic claims submission:

800.624.3958 In/Out of state
406.442.1837 Helena
406.442.4402 Fax

Mail to:

Attention: MT EDI
P.O. Box 4936
Helena, MT 59604

Fraud and Abuse

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

800.201.6308 Member Eligibility Fraud

800.362.8312 Medicaid Help Line

(Call this number to report suspected member abuse of Medicaid.)

800.376.1115 Provider Fraud

Member Eligibility

There are several methods for verifying member eligibility. For additional methods and details on each, see the Verifying Member Eligibility table in the Member Eligibility and Responsibilities chapter in this manual.

FaxBack

800.714.0075 (24 hours)

Integrated Voice Response

800.714.0060 (24 hours)

Montana Access to Health Web Portal

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

Medifax EDI

800.444.4336, X 2072 (24 hours)

Paper Claims

Send paper claims to:

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

Presumptive Eligibility Verification

800.932.4453

Prior Authorization

For questions regarding prior authorization:

800.624.3958 In/Out of state

406.442.1837 Helena

Mail backup documentation to:

Claims Processing Unit

P.O. Box 8000

Helena, MT 59604

Fax backup documentation to:

406.442.4402

Program Policy

For program policy questions:

406.444.3182 Phone

406.444.1861 Fax

Send written inquiries to:

Dental Program Officer

Medicaid Services Bureau

P.O. Box 202951

1400 Broadway

Helena, MT 59620-2951

Provider Enrollment

For enrollment changes or questions:

800.624.3958 In/Out of state

406.442.1837 Helena

Send written inquiries to:

Provider Enrollment Unit

P.O. Box 4936

Helena, MT 59604

Provider Relations

For general claims questions or questions about eligibility, payments, or denials:

800.624.3958 In/Out of state

406.442.1837 Helena

Send written inquiries to:

Provider Relations Unit

P.O. Box 4936

Helena, MT 59604

Third Party Liability

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

800.624.3958 In/Out of state

406.442.1837 Helena

Send written inquiries to:

Third Party Liability Unit

P.O. Box 5838

Helena, MT 59604

Key Websites

Web Address	Information Available
EDI Gateway www.acs-gcro.com/	EDI Gateway is Montana's HIPAA clearinghouse. Visit this website for more information on: <ul style="list-style-type: none"> • EDI support • EDI Enrollment • FAQs • Manuals • Provider services • Related links • Software
Health Resources Division http://www.dphhs.mt.gov/hrd/index.shtml	<ul style="list-style-type: none"> • BigSky Rx • Healthy Montana Kids: Information on HMK. • Montana Medicaid: Member guide. • Prescription Assistance Programs
Montana Access to Health (MATH) Web Portal https://mtaccesstohealth.acs-shc.com/ Montana Medicaid Provider Information http://medicaidprovider.hhs.mt.gov/ (www.mtmedicaid.org)	<ul style="list-style-type: none"> • FAQs • Fee schedules • HIPAA update • Key contacts • Links to other websites • Medicaid forms • Medicaid news • Newsletters • Notices and manual replacement pages • Passport to Health information • Provider enrollment • Provider manuals • Remittance advice notices • Training resources • Upcoming events
Montana Medicaid Member Information http://www.dphhs.mt.gov/medicaid/member/	<ul style="list-style-type: none"> • Medicaid program information • Member newsletters • Who to call if you have questions • Member notices and information
Public Assistance Toolkit https://dphhs.mt.gov/	Select <i>Human Services</i> for the following information: <ul style="list-style-type: none"> • Medicaid: Member information, eligibility information, and provider information. • Applications for Public Assistance
Secretary of State http://sos.mt.gov/ http://sos.mt.gov/ARM/index.asp Administrative Rules of Montana (ARM) http://www.mtrules.org/	Secretary of State website and Administrative Rules of Montana

Verifying Member Eligibility

Contact	Information Available	Special Instructions	Hours (Mountain Time)
FaxBack 800.714.0075	<ul style="list-style-type: none"> • Member eligibility • Third party liability • Managed care and other restrictions 	<ul style="list-style-type: none"> • Call the number and enter your NPI or provider number, a member ID, and specific dates of service. • Before using FaxBack, have your fax number on file with Provider Relations. • When prompted, request the audit number or the transaction will not be completed. 	24/7
Integrated Voice Response (IVR) 800.714.0060	<ul style="list-style-type: none"> • Member eligibility • Third party liability • Managed care and other restrictions • Amount of last check sent to provider 	<ul style="list-style-type: none"> • Call the number and enter your NPI or provider number, a member ID, and specific dates of service. • Verify eligibility for up to 5 members in one call. • Program benefit limits not available here. Contact Provider Relations for limits (see below). 	24/7
Local Offices of Public Assistance	Member eligibility.	<ul style="list-style-type: none"> • See Appendix C: Local Offices of Public Assistance in the <i>General Information for Providers</i> manual. 	8 a.m.–5 p.m. Mon–Fri
Medifax EDI, now Emdeon 800.444.4336 X2546/X2072 http://www.emdeon.com/	<ul style="list-style-type: none"> • Member eligibility • Managed care and services restrictions • Member demographics • Third party liability 	<ul style="list-style-type: none"> • Provides real time access for verifying patient eligibility for Montana Medicaid and other commercial payers. • Offers a variety of products to meet the needs of health care providers to include eligibility verification, claims credit card processing and statements. 	24/7
Montana Access to Health (MATH) Web Portal https://mtaccesstohealth.acshc.com/mt/general/home.do	<ul style="list-style-type: none"> • Member eligibility • Managed care and service restrictions • Member demographics • Third party liability • Member status history • RAs • Claim-based medical history • Warrant status • Provider enrollment 	<ul style="list-style-type: none"> • From the Provider Information website (www.mtmedicaid.org) click the Log in to Montana Access to Health link. • Before accessing the MATH web portal, you must be an enrolled Medicaid provider and complete the web registration available on the site. • If the member is not currently eligible, any managed care or third party liability information will not be displayed. The user will receive a response with a status of “inactive” reported in the Member Demographic Information. 	24/7
Provider Relations P.O. Box 8000 Helena, MT 59604 406.442.1837 800.624.3958 In/Out of state 406.442.4402 Fax	<ul style="list-style-type: none"> • Member eligibility • Prior authorization status • Claim status • Amount of last check sent to provider • Enrollment status • Service limits 	Have your NPI or provider number and member ID number ready when you call.	8 a.m.–5 p.m. Mon–Fri
Presumptive Eligibility			
800.932.4453	Presumptive eligibility information	To become a provider who determines presumptive eligibility, call 800.932.4453.	8 a.m.–5 p.m. Mon–Fri

Introduction

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

Manual Organization

This manual provides information specifically for dental providers and denturists.

Each chapter has a section titled Other Programs that includes information about other Department programs such as the Mental Health Services Plan (MHSP) and Healthy Montana Kids (HMK)/Children's Health Insurance Plan (CHIP). Other essential information for providers is contained in the separate *General Information for Providers* manual. Each provider is asked to review both the general manual and the specific manual for his/her provider type.

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

Manual Maintenance

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

Rule References

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

- Code of Federal Regulations (CFR)
 - 42 CFR
- Montana Codes Annotated (MCA)
 - MCA 53-6-101, 53-6-113
- Administrative Rules of Montana (ARM)
 - ARM 37.86.1001–ARM 37.86.1006 Dental Services

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

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

Getting Questions Answered

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

Covered Services and Limitations

General Coverage Principles

Medicaid covers almost all dental and denturist services when they are medically necessary for members under age 21. This chapter provides covered services information that applies specifically to dental and denturist services. Like all health care services received by Medicaid members, these services must also meet the general requirements listed in the Provider Requirements chapter of the *General Information for Providers* manual.

The rules, regulations, and policies described in this manual apply to services provided by dentists, denturists, orthodontists, and oral surgeons. Providers may be reimbursed for Medicaid covered services when the following requirements are met:

- Provider must be enrolled in Medicaid (ARM 37.85.402).
- Services must be performed by practitioners licensed and operating within the scope of their practice as defined by law (ARM 37.85.401).
- Member must be Medicaid eligible and non-restricted (ARM 37.85.415).
- Service must be medically necessary (ARM 37.85.410). The Department may review medical necessity at any time before or after payment.
- Service must be covered by Medicaid and not be considered cosmetic, experimental or investigational (ARM 37.85.415).
- Charges must be usual and customary (ARM 37.85.212).
- Claims must meet timely filing requirements (ARM 37.84.406).
- Prior authorization requirements must be met (ARM 37.86.1006).
- Passport approval requirements must be met.

Covered Dental Services

Full Medicaid

All members under age 21 and some members age 21 and over who have Full Medicaid coverage are eligible for only:

- Diagnostic
- Preventative
- Basic restorative (including prefabricated stainless steel crowns)
- Dentures (immediate, full and partial); and
- Extraction services (ARM 37.86.1006)

Some Full Medicaid services are only available to those age 20 and under. Please review the most recent Department dental fee schedule for specific code coverage available for specific ages. Fee schedules are available on the Provider Information [website](#). (See Key Websites.)

Pregnant women who present a Presumptive Eligibility Notice of Decision. Providers should call 1-800-932-4453 to verify presumptive eligibility.

Basic Medicaid (ARM 37.85.206)

The **only** time members who have Basic Medicaid benefits are eligible for dental coverage is when emergency dental services are necessary and when dental work is “essential for employment.”

Emergency Dental Services for Adults Ages 21 and Over with Basic Medicaid (ARM 37.85.207)

Medicaid may cover emergency dental services for those members who are on Basic Medicaid. Subject to the dental program limitations, the Medicaid program will reimburse dental providers for palliative treatment and diagnostic services related to the treatment of emergency medical conditions.

Emergency dental services means covered inpatient and outpatient services that are needed to evaluate and stabilize an emergency medical condition. An emergency medical condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (included severe 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 in serious jeopardy, serious impairment to body functions, or serious dysfunction of any bodily organ or part. If the Medicaid professional rendering the medical screening deems an emergency dental condition does exist, stabilization treatment is rendered.

The following are acceptable dental emergency codes listed on the Emergency Dental Services Form. If the dental emergency treatment requires a code other than these, indicate the code on the form and explain. Treatment may be approved if adequate documentation of the emergency treatment is provided on the form.

Emergency Dental Codes for Adults on Basic Medicaid					
D0140	D0273	D2161	D3346	D7270	D9420
D0220	D0274	D2330	D7140	D7510	D9612
D0230	D0275	D2331	D7210	D7520	D9920
D0240	D0277	D2332	D7220	D7910	
D0250	D0330	D2335	D7230	D9110	
D0260	D2140	D2940	D7240	D9241	
D0270	D2150	D3310	D7241	D9242	
D0272	D2160	D3331	D7250	D9248	



Preventive treatments or routine restorative services are excluded from emergency dental services under Basic Medicaid.



Emergency dental claims for adults 21 and over with Basic Medicaid must be accompanied by a completed Emergency Dental Services Form. See Appendix A: Forms.)

- Routine restorative or preventive treatments are specifically excluded from any emergency dental services.
- Root canals are allowable on anterior teeth only.
- All other program limits still apply. RHCs and FQHCs will continue to bill Revenue Code 512 for these services.
- Document any delay between date of diagnosis and date of treatment. As a guideline, this time frame should be within 30 days of initial date of exam.
- Emergency dental claims for adults 21 and over on Basic Medicaid must be accompanied by a completed Emergency Dental Services Form located in Appendix A: Forms and on the Provider Information website.

Essential for Employment Program (37.85.206)

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

- Routine dental services (i.e., exam, x-rays and prophylaxis) are not covered services under the Essential for Employment program.
- Service/limitations, coverage, and reimbursement are the same for approved services as they would be for a Full Medicaid member.
- Claims must be accompanied by a completed Medicaid Services Essential for Employment Form (DPHHS-HCS-782), located in Appendix A: Forms and on the Provider Information website.

Access to Baby and Child Dentistry (AbCd)

The Access to Baby and Child Dentistry (AbCd) program was established to increase access to dental services for Medicaid-eligible children under age 6. AbCd focuses on preventive and restorative dental care for children from birth to age 6, with emphasis on the first dental appointment by age 1, if not sooner. It is based upon the premise that starting dental visits early will yield positive behaviors by both parents and children, thereby helping control the caries process and reduce the need for costly future restorative work.

Dentists must receive continuing education in early pediatric dental techniques to qualify as an AbCd specialist. This specialty endorsement will allow AbCd dentists to be reimbursed for the following procedures:

- D0145, Oral evaluation, for patients under 3
- D0425, Caries susceptibility test, for patients under 3
- D1310, Nutritional counseling (age 0–5)
- D1330, Oral hygiene instruction (age 0–5)

- Based upon the results of a caries risk assessment (CRA), each individual child will be determined either high risk or low/medium risk. This is a result of measuring clinical conditions, environmental characteristics and general health conditions to document caries risk level. Risk level will determine visit frequency (up to three times per year for low/medium risk, up to six times per year for high risk).
- The risk assessment shall be completed at each initial visit and annually thereafter up to age 3. Risk assessments are valid for one year.

AbCd Visit Frequency Related to Age and Level of Risk			
	< 18m	> 18m and < 36m	> 36m and < 72m
Allowable Procedure Codes	D0145	D0145	D0150
	D0425	D0425	D1120
	D1206	D1206	D1206
	D1310	D1310	D1330
	D1330		
Low/Medium Risk	Up to three/year	Up to three/year	Up to three/year
High Risk	Up to six/year	Up to six/year	Up to three/year

Family oral health education is a strong component of this program. This is completed at the dental office. Other components of the program include proper training in oral hygiene techniques and the application of fluoride varnish. Restorative and radiographic services are used as determined necessary by the dentist.

Tamper-Resistant Prescription Pads

As of October 1, 2008, all fee-for-service Medicaid prescriptions that are either handwritten or printed from an EMR/ePrescribing application must contain **three different tamper-resistant features**, one from each of the three categories described below.

Feature descriptions:

- One or more industry recognized features designed to prevent unauthorized copying of a completed or blank prescription.
- One or more industry recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber.
- One or more industry recognized features designed to prevent the use of counterfeit prescriptions.

Prescriptions for Medicaid patients that are telephoned, faxed or e-prescribed are exempt from these tamper-resistance requirements.

Noncovered Services

1. **Porcelain/ceramic crowns, noble metal crowns and bridges are not covered for members 21 years of age and older.**
2. **No-show appointments.** A no-show appointment occurs when a member fails to arrive at a provider's office for a scheduled visit and did not cancel or reschedule the appointment in advance. No-show appointments are not a covered service and cannot be billed to Medicaid.
3. **Cosmetic dentistry.** Medicaid does not cover cosmetic dental services.
4. **Splints/mouthguards.** Splints and mouth guards for members 21 years of age and older are not a covered service of the Medicaid program.
5. **Qualified Medicare Beneficiary (QMB).** Medicaid does not cover dental services for members that have "QMB" on their Medicaid eligibility information. See the *General Information for Providers* manual, *Member Eligibility and Responsibilities* chapter for more information on QMB.
6. **Basic Medicaid Coverage.** Dental services are not covered for members that have "Basic" on their Medicaid eligibility information. However, the member may be eligible for emergency dental services and/or when dental work is essential for employment. (See Who Is Eligible for Dental Services at the beginning of this chapter.)
7. **Dental implants**

Coverage of Specific Services (ARM 37.86.1006)

Medicaid allowable procedure codes and limitations can be found online under Fee Schedules. Use the CDT resource for a complete description of each code.

Diagnostic

The collection and recording of some data and components of the dental examination may be delegated; however, the evaluation, diagnosis, and treatment planning are the responsibility of the dentist. As with all ADA procedure codes, there is no distinction made between the evaluations provided by general practitioners or specialists.

- Examinations for adults will be allowed every six months or more often if a referral has occurred. If both the dentists involved in the referral have done full exams, both can be paid. For this exception to be made, the providers must both indicate on their claims that a referral has occurred and the name of the other dentist involved. This information should be reported in the remarks section of the claim form. If you have a denial of the referral visit, review your claim to ensure you have the referring dentist's name and resubmit for payment. If you have a copy of your claim and the referring dentist's name is listed, call Provider Relations for a request to reprocess this claim. (See Key Contacts.)
- Exams, x-rays, and prophylaxis are not covered for adults on Basic Medicaid who qualify for the Essential for Employment program.



Medicaid allowable procedure codes and limitations can be found online under Fee Schedules. Please use the ADA CDT resource for a complete description of each code.

Radiographs

Radiographs should be taken only for clinical reasons as determined by the member's dentist. They should be of diagnostic quality, properly identified and dated. They are considered to be part of the member's clinical record.

If additional panoramic films are needed for medical purposes (i.e., to check healing of a fractured jaw), they can be billed on an ADA form (2006) as long as it was done in an office setting. Otherwise, they should be billed on the CMS-1500 claim form using the CPT Code 70355 for panoramic x-ray. Exams, x-rays, and prophylaxis are not covered for adults on Basic Medicaid who qualify for the Essential for Employment program.

When more than one film has been taken, add the number of units in the description box and multiply the fee by the units in the fee box.

Preventive

Prophylaxis and fluoride treatments are allowed every six months.

- If providers are treating individuals with a developmental disability who require a prophylaxis treatment more often than six months intervals, indicate "Developmentally Disabled" in the remarks section of the ADA claim form.
- Billed code choices of adult or child prophylaxis are up to the professional expertise of the provider (i.e., D1110, D1120, D1203, D1204).
- Exams, x-rays, and prophylaxis are not covered for adults on Basic Medicaid who qualify for the Essential for Employment program.
- Physicians (only) will be reimbursed by Montana Medicaid for applying fluoride varnish (Code D1206) to children under age 21 at well-child appointments. Physicians are encouraged to make referrals when appropriate in an effort to help the child establish a dental home. Physicians should bill Code D1206 on a CMS-1500 claim form. If the child is determined high-risk for early childhood caries, up to six treatments per year will be allowed.

Restoration***Fillings***

For complete restoration of a tooth (filling of all surfaces currently damaged by caries), the following policies apply:

- When more than one surface is involved, and one continuous filling is used, select the appropriate code from the range of D2140 through D2394.
- When there are separate fillings on each surface, the one-surface codes (D2140 and D2330) are to be used. Your records must clearly indicate each filling is treatment for a separate cavity.



When more than one film has been taken, add the number of units in the description box and multiply the fee by the units in the fee box.

- The ADA views restorative work done on the same day and same tooth as one tooth with five surfaces.
- Only one payment will be allowed for each surface.
- When more than one filling is included on a surface, combine the code. For example, MO and LO on a permanent molar restored in the same day should be coded as MOL. This should be coded this way whether the filling on the occlusal is a continuous filling or two separate fillings. The ADA views work done on the occlusal as one of the five surfaces that are billable.
- When more than one filling is included on a surface and restored on different days, they should be coded on different days. For example, if MO and LO on a permanent molar are restored on subsequent days, they should be coded as a MO on the first day and LO on the second day.
- **Amalgam Restorations (Including Polishing).** All adhesives (including amalgam bonding agents), liners, and base are included as part of the restoration. If pins are used, they should be reported separately. (See Procedure Code D2951.)
- **Silicate and Resin Restorations.** Resin refers to a broad category of materials including, but not limited to, composites. Also included may be bonded composite, light-cured composite, etc. Light-curing, acid-etching, and adhesives (including resin bonding agents) are included as part of the restoration. If pins are used, they should be reported separately. (See Procedure Code D2951.)

Crowns

Crowns are covered only for members with Full Medicaid coverage. Crowns are limited to situations where the tooth is periodontally healthy and without pulpal pathology and the tooth cannot be restored by any means other than a full coverage restoration.

- **Prefabricated Crowns.** Prefabricated stainless steel and prefabricated resin crowns D2930–D2933 are available for all members, regardless of age and regardless of tooth number. There is a limit for crowns of one per tooth, every five years.
- **All other Crowns – Porcelain/Ceramic, High Noble Metal, Non-Prefab, High Metal, Gold, Porcelain.** All crowns, other than prefabricated stainless steel and prefabricated resin, are only available to Full Medicaid members age 20 and under. Porcelain or ceramic crown restorations are only available for anterior teeth (6 – 11 and 22 – 27). Generally, crowns on posterior teeth are limited to pre-fabricated resin and/or pre-fabricated stainless steel, except when necessary for partial denture abutments. Indicate in the Remarks section of the claim form which teeth are abutment teeth. Crowns are limited to one per tooth every five years.

- Crown coverage is available using procedure codes D2751, D2781, and D2791 (porcelain fused to base metal crowns) for anterior or posterior teeth. These codes are open to children and adults on Full Medicaid and adults approved under the Essential for Employment program. Crown code D2750 (porcelain with high noble metal) is now allowed for children under 21 years of age for posterior teeth.
- **Dental Services – Crowns.** Limits have been established for adults age 21 and over for porcelain fused to base metal crowns (D2751). Limited to two per person per calendar year, total. Second molars (2, 15, 18, and 31) will receive base metal crowns only (D2791).

Endodontics

Canal therapy includes primary teeth without succedaneous teeth and permanent teeth.

- ***Complete Root Canal Therapy.*** Pulpectomy is part of root canal therapy (dental pulp and root canal are completely removed). It includes all appointments necessary to complete treatment and intra-operative radiographs. It does not include diagnostic evaluation and necessary radiographs/diagnostic images.
- Pulpotomy (pulp tissue in crown removed, but tissue in root canal remains) (covered for ages 20 and under only) cannot be billed on the same day as endodontic therapy for the same tooth. Per guidance from the American Dental Association coding department, Code D3220 should never be billed if a root canal is to be performed by the same provider.

Periodontics

- ***Apicoectomy/Periradicular Services (Ages 20 and under Only).*** Periradicular surgery (removal of root top after root canal) is a term used to describe surgery to the root surface such as apicoectomy, repair of a root perforation or resorptive defect, exploratory curettage to look for root fractures, removal of extruded filling materials or instruments, removal of broken root fragments, sealing of accessory canals, etc. This does not include retrograde filling material placement.

- ***Gingivectomy/Gingivectomy per Quadrant.*** Is limited to cases involving gingival hyperplasia due to medication reaction or pregnancy. One quad equals one unit of service. Per quadrant should be listed in the Tooth Number column as follows:
 - LL – Lower Left
 - UL – Upper Left
 - LR – Lower Right
 - UR – Upper Right
- ***Full Mouth Debridement.*** Full mouth debridement is to be used prior to periodontal scaling and root planning only if the provider cannot determine the extent of periodontal scaling and root planning without this procedure. It is limited to one time per year if medically indicated. If providers are treating individuals with a developmental disability who require this treatment more often than once a year, indicate ‘Developmentally Disabled’ in the Remarks section of the ADA claim form.

Prosthodontics, Removable

This services is available to members of all ages with Full Medicaid. A partial denture five years or older may be replaced by full and/or partial dentures. Full dentures, ten years old or older, may be replaced when the treating dentist documents the need for replacement. Payment for the denture includes payment for any tissue conditioners provided. Payment for denture adjustments during the first year after delivery of the dentures is available only to a dentist or denturist who did not make the dentures. The first three adjustments after dentures are placed are included in the denture price. Complete and partial dentures include routine post delivery care. **Call Provider Relations to verify if a member is eligible for a new denture or replacement for a lost one. (See Key Contacts.)**

Medicaid will replace lost dentures for eligible members with a lifetime limit of **one** set. The claim form must include the age of the lost dentures and the term ‘Lost Dentures’ written in the Remarks section of the claim.

A dentist’s prescription is required and must be kept in the member file in the following circumstances:

- All partial denture work
- All immediate denture work

Limitations or requirements for the dental codes are listed with the procedure codes on the fee schedule. No prescription is necessary when a new patient requires repairs to existing dentures or partials.

The above limits may be exceeded when the dentist and the Department consultant agree the current dentures are causing the member serious physical health problems. In these situations, the provider should submit a prior authorization request. See the Prior Authorization chapter in this manual.



A dentist's prescription is required for all partial and immediate denture work.

Denture Billing Date

Dentures must be billed using the date of service the member receives the dentures. The only exception is when the member is not eligible on the date of service, then the date of impression may be used.

Prosthodontics, Fixed

These services are only available to members age 20 and under. Tooth colored, fixed partial denture pontics are only available for anterior teeth 6–11 and 22–27. Fixed partial denture pontics are not allowed for posterior teeth unless used to replace an anterior tooth. As an example, if tooth 6 is missing, the fixed denture pontic will cover teeth 5–7. In this example, tooth 5 can be tooth colored. In cases where a posterior tooth is to be replaced, a partial denture must be used. Review the Prosthodontics, Removable section for information regarding partial dentures. Fixed partial denture pontics are limited to one every tooth, every five years.

Oral Surgery

Impacted third molars or supernumerary teeth are covered only when they are symptomatic; that is, causing pain, infected, preventing proper alignment of permanent teeth or proper development of the arch.

Providers may use current CPT procedure codes for **medical** services provided in accordance of practice permitted under state licensure laws and other mandatory standards applicable to the provider. Medical services are those that involve the structure of the mouth (i.e., jaw bone). Any services involving the tooth, are considered **dental** services. Medical services can be billed on an ADA form as long as the services were provided in an office. If the procedures were done in a hospital or nursing facility setting, they must be billed on the CMS-1500 claim form with valid CPT procedure codes and valid ICD diagnosis codes. Providers who frequently bill for medical services should obtain a copy of the *Physician-Related Services* manual. This manual is available on the Provider Information [website](#). (See Key Websites.)

These procedures will be reimbursed through the Resource-Based Relative Value Scale (RBRVS) fee schedule. All current CPT codes billed will comply with rules as set forth in the Administrative Rules of Montana (ARM) for physicians. General anesthesia is listed in the current CPT procedures codes and must be billed using a CMS-1500 claim form.

Orthodontics

See the Orthodontia Services and Requirements chapter in this manual for more information on covered orthodontia services and limitations.



Fixed prosthodontics services are only available to members age 20 and under.



Surgical extractions include local anesthesia and routine postoperative care.

Date of Service

Date of service is the date a procedure is completed. However, there are instances where Medicaid will allow a date other than the completion date.

Dentures must be billed using the date of service the member receives the dentures. The only exception is when the member is not eligible on the date of service, then the date of impression may be used.

If a crown or bridge has been sent to the laboratory for final processing, and the member never shows for the appointment to have the final placement, providers may bill the date of service as the date the crown or bridge was sent to the laboratory for final processing. However, the member must have Medicaid eligibility at the time the crown or bridge is sent to the lab. Bridges are limited to members age 20 and under. All crowns other than prefabricated stainless steel and prefabricated resin are only available to members with Full Medicaid coverage age 20 and under.

If a provider has opened the area for a root canal but anticipates the member will not return for completion or is referring member to another provider for root canal completion, procedure D3220 (covered for ages 20 and under only) may be billed. However, root canal codes must be billed to Medicaid at the time of completion.

Fee Schedule

All procedures listed in the Montana Medicaid fee schedule are covered by the Medicaid program and must be used in conjunction with the limits listed in this manual. If current CDT codes exist and are not listed in the Montana Medicaid fee schedule, the items are not a covered service of the Medicaid program. Services that are not covered or exceed the specified limits can be billed to the member as long as the provider informs the member, prior to providing the services, that the member will be billed and the member agrees to be private pay. Fee schedules are available on the Provider Information [website](#). (See Key Websites.)

Calculating Service Limits

Any service which is covered only at specified intervals for adults will have a notation next to the procedure code with information about the limit in the Coverage of Specific Services section of this chapter. When scheduling appointments, please be aware limits are controlled by our computerized claims payment system in this manner. Limits on these services are controlled by matching the date on the last service against the current service date to assure the appropriate amount of time (six months, one year, or three years) has elapsed. Procedure codes that have limits are described on the fee schedule.

For example, if an adult received an examination on February 27, and the same service was provided again on February 26 of the following year, the claim would be denied as a complete year would not have passed between services. If the service were provided on February 27 of the following year, or after, it would be paid.

Providers should call Provider Relations to get the last date of service for those procedure codes with time limits or other limitations of dental services. This information will allow the provider to calculate service limitations, but it does not guarantee payment of service for service-limited procedures. In certain circumstances, prior authorization may be granted for services when limits have been exceeded. See the Prior Authorization chapter in this manual.

EPSDT Services for Individuals Age 20 and Under

Limits on medically necessary services (e.g., exams, prophylaxis, x-rays) do not apply to members age 20 and younger as part of the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program. Medicaid has a systematic way of exempting children from the service limits. Therefore, providers no longer need to indicate *EPSDT* on the claim form for the limits to be overridden.

If you are providing a medically necessary procedure to a child, and the procedure is not listed in the Montana Medicaid fee schedule, contact the Dental Program Officer for claims processing instructions. (See Key Contacts.)

Other Programs

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

Mental Health Services Plan (MHSP)

The information in this manual does not apply to the Mental Health Services Plan (MHSP). For more information on MHSP, see the mental health manual available on the Provider Information website. (See Key Websites.)

Healthy Montana Kids (HMK)

The information in this chapter does not apply to HMK members. Dental services for children with HMK are covered by the HMK plan of Blue Cross and Blue Shield of Montana (BCBSMT). For more information contact BCBSMT at 800.447.7828 (toll-free) or 406.447.8647. Additional information regarding HMK is available on the HMK website. (See Key Websites.)



Service limits do not apply to individuals up to and including age 20.

Orthodontia Services and Requirements

There are numerous types of congenital craniofacial anomalies, the most common of which is cleft lip and/or palate. In the United States this birth defect affects approximately one in 450 newborns each year. Approximately one-half of these infants have associated malformations, either major or minor, occurring in conjunction with the cleft.

The health and well being of these children is dependent upon the clinical expertise of those who serve them. The American Cleft Palate/Craniofacial Association has developed a list of fundamental principles regarding the optimal care of members with craniofacial anomalies, regardless of the specific type of disorder. The following are included:

- Management of members with craniofacial anomalies is best provided by an interdisciplinary team of specialists.
- Treatment plans should be developed and implemented on the basis of team recommendations.
- Care should be coordinated by the team but should be provided at the local level whenever possible. However, complex diagnostic and surgical procedures should be restricted to major centers with the appropriate facilities and experienced care providers.
- It is the responsibility of each team to monitor both short-term and long-term outcomes. Thus, longitudinal follow-up of members, including appropriate documentation and record keeping, is essential.

Orthodontia Services and Limitations

Medicaid and Children's Special Health Services (CSHS) will cover eligible children in need of orthodontic treatment for a medical condition with orthodontia implications. Eligible children will be referred to a regional cleft/craniofacial clinic for orthodontic evaluation. Medicaid eligible children in need of orthodontic treatment due to anomalies (Category A) will participate in the CSHS Clinic program and Medicaid will pay for orthodontic services under the conditions listed below.

Category A Criteria

Orthodontic services needed as part of treatment for a medical condition with orthodontia implications including but not limited to the following conditions:

- Chromosomal syndromes with intact neuro-developmental status*
- Syndromes affecting bone
- Syndromes of abnormal craniofacial contour

- Syndromes with craniosynostosis
- Proportionate short stature syndromes
- Syndromes of teratogenic agents
- Deformations and disruptions syndromes
- Syndromes with contractures
- Branchial arch and oral disorders
- Overgrown syndromes, postnatal onset syndromes
- Hamartoneoplastic syndromes
- Syndromes affecting the central nervous system
- Orofacial clefting syndromes
- Syndromes with unusual dental acral findings
- Syndromes affecting the skin and mucosa
- Syndromes with unusual facies
- Syndromes gingival/periodontal components
- Malocclusion resulting from traumatic injury

*Cromosomal syndromes with a neurological component that precludes optimal outcome must have prior approval by the Cleft/Craniofacial Quality Assurance Panel prior to authorization of payment.
Syndromes of the Head and Neck, Gorlin, Cohen, Jr., Levin Oxford Press, 1990

When a cleft/craniofacial team determines that a member is in Category A, CSHS, through regional clinic coordinators, will assume the role of providing integrated care coordination through referral to local agencies. This will assure quality and continuity of member care and longitudinal follow-up. Each member seen by the team requires comprehensive, interdisciplinary treatment planning to achieve maximum results with efficient use of parent and member time and resources. For specific responsibilities of CSHS and the team related to integrated case management refer to pages 7–9 of *Parameters for Evaluation and Treatment of Clients with Cleft Lip/Palate or Other Craniofacial Anomalies*, an official publication of the American Cleft Palate–Craniofacial Association published in March 1993.



CSHS will not fund orthodontia for children in Category B.

Category B Criteria

Interceptive orthodontic services (Category B) will be funded for Medicaid eligible children only. Category B services are limited to Medicaid eligible children 12 years of age or younger with one or more of the following conditions:

- Posterior crossbite with shift (bilateral)
- Anterior crossbite

Referral

All Medicaid/Children's Special Health Services (CSHS) eligible children (members) needing orthodontic treatment will be referred as follows:

- For those eligible children needing orthodontia that qualify under Category A with a cleft/craniofacial condition, contact CSHS at 406.444.3622 for referral to a regional cleft/craniofacial clinic for evaluation. Complete the Ortho1 form in the Prior Authorization chapter and submit to CSHS. (See Category A Protocol.)
- For those eligible children needing orthodontia who may qualify under Category A with a possible cleft/craniofacial condition or syndrome with orthodontic implications, contact CSHS at 406.444.3622, to request a regional cleft/craniofacial clinic screening.
- For those eligible children that qualify under Category B, complete the Ortho1 form in the Prior Authorization chapter and submit to Claims. (See Key Contacts.) X-rays, molds, and/or photographs must also be included in order to complete the review.
- For those eligible children with malocclusion resulting from traumatic injury complete form Ortho1 (in the Prior Authorization chapter) and submit to Claims. (See Key Contacts.) Evaluation and management by a cleft/craniofacial team is not required.
- For those eligible children that do not meet Category A or B, orthodontia services are not a covered benefit of the Medicaid program or CSHS. For questions regarding noncoverage, contact the Provider Hotline 1.800.480.6823; Member Hotline 1.800.362.8312.

Orthodontia Procedure Limits and Requirements

The codes listed below only include procedures that have a descriptive limitation or requirement. See the ADA CDT practical guide for further details.

Code	Procedure Description	Limitation or Requirement
D8050	Interceptive orthodontic treatment of the primary dentition	The treatment plan form (Ortho 1) required for PA approval is at the end of the Prior Authorization chapter.
D8060	Interceptive orthodontic treatment of the transitional dentition	The treatment plan form (Ortho 1) required for PA approval is at the end of the Prior Authorization chapter.
D8070	Comprehensive orthodontic treatment of the transitional dentition	The treatment plan form (Ortho 1) required for PA approval is at the end of the Prior Authorization chapter.
D8080	Comprehensive orthodontic treatment of the adolescent dentition	The treatment plan form (Ortho 1) required for PA approval is at the end of the Prior Authorization chapter.
D8090	Comprehensive orthodontic treatment of the adult dentition	The treatment plan form (Ortho 1) required for PA approval is at the end of the Prior Authorization chapter.
D8670	Periodic orthodontic treatment visit (as part of contract)	The treatment plan form (Ortho 1) required for PA approval is at the end of the Prior Authorization chapter.
D8680	Orthodontic retention	The treatment plan form (Ortho 1) required for PA approval is at the end of the Prior Authorization chapter.

Category A Protocol

1. All Medicaid/Children's Special Health Service (CSHS) members must be followed by a cleft/craniofacial team according to the team's recommended schedule. The composition of team members staffing the clinic will be determined by CSHS.
2. All eligible members must have a current treatment plan (Ortho 1 form in the Prior Authorization chapter) completed for authorization of care by the treating orthodontist.
3. The plan will include the following information: Documentation of oral hygiene status, recommended phases of treatment, appliances or therapies, if applicable, at each phase and the estimated time and cost of each phase.
4. The treatment plan will be updated when a member completes a phase of treatment prior to authorization of payment for the next phase of treatment.
5. Members included within Category A requiring orthodontic treatment, as determined by the team, will be referred to a board-certified or board-eligible orthodontist for orthodontic treatment. Some phases of treatment may be completed by a pediatric dentist when appropriate, until a child reaches age 10, and as part of the approved orthodontic plan.
6. CSHS will review the treatment plan for each member, and complete the following:
 - Review of initial and updated plans for orthodontic treatment. If questions arise after consultation with the provider, a member of the quality assurance panel for CSHS cleft/craniofacial teams will review the plan.
 - Review requests of providers for changes in treatment plan and reimbursement due to unforeseen treatment complications. Deviation from the contract regarding cost or length of treatment phases after consultation with the providers will be referred to a member of the CSHS cleft/craniofacial quality assurance panel.
 - Authorization of orthodontia treatment
7. Completed treatment plans will be submitted to: CSHS, 1400 Broadway, P.O. Box 202951, Helena, MT 59620.
8. Medicaid members, who are currently receiving orthodontic treatment or have authorization for treatment prior to the effective date of the protocol, will **not** be included in this plan unless agreed to by Medicaid and CSHS.

9. Treatment plans submitted to CSHS for Non-Category A Medicaid-eligible children will be forwarded to the Medicaid dental/orthodontia program for review by Medicaid orthodontia consultant for determination of qualifying for interceptive orthodontia services under Category B.
10. This protocol will be reviewed and revised upon agreement between CSHS and Medicaid.

Category B Protocol

1. All Medicaid members must have a treatment plan (Ortho1 form in the Prior Authorization chapter) completed and submitted to the Claims Processing Unit. (See Key Contacts.) Prior authorization must include the following:
 - Documentation of oral hygiene status
 - Appliances or therapies
 - Number of treatment months requested
 - The estimated time and cost of the service
 - X-rays, molds, and/or photographs must also be included to allow prior authorization determination completion.
2. Members included within Category B requiring interceptive orthodontic treatment as determined by the Department's designated peer reviewer, may be treated by a licensed dentist.
3. Any deviation from the treatment plan as initially submitted regarding cost or length of time will be referred to the department's designated peer reviewer for further review.
4. Montana Medicaid will pay per procedure code based on the fee-for-service schedule. This reimbursement includes the appliance, follow-up visits, and removal of the appliance.

General Considerations

- There is a fee cap of \$7,000 for orthodontic treatment.
- Payment for orthodontic services will not be authorized without documentation of oral hygiene and dental health status. (See treatment plan for criteria.)
- Reimbursement will be based on the current fee-for-service schedule.
- Providers should be aware that in the event a member is no longer eligible for Medicaid/CSHS, the parent or guardian assumes responsibility for the remainder of the balance.

Noncovered Services

Cosmetic orthodontics is **not** a benefit of the Medicaid program.

Other Programs

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

Mental Health Services Plan (MHSP)

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

Healthy Montana Kids (HMK)

The information in this chapter does not apply to HMK members. Dental services for children with HMK coverage are covered by the HMK plan of Blue Cross and Blue Shield of Montana (BCBSMT). For more information contact BCBSMT at 800.447.7828 (toll-free) or 406.447.8647. Additional information regarding HMK is available on the HMK website. (See Key Contacts.)

Passport to Health Program

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

Passport to Health is the managed care program for Montana Medicaid and Healthy Montana Kids (HMK) *Plus* members. The four Passport programs encourage and support Medicaid and HMK *Plus* members and providers in establishing a medical home and in ensuring the appropriate use of Medicaid and HMK *Plus* services:

- Passport to Health Primary Care Case Management
- Team Care
- Nurse First Advice Line
- Health Improvement Program

Medicaid and HMK *Plus* members who are eligible for Passport must enroll in the program (about 70% of Montana Medicaid and HMK *Plus* members are eligible). Each enrollee has a designated Passport provider who is typically a physician, midlevel practitioner, or primary care clinic.

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

The Passport provider provides primary care case management (PCCM) services to their members. This means he/she provides or coordinates the member's care and makes referrals to other Montana Medicaid and HMK *Plus* providers when necessary. Under Passport, Medicaid, and HMK *Plus* members choose one primary care provider (PCP) and develop an ongoing relationship that provides a medical home. The medical home is a concept that encourages a strong doctor–patient relationship. An effective medical home is accessible, continuous, comprehensive, coordinated, and operates within the context of family and community.

With some exceptions (see Services That Do Not Require Passport Provider Approval in this chapter), all services to Passport members must be provided or approved by the member's Passport provider or Medicaid/HMK *Plus* will not reimburse for those services. The member's Passport provider is also referred to as the PCP.

Team Care (ARM 37.86.5303)

Team Care is designed to educate members to effectively access medical care. Members with a history of using services at an amount or frequency that is not medically necessary are enrolled in Team Care. Members enrolled in Team Care are also enrolled in Passport. Team Care follows the same Passport rules and guidelines for referrals, enrollment/disenrollment, prior authorization, and

! Different codes are issued for Passport approval and prior authorization, and both must be recorded on the CMS-1500 claim form, if appropriate.

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

billing processes. However, while Passport members can change providers without cause, as often as once a month, Team Care members are locked in to one provider and one pharmacy. Providers are encouraged to make a referral to the Team Care Program Officer if they feel one of their members is appropriate for the program. A Passport provider receives an enhanced case management fee of \$6 per member per month for Team Care members. When checking Medicaid or HMK *Plus* eligibility on the MATH web portal, a Team Care member's provider and pharmacy will be listed. Write all Medicaid and HMK *Plus* prescriptions to the designated pharmacy.

Nurse First Advice Line

The Nurse First Advice Line at 1-800-330-7847 is a 24/7, toll-free, and confidential nurse triage line staffed by licensed registered nurses and is available to all Montana Medicaid, HMK, and HMK *Plus* members. There is no charge to members or providers. Members are encouraged to use the Nurse First Advice Line as their first resource when they are sick or hurt. Registered nurses are available 24/7 to triage members over the phone and recommend appropriate care. Health coaches are also available to answer general health or medication questions. Nurses do not diagnose or provide treatment. The Nurse First Advice Line will fax a triage report to the Passport PCP when one of their members calls to be triaged.

Passport providers are encouraged to provide education to their members regarding the appropriate use of the emergency department (ED), including using the Nurse First Advice Line before going to the ED.

Health Improvement Program (ARM 37.86.5201–5206)

The Health Improvement Program (HIP) is for Medicaid and HMK *Plus* members with chronic illnesses or risks of developing serious health conditions. HIP is operated statewide through a regional network of 14 community and tribal health centers. Medicaid and HMK *Plus* members eligible for the Passport program are enrolled and assigned to a health center for case management. Current Passport members stay with their PCPs for primary care, but are eligible for case management services through HIP. Nurses and health coaches certified in professional chronic care will conduct health assessments; work with PCPs to develop care plans; educate members in self-management and prevention; provide pre- and post-hospital discharge planning; help with local resources; and remind members about scheduling needed screening and medical visits.

Medicaid uses predictive modeling software to identify chronically ill members. This software uses medical claims, pharmacy and demographic information to generate a risk score for each member. Although the software will provide a great deal of information for interventions, it will not identify members who have not received a diagnosis or generated claims. PCPs may also identify and recommend Passport members at high risk for chronic health

conditions that would benefit from case management from HIP using the [HIP referral form](#) included at the Health Improvement Program link on the Provider Information [website](#).

In practice, providers will most often encounter Medicaid and HMK *Plus* members who are enrolled in Passport. Specific services may also require prior authorization (PA) even if the member is a Passport enrollee. Specific PA requirements can be found in the provider fee schedules.

Role of the Passport Provider

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

Providing Passport Referral and Authorization

- Before referring a Passport member to another provider, verify that the provider accepts Medicaid.
- When referring a member to another provider, give that provider your Passport number.
- All referrals must be documented in the member's medical record or a telephone log. Documentation should not be submitted with the claim.
- Passport approval may be for a one-time visit, a time-specific period, or the duration of an illness or pregnancy, as determined by the Passport provider.

See the Passport Referral and Approval section on the next page for details.

Member Disenrollment

A provider can ask to disenroll a Passport member for any reason including:

- The provider-member relationship is mutually unacceptable.
- The member fails to follow prescribed treatment (unless this lack of compliance is a symptom of the medical condition).
- The member is abusive.
- The member could be better treated by a different type of provider, and a referral process is not feasible.

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

Termination of Passport Agreement

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

Utilization Review

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

Caseload Limits

Passport providers may serve as few as one or as many as 1,000 Medicaid members. Group practices and clinics may serve up to 1,000 members for each full-time equivalent provider.

Member Eligibility Verification

Member eligibility verification will indicate whether the member is enrolled in Passport. The member's Passport provider and phone number are also available, and whether the member has Full or Basic Medicaid coverage. To check a member's eligibility, go to the MATH web portal. (See Key Websites.) Other methods of checking member eligibility can be found in the Member Eligibility and Responsibilities chapter of the *General Information for Providers* manual.

Medicaid Services – Provider Requirements

To be covered by Medicaid, all services must be provided in accordance with the requirements listed in the Provider Requirements chapter of this manual and in the Covered Services chapter of this manual. PA and Team Care requirements must also be followed.

Passport Referral and Approval (ARM 37.86.5110)

If a member is enrolled in Passport, most services must be provided or approved by the member's Passport provider. While Passport referral and approval is needed for most medically-necessary services that the member's Passport provider does not provide there are some exceptions. (See Services That Do Not Require Passport Provider Approval below.)

Making a Referral

Referrals can be made to any other provider who accepts Montana Medicaid. Referrals can be verbal or in writing, and must be accompanied by the Passport provider's Passport approval number. Passport providers are required to document Passport referrals in the member's records or in a log book. Documentation should not be submitted with the claim. The Passport provider establishes the parameters of referrals, which may be for a one-time visit, a time-specific period, or the duration of an illness or pregnancy. An optional referral form is available at the Passport link on the Provider Information website. (See Key Websites.)

Receiving a Referral as the Non-PCP

The member's Passport provider must be contacted for approval for each visit unless another time parameter was established. It is best to get Passport approval in advance, in writing, and specific to services and dates. Using another provider's Passport number without approval is considered fraud. If a provider accepts a member as a Medicaid member and provides a service that requires Passport provider approval without the member's Passport provider's approval, Medicaid will deny the claim. If a provider tries unsuccessfully to get approval from the PCP, the provider cannot bill the member. The provider can bill the member if the member agreed to pay privately before services were rendered (ARM 37.85.406).

For details on when providers can bill Medicaid members, see the Billing Procedures chapter in the Medicaid billing manual for your provider type.

If a Passport provider refers a member to you, do not refer that member to someone else without the Passport provider's approval, or Medicaid will not cover the service.

Passport Approval and Prior Authorization (PA)

Passport approval and PA are different, and both may be required for a service. PA refers to a list of services that require prior authorization through a Department contractor, Mountain-Pacific Quality Health. See the *Passport to Health Provider Handbook* for more information on Passport.

Services That Do Not Require Passport Provider Approval (ARM 37.86.5110)

- Ambulance
- Anesthesiology
- Audiology
- Blood lead testing
- Dental
- Dialysis
- Durable medical equipment
- Emergency department
- Eye exams and eyeglasses
- Family planning
- Hearing exams and aids
- Home- and community-based services
- Home infusion therapy
- Hospice
- Hospital swing bed
- Immunizations
- Intermediate care facilities for the mentally retarded
- Laboratory tests
- Licensed clinical counseling
- Mental health case management
- Mental health services
- Nursing facilities
- Obstetrics

- Optometrists and ophthalmologists
- Personal assistance services in a member's home
- Pharmacy
- Podiatry
- Psychologists
- Residential treatment centers
- Social workers (licensed)
- Substance dependency treatment
- Targeted case management
- Therapeutic family care
- Transportation (commercial and specialized non-emergency)
- X-rays

Passport and Emergency Services (37.86.5110)

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

- **Emergency services provided in the ED.** Passport provider approval is not required for emergency services. Emergency medical services are those services required to treat and stabilize an emergency medical condition. Non-emergencies in the ED will not be reimbursed, except for the screening and evaluation fee and any appropriate imaging and diagnostic services that are part of the screening. For more information, see [Emergency Services](#) on the Provider Information website.
- **Post stabilization and Passport.** Services for members admitted through an emergency room (identified by the presence of Revenue Code 45X or 65X on the claim) will be exempt from Passport requirements and from cost share requirements.

Passport and Indian Health Services

Members who are eligible for both Indian Health Service (IHS) and Medicaid may choose IHS or another provider as their Passport provider. Members who are eligible for IHS do not need a referral from their Passport provider to obtain services from IHS. However, if IHS refers the member to a non-IHS provider, the Passport provider must provide the referral.

Complaints and Grievances

Providers may call Provider Relations to report a complaint that something inappropriate has taken place. A grievance is a written complaint and must be addressed to the Passport to Health Program Officer. (See Key Contacts.) See the *Passport to Health Provider Handbook* for a full review of complaints, administrative reviews and fair hearings.

Getting Questions Answered

The Key Contacts list provides important phone numbers and addresses. Provider and member help lines are available to answer almost any Passport or general Medicaid question. Providers may call Provider Relations to discuss any problems or questions regarding your Passport members, or to enroll as a Passport provider. Providers can keep up with changes and updates to the Passport program by reading provider notices, newsletters, and other information at the [Passport to Health](#) link on the Provider Information website. For claims questions, call Provider Relations.

Becoming a Passport Provider (ARM 37.86.5111–5112)

A primary care provider (PCP) can be a physician, primary care clinic, or mid-level practitioner (other than a certified registered nurse anesthetist) who provides primary care case management by agreement with the Department. The Department allows any provider who has primary care within his/her professional scope of practice to be a PCP. The Department does, however, recognize that certain specialties are more likely to practice primary care. The Department actively recruits these providers. Passport providers receive a primary case management fee of \$3.00 a month for each enrollee.

To enroll in Passport, Medicaid providers must complete and sign a Passport provider agreement. The Passport provider agreement and the *Passport to Health Provider Handbook* are available on the Provider Information website (see *Key Websites*). Providers may also call Provider Relations for information on becoming a Passport provider and to get the Passport provider agreement. (See Key Contacts.)

Solo Passport Provider

A solo Passport provider is enrolled in the program as an individual provider with one Passport number. The solo provider is listed as the member's Passport provider. The solo provider is responsible for managing his/her individual Passport caseload. For details on referral documentation, see *Passport Referral and Approval* in this chapter. Case management fees are paid to the individual provider under the solo provider's Passport number in addition to the fee-for-service reimbursement.

Group Passport Provider

A group Passport provider is enrolled in the program as having one or more Medicaid providers practicing with one Passport number. The group name will be listed as the member's Passport provider and could be a private group clinic, rural health clinic, federally qualified health center, or Indian Health Service (IHS). All participating providers sign the Passport agreement group signature page and are responsible for managing the caseload. As a group provider, members may visit any provider within the group practice without a Passport referral. Case management fees are paid as a group under the group Passport number in addition to the fee-for-service reimbursement.

Passport Tips

- View the member's Medicaid eligibility verification at each visit by going to the MATH web portal or by using one of the other methods described in the Member Eligibility and Responsibilities chapter of the *General Information for Providers* manual.
- Do not bill for case management fees; they are paid automatically to the provider each month.
- If you are not your member's Passport PCP, include the Passport PCP's Passport approval number on the claim, or it will be denied.
- The same cost sharing, service limits, and provider payment rules apply to Passport and non-Passport Medicaid members and services.
- For claims questions, refer to the Billing Procedures chapter in this manual, or call Provider Relations. (See Key Contacts.)

Other Programs

Members who are enrolled in the Mental Health Services Plan (MHSP) or Healthy Montana Kids (HMK) are not enrolled in Passport, so the Passport requirements in this chapter do not apply. However, prior authorization may be required for certain services. Refer to the mental health manual.

For more information contact Blue Cross and Blue Shield of Montana (BCBSMT) at 800.447.7828 (toll-free) or 406.447.8647. Additional HMK information is available on the HMK website. (See Key Websites.)

Prior Authorization

Prior authorization (PA) is another example of the Department's efforts to ensure the appropriate use of Medicaid services. This program also has specific requirements.

PA refers to a list of services that require Department authorization before they are performed. If a service requires PA, the requirement exists for all Medicaid members. When PA is granted, the provider is issued a PA number that must be on the claim.

Some services require both Passport approval and PA. A different code is issued for each type of approval, and if both are required for a service, both must be included on the claim form. (See the Submitting a Claim chapter in this manual.)

In practice, providers will most often encounter members who are enrolled in Passport. Specific services may also require prior authorization regardless of whether the member is a Passport enrollee. For example, if a Passport member comes to a plastic surgeon requesting a cosmetic procedure, then Passport approval is required from the Passport provider and PA is required. Refer to the fee schedules for PA requirements. Refer to the Passport chapter for information on Passport approval.

When Do I Need Prior Authorization?

Some services require PA before providing the service. The current Montana Medicaid fee schedule indicates which services require PA. See the Provider Information website provider type page.

- In certain circumstances, procedures that exceed limits or requirements may be covered if PA is granted. See Covered Services for procedure limits and requirements.
- PA is required for **all** orthodontic treatment. Prior to rendering services, providers must contact Provider Relations to determine whether procedure limits will be exceeded.

When seeking PA, keep in mind the following:

- The referring provider should initiate all authorization requests.
- Refer to the current Medicaid fee schedule to verify if PA is required for specific services.
- Have all required documentation included in the packet before submitting a request for PA.
- When PA is granted, providers will receive notification containing a PA number. This PA number must be included on the claim.



All PA requests not on the proper form will be returned to the provider.

Medical Necessity

The designated review organization conducts utilization and peer review of dental and denturist services. Medicaid payments are not available for dental and denturist services unless the services are considered medically necessary.

How Do I Get Prior Authorization?

The Dental Services Prior Authorization Request (MA-4PA) form is required for all PA requests. For PA on orthodontia procedures, complete both the MA-4PA and the HMK Coverage Group/CSHS Orthodontia Treatment Plan. (See Appendix A). See page 5.4 for a sample of a completed MA-4PA form. For further instructions on completing the Medicaid/Special Health Services Orthodontia Treatment Plan form, see the Orthodontia Services and Requirements chapter. Providers need to:

1. Download the MA-4PA (and the HMK Coverage Group/CSHS Orthodontia Treatment Plan if requesting orthodontia PA) from the Provider Information [website](#) and complete the required information.
 - Use the appropriate form for the procedure code to request authorization.
 - Do not list services that do not require PA on the prior authorization form.
2. Photocopy the completed form to keep for the member's file.
3. Mail, **do not fax**, the completed form to Provider Relations. Do **not** send a claim form with the PA request.

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

Do **not** send prior authorization requests on the ADA claim form with the pre-treatment estimate box checked. Use the Dental Services Prior Authorization Request (MA-4PA) or HMK Coverage Group/CSHS Orthodontia Treatment Plan (Ortho 1) form to ensure your requests are processed quickly.

The dental consultant reviews PA requests for medical necessity. The provider will then receive a prior authorization notice with approval or denial. The notification contains a 10-digit PA number and details on the approved and denied services. The original PA requests are not returned to the provider. PA notices are generated twice weekly.

How Do I Bill a Prior Authorized Procedure?

- The PA number is specific to each prior authorization request, and must be entered in field 2 of the ADA 2006 claim form as proof of authorization.
- There is no need to attach a paper copy of the prior authorization to the claim. Many providers have found that highlighting this number or writing it in red on

the claim form helps claims processing personnel easily spot this number when processing the claim.

- X-rays or models must be labeled with the member's name and Medicaid number and the provider's name or NPI to ensure proper return.
- If more than one PA number has been assigned to a member because of multiple PA requests, the services must be billed separately. Only one PA number can be reported on a claim form.
- Authorization for a procedure code may be denied when the dental consultant determines the code to be an inappropriate description of services requested. The PA notification will reflect the denial of the original code and approval for the more appropriate code.

Other Programs

Prior authorization may be required for certain services for members who are enrolled in the Mental Health Services Plan (MHSP) or Healthy Montana Kids (HMK)/(CHIP). Refer to the mental health manual.

For more information contact Blue Cross and Blue Shield of Montana (BCBSMT) at 800.447.7828 (toll-free) or 406.447.8647. Additional HMK information is available on the HMK website. (See Key Websites.)

DENTAL SERVICE PRIOR AUTHORIZATION REQUEST

STATE OF MONTANA - SOCIAL and REHABILITATION SERVICES

FOR USE BY DENTISTS/DENTURISTS

PLEASE TYPE OR PRINT

FORM NO. MA-4PA

1 NAME & ADDRESS OF PROVIDER OF SERVICES U. B. Smiling, DDS 100 Main Anytown, MT 59000	NPI 1234567890 2	MAIL TO: MONTANA MEDICAID DEPT. MA-4 P.O. BOX 8000 HELENA, MT 59604 TELEPHONE NUMBER 1-800-624-3958	4 5 6 INDIVIDUAL NUMBER 555-55-5555
PATIENT: LAST NAME FIRST MIDDLE INITIAL		DATE OF BIRTH MO. DAY YEAR 11 02 1989	

SURFACE NO.	TOOTH NUMBER	PROCEDURE NUMBER	DESCRIPTION OF SERVICE	EXPECTED DATE OF SERVICE	NO. SVCS.	CHARGES	APPROVAL	
							YES	NO
1		D8080	Complete orthodontic treatment of the	09-12-01		\$2,400		
2		D8670	contract	09-12-01	30	\$2,100		
3								
4								
5								
6								
7								
8								

	REASON FOR REQUESTED PROSTHESIS/SIGNS AND SYMPTOMS 14 Class 1 6s #10 crossbite	PROSTHESIS (COMPLETE ONLY IF BEING REQUESTED) DATE INSERTION OF LAST PROSTHESIS MO. DAY YEAR TYPE OF LAST PROSTHESIS 15 16 DATE OF LAST EXTRACTION MO. DAY YEAR TYPE OF PROSTHESIS REQUESTED 17 18 IS THIS A NEW PATIENT? <input type="checkbox"/> YES PLACE OF SERVICE IF OTHER THAN OFFICE If it is a new patient, please complete this prescription block with the dentist Rx Patient Name 19 Signature of Prescribing Dentist Date
--	--	---

CHARTING SYMBOLS ■ SURFACES TO BE FILLED / TEETH TO BE EXTRACTED x MISSING TEETH	ABBREVIATIONS 1-MESIAL 2-DISTAL 3-OCCLUSAL 4-LINGUAL 5-INCISAL 6-FACIAL A-AMALGAM S-SILICATE P-PLASTIC C-CROWN G-GOLD	Authorization approves the medical necessity of the requested service only. It does not guarantee payment, nor does it guarantee that the amount billed will be the amount reimbursed. The recipient must be Medicaid Eligible on the date of service or date the prosthesis is received by the recipient. Authorization is valid for 180 days from the date of approval, if the patient is eligible on the date the services are rendered.
---	---	---

FOR ORTHODONTIA REQUESTS ONLY: TO BE COMPLETED BY REQUESTING DENTIST NUMBER OF MONTHS OF SERVICE REQUESTED ESTIMATED START DATE OF TREATMENT	CONSULTANT'S COMMENTS: 04-01-01 DATE: ___/___/___	ORTHODONTIA APPROVAL MONTHLY ADJUSTMENT _____ MONTHS APPROVED RETAINER SERVICE _____ MONTHS APPROVED OTHER _____
--	---	---

SIGNATURE OF PROVIDER REQUESTING AUTHORIZATION DATE: ___/___/___	APPROVED BY DATE: ___/___/___
---	----------------------------------

NOTE: This form will not be returned to you. You will receive notification through the PA notification.

20

21

Prior Authorization Guide		
Field	Title	Instructions
1	Name and Address of Provider of Services	Enter the provider's name and address.
2	NPI	Enter the National Provider Identifier.
3	Patient Last, First Name, Middle Initial	Enter the member's last name, first name, and middle initial.
4	Sex	Enter the member's gender.
5	Date of Birth	Enter the member's date of birth in MMDDYYYY form.
6	Individual Number	Enter the member's 9-digit ID number.
7	Surface Number	Enter the surface number, when applicable.
8	Tooth Number	Enter the tooth number, when applicable.
9	Procedure Number	Enter the service procedure code.
10	Description of Service	Describe the service requiring prior authorization.
11	Expected Date of Service	Enter the date the service is scheduled to be performed, or the beginning and ending dates of the treatment plan.
12	Number of Services	Enter the number of services or treatments.
13	Charges	Enter the charges for the services or treatments.
14	Reason for Requested Prosthesis/ Signs and Symptoms	Describe the member's symptoms requiring treatment.
15	Date insertion of Last Prosthesis	Enter the date the last prosthesis was inserted when applicable.
16	Type of Last Prosthesis	Enter the type of prosthesis.
17	Date of Last Extraction	Enter the date prosthesis was extracted.
18	Type of Prosthesis Requested	Enter the type of prosthesis requested.
19	Patient Name, Signature of Prescribing Dentist, and Date	If the member chooses to obtain services from a denturist, the prescribing dentist must complete this section.
20	Signature of Provider Requesting Authorization	PA request must contain the provider's signature.
21	Date	Enter the signature date.

Coordination of Benefits

When Members Have Other Coverage

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

Identifying Other Sources of Coverage

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

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

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

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

When a Member Has Medicare

Medicare claims are processed and paid differently than claims involving other payers. The other sources of coverage are referred to as TPL, but Medicare is not.

Medicare Part A Crossover Claims

Medicare does not cover routine dental care or most dental procedures such as cleanings, fillings, tooth extractions, or dentures. Medicare does not pay for dental plates or other dental devices. Medicare Part A will pay for certain dental services that members get when they are in the hospital. These

claims automatically cross over from Medicare for dually eligible members, so providers do not need to send in their Part A crossovers on paper. The Department's fiscal agent must have the provider's Medicare number on file to process claims and providers should include their Medicaid number on their Medicare claims.

Medicare will process the claim, submit it to Medicaid, and send the provider an Explanation of Medicare Benefits (EOMB). Providers must check the EOMB for the statement indicating that the claim has been referred to Medicaid for further processing. It is the provider's responsibility to follow up on crossover claims and make sure they are correctly billed to Medicaid within the timely filing limit.

When you receive an Explanation of Medicare Benefits from Medicare stating that your claim has been processed, please wait 45 days for that claim to cross over from Medicare to Medicaid before submitting that claim to Medicaid. This allows time for the claim to cross over and be processed through our system. If your claim is submitted to Medicaid prior to the 45-day limit, it will be returned to you as soon as it is received.

When Medicare Pays or Denies a Service

- When Medicare automatic crossover claims are paid or denied, they should automatically cross over to Medicaid for processing, so the provider does not need to submit the claim to Medicaid. If Medicare denies a claim because the service was not medically necessary, Medicaid will also deny the claim.
- When Medicare crossover claims are billed on paper and are paid or denied, the provider must submit the claim to Medicaid with the Medicare EOMB (and the explanation of denial codes).

When Medicaid Does Not Respond to Crossover Claims

When Medicaid does not respond within 45 days of the provider receiving the Medicare EOMB, submit a claim and a copy of the Medicare EOMB to Medicaid for processing. When Medicaid is a secondary payor to Medicare and Medicare has paid the claim but not crossed it over to Medicaid, you must submit Medicare's payment in box 29 of the CMS-1500 form. When Medicare has denied the service, you must attach the denial along with any explanation of denial codes to the claim.

Submitting Medicare claims to Medicaid

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

When a Member Has TPL (ARM 37.85.407)

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

When another payer is involved, Medicaid cannot process dental claims without being accompanied by either a denial or statement indicating the payment from the relevant third party payer.

Providers are required to notify their members that any funds the member receives from third party payers equal to what Medicaid paid (when the services were billed to Medicaid) must be turned over to the Department. Amounts in excess of what Medicaid paid must be returned to the provider. The following words printed on the member's statement will fulfill this requirement: *When services are covered by Medicaid and another source, any payment the member receives from the other source must be turned over to Medicaid.*

Exceptions to Billing Third Party First

In a few cases, providers may bill Medicaid first.

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

- If another insurance has been billed, and 90 days have passed with no response, attach a note to the claim explaining that the insurance company has been billed, or attach a copy of the letter sent to the insurance company. Include the date the claim was submitted to the insurance company and certification that there has been no response.
- When the provider has billed the third party insurance and has received a non-specific denial (e.g., no member name, date of service, amount billed), submit the claim with a copy of the denial and a letter of explanation directly to Medicaid in order to avoid missing the timely filing deadline.

- When the child support enforcement division has required an absent parent to have insurance on a child, the claim can be submitted to Medicaid when the following requirements are met:
 - The third party carrier has been billed, and 30 days or more have passed since the date of service.
 - The claim is accompanied by a certification that the claim was billed to the third party carrier, and payment or denial has not been received.

When the Third Party Pays or Denies a Service

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

- Pays the claim, indicate the amount paid in the amount paid field of the claim when submitting to Medicaid for processing. These claims may be submitted either electronically or on paper.
- Allows the claim, and the allowed amount went toward the member's deductible, include the insurance Reason and Remarks (formerly EOB) when billing Medicaid. With HIPAA implementation, these claims may be submitted on paper or electronically with the paper attachment mailed in separately. A paper attachment cover sheet is available on the Provider Information website. (See Key Contacts.) Until HIPAA implementation, continue to bill on paper with attachments.
- Denies the claim, include a copy of the denial (including the denial reason codes) with the claim form, and submit to Medicaid on paper.

When the Third Party Does Not Respond

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

- Attach a note to the paper claim explaining that the insurance company has been billed, or attach a copy of the letter sent to the insurance company.
- Include the date the claim was submitted to the insurance company.
- Send this information to the Xerox Third Party Liability Unit. (See Key Contacts.)

When Other Insurance Pays, What Will Medicaid Pay?

There are instances where members have other insurance that pays for dental services at a higher rate than allowed by Medicaid. In these instances, a provider may bill Medicaid and receive a payment from Medicaid equal to \$0.00. This is because the amount paid by the insurance company is more than what Medicaid would have allowed for the same procedure. Medicaid payment for dental services is based on a fee schedule for each procedure code and does not make up the difference between what an insurance company paid and the billed amount by the dental provider. See the following examples.

The dental provider performs the following:

Scenario 1

Procedure Code	Description	Dentist Charge
D0120	Periodic oral examination	\$25.00
D1203	Topical application of fluoride – child	\$50.00
Total for visit		\$75.00

Service covered by TPL & Medicaid - TPL greater than Medicaid on all services.

In this instance, the child has both BCBS and Medicaid. The dentist accepted both insurances. The dental provider received a payment from BCBS totaling \$60.00. The Explanation of Benefits from BCBS shows the following:

Allowed Procedures	Description	Allowed Amount
D0120	Periodic oral examination	\$20.00
D1203	Topical application of fluoride – child	\$40.00
Total allowed for visit by insurance company		\$60.00

The dental provider then bills Medicaid. The provider would receive a payment of \$0.00. As explained below:

Allowed Procedures	Description	Medicaid Allowed Amount	Insurance Allowed Amount
D0120	Periodic oral examination	\$21.89	\$20.00
D1203	Topical application of fluoride – child	\$15.64	\$40.00
Total allowed for visit		\$37.53	\$60.00

In this instance, the dental provider would receive a payment of \$0.00 from Medicaid because the insurance company allowed more for services provided than Medicaid allowed for each service. Because the dental provider accepted this member as a Medicaid member, the difference between the amount allowed by the insurance company and the total amount for services provided cannot be billed to the member. Even though Medicaid paid \$0.00, this is considered payment in full.

Scenario 2

Service covered by TPL & Medicaid - Medicaid greater than TPL on all services

In this instance, the child has both BCBS and Medicaid. The dentist accepted both insurances. The dental provider received a payment from BCBS totaling \$40.00. The explanation of benefits from BCBS shows the following:

Allowed Procedures	Description	Allowed Amount
D0120	Periodic oral examination	\$10.00
D1203	Topical application of fluoride – child	\$20.00
Total allowed for visit by insurance company		\$30.00

The dental provider then bills Medicaid. The provider would receive a payment of \$6.00. As explained below:

Allowed Procedures	Description	Medicaid Allowed Amount	Insurance Allowed Amount
D0120	Periodic oral examination	\$21.89	\$10.00
D1201	Topical application of fluoride – child	\$15.64	\$20.00
Total allowed for visit		\$37.53	\$30.00

In this instance, the dental provider would receive a payment of \$7.53 from Medicaid because Medicaid allowed more for services provided than the insurance allowed for each service. Because the dental provider accepted this member as a Medicaid member, the difference between the amounts allowed by the insurance company, the amount allowed by Medicaid, and the total amount for services provided cannot be billed to the member. Even though Medicaid paid only \$7.53, this is considered payment in full.

Scenario 3

Service covered by TPL & Medicaid - TPL Greater than Medicaid on some services

In this instance, the child has both Blue Cross and Blue Shield and Medicaid. The dentist accepted both insurances. The dental provider received a payment from Blue Cross/Blue Shield totaling \$50.00. The Explanation of Benefits from Blue Cross and Blue Shield shows the following:

Allowed Procedures	Description	Allowed Amount
D0120	Periodic oral examination	\$0.00
D1203	Topical application of fluoride – child	\$50.00
Total allowed for visit		\$50.00

The dental provider then bills Medicaid. The provider would receive a payment of \$16.00. As Explained below:

Allowed Procedures	Description	Medicaid Allowed Amount	Insurance Allowed Amount
D0120	Periodic Oral Examination	\$ 21.89	\$ 0.00
D1203	Topical application of Fluoride – child	\$ 15.64	\$ 50.00
Total allowed for visit		\$ 37.53	\$ 50.00

This example is somewhat more complicated. The insurance company paid \$50.00 for the fluoride treatment but did not allow payment for the oral examination. In this instance, the dental provider should bill only procedure code D0120, Periodic Oral Examination, to Medicaid to receive a payment for \$21.89. This example is different than Example 1. In Example 1, the insurance provider paid more on both procedure codes than would be allowed by Medicaid. In this example, the insurance provider only paid on one procedure code. Even though the total reimbursement amount on one procedure code is greater than allowed by Medicaid for both procedure codes, the provider did not receive any payment from the insurance company for the exam. Therefore, the dentist can bill Medicaid for the oral examination and show a \$0.00 payment from the insurance company. Again, once the provider receives payment from Medicaid, this is considered payment in full for services provided, therefore, the difference between the amount reimbursed by the insurance company and Medicaid cannot be billed to the member.

Billing Procedures

Claim Forms

Services provided by the health care professionals covered in this manual must be billed either electronically or on the 2006 version of the American Dental Association (ADA) claim form. ADA forms are available from the ADA. (See Key Contacts.)

Timely Filing Limits (ARM 37.85.406)

Providers must submit clean claims to Medicaid within:

- 12 months from whichever is later:
 - the date of service
 - the date retroactive Medicaid eligibility or disability is determined

For claims involving Medicare or TPL, if the 12-month time limit has passed, providers must submit clean claims to Medicaid within:

- **Medicare crossover claims:** Six months from the date on the Medicare explanation of benefits (if the Medicare claim was timely filed and the member was eligible for Medicare at the time the Medicare claim was filed).
- **Claims involving other third party payers (excluding Medicare):** Six months from the date on an adjustment notice from a third party payer who has previously processed the claim for the same service, and the adjustment notice is dated after the periods described above.

Clean claims are claims that can be processed without additional information or documentation from or action by the provider. 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

The best method to guard against claim denial for timely filing is to establish and employ strict office procedures for claim follow-up. Follow-up procedures should include these steps:

- Always work the denied claims on the Medicaid remittance advice.
- Correct and resubmit denied claims promptly. (See the Remittance Advices and Adjustments chapter in this manual.)
- Call and ask if you do not understand a denial; **do not continue** to resubmit the same claim with no corrections.



When submitting claims to Medicaid, bill using your usual and customary charges, not the Medicaid reimbursement fee.

- 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.)
- A common reason for exceeding the timely filing limit is waiting for another insurance to pay. If another insurer has been billed and 90 days have passed with no response, you can bill Medicaid. (See the Coordination of Benefits chapter in this manual for more information.)
- To meet timely filing requirements for Medicare/Medicaid crossover claims, see the Coordination of Benefits chapter in this manual.
- Report eligibility problems to the county office as soon as they appear on the remittance advice.
- Submit and/or resubmit only legible claims.

When to Bill Medicaid Members (ARM 37.85.406)

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

More specifically, providers cannot bill members directly:

- For the difference between charges and the amount Medicaid paid.
- For a covered service provided to a Medicaid-enrolled member who was accepted as a Medicaid member by the provider, even if the claim was denied.
- When the provider bills Medicaid for a covered service, and Medicaid denies the claim because of billing errors.
- When a third party payer does not respond.
- When a member fails to arrive for a scheduled appointment. Medicaid may not be billed for no-show appointments.
- When services are free to the member, such as in a public health clinic. Medicaid may not be billed for those services.

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

When to Bill a Medicaid Member (ARM 37.85.406)			
	Member is Medicaid-enrolled and provider accepts as a Medicaid member	Member is Medicaid-enrolled and provider does not accept as a Medicaid member	Member is not Medicaid-enrolled
Service is covered by Medicaid	Provider can bill member only for cost sharing	Provider can bill Medicaid member if the member has signed a routine agreement	Provider can bill member.
Service is not covered by Medicaid	Provider can bill member only if custom agreement has been made between member and provider before providing the service	Provider can bill Medicaid member if the member has signed a routine agreement	Provider can bill member.

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

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

Member Cost Sharing (ARM 37.85.204 and 37.85.402)

Cost sharing fees are a set dollar amount per visit, and they are based on the average Medicaid allowed amount for the provider type and rounded to the nearest dollar. There is no cost sharing cap. Cost sharing for dental services is \$3.00 per date of service.

The following members are exempt from cost sharing:

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

Cost sharing may not be charged for the following services:

- Emergencies (See Definitions.)
- Family planning
- Hospice
- Independent lab and x-ray services
- Personal assistance services
- Home dialysis attendant services
- Home- and community-based waiver services
- Non-emergency medical transportation services
- Eyeglasses purchased by the Medicaid program under a volume purchasing arrangement
- EPSDT services

A provider cannot deny services to a Medicaid member because the member cannot pay cost sharing fees at the time services are rendered. However, the member's inability to pay cost sharing fees when services are rendered does not lessen the member's obligation. If a provider has a policy on collecting delinquent payment from non-Medicaid members, that same policy may be used for Medicaid members.

Billing for Members with Other Insurance

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

Billing for Retroactively Eligible Members

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

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

When the provider accepts the member's retroactive eligibility, the provider has 12 months from the date retroactive eligibility was determined to bill for those services. When submitting claims for retroactively eligible members, attach a copy of the FA-455 (eligibility determination letter) to the claim if the date of service is more than 12 months earlier than the date the claim is submitted. Providers may need to contact the member's local Office of Public Assistance. (See the *General Information for Providers* manual, Appendix C: Local Offices of Public Assistance.)

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

Place of Treatment

Place of treatment must be entered correctly in Field 38.

Coding

Providers are responsible for billing their services correctly. Standard use of medical coding conventions and the rules established by the American Dental Association (ADA) are required when billing Medicaid. Providers should become familiar with these volumes as Medicaid relies on them when setting its coding policies. If providers have questions regarding definition of codes, they may be directed to the ADA. (See Key Contacts.) Provider Relations or the Department cannot suggest specific codes to be used in billing for services. For coding assistance and resources, see the Coding Resources table on the next page. The following suggestions may help reduce coding errors and unnecessary claim denials:

- Use current CPT, HCPCS Level II, and ICD coding books.
- Always read the complete description and guidelines in the coding books. Relying on short descriptions can result in inappropriate billing.
- Attend classes on coding offered by certified coding specialists.
- Use specific codes rather than unlisted codes. For example, do not use 53899 unlisted procedure of the urinary system, when a more specific code is available.
- Bill for the appropriate level of service provided. See your CPT manual for instructions on determining appropriate levels of service.
- CPT codes that are billed based on the amount of time spent with the member must be billed with the code that is closest to the time spent. For example, a provider spends 60 minutes with the member. The code choices are 45 to 50 minutes or 76 to 80 minutes. The provider must bill the code for 45 to 50 minutes.
- Take care to use the correct "units" measurement. In general, Medicaid follows the definitions in the CPT and HCPCS Level II billing manuals. Unless otherwise specified, one unit equals one visit or one procedure. For specific codes, however, one unit may be "each 15 minutes." Always check the long text of the code description published in the CPT or HCPCS Level II coding books.

Coding Resources		
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 member on the same date of service.	National Technical Information Service http://www.ntis.gov/products/cci.aspx (800) 363-2068 (703) 605-6060 (703) 605-6880 (fax) subscriptions@ntis.gov
CPT	<ul style="list-style-type: none"> • CPT codes and definitions • Updated each January 	American Medical Association (800) 621-8335 (800) 262-3211 AMA Members https://commerce.ama-assn.org/store/ or Optum (800) 765-6588 https://www.optumcoding.com/
CPT Assistant	A newsletter on CPT-4 coding issues	American Medical Association (800) 621-8335 (800) 262-3211 AMA Members https://commerce.ama-assn.org/store/
HCPCS Level II	<ul style="list-style-type: none"> • HCPCS Level II codes and definitions • Updated each January and throughout the year 	Available through various publishers and bookstores or from CMS at www.cms.gov
ICD	<ul style="list-style-type: none"> • ICD diagnosis and procedure codes definitions • Updated each October. 	Available through various publishers and bookstores
Miscellaneous Resources	Various newsletters and other coding resources.	Medicode (Ingenix) (800) 765-6588 www.medicode.com or www.ingenixonline.com

Billing Tips for Dental Services

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

Dental services are any services involving a tooth. Dental services are billed using the current CDT procedure codes.

Medical services are those that involve the structure of the mouth (i.e. jaw bone).

Providers may use current CPT procedure codes for all medical services they are allowed to provide under their practice act. CPT procedures that are performed in the dental office may be billed on the ADA claim form. Those services provided outside the dental office must be billed on the CMS-1500 claim form with valid CPT procedure codes and valid ICD diagnosis codes. Providers who frequently bill for medical services should obtain a copy of the *Physician-Related Services* manual for billing instructions. These manuals are available on the Provider Information website. (See *Key Contacts*).

Using Modifiers

- Review the guidelines for using modifiers in the current CPT, HCPCS Level II, or other helpful resources.
- Always read the complete description for each modifier; some modifiers are described in the CPT manual while others are in the HCPCS Level II book.
- The Medicaid claims processing system recognizes only two pricing modifiers and one informational modifier per claim line. Providers are asked to place any modifiers that affect pricing in the first two modifier fields.
- When billing with modifier 50 for bilateral services, put all information on one line with one unit of service. Care should be taken not to designate a procedure as bilateral when the procedure is already identified as a bilateral service in the CPT definition. Modifiers RT and LT should **not** be billed by ambulatory surgical centers.
- When bilateral procedures are performed at the same session on the same patient, the procedure will be paid at 150% of the customary rate.
- For codes defined as bilateral when a unilateral procedure is done, the procedure should be reported with modifier 52.
- Check the fee schedule to see if Medicaid allows the use of the following modifiers for a particular code: bilateral (50), multiple procedures (51), co-surgery (62), assistant at surgery (80, 81, 82, AS), and team surgery (66).
- When multiple procedures are performed at the same session on the same patient, the primary procedure will be paid at 100% of the customary rate. Subsequent procedures will be paid at 50% of the customary rate. Modifiers are to be placed in the first or second slot of field 24d so that the claim will price correctly.
- The following modifiers should be used, as appropriate, for reporting discontinued or reduced procedures:
 - 52—Reduced services: Under certain circumstances, a service or procedure is partially reduced or eliminated at the physician’s discretion. In this case, the procedure should be reported with modifier 52. Documentation should be present in the medical record to explain the circumstances surrounding the reduction in services. This modifier is also used to report

codes defined in CPT as bilateral, when only a unilateral procedure is done. This procedure will be paid at 50% of the customary rate.

- 73—Discontinued ambulatory surgery center (ASC) procedure prior to the administration of anesthesia will be paid at 50% of the customary rate.
- 74—Discontinued ambulatory surgery center (ASC) procedure after administration of anesthesia will be paid at 100% of the customary rate.
- Modifiers 73 and 74 should be reported when, due to extenuating circumstances or those that threaten the well being of the patient the physician terminates a surgical or diagnostic procedure. **Note:** The elective cancellation of a service prior to administration of the anesthesia and/or surgical prep should **not** be reported.
- It should be noted that, in some instances, more than one modifier may be necessary per line. All applicable modifiers must be reported.
- Always bill your main surgical procedure on line 1 of the claim with one unit only. All other subsequent procedures should be billed with the number of units done for each code per line. Do not separate out subsequent procedure codes (e.g., code 11601-51 twice) on separate lines. This will cause exact duplicate line denials. Subsequent procedure modifiers should be used when appropriate (for example, modifiers 51 and 59), except when billing add-on codes and modifier 51 exempt codes.

Submitting a Claim

Paper Claims

Unless otherwise stated, all paper claims must be mailed to:

Claims Processing

P.O. Box 8000

Helena, MT 59604

Electronic Claims

Providers who submit claims electronically experience fewer errors and quicker payment. Claims may be submitted electronically by the following methods:

- **WINASAP 5010.** Xerox makes this free software available. Providers can use it to create and submit claims to Montana Medicaid, MHSP, and HMK/CHIP (dental and eyeglasses only). It does not support submissions to Medicare or other payers. This software creates an 837 transaction, but does not accept an 835 transaction back from the Department.
- **Xerox clearinghouse.** Providers can send claims to the Xerox 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 Xerox 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 Xerox 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 Xerox 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.)

Claim Inquiries

Contact Provider Relations for general claim questions or questions regarding payments, denials, or member eligibility. (See *Key Contacts*.)

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

The Most Common Billing Errors and How to Avoid Them

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

Common Billing Errors

Reasons for Return or Denial	How to Prevent Returned or Denied Claims
Provider NPI number and taxonomy number missing or invalid	The NPI number is a 10-digit number assigned to the provider during Medicaid enrollment. Verify the correct NPI number and taxonomy are on the claim.
Authorized signature missing	Each claim must have an authorized signature belonging to the provider, billing clerk, or office personnel. The signature may be typed, stamped, hand-written, or computer generated.
Signature date missing	Each claim must have a signature date.
Incorrect claim form used	The claim must be the correct form for the provider type. Services covered in this manual require an ADA 2006 claim form.
Information on claim form not legible	Information on the claim form must be legible. Use dark ink and center the information in the field. Information must not be obscured by lines.
Member number not on file, or member was not eligible on date of service	Before providing services to the member, verify member eligibility by using one of the methods described in the Member Eligibility and Responsibilities chapter of the <i>General Information for Providers</i> manual. Medicaid eligibility may change monthly.
Procedure requires PASSPORT provider approval – No Passport approval number on claim	A Passport provider approval number must be on the claim form when such approval is required. Passport approval is different from prior authorization. See the Passport chapter in this manual.
Prior authorization number is missing	Prior authorization (PA) is required for certain services, and the PA number must be on the claim form in Field 2. Prior authorization is different from Passport authorization. See the Prior Authorization chapter in this manual.
Prior authorization does not match current information	Claims must be billed and services performed during the prior authorization span. The claim will be denied if it is not billed according to the spans on the authorization.
Duplicate claim	Please check all remittance advices (RAs) for previously submitted claims before resubmitting. When making changes to previously paid claims, submit an adjustment form rather than a new claim form. (See Remittance Advices and Adjustments in this manual.)
TPL on file and no credit amount on claim	If the member has any other insurance (or Medicare), bill the other carrier before Medicaid. See the Coordination of Benefits chapter in this manual. If the member's TPL coverage has changed, providers must notify the TPL unit before submitting a claim.

Common Billing Errors (Continued)	
Reasons for Return or Denial	How to Prevent Returned or Denied Claims
Claim past 365-day filing limit	<p>The Claims Processing Unit must receive all clean claims and adjustments within the timely filing limits described in this chapter.</p> <p>To ensure timely processing, claims and adjustments must be mailed to Claims Processing at the address shown in Key Contacts.</p>
Missing Medicare EOMB	All denied Medicare crossover claims billed to Medicaid on paper must have an Explanation of Medicare Benefits (EOMB) with denial reason codes attached.
Provider is not eligible during dates of services, enrollment has lapsed due to licensing requirements, or NPI terminated	<p>Out-of-state providers must update licensure for Medicaid enrollment early to avoid denials. If enrollment has lapsed due to expired licensure, claims submitted with a date of service after the expiration date will be denied until the provider updates his or her enrollment.</p> <p>New providers cannot bill for services provided before Medicaid enrollment begins.</p> <p>If a provider is terminated from the Medicaid program, claims submitted with a date of service after the termination date will be denied.</p>
Procedure is not allowed for provider type	<p>Provider is not allowed to perform the service. Verify the procedure code is correct using current HCPCS and CPT billing manual.</p> <p>Check the appropriate Medicaid fee schedule to verify the procedure code is valid for your provider type.</p>

Other Programs

The billing procedures in this chapter apply to those services that are covered under the Mental Health Services Plan (MHSP).

These billing procedures do not apply to Healthy Montana Kids (HMK). The HMK medical manual is available through Blue Cross and Blue Shield of Montana (BCBSMT). For information about medical benefits, contact BCBSMT at 1.406.447.8647 (in Helena) or toll-free 1.800.447.7828.

Submitting a Claim

The services described in this manual are billed either electronically on a professional claim or on the 2006 American Dental Association (ADA) paper claim form. Claims submitted with all of the necessary information are referred to as “clean” and are usually paid in a timely manner. (See the Billing Procedures chapter in this manual.)

Claims are completed differently for the different types of coverage a member has.

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

When completing a claim, remember the following:

- Field 1, EPSDT/Title XIX, is an indicator used to specify additional details for certain members or services. The following are accepted codes:

EPSDT		
Code	Member/Service	Purpose
1	EPSDT	This indicator is used when the member is under age 21 and limited need to be waived, Field 1.

- There are certain mandatory items on each dental claim. These include:
 - Provider NPI and taxonomy
 - Patient Name
 - Patient ID
 - Provider’s Signature
 - Billed Date
- Box 2 is reserved for the prior authorization number.
- If there is more than one unit per code, write in the description box (2 units) and double the fee.
- In Box 27, use tooth numbers 95–99, which describe Supernumerary. Also use Box 27, Tooth Number, to describe per quadrant (LL, UL, LR, UR).
- Use Box 35, Remarks, to note the reason to waive procedure limits (such as disabled, once-in-a-lifetime replacement).
- Box 52A is reserved for the billing dentist taxonomy code preceded by ZZ.
- Box 56A is reserved for the treating dentist’s taxonomy code.



Claims will deny if any of this information is missing.

- The CDT book has an entire chapter devoted to claim form instructions. Refer to this resources for additional claim instructions.
- Unless otherwise stated, all paper claims must be mailed to:
Claims Processing Unit
P.O. Box 8000
Helena, MT 59604

Remittance Advices and Adjustments

Remittance Advice Description

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. Each line of the RA represents all or part of a claim, and explains whether the claim has been paid, denied, or suspended (also referred to as pending). If the claim was suspended or denied, the RA also shows the reason.

RA Notice

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

Paid Claims

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

Denied Claims

This section shows claims denied during the previous cycle. If a claim has been denied, refer to the Reason/Remark Codes column (Field 16). The reason and remark code description explains why the claim was denied and is located at the end of the RA. See *The Most Common Billing Errors and How to Avoid Them* in the Billing Procedures chapter. Make necessary changes to the claim before rebilling Medicaid.

Pending Claims

All claims that have not reached final disposition will appear in this area of the RA. The RA uses "suspended" and "pending" interchangeably. 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. Do not take any action on claims displayed here. Processing will continue until each claim is paid or denied.

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



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

Key Fields on the Remittance Advice

Field	Description
1. Provider name and address	Provider's business name and address as recorded with the Department
2. Provider NPI	The 10-digit number assigned to the provider by Medicaid
3. Remittance advice number	The remittance advice number
4. Warrant number	Not used
5. Date	The date the RA was issued
6. Page Number	The page number of the RA
7. Recipient ID	The member's Medicaid ID number
8. Name	The member'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 style="margin-left: 20px;"> <u>0</u> <u>00111</u> <u>11</u> <u>123</u> <u>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 home turn-around document, or point-of-sale (POS) pharmacy claim) 6 = Pharmacy 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	Date(s) services were provided. If service(s) were performed in a single day, the same date will appear in both columns
11. Unit of service	The units of service rendered under this procedure, NDC code or revenue code.
12. Procedure/revenue/NDC	The procedure code (CPT, HCPCS, or local), National Drug Code (NDC), or revenue code 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	A "Y" indicates cost sharing was deducted from the allowed amount, and an "N" indicates cost sharing was not deducted.
16. Reason/Remark code	A code which explains why the service was denied or pended. Descriptions of these codes are listed at the end of the RA.
17. Deductions, billed amount, and paid amount	Any deductions, such as cost sharing or third party liability are listed first. The amount the provider billed is next, followed by the amount of Medicaid reimbursement.

Claims shown as pending with Reason Code 133 require additional review before a decision to pay or deny is made. If a claim is being held while waiting for member eligibility information, it may be suspended for a maximum of 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.

Credit Balances

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

Credit balances can be resolved in two ways:

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

Rebilling and Adjustments

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

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

- Providers may resubmit or adjust any initial claim within the timely filing limits described in the *Billing Procedures* chapter of this manual.
- These time periods do not apply to overpayments that the provider must refund to the Department. After the 12 month time period, a provider may not refund overpayments to the Department by completing a claim adjustment. The provider may refund overpayments by issuing a check or asking TPL to complete a gross adjustment. (See #2 above.)

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 NPI or authorized signature and date are missing or unreadable. For tips on preventing returned or denied claims, see the Billing Procedures and Submitting a Claim chapters.

When to Rebill Medicaid

- ***Claim Denied.*** Providers can rebill Medicaid when a claim is denied in full, as long as the claim was denied for reasons that can be corrected. When the entire claim is denied, check the reason and remark code, make the appropriate corrections, and resubmit the claim on a CMS-1500 form (not the adjustment form).
- ***Claim Returned.*** Rebill Medicaid when the claim is returned under separate cover. Occasionally, Medicaid is unable to process the claim and will return it to the provider with a letter stating that additional information is needed to process the claim. Correct the information as directed and resubmit your claim.

How to Rebill

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

Adjustments

If a provider believes that a claim has been paid incorrectly, the provider may call Provider Relations or submit a claim inquiry for review. (See the Claim Inquiries section in the Billing Procedures chapter.) Once an incorrect payment has been verified, the provider may submit an Individual Adjustment Request form to Provider Relations. If incorrect payment was the result of a Xerox keying error, contact Provider Relations.

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



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



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

When to Request an Adjustment

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

How to Request an Adjustment

To request an adjustment, use the Individual Adjustment Request form. The requirements for adjusting a claim are as follows:

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

Completing an Adjustment Request Form

1. Download the Individual Adjustment Request form from the Provider Information website. (See Key Websites.) Complete Section A first with provider and member information and the claim's ICN.
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.



Rebill denied claims only after appropriate corrections have been made.



Adjustments can only be made to paid claims.

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. Member name	The member'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	The provider's National Provider Identifier.
5. *Member Medicaid number	Member's Medicaid ID number.
6. Date of payment	Date claim was paid is 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	If a payment error was caused by an incorrect number of units, complete this line.
2. Procedure code/NDC/Revenue code	If the procedure code, NDC, or revenue code is incorrect, complete this line.
3. Dates of service (DOS)	If the date of service is incorrect, complete this line.
4. Billed amount	If the billed amount is incorrect, complete this line.
5. Personal resource (Nursing facility)	If the member's personal resource amount is incorrect, complete this line.
6. Insurance credit amount	If the member's insurance credit amount is incorrect, complete this line.
7. Net (Billed - TPL or Medicare paid)	If the payment error was caused by a missing or incorrect insurance credit, complete this line. Net is billed amount minus the amount third party liability or Medicare paid.
8. Other/Remarks	If none of the above items apply, or if you are unsure what caused the payment error, complete this line.

* Indicates a required field

3. Attach copies of the RA and a corrected claim if necessary.
 - If the original claim was billed electronically, a copy of the RA will suffice.
 - If the RA is electronic, attach a screen print of the RA.
4. Verify the adjustment request has been signed and dated.
5. Send the adjustment request to Claims Processing. (See Key Contacts.)
 - If an original payment was an underpayment by Medicaid, the adjustment will result in the provider receiving the additional payment amount allowed.
 - If an original payment was an overpayment by Medicaid, the adjustment will result in recovery of the overpaid amount through a credit. If the result is a credit balance, it can be worked off or the provider can pay off the balance by check. (See Credit Balances earlier in this chapter.)
 - Any questions regarding claims or adjustments must be directed to Provider Relations. (See Key Contacts.)

Mass Adjustments

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

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

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

Payment and the RA

Providers receive their Medicaid payment and remittance advice weekly. Payment can be via check or electronic funds transfer (EFT). Direct deposit is another name for EFT. **Effective July 1, 2013, providers who have EFT must receive electronic RAs.**

MONTANA DPHHS Health Care Quality Improvement				Sample Adjustment Request	
Montana Health Care Programs Medicaid • Mental Health Services Plan • Healthy Montana Kids Individual Adjustment Request					
Instructions: This form is for providers to correct a claim which has been paid at an incorrect amount or was paid with incorrect information. Complete all the fields in Section A with information about the paid claim from your statement. Complete only the items in Section B which represent the incorrect information that needs changing. For help with this form, refer to the Remittance Advices and Adjustments chapter in your program manual or the General Information for Providers manual, or call Provider Relations at 1.800.624.3958 (Montana and out-of-state providers) or 406.442.1837 (Helena).					
A. Complete all fields using the remittance advice (RA) for information.					
1. Provider Name and Address Community Surgical Center		3. Internal Control Number (ICN) 00204011250000600			
Name 123 Medical Drive		4. NPI/API 1234567			
Street or P.O. Box Anytown, MT 59999		5. Member ID Number 123456789			
City State ZIP		6. Date of Payment 02/15/07			
2. Member Name Jane Doe		7. Amount of Payment \$ 11.49			
B. Complete only the items which need to be corrected.					
Item	Date of Service or Line Number	Information on Statement	Corrected Information		
1. Units of Service	Line 2	2	1		
2. Procedure Code/NDC/Revenue Code					
3. Dates of Service (DOS)	Line 3	02/01/07	01/23/07		
4. Billed Amount					
5. Personal Resource (Nursing Facility)					
6. Insurance Credit Amount					
7. Net (Billed - TPL or Medicare Paid)					
8. Other/Remarks (Be specific.)					
Signature John R. Smith, M.D.		Date 04/15/07			
<small>When the form is complete, attach a copy of the RA and a copy of the corrected claim, and mail to: Claims P.O. Box 8000 Helena, MT 59604</small>					
<small>Updated 03/2013</small>					

Electronic Funds Transfer

With EFT, the Department deposits the funds directly to the provider's bank account. If the scheduled deposit day is a holiday, funds will be available on the next business day. This process does not affect the delivery of the remittance advice that providers currently receive with payments. **Effective July 1, 2013, providers who have EFT must receive electronic RAs.**

To participate in EFT, providers must complete a Direct Deposit Sign-Up Form (Standard Form 1199A). 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, contact Provider Relations or fax information to the number listed under Direct Deposit Arrangements in Key Contacts.

Electronic Remittance Advice

To receive an electronic RA, the provider must complete the Electronic Remittance Advice and Payment Cycle Enrollment Form, have Internet access, and be registered for the Montana Access to Health (MATH) web portal. Providers can access their electronic RA through the MATH web portal by going to the Provider Information [website](#) and selecting Log In to Montana Access to Health. To access the MATH web portal, providers must first complete an EDI Provider Enrollment Form and an EDI Trading Partner Agreement.

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

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



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

Required Forms for EFT and/or Electronic RA			
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. (See Key Websites.) • Provider Relations (See Key Contacts.) 	<ul style="list-style-type: none"> • Provider Relations (See Key Contacts.)
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 Key Websites.) • Provider's bank 	<ul style="list-style-type: none"> • Provider Relations (See Key Contacts.)
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. (See Key Websites.) • EDI Gateway website (See Key Websites.) 	Fax to 406.442.4402.

Other Programs

The information in this chapter applies to ambulatory surgical center services for members who are enrolled in the Mental Health Services Plan (MHSP).

The information in this chapter does not apply to members enrolled in Healthy Montana Kids (HMK). The HMK medical manual is available through Blue Cross and Blue Shield of Montana at 1.800.447.7828.

How Payment Is Calculated

Overview

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

Payment for Dental Services

Payment for dental services shall be limited to the lowest of the provider's usual and customary charge for the service or the Medicaid fee schedule.

Under the Administrative Rules of Montana (ARM 37.86.1005), reimbursement is based on the following:

Reimbursement for services delivered to children and adults is the fee specified in the fee schedule or, if reimbursement is based on the "by report" method, 85% of the provider's usual and customary charge for the service.

Medicaid Payment Is Payment in Full (ARM 37.85.406)

As a condition of participation, providers must accept as payment in full the amount paid by Medicaid for any covered service provided to an eligible member. Providers may not seek any payment from a member in addition to or in lieu of the amount paid by Medicaid, except Medicaid copayment. (See Billing Procedures, When Can I Bill a Medicaid Member section.)

Appendix A: Forms

- **Emergency Dental Services Form**
- **Individual Adjustment Request**
- **Paperwork Attachment Cover Sheet**
- **Dental Services Prior Authorization Request (MA-4PA)**
- **Handicapping Labio-Lingual Deviations Form (HDL Index)**
- **Healthy Montana Kids Coverage Group/
Children's Special Health Services
Orthodontia Treatment Plan**



Emergency Dental Services Form

For Basic Medicaid Adults Age 21 and Over

Member Name _____

Medicaid ID _____ Date of Injury/Infection _____

The above-named person has received emergency dental services. Describe in detail the reason for the emergency dental services and the treatment that was required.

Provider Signature _____ NPI _____ Date _____

Emergency dental services are covered inpatient and outpatient services that are needed to evaluate and stabilize an emergency medical condition. An emergency medical condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe 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 in serious jeopardy, serious impairment to body functions, or serious dysfunction of any bodily organ or part. If the Medicaid professional rendering the medical screening deems an emergency dental condition does exist, stabilization treatment is rendered.

Emergency Dental Codes for Adults on Basic Medicaid

D0140	D0273	D2161	D3346	D7270	D9420
D0220	D0274	D2330	D7140	D7510	D9612
D0230	D0275	D2331	D7210	D7520	D9920
D0240	D0277	D2332	D7220	D7910	
D0250	D0330	D2335	D7230	D9110	
D0260	D2140	D2940	D7240	D9241	
D0270	D2150	D3310	D7241	D9242	
D0272	D2160	D3331	D7250	D9248	

All other program limits still apply. RHCs and FQHCs will continue to bill revenue code 512 for these services. Routine restorative or preventive treatments are specifically excluded from any emergency dental services.

Document any delay between date of diagnosis and date of treatment. This timeframe must be within 30 days of initial date of exam. A copy of this form must be attached to the dental claim. Providers should retain the original copy in their files. Send a copy of the form and your claims to:

Xerox State Healthcare, LLC
 Claims Processing Unit
 P.O. Box 8000
 Helena, Montana 59604



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

Instructions:

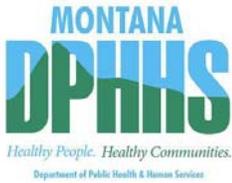
This form is for providers to correct a claim which has been **paid** at an incorrect amount or was **paid** with incorrect information. Complete all the fields in Section A with information about the paid claim from your statement. Complete **only** the items in Section B which represent the incorrect information that needs changing. For help with this form, refer to the Remittance Advices and Adjustments chapter in your program manual or the *General Information for Providers* manual, or call Provider Relations at 1.800.624.3958 (Montana and out-of-state providers) or 406.442.1837 (Helena).

A. Complete all fields using the remittance advice (RA) for information.			
1. Provider Name and Address _____ Name _____ Street or P.O. Box _____ City State ZIP	3. Internal Control Number (ICN) _____ 4. NPI/API _____ 5. Member ID Number _____ 6. Date of Payment _____ 7. Amount of Payment \$ _____		
2. Member Name _____			

B. Complete only the items which need to be corrected.			
Item	Date of Service or Line Number	Information on Statement	Corrected Information
1. Units of Service			
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, and mail to:
 Claims
 P.O. Box 8000
 Helena, MT 59604



Paperwork Attachment Cover Sheet

Paperwork Attachment Control Number _____

Date of Service _____

Billing NPI/API _____

Member ID Number _____

Type of Attachment _____

Instructions

This form is used as a cover sheet for attachments to electronic and paper Montana Health Care Programs (Medicaid; Mental Health Services Plan; Healthy Montana Kids; Indian Health Services Program) claims sent to the address below.

The Paperwork Attachment Control Number must be the same number as the Attachment Control Number on the corresponding electronic claim. This number consists of the provider's NPI/API, the member's ID number and the date of service (mmddyyyy), each separated by a dash (NPI: 9999999999-9999999999-99999999/Atypical Provider ID: 9999999-9999999999-99999999).

This form may be copied or downloaded from the Provider Information website (<http://medicaidprovider.hhs.mt.gov/>).

If you have questions about paper attachments that are necessary for a claim to process, call Provider Relations at 1.800.624.3958 or 406.442.1837.

Completed forms can be mailed or faxed to: P.O. Box 8000
Helena, MT 59604
Fax: 1.406.442.4402

DENTAL SERVICE PRIOR AUTHORIZATION REQUEST

STATE OF MONTANA - SOCIAL and REHABILITATION SERVICES

FOR USE BY DENTISTS/DENTURISTS

PLEASE TYPE OR PRINT

FORM NO. MA-4PA

NAME & ADDRESS OF PROVIDER OF SERVICES		NPI	MAIL TO: MONTANA MEDICAID DEPT. MA-4 P.O. BOX 8000 HELENA, MT 59604 TELEPHONE NUMBER 1-800-624-3958		
PATIENT: LAST NAME		FIRST	MIDDLE INITIAL	DATE OF BIRTH MO. DAY YEAR	INDIVIDUAL NUMBER
		<input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> F <input type="checkbox"/> X			

SURFACE NO.	TOOTH NUMBER	PROCEDURE NUMBER	DESCRIPTION OF SERVICE	EXPECTED DATE OF SERVICE	NO. SVCS.	CHARGES	APPROVAL	
							YES	NO
1								
2								
3								
4								
5								
6								
7								
8								

	REASON FOR REQUESTED PROSTHESIS/SIGNS AND SYMPTOMS	PROSTHESIS (COMPLETE ONLY IF BEING REQUESTED)	
		DATE INSERTION OF LAST PROSTHESIS MO. DAY YEAR	TYPE OF LAST PROSTHESIS
		DATE OF LAST EXTRACTION MO. DAY YEAR	TYPE OF PROSTHESIS REQUESTED
	IS THIS A NEW PATIENT? <input type="checkbox"/> YES	PLACE OF SERVICE IF OTHER THAN OFFICE _____	
<p>If the patient chooses to use a dentist, please complete this prescription block and give the form to the patient. The patient will take the form to the dentist who will complete the rest of it and submit it for approval.</p>			
R ^x Patient Name _____		Signature of Prescribing Dentist _____ Date _____	

CHARTING SYMBOLS	ABBREVIATIONS
■ SURFACES TO BE FILLED / TEETH TO BE EXTRACTED x MISSING TEETH	1 - MESIAL 2 - DISTAL 3 - OCCLUSAL 4 - LINGUAL 5 - INCISAL 6 - FACIAL A - AMALGAM S - SILICATE P - PLASTIC C - CROWN G - GOLD

Authorization approves the medical necessity of the requested service only. It does not guarantee payment, nor does it guarantee that the amount billed will be the amount reimbursed. The recipient must be Medicaid Eligible on the date of service or date the prosthesis is received by the recipient. Authorization is valid for 180 days from the date of approval, if the patient is eligible on the date the services are rendered.

FOR ORTHODONTIA REQUESTS ONLY; TO BE COMPLETED BY REQUESTING DENTIST NUMBER OF MONTHS OF SERVICE REQUESTED _____ ESTIMATED START DATE OF TREATMENT _____	CONSULTANT'S COMMENTS: _____ _____ _____ DATE: ____/____/____	ORTHODONTIA APPROVAL MONTHLY ADJUSTMENT _____ MONTHS APPROVED RETAINER SERVICE _____ MONTHS APPROVED OTHER _____
--	---	---

SIGNATURE OF PROVIDER REQUESTING AUTHORIZATION _____ DATE _____	APPROVED BY _____ DATE _____
---	------------------------------

NOTE: This form will not be returned to you. You will receive notification through the PA notification.



Handicapping Labio-Lingual Deviations Form (HDL Index)

FOR OFFICE USE ONLY: First Review _____ Second Reviewer: _____

The Handicapping Labio-Lingual Deviations Form (HDL) is a quantitative, objective method for measuring malocclusion. The HDL provides a single score, based on a series of measurements that represent the degree to which a case deviates from normal alignment and occlusion. You will need this form and a Boley Gauge.

The following items **must** be submitted with this form:

- Full mouth panoramic or cephalometric film
- and Photos

PROCEDURE:

1. Occlude patient or models in occlusion position.
2. Record all measurements in the order given, and round off to the nearest millimeter.
3. **Enter score "0" if condition is absent.**
4. Start by measuring **overjet** of the most protruding incisor.
5. Measure **overbite** from the labio-incisal edge of overlapped front tooth (or teeth) to point of maximum coverage.
6. Score all other conditions listed:
7. **Ectopic eruption and anterior crowding: Do not double score.** Record the most serious condition.
8. Deciduous teeth and teeth not fully erupted are not to be scored.

Patient's name (please print): _____ Member ID: _____

Patients Address: _____

Street	City	State	Zip
Conditions Observed		Finding:	HLD Score
1. Cleft palate			Score "X"
2. Deep impinging overbite			Score "X"
3. Anterior impactions			Score "X"
4. Severe traumatic deviations			Score 15
5. Overjet in mm			X1=
6. Overbite in mm			X1=
7. Mandibular protrusion in mm			X5=
8. Open bite in mm			X4=
9. Ectopic eruption (number of teeth, excluding third molars)			X3=
10. Anterior crowding: maxilla: _____ mandible: _____			X5 ea=
11. Labio-lingual spread, in mm (anterior spacing)			X1=
12. Posterior unilateral crossbite			Score 4=
13. Bilateral crossbite			Score 8=
		Total score:	_____

I certify under the pains and penalties of perjury that I am the prescribing provider identified below. Any attached statement on my letterhead has been reviewed and signed by me. I certify the medical necessity information on this form is true, accurate, and complete, to the best of my knowledge.

Prescribing provider's signature/date: _____

Printed name of prescribing provider: _____ NPI: _____

Handicapping Labio-Lingual Deviations Index Scoring Instruction

All measurements must be made with a Boley Gauge, scaled in millimeters. Absence of any conditions must be recorded by entering "0".

The following information should help clarify the categories on the HLD index.

1. **Cleft Palate Deformities:** Indicate an "X" on the form (This condition is considered to be a handicapping malocclusion)
2. **Deep Impinging Overbite:** Indicate an "X" on the form when lower incisors are destroying the soft tissue of the palate.
(This condition is considered to be handicapping malocclusion.)
3. **Anterior Impactions:** Indicate an "X" on the form. Anterior impactions include central incisors, lateral incisors, and canines in the maxillary and mandibular arches.
4. **Severe Traumatic Deviations:** Traumatic deviations are, for example, loss of a premaxilla segment by burns or by accident, the result of osteomyelitis, or other gross pathology. The presence of severe traumatic deviations is indicated by a score of 15 on the form.
5. **Overjet in Millimeters:** This is recorded with the patient in the centric occlusion and measured from the labial of the lower incisor to the labial of the upper incisor. The measurement could apply to a protruding single tooth as well as to the whole arch. The measurement is read and rounded off to the nearest millimeter and entered on the form.
6. **Overbite in Millimeters:** A pencil mark on the tooth indicating the extent of overlap facilitates this measurement. It is measured by rounding off to the nearest millimeter and entered on the form. Reverse overbite may exist in certain conditions and should be measured and recorded.
7. **Mandibular Protrusion in Millimeters:** Score exactly as measured from the labial of the lower incisor to the labial of the labial of the upper incisor. The measurement is entered on the form and multiplied by 5. A reverse overbite, if present, should be shown under "overbite."
8. **Open Bite in Millimeters:** This condition is defined as the absence of occlusal contact in the anterior region. It is measured from edge to edge in millimeters. This measurement is entered on the form and multiplied by 4. In cases of pronounced protrusion associated with open bite, measurement of the open bite is not always possible. In those cases, use a close approximation.
9. **Ectopic Eruption:** Count each tooth, excluding third molars. Enter the number of teeth on the form and multiply by 3. If "Condition No. 10, Anterior Crowding," is also present, with an ectopic eruption in the anterior portion of the mouth, score only the most severe condition. Do not score both conditions.
10. **Anterior Crowding:** Arch length insufficiency must exceed 3.5 mm. Mild rotations that may react favorably to stripping or mild expansion procedures are not to be scored as crowded. Enter 5 points for maxillary and mandibular anterior crowding. If "Condition No. 9, Ectopic Eruption," is also present in the anterior portion of the mouth, score the most severe condition. Do not score both conditions.
11. **Labio-Lingual Spread:** The Boley Gauge is used to determine the extent of deviation from a normal arch. Where there is only a protruded or lingually displaced anterior tooth, the measurement should be made from the incisal edge of that tooth to the normal arch line. Otherwise, the total distance between the most protruded tooth and the lingually displaced anterior tooth is measured. The labio-lingual spread probably comes close to a measurement of overall deviation from what would have been a normal arch. If multiple anterior crowding of teeth is observed, all deviations from the normal arch should be measured for labio-lingual spread, but only the most severe individual measurement should be entered on the index.
12. **Posterior-Unilateral Crossbite:** This condition involves two or more adjacent teeth, one of which must be a molar. The crossbite must be one in which the maxillary posterior teeth may either be both palatal or both completely buccal in relation to the mandibular posterior teeth. The presence of posterior unilateral crossbite is indicated by a score of 4 on the form.
13. **Bilateral Posterior Crossbite:** This condition involves two or more adjacent teeth on both sides including a molar. The presence of a bilateral crossbite is indicated by a score of 8 on the form.

Department of Public Health and Human Services Healthy Montana Kids Coverage Group/Children's Special Health Services Orthodontia Treatment Plan

Name:	Provider Name:	Tax ID #:
DOB:	NPI:	Taxonomy:
Address:	Address:	
Phone:	Phone:	Fax:
Health Insurance:	Number:	Signature:

For Category A, complete the following information, include appropriate Phase of Treatment and submit to Xerox, P.O. Box 8000, Helena, MT 59604; include x-rays, molds, and or photographs.

Molar Relationship Class I <input type="checkbox"/> Class II <input type="checkbox"/> Class III <input type="checkbox"/> Class III Facial <input type="checkbox"/>	Habits Tongue Thrust Swallow <input type="checkbox"/> Thumb/finger <input type="checkbox"/> Large Tonsils/Adenoids <input type="checkbox"/> Muscle Strain <input type="checkbox"/> Clenching Teeth/Grinding <input type="checkbox"/> Mouth Breathing <input type="checkbox"/>	Oral Hygiene Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/>
Areas of Concern: Crossbite <input type="checkbox"/> Missing Teeth <input type="checkbox"/> Impaction <input type="checkbox"/> Frenum Abnormality <input type="checkbox"/> Cleft Lip &/or Palate <input type="checkbox"/> Gum Defects <input type="checkbox"/> Extra Teeth <input type="checkbox"/> Craniofacial Anomaly <input type="checkbox"/>		No plaque present Plaque present on some tooth surfaces Plaque present & covering < 1/2 of all tooth surfaces Plaque present & covering > 1/2 of all tooth surfaces
		DPHHS Authorization

Phase 0 Interceptive Orthodontia for Medicaid/HMK Plus members only; Category B

TREATMENT RECOMMENDATIONS

Treatment Goal: Crossbite Correction

Appliances: Hyrax Quad Helix Hass Anterior Crossbite Posterior Crossbite

Reverse Headgear/Facemask Length of Treatment _____

Retainers Other Cost _____

DENTAL DEVELOPMENT

**ABCDEFGHIJ
TSRQPIONMLK**

87654321 12345678 Start Date _____
87654321 12345678

Over for Phase I through IV

Category A

Phase I Early Expansion with Retention

TREATMENT RECOMMENDATIONS

Treatment Goal: Maxillary Expansion

Appliances: Hyrax Quad Helix Hass

Oral Surgery Recommendations

Reverse Headgear/Facemask

87654321 12345678

Length of Treatment _____

Retainers Other

87654321 12345678

Cost _____

Exposure At: _____

Start Date _____

Phase II Partial Banding with Retention

TREATMENT RECOMMENDATIONS

Treatment Goal: Maxillary Development; Dental Alignment with Mixed Dentition

Appliances: Hyrax Quad Helix Hass

Oral Surgery Recommendations

Reverse Headgear/Facemask

87654321 12345678

Length of Treatment _____

Retainers Other

87654321 12345678

Cost _____

Exposure At: _____

Start Date _____

Phase III Banding with Retention

TREATMENT RECOMMENDATIONS

Treatment Goal: Maxillary Development; Dental Alignment of Permanent Dentition; Retention

Nonsurgical

Oral Surgery Recommendations

Partial/Full Banding

Length of Treatment _____

Retainers Other

87654321 12345678

Cost _____

Exposure At: _____

Start Date _____

Phase IV Presurgical, Surgery, and Retention

TREATMENT RECOMMENDATIONS

Treatment Goal: Crossbite Correction

Surgical

Oral Surgery Recommendations

Partial/Full Banding

Length of Treatment _____

Retainers

87654321 12345678

Cost _____

Exposure At: _____

Start Date _____

Definitions

This section contains definitions, abbreviations, and acronyms used in these billing instructions which relate to the Dental and Denturist Program.

Administrative Rules of Montana (ARM)

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

Authorization

An official approval for action taken for, or on behalf of, an eligible Medicaid member. This approval is only valid if the member is eligible on the date of service.

Basic Medicaid

Patients with Basic Medicaid have limited Medicaid services. See the Covered Services and Limitations chapter.

Dental Services

The medically necessary treatment of the teeth and associated structures of the oral cavity. Dental service includes the provision of orthodontia and prosthesis.

Denturist Services

Full or partial denture services that are provided by a licensed denturist. Services provided must be within the scope of their profession as defined by law.

DPHHS, State Agency

The Montana Department of Public Health and Human Services (Department) is the designated State Agency that administers the Medicaid (Title XIX) 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.

Emergency Medical Condition

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain). In such, 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 in serious jeopardy, serious impairment to body functions, or serious dysfunction of any bodily organ or part.

Emergency Services

Covered inpatient and outpatient services that are needed to evaluate or stabilize an emergency medical condition that is found to exist using a prudent layperson standard.

Essential for Employment Services for Basic Medicaid Members

Medicaid may reimburse for dental services for recipients who are employed or have been offered employment. Refer to the Covered Services and Limitations chapter for more information related to this service.

Fiscal Agent

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

Full Medicaid

Patients with Full Medicaid have a full scope of Medicaid benefits. See the Covered Services and Limitations chapter.

Healthy Montana Kids (HMK)

HMK offers low-cost or free health care coverage for low-income children younger than 19. Children must be uninsured U.S. citizens or qualified aliens, Montana residents who are not eligible for Medicaid. DPHHS administers the program with Blue Cross and Blue Shield of Montana (BCBSMT).

For eligibility and enrollment information, contact HMK toll-free at 877.543.7669 (follow menu) or 855.258.3489 (direct).

For information about medical benefits, contact BCBSMT at 406.447.8647 (in Helena) or toll-free at 800.447.7828.

HMK dental and eyeglasses benefits are provided by DPHHS through the same contractor (Xerox State Healthcare, LLC) that handles Medicaid provider relations and claims processing. This set of manuals applies to HMK dental and eyeglass providers only. See the Other Programs section in most chapters.

Medicaid

The federal aid Title XIX program under which medical care is provided to:

- Categorically needy as defined in ARM
- Medically needy as defined in ARM

Medically Necessary

A term describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the member. These conditions must be classified as one of the following: endanger life, cause suffering or pain, result in an illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There must be no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the member requesting the

service. For the purpose of this section, *course of treatment* may include mere observation or when appropriate, no treatment at all.

Medicare

The federal government health insurance program for certain aged or disabled members under Titles II and XVIII of the Social Security Act. Medicare has two parts:

- Part A covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
- Part B is the supplementary medical insurance benefit covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care and other health services and supplies not covered under Part A of Medicare.

Member

An applicant for or client of DPHHS medical care programs.

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 members; and
- Eligible to receive payment from the department.

Third Party Liability (TPL)

Any entity that is or may be liable to pay all or part of the medical cost of care of a federal Medicaid or state medical care member.

Usual and Customary

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

Acronyms

This section contains a list of commonly used acronyms. Please refer to Definitions or specific chapters for more information.

ADA

American Dental Association

ARM

Administrative Rules of Montana

CDT

Current Dental Terminology

DPHHS

The state Department of Public Health and Human Services. Also referred to as *the Department*.

EPSDT

Early Periodic Screening Diagnosis and Treatment program

FAIM

Families Achieving Independence in Montana

PA

Prior Authorization

RA

Remittance Advice

RBRVS

Resource-Based Relative Value Scale

RVD

Relative Value for Dentists

SHS

Special Health Services

TPL

Third Party Liability

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