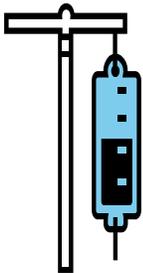


Dialysis Clinic Services



*Medicaid and Other Medical
Assistance Programs*



This publication supersedes all previous Dialysis Clinic Services handbooks. Published by the Montana Department of Public Health & Human Services, July 2005.

| Updated October 2013.

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My NPI/API:

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Key Contacts

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

Claims

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

Member Eligibility

FaxBack
 800.714.0075 (24 hours)
Integrated Voice Response (IVR)
 800.714.0060 (24 hours)
Montana Access to Health Web Portal
<http://mtaccesstohealth.acs-shc.com/>
Medifax EDI
 800.444.4336, X2072 (24 hours)

Dialysis Services Program

406.444.4540 Phone
406.444.1861 Fax

Send written inquiries to:
 Dialysis Program Officer
 Hospital and Clinic Services Bureau
 DPHHS
 P.O. Box 202951
 Helena, MT 59620-2801

Direct Deposit Arrangements

See Electronic Funds Transfer/Electronic Remittance Advice. Direct deposit is another term for electronic funds transfer (EFT).

EDI Technical Help Desk

For questions regarding electronic claims submission:

800.987.6719 In/Out of state
850.385.1705 Fax

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

Electronic Funds Transfer/ Electronic Remittance Advice

Providers who need to enroll in electronic funds transfer (EFT) and register for the Montana Access to Health web portal in order to receive electronic remittance advices (ERAs) should contact Provider Relations. Completed documentation should be mailed or faxed to Provider Relations.

Provider Relations
 P.O. Box 4936
 Helena, MT 59604
800.624.3958 In/Out of state
406.442.1837 Helena
406.442.4402 Fax

Medicaid Help Line

Members who have Medicaid or Passport questions may call the Montana Medicaid Help Line:

800.362.8312

Send written inquiries to:
 Passport to Health
 P.O. Box 254
 Helena, MT 59624-0254

Provider Policy Questions

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

Provider Relations

For questions about enrollment, eligibility, payments, denials, claims, or Passport:

800.624.3958 In/Out of state
406.442.1837 Helena
406.442.4402 Fax

Send written inquiries to:

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

Secretary of State

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

406.444.2055 Phone

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

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
Blue Cross and Blue Shield of Montana (BCBSMT) www.bcbsmt.com	BCBSMT processes HMK/CHIP medical claims. For an HMK medical manual, contact BCBSMT.
EDI Gateway www.acs-gcro.com/	EDI Gateway is the Xerox HIPAA clearinghouse. Visit this website for more information on: <ul style="list-style-type: none"> • EDI support • Enrollment • FAQs • Manuals • Provider services • Related links • Software
Healthy Montana Kids (HMK) www.hmk.mt.gov/	Information on Healthy Montana Kids (HMK).
Montana Access to Health (MATH) Web Portal https://mtaccesstohealth.acs-shc.com Provider Information Website 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 • Upcoming events
Public Assistance Toolkit https://dphhs.mt.gov/	Select Human Services for information on: <ul style="list-style-type: none"> • Medicaid: Member information, eligibility information, an provider information • Montana Access Card • Provider Resource Directory • Third Party Liability Carrier Directory
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
Washington Publishing Company www.wpc-edi.com/ A fee is charged for documents; however, code lists are viewable online for no charge.	<ul style="list-style-type: none"> • HIPAA guides • HIPAA tools

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 dialysis clinics. It includes a section titled Other Programs with information about other Department programs such as the Mental Health Services Plan (MHSP) and Healthy Montana Kids (HMK). Other essential information for providers is contained in the separate *General Information for Providers* manual. Each provider is asked to review both the general manual and the specific manual for his or her provider type.

A table of contents and an index allow you to quickly find answers to most questions. The margins contain important notes with extra space for writing notes. There is a list of Key Contacts at the beginning of each manual. We have also included a space on the back of the front cover to record your NPI/API 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 rule references are available on the Provider Information [website](#) (see Key Contacts). Paper copies of rules are available through the Secretary of State's office (see Key Contacts).



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

In addition to the rules listed in the *General Information for Providers* manual, the following rules and regulations are applicable to the dialysis program:

- Administrative Rules of Montana (ARM)
 - ARM 37.86.4201–37.86.4205
Freestanding Dialysis Clinics for End-Stage Renal Disease
- Montana Codes Annotated (MCA)
 - MCA Title 53, Chapter 6, Part 2: 50-44-101–50-44-102

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, provider notices, replacement pages, fee schedules, forms, and much more are available on the Provider Information [website](#). (See Key Websites.)

Covered Services

General Coverage Principles

Medicaid covers most dialysis services when they are medically necessary. This chapter provides covered services information that applies specifically to dialysis clinics. Like all health care services received by Medicaid members, dialysis services must also meet the general requirements listed in the Provider Requirements chapter of the *General Information for Providers* manual.

Dialysis Clinic Requirements (ARM 37.86.4201)

Dialysis clinics must be licensed to provide services in the state in which the clinic is located. The dialysis clinic must also be certified by the Centers for Medicare and Medicaid (CMS) to provide outpatient maintenance dialysis directly to end-stage renal disease (ESRD) members. Dialysis services are provided to only those members who have been diagnosed by a physician as suffering from chronic ESRD. Supporting documentation must be kept on file.

Services for Children (ARM 37.86.2201–2221)

The Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) is a comprehensive approach to health care for Medicaid members ages 20 and under. It is designed to prevent, identify, and then treat health problems before they become disabling. Under EPSDT, Medicaid eligible children may receive any medically necessary covered service, including all services described in this manual.

Coverage of Specific Services

Medicaid follows Medicare’s rules for coverage of most services. The following are Medicaid’s coverage rules for dialysis services.

Drugs and Biologicals

Most drugs and biologicals used in the dialysis procedure are covered under the composite rate and may not be billed separately. They include:

• Heparin	• Mannitol	• Glucose
• Antiarrhythmics	• Pressor drugs	• Dextrose
• Saline	• Antihypertensives	• Protamine
• Antihistamines	• Local anesthetics	• Heparin antidotes

Epoetin (EPO)

Medicaid covers EPO therapy for members who have been diagnosed with chronic ESRD. EPO is covered when administered in a facility; however, it is included in the composite rate.

Hemodialysis and Peritoneal Dialysis Services

Hemodialysis and peritoneal dialysis are covered under a composite rate for the dialysis facility.

Home Dialysis Training

Medicaid covers training for patients (and a helper/backup person) to learn to perform their own dialysis at home.

Home Dialysis Equipment, Support and Supplies

Medicaid covers home dialysis equipment, support and supplies. The patient has the option of having the facility provide the equipment under the composite rate, or of renting or purchasing such equipment directly from a supplier. The dialysis facility must provide the home dialysis patient with the following, which are included in the facility's composite rate:

- Periodic monitoring of the patient's home adaptation (including visits to the home, in accordance with a written plan prepared and periodically reviewed by a team that includes the patient's physician and other professionals familiar with the patient's condition)
- Emergency visits by qualified ESRD facility personnel
- Providing and arranging for supplies when dialysis equipment is provided by the facility
- Installation and maintenance of dialysis equipment when provided by the facility
- ESRD related laboratory tests
- Testing and appropriate treatment of water
- Monitoring the functioning of the dialysis equipment when provided by the facility

Some covered support services may involve indirect patient contact. The patient, for example, may need to consult with a nurse regarding dietary restrictions or with a social worker if he is having problems adjusting. The consultations may be by phone.

Lab Services

Most lab services are included in the composite rate; however, the following lab tests may be billed separately to Medicaid when within the specified limit:

- Serum Aluminum: one every 3 months
- Serum Ferritin: one every 3 months
- Lab services are billed to Medicaid by the lab performing the tests.

The following tests are included in the composite rate unless they are performed more frequently than specified. In this case they may be billed separately.

- **Per treatment:** All hematocrit, hemoglobin, and clotting time tests furnished incident to dialysis treatments
- **Weekly:** Prothrombin time for patients on anticoagulant therapy, Serum Creatinine
- **Weekly or thirteen per quarter:** BUN
- **Monthly:** Serum Calcium, Serum Bicarbonate, Serum Potassium, Serum Phosphorous, Alkaline Phosphatase, AST, SGOT Serum Chloride, Total Protein, LDH, CBC, Serum Albumin

Supplies and Equipment

The supplies necessary to administer dialysis (e.g., needles, tubing) are included in the facility's composite rate.

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). Members who qualify for MHSP may receive mental health services in addition to dialysis services. For more information on the MHSP program, see the mental health manual available on the Provider Information [website](#) (see Key Contacts).

Healthy Montana Kids (HMK)

The information in this manual does not apply to HMK/CHIP members. For an HMK/CHIP medical manual, contact Blue Cross and Blue Shield of Montana (BCBSMT) at 1.800.447.7828, Extension 8647. Additional information regarding HMK/CHIP is available on the HMK website and the BCBSMT website (see Key Websites).

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 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 Medicaid 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 *third party liability* (TPL), but Medicare is not.

Medicare Part A Claims

Medicare Part A covers dialysis services. To date, arrangements have not been made with Medicare Part A carriers for electronic exchange of claims covering Part A services. Providers must submit the claim first to Medicare. After Medicare processes the claim, an Explanation of Medicare Benefits (EOMB) is sent to the provider. The provider then reviews the EOMB, and submits the claim to Medicaid on paper.

When Medicare Pays or Denies a Service

When dialysis claims for members with Medicare and Medicaid are submitted to Medicare, and Medicare:

- ***Pays the claim.*** Submit the claim to Medicaid on a UB-04 with the Medicare coinsurance and deductible information in value codes form locators (FL 39-41) and Medicare paid amounts in the prior payments form locator (FL 54). See the Billing Procedures and Submitting a Claim chapters in this manual.
- ***Allows the claim, and the allowed amount went toward the member's deductible.*** Include the deductible information in value codes form locators (FLs 39-41), and submit the claim to Medicaid on paper.
- ***Denies the claim.*** The provider submits a paper claim to Medicaid with the Medicare EOMB and the explanation of denial codes attached. If Medicare denies a claim because the service was not medically necessary, Medicaid will also deny 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 provider's NPI and member's Medicaid ID number. The Medicare EOMB and explanation of denial codes are required only if the claim was denied. When submitting electronic claims with paper attachments, see the Billing Electronically with Paper Attachments section of the Submitting a Claim chapter in this manual.

When 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 TPL. In most cases, providers must bill other insurance carriers before billing Medicaid.

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



Medicare Part A crossover claims do not automatically cross over from Medicare.

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 third party liability.
- 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, notify the Department of the potential third party by sending the claim and notification to the Third Party Liability unit. (See Key Contacts.)

Requesting an Exemption

Providers may request to bill Medicaid first under certain circumstances. In each of these cases, the claim and required information must be sent to the 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

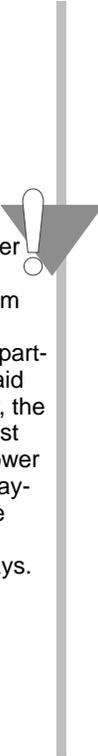
When a third party payer is involved (excluding Medicare) and the other payer:

- ***Pays the claim***, indicate the amount paid in the prior payments form locator of the claim when submitting to Medicaid for processing.
- ***Allows the claim***, and the allowed amount goes toward the member's deductible, include the insurance Reason and Remarks (formerly EOB) when billing Medicaid.
- ***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, and 90 days have passed with no response, bill Medicaid as follows:

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



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

Billing Procedures

Claim Forms

Services provided by the health care professionals covered in this manual must be billed either electronically or on a UB-04 claim form. UB-04 forms are available from various publishing companies; they are not available from the Department or Provider Relations.

Timely Filing Limits (ARM 37.85.406)

Providers must submit clean claims to Medicaid within:

Twelve months from whichever is later:

- the date of service
- the date retroactive 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 approving the service (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 action from the provider. The submission date is defined as the date that the claim was received by the Department or the claims processing contractor. All problems with claims must be resolved within this 12-month period.

Tips to Avoid Timely Filing Denials

- Correct and resubmit denied claims promptly. (See the Remittance Advices and Adjustments chapter in this manual.)
- If another insurer has been billed and 90 days have passed with no response, you can bill Medicaid. (See the Coordination of Benefits chapter in this manual for more information).
- To meet timely filing requirements for Medicare/Medicaid crossover claims, see the Coordination of Benefits chapter in this manual.

When to Bill Medicaid 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 and free to non-Medicaid covered individuals, such as in a public health clinic.

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



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

When to Bill a Medicaid Member (ARM 37.85.406)		
	Patient is Medicaid-enrolled and provider accepts him/her as a Medicaid member	Patient is Medicaid-enrolled and provider <i>does not</i> accept him/her as a Medicaid member
Service is covered by Medicaid	Provider can bill member only for cost sharing	Provider can bill Medicaid if the member has signed a routine agreement
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 he/she has signed a routine agreement

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 or 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. Do not show cost sharing as a credit on the claim; it is automatically deducted during claims processing and is shown on the remittance advice. Cost sharing for dialysis services is \$5.00 per visit.

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 the Definitions chapter.)
- Hospice
- Independent lab and x-ray services
- Personal assistance services• Home dialysis attendant services
- Home dialysis attendant services
- Home- and community-based waiver services
- Non-emergency medical transportation services
- 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.



member cost sharing for dialysis services is \$5.00 per visit.



Do not show cost sharing as a credit on the claim; it is automatically deducted.

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.

When completing a claim for members with Medicare and Medicaid, Medicare coinsurance and deductible amounts listed in FL 39 must correspond with the payer listed in FL 50. For example, if the member has Medicare and Medicaid, any Medicare deductible and coinsurance amounts should be listed in FL 39 preceded by an A1, A2, etc. Because these amounts are for Medicare, Medicare should be listed in FL 50A.

Billing for Retroactively Eligible Members

When a member becomes retroactively eligible for Medicaid, the dialysis 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 in which the date of service is more than 12 months earlier than the date the claim is submitted, Provider Notice of Eligibility (Form 160-M). To request Form 160-M, the provider needs to contact the member's local Office of Public Assistance. (See the *General Information for Providers* manual, Appendix C: Local Offices of Public Assistance.)

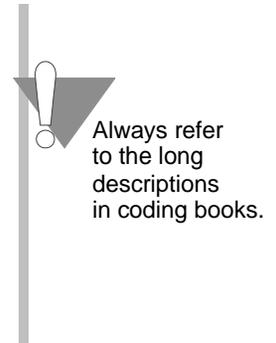
When a provider chooses to accept the member from the date retroactive eligibility was effective, and the member has made a full or partial payment for services, the provider must refund the member's payment for the services before billing Medicaid for the services.

Coding

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

- Use current CPT, HCPCS Level II, and ICD diagnosis 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.
- 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
CPT	<ul style="list-style-type: none"> • CPT codes and definitions • Updated each January 	American Medical Association 1.800.621.8335 www.amapress.com or Optum Insight 1.800.464.3649 www.optumcoding.com
CPT Assistant	A newsletter on coding issues	American Medical Association 1.800.621.8335 www.amapress.com
HCPCS Level II	<ul style="list-style-type: none"> • HCPCS Level II codes and definitions • Updated each January and throughout the year 	Available through various publishers and bookstores or from CMS at www.cms.gov/ .
ICD	<ul style="list-style-type: none"> • ICD diagnosis and procedure codes definitions • Updated each October. 	Available through various publishers and bookstores
NCCI Policy and Edits Manual	This manual contains National Correct Coding Initiative (NCCI) 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 1.800.363.2068 1.703.605.6060 http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html
Miscellaneous Resources	Various newsletters and other coding resources.	Optum Insight 1.800.464.3649 www.optuminsight.com
UB-04 National Uniform Billing Expert	National UB-04 billing instructions	Available through various publishers and editors

Number of Lines on Claim

Providers are requested to put no more than 40 lines on a paper UB-04 claim. Although additional lines may be billed on the same claim, the Department claims processing system is most efficient for outpatient claims with 40 lines or fewer.

Multiple Services on Same Date

Dialysis providers must submit a single claim for all services provided to the same member on the same day. If services are repeated on the same day, use appropriate modifiers.

Span Bills

Dialysis providers may include services for more than one day on a single claim, so long as the date is shown on the claim.

Reporting Service Dates

- All line items must have a valid date of service in form locator (FL) 45.
- The following revenue codes require a separate line for each date of service and a valid CPT or HCPCS Level II code.

Revenue Codes That Require a Separate Line for Each Date of Service and a Valid CPT or HCPCS Code

26X	IV Therapy	51X	Clinic
28X	Oncology	52X	Free-Standing Clinic
30X	Laboratory	61X	Magnetic Resonance Imaging (MRI)
31X	Laboratory Pathological	63X	Drugs Requiring Specific Identification
32X	Radiology – Diagnostic	70X	Cast Room
33X	Radiology – Therapeutic	72X	Labor Room/Delivery
34X	Nuclear Medicine	73X	Electrocardiogram (EKG/ECG)
35X	Computed Tomographic (CT) Scan	74X	Electroencephalogram (EEG)
36X	Operating Room Services	75X	Gastrointestinal Services
38X	Blood	76X	Treatment or Observation Room
39X	Blood Storage and Processing	77X	Preventive Care Services
40X	Other Imaging Services	79X	Lithotripsy
41X	Respiratory Services	82X	Hemodialysis – Outpatient or Home
42X	Physical Therapy	83X	Peritoneal Dialysis – Outpatient or Home
43X	Occupational Therapy	84X	Continuous Ambulatory Peritoneal Dialysis (CAPD) – Outpatient
44X	Speech-Language Pathology	85X	Continuous Cycling Peritoneal Dialysis (CCPD) – Outpatient
45X	Emergency Department	88X	Miscellaneous Dialysis
46X	Pulmonary Function	90X	Psychiatric/Psychological Treatments
47X	Audiology	91X	Psychiatric/Psychological Services
48X	Cardiology	92X	Other Diagnostic Services
49X	Ambulatory Surgical Care	94X	Other Therapeutic Services

Reference Lab Billing

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

Submitting a Claim

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

The Most Common Billing Errors and How to Avoid Them

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

Common Billing Errors	
Reasons for Return or Denial	How to Prevent Returned or Denied Claims
Provider's NPI and/or taxonomy missing or invalid	Verify the correct NPI 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, handwritten, 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 a UB-04.
Information on claim form not legible	Information on the claim form must be legible. Use dark ink and center the information in the form locator. Information must not be obscured by lines.
Medicaid 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.
Duplicate claim	Check all remittance advices (RAs) for previously submitted claims before resubmitting. When making changes to previously paid claims, submit an adjustment form (see the Remittance Advices and Adjustments chapter).

Common Billing Errors	
Reasons for Return or Denial	How to Prevent Returned or Denied Claims
TPL on file and no credit amount on claim	<p>If the member has other insurance (or Medicare), bill the other carrier before Medicaid. See Coordination of Benefits in this manual.</p> <p>If the member’s TPL coverage has changed, providers must notify the TPL unit (see Key Contacts) before submitting a claim.</p>
Claim past 365-day filing limit	The Claims Processing Unit must receive all clean claims and adjustments within the timely filing limits described in this chapter. To ensure timely processing, claims and adjustments must be mailed to Claims Processing at the address shown in Key Contacts.
Missing Medicare EOMB	All denied Medicare crossover claims must have an Explanation of Medicare Benefits (EOMB) with denial reason codes attached, and be billed to Medicaid on paper.
Type of service/procedure is not allowed for provider type	Provider is not allowed to perform the service, or type of service is invalid. Verify the procedure code is correct using current HCPCS and CPT billing manual.
Provider is not eligible during dates of services, enrollment has lapsed due to licensing requirements, or provider number 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/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>

Submitting a Claim

Electronic Claims

Institutional claims submitted electronically are referred to as ANSI ASC X12N 837 transactions. Providers who submit claims electronically experience fewer errors and quicker payment. Providers should be familiar with federal rules and regulations regarding electronic transactions. Claims may be submitted electronically by the following methods:

- **Xerox Clearinghouse.** Providers can send claims to EDI Solutions 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 EDI Solutions. EDIFECS certifies the 837 HIPAA transactions at no cost to the provider. EDIFECS certification is completed through EDI Solutions.
- **B2B Gateway SFTP/FTPS Site.** Providers can use this method to send electronic transactions through this secure FTP process. This is typically encountered with high volume/high-frequency submitters.
- **Clearinghouse.** Providers can contract with a clearinghouse and 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 EDI Solutions. For more information on electronic claims submission, contact Provider Relations or the EDI Technical Help Desk. (See Key Contacts.)
- **Montana Access to Health (MATH) Web Portal.** Providers can upload electronic transactions 7 days a week through the web portal. This availability is subject to scheduled and unscheduled host downtime.
- **MOVEit DMZ.** Providers can use this secure transmission protocol and secure storage landing zone (intermediate storage) for the exchange of files between trading partners and Xerox. Its use is intended for those trading partners/submitters who will be submitting a larger volume of physical files (in excess of 20 per day) or whose physical file sizes regularly exceed 2 MB.
- **WINASAP 5010.** Xerox makes this field software available to providers free of charge. Providers can create and submit claims to Montana Medicaid, MHSP, HMK (dental and eyeglasses only) and FQHC/RHC. WINASAP 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.

Billing Electronically with Paper Attachments

When submitting claims that require additional supporting documentation, the Attachment Control Number field must be populated with an identifier. Identifier formats can be designed by software vendors or clearinghouses, but the preferred method is the provider's NPI followed by the member's ID number and the date of service, each separated by a dash:

999999999	- 888888888	11182012
Provider NPI	Member ID Number	Date of Service (mmdyyy)

The supporting documentation must be submitted with a Paperwork Attachment Cover Sheet (see the Forms page of the Provider Information [website](#)). The number in the paper Attachment Control Number field must match the number on the cover sheet. For more information on attachment control numbers and submitting electronic claims, see the [EDI website](#).

Paper Claims

The services described in this manual are billed on UB-04 claim forms. Claims submitted with all of the necessary information are referred to as *clean* and are usually paid in a timely manner (see the Billing Procedures chapter of this manual).

Claims are completed differently depending on the types of coverage a member has. Sample UB-04 claims are posted on the Forms page of the website.

When completing a claim, remember the following:

- All form locators shown in this chapter are required or situational. Situational form locators are required if the information is applicable to the situation or member and are indicated by “**”.
- Form locator 78 is used for cost sharing override codes:
 - E – Overrides cost sharing for emergency services
 - P – Overrides cost sharing for pregnant women

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

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

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

Remittance Advices and Adjustments

The Remittance Advice

The remittance advice is the best tool providers have to determine the status of a claim. Remittance advices accompany weekly payment for services rendered and provide details of all transactions that have occurred during the previous remittance advice cycle. Each line of the remittance advice represents all or part of a claim and explains whether the claim or service has been paid, denied, or suspended (also referred to as pending). If the claim was suspended or denied, the remittance advice also shows the reason.

Providers who enrolled in Montana Health Care Programs after July 2013, were required to enroll in electronic funds transfer (EFT) and register to receive electronic remittance advices (ERAs). Existing providers who receive paper checks or paper remittance advices will be being transitioned to the electronic-only system by March 1, 2014.

To enrollment in EFT (also known as direct deposit), providers must complete the Montana Medicaid Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA) Authorization Agreement found on the [Provider Enrollment page](#) of the Montana Medicaid Provider Information website.

To receive ERAs, providers must have Internet access, complete the EDI Trading Partner Agreement, and register for the Montana Access to Health web portal. Providers access ERAs through the MATH web portal.

ERAs are available in PDF format, and providers can read, print, or download PDF files using Adobe Acrobat Reader, which is available on the Adobe website. **Due to space limitations, each RA is only available for 90 days.**

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; however, if there are several providers in one location who are under one tax ID number, they can use one submitter number. These providers should enter the submitter ID in both the provider number and submitter ID fields. Otherwise, enter the provider number in the provider number field.

After enrollment, providers receive a user ID and password to log on to the MATH web portal.



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



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.

Sections of the RA

RA Notice

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

Paid Claims

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

Denied Claims

This section shows claims denied during the previous cycle. If a claim has been denied, refer to the Reason/Remark column. The reason and remark code description explains why the claim was denied and is located at the end of the RA.

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. The Reason/Remark Code description located at the end of the RA explains 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.

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 NPI/API was billed. If the ID number was incorrect, resubmit the claim with the correct ID number.

Credit Balance Claims

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

Credit balances can be resolved in two ways:

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

Gross Adjustments

Any gross adjustments performed during the previous cycle are shown here.

Reason and Remark Code Description

This section lists the reason and remark codes that appear throughout the RA with a brief description of each.

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.

Timeframe for Rebilling or Adjusting 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 the TPL unit to complete a gross adjustment.

Rebilling Medicaid

Rebilling is when a provider submits a claim to Medicaid that was previously submitted for payment but was either returned or denied. Claims are often returned to the provider before processing because key information such as Medicaid provider number or authorized signature and date are missing or unreadable. For tips on preventing returned or denied claims, see the Billing Procedures 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 UB-04 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 should contact Provider Relations.

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

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 client ID, provider number, date of service, procedure code, diagnoses, units, etc.).
- Request an adjustment when a single line on a multi-line claim was denied. The denied service must be submitted as an adjustment rather than a rebill.

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 the *Definitions* chapter.)

- Use a separate adjustment request form for each ICN.
- If you are correcting more than one error per ICN, use only one adjustment request form, and include each error on the form.
- If more than one line of the claim needs to be adjusted, indicate which lines and items need to be adjusted in the Remarks section of the Individual Adjustment Request.

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 first and last name.
3. Internal control number (ICN)	There can be only one ICN per Adjustment Request form. When adjusting a claim that has been previously adjusted, use the ICN of the recent claim.
4. Provider number	The provider's NPI.
5. Member Medicaid ID number	Member's Medicaid ID number.
6. Date of payment	Date claim was paid. See your remittance advice.
7. Amount of payment	The amount of payment. See your remittance advice.
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.

Completing an Individual Adjustment Request

- Download the form from the Provider Information website. Complete Section A with provider and member information and the claim's ICN number.
- Complete Section B with information about the claim. Fill in only the items that need to be corrected:

- 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.

- 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.

- Verify the Adjustment Request has been signed and dated.
- 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.)



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		3. Internal Control Number (ICN)	
Hometown Audiology		00404011250000600	
Name			
P.O. Box 999		4. NPI/API	
Street or P.O. Box		1234567	
Anytown, MT 59999		5. Member ID Number	
City	State	ZIP	123456789
2. Member Name		6. Date of Payment	
Jane Doe		10/01/12	
		7. Amount of Payment	
		\$ 180.00	

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	09/01/05	09/15/05
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 <i>Mary Bender</i>		Date 10/15/12	

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 3000
 Helena, MT 59604

Updated 03/2013

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.

Payment and the RA

As of July 2013, new providers were required to register for payment via electronic funds transfer (EFT) and electronic remittance advice (ERAs). Existing providers who receive paper checks or paper RAs are being transitioned over time.

Direct deposit is another name for EFT. With EFT, the Department deposits the funds directly to the provider's bank account. If the scheduled deposit day is a holiday, funds and the RA will be available on the next business day.

To participate in EFT, providers must complete the Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA) Authorization Agreement. One form must be completed for each provider number.

Once electronic transfer testing shows payment to the provider's account, all Medicaid payments will be made through EFT. Contact Provider Relations for instructions enrolling for EFT and ERAs.

Required Forms for EFT and ERA			
Form	Purpose	Where to Get	Where to Send
EFT & ERA Authorization Agreement	Allows the Department to automatically deposit Medicaid payment into provider's bank account	• Provider Information website.	Fax to Provider Relations 406.442.4402.
EDI Trading Partner Agreement	Allows provider to access their ERA on the Montana Access to Health Web Portal (must also include the form above)	Provider Information website.	Fax to Provider Relations 406.442.4402.

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.

Dialysis Center Rates

Reimbursement for dialysis clinics is based on a bundled composite rate. The fee scheduled is subject to periodic adjustment due to changes in appropriated funds and modifications to the Medicare allowed amount for services. All rates including current and prior rates are published and maintained on the agency website.

How Payment Is Calculated on TPL Claims

When a member has coverage from both Medicaid and another insurance company, the other insurance company is often referred to as Third Party Liability or TPL. In these cases, the other insurance is the primary payer (as described in the Coordination of Benefits chapter of this manual), and Medicaid makes a payment as the secondary payer. Medicaid will make a payment only when the TPL payment is less than the Medicaid allowed amount.

How Payment Is Calculated on Medicare Crossover Claims When a member has coverage from both Medicare and Medicaid, Medicare is the primary payer. Medicaid will pay the coinsurance and deductible, less any TPL or incurment, on dialysis claims for these dually eligible individuals.

Payment Examples for Dually Eligible Members

Member has Medicare and Medicaid coverage. A provider submits a dialysis claim for a member with Medicare and Medicaid. The Medicare coinsurance and deductible are \$65.00 and \$185.00. This total (\$250.00) becomes the Medicaid allowed amount. Medicaid will pay this amount (\$250.00) as long as no TPL or incurment amounts are applicable.

Member has Medicare, Medicaid, and TPL. A provider submits a dialysis claim for a member with Medicare, Medicaid, and TPL. The Medicare coinsurance and deductible are \$65.00 and \$185.00. This total (\$250.00) becomes the Medicaid allowed amount. The other insurance company paid \$225.00. This amount is subtracted from the Medicaid allowed amount leaving \$25.00. Medicaid pays \$25.00 for this claim. If the TPL payment had been \$250.00 or more, this claim would have paid at \$0.00.

Member has Medicare, Medicaid, and Medicaid Incurment. A provider submits a dialysis claim for a member with Medicare, Medicaid, and a Medicaid incurment. The Medicare coinsurance and deductible are \$65.00 and \$185.00. This total (\$250.00) becomes the Medicaid allowed amount. The member owes \$150 for his Medicaid incurment, so this amount is subtracted from the \$250.00. Medicaid will pay the provider \$100.00 for this claim.

Appendix A: Forms

These forms are available on the [Forms](#) page of the Provider Information website.

Individual Adjustment Request

Paperwork Attachment Cover Sheet

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

Instructions:
 This form is for providers to correct a claim which has been paid at an incorrect amount or was paid with incorrect information. Complete all the fields in Section A with information about the paid claim from your statement. Complete **only** the items in Section B which represent the incorrect information that needs changing. For help with this form, refer to the Remittance Advices and Adjustments chapter in your program manual or the *General Information for Providers* manual, or call 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 _____

2. Member Name _____

3. Internal Control Number (ICN) _____

4. NPI/API _____

5. Member ID Number _____

6. Date of Payment _____

7. Amount of Payment \$ _____

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

Updated 03/2013

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: 999999999-99999999-99999999/Atypical Provider ID: 9999999-99999999-99999999).

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

Updated 03/2013

Definitions and Acronyms

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

Administrative Rules of Montana (ARM)

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

Allowed Amount

The maximum amount reimbursed to a provider for a health care service as determined by Medicaid/MHSP/HMK or another payer. Other cost factors, (such as cost sharing, third party liability (TPL), or incurment) are often deducted from the allowed amount before final payment. Medicaid's allowed amount for each covered service is listed on the Department fee schedule.

Ancillary Provider

A voluntary decision by the member to have insurance benefits paid directly to the provider rather than to the member. The act requires the signing of a form for the purpose. The provider is not obligated to accept an assignment of benefits. However, the provider may require assignment in order to protect the provider's revenue.

Assignment of Benefits

A voluntary decision by the member to have insurance benefits paid directly to the provider rather than to the member. The act requires the signing of a form for the purpose. The provider is not obligated to accept an assignment of benefits. However, the provider may require assignment in order to protect the provider's revenue.

Authorization

An official approval for action taken for, or on behalf of, a 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 *General Information for Providers* manual, Medicaid Covered Services.

Bundled

Items or services that are deemed integral to performing a procedure or visit are not paid separately in the APC system. They are packaged (also called bundled) into the payment for the procedure or visit. Medicare developed the relative weights for surgical, medical and other types of visits so that the weights reflect the packaging rules used in the APC method. Items or services that are packaged receive a status code of N.

Cash Option

Cash option allows the member to pay a monthly premium to Medicaid and have Medicaid coverage for the entire month rather than a partial month.

Centers for Medicare and Medicaid Services (CMS)

Administers the Medicare program and oversees the state Medicaid programs.

Children's Health Insurance Program (CHIP)

The Montana plan is known as Healthy Montana Kids.

Children's Special Health Services (CSHS)

Children's Special Health Services (CSHS) assists children with special health care needs who are not eligible for Medicaid by paying medical costs, finding resources, and conducting clinics.

Clean Claim

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

Code of Federal Regulations (CFR)

Rules published by executive departments and agencies of the federal government.

Coinsurance

The member's financial responsibility for a medical bill as assigned Medicare (usually a percentage). Medicare coinsurance is usually 20% of the Medicare allowed amount.

Conversion Factor

A state specific dollar amount that converts relative values into an actual fee. This calculation allows each payer to adopt the RBRVS to its own economy.

Copayment

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

Cosmetic

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

Cost Sharing

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

Crossovers

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

DPHHS, State Agency

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

Dual Eligibles

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

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

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

Emergency Services

A service is reimbursed as an emergency if one of the following criteria is met:

- The service is billed with a CPT code of 99284 or 99285
- The member has a qualifying emergency diagnosis code. A list of emergency diagnosis codes is available on the Provider Information website.
- The services did not meet one of the previous two requirements, but the hospital believes an emergency existed. In this case, the claim and documentation supporting the emergent nature of the service must be mailed to the emergency department review contractor. (See Key Contacts.)

Experimental

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

Fiscal Agent

(Note: As of April 1, 2012, ACS State Healthcare, LLC, became Xerox State Healthcare, LLC.) 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.

Dialysis Clinic

Dialysis clinics are clinics that provide dialysis services to members suffering from end-stage renal disease (ESRD).

Full Medicaid

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

Gross Adjustment

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

Home Dialysis

Dialysis performed by an appropriately trained patient at home.

Indian Health Service (IHS)

IHS provides health services to American Indians and Alaska Natives.

Individual Adjustment

A request for a correction to a specific paid claim.

Investigational

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

Mass Adjustment

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

Medicaid/HMK Plus

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

Medically Necessary

A term describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the 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 definition, *course of treatment* may include mere observation or, when appropriate, no treatment at all.

Medicare

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

Member

An individual enrolled in Medicaid.

Mental Health Services Plan (MHSP)

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

Mutually Exclusive Code Pairs

These codes represent services or procedures that, based on either the CPT definition or standard medical practice, would not or could not reasonably be performed at the same session by the same provider on the same patient. Codes representing these services or procedures cannot be billed together.

Outpatient Maintenance Dialysis

Dialysis furnished on an outpatient basis at a renal dialysis center or facility. Outpatient dialysis includes staff-assisted dialysis, self-dialysis, and home dialysis.

Packaged

Items or services that are deemed integral to performing a procedure or visit are not paid separately in the APC system. They are packaged (also called bundled) into the payment for the procedure or visit. Medicare developed the relative weights for surgical, medical and other types of visits so that the weights reflect the packaging rules used in the APC method. Items or services that are packaged receive a status code of N.

Passport to Health

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

Prior Authorization (PA)

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

Private-Pay

When a member chooses to pay for medical services out of his/her own pocket.

Provider or Provider of Service

An institution, agency, or person having a signed agreement with the Department to furnish medical care, goods and/or services to members, and eligible to receive payment from the Department.

Qualified Medicare Beneficiary (QMB)

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

Reference Lab Billing

Reference lab billing occurs when a Medicaid provider draws a specimen and sends it to a reference lab for processing. The reference lab then sends the results back to the Medicaid provider. Medicaid does not cover lab services when they are billed by the referring provider.

Remittance Advice (RA)

The results of claims processing (including paid, denied, and pending claims) are listed on the RA.

Retroactive Eligibility

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

Sanction

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

Self Dialysis

Dialysis performed by an ESRD patient who has completed an appropriate course of training with little or no professional assistance.

Specified Low-Income Medicare Beneficiaries (SLMB)

For these members, Medicaid pays the Medicare premium only. They are not eligible for other Medicaid benefits, and must pay their own Medicare coinsurance and deductibles.

Spending Down

Members with high medical expenses relative to their income can become eligible for Medicaid by spending down their income to specified levels. The member is responsible for paying for services received before eligibility begins, and Medicaid pays for remaining covered services.

Staff-Assisted Dialysis

Dialysis performed by the staff of the center or facility.

Third Party Liability (TPL)

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

Timely Filing

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

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

Usual and Customary

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

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