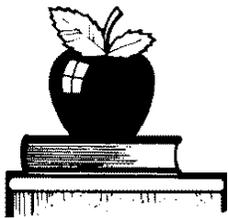
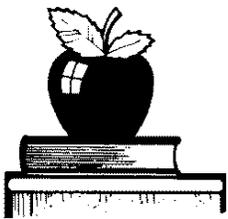
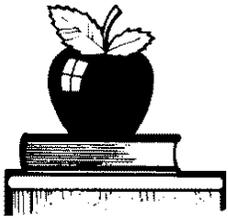
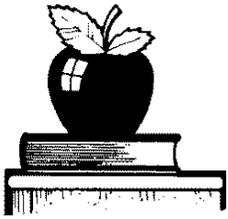
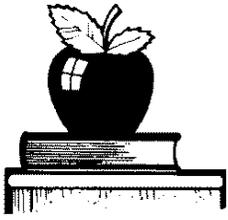

General Information for Providers

Medicaid and Other Medical Assistance Programs



This publication supersedes all versions of previous general information provider handbooks. This publication is to be used conjunction with provider type manuals. Published by the Montana Department of Public Health & Human Services, February 2002.

Updated September 2002, October 2003, September 2004, November 2004, April 2005, April 2008, February 2012, April 2012, June 2014, and July 2014.

CPT codes, descriptions and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS Apply.

Member Eligibility and Responsibilities

Medicaid ID Cards

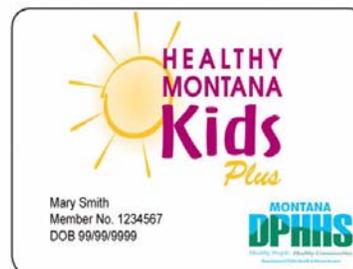
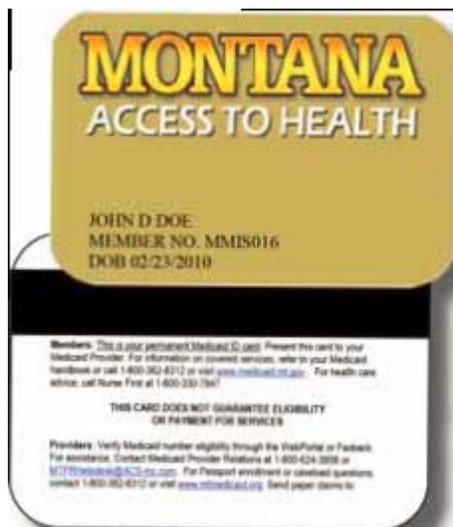
Each Medicaid member is issued his/her own permanent Montana Access to Health Medicaid ID card (including QMB only members), Healthy Montana Kids *Plus* (HMK *Plus*) card.

Members must never throw away the card, even if their Medicaid eligibility ends.

The ID card lists the member's name, member number, and date of birth. The member number may be used for checking eligibility and for billing Medicaid.

Since eligibility information is not on the card, providers must verify eligibility before providing services. See the Verifying Member Eligibility section below.

Providers should verify eligibility before providing services.



Verifying Member Eligibility

Member eligibility may change monthly, so providers should verify eligibility at each visit. Providers can check eligibility using any of the methods described in the following table.

Verifying Member Eligibility		
Contact	Information Available	Special Instructions
Member Eligibility Hours are Mountain Time. Providers may use whichever method they find most convenient.		
FaxBack 800-714-0075 Available 24/7	<ul style="list-style-type: none"> • Managed care and other restrictions • Member eligibility • Third party liability 	<ul style="list-style-type: none"> • Before using FaxBack, your fax number must be on file with Provider Relations. • Call FaxBack and enter your NPI/API, the member's ID, and specific dates of service. • When prompted, ask for the audit number or the transaction will not be completed.
Integrated Voice Response (IVR) 800-714-0060	<ul style="list-style-type: none"> • Amount of last payment to provider • Managed care and other restrictions • Member eligibility • Third party liability 	<ul style="list-style-type: none"> • Call IVR 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.
Local Offices of Public Assistance	<ul style="list-style-type: none"> • Member eligibility. 	<ul style="list-style-type: none"> • For local office information, see the website: http://www.dphhs.mt.gov/contactus/humancommunityservices.shtml
Montana Access to Health (MATH) Web Portal https://mtaccesstohealth.acs-shc.com Available 24/7	<ul style="list-style-type: none"> • Claim-based medical history • Electronic remittance advices • Managed care and service restrictions • Member demographics • Member eligibility • Member status history • Payment status • Provider enrollment • Third party liability 	<ul style="list-style-type: none"> • Before accessing the MATH web portal, you must be an enrolled Medicaid provider and complete the web portal registration online or by calling Provider Relations • From the Provider Information website, click on the Log in to Montana Access to Health link. • 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.
Provider Relations P.O. Box 8000 Helena, MT 59604 406-442-1837 800-624-3958 In/Out of state 406-442-4402 Fax 8 a.m.–5 p.m. Monday–Friday	<ul style="list-style-type: none"> • Amount of last payment to provider • Claim status • Enrollment status • Member eligibility • Prior authorization status • Service limits 	<ul style="list-style-type: none"> • Have NPI and member ID number ready when you call.
Presumptive Eligibility		
406-655-7683 8 a.m.–5 p.m. Monday–Friday	<ul style="list-style-type: none"> • Presumptive eligibility information 	<ul style="list-style-type: none"> • For information on presumptive eligibility, see http://medicaidprovider.hhs.mt.gov/providerpages/presumptivesindex.shtml • To become a provider who determines presumptive eligibility, call 406-655-7683.

The list below shows information returned to the provider in response to an eligibility inquiry:

- **Member's Medicaid ID number.** Used when billing Medicaid.
- **Eligibility status.** Medicaid eligibility status for the requested dates:
 - **Full Medicaid.** Member is eligible for all Medicaid covered services.
 - **Basic Medicaid.** Member is eligible for some Medicaid services.
 - **QMB.** Member is a qualified Medicare beneficiary. See When Members Also Have Other Insurance in this chapter.
 - **Team Care.** TC indicator means member is enrolled in the Team Care program. All services must be provided or approved by the designated Passport provider.
- **Designated provider.** The member's primary care provider's name and phone number are shown for members who are enrolled in Passport to Health or Team Care. In either case, all services must be provided or approved by the designated provider. See the Passport chapter in this manual.
- **TPL.** If the member has other insurance coverage (TPL), the name of the other insurance carrier is shown.
- **Medicare ID number.** A Medicare identification number for members who are eligible for both Medicaid and Medicare.

Member without Card

Since eligibility information is not on the card, it is necessary for providers to verify eligibility before providing services whether or not the member presents a card. Confirm eligibility using one of the methods shown in the Verifying Member Eligibility table. If eligibility is not available, the provider may contact the member's local Office of Public Assistance (OPA).

Newborns

Care rendered to newborns can be billed under the newborn's original Medicaid ID number assigned by the mother's local OPA until a permanent ID number becomes available. The hospital or the parents may apply for the child's Social Security number. Parents are responsible for notifying their local OPA when they have received the child's new Social Security number.

Inmates in Public Institutions (ARM 37.82.1321)

Medicaid does not cover members who are inmates in a public institution.

Presumptive Eligibility

Presumptive Eligibility is available to hospitals and their affiliated facilities that participate with Montana Medicaid. Personnel must be trained and certified to make Presumptive Eligibility determinations for short-term, temporary coverage for the following coverage groups:

- Adults between the ages of 18 and 26 who were in Foster Care and receiving Medicaid at age 18
- Healthy Montana Kids *Plus*
- Healthy Montana Kids
- Parent/Caretaker Relative Medicaid
- Pregnant Women (ambulatory prenatal care)
- Women between the ages of 19 and 64 who have been screened and diagnosed with breast or cervical cancer.

To encourage prenatal care, uninsured pregnant women may receive presumptive eligibility for Medicaid.

Presumptive eligibility may be for only part of a month and does not cover inpatient hospital services, but does include other applicable Medicaid services.

For more information about Presumptive Eligibility, training or certification, see the [Presumptive Eligibility](#) page:

Retroactive Eligibility

When a member is determined retroactively eligible for Medicaid, the member should give the provider a Notice of Retroactive Eligibility (160-M). The provider has 12 months from the date retroactive eligibility was determined to bill for those services.

Retroactive Medicaid eligibility does not allow a provider to bypass prior authorization requirements. See specific provider manuals for requirements.

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.

Institutional providers (nursing facilities, skilled care nursing facilities, intermediate care facilities for the mentally retarded, institutions for mental disease, inpatient psychiatric hospitals, and residential treatment facilities) must accept retroactively eligible member from the date eligibility was effective.

Non-emergency transportation and eyeglass providers cannot accept retroactive eligibility.

For more information on billing Medicaid for retroactive eligibility services, see the Billing Procedures chapter in the Medicaid billing manual for your provider type.