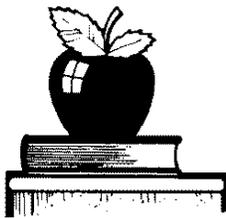
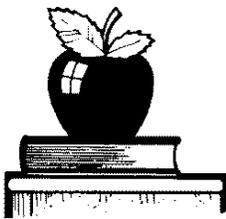
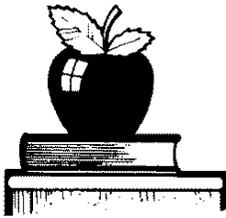
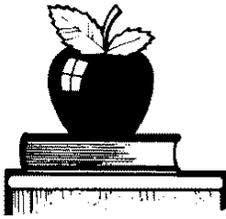
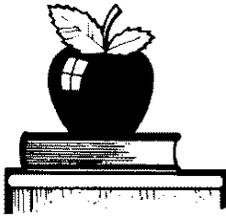

General Information for Providers

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.

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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 *Additional Medicaid Requirements for Passport Members* in the *Passport to Health Provider Handbook*, and the Medicaid billing manual for your specific provider type for more information on PA and Passport.

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

- Ambulance
- Anesthesiology
- Audiology
- Blood lead testing
- Case management services
- Dental
- Dialysis (home and freestanding)
- Durable medical equipment
- Emergency services
- Eye exams and eyeglasses
- Family planning
- Hearing exams and aids
- Home- and community-based services
- Home infusion therapy
- Home support services
- Hospice
- Hospital swing bed
- Immunizations
- Intermediate care facilities
- Laboratory/Pathology tests
- Licensed professional counselor
- Licensed social worker
- Mental health center services
- Nursing facilities
- Obstetrics
- Optometrists and ophthalmologists
- Personal assistance/Community First Choice services in a member's home

- Pharmacy (For Team Care members, providers are encouraged to write all Medicaid and HMK *Plus* prescriptions to the designated pharmacy)
- Psychiatric Residential Treatment Facilities
- Psychologists
- School-based services
- STD testing and treatment
- Substance dependency treatment
- Therapeutic Foster Care
- Transportation (commercial and specialized non-emergency)

Passport and Emergency Services (ARM 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 Montana Medicaid Provider Information [website](#) or in the Medicaid billing manual for your provider type.
- **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 an IHS or other provider as their Passport provider. Members who are eligible for IHS do not need a referral from their Passport provider to obtain services from an IHS. However, if IHS refers the member to a non-IHS provider, the Passport provider must provide a referral or Medicaid will not pay for the services.

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 Program Officer. See the *Passport to Health Provider Handbook* for a full review of complaints, administrative reviews and fair hearings.

Medicare Part A Claims

Medicare Part A carriers and Medicaid use electronic exchange of institutional claims covering Part A services. Providers must submit these claims 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.

Medicare Part B Crossover Claims

The Department has an agreement with the Medicare Part B carrier for Montana (Noridian) and the Durable Medical Equipment Regional Carrier (DMERC) under which the carriers provide the Department with claims for members who have both Medicare and Medicaid coverage. Providers must tell Medicare that they want their claims sent to Medicaid automatically, and must have their Medicare provider number on file with Medicaid.

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

Providers should submit Medicare crossover claims to Medicaid only when:

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

When submitting electronic claims with paper attachments, see the Billing Electronically with Paper Attachments section of the Billing Procedures chapter.

When submitting a claim with the Medicare EOMB, use Medicaid billing instructions and codes. Medicare's instructions, codes, and modifiers may not be the same as Medicaid's. The claim must also include the Medicaid provider number and Medicaid member ID number. It is the provider's responsibility to follow up on crossover claims and make sure they are correctly billed to Medicaid within the timely filing limit.

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 or 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 (when the services were billed to Medicaid) must be turned over to the Department. These words printed on the member's statement fulfill this obligation: *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 Crime Victim Compensation Program, providers must bill Medicaid first. These are not considered a third party liability.
- When a member has Medicaid eligibility and MHSP eligibility for the same month, Medicaid must be billed first.
- ICD prenatal and ICD preventive pediatric diagnosis conditions may be billed to Medicaid first. In these cases, Medicaid will “pay and chase” or recover payment itself from the third party payer.
- The following services may also be billed to Medicaid first:
 - Nursing facility (as billed on nursing home claims)
 - Audiology
 - Dental and dentist (as billed on dental claims)
 - Drugs (as billed on drug claims)
 - Eyeglasses
 - Hearing aids and batteries
 - Home and community-based services (waiver)
 - Optometry
 - Oxygen in a nursing facility
 - Personal assistance/Community First Choice
 - Transportation (other than ambulance)
 - If the third party has only potential liability, the provider may bill Medicaid first. Do not indicate the potential third party on the claim. Instead, notify the Department by sending the claim and notification to Third Party Liability, P.O. Box 5838, Helena, MT 59604.

Requesting an Exemption

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

Custom Agreement: A specific agreement that includes the dates of service, actual services or procedures, and the cost to the patient. It states the services are not covered by Medicaid and the member will pay for them.

Member Cost Sharing (ARM 37.85.204)

Cost sharing fees are a set dollar amount per visit 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 outpatient hospital services is \$5.00 per visit.

The following members are exempt from cost sharing:

- An Indian who has ever been seen at an Indian Health Service (IHS), an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U).
- 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)
- Institutionalized individuals for services furnished to any individual who is an inpatient in a hospital, skilled nursing facility, intermediate care facility or other medical institution if such individual is required to spend for the cost of care all but their personal needs allowance, as defined in ARM 37.82.1320.

Cost sharing may not be charged for the following services:

- Emergencies
- Eyeglasses purchased by the Medicaid program under a volume purchasing arrangement
- EPSDT services
- Family planning
- Hospice
- Independent laboratory and x-ray services
- Home dialysis attendant services
- Home and community-based waiver services
- Medicare crossover claim services where Medicaid is the secondary payer under ARM 37.85.406(18). If a service is not covered by Medicare but is covered by Medicaid, cost sharing will be applied.
- Nonemergency medical transportation services
- Personal assistance/Community First Choice services
- TPL claim services where Medicaid is the secondary payer under ARM 37.85.407. If a service is not covered by TPL but is covered by Medicaid, cost sharing is applied.



Cost sharing for hospital outpatient services is \$5.00 per visit.



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

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. A provider's policy on collecting delinquent payment from non-Medicaid members (if there is one) 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 Passport to Health and Prior Authorization chapters in this manual.

When completing a claim for members with Medicare and Medicaid, Medicare coinsurance and deductible amounts must correspond with the payer listed. For example, if the member has Medicare and Medicaid, any Medicare deductible and coinsurance amounts must be listed and preceded by an A1, A2, etc. Because these amounts are for Medicare, Medicare must be listed in the corresponding field. (See the Submitting a Claim section in this manual.)

Billing for Retroactively Eligible Members

When a member becomes retroactively eligible for Medicaid, the hospital 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, attach a copy of the Provider Notice of Eligibility (Form 160-M). To obtain this form, the provider should contact the member's Local Office of Public Assistance. See <http://www.dphhs.mt.gov/contactus/humancommunityservices.shtml>.

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 Tips

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. See the Coding Resources table.

For elective sterilizations, a completed Informed Consent to Sterilization (MA-38) form must be attached to the claim for each provider involved or payment will be denied. This form must be legible, complete, and accurate, and revisions are not accepted. It is the provider's responsibility to obtain a copy of the form from the primary or attending physician.

For medically necessary sterilizations, including hysterectomies, oophorectomies, salpingectomies, and orchiectomies, one of the following must be attached to the claim, or payment will be denied:

- A completed Medicaid Hysterectomy Acknowledgement form (MA-39) for each provider submitting a claim. It is the provider's responsibility to obtain a copy of the form from the primary or attending physician. Complete only one section (A, B, or C) of this form. When no prior sterility (Section B) or life-threatening emergency (Section C) exists, the member (or representative, if any) and physician must sign and date Section A of this form prior to the procedure. (See 42 CFR 441.250 for the federal policy on hysterectomies and sterilizations.) Also, for Section A, signatures dated after the surgery date require manual review of medical records by the Department. The Department must verify that the member (and representative, if any) was informed orally and in writing, prior to the surgery, that the procedure would render the member permanently incapable of reproducing. The member does not need to sign this form when Sections B or C are used.
- For members who have become retroactively eligible for Medicaid, the physician must certify in writing that the surgery was performed for medical reasons and must document one of the following:
 - The individual was informed prior to the hysterectomy that the operation would render the member permanently incapable of reproducing.
 - The reason for the hysterectomy was a life-threatening emergency.
 - The member was already sterile at the time of the hysterectomy and the reason for prior sterility.

When submitting claims for retroactively eligible members, for which the date of service is more than 12 months earlier than the date the claim is submitted, contact the member's local office of public assistance and request a Provider Notice of Eligibility (Form 160-M). Attach the form to the claim.

Supplies

Supplies are generally bundled, so they usually do not need to be billed individually. A few supplies are paid separately by Medicaid. The fee schedule on the website lists the supply codes that may be separately payable.

Submitting a Claim – Paper

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

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

On the CMS-1500, EPSDT/Family Planning, is used as an indicator to specify additional details for certain members or services. The following are accepted codes:

EPSDT/Family Planning Indicators		
Code	Member/Service	Purpose
1	EPSDT	Used when the member is under age 21
2	Family planning	Used when providing family planning services
3	EPSDT and family planning	Used when the member is under age 21 and is receiving family planning services
4	Pregnancy (any service provided to a pregnant woman)	Used when providing services to pregnant women
6	Nursing facility member	Used when providing services to nursing facility residents

Electronic Claims

Providers who submit claims electronically experience fewer errors and quicker payment. Claims may be submitted using the methods below.

- **WINASAP 5010.** Xerox makes this free software available to providers who may use it to submit claims for Montana Medicaid, MHSP, HMK (dental and eyeglasses only) and FQHC/RHC. It does not support submissions to Medicare or other payers. This software creates an 837 transaction, but does not accept an 835 transaction back from the Department.
- **Xerox EDI Solutions.** Providers can send claims to the Xerox clearinghouse (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.
- **Clearinghouses.** Providers can contract with a clearinghouse to send claims in whatever format the clearinghouse accepts. The provider's clearinghouse sends the claims to EDI Solutions in the X12 837 format. The provider's clearinghouse also needs to have their 837 transactions certified through EDIFECS before submitting claims to Xerox. EDIFECS certification is completed through EDI Solutions.
- **Montana Access to Health (MATH) Web Portal.** A secure website on which providers may view members' medical history, verify member eligibility, submit claims to Medicaid, check the status of a claim, verify the status of a warrant, and download remittance advice reports.

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